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My secret struggle: starving, purging, and numbing my emotions. An autoethnographic analysis of my lifelong battle with anxiety, depression, and eating disorders

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MY SECRET STRUGGLE: STARVING, PURGING, AND NUMBING MY EMOTIONS. AN AUTOETHNOGRAPHIC ANALYSIS OF MY LIFELONG BATTLE WITH ANXIETY, DEPRESSION, AND EATING DISORDERS

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by

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ABSTRACT

Adolescent females and young adult women between the ages of 12 and 25 are at a higher risk of engaging in self-destructive and life-threatening behaviors linked to anxiety, depression, and eating disorders when they do not have access to suitable treatment options or coping mechanisms (Garcia et al., 2020). This study highlights the heightened vulnerability of adolescent females and young adult women aged 12 to 25 who engage in self-destructive behaviors associated with anxiety, depression, and eating disorders when adequate treatment options or coping mechanisms are lacking. Through an autoethnographic approach, the researcher delves into her daily struggles and breakthroughs concerning these mental health issues, alongside her self-care practices, to explore their potential as catalysts for personal and communal change.

Analyzing 28 journal entries, 78 photographs, and 21 written materials spanning 33 years of her battle, the study uncovers recurring patterns such as societal pressures, perfectionism, control through food, and existential struggles that originated in youth and evolved through adulthood. The research identifies social-cultural factors, particularly Armenian cultural norms and family dynamics, as pivotal in shaping the researcher's mental health challenges. Despite numerous setbacks in recovery efforts, the study underscores the significance of perseverance and adaptive coping strategies, including structured planning, support groups, therapy, journaling, and mindfulness-based practices. Furthermore, it highlights the detrimental impact of low emotional intelligence and maladaptive coping mechanisms on the researcher's overall well-being and interpersonal relationships. Overall, the study offers a candid portrayal of enduring personal battles with anxiety, depression, and eating disorders, shedding light on the complexities of mental health struggles and the importance of resilience in overcoming them.

Keywords: Autoethnography, eating disorder, anxiety, depression, emotional intelligence

Chapter 1: Introduction

> My bed is the safest place, not only from the world but from myself. I do not want to be awake. I do not want to feel. I want to be numb. I am in so much pain, and I wish I could cry it out, but I cannot even get myself to cry. All I know is that I wish I could sleep away the pain. If I am asleep, I do not have to feel a thing. When I am awake, all I want to do is binge and purge away my emotions, and that is precisely what has been happening since I lost my job. I feel like my heart has been stabbed with a knife, and the pain is just ongoing. I feel hopeless, purposeless, unseen, unheard, unwanted, and disappointed. (Journal Entry, November 2023)

An eating disorder is a sneaky, manipulative, deadly beast that visits one day and never goes away. The beast is not always obvious, as an individual maintaining a healthy weight, such as myself, can be masking their ongoing battle with their deadly demons internally. From my perspective, an eating disorder is a beast that cannot be eliminated but can be tamed. I do not wish this curse upon any living human being. My earliest recollection of using food to numb my pain was around the age of four in kindergarten, when I locked myself in my locker and started eating chips because I felt alone. Since then, every single day has felt like a curse. My biggest wish would be to wake up one day free from anxiety, intense sadness, and obsessive thoughts of food: eating food, not eating food, where to find food, and how to hide my secret stash of food.

It was not until I began this research journey that I realized I was not alone. Researchers have determined that 15% of girls and women between the ages of 12 and

25 from middle to high-income countries are most susceptible to eating disorders (Garcia et al., 2020). To confound this issue, just less than 100% of individuals who are hospitalized for an eating disorder also have a co-existing mood or anxiety disorder (Tagay et al., 2013). While researchers have explored several treatment options and the effectiveness of these, little is known about long-term treatments that are not experimental and time-bound. Therefore, the following study will focus on my 33-year battle with anxiety, depression, and eating disorders, including significant transformative events regarding struggles and triumphs from childhood to the present day. I will take the reader through significant events in my formative years, school, adolescence, teenage years, adulthood, family life, marriage, divorce, bodybuilding, and entering the workforce. Within these specific events, anxiety and depression were triggered, which initiated the onset of my eating disorders, including anorexia nervosa, binge eating disorder, and bulimia nervosa. I will be highly raw, candid, and vulnerable as I reflect on the triggers and influential life events as in Muncey's (2005) autoethnographic portrayal of her life and Tillman's (2009) autoethnographic portrayal of her battle with bulimia nervosa. For most of my life, my eating disorder was my most significant source of shame. However, I now seek to utilize my weakness as my strength to provide hope, inspiration, and a new perspective for readers who struggle with anxiety, depression, eating disorders, and mental illness daily.

Background and Context

In 2021, about 57.8 million people in the United States, namely 22.8%, encountered a significant mental health illness, including severe anxiety, depression, or eating disorders, of which 7.6% (19.4 million) of the cases were co-occurring (Vahratian

et al., 2021). According to The Diagnostic and Statistical Manual of Mental Health Disorders, 5th Edition (DSM-V) (Sarmiento & Lau, 2020), mental disorders include (a) eating disorders, (b) generalized anxiety disorder (GAD), (c) panic disorder, (d) social anxiety disorder, (e) stress, (f) major depressive disorder, (g) persistent depressive disorder, and (h) specific phobias. Phobias consist of obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). Reeves et al. (2011) defined mental illness as "characterized by sustained, abnormal alterations in thinking, mood, or behavior associated with distress and impaired functioning" (p. 2). Often, the individual suffering from a mental disorder will show no outward signs of their disability.

According to the DSM-V (Sarmiento & Lau, 2020), GAD is characterized by extreme worry and anxiety on many topics for at least six months. GAD can also be described as uncontrollable and extreme worry about several issues without stimuli (Gottschalk & Domschke, 2017). This uncontrollable and excessive worry often stems from intense fear tied to an emotional trigger starting from childhood. According to Dymond et al. (2015), 25% of children suffer from anxiety disorders, which affect their performance in school, increase substance abuse, and affect social functioning. Factors such as family environment, daily stressors, and natural disasters are all considered emotional triggers (Gottschalk & Domschke, 2017). It is also important to note that anxiety and depressive disorders are twice as likely to occur in women compared to men (Facts & Statistics, n.d.; Bekker & Van Mens-Verhulst, 2007; Kessler et al., 2005; Seedat et al., 2009; Women & Anxiety, 2023; Women & Depression, 2023). The following section will discuss facts and statistics regarding the increased prevalence of

anxiety and depressive disorders in women compared to men and the scientific research to support these findings.

Prevalence of Anxiety and Depression in Women

The current global statistics regarding anxiety and depression suggest that most of these mood disorders are not only a worldwide issue but that women are twice as susceptible than men in struggling with these mental health battles (Facts & Statistics, n.d.; Bekker & Van Mens-Verhulst, 2007; Kessler et al., 2005; Seedat et al., 2009; Women & Anxiety, 2023; Women & Depression, 2023). According to the American Depression and Anxiety Association of America (ADAA), approximately 374 million individuals globally are affected by anxiety disorders (Facts & Statistics, n.d.; Women & Anxiety, 2023). From the onset of puberty until the age of fifty, females have a significantly higher likelihood of receiving a diagnosis of an anxiety illness throughout their lifespan, approximately twice as much as their male counterparts (23.4% in females and 14.3% in males; Bahrami & Yousefi, 2011; Facts & Statistics, n.d.; McHenry et al., 2014; Women & Anxiety, 2023). Similarly, the prevalence of depression among women (10.4%) is twice that of men (5.5%; McHenry et al., 2014; Seedat et al., 2009; Women & Depression, 2023). Hence, there is a substantial body of research supporting the existence of widespread sex differences in pathological illnesses, such as anxiety and depressive disorders, with females exhibiting a prevalence rate more than twice that of males (Facts & Statistics, n.d.; Bekker & Van Mens-Verhulst, 2007; Kessler et al., 2005; Seedat et al., 2009; Women & Anxiety, 2023; Women & Depression, 2023).

Several researchers have found that sex differences in mood disorders are primarily hormone-dependent (McHenry et al., 2014; Rainville & Hodes, 2018). The observed discrepancy in mood disturbances between genders could be attributed to the influence of gonadal hormones, which play a significant role in developing anxiety and depressive disorders (McHenry et al., 2014; Rainville & Hodes, 2018). Research findings indicate that women are prone to experiencing mood disturbances, anxiety, and depression during periods characterized by hormonal fluctuations, including puberty, menopause, perimenstrual phases, and post-partum periods (Ahokas et al., 2001; Parker & Brotchie, 2004; Douma et al., 2005; Solomon & Herman, 2009). While mood problems in females seem to be influenced by hormonal fluctuations, research conducted on both clinical and preclinical levels indicates that testosterone may have protective effects against anxiety and depression in males affected by the organizational activation actions of testosterone (McHenry et al., 2014; Rainville & Hodes, 2018). Therefore, hormones play a significant role in the higher prevalence of mood disorders in women versus men, as the protective effects of testosterone may decrease the probability of anxiety and depressive symptoms in men (McHenry et al., 2014; Rainville & Hodes, 2018).

Depression General Facts

Like anxiety, depression is also a common mental disorder that affects more than 280 million people in the world, with 50% more commonality in women compared to men (World Health Organization (WHO) 2023). Moreover, depression currently affects a significant portion of the population in the United States, with over 21 million adults experiencing this mental health condition. Among adolescents, major depression is

reported in approximately 3.7 million individuals aged 12 to 17, while about 2.5 million individuals experience severe depression within the same age group (WHO, 2023). According to the Centers for Disease Control and Prevention (CDC) (Vahratian et al., 2021), the COVID-19 pandemic has been found to increase mental health disorders. Between August 2020 and February 2021, there was a notable increase in the proportion of individuals who were diagnosed with either anxiety or depressive disorder (Vahratian et al., 2021). Specifically, the percentage rose from 36.4% to 41.5%. It is worth mentioning that the most significant increments were observed within the age group of 18 to 29 years (Vahratian et al., 2021). The current global depression statistics suggest that depression affects a substantial portion of the world population, with a 50% higher prevalence in women than men.

Eating Disorders

Eating disorders encompass disturbed and abnormal eating habits (Fragkos & Frangos, 2013), as identified by the DSM-V (Sarmiento & Lau, 2020). Three specific disorders are bulimia nervosa, anorexia nervosa, and binge eating disorder, each characterized by specific criteria and behaviors. A diagnosis of bulimia nervosa is dependent upon criteria such as frequent episodes of binge eating while lacking control over the eating. These behaviors are followed by frequent compensatory self-destructive behaviors to prevent weight gain, including laxative and diuretic abuse, self-induced vomiting, over-exercising, and judging oneself based on weight and physical appearance (Levinson et al., 2017; Mehler & Rylander, 2015). Anorexia nervosa is described as restricting food intake due to an extreme fear of becoming fat or gaining weight while being underweight (Bora & Köse, 2016). Binge eating disorder includes

frequent episodes of binge eating without compensatory self-destructive behaviors to prevent weight gain (Agh et al., 2015; Mehler & Rylander, 2015). Relatively little is known about the prevalence and connection of anxiety disorders to depression and eating disorders and how individuals cope with these mental battles. The Anxiety and Depression Association of America (ADAA; Facts & Statistics, n.d.) states that nearly half of those who suffer from depression also suffer from anxiety. According to research, the comorbidity between anxiety disorders, depression, and eating disorders is high (Becker et al., 2014; Hughes et al., 2013). Several researchers have determined that anxiety and depression are co-occurring and highly correlated (Brand-Gothelf et al., 2014; Bühren et al., 2013; Godart et al., 2015). Hence, with most of the research on anxiety, depression, and eating disorders being quantitative, researchers have called for more qualitative research on individuals' coping processes and experiences (DeBar et al., 2013; Marzilli et al., 2018; Hilbert et al., 2019; Moghimi et al., 2022; Wagner et al., 2016).

Problem Statement

Approximately 97% of people hospitalized for an eating disorder have a coexisting mood disorder, such as major depressive disorder or anxiety disorder, including but not limited to obsessive-compulsive disorder, post-traumatic stress disorder, and substance abuse disorder (Tagay et al., 2013). Eating disorders affect 15% of young women in middle to high-income countries (Garcia et al., 2020). Girls and women, specifically between the ages of 12 and 25, struggle daily with this condition's mental, physical, and emotional side effects and challenges, which can have life-threatening consequences (Garcia et al., 2020). Hence, eating disorders affect a

considerable percentage of young women, leading to potentially life-threatening consequences. The lack of adequate treatment options and coping mechanisms increases the risk of relapse into self-destructive behaviors.

The statistics surrounding eating disorders are essential given the fact that eating disorders are one of the deadliest mental illnesses, resulting in 10,200 deaths yearly (Giachin, 2023; Smink et al., 2012). Although eating disorder treatment is available through psychologists, psychiatrists, and treatment facilities, insurance companies do not adequately cover eating disorder treatment costs (Agh et al., 2015; Isserlin et al., 2020; Toulany et al., 2015). Without proper treatment options or coping mechanisms, women aged 12 to 25 are at a higher risk of relapsing into self-destructive and life-threatening patterns caused by anxiety, depression, and eating disorders (Garcia et al., 2020). For these reasons, exploring young women's coping mechanisms related to combating the life-threatening effects of anxiety, depression, and eating disorders is crucial.

While researchers have determined that anxiety, depression, and eating disorders (i.e., anorexia nervosa, bulimia nervosa, and binge eating disorder) co-occur, there is a paucity of research detailing real-life models of inspiration and motivation to support young girls and women who are struggling with an onset of anxiety, depression, and eating disorders (Levinson et al., 2017). For years, researchers have called for more research concerning the comorbidity of GAD, depression, and eating disorders due to the life-threatening situations that arise for women (Fichter & Quadflieg, 2016); Smink et al., 2012; Tagay et al., 2013). By providing real-life models of coping mechanisms, the potential exists for women ages 12 to 25 to gain the skills, inspiration,

and motivation to combat the onset of life-threatening experiences from anxiety, depression, and eating disorders.

> How the heck am I supposed to get rid of this “lack of breath” 24/7? I feel like I am suffocating in my skin, constantly fighting to stay afloat as my mind races over my lack of money, a failed competition, my old coaches telling me I will never amount to anything, and that I was not made for bodybuilding. I lack purpose, direction, and a sense of being. My home is also a significant factor in my inability to breathe. I know I need a lot of help. I do not know if I am going to survive this process. I feel hopeless, despondent, powerless. I feel like utter death. (Journal Entry, December 2020)

The problem statement highlights the significant prevalence of coexisting mood disorders alongside eating disorders, particularly among hospitalized individuals. It emphasizes the impact of eating disorders on young women aged 12 to 25, detailing the mental, physical, and emotional challenges they face, which can lead to life-threatening consequences. Additionally, it underscores the lack of adequate insurance coverage for eating disorder treatment, increasing the risk of relapse into self-destructive behaviors. Moreover, it points out the scarcity of research addressing coping mechanisms for individuals grappling with the onset of anxiety, depression, and eating disorders.

Purpose Statement and Research Questions

The purpose of the autoethnographic study is to explore the researcher's daily battles and triumphs with anxiety, depression, and eating disorders, along with their self-care patterns, to understand their potential as agents of change. Research questions aim to delve into the manifestations of these battles in different life areas and

their contribution to personal growth and inspiring others. The daily battles that come with the comorbidity of anxiety, depression, and eating disorders include but are not limited to starvation, binge eating, and binge and purging behaviors (e.g., self-induced vomiting, laxative abuse, and over-exercising). Self-care patterns consist of journaling, daily exercise, following a structured meal plan, attending peer support groups such as Overeaters Anonymous (OA), regular communication with an OA sponsor, and engaging in mindfulness and energy healing practices (i.e., reiki, yoga, meditation).

The research questions guiding this study are as follows:

- *RQ1:* What are the daily battles and triumphs that arise with the comorbidity of anxiety, depression, and eating disorders?
- *RQ 2:* In what ways (if any) have these daily battles and triumphs manifested in different areas of my personal and professional life?
- *RQ 3:* How might the battles and triumphs experienced with the comorbidity of anxiety, depression, and eating disorders contribute to becoming a change agent in my life, other individuals struggling with similar life challenges, and future researchers?

Rationale of Methodology

Autoethnography is a qualitative research design that emphasizes personal experiences to expand sociological understanding (Wall, 2008). Autoethnographers aim to connect the past with the present through personal, political, social, cultural, and transpersonal means (Chapman-Clarke, 2016). The associated writing style is called self-narrative and is unique due to its authentic, passionate, and emotional nature (Ellis et al., 2011). In these processes, the author's complete vulnerability is essential.

Regarding the proposed autoethnography, the researcher chose to display utmost vulnerability with her struggles because she believes that total exposure of her innermost thoughts, self-destructive behaviors, and patterns of self-care leading to abstinence of these behaviors can help inspire, motivate, and give hope to all those who can relate to her story. According to Reed-Danahay (1997), autoethnography emphasizes -*auto*, which refers to the self, -*ethno*, which refers to the sociocultural connection, and -*graphy*, which refers to the research writing processes. These unique counterparts distinguish autoethnography from all other forms of qualitative research. Autoethnographic researchers seek to critique their own experiences to gain awareness and insight while connecting content from the literature to their personal experiences surrounding the phenomenon (Holt, 2003; Sparkes, 1996; Wall, 2008). Through this study, the researcher seeks to address the paucity of research exploring individual processes by providing an in-depth, personal perspective. The researcher also aims to provide tools and inspiration for others to combat these self-destructive patterns of eating disorders in connection to anxiety disorders and depression.

Jones et al. (2013) described autoethnography as more than "a way of knowing" in this world. Autoethnography is a "*way of being in the world that requires living consciously, emotionally, and reflexively. It asks that we examine our lives and consider how and why we think, act, and feel as we do*" (Jones et al., 2013, p. 10). Speaking to the processes of autoethnography, Jones explained that:

> We observe ourselves, interrogate what we think and believe, and challenge our assumptions, asking repeatedly if we have penetrated as many layers of our defenses, fears, and insecurities as our project requires. It asks that we rethink

> and revise our lives, making conscious decisions about who and how we want to be. Moreover, in the process, it seeks a hopeful story, where authors ultimately write themselves as survivors of the story they are living. (p.10)

Hence, in the process of self-reflection, the researcher will engage in the act of witnessing her observations, critically examining her thoughts and beliefs, and actively questioning her underlying assumptions about her lifelong battle with comorbid anxiety, depression, and eating disorders (i.e., anorexia nervosa, bulimia nervosa, and binge eating disorder). In this iterative process, the researcher will continuously evaluate how much she has delved into the many layers of her personal defenses, anxieties, and insecurities. This self-reflective analysis has driven her to reconsider and modify her lifestyle and deliberately make choices based on her desired identity and behavior. Furthermore, during this process, the researcher aims to construct a personal narrative that is optimistic, wherein she finally portrays herself as an individual who has overcome the challenges presented by her battle with comorbid anxiety, depression, and eating disorders.

Significance of Study

The significance of this autoethnographic research has many layers. The primary importance of this study is that there is a lack of autoethnographic research intersecting anxiety, depression, and eating disorders in the current literature (Levinson et al., 2017). With the first-hand, raw, personal accounts of this self-narrative, individuals who suffer from the same or similar mental illnesses may relate and benefit in terms of their recovery journey. Further, this autoethnography has the potential to contribute to the field by showing the personal details that have been omitted from the research until

now. Through this vulnerable, personal perspective, the researcher might open the door for people with similar or different struggles to come forth and write their self-narratives; thus, more knowledge will be gained in the field. Finally, the goal of this autoethnography is to be a catalyst for change for all those who not only suffer from anxiety, depression, and eating disorders but also those who struggle with mental illness in general.

This research is unique, given the methodology and research design regarding mental health research. Custer (2014) argued that autoethnography is a transformative research process due to its vulnerable, empathetic, creative, innovative, and therapeutic nature. With the researcher being the only research subject of the manuscript, the data and findings will embody her unique living experience, which has the potential to benefit others seeking relief from similar struggles.

Theoretical Framework Overview

This autoethnography underpins the Self-Determination Theory (SDT; Deci & Ryan, 1985; Ryan & Deci, 2008), which serves as the foundational framework for intrinsic motivation. While people possess inherent motivational tendencies, studies have indicated that these tendencies require nurturing and reinforcement in conducive environments, as they might be susceptible to disruption caused by unfavorable settings (Ryan & Deci, 2008). Hence, the self-determination theory emphasizes the conditions that prompt and maintain intrinsic drive rather than hinder and diminish it (Ryan & Deci, 2008).

Ryan and Deci (2008) propose that researchers employ the Self-Determination Theory (SDT) to examine individuals' motivation and the psychological demands of

competence, autonomy, and relatedness. Essentially, individuals can become self-determined by fulfilling their need for competence, autonomy, and relatedness. According to Deci and Ryan (2000), engaging in autonomous regulation, which refers to behaving out of one's own volition or choice, has enhanced overall well-being. According to Deci and Ryan (2000), engaging in behaviors characterized by a lower degree of external control and a higher degree of self-endorsement can result in heightened levels of personal commitment, persistence, positive affect, and mental well-being. For instance, research has indicated that individuals actively seeking eating disorder treatment to achieve recovery demonstrate higher levels of treatment compliance (Zeldman et al., 2004). Additionally, these individuals experience a decrease in depressive symptoms (Zuroff et al., 2007) as well as a reduction in disordered eating symptoms associated with bulimia nervosa (Mansour et al., 2012) and anorexia nervosa (Mask & Blanchard, 2011; Rieger et al., 2000; Vandereycken & Vansteenkiste, 2009). The incorporation of the self-determination theory is crucial for the proposed autoethnography due to its association with the researcher's personal drive, self-determination, and perseverance in confronting her enduring struggle with comorbid anxiety, depression, and eating disorders. A comprehensive examination of the topic of self-determination theory will be provided in Chapter Four of this research endeavor.

Self-Determination Theory and the Comorbidity of Anxiety, Depression, and Eating Disorders.

The present study explores the relationship between Self-Determination Theory and the recovery process from comorbid conditions, including anxiety, depression, and

eating disorders. The inclusion of the self-determination theory is of utmost importance in our present investigation due to its fundamental role in the researcher's journey of eating disorder recovery. This process heavily relies on an individual's motivation and willingness to engage in recovery efforts (Bégin et al., 2018; Pelletier & Dion, 2007; Ryan et al., 2010; Van Der Kaap-Deeder et al., 2014; Vansteenkiste et al., 2005). Furthermore, the researcher's autoethnographic account in Chapter Four serves as a concrete demonstration of this phenomenon. The decision of the researcher to engage in the process of recovery stems from the recognition that her eating disorder has adverse effects on various vital aspects of her life, such as education, career, and intimate relationships. This acknowledgment serves as a strong motivation for the researcher's commitment to pursue treatment. According to Van Der Kaap-Deeder et al. (2014), those who have fully acknowledged the significance of recovery are more inclined to have a proactive inclination toward pursuing recovery. Therefore, individuals should advocate the pursuit of rehabilitation personally rather than being compelled to do so.

Furthermore, numerous studies have demonstrated that self-endorsed change is associated with enhanced treatment compliance (Zeldman et al., 2004), a decrease in depressive symptoms (Zuroff et al., 2007), and a reduction in eating-related preoccupation in individuals diagnosed with bulimia nervosa (Mansour et al., 2012). Previous studies have also found that individuals with anorexia nervosa who exhibit higher levels of self-endorsed motivation for recovery from eating disorders tend to have a higher body mass index (BMI; Mask & Blanchard, 2011; Rieger et al., 2000; Vandereycken & Vansteenkiste, 2009). Hence, implementing autonomous regulation in

eating disorder recovery is paramount in mitigating symptomatology. The Self-Determination Theory and its connection to the proposed autoethnography will be discussed in further detail in Chapter Two.

Assumptions

This autoethnography is framed around the following key assumptions:

- A primary assumption of this study is that within the researcher's personal accounts (i.e., data), there are both battles and triumphs related to the comorbidity of anxiety, depression, and eating disorders.
- I will be reflexive about the data regarding my battles and triumphs with anxiety, depression, and eating disorders during the data analysis and writing up of the findings.
- My recollections regarding my personal experiences will be as accurate as possible due to the nature of the research.
- I thoroughly understand the qualitative/autoethnographic methodology to conduct the following autoethnography.
- Another assumption of mine is that other individuals and future researchers will read and learn from the research.

Limitations

Autoethnographic research necessitates careful consideration of certain constraints. For example, the reader may experience unpleasant feelings, and it is impossible to predict and regulate their connection to the research (Bochner & Ellis, 1996). The autoethnography has a profound level of vulnerable and sensitive information, which has the potential to evoke both triggering and inspiring effects on

readers who share a personal connection with the author's narrative. One limitation is the revelation of the researcher's thoughts and emotions, necessitating openness, susceptibility, and readiness to disclose oneself (Ellis & Bochner, 2000; Méndez, 2014). Concerning the proposed autoethnography, the researcher experienced a significant challenge in reconciling the notion of vulnerability and openness with her mental difficulties, given the deeply intimate nature of the subject matter.

Another challenge associated with autoethnographic writing pertains to the inherent inaccuracy of memory recollection. It is widely acknowledged that memory is prone to inaccuracies and unreliability, particularly when recounting a personal experience that transpired some years ago (Ellis et al., 2011). Ellis (2007) emphasizes that autoethnography possesses subjectivity and bias, which is accurate, yet this characteristic should be seen as one of its merits. Autoethnography openly welcomes bias, as one of its fundamental principles is the refusal to adhere to impartiality. Autoethnography unapologetically accepts bias, as it is rooted in the fundamental principle of rejecting objectivity (Ellis, 2007).

Lastly, the proposed autoethnography is based solely on one person (i.e., the researcher), and as such, there is a finite limit to what any person can experience. Moreover, the researcher's experience with the comorbidity of anxiety, depression, and eating disorders may be particularly unique from others. Therefore, using autoethnography as a research methodology presents a formidable challenge due to the limitations mentioned in this section, thereby giving rise to many ethical concerns that can be quite arduous for the researcher to navigate (Méndez, 2014).

Definitions of Terms

To provide the requisite, formal background of the phenomenon being explored, the following keywords have been defined:

Comorbidity: Comorbidity is the presence of one or more conditions or disorders in a person (Valderas et al., 2009). Concerning this study, anxiety, depression, and eating disorders co-occur with high comorbidity among these three.

Eating Disorders: Eater disorders are psychosomatic disorders with lifetime mortality and high death rates (Friederich et al., 2013). Characteristics include self-induced starvation, self-induced binging and purging of food, and substance abuse such as diuretics or diet pills. The individual usually has an intense fear of becoming fat (Facts & Statistics, n.d.). Eating disorders are said to be a symptom of underlying root causes.

Generalized Anxiety Disorder (GAD): GAD is a future-oriented state or mood, anticipating possible adverse events. GAD is a disabling disease characterized by excessive and uncontrollable fear and worry over future events and the overestimation of adverse outcomes (Hirsch et al., 2013). Individuals battling GAD describe this condition as the inability to breathe, suffocation, or the feeling of having a heart attack. Diagnosis is initiated if the uncontrollable fear and worry persist for at least six months or longer, with at least three or more symptoms (Facts & Statistics, n.d.).

Major Depressive Disorder (MDD): According to the Anxiety and Depression Association of America (ADAA; Facts & Statistics, n.d.), MDD is characterized as experiencing five out of the nine significant symptoms, which include extreme sadness and loss of interest in normal daily activities, appetite fluctuations, excessive sleep, trouble sleeping, fatigue, feelings of guilt, feelings of worthlessness, suicidal thoughts,

inability to function in a social setting. These symptoms must persist for two weeks or longer (Facts & Statistics, n.d.). Concerning the researcher's account of depression, the condition can be rather debilitating and paralyzing.

Summary

Chapter One introduced a brief background concerning the comorbidity of anxiety, depression, and eating disorders in adolescent girls and women. The rationale for choosing autoethnography is discussed, depicting the researcher's personal account of struggling with comorbid anxiety, depression, and eating disorders. Furthermore, the purpose of this study is detailed with an emphasis on exploring how the researcher's daily battles with anxiety, depression, and eating disorders combined with her patterns of self-care can be used as a source of positive change and inspiration in her life and others. The significance of the study included the current lack of autoethnographic studies connecting anxiety, depression, and eating disorders in adolescent girls and women in the existing literature (Levinson et al., 2017).

It is also important to note that although the statistics suggest that adolescent girls and women between the ages of 12 and 25 are most susceptible to eating-disordered behavior, the current autoethnography begins with the researcher's awareness of eating-disordered behavior starting at the age of four. The researcher intends to emphasize her awareness of using food as a source of comfort prior to the onset of significant eating disorders, such as anorexia nervosa, at the age of 11, as detailed in Chapter Four.

Chapter Two consists of an extensive review of current literature discussing the treatment of anxiety, depression, and eating disorders in adolescent girls and women.

Additionally, due to the high rate of relapse of eating disorders after clinical treatment (Berends et al., 2016; Filipponi et al., 2022; Sacchetti et al., 2019), the efficacy of adaptive coping mechanisms, including peer support groups and mindfulness practices are also discussed.

Chapter 2: Literature Review

> I feel weak, and my anxiety is intense and unbearable. I cannot breathe, and I fear the day ahead. I fear the self-destructive beast that is going to rear its ugly head. The first thing I think about when I wake up is food. I feel powerless and ashamed over my lack of control over this disease. It feels like I am a ticking time bomb about to explode at any minute. I am scared to death. I am afraid of myself. Praying for strength! (Journal Entry, May 2020)

Background: Eating and Mood Disorders

According to the National Institute of Mental Health (NIMH; Eating Disorders, 2023), eating disorders are severe and fatal illnesses that seriously interfere with a person's eating habits. The most common eating disorders include bulimia nervosa, binge eating disorder, and anorexia nervosa (Eating Disorders, 2023). Eating disorders are psychosomatic disorders with lifetime mortality and high death rates (Friederich et al., 2013). They are characterized by self-induced starvation, self-induced binging and purging of food, substance abuse such as diuretics or diet pills, obsession with food and body weight, and an intense fear of becoming fat (Bora & Köse, 2016). According to Bora and Köse (2016), eating disorders are a symptom of underlying root causes, which can impair social functioning due to cognitive deficits (Bora & Köse, 2016). The following section will provide a thorough breakdown of definitions, facts, and current statistics concerning the eating disorders (i.e., anorexia nervosa, bulimia nervosa, and binge eating) and mood disorders (i.e., generalized anxiety disorder and major depressive disorder) relevant to our dissertation.

Multimorbidity

Regarding the overlapping chronic health conditions discussed in this research, such as anorexia, bulimia, binge eating disorder, anxiety, and depression, it is best to define “multimorbidity.” Multimorbidity, also known as multiple long-term conditions (MLTC) (NIHR, 2023), is identified as the co-occurrence of two or more chronic conditions (Almirall & Fortin, 2013; Navickas et al., 2016; Van Den Akker et al., 1996) and interactions between illnesses that can aggravate the course of both (Hughes et al., 2013). These conditions are usually long-term and complex (Navickas et al., 2016). According to Violan et al. (2014), people with long-term conditions generally have multiple simultaneous conditions. In 2007, Sawyer et al. identified that people at risk for long-term health conditions, such as mental health disorders, are increasing. Due to this rapid growth, multimorbidity is used interchangeably in the scientific literature with comorbidity, polymorbidity, polypathology, pluripathology, multipathology, and multiconditon (Almirall & Fortin, 2013). However, it must be noted that comorbidity refers to two coexisting, co-occurring chronic conditions (Garcia et al., 2020; Hughes et al., 2013; Valderas et al., 2009). While comorbidity only refers to two coexisting or co-occurring chronic conditions, this term is still used interchangeably with other medical terms that refer to experiencing multiple simultaneous conditions. Hence, understanding the comorbidity and multimorbidity is essential for understanding the comorbidity of anxiety, depression, and eating disorders in my current autoethnography.

Facts and Definitions Regarding Anorexia Nervosa

Anorexia nervosa is a severe eating disorder characterized by distorted body image and set beliefs about being overweight (Bora & Köse, 2016). The National Institute of Mental Health (NIMH) (Eating Disorders, 2023) defines anorexia nervosa as

the relentless pursuit of thinness, involving deliberate, persistent, and significant food restriction and exercising, leading to dangerously low body weight in terms of sex, age, and physical health (Bora & Köse, 2016; Eating Disorders, 2023). Individuals with anorexia nervosa tend to weigh themselves obsessively and consider themselves overweight despite their dangerously low body weight. Symptoms include highly restrictive eating patterns, emaciation, resistance to maintaining a healthy body weight, self-worth that is heavily dependent upon perceptions of body shape and weight, and denial of dangerously low body weight (Bora & Köse, 2016; Eating Disorders, 2023). Anorexia nervosa is categorized into the “restrictive” subtype and “binge-purge” subtype. Concerning the “restrictive” subtype, individuals drastically limit the type and amount of food consumed. With the “binge-purge” subtype, individuals restrict food intake while engaging in binge eating and purging episodes (Eating Disorders, 2023). Considering anorexia nervosa as one of the major eating disorders discussed in my current autoethnography, understanding the facts and definitions of anorexia nervosa is critical in understanding the impact the eating disorder had on the researcher.

Facts and Definitions Regarding Bulimia Nervosa

Bulimia nervosa is an eating disorder characterized by frequent and reoccurring episodes of consuming a large amount of food within any 2-hour period, where the individual feels a sense of loss of control, followed by *compensating behavior* such as self-induced vomiting (Mehler & Rylander, 2015). Compensatory behavior also may include excessive use of diuretics or laxatives, starvation, or excessive exercise (Mehler & Rylander, 2015). While the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) stated that bulimia nervosa is diagnosed if the individual

engages in binge eating and uses compensatory behaviors at least two times per week for three months, the diagnostic criteria changed in the DSM-V criteria to binge eating and using compensatory behaviors is required at least one time per week for three months for the diagnosis (SAMHSA, 2016). Like anorexia nervosa, the standard behavior of bulimia nervosa includes over-evaluation of weight and shape, fear of weight gain, and avoidance of food (SAMHSA, 2016; Mehler & Rylander, 2015). Unlike anorexia, individuals with bulimia can be underweight, average, or overweight (Levinson et al., 2017; Eating Disorders, 2023). According to Levinson et al. l. (2017), people with bulimia can experience the alleviation of anxiety and then an immense sense of guilt after their frequent episodes. Hence, this binge-purge behavior becomes a vicious pattern. According to the DSM-V, bulimia nervosa severity is identified by mild, moderate, and severe criteria. Mild severity is characterized by an average of 1 to 3 episodes of inappropriate compensatory behavior per week. Moderate severity is characterized by an average of four to seven episodes of inappropriate compensatory behavior per week. Severe severity is characterized by an average of eight to 13 episodes of inappropriate compensatory behavior per week. Extreme severity is characterized by an average of 14 or more episodes of inappropriate compensatory behavior per week (SAMHSA, 2016). The following autoethnography will discuss bulimia nervosa as one of the dominating eating disorders of the researcher. Therefore, understanding the facts and definitions regarding bulimia nervosa is essential in comprehending the eating disorder's impact throughout the researcher's life.

Facts and Definitions Regarding Binge Eating Disorder

According to the National Institute of Mental Health (NIMH; Eating Disorders, 2023) and the National Institute of Health (NIH; Berkman, 2023), binge eating disorder is an eating disorder where individuals lose control over their eating and frequently consume enormous quantities of food within two hours. Unlike bulimia nervosa, binge eating episodes are not followed by compensatory behavior such as fasting, purging, or excessive exercise. Subsequently, individuals with binge eating disorders are usually obese or overweight. This disorder is the most common eating disorder in the United States (Eating Disorders, 2023). According to DSM's IV and V (Berkman, 2023), binge eating episodes include eating more rapidly than usual; eating until uncomfortably full; eating excessive amounts of food when no physical hunger is present; isolating during binge eating episodes due to fear of embarrassment; and feelings of depression, guilt, and disgust with oneself after overeating (Berkman, 2023).

Regarding the frequency and duration criteria, the DSM-IV requires binge eating episodes at least two days a week for six months, while the DSM-V requires at least one day a week for three months (Berkman, 2023). While a binge eating disorder severity scale was not applicable in the DSM-IV, the DSM-V includes a severity scale ranging from mild (1 to 3 episodes weekly), moderate (4 to 7 episodes weekly), severe (8 to 13 episodes weekly), and extreme (14 or more episodes weekly) (Berkman, 2023). The following dissertation will discuss binge eating disorder as a prominent struggle in the researcher's adolescence and adulthood. Therefore, understanding the facts and definitions regarding binge eating disorder is crucial in understanding the impact the eating disorder had throughout the researcher's life.

Facts and Definitions Regarding Generalized Anxiety Disorder (GAD)

According to the National Institute of Health (NIH; SAMHSA, n.d.-a), DSM's IV and V define Generalized Anxiety Disorder (GAD) as excessive anxiety and uncontrollable worry or "apprehensive anticipation," arising "more days than not" for the past six months (SAMHSA, n.d.-a). The anxiety and worry are aligned with three or more of the following six symptoms for the past six months: (1) feeling restless or on edge; (2) experiencing fatigue quickly; (3) having a hard time concentrating; (4) being irritable; (5) having muscle tension; and (6) experiencing sleep disturbances such as difficulty falling or staying asleep, or unsatisfying and restless sleep (SAMHSA, n.d.-a) Hirsch et al.'s (2013) definition of GAD aligns with DSM IV and V's definition, describing GAD as excessive and uncontrollable fear and worry over future events and an overestimation of adverse outcomes and future-oriented state or mood. According to DSM's IV and V, "The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, other important areas of functioning" (SAMHSA, n.d.-a, para. 6). Hirsch et al. (2013) align with this description by stating that GAD is a disabling disease where individuals attest to feeling the inability to breathe, a sense of suffocating, or the feeling of having a heart attack. According to the DSM-V (SAMHSA, n.d.-a), it is essential to note that the disturbance in GAD is not explained by another mental disorder, such as gaining weight in anorexia nervosa or perceived appearance flaws in body dysmorphic disorder (SAMHSA, n.d.-a). Further, the disturbance in GAD is not attributed to the physiological effects of substance abuse, such as drugs and medication, or other medical conditions, such as hyperthyroidism (SAMHSA, n.d.-a). GAD has been a lifelong battle in the researcher's life, especially concerning its comorbidity with eating disorders and depression. Therefore, the facts

and definitions regarding GAD refer to the severe, prolonged anxiety experienced by the researcher in this autoethnography.

Facts and Definitions Regarding Major Depressive Disorder (MDD)

Major Depressive Disorder (MDD) is a severe and debilitating public health dilemma with high prevalence rates (Kupfer et al., 2012). Kessler et al. (2007) found that MDD has a lifetime prevalence of 16.2% and a 12-month prevalence of 6.6%. According to DSM's IV and V, Major Depressive Disorder is a mood disorder that is diagnosed with five or more of the following nine criteria for most of the day, daily for at least two weeks in a row, excluding A3 and A9 (SAMHSA, n.d.-b):

- A1: Depressed mood
- A2: Loss of interest or pleasure in almost all activities
- A3: Significant (more than 5 percent per month) and unintentional weight loss or gain or a decrease or increase in appetite,
- A4: Insomnia or hypersomnia
- A5: Psychomotor changes such as retardation or agitation
- A6: Fatigue
- A7: Sense of worthlessness or delusional guilt
- A8: Inability to concentrate or make decisions.
- A9: Frequent thoughts of death, such as fear of dying, suicidal ideation, or attempts.

Based on the DSM's IV and V criteria (SAMHSA, n.d.-b), these symptoms cause clinically significant distress, such as deterioration of social or occupational functioning (i.e., social anxiety disorder). Beesdo et al. (2007) supported these facts by concluding

that social anxiety disorder is a consistent risk factor for developing Major Depressive Disorder. Furthermore, like GAD, these symptoms are not connected to the physiological effects of substance abuse or a medical condition (SAMHSA, n.d.-b). Regarding my current autoethnography, major depressive disorder has been a comorbid mood disorder in the researcher's life. Therefore, understanding the diagnostic criterion, definition, and statistics is a reference in understanding the researcher's struggles.

Statistics and Facts – Girls and Women with Eating Disorders

According to the National Association of Anorexia Nervosa and Associated Disorders (ANAD) (Giachin, 2023), about 30 million individuals in the United States suffer from an eating disorder, of which 20 million are women, while 9% of the world population currently have an eating disorder. Subsequently, 9% of the U.S. population (28.8 million Americans) will experience an eating disorder in their lifetime (Eating Disorders, 2023; Giachin, 2023)**.** Furthermore, of the individuals diagnosed with an eating disorder, 95% are 12 – 25 years of age (Eating Disorders, 2023; Giachin, 2023). Sala et al. (2013) state that eating disorders are the third most common chronic illness in teenage girls in the United States, affecting 3.8% of adolescent girls and 1.5% of teenage boys. According to Micali et al. (2015), 2.5% of youth met the DSM-V criteria for anorexia nervosa, while 3.2% met the criteria for bulimia nervosa. Numerous studies indicate that the lifetime prevalence of eating disorders is higher in women vs. men, with anorexia nervosa at 0.9% in women vs. 0.3% in men. Bulimia nervosa prevalence is also higher for women at 1.5% in women vs. 0.5% in men (Rikani et al., 2013; Sala et al., 2013; Mairs & Nicholls, 2016). Understanding the prevalence and statistics of

eating disorders in women is crucial in this autoethnography because the researcher, also a woman, fits the statistical facts.

When understanding eating disorders, it is crucial to know the ramifications of experiencing these disorders. Zhao and Encinosa (2009) determined that hospitalization of children with eating disorders under the age of 12 increased by 119% from 1999 – to 2000 and from 2005 to 2006. Also, an 18% increase in eating disorder-related hospitalizations was seen between 1999 – 2000 and 2005 – 2006. Anorexia nervosa-related hospitalizations increased by 17%, while all other eating disorder hospitalizations increased by 38% (Zhao & Encinosa, 2009). With regards to the onset and prevalence of bulimia nervosa in adolescents, individuals with the onset of binging before the age of 18 have a greater lifetime risk of bulimia nervosa, high rates of post-traumatic stress disorder, and substance abuse (Mairs & Nicholls, 2018). Further, only 40% recover from bulimia nervosa after 6–12 months of treatment and with a high relapse rate within five years of treatment (Mairs & Nicholls, 2016). The ramifications mentioned above experienced in eating disorders are essential to understand, especially the prevalence of adolescent bulimia nervosa, as it aligns with the struggles of the research in this autoethnography.

Eating disorders are one of the deadliest mental illnesses, second to opioid overdose, attributing to about 10,200 deaths yearly, which equates to one death every 52 minutes (Arcelus et al., 2011; Giachin, 2023; Micali et al., 2015;). The importance of exploring peoples' experiences with eating disorders is heightened by the fact that 26% of people with an eating disorder attempt suicide, and about 5-10% of people with anorexia die within their first ten years of beginning the disease (Arcelus et al., 2011;

Fichter & Quadflieg, 2016; Smink et al., 2012). It must be noted that eating disorders affect 15% of young women in middle to high-income countries (Garcia et al., 2020). In conclusion, the abovementioned eating disorder facts serve as the rationale for the proposed autoethnography.

Statistics and Facts – Comorbidity of Anxiety, Depression, Eating Disorders

The multimorbidity of anxiety, depression, and eating disorders is inevitable. About 97% of individuals who are hospitalized for an eating disorder have a coexisting mood disorder such as major depressive disorder and anxiety disorders such as obsessive-compulsive disorder, post-traumatic stress disorder, and substance abuse disorder (Brandd-Gothelf et al., 2014; Tagay et al., 2013). Also, 55% and 98% of individuals with anorexia nervosa and 88% and 97% with bulimia nervosa have another Axis I disorder (e.g., mood, anxiety, eating, or sleeping disorder) (Hughes et al., 2013). According to the NIMH (Eating Disorders, 2023), bulimia has a higher rate of comorbidity with depression than other eating disorders. Additionally, over 70% of people with bulimia also have a mood disorder, compared with 40% of people with anorexia. Garcia et al. (2020) indicated that 12 – 25-year-old females with a lifetime of anxiety or major depressive disorder were four times more likely to have a lifetime of eating disorders (Garcia et al., 2020). Furthermore, 80% of adults with a lifetime of bulimia nervosa also had a lifetime of anxiety disorders, and over 70% had a lifetime of mood disorders (Garcia et al., 2020). Regarding mortality rates, 10% to 20% of patients with anorexia nervosa and 25% to 35% of patients with bulimia nervosa have a history of at least one suicide attempt (Rikani et al., 2013). The statistics mentioned above

suggest that eating disorders are highly comorbid with anxiety and depression, especially in 12 – 25-year-old females.

The following section will discuss current research regarding the treatment of anxiety, depression, and eating disorders in adolescent females and women. It is important to note that there was a lack of studies targeting the comorbidity of anxiety, depression, and eating disorders. However, researchers explored anxiety, depression, and eating disorders (i.e., anorexia nervosa, bulimia nervosa, and binge eating disorder) separately. Furthermore, due to the high relapse rate of eating disorders after treatment (Berends et al., 2016; Filipponi et al., 2022; Sacchetti et al., 2019), adaptive coping strategies will also be discussed which include peer support programs and mindfulness practices as preventative tools supporting anxiety, depression, and eating disorders in adolescent females and women.

Recent Studies Encompassing the Treatments for Anxiety, Depression, and Eating Disorders in Adolescent Females and Women

Treatments for Binge Eating Disorder in Adolescent Females and Women

Researchers have explored binge eating disorder treatment in adolescent girls and women. In several empirical studies of binge eating disorders, researchers have found that cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), and interpersonal psychotherapy (IPT) are efficacious in supporting adolescent girls with binge eating disorders. CBT focuses on altering dysfunctional eating-related behaviors and attitudes (DeBar et al., 2013; Jones et al., 2008). While DBT specializes in emotional dysregulation and struggles with handling one’s emotions, it facilitates the ability to tolerate, recognize, and regulate one's moods and emotional states (Safer et

al., 2007; Mazzeo et al., 2016). Lastly, IPT is a short-term psychotherapy specializing in alleviating interpersonal difficulties related to the onset or maintenance of binge eating disorder (Tanofsky-Kraff et al., 2009; Marzilli et al., 2018). Studies regarding the psychological treatments of CBT, DBT, and IPT in adolescent girls with binge eating disorders will be discussed in detail in the following section.

Psychological treatments for binge eating disorder in adolescent females have also been a topic of interest in women. Like adolescent female binge eating disorder treatments, CBT and DBT treatments have exhibited positive improvements in women with binge eating disorders. Furthermore, compassion-focused therapy and behavioral-based interventions have also played a part in the reduction of binge eating frequency in women struggling with binge eating disorder (Carter et al., 2020; Hildebrandt et al., 2020; Kelly & Carter, 2014; McIntosh et al., 2016; Moghimi et al., 2022; Peterson et al., 2020; Wagner et al., 2016). The following section will discuss current binge eating disorder treatment research, including CBT, DBT, IPT, compassion-focused therapy, and behavioral intervention in adolescent girls and women with binge eating disorders.

Binge Eating Disorder Treatment Related to Adolescent Girls

Binge eating disorder is the most common and problematic clinical condition among adolescent girls, with a peak prevalence of 16 – 17 years of age. Binge eating disorder presents a severe risk to their mental and physical health (Marzilli et al., 2018). Binge eating disorder is associated with an extensive list of negative consequences in adolescent girls, including psychological, physical, and social functioning, and may lead to adverse effects such as obesity, substance abuse, suicidal tendencies, emotional-behavioral problems; and weight and shape concerns (Tanofsky-Kraff et al., 2009;

DeBar et al., 2013; Tanofsky-Kraff et al., 2014; Marzilli et al., 2018). Due to the extensive list of psychological, physical, and social functioning issues, several researchers have explored binge eating disorder treatment to support adolescent girls. The following section will review current binge eating disorder treatments in adolescent girls, including CBT, IPT, and DBT, and their efficacy in treating adolescent girls with binge eating disorders.

Treatments Facilitating Abstinence from Binge Eating & Reducing Binge Eating in Adolescent Girls

Several research patterns emerged with the literature on binge eating disorder treatment in adolescent girls. Firstly, researchers found that CBT, IPT, and DBT have the potential to facilitate abstinence from binge eating and reduce binge eating frequency in adolescent girls. In a pilot trial study exploring CBT for the treatment of reoccurring binge eating in adolescent girls, researchers examined 26 adolescent females between the ages of 12 – 18 years old who were enrolled in a large non-profit health maintenance organization (HMO) in the northwestern United States (DeBar et al., 2013). Participants with a body mass index (BMI) below 18 and over 40 were excluded according to the exclusion criteria. This quantitative study consisted of 8 CBT sessions over six months. However, all 26 participants were not available for the 6-month follow-up assessment. Researchers found that CBT achieved a significantly high abstinence rate from recurrent binge eating at three and six months (DeBar et al., 2013). Based on DeBar et al.'s (2013) pilot study, it is safe to conclude that CBT has the potential to foster abstinence in adolescent girls. However, the number of CBT studies facilitating

abstinence in adolescent girls is scarce. Therefore, future studies are needed to substantiate the current data.

DeBar et al.'s (2013) study has additional strengths and limitations that must be discussed. The strength of the study includes the predominant female participant base. However, the participants were not ethnically diverse, and the sample size was relatively small, with only 26 participants between the ages of 12 and 18. Additionally, the participants were recruited strictly from the HMO health plan, which decreases the generalizability of the findings. Another limitation was the strict exclusion criteria, which eliminated all participants with a BMI below 18 and over 40. Lastly, similar to previously mentioned eating disorder studies, DeBar et al.'s (2013) CBT study was short-term, consisting of 8 CBT over six months, with 100% of the participants unavailable for the follow-up assessment. While DeBar et al.'s (2013) study produced positive results in terms of abstinence from binge eating, future longer-term studies are needed with a more extensive and more ethnically diverse population of adolescent girls recruited from a community setting to validate the efficacy of CBT in fostering abstinence from binge eating in adolescent girls and to make the data more generalizable.

Internet-Facilitated CBT for Decreasing Binge Eating Frequency

Researchers have also explored internet-facilitated CBT treatment for decreasing binge eating frequency in adolescent girls. Internet-facilitated CBT was also efficacious in reducing binge eating frequency (Jones et al., 2008). In a quantitative CBT study, Jones et al. (2008) investigated internet-facilitated treatment for decreasing binge eating in overweight adolescents. This quantitative study explored 52 female adolescents with binge eating disorders who were all 15 years of age at the Stanford Medical Center in

California. During the study, 16 sessions of CBT were administered over six weeks, followed by a 6-month follow-up assessment. Researchers found that CBT treatment significantly reduced subjective and objective binge eating episodes in adolescent girls at the end of treatment and maintained during the 9-month follow-up assessment (Jones et al., 2008). The strengths and limitations of Jones et al.'s (2008) CBT study are similar to the eating disorder studies listed in my current research. The strength of this study is the decent-sized (n=52) predominant adolescent female participant base. However, the limitations outweigh the strengths, as seen in the eating disorder studies in my research. The limitations of Jones et al.'s (2008) study include only utilizing 15-year-old adolescent females rather than a more comprehensive age range like DeBar et al. (2013) CBT study of 12 – 18-year-old adolescent females. This limited age range limits the generalizability of the data. Additionally, the short-term nature of this study of 16 CBT sessions over six weeks and a 9-month follow-up is not enough time to assess the efficacy of CBT in decreasing binge eating frequency in adolescent girls. Therefore, longer-term studies of a more comprehensive age range of adolescent females, like DeBar et al.'s (2013) study, would better assess the effectiveness of CBT in decreasing binge eating frequency in adolescent females.

Interpersonal Therapy for Decreasing Binge Eating Frequency

Researchers have also explored IPT treatment studies in supporting adolescent girls with binge eating disorders. Based on the current research, IPT treatment also has the potential to decrease binge eating frequency in adolescent girls. In a quantitative pilot study in the greater Washington D.C. metropolitan area, researchers explored the efficacy of IPT in preventing excess weight gain in adolescent girls at risk for obesity

(Tanofsky-Kraff et al., 2009). Based on the study's strict exclusion criteria, this quantitative study included 38 adolescent females between 12 and 17 with BMIs ranging from the 75th to 97th percentile. The participants were treated with 12 sessions of IPT over 12 weeks and a 6-month follow-up assessment. All 38 participants completed the treatment and follow-up visits for up to 6 months and returned to the assessment visit for one year. Based on the data, researchers concluded that IPT treatment significantly reduces binge eating frequency in adolescent girls (Tanofsky-Kraff et al., 2009). In a similar IPT study investigating excess weight gain in high-risk adolescent girls, 113 girls between 12 and 17 years old were investigated in a clinical research center in Maryland (Tanofsky-Kraff et al., 2014). The participants had binge eating disorders and were limited based on BMI ranging between the 75th and 97th percentiles. The adolescent girls were treated with 12-weekly sessions of IPT in 90-minute group sessions over 12 weeks and follow-up assessments at 6 and 12 months. Researchers found that a significant reduction in objective binge eating days was achieved with the administration of IPT (Tanofsky-Kraff et al., 2014). Based on the two IPT treatment studies by Tanofsky-Kraff et al. (2009) and Tanofsky-Kraff et al. (2014), we can conclude that IPT is an efficacious treatment option for decreasing binge eating frequency in adolescent girls.

The IPT treatment studies by Tanofsky-Kraff et al. (2009) and Tanofsky-Kraff et al. (2014) have similar strengths and limitations. The strengths of both studies include the predominantly adolescent female participants who were ethnically diverse. The limitations of both studies include the strict exclusion criteria limiting participants to BMI ranging from 75th to 97th percentile. This strict BMI requirement limits other adolescent

females with binge eating disorders who may benefit from IPT. Additionally, both IPT studies were short-term, consisting of 12 IPT sessions over 12 weeks, which is too short of a timeframe to assess the effectiveness of IPT on reducing binge eating frequency. Lastly, while Tanofsky-Kraff et al.'s (2009) study consisted of a small participant base of 38 adolescent girls, Tanofsky-Kraff et al.'s (2014) study comprised a decent participant pool of 113 adolescent girls. Nevertheless, a more extensive participant base is more favorable for having a representative sample and for generalization purposes. In conclusion, longer-term studies with larger participant pools and less stringent exclusion criteria are warranted to validate the effectiveness of IPT on a more representative adolescent female sample base.

Dialectical Behavioral Therapy for Reducing Binge Eating Frequency

Lastly, researchers have also investigated the effectiveness of DBT in reducing binge eating frequency. Recent empirical data shows that DBT is a possible option for decreasing binge eating frequency. In a case study involving a 16-year-old female in a university-based clinic specializing in binge eating disorder treatment, 30 sessions of DBT were administered over six months. Researchers found that DBT decreased binge eating frequency by the end of treatment and achieved abstinence at the 3-month follow-up (Safer et al., 2007). However, this study has several limitations that need to be addressed. Firstly, the data is not generalizable since the study is a single case report. Another limitation is that the participant did not achieve abstinence at the end of treatment, which would be her risk for relapse. However, the participant achieved abstinence at the three-month follow-up, emphasizing the importance of longer-term follow-up assessments.

Treatments Decreasing Body Mass Index (BMI) in Adolescent Girls with Binge Eating Disorder

The second pattern of research that emerged from the current literature on adolescent binge eating disorder treatment was the decrease in body mass index. Body mass index (BMI) is a measure of body fat concerning height and weight and is a measure of defining nutritional status in children, adolescents, and adults. (Calculate Your BMI, 2023; WHO, 2023). BMI categorizes an individual as underweight, average weight, or pre-obese, and obese based on the following criteria by WHO (2023): Underweight: Below 18.5; Normal weight: 18.5 – 24.9; Pre-obesity: 25.0 – 29.9; Obesity class I: 30.0 – 34.9; Obesity class II: 35.0 – 39.9; Obesity class III: Above 40. Also, it is essential to note that the BMI scale was developed to indicate disease. Hence, as BMI increases, the risk for diseases increases as well. Common diseases connected to being overweight and obese include cancers, diabetes, cardiovascular disease, osteoarthritis, high blood pressure, and premature death (WHO, 2023). Binge eating disorder in adolescent girls is directly linked to obesity, Type 1 diabetes, metabolic syndrome, and sudden death (Hudson et al., 2010; Blomquist et al., 2012; Succurro et al., 2015). Therefore, researchers have explored treatment methods to facilitate the reduction of BMI in adolescent girls. The following section will discuss current treatment methods in the literature, including CBT and IPT, which researchers have found to foster the reduction of BMI in adolescent females.

Cognitive Behavioral Therapy (CBT) Facilitates the Reduction of Body Mass Index (BMI).

The efficacy of CBT treatment in facilitating the reduction of BMI in adolescent girls with binge eating disorders has been investigated by several researchers. Empirical studies have shown that CBT significantly reduces BMI in adolescent girls with binge eating disorder. Quantitative research explored internet-facilitated CBT with 52 female adolescents with binge eating disorders who were 15 years of age at the Stanford Medical Center in California. The participants were treated with 16 sessions of CBT over six weeks. Researchers found a significant decrease in BMI at the end of treatment and the 9-month follow-up assessment (Jones et al., 2008). Similar BMI reduction results were achieved with a quantitative pilot IPT treatment study. Tanofsky-Kraff et al. (2009) explored 38 adolescent females between the ages of 12 and 17 with BMIs ranging from 75th to 97th percentile binge eating disorder in the greater Washington D.C. metropolitan area. After receiving 12 sessions of IPT for over 12 weeks, researchers found significant reductions in BMI in female adolescents at the end of treatment. They maintained at the 6-month and 1-year follow-up assessments (Tanofsky-Kraff et al., 2009). Considering the results of Jones et al.'s (2008) CBT study and Tanofsky-Kraff et al.'s (2009) IPT study, we can conclude that CBT and IPT can significantly reduce BMI in adolescent girls with binge eating disorder.

The studies by Jones et al. (2008) and Tanofsky et al. (2010) had many significant strengths and weaknesses that need to be discussed. Both studies' strengths include the dominating adolescent female participants with binge eating disorders. On the other hand, the limitations of both studies have the small sample sizes of 52 participants in Jones et al.'s (2008) study and 38 participants in Tanofsky-Kraff et al.'s (2009) study, which is too limited to represent the adolescent female bine-eating

population. The abovementioned studies were also short-term, with 16 CBT sessions over six weeks in Jones et al.'s. (2008) study and 12 sessions of IPT over 12 weeks. Furthermore, Jones et al.'s (2008) internet-facilitated study only included 15-year-old girls, which is not representative of the adolescent female binge eating population. Additionally, the inclusion criteria limiting participants to BMI ranging from 75th to 97th percentile in Tanofsky-Kraff et al.'s (2009) study is too strict of a BMI requirement, which limits other adolescent females with binge eating disorder who may benefit from IPT. Based on the limitations of Jones et al.'s (2008) CBT study and Tanofsky-Kraff et al.'s (2009) IPT study, we can conclude that longer-term studies are needed with larger participant pools and less stringent exclusion criteria to substantiate the efficacy of CBT and IPT on decreasing BMI in adolescent females with binge eating disorder.

Treatments Reducing Symptoms of Depression and Anxiety in Adolescent Girls with Binge Eating Disorder

With the certainty of comorbid mood disorders such as anxiety and depression in binge eating disorder in adolescent girls, research investigating the reduction of anxiety and depression is scarce. However, two quantitative studies have explored the reduction of anxiety and depression through CBT and IPT treatments. DeBar et al.'s (2013) CBT and Tanofsky-Kraff et al.'s (2014) IPT study found reductions in anxiety and depression symptoms at the end of treatment and follow-up assessments. The strengths and limitations of DeBar et al.'s (2013) and Tanofsky-Kraff et al.'s (2014) studies are similar to the eating disorder studies mentioned in my current study. The strength of both studies is the dominating adolescent female participant base.

On the other hand, Tanofsky-Kraff et al.'s (2014) IPT study had the upper hand with the more extensive ethnically diverse participant base with 113 participants, while DeBar et al.'s (2013) study was smaller, with 38 Caucasian participants. Limitations of both studies include the short-term nature of 8 CBT sessions over six months (DeBar et al., 2013) and 12 sessions of IPT over 12 weeks (Tanofsky-Kraff et al., 2014). Based on the limitations of the abovementioned studies, longer-term studies with more extensive and ethnically diverse participant pools are warranted to validate the efficacy of CBT and IPT in decreasing anxiety and depression in adolescent girls with binge eating disorders. Furthermore, studies focusing on targeting mood and eating disorders simultaneously are scarce. They are also needed in supporting the inevitable comorbidity of anxiety, depression, and binge eating disorder in adolescent females.

Treatments Decreasing Binge Eating Frequency in Women

Several researchers have explored cognitive behavioral therapy (CBT) in supporting people with eating disorders. Some researchers have determined that binge eating frequency decreased due to the CBT received within this area. Exploring several treatments for binge eating disorder in a meta-analysis, Peat et al. (2017) discovered that CBT, when led by a therapist, decreased binge eating frequency. Further, in two different meta-analyses, Hilbert et al. (2019) and Hilbert et al. (2020) investigated the long-term effectiveness of psychological treatments for binge eating disorder. These researchers discovered that CBT was efficacious in decreasing binge eating episodes. Limitations with the abovementioned meta-analysis may include studies that may have been missed, misinterpreted, or unaccounted for. While it is evident through the meta-analyses by Peat et al. (2017), Hilbert et al. (2019), and Hilbert et al. (2020) that CBT

has the potential to decrease binge eating frequency in women, further studies are needed to dig into information which may have been missed.

In several empirical studies outside of the United States, researchers also discovered that binge eating frequency decreased when women specifically were engaged in CBT (McIntosh et al., 2016; Moghimi et al., 2022; Wagner et al., 2016). In two United States randomized control trials, researchers examined CBT-guided self-help (CBT-GSH) and found a significant decrease in binge eating frequency (Hildebrandt et al., 2020; Peterson et al., 2020). The only difference in the CBT-GSH studies is that Hildebrandt et al. (2020) examined CBT-GSH attached to a smartphone called the Noom Monitor. Nevertheless, both studies produced identical results. There are many strengths and weaknesses in the abovementioned studies. One of the strengths is that all these studies included predominantly female participants with a significant age range between the ages of 16 and 65, which aligns with the purposes of the current study. However, many of these female participants were Caucasian, which limits generalization and is not representative of the binge eating disorder demographic.

Further, United States studies were scarce, which is a limitation considering that binge eating is the most common eating disorder globally (Hilbert et al., 2019; Hilbert et al., 2020). Another limitation is that most of these studies were quantitative, which warrants further research for qualitative first-hand experiences of CBT in its role in decreasing binge eating frequency. The abovementioned studies were also short-term studies from three-month to 12-month follow-ups, which does not allow for longer-term monitoring of the positive effects of CBT in decreasing binge eating frequency. Longer-term studies are necessary to substantiate the effectiveness of CBT. The impact of CBT

in alleviating binge eating frequency is evident in several studies. Therefore, it is safe to say that CBT is an effective treatment option for decreasing binge eating episodes.

Aside from CBT, researchers have explored several other treatment forms to reduce binge eating frequency. Dialectical behavioral therapy-guided self-help, group dialectical behavioral therapy, compassion-focused therapy, and behavioral-based intervention significantly reduced binge eating frequency (Carter et al., 2020; Kelly & Carter, 2014). In a randomized controlled trial in Canada, researchers found a significant decrease in binge eating frequency with dialectical behavioral therapy-guided self-help in women ages 19 – 65 (Carter et al., 2020). Further, group behavioral therapy in the United Kingdom resulted in abstinence from binge eating in women ages 21 – 73 (Blood et al., 2020). Researchers have also determined that compassion-focused therapy (CFT), self-help, and behavioral intervention decreased weekly binge episodes in women. It is essential to note the many strengths and weaknesses of this research. One strength includes the reduction in binge eating frequency among the prevailing female participants ages 19 to 73, which supports the purposes of the current study. However, the predominantly Caucasian population is not representative of the binge eating disorder demographic.

Additionally, there were no United States studies, which is a considerable limitation considering that binge eating disorder is the most common eating disorder worldwide (Hilbert et al., 2019). Another limitation is the predominantly quantitative studies, which warrant further research for qualitative studies in dialectical behavioral therapy and behavioral-based interventions. Furthermore, the studies were relatively short-term with small sample sizes. Therefore, longer-term studies with larger sample

sizes are needed to strengthen the evidence base. Dialectical behavioral therapy guided self-help, group dialectical behavioral therapy, compassion-focused therapy, and behavioral-based intervention can decrease binge eating frequency in women. However, due to the many limitations of these studies, additional research is warranted to substantiate the current evidence.

Treatments Decreasing Eating Disorder Pathology in Binge Eating Disorder

Decreasing eating disorder pathology in binge eating disorders has been of great interest among researchers in and outside of the United States. Eating disorder pathology is a range of specific attitudes, behaviors, and biological and psychological factors related to a particular eating disorder (Latzer et al., 2019). Binge eating disorder pathology includes frequent, excessive, and out-of-control eating followed by feelings of guilt, shame, and embarrassment (Wagner et al., 2016). The following section will discuss research in terms of binge eating disorder therapies as treatments, the effects of pharmacotherapy on binge eating disorder, and qualitative binge eating treatment studies.

Dialectical Behavioral Therapy Self-Help Treatment for Binge Eating Disorder. The first main area researchers have focused on in decreasing global eating disorder pathology is self-help therapies. A quantitative study in Canada investigating 67 female participants found that DBT self-help treatment reduced eating disorder pathology up to the 3-month follow-up (Carter et al., 2020). In a 3-week quantitative study in Canada, researchers found that compassion-focused therapy (CFT) self-help intervention decreased global eating disorder pathology (Kelly & Carter, 2014). Of importance in this study is that those participants who exhibited a low fear of self-

compassion benefited more from the self-compassion intervention than those with a high fear of self-compassion. Therefore, participants with higher levels of fear of self-compassion are less likely to benefit from compassion-focused therapy.

Integrative Cognitive-Affective Therapy & Guided Self-Help Cognitive Behavioral Therapy. The second main area of focus, integrative cognitive-affective therapy (ICAT) and guided self-help cognitive behavioral therapy have also been found to exhibit positive effects on the improvement of eating disorder pathology in women with binge eating disorders. In a multi-site randomized control trial in the United States, 92 women ages 18 to 65 years old experienced significant improvements in binge eating disorder pathology. Both ICAT and CBT-guided self-help resulted in similar improvements in emotional regulation, self-directed style, cognitive self-discrepancy, anxiety, depression, negative affect, and impulsivity after treatment and follow-up (Peterson et al., 2020). According to the randomized controlled trial by Peterson et al. (2020), integrative cognitive behavioral therapy and guided self-help cognitive behavioral therapy can potentially increase eating disorder pathology in women struggling with binge eating disorders.

Internet-Based Cognitive Behavioral Therapy and Dialectical Behavioral Therapy. The efficacy of internet-based CBT and DBT in decreasing binge eating frequency in women with binge eating disorders has also been explored. In a quantitative study exploring 133 women in Germany, Wagner et al. (2016) discovered that internet-based (CBT) with intensive therapeutic support reduced binge eating disorder pathology up to one year after treatment. Similarly, group dialectical behavioral therapy (DBT) has also been found to exhibit positive effects on binge eating disorder

pathology in females 21 to 73. In a quantitative study in the United Kingdom, researchers explored 56 women with binge eating disorders and determined that group DBT reduced eating disorder pathology in women for up to one month; however, this group DBT did not positively affect the participants' psychological mood. According to the studies by Wagner et al. (2016), Carter et al. (2020), and Kelly and Carter (2014), internet-based CBT and DBT have the potential to reduce eating disorder pathology in women with binge eating disorders.

Although the studies mentioned above effectively reduced binge eating disorder pathology, several limitations must be addressed. The small sample sizes are of concern, particularly with Wagner et al.'s (2016) group DBT study, with only 22 out of the 133 participants remaining at the end of the treatment. Additionally, Carter et al.'s (2020) study with 71 participants and Kelly and Carter's (2014) study with 42 participants were too small and not representative of women struggling with binge eating disorder. Furthermore, the longevity of the studies is short-term, particularly Kelly and Carter's (2014) three-week compassion-focused therapy (CFT) self-help. The remainder of the investigations led to a three-, six-, and 12-month follow-up, which is too short to determine if the positive treatment effects are permanent. It is also important to note that a couple of diagnoses studies examined bulimia nervosa and binge eating disorder (Blood et al., 2020; Hildebrandt et al., 2020). Also, most of the studies consisted of mainly Caucasian participants outside of the United States. Hence, it is safe to say that future long-term studies with a more diverse demographic base are warranted. Moreover, studies focusing solely on binge eating disorder treatment rather

than mixed diagnosis are needed to focus on the treatment effects of binge eating disorder alone.

Effects of Pharmacotherapy on Binge Eating Disorder

Lisdexamfetamine and Methylphenidate as Binge Eating Disorder Treatment in Women.

Aside from psychotherapy, such as CBT, and talk therapy, such as dialectical behavioral therapy, researchers have determined that pharmacotherapy effectively minimizes binge eating disorders. Researchers in several systematic comparison studies highlight pharmacotherapy as a critical possibility for reducing binge eating symptoms. Conducting a meta-analysis of several studies to determine the comparative effectiveness of pharmacological drugs, Peat et al. (2017) discovered that the FDA-approved medication for binge eating disorder, lisdexamfetamine, was more effective than second-generation anti-depressants (SGAs) in addressing binge eating abstinence. Nevertheless, the researchers determined that SGAs still provide an alternative pharmacological option for decreasing binge eating frequency and improving eating psychopathology for individuals who are not lisdexamfetamine candidates. In a systematic review by Hilbert et al. (2019), pharmacotherapy was found to be an effective alternative to alleviating binge eating disorder pathology. Outside of systematic reviews, one set of qualitative researchers (Moghimi et al., 2022) empirically examined the personal experiences of 15 women who professed that the pharmacological drug methylphenidate (MP) helped to reduce their preoccupation with food and decreased binge eating frequency. However, Moghimi et al. (2022) discovered that the positive effects of lowering binge eating frequency were short-lived without the medication. The fact that a greater risk of relapse exists with MP patients in decreasing binge eating

disorder pathology without medication can be problematic, suggesting more long-term research is needed in this area. The limits of MP notwithstanding, together, these researchers condone pharmacotherapy as an effective means to alleviating binge eating disorder pathology.

Some limitations exist concerning the abovementioned pharmacotherapy comparison studies. The pharmacotherapy reviews by Peat et al. (2017), Hilbert et al. (2019), and Moghimi et al. (2022) were all randomized controlled trials consisting mainly of middle-aged Caucasian women who were overweight and obese. Although the eligibility criteria called for a diverse range of ethnicities, cultural groups, and races, this criterion must be applied in the study. Unlike these studies, a meta-analysis by Hilbert et al. (2019) consisted of a more extensive combined participant base of 7,515, providing a more comprehensive and representative review of general binge eating disorder treatment outcomes. The qualitative study assessing the effectiveness of the medication MP provided an excellent first-hand account of the positive and negative attributes of MP in alleviating binge eating disorder pathology.

Qualitative Binge Eating Treatment Studies. With most binge eating disorder treatment research based on quantitative data, it is vital to highlight the two qualitative studies in this area. The qualitative studies by Moghimi et al. (2022) and Salvia et al. (2023) provide first-hand narratives of patient experiences with binge eating disorder treatment. The Canadian qualitative study by Moghimi et al. (2022) compared the effectiveness of pharmacotherapy (MP) and CBT through 15 Caucasian women's personal experiences with binge eating disorder. The participants attested to becoming more self-aware regarding their binge eating, emotions, and thoughts with CBT. Daily

food journals as a data collection method proved helpful for participants in connecting their thoughts and emotions to their eating habits. The CBT group also attested that the psychological component of binge eating disorder was the focus and that CBT provided a toolbox of skills they could refer to following therapy. The MP group professed that the medication helped to reduce their preoccupation with food, decreasing binge frequency. However, the positive effects for the women in the MP group were short-lived. Women in both groups attested to stress as being their main trigger for binging and relapsing.

Another qualitative study by Salvia et al. (2023) explored the personal experiences of women in a weight-neutral treatment setting. Researchers examined the perceptions of 21 Hispanic women with a mean age of 49 concerning their experiences in weight-neutral treatment for binge eating disorder. With regards to their expertise in a weight-neutral treatment setting, participants reported that elements such as consistency of eating patterns, comprehensive support, and specific and thorough education were helpful compared to previous healthcare settings where they experienced an internalized sense of failure, embarrassment and felt at fault for their weight and health conditions. These Hispanic women also encountered fewer binge eating episodes, less shame, more resiliency, and fewer negative self-perceptions. Improved physical health, such as diabetic self-care behaviors, was also reported. Based on Salvia et al.'s (2023) qualitative study, weight-neutral treatment settings are efficacious in supporting women in their binge eating disorder recovery journey in a comfortable, empowering, and non-judgmental environment.

Like all studies, these qualitative studies also included limitations. Although CBT and MP proved helpful with binge eating disorder behavior in the Moghimi et al. (2022)

study, different mechanisms were utilized to achieve this. While CBT is a form of psychotherapy, MP is a medication and, therefore, completely different in how they treat binge eating disorders. Also critical was the strict exclusion criteria, which limited the findings to a narrow, less diverse demographic. Regarding Salvia et al.'s (2023) weight-neutral study for binge eating disorder, the study was short-term for up to 12 months. Therefore, more extended studies are needed to examine the longer-term effect of weight-neutral treatment in relieving binge eating in women. The benefits of these studies far outweighed these limitations. The ability of the qualitative researchers to explore individual experiences highlighted the vulnerable accounts of women in a weight-neutral setting, which researchers cannot capture in quantitative studies. For this reason, additional qualitative studies are needed to explore the perspectives of more diverse racial, gender, and ethnic demographics. In conclusion, the personal experiences of both studies provide a raw perspective on the efficacy of binge eating disorder treatment in women.

Treatments for Bulimia Nervosa in Adolescent Females and Women

Researchers have explored bulimia nervosa treatment in adolescent girls and women. In the research treatments for bulimia nervosa disorders for adolescent young women, researchers have found that enhanced cognitive behavioral therapy (CBT-E), dialectical behavioral therapy (DBT), and family-based therapy (FBT) exhibit significant improvements in adolescent girls with bulimia nervosa. Dialectical behavioral therapy, family-based therapy, and cognitive behavioral therapy are all conceptually distinct. Family-based therapy is based on parental control and managing eating disorder behaviors without focusing on altering pathological thoughts related to weight and

shape. Cognitive behavioral therapy is mainly an individual therapy focusing on decreasing dieting and changing distorted behaviors and perceptions related to weight and shape (Le Grange et al., 2015). In contrast, dialectical behavioral therapy is based on cognitive behavioral therapy and specializes in helping individuals who feel intense emotions (Pennell et al., 2019). The following section will discuss dialectical behavioral therapy, family-based therapy, and cognitive behavioral therapy in adolescent girls.

Several researchers have also explored CBT and enhanced cognitive behavioral therapy (CBT-E) in supporting women with bulimia nervosa. CBT is a type of psychotherapy that focuses on altering negative thought patterns and unwanted behaviors related to oneself (Poulsen et al., 2014). While CBT-E is goal-focused talk therapy explicitly designed to treat adults with eating disorders (Melisse et al., 2022), Additionally, CBT-E specializes in addressing eating disorder psychopathology despite the eating disorder diagnosis. CBT-E is customized to match the eating disorder psychopathology of each patient (Cooper & Fairburn, 2011). The following section will cover bulimia nervosa treatment in adolescent girls and women in dialectical behavioral therapy, family-based therapy, cognitive behavioral therapy, and enhanced cognitive behavioral therapy.

Dialectical Behavioral Therapy (DBT) for the Treatment of Bulimia Nervosa in Adolescent Girls

Research Findings Related to Adolescent Girls. Research concerning the effects of DBT on adolescent bulimia nervosa is scarce. However, of the handful of data available, DBT seems promising in treating adolescent bulimia nervosa. DBT helps patients identify their negative thinking patterns and emotions and become aware and

mindful of how their emotions affect their behaviors (Groves et al., 2011). In a review of the literature exploring DBT with adolescents, Groves et al. (2011) determined that DBT is an efficacious treatment for adolescents with different behaviors and psychological disorders, such as suicidal patients diagnosed with borderline personality disorder. Through empirical support, researchers have also determined DBT to be a productive and promising treatment for adolescents with disordered eating behaviors such as bulimia nervosa and comorbid anxiety and depression. Researchers found significant improvements concerning symptoms of depression, eating disorder behavior, and a decrease in eating disorder psychopathology with the treatment of DBT (Salbach-Andrae et al., 2008; Safer et al., 2007). Moreover, researchers also found that adolescents were hospitalized less frequently under DBT (Groves et al., 2011). In conclusion, DBT has the potential to be an efficacious treatment for adolescent bulimia and comorbid anxiety and depression by helping individuals become more aware of how their emotions impact their actions.

Like the studies mentioned in my current research, the study by Groves et al. (2011) has many apparent strengths and limitations that must be addressed. Concerning the factors that make a study viable, participant retention is vital in a treatment's acceptability and tolerability. Groves et al.'s (2011) DBT study had low retention rates, with only one person dropping out, which is a considerable strength in terms of the viability of the study. However, Groves et al.'s (2011) study is not without limitations, including the fact that only 12 DBT studies were utilized, and of the 12 DBT studies, only three were geared towards the effects of DBT on adolescent bulimia nervosa. The limited number of studies was due to the lack of DBT and adolescent

bulimia nervosa studies. Therefore, future efficacy studies regarding DBT and bulimia nervosa are needed to substantiate the current findings.

In several systematic reviews exploring the efficacy of DBT on adolescent bulimia nervosa, researchers have found promising results in terms of the effectiveness and feasibility of DBT in treating adolescent bulimia nervosa. In a systematic review of eligible studies by Vogel et al. (2021), DBT-based treatments indicated high effectiveness, acceptability, and feasibility in reducing bulimia nervosa in adolescents. Furthermore, another systematic review explored 11 DBT studies' role in improving emotion dysregulation in bulimia nervosa in adolescents. Researchers found significant improvement in emotion regulation, depressive symptoms, eating disorder psychopathology, objective binge episodes, and body mass index with DBT treatment (Rozakou-Soumalia et al., 2021). The systematic reviews by Vogel et al. (2021) and Rozakou-Soumalia et al. (2021) had many limitations that must be mentioned. Firstly, the systematic review by Vogel et al. (2021) was based solely on the findings of the PsychINFO and PubMed databases. Therefore, based on the limitations of the databases, significant results may have been missed or misinterpreted. Similarly, the systematic review by Rozakou-Soumalia et al. (2021) was also limited because the study only utilized 11 DBT studies. Therefore, additional DBT studies on adolescent bulimia are warranted to substantiate the efficacy of DBT treatment on adolescent bulimia nervosa.

Family-Based Therapy (FBT) for Treating Bulimia Nervosa in Adolescent Girls.

FBT Treatment and Abstinence from Binging and Purging in Adolescent Girls with Bulimia Nervosa. Several researchers have explored family-based therapy

in the treatment of adolescent bulimia nervosa. Several empirical studies have determined that family-based therapy is highly efficacious in supporting abstinence from binging and purging in adolescent females with bulimia nervosa. Family-based treatment emphasizes parental control and management of eating disorder behaviors and is based on five principles such as 1) the therapist holding an agnostic view of the root cause of the bulimia nervosa; 2) the therapist taking a non-authoritarian role in the treatment; 3) parental empowerment in facilitating the recovery of their child; 4) the bulimia nervosa is separated from the adolescent and externalized; 5) a logical approach is utilized with the focus on the here and now (Rienecke & Grange, 2022). The following section will discuss current research supporting abstinence from binging and purging in adolescent females with bulimia nervosa with FBT treatment.

Several researchers have found FBT to be highly effective in fostering abstinence from binging and purging in adolescent girls with bulimia nervosa. In a multi-site quantitative study exploring 130 adolescent female participants with bulimia nervosa at the University of Chicago and Stanford University, researchers found that participants achieved and maintained high rates of abstinence under FBT at the end of treatment, six-, and 12-month follow-ups (Grange et al., 2015). Similarly, another quantitative study explored the efficacy of FBT in facilitating abstinence from bingeing and purging in 41 adolescent females with bulimia nervosa at the University of Chicago over six months. Researchers found that participants achieved abstinence from binging and purging at the end of treatment and at the 6-month follow-up (Grange et al., 2007). Another quantitative study investigated 41 adolescent females with bulimia nervosa in the United Kingdom across six months. Researchers found that bingeing and purging

episodes significantly decreased at the end of treatment and the 12-month follow-up with FBT treatment (Schmidt et al., 2007). Moreover, in a systematic review exploring adolescent eating disorder treatments, FBT was highly efficacious in treating adolescent bulimia nervosa (Vogel et al., 2021). Based on the abovementioned studies, FBT is a highly effective treatment for adolescent bulimia nervosa.

The FBT studies by Grange et al. (2015), Grange et al. (2007), Schmidt et al. (2007), and Vogel et al. (2021) have many strengths and limitations. The strengths of these studies include a predominantly female adolescent participant pool and a broad inclusion criterion that aligns with the purposes of my current study. Further, studies by Grange et al. (2007) and Grange et al. (2015) utilized independent assessors in the data collection process, limiting the potential for bias. However, the limitations of the FBT studies outweigh the strengths. The FBT studies by Grange et al. (2015), Grange et al. (2007), and Schmidt et al. (2007) were all short-term studies of up to 6- and 12-month studies, which is too restrictive of a period to determine the viability of FBT in supporting abstinence from binging and purging in adolescent bulimia nervosa. Additionally, the studies by Grange et al. (2015), Grange et al. (2007), and Schmidt et al. (2007) consisted of small participant pools and extensive exclusion criteria, which limited the number of eligible participants. The abovementioned FBT studies were also conducted at specialized eating disorder treatment sites, which may limit the generalizability of the findings. Moreover, since the systematic review by Vogel et al. (2021) was based solely on the conclusions of the PsychINFO and PubMed databases, significant results may have needed to be included or corrected. Lastly, the studies by Grange et al. (2015), Grange et al. (2007), and Schmidt et al. (2007) were quantitative,

which warrants the need for data stemming from the personal experiences of adolescents with bulimia nervosa. Therefore, qualitative studies are warranted for this purpose.

FBT Treatment and the Decrease in Eating Disorder Pathology in Adolescent Girls with Bulimia Nervosa. FBT's role in decreasing eating disorder pathology in adolescent girls with bulimia nervosa has also been explored by researchers. In several empirical studies, researchers have found that FBT treatment significantly reduces eating disorder pathology in adolescent females with bulimia nervosa. A quantitative study by Lock et al. (2008) explored treatment outcomes for family-based therapy among 41 adolescents with bulimia nervosa in a specialist university clinic in the United States. Participants received 20 sessions of FBT over six months.

Additionally, the study consisted of three phases, starting with negotiated parental control concerning weight-related and eating behaviors; transitioning control of the weight-related and eating behaviors back to the adolescent while under parental supervision; and addressing the effects of bulimia nervosa on the adolescent developmental process (Lock et al., 2008). Researchers found that FBT treatment significantly decreased eating disorder pathology in adolescents with bulimia nervosa by mid-treatment, end-of-treatment, and follow-up. However, this study did not specify the follow-up time frame (Lock et al., 2008). In another quantitative research at the University of Chicago, researchers investigated the efficacy of FBT through 41 adolescent female participants with bulimia nervosa (Grange et al., 2007). The study involved 20 outpatient visits of FBT over six months, with a 6-month follow-up

assessment. Grange et al. (2007) found a significant decrease in eating disorder pathology with the administration of FBT at the end of treatment and the 6-month follow-up. Based on the FBT studies, we can conclude that FBT treatment is highly efficacious at decreasing eating disorder pathology in adolescent females with bulimia nervosa.

Like previously mentioned eating disorder studies, the FBT treatment studies by Lock et al. (2008) and Grange et al. (2007) have many strengths and limitations. The strengths of the 2 FBT treatment studies include the predominantly adolescent female participants and broad inclusion criteria comparable to my current study. Once again, the limitations outweigh the strengths of the abovementioned studies. The limitations include the short-term nature of both studies of 20 sessions of FBT over six months and post-treatment follow-up of 6-months. However, the follow-up period in Lock et al.'s (2008) study was not specified. Therefore, longer-term studies are necessary to substantiate the efficacy of FBT treatment in decreasing eating disorder pathology in adolescents with bulimia nervosa. This study had a small participant pool, which limited its generalizability. Also, similar to other studies, the treatment was short-term, up to a 6-month follow-up, which is too restricted of a period to determine the efficacy of FBT in supporting abstinence from binge and purging in adolescents with bulimia nervosa. Another striking similarity between Lock et al.'s (2008) and Grange et al.'s (2007) FBT studies was the relatively small participant base of 41 adolescent females. The limited number of participants may have been attributed to the broad exclusion criterion in both studies. Based on the limitations of the studies mentioned above, we can suggest that longer-term studies with limited exclusion criteria are necessary to substantiate the

long-term efficacy of FBT treatment with a more representative sample base of adolescent females struggling with bulimia nervosa.

Integrating Dialectical Behavioral Therapy and Family Based Therapy for the Treatment of Bulimia Nervosa in Adolescent Girls

Research Findings Related to Adolescent Girls. Several researchers have also explored the two evidence-based interventions, dialectical behavioral therapy (DBT) and family-based therapy (FBT), in supporting adolescent girls with bulimia nervosa. While DBT is individualized one-on-one therapy that specializes in coping with emotion dysregulation like depression and anxiety, which often takes place simultaneously with bulimia nervosa, FBT focuses on normalizing eating patterns and building a healthy relationship with food with the family as the integral component of the treatment (Anderson et al., 2015; Murray et al., 2015). Hence, researchers have found that FBT and DBT complement one another and, when integrated, can support the range of behaviors and symptoms in adolescent bulimia nervosa (Anderson et al., 2015; Murray et al., 2015). The following section will cover studies integrating FBT and DBT therapies for adolescent bulimia nervosa, as well as stand-alone FBT and DBT therapies for the treatment of adolescent bulimia nervosa in females.

The integration of FBT and DBT therapies in treating adolescent bulimia in females has been a topic of interest among researchers. Several studies have determined that FBT and DBT complement each other and can be efficacious in treating adolescent bulimia nervosa when integrated (Anderson et al., 2015; Murray et al., 2015). In a quantitative, open-trial study integrating family-based therapy and dialectical behavioral therapy, researchers explored 35 Caucasian adolescent females with bulimia

nervosa at the University of California San Diego (Murray et al., 2015). The study consisted of family, multi-family, individual, and parent-only components administered six days a week for 3-10 hours a day, depending on the severity of the bulimia nervosa. Murray et al. (2015) significantly improved general eating disorder pathology and core bulimia nervosa symptoms such as objective binge episodes, shape and weight concerns, and self-induced vomiting.

Additionally, parental efficacy increased throughout the treatment. However, no improvement in emotion regulation difficulties was exhibited (Murray et al., 2015). The predominantly adolescent female participant pool and the lack of exclusion criteria were significant strengths in this study, considering my main demographic and need for representative data. However, the study had significant limitations. The fact that follow-up data needed to be available to solidify the accuracy of the findings is a significant setback in this study. Without sufficient follow-up data, there is no way to substantiate the long-term efficacy of the integrated treatment.

The integration of FBT and DBT for adolescent bulimia nervosa has also been explored by Anderson et al. (2015). In a conceptual review of the integration of FBT and DBT for adolescent female bulimia nervosa, Anderson et al. (2015) argue that although FBT and DBT are two different clinical approaches to treating adolescent bulimia nervosa, the integration of FBT and DBT can offer significant advancements in the current treatments of adolescent female bulimia nervosa. Researchers also state that the dual therapeutic approach of integrating FBT and DBT may assist in the elimination of behavioral symptoms and underlying emotional states of the adolescent and the family (Anderson et al., 2015). Based on the abovementioned studies, integrating FBT

and DBT for treating adolescent female bulimia nervosa looks promising. However, the evidence is scarce; therefore, further controlled empirical research is needed to support the integration of FBT and DBT in treating adolescent bulimia nervosa.

CBT & CBT-E Treatment for Bulimia Nervosa in Adolescent Girls and Women

Research Findings Related to Adolescents. The efficacy of cognitive behavior therapy in treating bulimia nervosa in adolescent females has been of particular interest to researchers. Based on systematic reviews and empirical studies, CBT has consistently been effective in providing relief from bulimia nervosa in adolescent girls. In a systematic review by Vogel et al. (2021), researchers found that cognitive behavioral therapy is practical and feasible for adolescent eating disorders through all diagnoses and levels of self-care. Further, CBT was consistently effective in bulimia nervosa, significantly reducing binging and purging behaviors. In a quantitative study exploring 130 adolescent females with bulimia nervosa and partial bulimia nervosa, Grange et al. (2015) also determined that cognitive behavioral therapy effectively achieved abstinence from bulimia nervosa. The studies by Vogel et al. (2021) and Grange et al. (2015) have many strengths and limitations. Vogel et al.'s (2021) systematic review was based solely on the findings of the PsychINFO and PubMed databases. Therefore, essential findings may have been missed or misinterpreted.

On the other hand, Grange et al.'s (2015) cognitive behavioral study had several strengths, such as trained and skilled therapists, large sample size, low treatment, study dropout rate during treatment, and ongoing supervision by experts. However, the study of Grange et al. (2015) had limitations. The treatment and recruitment of the participants took place in specialized university treatment sites, which limits the generalizability of

the data. Further, there was a loss of follow-up data at the 12-month mark, which halts the long-term efficacy results of cognitive behavioral therapy in the treatment of adolescent bulimia nervosa (Grange et al., 2015). Therefore, the findings of Grange et al. (2015) would be validated if the study was replicated in multiple treatment settings with sufficient long-term follow-up data.

Research Findings Related to Women. In several empirical quantitative studies and systematic reviews outside the United States, researchers have found that enhanced cognitive behavioral therapy (CBT- E) is highly efficacious in supporting outpatient women with bulimia nervosa. In a quantitative study in the United Kingdom, Fairburn et al. (2009) administered two different types of CBT-E on 57 outpatient women ages 18 – 65 with bulimia nervosa over 20 weeks with a 60-week follow-up. While one CBT focused on eating disorders features, the other more complex treatment was designed to support mood disorders, low self-esteem, clinical perfectionism, and interpersonal difficulties. Fairburn et al. (2009) concluded that the two transdiagnostic treatments are effective for outpatients with eating disorders. Both CBT-E treatments exhibited significant and equivalent change, which was well maintained at the 60-week follow-up assessment. However, researchers also determined that patients with mood disorders, low self-esteem, clinical perfectionism, and interpersonal difficulties had a better outcome with the more complex treatment. In another quantitative study in the Netherlands consisting of 596 adult women with a mean age of 31, researchers found that CBT-E significantly decreased eating disorder pathology (Melisse et al., 2022). It is important to note that while treatment benefits were maintained at the 20-week follow-up, compliance at the 60-week follow-up was only 30% (Melisse et al., 2022). In a

similar quantitative study in London, Cooper et al. (2016) explored 65 women ages 18 – 65 years old who were treated with CBT-E over 20 weeks, followed by a 60-week follow-up. Researchers determined that patients with a more prolonged experience with bulimia (8 years or more) and low self-esteem were less likely to benefit from CBT-E.

Further, at the 60-week follow-up, those with a longer duration with bulimia nervosa exhibited higher levels of bulimia nervosa than those with a shorter duration (Cooper et al., 2016). In a systematic review exploring CBT-E for patients with eating disorders, researchers found that CBT-E is a practical and cost-effective choice for treating bulimia nervosa in adults (De Jong et al., 2018). Similarly, in a network meta-analysis by Slade et al. (2018) exploring treatment for bulimia nervosa, researchers found that individual CBT-E specific to eating disorders was most productive in achieving full recovery at the end of the treatment. Based on the abovementioned CBT-E studies, we can conclude that CBT-E is a highly productive and cost-effective choice in treating women with shorter bouts of bulimia nervosa.

As with most studies, the abovementioned CBT-E research has many strengths and limitations. The strengths include alignment with the demographic base of my current study, predominantly adult women, with a large sample pool of 596 participants in Melisse et al.'s (2022) study. However, the CBT-E treatments administered over 20 weeks by Melisee et al. (2022), Cooper et al. (2016), and Fairburn et al. (2009) are not enough time to warrant long-term recovery. With only 30% compliance at the 60-week follow-up in Melisse et al.'s (2022) study and the fact that those with more prolonged bouts of bulimia nervosa are less likely to benefit from CBT-E (Cooper et al., 2016) suggests that longer-term CBT-E studies are needed to determine the efficacy of CBT-E

in treating bulimia nervosa. It is important to note that Fairburn et al.'s (2009) study with the more complex treatment was successful with patients with mood disorders, low self-esteem, clinical perfectionism, and interpersonal difficulties. Therefore, applying Fairburn et al.'s (2009) complex treatment to Melisse et al. (2022) and Cooper et al.'s (2016) CBT-E studies would produce a better outcome in bulimia nervosa treatment.

Further, in De Jong et al.'s (2018) systematic review examining CBT-E for patients with eating disorders, the identification of relevant studies and a literature search were performed by one researcher, suggesting that the studies might have been missed or studies may have been misinterpreted. Lastly, it is essential to note that the abovementioned studies were all quantitative studies based outside of the United States, which calls for qualitative studies based in the United States as the lifetime prevalence of bulimia nervosa in women is 1.5% in the United States (Patel et al., 2018). While CBT-E is a practical treatment choice in alleviating bulimia nervosa, the short-term studies mentioned above conclude that longer-term treatment studies would better determine the efficacy of CBT-E in permanently treating bulimia nervosa.

Although CBT-E is explicitly focused on treating eating disorders, researchers have also explored CBT in treating bulimia nervosa in adult women. Within the realm of CBT, researchers have determined significant improvements in treating bulimia nervosa. In a quantitative study exploring 36 patients with bulimia nervosa in their mid-20s in Denmark, 20 sessions of CBT were administered over five months. Researchers found that 42% of the patients exhibited improvements due to the CBT issued. However, at the two-year mark, 44% of the bulimia nervosa patients had stopped all bulimia nervosa behaviors.

In comparison, 56% of the CBT patients still engaged in binging and purging behavior, and 31% still met the diagnosis of bulimia nervosa (Poulsen et al., 2014). Additionally, in a quantitative study investigating 59 women ages 17 to 59 with bulimia nervosa in the United Kingdom, patients were administered CBT over three years. Research determined that CBT, when administered in a routine clinical setting, produced significant improvements in anxiety, depression, eating disorder pathology, general functioning, and changes to eating attitudes early in therapy. A significant overall reduction in eating disorder behaviors and attitudes was also found (Turner et al., 2015).

Although the studies by Poulsen et al. (2014) and Turner et al. (2015) exhibited positive results in the effectiveness of CBT in treating bulimia nervosa, several limitations must be addressed. Firstly, the study consisted of a small sample size of 36 bulimia nervosa patients, making it difficult to determine if the improvements exhibited by CBT are accurate. Further, the treatment span included 20 sessions of CBT over five months, which is a relatively short duration to achieve significant improvements in bulimia nervosa treatment. Therefore, longer-term studies with a larger participant pool are necessary to determine a more representative and more accurate outcome regarding the efficacy of CBT on bulimia nervosa. According to the CBT study by Turner et al. (2015), the therapists administering the CBT had different levels of experience and training, which may have influenced the outcomes. Also, the study by Turner et al. (2015) lacked follow-up data, limiting the knowledge base on whether the positive changes made during the treatment were maintained long-term. However, a relatively decent participant pool of 190 adult women aligns with the demographic base of my

current study. Therefore, further investigation is warranted to include therapists with equal expertise and training with comprehensive follow-up data. The CBT studies by Poulsen et al. (2014) and Turner et al. (2015) have exhibited positive outcomes when CBT is administered to adult women with bulimia nervosa. However, based on the several limitations of these studies, further research is needed to substantiate the effectiveness of CBT on women with bulimia nervosa.

Treatments for Anorexia Nervosa in Adolescent Females and Women

Several researchers have explored psychotherapeutic and inpatient treatments in helping adolescent girls and women with bulimia nervosa. With regards to psychotherapeutic treatments, the Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA), Specialist Supportive Clinical Management (SSCM), and Enhanced Cognitive Behavioral Therapy (CBT-E) have exhibited positive results in the treatment of anorexia nervosa in adolescents. The following section will cover the effects of psychotherapeutic and inpatient treatments in women and adolescent females with anorexia nervosa.

Psychotherapeutic Treatments for Adolescent and Adult Anorexia Nervosa

The Maudsley Model of Anorexia Nervosa Treatment for Adolescents and Adults (MANTRA)

Research findings related to Adolescent Girls. Anorexia nervosa treatments in adolescent females have been a topic of interest among researchers. A well-known treatment for adolescent anorexia nervosa is the Maudsley Model of Anorexia Nervosa Treatment for Adolescents (MANTRA), also known as family-based treatment (FBT), has exhibited both positive and negative outcomes in weight gain in adolescent females

with anorexia nervosa. MANTRA gives parents and caregivers full authority to strictly monitor their child's eating, intending to help restore their child's weight and eating habits (Martin-Wagar et al., 2018). The following section will discuss several meta-analyses and empirical studies of MANTRA treatment in adolescent anorexia nervosa.

Several researchers have investigated the effectiveness of the family-based approach MANTRA in treating adolescent anorexia nervosa. In a meta-analysis exploring the efficacy of family-based treatment in adolescent anorexia nervosa, Van Den Berg et al. (2019) determined that adolescents struggled with weight gain under MANTRA. On the other hand, the studies with reported therapist training achieved higher effects on weight gain than those without documented therapist training (Van Den Berg et al., 2019). Differentially, in a separate network meta-analysis exploring psychological treatments in adolescent anorexia nervosa, Zeeck et al. (2018) discovered that family-based approaches were superior in adolescent intervention in inpatient and outpatient treatment settings. Regarding the meta-analyses by Van Den Berg et al. (2019) and Zeeck et al. (2018), limited databases were used in both studies. While Van Den Berg et al. (2019) filtered their search criteria based on end-of-treatment results, Zeeck et al. (2018) filtered their criteria based on randomized control trials. As a result of the strict exclusion criteria, significant studies related to MANTRA in adolescent anorexia nervosa may be missed. Further, the possibility of misinterpretation of the data is inevitable with all meta-analyses. Therefore, future studies can re-analyze and interpret the findings for misinterpreted or biased results.

Several empirical studies have also had positive results in adolescent anorexia nervosa treatment with family-based approaches like MANTRA. In a quantitative

analysis exploring 87 adolescent females in a Maudsley family-based day treatment program in an eating disorder specialty clinic in Ohio, researchers found that lower levels of parental empowerment were associated with a higher likelihood of weight restoration at the end of treatment (Martin-Wagar et al., 2018). This outcome is because parents with higher levels of empowerment did not find it necessary to provide their children with a level of care. After all, they felt more capable of helping their adolescent themselves (Martin-Wagar et al., 2018). Additionally, researchers determined that weight gain during the first four weeks in a family-based day treatment program is the key to success.

On the other hand, Martin-Wagar et al. (2018) also concluded that the more severe the initial eating disorder pathology, the poorer the family-based treatment response. Also, those with lower body mass index who have more weight gain pre-treatment need extra attention during treatment (Martin-Wagar et al., 2018). In a similar quantitative MANTRA study exploring 100 adolescent females, Wittek et al. (2021) also determined that MANTRA can be efficacious in supporting weight gain and decreased eating disorder pathology in adolescent females with anorexia nervosa. Regarding Martin-Wagar et al.'s (2018) and Wittek et al.'s (2021) MANTRA studies, we can conclude that family-based treatments like MANTRA are effective for adolescent weight gain and decreased eating disorder pathology. However, those individuals with severe eating disorder pathology and low body mass index may not benefit from MANTRA. Therefore, providing extra care and attention to those individuals with severe eating disorder pathology and low body mass index may help adolescent females with anorexia nervosa.

The MANTRA studies by Martin-Wagar et al. (2018) and Wittek et al. (2021) have many strengths and limitations. It is also important to note that most of these studies were quantitative and based mainly outside the United States. However, the studies by Martin-Wagar et al. (2018) and Wittek et al. (2021) were significant due to their larger female adolescent participant pool. Also, Wittek et al.'s (2021) study was the only multi-center study with more explicit representation than the other studies. In conclusion, FBT studies based on less restrictive exclusion criteria and larger participant pools recruited from multiple locations are needed for more conclusive and representative MANTRA data.

Research Findings Related to Women. The Maudsley model for adults with anorexia nervosa (MANTRA) has also been investigated by researchers in alleviating anorexia nervosa symptoms in adult women. MANTRA for adults is a specialist integrative therapy that addresses the emotional, cognitive, biological, and relational factors of anorexia nervosa by helping patients find alternative ways of coping with the eating disorder. MANTRA consists of weekly treatments, including individual therapy, family therapy, and dietetic support (Schmidt et al., 2013). The following section will discuss current literature regarding the efficacy of MANTRA treatment in adult women with anorexia nervosa.

Several researchers have found MANTRA treatment to be efficacious in treating anorexia nervosa in women. In a multi-site quantitative study in Central London, Schmidt et al. (2013) investigated 138 adult women with anorexia nervosa receiving MANTRA in an outpatient eating disorder setting. The women received 20 sessions at once-a-week intervals, and the severely ill cases received ten extra weekly sessions.

Researchers found that MANTRA is an efficacious treatment for women with anorexia nervosa, however (Schmidt et al., 2013). Similarly, in a quantitative multi-site study exploring 100 women with anorexia nervosa receiving MANTRA in Austria, Wittek et al. (2021) also determined that MANTRA has the potential to be a helpful and productive treatment for women suffering from anorexia nervosa. The women received 24 to 34 individual MANTRA therapy sessions or weekly psychotherapeutic treatments (Wittek et al., 2021). Lastly, in a systematic review and network analysis exploring psychotherapeutic treatments for 622 women with anorexia nervosa, Zeeck et al. (2018) determined that MANTRA is an effective treatment for women with anorexia nervosa. However, weight gain was observed to be greater in intense treatment settings. Based on the MANTRA studies mentioned above, we can conclude that MANTRA is a practical treatment choice for women with anorexia nervosa.

The strengths and limitations of the abovementioned MANTRA studies are similar to the anorexia nervosa treatments listed in my current study. The studies by Schmidt et al. (2013), Wittek et al. (2021), and Zeeck et al. (2018) consisted of decent-sized participant pools with predominantly adult women. Further, the abovementioned MANTRA studies consisted of broad inclusion criteria, allowing for a more significant and representative participant base. Additionally, both analyses by Schmidt et al. (2013) and Wittek et al. (2021) were based on a multi-center quantitative setting. While a multi-center approach allows for a more representative participant base, the personal experiences provided by qualitative studies may give a clearer picture of the efficacy of MANTRA based on first-hand accounts. Also, the MANTRA studies were conducted

outside of the United States, restricting data connected to the significant number of women who suffer from anorexia nervosa in the United States (Meule et al., 2020).

Furthermore, the MANTRA studies were short-term with broad exclusion criteria. While short-term term studies limit long-term efficacy data, the broad exclusion criteria decrease the representation of women with anorexia nervosa while limiting the participant base. Therefore, longer-term studies are necessary to validate the long-term efficacy of MANTRA in women with anorexia nervosa. Further, qualitative studies conducted in the United States are needed to provide first-hand accounts of women in the United States.

Enhanced Cognitive Behavioral Therapy for Women

Anorexia Nervosa Treatments in Adult Women. Enhanced cognitive behavioral therapy (CBT-E) has been a topic of interest in supporting adult women with anorexia nervosa. CBT-E is goal-focused talk therapy that addresses eating disorder psychopathology despite the eating disorder diagnosis (Cooper & Fairburn, 2011). Several researchers have found that CBT-E significantly decreased the core symptoms of anorexia nervosa in women. In a qualitative study exploring 190 women at an outpatient eating disorder center in the United Kingdom, Turner et al. (2015) discovered that significant improvements were achieved in anxiety, depression, eating disorder pathology, general functioning, and changes to eating attitude early in therapy due to the CBT-E received.

Further, researchers also found a significant overall reduction in eating disorder behaviors and attitudes. Similarly, in a multi-center quantitative study investigating 120 women from five outpatient treatment centers in Australia, researchers found clinically

significant improvements in body mass index, eating disorder psychopathology, social impairment, and healthy weight gain with the administration of CBT-E, which was maintained over a one-year follow-up (Byrne et al., 2017). In another multi-site quantitative study exploring 63 women with severe and enduring anorexia nervosa in Australia and London, researchers found that CBT-E exhibited significant improvements at the end of treatment and the 12-month follow-ups. CBT-E decreased core eating disorder symptoms at the post-treatment follow-up and achieved overall health-related improvements such as depression, body weight, higher quality of life, motivation to change, and decreased eating disorder pathology (Touyz et al., 2013). The abovementioned studies had many strengths, such as decent-sized adult female participant pools.

Further, the studies by Byrne et al. (2017) and Touyz et al. (2013) were conducted at multi-site locations, which expanded the participant pool to a more representative anorexia nervosa population. On the other hand, the studies by Byrne et al. (2017) and Touyz et al. (2013) had limitations due to their short-term nature, consisting of 25 to 40 sessions of CBT-E over ten months with no follow-up with Byrne et al. (2017); and 30 outpatient sessions over eight months followed by a 12-month follow-up with Touyz et al. (2013). The short-term nature of treatments is not sufficient for treating anorexia nervosa. Furthermore, all three studies were conducted outside of the United States. United States-based studies are necessary, considering that approximately 2,600 deaths attributed to anorexia nervosa occur in the United States every year (Meule et al., 2020).

Further, all three studies were quantitative, which limits the first-hand personal experiences that qualitative studies offer. Based on these limitations, we can conclude that longer-term studies are necessary to substantiate the efficacy of CBT-E in alleviating the core symptoms of anorexia nervosa. Additionally, qualitative studies of women with anorexia nervosa within the United States are warranted to provide first-hand personal accounts in the United States where the death toll is significant.

Specialist Supportive Clinical Management (SSCM) for Women

Research Findings Related to Women. Several researchers have also explored specialist supportive clinical management (SSCM) in treating adult women with anorexia nervosa. SSCM is a form of psychotherapy with two different components, such as clinical management involving alleviation of anorexia nervosa symptoms focusing on resuming eating behaviors to achieve healthy weight gain. SSCM also consists of a psychotherapeutic approach concerning issues that the patients find necessary (Byrne et al., 2017). Many researchers have found SSCM to be an excellent psychotherapeutic choice in alleviating anorexia nervosa symptoms in women. In a multi-site quantitative study exploring 120 outpatient women with anorexia nervosa across 3 Australian cities, Byrne et al. (2017) discovered that SSCM achieved significant improvements in general psychopathology, BMI, eating disorder psychopathology, and social impairment maintained over a one-year follow-up.

Additionally, 50% of the participants achieved a healthy weight with SSCM and recovery rates of 28.3% (Byrne et al., 2017). The efficacy of SSCM was also investigated by researchers in an outpatient treatment center in Central London, exploring 138 women. Schmidt et al. (2013) found that SSCM is an efficacious

treatment in alleviating anorexia nervosa symptoms in women. However, the effectiveness of SSCM appeared to diminish over time. Another multi-cite quantitative study explored 32 women with severe and enduring anorexia nervosa in two intervention sites in Australia and London. Touyz et al. (2013) found that patients achieved significant overall health-related improvements such as decreased eating disorder pathology, decreased depressive symptoms, healthy body weight, higher quality of life, motivation to change, and social adjustment due to the SSCM received. Lastly, in a systematic review and meta-analysis exploring psychotherapeutic treatments for anorexia nervosa, Zeeck et al. (2018) also determined that SSCM is an effective psychotherapeutic in alleviating anorexia nervosa symptoms in women. Based on the SSCM treatment studies by Byrne et al. (2017), Schmidt et al. (2013), Touyz et al. (2013), and Zeeck et al. (2018), we can conclude that SSCM is efficacious in helping women with anorexia nervosa achieve significant improvements in BMI, eating disorder psychopathology, social impairment, decreased depressive symptoms, healthier weight, and motivation to change.

The studies by Byrne et al. (2017), Schmidt et al. (2013), Touyz et al. (2013), and Zeeck et al. (2018) have strengths and limitations that need to be addressed. The studies were based on a predominantly adult female population with large participant pools. Further, the studies by Schmidt et al. (2013) and Touyz et al. (2013) were multi-site studies that allowed for a broader and more representative participant pool. Additionally, the abovementioned studies consisted of broad inclusion criteria, which decreases the chance of qualified participants being missed during recruitment.

However, the abovementioned studies had limitations. All the studies were quantitative and based outside of the United States.

Further, the studies were short-term, with 6- and 12-month follow-up periods, which is insufficient to determine the long-term effects of SSCM on anorexia nervosa in women. Additionally, the studies had broad exclusion criteria, which limits the number of eligible candidates for the studies. Therefore, qualitative studies are necessary to provide the personal experience of these participants who have received SSCM. Further, United States studies are needed concerning the significant death toll attributed to anorexia nervosa yearly (Meule et al., 2020). In conclusion, longer-term studies are required to substantiate the long-term efficacy of SSCM on adult women with anorexia nervosa.

Inpatient Treatment for Anorexia Nervosa in Adolescent Girls and Women

Research Findings on Inpatient Treatment Related to Adolescent Girls.

Aside from psychological treatments, inpatient treatments for anorexia nervosa in adolescent females have also been explored by researchers. In a quantitative study investigating 121 adolescent females in Germany, researchers discovered that inpatient treatments for adolescent females with anorexia nervosa are highly effective and that the efficacy of the treatment improves and remains stable at the one-year follow-up and beyond (Meule et al., 2020). However, older patients with previous inpatient treatments and a longer duration of anorexia nervosa need specialized attention during inpatient and aftercare treatment to avoid relapse (Meule et al., 2020). Further, in a two-site randomized control study by Madden et al. (2014), researchers compared the effectiveness of hospitalization for medical stabilization and weight restoration in

adolescent females with anorexia nervosa. Both randomized groups also completed 20 outpatient family-based therapy sessions. Based on the results of this randomized control trial, researchers determined that the weight restoration group spent more days in the hospital than the medical stabilization group (Madden et al., 2014). Also, the medical stabilization group with compulsive features and higher eating pathology achieved more improved clinical outcomes. It is also important to note that the weight reduction group also had a more extended initial hospitalization, which was Necessary and proved effective. Based on the inpatient anorexia nervosa treatment studies by Meule et al. (2020) and Madden et al. (2014), we can conclude that inpatient treatment effectively treats adolescent girls with anorexia nervosa, especially individuals with more critical features and higher eating disorder pathology.

The studies by Meule et al. (2020) and Madden et al. (2014) have strengths and limitations that must be addressed. Both studies had a decent-sized adolescent female participant pool. However, both were conducted outside the United States. Studies conducted in the United States are necessary since approximately 2,600 deaths attributed to anorexia nervosa occur yearly (Meule et al., 2020). Further, both studies were quantitative, which limits the first-hand personal experiences that qualitative studies offer. Also, both studies were short-term, following up with the participants for up to 12 months.

Regarding Meule et al.'s (2020) study, data regarding body weight and compulsive exercise at the 12-month follow-up was based on self-reporting, allowing for partial data. It has been found that participants will overestimate their weight by an average of 1 kg (Meule et al., 2020). Based on the limitations of the abovementioned

studies, we can conclude that future long-term studies, which are based in the United States and are qualitative, are necessary to provide more representative first-hand data. Also, studies in which an unbiased individual records the follow-up data would provide more accurate results.

Research Findings on Inpatient Treatment Related to Women. Several researchers have also explored inpatient treatment to support women with anorexia nervosa. Inpatient treatment provides patients with a structured and well-defined environment to allow patients a space to concentrate on their psychological and physical healing process (Schlegl et al., 2014). Researchers have found that inpatient treatment is highly effective in weight restoration in women with anorexia nervosa. A quantitative study by Schlegl et al. (2014) investigated 435 women with anorexia nervosa in a specialized inpatient treatment setting in Germany. Researchers found that inpatient treatment for anorexia nervosa is highly efficient in weight restoration and the treatment of anorexia nervosa (Schlegl et al., 2014). Also, one-third to more than one-half of the patients showed clinically significant improvement, and 30% exhibited a reliable change in an inpatient setting. The results of this study also determined that motivational strategies should be the main starting point for increasing the effectiveness of inpatient treatment.

Furthermore, in a systematic review and network meta-analysis investigating psychotherapeutic treatment for anorexia nervosa, Zeeck et al. (2018) determined that weight restoration was more effective with intense treatment settings such as inpatient treatment. The strengths of the abovementioned inpatient studies include a large female participant base and broad inclusion criteria. However, the lack of qualitative data limits

the personal experiences of these participants. Moreover, the fact that both studies were conducted outside of the United States limits a representative sample of women globally. Therefore, qualitative studies conducted in the United States are necessary to provide the personal experiences of women in a country where anorexia nervosa in women is prevalent.

Eating Disorder Treatment Challenges – Lack of Insurance Coverage

Eating disorders, the most fatal among mental illnesses, present challenges for patients accessing adequate healthcare (Tamargo, 2022). Specific individuals within the patient population face a complete absence of insurance coverage, while another subgroup of patients encounters difficulties obtaining adequate coverage for their treatment while insured. The absence of insurance coverage primarily arises from the contentious issue of medical necessity and the prevalent pseudo-pay-for-performance paradigm in the insurance sector (Tamargo, 2022). The lack of comprehensive insurance coverage has resulted in substandard healthcare provision, unfavorable treatment outcomes, and potential mortality among those with eating disorders. This situation raises concerns regarding the underlying motivations of insurance firms, as it questions whether their actions prioritize patient well-being or financial gain (Tamargo, 2022). Considering prioritizing revenue, insurance companies are increasingly exhibiting tendencies toward wastefulness, negligence, and inequitable practices, thereby compromising their ethical obligations (Tamargo, 2022)

Barriers to Obtaining Insurance Coverage for Eating Disorder Treatment. A protracted duration frequently characterizes the treatment of eating disorders and necessitates the involvement of multiple healthcare professionals and varying levels of

care (Cha & Cohen, 2022). Consequently, this can impose a substantial financial burden on patients and potentially impede their ability to obtain necessary treatment (Tamargo, 2022). Much existing research about utilizing various therapeutic services relies on data derived from insurance claims (Cha & Cohen, 2022). Although the study by Cha & Cohen (2022) does not provide a comprehensive analysis of the complete population of the United States, it is noteworthy as it sheds light on the difficulties encountered mainly by individuals with insurance coverage. However, it fails to address the changes to healthcare access experienced by about ten percent of the uninsured US population (Cha & Cohen, 2022).

Two separate studies conducted on private insurance claims for adults have revealed that individuals with eating disorders typically had between 4.7 and 18.1 outpatient treatment visits per year (Ballard & Crane, 2014; Striegel-Moore et al., 2008; Striegel-Moore et al., 2000). In several instances, attaining complete remission or medical maintenance can span several years of treatment. A study conducted in 1995 investigated insured individuals with eating disorders. It revealed that the total number of days spent in inpatient and outpatient therapy fell below the minimum duration suggested by the standard of care (Striegel-Moore et al., 2000). Additionally, the prevalence rates of eating disorders identified in this study were approximately one-tenth of the point prevalence rates projected by epidemiological studies on eating disorders. This finding implies that a significant proportion of individuals with eating disorders do not receive adequate treatment, a conclusion that is corroborated by multiple additional research investigations (Garvin & Striegel-Moore, 2001; Marshall et al., 2001; Striegel-Moore et al., 2008).

The cost of mental health therapy, including treatment for eating disorders, is a significant barrier that hinders access to such services (Alonso et al., 2004; Wang et al., 2005). The study conducted in 1995 investigated the annual age-adjusted expenses associated with treating anorexia nervosa and bulimia nervosa. The findings revealed that females with anorexia nervosa incurred costs of $6,045. At the same time, females with bulimia nervosa incurred $2,962 (Striegel-Moore et al., 2008). The amounts in question are considerable, particularly considering this group had previously received inadequate coverage, with an annual range of visits between 4.7 and 18.1 (Tamargo, 2022). It is important to note that the data provided is from 1995, and it is worth remembering that healthcare expenditures have significantly risen since that time (Kurani et al., 2022). In a recent study conducted on individuals diagnosed with bulimia nervosa, it was observed that over 62 weeks of cognitive behavioral therapy (CBT) resulted in a cost of $20,317 (Crow et al., 2013). A research investigation on the expenses incurred by individuals diagnosed with anorexia nervosa who were admitted to a hospital for a minimum duration of two days revealed that the mean cost per case amounted to $6,831 (Crow et al., 2013; Guarda et al., 2017; Haas et al., 2012). Researchers analyzed the expenses associated with an inpatient-partial hospitalization program for individuals diagnosed with anorexia nervosa. The findings revealed that the average daily cost for inpatient treatment amounted to $2,295, while outpatient therapy incurred an average daily cost of $1,567 (Guarda et al., 2017).

Insurance Coverage. The provision of insurance coverage for treating eating disorders is contingent upon two factors: insurance availability and insurance companies' willingness to extend coverage for such treatment. Both factors, in turn, are

influenced by insurance policies in the United States (Alderman, 2010; Frank et al., 2014). The Mental Health Parity and Addiction Equality Act (MHPAEA), enacted in 2008, is a legislation at the federal level that serves to prohibit insurance companies from putting yearly limitations or higher co-payment or deductible requirements on mental health treatment in comparison to medical and surgical treatment (Alderman, 2010; Frank et al., 2014). The Mental Health Parity and Addiction Equity Act (MHPAEA) does not mandate the inclusion of mental health coverage. Instead, it focuses on establishing rules for coverage when mental health services are included in an insurance plan (Alderman, 2010; Frank et al., 2014). This underscores the significance of enacting the Affordable Care Act (ACA) in 2010, which introduced a broader range of insurance plans incorporating mental health coverage and mandated Medicaid to give mental health treatment (Tamargo, 2022).

Consequently, the implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act (ACA) has expanded mental health coverage options for Americans while also limiting the potential exemptions imposed by insurance agencies (Li & Ma, 2020). Notably, the 2014 ACA insurance expansions substantially decreased the uninsured rate among individuals with mental disorders (Li & Ma, 2020). Nevertheless, it is essential to acknowledge that health insurance policies are subject to change, especially during transitions of political power. In addition, the potential repeal of some provisions of the Affordable Care Act (ACA) may result in individuals being deprived of mental health coverage.

One further obstacle to achieving comprehensive treatment for eating disorders is the persistent or diminishing reimbursement rates for mental health care (Whitelaw et

al., 2014). The operational expenses associated with running a practice have risen, but the reimbursement rates offered by most insurance carriers have remained stagnant for an extended period (Whitelaw et al., 2014). Consequently, many networks suffer from a shortage of mental health experts, impeding individuals' ability to obtain necessary healthcare services (Tamargo, 2022).

Factors Leading to Denial of Insurance Coverage. Although there is a lack of comprehensive data on insurance denial rates, anecdotal evidence suggests that the current system can hurt those with eating disorders (Pelley, 2014; Tamargo, 2022). One illustrative instance is the case of Katherine West, whose death occurred at 15 due to problems arising from bulimia nervosa. The treatment regimen for West, as recommended by her medical practitioners, was intended to be conducted over 12 weeks within a hospital setting, with an estimated cost exceeding $50,000 (Pelley, 2014; Tamargo, 2022). However, the insurance coverage ceased after around six weeks due to the determination that her weight had reached an acceptable level (Pelley, 2014; Tamargo, 2022). Despite the medical advice provided by her doctor on the anticipated weight loss following her discharge, the decision made by the insurance company took precedence, ultimately resulting in her untimely death. The objective insurance evaluation procedure and the inadequate application of medical necessity standards frequently fall short of adequately addressing the intricate nature of eating disorders. According to the statement made by Katherine West's mother, it is asserted that treating a mental disease cannot be effectively resolved within just a six-week timeframe (Pelley, 2014; Tamargo, 2022).

A significant portion of insurance coverage for eating disorders is contingent upon an individual's weight (Peebles et al., 2010; Sawyer et al., 2016; Whitelaw et al., 2014; Whitelaw et al., 2018). Following the assessments conducted by insurance physicians, patients with a weight deemed adequate may not satisfy the established requirements for medical necessity. This issue presents several challenges from various perspectives (Peebles et al., 2010; Sawyer et al., 2016; Whitelaw et al., 2014; Whitelaw et al., 2018). Initially, it is worth noting that individuals diagnosed with anorexia nervosa typically exhibit low body weight. However, patients with bulimia nervosa and binge eating disorder commonly maintain average or above-average body weights despite being significantly affected by their respective disorders (Peebles et al., 2010; Sawyer et al., 2016; Whitelaw et al., 2014; Whitelaw et al., 2018). Furthermore, it is essential to note that weight restoration alone does not serve as a cure for eating disorders, as underlying psychological factors fundamentally influence these conditions. Addressing malnourishment is a crucial step toward attaining optimal treatment outcomes; nevertheless, it is essential to acknowledge that this represents only a portion of the broader narrative (Peebles et al., 2010; Sawyer et al., 2016; Whitelaw et al., 2014; Whitelaw et al., 2018). However, it should be noted that in certain instances of severe anorexia nervosa, insurance providers may only offer coverage for partial weight restoration despite research findings suggesting that complete weight restoration is the only approach associated with a better prognosis (Guarda, 2017).

Patients may face denial of insurance benefits due to their medical treatment history (Tamargo, 2022). Regarding obtaining coverage for residential or inpatient therapy, patients must demonstrate a need for improvement or success with lesser

levels of care. Care may also be withheld from a patient if previous interventions at the equivalent care level have proven futile (Tamargo, 2022). Insurance providers may also decline coverage for medical treatment based on a patient's insufficient improvement. For instance, in cases when a patient fails to regain weight or persists in engaging in disordered eating habits such as purging, restricting, over-exercising, or bingeing, the individual may be deemed ineligible for further benefits (Tamargo, 2022). This situation underscores the frequently insincere character of the insurance sector, wherein claims may be rejected if a patient does not regain weight. However, claims can also be denied based on the justification of medical necessity once weight has been recovered.

Similarly, it is worth noting that persistent engagement in certain behaviors might lead to the denial of certain privileges or benefits (Tamargo, 2022). Conversely, the absence of such behaviors may indicate sufficient improvement, justifying the withdrawal of these benefits. Therefore, insurance firms can manipulate a patient's condition, regardless of its nature, to render them ineligible for insurance coverage for medical treatment (Tamargo, 2022).

Another factor contributing to the refusal of insurance coverage is the remuneration structure of insurance doctors, who often get compensation on a per-case basis (Tamargo, 2022). Therefore, an insurance physician can gain more significant financial compensation by rejecting a particular case and promptly transitioning to the next patient rather than persistently evaluating the circumstances of a patient who continues residential treatment for an extended period (Tamargo, 2022). In brief, the framework of insurance evaluations facilitates the subsidization of denial.

Adaptive Coping Tools for Preventing Eating Disorder Relapse

One of the crucial aspects of maintaining recovery and avoiding relapse after undergoing intensive eating disorder treatment is the ability to maintain the improvements developed during recovery and focus on the positive aspects of oneself (Bello & Yeomans, 2017; Berends et al., 2016; Dawson et al., 2014; Fogarty et al., 2016; Fredrici & Kaplan, 2007; Hanly et al., 2020; Lindgren et al., 2014; Olmsted et al., 2014). Researchers have found that more than a third of individuals who undergo treatment for anorexia or bulimia nervosa relapse within the first few years after completion of treatment (Berends et al., 2016; Filipponi et al., 2022; Sacchetti et al., 2019). Therefore, the most significant risk of relapse from anorexia usually takes place within the first 18 months after treatment, with 35% of individuals fully relapsing into eating-disordered behaviors (Berends et al., 2016; Carter et al., 2012; Filipponi et al., 2022; McFarlane et al., 2008). Moreover, a 27.6 to 41% relapse rate with bulimia nervosa within two years after treatment, with a majority of the relapse taking place in the first few months after recovery (McFarlane et al., 2008; Olmsted et al., 2014; Saccetti et al., 2019). Considering the high relapse rate among individuals with eating disorders, some support must be accessible when they leave eating disorder treatment centers. Hence, several researchers have found peer support programs and mindfulness practices to be effective adaptive coping tools for individuals recovering from an eating disorder (Dawson et al., 2014; Fogarty et al., 2016; Frederici & Hanly et al., 2020; Hernando et al., 2019; Jimenez et al., 2010; Kaplan, 2008; Lindgren et al., 2014; Ma & Fang, 2019; Omiwole et al., 2019; Perez et al., 2014). The following section will discuss the efficacy of peer support programs and mindfulness exercises in

maintaining long-term eating disorder recovery and comorbid anxiety and depression in adolescent females and women.

Peer Support. Peer support refers to individuals who face common challenges, share similar experiences, and work together to help each other by giving and receiving the knowledge that results from shared experiences (Penney, 2018). The term peer is defined as an equal and someone with whom social and demographic similarities are shared. Support is defined as deeply felt empathy, encouragement, and help that individuals with shared experiences can offer each other within a reciprocal relationship (Penney, 2018). Peer support is viewed as an organized strategy for giving and receiving help, an extension of the natural human tendency to respond compassionately to shared challenges (Penney, 2018). Individuals who have experienced complex challenges empathize with and tend to help others with similar problems. Therefore, peer support helps the individuals receiving the support and makes the supporter feel needed and valued (Penney, 2018; Riessman, 1965).

Peer support, also referred to as self-help or mutual aid, can improve an individual's coping mechanisms by providing adaptive tools to deal with the emotional consequences of stress (Trojan, 1989). Furthermore, peer support groups empower participants to help fellow group members cope with their struggles by sharing experiences. Support groups have been known to foster benefits, including dealing with psychiatric diagnoses, mental health issues, and emotional challenges, including disordered eating behaviors, anxiety, and depression (Trojan, 1989). Several studies show that peer support fosters positive self-conceptions, social skills, responsibility, competence, and impulse control by facilitating behavioral control, which leads to lower

levels of depression, anxiety, and eating disorder behaviors (Beveridge et al., 2019; Hanly et al., 2020; Ramjan et al., 2017; Ramjan et al., 2018; Roohafza et al., 2014). The following section will discuss current literature on the efficacy of peer support as an adaptive coping mechanism for eating disorders and comorbid anxiety and depression in women.

Out-Patient Peer Mentoring Programs for Women with Eating Disorders. The efficacy of in-patient peer mentoring programs focusing on the recovery of eating disorders, including anorexia nervosa and bulimia nervosa, has been explored by several researchers. Peer mentoring programs (PMP) are no-cost or non-profit organizations that take place face-to-face in an eating disorder out-patient hospital setting (Beveridge et al., 2019; Hanly et al., 2020; Ramjan et al., 2017; Ramjan et al., 2018), or in a global eating disorder mentoring community setting such as *MentorCONNECT* (Perez et al., 2014), involving 13 sessions of PMP of up to three one-hour long sessions weekly over six months. The similarities and differences between outpatient hospital settings and global eating disorder mentoring communities will be discussed below.

Peer mentoring programs in outpatient eating disorder hospital settings and global eating disorder mentoring communities have a common goal in mind of supporting patients in their quest for recovery. However, both plans are structured differently. In an eating disorder out-patient hospital setting, the mentors and mentees develop an individualized wellness plan, including short-term goals in living circumstances and skills, self-care, health, creative interests and hobbies, social relationships and connectedness, identity and sense of self, work/career and education,

and community roles and responsibilities (Beveridge et al., 2019; Hanly et al., 2020; Ramjan et al., 2017; Ramjan et al., 2018). The wellness plan also details thoughts, behaviors, feelings, personal qualities, characteristics, interests, relationships, and activities. It is important to note that the mentees and mentors worked together to achieve identified goals (Beveridge et al., 2019; Hanly et al., 2020; Ramjan et al., 2017; Ramjan et al., 2018). Global eating disorder mentoring communities such as MentorCONNECT (Perez et al., 2014) consist of three phases: 1) The first phase of the mentoring relationship is the initiation phase, where the mentor and mentee get to know each other and decide if they are a good fit. 2) The second phase of the mentoring relationship is the cultivation phase, during which the mentor and the mentee simultaneously benefit and develop the mentoring relationship based on the interests and needs of both the mentor and the mentee. 3) The third and last phase is the separation phase, which may involve sadness as the mentor may report not feeling needed or that the support they can offer is limited (Perez et al., 2014). Compared to the PMP outpatient hospital setting, eating disorder-based mentoring communities allow mentors and mentees to communicate daily, almost daily, two to three times a week, once a week, twice a month, or more, and once a month. Therefore, the length of the mentoring relationship is flexible, and the time frame may be short or may last several years based on the mentee's needs (Perez et al., 2014). The following section will discuss five prominent themes that emerged from the peer mentoring program studies: 1) Mentors serve as a source of hope, motivation, and commitment to recovery; 2) Mentees feel a sense of connection and re-engagement with the world and others due to the isolated state of the disease. 3) Mentors provide a sense of positive support and

encouragement. 4) Mentees feel a sense of non-judgment, comfort, belonging, understanding, and empathy from the mentor. 5) Mentees experience a sense of physical, emotional, and psychological well-being while working with their mentor. Moreover, the strengths and limitations of the peer mentoring studies below will be summarized at the end of this section due to their similarities.

Mentors Serve as a Source of Hope, Motivation, and Inspiration for Recovery in Out-Patient Peer Mentoring Programs. Hope is a crucial aspect of eating disorder recovery, closely connected to increased motivation and inspiration for change (Colla et al., 2022). The mentor's role in cultivating hope, motivation, and inspiration for commitment to recovery is perhaps the most substantial common finding in the limited research examining peer mentoring programs for women with eating disorders and comorbid anxiety and depression (Beveridge et al., 2019; Dawson et al., 2014; Fogarty et al., 2016; Hanly et al., 2020; Linville et al., 2012; Perez et al., 2014; Ramjan et al., 2017; Ramjan et al., 2018). Ramjan et al. (2018) also found that the mentor's resilience, positivity, and strength gave the mentee tangible hope for recovery. Out-patient peer mentoring program sessions are customized to the mentee's goals, including practicing social interactions with food, daily living tasks, and making connections in the community. It is also important to note that mentors shared their journey to eating disorder recovery to facilitate hope and motivation for the mentee. Several qualitative, quantitative, and mixed methods studies exploring predominantly Caucasian women outside of the United States (majority with anorexia and some with bulimia) have determined that the skills and behaviors passed on through healthy role modeling from the mentors to the mentees play a crucial role in the mentee's pursuit of

recovery (Beveridge et al., 2019; Dawson et al., 2014; Fogarty et al., 2016; Hanly et al., 2020; Linville et al., 2012; Perez et al., 2014; Ramjan et al., 2017; Ramjan et al., 2018). Participants in several studies self-reported that their mentor inspired a great belief that recovery was possible by witnessing their mentors' successful recovery (Beveridge et al., 2019; Dawson et al., 2014; Fogarty et al., 2016; Hanly et al., 2020; Linville et al., 2012; Perez et al., 2014; Ramjan et al., 2017; Ramjan et al., 2018). The studies mentioned above suggest that peer mentoring programs facilitate eating disorder recovery through the hope, motivation, and inspiration that the mentor provides for the mentee.

Mentee's Sense of Reconnection to the World. The following theme from the peer mentoring program for eating disorders in women was the mentee's sense of reconnection with the world due to the isolated state of their eating disorder (Beveridge et al., 2019; Hanly et al., 2020; Linville et al., 2012; Ramjan et al., 2017; Ramjan et al., 2018). In several empirical qualitative, quantitative, and mixed methods studies exploring Caucasian women (predominantly anorexia and some bulimia) outside of the United States, mentees self-reported that they felt reconnected and reengaged with the world (Beveridge et al., 2019; Hanly et al., 2020) by asking questions and feeling challenged (Ramjan et al., 2018), felt less isolated with their social, romantic, and close relationships, work, and family life (Linville et al., 2012; Ramjan et al., 2017). The studies above suggest that peer mentoring programs can foster a mentee's reconnection with the world and others, including their relationships.

Mentor Provides a Sense of Positive Support and Encouragement. The third emerging theme from the peer mentoring program studies is the mentor providing a

positive sense of encouragement and support to the mentee (Fogarty et al., 2016; Linville et al., 2012; Roohafza et al., 2014). In a qualitative study exploring 22 predominantly Caucasian women at Oregon State University who had recovered from an eating disorder, participants attested that the positive support and encouragement they experienced from their mentors and family members helped boost their eating disorder recovery (Linville et al., 2012). Similarly, in a cross-sectional study exploring 4658 individuals (56% female, 44% male) with anxiety and depression, researchers found that positive encouragement from social supports (i.e., family social support, mentors) can foster positive self-conceptions, social skills, responsibility, competence, and impulse control by facilitating behavioral control which leads to lower levels of depression and anxiety (Roohafza et al., 2014). Lastly, in a systematic review and meta-synthesis of the effects of mentoring on eating disorders, Fogarty et al. (2016) found that the mentees experienced positive support and encouragement from their mentor because they were sharing their experience with someone who had walked into their shoes. Hence, Fogarty et al. (2016) concluded that a mentee could provide positive encouragement for recovery based on shared experiences. The findings suggest that positive encouragement from social support systems such as mentors and family significantly influences eating disorders, anxiety, and depression recovery.

Mentee Feels a Sense of Non-Judgement, Acceptance, Comfort, and Belonging. The fourth emerging theme in the peer mentoring program studies is the mentee's sense of non-judgment, acceptance, comfort, and belonging while working with their mentor (Beveridge et al., 2019; Hanly et al., 2020; Fogarty et al., 2016; Linville et al., 2012; Ramjan et al., 2018). In several qualitative studies exploring women with

eating disorders, participants attested that working with a mentor made them feel accepted without judgment. Therefore, they were more willing to show their imperfections (Beveridge et al., 2019; Hanly et al., 2020). Similarly, in a mixed methods study by Ramjan et al. (2018), participants professed that their mentor could understand, relate, and show empathetic support, facilitating their eating disorder recovery. Lastly, Fogarty et al.'s (2016) systematic review of the efficacy of mentoring on eating disorders revealed that the mentee's experience of finding comfort, belonging, feeling understood, and acceptance were the key to their eating disorder recovery. Therefore, the studies mentioned above suggest that compassion, understanding, and empathy from the mentor who has experienced the same challenges as the mentee provides a sense of comfort, belonging, and acceptance, fostering eating disorder recovery.

Mentees Experience Improvements in Quality of Life, Mood, Physical, Emotional, and Psychological Well-Being. The last emerging theme from the peer mentoring program studies includes improvements in quality of life, mood, and physical, psychological, and emotional well-being experienced by the mentee (Beveridge et al., 2019; Perez et al., 2014). At the end of the peer mentoring program for participants with eating disorders, researchers found improvements in eating disorder symptomology**,** body mass index, mood, perceived disability, and quality of life (Beveridge et al., 2019). Similarly, in Perez et al.'s (2014) *MentorCONNECT* eating disorder mentoring study, mentees also exhibited a higher quality of life and self-reported improvements in their physical, emotional, and psychological well-being. The data suggest that peer support in terms of mentorship is an effective adaptive coping tool for individuals recovering from

an eating disorder regarding quality of life, mood, and physical, emotional, and psychological well-being.

Strengths and Limitations of Peer Mentoring Program Studies. The peer mentoring program (PMP) studies mentioned above have strengths and limitations that warrant discussion. The outstanding strength in all PMP studies was the predominantly female participant base, which aligns with the demographic of my current autoethnography. However, the participants consisted of predominantly Caucasian women with anorexia nervosa with small participant pools across all PMP eating disorder studies (7 – 58 participants), which decreases the generalizability of the findings. Additionally, most of the PMP studies were conducted in Australia (Beveridge et al., 2019; Hanly et al., 2020; Ramjan et al., 2017; Ramjan et al., 2018), Iran (Roohafza et al., 2014), and the United States (Linville et al., 2012; Perez et al., 2014). There is also a lack of solely qualitative PMP studies, with most of the studies being participant self-reported mixed methods (quantitative/qualitative) (Beveridge et al., 2019; Hanly et al., 2020; Ramjan et al., 2018), quantitative (Perez et al., 2014; Ramjan et al., 2017), and qualitative (Linville et al., 2012). Lastly, there is a lack of PMP studies focusing on the efficacy of PMP in coping with anxiety and depression. Roohafza et al.'s (2014) quantitative study examining the role of social support in coping with anxiety and depression study was the only one of its kind. According to the strengths and limitations of the PMP studies, qualitative studies in the U.S. exploring the efficacy of PMP on racially diverse women with anxiety, depression, and eating disorders are lacking. Therefore, qualitative PMP studies in the United States investigating anxiety, depression, and eating disorders (anorexia, bulimia, and binge eating disorder) while

utilizing a more racially diverse participant base are warranted to provide representative and generalizable data.

Online Peer Support Groups for the Recovery and Adaptive Coping of Adolescent and Adult Anxiety, Depression, and Eating Disorders

A limited number of studies have explored the efficacy of online peer support groups as an adaptive coping option for adolescents and adults struggling with anxiety, depression, and eating disorders. Unlike peer mentoring programs for mental health and eating disorders, where the mentee is assigned to a structured and customized 13-week recovery plan with the mentor (Beveridge et al., 2019; Hanly et al., 2020; Ramjan et al., 2017; Ramjan et al., 2018), online peer support groups provide an autonomous, anonymous, and no-cost space for individuals seeking self-help services (Bryom, 2018; Horgan et al., 2013; Kendal et al., 2016; McCormack & Coulson, 2009; O'Leary et al., 2018). Two common themes emerged from the online peer support group studies: 1) Online peer support groups provide a safe, private, anonymous, and non-judgmental space for sharing, offering, receiving, and reciprocating emotional support; 2) Online peer support groups encourage recovery from eating disorders and boost self-esteem and mental well-being. The following section will discuss the findings of the two emerging themes. Due to the shared limitations of all online peer support studies, the limitations will be summarized towards the end of this section.

Online Peer Support Groups for Eating Disorders, Anxiety, and Depression

Studies exploring the effectiveness of online peer support groups for eating disorders, anxiety, and depression are scarce. However, based on the current data, researchers determined that online peer support for eating disorders and mood

disorders (i.e., anxiety and depression) can be a beneficial tool for adaptive coping and recovery (Bryom, 2018; Horgan et al., 2013; Kendal et al., 2016; McCormack & Coulson, 2009; O'Leary et al., 2018). The main common finding in online peer support studies is that online peer support groups are a safe, private, anonymous, and non-judgmental space for sharing, offering, receiving, and reciprocating emotional support (Bryom, 2018; Horgan et al., 2013; Kendal et al., 2016; McCormack & Coulson, 2009; O'Leary et al., 2018). Several qualitative studies downloaded and thematically analyzed 325 (McCormack & Coulson, 2009), and over 400 (Kendal et al., 2016) posted messages from youth-oriented and adult-oriented online eating disorder discussion forums based in the United Kingdom (Kendal et al., 2016) and European, North American, and Australian countries (McCormack & Coulson, 2009). Based on the online forum posts, researchers determined that participants struggled mainly with a perceived lack of socialization skills and loneliness (Bryom et al., 2019; Horgan et al., 2013). Hence, online discussion forums can provide a safe and non-judgmental space for individuals to talk about their feelings without having to deal with the reactions of others (McCormack & Coulson, 2009; Kendal et al., 2016). The anonymity aspect of the online group was vital in allowing the participants to articulate and acknowledge the frightening feelings fully. Researchers also determined that the participants could reflect on their experiences and define the root of their problem through the shared experiences of their peers (McCormack & Coulson, 2009; Kendal et al., 2016). Therefore, online discussion forums can be a safe, non-judgmental, and acceptable space for adults and adolescents to find support for eating disorders.

The data on the efficacy of online peer support groups as effective and no-cost recovery and coping alternatives for anxiety, depression, and eating disorders in adolescents and adults is also limited. However, based on the limited data, the second theme that emerged from the online peer support studies is that online peer support groups encourage recovery from eating disorders, anxiety, and depression and boost self-esteem and mental well-being (Bryom et al., 2018; Horgan et al., 2013; McCormack & Coulson, 2009; O'Leary et al., 2018). Several quantitative and mixed methods (qualitative/quantitative) empirical studies outside of the United States discovered that online forums encouraged recovery from eating disorders (McCormack & Coulson, 2009; O'Leary et al., 2018), reduced anxiety and depression (Bryom, 2018; Horgan et al., 2013; O'Leary et al., 2018), boosted self-esteem and mental well-being, and supported individuals concerning diagnosis, treatment, and interaction with health care specialists (McCormack & Coulson, 2009). Hence, the current data suggests that online peer support groups have the potential to provide accessible and affordable mental health and eating disorder care to individuals with anxiety, depression, and eating disorders.

Limitations of Online Peer Support Studies. Online peer support studies have several crucial limitations that need to be discussed. Firstly, due to the anonymous nature of online peer support groups, demographics could not be established (i.e., unknown ethnicity, age, and location). However, Horgan et al. (2013) indicated a 64% male participant base, and Bryom (2018) and McCormack & Coulson (2009) showed a 100% female participant pool. Furthermore, the peer support studies lacked qualitative studies, which consisted of quantitative and mixed methods (qualitative/quantitative).

Additionally, O'Leary et al.'s (2018) online peer support study for eating disorders and mental health was the only one in the United States. In contrast, the other four studies were in the United Kingdom (Bryom, 2018; Kendal et al., 2016), Ireland (Horgan et al., 2013), and European, North American, and Australian countries (McCormack & Coulson, 2009). It is also important to note that the only eating disorder highlighted in the online eating disorder forums was anorexia nervosa (McCormack & Coulson, 2009). Moreover, only one online peer support study was dedicated to adolescents (Kenal et al., 2015). Hence, based on the online peer support group limitations mentioned above, qualitative studies conducted in the United States with a predominantly adolescent female and women participant pool highlighting specific eating disorders (i.e., anorexia, bulimia, and binge eating disorder) are warranted for future study.

Overeaters Anonymous as Peer Support

Unlike medical-based treatment programs of support, Overeaters Anonymous (OA) is regarded as an adaptive coping tool to support compulsive overeaters (Russell-Mayhew et al., 2010). OA provides a non-judgmental, relatable, and no-cost space where members support one another by openly discussing their shared struggles to recover and cope with their eating disorders (Hertz et al., 2012; Russell-Mayhew et al., 2010). In this section, I briefly describe OA and then present the research discoveries regarding the 12-step program concerning adolescent females and women. As with medical-based treatment programs, researchers have also discovered benefits and challenges to the OA program and processes for adolescent females and women with compulsive eating behaviors.

Background of Overeaters Anonymous

Overeaters Anonymous (OA) is a 12-step program for compulsive overeaters founded in the United States in 1960. Based on the principles of Alcoholics Anonymous (Russell-Mayhew et al., 2010), OA is a multi-faceted, non-professional, non-profit, free-of-charge organization that individuals can seek out confidentially without a diagnosis. OA members share an irregular relationship with food and several failed attempts at overcoming this problem (Rodríguez-Martín & Gallego-Arjiz, 2018). OA provides face-to-face and phone meetings in several languages and helps members overcome significant barriers of stigma, lack of diagnosis, and lack of insurance coverage, preventing all those who suffer from binge eating disorder from receiving treatment (Bray et al., 2021).

Further, the OA program offers recovery-based practices in which members can adopt a lifestyle that leads to emotional, spiritual, and physical well-being. Additionally, OA's Twelve Steps, Twelve Traditions, and Nine Tools (see Tables 1 – 3) serve as the programmatic guides of social and structural support for all those suffering from binge eating disorder and bulimia nervosa (Rodríguez-Martín & Gallego-Arjiz, 2018). The following section will discuss two significant patterns that emerged in OA research in helping women adaptively cope with compulsive overeating issues, including binge eating disorder and bulimia nervosa. These patterns include the efficacy of the Nine Tools of OA (see Table 3) and peer support serving as an emotional support tool for the members of OA. It is also important to note that one study that addresses worldview transformation will be discussed separately. The Worldview Transformation study is a qualitative study that is a detailed portrayal of women's recovery process in OA. The extra detail in the following qualitative studies will be included as it is pertinent and

essential to the depth and portrayal of the firsthand experiences of women in OA. The strengths and limitations of all studies will be addressed in one main paragraph as they are identical in all the studies.

Table 1

The 12 Steps of Overeaters Anonymous

1. We admitted we were powerless over food – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Decided to turn our will and lives to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed and made amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to compulsive overeaters and to practice these principles in all our affairs.

Note. Information taken from: (Overeaters Anonymous, 2023b)

Table 2

The Twelve Traditions of Overeaters Anonymous

1. Our common welfare should come first; personal recovery depends upon OA unity.
2. For our group purpose there is but one ultimate authority – a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for OA membership is a desire to stop eating compulsively.
4. Each group should be autonomous except in matters affecting other groups or OA.

5. Each group has but one primary purpose – to carry its message to the compulsive overeater who still suffers.
6. An OA group ought never endorse, finance, or lend the OA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.
7. Every OA group ought to be fully self-supporting, declining outside contributions.
8. Overeaters Anonymous should remain forever non-professional, but our service centers may employ special workers.
9. OA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Overeaters Anonymous has no opinion on outside issues; hence, the OA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, films, television, and other public media of communication.
12. Anonymity is the spiritual foundation of all these Traditions, ever reminding us to place principles before personalities.

Note: Information taken from: (Overeaters Anonymous, 2023c)

Table 3

The Nine Tools of Overeaters Anonymous

1. A Plan of Eating: A plan of eating helps us abstain from compulsive eating, guides us in our dietary decisions, and defines what, when, how, where, and why we eat. This Tools helps us deal with the physical aspects of our disease and achieve physical recovery.
2. Sponsorship: We ask a sponsor to help us through all three levels of our program of recovery: physical, emotional, and spiritual. Find a sponsor who has what you want and ask that person how they are achieving it.
3. Meetings: Meetings give us an opportunity to identify our common problem, confirm our common solution, and share the gifts we receive through this Twelve Step program.
4. Telephone: Many members call, text, or email their sponsors and other OA members daily. Telephone or electronic contact also provides an immediate outlet for those hard-to-handle highs and lows we may experience.
5. Writing: Putting our thoughts and feelings down on paper, or describing a troubling or joyous incident, helps us better understand our actions and reactions in a way that is often not revealed by simply thinking or talking about them.
6. Literature: We read OA-approved literature, which includes numerous books, study guides, pamphlets, wallet cards, and selected Overeaters Anonymous texts. All this material provides insight into our disease and the experience, strength, and hope that there is a solution for us.

7. Action Plan: Creating an action plan is the process of identifying and implanting attainable actions to support our individual abstinence and emotional, spiritual, and physical recovery.
8. Anonymity: Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities. Within the Fellowship, anonymity means that whatever we share with another OA member will be respected and kept confidential.
9. Service: Any form of service – no matter how small – that helps reach a fellow sufferer adds to the quality of our own recovery. Members who are new to OA can give service by attending meetings, sharing, and putting away chairs. As OA's Responsibility Pledge states: "Always to extend the hand and heart of OA to all who share my compulsion; for this I am responsible."

Note. Information taken from: (Overeaters Anonymous, 2023a)

Nine Tools of OA. In three empirical studies, researchers found that the Nine Tools of OA (see Table 3) were the key to overcoming compulsive overeating in women suffering from bulimia nervosa and binge eating disorder (Kriz, 2002; Russell-Mayhew et al., 2010; Wasson & Jackson, 2004). In a quantitative study, Kriz (2002) explored 231 active female members of OA between the ages of 34 and 44 in the Washington Metropolitan area. In this quantitative study, researchers found that adherence to the Nine Tools of OA, including regular attendance at meetings, following a food plan, journaling, performing service for OA, and phone calls to sponsors and members, aids in fostering abstinence in binge eating disorder and bulimia nervosa. Furthermore, in a qualitative study by Russell-Mayhew et al. (2010) in Canada, female participants reported that the Nine Tools of OA's writing and food planning practices were particularly helpful in their abstinence from compulsive overeating. Lastly, Wasson and Jackson (2004) qualitatively explored the role of OA in women's recovery from bulimia nervosa. Twenty-six women aged 20 to 59 with at least six months of abstinence from bingeing and purging were investigated in an OA group in Arlington, Texas. Abstinence, in terms of bulimia nervosa recovery, refers to managing eating every day because of

the need of food for survival (Wasson & Jackson, 2004). In this qualitative analysis, the researchers utilized focus groups and individual interviews to investigate the specific elements of OA and its role in supporting bulimia recovery. Wasson and Jackson (2004) discovered that the participants used the 5 OA strategies or skills, which include OA meeting attendance and participation; interaction with a sponsor; processing (i.e., writing and journaling); spirituality (i.e., prayer and meditation); and adherence to a food plan. However, all participants attested to using a food plan to track daily eating and regular participation at OA meetings as the two most crucial skills to recovery. According to these researchers, the Nine Tools of OA are essential to OA members being able to adaptively cope and recover from compulsive overeating addiction, including binge eating disorder and bulimia nervosa.

The OA studies by Kriz (2002), Russell-Mayhew et al. (2010), and Wasson and Jackson (2004) have several strengths and limitations. Firstly, the strengths of all studies are the predominant female participant base and the qualitative nature of all studies except for Kriz (2002). The researchers in this area focused on abstinence or success in the OA program. However, they only broadly explained that the OA programs vary (Kriz, 2002; Russell-Mayhew et al., 2010; Wasson & Jackson, 2004). For this reason, little is known about how individuals understand their abstinence experiences and goals within OA. Another limitation of these OA studies lies in the fact that the participants were current OA members; therefore, they were not representative of the bulimia nervosa and binge eating community (Kriz, 2002; Russell-Mayhew et al., 2010; Wasson & Jackson, 2004). A final limitation is that these researchers should have included former members. Exploring former and current members' experiences could

provide more insight and perspective on the individual benefits of the Nine Tools of OA in supporting individuals with binge eating disorder and bulimia nervosa.

The Nine Tools of OA: Emotional Support and Recovery. Several researchers have investigated OA's role in supporting women with compulsive overeating addiction. Qualitative researchers emphasized that the peer support aspect of the Nine Tools of OA, including OA meetings, telephone calls, and working with a sponsor, served as an emotional support and recovery tool for members of OA with compulsive overeating tendencies (Hertz et al., 2012; Russell-Mayhew et al., 2010; Rodríguez-Martín & Gallego-Arjiz, 2018). In a qualitative study by Russell-Mayhew et al. (2010), 19 self-selected Caucasian females in an OA group in Canada attested that regular attendance at meetings and working with a sponsor were a source of strength for them due to the emotional support the OA meetings and sponsors provided. Participants also professed that they found comfort in gathering with a group of people like themselves who were also aiming to stop compulsive overeating (Russell-Mayhew et al., 2010).

Furthermore, in a literature review by Rodríguez-Martín & Gallego-Arjiz (2018), several components of OA were explored, such as utilizing the Nine OA tools in dealing with food cravings and body/weight concerns including telephone calls, the efficacy of meetings and social support concerning OA, sponsorship, and emotional and spiritual recovery. Researchers found that OA tools such as telephone calls, meetings, and sponsorship were perceived by its members as the most efficacious for their abstinence (Rodríguez-Martín & Gallego-Arjiz, 2018). Researchers also determined that spiritual and emotional recovery in OA is achieved through interpersonal relations developed

with OA program members and the sponsor (Rodríguez-Martín & Gallego-Arjiz, 2018). Hence, the peer support components of the Nine Tools of OA, such as meetings, telephone calls, and working with a sponsor, serve as emotional support and recovery tools for OA members struggling with compulsive overeating addiction.

The Nine Tools of OA serve as emotional support and recovery tools for OA members. In a study investigating the role of OA in binge eating disorder recovery in women, Hertz et al. (2012) discovered that emotional support in addiction stemming from peer support is crucial for recovery. These researchers explored 20 Hebrew-speaking women ages 26 to 62 in Israel through a qualitative phenomenological study geared towards the emotional healing of OA members. This study focused on the thoughts and memories of OA members concerning their emotional transformation and struggles for recovery, as well as personal narratives obtained through semi-structured, in-depth interviews. Researchers found that the Nine Tools of OA utilized for emotional and spiritual work are essential for recovery (Hertz et al., 2012). Participants attested to the ease and comfort of talking about their struggles in an OA environment without feeling scared, judged, or rejected (Hertz et al., 2012). Participants also confessed that before OA, they felt alone within their disease, and now they feel that they are not alone anymore because of the program; they also felt a sense of belonging and being cared for by members of OA. Participants also confided that working with a sponsor gave them support, strength, and confidence to battle difficult situations. They felt comfort knowing their sponsor was only a call away if they needed help (Hertz et al., 2012). As a result of the social aspects of the OA program, the female participants experienced an increased awareness of their inclinations to eat emotionally. They saw these inclinations

as a maladaptive coping strategy to decrease and regulate negative emotions such as anxiety and depression. In conclusion, the peer support components of the Nine Tools of OA were identified as aids in the emotional support and recovery of OA members struggling with binge eating disorders.

The studies mentioned above (Hertz et al., 2012; Russell-Mayhew et al., 2010; Rodríguez-Martín & Gallego-Arjiz, 2018) have strengths and limitations for discussion. The OA studies by Russell-Mayhew et al. (2010), Rodríguez-Martín & Gallego-Arjiz (2018), and Hertz et al. (2012) were like other OA studies in that their samples consisted solely of women participants. As more females experience struggles with binge eating disorders, this pattern makes sense (Eating Disorders, 2023; Berkman, 2023). Russell-Mayhew et al. (2010) identified that definitions of abstinence or experiencing success in the OA program vary greatly. According to OA, abstinence can be defined as withdrawing from addictive-like eating behaviors. The members individually identify this definition of abstinence to support their eating disorder recovery.

Given that different individuals' definitions of abstinence vary, exploring smaller samples of women has the potential to provide a more in-depth understanding (Russell-Mayhew et al., 2010). The researchers also discussed the high attrition rate of OA. Unfortunately, the researchers in these studies only gathered data for short periods, leaving the long-term experiences unknown. Tracking individuals throughout their tenure with OA would be essential to determine the differences between temporary and long-term members.

Lastly, Rodríguez-Martín and Gallego-Arjiz (2018) identified the crucial aspects of OA in their systematic review. These aspects of OA included utilizing OA tools in

dealing with food cravings and body/weight concerns, the efficacy of meetings and social support about OA, sponsorship, and emotional and spiritual recovery. However, the specifics about these aspects of OA are missing. Crucial components, including methods and discussion section, were missing from Rodríguez-Martín & Gallego-Arjiz's (2018) literature review. Based on the limitations of Russell-Mayhew et al. (2010), Rodríguez-Martín & Gallego-Arjiz (2018), and Hertz et al.'s (2012) OA studies, we can conclude that qualitative studies focusing on a specific compulsive overeating population, such as bulimia nervosa or binge eating disorder with similar abstinence goals would provide a clearer picture of the efficacy of peer support in aiding recovery with each eating disorder.

Worldview Transformation. In a qualitative-naturalistic study, Ronel and Libman (2003) took a unique approach to explore the experience of OA members through "worldview transformation." A qualitative-naturalistic method is suitable for investigating self-help groups as it allows for a more extensive range of expressing emotions and experiences (Schubert, 2015). Being the only study of its kind, the worldview transformation study of OA members is a crucial piece of qualitative research in understanding the experiences of OA members in depth. Therefore, the worldview transformation study of OA members by Ronel and Libman (2003) will be discussed in detail through the personal experiences of OA members.

A worldview transformation has four components: experience of self, universal order/God, relationships with others, and perception of the problem (Ronel & Libman, 2003). The worldview transformation study of OA members (Ronel & Libman, 2003) occurred in Israel, where 80 female OA members between the ages of 15 and 63 were

interviewed. As mentioned above, the transformation of the 80 female OA members within the four components of the worldview transformation will be discussed thoroughly below.

The first component of the worldview transformation is the experience of self. Members were asked about their lives before OA. They attested that they were seeking complete control of their lives and felt a strong sense of personal failure, stress, despair, low self-esteem, self-pity, powerlessness, lack of control, loneliness, and frustration. However, due to their change in worldview, they professed that their self-esteem shifted to terms of more balanced and thought-out self-esteem. They also became more self-accepting due to their newfound self-esteem. The members attested to a sense of liberation and relaxation with increased restraint and modesty (Ronel & Libman, 2003). The OA program produced an internal transformation of the OA members in terms of self-esteem and self-acceptance, which is positively profound.

The second component of the worldview transformation is the universal order/God. The OA members were asked about their spirituality and relationship with God before joining OA. The OA members stated that spirituality had not been a part of their lives before joining OA and that God was perceived as distant and threatening. After recovering from their compulsive overeating issues under OA, members attested that their spiritual idea of the 12-step program and the likelihood of introducing a Higher Power into their lives changed. The OA members also stated they were more confident, had less anxiety, and found a richer meaning in their lives because of their newfound belief in God. Believing in a Higher Power provided a sense of direct self-esteem empowerment (Ronel & Libman, 2003). It is important to note that the OA program is

not affiliated with a specific religious group and that its core values are connected to the desire for spiritual growth as a basis for recovery. Introducing a Higher Power through OA increased confidence, decreased anxiety, and increased self-esteem empowerment.

The third component of the worldview transformation is relations with others. The 80 female OA members were asked about their interpersonal relationships before joining OA. They testified that before joining OA, their interpersonal relationships were superficial and marked by competitiveness and aggressiveness. OA members described their former relationships as judgmental and based on gossip. They explained that they had difficulty setting boundaries between themselves and others. OA members attested that sharing their vulnerabilities, weaknesses, and demanding situations within their OA group while simultaneously hearing the relatable experiences of their fellow members created an atmosphere of love, identification, and understanding. OA members also professed positive changes in their relationships and social connections. OA members also claimed they stopped needing to please others while taking personal responsibility and becoming more assertive (Ronel & Libman, 2003). The OA program produced positive results in the interpersonal relationships and social connections of the 80 female members by allowing them to set boundaries and weed out superficial connections.

The fourth and last component of the worldview transformation is the problem. The 80 female OA members were asked what they believed to be the cause of their addiction to compulsive overeating. The participants believed their condition is rooted in their weak willpower, lack of self-control, and an attitude that produces guilt and failure.

The women in OA also believe that their eating disorder is a chronic disease or allergy that worsens with time. OA members attested that they resorted to OA after trying solutions like alternative therapies, drastic diets, and surgery. However, OA perceives compulsive overeating as a disease out of the individual's control. OA members stated that they had fewer feelings of self-punishment and guilt and that self-responsibility was important. OA members also believe recovery can be maintained as an ongoing process (Ronel & Libman, 2003). The OA program allowed the members to identify the root of the problem which led to their compulsive overeating. Consequently, identifying the source of their problem led to decreased tendencies of self-punishment and increased self-accountability.

The worldview transformation study by Ronel and Libman (2003) has many strengths and limitations. Firstly, the study by Ronel and Libman (2003) was the first and only study to explore the firsthand experiences of OA members in detail through worldview transformation. Another apparent strength is the predominantly female participant base, which aligns with the demographic of my current autoethnography. However, the OA recovery process may have influenced the depiction by OA members concerning their experiences before they joined OA. Those depictions may have been reconstructed to match OA's philosophy. Therefore, a qualitative case study exploring an individual's recovery through OA would provide a clear representation of the efficacy of OA as an adaptive tool for eating disorder recovery.

Mindfulness

With the growing evidence of relapse regarding the comorbidity of anxiety, depression, and eating disorders due to maladaptive coping mechanisms (Bello &

Yeomans, 2017; Berends et al., 2016; Olmsted et al., 2014), researchers have explored mindfulness-based practices as an adaptive therapeutic coping mechanism in adolescent and adult anxiety, depression, and eating disorder relapse. Mindfulness is a form of paying attention to oneself without judgment, taught through meditation and other exercises such as yoga (Baer et al., 2005; Kabat-Zinn, 1982;). Participants are trained to regulate their focus by non-judgmentally paying attention to their thoughts, physical sensations, and emotions. Individuals are taught to observe these stimuli without trying to change, avoid, or escape them. The following section will discuss current research on mindfulness practices as adaptive coping strategies in adolescent and adult anxiety, depression, and eating disorders.

Mindfulness-Based Practices as Adaptive Coping Mechanisms

Mindfulness training promotes meditation techniques that increase self-acceptance and awareness of the present moment, such as bodily sensations, emotions, thoughts, and acceptance towards oneself (Kabat-Zinn, 1982). Examples of mindfulness meditation exercises include body scan, sitting, and walking meditation. Body scan meditation involves laying on the back with legs extended and arms at the sides. The focus is directly consciously on each part of the body, from head to toe (Kabat-Zinn, 1982; Baer et al., 2005). While sitting, meditation involves sitting comfortably with the back straight, feet flat on the floor, and hands placed on the lap. The focus is breathing through the nose and paying attention to the breath moving in and out of the body.

Moreover, walking meditation is considered meditation in motion and focuses on the movement of the feet, legs, and body rather than breathing (Kabat-Zinn, 1982; Baer

et al., 2005). By acquiring meditation skills, the individual will become more reflective and less reactive to uncomfortable internal phenomena, resulting in decreased anxiety, depression, and relapse from eating disorders (Kabat-Zinn, 1982; Baer et al., 2005). The following section will discuss four area significant areas within mindfulness and eating disorder studies, which include: 1) The relationship between mindfulness and eating disorders; 2) Mindfulness-Based Stress Reduction (MBSR) in adolescents; 3) Mindfulness practices in women and eating disorders; and 4) Mindfulness-Based Cognitive Therapy (MBCT) as an eating disorder treatment.

Mindfulness and Psychological Disorders in Adolescent Females. Many researchers have explored the relationship between mindfulness and psychological disorders, including eating disorders (i.e., bulimia nervosa and binge eating disorder), anxiety, and depression in adolescent females. Several researchers have found a consistent relationship between low levels of mindfulness and high levels of psychological distress in adolescent females (Hernando et al., 2019; Jimenez et al., 2010; Ma & Fang, 2019; Omiwole et al., 2019). Jimenez et al. (2010) determined that adolescents with low levels of mindfulness lack emotional regulation skills, self-acceptance, and self-control. Furthermore, Hernando et al. (2019) determined that adolescent females diagnosed with eating disorders exhibit a significantly lower level of mindfulness and adaptive coping compared to a healthy control group. Individuals with higher levels of awareness and attention to their thoughts are less likely to have disordered eating behavior (Hernando et al., 2019; Omiwole et al., 2019).

Researchers also discovered that mindfulness abilities could help individuals with adaptive coping strategies when dealing with psychological disorders, including eating

disorders, anxiety, and depression (Hernando et al., 2019; Jimenez et al., 2010; Ma & Fang, 2019; Omiwole et al., 2019). Researchers have determined that mindfulness techniques decrease weight and shape concerns, body mass index (BMI), dietary restraint, binge eating, eating in the absence of hunger (EAH), eating disorder psychopathology, and increased willingness to eat healthy foods (Hernando et al., 2019; Ma & Fang, 2019; Omiwole et al., 2019). The results suggest that mindfulness skills can be an adaptive coping tool in creating new behaviors and dealing with difficult emotions and situations. The following section will discuss the mindfulness-based stress reduction (MBSR) pattern that emerged in adolescent girls' mindfulness practices and psychological distress research.

Mindfulness-based Stress Reduction (MBSR) in Adolescent Females with Anxiety, Depression, and Eating Disorders. Several researchers have found mindfulness-based interventions such as MBSR to be highly efficacious in treating psychological disorders, including anxiety, depression, and eating disorders, including binge eating disorder and bulimia nervosa in women and adolescent females. MBSR, developed by Kabat-Zinn (1982), is an 8-week treatment program focused on decreasing stress through enhanced mindfulness skills developed through regular meditation practices. The program is comprised of two to two and a half hours of weekly group-based meditation classes with a trained instructor, 45 minutes of daily audio-guided home practice, and a day-long mindfulness retreat that takes place during the sixth week (Carmody et al., 2009; Dobkin, 2008; Kabat-Zinn, 1982). The MBSR program content aims to teach how to mindfully pay attention to bodily sensations through meditative exercises, including sitting meditation, gentle stretching, body scans,

and yoga. The weekly group meditation classes teach the application of mindful practices in everyday life (Carmody et al., 2009; Dobkin, 2008; Kabat-Zinn, 1982). In this section, I discuss several empirical studies utilizing MBSR in treating psychological disorders, including eating disorders, anxiety, and depression in adolescent females.

Mindfulness-Based Stress Reduction (MBSR) interventions have consistently exhibited positive effects in treating psychological disorders, including eating disorders (i.e., bulimia nervosa and binge eating disorder), anxiety, and depression. Using quantitative methods, Khoshkerdar and Raeisi (2020) and a systematic review by Lin et al. (2019) determined that mindfulness-based interventions improve emotion regulation and positively affect several mental disorders in adolescent females. These mental disorders include decreased symptoms of anxiety and depression and help with the prevention and treatment of eating disorders, including bulimia nervosa and binge eating disorders. Researchers determined that MBSR positively influenced the body image concerns of adolescent girls with dysfunctional eating attitudes (Khoshkerdar & Rasisi, 2020). Additionally, researchers found that the relaxation techniques utilized in MBSR facilitated conscious awareness of different parts of their bodies (Khoshkerdar & Raeisi, 2020; Lin et al., 2019). Therefore, structured eight-week mindfulness-based programs such as MBSR improved quality of life and mental and physical health. The mindfulness skills acquired with an MBSR intervention were also determined to serve as adaptive coping tools for adolescent girls struggling with eating disorders (i.e., bulimia nervosa and binge eating disorder), anxiety, and depression.

Several quantitative empirical studies and systematic reviews focused solely on the efficacy of MBSR practices in treating psychological disorders, including anxiety and

depression in adolescent girls. MBSR interventions exhibited positive results in improving and mitigating anxiety and depression in adolescent girls (Biegel et al., 2009; Diaz-Gonzalez et al., 2018; Kallapiran et al., 2015; Zhang et al., 2019). In several randomized controlled trials (Biegel et al., 2009; Diaz-Gonzalez et al., 2018; Zhang et al., 2019) and one systematic review (Kallapiran et al., 2015), researchers compared the efficacy of mindfulness-based stress reduction (MBSR) practices to a control group (i.e., traditional psychotherapy or pharmacological treatment or both) for adolescents with anxiety and depression. The researchers discovered that individuals in the MBSR group exhibited a higher percentage of mental health changes, including a significant decrease in negative feelings and thought patterns and a significant reduction in symptoms of anxiety and depression. The mindfulness practices took place once a week for eight weeks, followed by a three-month follow-up and consisted of sitting meditation, body scan meditation, Hatha yoga, and informal mindfulness practices (Biegel et al., 2009; Diaz-Gonzalez et al., 2018; Kallapiran et al., 2015; Zhang et al., 2019). The participants reported improved self-esteem and sleep quality compared to the control group with only the psychotherapy (Beigel et al., 2009). Furthermore, the MBSR group reported decreased stress, interpersonal problems, and obsessive symptoms (Biegel et al., 2009; Diaz-Gonzalez et al., 2018; Zhang et al., 2019). Researchers also determined that regular and consistent at-home mindfulness exercises, such as sitting practices, were associated with several positive changes in anxiety and depressive symptoms from pre-treatment to post-treatment follow-ups (Biegel et al., 2009; Zhang et al., 2019). Based on these MBSR studies, it seems that

MBSR intervention is efficacious in improving adolescents' psychological health with anxiety, depression, and negative feelings and thought patterns.

The studies on MBSR have several limitations. Firstly, while the studies consisted of predominantly adolescent females, the sample sizes of all MBSR studies were relatively large (ranging between 30 to 80 participants across all studies; Biegel et al., 2009; Diaz-Gonzalez et al., 2018; Kallapiran et al., 2015; Khoshkerdar & Raeisi, 2020; Lin et al., 2019; Zhang et al., 2019). With larger sample sizes, the variations in individual experiences are often overlooked. Similar to research in other sections, the MBSR studies relied on a short follow-up period of three months post-treatment. This limitation of time presents a gap in understanding the longer-term experiences of individuals struggling with psychological health with anxiety, depression, and negative feelings and thought patterns.

According to Grossman (2011), it takes a certain degree of mindfulness to assess one's mindfulness traits. It is also important to note that the studies included different age groups and methodologies in the systematic reviews by Kallapiran et al. (2015) and Lin et al. (2019). The inconsistency with the systematic reviews makes it difficult to compare the findings accurately. With all the MBSR studies being conducted with quantitative methods, only a less detailed picture of the first-hand experiences of the participants is available. Implementing smaller-scale qualitative studies focused on MBSR would provide more in-depth and detailed first-hand accounts from the individuals' perspectives.

Mindfulness Practices in Women with Eating Disorders

Many researchers have explored the relationship between mindfulness and eating disorders (i.e., anorexia nervosa, bulimia nervosa, and binge eating disorder) in women. Several quantitative empirical studies examining women with eating disorders (i.e., anorexia nervosa, bulimia nervosa, and binge eating disorder) in the United States (Baer et al., 2005; Masuda et al., 2018; Sala et al., 2018) and outside of the United States (i.e., Netherlands, Singapore, United Kingdom) (Hessler-Kaufmann et al., 2020; Keng & Ang, 2019; Lattimore et al., 2017) found a consistent relationship between lower levels of mindfulness and lack of awareness, emotion dysregulation, interoceptive awareness, and higher levels of impulsivity, body dissatisfaction, and emotional distress in women with anorexia nervosa, bulimia nervosa, and binge eating disorder. These same researchers also discovered that mindfulness practices ranging from body scanning, mindful stretching and walking, mindful eating, mindful sitting meditation, mindful breathing exercises, and journaling thoughts and emotions are efficacious adaptive tools. These mindfulness practices decrease maladaptive eating behaviors and reduce restrictive, emotional, and binge eating, and binge eating and purging episodes in individuals struggling with anorexia nervosa, bulimia nervosa, and binge eating disorder from pre- to post-intervention across diverse populations (Baer et al., 2005; Hessler-Kaufmann et al., 2020; Katterman et al., 2014; Keng & Ang, 2019; Lattimore et al., 2017; Masuda et al., 2018; Sala et al., 2018).

A particular quantitative study by Masuda et al. (2018) exploring the relationship between mindfulness and eating disorders is essential to discuss due to its large participant size and highly ethnically diverse participant base, which makes the study highly generalizable. Masuda et al. (2018) explored the correlation between eating

disorder cognition and eating disorder behavior in 463 ethnically diverse female college students between the ages of 18 and 25, with an unspecified mix of anorexia, bulimia, and binge eating disorder diagnoses in a southeastern public university in the United States. The sample included 112 Asian Americans, 243 Black Americans, and 108 non-Hispanic White American women. Masuda et al. (2018) determined that participants with increased mindfulness had decreased eating disorder cognition (i.e., thinness expectancies, thin-ideal internalization, and shape-weight overvaluation) and eating disorder behavior. Hence, the following section will discuss current mindfulness studies and their efficacy in treating eating disorders (i.e., anorexia nervosa, bulimia nervosa, and binge eating disorder) in women. Due to the similarities in the strengths and limitations of mindfulness, as mentioned above, the strengths and limitations of all studies are summarized at the end of this section.

Mindfulness-Based Cognitive Therapy (MBCT) for the Treatment of Psychological Disorders in Women

In treating psychological disorders in women, several researchers investigated the efficacy of mindfulness-based cognitive therapy (MBCT), including eating disorders, anxiety, and depression. MBCT stems from MSBR in preventing relapse from depressive episodes. Mindfulness-based interventions such as MBCT and MBSR stem from ancient Buddhist and Yoga philosophies. MBCT combines the principles of cognitive behavioral therapy with mindfulness meditation practices. The following section will discuss several patterns that emerged from the empirical studies exploring the efficacy of MBCT in women with anxiety, depression, and eating disorders. Firstly, the studies predominantly examined the effectiveness of MBCT on bulimia nervosa and

binge eating disorder. Specific patterns that emerged include the significance of MBCT on anxiety, depression, stress, and self-esteem; the effectiveness of MBCT in reducing emotional eating, food cravings, and binge eating behaviors; and the effects of MBCT on increased body image in women struggling with bulimia nervosa and binge eating disorders.

Mindfulness-Based Cognitive Therapy as an Eating Disorder Treatment. Mindfulness-based cognitive Therapy (MBCT) was derived from the principles of MBSR to prevent relapse from depression. With this foundation, it is no surprise that researchers have found MBCT to be effective in the reduction of depression, anxiety, and stress in women struggling with psychological disorders (Azari et al., 2013; Sala et al., 2021; Moradi & Samari, 2017). These researchers have used a quasi-experimental design (Moradi & Samari, 2017) and two randomized controlled studies (Azari et al., 2013; Sala et al., 2021) outside of the United States (i.e., Iran and Paris). These researchers explored the efficacy of MBCT in decreasing anxiety and depression in women between the ages of 18 and 68. The MBCT studies involved a similar treatment format of 8 MBCT sessions divided into different mindfulness exercises within each session. The mindfulness exercise included: 1) 10 minutes of sitting meditation, practicing thoughts and feelings, 30 to 40 minutes of audio-visual meditation, walking with mindfulness, practicing awareness of breathing, body, sounds, and mind, and mindfulness practices homework (Moradi & Samar, 2017); 2) Eating with awareness, body scan exercises, learning to focus on the present, mindful breathing exercises, mindfulness daily practices, and relapse prevention (Azari et al., 2013); and 3) Focusing specifically on bringing attention to the present moment and familiarizing oneself with

their mental process and focusing on a recent life issue to develop a different relationship with challenging events and associated emotions (Sala et al., 2021). Based on the self-reported results of the participants, researchers determined that MBCT significantly reduced symptoms of anxiety, depression, and stress in women struggling with bulimia nervosa and binge eating disorder compared to the control group (control group = waiting list, no treatment) (Azari et al., 2013; Sala et al., 2021; Moradi & Samari, 2017). The studies suggest that MBCT is a highly efficacious option for women struggling with anxiety, depression, and stress associated with bulimia nervosa and binge eating disorder. Therefore, mindfulness tools learned through MBCT can serve as adaptive coping tools for women struggling with psychological disorders (i.e., anxiety, depression, bulimia nervosa, and binge eating).

MBCT and Reducing Binge Eating Behaviors, Emotional Eating, and Food Cravings. MBCT ‘s role in treating binge eating behaviors, emotional eating, and food cravings has been investigated in women with bulimia nervosa and binge eating disorder. MBCT guides individuals to focus on physical sensations and emotions with nonjudgmental awareness and self-acceptance, which may decrease the likelihood of binge eating behaviors (Azari et al., 2013; Kabat-Zinn, 1982). The following section will discuss the efficacy of MBCT in reducing binge eating behaviors, emotional eating, and food cravings in women with bulimia nervosa and binge eating disorder.

Several researchers have determined that MBCT is highly effective in reducing binge eating behaviors associated with bulimia nervosa and binge eating disorder, as well as emotional eating and food cravings (Alberts et al., 2012; Azari et al., 2013; Baer et al., 2005; Sala et al., 2021). Randomized controlled trials were conducted on small

sample sizes (i.e., 10 to 88 participants) of Caucasian women with bulimia nervosa and binge eating disorder between the ages of 18 and 68, predominantly outside of the United States (i.e., France, Netherlands (2), Iran, and Kentucky). A similar MBCT treatment approach was utilized across all studies with 8 MBCT sessions at 2.5-hour each with no follow-up assessment (Alberts et al., 2012; Azari et al., 2013; Sala et al., 2021) except for Baer et al. (2005) who utilized 10 MBCT sessions. Additionally, all studies randomly assigned participants to an MBCT or a control group (control group = waiting list, no treatment). Each researcher utilized different mindfulness exercises during each MBCT session, including body scan, mindful stretching and walking, mindful eating, meditation, and relapse prevention (Alberts et al., 2012; Azari et al., 2013; Baer et al., 2005; Sala et al., 2021). In the body scan, participants focused on several body parts where sensations were observed non-judgmentally. The mindful stretching and walking exercises facilitated awareness of sensations during gentle and slow movements. During the mindful eating exercise, individuals observed the movements and sensations associated with eating and the emotions and thoughts that arise. Lastly, during the sitting meditation, awareness was focused on breathing, sounds, bodily sensations, emotions, and thoughts. The participants noted down emotions and thoughts that arose and were encouraged to accept whatever entered their awareness (Alberts et al., 2012; Azari et al., 2013; Baer et al., 2005; Sala et al., 2021). At the end of the eight MBCT sessions, the female participants self-reported a significant reduction in uncontrolled binge eating behavior (Azari et al., 2013; Sala et al., 2021), binge eating and purging concerns (Baer et al., 2005), and a significant reduction in emotional eating and food cravings (Alberts et al., 2012) despite boredom and

negative emotions compared to the waiting list control group with no treatment. Sala et al. (2021) also discovered that MBCT is effective in reducing binge eating behaviors due to the reduction of cognitive load associated with bulimia nervosa and binge eating disorder. The MBCT studies above suggest that MBCT could facilitate positive changes in binge eating behaviors (Alberts et al., 2012; Azari et al., 2013; Baer et al., 2005; Sala et al., 2021). Additionally, increasing mindful awareness of automatic patterns and internal experiences regarding eating, self-acceptance, and emotion regulation can help decrease disordered eating behaviors (Albert & Raes, 2012). Therefore, mindfulness skills obtained from MBCT can be a productive tool to decrease disordered eating behaviors and decrease relapse after treatment.

MBCT's Efficacy in Self-Esteem and Positive Body Image in Women with Eating Disorders. The last pattern that emerged from the MBCT eating intervention studies was the effectiveness of MBCT in increasing self-esteem and positive body image in women with eating disorders (i.e., anorexia nervosa, bulimia nervosa, and binge eating disorder). Several researchers have found that MBCT increases self-esteem and positive body image in women with anorexia nervosa, bulimia nervosa, and binge eating disorders (Alberts et al., 2012; Azari et al., 2013; Moradi & Samari, 2017). Like the MBCT studies mentioned above, randomized control trials outside of the United States (i.e., Iran and Netherlands) explored small sample sizes (26 to 44 participants) of women between the ages of 18 to 65 with anorexia, bulimia, and binge eating disorder (Alberts et al., 2012; Azari et al., 2013; Moradi & Samari, 2017). The participants in all four MBCT studies were randomly assigned to either eight weeks of MBCT at two-and-a-half-hour sessions or a control group (control group = waiting list, no treatment). As

previously mentioned in the above MBCT studies, the 8 MBCT sessions were broken down into different mindfulness exercises, including eating with awareness, body scan exercises, exercises accepting one's body and self (Alberts et al., 2012; Azari et al., 2013), mindful breathing exercises, sitting and walking mediation, and 30 to 45 minutes of daily mindfulness homework (Azari et al., 2013; Moradi & Samari, 2017). Based on participant self-report data, researchers found a significant reduction in body image concerns (Alberts et al., 2012), an increase in positive body image (Moradi & Samari, 2017), and increased self-esteem (Azari et al., 2013). The data suggest that MBCT is highly efficacious in improving self-acceptance, especially regarding body image.

Mindfulness-Based Breathing Exercises. Several researchers have quantitatively explored mindfulness-based breathing practices in treating eating disorders in ethnically diverse women across the globe. The results of these quantitative studies have been promising in treating and maintaining eating disorders, including anorexia nervosa, bulimia nervosa, and binge eating disorder. Keng & Ang (2019) explored body dissatisfaction and disordered eating in 81 female college students with anorexia, bulimia, and binge eating disorder diagnoses in a sizeable Singaporean university. The participants were randomly assigned to a 10-minute audio-guided mindful breathing exercise (n = 43) or resting control condition (n = 38) in a laboratory setting across 20 sessions. The mindful breathing group was instructed to sit quietly, focus their attention on the sensations of their breath, and feel their emotions and thoughts as they are without self-judgment. Researchers found that the mindfulness-based breathing group exhibited significantly decreased feelings of emotional distress, emotional eating, urges to engage in binge eating and binge eating and purging, and

body dissatisfaction compared to the resting control group. A similar quantitative study by Hessler-Kaufmann et al. (2020) also explored the efficacy of mindful breathing exercises as an emotion regulation strategy in 48 female inpatients with bulimia nervosa in Germany. Like Keng & Ang's (2019) study, the participants were also asked to sit quietly and focus on their breath while feeling their thoughts and emotions without self-judgment. It is essential to mention that the length or duration of the sessions was not specified in this study (Hessler-Kaufmann et al., 2020). Based on the study's results, researchers determined that mindfulness exercises can increase self-acceptance and self-compassion and decrease the frequency of binge-purge cycles in women with bulimia nervosa (Hessler-Kaufmann et al., 2020). Therefore, based on the above-mentioned mindful-based breathing studies, we can conclude that mindfulness-based breathing practices are highly productive tools in the treatment of women with anorexia nervosa, bulimia nervosa, and binge eating disorder.

The Efficacy of Mindfulness Meditation in Improving Psychological Disorders

Mindfulness Meditation and Positive Alterations in Brain Functioning.

Researchers have found that eight brain regions are found to be positively altered in individuals who practice mindfulness meditation, including the frontopolar cortex, related to enhanced meta-awareness following mediation; the sensory cortices and insula, connected to body awareness; the hippocampus, related to memory processes; prefrontal cortices (the anterior cingulate cortex (ACC), mid-cingulate cortex, and orbitofrontal cortex, responsible for self an emotional regulation; and the superior longitudinal fasciculus and corpus callosum which are accountable for the intra-and inter-hemispherical communication (Allen et al., 2012; Fox et al., 2014; Tang et al.,

2015). Subsequently, several studies have also found a connection between the lack of engagement of the prefrontal cortex of the brain to the habitual use of food to relieve emotional discomfort and stress (Allen et al., 2012; Creswell et al., 2007; Dallman, 2010; Fox et al., 2014; Katterman et al., 2014; Lieberman et al., 2007). Hence, mindfulness meditation can relieve emotional eating and stress by actively engaging the prefrontal cortices (Creswell et al., 2007; Dallman, 2010; Fox et al., 2014; Lieberman et al., 2007; Tang et al., 2015). Additionally, intentionally training the cognitive and executive prefrontal brains through mindfulness meditation can help individuals overcome emotional and habitual responses connected to emotional and stress-induced eating (Dallman, 2010). A particular systematic review by Katterman et al. (2014) exploring mindfulness meditation studies as an intervention for binge eating, emotional eating, and weight loss in women determined that mindfulness meditation is efficacious in improving maladaptive eating behaviors and reducing emotional eating and binge eating episodes in individuals struggling with binge eating disorder and bulimia nervosa from pre- to post-intervention across various populations. The systematic review by Katterman et al. (2014) suggests that mindfulness mediation can be highly effective in decreasing binge eating behaviors in women struggling with bulimia nervosa and binge eating behaviors by engaging the prefrontal cortex of the brain responsible for regulating our emotions, thoughts, and actions (Creswell et al., 2007; Dallman, 2010; Fox et al., 2014; Lieberman et al., 2007; Tang et al., 2015). The following section will discuss several empirical studies related to mindfulness meditation’s efficacy in reducing binge eating behaviors, anxiety, and depression.

The Efficacy of Mindfulness Meditation and the Reduction of Binge Eating Behaviors, Anxiety, and Depression. The last pattern that emerged in the mindfulness literature was the effectiveness of mindfulness meditation in reducing binge eating behaviors associated with bulimia nervosa and binge eating disorder, as well as reducing symptoms of anxiety and depression in women (Dallman, 2010; Sear & Kraus, 2009; Katterman et al., 2014; Kristellar & Hallett, 1999). Non-randomized empirical studies exploring the efficacy of mindfulness-based meditation for the reduction of binge eating disorder and anxiety symptoms in women also determined that mindfulness meditation is highly efficacious in decreasing symptoms of binge eating and anxiety (Kristellar & Hallet, 1999; Sears & Kraus, 2009). Sears & Kraus (2009) investigated 57 Caucasian college students (59% women and 41% men) with a mean age of 22 in a small liberal arts college in Colorado who voluntarily completed surveys and participated in the study. The mindfulness meditation invention was designed into four different non-randomized mindfulness meditation groups, including a brief meditation focused on attention, a brief meditation focused on loving kindness, a more extended meditation combining mindfulness's attentional and loving-kindness components, and a control group. Data was based on participant self-report questionnaires. Each mindfulness meditation group met once a week throughout a semester (semester length was not specified) (Sears & Kraus, 2009). Based on the self-reported data, Sears and Kraus (2009) determined that the longer combined meditation group, including attentional and loving-kindness, significantly reduced anxiety and increased hope. Researchers also determined that positive changes in negative thinking patterns due to mindfulness meditation were the leading cause of decreased anxiety and increased hope (Sears &

Kraus, 2009). The study's findings suggest that longer mindfulness meditation practices can reduce anxiety and increase hope in a non-clinical population.

Lastly, Kristellar and Hallet (1999) explored mindfulness meditation's efficacy in 18 obese women between the ages of 25 and 62 with binge eating disorder and anxiety. In a single-group design, the 18 female participants were administered seven sessions of eating-specific mindfulness meditation over six weeks, followed by a three-week follow-up assessment. Mindfulness meditation was applied in three forms, including general mindfulness meditation, eating meditation, and mini meditations. Each session focused on specific themes relating to overcoming binge eating, including hunger and satiety awareness, awareness of binge eating triggers, self-forgiveness, relapse prevention, and the utilization of guided mindfulness meditations and exercises in mindful eating. The participants were also assigned daily mindfulness meditation homework with either a tape or self-guided mindful-eating activities. Based on the participant's self-reported data**,** researchers found that after the eating-specific six-week mindfulness meditation intervention, anxiety and binge eating episodes decreased in frequency from four times a week to once a week, while the sense of control increased. Participants reported significant improvements in awareness of hunger and satiety cues, increased sense of mindfulness, increased control of eating, and decreased symptoms of anxiety and depression. The results suggest that mindfulness meditation results in emotional improvements and increases sensitivity and awareness to hunger and satiety cues, which can be crucial factors in decreasing binge eating episodes.

Strengths and Limitations of Mindfulness Studies. The strengths and limitations of the mindfulness studies mentioned above in adolescents and women are

similar and are warranted for discussion. Firstly, the apparent strength of the mindfulness studies is the predominantly female participant base, which aligns with the demographic of my current autoethnography. However, the limitations outweigh the strengths. All studies included small sample sizes, participant self-report data, short-term (three weeks) to no follow-up assessments, and lack of racial diversity (predominantly Caucasian) across the studies. The small sample sizes and lack of cultural diversity make generalizing the data increasingly difficult.

Furthermore, the short-term nature of all studies makes it difficult to determine the effects of mindfulness on eating disorders, anxiety, and depression in the long run. Also, participant self-reporting across all studies is an illogical approach to take considering the emotional and cognitive issues of the participants. According to Grossman (2011), it takes a certain degree of mindfulness to assess one's mindfulness traits. Furthermore, people with eating mood disorders have many emotional and cognitive issues, making it difficult for them to provide feedback on their mindfulness. This fact suggests that the participants across all studies may have inaccurately reported on the efficacy of their mindfulness practices, which makes the results of the mindfulness studies questionable across the board.

Theoretical Framework

The theoretical framework for this autoethnography is the self-determination theory (SDT; Deci & Ryan, 1985; Ryan & Deci, 2008), which is the basis of intrinsic motivation. Although ingrained motivational tendencies are abundantly present in humans, research has shown that these tendencies must be maintained and enhanced under supportive conditions, as they can be easily disturbed by various non-supportive

conditions (Ryan & Deci, 2008). Therefore, the self-determination theory focuses on the circumstances that elicit and sustain rather than suppress and weaken this intrinsic motivation (Ryan & Deci, 2008).

According to Ryan and Deci (2008), researchers use self-determination theory (SDT) to explore people's motivation and the fundamental psychological needs for competence, autonomy, and relatedness. In essence, a person can become self-determined when their needs for competence, autonomy, and relatedness are met. Deci and Ryan (2000) suggested that autonomous regulation (i.e., acting out of willingness or choice) increases overall well-being. Behaviors that are less controlled and more self-endorsed can lead to increased personal commitment, persistence, positive feelings, and mental health (Deci & Ryan, 2000). For instance, individuals who willingly pursue eating disorder treatment because they want to recover show increased adherence to treatment (Zeldman et al., 2004), a decrease in symptoms of depression (Zuroff et al., 2007), and a reduction in disordered eating symptoms in bulimia nervosa (Mansour et al., 2012) and anorexia nervosa (Mask & Blanchard, 2011; Rieger et al., 2000; Vandereycken & Vansteenkiste, 2009). The self-determination theory is essential for the proposed autoethnography because it is linked with the researcher's willingness, self-determination, and grit to overcome her lifelong battle with comorbid anxiety, depression, and eating disorders, which will be discussed in further detail in Chapter Four of this study.

Autonomy, Competence, and Relatedness. The self-determination theory suggests that autonomy, competence, and relatedness are the three innate needs influencing people's behavior and well-being (Ryan & Deci, 2008). Autonomy is the

need to control one's decisions and behavior. Competence is the need to be successful, effective, and competent at mastering tasks. Moreover, relatedness is the need to feel connected to others and have meaningful relationships (Deci & Ryan,2000; Ryan & Deci, 2008).

The first innate need proposed by the self-determination theory is autonomy, which is a sense of being in control of one's actions (Ryan & Deci, 2008). It entails having control over one's life and achieving psychological freedom. Hence, autonomy is all about having a say and a voice. It satisfies a natural need to feel in control of our activities, enabling us to completely accept the results of our choices (Deci & Ryan, 2000). Autonomy can be viewed from three perspectives: the conviction that we have control over our behavior, the freedom from peer pressure to act in a certain way, and the freedom to make our own decisions (Ryan & Deci, 2008).

The second innate need of the self-determination theory is competence or the feeling that one can effectively accomplish a specific task (Deci & Ryan, 2000). Martela and Riekki (2018) suggest that when one feels inefficient, inadequate, or incapable of accomplishing their obligations, it renders their efforts senseless; nevertheless, when they feel capable, they are psychologically empowered. Martela and Riekki (2018) equate realizing one's full potential to the psychological demand for competence since it involves using one's talents and creativity in one's profession, which leads to a sense of accomplishment.

Lastly, the third innate need of the self-determination theory is relatedness, which is the feeling that one feels a sense of belonging and is an integral member of a community (Deci & Ryan, 2000). Relatedness can be cultivated by communicating

warmth, empathy, compassion, and open communication (Vansteenkiste et al., 2005). Therefore, surrounding oneself with high-quality relationships is crucial in strengthening the innate need for relatedness.

Self-Determination Theory and Recovery from Comorbid Anxiety, Depression, and Eating Disorders. The self-determination theory is vital for my current study because eating disorder recovery is primarily dependent on an individual's motivation and willingness to recover (Bégin et al., 2018; Pelletier & Dion, 2007; Ryan et al., 2010; Van Der Kaap-Deeder et al., 2014; Vansteenkiste et al., 2005; Vesrtuyf et al., 2012), as demonstrated by the researcher in Chapter Four of this autoethnography. An individual who pursues recovery because she believes her eating disorder has a detrimental impact on significant goals and values in her life (i.e., education, career, intimate relationships) fully supports her willingness to recover. Researchers have found that individuals with eating disorders must not only require but also desire recovery (Allen et al., 2011; Bégin et al., 2018; Deci & Ryan, 2000; Geller et al., 2005; Van Der Kaap-Deeder et al., 2014; Vansteenkiste et al., 2005; Zeldman et al., 2004; Zuroff et al., 2007). If individuals have entirely accepted the importance of recovery, they are more likely to initiate a willingness to seek recovery (Van Der Kaap-Deeder et al., 2014). Hence, the pursuit of recovery should be self-endorsed rather than forced. Several researchers have found that self-endorsed change exhibits improved treatment compliance (Zeldman et al., 2004), a reduction in depressive symptoms in individuals with depression (Zuroff et al., 2007), and a decrease in eating-related preoccupation in individuals with bulimia nervosa (Mansour et al., 2012). Researchers have also determined that higher levels of self-endorsed motivation for eating disorder recovery

led to increased body mass index (BMI) in individuals with anorexia nervosa (Mask & Blanchard, 2011; Rieger et al., 2000; Vandereycken & Vansteenkiste, 2009) and lower levels of eating preoccupation and binge eating and bulimia nervosa symptoms (Mansour et al., 2012). Therefore, autonomous regulation in eating disorder recovery is critical to decreasing symptomology.

The three tenets of the self-determination theory (i.e., autonomy, competence, and relatedness) are an integral component of the proposed autoethnography. In Chapter Four of this study, the researcher details how her willingness, self-determination, and grit to pursue eating disorder recovery stemmed from her internal belief that she was competent and able to achieve eating disorder recovery. Additionally, the unconditional support, empathy, and compassion from her Overeaters Anonymous (OA) sponsor strengthened her ammunition to persist in her recovery.

Summary

Chapter Two discussed relevant literature regarding the efficacy of psychological and pharmacological treatments and adaptive coping practices for treating, preventing, and maintaining anxiety, depression, and eating disorders in adolescent females and women. The self-determination theory was also presented as the theoretical framework for the proposed autoethnography. Prominent psychological treatments for bulimia nervosa and binge eating disorder in adolescent females included Cognitive Behavioral Therapy (CBT) (DeBar et al., 2013; Jones et al., 2008), Dialectical Behavioral Therapy (DBT) (Safer et al., 2007; Mazzeo et al., 2016), Family Based Therapy (FBT), and Interpersonal Therapy (IPT) (Tanofsky-Kraff et al., 2009; Marzilli et al., 2018). At the same time, CBT was the dominant treatment for bulimia nervosa and binge eating

disorder in women (Hilbert et al., 2019; Hilbert et al., 2020; McIntosh et al., 2016; Wagner et al., 2016). While studies regarding pharmacological treatment for anxiety, depression, and eating disorders were rare, Lisdexamfetamine and Methylphenidate were effective in decreasing binge eating frequency and improving eating disorder psychopathology in binge eating disorder in women (Hilbert et al., 2020; Moghimi et al., 2022; Peat et al., 2017). Furthermore, adaptive coping strategies, including peer support groups like Overeaters Anonymous (OA) (Bray et al., 2021; Russell-Mayhew et al., 2010; Rodríguez-Martín & Gallego-Arjiz, 2018) and Mindfulness-Based Practices (Kabat-Zinn, 1982; Ma & Fang, 2019; Omiwole et al., 2019) were effective in maintaining eating disorder recovery in adolescent girls and women.

One significant gap in the literature was the lack of studies targeting the comorbidity of anxiety, depression, and eating disorders in adolescent girls and women. Additionally, there was a lack of qualitative autoethnographic data exploring the comorbidity of anxiety, depression, and eating disorders in women, as most of the research in this study was quantitative and conducted outside of the United States. Hence, qualitative autoethnographic data is urgently needed to portray first-hand personal accounts of women struggling with comorbid anxiety, depression, and eating disorders.

Chapter 3: Methodology

Overview

The purpose of this qualitative study is to provide new meaning, insight, and perspective on the comorbidity of anxiety, depression, and eating disorders (i.e., anorexia nervosa, bulimia nervosa, and binge eating disorder) in children, adolescents, and women through autoethnography, hence filling the gap in the current literature. Chapter three details the chosen autoethnographic methodology and procedures for the proposed study influenced by the work of pioneers in autoethnography (Denzin & Lincoln, 2005; Ellis et al., 2011; Ellis & Bochner, 2000; Muncey, 2005). I first define qualitative research and autoethnography in-depth and justify why this approach is appropriate for this study. Next, I present the data collection and analysis processes, which are influenced by the recommendations of autoethnographic pioneers. Chapter three concludes with a discussion of qualitative trustworthiness, ethical considerations, and limitations related to the proposed study.

The following autoethnography is framed around the following research questions:

- *RQ1:* What are the daily battles and triumphs that arise with the comorbidity of anxiety, depression, and eating disorders?
- *RQ 2:* In what ways (if any) have these daily battles and triumphs manifested in different areas of my personal and professional life?
- *RQ 3:* How might the battles and triumphs experienced with the comorbidity of anxiety, depression, and eating disorders contribute to becoming a change agent

in my life, other individuals struggling with similar life challenges, and future researchers?

Qualitative Research

Qualitative researchers seek to highlight the voice of the participant and ascribe meaning that people make of their experiences and stories through non-numerical data, including personal experiences, texts, written material data, video, audio, interviews, and direct observations (Creswell, 2013; Denzin & Lincoln, 2005; Yilmaz, 2013). According to pioneers in qualitative research, Denzin and Lincoln (2005) state,

> Qualitative research is multimethod in focus, involving an interpretative, naturalistic approach to its subject matter. Qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena regarding the meanings people bring to them (Denzin & Lincoln, 2005, p. 2).

Similarly, Yilmaz (2013) describes qualitative research as an interpretive, inductive, emergent, and naturalistic framework for investigating individuals, cases, events, social situations, and processes within their authentic contexts. The primary objective of qualitative research is to elucidate the subjective interpretations and significance that individuals attribute to their experiences of the world and use descriptive language to convey these meanings. Given that qualitative researchers seek to understand people's experiences and the importance they ascribe to those experiences, it makes sense that a qualitative approach is used to explore in-depth actual experiences of people who experience the comorbidity of anxiety, depression, and eating disorders in their daily lives.

Utilizing a qualitative approach is also essential to the proposed study due to the need for more qualitative literature regarding the chosen topic. The current literature comprises predominantly quantitative research, which requires more vulnerability and depth of detail than qualitative research because it is based solely on large-scale numerical data (Rahman, 2016). Using this positivist paradigm, quantitative analysis creates distances between researchers and the people with the unique personal perspectives their experiences offer.

Research Design

The research methodology utilized for the current study is autoethnography. Autoethnography is a qualitative genre of research that places the self in a social context by fusing the personal and the cultural (Reed-Danahay, 1997). According to Sparkes (2000), an autoethnographic study entails the utilization of deeply personal narratives that leverage the researcher's experiences to further sociological awareness. Furthermore, autoethnography aims to describe and methodically evaluate (-*graphy*) personal experience (-*auto*) to comprehend cultural experience (-*ethno*) (Adams et al., 2017; Adams et al., 2022; Ellis, 2004; Holman Jones, 2005; Reed-Danahay, 1997). Hence, autoethnography is a socially conscious, political, and social act (Adams & Holman Jones, 2008) that challenges conventional research methods and represents people (Spry, 2001). Autoethnography differs from other qualitative research methods as it uses the self as the only data source and blends elements of autobiography and ethnography (Denzin & Lincoln, 2005; Ellis et al., 2011; Sparkes, 2000). Of particular importance to the current study is that autoethnographers seek to portray how people work through the challenges and successes in their lives and what meaning they

ascribe to these experiences (Bochner & Ellis, 2016, p. 111). In the current autoethnography, I utilized highly personalized accounts of my lifelong struggles and processes with comorbid anxiety, depression, and eating disorders. In critiquing these personal accounts, I sought to find meaning behind these experiences and make realizations about the processes that motivate me to make specific decisions daily.

The most common topics in autobiographies are epiphanies, remembered events thought to have significantly impacted a person's life (Bochner & Ellis, 1992; Couser, 1997; Denzin, 1989). These epiphanies reveal ways to deal with intense situations and "*effects that linger, recollections, memories, images, feelings, long after a crucial incident is supposedly finished*" (Bochner, 1984, p. 595). Hence, epiphanies are self-proclaimed phenomena in which one person may consider an experience transformative while another may not (Ellis et al., 2011). In the current autoethnography, I discussed epiphanies regarding my battle with comorbid anxiety, depression, and eating disorders, which have been transformative and shaped the context of my life.

Autoethnographers continue to utilize personal experiences, the root of the autoethnographic method, to find meaning behind significant life circumstances. Topics covered through autoethnography include finding meaning in challenging circumstances (Ellis & Bochner, 2006) and delving into personally significant topics (Sparkes, 1996). In terms of content, they cover a staggering array of subjects, including health issues (Ettorre, 2005; Sparkes, 1996), academics (Pelias, 2003), and family life (Muncey, 2005). According to Eisner (1988), knowledge is rooted in experience, and personal experience necessitates a technique for expression. The benefit of the personal perspective is that we are socially interconnected and constituted; nothing is entirely

distinctive about a single personality (Stivers, 1993, p. 413). Furthermore, using one's own distinctive personal experiences to shed light on the paucity of information in areas where sociological understanding is lacking, autoethnography has enormous potential for contributing to the body of sociological knowledge (Ellis et al., 2011; Ellis & Bochner, 2006).

Although autoethnographic research has been conducted regarding personal accounts of eating disorders, including bulimia nervosa (Tillmann-Healy, 1996), anorexia nervosa (Mukai, 1989), and anxiety and depression (Campbell, 2018), autoethnographic studies regarding the comorbidity of anxiety, depression, and eating disorders (i.e., anorexia nervosa, bulimia nervosa, and eating disorders) are lacking. For this reason, the following autoethnography addressed this gap through a detailed, personal perspective of lifelong battles with comorbid anxiety, depression, and eating disorders (i.e., anorexia nervosa, bulimia nervosa, and binge eating disorder). I seek to find meaning behind my battles with the comorbidity of anxiety, depression, and eating disorders and seek to empower my audience through vulnerable personal accounts. I also provide personal insights into my patterns of self-care and how the adaptive coping strategies have helped me withdraw from self-destructive coping mechanisms. With this focus, I aim to be a change agent and a source of inspiration for all those who struggle with similar battles.

Personal Narrative

Ellis et al. (2011) have identified different forms and approaches to autoethnography (*indigenous/native ethnographies, narrative ethnographies, reflexive dyadic interviews, reflexive ethnographies, layered accounts, interactive interviews,*

community autoethnographies, co-constructed narratives, and personal narratives). The proposed study can be classified as a personal narrative.

Personal narratives are intimate accounts of authors who see themselves as the phenomena and write vivid accounts of their professional, personal, and social lives (Ellis et al., 2011; Ettorre, 2005; Goodall, 2006; Tillmann-Healy, 1996). Personal narratives aim to understand oneself or some aspect of one's life as it interacts with a cultural context, connects to other participants as co-researchers, and invite readers to enter the author's world and use what they discover to reflect, comprehend, and adaptively cope as it relates to their own lives (Ellis, 2004, p.46). I classify the proposed study as a personal narrative due to the focus on raw personal accounts from my personal, social, and professional life during her struggle with comorbid anxiety, depression, and eating disorders. The following section will highlight the appropriate methods for autoethnography as substantiated by autoethnography and pioneers in autoethnography and their alignment with the proposed study.

Criticisms of the Autoethnographic Method

Autoethnography has been considered an avant-garde research method that challenges the unconventional research method (Holt, 2003; Méndez, 2014; Wall, 2006; Wall, 2016). "*The emergence of autoethnography and narratives of self … has not been trouble-free, and their status as proper research means problematic*" (Sparkes, 2000, p. 22). Critics hold autoethnographers responsible for norms of writing or criteria typically used with traditional ethnographies. According to social scientific standards, autoethnography is disregarded as ethnography because it is too aesthetic, emotional, unscientific, too scientific, therapeutic, and is not rigorous enough in its theory or

analysis (Ellis, 2009; Ellis et al., 2011; Hooks, 1994; Keller, 1995). Additionally, autoethnographers are frequently criticized because the autoethnographic research method combines ethnography and autobiography (Ellis et al., 2011). Criticisms for not spending enough time with the people and conducting insufficient fieldwork (Buzard, 2003; Fine, 2003; Delamont, 2009) were addressed by Ellis et al. (2011), stating that,

> Researchers do not exist in isolation. We live connected to social networks that include friends and relatives, partners and children, coworkers and students, and we work in universities and research facilities. Consequently, we implicate others in our work when we conduct and write research. (Ellis et al., 2011, p.8)

Moreover, autoethnographers are also perceived as navel-gazers (Madison, 2006), self-absorbed narcissists who fail to uphold their scholarly duties of hypothesizing, analyzing, and theorizing because they rely on allegedly biased personal experience (Anderson, 2006; Atkinson, 1997; Gans, 1999). Addressing whether autoethnography is a legitimate research method, Rorty (1982) states that the differences in the autoethnographic method are "*not an issue(s) to be resolved, only*"; instead, they are "*difference(s) to be lived with*" (p.197). Autoethnography aims to produce analytical, understandable texts that improve us and the society in which we live (Holman Jones, 2005, p.764). Autoethnographers see research and writing as socially just activities rather than being obsessed with correctness (Ellis et al., 2011). Lastly, a study contributes theoretically to the literature if it challenges, alters, or advances the individual's comprehension of the phenomenon (Bansal & Corley, 2011). Hence, the researcher for the proposed autoethnography intends to fill the gap of autoethnographic research and bring new meaning, perspective, and adaptive coping

solutions to the struggle of eating disorders. At the same time, they co-occur with anxiety and depression in women based on their personal experience. Hence, the following section will briefly address two significant limitations in autoethnography proposed by Bochner and Ellis (1996) and Méndez (2014) and their connection to the proposed autoethnography.

Data Collection Methods

This section details the appropriate data collection methods for this autoethnography. I first briefly describe autoethnographic data collection methods substantiated by autoethnographic pioneers in autoethnographic research. Then, the data collection methods utilized for this study are identified by referencing the autoethnographer and their specific study. Lastly, each data collection method and its alignment with the proposed research are determined.

Several autoethnographic researchers have utilized and identified acceptable sources of data material in autoethnographic studies. Acceptable sources of autoethnographic data material include document and artifact analysis (Muncey, 2005; Sparkes, 1996; Wall, 2008), photographs (Muncey, 2005), extracts from personal diaries and journals (Duncan, 2004; Ettorre, 2005; Goodall, 2006; Holt, 2003; Muncey, 2005; Wall, 2008), recollection of emergent memory (Coffey, 1999; Denzin & Lincoln, 2005; Ellis, 2009; Muncey, 2005; Poulos, 2012), and emails and memos (Duncan, 2004). The following autoethnography mimics Muncey's (2005) autoethnographic format of utilizing the "*art of memory*" (Muncey, 2005, p. 2) to share, analyze, and find meaning in the story of the researcher. Muncey (2005) defines the "*art of memory*" (p. 2) as the utilization of data collection techniques to "form a tapestry" (p. 2). Muncey (2005) shared

her life-changing story of teen pregnancy through sexual abuse by utilizing four data collection techniques, including snapshots, written material data, metaphor, and journey to "*form a tapestry*" or "*art of memory*" (p. 2). She then used the "*art of memory*" (p. 2) to share and analyze her story. Following this direction, I employed the "art of memory" (Muncey, 2005, p.2) to explore and find meaning from my experiences with comorbid anxiety, depression, and eating disorders through the utilization of personal journals, photographs/snapshots, and written material data (i.e., text messages, emails, yearbook messages, social media postings). The following section details the data collection techniques utilized in this autoethnography and their significance to the study.

Personal Journals

The personal journal entries utilized in this autoethnography highlighted the daily struggles I experienced with comorbid anxiety, depression, and eating disorders. The journal entries emphasize the last five years (2018 – 2023) of my mental battles, as I started to journal heavily within the specified timeframe. However, sporadic journal entries from 2014 to 2017 were also detailed. The journal entries detail times in my journey when I felt at my lowest point, imprisoned by my mental health struggles, and optimistic and determined to work toward recovery. The data from the journal entries were described and analyzed through the "*art of memory*" (Muncey, 2005, p. 2) to provide vulnerable detail and raw personal insight into the mental battles, abstinence from eating disorders, relapse from abstinence, the continuous pattern of eating disordered behavior, and the determination to make peace with this lifelong mental turmoil.

Photographs / Snapshots

Photographs were utilized to visually portray me before the onset of my eating disorder and the normalcy of my physique while struggling with the comorbidity of anxiety, depression, and eating disorders (anorexia nervosa, bulimia nervosa, and binge eating disorder). Since personal journal entries are not available to portray the mental struggles during childhood, adolescence, and early adulthood (i.e., 1991 to 2014), I used significant, relevant photographs to reflect upon this period. I also utilized photographs to portray my life beyond 2014 to illustrate that the normalcy of my physical appearance did not match the mental battles and self-destructive behavior that I experienced with the co-occurrence of anxiety, depression, and eating disorders. The snapshots are essential to portray, as eating disorders are not always obvious or apparent to the naked eye (Team, 2018). Additionally, images of bodybuilding participation, where I was incredibly lean to the naked eye but felt "fat" and unattractive, elucidated the depth of my body dysmorphia. The snapshots were described and reflected upon in detail through the "*art of memory*" (Muncey, 2005, p.2).

Written Material Data

The written material data utilized in this autoethnography includes personal text messages between my Overeaters Anonymous (OA) sponsor and me, email correspondences with my bodybuilding coach, yearbook messages from classmates, a meal plan, and social media postings. The text messages are essential to include as they provide detailed, raw, personal insight into conversations where I felt I had lost all hope of recovery. The sponsor's attempt to offer helpful tools for healing from bulimia nervosa was also highlighted. The text messages between my OA sponsor were

explained and analyzed to detail my mental battles while struggling with the comorbidity of anxiety, depression, and bulimia nervosa.

Timeframe of Proposed Study

This autoethnographic study is based on my struggles with the comorbidity of anxiety, depression, and eating disorders (i.e., anorexia nervosa, bulimia nervosa, and binge eating disorder) from the age of 4 to the present day. The studied timeframe begins around September 1991 and ends in the present day. The selection of this specific timeframe is based on my earliest memory of using food to cope with emotions, the onset of my eating disorders, periods of abstinence from my disordered eating behavior, relapse, and turning points that impacted my will and determination for permanent recovery. I also highlighted specific events during my formative years, adolescent and teenage years, and adulthood: formative years in kindergarten and elementary school; adolescent and teenage years (i.e., junior high school, high school); majority (i.e., the onset of college, entering the workforce, marriage, divorce, doctoral program, and participation in bodybuilding); utilizing the Overeaters Anonymous support group as an adaptive coping mechanism and the relationship with her sponsor; family and home life; and present day. These significant events are essential to highlight as they triggered anxiety and depression and initiated the onset of eating disorders, including anorexia nervosa, binge eating, and bulimia nervosa (in chronological order of eating disorder onset). The events I chose also highlighted my ongoing persistence to find inner peace, mental well-being, and resolution to this lifelong battle with the comorbidity of anxiety, depression, and eating disorders. This timeframe allowed me to

examine the root of my comorbid anxiety, depression, and eating disorder onset and similar ongoing patterns from my formative years to the present day.

Criteria for Data Collection

The proposed autoethnography is based on five main criteria for data collection. The criteria are centered around my chronological journey with anxiety, depression, and eating disorders. The criteria start with the awareness of my habits during my formative years (ages 4 to 10). The following criteria include the onset of critical eating disorder behavior during my adolescent and teenage years (ages 11 – 18). This leads to the following criteria, which encompasses ongoing critical eating disorder behavior in adulthood (ages 18 to 25)—followed by significant life events (26 to 30). Lastly, the data collection criteria concluded with recent battles and triumphs (ages 31 to present day).

The data consists of excerpts from approximately 28 journal entries, 78 photographs, and 21 written material data. An overview of the sequence of significant and transformative events during my battle with the comorbidity of anxiety, depression, and eating disorders is highlighted in Appendix A – Chronology of Significant and Transformation Events: Criteria for Data Collection (1991 to 2024).

Data Analysis

The first step in autoethnographic data analysis is recognizing that the researcher's direct personal experiences are tools for illustrating the researcher’s experiences and credible data (Buckley, 2015). In autoethnography, data analysis is a continuous process that develops and solidifies over time (Ellis & Bochner, 2000). In my autoethnographic study, I delved into deeper introspection and self-analysis to find clarity while reliving the experiences and emotions of the past during the analysis

processes. Considering the personal narrative approach to the proposed autoethnography, the following section describes the data analysis process from a personal narrative perspective. Narrative “thematic analysis” was employed as the primary analysis method for this autoethnography, per the recommendations of autoethnographic pioneers (Gibbs, 2007; Janesick, 2011).

According to Ellis and Bochner (2000), analyzing data from a personal narrative entails the researcher emotionally reliving the past. The researcher reflects on unique, remembered incidents and experiences, paying close attention to the feelings and immediate environment at the time of recall. Writing includes ideas, events, speech, and physical specifics of the relevant experience used to describe emotional memory (Ellis & Bochner, 2000). Hence, letting the data emerge as the research and writing are conducted is a distinctive feature of an autoethnographic investigation (Ellis & Bochner, 2000).

Several pioneers in autoethnographic research recommend utilizing thematic analysis to analyze the personal narrative approach to autoethnography (Gibbs, 2007; Janesick, 2011). Janesick (2011) asserts that the qualitative researcher engages in inductive analysis, wherein patterns, themes, and categories emerge from the data. The categorization process for interviews, papers, field notes, and papers is determined after data collection. Thematic analysis is predominantly an inductive qualitative data analysis method that systematically describes and identifies patterns or themes in a qualitative data set (Joffe & Yardley, 2004, p.65). The thematic analysis models of Gibbs (2007) and Janesick (2011) are listed in Tables Four and Five.

Table 4

Thematic Analysis Model by Gibbs (2007)

1. Look for the following: events (what happened), experiences (pictures, feelings, reactions, and meanings), and accounts (explanations, justifications).
2. Create a succinct summary highlighting the story's beginning, middle, and end.
3. Mark any mini-stories or supporting themes.
4. Look for themes.
5. Emphasize the use of emotional words, images, and sentiments.
6. Make memos or notes regarding your thoughts.
7. Develop a code framework and codify themes.
8. Create a more expansive thematic framework.

Table 5

Thematic Analysis Model by Janesick (2011)

1. Look for overarching themes, important words, and indicators of thought and action.
2. Create a preliminary list of minor and major categories.
3. Look for significant occurrences, tense situations, and conflict.
4. Look for inconsistencies and contradictions, then try to explain them.
5. Create a metaphor to express your feelings.
6. Make memos or notes regarding your thoughts.

Thematic Analysis Plan and Reflexivity

The data analysis process begins with a thorough read-through and highly reflective review (Humphreys, 2005) of my personal journal entries encompassing my daily mental battles with comorbid anxiety, depression, and eating disorders (i.e., anorexia nervosa, bulimia nervosa, and binge eating disorder) and my regular text message correspondences with her Overeaters Anonymous sponsor. Reflexivity is a "*creative, illuminative, dynamic, and self-affirming*" (Bolton, 2010, p.7) self-critical questioning and reflection that targets one's thoughts, role, fears, actions, hopes,

assumptions, and values (Bolton & Delderfield, 2018). Bolton (2010) defines reflexivity with the following statements:

> Finding strategies to question our attitude, thought processes, values, assumptions, prejudices, and habitual actions, to strive to understand our complex role concerning others… It is becoming aware of the limits of our knowledge … it is understanding how we relate with others … Thus, we recognize we are active in shaping our surroundings and begin critically to take circumstances and relationships into consideration rather than merely reacting to them and revise ethical ways of being and relating (p. 13 – 14).

Following the aims of a highly reflexive review (Humphreys, 2005) of the data (i.e., personal journals, photographs/snapshots, and written material data), I identified significant events, experiences, life-altering situations, and conflicts (Gibbs, 2007; Janesick, 2011) which initiated, impacted, and were turning points in my battle with comorbid anxiety, depression, and eating disorders. After identifying significant events, overarching themes, emotional words, images, sentiments, and indicators of behavior and action were identified (Gibbs, 2007; Janesick, 2011). Lastly, the findings were codified and organized by themes into a narrative account.

Qualitative Trustworthiness

Qualitative researchers determine a study's *trustworthiness* by questioning whether the findings can be trusted (Korstjens & Moser, 2017, p. 121; Lincoln & Guba, 1986). Korstjens and Moser (2017) state that the five components determine the quality of qualitative research: credibility, transferability, dependability, confirmability, and reflexivity, as opposed to quantitative analysis, which uses quality criteria in terms of

internal validation, generalizability, reliability, and objectivity, which are not appropriate to determine the quality of qualitative research (Korstjens & Moser, 2017). Qualitative researchers also ask questions regarding the novelty and relevance of ideas (Korstjens & Moser, 2017). In the following section, I define the five components of qualitative trustworthiness proposed by Lincoln and Guba (1986) and the various methods and processes associated with the proposed autoethnographic research.

Credibility

The first component of determining the trustworthiness of qualitative data is *credibility.* According to Lincoln and Guba (1986), credibility determines qualitative research's internal validity or trueness. Credibility is the degree of assurance that the research's findings are accurate and determines if the research findings are a valid interpretation of the participants' original perspectives. Further, credibility represents believable information derived from the participants' original data (Lincoln & Guba, 1986). In determining the credibility of the research findings in the proposed autoethnography, I will utilize three strategies, including methodological triangulation, prolonged engagement, and persistent observation (Lincoln & Guba, 1986), to validate the findings.

The first strategy, methodological triangulation, involves layering multiple sources of different data collection methods to enhance and achieve a more comprehensive understanding of a particular phenomenon (Bekhet & Zauszneiweski, 2012; Lincoln & Guba, 1986; Sim & Sharp, 1998). Several data collection methods were layered to substantiate the study's findings, including personal journals, photographs, and written data material, including text message correspondences with the Overeaters Anonymous

(OA) sponsor, emails, yearbook messages, and a meal plan. The data collection methods have been chosen because each data type adds a different layer to my experiences, enabling me to be reflexive and critical.

The second strategy that enhances the proposed autoethnography's credibility is the prolonged engagement or "*lasting presence*" (Korstjens & Moser, 2017, p.121) with the phenomenon, a significant strength of the current study. To date, I have spent 33 years battling eating disorder demons and the anxiety and depression that co-occur. This prolonged engagement and substantial personal experience enabled me to detail and critique my experiences over time, which is currently lacking in the research. That is, most of the previous research details only short-term treatment results or short-term experiences. Being able to present the phenomenon of comorbidity of anxiety, depression, and eating disorders from a long-term perspective not only contributes to the current knowledge base but also provides a more comprehensive narrative picture.

The third strategy connected to the accuracy of the data and findings is a detailed, persistent observation of significant elements and characteristics that are applicable, comparable, and consistent (Korstjens & Moser, 2017, p.121; Lincoln & Guba, 1986). In Chapter Two, I provided detailed evidence regarding what is known in the research about the comorbidity of anxiety, depression, and eating disorders. With this knowledge base, I compared, contrasted, and related data from other researchers to my analysis of my personal experiences and reflections.

Regarding my personal journal entries and written data material, I read and re-read my data to ensure that the interpretation and analysis of my findings were consistent.

Moreover, I also discussed my findings with my psychologist to ensure that my interpretation coincides with his.

Transferability

The second component of qualitative trustworthiness is transferability. According to Lincoln and Guba (1986), transferability refers to the applicability and the extent to which findings from qualitative research can be applied to different settings or situations with different respondents. Using “thick description” (Korstjens & Moser, 2017, p.121) and personal narratives, potential users will be able to decide whether the data is transferable to their experiences and contexts (Lincoln & Guba, 1986). Korstjens and Moser (2017) interpret thick description as describing the context of experience and behavior to bring clarity and meaning to the reader. In my autoethnography, I utilized “thick description” by vividly and explicitly detailing my data so that future researchers can quickly determine whether it is transferable to their unique life accounts.

Dependability and Confirmability

The third and fourth components of qualitative trustworthiness are dependability and confirmability, which are discussed concurrently as they go hand in hand with creating an audit trail (Korstjens & Moser, 2017). Lincoln and Guba (1986) describe dependability as the consistency of results over time. Hence, Lincoln and Guba (1986) suggest that an in-depth methodological design will ensure the consistency of the results over time. Per Lincoln and Guba’s (1986) recommendations, I incorporated a detailed methodological design in Chapter Three. Confirmability refers to the extent to which additional researchers could corroborate the research study’s conclusions (Lincoln & Guba, 1986). In this way, confirmability focuses on substantiating that the

data and interpretations of the findings are drawn from the data, not just the inquirer's imagination (Korstjens & Moser, 2017; Lincoln & Guba, 1986). For these reasons, I see consistency as a component of dependability (Lincoln & Guba, 1986).

An audit trail is required to maximize dependability and confirmability. Past journal entries, pictures, and text messages were utilized to capture the accuracy of what I experienced at specific times. Through reflexivity, the interpretations of my experiences critically reflected who I am now. Furthermore, I detailed my decisions during the data collection, analysis, and writing. Lastly, my audit trail consisted of several qualified individuals, including my qualitative expert, committee members, and doctoral colleagues, who reviewed my data to ensure that my findings were consistent.

Reflexivity

The fifth and last component I utilized to maximize the trustworthiness of this study is reflexivity. Reflexivity is the act of critically reflecting on one's conduct as a researcher, including prejudices, biases, and preferences, as well as the research relationship with others related to the phenomenon and the research focus (Korstjens & Moser, 2017; Lincoln & Guba, 1986). Reflexivity practices are conducted through diaries or personal journals, critically evaluating one's conceptual view, implicit and explicit presuppositions, and criteria in determining how these factors influence the research choices in all phases of their qualitative study (Korstjens & Moser, 2017; Lincoln & Guba, 1986). Therefore, qualitative researchers must be self-aware and reflective about their participation in the data collection, analysis, and interpretation process, as well as the preconceived notions they bring to their research (Mauthner & Doucet, 2003). I employed high reflexivity while critically evaluating my personal journals, pictures, and

written data material. I critically analyzed my conceptual views and implicit and explicit assumptions through reflexive practice to determine how these factors influenced my role and decisions with the research design.

Ethical Considerations

The focus on the self is one of the critical characteristics of autoethnography, which brings up the method's significant ethical issues (Ellis, 2007). Tullis (2013) highlights that since the autoethnographic nature makes the researchers vulnerable by sharing their intimate stories, the researcher becomes the primary risk. The context and others involved with the autoethnographer's accounts will emerge when a personal narrative develops in and through the reflexive practice (Ellis & Bochner, 2000). Regarding the proposed autoethnography, individuals who had a significant impact throughout the escalation and recovery of my mental struggles and self-destructive coping mechanisms were mentioned in terms of their role in my life (i.e., Immediate Family Member, Extended Family Member, Significant Other, Friend, Therapist, Mentor, Overeaters Anonymous Sponsor) without disclosing their actual identity. Several researchers suggest that at this stage, it is necessary to consider the issue of obtaining or not obtaining consent from these impactful associations (Ellis, 2007). Wall (2008) emphasizes that autoethnography may bring about delicate situations involving the researcher and those around them (Wall, 2008). Therefore, when speaking of loved ones like family or close friends' special consideration should be taken to protect their identity (Ellis & Bochner, 2000). Wall (2016) states that "there are always other characters in the story beyond the author, and it is important to consider how they are represented and included in the story'' (p. 4). While there are numerous factors to

consider when conducting autoethnographic research, the most important thing is that "...*autoethnography itself is an ethical practice*" (Ellis, 2007, p. 26). Being ethical and truthful regarding the events portrayed and the sentiments conveyed is required for writing autoethnographically (Ellis et al., 2011; Wall, 2008).

Institutional Review Board (IRB): Exempt Human Subjects Study

While this autoethnographic study may fall under the exemption category with Pepperdine IRB, considering I am the primary data source, consenting myself to the research is necessary per IRB advisement. I am required to submit an official IRB application for approval of my exempt human subjects' study through IRB's *eProtocol* online system (see Appendix B).

Furthermore, my notebooks consist strictly of my innermost personal thoughts, feelings, and reactions, excluding the mention of outside influences. Although outside influences such as family members, friends, classmates, and mentors significantly impacted the escalation of my mental battles, their identities were not revealed in this autoethnography. The outside influences were only mentioned in the reflective analysis in general terms based on their association with me (i.e., Immediate Family Member, Extended Family Member, Significant Other, Friend, Therapist, Mentor, Coach, Overeaters Anonymous Sponsor). Furthermore, my Overeaters Anonymous (OA) sponsor was also referred to in general terms (i.e., Overeaters Anonymous Sponsor), excluding names to protect their identity.

Limitations to the Autoethnographic Method

Various limitations should be considered in autoethnographic research. For instance, the emotions that arise in the reader may be unpleasant, and how the reader

relates to the study cannot be foreseen and controlled (Ellis & Bochner, 1996). The depth of vulnerable and sensitive detail in this autoethnography may trigger or inspire positive change in readers who can relate to her story. Another drawback is the implied disclosure of the researcher's private thoughts and feelings, which calls for candor, vulnerability, and willingness to self-disclose (Ellis & Bochner, 2000; Méndez, 2014). Concerning the proposed autoethnography, I grappled with the idea of complete honesty and vulnerability about my mental struggles due to the highly personal nature of the context. Hence, autoethnography is a challenging methodology because of this constraint, which raises several ethical issues that can occasionally be very challenging for the researcher to address (Méndez, 2014).

Summary

Chapter three discussed the vital methodological components of qualitative and autoethnographic research and how these essential components were utilized in the research design of this study. The unique autoethnographic research design was described with an emphasis on mimicking Muncey's (2005) research format of utilizing data collection methods to "*form a tapestry*" or "*art of memory*" (Muncey, 2005, p. 2). Next, the data collection methods (i.e., personal journals, photographs, and text message correspondences) and their significance and importance to my study were described in detail. Furthermore, the data analysis plan (i.e., thematic analysis) was described in detail by referencing the thematic analysis models of autoethnographic pioneers (Gibbs, 2007; Janesick, 2011). Next, qualitative trustworthiness was defined in detail, including its five components (i.e., credibility, transferability, dependability, confirmability, and reflexivity), which determine the quality of qualitative research

(Korstjens & Moser, 2017, p. 121; Lincoln & Guba, 1986). I then detailed how the proposed study conforms to the five components of qualitative trustworthiness. The ethical considerations of the proposed research were also highlighted, including the plan to protect the identities of the outsiders mentioned in the data analysis.

Further, the IRB exemption was also detailed since the current study did not utilize human subjects, as I was my research subject. Finally, the limitations of autoethnography were also addressed, highlighting its highly vulnerable and sensitive nature, which can trigger emotions in both the reader and the researcher. Chapter Four highlights the autoethnographic research design as detailed in Chapter Three.

Chapter 4: Data Analysis

I can feel my sadness in the pit of my stomach! It is physically paralyzing, isolating, and debilitating. I feel like a bird with a broken wing, unable to do life like the rest of the world. I am overwhelmed with intense emotion, and then I feel numb. I am slowly drowning without a life raft in sight. I feel tired and scared at the same time. My biggest fear is failing, but I am not motivated to be productive. I crave closeness with friends, but I dread socializing. I want to be alone but do not want to feel lonely. I find myself purposely pushing away friends, family, and anybody who even attempts to get close to me. My intense fear of the future is suffocating, and I cannot seem to shut out these voices in my head that tell me, "I will never be good enough. "I will never make it." "Nobody will ever want me when they discover the depths of my being." I have accomplished a lot, but I feel I have not accomplished anything. I do not think any amount of accomplishment will make me feel like I am enough. I am hurting myself, and I cannot stop. I feel like I am in an internal war with my bulimia, but I cannot let it go because it is all I have. I hate bingeing and purging, but I love it simultaneously. It is bizarre to write it out. Nevertheless, how can you love something and hate it simultaneously? I want to let it go, but I want it so bad. It feels like an abusive relationship that you know is bad for you, but you cannot let go. The only source of comfort I look forward to is a world where I belong. (Journal Entry, January 2024)

Background

Post-traumatic growth is defined as a positive personal and psychological transformation that may result from going through a traumatic and adverse event (Jayawickreme et al., 2020). Studies have shown that as many as 70 percent of individuals undergo positive psychological development during challenging periods, resulting in enhanced self-awareness, a stronger sense of purpose, heightened gratitude for life and relationships, and an increased inclination towards compassion and sympathy (Tan, 2013). This positive transition can help us develop resilience despite our challenges (Tan, 2013).

Situations related to post-traumatic growth are often the most difficult experiences to convey because they have transformed and challenged us (Ellis et al., 2011). Hence, these stories are also the most meaningful to share since they profoundly understand our human nature (Ellis & Bochner, 2000). Writing Chapter Four, which delved into my experiences with anxiety, depression, and eating disorders from age four through the present day, was a challenging and emotionally exhausting task. It required me to confront and relive the intense emotions associated with these painful experiences, showcasing my raw vulnerability and authenticity.

While writing my story, I had trouble articulating my narrative due to the profound emotional distress that is embedded in my heart. At times, I recalled the significant events that contributed to my anxiety, depression, and eating disorders, while at other times, my reflections on these experiences were blocked completely. To restore my memory, I would listen to eating disorder podcasts such as "*The Eating Disorder Diaries"* by Amy Goechel, "*Binge Breakers Bulimia Recovery*" by Jacqueline Davis, and

"*Bulimia Sucks*" by Kate Hudson Hall, all on the *Spotify* application. I came upon the idea of utilizing eating disorder podcasts as a tool to ignite my memory because, throughout the darkest moments in my 33-year battle, I recall listening to podcasts as a source of motivation and strength to pull myself out of my struggles. The podcasts were highly relatable to my story; therefore, I believed utilizing these tools would help revive the essential details of traumatic experiences. I hoped that my memory would be restored by hearing my story through the voice of strangers. As I listened to these individuals articulate their stories, I started recalling clear visions of my past and the intense emotions associated with these experiences. I revisited my writing and made additions or revisions as my memory crystallized.

Currently, I am proud to say that the self-destructive coping mechanisms (i.e., my eating disorders), which I once found to be the most shameful aspect of my identity, are now something I can discuss freely. I acknowledge that we all suffer from self-destructive coping mechanisms, whether we choose to share openly or not. Hence, my goal is to use my weakness as my strength to help all those who can relate to my story and find relief and inspiration.

My Vices: The Thieves of Joy

Vices are maladaptive coping mechanisms that are considered a worldwide phenomenon, as every human being has struggled with, is struggling with, or will inevitably struggle with a personal battle, which can lead them to seek self-defeating coping mechanisms (Anderson, 2016). A vice is a negative, self-destructive, chronic, or recurrent inclination or activity with an adverse effect. These self-destructive coping mechanisms can include eating-disordered behavior, drug abuse, alcoholism,

compulsive gambling, and compulsive shopping (Dill & Holton, 2014). Ultimately, life and being human encompass various aspects, including coping mechanisms, self-improvement approaches, and the degree of success in overcoming self-destructive coping mechanisms (Anderson, 2016; Dill & Holton, 2014).

My vices (i.e., anorexia nervosa, binge eating disorder, and bulimia nervosa) have stripped me of experiencing happiness and a sense of normalcy in personal and professional relationships. Ironically, the happiness and control I was initially seeking in my self-destructive coping mechanisms ended up controlling me and stripping me of the joy I have always craved. The most profound and significant events in my life are attached to memories of discomfort from the overconsumption of food, followed by my head in the toilet during birthday parties, family vacations, holidays, and graduation parties. I was a slave to my anxiety, depression, and eating disorders, and I desperately wish I could turn back time and be fully present, experiencing every moment of every event that was interrupted by the voices in my head that would tell me that I did not deserve to be happy.

The following chapter provides a chronological self-critical analysis of significant and influential life experiences that have initiated and impacted my lifelong battle with anxiety, depression, and eating disorders. The analysis of my life experiences is divided into five categories: 1) Awareness of habit; 2) Onset of critical eating disorder behavior; 3) Ongoing critical eating disorder behavior in adulthood; 4) Major life events; and 5) Recent battles and triumphs. By examining personal data, including personal journals, photographs, and written material data, I will address the following research inquiries through introspective and self-evaluative analysis of my enduring struggle with anxiety,

depression, and eating disorders: What are the daily challenges and successes that occur when someone has anxiety, depression, and eating disorders at the same time? How have these everyday struggles and successes been evident in my personal and professional life? How might the struggles and triumphs faced when dealing with the coexistence of anxiety, depression, and eating disorders contribute to becoming a catalyst for change in my own life, as well as for others facing similar issues, and for future researchers?

Cultural Exposition

One of the most significant influences in my battle with anxiety, depression, and eating disorders was growing up within the traditional Armenian cultural norms in a highly Americanized society. Within these childhood experiences, I found myself juggling with my confusion surrounding identity, isolation, and "fitting in" into society. Researchers have found that anxiety and depression are some of the most prevalent mental health disorders within the Armenian population, and they are more prevalent among immigrants who came to the United States from nations such as Lebanon and Armenia (Amazaspyan, 2018). The immigrants were impacted by the Armenian Genocide of 1915, in which the Turks massacred over 1.5 million Armenians. Hence, the animosity and resentment passed down from generation to generation have strengthened the bond in the Armenian community, driving them to obsessively maintain their cultural values, beliefs, traditions, and expectations (Kalayjian & Weisberg, 2002). This obsession with maintaining the culture can have a significant impact on establishing one’s own identity, especially with the second generation of Armenians who struggle with not only fitting into society but also fitting into their own

culture, which plays a prominent role in the development of mental health issues, such as anxiety and depression (Amazaspyan, 2018).

Speaking from my experiences, living in a traditional Armenian household felt like a tug-of-war between two cultures (Armenian and American). My guardians were extremely strict and conservative and set high standards and expectations for me. I often felt the only way to win my guardians' love was to be the "perfect" child. Other times, I thought I could not be myself or speak my mind because I would be shut down and rejected for who I was. This pressure to meet my guardians' expectations in a traditional Armenian household instilled a sense of confusion within my identity. Although I love and am proud of my Armenian culture and hold its values close to my heart, being born and raised in the United States and influenced by a highly Americanized society, I feel more aligned and resonate more with the American culture. This position has left me feeling like a "*black sheep*" and "*outsider*" in both my family and society. My need to break free from the control of my immediate and extended families to establish my independence, set boundaries, be my own person, and pursue my passions (i.e., bodybuilding) while seeking acceptance has been an ongoing battle that was exacerbated through my mental health issues.

The cultural drawback that I observed with my guardians, who were first-generation Armenians from Beirut, Lebanon, and Yerevan, Armenia, was their lack of belief, value, and resistance to mental health services. Rickwood et al. (2007) found that ethnic minority groups are hesitant to seek mental health assistance, particularly when faced with suicidal thoughts. They also have negative views about receiving help and believe they can address the situation independently (Amazaspyan, 2018). This cultural

stigma is significant to address as my guardian's resistance to seeking mental health services with my battle with anxiety, depression, and eating disorders escalated my mental illness, which not only affected my personal and professional relationships but also led to several periods of suicidal ideations in my adulthood.

Finally, but most important to the current study, the Armenian culture is tightly bonded via weekly family gatherings, with gluttonous amounts of food being the focal point (see Figure 1). Attendance at these family gatherings is mandatory, and lack of attendance is considered disrespectful. Being on a diet and choosing to attend but refrain from indulging in the family dinner is considered highly rude. Considering my cultural norms and traditions, escaping food has been an ongoing battle as food bonds us as a society and family. Nevertheless, food has proven to be one of the most self-destructive drugs in my lifetime. Food is inescapable and necessary for survival, which is a Catch-22 for anybody struggling with eating disorders. Often, I would joke and say, "*I wish I were an alcoholic because escaping it would be so much easier than escaping food, which is crucial for survival*."

Figure 1

Typical Armenian Family Dinner

Note. One of our typical Armenian family dinners consists of a gluttonous amount of food, and the host feels "*it is just not enough*."

Awareness of Habit: Ages 4 to 10 (1991 – 1996)

Childhood: Food = Happiness

All I have ever wanted was to fit in, to belong, to be seen, to be heard, to be acknowledged, to be understood, and to be "normal" just like everyone else. I believe that these factors have been the root of my pain, sadness, anxiety, and eating disorders. For as long as I can remember, I have been like a prisoner to excruciating anxiety, extreme sadness, and ongoing intrusive thoughts. The sadness and anxiety are constant and torturous, and it seems like I am trapped and cannot break free. Moreover, I always ask myself, "*I wonder what it is like not to feel this way*?" *"I wonder what it is like to be happy*?" "*I wonder what it is like to be able to breathe*?"

Since childhood, I remember associating food with happy (see Figures 2 & 3) and sad emotions. As a child, one of my guardians would take me for a walk every day after dinner. We would walk to the local convenience store, and my guardian would buy us our favorite candy; in my case, it was *Haribo* gummy bears, which brought me a sense of happiness as I connected it to my childhood memory. I also recall a childhood memory when one of my guardians would walk me to the park and treat me to a *Winchell's* donut. Furthermore, every Saturday night, my guardian would take me out and treat me to McDonald's fries on our way home (see Figures 2 & 3). As I recall these childhood memories with my guardian, I only feel joy and happiness, wishing I could go back in time and enjoy my *Haribo* gummy bears, my *Winchell's* donut, and my *McDonald's* fries without the fear and anxiety that I would gain weight. I would give anything to not overthink consuming the foods that once brought me joy.

Figure 2

Enjoying McDonald's on a Saturday Night, Age 8, 1994

Note. Enjoying McDonald's on a Saturday night with my immediate family, without worrying about the world, resembles some of the happiest times in my life. I often wish I could turn back time and enjoy being in the present moment, enjoying my French fries.

Figures 3 & 4

My Guardian, Cousin, and Me on Our Way to McDonald's Age 8, 1994 (left) and (right) Kindergarten School Picture, Age 4, 1991

Note. (Left) Happy memories revolved around family and food—the best times I miss dearly. (Right) I felt lonely, isolated, sad, and highly anxious. I felt uncomfortable around the other kids and do not remember having friends.

Kindergarten – Ages 4 - 5

My earliest recollection of using food as comfort stems from my formative years at the age of four in kindergarten at the small private Christian Armenian school I attended (see Figure 4). I remember feeling alone, sad, and anxious, hiding in my locker and eating "*Sunchips*" to feel better. The lockers were tall and narrow, allowing a tiny five-year-old to fit in. My classmates were tactless, mean, unaware, and oblivious of how their words and behavior affected their classmates. Reflecting on myself, I have always been a sensitive soul. I still cannot comprehend my classmates' confidence level and why I could not be just like them. I wanted to fit in, belong, be liked, admired, and seen.

I knew I was different, but I could not figure out why. I always thought that I was the "*ugly duckling,"* but reflecting on my pictures from my childhood years, I now know that was not the case. What I know to be true is the extreme discomfort and awkwardness I felt while being around others. Why would I feel this way as a four-year-old? What was the root cause at such a young age? Was an issue at home affecting my ability to function normally in society? Could I possibly have had an undiagnosed developmental disorder like Asperger's syndrome or autism spectrum disorder? Did I have a chemical imbalance attributing to my anxieties? Was I incapable of seeing my worth? These questions remain unanswered.

Grades 1 – 3 (Ages 6 – 8)

My early school years were difficult and uncomfortable. Reflecting on grades one through three (see Figures 5 – 7), I recall feeling sad, painful, and anxious among my peers. I attended an upscale Armenian private school where the students came from

wealthy, well-to-do families, and the students could distinguish those kids whose guardians were not as well off by the car the guardians drove. My guardians worked hard but struggled financially and sacrificed everything to enroll me in a private Armenian school (see Figures 5- 7). A classmate once said, "*My guardian drives a Jaguar, and your guardian drives a minivan. I cannot hang out with you*." I did not understand why a specific car would make me worthy of friendship and belonging.

As one of my guardians would drop me off at school, I would start smelling my clothes, as the fabric softener comforted me and made me feel as though my guardian was still with me. I dreaded being at school and remember feeling extraordinarily alone and not having many friends. Recess and lunchtime were spent hiding in bathroom stalls and dark hallways, hoping and praying that break would end soon so I could return to class. I remember one specific instance where I was hiding in a bathroom stall and overheard one of the popular girls in my class forbidding two other female classmates that they were not allowed to be my friends. I felt extremely hurt, unloved, and unwanted, and I did not understand why I was not worthy of having normal friendships. I always had the impression that I was somehow going through my "ugly duckling" phase and was not pretty enough to be included with the rest of my classmates. However, now that I reflect on pictures from that period (1992 to 1994), I know my appearance was not the case. I remember craving friendship and belonging so severely that I would buy my classmates' company by giving away my valuables, like the beautiful seashells my guardian had purchased for me over the weekend from the KCET store. To cope with loneliness and lack of belonging, I unconsciously ate my classmate's snacks during break time, as if on autopilot. I was unaware and did not fully

understand that taking food that did not belong to me was wrong. I did not fully understand that I was trying to fill the loneliness by seeking comfort and belonging in food. All I wanted as a child was to be seen, heard, and accepted, but above all else, I craved belonging, and I wish I could go back in time and give my six-year-old self (see Figure 3) a hug and tell her how beautiful, unique, and loved she is.

Figure 5

1st Grade School Picture, Age 6, 1992

Figure 6

2nd Grade School Picture, Age 7, 1993

Figure 7

3rd Grade School Picture, Age 8, 1994

Figure 8

My 10th Birthday, December 1996

Note. As a second-generation Armenian American female, I experienced large family gatherings centered around consuming copious amounts of food. During these family gatherings, I distinctly remember grappling with profound anxiety that hindered my ability to smile.

Onset of Critical Eating Disorder Behavior: Ages 11 to 18 (1997 - 2004)

Onset of Anorexia Nervosa - 1997

Between the ages of four and 10, food was an unconscious coping tool in sad and happy situations (see Figure 8). However, in the fall of 1997, while I was in the 6th Grade (see Figure 9), starvation was the only way I was able to numb the sense of unworthiness, pain, loneliness, extreme sadness, low self-esteem, and lack of belonging. Starvation was my silent cry for help, and it was a way in which I felt in control of the mental chaos that had taken me as a prisoner. I felt uncomfortable and unattractive, hated my body, and did not feel smart compared to my peers. I thought I would be accepted if I lost some weight. My teachers placed me in the primary level classes compared to the advanced courses, contributing to my feeling "*less than*" my peers. I felt alone, drowning in my pain; I was scared; I did not believe in myself, and I just wanted to be heard and seen.

I remember the summer of 1997 to be highly joyful and carefree, and I did not want it to end. I can still taste the delicious Napoleon ice cream while watching "*I Love Lucy,"* "*Bewitched,"* and "*I Dream of Jeanie"* reruns with my immediate family. Life was as good as it was going to get. It was a couple of months into 6th Grade, and for the first time, I was completely aware of the weight I had put on during the summer break. I asked one of my guardians if I had gained weight, and she responded, "Yes, *you have. What has happened to you, Hasmek? You must drop some weight!"* I felt ashamed, humiliated, and belittled by her response. Although I became highly self-conscious at that moment, with my self-esteem shattered, I continued to enjoy the same foods as usual.

Then, on a cold Wednesday afternoon in early November 1997 (see Figure 9), while in music class at the private Armenian school I was attending, all the pain I was feeling finally found its outlet through extreme starvation, the beginning to my end. I anxiously awaited my turn to sing in front of the class and was excited about our usual Wednesday pizza lunch. While sitting down and waiting my turn, I attempted to cross my legs but failed. One of my classmates compared me to a female classmate who I thought was heavy and who I wished I would never look like. She said to me, "*Oh my goodness! She can cross her legs, and you cannot?*" Moreover, that one sentence triggered the deadly beast known as anorexia nervosa. I felt extreme humiliation, shame, and disgust, and from that moment forward, I started starving myself. I skipped the pizza lunch that I was looking forward to and remember feeling in control, relieved, empowered, and that I had found the solution to my pain, which was controlling my food intake.

Figures 9 and 10

(Left) *6th Grade School Pic., Age 11, 1997, (Right) 7th Grade School Pic., Age 12, 1998*

As my anorexia escalated, my weight loss started to become more and more evident as I dropped from 115 pounds to 85 pounds in two months. My guardians did not know how to help me other than use physical force so that I would eat. Seeking mental health counseling was a path that my guardians were not willing to take as they did not believe I was sick, and they did not believe in the benefits of mental health services. I remember one of my guardians placing several slabs of butter in pita bread and force-feeding me, but I would throw a tantrum not to eat. The sight of food nauseated me, and mealtime was an utter nightmare. I was hungry, but I felt in control of my emotions, and that overpowered everything. Hunger felt like a sense of safety. I felt invincible. I remember throwing away my school lunches and telling my guardians I had eaten lunch. The school custodian witnessed me throwing my lunch away daily and reporting it to my guardians. Frequently, I would get so hungry I could not sleep, so I would wake up in the middle of the night and have a peach, which soothed my soul. Furthermore, to this day, peach is one of my favorite fruits because of the comfort it brought me during my battle with anorexia. The anorexia took control of my life for the next year and a half (see Figures 8 - 11), after which I was hit with another deadly uncontrollable beast, a binge eating disorder.

Figures 11 and 12

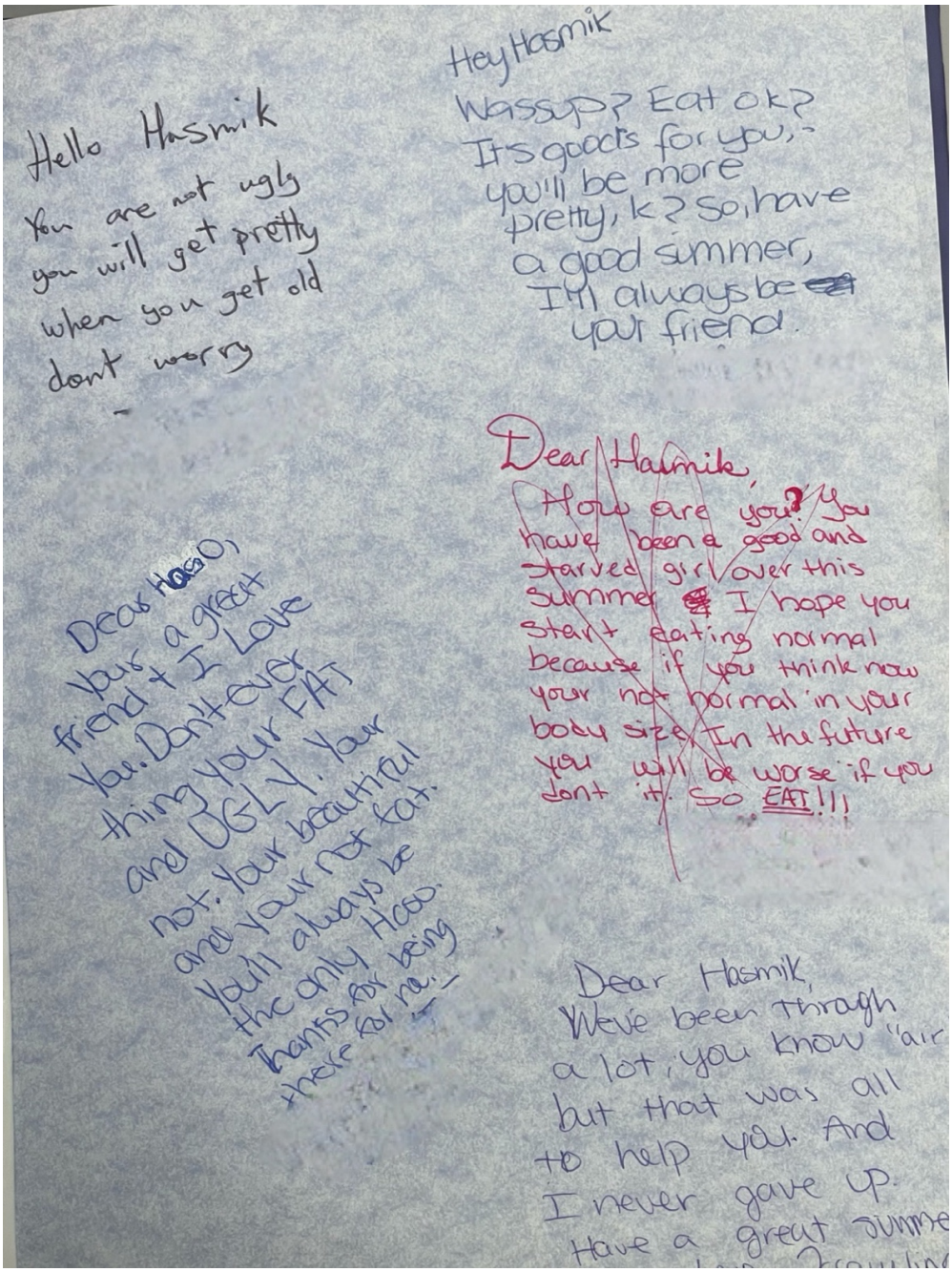
January 1998: Two Months After Anorexia Onset at a Family Event

As I scroll through my 7th-grade yearbook, I reflect upon my classmates' caring and concerned yearbook messages (see Figures 13 & 14). A few key observations that stand out to me through these messages are how "*shy, quiet and reserved*" (see Figures 13 & 21) based on my classmate's perspective. My classmates emphasized/convinced me that "*I am not fat and ugly and need to eat*" (see Figure 14) to save me from myself. I had read these messages initially but had not fully processed that I was loved and cared for, even though I did not feel it then. My anxiety, depression, low self-worth, and lack of love for myself had overpowered and prevented me from seeing and thinking clearly. I wish my guardians had enrolled me in mental health services at the time so that I was able to see and feel all the love that was around me. A huge part of me was lost in this disease, and I wish I had been more aware at the time

that I needed help. Little did I know that my unhealed anxiety, depression, and lack of self-love would continue to follow me for the next 25 years.

Figure 13

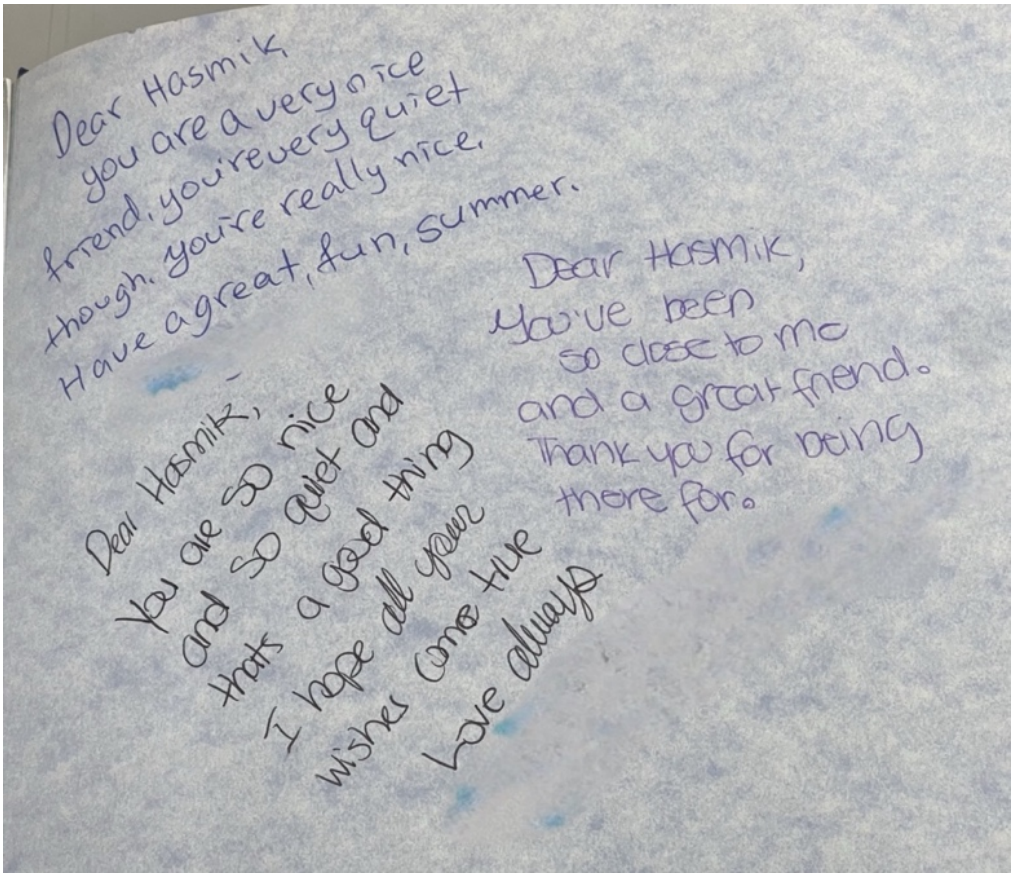
7th Grade, 1998: End of the Year Yearbook Messages from Classmates



Note. The pink message was from the classmate who triggered my anorexia in music class.

Figure 14

7th Grade, 1998: End of the Year Yearbook Messages from Classmates



Onset of Binge Eating Disorder - 1998

Directly following my 12th birthday in December of 1998, I developed a binge eating disorder. I do not recall precisely how it came about. Still, I do remember feeling uncontrollably hungry and switching from numbing my emotions through starvation to numbing my emotions by binging on large amounts of food. I would restrict food during the day and then binge after school. Although my guardian would have a healthy dinner prepared for me when I got home from school, I still managed to binge on sweets in the house, such as boxes of cereal or pastries. My binge would be followed by feelings of intense shame, guilt, and feeling sorry for myself. I promised myself that tomorrow

would be different, and the repetitive pattern of restricting food intake during the day, followed by binging on sweets in the evening, was a continuous daily battle.

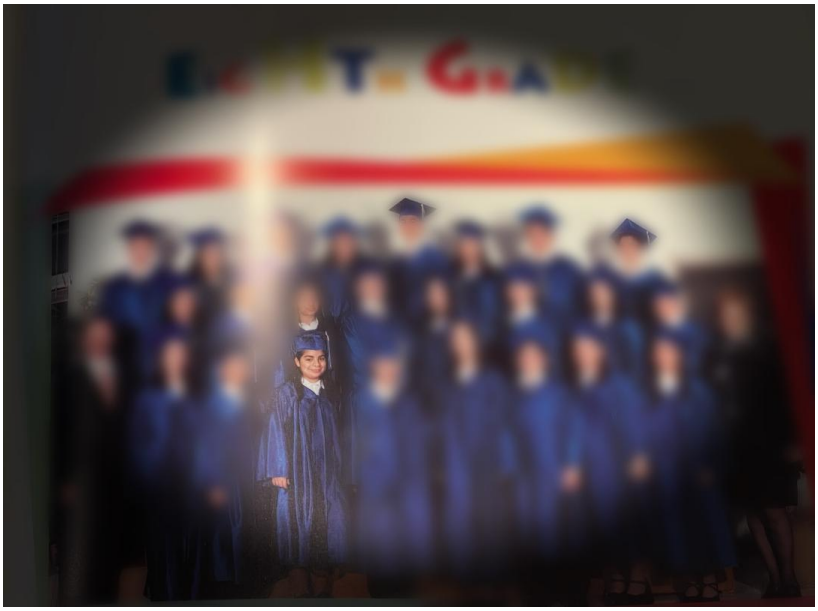
My weight increased by 40 to 50 pounds in a few months (see Figures 15 - 17). The rapid weight gain brought about feelings of intense shame, guilt, and disgust in myself. My self-esteem plummeted further; I loathed the person I was becoming, wished I could disappear, and felt utterly alone, unaccepted, and unloved. All I ever wanted was to be connected to others, to belong, to be seen, and to feel confident and beautiful like the other girls in my class. What I failed to recognize then was that my body was growing and developing during that period, and perhaps the hunger was my body's way of telling me I needed to eat to grow. Puberty and the hormonal changes that come along with it may have also escalated my anxiety and depression. My body was asking for love, and I could not recognize it at the time to give myself some grace.

Figure 15

July 1999, Age 12. Eight Months into Binge Eating Disorder

Figure 16

Sept. 1999: Ten Months into Binge Eating Disorder - 8th Grade Graduation School Pic



Tears roll down my eyes as I reflect upon these pictures, which illustrate the pain I felt during the onset of my critical eating disorder. My heart aches for that lonely little girl who just wanted to fit in, be accepted, wanted, seen, and heard. I wish I could go back in time and pour self-love into the little girl who had so much love to give. I engaged in binge eating behavior not because I lacked willpower but because I had unmet emotional needs. I wish I had someone to talk to who understood the emotions I was going through. I wanted my guardians to recognize the importance of mental health services. If I knew then what I know now, I would have pushed to get the help I needed before my condition worsened.

An excerpt I had written for my 8th-grade senior yearbook perfectly sums up the pain I felt in a few short words (see Figure 18). I talk about my difficulties, challenges, and expectations as a five-year-old starting school. In the excerpt, I state, "*In life, we go through so many difficulties, but the moment I set foot in this school at age five, I knew*

my teachers were going to help me overcome my difficulties." I also state my motto, a quote by Woodrow Wilson, "*Friendship is the only cement that will hold the world together*," which emphasizes my need for friendship and connection. Reflecting on the except (see Figure 18), I ask the following questions: How can a five-year-old face so many difficulties at such a young age? Why did I feel like every day was a challenge? Did my anxiety and depression as an adolescent girl prevent me from having healthy friendships? Was the school environment the root of my problems? As I reflect upon sweet, loving, and humbling yearbook messages from classmates as I transitioned from 8th grade and into high school (see Figures 19 – 22), I question whether I self-isolated due to my anxiety and depression. Did my peers accept me but were too blinded by my disease to see that I was wanted and accepted all along? Did I isolate as a means of self-defense to avoid hurt and rejection? Critically reflecting on the past, I realize I lacked self-worth and devalued myself. I found hiding in isolation safer than opening myself up to my peers. I would give anything to turn back time and interview my younger self. I wish I knew why my beautiful, bright, and intelligent self could not see the gifts within me.

Figure 17

With my 8th Grade Class Isolated in the Far-Left Corner, Year 2000

Figure 18

Personal Excerpt from 8th Grade Yearbook, Year 2000

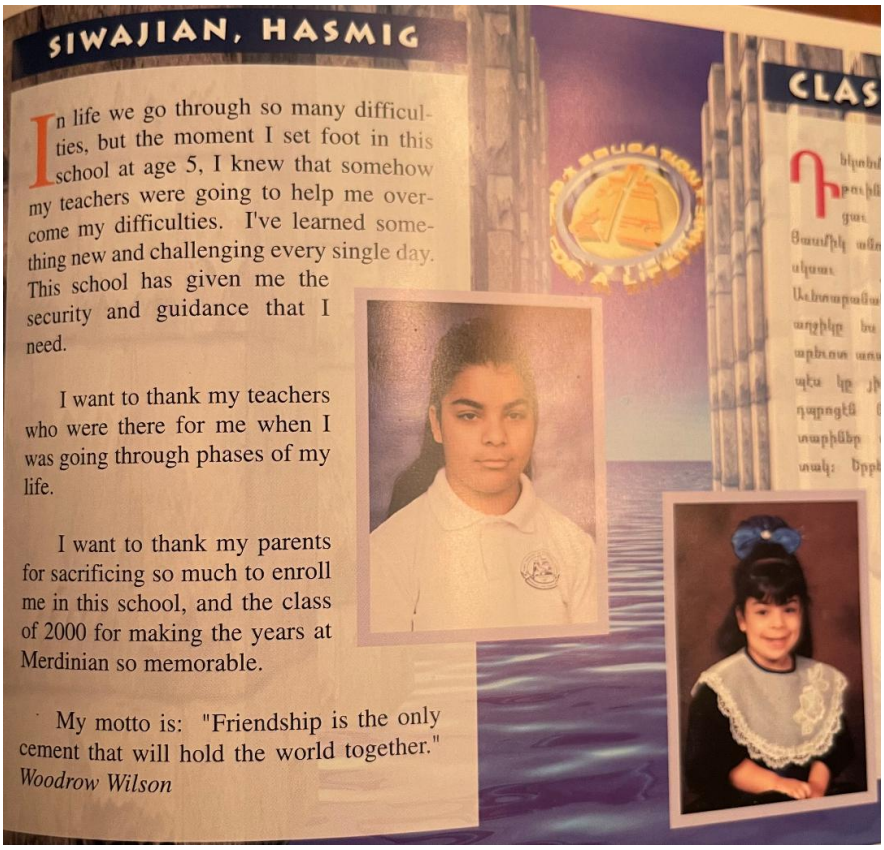


Figure 19

8th Grade Yearbook Message # 1 From Classmate, Year 2000

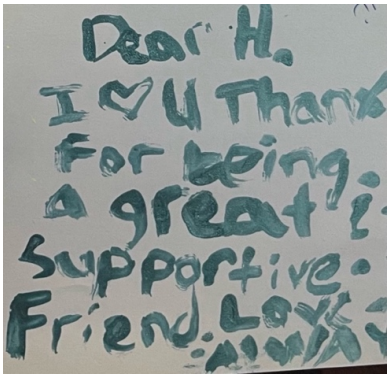


Figure 20

8th Grade Yearbook Message # 2 From Classmate, Year 2000

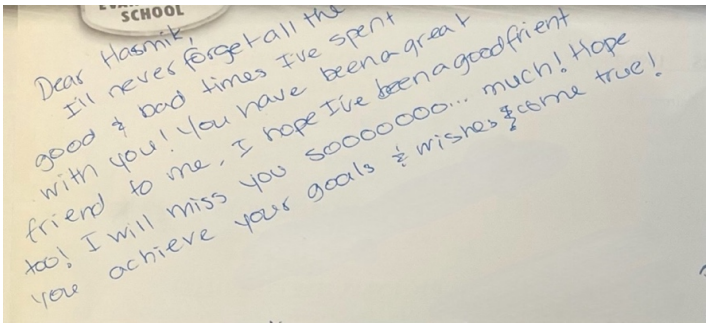


Figure 21

8th Grade Yearbook Message # 3 From Classmate, Year 2000

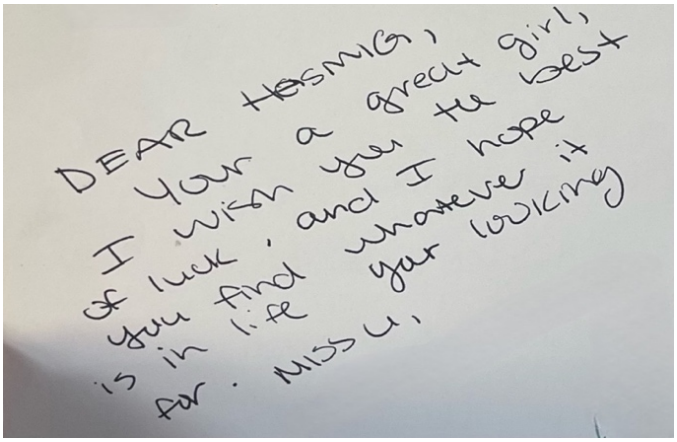
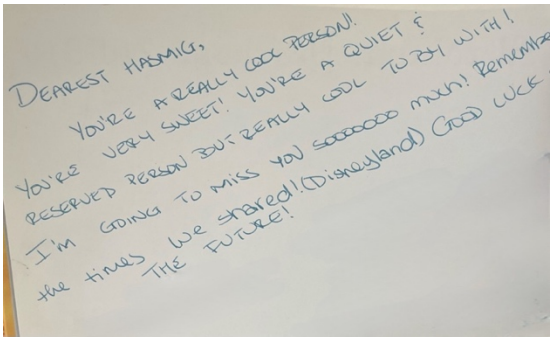


Figure 22

8th Grade Yearbook Message # 4 From Classmate, Year 2000



High School – Binge Eating and the Onset of Bulimia Nervosa (2000 – 2004)

It was the year 2000, and my pre-teen self was excited and nervous about starting High School. I was transitioning from a private upscale Christian Armenian school to a public American school comprising students of different nationalities and economic backgrounds. I was optimistic about entering a new environment where I did not know any of my peers and having a fresh start. I was looking forward to making new friends and being surrounded by individuals who were more down-to-earth and not so well-to-do as the Armenian private school I attended. "*Perhaps I would be more accepted*," I thought. Little did I know of the eating disorder beast that was waiting to feed on my emotions and the one eating disorder that has held me hostage till the present day, bulimia nervosa.

Although I was optimistic about the start of High School, my mental demons and daily intrusive thoughts were deemed to be more powerful than I had anticipated. Although I made friends who were more down-to-earth and accepting of me, my lack of self-acceptance and self-confidence was the real issue. Reflecting on that time, the students wanted to be my friend, but I remember having a guard up and did not allow anyone to get too close. Thoughts of "*What if they figure out how weird I am and reject*

me?" or "*Why would they want to be my friend when I am so fat and ugly*?" or "*I cannot get hurt if I do not let anyone in*," ruled my mind daily.

I carried the same repetitive daily cycle from my Armenian school days of restricting food intake and then binging after school. My weight continued to increase, along with shame and ridicule from one of my guardians. My guardian compared my heavier body to thinner female cousins to push me to stop binging. The guilt and ridicule only aggravated my mental illness. Not one day passed by when I was not anxious, depressed, and on a diet. I spent my time in class calculating calories and fat grams and determining how much weight I would lose if I were on a specific diet, then paying attention to the teacher's lecture. Then, one day, I witnessed one of my guardians drinking laxative tea, and I started drinking it daily until my body became dependent on it. The laxative teas made me sick to my stomach, but I still drank them to purge myself of my binge eating cycles. The obsession with my weight was debilitating, and I did not know how to escape the self-destructive thoughts. All I was seeking at the time was to be thin, beautiful, popular, and confident like the other girls. I loathed who I was and was highly uncomfortable in my skin. I felt mentally and emotionally exhausted, and I just wanted an escape, a solution, and a miracle.

Then, one day in early November 2003 (see Figures 23 & 24), what I thought was my solution was introduced to me by a female cousin during a weekend family lunch at my home. Little did I know then that what I had deemed a miracle was the ultimate beast and the biggest curse I would not wish upon any living soul. This beast was named bulimia nervosa, which has ruled my life and held me captive for the last 21 years. My female cousin quickly lost weight while eating whatever she wanted without

exercising or counting calories or fat grams. I admired her physique and said, “I wish I could *be as thin as you*.” She replied and said, “*The only way you can look like me is if you starve yourself or purge your meals.*” I was intrigued by eating whatever I wanted and not gaining weight. I asked her to show me how to purge, after which she took me to my guardian’s private bathroom and showed me exactly what to do. That evening, I binged on a large amount of food and purged, just like she had demonstrated earlier that day. “*Purging is so easy. I can do this!*” I thought to myself. I felt so accomplished and successful, and that was the beginning of the next 21 years of ultimate self-destruction, which I have not been able to escape from. In the years to come, I grew increasingly resentful towards this female cousin for “cursing” me with this habit until the day she took her life in October of 2017, two months shy of her 34th birthday. Although my cousin was bulimic and struggled with chronic depression and anxiety, her suicide was also connected to several other factors, such as her personal trauma and hardcore drug addiction.

Figures 23 & 24

High School Senior Pictures November 2003: One Week Before Bulimia Onset

Note. I looked healthy and happy, but I remember forcing myself to smile.

Bulimia nervosa felt like the answer to my childhood physique dreams. At the time, I was solely using bulimia for weight loss purposes and was oblivious to the lifelong repercussions. I was highly unaware of how dangerous and addicting this habit was and how it was going to control me for the rest of my life. I began overeating and purging all my meals daily. My weight dropped by about 60 pounds, dropping from 160 to 100 pounds in three short months. By February 2004, I had achieved "*The physique of my dreams*." I could not explain the drastic drop other than it was a miracle from the universe. "*How did I not know about bingeing and purging before?*" I thought to myself. I had watched movies where the characters would purge their meals, but it had never crossed my mind before my cousin's demonstration that I could purge my meals thoroughly and successfully. For the first time, I felt powerful and in control. My obsession with my physique and body dysmorphia grew increasingly as my weight continued to drop. I was highly addicted to the most self-destructive, most consuming eating disorder of them all.

My new self-destructive obsession caused increasing tension in my household. I was unable to hide my daily bouts of binging and purging. My guardians caught on quickly and did not know how to get me to stop. They would not only hear me purge my food, but the foul smell of vomit was also overpowering. Seeking mental health services for my eating disorder was not an option for them as they did not think I had a problem. My immediate family truly believed I was purging for attention and verbally abused me by shaming, humiliating, guilting, and using physical force to get me to stop.

The truth was that I could not get myself to stop. I felt trapped and imprisoned inside the mental barriers of this disease. I remember one of my guardians who would

stand in front of the bathroom door and call me degrading and humiliating names, which aggravated my condition further. My guardian even went to the lengths of chaining our refrigerators to control my compulsive overeating. Locking the refrigerator only humiliated and isolated me and added fuel to the emotional turmoil I was experiencing.

When verbal abuse did not seem to do the trick, my guardians set forth an ultimatum: I would either stop purging my meals or be allowed to go to my Senior prom in June, which I had been looking forward to all year. Therefore, my old anorexia nervosa habits resurfaced, and I stopped purging until the day after my Senior prom (see Figure 25). What my guardians failed to understand at the time was that I was suffering from a severe mental illness that was out of my control. The longer my condition was left untreated, the worse it got (see Figures 26 & 27). I needed serious professional help and craved love, compassion, and understanding from the people who loved me the most instead of an ultimatum, which was only counterproductive.

Figure 25

May 2004: Senior Prom Picture Seven Months After Bulimia Onset

Note. I felt empty, numb, and hopeless.

What I also find mind-boggling was the fact that my guardians did not feel the need to intervene while I was suffering from my binge eating disorder because I was not "*too thin*," so therefore, "*there is nothing to be concerned about*." I cannot blame them because they were not aware that body size does not determine a person's mental state. However, a pattern I recognized during my binge eating and bulimia phases was that verbal abuse was at its peak. Shame, guilt, ridicule, and humiliation were used to control my behavior, but the verbal abuse only drove me to be more secretive about my self-destructive coping mechanisms. Love, compassion, and empathy were the medicine I craved and would have healed me in so many ways.

Figures 26 and 27

June 2004 - High School Graduation Celebration, Eight Months After Bulimia Onset.

College, Entering the Workforce, & the Escalation of my Bulimia (2004 to 2012)

The summer of 2004 was a unique and memorable time as I took a trip to New York with my cousins in anticipation of the start of my first year of college. Taking trips and being confined with others was extremely difficult as I was addicted to bulimic behavior and could not binge and purge as freely as I would at home. Nevertheless, I would obsessively count my calories on trips and undereat because it felt like the only aspect I could control and provided a sense of safety (see Figure 28).

Figure 28

June 2004 – Trip to New York with My Cousins Before the Start of College.

Note. This was my first trip to New York City and a high school graduation gift from my guardians. I could not enjoy myself as I was in a heightened state of anxiety because I could not binge and purge freely.

Ongoing Critical Eating Disorder Behavior: Ages 18 to 25 (2004 - 2011)

College – 2004 to 2009

> Why does feeling empty make me feel so pure and perfect? The lack of something I need makes me crave it even more and gives me a weird, unusual high. The feeling of an empty stomach after restriction, dizziness, and the lack of energy inside my body is freeing. I do not want to eat because I do not like introducing anything new into my body. I do not want to mess things up. Emptying my bowels with a couple of laxatives makes me feel better, draining out the meal that made me feel like a total screw-up. Nevertheless, why does emptying my body feel so amazing? Do I want to empty only my body or mind and soul? I cannot just quit what I have begun because there will be no way to feel relieved. This is all I am now. Sometimes, I feel furious and sad as my weight goes higher on the scale. Maybe the toilet never flushed those feelings. Perhaps the only empty thing within me today is where I used to find happiness. I do not know how I became so unhappy, and I do not know if I will ever see it again. (Journal Entry, December 2004)

By the time I entered my first year of college in August of 2004, the obsession with my physical appearance and my bulimic habits were at their peak. I felt anxious and sad every single day, but I did not see the connection between my emotions and my eating disorder. I thought I was in control and merely trying to manage my weight. I could stop the bulimia at any point; however, the more I binged, purged, and abused laxatives, the worse my condition got, like a domino effect. I was still living at home per the Armenian cultural expectations I had observed within my community. I had

"*perfected the art of bingeing and purging*" while becoming more and more secretive about my self-destructive coping mechanisms. I had also introduced a dangerously high dosage of laxatives into my daily routine, which only fed and aggravated my disease and weakened me further.

My guardians, who had been extremely controlling and overprotective throughout my childhood and adolescence, had now slightly relinquished their control. I had just begun driving; my car was my savior and key to my freedom and independence. Independence meant I could start working, earn money, and pay for school. Independence also meant I could go anywhere and do anything while having access to unlimited amounts of food and binge and purge before coming home. Having a car felt like I could escape prison for a few hours daily. I loved and appreciated my immediate family, but their control over my every move was suffocating. My guardians were extremely overprotective and never really accepted the fact that I was now a grown-up and needed to be trusted to make my own decisions. Ultimately, I had no voice in the decisions in my life, as all my choices were downplayed and criticized. Despite the independence of owning a car, I always felt like the little girl who could never break free and never grew up in her guardian's eyes.

By the end of my first year of college, I had never felt more alone, anxious, and depressed (see Figures 29 & 30). My bulimia felt like the devil and the silent killer that was sucking the emotions and life out of me. I had never felt more physically weak, and I felt like I was dying slowly with each passing day. I had "*perfected the art of binging and purging*" and memorized all the school bathrooms where I could purge. During my breaks between classes, I would leave campus and buy massive amounts of food

consisting of two dozen pastries and three to four fast food meals, after which I would sit in my car in a private location and eat until I was physically incapable. The distorted perception of myself after a binge was that "*I looked like I was nine months pregnant with twins.*" I would binge and purge twice in a row, with each session lasting between two to three hours, leaving me emotionally and physically exhausted. The initial binge and purge session would aggravate my anxiety and fill me with so much shame and guilt that I had to binge and purge a second time to calm down my emotions. After I had purged, I would redo my makeup and clean my car to hide any traces of my binge and purge sessions. My self-destructive state pushed me into isolation, not allowing myself to form close friendships. My increased state of anxiety caused by the binge and purging made it increasingly difficult to concentrate on my studies.

Figure 29

May 2006: End of my 1st Year of College

Note. The bulimia had left teeth marks on my right hand from the continuous binging and purging. As evident in the picture above, I was ashamed and self-conscious about the teeth marks and would always try to conceal them.

I wanted to stop my bulimic behavior more than anything. Therefore, I started weighing all my meals on a portable food scale. If I could keep a record and control the calories that entered my body, the binging and purging would stop. The downside of weighing and measuring my meals was that the numbers became an obsession. I would not allow myself to go over the daily caloric limit I set for myself, which was too low to be at my optimum. Also, I ate the same meals daily, limiting the nutrients my body desperately needed. I vividly remember feeling hungry all the time, which eventually led me back to my bulimic behaviors and continuing the repetitive, self-destructive cycle.

Figure 30

May 2006: End of My 1st Year of College

Entering the Workforce – 2005

On May 1st, 2005, I started my first long-term job at one of my favorite department stores. I remember feeling awkward and lacking appropriate social skills compared to the rest of my colleagues. I continuously apologized for everything and guarded myself from making close friends. My anxiety was at an all-time high due to my bulimia, and I felt exceptionally physically weak (see Figure 31). However, despite everything, I was highly driven to succeed in this commission-based department store. What mattered to me the most was maximizing my commission, disregarding the importance of friendships and relationships. I did not see the entire picture at the time. Still, isolation meant safety; isolation meant I could not get hurt, and isolation meant hiding myself to conceal my flaws, not only in my professional relationships but also in my relationships. While I thought I was in control of my disease, my mental illness had its claws around me and was not going to let me escape anytime soon.

As an aside, I never binged and purged at work because I was aware of the anxiety that binging and purging caused, and I wanted to be at my optimum. Although I strived for perfection and did my absolute best at performing my job, I was never satisfied with myself and never felt good enough. Feelings of self-loathing and self-critical thoughts pushed me to binge/purge every day after work. I binged and purged to alleviate my anxiety, but what I was doing was punishing myself for not being perfect. I can also attest that binging and purging was the highlight of my day because I felt like I did not have anything to look forward to.

Figure 31

Summer 2006: Around the Time I was Working at My First Job

Note. I looked healthy but was crippling inside. I was depressed and anxious, and I never smiled.

In October of 2006, I decided to leave my job at the department store because I felt physically and mentally weak due to the toll the bulimia had taken on my body. As a result, I perceived myself unable to keep up with my job and school demands. In the meantime, I continued to push myself through school. However, I feel that my self-destructive behavior and the lack of belief in myself hindered my mental capacity. I remember studying for hours and not achieving the grades I wanted. I was striving for a perfect score and achieving a B average. I truly believed I was not smart enough to

succeed when I needed to show myself some love and feed it with the proper nutrients to maximize my mental capacity.

I was studying to be a registered dietitian at the time, which fed my obsession with my weight and disordered eating behavior. Enrolling in a nutrition-based program would help me find the perfect weight loss regimen. As an accessory to my nutrition program, in December 2007, I applied for a part-time entry-level nutrition assistant position at a local hospital (see Figure 32). Although I loved working and performed well, I was miserable in this position due to the lack of challenge associated with my daily tasks. The work was easy and mediocre, and I felt I lacked purpose and did not feel valuable to the hospital, essentially devaluing my efforts. The mediocrity of the position triggered my anxiety, and I found myself in the hospital cafeteria, binging on large plates of food. I was called out on my binging by my manager and felt humiliated, ashamed, and disgusted at myself for my lack of control. I voluntarily quit my position soon after, in October 2008, due to my shame for binging.

Soon after I left my nutrition assistant position at the hospital, I applied for an entry-level scientist position for a personal care manufacturer in December 2008. The place also felt mediocre, and the same feelings of anxiety and lack of purpose I felt while working at the hospital resurfaced. The work was easy, but rather than acknowledging my strengths and capabilities, I devalued myself, which fed my ongoing eating disorder behavior. I craved acknowledgment and recognition from others when I could not acknowledge myself.

Bulimia Brought About the Insanity in Me – Spring 2008

Bulimia sucks the life out of you, literally and figuratively speaking. It is not merely an eating disorder or a mental illness. Bulimia is a demon that takes over your mind and convinces you that "*you are not worth living because if you binge and cannot purge for whatever reason, you are disgusting, worthless, and better off dead."* These thoughts ran through my head in Spring 2008 (see Figure 32). I had binged on several loaves of bread and could not purge because I did not drink enough water to soften and break up the bread so that it could come up quickly. The ratio of liquid and food needs to balance itself out so that the food can come up with ease, a technique my cousin who had introduced me to bulimia had taught me. I wish I never knew "*the tricks of the bulimia trade" because once you know what to do,* "*you are cursed forever."* Hence, I have always sarcastically referred to bulimia as the "curse" that my cousin blessed me with. A curse that kills you a little bit every single day.

My guardians had left the house to conduct personal business, and I was left home alone. Every time my guardians went anywhere, I would start feeling intense sadness, anxiety, and a sense of feeling unsafe, which led me to cry uncontrollably due to the importance of abandonment I felt. I cannot explain the root of where these emotions originated other than feeling betrayed and unloved. Before my guardians left the house to go about their business, I started anticipating and planning my upcoming binge, feeling both excitement and fear. I knew I would soon regret what I was about to do, but I could not control myself. I feel incredible sadness when describing this scenario because I know my 21-year-old self just wanted to be held, loved, and nurtured.

I attempted to purge like I always had with previous binges, and the bread would not come up. I felt a sense of intense anxiety, lack of breath, and panic seize my entire body. With the pressure building up, making me feel as though I was helpless and drowning, I placed my fingers down my throat and tried to regurgitate the bread but had no success. I felt utterly helpless and thought to myself, "*If I only controlled the binge, then I would not be in this situation. I knew I would regret it, and I did it anyway."* I decided that I did not deserve to live anymore and that I was going to drink chlorine to end my life. I was not the one who crafted her suicide ahead of time or was knowledgeable in suicidal techniques. Therefore, the first thought that came to my mind was chlorine. I would drink it and be gone shortly afterward.

I sent my last text message to my extended family member, with whom I had confided with complete trust with my issues with bulimia, and thanked her for everything she had done to help me, how much I loved her, will miss her, and how she is going to be a great Mom one day because she cared for me so profoundly. As I was writing this message, I started to cry uncontrollably for several hours because I did not want to die. Thoughts of how much I loved my immediate and extended families and how profoundly my death would affect them brought me back to my senses. I was eventually able to calm myself down, and the thoughts of ending my life dissipated. I wanted to live and experience life, build meaningful connections, get married, have babies, and build a successful career. When I think about what I was about to do 16 years ago, it fills my eyes with tears and my heart with deep sadness. I am grateful that I was able to pull myself out of the demonic intrusive thoughts that would have ended my life when I had so many gifts and a heart full of love to offer the world.

In the meantime, I had not heard a response from my extended family member and felt horrible for sending her my last text message, which would send her into an emotional whirlwind. As I was about to pick up the phone to call her and reassure her that I was ok, she called me in utter panic, crying and mortified by the suicidal letter I had sent her. I explained the trigger to my suicidal thoughts but that I had calmed myself down and reassured her that she had nothing to worry about. I am grateful for my extended family members who loved me unconditionally and without judgment. Her selflessness and unconditional love helped me realize that life is worth experiencing.

Figures 32 and 33

(Left) Summer 2008: Before My Suicide Attempt. (Right) Summer 2008: Going to Work

Note. (Left) I was chronically depressed, and my heart was in pain. It was hard for me to smile. I looked healthy on the outside but was dying on the inside. I felt lost and purposeless and hated myself completely. (Right) I just wanted to get the day over with so that I could come home and binge and purge.

Another Day, Another Broken Promise - My Failed Attempts Towards Self-Healing

My biggest wish was to stop the bingeing and purging behavior. However, my biggest misconception, which prevented my healing, was believing that I was able to control and self-heal my anxiety, depression, and eating disorders. During this time, my attempts at controlling my binging and purging habits manifested into obsessively controlling my caloric intake by weighing and measuring every morsel of food. Also, to trick my body and mind into thinking I was full, I ate large portions of low-caloric vegetables; however, the excessive hunger resulting from the low-caloric intake triggered my endless and vicious binging, purging, and laxative abuse habits. Additionally, I utilized other methods of self-healing, such as speaking with an older mentor several times a week, which was my version of pro-bono therapy; sporadically attending the 12-step support group Overeaters Anonymous (OA); and enrolling in a macrobiotic leadership program in Massachusetts for three months (January 2011 – April 2011).

Discovering Overeaters Anonymous – Fall 2008

In the Fall of 2008 (see Figure 34), I discovered the 12-step support group Overeaters Anonymous (OA) for individuals struggling with compulsive overeating. OA promised that if we attend meetings regularly, find a sponsor, and put the OA Tools (see Tables 1 – 3) to work, then we would achieve and maintain our abstinence from our disease. I did not take OA seriously and attended meetings sparingly. I found an OA sponsor but was entirely on guard and lacked trust in others. As a result, I found it difficult to open myself up to her. Essentially, I did not put in sufficient effort to achieve abstinence from binging and purging. Deep down, I do not think I wanted to recover. My

bulimia was my safety net and a part of my Identity, and I was too afraid to let It go. Moreover, having utilized food as my coping mechanism, I subconsciously felt like I would drown without my eating disorder. My eating disorder was my best friend for life.

Figure 34

October 2008: During a Family Cruise While Attending OA

Note. I was barely hanging on during a family cruise while attending OA. I hated being on the family trip. I would disappear from my family frequently and head to the buffet to binge. The idea of going on a trip was exciting, but the actual trip was a nightmare as it triggered my anxiety.

Meeting My Guardian Angel in Human Form – Summer 2009

In the Summer of 2009 (see Figure 35), fate led me to a female mentor who owned a naturopathic clinic near my home. I stepped into her clinic out of curiosity, and coincidentally, I was wearing my open-toed sandals that day. The first thing she said to me, which caught me off guard, was that my heart was not doing well because of the edema in my feet. I was unaware then, but edema in the feet is a sign of heart issues. I felt drawn to this woman and quickly opened myself up to her about my ongoing eating disorder and self-destructive behaviors, which I felt may have contributed to the edema

in my feet. She offered counseling services for me; however, being unemployed at the time with no insurance coverage, I explained that I could not pay for her services. She offered to donate her time to me despite my lack of income. I began counseling with her for the next seven years. She was tough on me and pushed me to recognize the connection between my self-destructive habits and emotions. The support and care she provided at the time provided comfort in knowing that somebody out there understood my struggles. Although I never achieved any form of abstinence from my eating disorder during my time with her, I am grateful for her genuine support, care, and selflessness towards my healing and recovery. She was an angel in human form.

Figure 35

Summer 2009: Around the Time I Met My Mentor

Note. My face was always swollen from the binging and purging. I still could not get myself to smile because it felt unnatural.

The Macrobiotic Diet as a Healing Tool – January 2011 – April 2011

As my mental illness continued to escalate throughout my work experiences and bachelor's and master's degree programs between 2004 and 2011, I was desperate to find a way to tame my eating disorder beast. In late 2010, I discovered a dietary philosophy called the Macrobiotic diet by George Osawa. The Macrobiotic diet, derived from the Greek words "*makro bios,*" meaning "*Long Life*" and "*Great Life*," is a modern diet philosophy that incorporates dietary principles derived from Zen Buddhism. The diet balances food and cookware's purported yin and yang components (Harmon et al., 2015). The primary tenets of macrobiotic diets involve minimizing the consumption of animal products, prioritizing the consumption of locally sourced foods that are currently in season, and practicing moderation in meal portions (Lerman, 2010).

After researching the healing and dietary benefits of the Macrobiotic diet, I was highly intrigued and motivated to learn if this dietary approach can assist in healing my anxiety, depression, and eating disorders. Therefore, in January of 2011, directly following my Master's degree coursework, which was ironically in Food Science, an applied science focusing on the science of food processing, I enrolled in a three-month Macrobiotic Leadership in Boston, Massachusetts. My goal was to heal from my ongoing mental demons, but subconsciously, my goal was to lose as much weight as possible. At the end of the 3-month program, I fully understood the macrobiotic principles and dropped the weight I had hoped would come off. In addition, I observed and felt improvements in my energy levels, skin, hair, and overall well-being, and I abstained from bingeing and purging (see Figure 36). However, I was still not healed from my eating disorder as I reverted to my old self-destructive habits within one month

after I returned home (see Figures 37 & 38). I did not fully understand the concept of my mental illness stemming from deep-rooted emotional issues that needed to heal before any abstinence could be achieved.

Figure 36

April 2011: The End of My Macrobiotic Leadership Program in Boston, Massachusetts

Note. I felt improvements in my overall well-being and had a healthy glow.

Figures 37 and 38

(Left) May 2011: One Month After the Macrobiotics Program in Massachusetts, (Right) May 2011: Master's Degree Graduation Ceremony

Note. May 2011: One month after completing the macrobiotics program in Massachusetts, I experienced a relapse into my bulimia. In this image, I am heading to my Master's graduation ceremony, with my face visibly swollen because of my earlier episode of binging and purging prompted by my anxiousness. I was not fully present and, hence, unable to appreciate this day, diminishing the value of my efforts.

Major Life Events: Ages 26 to 30 (2012 – 2016)

I was not consciously aware at the time that my anxiety, depression, and eating disorders affected every part of my life, from work, school, friendships, and relationships. Not only did I guard myself from close friendships, but I also guarded my heart from romantic relationships. Due to my lack of experience in the romantic arena, I was highly oblivious and naive to so-called red flags. I believed that verbal, mental, and psychological abuse was expected due to my living environment during childhood.

My First Serious Romantic Interest

I met my first romantic interest through an online dating app. Having no prior relationship experience, I needed clear expectations of what I was looking for in a relationship and a future life partner. I can attest to the fact that I was feeling suffocated under my guardian's roof and did not have any sense of self-worth or self-love. Deep down, I wanted independence and respect from my family. Therefore, my goal was to find my life partner so that I could move out. Reflecting on that time, I was chronically depressed and incredibly trusting and vulnerable. I saw the good in everyone and closed my eyes to potential issues that may present more significant future problems. As mentioned, I was incredibly naive and oblivious and did not consider the qualities I sought in a long-term life partner.

About two months into the relationship, I developed a sense of comfort and trust with my partner. A huge part of me felt unworthy of his love because of the shame and guilt I felt surrounding my eating disorder. The shame and guilt compelled me to confess about my bulimia and co-occurring laxative abuse. Ignorant of the complexity of my disease, my partner gave me an ultimatum: either I quit cold turkey immediately, or

he would leave me. The fear of losing my partner and being alone forever motivated me to attempt to stop the bulimia and laxative abuse despite my numerous previous unsuccessful attempts. That night, I promised my boyfriend and myself that I would stop the binging, purging, and laxative abuse. I convinced myself that this time, I was ready to stop completely, and I truly believed this would be the end of my self-destruction.

In my attempt to stop binging and purging, I once again reverted to previous methods of blunting my bulimia, which were obsessive calorie counting and restriction. I also tried halting the laxatives cold turkey, but much to my dismay, my body had become dependent, and my digestive system would not function without daily use. Moreover, the excessive hunger that resulted from the severe calorie restriction once again led me led my back to my bulimic habits within a matter of days. The guilt and shame once again took over, and I confessed to my boyfriend that I had "*attempted to stop the bulimia and laxative abuse but failed*." He gave me another ultimatum to stop completely. I tried to stop again and failed. After that, I decided to keep my eating disorder a complete secret.

Moving forward, I became highly secretive about my self-destructive habits rooted in the intense fear of losing him. Deep down, I was unworthy of anyone's love because I devalued every part of my being. Had I loved and respected myself and found even a morsel of worth within me, I would have ended the relationship rather than succumb to my partner's ultimatum. His ultimatum gave me a glimpse of my partner's verbally abusive, controlling, and narcissistic nature and how he fed off my weakness and insecurities. This was perhaps the giant red flag I chose to ignore because I believed I was not worthy of love. Lastly, growing up in a verbally abusive and

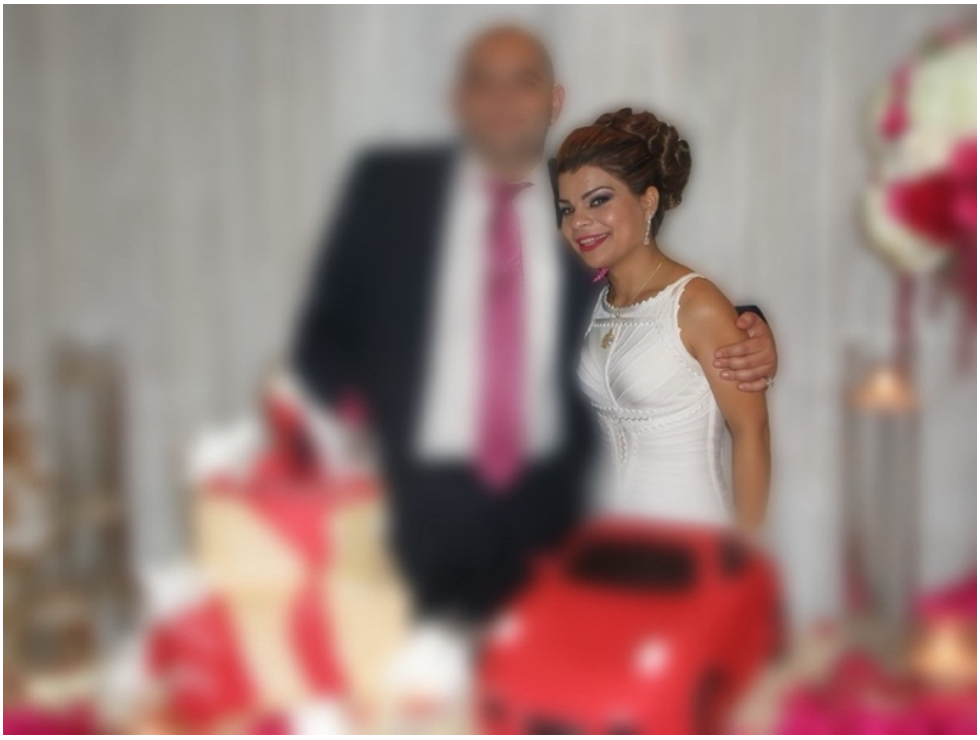
controlling household, with one of my guardians also exhibiting narcissistic tendencies, made my boyfriend's behavior appear familiar and routine.

Moving in with My Significant Other

Blinded by my partner's abusive, controlling, and narcissistic tendencies, I accepted his offer to move in together ten months after we initially met (see Figure 39). The day he asked me to move in with him made me feel that I was the luckiest girl in the world, and I could not believe he wanted to take this next big step. The feeling of unhappiness and imprisonment started the day I moved in with him, and I entered what I call the unhappiest time of my life and the ultimate prison for the next 19 months. My bulimic and anorexic tendencies escalated in the months following the move, and my extreme weight loss became concerning to my boyfriend and family members. I always found a way to reassure everyone that I felt healthy and amazing, but I kept on dropping weight. In Figure 39, with my partner, I dropped 30 pounds from that point, which weakened me further, all the while becoming increasingly more and more secretive about my eating disorder. As mentioned previously, my biggest fear was losing my partner and ending up alone; ironically, though, I had never felt more alone than I did in my relationship, which I dealt with by numbing, purging, and starving my emotions through my eating disorders.

Figure 39

My Partner and I at a Family Party One Year After We Met



Note. We had moved in together, and emotions were running on high as my partner, and I fought excessively as my subconscious was trying to fight off his control, verbal, mental, and emotional abuse. My self-worth crumbled further, along with my anxiety and depression taking a deeper dive. My forced smile hid the great imprisonment, pain, and unhappiness I felt.

My unhappiness within the relationship was becoming extremely difficult to ignore as I was having thoughts of ending my relationship with my partner. I confessed to one of my guardians that I no longer felt that my boyfriend and I were a good fit and wanted to end the relationship. My guardian, who mirrored my partner's abusive, controlling, and narcissistic tendencies, responded, "*Who else is going to want you? At least he wants you with all your issues.*" I should have refrained from sharing my feelings with my guardian and followed my intuition in what I felt was best for my well-being. My lack of self-worth and self-devaluation stemmed from my guardians' verbal, mental, and

emotional abuse since childhood, which made me believe that I was not worthy of love of any sort.

First Big Trip with My Significant Other

A few months after my significant other and I moved in, we decided to take our first big trip abroad. The feelings of unhappiness and imprisonment intensified as my partner's unbearable verbal abuse began on the second day of our arrival. His abusive behavior brought about intense feelings of self-hate, self-loathing, and regret. To cope with my triggered chronic anxiety and subsequent elevated emotions, I escaped from my partner several times on our trip, where I binged and purged to calm down. I purged every single meal and dropped 10 pounds within a matter of one week (105 lbs. – 95 lbs.), while my intrusive thoughts were telling me I was "*fat and disgusting*."

After we returned from our trip and throughout our relationship, I began sporadically journaling my feelings as a coping tool. An excerpt of my journal entry below from September 2014 was written the day after we returned from our trip, as I was simultaneously sitting in my private bathroom and crying my eyes out. My partner heard me crying and knocked on the bathroom door, asking me what was wrong. I responded, "*I am just tired and jetlagged from our trip. Nothing to worry about.*" The second day back from our trip symbolized the intense pain and sadness I would feel for the rest of our relationship. I had major regrets about my decision to move in with this man.

> What have I done? Why did I move in with this soulless human being? I feel humiliated, ashamed, and worthless, and I wish I had not agreed to move in with him. It is too late, and I feel trapped. I want to end this relationship, but what will

> people think? How can someone who loves me treat me this way? Is this love or control? It is weird how he reminds me of my guardian. I almost feel as though he is an abusive guardian rather than my loving partner. I am unhappy and feel misunderstood. He does not see or appreciate me. I want to disappear. I pray we find some common ground! (Journal Entry, September 2014)

While living with my partner, I felt like I never left my guardian's house, trapped, disrespected, alone, lacked purpose, and unworthy of having a say in any aspect of significant decisions, from having children and finances to approving my grocery lists and going back to school for my doctorate. I felt a lack of support regarding my goals and dreams in my career and higher education. Money was my partner's ruling authority, and anything interrupting our finances was dismissed, discounting my feelings. His lack of support for my feelings, who I was, my passions, interests, and emotions triggered my anxiety and depression, and the only way I would feel any sense of control and power was when I binged and purged.

I felt unloved, miserable, and chronically depressed, and not a day went by when I did not binge and purge during the relationship. I hated myself and my life and was drowning in utter pain and misery. The worst aspect was that I felt I could not disclose my feelings to family or friends because I did not want my family to resent my partner. I binged and purged my emotions daily and had absolutely no motivation to stop. A big part of me wanted to end the relationship with my significant other, and another part of me was afraid to be alone because I thought nobody would want me. In the end, my eating disorder was my best friend and most trusted confidante and the only way I got through my relationship.

> I am feeling broken, feeling like a loser, feeling misunderstood and misperceived in this relationship. My anxiety is constant, and I feel like I can never fully breathe. When I attempt to verbalize what I am feeling, he does not understand my pain. All I can think about is how to get rid of the uncomfortable feeling of being trapped here with him. It is not supposed to be like this. This does not feel right. I am supposed to be happy and in love, and I do not feel any love or happiness. All I want to do at night now is binge instead of keeping him company while he plays his video games. I need clarity, strength, and a miracle. (Journal Entry, June 2015)

Below is an excerpt from my journal entry after surviving a major car accident on my way to work. In the journal entry, I am venting about my partner's abuse, lack of empathy, and compassion following the accident. I remember how scared I was because I knew how much he valued money and how upset he was going to be because the accident would negatively impact our car insurance. After arriving at the accident scene, my partner was furious and could not stop yelling. I was scared to death and was appalled by the fact that he could not appreciate the miracle of my survival. I felt alone and scared and felt as though I was not present in my body. His reactions felt inhumane and made me feel worthless. I knew this was not the behavior of a loving partner, but I somehow felt worthy of his abuse because, in the words of my ex-partner, "*How can I have been so stupid, braindead, and careless to let this happen?*"

> His biggest worry is the car insurance rate increasing rather than being grateful that I am alive. I asked him to drop me off at home because I could not go to work. He told me that I was not dead, I had no sick time, and we needed the

> money. He is heartless, has no soul, and is utterly convinced that he does not love me. My boss witnessed my accident on her way to work and stopped by to help me. My partner could not stop yelling at me, and my boss witnessed everything. I am so humiliated. (Journal Entry, December 2015)

It was not long after my horrific car accident that I finally decided to end my relationship. The excerpt below was written two days before leaving my partner. It was a cold Sunday morning in April of 2016, and we were on our way to grocery shopping. I do not remember the context of the argument, but what I vividly remember was the lack of breath I felt in the car and the feeling like I was going to die. He pulled over to the side of the road and asked me to walk home. I sat on the sidewalk, scared out of my mind, crying my eyes out and thinking that my life was over. I proceeded to call him to pick me up, apologizing endlessly about the argument, but he refused to pick me up. I thought about calling my guardian to pick me up, but I was highly secretive about the issues in my relationship. I felt helpless, scared, humiliated, and worthy of his abuse. I called my partner once again, after which he decided to come and pick me up and forced me to apologize for an argument where I had no wrongdoing other than having an opinion and standing up for myself.

> I have never been more humiliated. This is the fourth time he has left me on the side of the road and asked me to walk home. I do not deserve this. All I did was stand up for myself. I feel like I have no voice, no say, and my opinion means nothing. I feel sick to my stomach and cannot breathe. I cannot go on like this. (Journal Entry, April 2016)

Healthy Coping Mechanisms

During my relationship with my significant other, I used several healthy coping mechanisms aside from journaling, as mentioned in the previous section. I resumed counseling sessions with my mentor, whom I call "*my angel in human form.*" I would visit her sporadically and vent about the issues in my relationship. I had incredible trust and respect for her, and her support during this emotionally difficult time was extremely valuable in dealing with my relationship. Additionally, I met with spiritual energy healers on occasion, where healing modalities such as reiki and hypnosis were utilized to calm down my emotions and intrusive and self-destructive thoughts. Further, mindfulness exercises consisting of yoga and meditation were also highly efficacious in eliminating my self-defeating thoughts. The spiritual and mindfulness modalities and the unconditional support of these trusted individuals made me feel loved and understood and decreased my sense of loneliness within my tumultuous relationship.

End my Relationship with My Significant Other

My "*angel in human form,"* who had been my respected mentor and confidante for the past seven years, was pivotal in ending my relationship. This difficult step was the greatest form of love, strength, and empowerment I could have given myself because I decided to respect myself and do what was in my best interest. Counseling sessions with my mentor helped me realize that I was no longer going to tolerate the abuse and mistreatment from my partner.

Ending my relationship felt like I had escaped from prison, and it was the most liberating feeling to do what was good for my mental well-being. I was not scared anymore, and I felt my lungs fill back up with oxygen as I could finally breathe again. Although I took a brave and self-loving step by ending my relationship, I was chronically

depressed and could not get myself to snap out of the sadness (see Figure 40). The bulimia and laxative abuse continued to overpower every aspect of my life, and I did not want to let go of the vice that made the relationship bearable. I remember feeling numb and unable to speak very much for about one year following the ending of my relationship with my ex-partner.

Figure 40

Two Weeks After Leaving My Partner During a Mother's Day Dinner with My Family

Note. I could barely smile and lost my appetite, but I felt relieved to leave the prison I called my relationship. I remember taking a trip to Costco during my first week back home and not being limited to what I could purchase or spend, which was the most liberating feeling. I felt human and hopeful for the future.

Relationship Aftermath

In the months following my separation from my ex-partner, my bulimia continued to be my coping tool for my depressed and anxious state of being. Healing from my

trauma came from loving immediate and extended family who did everything in their power to pull me out of my depressed state. I took several trips that year to get my mind off the ending of my relationship. My immediate family members would take me on mini trips on the weekends (see Figures 41 & 42), while my cousins took me on a trip to New York in September 2016 (see Figures 42 & 44).

Figures 41 and 42

(Left) Three Months After Leaving My Partner on a Weekend Trip, (Right) September 2016: Trip to New York City (NYC) with My Cousins

Note. I am grateful for my immediate and extended family because they supported me in ending my relationship and brightening up my spirits, such as taking random trips together, as portrayed in these two memories. However, I continued to self-destruct as it gave me a sense of control. In the meantime, my weight continued to drop.

Personal Training

I decided to take better care of my body and overall health by hiring a personal trainer in the months following my breakup (see Figures 43 & 44). Although I enjoyed the physical and psychological benefits that came with exercise, the personal training soon turned into an obsession and a quest for physical perfection, which was

counterproductive to my mental illness. Instead of exercising to improve my health, the obsession with perfection and weight loss negatively impacted my eating disorder. The lack of a model within my diet and exercise routine triggered guilt, shame, self-loathing, and anxiety, which fueled my binging and purging behavior. Therefore, the personal training sessions were short-lived because my all-or-nothing mindset did not allow me to appreciate my efforts and the health benefits of exercise. Had I utilized the personal training as an anti-depressant rather than an obsessive tool, I believe my anxiety and depressive symptoms would have been alleviated, also taming my disordered eating tendencies.

Figures 43 and 44

One Month into Working with a Personal Trainer

Note. I was feeling physically, mentally, and emotionally healthier. Despite the alleviation of my depressive symptoms, the exercise soon turned into an obsession and quest for perfection, which was counterproductive to my eating disorder.

Recent Battles and Triumphs: Age 31 to Present (2017 - 2024)

Following my Heart: Pursuing my Higher Education Goals – August 2017

My dream of pursuing my Doctor of Education degree has been profound since I was a little girl. Although I wanted to pursue higher education during my relationship, my partner was against it, so I had to respect his wishes. Even though I was a skilled scientist and enjoyed my work immensely (see Figures 45 - 47), I felt I needed more purpose and fulfillment in my specific line of work. My drive to improve and challenge myself pushed me to apply for the Doctor of Education in Organizational Leadership program at Pepperdine University.

Figures 45 – 47

I worked as a Cosmetic Chemist in the Personal Care Industry

Note. I felt the happiest at work because I truly loved what I did. I had no problem working 12-hour days because of my passion and dedication to my craft. Also, working longer hours after the end of my relationship occupied my mind, increased my self-worth, and made me feel purposeful, helping me shut off my emotions through work.

In August 2017, I started my life-changing doctoral journey at Pepperdine University Graduate School of Education and Psychology. Although accepted into this

excellent program, I felt insecure, devalued my abilities, and feared failure greatly. I was fortunate to cross paths with amazing mentors who recognized my potential and opened my eyes to what can be achieved with self-belief, determination, courage, and never-ending grit. I realized that I had been holding myself back and undermining my abilities for the entirety of my life. I could see myself for all I had to offer for the first time, and my confidence increased significantly. However, my anxiety and depression were at their highest, and I coped with the pressures of the first year of my program through binge eating and binge eating and purging, and yo-yo dieting, which led to a weight gain of 20 pounds within the first nine months of my program. As my weight increased, my self-love decreased, which pushed me into further isolation from my peers. This pattern of self-isolation seemed to be a common theme in my life starting from childhood, as it was my way of hiding my imperfections and guarding my heart from the rest of the world.

My anxiety was mentally debilitating, and I felt as though the only way to survive my doctoral program was to use food for comfort. I had extremely high and unrealistic expectations of myself to be perfect in my studies, and anything less than that was unacceptable. I continued to be highly self-critical and hard on myself, surrounding every aspect of my life, such as every interaction with a colleague, every word that came out of my mouth, every assignment, and every presentation. Before each class, I would drop by the well-known grocery store, Trader Joe's, and purchase several meals and snacks, which I would keep in my car to binge on my 45-minute drive home after class. If I knew my binge food was waiting for me in my car, the course would become more bearable, and my anxiety would feel less intense. Ultimately, my body and my mental health paid the price for my unrealistic quest for perfection.

During my doctoral studies, I always felt less than if I did not have my plate unrealistically full. Aside from working full-time, I began presenting my research at local and out-of-state in-person conferences and created a website supporting my doctoral studies (see Figures 48 – 53). I always felt inadequate and "*not good enough*" if I did not have several projects going on simultaneously. No matter how successful my conference presentations were, I was never satisfied at the end of the day as the voices in my head held me hostage—overachieving in every aspect of my doctoral program fed into my disease. The scope of my life revolved around being perfect and proving to myself and others that I was good enough. However, no matter how many conference presentations I did or how high my GPA was, I would never feel "*good enough*." I was seeking my validation, which I refused to give myself.

Figures 48 and 49

(Left) March 2018: First Doctoral Conference at the IOSSBR conference in New Orleans, LA, (Right) June 2018: Poster Presentation - GSEP 4th Annual Research/Project Symposium

Note. (Left) *March* 2018: My first doctoral conference at the International Association of Social Sciences and Behavioral Research (IOSSBR) conference in New Orleans,

LA, where I presented my research on Generation Alpha via a paper and poster session. I won “Best Paper.” (Right) Poster presentation at the Pepperdine University Graduate School of Education and Psychology 4th Annual Research/Project Symposium in Malibu, CA, June 2018.

Figure 50

January 2019: At the International Conference on Education (IAFOR) – Honolulu, Hawaii

Figure 51

January 2019: At the International Conference on Education (IAFOR) – Honolulu, Hawaii

Note. I presented on Cyberbullying in Higher Learning. I was compelled to write about this topic because a friend of mine was being cyberbullied.

Figures 52 and 53

January 2019: Poster presentation at the Hawaii International Conference on Education

Note. I exerted maximum effort in every project and conference during my Doctoral program at Pepperdine. However, I perpetually felt dissatisfied with my performance and constantly believed that I needed to meet the standards of excellence. I had a strong tendency to criticize myself. I engaged in a pattern of excessive eating followed by purging at my conference presentations in Hawaii. I failed to fully acknowledge and appreciate my achievement due to a lack of mental presence.

My Life-Changing Body-Building Journey – July 2018

About ten months into my doctoral program at Pepperdine, the stress and demands of the program, my full-time job as a cosmetic chemist, my continuous self-criticism, and my strive for perfection had triggered my anxiety, depression, chronic bulimia, binge eating disorder, and yo-yo dieting. My self-destructive coping mechanisms resulting from my mental battles had resulted in a weight gain of 20 pounds on my 5’0” frame (see Figure 54). Additionally, my guardian, who utilized verbal abuse to strike a nerve to motivate me to stop my self-destructive habits, had only

added fuel to my destruction. Unfortunately, this had been an ineffective and somewhat toxic pattern of my guardian since I was a little girl.

One of the most pivotal and life-changing experiences during my lifelong battles with anxiety, depression, and eating disorders was when I began my body-building journey in July of 2018. This time was crucial because it showed me several key factors that drove my success, not only in transforming my physique but also in transforming and strengthening my mental capacity. The first key factor I noticed was that having the right mentor, whom you trust and respect and who believes in you and is rooting for your success, is crucial to amping up my internal drive to succeed. The second key factor determining my success was my intense desire, determination, and grit to reach my end goal no matter what obstacles I had to overcome. The third key factor that drove my success was a clear-cut picture of my end goal and embodying my future self before I physically met the goal. Ultimately, my body-building journey showed me that anything is possible if your heart and mind are aligned and you have the right mentors to provide the guidance and support you need to achieve your goal.

Figure 54

July 15, 2018: The Initial Picture I Sent My New Coach

Note. July 15, 2018: The initial picture I sent my new coach ten months into my doctoral program, having gained 20 pounds because of my binge eating and bulimia, which was triggered by my chronic anxiety and depression. I was ashamed, hated myself, and wanted to crawl out of my skin.

During this time, my guardian persisted in using abusive language to compel me to lose weight and felt that punishing me with verbal, physical, and psychological abuse would help me overcome my bad habits. Nevertheless, my guardian failed to grasp that her endless attempts had exacerbated my situation. Several distressing instances occurred in which my guardian said hurtful words such as:

"*Somebody has got to tell you that you are fat."*

"When you eat, you look like you are nine months pregnant. Make sure you wear a loose shirt to cover your stomach."

"Your cellulite looks disgusting under those pants."

"You look like a fat blimp in that dress."

"Your arms have always been fat."

"Who would want a woman with muscular calves? Muscular calves are not feminine!"

"They would not want you only because you are short."

My guardian's words were painful and debilitating, but the hurt ignited the fire in me to better myself and stop this self-destructive cycle. It was apparent that my binge eating and bulimia were only resulting in weight gain and making my anxiety and depression worse. I did not want to hurt anymore, and even though my previous attempts at stopping the bulimia were short-lived, I was determined to find a permanent solution to my ongoing battle.

The Right Mentors, the Right Mindset, and a Clear-Cut Vision are the Keys to Success

The intense pressure of my doctoral studies had worsened my pre-existing conditions of anxiety, depression, binge eating disorder, and bulimia nervosa, leading to a significant weight gain of 20 pounds within the first ten months of my program. Moreover, the verbally oppressive strategies employed by my guardian to force me to lose weight had inflicted significant emotional distress upon me. At this point, I was mentally ready to stop the binging and purging once and for all.

I was introduced to a respectable bodybuilding coach with an exceptional track record with client transformations, and I intuitively knew that this coach could help me achieve my goals. Before my initial meeting with my new coach, I quit binging and purging and followed a clean diet to prepare mentally and physically for my new

journey. I was already convinced that I was going to succeed, which was the catalyst that ignited the initial fire within me to stop my self-defeating coping mechanisms.

I desperately sought the approval and validation of my well-respected and knowledgeable bodybuilding coach. On his social media page, my coach posted incredible client physique transformations, and my competitive nature was determined to succeed tremendously. I knew I would achieve my physique goals and surpass all expectations. I recall my incredible focus, tunnel vision, and determination to achieve my physique goals and follow the strict diet and exercise protocol set forth by my coach without any hindrance to the protocol. After the first couple of weeks of starting my program, I confided in my coach about my ongoing bulimia and laxative abuse, stating that I had stopped my bulimic habits but could not stop the laxatives because my body had become dependent on long-term use. He convinced me that if I am taking the necessary steps to improve my health through bodybuilding and halting bulimia, it would also be crucial to stopping the laxatives. I had never been more scared in life and did not know how my body was going to react to no laxatives. Still, I found healthier and alternative methods to wean off the laxatives and eventually stopped entirely and never turned back.

By September of 2018, two months into my bodybuilding program with my new coach, I had stopped the bulimic habits and laxative abuse, and I was hyper-focused on my goal, strictly following my protocol and not giving myself room for error. I would describe myself as robotic, waking up at the same time every morning, performing "*fasted cardio*" (i.e., cardio performed on an empty stomach first thing in the morning) with painful blisters on my feet, eating the same meals at the same time every day,

showing up for my workouts with my coach, and most importantly embodying and envisioning myself at the finish line. I reflect as I walk on the treadmill every morning, dreaming of walking up on a body-building stage one day and seeing and hearing everyone yelling my name as I won my show.

At this point, I had lost about 15 pounds and felt the most confident I had ever felt. Around late September, I was invited to a family party, and I was excited and proud to show off my new physique. I bought a new dress and got my hair and makeup done to compliment my newly transformed physique. I felt confident and fabulous and wanted to show off my hard work.

Figure 55

September 23, 2018: Two Months into My Bodybuilding Journey

Note. My first family event since my transformation. I bought a new dress and got my hair and makeup done as icing on the cake to compliment my new physique. The lack of acknowledgment from my extended family members was a significant form of rejection.

I arrived at my family party without acknowledgment from my extended family members. I started thinking my weight loss was not noticeable enough to warrant a compliment. Feelings of rejection, loneliness, failure, and self-loathing filled my heart, and I wanted to binge and purge to numb the pain. I remember barely being able to control my tears. I then left the party early and went home, where I cried all night and talked myself out of the self-defeating coping mechanisms that I was used to. I could refrain from binging and purging, but my emotions were hanging by a thread.

The next day, I woke up with high levels of anxiety, and there was a voice inside my head telling me I would feel better if I just binged and purged one time to get it out of my system. The voice in my head felt like the devil was magnetically pulling me into the dark side again, and I had no way to fight back. I drove to all my favorite pastry and fast-food locations, binging as I had never binged before, and purged my food at the local supermarket restroom. The supermarket restroom was a location I had used previously to purge my meals. Following my first bulimic session after over two months of being abstinent for disordered eating behavior, the sense of shame, guilt, disgust, and feeling of defeat once again overpowered my entire body. I felt I had disappointed myself and my bodybuilding coach, whom I respected and the one person who believed in my ability to succeed. I texted my coach immediately, confessing how I had "*fallen apart,"* binging and purging, promising it would never happen again. My coach acknowledged my feelings, and his words were filled with empathy and compassion. He calmed me down by telling me how proud he was of my accomplishments and that he could not wait to see what I could achieve with my physique in the coming months.

My coach's words of affirmation made me feel understood and validated, and from that moment forward, I pushed myself harder with my diet and exercise protocol. I followed my diet plan perfectly; however, I doubled my cardio daily, increasing from 60 minutes on the Stairmaster to 120 minutes. I was more determined than ever to drop a drastic amount of weight and receive the acknowledgment of my family members. I assured myself that the next time they saw me, they would be amazed by my transformation. Also, I was going to make sure that my family would never make me feel less than worthy, incapable, and unattractive moving forward. The intense level of exercise that I had set forth for myself increased my hunger drastically to the point where I felt I could not control the urge to binge and purge. Feeling ashamed of my relapse into my old self-destructive coping mechanisms, I maintained a level of perfection for my coach and never disclosed that I had fallen back into my old habits again.

Figure 56

September 27, 2018: One Week After My Bulimia Relapse

Note. I pushed myself in every way possible to be the perfect athlete for my coach, as I felt he was the only one who gave me the validation I desperately needed. My coach was the only one who saw my potential, which is internal motivation. I needed to keep going and not give up.

My physique goal consumed me, and I was going to do whatever it took in my ability to surpass the goal I set for myself. My hyper-focus turned into an obsession, which took away from the hyper-focus I once had for my doctoral studies. I was further isolated from my colleagues and felt alone in my program. My anxiety and depression were at an all-time low, and I did not know how to feel normal and a part of the group. The bulimia resumed per usual, and bingeing and purging after class became the only way I thought I could cope with my intense feelings of shame, guilt, and unworthiness. The more weight I lost, the more intense the body dysmorphia became. I wish I could see myself in the eyes of all those around me who witnessed my physical transformation.

Figure 57

October 13, 2018: 12 Weeks into My Bodybuilding Journey

Note. 12 weeks into my bodybuilding journey, where I had lost close to 25 pounds from my initial starting point. As pictured above, I was attending my first bodybuilding competition as an attendee. I felt I belonged on that stage and was determined to make it happen. Deep down, I thought I was insufficient and could not appreciate how far I had come. The bulimic episodes were up to one to two times a week, in addition to my strict exercise protocol and meal plan.

Nevertheless, I not only achieved my physique goals but surpassed the expectations of myself and my coach, which only reinforced my self-destructive and unloving behavior. I devalued my efforts and never gave myself the self-love and acknowledgment I desperately needed. Although I had achieved a drastic physical transformation of 30 pounds through hard work (see Figures 58 - 60), determination, and suffering, I could not be proud of my accomplishments. No matter what caliber of goal I achieved, it would never be enough to fill the emptiness and void I felt inside. My initial physical transformation taught me that anybody can achieve anything through hard work, determination, and grit. Still, if the mind is not healed from the inner wounds and past trauma, then the progress would be impossible to maintain.

Figure 58

First Day of Initial Transformation vs. 16-week Bodybuilding Transformation

Note. I lost 30 pounds during my 16-week bodybuilding transformation. I celebrated with a photo shoot with a well-known fitness photographer. Before the photoshoot, my guardian, who was against me doing a photoshoot, told me that the pictures would not come out well because I had no muscle mass and looked like I was struggling with cancer.

Figures 59 and 60

November 15, 2018: My Initial 16-week Bodybuilding Transformation.

Note. A photoshoot celebrating my 16-week bodybuilding transformation. After the photoshoot, I remember feeling anxiety and self-loathing because I thought I did not look good enough due to the abusive words of my guardian before my photoshoot, which led me to a six-hour binge and purge episode at a local shopping mall. I could not validate myself because of the lack of validation I received from the people I valued.

Parting Ways with My First Bodybuilding Coach – May 2018

Between February and May 2018, I started experiencing many issues with my bodybuilding coach and mentor (see Figures 61 & 62). He started becoming increasingly obsessive over my physique and required that I take steroids, estrogenic blockers, and illegal fat burners to aid in muscle building and further fat loss. He stated, "*If I refuse to take the bodybuilding drugs, then I will not be allowed to compete in a competition because I would not be able to place well."* His statement instilled a sense of insecurity within me and showed me that my coach did not believe in my ability to succeed naturally. I was firmly against ingesting performance-enhancing drugs, and I did not allow my coach's ultimatum of not being able to compete if I did not follow his orders to pressure me into using steroids. I also firmly believed in my ability to place well in my future competitions through sheer hard work and determination.

In addition to the bodybuilding drugs, my mentor required that I test my body fat percentage weekly through a DEXA (i.e., Dual X-Ray Dual Absorptiometry) body scan, where even the slightest weight gain would result in reprimanding and scolding me as his athlete. I felt like a toy, which he felt free to mold as he wished, and I did not feel human anymore. Also, his unhealthy obsession with sculpting my perfect physique triggered my bulimia and compulsive exercising, where, at times, I felt my heart rate rise to dangerous levels (i.e., 180 rpm). The mentor and mentee relationship we had at the start of my transformation had diminished as a part of me had lost the trust and respect

I once had for this well-renowned bodybuilding coach. Also, the motivation and passion I once had to transform and improve my health disappeared. Hence, my motivation and determination dwindle once I lose trust and respect for a mentor.

Figures 61 and 62

Workouts with My Bodybuilding Coach

Note. (Left) March 2019: During a workout with my bodybuilding coach. (Right) April 2019: The pressure to be perfect in the fitness world and by my mentor was unbearable.

As a result of the tension and issues I was experiencing with my bodybuilding coach, I abruptly left him in early May 2019 and hired another well-respected bodybuilding coach immediately. My new bodybuilding coach did not require that I take dangerous bodybuilding drugs to compete in a competition, and we started preparing for my first competition in September 2019. Although my new coach was taking a healthier approach to preparing me for my first competition, I did not feel the mentor and mentee connection I once had with my former coach. During my 16-week competition

preparation, I continued to abuse my body with self-destructive bulimic tendencies. I also relapsed into my laxative abuse, which weakened me to the point that I was unable to work out like I used to with my previous mentor. I felt alone and unable to vent my struggles to anybody in my circle. I lost faith in myself and my ability to succeed, which was the catalyst to my ongoing downward spiral into my disordered eating and laxative abuse pattern.

My First Bodybuilding Competition – September 2019

However, I managed to participate in my first bodybuilding competition in September of 2019, despite not being in optimal condition because of the water retention resulting from my episodes of binge eating and purging. Additionally, per the competition preparation guidelines, I had to collaborate with a certified posing coach to develop my posing routine. My inadequate rehearsal of the posing routine led to a sense of unpreparedness, which in turn exacerbated my anxiety and hindered my performance.

Despite achieving third and fourth places among the two divisions I participated in (see Figures 63 & 64), I felt a sense of failure as I recognized that I could have attained a better ranking had I adhered to my assigned protocol. Following this realization, I was compelled to register for my second competition scheduled for December 2019 with the mindset of abstaining from all disordered eating behavior. I knew that the key to winning was stopping the abuse to my body, and with my goal in mind, I stopped binging and purging, leading up to my next show in December 2019.

Figures 63 and 64

September 7, 2019: My First Bodybuilding Competition

Note. In my first bodybuilding competition, I placed 3rd and 4th in my two categories. Despite my placements, I was disappointed because I knew I could have landed a higher place had I refrained from binging and purging and followed my coach's instructions.

During the 12 weeks preceding my second bodybuilding competition, my primary objective was to achieve my most extraordinary physique. Regardless of the sacrifices required, I was determined to surpass my expectations. I fully understood my abilities and diligently pursued a well-defined objective for the subsequent three months. I ceased all episodes of binge eating and purging and misuse of laxatives due to my realization that participating in these self-destructive actions would inevitably result in another disappointment. The only missing element was my initial bodybuilding mentor,

with whom I had developed a strong connection and who provided me unparalleled motivation, unlike the coach who had taken his place.

Despite my utmost efforts, I could not establish a connection with my second coach. Three weeks before my show, I relapsed into my binge and purge coping habits because I felt like I was subconsciously pursuing the same kind of acceptance and connection I experienced with my first coach. My mind was overwhelmed by intrusive thoughts, and my self-destructive tendencies triumphed over my frantic struggle. Due to my body dysmorphia, I was convinced that I was "*too fat*" and "*not ready*" to participate in my upcoming competition (see Figure 65). Consequently, I informed my coach of my decision to withdraw from the show.

Figure 65

December 5, 2019: Weekly Progress Picture to My Coach

Note. I sent my weekly progress picture to my coach, and I was convinced that I was "*too fat*" and "*not ready*" to compete. I call this "*body dysmorphia at its finest*."

Reflecting upon Figure 65, I recognize that I was the leanest I had been throughout my initial and subsequent competition preparations. However, I failed to see the detrimental effects of my eating disorder and the evident distortion in my perception of my own body. Moreover, reverting to my binge eating and purging patterns exacerbated my depression and disillusionment, posing a threat to undermine all the diligent effort and commitment I had invested in my second competition. I am profoundly sad that I could not recognize and acknowledge the qualities that the rest of the world recognized in me. The humiliation and remorse I experienced after my relapse may have led to my disillusionment, which drove me to undermine my efforts through self-sabotage.

> It is truly minute by minute and hour by hour. I am feeling lonely, confused, scared, and empty. I fear failure on all levels. Not winning my bikini competition and not excelling in my doctoral program mortifies me. I seek perfection with everything and fear anything getting in my way. I genuinely want to release the anxiety and fear I have right now. I feel guilty because I am supposed to be a good student and prep for my comp, but I can only think about controlling my hunger. I do not know if it is my hunger or emotions. (Journal Entry, December 2019)

I intentionally scheduled my second competition on December 13, 2019, my 33rd birthday, hoping the day would bring me luck. Although I briefly relapsed into my bulimic habits, my physique was at its peak. Nevertheless, my mental illness hindered my ability to perceive or experience the positive outcomes of my efforts. I was overwhelmed by anxiety due to my belief that I was unlikely to achieve a high ranking, as I judged myself

in comparison to the other female competitors. Despite my disillusion, I earned second place in a competition against 30 female participants, allowing me to compete nationally (see Figures 66 - 68). Unfortunately, I did not achieve my goal of securing the top position, leading to self-hatred and discontent. Consequently, the evening of my competition consisted of excessive binge eating and purging, further solidifying my belief that "*I will never be good enough*."

Reflecting on my second competition, I regret my inability to fully acknowledge and value the fruits of my labor. How did I fail to perceive the extent of my progress, not only about my first competition but also in contrast to my initial starting point in July 2018? Within 18 months, I successfully transformed my physique so that numerous others doubted my identity as the woman in the original photograph. Despite my mental illness causing me to lose sight of my overall progress, I deeply regret not valuing and embracing my remarkable accomplishments, resilience, determination, and unwavering persistence in the face of any challenge.

Figures 66 – 68

December 13, 2019: My Second Bodybuilding Competition

Note. December 13, 2019: My second bodybuilding competition, where I placed second place, competing against 30 female competitors. My eating disorder/mental illness hindered my ability to see how far I had come and the significance of achieving second place among 30 competitors.

Post Show Blues and Suicidal Ideations – December 14 to December 31, 2019

A profound spiral into darkness characterized the weeks following my second bodybuilding competition as my ongoing depression intensified. Being a competitive perfectionist, I experienced intense suicidal ideations for two weeks after my competition, as I perceived yet another failure in achieving my goal.

> I feel suffocated in my thoughts and afraid to be alone. It makes me sad to think that I do not want to be here, but the pain has become unbearable. I feel entangled in my emotions, and every day feels like déjà vu, like a bad nightmare I keep reliving repeatedly. I have tried everything, but I am worse now than ever. I feel worthless and alone in the world; the only thing that does not judge me is food. Nevertheless, to think that I must wake up tomorrow and binge and purge

again feels like agony. I want to be ok. I want to be free for once. Free of these crazy thoughts that consume me. I almost feel possessed by a demon, like I have been cursed. God, please help. I want to be better, but I do not know how. (Journal Entry, December 2019)

I carried an intense resentment and disappointment towards myself, experiencing a sense of isolation and lack of direction, along with a belief that I would never achieve any significant accomplishments. Upon confiding in my bodybuilding coach regarding my thoughts and emotions, he responded with the following statement:

Coach: Hasmek, do you realize you placed in the top two among 30 competitors? Do you see what a fantastic accomplishment that is? Stepping on that stage is an accomplishment alone, as only 1% of the population can do what you do.

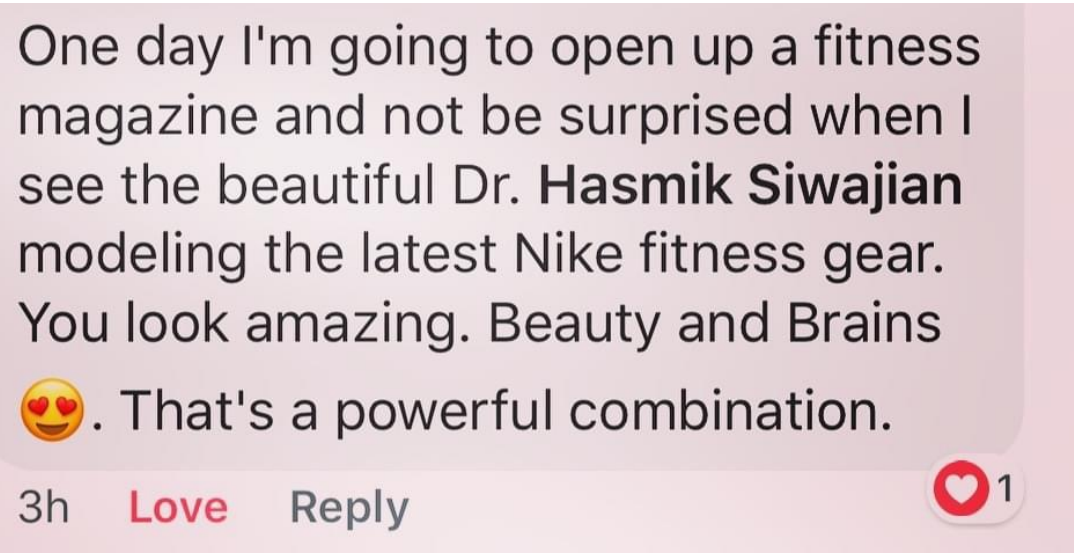
Me: I do not want to be here. I cannot explain this feeling. I feel ashamed and humiliated, and now the world can see that I am the failure I always feared I was. I do not know how to snap out of this. Please help.

Notwithstanding my coach's encouraging words, my emotional and mental state persisted as I perceived myself as a failure, immune to any form of encouragement and devoid of any sense of purpose in life. "*Although I was a part of the 1% of the population who could step on stage, I was a failure. My accomplishment was not that big of a deal,*" I thought. Simultaneously, my binge eating and purging episodes increased as I searched for a means to alleviate the overwhelming pain I was experiencing. As I engaged in recurrent bouts of overeating followed by self-induced purging, my levels of depression and anxiety escalated.

I perceived bulimia as the sole source of happiness in my life. I had the perception that my bulimia was the only thing worth anticipating and the isolated area in which I could succeed. The most challenging concept was acknowledging my worth, talents, and accomplishments. Not even the most significant achievement would make me "*good enough*." I wish I could see myself from the eyes of all those around me. I could inspire myself like others (see Figures 69 – 71). My chronic depression hindered me from recognizing my own unique identity, talents, and abilities. The tormenting voices in my head undermined my achievements, suggesting that they were insignificant and that my true lack of success would soon be exposed to others. The persistent fear of being perceived as a failure by the entire world was paralyzing.

Figure 69

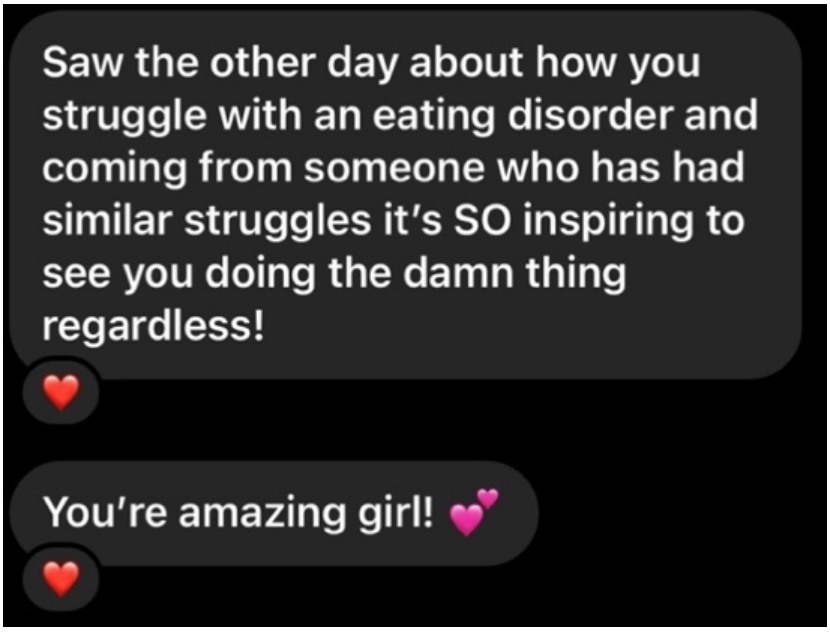
Social Media Communication from a Doctoral Colleague



Note. A communication received on a social networking platform from a classmate in my doctoral program. Upon reading this message for the first time, I was both taken aback and surprised, as I hoped to one day achieve the honor of gracing the cover of a fitness magazine. Whenever I need a source of inspiration, I refer to this message.

Figure 70

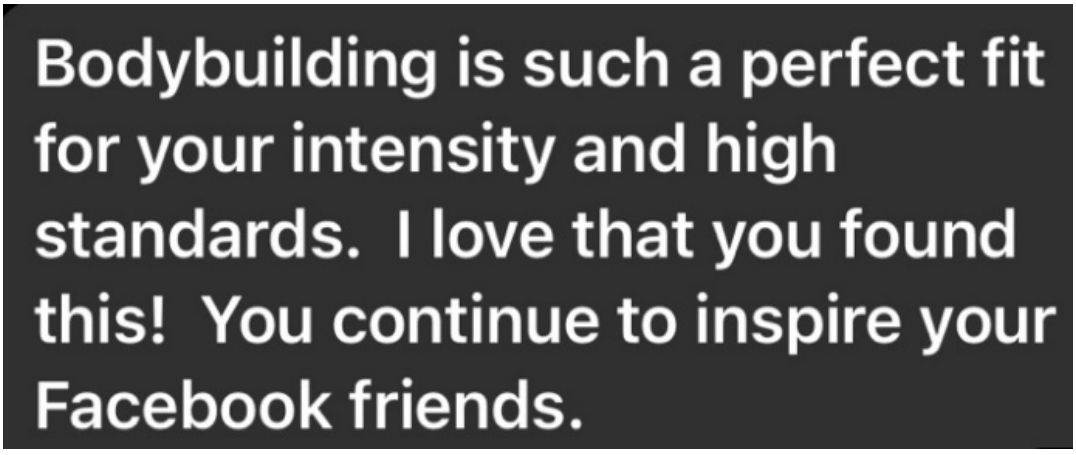
Social Media Communication from Fellow Bodybuilder



Note. A social media message from a fellow bodybuilding competitor conveyed her issues with eating disorders in this message. This statement instilled in me a sense of purpose and an awareness that my journey was beneficial to those who can relate to my journey**.**

Figure 71

Social Media Communication from Macrobiotic Classmate



Note. This is a social media communication from a fellow attendee in my macrobiotic leadership program in 2011. Messages of this nature strengthen the notion of leveraging my vulnerabilities as assets to help others. By sharing my narrative on a public platform, I helped an individual whom I did not expect to remember me.

Despite the excruciating pain caused by my emotional turmoil, I actively sought assistance from spiritual healers to alleviate the pain that I was experiencing. I wanted to feel happiness, embrace being alive, and eventually wake up with a profound satisfaction regarding who I am. I regularly attended therapy sessions with my spiritual healers, during which I would discuss my emotions and receive Reiki healing treatments. Reiki is a complementary therapy that promotes a balanced energy flow throughout the body, decreases stress, promotes healing, and improves mood and emotional well-being (Pilkington et al., 2006). Moreover, Reiki is recognized for its ability to reduce stress, promote deep relaxation, and improve sleep quality, reducing insomnia symptoms (VanderVaart et al., 2009). Additionally, I enrolled in an introductory Reiki certification course to gain the skills needed to practice self-healing whenever necessary.

> I want to be okay, but the voices in my head would not shut up. They are parasites eating me alive, telling me I do not deserve to be here. The truth is that I want to be here, to thrive, to live life, to be present. Pretending to be happy, healthy, and positive is becoming exhausting, and I do not know if I can keep up my façade. I woke up this morning and was fine until I looked at myself in the mirror; everything went downhill mentally. Why do I hate myself so much? I decided to put on my makeup and dress in an outfit that made me feel good. Maybe feeling beautiful will brighten my mood. It is all I can do now to motivate myself to get through the day. I mask my sadness with makeup, and nobody knows what happens inside me. Everyone sees me as a woman who has it all together, but nobody will ever understand my pain. I wish I could be the woman

who has it all together, just like everyone thinks I already do. (Journal Entry, December 2019)

With the support of spiritual healers and the implementation of reiki practices, I successfully managed to control my momentary thoughts of suicide. Nevertheless, my persistent depression reached its peak during the period from January to March 2020, resulting in an increase in weight of around 30 pounds within three months because of engaging in emotional eating and episodes of bingeing and purging. Throughout my lifetime, I consistently experienced a low to moderate mood due to my depression. Nevertheless, I would sometimes encounter bouts of chronic depression, and this happened to be one of those crucial times. I had experienced a loss of motivation for activities that previously brought me joy, such as spending time with family and exercising. This was accompanied by emotions of powerlessness, exhaustion, worthlessness, and helplessness, which had a paralyzing effect on both my mental and physical well-being. My job was the sole aspect of my life that motivated me. I attempted to do it independently despite terribly needing professional help. I was trying to "*be my hero*," although I was reluctant to acknowledge that I was incapable of helping myself.

COVID-19 and its Mental Demons – March – June 2020

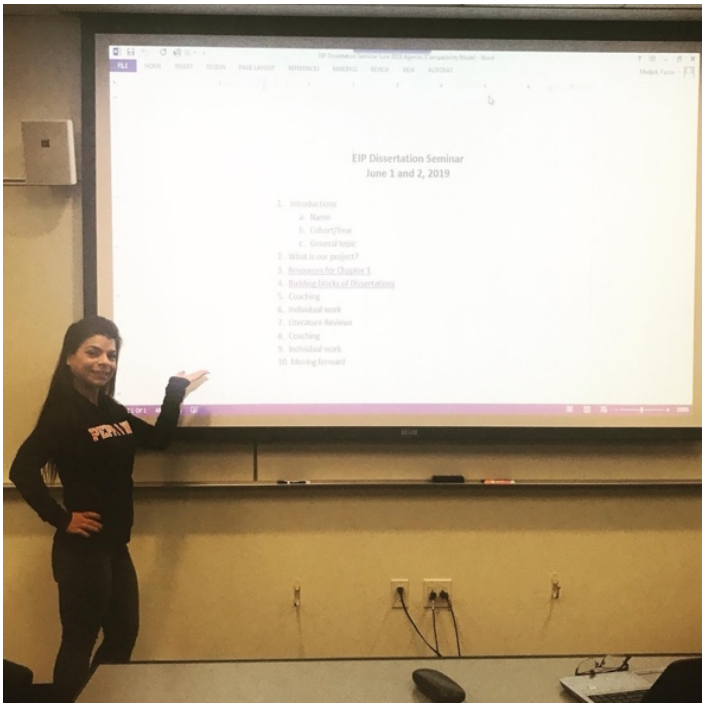
In March of 2020, as the world shut down due to the COVID-19 pandemic, I was particularly distressed, not due to the fear of contracting the virus, but because everyone in my doctoral cohort was finalizing their dissertations. I struggled to achieve optimal cognitive functioning, hindering my ability to write even just one sentence. I

experienced a sense of inadequacy and a loss of motivation and direction that I initially felt when I started my doctoral program in August 2017.

I started experiencing feelings of inadequacy and a sense of aimlessness in May 2019, stemming from the loss of one of my dearest mentors and a significant figure in my growth as a human being. During that time, I registered for a doctoral dissertation course at my university designed to assist students in successfully expediting their research. I joined this course to finish my dissertation alongside my cohort by Spring 2020 (see Figure 72).

Figure 72

June 2019: Doctoral Dissertation Course



Note. I enrolled in a doctoral dissertation course to graduate with my cohort in Spring 2020.

Due to my feelings of worthlessness and incompetency following the loss of my mentor, I dropped my dissertation course and dedicated myself solely to my bodybuilding aspirations. The loss of my mentor had a profound impact on my mental

well-being since I perceived this person as an angel sent from the universe who was meant to guide me in recognizing my skills and capabilities and empower me to pursue my aspirations. The pain and anger resulting from the loss of my mentor caused me to lose my identity and sense of self, so undermining my efforts to achieve my primary goal of completing my doctoral degree.

The COVID-19 shutdown intensified my mental condition, leading to a complete loss of any ambition I had to improve my well-being. I experienced an overwhelming sense of humiliation, self-loathing, and self-pity. I spent my days deliberately sabotaging myself due to a profound sense of purposelessness in life. I was indifferent to my survival or demise. I solely concentrated on desensitizing myself to avoid experiencing the excruciating agony of feeling inadequate and devoid of purpose. Every waking moment was spent in a marathon of binge eating and purging, followed by consuming sleeping pills, which would put me to sleep for ten or twelve hours at a time. My self-destructive behavior led me to gain an additional 20 pounds on top of the 30 pounds I had gained between January and March.

> Another day, I have wasted destroying my body because I frankly do not care what happens to me. I do not know how big my body will get from the crazy binging and purging, and if I die in the middle of the night because of a heart attack, I would not be surprised—shocked that I am still alive, to be completely honest. Maybe God is keeping me alive to torture me? Or perhaps I have a higher calling? I have no idea! All I want is freedom from this pain. I am crying in my heart, but nobody can hear me. I cannot take it anymore. (Journal Entry, April 2020)

Every day, I would wake up feeling more defeated than the day before. Sometimes, I would contemplate if it was worth fighting a battle I would lose. Suffering from chronic perfectionism, which was ultimately the root of my self-destruction and anxiety, and deterring from anything less than perfect was a cause for punishment (i.e., binge eating and purging). Moreover, I did not allow myself to feel the discomfort and pain of the COVID-19 pandemic and life. Instead of feeling the misery of the times, my lifelong habit of impulsively trying to numb to eliminate the uncomfortable feeling exacerbated my existing mental issues.

> I feel weak, and my anxiety is intense and unbearable. I cannot breathe, and I fear the day ahead. I am afraid of the self-destructive beast that will rear its ugly head. The first thing I think about when I wake up is food. I feel powerless and ashamed over my lack of control over this disease. It feels like I am a ticking time bomb about to explode at any minute. I am scared to death. I am afraid of myself. Praying for strength! (Journal Entry, May 2020)

Losing my Job Amid my Third Bodybuilding Competition Preparation

Upon resuming work after the COVID-19 shutdown, my coach and I finalized the decision to start the typical 16 to 20-week competition preparation for two upcoming competitions: Nationals, scheduled for the third week of November 2020 in Orlando, Florida, and a local show planned on my birthday in December. The National level competition held great importance since winning would earn me the highly coveted title of a professional bodybuilder, specifically an International Fitness and Body Building (IFBB) Pro. Since starting my bodybuilding journey in July 2018, my goal has always been to achieve professional status. I was prepared mentally and physically to

implement my competition protocol to earn the title of my dreams. I was also convinced that I had recovered from my eating disorder and made a social media post articulating my story and my self-realizations to my following:

> One of the most significant milestones I have reached is my ability to accept and love my body for all my imperfections. My close circle of family and friends have witnessed my struggles with my eating disorder demons for the past 23 years. In November of 1997, just shy of my 11th birthday, I developed “anorexia nervosa” in the 5th grade. This was triggered when I was sitting in music class at the Armenian private school I attended and having difficulty crossing my legs. One of my classmates pointed out how heavy I had become. I remember it being a Wednesday when we usually had pizza for lunch. I skipped lunch that day and every other meal to follow. I did not realize then that my naturally big calves, which I despised my entire life, would be the body part I would love the most as an adult. In the years ahead, I developed eating disorders from all ends of the spectrum, including bulimia, binge eating disorder, diet pill abuse, and laxative abuse. Every morning for the last 23 years, I would validate my self-worth based on the numbers on the scale. I have now realized that my self-worth is not dependent on the numbers on the scale (Instagram Post, July 2020).

I was unexpectedly laid off from my job on Friday, July 17, 2020, two days after I had begun my competition preparation for my third show. The combination of losing my livelihood and feeling rejected after being laid off sent me into a tailspin of self-pity and depression. My career and financial independence were significant to me and played a defining role in shaping my identity. Devoid of employment, I experienced a

sense of aimlessness and a loss of my sense of self, which subsequently propelled me toward entering another harmful cycle of binge eating and purging continuously for two days. As a result, I gained 10 pounds during this two-day timeframe. Despite experiencing humiliation, remorse, and defeat due to my loss of control and failure to adhere to my protocol, I managed to regain my focus and motivation with the help of my coach's uplifting, supportive, and encouraging words.

> Ok, that ridiculous binge could have been avoided had I just kept it together mentally. I do not know what is wrong with me sometimes. How am I supposed to keep it together when I feel like the most significant part of me is taken away? I know work is not the end-all and be-all, but it gives me a sense of purpose in knowing that I am contributing to my organization and helping it grow. I understand that the world is in shambles now, and everyone is struggling to find work, but the lack of money means I must depend on my immediate family for survival. Although I am grateful for their unconditional support, having to be cared for by the people I am supposed to care for does not sit well with me. To be in my mid-30s and to be taken care of is humiliating. Where did I go wrong? (Journal Entry, July 2020)

The bodybuilding competition preparation process is a grueling protocol of specified meals and assigned cardio and workouts set forth by a bodybuilding coach. There is no room for error, as any deterrence from the assigned protocol can cost a competitor a potential win at their competition. The assigned protocol consists of a strict meal plan set to be eaten every three hours (my schedule revolved around meal timing), a cardio and workout regimen consisting of two to three hours a day spent in the gym,

and a required water and supplementation procedure (i.e., steroids (a.k.a. gear, Anavar), thyroid medication (i.e., T3), estrogen blockers (i.e., Nolvadex), appetite suppressants and fat burners (Ephedrine, Caffeine, and Aspirin Stack (ECA), Clenbuterol, and Cardarine) (see Figure 73). With perfection being required 100% of the time and my existing anxiety, depression, and eating disorder battles stemming from being perfect, being a competitor perhaps was not the healthiest option for my mental well-being.

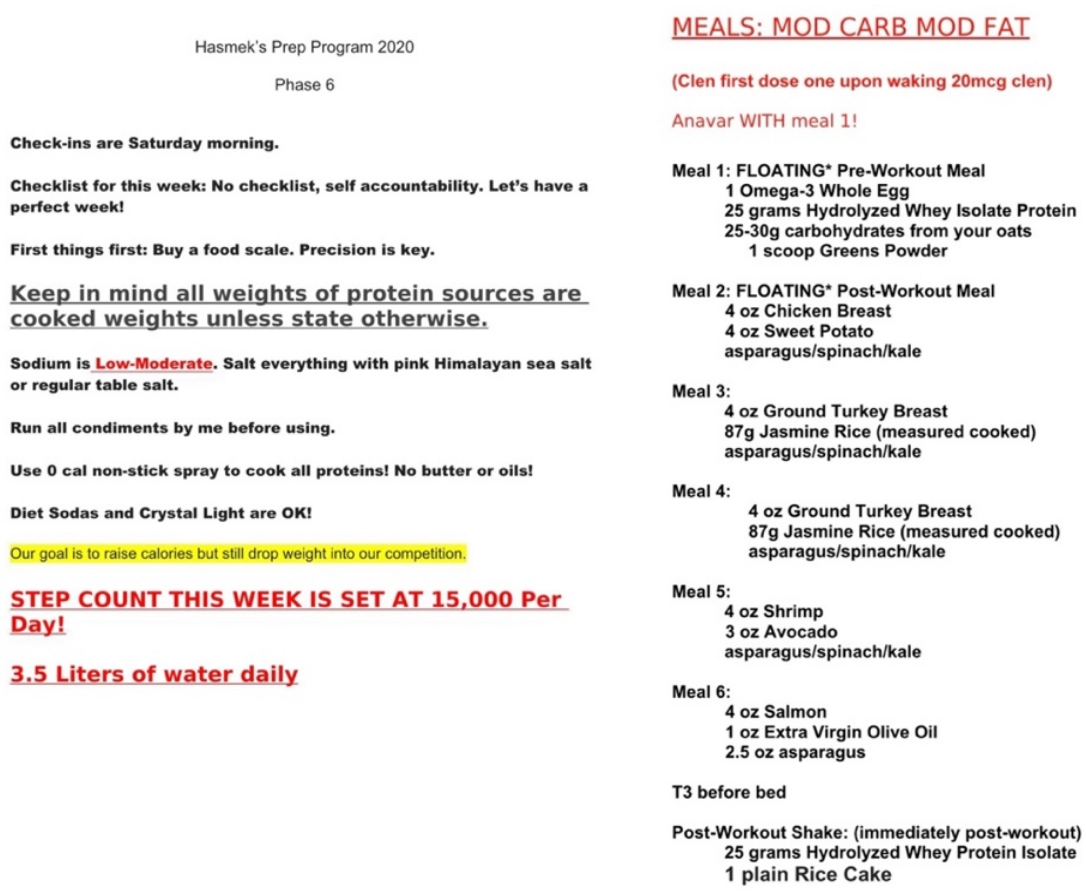
The preoccupation with food resulting from intense hunger and exhaustion created in me an overwhelming fear of deviating from my prescribed protocol. During the day, I made my utmost effort to maintain perfection and resist the temptation to binge. While eating one meal, I fantasized and fixated on my next meal. I had to keep myself busy with something to keep me from the realization that I was famished. Additionally, the fat-burning drugs I was required to take significantly elevated my heart rate to dangerously high levels, and I was afraid of having a heart attack and losing consciousness.

My low body fat, in combination with the estrogen blockers I had to consume, impacted my hormone levels. The imbalance of my hormones had a detrimental effect on my mood, causing me to be easily irritable and short-tempered. There was no means to avoid the hormonal disruption except for waiting for my competition to end so that I could increase my body fat to a healthy level and eliminate the estrogen blockers, which would help regulate my body. Due to my unfavorable mood, I want to seclude myself from society, distancing myself from both near and

extended relatives and close acquaintances. The process of preparing for a bodybuilding competition exacerbated my negative qualities.

Figure 73

Pages One and Two of My Third Competition Prep Protocol



Hasmek's Prep Program 2020

Phase 6

Check-ins are Saturday morning.

Checklist for this week: No checklist, self accountability. Let's have a perfect week!

First things first: Buy a food scale. Precision is key.

Keep in mind all weights of protein sources are cooked weights unless state otherwise.

Sodium is Low-Moderate. Salt everything with pink Himalayan sea salt or regular table salt.

Run all condiments by me before using.

Use 0 cal non-stick spray to cook all proteins! No butter or oils!

Diet Sodas and Crystal Light are OK!

Our goal is to raise calories but still drop weight into our competition.

STEP COUNT THIS WEEK IS SET AT 15,000 Per Day!

3.5 Liters of water daily

MEALS: MOD CARB MOD FAT

(Clen first dose one upon waking 20mcg clen)

Anavar WITH meal 1!

Meal 1: FLOATING* Pre-Workout Meal
1 Omega-3 Whole Egg
25 grams Hydrolyzed Whey Isolate Protein
25-30g carbohydrates from your oats
1 scoop Greens Powder

Meal 2: FLOATING* Post-Workout Meal
4 oz Chicken Breast
4 oz Sweet Potato
asparagus/spinach/kale

Meal 3:
4 oz Ground Turkey Breast
87g Jasmine Rice (measured cooked)
asparagus/spinach/kale

Meal 4:
4 oz Ground Turkey Breast
87g Jasmine Rice (measured cooked)
asparagus/spinach/kale

Meal 5:
4 oz Shrimp
3 oz Avocado
asparagus/spinach/kale

Meal 6:
4 oz Salmon
1 oz Extra Virgin Olive Oil
2.5 oz asparagus

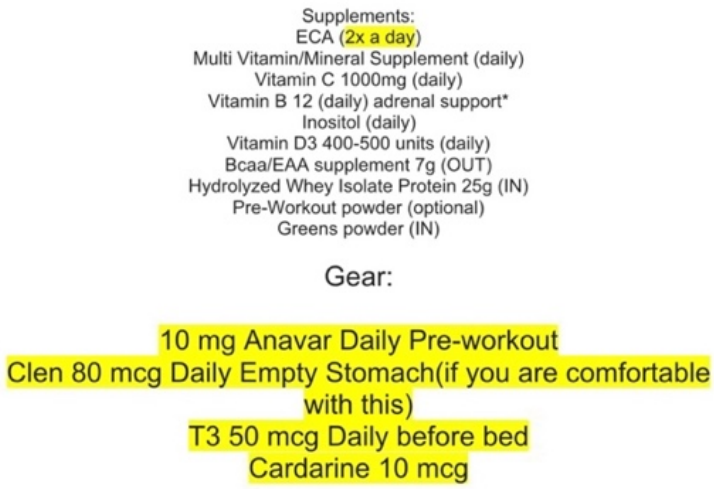
T3 before bed

Post-Workout Shake: (immediately post-workout)
25 grams Hydrolyzed Whey Protein Isolate
1 plain Rice Cake

Note. Pages one and two of my third competition preparation protocol assigned by my coach for my 2020 Nationals preparation. Phase six, in this case, refers to my coach's alterations as needed to achieve optimum progress. I was required to send progress pictures and weights to my coach once a week to determine if I was on track. Competition preparation phases lasted anywhere from 12 to 20 weeks.

Figure 73 (cont.)

Page Three of My Third Competition Prep Protocol



Note. This page is a breakdown of the supplements, fat burners (ECA, Clen), thyroid enhancers (T3), and steroids (i.e., gear) implemented by my head coach. I never consumed steroids (i.e., Anavar), estrogen blockers (i.e., Nolvadex, not listed here), and thyroid medication (i.e., T3). I did, however, utilize the fat burners, which consisted of ECA (i.e., Ephedrine, Caffeine, Asprin), Clenbuterol (i.e., an illegal and dangerous fat burner that increased my heart rate drastically), and Cardarine.

> I do not feel normal! I feel like I am mentally ill or something. I am angry, extremely exhausted, irritable, snappy, and cannot sleep if my life depended on it. Something seems off, and it is scary. Everyone and everything is annoying me, and I cannot control my reaction to them. I am exhausted and cannot be because I need to keep up with the cardio and workouts. I cannot tell my coach because he will think I am a weak loser. I do not know how to keep up. (Journal Entry, October 2020)

The hunger resulting from my strict diet and exercise protocol and the requirement to be perfect became unbearable, and I lost mental and physical control, causing me to binge and purge about eight weeks into my competition preparation

process. Feeling ashamed and guilty of "*not being strong enough*" led me not to disclose my bulimic incident to my coach. I pushed through and ensured my body was ready for weekly Saturday check-ins with my coach. I wanted to be the perfect athlete and achieve the validation of the authority figures who were counting on me to follow through and win my competition.

> My hunger feels like I have not eaten in years. How am I supposed to keep it together without eating everything in sight? I am hungry 24 hours a day and cannot sleep from the excruciating hunger pangs. On top of that, my coach cut out my carbs completely, making it nearly impossible to complete my one hour of fasted cardio on the Stairmaster in the mornings. I want to be the perfect athlete more than anything, but at this very moment, I do not feel human. I feel like a Zombie fighting for her life in the hopes of attaining her Pro card to prove to herself and the rest of the world that she can conquer this challenging sport. Is the validation worth the pain? I know I can do this, so why am I putting myself through this hell? I pray for strength, willpower, and a miracle to power through these last four weeks of utter misery in hopes that I would not pass out and drop dead in the middle of my cardio session. (Journal Entry, October 2020)

While preparing for my two highly anticipated bodybuilding competitions in November and December 2020, I contracted the COVID-19 virus three weeks before my national bodybuilding competition in late October 2020. During this time, I felt as if I were fighting for my life and doing my best to remain mentally strong. Despite my bodybuilding coach's reservations, I was determined and adamant about participating in the competition, having committed a substantial amount of money in preparation, as

well as travel, accommodations, and other related expenditures. The driving force behind my desire to compete was my need for validation and success rather than the monetary investment I had put forth in the competition. After one week of recovery from the COVID-19 virus, I convinced myself that I had recovered. I promptly returned to the gym, rigorously engaging in my cardio routine, fueled by the aspiration of securing my professional bodybuilding status at Nationals. My coach gave me his approval to compete at Nationals after I assured him that I felt fully prepared and ready.

Figure 74

Post-COVID-19 Progress Pictures

Note. Progress pictures were sent to my coach following my COVID-19 recovery and three days before Nationals in Orlando, Florida. I felt proud of my 40-pound weight loss over the last 16 weeks and fully prepared and confident with my results. Nothing was going to get in my way.

Unaccompanied and devoid of familial, friendly, or coaching support, I embarked on a journey to Orlando, Florida, where I braced myself for my competition. I had the confidence and enthusiasm to perform on a national platform and exhibit my diligent efforts; however, the absence of emotional support was apparent, leaving me feeling fearful, lonely, and alone without the physical presence of a support network at my show. I had an unprecedented level of anxiety, causing me to tremble uncontrollably before going on stage. Thirty minutes before my performance, I conversed with my coach, during which I conveyed my extreme nervousness and uncontrollable trembling (see Figure 75). He reassured me that my feelings were typical and that everyone was experiencing similar anxiety and emotions.

Figure 75

Pre-Stage Picture: Third Bodybuilding Competition

Note. Thirty minutes before stepping on stage at my third bodybuilding competition. With my anxiety running on high, I felt alone and scared and wished that I had at least one person with me for support. I expressed my emotions to my coach, who

assured me my feelings were normal. My emotions persisted, ultimately causing me to self-sabotage my 16 weeks of hard work in preparation for this day.

Nevertheless, his words of reassurance failed to alleviate my nervous thoughts and trembling limbs. As the judge called my name to perform my routine, I experienced complete physical paralysis, making it impossible for me to walk, use my hands, or execute my routine. I experienced an unprecedented level of embarrassment and humiliation, prompting an immediate desire to book a trip back home. Nevertheless, the tournament was not yet over since I was required to attend the finals the next day. Leaving early and returning home showed a lack of sportsmanship, creating an unfavorable and enduring impression on the judges.

Figures 76 and 77

Official Stage Photos: Third Bodybuilding Competition

Note. November 21, 2020: Official stage photos were retrieved from the National Physique Committee (NPC) website. I had difficulty performing my posing routine due to the complete physical paralysis that took over my entire body. It felt like I was

> learning how to use my limbs for the first time. My body began retaining water due to the elevated cortisol levels attributed to my anxiety and stress.

I followed my coach's advice and stayed for the final round scheduled for the next day. The profound sense of shame, disillusionment, and isolation I experienced during my first posing regimen compelled me to want to disappear completely. Despite having to go on stage the next day, I spent the entire day bingeing and purging after ordering over $400 worth of room service. I recollect experiencing endless tears and harboring a more tremendous self-loathing than ever before. I was ridiculed and belittled by the bodybuilding world, and I felt that I had let down my coach, who was relying on me to perform at my very best. Due to my typical inclination to share competition updates and photographs on my social media platform, I started receiving messages from my followers requesting pictures and updates regarding the competition. I was unable to muster up the courage to disclose the circumstances of my physical impairment and my humiliating defeat. I put forth an encouraging message about my competition on my social media platform (see Figures 76 & 77). I portrayed strength and contentment in the pursuit of triumph. I wanted to conceal from the world the extent of my profound vulnerability:

> I am so proud of myself. Being a winner is not about a placing. It really is not. It is about NOT giving up. It is about perseverance. It is about giving it your all. It is about having the guts to get up on that stage and have your body critiqued to the tiniest detail. I am so proud of myself for competing alongside the top competitors in the nation despite the difficulty of this grueling prep and the obstacles I had to face along the way. All I wanted was to have the opportunity to compete at the National level, and I did it. A week ago, I argued with my coach about practicing

> in a bikini because I felt uncomfortable. Moreover, now I am on stage in a bikini. We used this show to warm up our primary goal, the “NPC USA’s” on December 13th. We have three more weeks to bring our best package (Instagram Post, November 22, 2020).

I felt anger and resentment towards my coach for his lack of commitment, engagement, and initiative to be present at my competition. I thought we were a team and felt betrayed by his indifference. However, throughout my time in Florida, I refrained from expressing my feelings to my coach to minimize further stress and prevent a potentially uncomfortable situation that could lead to rejection by my coach.

After returning home from Florida, my anger stemming from feeling abandoned by my coach compelled me to express my feelings fully and honestly to him. I hoped he would show up because we were a team. His lack of support and indifference contributed to my elevated anxiety levels and total physical paralysis on stage. My coach did not take accountability for his actions and did not take my criticisms well, and my fear of rejection came to light. He not only dropped me from my second show in December, but he dropped me as an athlete and expressed that “*I am not made for this sport and should make better use of my money by seeking therapy*,” implying that I was mentally ill. The internal hurt I felt from his inappropriate, unnecessary, and damaging use of words due to the bruise on his ego felt like someone had stuck a knife in my heart and pulled it out. The intense rejection, coupled with my existing hormonal imbalance, sent me into the most profound tailspin I had ever experienced in my entire existence.

> How can I get rid of this lack of breath 24/7? I feel like I am suffocating in my skin, constantly fighting to stay afloat as my mind races over my lack of money, a failed competition, my old coaches telling me I will never amount to anything, and that I was not made for bodybuilding. I lack purpose, direction, and a sense of being. My home is also a significant factor in my inability to breathe. I know I need a lot of help. I do not know if I am going to survive this process. I feel like utter death. (Journal Entry, December 2020)

Déjà vu repeated itself from my second show a year prior, as my extreme self-loathing and self-hate intensified my suicidal ideations. My deficient mental state led me to gain 45 pounds in less than a month (see Figure 78). My body started to retain excessive water, especially my feet, which prevented me from fitting into my old tennis shoes, which fit only a month ago. To exacerbate my situation further, a friend of mine sent me disturbing screenshots of text messages circulated by my former coach joking about my mental health and "*my oversized waistline*," stating that "*A six-foot male would not be able to wrap themselves around my oversized abdomen.*"

Figure 78

My 34th Birthday: Three Weeks Post Competition

Note. December 13th, 2020: My 34th birthday and three weeks following my third competition. The water retention from the binging and purging following my competition manifested on my face, having already gained about 20 pounds. I was extremely depressed in this picture because I planned on competing on my birthday and kept replaying the events of my last competition and verbal altercation with my coach.

It was tough to ignore these hurtful messages, and I had the intense urge to confront my coach about his humiliating messages. Nonetheless, I shifted my focus to putting behind the events surrounding my competition and the ending of my bodybuilding relationship with my coach, whom I once respected. Instead, I started surrounding myself with friends in the bodybuilding community by meeting with them daily for a workout and vent session. Within a few months, I was able to overcome the pain of the past due to close connections and support from selfless friends who were dedicated to helping me pull myself out of one of the darkest periods in my life.

> I find my car to be the safest and most peaceful place sometimes. Free of outside energies and influences, where nobody can judge me for being myself. I sit here on this rainy, cold Saturday afternoon, and I am hopeful for the future and all the possibilities just waiting for me. I started this morning on a positive note, determined to make all my efforts count, not only in my body-building goals but also in my school, education, and life's purpose. I am still trying to wrap my head around how we can wake up with positive intent, but I have these feelings and emotions that come up in the day that led us down an unhealthful, self-destructive path. (Journal Entry, December 2020)

Moreover, sharing my journey and the lessons I learned with my social media audience helped facilitate my healing process. I felt isolated in my turmoil and connected with my supporters. My pain made me feel like I was a part of the world again. The excerpt below is taken from my social media post about one month later, on December 20, 2020, where I am sharing my optimism for the future, self-reflections, and lessons learned from my last bodybuilding competition:

> I want to share two major life lessons from this past year and competition experience: 1) You are more powerful than your mind's lies. Therefore, if you can control your mind, you can do anything. It is easier said than done, but constant practice and patience make everything possible. 2) We are resilient and unique beings; every experience is put before us to hone our resilience further. There is absolutely nothing we cannot handle. From coming down with COVID a month before my first national show to losing my steady corporate job to losing several loved ones to illness, I am grateful for the strength from above for helping me

> battle with ease through these tough times. As the saying goes, the tougher the battle, the more glorious the outcome. So, never stop fighting. Never give up, no matter what. (Instagram Post, December 20, 2020)

Overeaters Anonymous – January 2021 - Present

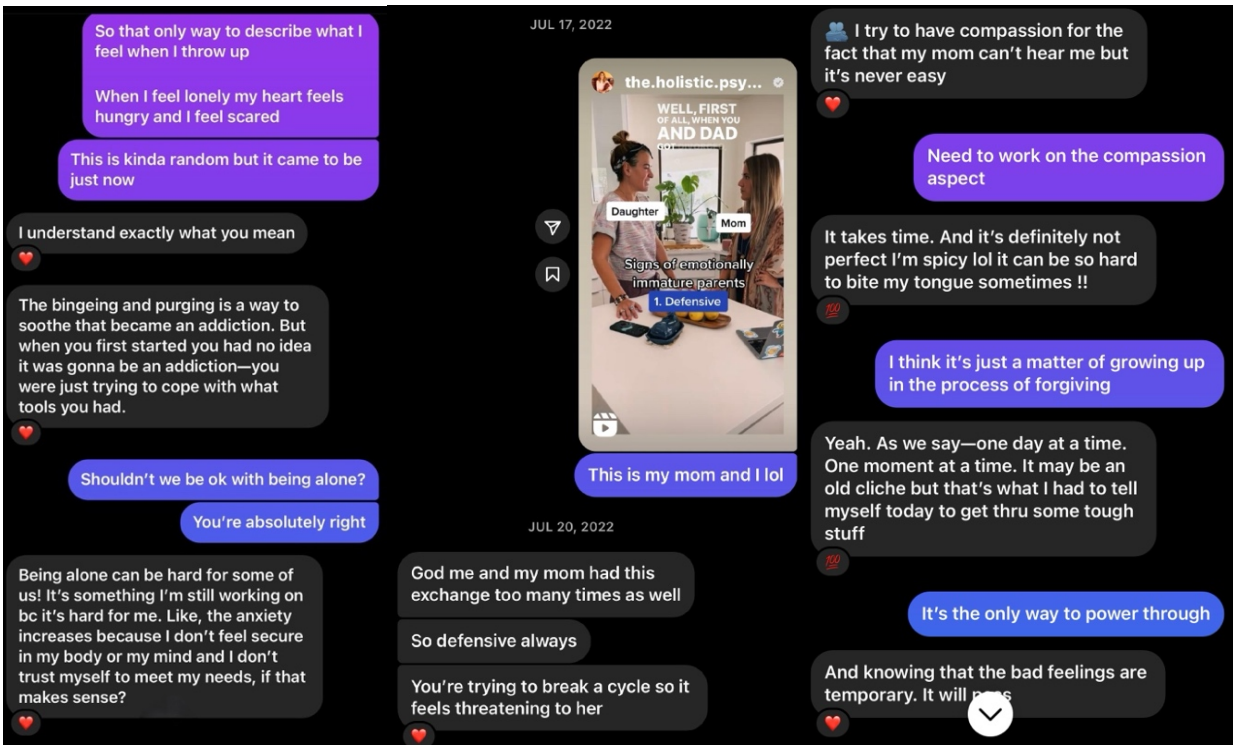
After parting ways with my bodybuilding coach in November 2020, I felt an extreme level of despondence, loneliness, and purposelessness. I was at my breaking point and mentally exhausted with these extreme emotional highs and lows. With my lack of health insurance and minimal income, my desperation to make a permanent change with these lifelong patterns compelled me to revisit an in-person Overeaters Anonymous (OA) meeting I had sporadically attended in 2008. OA is a 12-step non-profit support group for individuals who suffer from compulsive overeating or use food to cope with their extreme emotions. OA is a non-judgmental, safe space for individuals who struggle to be vulnerable, share their battles, and feel supported.

Due to the transition from in-person OA meetings to virtual meetings due to the COVID-19 pandemic, I was grateful to have found one meeting in my area that I was able to attend in person where I can interact, relate, and hear the stories of individuals who suffer with compulsive overeating and purging just like me. I started attending regular weekly meetings where I gravitated towards a sponsor who had recovered from bulimia nervosa. We immediately connected and started interacting regularly via text messages and phone calls. I felt safe, had a sense of non-judgment, and had ease while interacting with my sponsor; therefore, being vulnerable and being myself with her became very easy (see Figures 79 - 81). Talking through my issues provided temporary relief from engaging in bulimic behavior. It felt refreshing to know that I was not alone,

crazy, or nonsensical with my emotions and that another individual understood precisely what I was talking about. The safe space in OA was a part of its healing qualities.

Figures 79 – 81

Text Message Correspondences with My OA Sponsor



Note. (Far Left) January 2021: One of my first text message correspondences with my OA sponsor. I started messaging her randomly with thoughts and feelings that would arise. She would provide comfort by resonating with my emotions. My communication with her felt very natural. (Middle and Far Right) July 2022: Text correspondence with my OA sponsor. I sent her an Instagram video reflecting my relationship with my guardian.

New Bodybuilding Mentors Instills Confidence & Hope: February and March 2021

Recovering from the mental and emotional repercussions of my third bodybuilding competition and the unfavorable outcome with my former coach, I was determined to redeem myself by dedicating myself to another bodybuilding competition preparation. My goal was to find a mentor(s) who wholeheartedly believed in me and were invested in helping me achieve my bodybuilding goals. I also wanted my support

system to understand me not as "*Hasmek, the robotic athlete*," but "*Hasmek, the driven, goal-oriented human being with intense emotions who craved compassion, empathy, and understanding*."

I found the qualities I sought in two bodybuilding mentors who crossed my path in March and June 2021. My first mentor was my personal trainer, who guided my workouts three to four times a week. He was a caring, dedicated, and genuine human being who instilled new hope and knew how to help me believe in myself again. As I continued my personal training with my new coach, my strength increased, my body transformed, and I started seeing the light at the end of the tunnel. My mentor's training technique resulted in optimal muscle gain within four months, which inspired me to switch to a bodybuilding division more suitable for females with lower body development. Hence, the new division I would pursue with my upcoming competition was "*Wellness*." I loved the Wellness division because it promoted a more curvy and natural-looking female physique, which I felt more aligned with, rather than the leanness required for my previous bikini division.

Although I felt content and supported by my personal trainer, I was still searching for a qualified head coach/nutritionist who would oversee my diet for my anticipated Wellness debut. A "*head coach*" in bodybuilding refers to the brains behind the competitor's ultimate competition outcome. This individual oversees and controls a competitor's nutrition and exercise protocol. The key to the competitor's success is how well the head coach can understand how to manipulate the athlete's body under a unique diet and exercise strategy.

After months of researching and interviewing potential head coaches and asking for recommendations from fellow bodybuilders, in March of 2021, I found a functional food expert through social media who had a fantastic track record with female competitors in the "*Wellness*" division. His down-to-earth and humble persona, alongside his incredible knowledge base and accomplishments within the bodybuilding industry, convinced me that I had found my head coach and nutritionist for my Wellness debut. His dedication and commitment were aligned with my dedication and commitment to bringing my best physique to the stage. I felt a sense of comfort, ease, and great respect for my new head coach, and I trusted that following his nutrition and workout strategy would lead me to victory. My trust and respect in this specific coach were very similar to my faith and respect in my very first bodybuilding coach in July of 2018, where I achieved my radical physical transformation and stopped binge eating, purging, and abusing laxatives.

Breakthrough in my Abstinence from Bulimia and my Fourth Competition

With my "*dream team*" in place with my two incredible bodybuilding mentors, I scheduled my Wellness debut for August 14, 2021. I was also mentally ready to stop all my bulimic habits and take care of myself fully, as I knew that if I continued down my self-destructive path, I would end up with less-than-optimal results for my upcoming show. A pattern I had also noticed in my 20 years of battling with bulimia was that I had the tendency to achieve weight loss and looked optimal when I did not engage in these self-defeating habits. My trust and respect for my mentors, along with my unbreakable work ethic, discipline, and determination, led me to abstinence from bulimia, along with an incredible physical transformation and weight loss of 35 pounds.

Below is an example of my weekly email correspondence of my progress with my head coach/nutritionist. My head coach had a list of mandatory questions (Weekly Email Update with Head Coach, July 2021) and progress pictures I was required to send him leading up to my competition. Based on my progress, my head coach would make necessary changes to my diet and workout regimen. Although my mentor was strict with his guidelines and expectations, my trust and respect for him motivated me to meet his expectations despite the difficulty level. I respected his meticulousness, attention to detail, and commitment to helping me succeed.

Weekly Email Update with My Head Coach and Nutritionist - July 2021

Body Weight and amount changed: 138.8 (-0.6 lbs.)

Workout/Cardio Compliance %: 100%

Nutrition Plan Compliance %: 100%

Hunger/Appetite: Hunger pangs and cravings (mainly towards the evening)

Energy, rate on 1-10 (1 exhausted, 10 feeling ALIVE): 6 (finding it harder to push myself with my lifts).

Sleep: Any difficulties falling asleep, staying asleep, midday naps, etc.: 7-8 hours a night

Digestion: GREAT. Getting better day by day. I can say I am at about 95%.

Bloating: Normal bloating after meals (nothing unusual)

Periods: Nothing this week!

Stress: Normal life stuff (nothing too serious).

Positive changes since last week: We are improving daily!

Main concerns: My main concern now is my impatience, and I cannot wait to get to that finish line lol... Also, since we are so close and pushing hard, are we still taking a weekly rest day? (this question will probably frustrate you, lol, but I need to make sure so that I am not skipping any days)

One thing you are most grateful for this week: I am thankful for the mental, physical, emotional, and spiritual strength developed during this prep. (Weekly Email Update with Head Coach, July 2021)

My Fourth Body Building Competition – August 15, 2021

My highly anticipated fourth bodybuilding competition took place in Lake Tahoe, CA. This competition felt significantly different from my national competition in Orlando, Florida, nine months prior. First and foremost, I had an incredible support system who traveled with me to Lake Tahoe, including my guardian, two aunts, and a couple of my closest friends. Although my mentors could not be present, my head coach had assigned a trusted bodybuilding coach, his employer, to assist me and provide me with emotional support before, during, and after the show. Lastly, my mental capacity evolved tremendously as I had more love and appreciation for myself, my physique, my dedication, and how far I have evolved as a woman while preparing for my fourth show. I knew that whatever the outcome of my competition, I felt like a winner regardless of my placing.

I was so proud of myself and all I had accomplished physically and mentally as I walked to the stage (see Figure 82). I knew that my physical results were self-evident, and even when I was again placed last, I did not have a sense of defeat. However, I was determined and committed to implementing the judges' critique of "*achieving a*

leaner physique" for my next competition (Judges Feedback, August 2021). Following my competition, I maintained a diet consisting of nutritious foods while sometimes allowing myself to enjoy my favorite dishes in moderation.

Figure 82

Comparison: Fourth Competition's Initial Starting Point vs. Show Day

Note. A side-by-side comparison of my fourth competition's initial starting point (April 12, 2021) versus my fourth competition day (August 15, 2023). I transformed my physique for my "Wellness Debut" by losing 33 pounds (160 lbs. vs. 127 lbs.) by adhering to a strict diet and exercise protocol. I placed last in a group of 15 female competitors. Although my goal was to land on top, I felt like the winner, not only because of my physical transformation but also because of my mental transformation and love and appreciation for myself.

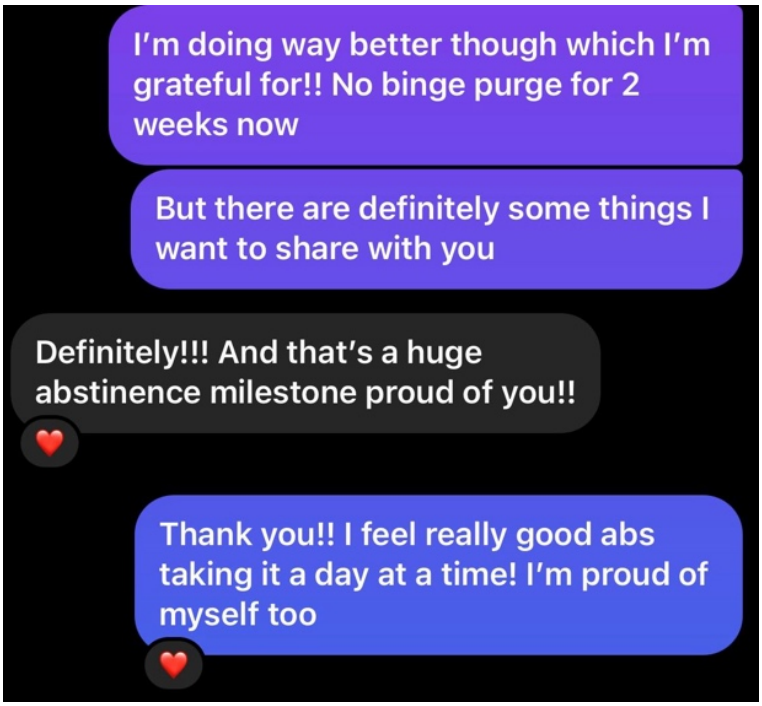
> Your overall look (hair, makeup, suit) is good. From photos over the last two years, it does look like you added more development to your lower body, but you need to work on conditioning. I do think you need more legs and probably more

> glute development, but you need to be tighter to assess the amount of development that you have. Good luck in future shows. (Judge's Feedback via Email, August 2021)

The most significant accomplishment I achieved during my fourth bodybuilding competition was abstaining from binge eating and purging for five consecutive months (see Figure 83). The impetus behind my decision to put an end to my self-destructive behaviors emerged from my desire to win my fourth competition. I was aware that by precisely following the procedure set forth by my head coach, even if I did not win, I would have the satisfaction of knowing that I had put forth every effort to succeed and would not have any feelings of regret over the result.

Figure 83

April 2021: Text Correspondence with My OA Sponsor



Note. I am sharing the good news of my two-week abstinence from binging and purging. I was incredibly proud of myself for abstaining for two weeks, and my motivation was at its peak.

I previously observed the benefits of abstaining from bingeing, purging, and maintaining a nutritious diet, resulting in weight loss. My bulimic behaviors led to significant water retention and fat gain, hindering my progress. Instinctively, I sought the validation of my esteemed mentors, who had faith in my bodybuilding abilities, and I could not disappoint them. Despite occasional urges to binge and purge throughout my five-month period of abstaining, my determination to flawlessly execute my protocol and gain the approval of my mentors empowered me to develop mental resilience and resist temptation. As my resistance increased, my determination became more robust, and I began to believe that if I took good care of my body, it would take care of me.

I continued to be the perfect athlete in the days following the show. I continued to pursue my competition preparation protocol to drop additional weight in hopes that my head coach would submit me to my desired show in October of 2021. My competitive urge never dissipated, and I would only rest once I placed first in a bodybuilding competition. Also, I was more obsessed and terrified of weight gain, and therefore, committing to another competition would be my version of damage control and would prolong my lean physique. I continued to send meticulous weekly updates to my head coach and felt comfortable being vulnerable with my mentor, who believed in me. (Weekly Email Update to my Head Coach, August 2021)

Below is my detailed and vulnerable update for the one-week post-show. I expressed my fears and anxieties regarding how terrified I was of weight gain and how I did not want to fall back into old self-destructive habits, emphasizing that "*the urge to binge and purge are at an ultimate high*." My coach had implemented a so-called "*reverse diet,"* which adds macronutrients slowly since the body becomes

hypersensitive to additional food due to prolonged calorie restriction. Hence, I was having a hard time digesting the additional food, such as red potatoes, which were causing gas and bloating and were triggering my anxiety (see Figure 84).

Weekly Email Update to My Head Coach – August 2021

Body Weight and amount changed: 126.2 (-1.8)

Workout/Cardio Compliance %: 80% - 2 leg days, 2 upper body days this week, cardio was on point.

Nutrition Plan Compliance %: 90% - My food was on point except Friday evening when I ate dinner. I subbed Meals 4 and 5 with the following: 10 oz. Grilled swordfish, steamed veggies, veggie rolls with rice, vegetables, a tempura piece, tuna tartar, 2 cups of red wine, and a couple of butter cake bites. The following day, Saturday, I was crazy bloated, and my weight was up by 2 pounds. I do not think I went overboard the night before by any means, but all of this was SUPER triggering, and I was barely controlling the urge to binge. It was a scary day on Saturday, mentally! I do not want to fall into my self-destructive habits! Also, the 6 oz of red potatoes with meal three is triggering my anxiety big time. I honestly feel like purging afterward. I do not know if I cannot digest it or if it is fear of weight gain because I get crazy bloated, gassy, and full afterward, which makes me nervous. I have been subbing this out with 1/3 cup dry oat bran instead. Also, if you have any other carb substitution recommendations for meal 3, I would appreciate it.

Digestion / Bloating: I have been crazy bloated and gassy this entire week, especially starting Friday after my big meal! Maybe I did not digest the raw tuna; I do not know. The bloat is uncomfortable at times.

Positive changes since last week: My strength is almost back to normal, and I am feeling back to normal. Also, I am proud of myself for staying on point with everything!

Challenges since last week: Crazy anxiety and triggers to my eating disorder. The urge to throw up my food was on a high.

Primary concerns currently: I am terrified of weight gain and want to drop down further. If possible, I want to feel comfortable in my skin and maintain a lean physique year-round. FEAR of fat is on an ultimate HIGH.

One thing you are most grateful for this week: I am grateful for EVERYTHING, but I am most grateful that I love myself now. I am grateful to have regained my health and confidence. I do not want to lose this by any means. I am SUPER grateful to be mentored by you. Sometimes, I want to fall back into my old habits, but I remember having a coach who had my back and believed in me, which got me through. (Weekly Email Updates to my Head Coach, August 2021)

The Natural Physique I Achieved Through Hard Work and Determination

Some of my biggest triggers, which are directly tied to my mental illness, are when people question the authenticity of my physique. Some individuals assume that my drastic transformation was achieved by a magic pill, a surgical procedure, or steroids that magically helped me put on muscle overnight. These assumptions are triggering because they devalue my identity, inner strength, grit, and perseverance to

achieve the goals I often believed were impossible. The assumptions and statements I have received in response from strangers who are new to my journey include:

"*How could you have achieved a transformation so drastic? You must be fabricating or filtering the pictures!"*

So, will you gain all the weight you usually gain after competitions?"

I would have never guessed that you are a bodybuilder. You do not look like one!"

"Did you put your head on someone else's body?"

"That picture does not even look like you!"

Adversity helped me grow a thicker skin and helped desensitize myself from hurtful people or situations. However, when these comments are made, the intrusive thoughts, which were once dormant, rise from the dead and continue to torment me. I realize that no matter how invincible I think I am, sometimes my skin cannot be thick enough. Even though the individuals making these comments are incredibly hurtful and triggering, I do not believe they are intentionally conveying these comments to hurt me. The hurt I experience is linked to my trauma because it activates the rejection I have felt throughout my life, which compels me to argue with others to justify my existence.

I am proud to confirm that my extreme physical transformation was achieved naturally, credited to my genetics, competitive perfectionism, and stubbornness to succeed at all costs. This leads me to ask myself, "*If I can achieve a drastic external transformation, what stops me from achieving a drastic internal transformation"?* "Succeeding at all costs" means not deterring from my assigned diet and exercise protocol no matter what obstacle life brings my way. I would also like to reiterate that

although I was assigned body-enhancement drugs such as steroids, estrogen blockers, and thyroid medication, I never consumed them because I was afraid of possible adverse side effects that would follow.

Bulimia Resumes – September 2021

During my five-month and most prolonged abstinence from bulimia to date, I was convinced that I had everything under control, that my eating disorder days were finally over, and that I was somehow healed. Although I still struggled with my disordered eating tendencies, such as obsessively counting my calories and continuing to drop additional weight stemming from the incredible fear of gaining weight, it was an incredibly liberating time when I felt like my handcuffs were finally released from my 18-year battle (i.e., in 2021) with bingeing and purging. I had developed a love and appreciation for myself and had complete faith in my sense of control with my bulimic tendencies. However, I was also utterly oblivious to the fact that if I am still obsessed and terrified with "*not gaining weight*," then I am not truly free of my eating disorder. Hence, I did not expect that I would succumb to the urge to binge and purge and, in the blink of an eye, place me back at square one.

My urge to reengage in my bulimic tendencies was triggered by the hesitation and lack of support of my head coach in submitting me for an upcoming bodybuilding competition. I desperately wanted to hone my physique and enter a competition by late October 2021. I was confident that I could win my next show if I worked on executing the judge's feedback of "*bringing in a conditioned physique*" (i.e., leaner physique) and more muscular physique to my next show (Judge's Feedback via Email, August 2021). I expressed my desire to compete in another show, and my head coach expressed how I

had a lot more work to do before he would allow me to step on a bodybuilding platform (Email Correspondence with Head Coach, September 2021). I followed his orders out of respect, but I felt rejected, and the feelings of unworthiness and never being enough that I experienced previously took over my mental psyche.

Email Correspondence with my Head Coach - September 2021

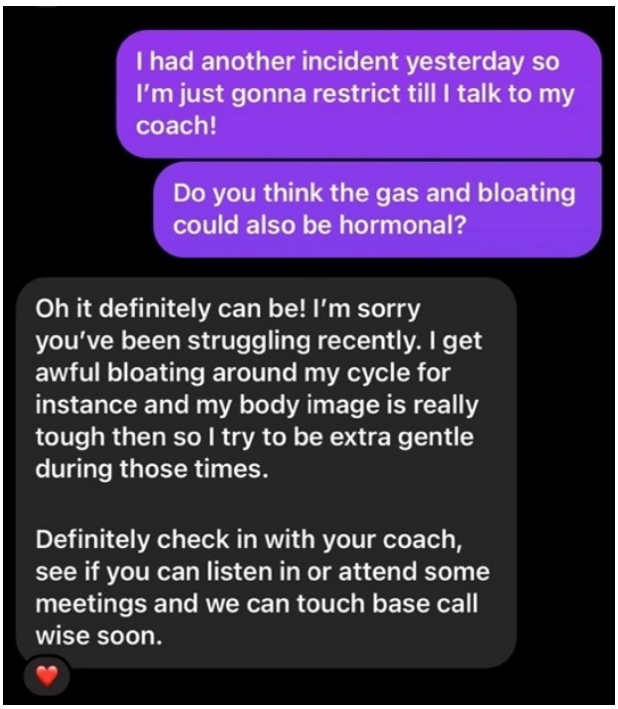
> *My Message to my Coach:* I would love to do another show soon because I am leaning out weekly. I know you have my best interest at heart, but I would like your thoughts. I respect whatever you think is best. Legion on October 22nd is still on my mind. However, I am open to doing a show in November and qualifying for Nationals in December.
>
> *Coaches Response:* We still need to bring up your glutes and hamstrings, but we could go for a prep if your body allows us. I was thinking about an off-season to bring up those areas. Glutes need to be trained directly in some fashion four days per week; 3 days should be very heavy. At a national level, though, we need about 5-1 more-inch glute. This is just from an objective standpoint. I do not think this is feasible by the end of this year; this will take more than just 2-to 3 months to grow. We are looking at a caloric surplus for six months or so for this muscle growth. This is my honest opinion if you want to be competitive on a national stage. You must overshoot a national stage if you want a chance to go pro. I will bump up your food this week since metabolism is adjusting. (Email Correspondence with Head Coach, September 2021)

Reflecting on my coach's response regarding my desire to compete again, he was honest and wanted me to be at my best to achieve my bodybuilding goals.

However, my stubbornness and eagerness to compete soon after my last show with the intention of "*proving myself*" is what ultimately led me to fall back into my bulimic tendencies. I felt my coach did not believe in my potential like he did when we started working together in April of 2021. I was entangled with intrusive thoughts telling me I would never be good enough as yet another mentor was rejecting my capabilities. Thoughts replayed in my head, such as *"It was only a matter of time until he saw what a failure you are!"* Ultimately, my self-destructive thoughts placed me back at square one, and my binge eating and purging resumed with a vengeance.

Figure 84

September 2021: Text Message Correspondence with My OA Sponsor



Note. I had fallen back into my binging and purging habits and was feeling a total loss of control once again. I was experiencing indigestion due to the prolonged calorie restriction, which was contributing to my gas and bloating.

I started feeling that the connection and trust I once had for my coach slowly dwindled, along with my love and motivation for bodybuilding. Furthermore, I stopped

believing in my potential to succeed in the sport and stopped my regular strength training sessions. Moreover, I began masking the fact that I had fallen victim to my self-destructive habits and concluded my working relationship with my coach in January 2022. On the other hand, my mentor and personal trainer, with whom I continue to train sporadically, never stopped believing in my potential to succeed in the bodybuilding industry. He continues to motivate, encourage, and empower me to prepare for another competition, but I need more motivation, drive, and belief in my potential to move forward.

Unemployment and Losing My Sense of Purpose – March 2022 – August 2023

A large percentage of my identity is attached to success in my career and livelihood and the respect I earn because of my success. My work boosts my self-esteem and self-worth and gives me a sense of purpose and identity, and a lack thereof tears me down mentally and physically. It is not about the money but the freedom and independence I gained from earning my income. Hence, my inability to find the right job, lack of income, and dependence on my family took a mental toll between March 2022 and August 2023. Chronic anxiety, depression, and bulimia nervosa were constant during this time, and mustering up the faith and inner strength to remain optimistic, focused, hopeful, and to keep moving forward became extremely difficult.

> My biggest wish in life is to be financially stable. Lack of money is the single thing that stresses me out the most in the world. I want to buy what I want when I want it and not have to be accountable to anybody but myself. I wish to travel worldwide and take random trips when I feel like it. I envy and look up to those who have made it big. I want to be prominent, prosperous, and stable, so I never

> want for anything. I want to take care of my guardians so they do not have to worry and can work if they want to, not because they need to. I am going to find a way to make this happen. I am determined. (Journal Entry, June 2022)

In March 2022, I quit my full-time job as a quality control chemist for a personal care contract manufacturer. Although I loved my job, I was being verbally abused and harassed continuously by an older gentleman whom I worked with closely. When I decided to stand up for myself by expressing my concerns to my superiors, I was retaliated against and moved from the day shift to the graveyard shift. I felt misunderstood, unseen, and upset with the outcome of my complaint. However, I needed the income, so I agreed to the drastic change in my schedule, having faith that I could adjust to the irregular time of 12 a.m. to 8:30 a.m. Two weeks after working the graveyard shift, I felt like a zombie due to the irregularity in my sleep patterns and mood. I quit my job in hopes of finding a new job shortly afterward. Deep down, I did not want to stop working; I hoped for respect and acknowledgment from my superiors and a peaceful and healthy working environment.

Immediately after leaving my position with the personal care contractor manufacturer, I started working with headhunters and applied to every job aligned with my skillset and expertise. However, finding the right job became challenging because I was either overqualified or underqualified for the positions I was applying for. Feeling an extreme sense of frustration and anger for the outcome of my last job and my inability to find a new job, I started to self-destruct through my bingeing and purging tendencies. I felt sorry for myself and felt like "*the loser that would never amount to anything,"* and this feeling of inadequacy resulted in a marathon of binge and purge sessions every

day. A marathon consisted of three to five binge and purge sessions, each session lasting about three hours total. I felt like my body was imbalanced and my anxiety on high, which I could not break free from.

> I wake up every morning fighting the same battles and mental demons that I did the day before, and I cannot do it anymore. It is 11 a.m., and I have already collapsed. I feel hopeless and paralyzed. I slept through my alarm and missed my training session, and that provoked my anxiety. I then got dressed, meal prepped, and made plans to head to the gym near my home. Then, my hunger was so unbearable that I had dinner and a bunch of cookies. This binge will continue until I have no feeling left. Why must I feel this defeated every single day? I am disappointing myself and everyone I love. Hopefully, I can successfully purge and still get my workout in. I feel this day is already a complete failure. I fear myself. I do not know what to feel right now. (Journal Entry, May 2022)

I began feeling regretful about leaving my position and thoughts of "*I should have just sucked it up*," "*I could have pushed through if I tried, but I just mess up as always*," and "You did this to yourself, and now you have to suffer the consequences" kept running through my mind 24 hours a day. My sense of purpose and identity were stripped, and I was worthless, as I felt as though I had nothing to show for all my hard work. I felt intense shame, guilt, and humility for "*being a loser and failure*" at this point in my life, where I had goals of an established, stable, and lucrative career with a loving partner and children. I was behind and could never catch up to the other successful colleagues who had "*made it*." "*Why am I struggling so much, and why is this happening to me*?"

> Lack of financial stability as a grown woman is humiliating and embarrassing. Having to depend on my guardians for survival at this age is something I would have never predicted. I always had a clear picture in my head that by this age, I would be established in my career with a loving partner, children, and the ability and means to support myself and my family. Lack of money makes me feel like I live on the edge of no return. I literally cannot breathe. As the saying goes, "Money buys happiness." Money buys freedom and stability, and that is my definition of happiness. My biggest fears are lack of income and inability to support myself. Moreover, I spend my days living in utter mental chaos, always in a state of worry and panic about survivability. Furthermore, I should be caring for and supporting my guardians instead of being cared for. I know I am going to be ok, but the feeling of instability is suffocating. A big part of me wishes I could binge and purge my emotions away. My only salvation is keeping my mind busy. (Journal Entry, September 2022)

Every day felt like I was reliving my daily hell all over again. My chronic anxiety was ruling my thoughts, and I dreaded being awake and feeling the discomfort and pain of my emotions, which I did not want to deal with. I hated myself, became increasingly irritable, and acted out of character towards family and friends, thus subconsciously attempting to push them further and further away. The mental and physical exhaustion from the excessive bingeing and purging had taken its toll as my weight started to increase due to the water retention and fat gain. Although the bulimia was numbing and temporarily took my mind off my problems, I would not say I liked binging and purging, but I could not stop due to the firm hold my mental illness had on me. I would wake up

every morning to "*be better than yesterday*" and to go "*cold turkey*," but every day proved to be a failure. Despite my failed attempts at halting my self-destructive behavior, I never gave up on myself despite my utter despondence.

> I am about to go to bed from a day I would describe as hell. I woke up with the same intention every morning: to not destroy myself. However, every day, I seem to fail terribly. I am praying that this will be the last day. I woke up, got dressed, packed my meals, and got into a discussion with my guardian, which aggravated my ongoing anxiety. Then, the lack of money in my wallet also exacerbated my anxiety. With $20 in my purse and no gas, how was I supposed to make it to my workout, 40 miles away, then my other appointments? The anxiety was unbearable and almost suffocating. I kept chewing gum to alleviate the anxiety, but my inability to breathe felt like a panic attack. I ate some candy and bagels in the backseat of my car, which I felt a magnetic pull towards. I felt like they were calling my name. Ironically, I did not want to toss them, but I did not want to eat them. I lasted till about 2:30 p.m.; then, I ate the snacks in the back of the car like I knew I would. This escalated to an ongoing binge till 30 minutes ago (2:30 a.m.). This was the unproductive day from hell. I hope and pray for a better day tomorrow. (Journal Entry, April 2023)

A Necessary Medical Procedure Leads to a Temporary Breakthrough in My Abstinence from Bulimia – August - November 2023

Often, the universe has a mysterious way of showing us our strength and resilience to overcome our most brutal battles despite our numerous failed attempts. On August 1st, 2023, I had a necessary surgical procedure unrelated to my mental illness,

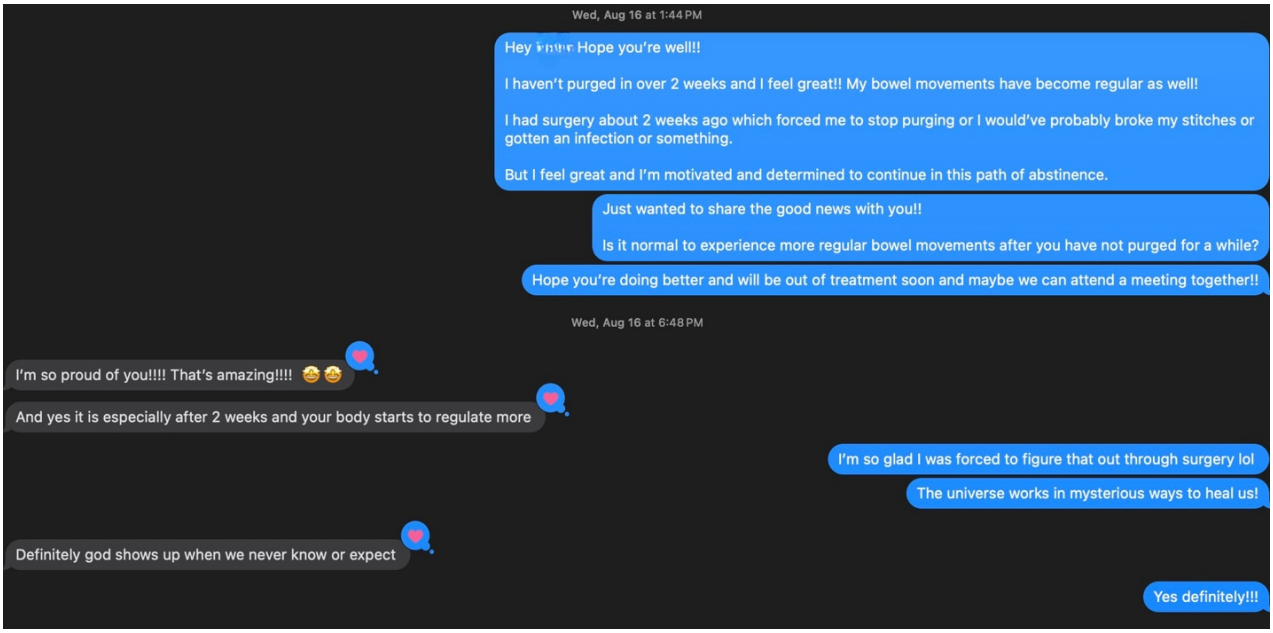
which was the universe's way of showing me that if I was determined to stop binging and purging, I was competent. The physical discomfort and pain following the surgery prevented me from binging and purging, which was a relief despite my occasional urges to binge and purge while in recovery. Moreover, engaging in my bulimic tendencies would break my stitches, thus making me susceptible to infection and further exacerbation of my health issues. I was indeed determined to end the bulimia once and for all, and I loved the feeling of taking care of myself by keeping the nutrients in my system. After one week of abstaining from bulimic behavior, I had more energy, my mood had improved, and I was feeling the best I had in a long time, despite having critical surgery a week prior. I was determined to maintain my abstinence from bulimia and finally end the maladaptive coping mechanisms I had been struggling with for so long. I loved the feeling of taking care of myself by keeping the nutrients in my system. Nourishing my body and giving it what it needs felt amazing. The more I took care of my body, the more obsessed I became with continuing to care for myself. I had been struggling with gastrointestinal (GI) issues (i.e., constipation, irregular bowel movements, gas, and bloating) due to my past laxative abuse and ongoing bulimia. I finally noticed that the love, care, and patience I was giving my body slowly paid off as I observed the regularity of my GI issues (see Figure 84). As a result, I began thinking clearly and felt my mood improve as my anxiety levels gradually decreased. I finally felt hopeful, like there was a light at the end of the tunnel and that I would be ok.

> The past 2.5 weeks have been perfect, thanks to my surgery. I am grateful that I was not physically able to purge, or I would have broken my stitches or caused some infection. My anxiety has decreased, I feel excellent and focused, I am in a

better mood, and I have more energy. My digestion has even been regulated, which is a complete miracle. I feel normal and like my happy, bubbly, positive, and optimistic self, who had been hiding beneath the demons of this crazy disease. I have been tracking and measuring my food daily, but I am not starving myself. Monitoring and measuring my food makes me feel like I am in control, reduces my anxiety, and gives me peace of mind. This is the happiest and most human I have ever felt, and I am determined to continue this path of non-self-destructive and more loving behavior. (Journal Entry, August 2023)

Figure 85

August 2023: Text Message Correspondence with My OA Sponsor



Note. I am excitedly sharing my two-week abstinence from binge and purging. I was so proud of my strength and determination to halt the bulimic tendencies and felt hoping for a continuing clean streak.

Employment: Maintaining My Newfound Sense of Purpose in a Highly Toxic Work Environment - August 2023

As I continued to care for myself, I felt my luck taking a positive turn with my struggle with unemployment for the past 18 months. Two weeks following my surgery, I landed what I thought was my dream job as a senior chemist and supervisor for a start-up personal care manufacturer. I wanted this position with every fiber of my being and thought that all my prayers would be answered once I got settled into my new job. It was also an opportunity to move into my apartment and establish my craving for independence and freedom. My new position also reestablished my identity and sense of purpose, which I had lost for a long time. I was hopeful that life would improve and that I was finally where I was supposed to be.

However, I soon realized that my new organization operated with unethical and immoral values that did not align with who I was as a human being. I worked in a Food and Drug Administration (FDA) mandated laboratory producing Over the Counter (OTC) personal care products that must comply with FDA guidelines. Being a "*by the book*" individual regarding laboratory practices, I felt bothered and discouraged that this organization has been operating in such a manner. I was hired due to my expertise in helping to build the laboratory to meet FDA regulations. My superiors were unethical and dishonest with their operations, making up test results, using inefficient equipment, and improper test methods. Further, my recommendations were taken as a threat and were dismissed, as they felt I was stepping over their toes.

On my second day in my new position, the pressure to be perfect was emphasized by my boss, who called me into her office and firmly stated that "I *am expected to know everything within a week, and no training will be provided,*" as they expected me to be fully knowledgeable based on my 15 years of experience within the

industry. I felt my anxiety levels increase as my questions regarding my position were ignored within a couple of days, and the "*pressure to be perfect*" was instilled from the get-go. I proved myself within one week, putting in 12 to 15-hour days to ensure I learned the organization's ins and outs and confirmed that I was the perfect employee. My boss acknowledged my efforts and gave me control of the lab and those who worked under me. I finally felt like I was being seen and had a purpose, and I was hopeful that I had found my long-term position where I could grow, prosper, and thrive.

> For the first time, I feel in control of my personal and professional life. The first week of work was tough, but I survived. My manager gave me complete and total control of the lab, and for once in my life, I had people reporting to me. I feel a sense of accomplishment and power, and I can treat my employees how I have always wanted my employers to treat me. They are a group of chemists just starting their careers, and I can significantly impact their lives. One of my employees even asked me if I would write her a letter of recommendation for medical school, which was incredibly humbling. It is a great feeling when people look up to you and are inspired by your knowledge and expertise. Also, it has been almost a month since I have purged, and I feel like a different person. My anxiety and depression have decreased, and I am more in control of my moods. I wish never to go back to the hell that was my bulimia. (Journal Entry, September 2023)

I had an intense drive and determination to move up in the company and be seen and respected for my talents, which would benefit the company. I thrived off productivity and success, and the more I excelled within my position, the more hostile and

aggressive my boss's behavior became towards me. She perceived me as a threat as I could easily replace her. I loved my job, but I was constantly anxious at work, as I felt I could lose my livelihood at any moment. I felt the constant fear of breaking my abstinence from bulimia as my anxiety levels increased, and my body felt burned out due to the stress and long hours. I would cry uncontrollably on most days on my commute home from work. I felt rejected, unseen, unappreciated, and disrespected by the one person I hoped would recognize me for my dedication and efforts. Despite my hostility towards my boss, I tried to put myself in her shoes and justify her actions as "*normal*." I tried to see the good in her to calm down my anxiety and make it more bearable to work at this organization.

> I am grateful for my new job, and although I know I am competent and knowledgeable, I keep encountering managers who make me feel incompetent. The pressure to be perfect is intense, and I am tired, and my anxiety is through the roof. I am deathly afraid of losing my job every single day, which is causing me severe chest pains. My biggest fear is breaking my abstinence and falling into old patterns of self-destruction because of all the stress. I need strength to get through this, and I wish people could see me for who and what I am and everything I have to offer. I need strength! I need so much strength so I do not break at work and with my abstinence from binging and purging. I cannot control my tears. (Journal Entry, October 2023)

Termination – November 2023

With my position being over sixty miles from my residence, the long drive, long hours, mistreatment, and unappreciation from my superior took its toll on me. My

lifelong pattern of rejection from superiors was repeating itself once again, and I came to terms with the fact that I would never receive the validation from my manager that I was looking for. However, despite my realization about her, the more she rejected me, the harder I tried to prove myself. I found my defense mechanisms arose as I pushed towards protecting my position. I loved my job and treated my department as if it were my own. Hence, the hurt I felt from the mistreatment and unappreciation, combined with my straightforward and blunt nature, compelled me to speak my mind impulsively, leading to my termination.

Despite the issues between my boss and me, termination never crossed my mind. On November 2, 2023, as I was called into the human resources office with my boss and the human resource representative waiting for me, I felt my soul exit my body as I knew my fate at this company was over. This moment was my worst nightmare come true. "*How could I have been so trusting?" "How could I have not seen this coming?"* I thought to myself. I felt angry and heartbroken as if I had been stabbed with a knife in my heart and was bleeding on the inside. I thought the termination was unjust as I had helped restructure their testing laboratory, leading to significant financial growth in my short time there. I felt helpless as I sat there in disbelief. My emotions were so intense, and my biggest fear at this point was breaking my abstinence from bulimia. On the evening of my termination, I broke my three-month abstinence, placing me back where I started.

> I feel like I am back at square one. I feel numb, angry, and out of control. I have been bingeing and purging daily since I lost my job ten days ago, and I cannot seem to stop. I feel worthless, useless, and purposeless. I cannot believe I am at

> this point in my life with years of schooling and work experience, and I cannot find the right job. Everywhere I go is a complete disaster. I am applying to every single local and out-of-state job I can think of. I desperately need a job, yet I will not settle for anything, making this process difficult. I have faith that God will send me the right job and that the stars will align when it is the right time, but my patience is running out, and I am afraid of myself. Every day I am jobless is just another day I destroy myself. I am powerless over this disease, and I cannot seem to control my thoughts and actions. I am despondent, yet I cannot cry. I need to let it out. My body hurts my throat, my chest. Everything hurts from all the binging and purging. I have a few hundred dollars left in my bank account, yet I run out on daily binges. I cannot seem to stop. I desperately need help. I desperately need a job and my stability back. I need to feel like I have a purpose again and know everything will work out. I pray for peace, both mentally and emotionally. I pray for the dream job. The right job. However, most importantly, I pray for stability. (Journal Entry, November 2023)

Chronic Depression, Anorexia, Illness within the Family, and Possible Asperger's Syndrome – November 2023

My unexpected termination and the betrayal I felt added fuel to my existing depression. This was by far the most significant pain I had felt since the ending of my relationship in 2016. At the initial phase of my termination, chronic depression manifested itself in the form of anger and bitterness towards the friends and family I loved the most. I was irritable, anxious, and sensitive to everyone and everything that crossed my path.

Losing my job could not have happened at a worse time as my guardian's existing heart condition had taken a turn for the worse within the same week, affecting his ability to work and bring income into our household. He was exhausted, dizzy, forgetful, and had lost his sense of focus. The emotions and guilt of being unable to help my family financially were eating me up inside, as they were on the verge of losing our house. I felt immense guilt as I felt like I was letting my family down when they needed my help. Moreover, recurrent thoughts of "*Losing our house is all my fault had I only been able to help* financially." "*Had I been smarter with my money when working, I would have enough money saved to help my family now*."

> I have been experiencing traumatic flashbacks of my last job: painful scenarios, panic attacks, uncomfortable conversations, things I should have said and done, etc. I feel like I am grieving the loss of a breakup. I feel completely heartbroken. The environment may have been toxic, but I loved my work. I was proud of what I had accomplished for the company. I put everything in my position as my heart was embedded in my work. The painful flashbacks would not go away, and I do not know how to get rid of them. I pray for a healthy, prosperous, supportive work environment that appreciates me for who I am and everything I have to offer. I wish I could return, minus those coworkers and managers. I hope things did not turn out the way they did. I crave my dream job. Working is the only thing that will make me whole again. (Journal Entry, December 2023)

I was in so much pain, guilt, and shame from the repercussions of my termination that sleeping felt like the only escape from the excruciating internal turmoil I was experiencing. I could not hold regular conversations as speaking made me sick. I was

starting to become extremely sensitive and irritable to any sound or noise, as the slightest noise aggravated my anxiety tenfold. Further, my anorexia kicked in, and I started losing my appetite, unlike anything I had experienced before. My inability to eat gave me a sense of safety and stability. I felt like when I was restricted, I was invincible and in control of my situation. In addition to limiting, I purged the food I did consume and began over-exercising obsessively.

> Often, I feel like my bed is the safest place, not only from the world but from myself. I do not want to be awake. I do not want to feel. I want to be numb. I am in so much pain, and I wish I could cry it out, but I cannot even get myself to cry. All I know is that I wish I could sleep away the pain. If I am asleep, I do not have to feel a thing. When I am awake, all I want to do is binge and purge away my emotions, and that is precisely what has been happening since I lost my job. I feel like my heart has been stabbed with a knife, and the pain is just ongoing. I feel hopeless, purposeless, unseen, unheard, unwanted, and utterly disappointed. I pray for a stable, secure job where my talents can be seen and appreciated and well compensated. I want to wake up one morning and be proud of where I am in my life. I have faith that day will come eventually, but I need a double dose of patience until I make my dreams a reality. (Journal Entry, November 2023)

I was also starting to become hyper-aware that I was exhibiting signs of a developmental disorder called Asperger's syndrome, which is a high-functioning form of autism spectrum disorder (Rinaldi et al., 2021; Roy et al., 2009). I came to this conclusion because my symptoms were identical to another family member who had

been diagnosed with Asperger's syndrome. The symptoms that I aligned with included an inability to make eye contact with others, difficulty interacting in social situations, trouble with facial expressions such as smiling, hypersensitivity to sound, talking repetitively about a single topic and not being able to stop, anxiety, depression, disordered eating, hyperfocus on a single subject for an extended period, obsession with routines and rituals, and the inability to control my extreme honesty and bluntness (Rinaldi et al., 2021; Roy et al., 2009). I began conducting online research of peer-reviewed articles to confirm my Asperger's self-diagnosis (Roy et al., 2009), and I also discovered the high prevalence and link between eating disorders and autism spectrum disorders (Carton & Smith, 2013; Karjalainen et al., 2016; Kerr-Gaffney et al., 2020; Rastam, 2008). My cousin and OA sponsor, who was also diagnosed with autism, struggled with disordered eating patterns and anorexia nervosa. Additionally, my difficulty with interacting and relating to my peers during my elementary and junior years confirmed my suspicions of Asperger's further.

> My heart hurts, and I am in pain. I cannot stop crying. I feel I am grieving the loss of a person who is still alive. I miss my cousin. I miss our childhood. I miss seeing him happy, laughing, and talkative. I have come to realize that I am just like him. I feel his pain and anxiety. I think I suffer from autism just like he does. I have a heightened level of sensitivity to everything, especially sound. Although I am scared, I know my new therapist will help me figure myself out. I feel my anxiety and depression on a deeper level than I ever have. I am sad, angry, and moodier than ever. I am pushing away people whom I consider close friends. It is as if I am ending friendships before I have a chance to get hurt. Not eating feels safe.

> Emptiness feels safe. If I am empty, then I am in control. If I start eating, then I will not be able to stop. Restricting is the only solution. I fear the future of losing my guardians or not finding the right job to support myself and my family. My soul feels empty. I want to be happy but do not know how to be. I am hopeful, however. I know if I force myself to put in the work with my new therapist, I will get better. My first session was last Friday, and I already feel understood, heard, and acknowledged. I know I will be ok. (Journal Entry, December 2023)

Seeking Professional Help and Starting my Healing Process – December 2023

As I started putting the pieces together regarding my potential Asperger's diagnosis, I felt a sense of relief and wanted to shout it from the rooftops. I had found the root of my anxiety, depression, eating disorders, and societal anxiety. "*Oh my God! Bingo!"* I thought to myself. "*All this time, and I am just now figuring this out*." Although a medical professional did not officially diagnose me, I was convinced that my self-diagnosis of Asperger's syndrome was the root of my mental illness.

My curiosity to confirm my Asperger's self-diagnosis motivated me to seek professional counseling with a relationship and family therapist who specialized in autism spectrum disorders and attention deficit hyperactivity disorder. I expected to meet with my therapist and receive a diagnosis confirmation the same day. However, during the first therapy session, I did not expect to talk openly about my emotions so deeply, causing me to relive the pain of my past, which led to a mountain of tears that I was not expecting. At the end of the first therapy session, my therapist told me that I was in a complex case and in a lot of pain and highly recommended that I start seeing

him twice a week. I agreed to see him twice a week. However, I was more confused about my possible Asperger's diagnosis.

I started seeing my therapist twice a week as recommended and felt I could trust him immediately. It felt natural to talk to my therapist about my lifelong battles and the emotions associated with them, and I did not sense any judgment. I started looking forward to my therapy sessions as they helped me uncover the root of my behavioral patterns, which helped me understand the triggers connected to my anxiety and depression. Often, right before a therapy session, I would think to myself that I had nothing to talk about, and I would end up crying uncontrollably for the entire duration of my session.

Therapy Session Conversation – December 2023

Me: *"The most important thing to me is to be successful."*

Therapist: *"What does success mean to you?"*

Me: *"To be respected, heard, seen, acknowledged."*

Post Therapy Session Journal Reflections– January 2024

If I am innately a trusting individual who wears her heart on her sleeve, how do I practice self-control so that I do not end up hurt in professional and personal situations?

How do I set boundaries so I do not end up in similar situations in friendships or work?

How do I practice impulse control? How do I slow down my brain?

How can I accept what happened to me in my previous workplace without letting it destroy me?

> How can I practice self-compassion and stop blaming myself for losing my job? I need to start acknowledging that I am doing everything I can to find the right job, controlling what I can control, and accepting that some things are out of my control!
>
> How do I control the chest pains and anxiety which are constant? Feeling choked up and in pain. I wonder what it is like to not feel like this (Post Therapy Session Journal Reflections, January 2024)

I felt like I was starting to understand myself and the root of my mood disorders and eating-disordered behavior. However, I was still unsure whether I had Asperger's syndrome. Then, about six weeks into our sessions, I nervously asked my therapist if he thought I suffered from autism spectrum disorder or Asperger's syndrome.

Therapy Session Conversation – January 26, 2024

> Me: "Doctor, do you think I am on point with my self-diagnosis of autism/Asperger's?"
>
> Therapist: "*From my clinical perspective, you do not have autism*. *You have deep chronic depression and anxiety, which we must work on."*
>
> Me: *"But, I am sensitive to sound, cannot look anyone in the eyes when talking to them, and have no filter when conveying my thoughts."*
>
> Therapist: *"I know it can get confusing, but all your symptoms are connected to your chronic depression. You cannot look people in the eye because of the discomfort and insecurity you have within yourself. Moreover, your bluntness stems from the little girl inside who always had to defend herself."*

I was confused because I could have sworn that my suspicions of Asperger's were correct, but I was also relieved to have found the root of my issues because now I know exactly what to target to start my healing process.

Healing started from my first therapy session, as I started noticing significant patterns associated with my struggle with anxiety, depression, and eating disorders. I found that talking out loud about my struggles with a medical professional helped me make sense of my pain. My therapist helped me feel validated and took the edge off my self-blame, shame, and guilt about the painful occurrences throughout my lifetime. My eating disorder will always be a part of who I am, and I have accepted that I am a work in progress. However, as I continue to consciously work on myself with the self-awareness of my upbringing, culture, positive and negative experiences, triggers, and shortcomings, my attitude and approach toward tackling the hard road ahead will continue to evolve and progress, thus decreasing my self-destructive coping mechanism. I am proud of myself for continuing to persist thus far despite the challenges and obstacles that have crossed my path.

My Higher Power, Faith, and Humor as Key Components in My Persistence for Survival

I believe that faith is comparable to the air we breathe. We cannot see it, but we need it for survival. I have come very close to losing my faith in God and have almost given up the fight to survive, especially when I would contemplate taking my own life to escape my pain. However, the angel in my heart would tell me to stay strong, not to give up, and to keep going even if I do not know where I am headed. However, despite my life-altering and life-threatening struggles, I have always remained optimistic even when the future felt so out of reach. Faith has also helped me realize that sometimes I must sit with the pain and discomfort of my struggles, knowing that I have nothing to fear and that my higher power will always take care of me. This realization has provided a sense

of safety during my latest battle with chronic depression and hopelessness due to the loss of my job. No matter how difficult it is to keep my motivation, I force myself not to give up through positive self-talk and praying to my higher power for strength.

I have also incorporated humor and finding something to laugh about every day to get me through the toughest of life circumstances, including my anxiety, depression, and eating disorder battles. I have always believed that difficult situations do not always remain difficult. We must make the best of them by mustering up the courage and strength to power through the tough times and keep the faith even if we do not see the entire staircase. No matter how many times we must fall and get up to finally be ok, the key is never giving up on yourself. After all, I know my pain is connected to my purpose. In the words of Pablo Picasso, "*The meaning of life is to find your gift. The purpose of life is to give it away*."

Closure and Forgiveness

Another critical component in my persistence towards surviving the daily beast was achieving closure through forgiving myself and all others whose behavior had a profound negative impact on my lifelong battle with anxiety, depression, and eating disorders. I forgive myself for not always knowing how to care for my needs and show myself love and compassion, which I needed the most.

I forgive my classmates during my adolescent years for not consistently articulating themselves most lovingly, as they were still young and unaware of how their words and actions could have had lifelong effects on others. I forgive my guardians for not always knowing how to show me the love and care I needed or seeking mental health services during the onset of my eating disorders. My guardians did their best to

give me the best life and childhood possible while battling the stresses of life, putting food on the table, and a roof over my head. I also forgive my ex-partner for not being able to love me the way I deserved to be loved, as I have come to realize that "*hurt people, hurt people."* These realizations have allowed me to achieve closure through forgiveness, which I am grateful to have achieved.

Significant Threads

The analysis of my journals, snapshots, and written material data portrays my eating disorders (i.e., the beast, demon, and curse) as the symptom or self-defeating coping mechanism for a complex thread of significant patterns. As part of my supporting data, I also intended to conduct conversational-type interviews with five impactful associations, including my guardians, cousins, and OA sponsor. However, they did not meet my inclusion criterion for this study. My inclusion criterion required that participants be mentally and physically healthy, with a sharp memory of the past. However, all my intended impactful associations did not meet at least one required criterion.

The general misconception about eating disorders is the unhealthy obsession with the body and weight loss. However, an eating disorder is not about weight loss; instead, it is a deeper issue that is attached to anxiety and depression. In my case, anxiety and depression came about from a series of factors such as cultural expectations, feelings of rejection, obsession with perfection, seeking control through my eating disorders, and fighting to justify my existence.

The persistent pattern throughout my life is the battle to survive the beast. These patterns originated in my childhood and morphed into more complex patterns in my adolescence and adulthood. Furthermore, isolation became an unconscious defense

mechanism to the fear of rejection, affecting my personal and professional life. Lastly, my anxiety and depression fed my beast. They exacerbated my eating disorder to the point of insanity, where I often contemplated suicide to escape the pain caused by my demons.

I discovered significant threads during the thematic data analysis process, as recommended by Gibbs (2007; see Table 4) and Janesick (2011; see Table 5). As I wrote, I recognized recurring themes and emotional words. These trends would not have been apparent had I not gone through the highly reflexive process of analyzing my data. Also, working with a mental health expert while writing Chapter Four offered me an excellent opportunity to debate my ideas and reach a more certain conclusion. While the patterns I discovered were specific to my interpretation of my life experiences with anxiety, depression, and eating disorders, it is crucial to emphasize that the reader may encounter additional patterns and interpretations.

Growing Up Armenian American

My Armenian culture and growing up in a traditional Armenian household have had a significant influence on the origination and development of my comorbid anxiety, depression, and eating disorders. Based on my experiences with the Armenian culture, I have observed the extremely perfectionistic, judgmental, shame-based, and guilt-based tendencies, where I always feel rejected by my immediate and extended family members. Growing up in a traditional Armenian household with immigrant guardians who set high expectations for me, the pressure to be perfect was experienced starting at a very early age. There was always an internal feeling of "*I will never be good enough*," as my guardians compared me to other children my age, emphasizing my

shortcomings or how I could improve. During my childhood, I felt I had to be perfect, or else I would be rejected by my guardians. I also felt as though if I were myself, I would be rejected and unloved, therefore creating insecurity and confusion within my identity.

The Armenian community is competitive with one another, always striving to show off how perfect they are compared to others. In my case, what I noticed with my immediate family was my guardians working hard to show perfection to the world despite our imperfections. Hence, the idea of seeking mental health was a sign of imperfection and was highly discouraged and frowned upon within the Armenian community. For example, when I initially wanted to attend an OA meeting in 2006, my guardian would tell me to make sure I went to a location where nobody knew who I was, which instilled shame and guilt in me about my mental illness.

Rejection and the Obsession with My Body

Rejection from Others

Rejection is the main underlying thread behind the onset of my eating disorder. Expectations of perfection led to feelings of "not being wanted" by my guardians, which were instilled in me during my formative years. My lack of self-worth and low self-confidence led to feelings of rejection during my early school years. Hence, feelings of rejection led to self-isolation and extreme loneliness. Self-isolation translated into shame in who I was and wanting to hide as a form of self-defense and safety. However, loneliness led me to seek food as a source of comfort, for example, unconsciously consuming my classmates' snacks between grades one and three.

Feelings of shame, humiliation, and "not being wanted" also arose in my sixth-grade music class when a classmate shamed me for "*having big calves*" and the

inability to cross my legs, igniting the onset of my first eating disorder, anorexia nervosa. Craving acceptance from my peers triggered me to change my body by starving myself. At the time, I thought, "*If I drop weight, then they will accept me."* Also, restriction and hunger provided a sense of safety, control, power, and a feeling that "*everything will be all right if I just do not eat." Moreover,* eating provided a feeling of "*everything is out of control when I do eat.*" Hence, my obsession with my body began, as it offered a delusion that "*If I am skinny, then everyone will love me."*

This obsession with my body and the hope of being accepted morphed into bulimia nervosa and laxative abuse in my senior year of high school in 2003. The drastic weight loss resulting from my binging and purging brought about acceptance and praise from others and acceptance of myself. Moving forward, I dealt with feelings of rejection with bulimic behavior throughout higher education, personal relationships, and the pursuit of competitive endeavors such as bodybuilding, hence binging and purging my emotions for the past 20 years.

Rejection from Self

The most significant form of rejection came from myself daily. My obsession with perfection in all aspects of my daily life consumed me. From my performance in school to interactions with family, friends, and colleagues, and my workplace performance, I would overthink every detail of my everyday activities and abuse myself mentally for being imperfect. Binging and purging were a means of punishing myself for my imperfection. At the same time, the punishment relieved me of the delusion of making things perfect by purging out my imperfections. This obsession with perfection has followed me to the present day. There is no room for error.

Rejection of my Success, Imposter's Syndrome, and Competitive Perfectionism

No matter what I accomplished or how far I rose in life, I never felt enough. The more I accomplished, the more I needed to accomplish to feel whole. I always thought that if I pursued one more degree or credential, then that would be it, but it never was, and I will always need more to feel complete. Pursuing degree after degree, bodybuilding competition after bodybuilding competition, I never felt accomplished or worthy of praise. The rejection of my success also ties into my *imposter's syndrome* (Thomas & Bigatti, 2020), constantly feeling like a phony or a fraud and being highly paranoid as though at any moment everyone is going to figure out how "*stupid and incapable"* I am. Regarding my doctoral degree and finally being at the finish line, the feeling of "*still not having accomplished* anything" and "*Now what? What is next because I do not feel complete*" torments me daily. This self-devaluing and self-defeating mindset will always be a part of who I am, and with this awareness, the best I can do is give myself as much grace and forgiveness when I do not feel I will ever amount to anything in life.

Rejection of my success is also tied to my competitive perfectionism. I must be the best at everything to feel I am worth something. For instance, I am achieving my bodybuilding goals and education, but I still think it will never be enough. My harsh critical self-judgment of not being perfect, such as the outcome of my bodybuilding competitions where I did not place on top, led to suicidal ideations. I am naturally a competitive perfectionist, a part of my identity that I cannot eliminate. Hence, I will always be hard on myself if I am less than perfect in any aspect of my life, including success in work, school, bodybuilding, and being the ideal daughter for my guardians.

Being a competitive perfectionist will push you to higher places; the dilemma is to remain loving and forgiving and eliminate self-destructive coping mechanisms as much as possible. This competitive perfectionistic aspect of myself is one of the most brutal battles to tackle within myself.

Justification of my Existence and Perfection

The obsession with perfection has been a continuous thread in the origination and development of my eating disorders. I constantly pursued this everlasting pursuit to "*prove myself*" to everyone. The notion of "*proving myself*" stemmed from feelings of imperfection, rejection, and continually feeling less than everyone else, which led to heightened levels of anxiety, which exacerbated my eating disorder. Hence, I was not only in the constant pursuit of justifying my existence but also in the constant pursuit of attaining an unrealistic level of perfection. The obsession with my body and weight was the first manifestation of my need to be seen, heard, and acknowledged. "*If I am skinny and beautiful, everyone will see how amazing I am.*" However, the question to ask myself is, "*If the world accepts me, am I capable of accepting myself*?" Moreover, my answer is, *"Not at this point. Maybe not ever."*

Justification of Existence and the Urge to Argue with Others

My need to justify my identity and existence manifests in my lack of patience and uncontrollable urge to argue with unknowledgeable, ignorant, and unbright individuals in familial, personal, and professional environments to prove them wrong. Family and close friends may be able to tolerate my need to exert my opinion and be argumentative; however, this attitude has created enemies in the workplace, especially with those individuals in higher positions who have stripped me of my work and

livelihood, such as termination from my recent position due to being outspoken and the constant need to prove myself. However, I am contemplating whether my bluntness and straightforwardness are innate or arose from my need to defend my existence throughout my childhood and adolescence. I often joke and connect my bluntness to my astrological sign of being a Sagittarius, as one of the main characteristics of being a Sagittarius is being overly straightforward and sometimes tactless (Benda, 2019).

The Beast, Demon, Curse – My Eating Disorders

Once you have an eating disorder, you will always have an eating disorder, which is why I named my trilogy of eating disorders "*The beast, demon, and curse*." The underlying need to feel powerful and in control of every aspect of my life and ensure that it was nothing less than perfect manifested itself through the all-encompassing beast of my eating disorders. A lack of perfection felt suffocating, hence triggering my anxiety, which provoked my binge and purge tendencies to relieve the discomfort of my anxiety. Being in a constant state of denial that there is no such thing as perfection and that some things are out of my control drove me to control my life through my maladaptive coping mechanisms, including anorexia, bulimia, and binge eating disorders. However, my need to feel powerful and in control through my eating disorders ended up controlling me by draining me of my power. Often, I wish I felt the same euphoria and power I felt the first time I purged my meal; however, the demons of the disease still convince me to keep chasing the feeling that I know I will never feel again.

I have always described my bulimia nervosa as "*the curse*" that will torment me for the rest of my life. Once you know what to do to get rid of the food, the intrusive

thoughts will continue to torture you until you act upon them. When my cousin introduced bulimia nervosa to me during my senior year of high school, what I thought was the answer to my prayers was the curse that I would not wish upon my worst enemy. When the bulimia demons take over my body, I feel powerless, possessed, and helpless beyond control. The anguish of the disease has driven me to the brink of insanity, convincing me to end my life because I was imperfect and worthless and had nothing to offer the world. I am incredibly grateful to have not fallen victim to the extreme darkness of the disease and grateful to be alive today. However, the daily fear of losing control and falling victim to my bulimic tendencies leaves me mentally exhausted. Hence, bulimia is the beast that slowly sucks the life out of you. Furthermore, the comorbidity of anxiety and depression increases the power of the beast, making me feel increasingly helpless with each passing day.

The Effects of my Mental Illness on my Familial, Personal, and Professional Relationships

Isolation, Safety, and Rejecting Others as a Defense Mechanism

I was not fully conscious of the effects of my addiction and trauma on our familial, personal, and professional relationships. I was also oblivious that I unconsciously sabotaged relationships and behaviors I could not control. The feeling of being misunderstood and rejected has transcended every aspect of my life. The feeling of not fitting in anywhere, including with my immediate and extended families, Armenian culture, and personal and professional relationships. The sense of awkwardness, fear of getting hurt, and feeling out of place triggers my anxiety and my unconscious need to

become cold and distant, isolate myself, and sabotage relationships as a defense mechanism. Therefore, this prevents me from forming close bonds with others.

Lack of Patience and Compassion for the Imperfections of Others

I have also found that my lack of patience and self-compassion affects my ability to have patience and compassion for others. I find it extremely challenging to tolerate the mistreatment and imperfections of others, not only in their association with me but also in terms of their life choices as well. Therefore, pushing them away by abruptly breaking off friendships and relationships mimics my harsh stance against imperfection towards myself. Also, breaking off connections is a means of protecting myself from future hurt. It is like an "*I will get rid of you before you get rid of me*" attitude.

Lack of Impulse Control Leads to Dire Consequences

Moreover, most importantly, my lack of impulse control stemming from my disease also ties into my behavior in familial, personal, and professional environments. Based on my ongoing battle with bulimia and binge eating disorder, I can safely conclude that it is the lack of impulse control that compels me to give in to the intense urge to relieve my emotions through maladaptive coping mechanisms such as binging and purging. My mind is often working so fast that I do not take the time to sit with my emotions but act on impulse to alleviate my discomfort. My uncontrollable urge to argue or exude my raw thoughts and feelings stemming from anger and frustration often ends in unfavorable consequences, such as losing my job in November of 2023. As mentioned, family and friends may unconditionally tolerate my compulsive outbursts. However, such behavior is deemed detrimental in professional and competitive environments.

Surviving the Daily Beast – Persistence, Determination, Resilience, and Hope

My unrelenting persistence in surviving my constant daily battle with anxiety, depression, and eating disorders despite my imperfect coping attempts identifies my innate power, which I thought never existed. However, my issue throughout my battles was seeking perfection in my adaptive coping endeavors. My adaptive coping attempt included following a strict meal plan, weighing and measuring my food, seeking support from my OA sponsor, and attending therapy sessions.

My definition of progress and recovery in my eating disorder battles was this aspect of halting my self-destructive habits cold turkey, and anything outside of being perfect was a cause to destroy or punish myself again. I never gave myself credit for my small wins and persistent attempts to find healing in my journey, which I feel ties into my obsession with perfection and rejection of myself. Through my journey, I have discovered that abstinence and recovery are not black and white, and any progress toward recovery is still progress. Even after accepting this concept, anything short of perfection brings me down mentally.

Final Thoughts

My biggest goal in life has been to treat myself with the love and respect I deserve; however, this is the most challenging goal. My all-or-nothing approach to life, my goals, and my lack of flexibility are parts of myself that I am trying to work on. I know that inflexibility and giving myself grace is a big part of my recovery process. I am working on the notion of "*there is no such thing as perfect*" and rewarding myself for my small wins. My mental illness is a big part of my identity and will always be a part of who

I am. However, I know that with time, patience, persistence, and determination, the pain of my battles will slowly dissipate.

Chapter 5: Conclusions/Discussion

Problem Statement

According to Tagay et al. (2013), over 97% of individuals hospitalized for an eating disorder also have a concurrent mood problem, such as major depressive disorder or anxiety disorder, which may include obsessive-compulsive disorder, post-traumatic stress disorder, and substance abuse disorder. According to Garcia et al. (2020), 15% of young women in middle- to high-income nations suffer from eating disorders. Girls and women between the ages of 12 and 25 have common daily issues related to the mental, physical, and emotional repercussions of this disease, which may potentially be life-threatening (Garcia et al., 2020).

Statistics on eating disorders are crucial since they are among the most fatal mental diseases, causing 10,200 fatalities annually (Giachin, 2023; Smink et al., 2012). Despite the availability of eating disorder therapy from psychologists, psychiatrists, and treatment facilities, insurance companies do not sufficiently pay the price of such treatment (Agh et al., 2015; Isserlin et al., 2020; Toulany et al., 2015). Women between the ages of 12 and 25 are more likely to revert to self-destructive and life-threatening behaviors related to anxiety, depression, and eating disorders if they lack appropriate treatment alternatives or coping strategies (Garcia et al., 2020). It is essential to investigate how young women cope with and address the life-threatening impacts of anxiety, depression, and eating disorders.

Researchers have found that anxiety, depression, and eating disorders often take place simultaneously. Still, there is insufficient research on practical examples of inspiration and motivation to help young girls and women with these issues.

Researchers have long advocated for more investigation into the co-occurrence of GAD, depression, and eating disorders since these may lead to life-threatening conditions for women (Fichter & Quadflieg, 2016; Smink et al., 2012; Tagay et al., 2013). Offering tangible examples of coping strategies may empower females aged 12 to 25 to develop the skills, drive, and resilience needed to address the emergence of severe challenges such as anxiety, depression, and eating disorders.

Purpose Statement and Research Questions

This autoethnographic study aims to investigate whether the researcher's everyday experiences with anxiety, depression, and eating disorders, as well as her self-care practices, may serve as catalysts for personal and communal transformation. Dealing with the coexistence of anxiety, depression, and eating disorders involves struggles such as malnutrition, binge eating, and harmful behaviors, including self-induced vomiting, laxative misuse, and excessive exercise. Self-care behaviors include journaling, daily exercise, adhering to a designated food plan, participating in peer support organizations like Overeaters Anonymous (OA), and maintaining frequent contact with an OA sponsor.

The research questions that this study aimed to answer include the following:

- *RQ1:* What are the daily battles and triumphs that arise with the comorbidity of anxiety, depression, and eating disorders?
- *RQ 2:* In what ways (if any) have these daily battles and triumphs manifested in different areas of my personal and professional life?
- *RQ 3:* How might the battles and triumphs experienced with the comorbidity of anxiety, depression, and eating disorders contribute to becoming a change agent

in my life, other individuals struggling with similar life challenges, and future researchers?

Overview of Methodology

According to Wall (2008), autoethnography is a qualitative research approach that stresses individual experiences to deepen social knowledge. Autoethnographers strive to connect the past and the present using personal, political, social, cultural, and transpersonal methods (Chapman-Clarke, 2016). The literary style in question is known as self-narrative, characterized by its genuine, fervent, and emotive qualities where the author's complete vulnerability is crucial (Ellis et al., 2011). I decided to demonstrate extreme vulnerability in my autoethnography by sharing my innermost thoughts, self-destructive behaviors, and patterns of self-care that led to abstaining from these behaviors. With this complete exposure, I hope to inspire, motivate, and offer hope to others who can relate to my experiences. The researcher aims to fill the gap in research on individual processes by offering a detailed, personal viewpoint.

Initially, I had planned on interviewing about five impactful associations who witnessed and had a solid understanding of my journey with anxiety, depression, and eating disorders. However, the impactful associations I had in mind did not meet my main inclusion criteria of being mentally and physically healthy to provide reliable information. Therefore, I was the only participant in this autoethnography, utilizing a vast combination of data collection resources such as 78 photographs, 28 personal journal entries, and 21 written material data, including yearbook messages, text message correspondences, email correspondences, social media posts, a meal plan, and memory of conversations.

The theme analysis frameworks of Gibbs (2007) and Janesick (2011) were utilized to analyze the data (see Tables 4 & 5). Thematic analysis is primarily an inductive qualitative data analysis technique that systematically discovers patterns or themes in a qualitative dataset (Joffe & Yardley, 2004, p.65). After the data-collecting phase, inductive analysis was used to identify patterns, themes, and categories from the data (i.e., photographs, personal journal entries, yearbook messages, text message and email correspondences, social media posts, meal plans, and significant conversations).

Findings

After examining my personal diaries, photos, social media postings, written material data, and significant conversations, I have concluded that my eating disorders—which I also referred to as the beast, demon, or curse—are a symptom or self-defeating coping strategy to a complicated web of noteworthy patterns. Many people mistakenly believe that eating disorders include an excessive preoccupation with the body and losing weight. An eating disorder is not primarily focused on weight reduction but is instead linked to underlying issues such as depression and anxiety. A multitude of reasons, including cultural expectations, rejection from myself and others, a preoccupation with perfection, seeking control by controlling my food consumption, and the need to defend my existence, contributed to my battle with depression and anxiety.

However, my life's most significant recurring theme has been the struggle to survive the beast. The patterns developed in my youth and evolved into more intricate forms over adolescence and adulthood. Isolation served as an unconscious defensive mechanism against the dread of rejection, impacting my personal and professional life. Finally, my anxiety and depression nourished my inner turmoil. They escalated my

eating disorder to the point of extreme mental distress, leading me to contemplate suicide to escape the suffering caused by my inner struggles.

Conclusions and Discussion of Research Questions

RQ 1 – What are the daily battles and triumphs that arise with the comorbidity of anxiety, depression, and eating disorders?

Conclusion 1

One of the daily battles with my comorbidity experiences is the struggle to survive the sense of loss of control through maladaptive perfectionism. The struggle includes giving into the beast's self-destructive coping mechanisms, including extreme calorie restriction, binging and purging, laxative abuse, and binge eating. My eating disorder is attributed to the lack of control and sense of security in daily life struggles. My eating disorders felt like an internal tug-of-war and a minute-to-minute disease with the presence of the constant and ever-present beast convincing me to engage in self-destructive behavior. I always ask myself, "*How do I give up food when I need food to survive"?* Food is essential for survival as opposed to alcohol or drugs, making it incredibly challenging for those dealing with eating disorders.

The struggle to survive the sense of loss of control through maladaptive perfectionistic practices such as anorexia, bulimia, and binge eating disorder has been reported by several researchers (Bills et al., 2023; Campbell & Peebles, 2014; Culbert et al., 2015; Rutter-Eley et al., 2020; Petersson et al., 2018), but none of these researchers have gone into the extent of detail provided in the current study, as most of the recent studies consist of predominantly quantitative research. Qualitative studies supporting the comorbidity struggles of anxiety, depression, and eating disorders are scarce. Moghimi et al. (2022), Salvia et al. (2023), and Turner et al. (2015) provide first-hand narratives of patient experiences with binge eating disorder treatment; there is a

definite lack of qualitative research, particularly first-hand accounts that delve deeper into the intricacy of the comorbidity struggles directly from the participant. Furthermore, most qualitative and quantitive studies are not long-term, and no researcher has provided an in-depth and descriptive personal narrative over a lifetime, such as the current autoethnography.

Conclusion 2

Another battle that arose for me and my comorbidity battle with anxiety, depression, and eating disorders includes the sociocultural factors (i.e., culture and society) surrounding me in the different phases of my life. The pressure to be perfect in my Armenian culture and household instilled the fear of being rejected if I was not the ideal child or failed to meet the high expectations set forth by my guardians. Additionally, not fitting in at the Armenian private school I attended left me with additional feelings of loneliness and rejection, which led to unconsciously consuming my classmate's snacks to cope with my emotions. Lastly, societal influences, including social media, living in a male-dominated society where women are expected to be in shape, and additional psychological pressure to meet societal standards to be accepted.

The negative impact of sociocultural factors, including culture, social media, school, and the environment we live in, has been confirmed by several researchers (Alfalahi et al., 2021; Culbert et al., 2015; Dion et al., 2014; Marks et al., 2020; Vannucci & Ohanessian, 2017). Alfalahi et al. (2021) confirmed that low self-esteem, low sense of self-worth, poor body image, chronic depression, and anxiety disorders were prevalent in Armenians (Alfalahi et al., 2021). However, studies confirming this finding are scarce. Further, Vannucci & Ohanessian (2017) found that peer rejection leads to long-term

anxiety and depression, while Dion et al. (2014) found that 80% of body dissatisfaction linked to a sense of rejection in adolescents leads to long-term anxiety-related eating disorders. The influence of social media on body image has also been explored. Thin idealization and maintaining a thin and athletic figure in hopes of finding acceptance from the self and others are linked to eating-disordered tendencies (Marks et al., 2020; Vannucci & Ohanessian, 2017). Despite the vast evidence confirming the adverse effects of culture and society on the comorbidity of anxiety, depression, and eating disorders, qualitative, in-depth, first-person narratives, such as the proposed autoethnography, are extremely rare.

Conclusion 3

My relentless pursuit, motivation, and persistence to continuously seek healing with my eating disorder stems from not only recognizing that I need help but also my recognition of the personal significance and importance of the change. I have always had the awareness and recognition that my self-destructive behavior is slowly killing me, and by taking accountability for my maladaptive coping mechanisms, I was always willing to take steps to make a change; I just did not realize how difficult making the change would be. Without the recognition of my weaknesses, I would not have been able to consciously assist myself in seeking lasting relief and enlist the assistance of others to assist me in conquering my mental health challenges. The unpleasant facets of my identity could not have been revealed had I not accepted responsibility for my deficiencies. Although I continue to grapple with the co-occurrence of anxiety, depression, and eating disorders, these challenges have yielded successes, such as phases of abstinence from self-destructive practices via organized meal plans and

structured tactics. Achieving a sense of control and security by strict adherence to a food program resulted in a reduction in anxiety levels and, consequently, a mitigation of co-occurring maladaptive behaviors. Furthermore, I deliberately pursued assistance from peer support services, including the 12-step support organization Overeaters Anonymous. I established a relationship with a sponsor, which provided me with a sense of support and validation during my struggles. Lastly, engaging in both professional and spiritual treatment assisted me in comprehending the origins of my triggers and equipped me with the necessary strategies to control the beast.

Vansteenkiste et al.'s (2005) findings in their study exploring the motivation to change in eating disorder patients suggest that intrinsic motivation and the willingness to change are crucial in seeking help and support, which aligns with the findings of my study. However, Vansteenkiste et al. (2005) also suggest that the extent to which an individual internalizes the change is a better indicator of the rate of change than being motivated. Van Der Kaap-Deeder et al. (2014) have also confirmed that autonomous motivation leads to decreased eating disorder symptoms in patients with anorexia nervosa and bulimia nervosa. According to the self-determination theory, individuals must be motivated to change and gradually become accepting and open to change (Ryan et al., 2010; Vansteenkiste et al., 2005). If an individual has entirely accepted the personal significance of the change, they are more likely to indicate that they are willing to do it (Deci & Ryan, 2000). As demonstrated by previous studies, numerous benefits can be obtained from pursuing change self-endorsed rather than under extreme pressure (Mansour et al., 2012; Zuroff et al., 2007; Zeldman et al., 2004). These benefits include reduced depressive symptomatology in patients with depression (Zuroff

et al., 2007), improved treatment adherence (Zeldman et al., 2004), and decreased body and eating obsession in outpatients with bulimia nervosa (Mansour et al., 2012). Although there is a wealth of research supporting the beneficial effects of self-endorsed motivation on the co-occurrence of eating disorders, anxiety, and depression, qualitative, in-depth first-person narratives—such as my current autoethnography—are incredibly uncommon.

Conclusion 4

Another triumph that I experienced in my comorbidity experiences is the persistence to survive, leading to post-traumatic growth and the gradual development of my resilience over time, which I could not recognize as I was going through my battles. Resilience is adapting well to trauma, adversity, tragedy, and high-stress situations (Bonanno, 2004). Resilience demonstrates the capacity to sustain a steady balance and rise from challenges (Bozikas & Parlapani, 2016). At the same time, post-traumatic growth is a positive emotional and psychological transformation that may occur after experiencing a traumatic and challenging incident (Jayawickreme et al., 2020). I have always thought, “I might fall, but I will get back up.” “If I get punched on my left cheek, I will give them my right cheek.” My younger self could not have recognized the significance of my “*I will never give up*” mindset because I did not have enough experience with the disease to realize my positive patterns. My shame only allowed me to see the negatives within myself. However, I always had internal stubbornness to conquer my torturous mental health demons, no matter how long it took.

The ever-evolving resilience that I have gained and continue to gain is an aspect of my comorbidity battles that I consider a triumph. In a qualitative study exploring ten

female eating disorder patients and the development of their resilience in eating disorder recovery, Hayas et al. (2015) confirmed growth following eating disorder recovery. Researchers found that profound discontent with life was the pivotal moment where resilience started building, accompanied by acceptance and hope, an intense desire to tackle the eating disorder, proactively looking for social support, acquiring self-awareness and knowledge about eating disorders, improving overall well-being, demonstrating resilience, embarking on new endeavors, and focusing on the present moment (Hayas et al., 2015). Several qualitative and quantitative studies have confirmed a substantial relationship between resilience and mental illness (Lee et al., 2021; Reupert et al., 2020). Findings suggest that individuals who suffer from mental disorders tend to have lower levels of resilience (Lee et al., 2021; Reupert et al., 2020). In contrast, a high degree of resilience may help avoid the onset of a disease or reduce its severity (Lee et al., 2021). Hence, experiencing several traumatic situations significantly reduces resilience levels, decreasing the likelihood of developing mental illnesses, including depression and suicidal tendencies (Lee et al., 2021).

Regarding post-traumatic growth after eating disorder recovery, a quantitative study determined significant posttraumatic development in areas such as interpersonal relationships, inner strength, potential for new opportunities, gratitude for life, and spiritual transformation (Eaton & Phillips, 2024). Studies have also confirmed that eating disorder treatment may allow an individual to develop an awareness of oneself and undergo personal, spiritual, and psychological transformation (Bardone-Cone et al., 2018; Wetzler et al., 2020). While there are a significant number of qualitative and quantitative studies substantiating the connection between the development of

resilience and post-traumatic growth after eating disorder recovery, a gap exists with first-hand personal narratives portraying an individual's experiences with the comorbidity of anxiety, depression, and eating disorders over time.

Battles and Triumphs

Based on my conclusions regarding my daily battles and triumphs that come with the comorbidity of anxiety, depression, and eating disorders, it is essential to note that my battles and triumphs overlap. Considering the post-traumatic growth and resilience that I built because of my battles, I consider my adversity a gift. The trials and tribulations of my comorbidity battles helped me recognize how I can survive even the most life-threatening circumstances through mental strength, determination, and grit. I now realize my strength because I proved I can achieve the most unattainable goal through sheer determination and resilience. Although I am a work in progress, I am proud to have come this far in my journey without giving up on myself. Twenty years ago, I would never have predicted the brutally dark periods and evolution I experienced because of my mental illness. I am grateful for my struggles because they made me who I am today. I look forward to the future as I continue to grow through the self-care practices I have implemented for myself.

RQ 2 - In what ways (if any) have these daily battles and triumphs manifested in different areas of my personal and professional life?

Conclusion 1

My daily battles have caused me to develop social anxiety, which compels me to distance myself from family, friends, and romantic partners as a form of self-defense against rejection. Isolation translates into safety, avoiding an escalation of anxiety and

judgment. However, distancing myself from my close circle leads me to miss out on significant and memorable events, causing a sense of regret in the long run. While the positive aspect of distancing myself has helped me avoid potentially anxiety-provoking situations with family and friends, the negative part of isolation is the sadness that comes over me when I think about the holidays, birthdays, and significant moments I have missed because of my fears and anxieties. Even amid my physical presence at essential functions, I have difficulty being fully present and engaged in the moment. The only thing consuming my mind is escaping the social situation so that I can go home and binge and purge my feelings of low self-worth, shame, guilt, and anxieties triggered by self-consciousness. Isolation made me doubly vulnerable as I recognized something that was causing me pain, so I intentionally isolated myself. As a result, I caused myself pain and regret, missing out on important life moments I could never get back.

Several researchers have explored social isolation and difficulty with social functioning in individuals with eating disorders. Social functioning pertains to an individual's capacity to effectively engage with their surroundings, including employment, education, social activities, and connections with partners and family (Patel et al., 2016). Studies show that individuals with eating disorders have smaller social networks and struggle with interactions with others (Doris et al., 2014). Difficulty in social interactions is due to unusual emotional and social behavior linked to challenges in recognizing and controlling emotions in social situations (Harrison et al., 2010; Tchanturia et al., 2012). Regarding anorexia nervosa, Råstam et al. (2003), Cardi et al., 2018, and Muehlenkamp et al. (2019) found a significant correlation between social interaction difficulties and anorexia nervosa. Similarly, researchers have also

found a link between social interaction challenges and individuals with bulimia nervosa (Cardi et al., 2018; Monteleone et al., 2020; Muehlenkamp et al., 2019). Given the large body of qualitative and quantitative research supporting the connection between isolation and social functioning and eating disorders, there is still a relative lack of first-hand personal narratives like our proposed autoethnography depicting an individual's experiences with the co-occurrence of anxiety, depression, and eating disorders over time.

Conclusion 2

My daily battles, such as lack of impulse control and difficulty controlling my emotions, have affected my personal and professional relationships. For instance, I have found that my intense emotions have significantly impacted my choices, sometimes leading to adverse outcomes, for instance, the loss of my job in November of 2023. The adverse outcomes resulting in losing my livelihood have hindered my long-term objectives of growing and prospering in a corporate environment and have hurt my overall welfare. My inability to regulate my emotions has compelled me to behave in ways that are out of character in personal and professional environments, along with making impulsive decisions that prove to be detrimental in the long run. My lack of sound decision-making skills leads to me overreacting and acting without considering the long-term consequences. For example, I tend to speak my mind bluntly, which has caused disagreements between my family and friends. Moreover, I argue my point incessantly, especially when I feel rejected, to justify my existence. While family and friends may forgive my actions, my professional life has been adversely affected, for instance, losing my job as a leader in November of 2023. My lack of impulse control has

led to my inability to control my emotions in leadership positions. Also, my lack of impulse control leads me to trust untrustworthy colleagues, which has caused my demise with a professional organization.

Several quantitative research studies have investigated the connection between emotional intelligence and eating disorders (Foye et al., 2018; Peláez-Fernández et al., 2021; Markey & Wal, 2007; Zhang et al., 2019; Zysberg & Tell, 2013). Being emotionally intelligent means having the capacity to control your own emotions and comprehend the emotions of others around you (Zhang et al., 2019). The five essential components of emotional intelligence are self-regulation, self-awareness, social skills, empathy, and motivation (Zhang et al., 2019).

Researchers have found that individuals with eating disorders such as binge eating disorder (Zhang et al., 2019) and bulimia nervosa (Markey & Wal, 2007) had low emotional intelligence. Research also suggests that individuals with high emotional intelligence exhibit lower eating disorder symptoms than individuals with lower emotional intelligence, who may struggle with emotional regulation and be more prone to experiencing painful emotions that trigger binge eating episodes (Foye et al., 2018). Lastly, researchers have found a link between increased self-esteem and decreased anxiety with increased emotional intelligence and decreased eating disorder symptoms (Palalez-Fernandez et al., 2021), further confirming the strong connection between eating disorders, emotional intelligence, and lack of impulse control and emotion regulation. Like other eating disorder studies, there is a vast array of quantitative data verifying the connection between low emotional intelligence and high eating disorder

symptomology. However, a severe lack of long-term first-hand qualitative data supports these quantitative studies.

Conclusion 3

Refraining from self-destructive behavior allows me to be more present and involved in my relationships with loved ones. Additionally, when I prioritize self-love, I am better able to receive love from those around me. Although I tend to feel rejected, practicing self-love helps me feel less defensive, less anxious, and more open in my interactions with others. Additionally, my periods of self-care have also resulted in feeling more at peace in professional environments. When I refrain from binging and purging, my anxiety and depression decrease, hence leading to increased confidence, controlled impulses, increased patience, and decreased sensitivity to rejection in the workplace. Lack of rejection eliminates arguments, confrontation, and unnecessary mental and interpersonal conflict in the workplace.

Researchers have discovered that decreased eating disorder symptomology improves the quality of life (Touyz et al., 2013), decreases social impairment (Byrne et al., 2017), and improves interpersonal relationships and social functioning (Byrne et al., 2017); Schmidt et al., 2013; Touyz et al., 2013; Zeeck et al.,2018), which aligns with the findings of my autoethnographic study. These findings make sense, as individuals with anxiety disorders are known to have social and cognitive functionality issues (Dymond et al., 2015). Considering that anxiety is considered one of the core symptoms of eating disorder symptomology, it can be assumed that anxiety decreases as eating disorder symptomology decreases (Martín et al., 2019). Although there is a wealth of evidence to confirm the connection between decreased eating disorder symptomology and

increased social functioning, long-term personal narratives confirming this phenomenon are lacking.

RQ 3 - How might the battles and triumphs experienced with the comorbidity of anxiety, depression, and eating disorders contribute to becoming a change agent in my life, other individuals struggling with similar life challenges, and future researchers?

Conclusion 1

The battles and triumphs experienced with my comorbidity with anxiety, depression, and eating disorders contribute to becoming a change agent in my life by helping me realize and gain awareness of my character defects, strengths, weaknesses, motivators, triggers, and self-defeating patterns in my behavior in different situations. The act of writing, seeing the words on the page, and recognizing trends helps me understand my triggers, helps challenge my shame and guilt following my self-destructive behaviors, and helps me show myself compassion by helping me repeat healthier coping skills that help me stay abstinent from self-destructive behavior and delay self-defeating urges. Understanding my triggers and controlling the emotions attached to those triggers also help me build emotional intelligence, improving my personal and professional relationships. Furthermore, by acknowledging that progress is not black and white and that the perfect recovery does not exist, learning to celebrate the small wins in my day-to-day battles with the beast, and, most importantly, understanding the power of persistence and consistency as the key to long-term success with my comorbidity experiences. Hence, my autoethnography illuminated the

darkness in my mind and heart, alleviating the impacts of my negative internalized emotions on my overall quality of life.

The internal healing and transformative experiences through my narrative, such as gaining awareness of my character defects, strengths, weaknesses, motivators, triggers, and self-defeating patterns, make sense, as autoethnography can provoke individualistic transformation and healing after traumatic occurrences (Custer, 2022). Ellis and Bochner (2006) confirm that autoethnography is therapeutic because it heals a person's identity's emotional, mental, and spiritual elements. Personal narratives also encourage individuals to confront their fears and build resilience in difficult situations (Custer, 2014; Haynes, 2006). Lastly, autoethnography serves as both a weapon and a defense mechanism, eliminating the negative influences that create darkness and safeguarding the soul and psyche from further damage (Raab, 2015).

> Writing and telling a story about myself opened old wounds and manifested. The energy needed to heal them completely. I had to be available to the past as I wrote about pedophilia, sexual, emotional, and psychological abuse, and discrimination in the form of homophobia. (Custer 2014, p. 9)

Conclusion 2

The battles and triumphs I experienced with the comorbidity of anxiety, depression, and eating disorders have the potential to contribute to positive change in other individuals with similar battles by supporting, motivating, challenging, and facilitating adaptive coping mechanisms in hopes of alleviating their struggles (Custer, 2022). In my case, I would regularly search for experiences like my battles to find hope, support, motivation, and inspiration to make my change. My battles and triumphs with

my maladaptive coping mechanisms can help to provide hope, comfort, and optimism toward positive change in individuals who are ready to make a change.

Several researchers have emphasized autoethnography's transforming and therapeutic potential on the reader (Denzin, 2006; Jones et al., 2013; Spry, 2017). Personal narratives are described as a magical transformation involving a powerful, expressive interaction between the author and their audience, which can evoke feelings, inspire action, and elicit strong emotions (Denzin, 2006; Jones et al., 2013; Spry, 2017). In this sense, transformation refers to the rehabilitative process of transforming psychological, emotional, and spiritual views on events and memories to facilitate closure and healing (Custer, 2014). This interaction also allows the reader to follow the author or take the initiative toward positive change (Denzin, 2006; Jones et al., 2013; Spry, 2017). Like in other forms of storytelling, relatability and connection to the author's story may provoke enlightening experiences in the reader (Wright, 2008). Hence, narratives have a lasting impact on the minds of individuals by creating connections with other narratives and experiences. This network of connections strengthens and reinforces the collective (Custer, 2022; Wright, 2008).

Conclusion 3

The battles and triumphs experienced with the comorbidity of anxiety, depression, and eating disorders contribute to becoming a change agent for future researchers by encouraging them to conduct their own qualitative and autoethnographic studies based on their unique perspectives. From a personal standpoint, exposing the most vulnerable aspects of myself was scary and intimidating because telling my story to a collective audience who are unfamiliar with eating disorder tendencies can subject

me to criticism and judgment. Therefore, my story can open the door and give strength to all who are fearful to share their story, serving as a source of inspiration to others. Although individuals battling the same battles experience similar struggles, everyone's battle is unique. Furthermore, mental health research regarding Armenian American adolescents and adults is exceptionally scarce, and further studies are warranted to fill this gap. The challenges and successes of my comorbidity experiences can help develop hypotheses for possible quantitative research (Creswell, 2009).

Qualitative research is experimental, aids in understanding behaviors and motivations, and substantiates the rationale behind further research (Creswell, 2009; Creswell, 2013). It offers profound insights into a problem and aids in generating concepts or hypotheses for additional quantitative analysis (Kelle, 2008). Hence, qualitative and quantitative research are complementary (Creswell, 2009; Creswell, 2013). While quantitative research is ideal for discovering connections between variables, testing hypotheses, and assessing a broad population's views, beliefs, and behaviors, qualitative research effectively generates hypotheses and theories. It explains decision-making and communication processes (Verhoef & Casebeer, 1997). Quantitative research provides verifiable and trustworthy result data that may be applied to broader populations, whereas qualitative research offers thorough and reliable data collection based on individuals' viewpoints and perceptions (Verhoef & Casebeer, 1997). Given these complementary attributes, the current study provides fruitful ground for quantitative research exploring the comorbidity experiences of girls and women struggling with anxiety, depression, and eating disorders.

Impact of My Study on the Armenian Culture

The current autoethnography is the first study to provide a raw, first-person perspective regarding the negative mental health impact of growing up in a traditional Armenian household in a highly Americanized society in the United States. Based on my experiences in the Armenian community, Armenian Americans are bombarded with excessive shame and guilt surrounding self-destructive behavior and mental health as they attempt to maintain the unrealistic notion of perfectionism. Additionally, the negative stigma of seeking professional help negatively impacts the Armenian Americans in the long run who struggle with mental health issues. My study sheds light on the imperfections and the “skeletons in the closet” that the Armenians, such as myself, attempt to conceal. My first-person perspective as an Armenian American attempting to conform to a highly Americanized society while maintaining cultural norms can have an overall therapeutic and healing effect on all Armenian Americans who can relate in some way to my experience. Moreover, the revelations in my study can provide a blueprint of how the future generation of Armenian parents can counteract mental health battles in their children by understanding the value of psychotherapy on youth mental health, as evidenced in my autoethnography.

Connections Between The Self-Determination Theory & My Autoethnography

The current autoethnography portrays clear examples of the self-determination theory from a first-person perspective. The Self-Determination Theory (SDT) investigates people's motivation and psychological needs for competence, autonomy, and relatedness (Deci & Ryan, 2000). Researchers found that participating in autonomous regulation, which involves acting based on one's own decisions or choices, improves one's general well-being (Deci & Ryan, 2000). Furthermore, Deci and Ryan

(2000) suggest that activities with greater self-endorsement and less external control may lead to higher mental well-being, perseverance, positive affect, and personal commitment.

Aspects of the self-determination theory are crucial in my persistence to overcome my lifelong comorbidity battles. My decision to seek professional and spiritual help was due to my awareness of my self-destructive habits and the negative toll that these maladaptive coping mechanisms took on my physical and mental health. My internal motivation to allow others to help me overcome my mental health demons ties into the importance of autonomous regulation in achieving one's goals. Had I been forced to seek help, I would not have persisted as long as I have. Making my own life decisions is extremely important, and feedback from my friends and family will deter me from pursuing their advice. Furthermore, once I set my mind to any goal, I usually follow through until completion because I believe in my competence. If I do not believe in myself, I will not attempt to pursue the goal in the first place. Lastly, the genuine support of strangers (i.e., OA sponsor, therapists, cousin, and spiritual healers) eliminated my loneliness and gave me the strength to push forward in my darkest moments. Essentially, the ability to set my own long-term goals and follow through to completion provides a sense of fulfillment and accomplishment.

Implications for Practice

The current autoethnography consists of several layers of practical significance. One of the most essential components of practical significance is the unique personal portrayal of a lifetime battle with anxiety, depression, and eating disorders. My personal experiences with my comorbidity struggles illustrate similarities and differences with

mental illness and a potentially new perspective to the literature. The concept of relatability to my extraordinarily raw and vulnerable portrayal of my lifelong battle with anxiety, depression, and eating disorders can provide a sense of hope, strength, and inspiration to all individuals struggling with similar battles or any self-destructive behavior in general. Additionally, this study emphasizes and brings awareness to the sociocultural impact on anxiety, depression, and eating disorders. My first-hand perspective on my Armenian cultural upbringing and the significant impact it has had on the onset and escalation of my mental battles. Hence, this study can also provide excellent support and comfort to Armenians suffering from similar mental battles.

Another significant implication is the concept of resilience and post-traumatic growth, built over a lifetime. This autoethnography details my relentless pursuit of recovery, the power of persistence, and learning to adapt to struggle as critical factors in the will to keep moving forward despite adversity. Furthermore, the concept of post-traumatic growth is the positive side of the struggle. The greatest gift and growth that I experienced because of my trauma was detailed in terms of increased self-awareness of my character flaws, motivators, triggers, self-defeating behavior, and overall healing from painful embedded wounds. Recognizing these aspects of growth from a personal standpoint emphasizes that despite our darkest struggles, there is an essential lesson with every painful experience that helps us improve.

Another aspect of practical importance in this personal narrative is portraying emotional intelligence and its connection to personal and professional relationships. We all struggle with character defects that enable our self-destructive coping mechanisms, which in turn manifest in our daily lives (Anderson, 2016; Dill & Holton, 2014). Detailing

the repercussions of my lack of emotional intelligence, including my lack of impulse control, decision-making skills, trusting others too quickly, and inability to regulate my emotions, interfered with my potential to excel in my latest leadership position despite my knowledge and expertise in my field. Ambitious and goal-oriented individuals with a history of trauma and maladaptive coping mechanisms, like me, who struggle to move up the ladder in professional environments, can benefit from the data presented in this autoethnography.

Lastly, this autoethnography, which illustrates the sincere, raw, and vulnerable lifelong impact of mental health, particularly in individuals coming from ethnic households, provides a wealth of knowledge to the literature from a first-person point of view. Armenian Americans and individuals of other ethnic backgrounds can find comfort, support, closure, and inspiration in knowing they are not alone in their cultural struggles. Hence, the cultural references presented in this personal narrative are of great value to ethnic minorities with mental health struggles.

Recommendations for Practice & Research

Through the analysis of relevant research in my study, several gaps in the literature have been identified. The most apparent gap is the lack of long-term qualitative autoethnographic research exploring the comorbidity of anxiety, depression, and eating disorders in adolescent girls and women. Everyone has unique experiences with their eating disorder battles. Therefore, sharing their narratives will produce findings that are unique to everyone. Additionally, long-term autoethnographic research exploring various maladaptive coping mechanisms such as alcoholism or drug addiction can also contribute a wealth of knowledge from a first-person perspective. Furthermore,

qualitative autoethnographic research exploring the effects of trauma and mental health issues on emotional intelligence in the workplace and personal relationships is also a gap in the research that would benefit future leaders. Most importantly, exploring the impact of sociocultural influences on mental health, such as personal narratives from Armenian Americans, would provide supporting data to the current autoethnographic study, in addition to increased awareness about mental health struggles in ethnic minorities.

My autoethnographic study also opens the door for quantitative research, as qualitative and quantitative research complement and support one another (Creswell, 2009; Creswell, 2013). For instance, qualitative research allows researchers to address problems that quantitative approaches may not be able to address (Kelle, 2008) when examining the effects of mental health conditions on an individual's personal and professional life. Descriptive research can be utilized to study the effects of self-destructive coping mechanisms on work performance, professional relationships, and personal relationships over an extended period. Additionally, correlational research can be beneficial in studying the relationship between overcoming eating disorders and long-term post-traumatic growth—also, correlational research exploring self-defeating coping mechanisms on long-term career self-sabotage.

Limitations

This autoethnographic study must consider specific limitations that are important to address. One cannot predict or control how the reader will respond to the research, as negative and uncomfortable feelings are possible (Bochner & Ellis, 1996). This autoethnography contains profound and delicate personal details regarding my

comorbidity battles that may evoke or motivate transformation in readers who resonate with my struggles. Furthermore, the researcher being its research subject makes the researcher a primary risk target. The researcher's feelings and thoughts are the primary data source, requiring honesty, openness, and readiness to provide intimate data (Ellis & Bochner, 2000; Méndez, 2014). I struggled with the concept of being completely open and vulnerable about my mental challenges, in part due to the highly private aspect of eating disorders.

Furthermore, the emotional intensity surrounding my painful experiences led to a memory blockage, preventing me from recalling significant painful and uncomfortable details about my journey. When I encountered memory blockages, I would step back from my writing until I felt my memory was restored. Alternatively, listen to eating disorder podcasts such as "*The Eating Disorder Diaries"* by Amy Goechel, "*Binge Breakers Bulimia Recovery*" by Jacqueline Davis, and "*Bulimia Sucks*" by Kate Hudson Hall, all on the *Spotify* application, which helped me recall my story by relating to the journey of other individuals in my shoes. However, there is a definite possibility of significant details being missed due to the blockage of painful experiences in my memory. It is also important to note that this autoethnography presents issues due to ethical challenges (Méndez, 2014), such as preserving the anonymity of the individuals portrayed in my analysis. Although I did my best to assign anonymous identifications to associations in my life, their identities may be determined by those familiar with my story.

My Leadership Evolution

One of the greatest gifts of this dissertation process was the opportunity to reflect on my leadership style about my eating disorder. Moreover, my views on leadership began to evolve as I recognized that being a great leader does not depend on one's schooling, intelligence, credentials, hours worked daily, loyalty, or expertise. Rather, being a great leader depends on having solid emotional intelligence and regulating my emotions in stressful situations. Being a great leader is recognizing how my actions, attitude, and reactions to work-related situations affect my team. For instance, some of the most outstanding leaders I have worked for and admire are those who are calm and able to disguise their emotions when their world is crumbling. They walk out of a stressful meeting with a big smile, where their colleagues and employees would not be able to tell that anything is wrong. Furthermore, being a great leader entails communicating effectively without incorporating emotion to make the employee feel uncomfortable. I am conscious of these character flaws and am working to become an effective leader through tools such as emotional intelligence courses, psychotherapy, and spiritual practices.

Final Reflections

The current study fills in the gap in qualitative autoethnographic research by exploring an eating-disordered female's long-term individualistic struggles with the comorbidity of anxiety, depression, and eating disorders. This study was also unique in the sense that social-cultural influences, particularly my Armenian culture and familial environment, were the root of my mental health battles. My narrative is a raw, honest, vulnerable, and highly descriptive portrayal of my lifelong comorbidity battles that

illustrate the power of persistence and self-determination through continuous failed attempts at self-preservation. This autoethnography also shows different adaptive coping mechanisms I have utilized, such as structured meal plans, peer support, psychotherapy, journaling, and spiritual healing practices. Moreover, the connection between low emotional intelligence and maladaptive coping mechanisms was identified as negatively impacting the overall quality of life and personal and professional relationships.

I would also like to give future researchers my perspective regarding the challenges and rewards of writing an autoethnography where complete exposure and vulnerability of my comorbidity experiences are at the heart of the study. First and foremost, when I decided upon the autoethnography methodology, I was fully prepared to pour my heart out about my mental health battles. I intended to utilize explicit and relatable details to portray the complexity and pain behind eating disorders, as society views eating disorders as a vanity issue rather than connected to deeply embedded emotional trauma. However, the intensity of emotions during the data analysis process was more challenging than I expected. During the data analysis process, I relived every pleasant, negative, and uncomfortable memory as if I had turned back time and was fully present. Simultaneously, while working with a mental health professional twice a week, I chose to share the unbearably painful emotions I experienced during my writing. My therapist helped me connect my trauma to my maladaptive coping mechanisms, and this understanding helped alleviate the shame and guilt attached to my disease. I am slowly learning to forgive myself for a lifetime of not finding myself worthy of my love, compassion, and empathy. To be completely transparent, full disclosure of my battles

and the pain of reliving the associated trauma was one of the most challenging things I have ever had to do in my life.

The writing process in autoethnographic methodology is extremely rewarding because by writing the words and thinking out loud, I could immediately pick up patterns connected to my character defects, motivators, and triggers. Subsequently, I started to become hyper-aware of the emotional patterns that trigger my maladaptive coping mechanisms daily. Ironically, my OA sponsor had asked me to write the story behind my eating disorder, which is a healing component of OA's 12-step work (see Tables 1 and 6). Working through *The 12 Steps of Overeaters Anonymous* (see Tables 1 and 6) with a sponsor is part of the healing magic that comes with OA. However, while working with my sponsor, I procrastinated and found excuses to avoid the step work because I did not want to face the emotions and realization associated with my trauma. Hence, I could not get past step one (see Tables 1 and 6), which states, "*We admitted we were powerless over food and that our lives had become unmanageable." Step four states, "Making a searching and fearless moral inventory of ourselves,"* precisely what I did in this autoethnography. I regret avoiding the emotional step work in OA, as now I have come to the realization that humbling myself to the painful circumstances in my life and becoming aware of my shortcomings are the keys to starting the healing process within my mental health battles. I have listed *The 12 Steps of Overeaters Anonymous* a second time for ease of referencing (see Tables 1 and 6).

Table 6

The 12 Steps of Overeaters Anonymous

1. We admitted we were powerless over food – that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Decided to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to compulsive overeaters and to practice these principles in all our affairs.

Note. Information taken from: (Overeaters Anonymous, 2023b)

I am grateful for the rewarding and healing experience that my autoethnography has brought me. Although I have evolved mentally, emotionally, and spiritually throughout this autoethnographic journey, I am a work in progress and have a long way to go before I can say that I am fully healed from the pain of the past. However, I am proud and relieved that the newfound love for myself has motivated me to resist my maladaptive coping mechanisms. Instead of giving in to the urge to binge and purge, I try listening to my mind and body and giving it exactly what it needs (i.e., sleep, nutrients, relaxation, laughter, and connecting with others). The perfect recovery does not exist, as healing is not black and white. I know that my eating disorder will be a part of my identity for the rest of my life. Still, if I am aware of triggers, I can do my best to resort to adaptive coping mechanisms that have served me during my periods of abstinence from my eating disorder. Moreover, if I have imperfect days with my

recovery, I can forgive and pick myself back up instead of punishing myself, as evident in my patterns. Lastly, the ability to forgive the individuals in my life who have caused me pain has been emotionally freeing and has provided me with the closure I had been seeking.

I also want to let future researchers who have not experienced similar battles as myself know that we are all more alike than we realize. Although our battles may not be identical, we are all doing our best to cope with the trials and tribulations of life despite the self-destructive nature of our self-help mechanisms. We are humans and not robots, and perfection does not exist. Therefore, we must not be ashamed of our self-defeating tendencies. Hence, I encourage all future researchers to find the opportunity in every difficulty and to give themselves grace as they walk through this challenging human experience, knowing that our battles are temporary and meant to teach us a lesson.

My autoethnographic journey has also inspired me to work towards publishing a future non-fiction book series about my comorbidity experiences with anxiety, depression, and eating disorders. I hope the power of vulnerability and relatability can support and inspire others to love themselves as I have. In addition to a potential non-fiction book, I would also like to work on a unique eating disorder podcast, like the podcasts mentioned in this study, because I have realized the power of one individual's story contributing to the healing of another. Lastly, I dream of pitching my non-fiction book into a television series, hoping to make a more significant impact through a virtual onscreen portrayal of my comorbidity experiences.

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APPENDIX A

Chronology of Significant and Transformative Events:

Criteria for Data Collection (1991 to 2024)

My overall goal in determining which data to include was dependent upon events and behaviors characteristic of the comorbidity of anxiety, depression, and eating disorders. Below is an outline of the significant events included in my study.

Awareness of Habit: Ages 4 to 10 (1991 - 1996)

- **1991** – Kindergarten - I hid inside my locker and ate chips due to feeling lonely.
- **1992 – 1994** – Grades 1 to 3 – I was compelled to eat my classmates' snacks during break time because I felt sad and lonely.

Onset of Critical Eating Disorder Behavior: Ages 11 to 18 (1997 - 2004)

- **November 1997** – 6th Grade– Onset of Anorexia Nervosa. I started starving myself after a classmate pointed out that I was heavy.
- **1999** – 8th Grade – Onset of Binge Eating Disorder – I would restrict myself during the day and binge after school/ Yo-Yo Dieting.
- **2000 – October 2003—High School—Repetitive daily cycles of restricting food intake and** binging after school / Yo-Yo Dieting / Laxative Tea.
- **Early November 2003 – February 2004 –** Senior Year of High School – Onset of Bulimia Nervosa, which a cousin introduced.
- **February 2004 – May 2004** – Anorexia Nervosa – Immediate family members gave me an ultimatum stating that I could not go to prom if I continued to binge/purge, so I restricted myself entirely.

- **Mid-May 2004 –** The day after my high school prom - Bulimia Nervosa came back with a vengeance.

Ongoing Critical Eating Disorder Behavior in Adulthood: Ages 18 to 25 (2004 – 2011)

- **August 2004 – May 2011 –** College/Graduate School**–** Binged/purged/abused laxatives.
    - Spring 2008 – I had severe suicidal thoughts (i.e., cry for help).
    - Fall 2008 - Started attending Overeaters Anonymous sporadically (2007)
    - 2009 – 2011 - Started seeing a therapist weekly (i.e., my angel in human form)

Major Life Events: Ages 26 to 30 (2012 to 2016)

- **November 2012 – April 2016:** My first romantic interest - I confessed I was bulimic and abused laxatives. My partner gave me an ultimatum to stop, but I could not, and I became very secretive about my disease. We later decided to move in together. The relationship deteriorated from that point forward.

Recent Battles and Triumphs: Age 31 – Present (2017 to 2024)

- **August 2017 – July 2018 –** I began my Doctoral Program **–** Bulimia/binge eating/yo-yo dieting/anxiety/depression escalated, and I gained 25 pounds in 10 months.
- **July 2018 – September 2018 -** I began my bodybuilding journey- I stopped binging/purging /laxative abuse. I followed a strict diet/exercise protocol.
- **Mid-September 2018 –** I broke my abstinence from bulimia nervosa/laxative abuse while bodybuilding.

- **November 2018 –** End of my initial bodybuilding transformation – Dropped close to 30 pounds and received immense praise, escalating my eating disorder.
- **June 2019 – September 2019 –** Bodybuilding Competition Prep – Binge Eating/ Bulimia Nervosa/Laxative Abuse/abuse of dangerous illegal fat burners**.**
- **September 2019 – December 2019 –** 2nd Bodybuilding Competition Prep **-** Binge Eating/Bulimia Nervosa/Laxative Abuse/Abuse of Dangerous Illegal Fat Burners.
- **December 13, 2019 –** 2nd Body Building Competition (My 33rd Birthday)– Felt like death/body dysmorphia/suicidal ideations.
- **December 14 – December 31, 2019 –** I was suicidal due to "post-show blues" and worked with spiritual healers as a coping tool.
- **January – March 2020 –** I gained 30 pounds in 3 months due to binge eating and bingeing/purging. Depression was at an all-time high.
- **March 2020 – May 2020 –** Chronic anxiety, depression, binge eating, and binge eating and purging escalated due to the COVID-19 pandemic, along with feeling behind and incompetent with my doctoral dissertation.
- **Mid-July 2020 –** I lost my job and started a bodybuilding competition preparation day apart from each other. I binged excessively and gained 10 pounds that week alone. Anxiety and depression continued to escalate.
- **November 2020 –** National level competition in Florida without support from coaches, friends, or family members. I experienced physical paralysis on stage due to chronic anxiety. My coaches dropped me a week later, and my binge eating, and bulimia spiraled out of control as a result.

- **Late November – Late December 2020 -** I gained 40 pounds in 6 weeks due to elevated levels of anxiety, depression, binge eating, and bulimia. I lost motivation with the sport.
- **January 2021 –** I started attending Overeaters Anonymous and working with a sponsor—daily interaction with the sponsor via telephone and text message.
- **March 2021 –** I found a new personal trainer who believed in me and found my motivation again. The bulimia was ongoing/uncontrollable.
- **April 2021 – August 2021**: I started a new bodybuilding competition prep. I stopped binging and purging, physically transformed and started believing in myself.
- **Mid-August 2021 –** 4th Bodybuilding Competition **–** I placed last but did not break my abstinence from bulimia.
- **September 2021 –** Bulimia obsession with excessive exercise resumes. Food restriction was prominent.
- **October 2021 – March 2022 –** I started a job in a toxic work environment, and my eating disorder continued to escalate.
- **January 2022—**My bodybuilding coach became highly critical of my body, and I lost motivation regarding my sports competence.
- **March 2022 – August 2023 –** Unemployment – My inability to find the right job, lack of money, and dependence on my family took a mental toll. Anxiety, depression, and bulimia nervosa were constant during this time.

- **Early - August 2023–** I had surgery unrelated to my eating disorder, which motivated/forced me to stop my bulimia. I physically could not purge, or I would break my stitches). I was determined to end the bulimia once and for all.
- **In Late August 2023** – I started working again – The environment was toxic, and I was highly stressed, but my eating disorder was under control.
- **Early November 2023 –** I was terminated from my job, triggering my bulimia.
- **Early – Late November 2023 –** My bulimia returned with a vengeance. Depression and anxiety are unbearable.
- **Early December 2023 –** Chronic depression, anorexia, suspicion of possible Asperger's/Autism, and an intense obsession with my body provoked me to seek professional help.
- **Mid-December 2023 –** I started seeing a mental health professional twice a week, which has helped with awareness of character defects, motivators, and triggers.

APPENDIX B

eProtocol
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: February 05, 2024

Protocol Investigator Name: Hasmek Siwajian

Protocol #: 23-12-2330

Project Title: My Secret Struggle: Starving, Purging, and Numbing my Emotions. An Autoethnographic Analysis of my Lifelong Battle with Anxiety, Depression, and Eating Disorders.

School: Graduate School of Education and Psychology

Dear Hasmek Siwajian:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

cc: Mrs. Katy Carr, Assistant Provost for Research

APPENDIX C

CITI PROGRAM

Completion Date 02-Dec-2023
Expiration Date 02-Dec-2028
Record ID 52941053

This is to certify that:

Hasmek Siwajian

Not valid for renewal of certification through CME.

Has completed the following CITI Program course:

GSEP Education Division
(Curriculum Group)
GSEP Education Division - Social-Behavioral-Educational (SBE)
(Course Learner Group)
2 - Refresher Course
(Stage)

Under requirements set by:

Pepperdine University

CITI
Collaborative Institutional Training Initiative
101 NE 3rd Avenue, Suite 320
Fort Lauderdale, FL 33301 US
www.citiprogram.org

Generated on 05-Mar-2024. Verify at www.citiprogram.org/verify/?w5daf76f2-fb6f-4e1d-99dc-6194a3631ab2-52941053