Reviving Recovery: A Supplemental Approach in Treating Eating Disorders

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Abstract

Eating disorders are bio-psycho-social diseases that affect nearly twenty million women and ten million men in America (National Eating Disorder Association, 2018). They are serious but treatable illnesses that develop when a genetic predisposition is paired with an environmental activation. Out of all mental illnesses, eating disorders have the highest mortality rate, with one person dying as a direct result of an eating disorder every 62 minutes (Smink, Van Hoeken, & Hoek, 2012). Eating disorders adversely affect every aspect of human life, including physical and mental health, intrapersonal and interpersonal relationships, professional pursuits, sense of meaning and purpose, and overall well-being. Existing treatment methods provide opportunities for individuals with eating disorders to interrupt and reduce symptoms. Relapse during and soon after treatment, however, is extremely common. The field of eating disorders has not yet pivoted to address what patients need to sustain recovery and thrive. Positive psychology's theory, research, and interventions present a supplemental treatment approach for practitioners to implement to revive the recovery process to increase the success for those struggling with eating disorders. Positive psychology can operate to empower and motivate patients, reconnecting them to their meaning and purpose outside of the illness. This paper discusses eating disorders in depth, recognizes and applauds traditional treatment methods, and proposes how enhancing positive emotions, engagement, relationships, meaning, and accomplishment can further promote recovery.

Keywords: positive psychology, eating disorder, recovery, treatment methods, patients, disconnection, practitioners, well-being

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An Introduction to Eating Disorders

It was like someone had taken over my daughter.

I lost myself to this thing no one could see, no one could explain, no one could understand.

The house was on fire, yet I couldn't see the flames.

What others called starvation; I called my salvation.

It felt like I was fighting with myself in every moment; yes, no, right, wrong, good, bad.

I don't even know myself. I feel so disconnected from the person I once was.

She was fine until she was gone.

It was the one thing I had control over when everything else felt out of control.

If love was enough, my daughter would still be alive.

We didn't know. We thought we were trusting her when really we were trusting the illness.

The doctor explained her organs were failing and that there may be brain damage.

How did I not see it; how did I not do something earlier.

I couldn't be in my skin; it was like bugs were crawling under my clothes. Get me out.

What happened to my perfect child?

I am not sick enough. I don't need help. Not yet. You're overreacting.

I hate you. I hate you. I hate you. I love you. I love you. I love you. [1]

Ernest Hemingway (1954) once said, "…the effects of our habits always happen gradually, then suddenly" (p. 136). I believe there is nothing exempt from this notion; productive habits, insignificant mannerisms, addictions, and mental illness. If we stay on the ride for too long it may never stop. Eating disorders manifest as such. Every victim—patient, family, friend,

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[1] The quotes in italics are meant to offer voice to those suffering from eating disorders. They are not direct quotations, but rather composites of experiences from individuals I have met who have struggled with an eating disorder. This paper will contain several of these aggregate expressions with the intention of illustrating the patient experience.

and provider —comes to witness the trajectory of this significant, life-threatening medical and

psychiatric mental illness. Eating disorders are bio-psycho-social conditions: genetic, biological,

environmental, and social elements all contribute to the illness (National Eating Disorder

Association [NEDA], 2018).

Decades of genetic research indicate that biological factors have a substantial influence in

who develops an eating disorder, such that over 60% of shape and weight concerns are heritable

(Bulik et al., 2006; Munn et al., 2010; Wade, Martin, & Tiggermann, 1998). Eating disorders are

"diseases of disconnection" in which biogenetically vulnerable individuals struggle to stay

connected to and develop an authentic sense of self within relationships with others and oneself

(Tantillo, 2006). This challenge is heightened with the effects of starvation, binging or purging,

excessive exercise, and a culture that emphasizes and prioritizes thinness, appearance, and

performance. Thus, one does not *choose* to have an eating disorder (Gaudiani, 2018; Academy

for Eating Disorders, 2016; NEDA, 2018). Contrary to societal beliefs, eating disorders do not

discriminate (NEDA, 2018). They affect people of every age, sex, gender, race, ethnicity,

socioeconomic group, and with a variety of body shapes, weights, and sizes (NEDA, 2018).

National reports find that twenty million women and ten million men in America will

have an eating disorder at some point in their lives (NEDA, 2018). Out of all mental illnesses,

eating disorders have the highest mortality rate, with patients experiencing six times the death

rate of their healthy peers (Eating Disorders Coalition, 2016; Gaudiani, 2018). One person dies

as a direct consequence of an eating disorder every 62 minutes (Smink et al., 2012); with up to

20 percent of those who die from anorexia nervosa dying by suicide (Arcelus, Mitchell, Wales,

& Nielsen, 2011). Those with atypical eating disorders and bulimia nervosa are seven times more

likely to die by suicide compared to those without eating disorders (Smith, Zuromski, & Dodd,

2017). Eating disorders rank as the twelfth leading cause of death in young women in the

industrialized countries (Hoek, 2016). Weight is not the only clinical marker of an eating

disorder, for individuals at any weight may be malnourished and/or engaging in unhealthy

weight control practices that can lead to acute complications (Academy for Eating Disorders,

2016). *Table 1* below presents and differentiates the eating disorders recognized in the

Diagnostic and Statistical Manual-5 (DSM-5). Table 2, then, identifies the various signs and

symptoms of eating disorders from a general, oral and dental, cardiorespiratory, gastrointestinal,

endocrine, neuropsychiatric, and dermatologic evaluation. Other disordered eating and

compulsive exercise patterns that are not yet classified by the DSM-5 are not included in this

table, but can still be life-threatening and should be treated in a similar, critical manner.

Table 1. *Types of Eating Disorders according to DSM-5*

Eating Disorder	Description
Anorexia Nervosa (AN)	Restriction of energy intake relative to an individual's requirements, leading to significantly low body weight in the context of sex, age, developmental trajectory and health status. Disturbance of body image, an intense fear of gaining weight, lack of recognition of the seriousness of the illness and/or behaviors that interfere with weight gain are also present.
Bulimia Nervosa (BN)	Binge eating (eating large amounts of food in a relatively short period of time with concomitant sense of loss of control) with purging/compensatory behavior (e.g. self-induced vomiting, laxative or diuretic abuse, insulin misuse, excessive exercise, diet pills)

	once a week or more for at least 3 months. Disturbance of body image, an intense fear of gaining weight and lack of recognition of the seriousness of the illness may also be present.
Binge Eating Disorder (BED)	Binge eating, in the absence of compensatory behavior, once a week for at least 3 months. Binge eating episodes are associated with eating; rapidly, when not hungry, until extreme fullness, and/or associated with depression, shame, or guilt.
Other Specified Feeding and Eating Disorder (OSFED)	An ED that does not meet full criteria for one of the above categories, but has specific disordered eating behaviors such as restricting intake, purging and/or binge eating as key features
Unspecified Feeding or Eating Disorder (UFED)	ED behaviors are present, but they are not specified by the care provider
Avoidant/ Restrictive Food Intake Disorder (ARFID)	Significant weight loss, nutritional deficiency, dependence on nutritional supplement or marked interference with psychosocial functioning due to calorie and/or nutrient restriction, but without weight or shape concerns.

Note: Descriptions in this table have been taken from the American Psychiatric Association's

DSM-5, p. 329-354.

Table 2. *Signs and Symptoms of Eating Disorders* (Note: A life-threating ED may occur without obvious physical signs or symptoms)

Category	Description
General	- Marked weight loss, gain, fluctuations or unexplained change in growth curve or BMI percentiles in a child or adolescent who is growing and developing - Cold intolerance - Weakness - Fatigue or lethargy - Presyncope (dizziness) - Syncope (fainting) - Hot flashes, sweating episodes
Oral and Dental	- Oral trauma, lacerations - Perimyolysis (dental erosion on posterior tooth surfaces) and dental cavities - Parotid gland enlargement
Cardiorespiratory	- Chest pain - Heart palpitations - Orthostatic tachycardia/hypotension (low blood pressure) - Dyspnea (shortness of breath) - Edema (swelling)
Gastrointestinal	- Epigastric discomfort - Abdominal bloating - Early satiety (fullness) - Gastroesophageal reflux (heartburn) - Hematemesis (blood in vomit)

	- Constipation
Endocrine	- Amenorrhea or oligomenorrhea (absent or irregular menses) - Loss of libido - Stress fractures due to low bone mineral density/osteoporosis - Infertility
Neuropsychiatric and Psychological	- Depressive, anxious, obsessive, compulsive, impulsive - Memory loss - Poor concentration - Insomnia - Alexithymia (inability to identify and express feelings) - Difficult tolerating emotion and body states - Internalize emotions - Perfectionism - Behavioral inflexibility - Body image dissatisfaction - Low self-esteem, low self-efficacy - Relational disconnection - High IQ, low EQ - Self-harm - Suicidal thoughts, plans, or attempts - Seizures
Dermatologic	- Lanugo Hair - Hair loss - Carotenoderma (yellowish discoloration of skin)

	- Russell's sign (Calluses or scars on the back of the hand) - Poor wound healing - Dry brittle hair and nails

Note: Data in this table have been taken from the Academy for Eating Disorders Report (2016)

Keep in mind that a large majority of individuals do not fall rigidly into these classifications, such that many individuals with eating disorders cannot be categorized into just one of these classified diagnoses. The majority of women meet a subset of the diagnostic criteria for an eating disorder and function in what is referred to as the "subclinical population" or "eating disorder not otherwise specified (NOS)". Individuals who do not fall into the stated categories are still very much at risk. Killen and colleagues (1986) conducted a study of high school student's relationship with eating, dieting, weight control, and purging and found that an alarming number of young adolescents employ unhealthy weight regulation strategies, even though they may not be diagnosed with a clinical eating disorder. In 1989, an estimated one half to two-thirds of preadolescent and adolescent girls felt dissatisfied with their body weight and shape, and close to three-quarters of 14-year old girls have been on a weight loss diet (Leon, Perry, Mangelsdorf, & Tell, 1989). More recent research reveals that as early as age 6, young girls begin to reveal concerns about their shape and weight and that 40-60% of elementary school girls (6-12 years of age) are worried about their weight or becoming too fat (Cash & Smolak, 2011). Neumark-Sztainer (2005) has also found that over one-half of teenage girls and approximately one-third of teenage boys use unhealthy weight control behaviors such as skipping meals, fasting, smoking cigarettes, vomiting and taking laxatives. Later in life, nearly 75% of American women between the ages of 25-45 report disordered eating and body image dissatisfaction, and 67% report trying to lose weight, although over half of these dieters were

already at a normal weight (Reba-Harrelson et al., 2008; Maine & Kelly, 2016). Such body

dissatisfaction and disordered eating behavior are associated with countless other problems, such

as low self-esteem, difficulty coping with stress, depression, impaired relationships, substance

abuse, and clinical eating disorders (Dykens & Gerrard, 1986; Leon, Fulkerson, Perry, &

Cudeck, 1993). Although the media, culture, and athletics of today normalize body

dissatisfaction and disorder eating practices, these practices and perspectives remain unhealthy.

The figure below illustrates the prevalence of these issues in adolescence.

So Just How Many Teens are We Talking About?
Prevalence of Body Dissatisfaction, Weight Control Behaviors, Obesity, and Eating Disorders

	Teen Girls	Teen Boys
• Unhealthy weight control behaviors (e.g., skipping meals, eating very little, fasting, or smoking for weight loss)	57%	33%
• Dieting Behaviors	55%	26%
• Body Dissatisfaction	46%	26%
• Extreme Weight Control Behaviors, e.g., (vomiting, laxatives, diet pills)	12%	5%
• Binge Eating Behaviors	17%	8%
• Obesity	15%	15%
• Moderately Overweight/At Risk for Obesity	15-20%	15-20%

Note: Neumark-Sztainer, 2005, p. 10 - From Project EAT and other large studies on teens and young adults including Swanson et al., 2011

Figure 1. Body Dissatisfaction, Weight Control Behaviors, Obesity, and Eating Disorders in

Teenagers. From *I'm, like, SO fat!: Helping your teen make healthy choices about eating and*

exercise in a weight-obsessed world (p. 10), by Neumark-Sztainer, 2005, New York, NY:

Guilford Press.

Athletes are one example of the many populations that fall into the subclinical category,

primarily because athletes with eating disorders or disordered eating rarely report their symptoms

(Bonci et al., 2008). NEDA (2018) shares that in a study of Division 1 NCAA athletes, over one-

third of female athletes reported symptoms, signs, and attitudes that place them at high risk for

anorexia nervosa. One study showed that college athletes have a 35% at-risk rate of developing

anorexia nervosa and 58% at-risk rate for developing bulimia nervosa (Johnson, Powers, & Dick,

1999). As for female high school athletes in weight-centric sports, the 42% that reported

disordered eating were eight times more likely to experience an injury than those who did not

report disordered eating (Jankowski, 2012). Sundgot-Borgen and Torstveit (2004) also found that

the occurrence of eating disorders is higher in athletes than in nonathletes, higher in females than

in men, and more prevalent in those competing in sports that depend on weight and leanness than

other less aesthetic sports. When athletic competition and pressure are combined with an existing

culture of thinness, athletes become more vulnerable to disordered eating and eating disorders.

Sport can both, directly and indirectly, reinforce unrealistic body size and weight (Beals &

Manore, 1994), perfectionistic tendencies (Schwarz, Gairrett, Aruguete, & Gold, 2005), and

extreme behavior (Bonci et al., 2008). Many athletes, therefore, believe their obsessive and/or

restrictive eating behavior actually supports sport success or optimal performance. The athlete

population serves to illustrate the prevalence of this illness beyond the clinical context.

  I state these devastating statistics not to induce sadness, but rather to bring awareness to

the paradox that exists between the reality of the illness and patient's perspective, adequate

education, and treatment effectiveness. Additionally, I believe that it is important to

acknowledge the perceived service or protection an eating disorder may provide in one's life. For

example, individuals with eating disorders may feel the illness offers them a sense of control

(Williams, Chamove, & Millar, 1990) and comfort, induces positive reinforcement around

external appearance (Polivy & Herman, 2002), supports optimal performance (Thompson &

Sherman, 2011), and/or enables them to deal with injury, stress, trauma, failures, and adversity

(Snyder, 2000). It also can operate to numb unwanted emotions or tame anxiety, depression, or

other non-desirable mental illness (Braun, Sunday, & Halmi, 1994). The apprehension around

embracing recovery is often rooted in the fear of losing the above positives or gaining the

mentioned negatives, plus several other perceived advantages and disadvantages that an

individual may believe accompany the eating disorder and recovery. This is important to keep in

mind as we later explore resistance to treatment. With that being said, existing eating disorder

treatment has done it's best to identify the cognitive, emotional, behavioral, and social

expressions of the illness. The next section of the paper will discuss the field of evidence-based,

eating disorder treatments.

Existing Eating Disorder Treatment

There are several approaches used to treat eating disorders. The core evidence-based

treatments include cognitive behavioral therapy (CBT) and cognitive behavior therapy enhanced

(CBT-E) (Fairburn, 2013; Agras & Apple, 2008; Fairburn, 2008), dialectical behavior therapy

(DBT) (Linehan, 2015; McKay, Wood, & Brantley, 2007), interpersonal therapy (IPT) (Wilfley

et al., 2002; Murphy, Straebler, Baden, Cooper, & Fairburn, 2012), integrative-cognitive

affective therapy (ICAT) (Wonderlich, Peterson, & Smith, 2015), acceptance and commitment

therapy (ACT) (Wilson & Roberts, 2002), family-based treatment and the Maudsley approach

(FBT) (Lock & le Grange, 2005), motivational interviewing (MI) (Wilson & Schlam, 2004), the

Maudsley Anorexia Nervosa Treatment for Adults (MANTRA) (Allen et al., 2016; Schmidt et

al., 2012; Schmidt, Wade, & Treasure, 2014), cognitive remediation therapy (CRT) (Ely,

Wierenga, & Kaye, 2016), exposure and response prevention (ERP) (Rosen & Leitenberg, 1982;

Steinglass et al., 2011), multi-family therapy and relational cultural theory (RCT) (Tantillo,

2006; Scholz & Asen, 2001; Jordan, Hartling, & Walker, 2004; Miller & Stiver, 1997), focal

psychodynamic therapy (Zipfel et al., 2014), and creative and expressive therapies (Gargaro et al., 2015).

In order for any of the therapies to be helpful, however, malnutrition must be corrected, weight gain must be started, and binge-purge symptoms must be substantially interrupted (Gaudiani, 2018). Individual ongoing psychotherapy is needed for at least a year and could take many years. Many of the therapies are paired with an antidepressant, anti-anxiety, or other necessary medications to support recovery goals and enable initial therapeutic progress (Peterson & Mitchell, 1999; Mayer & Walsh, 1998; Sherman, 2002). For the purpose of this paper, however, we will not explore the medications used to treat eating disorders, but rather focus on existing and potential methods to treat eating disorders therapeutically. Table 3 provides a brief description of each evidence-based treatment method.

Table 3. *Evidence-based treatments for Eating Disorders* (*Note:* There are therapeutic approaches beyond what is listed below that are used in treating eating disorders. Table 3 lists some of the most commonly used, evidence-based practices).

Treatment Approach	Description for Eating Disorder Treatment
CBT	Helps articulate specific treatment goals and teaches them how to attain them (Snyder, 2000). The main stages of CBT work are symptom interruption and behavior change, cognitive restructuring and behavioral coping skills, and relapse prevention (Wilson, Fairburn, Argas, Garner, & Garfinkel, 1997).
CBT-E	Enhanced cognitive behavioral therapy that has transdiagnostic effectiveness. Targets perfectionism, low self-esteem, and interpersonal difficulties that are heightened with the illness (Fairburn, 2008).

DBT	Assists in managing emotions. The four key skills of therapy are distress tolerance, mindfulness, emotion regulation, and interpersonal effectiveness (McKay, Wood, & Brantley, 2007).
IPT	Intended to help address the interpersonal difficulties which appear to be maintaining the eating disorder. Helps with developmental stressors and aims to identify and remove the mechanisms of interpersonal challenges (Murphy et al., 2012).
ICAT	Addresses eating disorder maintaining factors, specifically emotion responding and exposure, self-directed cognition, interpersonal behavior, and nutritional rehabilitation (Wonderlich et al., 2014)
ACT	Uses acceptance and mindfulness in various ways with commitment to values and behavior-change strategies to improve psychological flexibility (Hayes, Luoma, Bond, Masuda, & Lillis, 2006).
FBT/ Maudsley	Does not try to analyze why the eating disorder developed, but rather focuses on behavioral change with the support of parents to provide nutritional support. It presumes parents as experts on their child and as an essential part of the solution. Parents are asked to join the treatment team to support the child against the eating disorder (Lock & leGrange, 2015).
MI	Helps people reconcile difficult feelings and insecurities to find the internal motivation to change behavior to support recovery. It is a short-term process that focuses expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy to empower patients to make positive change (Miller & Rollnick, 2012)
MANTRA	Trains others to be in charge of refeeding process to the best of their ability. It is an adult version of the Maudsley approach. Highly focused and staged outpatient weight-gain treatment. Externalizes the illness to emphasis behavioral recovery rather than insight and understanding (Schmidt et al., 2014; Lock & leGrange, 2005).

CRT	Draws upon a neurobiological context to target strengths and weaknesses of neurocognitive abilities such as working memory, planning and flexibility, and executive functioning which is intended to lead to recovery behavior and elevated psychosocial functioning. (Tchanturia & Lock, 2010).
ERP	Designed to desensitize one to their fears. It allows individuals to learn that they can successfully face their fears related to the eating disorder through repeated exposure. Repeatedly facing one's fears and learning to manage the ambivalent feelings and thoughts associated with these fears lessens the anxiety around recovery (Rosen & Leitenberg, 1982).
Multi-family therapy	A form of family therapy in which family members, or those considered as family, are able to learn and gain insight from each other, provide support and encouragement, reduce isolation, and improve communication and social functioning to enable recovery (Colahan & Robinson, 2002). Inevitable differences are honored, while strong connection with one another are maintained to identify the disconnections that keep the eating disorder in place (Tantillo, 2006).
Relational Cultural Therapy (RCT)	Focusing on building a sense of mutual empathy and empowerment within the therapeutic social connections to support the individual with the illness (Tantillo, 2006). Pursues that people develop more fully through connections with others. RCT encourages circumstantial and relational perspective for understanding human development (Duffey & Somody, 2011).
Focal Psychodynamic therapy	Attempts to understand interpersonal relationships (what one thinks and feels about oneself and other people) and the link to eating habits and behaviors (Friederich, Wild, Zipfel, Schauenburg, & Herzog, 2019).

Creative and Expressive therapies	Activities such as yoga therapy, art therapy, dance therapy, and music therapy intended to help emotional expression/regulation, grounding, mindfulness, self-compassion, and body image (Gargaro et al., 2015).

All of the stated therapeutic approaches have shown to be beneficial in the treatment of eating disorders yet vary slightly in regard to which eating disorders they've proven most advantageous. For example, CBT (Argas & Apple, 2008), DBT (McKay et al., 2007), ICAT (Wonderlich et al., 2015), and ACT have seen to effectively treat bulimia nervosa and binge eating disorder, with IPT (Wilfley & Cohen, 1997) proving to decrease the binging behavior. Whereas, FBT (Lock & le Grange, 2015) and the Maudsley (Lock & le Grange, 2005; Wilson, Grilo, & Vitousek, 2007) treatment methods have proven to be more beneficial for adolescents with anorexia nervosa. CRT, exposure and response prevention, CBT, DBT, and focal psychodynamic therapy are additional treatments used for anorexia nervosa. Unfortunately, the evidence supporting currently available treatments for adults with anorexia nervosa is weak and unclear, and treatment effects, when found, are generally small (McIntosh et al., 2005; Channon, de Silva, Hemsley, & Perkins, 1989; Ball & Mitchell, 2004; Dahlgren, Lask, Landrø, Rø, 2013; Steinglass, et al., 2014; Tchanturia, Lloyd, & Lang, 2013; Zuchova, Erler, & Papezova, 2013).

The approaches currently being exercised to treat eating disorders have provided tremendous support for individuals suffering from the illness. They have offered individuals with eating disorders the awareness, skills, and strategies necessary to recover. Yet, according to Herzog and colleagues (1999) approximately one-third of both women with anorexia nervosa and bulimia nervosa relapse after full recovery. Deter and Herzog (1994) concluded from a long-term study that 22% of patients had suffered a relapse after remission as well. Similarly, Morgan and Russel (2009) found that relapses after discharge were common and readmissions were

necessary for half of the studied patients. Sadly, as both relapse rates and onset rates continue to

increase, the field of eating disorders has not pivoted from what it knows to address these issues.

I believe there are additional approaches and focuses that providers can access to not only

support recovery behavior but also enable recovery maintenance. The remainder of this paper

will discuss how positive psychology can offer the field of eating disorders an empowering

treatment method to supplement existing therapeutic approaches.

Positive Psychology

Prior to 1998, conventional psychology was interested in repairing pathologies. After

World War II, mending mental illness and other problems that surfaced in returning veterans

became the foremost priority for psychologists (Seligman, 2002). Psychology fixated on what

was wrong with individuals and their standing weaknesses to treat the abundance of mental

disorders that now existed and to create effective therapies for those suffering (Maddux, 2002).

Psychology's focus confirmed the human negativity bias, in which both animals and humans

developed a greater predisposition to negative entities based on evolution and survival instinct

(Rozin & Royzman, 2001). This psychological foundation then served as the primary approach

in remediating misery and treating mental illness for decades. Keep in mind that happiness does

not come from simply ameliorating misery (Seligman, 2011; Keyes, 2002). Psychology was

essentially one-sided, and perhaps wrongly-sided relative to what human beings truly desire out

of life. When Martin Seligman was named the president of the American Psychological

Association in 1998, he questioned this limited method of helping human beings (Seligman,

2002). Seligman encouraged his colleagues to embrace the full spectrum of humanity, which

includes more than simply correcting one's fragilities and disadvantages, but also attends to

one's strengths and potential. He focused on building beneficial cognitions about the future to

amend the former psychological imbalance (Seligman, 2002). This revolutionary turn in the science of behavior and mind became known as positive psychology.

Positive psychology is the scientific study of human flourishing (Peterson, 2006). The primary objective of positive psychology is to foster well-being and optimal functioning through the activation of personal and collective strengths (Seligman, 2011). It is intended to improve the quality of life and accentuate the positive characteristics that make life worth living (Seligman & Csikszentmihalyi, 2014). The field offers an opportunity to implement its constructs to enhance the conditions of any society. Positive psychology aims to cultivate a more realistic and appreciative perspective of humanity (Sheldon & King, 2001) while providing the skills and techniques to enhance life satisfaction in individuals, groups, and institutions. In doing so, positive psychology does not discount or abandon the importance of alleviating negative human attributes and despair (Maddux, 2009). Rather, it intends to broaden the existing science and research of traditional psychology by taking a more comprehensive and balanced approach towards the human experience, including both the positive and negative aspects, both the happiness and suffering of life.

In 2011, Seligman introduced the PERMA model of flourishing, in which well-being is defined in relation to five domains: positive emotions, engagement, relationships, meaning, and accomplishments. The PERMA model has served as an organizing framework to understand, enhance, and measure well-being. Each component of PERMA it thought to be pursued for its own sake and contributes independently to well-being as a whole (Seligman, 2011). Seligman's five pillars of well-being can each by cultivated to enhance well-being at an individual, group, or communal level (Seligman, 2011). The PERMA model focuses on positive attributes to improve the quality of life for both nonclinical and clinical populations. This paper will later discuss each

component of PERMA in-depth to then capitalize on Seligman's model to structure the

categories of proposed positive psychology options in treating eating disorders. It is important to

understand that the elements of PERMA are distinct, yet have natural overlap (Seligman, 2018).

With that, several interventions and concepts may fall under more than the identified element in

this paper, and thus can be used to ignite and support other elements as they are highly correlated

(Butler & Kern, 2016). For redundancy purposes, however, the overlapping concepts will be

covered once in the element I believe it is most strongly connected to.

Positive Psychology in Clinical Populations

Even though the field was intended initially for a non-clinical populace, focusing on what

is best within individuals has kindled supplemental treatment opportunities for clinical pursuits.

Positive psychology can add a deeper, more optimistic layer to clinical psychology to achieve

outcomes otherwise not probable (Seligman & Peterson, 2003). Dr. Tayyab Rashid, a licensed

clinical psychologist, and Seligman developed positive psychotherapy (PPT), a therapeutic

approach rooted in Peterson and Seligman's (2004) character strengths meant for application

within clinical settings. Character strengths are often described as the best parts of human beings

(Niemiec, 2017). They are positive capacities or traits that are intrinsically fulfilling,

representative and valued across cultures, and aligned with a surplus of beneficial outcomes for

oneself and others (Niemiec, 2017). PPT, like positive psychology, aims to highlight these

strengths to better understand the integral complexities of humanity in a more holistic manner

than the traditional deficit-oriented approach. The deficit model is based on the belief that

psychology is the result of identifying and targeting individual dysfunction or deficiency

(Wenzel, 2017). Rashid and Ostermann (2009) explain that the deficit approach, "… has created

a negative bias, considered strengths as clinical peripheries or by-products, tended to reduce

clients to diagnostic categories, and created a power differential, which could be counterproductive to clinical efficacy" (p. 1). PPT, however, juxtaposes typical interventions by increasing positive emotion, engagement, meaning, relationships, and accomplishments in addition to addressing existing symptoms (Seligman, Rashid, & Parks, 2006). It asks the questions, "What is *right* with you?", "How can you leverage your strength to help you heal?", or "How can you use your strength to support your treatment process?" Rashid and Seligman (2018) present this hybrid of a psychotherapy-coaching model and strength-based assessment to indirectly decrease symptoms by improving the lives of those suffering (Rashid, 2009). Positive interventions (PIs), evidence-based strategies designed to enhance well-being, are used in PPT to complement attempts to prevent and heal psychopathology (Duckworth, Steen, & Seligman, 2005).

There is strong empirical support for the efficacy of such interventions within clinical contexts. Seligman and colleagues (2006) have employed PIs with mild-to-moderate depressed individuals. Their studies suggest that PIs may significantly decrease levels of depression through 1-year follow-ups (Seligman et al., 2006). Furthermore, PIs produced higher remission rates than conventional treatment. PIs may be used to supplement treatments for depression by deliberately increasing positive emotion, engagement, and meaning (Seligman et al., 2006). Similarly, two exercises—*using your signature strengths in a new way* and *three good things*— have shown to increase happiness and decrease depressive symptoms in just six months (Seligman, Steen, Park, & Peterson, 2005). In fact, the *three good things exercise* have shown positive impact within 15 days, with 94% of participants experiencing relief (Layous, Chancellor, Lyubomirsky, Wang, & Doraiswamy, 2011). Both of these PIs will be described in detail in upcoming sessions to better inform application. Sin and Lyubomirksy (2009) have also

found that depressed individuals may essentially benefit more from PIs than non-depressed individuals. Seligman (2011) has even seen PPT and its interventions relieve depressive symptoms better than both antidepressant medications and better than typical treatment for depression. Such findings reinforce the advantage of integrating PIs within clinical work, specifically in individual treatment or therapy (Sin & Lyubomirsky, 2009).

Currently, there is limited evidence to support the application of positive psychology with the eating disordered population. The lack of research may pose an obstacle to provider receptivity for clinical application. Seligman and Diener (personal communication, October 6, 2018) have been steadfast in their research-based pursuit of positive psychology, while also being transparent about the areas that need further analysis and quality data. Though I concur with their conclusions about the need for transparency, I also recognize the abovementioned research as robust findings within a clinical context and believe it sets precedent for the potential within other clinical populations.

The remainder of the paper will explore the potential for the integration of positive psychology in the clinical context for eating disorder treatment. For each letter of PERMA, I will review relevant concepts (e.g., theory and research), describe experiences eating disorder patients have had that relate to the considered element, and then discuss specific ways in which the research can be applied to the eating disorder population. Each pillar of well-being will follow the same meta-structure: a review of theory and research, the experience of the patient, and the application within the population.

Positive Psychology to Support Eating Disorder Treatment

Positive Emotions

The field of positive psychology extends far beyond merely promoting a constant happy state. Indeed, Seligman himself would be the first to plead with marketers to remove the iconic smiley face that accompanied introductions to positive psychology (personal communication, October 6, 2015). Not because positive psychology is against happiness, but primarily because it is *more* than just happiness. With that being said, positive emotions do play an inevitable role in a well-lived, healthy life.

Barbara Fredrickson, a Kenan Distinguished Professor of Psychology and principal investigator of the Positive Emotions and Psychophysiology Laboratory at the University of North Carolina at Chapel Hill, has developed a theory rooted in research that confirms the fundamental role positive emotions play in human flourishing. Fredrickson developed her broaden and build theory of positive emotions to convey the empirical evidence that supports the relationship between positive emotions and individual growth and improvement (Fredrickson, 2001). It is valuable to think about and identify positive emotions that exist in addition to happiness; such as rapture, gratitude, awe, excitement, interest, love, contentment, and many more. Such emotions function to broaden one's scope of awareness and cognition to successively build personal resources.

To broaden one's mindsets has a complementary effect, in which an individual's collection of thoughts and action is widened and made more accessible (Fredrickson, 1998; Fredrickson & Branigan, 2001). Broadening awareness presents an opportunity to consider and collect more resources while enabling more fluent and innovative responses to life. Broadened mindsets come with long-term benefits as a result of accumulated resources, which operate as

reserves to be retrieved upon facing future challenges (Fredrickson, 2001). Resources range from

intellectual supports such as openness to new learning and improved working memory and

problem solving, to physical resources such as lessened inflammation and improved

cardiovascular health, to social resources such as making novel social connections or

strengthening existing relationships, and psychological resources such as optimism, resilience,

and sense of identity (Fredrickson, 2001; Cohn, Fredrickson, Brown, Mikels, & Conway, 2009;

Peterson, 2006). By experiencing positive emotions consistently, the ability to access them more

frequently is acquired. Providentially, positive emotions provide energy that is self-sustaining.

This self-reinforcing positivity cycle generates what is known as an upward spiral toward

improved odds for survival, health, and fulfillment (Fredrickson, 2013b). Fredrickson's (2001)

research suggests that experiences of positive emotions can transform individuals into becoming

more knowledgeable, resilient, healthy, creative, and socially integrated. Figure 2 below conveys

visually the spiral of positive emotions towards a positive lifestyle change. Positive emotions can

serve to build resources and motivate participation in healthy behaviors, an outcome that is
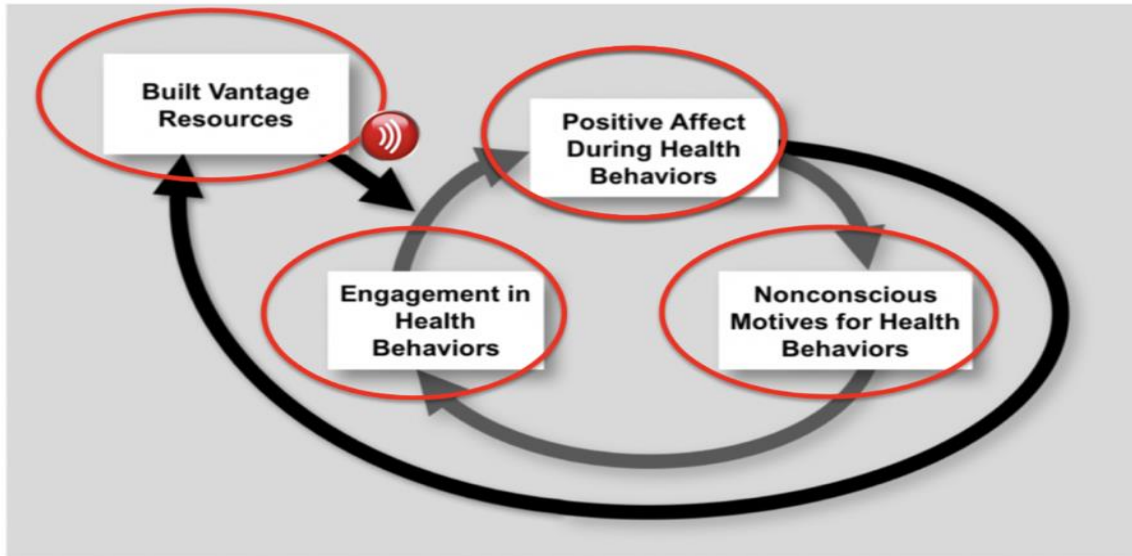
synonymous to recovery.

Figure 2. From "The Upward Spiral Theory of Lifestyle Change," by B. L. Fredrickson, 2013, *Advances in Experimental Social Psychology, 47,* pp. 1-53.

Different positive emotions can serve different purposes and can therefore be activated to generate this upward spiral. For example, interest can broaden one's cognitive scope to encourage exploration, ability to intake new information, and self-expansion (Csikszentmihalyi, 1990; Izard, 1977; Ryan & Deci, 2000; Tomkins, 1962). Joy can ignite a desire to play, extend limits, and act creatively in social, physical, intellectual, and artistic behavior (Ellsworth & Smith, 1988; Frijda. 1986). Contentment evokes a longing to savor present life conditions and use the conditions to inform views of self and the world (Izard, 1977). Pride compels individuals to be social and share updates of personal achievement with others and to imagine more superlative achievements in the future (Lewis, 1993). Love develops routine wishes to play with others, explore, and savor experiences and social bonds with loved ones (Fredrickson & Branigan, 2001). Humor broadens by enabling individuals to reappraise threats and providing a

stable affect, which relates positively to resilience and well-being (Cann & Collette, 2014). Awe

expands worldviews, while deepening absorption and accommodation of new information and

experiences (Fredrickson, 2013a). Hope builds resilience, optimism, and resources for a better

future, while inspiration broadens and ignites motivation for personal growth (Fredrickson,

2013a). Amusement functions to support social bonds, shared mutual care, and experiences of

laughter and cheerfulness (Fredrickson, 2013a). These positive emotions, amongst many more,

can be cultivated to shift perspectives, improve well-being, and motivate healthy behavior

(Fredrickson, 2013a).

Positive emotions have been shown to have profound benefits across many domains of

life. However, Fredrickson acknowledges the need and realistic presence of negative emotions,

both for survival purposes and logical rationale (Fredrickson, 2013c). The question then

becomes, how much positive emotion is necessary to overcome the negative emotions that occur

as part of our everyday lives, or more specifically, a recovery process? The Losada Ratio posits

that the emotional ratio tipping point for those who were flourishing is 3:1. That is, those who

were flourishing experienced three positive emotions for every one negative emotion

(Fredrickson & Losada, 2005). The mathematics behind the values here have since been

challenged (Brown, Sokal, & Friedman, 2013), yet conceptually and empirically, the defense for

the necessity of greater positive emotions compared to negative emotions is strong (Fredrickson,

2013c). The ratio illuminates the strength of the bad in comparison to good, in which bad

emotions, thoughts, and events hold more influence than the good (Baumeister, Bratslavsky,

Finkenauer, & Vohs, 2001). Given the human negativity bias, in which humans have become

predisposed to focus more on the negative for adaptation purposes (Rozin & Royzman, 2001), it

requires much more work and intention to cultivate positive emotions. Therefore, the more doses

of positive emotions one experiences, the better their ability to offset the disproportion delivered by one's negativity bias.

Individuals with eating disorders classify the mental chatter of the eating disorder as negative, critical, and automatic. Without interruption of the illness, the emotional tipping point can move drastically and promptly towards the negative. Such prominence of the negative can ignite a downward spiral towards depression and hopelessness (Fredrickson, 2013b). It becomes imperative that patients are given the tools to stop the disease thinking in its tracks and reclaim a ratio that can best support recovery.

In the midst of Me, It, ED

It was like there was a black cloud following me around. I was spotting what was wrong in every situation, every person, every day. I began to hyper focus on small choices as if every decision was life or death. I felt paralyzed by indecision and negativity. Problems began to arise at every corner, of which I had no solutions for. Mere misery is the only way I can explain this place I lived in. I felt exhausted; terribly exhausted by life. I began to feel hopeless and depressed. I knew in the darkness that no one or nothing could help me. All I could see was the black clouds in front of me, behind me, all around me. I was so stuck in the dark.

A study of more than 2,400 individuals hospitalized for an eating disorder found that 97% had one or more co-occurring conditions, of which 94% had co-occurring mood disorders, mostly major depression (Tagay, Schlottbohm, Reyes-Rodriguez, Repic, & Senf, 2014). Furthermore, when the body is malnourished and routinely subjected to its natural fight or flight response, patients' negativity bias is unusually heightened. This biological response to prolonged starvation over activates the evolutionarily adaptive hardwiring on the brain, inducing a

somewhat uncontrollable pessimistic perspective. On top of the physiological retort, the noise, or inner voice of the illness, is negative and critical (Noordenbos, Aliakbari, & Campbell, 2014). Relevantly, individuals with eating disorder often report lower levels of life satisfaction and higher levels of negative affect (Kitsantas, Gilligan, & Kamata, 2003).

Positive emotions, however, can serve as a buffer against both depression and the noise of the illness. Fredrickson's (2013a) research offers potential avenues for application within the clinical population. Frequent doses of positive emotions may enable patients to entertain and gather more resources that may assist in their progress. Positive emotions can promote thinking outside of the box to spawn more novel and self-generated solutions to achieve recovery. They can even urge patients to push the limits beyond what they may think is possible for their recovery and their lives. Positive emotions can operate to expand the self, in a way that would not be possible without such cognitive broadening (Csikszentmihalyi, 1990). Positive emotions can also combat the noise of the eating disorder by offsetting its negative affect. In recovery, micro-moments of positivity can free the patient from the constant mental agony that comes with living with this illness. The broad repertoires of thought and action that emerge from positive emotions help to build resilience (Fredrickson, 2009.) Resilience is defined as the ability to navigate adversity and to grow in the face of challenges (Keyes, 2002; Seligman, 2011; Revich & Shatté, 2002). Resilience, then, equips patients to deal with challenges and the associated negative emotions they may be experiencing in recovery. Profound appreciation for positive emotions may surface as a result of the previously experienced pain, or negative emotion. Positive emotions can thus serve to support a recovery mindset. The following section will describe a few PIs that have been used to prime an experience to elicit positive emotions or

sustain the presence of positive emotions. The PIs can be edited and adapted to supplement other therapeutic exercises in treating eating disorders.

Gratitude. Many of the very first PIs aimed to provoke the positive emotion of gratitude. Wood, Froh, and Geraghty (2010) define gratitude as "a life orientation towards noticing and appreciating the positive or good in the world or one's life" (p. 891). Emmons and Shelton (2002) recognize the emotional state of gratitude as a combination of thankfulness, appreciation, and a sense of wonder. A grateful orientation has shown to produce an economy of adaptive resources. Those that express gratitude often report improvement on measures of well-being (Fredrickson & Joiner, 2002) and more positive affect (Emmons & McCullough, 2003). Wood and colleagues (2010) believe gratitude to be relevant in clinical contexts as it offers not only a robust elucidatory power in making sense of well-being, but also holds the potential to elevate well-being through nurturing gratitude with basic exercises. For our specific population, gratitude can shift patient's perspective and enable them to reap the benefits of experiencing a positive emotion (i.e., broadening awareness and building resources).

The simplest activity to incite gratitude may be Emmons and McCullough's (2003) proposed *gratitude journal.* The weekly gratitude journal asked for participants to write down up to five things that they felt grateful for. When compared to those who kept track of neutral events or perceived troubles, participants in the gratitude group showed higher scores on emotional and physical health outcomes. Lyubomirsky, Sheldon, and Schkade (2005) repeated this study and found that the prescribed dose by Emmons and McCullough (2003), one time per week, may be the perfect frequency for a gratitude journal. Participants that were designated a more recurrent gratitude journal (three times per week instead of one time) did not experience the same advances as the less frequent group, instead reporting that the activity felt dull and overdone

(Lyubomirsky et al., 2005). The more frequent experience is most likely the result of hedonic adaptation, the natural tendency for humans to acclimate to positive effects of overtime, thus diminishing the reward experienced initially (Bao & Lyubomirsky, 2014). Weekly gratitude journals can be suggested as homework or "self-work" for patients to participate in to encourage the experience of positive emotions. More outstandingly, is the potential for this activity to shift patients' perspective towards noticing more of the good in their lives.

An activity related to the gratitude journal is the aforementioned *three good things* journal, recommended and tested by Seligman et al. (2005). This exercise happens more frequently than Emmons and McCullough's (2003) gratitude journal; participants were asked to keep a nightly journal of positive events that occurred throughout the day that just came to completion. This specific activity resulted in increased happiness and decreased depressive symptoms (Seligman et al., 2005). The activity may seem fairly similar to the gratitude journal, but differs in that the *three good things* requests that participants reflect on event that's took place during the current day, and therefore is everchanging inevitability. *Three good things* can help shift emotional states towards the positive, inviting a more optimistic frame of mind, and balancing out patients' emphasis on the negative. Patients have reported that it helps to prime or setup them up to have a more positive next day. The exercise can be tailored to focus on treatment or the recovery process specifically. I recommend adapting this intervention for the eating disorder population by asking patients to keep a nightly journal of three positive things they did in direction of their recovery over the course of the day. Other therapeutic goals, such as self-advocating or personal care, can be tied into this exercise and positively reflected upon. Essentially, the PI requires people to seek the good that transpires within their daily experiences (Reivich & Shatté, 2002).

Seligman and colleagues (2005) have found a third gratitude exercise to be advantageous, one in which participants create an in-depth thank you letter. The written gratitude letter can be delivered to the designated person (i.e. in a gratitude visit; Seligman et al., 2005), or can be kept confidential to express intrapersonal gratitude (Lyubomirsky, Dickerhood, Boehm, & Sheldon, 2011). This PI demonstrates how writing serves as a vehicle to well-being. Sexton and Pennebaker's (2009) research reveals that expressive writing can improve one's mental and physical health. The practice of writing presents a space for self-inquiry, an opportunity to express externally what has been experienced internally. It creates a degree of distance from an experience that can enable an elevated sense of self-understanding. Results indicated that writing letters of gratitude increased participants' happiness and life satisfaction, while decreasing depressive symptoms. (Toepfer, Cichy, & Peters, 2012). Gratitude letters seem to serve as a means of increasing the experience of a positive emotion and elevating a sense of connectiveness and perceived social support to the theoretical recipient (Wood, Maltby, Gillett, Linley, & Jopseh, 2008). It is important to keep in mind the potential redundancy of this exercise (perhaps more effective if used less frequently) and should therefore be implemented strategically for optimal effect.

Gratitude is a particular positive emotion that can be worked toward and improved upon to increase the frequency of its experience. Both empirical evidence and theoretical conclusions indicate that people can increase their overall happiness through simple and intentional positive activities of expressing gratitude (Lyubomirsky, Nelson, & Layous, 2013). Above all, gratitude is seen as a motivator of self-improvement and positive behavior change (Armenta, Fritz, & Lyubomirsky, 2017). It is motivating and invigorating in nature and can encourage kind behavior and prosocial action (Emmons & Mishra, 2011; McCullough,

Kimeldorf, & Cohen, 2008). Later in the discussion of relationships, it will become evident how

important reciprocal action and relationship incentives are for individuals with eating disorders.

The energizing effect of gratitude boosts resources for coping with challenge (Emmons, 2007),

and can increase positive outcomes beliefs individuals hold for themselves (Lambert, Graham,

Fincham, & Stillman, 2009). Emmons and Mishra (2011) have found that the positive emotion of

gratitude urges individuals to make behavioral progress towards their goals and has been linked

to success in several domains of life. In the coming section on accomplishments, this aspect of

gratitude will lend insight into prompting goal-oriented behavior. Expressing gratitude can

inspire patients to become better versions of themselves and better people within the world

around them (Armenta et al., 2017). Next, we will address an empirically supported action that

can be utilized to increase the lifespan of positive emotions, such as gratitude.

      Savoring. Savoring, the mindful act of engaging in thoughts or behavior to heighten a

positive experience of the past, present, or future, functions to further deepen gratitude and

increase positive emotions (Bryant & Veroff, 2007). There are three temporal forms in which

savoring can occur, 1) anticipating, 2) savoring the moment, and 3) reminiscing (Bryant, 2003).

Anticipating is the pleasure derived from looking forward to an event (e.g., daydreaming joyfully

about a future vacation or the excitement that accompanies thinking about visiting a friend for

the first time in a long while). Anticipating can be used to elevate the experience before it even

happens (Bryant, 2003). Savoring the moment strengthens and lengthens the enjoyment of the

experience in the present moment (e.g. stopping to smell the roses, basking in congratulations

offered). Savoring the moment requires mindful awareness of the present moment and an ability

to fully appreciate the good experience and feelings associated with it (Bryant, 2003). Lastly,

reminiscing is the savoring act of looking back on positive feelings to rekindle or relive the felt

emotions previously experienced (e.g. pondering one's wedding day or recalling a meaningful reunion; Bryant, Smart, & King, 2005). Reminiscing can enable one to re-cultivate the positive emotions once experienced in the present moment, thus prolonging and extending the life of a single positive event. Bryant and colleagues (2005) have found that intentional and frequent reminiscing leads to improvement in depressive and anxious symptoms and increases in positive affect and life satisfaction. In general, a regular practice of savoring predicts greater life satisfaction, optimism, and fewer depressive symptoms (Bryant, 2003).

Savoring can be useful in the treatment of eating disorders through sharpening the perception of sensory experience. Sharpening perceptions can be done by honing in on any of the sensory experiences listed: gustatory (e.g. food), visual (e.g. nature or a painting), tactile (e.g. warm shower or gentle touch), olfactory (e.g. smell of warm cookies) auditory (e.g. music or birds chirping), or any combination of these that demand a deliberate attunement to the present experience (Bryant & Veroff, 2007). In doing so, patients are given the opportunity, to seek, sense, and savor a positive experience within a potentially fearful situation (Bryant & Veroff, 2007). Let's consider food as an example, as rekindling a relationship with food is a primary objective in recovery. Sensory savoring may offer an opportunity to uncover a personal pleasure that the eating disorder has muted (e.g. love for ice cream). Identifying sensory savoring techniques can invite patients to have a positive experience with their nourishment, tasting and smelling it curiously and appreciatively. For individuals with eating disorders, savoring exercises around food must be approached delicately as a solid foundation of recovery is formed. Thus, it important that the practice is appropriate for the patient based on the stage of recovery they are in. At the beginning stages of recovery, food savoring exercises could be extremely difficult and triggering. The upcoming section on mindful distraction serves as a more apt coping strategy

during those times in recovery. When the individual's relationship with food is more established,

savoring activities can be explored. There is a surplus of food savoring exercises that can be

found online and in publicly available mindfulness resources.

A safer route with patients is often to focus savoring exercises on non-sensory

experiences. One PI intended to provoke positive emotions through the act of savoring is the

"positive portfolio." The goal of the positive portfolio is to evoke a particular positive emotional

state from experiencing a personalized verbal, visual, and auditory database. Participants are

asked to select a desired positive emotion, and then collect items, such as pictures, letters, emails,

poems, objects, etc., into a physical or electronic portfolio (Fredrickson, 2009). Once the

participant has created a portfolio intended for the specified emotion, they are asked to spend 15

minutes each day for the next week cultivating that emotion by spending time with items of their

portfolio. The time spent with the positive portfolio is savoring in action and can be used to reap

the benefits of both savoring and positive emotions. Participants can continue the intervention by

creating additional positive portfolios to cultivate other emotional states. The practitioner can

support the planning stages of this exercise (e.g. what types of things the patient may collect,

where those are located, and by what date), offer a session where they savor pieces from the

positive portfolio, or prescribe the exercise as homework. I would recommend that the positive

portfolio intervention be modified for this population to evoke an identified positive emotion, to

buffer against a downward spiral, and/or to create a felt sense of connection, purpose, and

positive affect for patients.

Savoring serves not only to elongate positive emotions, but also to deepen their effects.

Positive emotions and experiences should be capitalized and used up for all that they are worth,

and savoring enables individuals to reap the benefits most fully. Keep in mind that the cultivation

of certain emotions and the recommended exercises are most effective when they are tailored to

meet the individual needs of the person. Research suggests that happiness-increasing strategies,

like priming an experience to stimulate positive emotion, work best when there is a fit between

person and activity (Sin & Lyubomirsky, 2009). The figure below depicts the optimal

relationship between prescribed activity and individual variants.
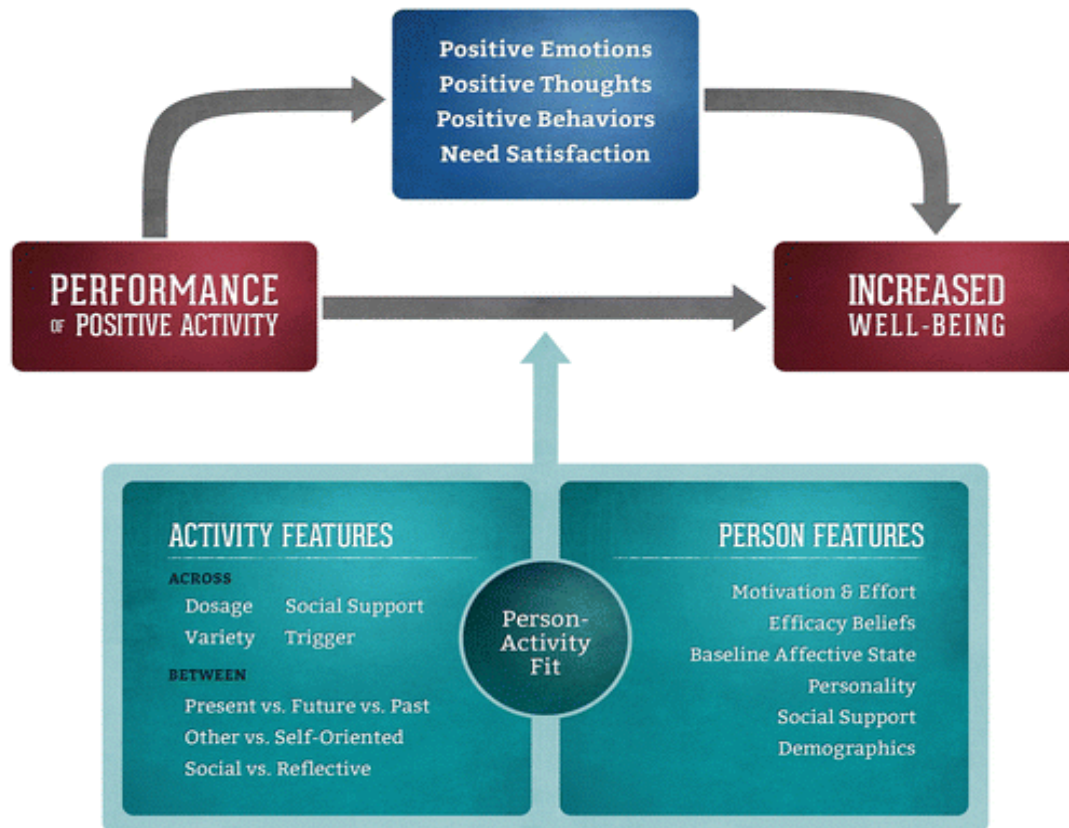

Figure 3. From "The Positive-Activity Model," by Lyubomirsky and Layous, 2013, *Current*

Directions in Psychological Science, *22*(1), p. 58.

Put simply, individuals with eating disorders could use more doses of positive emotions.

The hopeless, depressed, and shameful disposition (Geller, Williams, & Srikameswaran, 2001)

of the illness can often make experiences and the process of recovery far from positive.

Nonetheless, in knowing we can prime, provoke, and prolong positive emotions, we are given an

opportunity to shift the nature of recovery. And in doing so, patients are accruing resources that

can serve to motivate them to recover, broaden their cognitive awareness, and elevate their sense

of self (Fredrickson, 2009). Positive emotions and the act of savoring call for a degree of

presence and engagement. The subsequent section will focus on engagement, the second

component of the PERMA model, and explore how it serves to support recovery.

Engagement

Engagement, like positive emotions, is a distinct predictor of individual well-being

(Schueller & Seligman, 2010). Engagement focuses on the pursuit of absorbing activities and

focused attention as a pathway to optimal functioning and psychological well-being (Peterson,

2006). Active engagement holds the capacity to prompt an experience of flow, a mental state in

which one becomes submerged in an activity, in the omission of all other thoughts and emotions

(Csikszentmihalyi, 1990). Flow experiences are one of the markers of a life lived well and

therefore will be discussed further.

Flow. Mihaly Csikszentmihalyi, one of the founding fathers of positive psychology and

the Distinguished Professor of Psychology and Management at Claremont Graduate University,

is responsible for coining the term, flow. The deep and effortless concentration of a flow state

provides a gateway to meaning, enjoyment, and positive and productive functioning

(Nakamura & Csikszentmihalyi, 2003). These states are best described by the following eight

characteristics: 1) complete concentration on the task, 2) clarity of goals and immediate

feedback, 3) transformation of time, 4) intrinsically motivating experience, 5) a felt sense of

effortless and ease, 6) balance between challenge and skill level or strength, 7) loss of self-

consciousness and merging of action and awareness, and 8) a feeling of control over the task at

hand (Csikszentmihalyi, 1990). A prerequisite to the state is the balance between skill and

action, such that if the activity exceeds skill than it may become frustrating or anxiety provoking,

and likewise if skill surpasses the activity than boredom or distraction is more likely to be the

outcome (Nakamura & Csikszentmihalyi, 2009). Flow requires a landscape of perfect balance

between the two. Instead of challenges being demanding, they eventually became harmonious

and engaging. Subsequently, once flow is experienced, a want to experience it again and again

develops (Csikszentmihalyi, 1990). Flow is an opportunity for growth, as it lures towards an

improved sense of being. Csikszentmihalyi (1990) recommends applying one's character

strengths to access such flow states more readily.

      Character Strengths. Activating character strengths in original ways strengthen our

capacity to engage such strengths and increases the opportunity to enter flow (Csikszentmihalyi,

1990). Character strengths function to enhance the positive, buffer against the negative, and shift

perceived adversities. They are mechanisms that define various virtues. Virtues are the

overarching characteristics that are valued morally and religiously (Peterson & Seligman, 2004).

There are six virtues: wisdom, courage, humanity, justice, temperance, and transcendence, and

twenty-four-character strengths that function to create a pathway to each of the six virtues

(Niemiec, 2017). The awareness, exploration, and appreciation of strengths and virtues are key to

living a good psychological life (Peterson & Seligman, 2004). Strengths can be discovered and

made more tangible through the VIA character strengths assessment; a free online survey offered

by the VIA Institute on Character. Within the 24-character strengths, there are signature

strengths, lower strengths, happiness strengths, "rise to the occasion" strengths, middle strengths,

and lost strengths (Niemiec, 2017). Importantly, the survey allows individuals to identify and

claim ownership over their signature strengths, strengths that feel authentic to the individual.

Signature strengths are easy to connect with and have individual value. A person typically has

three to seven signature strengths, that usually fall within their top five strengths (Niemiec,

2017). They appear exciting and effortlessly exercised (Niemiec, 2017). These strengths tend to feel like they are part of one's identity and may ignite energy and joy while using them (Niemiec, 2017). These signature strengths can be explored and activated to enhance, shift, and moderate experiences. The strengths and virtues recognized by the VIA Institute on Character can be found in the figure below.

Figure 4. VIA Classification of Character Strengths. From "VIA Classification of Character

Strengths and Virtues" by the VIA Institute on Character, 2004-2016.

(https://www.viacharacter.org/character-strengths).

Never Present

It robs my attention in every moment. Move. Don't move. Eat this. Don't eat that. What's

in that? Don't have it. Not enough. Do more. Have more. Have less. Say no. Say yes. I

can't even tell you the last time I was where I was. It controls my every thought, my every

experience, my every day. So much noise, so much distraction. When I was a kid, I used

to be able to laugh at the dinner table, talk with my family–be normal, you know? I used

to be able to play the piano or go to the movies with friends and do the thing I was doing.

What I would give to have a moment of freedom. What I would do to feel normal again.

For the eating disorder population, exercising character strengths and entering into flow

states can offer an escape from the illness, an absorption outside the attainment of thinness or

disturbed eating practices. Exploring flow activities or experiences that elicit flow can empower

patients to engage in activities that free them from eating disorder narratives and rumination. In

such states, patients embrace new experiences and opportunities through the development of

skills and personal assets (Csikszentmihalyi, 1990). According to the National Center on

Addiction and Substance Abuse at Columbia University (2003), low self-esteem is a common

characteristic of individuals who have eating disorders. In response, flow states enable a loss of

self-consciousness and an increase in self-esteem, in which patients can take a break from

monitoring and worry about themselves and their appearances. Flow states require an acute

focus, during which the patient cannot be aware of or worry about the things he/she typically

does, such as food, body, or control (Csikszentmihalyi, 1990). Csikszentmihalyi (1990) refers to

this concentrated engagement as a way of escaping forward.

Research indicates that activities that are most likely to induce the experience of flow

include sports, dance, creative arts, sex, socializing, studying, listening to music, reading and

working (Csikszentmihalyi, 1990). Activities that avert flow states from occurring include

housework, watching television, and being in inactive solitude (Csikszentmihalyi, 1990; Delle

Fave, & Massimini, 2004). Encouraging patients to seek out flow inducing activities or to engage

in small pleasures can provide a taste of life absent of illness and offer a sense of hope and

optimism in their capacity to feel a similar way in the future. It can often be helpful to pinpoint

flow states experienced previously and use that to inform re-entry. Prompted journaling exercises

can be used to identify experienced flow states. Engagement and flow offer patients the

opportunity to feel in control of their lives, a feeling that is often perceived to be taken away

when surrendering to professional recommendations and medical care.

      In addition to galvanizing flow states, character strengths can be exercised to encourage

recovery behavior and empower patients from an autotelic space. Recovery calls individuals to

access the best part of themselves to progress. I have never met a patient that said I called on my

weaknesses, or the worst parts of myself, to overcome this life-threatening disorder. Thus, a

strength-based approach of PPT recognizes the inherent strengths of patients and accesses them

as a means of sparking recovery behavior.

      Strengths can function to combat thinking traps, or inflexible, mental short cuts that cause

us to miss critical information (Reivich & Shatté, 2002). For example, individuals with eating

disorders have significantly higher scores on a factor representing maladaptive perfectionism

(Ashby, Kottman, & Schoen, 1998). Such perfectionism operates as a thinking trap for patients

that tends to support the illness rather than the individual. Most people fall into thinking traps in

their daily life, with them arising most typically, and somewhat automatically, in situations

where they feel vulnerable, they feel depleted or exhausted, there's uncertainty, when they feel

they have missed something, or when they are in situation they have been in prior and they have

certain expectations of how the situation *should* turn out (Reivich & Shatté, 2002). Perfectionism

is a result of all or nothing thinking, a trap that operates in extremes and sees situations as

either/or (Reivich & Shatte, 2002). When patients perceive their recovery in the black and white

manner, it makes the inevitable ups and downs of the process unbearable to manage. The

recovery process is non-linear; thus, it becomes essential that patients are given the tools to

navigate the challenges that arise and entertain shades of grey.

Reivich and Shatte (2002) provide real-time resilience (RTR) strategies intended to quiet

counterproductive thinking and develop focus, confidence, and composure. Note that the

intention of correcting thinking traps is to guide thinking to become more accurate, thorough,

and flexible. Signature strength integration is one RTR strategy (Reivich, 2019) that patients may

use to build optimism and fight against thinking traps. The main tool then becomes to draw

awareness to the capabilities that reside within each patient. RTR sentence starters such as "a

strength I can pull on at this moment is……," can be used to shift the narrative of the pre-

existing thinking trap. Patients can evaluate what strengths they have exercised in other areas of

life to achieve success and use it to inform them of how they can use their strengths to achieve

recovery. For example, a patient could be asked to spot the strength of perspective in a previous

experience, such as lending insight to a friend. We can then invite the patient to identify how

they could use that same strength in the process of weight restoration. How can they use

perspective to create space and objectivity from bodily changes? How can perspective be

exercised to shift emphasis onto larger values in life, outside of appearance? Strengths can be

spotted and applied to reinforce the patient's power within their recovery journey. They can also

be accessed to reshape activities that were once controlled by the eating disorder motives (i.e.,

reframing exercise from punishment to a social activity by honoring the strength of connecting with others).

Ryan Niemiec, the Education Director and Psychologist for the VIA Institute of Character, has created a plethora of strength-based exercises in his book, *Character Strengths Interventions: A Field Guide for Practitioners,* intended to prime, activate, and exercise one's character strengths. As mentioned prior, *using signature strengths in a new way* is one activity in which individuals are asked to use one of their top strengths originally and differently every day for one week. Repeated research results show increased happiness and decreased depressive symptoms for six months post-intervention (Peterson, Park, & Seligman, 2005). Niemiec's book offers additional interventions that can be adapted for application with patients to support their recovery process and their life outside of the eating disorder.

It is important to be aware of the degree to which character strengths are used. Seligman (2002) proposed that people should detect their signature strengths and then seek to further develop them to improve well-being. To some, this theory infers that "the more developed any strength is, the better people are" (Schwartz & Sharpe, 2006, p. 380). Think of that notion; is too much of anything a good thing? Perhaps we look at the character strength of self-regulation. Research reveals that individuals with anorexia nervosa overuse of the strength of self-regulation. Kitsantas and colleagues (2003) found that college women with eating disorders reported more self-regulated strategies for managing their body and weight than their healthy peers. At-risk students also reported higher levels of self-regulation and negative affect than did students of normal weight. When self-regulation is used in excess, it can become destructive rather than productive. Staying steadfast to the character strength of self-regulation can lead to

inhibition, restriction, and deprivation (Seligman, 2015); all of which are characteristics of the

eating disorders.

      To date, research has found that there may be "darker sides" to character strengths

(Freidlin, Littman-Ovadia, & Niemiec, 2016). In such cases, the overuse or underuse of strengths

can potentially lead to undesirable outcomes and even psychopathology. Seligman (2015) has

uncovered that there is an optimal-use of strengths; where there is a right combination of

character strengths, the right degree or amount exercised, and the right time, situation or context

for the application. Figure 5 below illustrates the extreme of strength overuse and underuse.

Strengths and Virtues

	Strength	Opposite	Absence	Excess
Wisdom and Knowledge	creativity	triteness	conformity	eccentricity
	curiousity	boredom	disinterest	nosiness
	judgment	gullibility	uneffectiveness	cynicism
	love of learning	orthodoxy	complacency	"know-it-all"-ism
	perspective	foolishness	shallowness	ivory tower
Courage	bravery	cowardice	fright	foolhardiness
	persistence	helplessness	laziness	obsessiveness
	authenticity	deceit	phoniness	righteousness
	vitality	lifelessness	restraint	hyperactivity
Love	intimacy	loneliness	isolation/autism	emotional promiscuity
	kindness	cruelty	indifference	intrusiveness
	social intelligence	self-deception	obtuseness	psychobabbling
Justice	citizenship	narcissism	selfishness	chauvinism
	fairness	prejudice	partisanship	detachment
	leadership	sabotage	compliance	despotism
Temperence	forgiveness	vengefulness	mercilessness	permissiveness
	humility	arrogance	footless self-esteem	self-deprecation
	prudence	recklessness	sensation-seeking	prudishness
	self-regulation	impulsivity	self-indulgence	inhibition
Transcendence	awe	criticism	oblivion	snobbery
	gratitude	entitlement	rudeness	ingratiation
	hope	despair	present orientation	Pollyannaism
	humor	dourness	humorlessness	buffoonery
	spirituality	alienation	anomie	fanaticism

Figure 5. VIA Strengths & their Opposites, Absences, Excesses. From "Chris Peterson's

unfinished masterwork: The real mental illnesses," by Seligman, 2015, *The Journal of Positive*

Psychology, *10*(1), pp. 3-6.

When asking individuals with an eating disorder to identify and exercise strengths, it is important to be aware of the undesirable outcomes that may accompany the absence and/or excess of particular strengths. The above information conveys that strengths are multifaceted and must be used in a mindfully and intentionally. Therefore, the ensuing section will address the state of consciousness required to appropriately activate and apply character strengths.

Mindfulness. For strengths to be employed optimally, patients must first cultivate awareness. Self-awareness, discovery, and efficacy are made possible through the mindfulness practice. Mindfulness presents the opportunity for patients to connect with themselves fully. It is defined as intentionally attending to the present moment without judgment (Smalley & Winston, 2010). Mindfulness asks for detailed self-awareness without judgment on either the current experience or the emotional reactions that coincide with adversity and personal failing (Neff, 2011; Neff & Davidson, 2016). The practice enhances the awareness around the disconnection of the illness and strengthens the capacity to reconnect with self and life (Hölzel et al., 2011). The mindfulness practice offers eating disorder patients the space to feel whatever it is they are experiencing at the moment, without needing to fix or change anything. With a disease rooted in control, mindfulness operates to contradict the neural wiring of the disease. Instead of manipulating the body or food, mindfulness creates the space for patients to sit with the discomfort that may arise without needing to change it.

Hölzel and colleagues (2011) offer insight into the mechanism of exposure through which mindfulness works. The practice allows patients to repeatedly expose themselves to whatever is showing up within their awareness while refraining from internal reactivity. Research suggests that eating disorder patients have structural and functional impairments in their neurocircuitry that pose as an obstacle in recovery (Hill, 2017). Specifically, there is dysfunction in the area of

the brain called the insula, which can act as a significant barrier to recovery (Nunn, Frampton, Gordon, & Lask, 2008). The limited stimulation of the insula affects other areas of the brain which, in turn, support eating disorder behavior. The somatosensory cortex is responsible for distorted body image, the basal ganglia for the obsessive drive, the amygdala for extreme anxiety, and the prefrontal cortex for executive defects. The insula plays a significant role in offsetting these other areas, as it the bridge between the right and left sides of the brain, between the feeling brain and the thinking brain (Nunn, Frampton, Fuglset, Sonnevend, & Lask, 2011). The figure below illustrates the impact the insula imbalance has on the functioning of other areas of the brain.
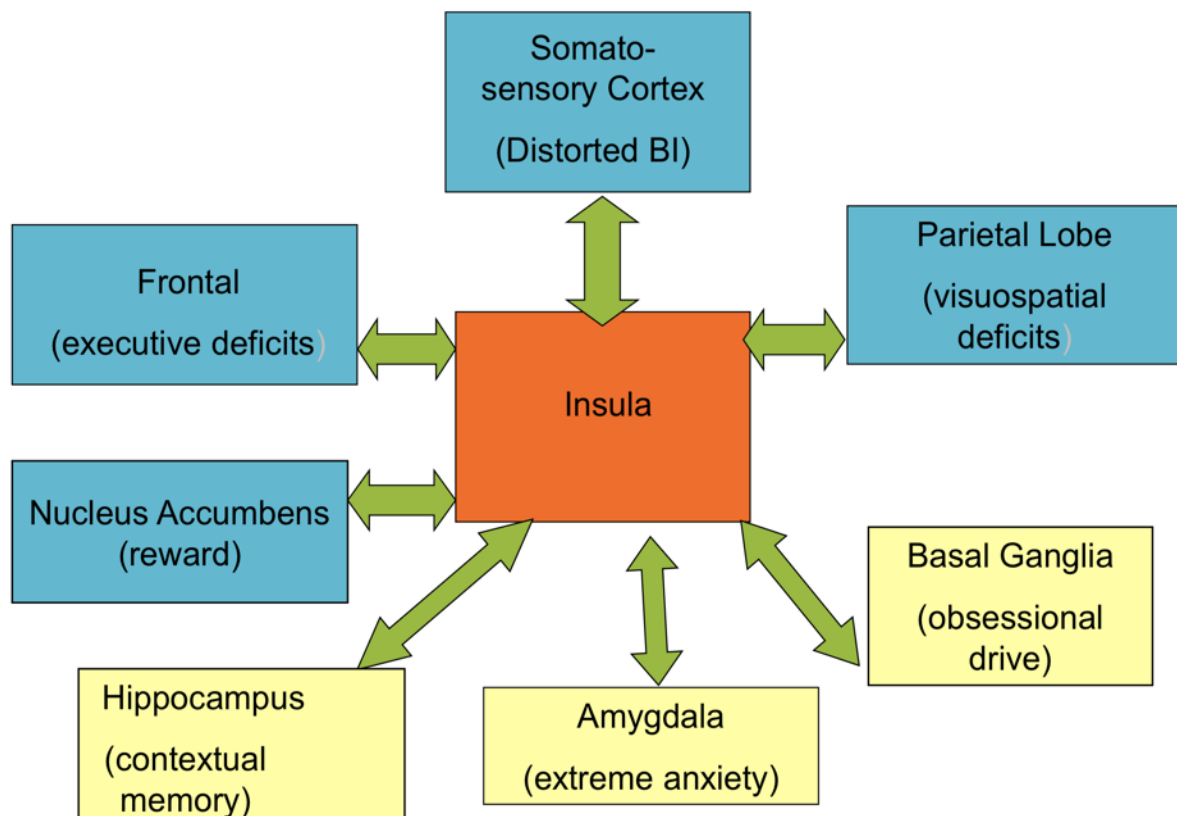

Figure 6. Insula dysfunction in Eating Disorders. From "Eating Disorders: An Overview," by The Healing Connection, 2018.

Mindfulness, on the contrary, increases activity in the insula and prefrontal cortex, while decreasing activity in the amygdala (Wheeler, Arnkoff, & Glass, 2017). The lessened activity in the amygdala during mindfulness enhances the capacity to regulate emotions. Eating disorders are often used to numb emotions, and the practice of mindfulness permits patients to feel emotions they previously suppressed in a regulated manner. Baime (personal communication, October 5, 2018) emphasizes the profound effect mindfulness has on reintegrating with oneself in a way that we can feel whole as a result of giving every emotion the space to be experienced.

More than anything, the mindfulness practice invites patients to connect with their bodies nonjudgmentally and from a place of self-compassion. The following section further explains the role such self-compassion can play in recovery. Moreover, body-awareness is a byproduct of the practice, as being with the self openly and curiously supports the ability to notice subtle bodily sensations and increase empathic and compassionate responses (Hölzel et al., 2011). To treat a disorder fueled by negative and critical body commentary, we need mindfulness to cultivate the capacity to notice and experience the body from a neutral point of view. Furthermore, the anterior cingulate cortex functioning is enhanced through the practice, which enables executive attention. Eating disorder patients have altered limbic and cognitive neural circuits directly affecting selective attention, planning, and effective response regulation (Kaye, Fudge, & Paulus, 2009). The self-talk of the disease can become all-encompassing. With repeated mindfulness practice, ruminative thoughts and reactivity to those repetitive thoughts decrease (Hölzel et al., 2011). Indeed, mindfulness enhances neuroplasticity, which supports greater mental flexibility (Baime, 2011). It also increases immunity, encourages healthy behaviors, and lowers stress levels (Greeson, 2009). Eating disorder patients need a practice that holds the space to experience the full spectrum of human emotion without judgment. It is in the mindfulness

practice that the plasticity of the brain is changed from the existing brain functioning of the eating disorder and cognitive improvements are made possible. With expanded awareness, patients are given the space to insert beforementioned tools, interventions, and strengths.

It is important to recognize the stage of recovery the individual is in when promoting certain mindfulness strategies. For example, if an individual is going through the depths of weight restoration, mindful body scans may be more triggering than helpful. Similarly, if an individual is anxious and uncomfortable around food, asking him or her to be present at mealtime may be more destructive than productive for some time. In such cases, I highly recommend mindful distraction. That is, intentionally choosing to focus the patient's attention elsewhere to support recovery action. Mealtime mindful distraction may include going around the table and sharing an experience where they used a strength to overcome a challenge, sharing a good thing that happened or something they are looking forward to, playing the questions game (e.g., having a cup of sticks that have silly questions written on them and going around the table posing the question on the stick chosen), creating a joint playlist and having it on in the background during mealtime, or offering a video during mealtime (e.g., an inspiring ted talk video, a funny agreed upon movie, or a feel-good sitcom). These distractions are intended to be consciously chosen based on the experience of the patient. They are not meant to numb or dismiss the felt experience, but rather accept where the patient is and act in accordance with what they can handle at that time. Mindful distractions also come in handy when dealing with body image. Again, being overly present with the body may not benefit the patient at different stages. I recommend encouraging patients to engage in mindful distractions until the body image diminishes some (e.g., this is a natural process that reduces as symptom use is eliminated and consistent nutrition is given to the body). Mindful distraction is a great option for patients at the

beginning stages and during uncomfortable moments of recovery and enables them to feel in

power of their decision to distract rather than feel as if they are surrendering hopelessly to

distractions.

Engagement functions as an entry into experiencing life most fully, serving as a

countermeasure to the blandness and disconnection of a life lived on automatic pilot. When

individuals with eating disorders are given opportunities to enter flow states, exercise their

strengths, and become deeply emerged and present in their lives, the need to use the destructive

coping skill of the eating disorder is diminished organically. The succeeding component of

PERMA, relationships, would not stand to produce the degree of beneficial effects without the

elements of engagement and mindfulness.

Relationships

Relationships are often considered the single most important factor for well-being

(Prilleltensky, 2016). Those with strong interpersonal relationships are less likely to have a heart

attack, more likely to resist the common cold virus, have lower mortality rates, experience less

stress, are more optimistic, more resilience, and recover faster from wounds (Prilleltensky,

2016). Furthermore, a lack of social relationships is as significant a risk factor as smoking,

excessive alcohol, and lack of physical activity (Holt-Lupstad, Smith, & Layton, 2010). A

relationship, however, does not only exist interpersonally but also intrapersonally. This section,

therefore, will be dual faceted, in that we will look at both the relationship with oneself and

relationships with others. Please note that this section will be condensed to the amount of

supporting evidence that exists regarding relationships, recovery, and well-being. The surface-

level analysis is primarily because several of the therapeutic methods described in the first

section already do a phenomenal job of supporting the development and maintenance of healthy

and meaningful relationships to encourage adaptive behavior change. Consequently, this section is intended to reinforce the importance of relational work and encourage its application with the specific population in mind.

Relationship with Oneself. The first focus of this section will be on the relationship with oneself, otherwise known as an intrapersonal relationship. It can be argued that strong intrapersonal relationships predict healthier interpersonal relationships, or relationships with other people (Schutte et al., 2001). To support this argument, we will stress the importance of intrapersonal justice and self-compassion before exploring social and interpersonal relationships.

Intrapersonal Justice. Intrapersonal justice is rooted in core concepts of mattering and fairness (Prilleltensky, 2012). Fairness can be defined as the exercise or act of justice (Prilleltensky, 2013) Justice, then, means giving what is deserved to a person, in which each person is given his or her due (Sandel, 2009). Prilleltensky (2012) suggests that prime conditions of justice lead to thriving. Without fairness, the pursuit of well-being cannot produce the outcome that individuals and communities desire and most need (Prilleltensky, 2013). This diverse set of justices includes intrapersonal justice, in which fairness is allocated to oneself through self-talk and self-permission, action and personal care, and feelings of worth and value. Intrapersonal justice happens at the personal level, a justice that sheds light on the constant relationship which exists within human beings (Prilleltensky, 2012). Our thoughts, behaviors, and feelings impact each other, and therefore can either network together to foster well-being or suffering. Prilleltensky (2012) argues and acknowledges that as human beings we can be fair or unfair, just or unjust, to ourselves based on what we offer ourselves and how we treat ourselves. This can be classified as intrapersonal distributive justice (i.e. what we give ourselves about the fair dissemination of outcomes, such as resources and opportunities) and/or

intrapersonal procedural justice (i.e. how we treat ourselves with the fair processes of choosing

and voicing our needs; Prilleltensky, 2012). When this inner justice is not afforded to oneself, a

degree of psychological corruption can surface. This contrary state is when one exhibits an

unfair relationship with themselves by putting themselves down and deeming themselves

unworthy of just thoughts and behaviors (Prilleltensky, 2012). Causing oneself unnecessary

pain and suffering adversely affects well-being. Examples of prevalent intrapersonal injustice

are found in those who suffer from eating disorders or self-harming tendencies (Prilleltensky,

2016). Many individuals give up control over their lives and depend upon professionals to fix

them and assume that relinquishing their power will change their behavior and internal

relationship (Powers, Faden, & Faden, 2006). However, Prilleltensky (2012) proposes personal

fairness as a means of empowerment, control, and ownership of one's well-being. The imbalance

of intrapersonal injustice can be offset by adopting a more self-compassionate and less critical

internal dialogue and approach with oneself.

   Self-Compassion. Dr. Kristin Neff, an Associate Professor of Human Development and

Culture at the University of Texas at Austin, serves as one of the leading researchers, authors,

and teachers in the field of self-compassion. Neff has experienced and witnessed the ample

amount of intrapersonal injustice present in the world today and found empirical evidence to

support an opposing approach in relating to oneself. Self-compassion is a way of relating

effectively, appropriately, and fairly to the suffering and adversity that are inevitable parts of

being human (Neff, 2011). Self-compassion consists of three elements: 1) self-kindness, 2)

common humanity, and 3) mindfulness (Neff, 2011). Self-kindness is about directing warmth

and understanding toward the self when we suffer or feel less than, rather than disregarding our

pain or punishing ourselves with harsh self-criticism. It is treating oneself with the care and

kindness that one would treat a good friend and offering positive, motivating, and supportive self-talk (Neff, 2011). Common humanity is the concept of having the awareness and understanding that suffering and struggle are part of the shared human experience. Given that facing adversity is part of this common experience, a deeper understanding that you are not alone in your suffering is presented. Having a mindset of common humanity might support people in feeling connected and supported rather than isolated and alone during challenging times (Neff, 2011). Mindfulness, as described earlier, is the act of tending deliberately to the present moment without judgment (Kabat-Zinn, 2009). Mindfulness enables one to witness negative thoughts and emotions, without trying to suppress or deny them. It keeps individuals from over-identifying with an emotional experience so that openness, clarity, and nonjudgmental observation is made possible (Neff, 2011). When the three elements of self-kindness, common humanity, and mindfulness cooperate, they form a self-compassionate mindset.

Unfortunately, there is a lot of resistance to the concept of self-compassion. The biggest fear around adopting a self-compassionate mindset is becoming lazy, content or unmotivated, and/or selfish or self-absorbed (Neff, 2011). The research, however, shows quite the contrary. Self-compassion enhances intrinsic motivation and self-improving behavior (Breines & Chen, 2012), in which people tend to establish goals related to personal knowledge and growth rather than trying to achieve external approval (Neff, 2011). It also increases one's self-confidence in their ability to succeed, or their self-efficacy beliefs. It leads individuals to take more, not less responsibility for one's actions (Breines & Chen, 2012). Self-compassion is also associated with positive psychological functioning (Neff et al., 2018; Neff & Costigan, 2014; Neff & Germer, 2017). Such positive psychological outcomes include lower levels of depression, anxiety, and rumination, higher levels of positive affect, emotional intelligence, life satisfaction, intellectual

flexibility, optimism and social connectedness (Neff & Germer, 2017). Furthermore, self-compassion is related to healthy responses to stress and more resilient behavior after challenges or failures (Neff & Germer, 2017). In essence, the research confirms that a self-compassionate mindset relates to higher well-being, better psychological functioning, and greater acceptance of oneself and one's circumstances (Neff & Germer, 2017).

Bullied by Bestie

> *Everything I do is wrong. I can't win at this game with ED. From the way I look, to what I say, or eat, or wear, or write; it ALWAYS has something critical to say. At this point I just wait, wait for it to drown me in its disapproving tone −"you've fucked up again, you're not enough, you'll always be this way." One time, upon request, I kept a hairband on my wrist and snapped it every time my ED criticized me. I had to stop when my wrist got so red it almost began to bleed. I tell you, the harsh inner critic, it never leaves my side. I hate it, yet at the same time, I have no idea what I'd be without it, but I also have no idea who I am with it. It feels like my worst best friend. And in listening to it, I have forgotten who I am.*

Intrapersonal injustice can lead to the physical injustice of an eating disorder. Individuals with eating disorders report feeling unworthy of just behavior as if they do not deserve certain fundamental needs, and that they should ignore their own needs and interests to serve others (Bachner-Melman, Zohar, Ebstein, & Bachar, 2007). This intrapersonal injustice can be a result of low self-worth and lack of self-esteem, two overly present characteristics in eating disorder patients (Kelly, Vimalakanthan, Carter, 2014; Williams et al., 1993; Silverstone, 1992). The injustice disconnects patients from their authentic selves (i.e., candid thoughts, feels, and needs) and from their bodies (i.e., accurate sensing and interpretation of bodily states; Tantillo, 2006;

Sanftner & Tantillo, 2010). Eating disorder patients also demonstrate intrapersonal perfectionism, which can fuel a critical, self-harming, and tyrannical inner dialogue (Claes, Soenens, Vansteenkiste, & Vandereycken, 2012). Many patients believe this intrapersonal injustice serves them or enables them to be successful, both in eating disorder objectives and life goals. Individuals with eating disorders tend to not only have lower self-compassion, but also a higher fear of self-compassion (Kelly et al., 2014; Kelly, Carter, Zuroff, & Borairi, 2013). However, addressing, facing, and combating these fears through the development of self-compassion can work to offset the intrapersonal injustice that fuels the narrative of the eating disorders.

Much research has been done to prove the benefits of building self-compassion for eating disorder prevention and treatment (Kelly et al., 2013). Currently, treatment centers around the world are integrating this empirically-based work to support recovery. Given its existing application within the eating disorder population, I will reiterate and applaud the related research simply and apace.

Self-compassion is proven to be negatively associated with eating disorder symptomatology and the external shame that coincides with the illness (Ferreira, Pinto-Gouveia, & Duarte, 2013). It can lessen body image dissatisfaction and the intense motive for thinness, as well as encourage body acceptance. Research by Braun, Park, and Gorin (2016) finds that self-compassion may work to fight against eating disorders by reducing eating disorder-related outcomes, interrupting risk factors, preventing the initial onset of risk factors, and interfering with the behavioral chain through which risk factors function. Their findings suggest that self-compassion is a protective factor against eating disorders and negative body image in both clinical and nonclinical populations. Self-compassionate women report experiencing less body

dissatisfaction, body shame, and body preoccupation (Neff & Lamb, 2009). Self-compassion reduces disordered eating behaviors, supports intuitive eating, and is linked with healthier beliefs, attitudes, and behaviors towards one's body (Neff & Lamb, 2009). It also serves as a key factor in offsetting the destructive psychological processes of the eating disorder that comprise well-being, such as body comparison, body shaming, self-objectification, and self-degrading body talk (Webb, Fiery, & Jafari, 2016). As seen, the effects of this practice are significant. Albertson, Neff, and Dill-Shackleford (2015) conducted a study of women with body image worries and found that after just three weeks of self-compassion meditation, body dissatisfaction lessened, and body appreciation increased. Also, the participants who were assigned the self-compassion meditation did not base their self-worth on their appearance as heavily as they did before the intervention (Albertson et al., 2015). Such improvements were sustained when measured three months later.

Self-compassion can be a beneficial means of combating the abusive mental noise of the eating disorder. Approaches to cultivating self-compassion are a cost-effective and empowering method of improving body image (Albertson et al., 2015), reducing eating disorder behavior (Kelly & Carter, 2015), and supporting healthy attitudes and behaviors around food and body (Neff & Lamb, 2009). The suffering that comes with having an eating disorder or recovering from an eating disorder requires patience, support, and gentle and unconditional care. I often ask patients, "If you are the only one with you 24/7 for the rest of your life, who are you being for you?" Most importantly, "How are you being to you as you go through this challenge?" "Would you be that way to your best friend?" In fact, "Would you even be that way to your worst enemy?" These questions bring awareness to how the eating disorder communicates and therefore can prompt alternative action. I believe that developing a self-compassionate inner

dialogue may be the most accessible and effective tool in fighting the illness's chatter. It is

important to note that certain research suggests that when intervening with individuals with

existing eating disorders, you must first target the fear of self-compassion before assigning the

exercises (Kelly et al., 2014; Kelly et al., 2013). The objective is for patients to be able to debunk

their fears to embrace the practice and supportive research. This may take time and may require a

routine practice before the patient believes or is comfortable with tending to oneself in this way.

I recommend normalizing that experience and encouraging the practice until the patient is

accepting of the self-compassion approach. I also find conveying the research to be a helpful tool

in attaining buy-in from patients. Appendix A offers research, resources, and exercises that be

used with patients to help build self-compassion.

As eating disorders disconnect patients from themselves and their bodies (Tantillo, 2006),

it becomes imperative that we provide patients with the skills necessary to reestablish a healthy

intrapersonal relationship. Self-compassion offers patients an opposing narrative to the illness

and serves to connect patients with themselves in an effective, empowering, and loving manner.

It is a means of correcting the terrible intrapersonal injustice that individuals with eating

disorders face. As the relationship with oneself heals, it is crucial that meaningful relationships

with others are present to support one's recovery, sense of connection, and feelings of belonging.

We will now move into the value of interpersonal relationships in the recovery process.

Relationship with Others. The section will direct its efforts on relationships with others,

otherwise known as interpersonal relationships. Much work has been done within eating disorder

treatment to encourage relational development and support. Family-based therapy, multi-family

therapy, relational-cultural therapy, MANTRA, and the Maudsley method are all examples of

therapeutic approaches that emphasize and highlight the interpersonal component of recovery.

Given the surplus of relational work being administered within the field of eating disorders, this section will be notably shortened in comparison to the research that supports its implementation. Therefore, we will primarily focus on the importance of interpersonal relationships and ways in which patients can increase their daily dosage of social connection.

    Interpersonal Relationships. Interpersonal relationships are strong predictors of well-being and prevention against ill-being (Ramsey & Gentzler, 2015; Wills, 1985; Fredrickson, 2013a). In 2001, Diener reported that social relationships were the only factor that consistently predicted subjective well-being. More recent reports convey similarly that subjective well-being is closely related to one's social life and relationships (Moore, Diener, & Tan, 2018). This relationship is bidirectional, such that relationships positive influence subjective well-being and subjective well-being positive influences relationships (Moore et al., 2018). This may be because having higher subjective well-being makes us more likable and therefore receive greater external approval (Boehm & Lyubomirsky, 2008). Subjective well-being also boosts participation and engagement in social activities (Berry & Hansen, 1996), and more regular and better-quality interaction with friends (Pinquart & Sörensen, 2000). For elucidation, subjective well-being refers to an individual's evaluation of the quality of their lives, including both cognitive judgments and emotional reactions (Kim-Prieto, Diener, Tamir, Scollon, & Diener, 2005; Diener, Lucas, & Oshi, 2002).

    Not surprisingly, people regularly state close relationships as one of their most important goals and aspirations for life (Emmons, 1999; Little, 1989). It can be argued that because human beings evolved in a social context, many of our fundamental human processes require sociality, interaction, and ongoing relationships (Reis, Collins, & Berscheid, 2000; Bugental, 2000). Reis and colleagues' (2000) review indicates that social relationships play a significant role in

emotion regulation, dealing with stress, self-perception, identify creation, uncertainty lessening, collective task performance, and actualization of personal aspiration. Keyes (1998), Ryff (1995), Seligman (2012), Fredrickson (2013), Reis and Gable (2003), and Diener, Oishi, and Lucas (2003) acknowledge and reinforce positive relationships as an intrinsic element of psychological well-being, physical well-being, and life satisfaction. Importantly, relationships support us when we face adversity by providing positive external perceptions of self, a sense of meaning and purpose, a means of engagement, and a generator of positive feelings (Roffey, 2012). The figure below highlights the potential pathways that connect social support to physical health.
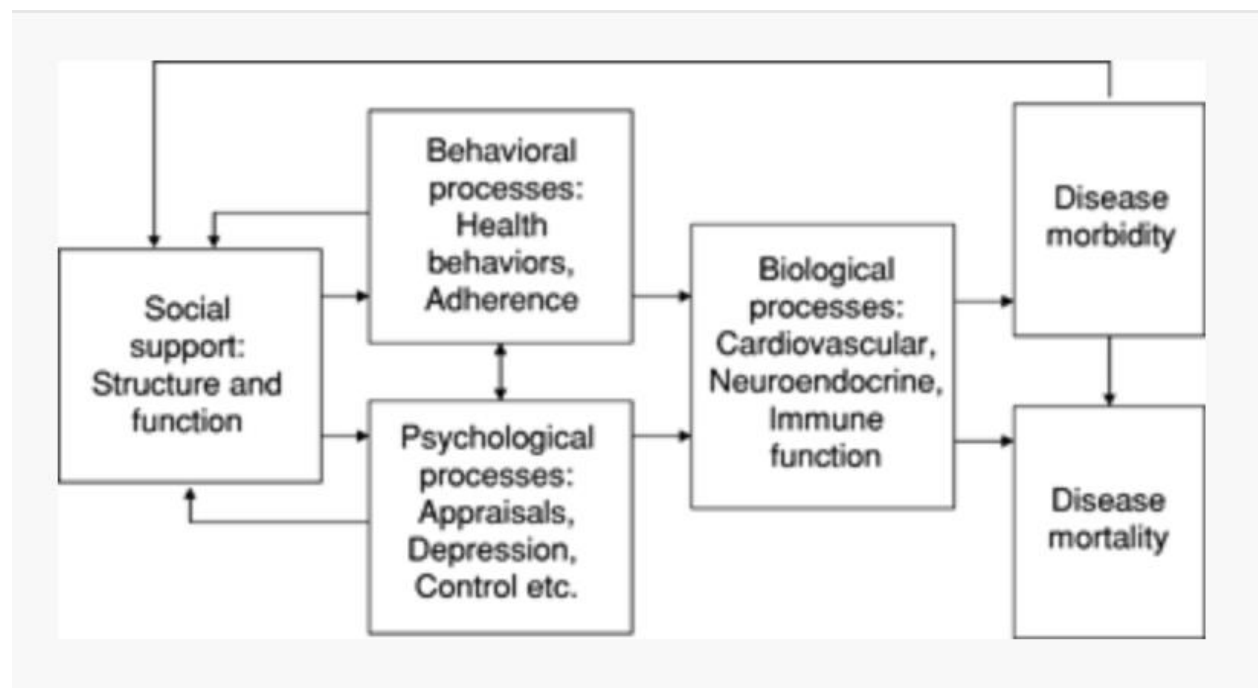

Figure 7. Linking Social Support to Physical Health. From "Social support and health: A review of a physiological processes potentially underlying links to disease outcomes," by Uchino, 2006, *Journal of Behavioral Medicine*, *29*(4), 377-387.

In thinking about social support, it is easy to overlook everyday social interactions that function to enhance life, provoke the experience of positive emotions, and foster health and well-being (Fredrickson, 2013a; Dutton, 2003). High-quality connections are life-giving social

connections, where energy and vitality are felt for both parties, positive regard is present, and a

sense of mutual participation and responsiveness is felt (Dutton, 2003; Heaphy & Dutton, 2008).

These high-quality connections lead to small micro-moments of positive emotions. Fredrickson

(2013) has found that these spurts of connection help the body regulate glucose, fight

inflammation and slow the heart rate through the vagus nerve. The more the vagus nerve is used,

the more we improve our capacity to love, and the more we love, we are essentially lowering the

odds of a heart attack and increasing the opportunity to live longer and healthier lives

(Fredrickson, 2013a). Fredrickson (2013a) also informs that it is the frequency of these

connections that prevails, for the duration of emotions is short-lived. Figure 8 illustrates the

value of high-quality connections on the individual, group, and organizational levels.
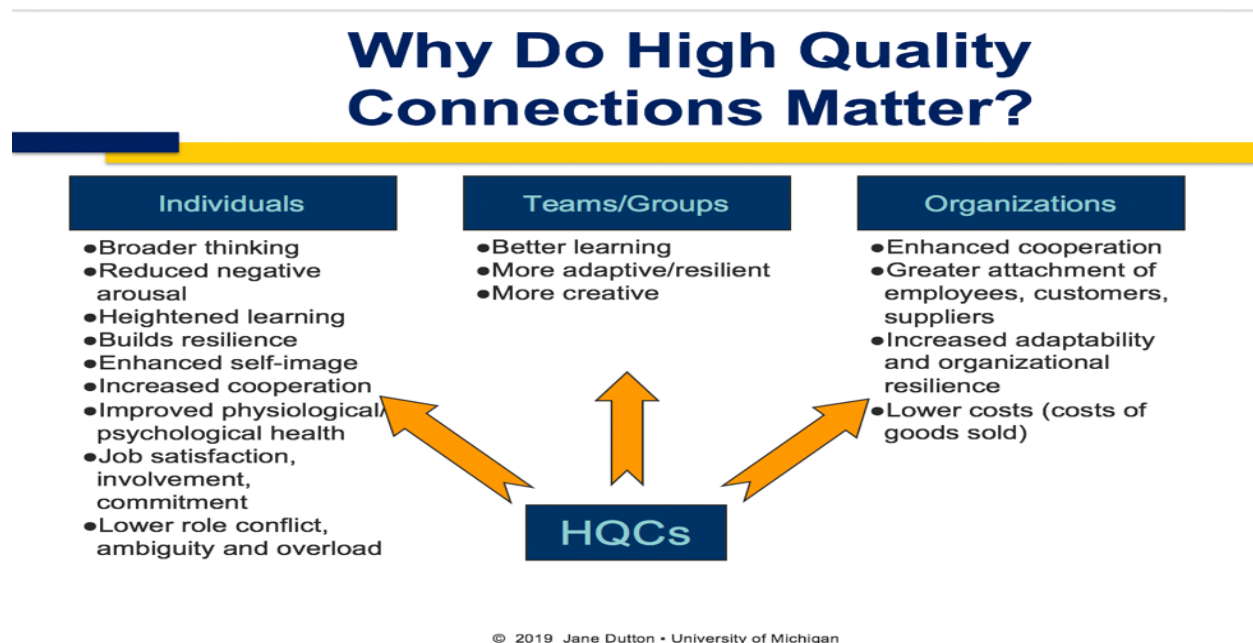

Figure 8. The Why behind High-Quality Connections. From "High quality connections: A

keystone to positive organizations," by Dutton, 2019.

Note: The figure is intended for working environments but remains true for other markets and

thus can be adapted accordingly.

Me, Myself, and ED

I began to say no to everything and everyone. I didn't see my friends much anymore, nor did I even want to. It felt safest to be alone. Safe and scary. If I was alone, I could tend to the demands of the ED; if I was with others, it got angry for snubbing it. When I did connect with other people I had moments away from it. Right after, however, it would get much louder. It always wanted my full attention. So, I spent days, nights, weeks, isolated from the rest of the world. Having an eating disorder is a full-time job; I can't possibly be with other people or do other things when I am catering to its every request. I thought that's how the rest of my life would be—an overbearing and all-encompassing relationship with ED.

Eating disorders are diseases of disconnection (Tantillo, 2006; Sanftner & Tantillo, 2010; Tantillo, Sanftner, & Hauenstein, 2013). In addition to the aforementioned disconnection from oneself, eating disorders disconnect patients interpersonally. Disconnection occurs between family, friends, and treatment teams (Tantillo, 2006; Sanftner & Tantillo, 2010; Tantillo et al., 2013). As disconnection increases, states of isolation, meaninglessness, and hopelessness become common for patients (Tantillo, 2006). The illness feeds off such isolation, as rumination around food and body can take over in solitude. I have several patients that report experiencing the eating disorder most strongly when alone. Connecting with another person can create space away from the eating disorder and help patients get outside of their heads. Social relationships can elicit positive emotions (Fredrickson, 2013a; Dutton, 2003) and provide a sense of comfort, belonging, and meaning for patients. Rarely is it seen, that individuals with eating disorders recover alone (R. Kreipe, personal communication, June 20, 2019). Thus, it is critical that relationships are identified, developed, and maintained to embark on and achieve recovery.

Identification of relationships is key to this population. I often find that because the illness is so convincing in making patients feel alone, they often forget and therefore neglect their present supports and connections. In Appendix B**,** research, resources, and exercises are provided and can be used to identify a patient's relationships, as well as distinguish the role each relationship can have in the recovery process. A high-quality connection exercise can also be explored to assist patients in experiencing more freedom from the illness through seeking more moments of connection in daily life. Lastly, exercises on relation boundaries can be used to enable patients to learn how to take care of themselves while engaging in a relationship.

As interpersonal relationships develop, the aloneness of living with an eating disorder diminishes organically. Several patients report using connection with others as a way to disconnect from the illness. Positive relationships, undeniably, serve to support recovery. The figure below illustrates many of the relationships necessary to reconcile the disconnection of the disease.
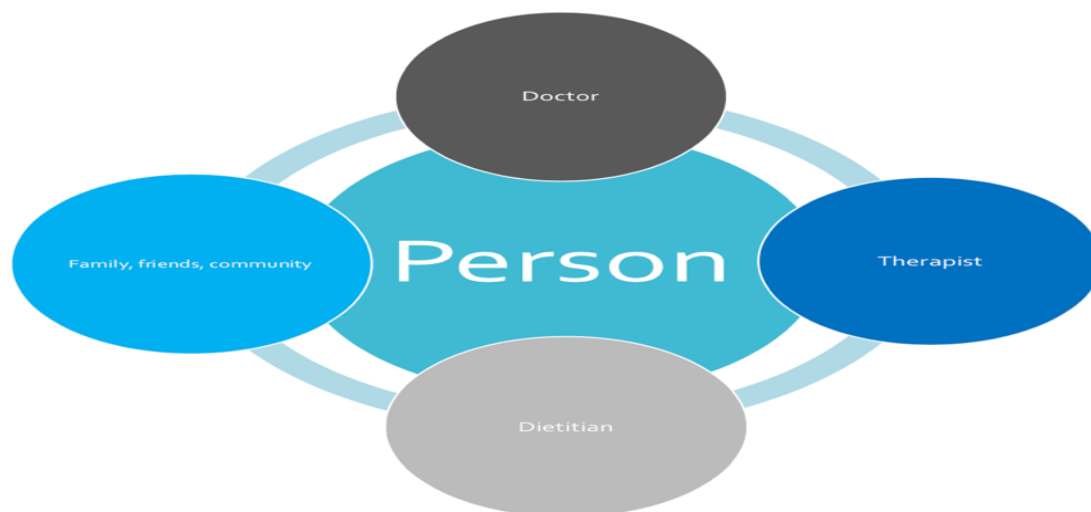

Figure 9. Optimal Treatment Relationships. From "Eating Disorders: An Overview," by The Healing Connection, 2018.

Relationships remain a focal point of therapeutic approaches intended to treat eating disorders. The combination of healing and reestablishing intrapersonal relationships with engaging and developing social relationships serve as a powerful tool in fighting the eating disorder. Perhaps the most important outcome of relationships is the sense of meaning that comes from them. Meaning, the fourth component of PERMA, can be used to catalyze an individual's purpose behind recovery. The next section identifies meaning as a driving and motivating force in the recovery process.

Meaning

Meaning has been a forever question and pursuit in human life. The inquiry and quest to a life of meaning have inevitable ambiguity. According to Baumeister and Vohs (2002), meaning is a "nonphysical reality" that can be "…regarded as one of humanity's tools for imposing stability on life" (pp. 608-609). It is a "mental representation of possible relationships among things, events, and relationships. Thus, meaning *connects* things" (Bauemeister et al., 2001, p. 15).

The four fundamental needs of meaning are as follows: 1) the need for purpose, 2) the need for values, 3) the need for a sense of efficacy, and 4) the need for a basis of self-worth (Baumeister & Vohs, 2002). Although it is believed that people can draw meaning from a single source to gratify all their needs, research suggests people usually draw meaning from multiple sources (Emmons, 1999). Individuals are more protected against a meaningless state if their meaning comes from numerous sources (Baumeister & Vohs, 2002). For example, consider an individual who derives meaning from family, friends, faith, athletics, and career. If this person endures an injury and can no longer participate in athletics, he or she can still derive meaning from other existing sources. Having multiple sources of meaning removes intense pressure or

emphasis on a single source to satisfy all four needs of meaning (Baumeister & Vohs, 2002).

Obtaining meaning from multiple domains of life imposes a more stable concept of coherence,

purpose, and significance to rest upon (Martela & Steger, 2016). Coherence refers to the sense

made of life, purpose as the aspiration for life, and significance as the worthiness and value of

life (Martela & Steger, 2016). Table 4 below marks these three facets of meaning when existing

and absent.

Table 4. *Distinguishing among the three facets of meaning.*

	Coherence	Purpose	Significance
Definition:	Sense of comprehensibility and one's life making sense	Sense of core goals, aims and direction in life	Sense of life's inherent value and having a life worth living
Opposite:	Uncertainty and incomprehensibility	Aimlessness and loss of direction	Absence of value
Normativity:	Descriptive	Normative	Normative
Domains:	Understanding	Motivation	Evaluation

Note: Reprinted from Martela & Steger (2016, p. 534).

Meaning Making, Hope, and Story-Telling. We, as humans, are given a unique

opportunity to make meaning out of life. Meaning-making is an explicitly human activity that

can encourage personal goals and life purpose (Emmons, 2003). The concept of meaning-making

refers to "…an active process through which people revise or reappraise an event or series of

events" (Baumeister & Vohs, 2002, p. 613). Such reevaluation tends to involve the discovery of

some positive aspects within a negative event (Baumeister & Vohs, 2002). Transforming a

negative to a positive is seen as the *benefit-finding* feature of meaning-making (Davis, Nolen-

Hoeksema, & Larson, 1998). Another aspect of mean-making is seeking for reasons to

understand the event, known as *sense-making* (Davis et al., 1998). Both *benefit-finding* and

sense-making seem to assist individuals when facing stressful or challenging life experiences

(Park, 2010).

Indeed, research suggests that the experience of meaning is a positive contributor to well-being, quality of life, and health (Steger, 2012; Heintzelman & King, 2014; Ryff, 1989). It has been shown to correlate positively with psychological well-being at nearly every stage of life, from adolescence to late adulthood (Wong, 1989; Zika & Chamberlain, 1992). Having a sense of meaning fuels individuals to make positive contributions in line with their strengths, values, and interests. Within the establishment of meaning, there are traits of belonging, purpose, storytelling, and transcendence (Smith, 2017). All of these involve an aspect of connection, whether it be to oneself or others.

Connection is believed to be the essence of meaning (Baumeister & Vohs, 2002). Connections with others allow for relationships in which we feel understood, recognized and valued (Smith, 2017). Increases in meaning function to not only help one escape from suffering but also enhance their satisfaction and sense of fulfillment (Baumeister & Vohs, 2002). This is derived from Frankl's (1963) work on meaning, where those who have a clear *why* are better able to live with any *how* or circumstance. Viktor Frankl (1963) explains that the way a person accepts fate and all the suffering it may entail grants a tremendous opportunity to add a deeper meaning to life. Frankl (1963) suggests that every individual is given the chance to achieve something through his or her suffering, yet there are only a few that tend to this moral standard. The *why* can then become united to a larger purpose and can embed a sense of hope.

Having an archive of hope provokes a sense of faith, meaning, and inspiration in one's life (Snyder, 2000). Magyar-Moe and Lopez (2015) present the hope theory, where all components of goal-pursuit are equally emphasized. The power of hope acts as a motivating factor of change. Hope finding, bonding, enhancing and reminding are the fundamental pathways for accenting hope. Cheavens and colleague's (2006) research also suggests that hope

interventions should boost areas of strength and resilience (as cited in Magyar-Moe & Lopez, 2015). Increasing the agency of hope empowers an individual to believe in their capacity to improve their life. Renewed hope enables a sense of control over one's circumstances, actively shifting a helpless perspective. Magyar-Moe and Lopez (2015) indicate that hope begets more hope, illustrating the reinforcing feedback effect of its existence. Hope makes people have confidence in life ahead and their role in its unfolding, which stimulates supplementary hope.

Research has found that higher hope is correlated with improved outcomes in physical health, psychological adjustment, and psychotherapy (Snyder, 2000). Such hope can be cultivated through story-telling and narrative sharing. Storytelling functions to not only heal the teller but also facilitate healing in others. A story rooted in vulnerability enables a deeper understanding of one's life as coherent (Smith, 2017.) Storytelling can stimulate a need to understand oneself and to develop a sense of purpose in life (Baumeister & Vohs, 2002). Through the process of storytelling, individuals can benefit from connection to others which can further highlight the essence of meaning and belonging (Baumeister & Vohs, 2002). It is from making sense of one's life that transcendence becomes possible for both the sharer and the receiver. Transcendence is often a defining moment of spirituality and sacredness; another source of meaning in one's life.

Spirituality. Pargament, Oman, Pomerleau, and Mahoney (2017) define spirituality as the process of searching for the sacred. Spirituality is an organizing force that tends to promote and integrate the wholeness of life and oneself (K. Pargament, personal communication, April 27, 2019). Spirituality can but does not have to be affiliated with a religion. In mere nature, spiritually embodies the search for meaning, union, community, transcendence, and for the greatest of human potential (Pargament, 1997). It connects an individual to something bigger

than oneself and therefore embeds a sense of belonging, community, and representation beyond subjective living (Emmons, Cheung, & Tehrani, 1998).

An abundance of empirical research focuses on well-being and its relation to spirituality and religion (Joseph, Linley, & Maltby, 2006). On average, individuals who identify religious or spiritual report having higher subjective well-being (Diener, Tay, & Myers, 2011), a greater sense of purpose in life, and less ambivalence (Emmons et al.,1998). A benefit of spirituality can be seen in positive spiritual coping, a practice in which support is sought from religion or spiritual backing (Pargament, Smith, Koenig, & Perez, 1998). Positive spiritual coping entails religious forgiveness, pursuing spiritual support, collective religious coping, spiritual connection, spiritual purification, and compassionate religious reappraisal (Pargament et al., 1998). Such coping is commonly used by many during times of adversity, stress, or struggle (Pargament et al., 1998). Spirituality can fuel personal ambitions and goal-striving and is seen to be intrinsically rewarding (Emmons, 2003). Emmons (2003) writes that spirituality, "…reflects an active engagement in life, a profound sense of connectedness to others, to the future, to the transcendent, and thus contain a glimpse of eternity" (p. 113). Hence, this connection to a higher power can serve to expand and deepen the meaning associated with one's life, enhance subjective well-being, and provide support in times of difficulty.

Emmanuel

The sicker I got, the more I forgot who I was and what I was doing here. It seemed

everything in my life started to fall apart. I lost so much of me and began to feel like I had

no purpose other than the eating disorder. I couldn't trust anyone; my family, my friends,

my treatment team, my eating disorder, nor myself. The only thing that remained true was

my faith in God and his purpose in my life. I sat in a hospital bed and recited the serenity

prayer on repeat. Before every meal, I asked God for the strength to do what I could not,

reminding myself that I can do all things through Christ who strengthens me. As my body

changed, I sobbed yet prayed, if God is for me who is against me. Through the

discomfort, through the pain, I knew he had something bigger intended for my life. And I

knew I wasn't alone; Emmanuel, Emmanuel, Emmanuel I whispered amidst all the doubt

in my head (e.g. God is always with you).

Re-connecting patients with their meaning and purpose outside of the eating disorder can

serve as a tool in recovery and enact stability during a time of perceived uncertainty. Lack of

motivation is often a trying barrier to recovery (Vitousek, Watson, & Wilson, 1998) Eating

disorder patients tend to be difficult to treat, as they resist the professional recommendation for

care out of persistence for the illness' incentives (Vitousek, et al., 1998). Such that the eating

disorder takes over the identity of the individual, constantly instilling that the meaning of their

life is to be thin or tend to symptom use (Snyder, Feldman, Taylor, Schroeder, & Adams, 2000).

Identifying meaning and purpose outside of the illness can unite individuals to their authentic

self and motivate behavioral change aligned with recovery. It can help inform future goals and

foster further experiences where they can confirm their life's significance (Martela & Stegar,

2015). Through the process of defining their meaning and purpose for recovery, patients can

better prepare for the difficult days where they may question why they are fighting the eating

disorder in the first place.

From my experience working with patients, having a sense of meaning, beyond the eating

disorder narrative, may be one of the most powerful driving forces behind recovery. I

recommend exploring what brings meaning and purpose to the patient's life and potentially

shedding light on how the eating disorder interrupts that pursuit. This can be done by discovering

the individual's values, passions, and interpersonal connections that support a felt sense of meaning or mattering. This presents a wonderful journaling opportunity where patients can craft a meaning story. This story could be about anything that has had an impact on their life and related to how they find meaning. Eventually, the goal is to transform one's expressed meaning into his or her *why* for recovery.

As patients are connected to their *why* an entirely deeper meaning can be added to the perceptive and rational behind recovery. As mentioned prior, those who have a clear *why* are better able to live with any *how* or circumstance (Frankl, 1963), such as the dreaded or undesired recovery process. The *why* can serve as the motivating force in taking action that otherwise would seem too difficult. The *why* can then become cohesive to a greater sense of meaning and purpose, and thus provide a sense of hope. Hope enables patients to formulate more pathways and persist to achieve their recovery goals amid challenges (Snyder et al., 2000).

Hope can be derived from multiple sources. One particular archive of hope can be found in the shared story of others who have endured the same illness and maintained recovery (C. Miller, personal communication, May 14, 2019). As we consider programs such as Alcoholics Anonymous (AA), it becomes undeniable that shared experiences of hope, recovery, and hardship generate a sense of community, meaning, motivation, and accountability. Individuals with eating disorders express frequently feeling alone, a feeling that is highly related to the eating disorder (Levine, 2012). Through this process of personal disclosure and storytelling, individuals can benefit from the aspect of connection to others who "get" the illness and the process, which can further highlight the essence of meaning (Baumeister & Vohs, 2002). I recommend finding a way to connect patients to individuals who have found recovery and are willing and able to share their experience of what worked, what didn't work, their success, and

their setbacks along the way. We often have providers who are well educated but cannot fully

understand the experience of living with an eating disorder. Providing a connection to someone

on the other side of the journey can be tremendously meaningful and inspiring for patients in the

depth of their process.

Monte Nido and Affiliates is a residential and intensive outpatient eating disorder and

exercise addiction treatment program that embeds recovered individuals within their staff.

Patients have reported this to the, "most helpful part of treatment." This example serves to

reinforce the need for community and an archive of hope for patients. Patients need to know that

being recovered is possible and that they can live a life of freedom and peace with the body and

food. In my opinion, there is no better way for this message to be disseminated than through the

lived experience of another. Thus, I recommend seeking out peer mentors, sponsors from eating

disorder anonymous groups, and/or other individuals willing to share their stories for your

patients to connect with. These resources are more available than one would think but do require

some seeking out and hand-holding for the patient to feel comfortable initiating communication.

As a practitioner, I would recommend using a session to gauge the interest of the individual in

having this kind of support, followed by setting up a concrete accountability plan to encourage

the patient to take the action of reaching out. These connections can enable a patient to feel

validated, acknowledged, and valued.

In addition to meaning-making and hope sharing, spiritual coping can be made more

accessible to patients. If patients have a religious or spiritual relationship, I encourage assisting

them in connecting to that source of meaning and larger purpose. This can be done by drawing

on passages that emphasize trusting God or the universe, honoring the body, loving oneself,

inner power and strength, and other readings that support recovery themes. In connecting

patients to something bigger than themselves, a sense of peace, comfort, and certainty can be added to their journey. With that being said, it is essential that the practitioner acknowledge and unpack the role religion or spirituality plays in the patient's life delicately. It is easy to oversimplify or make misstatements about an individual's belief systems, and thus is important that such exploration honors where the patient is and his or her desire to include their faith in the process.

I also recommend making the process of recovery sacred, which engrains a sense of meaning. This can be done by highlighting the innate wholeness that exists within every human being, including the individual suffering from an eating disorder. The concept of wholeness has a powerful potential within the clinical context. Patients often report feeling broken or damaged, a feeling that tends to induce shame, sustain symptom use, and exacerbate unhealthy behavior (Serpell, Treasure, Teasdale, & Sullivan, 1999; Gaudiani, 2018). What happens if we challenge the individual to reframe the definition of "brokenness"? What happens when their pain, scars, and perceived flaws become sacred? By doing so, I believe posttraumatic growth becomes more readily available, as does the possibility to accelerate the process of acceptance, freedom, and wholeness. Posttraumatic growth is the experience of positive change and adaptation that arises as a result of highly challenging life adversities (Tedeschi & Calhoun, 2004). I recommend having patients create a personal Kintsugi, an art form in Japanese culture that integrates brokenness into inherent wholeness, to support the self-acceptance necessary for recovery. This can be done through art-making, story-telling or poetry, and/or musical expression. Reappraising brokenness holds the power to transform a subjectively painful experience for patients and make it a sacred, transcendent one. The intervention can provide insight into perceiving recovery through a different lens and evoke a greater sense of meaning about the process.

As you may have noticed, there are several ways to cultivate meaning in the recovery process. I believe it is the role of the provider to help patients find their meaning, outside the eating disorder, when they may not be able to on their own. By doing so, we give patients a reason to recover. I can assure you that the process of recovery calls for reason to persevere, as it is often a difficult, exhausting, and uncomfortable journey to embark upon. With a *why* for recovery, we give patients a chance to undergo and persist through any *how*. Having meaning and purpose is often allied with a goal an individual is working towards and serves to motivate their efforts (Smith, 2017). The next section, therefore, will acknowledge the role achievement may play in recovery but does not go in much depth for intentions indicated.

Accomplishment

Accomplishment, the fifth pillar of well-being, is complex. I use the term accomplishment very intentionally, as its meaning can differ from the concept of achievement. Accomplishment focuses on the process towards mastery and the long-term journey. It is motivated by intrinsic drive, incorporating one's sense of identity, and the channeling of harmonious passion (G. Park, personal communication, March 9, 2019). Achievement, however, focuses on the outcome, winning, and short-term goals. It is externally motivated, defining of self-worth, and reinforces obsession passion (G. Park, personal communication, March 9, 2019). Achievement and superior performance have become leading motivators in Western societies (Butler & Kern, 2016), regardless of its foreseeable negative implications. It is the way we introduce ourselves, the way we determine if we should feel good or bad about our lives, and the way the materialistic world governs social rank. Achievement can influence negatively one's psychological and physical health, performance, relationships, and overall well-being (Burke & Fiksenbaum, 2009; Vallerand et al., 2007; Vallerand, 2012). In fact, when people put strong

value on extrinsic goals (e.g. the motivation source of achievement) research shows "…lower levels of a variety of indicators of well-being, including low self-actualization, self-esteem, and vitality, and high levels of a variety of indicators of ill-being, including greater anxiety, depression, and narcissism" (Deci & Vansteenkiste, 2003, p. 10). In addition, individuals with a high value on extrinsic goals are more likely to participate in high-risk behaviors (Williams, Cox, Hedberg, & Deci, 2000). It is important to acknowledge that there is a broad range of motivators, both intrinsic and extrinsic, that encourage goal striving and pursuit. Leveraging extrinsic motivators can sometimes help develop healthy and adaptive intrinsic motivations. For the purpose of this paper and the targeted population, however, I will concentrate on the concept of accomplishment and intrinsic motivation.

      Intrinsic Motivation. Accomplishment is a pathway towards feelings of happiness and fulfillment (Bradford, 2016). As human beings, we are inclined to have goals, work towards them, and feel a degree of attachment to them. A principal component of accomplishment is the motivation source. Accomplishment is catalyzed positively by intrinsic motivation. Intrinsic goals are those that are rewarding in their own right as a result of the inherent interconnectedness with one's basic psychological needs (Deci & Vansteenkiste, 2003). Values that contribute commonly to intrinsic goals are meaningful relationships, personal growth and development, and community inputs (Kasser & Ryan, 1996). Increasing intrinsic motivation supports lasting behavior change, higher-quality relationships, increased well-being, positive affect, and vitality (Ryan, Huta, & Deci, 2008). Enhanced intrinsic motivation is also negatively correlated to indicators of ill-being, such as depression, negative affect, anxiety, and physical symptoms (Ryan et al., 2008). Intrinsic motivation is rooted in three innate psychological needs— competence, autonomy, and relatedness— which when satiated result in elevated self-motivation

and mental health (Deci & Ryan, 2000). It is with such intrinsic motivation that productive,

sustainable, and self-supporting goals can be set and achieved (Ryan & Deci, 2000).

A positive intervention that can be used to increase intrinsic motivation is the *wanting*

what you want to want intervention. James Palwelski (personal communication, October 7, 2018)

acknowledges the human experience of wanting to do something, but knowing that we should

want to do another thing. The intervention is intended to direct your attention to align your

desires with your values (e.g. *wanting what you want to want)*. The exercise requires two

individuals that can help each other become more virtuous (Pawelski, 2018). One person chooses

a specific thing in their life that they are not that motivated to do, but that they *want* to want to do

or perhaps even *have* to want to do. The individual is asked to rate (on a scale from -10 to +10)

how much they want to do the thing that they chose to focus on (i.e. wake up earlier, studying

more for a test, etc.). The intervention would then call for the individual to be asked what they

need to make them want to do the thing more. The goal is to move the individual closer to +10

by continuing the questioning (what would make you want to do the thing more?). As you ask

the individual what *they* need to focus on, not what you think they should focus on, you are

organically increasing their intrinsic motivation as their focus pertains to their values. The

exercise is ended by doing the thing that was originally in question that is hopefully more

desirable to do (Pawelski, 2018).

Goal-Setting Strategy. Another means of moving towards your goals is the WOOP

method. WOOP is a scientific goal setting strategy and motivational technique. WOOP —which

stands for wish, outcome, obstacle, and plan— uses mental contrasting (e.g. a strategy

concerning the cognitive explanation of a desired future with acknowledgement of obstacles of

the present; Oettingen, Kappes, Guttenberg, & Gollwitzer, 2015; Duckworth, Grant, Loew,

Oettingen, & Gollwitzer, 2011) and implementation intentions (e.g. a tactic used to discover the

action one will take when a goal-directed opportunity surfaces; Duckworth, Kirby, Gollwitzer, &

Oettingen, 2013; Duckworth et al., 2011) to prime and support behavior change. It is an imagery

exercise that aims to encourage the actualization of a *wish* and in turn create habits. Step one

calls for an individual to identify their wish; that is, pinpoint a meaningful, and thus intrinsic,

goal—large or small. Step two asks the individual to identify the best possible outcome of the

wish or goal coming true; that is, explaining and imagining how it would feel to accomplish this

wish. Step three asks the individual to identify obstacles that would stand in the way from

attaining the wish. Lastly, step four targets a plan to fulfill effectively the wish; that is,

identifying what can be done to overcome the identified obstacles. The figure below provides an

example of the WOOP strategy.

WOOP steps	WOOP tips
Wish *I want to learn more about sepsis*	• The goal should be important *to you.* • It should be attainable but challenging.
Outcome *I will feel much more in control when managing these patients by myself*	• This should be the single best outcome of achieving the goal *for you.* • You must imagine the outcome.
Obstacle *I spend too much time on Facebook*	• The obstacle should be internal (something you can control), not external (eg, "I don't have time"). • You must imagine the obstacle.
Plan: "If [obstacle], then I will [action]" If... *I am looking through Facebook posts* Then... *I will turn off my phone and read one of my sepsis articles*	• The planned actions should promote your goal. • The action should be one that you plan to enact in the moment the obstacle arises.

Figure 10. Steps and Tips of WOOP. From "Changing resident physician studying behaviors: a randomized comparative effectiveness trial of goal setting versus use of WOOP," by Saddawi-Konefka et al., 2017, *Journal of Graduate Medical Education, 9*(4), pp. 451-457.

This integration of mental contrasting and implementation intentions accumulates the benefits of both practices. For example, mental contrasting has a stronger influence on behavior change when an implementation plan is in place. Implementation plans, however, depend upon the factors accelerated by mental contrasting, such as high goal commitment, identification of an obstacle, and detailed goal-oriented behavior (Saddawi-Konefka et al., 2017). Duckworth and colleagues (2011) find that mental contrasting and implementation plans can be a successful self-regulatory practice of goal pursuit for the adolescent population specifically. Additional research has been shown to support the WOOP method in goal attainment, such that WOOP lessened

insecurity-based behaviors and improved commitment in romantic partners (Houssais, Oettingen, & Mayer, 2013), increased attendance and grades in children from disadvantaged backgrounds (Duckworth et al., 2013), increased high school students' commitment to preparing for standardized tests by nearly 60% (Duckworth et al., 2011), and helped patients with chronic pain become more active during rehabilitation and up to three months later (Christiansen, Oettingen, Dahme, & Klinger, 2010). In giving individuals the steps and strategies necessary to set goals, acknowledge barriers, and plan accordingly, confidence in behavioral change develops.

Habit Formation. After the initial goal-directed action has been taken, repeated action and commitment must be taken to develop a habit. Positive behavior change is strengthened with habitual dedication in the proper direction. The uninterrupted devotion to the particular task paves progressive pathways in the brain and offers access to the desired behavior (Melchert, 2002). Deliberately pursuing a goal trains the mind to automatically respond to life in accordance with the goal's virtues. The virtue embedded within the action can be taught, learned, and applied to create a habit (Melchert, 2002). This cycle demands a deliberate commitment to the process and purposeful repetition of the action. This repeated action is required in order to form pathways of discharge in the brain. James (1892/1984) further explains that the formation of habits in living things is due to their mental plasticity. The maxims of habit development require as much immersion as possible into its formation while making no excuses until the habit is ingrained. Ingrained habits streamline actions, preserve energy, and reduce the conscious attention needed to perform a multitude of tasks (James, 1892/1984.) When this happens, the mind is free to access its attention to higher functions. Pain or discomfort can accompany the beginning stages of habit development. Unwavering commitment is again required to persevere through the difficult periods in order to enjoy the later freedom. Committing to the uninterrupted

repetition of the behavior until it is deep-rooted enough allows humans to cope with opposition

(James 1892/1984). Every action then leaves its trace, and the commitment and repetition to such

actions offer more automatic and habitual responses to support well-being.

I don't even know

I don't even know if I want to recover. Seriously, I think I'd rather be sick than do this.

Recovery seems so far away; I don't even know where to begin. I also am not sure it's

even possible. Usually, when you work hard in life you start to see progress, feel

progress, feel happy for your progress. Recovery doesn't feel like that, the better I do, the

worse I feel. It is like my victories are actually tragedies. Which always leads me back to-

why the hell am I doing this in the first place. The only thing scarier than dying is

recovering.

The most delicate component in PERMA, given the population, is unquestionably

accomplishment. As discussed previously, eating disorders, especially anorexia nervosa and

bulimia, are associated with self-imposed perfectionism (Lilenfeld et al., 2000; Ashby et al.,

1998; Bastiani, Rao, Weltzin, & Kaye,1995). In fact, some patients report that the eating disorder

is a form of accomplishment in itself (e.g., "I only ate 200 calories today" or "I worked out three

times today"). In such cases, the eating disorder behavior can provide a sense of pride and joy, as

if the individual has achieved something monumental. Consequently, it may be that goal-oriented

behavior can fuel the thinking of disease (e.g., do more, work harder, not enough; Kitsantas et

al., 2003). Moreover, recovery is often seen as a journey or process, not an end goal that is

waiting to be reached. From my experience, those in recovery or those who identify as recovered

take daily actions to maintain that level of freedom, peace, and recovery. Therefore, it is not

necessarily a goal that is achieved and then done away with. Recovery tends to be a lifelong

journey of maintaining productive and effective habits around the body and food.

We can, however, reframe accomplishments to align with recovery objectives,

emphasizing progress, not perfection and calling out when goal pursuit can become dangerous. I

recommend reinforcing and helping the patient explore and experience balance, rather than

extremes, in all areas of life. As patients take recovery behavior, they must be acknowledged and

rewarded for small victories, similar to the experience of accomplishing in other domains of life.

As mentioned in the quote above, recovery is unlike other goal trajectories in life—the more

recovery is made, the worse individuals feel for some time (e.g. discomfort with body changes,

flooding of previously numbed emotions, loss of a coping skill). Thus, I believe consistent

encouragement, acknowledgment, and validation is needed to celebrate the small wins along the

recovery journey, with an awareness that eating disorder noise may accompany taking contrary

action to its demands. For example, patients often report the eating disorder getting much louder

or more demanding after mealtime, expressing that the eating disorder will tell them they are

getting fatter, that they shouldn't have eaten X, and to plan for a future symptom use (e.g.

restriction at a later meal, purging to get rid of the nourishment, or compulsive exercise to

compensate). This experience diminishes motivation and fortifies the patient's desire to go back

to the eating disorder. The provider can help the patient's rebuttal the noise of the eating

disorder, and own and take pride in the accomplishment around recovery behavior, even if the

immediate feeling associated with the action does not feel positive. Accomplishment can then be

used to empower patients, and through shifting its focus on recovery progress, as opposed to

eating disorder progress, autonomous and self-reinforcing advances are supported.

It is essential that patients are encouraged to identify their own intrinsic motivation behind recovery. Eating disorder features most commonly develop in mid-adolescence (Fairburn, Welch, Doll, Davies, & O'Connor, 1997; Marchi & Cohen, 1990; Swanson, Crow, Le Grange, Swendsen, & Merikangas, 2011), a time where autonomy is sought the most (Eccles, Buchanan, Flanagan, Fuligni, Midgley, & Yee, 1991; Spear & Kulbok, 2004). The eating disorder manipulates the individual into believing it is taking control (Williams et al.,1990), creating an identity centered around the disease (Hesse-Biber, 1996). With an individual's sense of self-dependence upon the illness, developmental autonomy and motivation need to be re-identified and reclaimed. I recommend connecting patients to their values, interests, and passions outside of the eating disorder to ascertain the discrepancy between the eating disorder's motivation and the patient's personal motivation. When this is made clear to patients, they are able to set intrinsic goals based on a desire to ally personal values. Increasing intrinsic motivation can then support recovery-oriented behavior change. I recommend assisting the patient in identifying small, daily, recovery-based goals that are intrinsically rewarding. By doing so, you are reinforcing that the actions are controlled and taken by the patient, as opposed to demanded or required by professionals, parents, or other external sources. Behavior modification awakened by intrinsic sources leads to more sustainable and empowering change (Ryan & Deci, 2000). If a patient's intrinsic motivation is maladaptive as a result of the eating disorder, extrinsic motivators can be leveraged to initiate recovery behavior and eventually encourage the development of novel intrinsic motivators. I recommend evaluating where a patient is in their recovery process to determine which motivators promote healthy behavior change.

Even with identified sources of motivation, providers will without a doubt run into a lack of motivation in patients with eating disorders (Vitousek et al., 1998). Remember, the eating

disorder, at some time or another, has served this individual and therefore is a scary thing to let go of. From my experience, patients express wishing they wanted recovery more. In such cases the *what would you want to want* intervention is appropriate and can provoke insight and inspiration for patients. For example, a patient may *want to want recovery*, but currently is a -8 on the motivational scale. I recommend following the instructions of the intervention and asking the question, "What would make you want recovery more?" A common first response is nothing. With time, the patient may generate things that would make them want to recover more (i.e. being able to concentrate better at school, being able to have fun at mealtimes, not having to worry about gaining weight, etc.). As the patient identifies things that would make them want to want to recover more, try to witness if their vocal tone and facial expressions change. At the end of the exercise, re-evaluate where they are on the scale from -10 to +10. The goal is that the patient's motivation increases, and that he or she has generated several things that can encourage recovery behavior. The motivating factors can then be assigned to each day of the week (Monday-Friday). Each day, the patient can focus on the thing assigned for that day as an intrinsic reason to take recovery action (e.g. an implementation plan).

That said, my biggest fear around accomplishment work with this specific population is the trajectory of recovery. Recovery is not a perfect journey, in fact from my experience, I have never witnessed a linear recovery process. Most patients report having good days and bad days, starts and stops, ups and downs before recovery becomes stable. The figure below depicts the comic, but the real journey of recovery.

People expect recovery to look like this.

But really it looks more like this: Note that the trajectory is the same.

When you are at point B it sometimes feels like you have gone back to point A, but you are still further along the recovery path.

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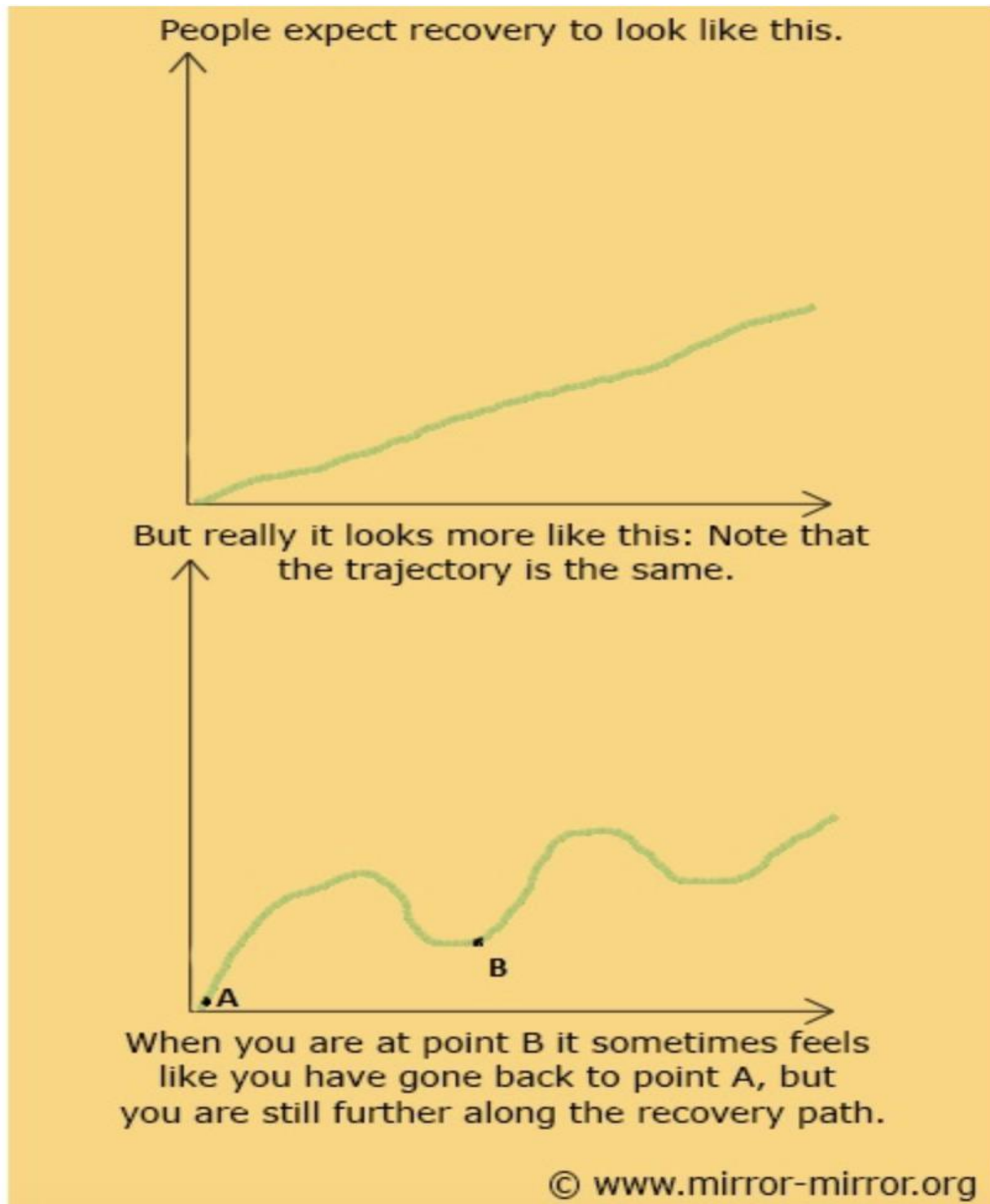
Figure 11. Real Recovery. From "Relapse Prevention Plan," by Mulheim, 2019

(https://www.mirror-mirror.org/eatdis.htm).

Given this reality, I recommend expecting setbacks, yet helping patients create a plan to overcome adversities, challenges, and obstacles that are going to present inevitably. WOOP is one strategy that can be used with patients to acknowledge and identify the obstacles that may surface throughout the recovery process. For example, a patient may identify a wish of completing lunch every day in the week ahead. The outcome of the fulfilled wish is that the patient knows how to nourish themselves during the school day and can, therefore, return to school with her friends. The patient then has an opportunity to address the barriers that may stand in the way of completion (i.e. eating alone and eating disorder noise increasing, meal prepping less based on this commitment, or an upcoming event that puts pressure on appearance and motive to be thin). Now that those obstacles are named, the patient can create a plan to overcome those obstacles so that as they surface, the patient is better equipped to overcome them and take recovery behavior. I recommend using the WOOP method in session and putting the plan in writing. Other goal-setting strategies (e.g., Cameron, 2013; O'Neil & Conzemius, 2006) and goal theories (e.g., Locke & Latham, 2006; Lunenburg, 2011) can be accessed to assist patients in taking the action they need to, even when they are not motivated to do so.

I believe action often precedes motivation in this context. Every action functions to leave a cognitive mark, and also indirectly regulate emotions. James (1899) declares that emotion needs not to lead to action. The Lange-James Theory, in fact, offers the phenomenon of "fake it until you make it," or "act as if." The emphasis is on the action igniting the emotion, rather than the emotion fueling the behavior. With a commitment to the right actions, patients have the control to experience desired emotions and attitudes. The theory emphasizes self-discipline and the commitment to tuning in to what is done and expressed, rather than what it is felt (James, 1899.) Emotions are the product of conditioning and conditioning is the product of commitment

to certain actions. In understanding eating disorders, we must not expect patients to have 100%

motivation. I recommend seeking 1% motivation, while reinforcing that action can be taken even

if he or she does not feel like it. Providers report feeling emotionally drained by the lack of

motivation individuals with eating disorders often exhibit (Warren, Schafer, Crowley, &

Olivardia, 2013). Many have shared that is it like "pulling teeth" when inviting patients to

consider making behavioral changes. I recommend that sometimes we not seek motivation, but

rather encourage that action may, in fact, lead to motivation. I pose questions such as, "Have you

ever done homework when you haven't wanted to?", or "Have you ever taken out the trash and

not wanted to?", or "Have you ever called your grandmother when you didn't feel it?" These

questions are intended to bring insight around how frequently we do things we "don't feel like

doing." And that sometimes recovery is just like that; we take the actions anyway. We "fake it

until we make it," we "act as if." Providers must acknowledge that this is a stage of recovery and

that action-based recovery accomplishment may not be filled with joy, motivation, vitality, and

passion. In accepting what is (e.g. the emotional and motivational state of the patient), we can

better help patients plan how to take the required recovery actions regardless of any felt

experience. Please note that these behavioral changes are exceptionally difficult for patients who

not only have deeply engrained eating disorder habits, but have also developed maladaptive

rituals around these habits (e.g., not eating past 6 pm, purging immediately following meals, or

running X amount of miles before nutritional intake). Patience, perseverance, accountability, and

support are all necessary for both undoing the habitual behavior of the eating disorder and in

cultivating new, adaptive habits.

Although I remain hesitant about overemphasizing accomplishment with this particular

population, I appreciate its role when tailored to recovery objectives. Recovering from an eating

disorder is not a short stunt; the protracted process requires a degree of goal acquisition and

recognition to maintain the pursuit. When the process feels draining, never-ending, and hopeless,

it is important that providers encourage patients to celebrate small victories, assist in developing

implementation plans for future progress, and validate that mechanical motions are part of

recovery. When accomplishment is related to recovery, progress—not perfection—is the goal.

Such progress, in the right direction, over a prolonged period of time, regardless of situational

and emotional experiences, leads eventually to a recovered state or recovery maintenance.

Limitations

Amongst the opportunities for positive psychology integration proposed thus far, there

are inevitable limitations to the application when dealing with an unresearched population. The

exercises discussed have not been clinically validated to support the treatment of eating

disorders. Vella-Brodrick (2014) emphasizes the need for high-quality research to be facilitated

for the ethical and scientific success and longevity of the study of positive psychology.

Therefore, these interventions need to be tested using randomized, placebo-controlled "gold

standard" studies and proven successful in order to be used and acknowledged as evidence-based

interventions appropriate for eating disorders treatment (Seligman et al., 2005).

From an ethical perspective, it is important to ensure that PI's are effective, non-harming,

and appropriate for the context (Vella-Brodrick, 2014). In order to do so, research is still needed

and must be administered based on the ethical principles of beneficence, respect, justice,

trustworthiness, responsible care, and autonomy (Jarden, Lomas, Rashid, & Roache, 2019). As

Vella-Brodrick (2014) explains, having ethical standards provides clarity around the objective of

researching the positive interventions with the specific population while encouraging competent

practice, nonmaleficence, and duty of care for the patient. Given many of these interventions are

new, it will require competent training of professionals, who are currently more disease-minded, to be able to deliver and execute responsibly.

As interventions prove to have beneficial effects, the transference of such discoveries must be done in a careful, diligent, and moral manner, especially given the clinical context. Research findings ought to be communicated in a professional manner, such that the integrity of the science that supports it adhere to ethical principles. It may be advantageous to conform the stated exercises to meet the demand of the patient or population. However, suggestions that are not wedded to the science pose a series of risks for the receiver, practitioner, and credibility of the field. Exaggeration and generalization of research operate as a liability to the study of human flourishing and the patient at hand (Jarden et al., 2019) Hence, it becomes imperative that findings related to human flourishing are relayed based on the truth of the research. The manner in which we transmit the empirical data of human flourishing can either function to support these ethical guidelines of a science-based practice or diminish entirely the integrity and promise of positive psychology. Judgment and decision-making based on ethical standards enable the execution of morally sound practices to secure the intention behind positive psychology and patient well-being.

In summary, the scientific research is still needed to confirm this paper's proposal— posing as the primary limitation to application. Moreover, the research has to be administered in an ethical fashion to protect the population (e.g., individuals with eating disorders) and the field of positive psychology. When research can support positive psychology as a supplemental treatment approach for eating disorders, factual and transparent dissemination is necessary for taking next steps.

Future Directions

With successful research, the recommended topics and exercises will be made into *A Positive Psychotherapy Eating Disorder Manual.* The Manual will condense the material into useable resources for the practitioner to implement with patients. The Appendix offers a sample page of the manual, highlighting intrapersonal and interpersonal relationships. The aim is to provide practitioners with positive psychology exercises, resources, and prompts in a digestible and applicable manner. With such resources, practitioners can integrate positive psychology more readily and seamlessly into their practice to support recovery.

Beyond the scope of the manual is the scalable application of positive psychology in treatment facilities around the nation. Again, successful "gold" standard research must precede such application— but with positive findings —expansive opportunities emerge. Facilities around the country offer weekly CBT, DBT, ACT and other therapeutic methods as part of their program schedule. With proven benefits, positive psychology could be its own group within treatment programing to empower and invigorate patients to encourage recovery behavior. Positive psychology is not intended to serve as an alternative method, but rather presents as a supplemental approach to the existing therapies used in eating disorder treatment facilities.

Conclusion

Perhaps not to your surprise, I have recovered from an eating disorder. After an 8-month cycle of treatment, I was determined to find an innovative way to get better. In short, positive psychology was my recovery story. From daily meditation, to embracing a self-compassionate internal dialogue, to consciously enhancing my PERMA, to engaging in many high-quality connections; I lived Positive Psychology. I live today with an overwhelming amount of freedom and peace around my body and food. The progressive effect positive psychology had on my

recovery and my motivation to recover made my interest turn not only into my profession, but my life. My unwavering pursuit of positive psychology no longer serves as a personal quest, rather a commitment to reach a population I know can and does benefit from the work of the field.

Positive Psychology has the ability to enhance patients' quality of life while inspiring recovery behavior. It focuses on what makes life worth living; and the happy, engaged, self-accepting person does not have time to entertain the eating disorder. Increasing meaning and purpose in one's life organically diminishes the need to use the destructive coping skills of the illness. Positive Psychology offers the potential to not only support recovery for those already in the disease, but also may enable recovery maintenance and prevent eating disorders or disordered eating behavior from initial development. The field of eating disorders must pivot to meet the needs of those afflicted. Individuals with eating disorders could use more doses of positive emotions, engagement, relationships, meaning, and accomplishment along their journey of recovery. Positive psychology can give them the means to experience such components of wellbeing to better take the actions needed to recover and to sustain recovery.

Appendix A- Self-Compassion Playbook:
Intrapersonal Relationship Building
(Note: The format of this playbook is taken from Angela Duckworth's Character Lab)

"If you don't love yourself, you cannot love others. You will not be able to love others. If you have no compassion for yourself then you are not able of developing compassion for others." – Dalai Lama

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Why Does Self- Compassion Matter?
A self-compassion frame of mind is associated with higher well-being and psychological functioning, healthier responses to stress, and lower levels of depression, anxiety, and rumination. It is also associated with higher levels of positive affect, emotional intelligence, intellectual flexibility, optimism, social connectedness, and higher life satisfaction (Neff, 2012). Self-compassion functions to combat the "critical noise" of the eating disorder.

Self-Compassion Resources
Books:
  ➢ *Self-Compassion,* Kristin Neff
  ➢ *The Mindful Path to Self-Compassion,* Christopher Germer
  ➢ *The Mindful Self-Compassion Workbook:* Germer and Neff
Websites:
  ➢ Self-compassion.org
  ➢ Centerformsc.org
  ➢ Chrisgermer.com
Meditations:
  ➢ Loving Kindness Meditation
  ➢ Self-Compassion Break
  ➢ Affectionate Breathing
  ➢ Soften, Soothe, Allow

How to encourage self-compassion:
Provide an opportunity for patients to incorporate self-compassion dialogue by:
  ➢ *Recognizing the moment of difficulty.* Instead of disregarding adversity, invite patients to become aware that it may be present and reinforce that all human beings go through difficult times. Perhaps guide them to think of others who have struggled, connecting them to this shared human experience. It is part of *common humanity.*
  ➢ *Self-coach/Self-kindness.* Guide patients to imagine a loved one going through a difficult time and think of the advice they would offer, and the way they would treat them. Then ask the patient to offer that same advice and kindness to oneself. Encourage the patient to show themselves the love and compassion given to others.
  ➢ *Writing.* Ask the patient to write a letter of encouragement. Re-read the letter daily for a week to increase comfort around supportive self-dialogue. This can be a repeated journaling activity to increase self-compassion.

Appendix B - Recovery Relationship Playbook
Interpersonal Relationship Building
(Note: The format of this playbook is taken from Angela Duckworth's Character Lab)

"Healthy relationships may be the single most important determinant to well-being."- James Pawelski

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Why Do Relationship Matter?

Those with strong, positive social relationships are less likely to have a heart attack, more likely to resist the common cold virus, have lower mortality rates, experience less stress, are more optimistic, more resilience, and recover faster from wounds. Relationships contribute to the way an individual finds purpose, meaning, belonging, engagement, and more in life. They can serve as a buffer against the disconnection generated by the eating disorder.

Relationships Resources:

Books:

- *Love 2.0,* Barbara Fredrickson
- *Toward a Positive Psychology of Relationships,* Warren and Donaldson
- *Positive Relationships,* Sue Roffey

Websites:
- Thepositivepsychologypeople.com
- Greatergood.berkeley.edu
- Pursuit-of-hapiness.org

Meditations:
- Loving Kindness Meditation
- Relationship Gratitude Meditation

How to encourage relationships:

Provide an opportunity for patients to build relationships by:

- *Engaging in High-Quality Connections (HQC).* Invite the patient to engage in an HQC with someone and help make a plan to carry it out. You can also prompt the patient to share an experience of an HQC to elicit positive feelings.

- *Creating a Who for What plan.* Create a list of supports the patient has in this process. Identify what relationship is helpful for what in recovery (e.g., mom is helpful for meal planning, a friend is supportive for body image, etc.). Help the patient recognize existing relationships and how they can function individually to support recovery.

- *Calling out Disconnection.* Assist the patient in calling out the desires of illness (e.g., isolation, disconnection, separation). Develop small goals of connecting with others that challenge the illness.

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