

# Christian Spirituality in Eating Disorder Recovery

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**Abstract:** Eating disorders are some of the most severe and destructive of all psychological conditions. They are associated with restricted capacities in cognitive, emotional, physical, and spiritual development. This paper provides an examination of the practical application of Christian spirituality as a force for recovery from an eating disorder. Specifically, it expounds the transformative potential in the spiritual qualities of hope, trust, acceptance, surrender, and courage underpinning engagement with evidence-based therapeutic models of care in eating disorder recovery.

**Keywords:** eating disorders; Christian spirituality; recovery

## 1. Defining an Eating Disorder

*Why is your spirit so vexed that you eat no food? (1 Kings, 21:5, English Standard Version)*

Eating disorders (EDs) are serious, complex, psychological conditions (Isomaa and Isomaa 2014; Smink et al. 2012; Ali et al. 2017; Barry and Lane 2006). EDs are recognised as having the highest mortality rate of any psychiatric condition (Miller and Golden 2010; Lelwica 2010; Barry and Lane 2006). A critical aspect of EDs lies in their constricting effect in the developmental life of the person with an ED, thereby relinquishing the capacity to establish healthy patterns of emotional stability (Isomaa and Isomaa 2014). Consequently, the person living with an ED becomes ever more embedded in persistent, self-destructive psychological frameworks, which inevitably impedes the ability to thrive and flourish as expected. The individual lived experience of an ED is curtailed to a battle for daily survival underpinned by a prevailing sense of despair (Ali et al. 2017; Isomaa and Isomaa 2014; Chithambo and Huey 2017). Given the dangerously covert nature of the illness, it is common amongst sufferers to deny or conceal its very existence and so not seek help (Smink et al. 2012; Matusek 2007; Hill et al. 2010; Wade et al. 2017; Ali et al. 2017). This suggests that a percentage of ED patients remain unaccounted for in statistical evidence. The incidence of EDs transcends socioeconomic, cultural, and professional boundaries. Indeed, EDs can and do exist in young children and right up to grandparents. The extent of their impact varies from mild to debilitating to fatal (Maine 2004).

EDs are clinically diagnosed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) as Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), and Other Specified Feeding or Eating Disorder (OSFED) (Ekeroth et al. 2013). It is within this last category that the majority of those diagnosed with an ED are categorised (Rosen 2010; Isomaa and Isomaa 2014; Fairburn et al. 2009). It comprises those who may present with atypical EDs but are recognised as being equally as ill as those with classically defined symptoms. Indeed, achieving a distinct diagnosis may be further challenged by the fluctuating nature of the illness whereby individuals with an ED are often found to merge from AN to BN, with a comorbidity of depression and anxiety being common (Collier and Treasure 2004; Milos et al. 2005; Miller and Golden 2010; Abbate-Daga et al. 2011).

Evidence suggests that EDs emerge from a complex interaction between genetic factors and cultural, environmental, and social influences (Rosen 2010; Collier and Treasure 2004; Barry and Lane 2006). Similarly, research and experience from ED professionals suggests that EDs

manifest from social and cultural constructs absorbed in the mind, body, and soul and thus have expression in the harried life of those living with an ED (Maine 2004). Further research highlights the correlation between psychological trauma and biological processes, thus recognising that incidents of trauma and shock are registered at the visceral level of the body (Van der Kolk 2014; Weinhold and Weinhold 2011; Costin 2007). Crucially, when traumatic experiences remain unprocessed, this creates a vulnerability toward developing a wide range of psychopathologies, including eating disorders (Van der Kolk 2014; Weinhold and Weinhold 2011). In addition, the field of epigenetics sheds further light on the etiology of EDs. This area of scientific study has determined that DNA exists in a state of fluctuation. Underpinning this theory is the notion that life events and environmental exposures, such as damaging emotional states, stress, or nutritional deprivation, can alter the behaviour of DNA, thereby affecting the quality of life (Van der Kolk 2014; Weinhold and Weinhold 2011; Costin 2007).

## 2. Defining Spirituality

*There's none but truth can stead you. Christ is truth.* (Hopkins 1962, p. 84)

The definition of spirituality validated by the Royal College of Psychiatrists, London, UK, is as follows:

Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as relationship with that which is intimately 'inner', immanent and personal, within the self and others, and/or as relationship with that which is wholly 'other', transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values. (Cook 2004, pp. 548–49)

Working from this basis, spirituality can be seen as an experiential process which concerns the relationship with the inner self, with others and with that which is beyond the self—the transcendent or sacred. At this level, it ceases to be a theoretical concept but rather is grounded in the lived experience and becomes an anchoring discipline (Lelwica 2010; Carthusian 2006; Cook 2004; Perrin 2007; Koenig 2012). It is a way or path of action from which arises the behaviour, whether consciously or otherwise (Lelwica 2010). In this way, spirituality can be deemed as lying outside the constructs of organised religion (Koenig 2012; Lelwica 2010). The value of spiritual practices lies in the intersection between the inner life and the outer reality (Smith 2004). The thirteenth century theologian Meister Eckhart grounds the spiritual life in the dual worlds of the inner soul and the outer world which is dominated by the striving self (Smith 2004). The essence of finding a balance between these two seeming opposite states becomes a spiritual practice. The one ought not to become more dominant than the other (Smith 2004).

## 3. Therapeutic Models of Care and Tools of ED Recovery

### 3.1. Cognitive Behavioural Therapy

A widely recognised model of care in ED treatment is that of cognitive behavioural therapy (CBT) (Isomaa and Isomaa 2014; Chithambo and Huey 2017; Barry and Lane 2006). This psychotherapeutic intervention seeks to challenge and reframe distortions in the cognitive processes (Barry and Lane 2006; Van der Kolk 2014; Chithambo and Huey 2017). In the context of ED recovery, CBT aims to transform negative mindsets related to body image, weight, shape, and eating patterns into more balanced frameworks surrounding the sense of self-worth (Chithambo and Huey 2017; Wade et al. 2017; Matusek 2007; Bowlby 1988).

### 3.2. Dialectical Behaviour Therapy

Similarly, Dialectical Behaviour Therapy (DBT) is a skills-based cognitive therapy with proven effectiveness in treating a wide range of mental health illnesses, including EDs (Linehan 2015; Van der Kolk 2014). It consists of modules such as emotional regulation, interpersonal effectiveness, distress tolerance, and mindfulness and radical acceptance designed to instill a sense of inner calm whilst providing practical tools for everyday application (Linehan 2015; Van der Kolk 2014).

### 3.3. Psychodynamic Therapy and Family Based Therapy

In conjunction with CBT, traditional psychodynamic therapy has been widely proven to provide valuable support to an individual with an ED (Isomaa and Isomaa 2014; Costin 2007; Barry and Lane 2006). A key strength of the psychotherapeutic relationship in ED recovery lies in its potential to challenge harmful behaviours resulting from unconscious maladaptive psychological patterns (Reeves 2013; Costin 2007). It also has a significant role to play in the development of personal bonding and secure attachment (Reeves 2013; Costin 2007; Bowlby 1988). Alongside individual psychodynamic therapy for the person living with an ED, Family Based Therapy (FBT) is frequently recommended as an effective component of treatment (Reeves 2013; Rosen 2010; Costin 2007; Barry and Lane 2006). Including family members or loved ones in the recovery process, where appropriate, aims to provide support, insight, and healing (Treasure et al. 2007; Costin 2007).

### 3.4. Multidisciplinary Treatment Teams

Increasingly, recommendations for effective ED treatment point to a multidisciplinary approach (Barry and Lane 2006; Isomaa and Isomaa 2014; Rosen 2010). This incorporates therapeutic input from experts in the field of psychiatry, psychotherapy, nursing, dietetics, and body therapies such as yoga, tai chi, and massage therapy, and creative practices such as art therapy (Rosen 2010; Barry and Lane 2006; Costin 2007; Reeves 2013).

### 3.5. Mindfulness Based Practices

Mindfulness-based practices are recognised as contributing much to the field of mental-health recovery (Van der Kolk 2014; Lelwica 2010; Reeves 2013; Costin 2007). Such practices include meditation, prayer, and mindfulness-based stress reduction. The central tenet involves developing the ability connect to the sensations of the physical body whilst allowing a non-judgemental awareness of thoughts and emotions as they emerge (Van der Kolk 2014; Lelwica 2010; Reeves 2013; Costin 2007). There is considerable evidence for the merits of mindfulness in treating psychological and emotional distress (Van der Kolk 2014; Linehan 2015; Reeves 2013; Leamy et al. 2011; Lelwica 2010). Neurological research shows that it stimulates cerebral pathways responsible for the ability to adopt a more measured response to life events, coupled with an attitude of acceptance toward the emotional experience (Van der Kolk 2014; Reeves 2013). Furthermore, evidence indicates that mindfulness-based practices provide a valuable avenue through which to harness qualities of self-compassion and stillness particularly when used in conjunction with other therapeutic tools such as CBT and DBT (Reeves 2013; Linehan 2015).

## 4. Christian Spiritual Principles

Underpinning the ability to engage with tools of recovery lies the application of key spiritual principles. In the dimension of spirit, time is seen as the lifespan of the spirit and exists in the present only (Carthusian 1975). Following this perspective then, the essential point is to begin the fight for recovery and peace, regardless of how long the ED has already taken root.

And I shall have some peace there, for peace comes dropping slow,  
Dropping from the veils of the morning to where the cricket sings;

... I hear it in the deep heart's core.

Thus wrote the poet W.B. Yeats in *The Lake Isle of Innisfree* (Yeats 2010, p. 26), which alludes to the almost imperceptible quality of interior calm. Yet, it is in cherishing each tiny moment of hard-won inner peace that the recoverer builds resilience and faith.

#### 4.1. Hope

“Hope” is the thing with feathers -  
That perches in the soul -  
And sings the tune without the words -  
And never stops - at all -

(Dickinson 1987, p. 116)

The Dominican theologian Thomas Aquinas posited that the human experience is essentially a pilgrim journey with humanity embodying the status viatoris—the condition of being ‘on the way’ (Pieper 1986). This ‘way’ is not only a concrete place or destination, but the orientation of the self towards a future not yet seen. The adoption of hope is regarded as an essential element on this odyssey (Kavanagh 2016). Although life is not ‘seen’, through daily engagement with it, a belief in it exists none-the-less (Carthusian 1975). Hope, then, has the potential to gradually and continually direct the mind towards the onward-ness of living. The spiritual virtue of hope is not based on human effort or wishful thinking. It is rooted in the certain expectation of goodness in the future whilst retaining an attitude of openness to the present reality (Kavanagh 2016).

In the context of recovery, cleaving onto hope implies a conscious choice to re-construct the story of the past whilst re-imaging a future life story (Matusek 2007). This practice of re-assessing the frameworks that have been thus far wholly believed, centres on igniting the impulse to live despite the fact that it may be incongruous to the outward form or to the onslaught of the ED cognitions which have enmeshed the person in a pattern of destruction. There is a deep humility in recognising that the constructs to which the ED survivor has been deeply adhered are, in fact, bound to falsehoods (Maine 2011; Matusek 2007). The questioning and re-assessing of those beliefs relies on both critical thinking and a deeper reconstructing of the consciousness and cognitive distortions (Lelwica 2010; Costin 2007; Bowlby 1988). The application of CBT and DBT practices are central components in this process, embedded in an attitude of self-compassion. Another crucial component is an inner reliance on the fire of hope residing within the deepest recesses of the heart (Collins 2010). Fanning the flames of hope is at once a delicate and steadfast endeavour. Recovery demands an interior clinging to the assurance of a brighter reality being possible (Collins 2010).

Evidence continues to show that the application of hope has far-reaching, positive impacts on both the mental and physical life (Koenig 2012). Experts in the fields of attachment theory and trauma recovery posit that human beings are in fact innately self-orientated toward healing and wellness (Bowlby 1988; Van der Kolk 2014). The status viatoris is akin to the essence of recovery which is often a fluid, non-linear journey of trial and error (Matusek 2007).

#### 4.2. Trust

*Deus caritas est* (1 John, 4:16, King James Version)

Within the Christian faith lies the belief that all things are permitted from a motive of love and kindness (Carthusian 2006). Believers hold that this truth remains, irrespective of circumstances. It is through trust that God is acknowledged as being present within the deepest interiority of the being (Carthusian 2006). It is a presence that not only resides within, but which permeates everything in a realm of love and care (Carthusian 2006; Lelwica 2010). This acknowledgment of the universality of God does not involve a fleeing from life but rather a constant emersion in the daily realities seeking attention. It assumes a fundamental element of trusting that God is in all things, both the comfortable and the

apparently destructive (Kavanagh 2016). As noted by the Lutheran writer, Carl E. Braaten, though spiritual solutions may be sought in the ‘sacred temples or royal castles’, rather it begins with trusting in God’s presence in the humble, and often harsh, reality of the lived experience (Collins 2010, p. 32).

It is at this barren threshold that the ED recoverer must also begin to build a foundation of trust. The spiritual life which emerges from this trust requires a steadfast and regular renewal of commitment (Carthusian 2006). This need not be a complicated affair. On the contrary, the simpler the re-connection to the inner quiet, the more potential there is for an effective outcome. This connection with the spirit-within is not determined by life experience or by body shape or size (Lelwica 2010). When confusion marks the way, it is worth adhering to the principle that whilst it is not known what or whom God is, faith and trust develop with a sense of what or where He is not (Kavanagh 2016). In addition, trust emerges as a key component of the positive attachments created during engagement in the therapeutic environment (Bowlby 1988; Costin 2007). A key shift is possible when the sense of trust begins to take root in the recoverer themselves (Matusek 2007).

#### 4.3. Acceptance and Surrender

*And in his will we find our peace* (Dante 1980, p. 318)

An eating disorder mindset incorporates the misguided belief that the person living with an ED is the master of a plan which will yield both the physical body desired and the peace so desperately yearned for (Lelwica 2010). The truth is that those with an ED are enveloped in a web of psychological, emotional, and spiritual deceit; there is an enslavement (Lelwica 2010; Maine 2011). The recognition of having committed the will to the destructive force of the ED distortions is an important discovery (Lelwica 2010).

The subsequent step involves accepting this lived reality. It demands a surrendering to the current experience and becoming aware of the torrent of thoughts and emotions as they emerge (Lelwica 2010). In line with all steps in ED recovery, the choice to make this decision rests with the recoverer. This approach can have a twofold outcome. First, it stills the mental and emotional states (Maine 2011). The result of surrendering the mind, will, and emotions and accepting the outward reality is reflected in Psalm 131:2 (English Standard Version):

But I have calmed and quietened my soul,  
like a weaned child with its mother;  
like a weaned child is my soul within me.

At the outset, this sense of calm may only be fleeting. However, experiencing even the faintest hint of inner peace has the potential to demonstrate to the ED survivor an ability to self-soothe in the midst of emotional and psychological disturbances (Carthusian 1975).

Second, as this practice is repeatedly adopted, it creates an opportunity to allow a different reality to potentially take shape by adopting healthier cognitive frameworks (Lelwica 2010; Matusek 2007). By continuing to engage in this way, the ED recoverer gradually gains strength and clarity to continue to apply effective therapeutic resources (Wade et al. 2017; Lelwica 2010).

When the results of outward strivings continue to yield destruction, it is only by returning to the heart that a peaceful resolution can be accessed (Smith 2004; Lelwica 2010). This process is not rooted within a dogmatic framework but rather in an attitude of surrender, acceptance, and self-compassion. At the outset, basic acts of kindness toward the self can appear inauthentic and conflicting for the ED recoverer (Lelwica 2010). However, it is vital to encourage these stirrings of kindness if recovery is to take root (Lelwica 2010).

#### 4.4. Courage

*Deep calleth unto deep* (Psalm 42:7, King James Version)



Developing courage is an essential element in seeking recovery. It requires discipline and determination to yield results. Courage is rooted in connecting with a calm internal stillness. Harnessing this aspect of the spiritual life can appear inaccessible in the face of the realities of recovery. However, courage does not gain momentum in isolation from the inner struggle (Chittister 2003). Rather, the extreme suffering at the root of an ED becomes a transformative force for ongoing fortitude. A determined insistence is necessary to quieten the mind and accept the present reality, which in turn cultivates resilience. In line with the characteristics of recovery, courage is an adaptable, fluctuating virtue that is harnessed according to the level of adversity being challenged (Matusek 2007). The fluid nature of courage is in sharp contrast to the restricted rigidity associated with an ED mentality. Spirituality is an avenue through which acts of courage can be continuously repeated, thereby gradually restoring the inner strength to continue to apply tools of recovery (Lelwica 2010).

A sobering truth in the recovery process lies in the knowledge that the recoverer does not wait for feelings of strength, enthusiasm, and bravery to emerge in order to continue forward (Lelwica 2010). On the contrary, it is by deliberately journeying in self-acceptance with a warrior spirit that progress is made (Matusek 2007). During moments of emotional overwhelm, the support and testimony of others both in the faith community and the therapeutic setting become an important means of renewal and connection, thereby bolstering the individual's own resolve (Matusek 2007; Koenig 2012). This attitude of unrelenting acceptance allows key elements of DBT practices including mindfulness and distress tolerance to be accessed. By engaging in this stepped-approach to well-being, recovery milestones can be integrated in a non-threatening way.

Continued movements of courage gradually open the way for freedom to develop. With freedom comes attitudes of ease, flexibility, and adaptability—attributes which may have hitherto lain dormant in the person with an ED (Lelwica 2010). Initially, freedom may yield an emotional response of terror and retreat. In his writings, Eckhart used the words 'frei' and 'ledig' to describe freedom (Smith 2004, p. 119). The latter translates alternately as light, untrammelled, or unbound. Becoming unshackled from harmful ED constructs relies on steadfast courage to question entrenched cognitive frameworks. This creates an opportunity to observe the behaviour (Smith 2004). Research indicates that certain ED patterns of thinking involve a contorted dependence on body image, weight and/or shape for the development and maintenance of a sense of worthiness and wholeness (Wade et al. 2017; Mitchison et al. 2017; Chithambo and Huey 2017; Lelwica 2010). Sustaining this corrupted sense of self at all costs then becomes a core function, a very reason for which to live, which only perpetuates the vicious cycle further.

As the process to challenge such cognitive patterns continues, a range of emotions may be unleashed (Van der Kolk 2014). At this juncture, a key component in recovery is repeatedly accessing the courage to commit to the process. In addition, a deep engagement with the personal psychodynamic relationship can act as a sustaining source of truth. Furthermore, there is evidence that spiritual beliefs can serve as compassionate holding vessels for dysfunctional behaviour and distressing emotions during recovery (Matusek 2007).

Enshrined within the Christian message is the belief that freedom is a fundamental element of human nature (Collins 2010). It follows, then, that by returning and living from a place of inner freedom, the recoverer is simply reclaiming their God-given nature.

## 5. Discussion

*Awake, awake, break through your Vailles of Lawne!*

*Then draw your Curtains, and begin the Dawne.* (D'Avenant 1964, p. 140)

The threads of recovery deepen with the identification and ownership of personal spiritual beliefs and values. Taking responsibility for individual spiritual needs may be a key element in developing a consistent pattern of healthy outcomes. This has the potential to harness real growth when practiced in conjunction with evidence-based therapeutic models of care delivered within the healthcare setting.

Given the isolating nature of this illness, engaging in authentic relationships where spiritual traditions are upheld and practiced could provide essential inner sustenance (Koenig 2012; Matusek 2007). Developing secure attachments instills a sense of connectedness and meaning, thereby helping to solidify the recovery process (Bowlby 1988; Van der Kolk 2014; Leamy et al. 2011; Costin 2007). Bowlby asserts that the ability to establish interpersonal relationships is a pivotal component in developing solid mental health capacities (Bowlby 1988; Costin 2007). Indeed, research elucidates this further by highlighting the positive effects that trustworthy relationships have on the physiological system of the body (Van der Kolk 2014; Bowlby 1988; Weinhold and Weinhold 2011). Favourable somatic responses in the central nervous system have been observed as a result of developing healthy connections. Fostering healthy bonds helps to consolidate a sense of selfhood, thereby strengthening the propensity for ongoing positive change (Linehan 2015; Bowlby 1988; Van der Kolk 2014; Leamy et al. 2011). As a result, these effects have powerful consequences on the ability to disengage from cognitive distortions experienced during various stages of an ED, particularly when implemented with mindfulness, CBT, and DBT practices.

In line with life itself, the application of spiritual practices for developing health and wellness in ED recovery is not a linear process. Various principles may be harnessed at different stages, together with appropriate recovery tools. Repeated episodes of relapse are not uncommon and so warrant no undue concern or despair. Setbacks in recovery reflect the natural ebbs and flows of life's turnings. Relapses can represent an opportunity for continued growth and commitment to recovery principles and spiritual practices whilst approached with an attitude of self-compassion and radical acceptance.

The extreme lack of hope experienced by those living with an ED emphasises the lifeline that healthcare settings could provide. Christian spiritual principles echo the essence of evidence-based recovery components such as connectedness, hope, identity, meaning, and empowerment (Leamy et al. 2011). There is scope for further discourse surrounding the very definition of recovery (Reeves 2013; Costin 2007; Barry and Lane 2006). From the perspective of the purely clinical model, meeting specific physical criteria may suffice for the person diagnosed with an ED to be recovered (Miller and Golden 2010; Keski-Rahkonen et al. 2007). Certainly, it is clear that becoming physically well enough to meet life's quotidian demands is a crucial starting point in ED treatment (Koenig 2012). Indeed, without first stabilising the nutritional and physical imbalances inherent in EDs, the individual remains ill-equipped to engage with other elements of recovery (Barry and Lane 2006). However, evidence suggests that a more all-encompassing gauge of recovery would include the extent to which the ED survivor actively participates in their life, possesses hope for their future and feels a sense of empowerment and meaning (Isomaa and Isomaa 2014; Leamy et al. 2011; Matusek 2007; Costin 2007).

Recent research confirms the misguided assumption that EDs are either a preferred way of living or simply a 'phase' as opposed to the serious and life-threatening mental health conditions that they are (Ali et al. 2017; Barry and Lane 2006). Such perceptions place lives at risk by creating additional barriers to accessing treatment and highlight the complex matrix of misunderstanding imbued within this attitude. It indicates the need to advocate for greater awareness of EDs. In addition, there is a distinct necessity to engage with a wider sector of society in the delivery of preventative ED measures. Further research investigating the application of spiritual practices with ED recovery outcomes is warranted.

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## References

- Abbate-Daga, Giovanni, Carla Gramaglia, Enrica Marzola, Federico Amianto, Maria Zuccolin, and Secondo Fassino. 2011. Eating disorders and major depression: Role of anger and personality. *Depression Research and Treatment* 2011: 1–7. [CrossRef]
- Ali, Kathina, Louise Farrer, Daniel B. Fassnacht, Amelia Gulliver, Stephanie Bauer, and Kathleen M. Griffiths. 2017. Perceived barriers and facilitators towards help-seeking for eating disorders: A systemic review. *International Journal of Eating Disorders* 50: 9–21. [CrossRef] [PubMed]
- Barry, Siobhan, and Abbie Lane. 2006. *Understanding Mental Health*. Dublin: Blackhall Publishing.

- Bowlby, John. 1988. *A Secure Base*. London: Routledge.
- Carthusian, A. 1975. *They Speak By Silences*. London: Darton, Longman and Todd.
- Carthusian, A. 2006. *The Prayer of Love and Silence*. Herefordshire: Gracewing Publishing.
- Chithambo, Taona P., and Stanley J. Huey Jr. 2017. Internet-delivered eating disorder prevention: A randomized controlled trial of dissonance-based and cognitive-behavioral interventions. *International Journal of Eating Disorders* 50: 1142–51. [CrossRef] [PubMed]
- Chittister, Joan D. OSB. 2003. *Scarred by Struggle, Transformed by Hope*. Michigan: William B. Eerdmans Publishing.
- Collier, David A., and Janet L. Treasure. 2004. The aetiology of eating disorders. *The British Journal of Psychiatry* 185: 363–65. [CrossRef] [PubMed]
- Collins, Gregory OSB. 2010. *Meeting Christ in His mysteries: A Benedictine Vision of the Spiritual Life*. Dublin: The Columba Press.
- Cook, Christopher C. H. 2004. Addiction and spirituality. *Addiction* 99: 539–51. [CrossRef] [PubMed]
- Costin, Carolyn. 2007. *The Eating Disorder Sourcebook—A Comprehensive Guide to the Causes, Treatments, and Prevention of Eating Disorders*. New York: McGraw Hill.
- D'Avenant, William. 1964. The Lark now leaves his watry Nest. In *The Penguin Book of English Verse*. Edited by John Hayward. Middlesex: Penguin Books, p. 140.
- Dante. 1980. The Divine Comedy—Paradiso, Canto III, v85. In *Dante: The Divine Comedy*. Translated by Charles H. Sisson. Manchester: Carcanet New Press, p. 318.
- Dickinson, Emily. 1987. "Hope" is the Thing with Feathers. In *Emily Dickinson: The Complete Poems*. Edited by Thomas H. Johnson. London: Faber and Faber, p. 116.
- Ekeroth, Kerstin, David Clinton, Claes Norring, and Andreas Birgegård. 2013. Clinical characteristics and distinctiveness of DSM-5 eating disorder diagnoses: Findings from a large naturalistic clinical database. *Journal of Eating Disorders* 1: 31–42. [CrossRef] [PubMed]
- Fairburn, Christopher G., Zafra Cooper, Helen A. Doll, Marianne E. O'Connor, Kristin Bohn, Deborah M. Hawker, Jackie A. Wales, and Robert L. Palmer. 2009. Transdiagnostic Cognitive-Behavioral Therapy for Patients with Eating Disorders: A Two-Site Trial With 60-Week Follow-Up. *American Journal of Psychiatry* 166: 311–19. [CrossRef] [PubMed]
- Hill, Laura S., Fiona Reid, John F. Morgan, and J. Hubert Lacey. 2010. SCOFF, the Development of an Eating Disorder Screening Questionnaire. *International Journal of Eating Disorders* 43: 344–51. [CrossRef] [PubMed]
- Hopkins, Gerard Manley. 1962. On the Portrait of Two Beautiful Young People. In *Gerard Manley Hopkins: A Selection of His Poems and Prose*. Edited by W. H. Gardner. Middlesex: Penguin Books, pp. 83–84.
- Isomaa, Rasmus, and Anna-Lisa Isomaa. 2014. And then what happened? A 5-year follow-up of eating disorder patients. *Nordic Journal of Psychiatry* 68: 567–72. [CrossRef] [PubMed]
- Kavanagh, Joseph OP. 2016. Dominic: ... 'there is nothing given that cannot be re-imagined'. *Spirituality* 22: 195–202.
- Keski-Rahkonen, Anna, Hans W. Hoek, Ezra S. Susser, Milla S. Linna, Elina Sihvola, Anu Raevuori, Cynthia M. Bulik, Jaakko Kaprio, and Aila Rissanen. 2007. Epidemiology and course of anorexia nervosa in the community. *The American Journal of Psychiatry* 164: 1259–65. [CrossRef] [PubMed]
- Koenig, Harold G. 2012. Religion, spirituality and health: The research and clinical implications. *International Scholarly Research Network Psychiatry* 2012: 1–33. [CrossRef] [PubMed]
- Leamy, Mary, Victoria Bird, Clair Le Boutillier, Julie Williams, and Mike Slade. 2011. Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry* 199: 445–52. [CrossRef] [PubMed]
- Lelwica, Michelle M. 2010. *The Religion of Thinness: Satisfying the Spiritual Hungers behind Women's Obsessions with Food and Weight*. California: Gurze Books.
- Linehan, Marsha M. 2015. *DBT Skills Training Manual*. New York: Guilford Press.
- Maine, Margo. 2004. *Father Hunger: Fathers, Daughters, and the Pursuit of Thinness*. California: Gurze Books.
- Maine, Margo. 2011. *Body Wars—Making Peace with Women's Bodies*. California: Gurze Books.
- Matusek, Jill Anne. 2007. Overcoming An Eating Disorder: A Narrative Approach to Long-Term Recovery. Masters of Arts thesis, Miami University, Oxford, OH, USA. Available online: [http://rave.ohiolink.edu/etdc/view?acc\\_num=miami1185928602](http://rave.ohiolink.edu/etdc/view?acc_num=miami1185928602) (accessed on 16 October 2017).
- Miller, Catherine A., and Neville H. Golden. 2010. An introduction to eating disorders: Clinical presentation, epidemiology, and prognosis. *Nutrition in Clinical Practice* 25: 110–15. [CrossRef] [PubMed]



- Milos, Gabriella, Anja Spindler, Ulrich Schnyder, and Christopher G. Fairburn. 2005. Instability of eating disorder diagnoses: Prospective study. *The British Journal of Psychiatry* 187: 573–78. [[CrossRef](#)] [[PubMed](#)]
- Mitchison, Deborah, Phillipa Hay, Scott Griffiths, Stuart B. Murray, Caroline Bentley, Kassandra Gratwick-Sarll, Carmel Harrison, and Jonathan Mond. 2017. Disentangling body image: The relative associations of overvaluation, dissatisfaction, and preoccupation with psychological distress and eating disorder behaviors in male and female adolescents. *International Journal of Eating Disorders* 50: 118–26. [[CrossRef](#)] [[PubMed](#)]
- Perrin, David B. 2007. *Studying Christian Spirituality*. New York: Routledge.
- Pieper, Josef. 1986. *On Hope*. San Francisco: Ignatius Press.
- Reeves, Andrew. 2013. *An Introduction to Counselling and Psychotherapy—From Theory to Practice*. London: Sage Publications.
- Rosen, David S. 2010. Identification and management of eating disorders in children and adolescents. *American Academy of Pediatrics* 126: 1240–53. [[CrossRef](#)] [[PubMed](#)]
- Smink, Frédérique R. E., Daphne van Hoeken, and Hans W. Hoek. 2012. Epidemiology of eating disorders: Incidence, prevalence and mortality rates. *Current Psychiatry Reports* 14: 406–14. [[CrossRef](#)] [[PubMed](#)]
- Smith, Cyprian OSB. 2004. *The Way of Paradox—Spiritual Life as Taught by Meister Eckhart*. London: Darton, Longman and Todd.
- Treasure, Janet, Grainne Smith, and Anna Crane. 2007. *Skills-Based Learning for Caring for a Loved One with an Eating Disorder—The New Maudsley Method*. East Sussex: Routledge.
- Van der Kolk, Bessel. 2014. *The Body Keeps The Score—Mind, Brain and Body in the Transformation of Trauma*. London: Penguin Books.
- Wade, Stephanie, Sue Byrne, and Karina Allen. 2017. Enhanced cognitive behavioral therapy for eating disorders adapted for a group setting. *International Journal of Eating Disorders* 50: 863–72. [[CrossRef](#)]
- Weinhold, Janae B., and Barry K. Weinhold. 2011. *Healing Developmental Trauma—A Systems Approach to Counseling Individuals, Couples, & Families*. Denver: Love Publishing Company.
- Yeats, W. B. 2010. The Lake Isle of Innisfree. In *The Best-Loved Yeats*. Selected by Mairéad Ashe Fitzgerald. Dublin: O'Brien Press, p. 26.



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