GUILT, FOOD, AND CONTROL- THREE WOMEN'S EXPERIENCE WITH EATING DISORDERS

CENTRE FOR NEWFOUNDLAND STUDIES

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Guilt, Food, and Control— Three Women's Experience with Eating Disorders

by
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A thesis submitted in partial fulfillment
of the requirements for the degree of
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ABSTRACT

Eating disorders have emerged over the last decade as a serious health and social problem. The challenge in understanding the developmental processes for eating disorders is in moving past the strange and fascinating behaviour. The literature points to three constellations of factors as significant in the emergence of eating disorders. These are: socio-cultural norms and expectations, family composition and relationships, and personal characteristics.

This study explores three women's experiences with the emergence and treatment of an eating disorder. The study examines, through the medium of in-depth personal histories, the life and treatment experiences of women who had been diagnosed as having anorexia nervosa, bulimia nervosa, or both.

The data analysis attempts to bring together the collective wisdom of the existing literature and the information provided by the women in this study. There was a great deal of consistency between the participant's stories with respect to their obsessions and rituals related to body shape, weight, and control of eating. The analysis revealed that the eating disorder is symbolic of more deep-seated emotional problems. Family experiences and socio-cultural pressures towards thinness were also seen as significant factors.

These issues are further analyzed to develop an understanding of the role of social work in the treatment of eating disorders. Consideration is given to the directions indicated for the development of early intervention strategies.

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"And so the young anorexic was caught in a cruel trap. She refused to eat in order to preserve her personal identity, but in order to preserve her life she had to eat, and this she experienced as an act of self betrayal..."

Hilde Bruch

(as cited in Selevini-Palazzoli,1974,p. 65)

INTRODUCTION

Eating is essential to life. Eating is also a ritual that has meaning beyond meeting a physical need and is associated with comfort, caring and socializing. Feeding is in fact the first form of contact between a parent and a child, and is viewed as integral to the development of their emotional bonds.

Disordered eating, such as anorexia nervosa and bulimia nervosa, has emerged over the past decade as both a serious health and social problem. Female adolescents appear to be most vulnerable to developing eating disorders. At a time when many natural body changes are occurring, adolescents with eating disorders become totally focused on body size. They appear to connect self-worth to a regimented and often destructive control of eating. Given the many changes that are seen as normal during adolescence, the rituals of eating disorders can be easily missed or overlooked by families and professionals.

Participation in the treatment of eating disorders presents a unique challenge to the social work profession. The debilitating, seemingly self-imposed, and potentially life threatening nature of anorexia and bulimia, often leave the social worker feeling tremendously inadequate. However the profession's strength lies in working with individuals in the context of their family and community. If anorexia and bulimia are viewed as representing an inadequate coping mechanism in the context of a dysfunctional family, then social work intervention should be seen as integral to treatment. Given this, an increased understanding of eating disorders from a social work perspective is necessary to provide more meaningful intervention.

This study is concerned with examining the factors that are associated with the development of eating disorders. It is qualitative in nature and will explore the life experiences and perceptions of women with an eating disorder. This enriched understanding of the client's perceptions of the developmental process for anorexia and bulimia, will enable social workers to be better equipped to detect these conditions and intervene more effectively.

The issues to be addressed are:

- The specific individual, family, and socio-cultural factors associated with the development of anorexia and bulimia.
- The activities, behaviours and family conditions that are associated the development of anorexia and bulimia.
- The individual's perceptions of the development and treatment of her eating disorder.

These issues will be further analyzed to develop an understanding of the role of social work in the treatment of eating disorders. Consideration will be given to the directions indicated for the development of early intervention strategies.

Problem Statement

This study explores eating disorders and the factors associated with their development. Anorexia nervosa and bulimia nervosa will be of primary interest. They represent two of the four diagnostic categories of eating disorders presented in the *Diagnostic and Statistical Manual for Mental Disorders (DSM III - R).* The other two categories are pica and rumination.

Pica is persistent eating of nonnutritive substances and is seen primarily in childhood. Rumination is persistent chewing and is seen primarily in infancy. (Goldman, 1988).

The DSM III-R is the recognized standard for psychiatric diagnosis in North America. According to Goldman (1988) the DSM III - R diagnostic criteria for anorexia nervosa are:

1. Refusal to maintain body weight with resulting weight loss below 15% of normal for age and height.

2. An intense fear of gaining weight and becoming fat.

3. A disturbance in the perception of body size and shape.

4. In females, missing at least three consecutive menstrual cycles, for which there is no other organic cause.

The diagnostic criteria for bulimia nervosa are:

1. Recurrent episodes of binge eating, which is described as rapid consumption of food in a discrete period of time.

2. A minimum average of two binge episodes a week, for at least three months.

3. A feeling of being out of control when overeating during a binging episode.

4. Regularly engaging in either self-induced vomiting, use of laxatives or diuretics, strict dieting, fasting or vigorous exercise to lose weight.

5. Persistent overconcern with body weight and shape. (Goldman, 1988)

Elements of anorexia and bulimia nervosa seem closely related despite the separate diagnostic categories; for example both demonstrate an overconcern with body size, food and weight. Furthermore studies have shown that there is often overlap between the two disorders. The most common presentation is the development of bulimia nervosa following an established anorexic period. Casper, Eckert, Halmi, Goldberg, and Davis (1980) (as cited in Clarke, Parr and Castelli, 1988) revealed that 47% of the anorexics they studied became bulimic. However the converse has not been found. It is rare for anorexia to be secondary to bulimia nervosa.

This suggests that there may be common issues in the developmental processes for anorexia and bulimia nervosa. This is most evident in the socio-cultural and family issues, which are particularly significant to a social work perspective. In this study the issues related to the development of both anorexia and bulimia nervosa will be examined. This choice however, is not intended to diminish the work of recent authors who have established bulimia nervosa as a unique clinical entity. (Root et al., 1986; Pope & Hudson, 1984)

Since the exploration of these issues may conceivably be directed towards enhancing early intervention or towards enhancing prevention, it is important to establish a focus of study. The literature reviewed does not address the efficacy of either direction. The literature primarily focuses on discussion of incidence rates for eating disorders, clinical symptoms and treatments, and the impressions of clinicians (Bruch, 1978; Emmett, 1985; Lachenmeyer & Muni-Brander, 1988; Liebman, Sargent & Silver, 1983; Root, Falon and Freiderich, 1986).

While one is drawn to the prevention direction, a focus on early intervention may be more useful considering Newfoundland and its needs. This conclusion is based on a recognition that there is little general awareness of eating disorders in Newfoundland. In addition, there is no recognized treatment centre within the Province. Treatment intervention appears to be fragmented and is primarily offered by professionals who have developed a special interest in eating disorders. The present level of service development in Newfoundland suggests a need for the enhancement of strategies for early intervention rather than prevention.

Anorexia and bulimia nervosa are viewed as multi-determined conditions. Three factors are seen as most significant in the development of anorexia and bulimia nervosa. These are: (a) socio-cultural norms, (b) family composition and relationships, and (c) personal characteristics (Bruch, 1978; Emmett,1985; Garner, Garfinkel, Schwartz & Thompson, 1980; Kinoy, 1984; Kog & Vandereychen, 1985; Lachenmeyer & Muni-Brander, 1988; Liebman et al, 1983; Minuchin & Baker, 1978; Root et al, 1986; Selevini-Palazzoli, 1974). Since this study is intended to enhance the understanding of eating disorders from a social work perspective, which as previously identified focuses on the individual and family in the context of a community, the association of each of these three factors will be examined.

A final consideration is the relevance of this kind of study. The life threatening and debilitating nature of eating disorders, forms a convincing motivation for further investigation. However criticism has been raised that anorexia and bulimia nervosa only affect a proportionately small number of

people and that research efforts may be better directed towards treatment of, for example, obesity (Brone and Fisher, 1988).

Two factors that serve to dispel this criticism are:

1. There has been a dramatic increase of the overall incidence of eating disorders in the past decade. While no Canadian statistics have been reported in the literature reviewed, Jones and coworkers (1980) reported on a survey in Monroe County, New York, which found a 400% increase in the number of new cases of anorexia nervosa in females when comparing the period 1970-1976 with 1960-1969 (as cited in Goldman, 1988). Furthermore, recent surveys of non-clinical college and high school populations indicate a more widespread incidence of sub-clinical disordered eating. Lachenmeyer and Muni-Brader (1988) report incidence rates of 59-79% in females and 30-49% in males. This is significantly higher than previous reports from clinical populations which indicate a 4.4-15% rate for both males and females (Lachenmeyer and Muni-Brader, 1988).

2. A further examination of the surveys reported by Lachenmeyer and Muni-Brader (1988) reveal that the proportion of males with sub-clinical disordered eating is significantly higher than previously thought. In addition, the lower socio-economic groups in their survey demonstrated incidence rates comparable with those from a higher socio-economic group. The only significant difference between these groups was that those of higher socio-economic status were more likely to report use of diet pills and

diuretics, while those from the lower group were more likely to report binge eating.

There is no way to relate such increases to the Canadian or Newfoundland experience as there are no prevalence statistics presently available (National Eating Disorder Information Centre [NEDIC], 1988). However, these statistics support the subjective reports in the literature of the increasing prevalence of anorexia and bulimia nervosa (Brone et al, 1988; Laschenmeyer et al, 1988).

Research Question

This study addresses two questions. What are the socio-cultural, familial, and personal factors associated with the emergence of anorexia nervosa and bulimia nervosa? How might an increased understanding of these factors from the client's perspective contribute to the development of early intervention strategies for social workers?

These questions form the direction for research. The study is qualitative in nature and explores, through the medium of personal histories, the life and treatment experiences of young women who have been treated for anorexia nervosa, bulimia nervosa, or both. The exploration of these factors is intended to enhance and enrich our understanding of the perceptions of the eating disordered person.

Data gathered from a review of the literature is analyzed and compared with the collective perceptions of the eating disordered individuals. This data is then further examined to develop directions for social work intervention.

LITERATURE REVIEW

Anorexia and bulimia nervosa are seen as multi-determined conditions. When the factors associated with anorexia and bulimia nervosa are examined, the literature consistently highlights three directions. These are: (a) socio-cultural norms and expectations, (b) family composition and relationships, and (c) personal characteristics of the individuals who develop eating disorders. Each of these directions will be discussed separately in the text that follows.

Socio-Cultural Norms and Expectations

Authors examining the cultural norms in reference to eating disorders focus mainly on the socialization of women. The two most consistent themes that emerge are: (a) exaggerated emphasis on women's body shape and weight, with a particular promotion of thinness, and (b) socialization of women to be passive and to defer to an external locus of control (Chernin, 1981; Garner, Garfinkel & Irvine, 1986; Hirschmann & Zaphiropolous, 1985; Orbach, 1986; Root et al, 1986; Selvini-Palazzoli, 1974, Sours, 1980).

Garner and his colleagues (1980) maintain there are cultural pressures for women to be thinner and to diet. To demonstrate this they chose to review the changes in weight over a 20 year span for Miss America contestants and Playboy centerfolds; two groups they felt symbolically represented the ideal woman. Their review of women in Playboy centerfolds showed a steady decrease over time in bust and hip size with a concurrent trend towards greater height. The idealized body shape for women changed to be leaner and more evenly proportioned.

Garner and his colleagues (1980) review of the Miss America Pageant revealed that the pageant winners were more likely to weigh significantly less than other contestants. Furthermore, the average weight of all of the contestants over the 12 year span dropped by 11% . The lowest weight was seen in the last year surveyed (1978) and was 12% lower than the actuarial average weight for women at that time. Since the diagnostic criteria for anorexia is 15% below the average weight, this representation of the symbolically ideal woman is very close to being anorexic.

Associated with this phenomenon is the cultural emphasis on dieting, particularly among women. A review of six women's magazines revealed that a total of 467 articles on dieting had been published between 1959 and 1979. The average number of articles had increased by over 56% in the second decade of this review (Garner et al, 1980). This escalation in the promotion of dieting is further highlighted by the work of Chernin (1981). She examined a number of books published on dieting. She found that just three titles had collectively sold over five hundred and eighty million (580,000,000) copies.

Root and her colleagues (1986) also found that some of the diets published advocate purging behaviour, which is associated with bulimia nervosa. They report on *The Beverly Hills Diet* (Mazel,1981 as cited in Root et al, 1986) which is based on the author's struggle with weight control through the use of diuretics, diet pills and starvation.

More recently this focus on dieting has shifted to include a concurrent promotion of fitness. Particular emphasis is given to the importance of fitness

in a healthy lifestyle. Ironically, studies have shown that mild to moderately overweight women have no higher mortality rates than those who are thinner. In fact, women in the highest and lowest 20% of weight distribution were reported to have greater mortality rates (Garner and Garfinkel, 1985).

These factors become particularly significant when viewed in the context of the literature on eating disorders. Dieting is consistently cited as being associated with the development of both anorexia and bulimia nervosa. (Garner et al, 1986; Hirschman and Zaphiropolous, 1985; Root et al, 1986; Sours, 1980) In addition, vigorous over-exercise is one of the diagnostic criteria for both anorexia and bulimia nervosa. Furthermore, Hawkins, Raymond, Fremoun, Williams, & Clement (1984) have found a positive correlation between dietary restraint and the binge eating that is associated with bulimia nervosa.

Paradoxically, this promotion of thinness is contrary to a parallel trend for the average North American woman to be heavier because of improved nutrition. The stress created by this disparity between cultural ideals for the woman's body and actual norms, is felt to further contribute to the development of extreme responses in order to attain thinness (Garner et al, 1980).

The second cultural factor identified is the socialization of women to be passive and to defer to an external locus of control. This factor becomes an important consideration as the development of eating disorders has also been associated with an attempt to impose control over life events (Orbach, 1986; Selivini-Palazzoli,1974; Selevini-Palazzoli & Viaro,1988; Root et al, 1986; Sours, 1980).

Root and her colleagues (1986) indicate that socialization encourages women to believe that power rests in their beauty and kindness. They state that this socialization begins early and is evidenced in fairy tales such as *Cinderella and Snow White*, and is later perpetuated in adult romance novels and soap operas. The qualities that are promoted as feminine are: nurturing, self-sacrificing, delicate, small, and helpless.

Orbach (1986) reinforces the assertions of Root and her colleagues (1986). She see that eating disorders (her work focused on anorexia) must be understood in a social/historical context. She states that throughout Western history a woman's body has been both an object and symbol of beauty. A beautiful woman confers an additional status to her male partner. Orbach further asserts that a woman's sense of identity has come to be deeply enmeshed with her view of herself as an attractive person, and of her body as an object with which to negotiate in the world. Women have thus come to define themselves in terms of their body shape and its influence on others.

Contrary to the traditional role of women to achieve self satisfaction by living through and for others, there is an increasing trend for women to pursue non-traditional careers and lifestyles. Women who have been socialized to maintain traditional qualities, now most compete in a male dominated career world that demands increased independence, assertiveness and achievement. The autonomy required to compete in these non-traditional careers is

incongruent with the socialization of women and cultural definitions of femininity (Orbach, 1986; Wells, 1977, as cited in Root et al, 1986).

The paradox of these conflicting messages is embodied in a recent magazine article entitled *Breast Frenzy* (1988, December). The article reported that an estimated average of $168-$374 million is spent annually on breast augmentation in the United States. North American women were more likely to proceed with this surgery despite significant health risks, when compared with Swedish woman. The article presented that the choice of breast augmentation was in fact a reflection of women's personal and financial freedom.

One must question though, how large breasts have come to be connected to self satisfaction. It appears that the cultural prescriptions for the female shape remain intricately intertwined with the issue of deferring control to others. In this example of breast augmentation Dr. Marcia Huchinson (1988, December) maintains that women are in fact "... substituting mastery over one part of their bodies for mastery over their self images and their lives" (p.89) This is analogous to the search for control by the eating disordered person.

The literature pays very little attention to the impact of cultural norms on men. Root and her colleagues (1986) propose that men are socialized differently than women in that a man's self-worth is more connected with occupation and financial status. They maintain that body size and weight will have fewer implications for achievement in these areas.

Despite this assertion we have seen that the emergence of eating disorders in men is increasing. Recent surveys of the eating patterns of college students showed that the incidence of sub-clinical disordered eating among men has increased. Statistics for men ranged between 30-49% and while this is still lower than the rates for women in the same survey group, the numbers represent a significant portion of the male population (Lachenmeyer and Muni-Brader, 1988).

Of further significance is recent research by Turnbull, Freeman, Barry and Annadale (1987), which showed that present standardized questionnaires may not be effective in identifying males with eating disorders. They found that of the five men being treated for moderate - severe bulimia nervosa, none would have been identified by present recognized scales (EAT, EDI -Garner & Garfinkel, 1983; BITE -Henderson & Freeman,1987). They propose that these questionnaires were developed based on female population and thus do not reflect the special expression of eating disorders in males.

At present the association between socio-cultural norms and men, in the development of eating disorders has not been established. It is recognized though that as the roles of women change to non-traditional fields, a concurrent change may also occur among males. These changes may affect the impact of socio-cultural norms on development of eating disorders in men.

Personal Characteristics

Despite the unique diagnostic categories for anorexia and bulimia nervosa, the literature reports certain personal characteristics which appear to be common to

both disorders. The personal characteristics reported here will reflect the qualities most frequently reported in the literature, and are broader in scope than the DSM - III -R criteria (Bryant- Waugh, Knibbs, Fossen, Kaminski & Lask, 1988; Goldman, 1988; Hirshman & Zaphiropolous, 1985; Minuchin & Baker, 1978; Root et al, 1986; Selevini-Palazzoli, 1974; Sours, 1980).

The reported characteristics associated with both anorexia and bulimia nervosa fall into four broad categories: (a) personal demographics,(b) personal history,(c) eating habits, and (d) distortions of body perception. Each of these categories will be discussed in greater detail in the text that follows.

Personal Demographics

There are two factors related to personal demographics: sex and age. While data from non-clinical populations show that the number of males are at risk of developing eating disorders is increasing significantly more females are diagnosed with eating disorders than males (Goldman, 1988; Lachenmeyer & Muni-Brander, 1988; Root et al, 1986).

Adolescents appear to be at greatest risk, although the average age of onset differs for anorexia and bulimia. Anorexia is more likely to develop in early adolescence, while bulimia is more common in the late teens, early twenties age group.

Personal History

The factors related to personal history are: high achievement, depression, and sexual victimization.

A history of expressed desire for high achievement, and a concern about the attitude of others towards personal achievement, have been associated with eating disorders. Goldman (1988) reports that these individuals demonstrate perfectionistic tendencies, good academic achievement, and active involvement in extra-curricular activities.

Some have postulated that this desire for high achievement is more an expression of concern about the view of others, particularly parents, than actual desire for achievement. This is reinforced by Bruch (1978) who maintains that the adolescent's pleasing "superperfection" is in fact a mask that serves to hide an inner misery. These positions may be indirectly supported by the research of Szumukler, Berkowitz, Eisler, Leff & Dare (1987) on expressed emotion in families of anorexic daughters. Their observations revealed that the number of critical comments by the parents were higher towards the anorexic daughter than in a control group. Furthermore these critical comments were more evident when the daughter was present, than when the parents were interviewed alone.

A history of depression is often associated with both anorexia and bulimia nervosa. Pope and Hudson (1984) have reported on a double-blind controlled clinical trial of imipramine, an anti-depressant drug, in the treatment of bulimia nervosa. Their results reveal that the drug was successful in reducing the binge

eating episodes by 70%. It is felt that the anti-depressant qualities of the drug were the most significant factors, as there was a concurrent 50% improvement in depressive symptoms during the clinical trial.

Chronic tension has been related to depression, and has been demonstrated to be higher in bulimic women when compared to control groups. (Butterfield & LeClair, 1988). Depression and chronic tension have also been also related to the desire for high achievement. Cattenach and Rodin (1988) found that the bulimic women they interviewed had set impossibly high standards for themselves. The women reported feeling tense and depressed when they did not achieve these unrealistic goals.

Sexual victimization has more recently been associated with eating disorders. Root and her colleagues (1986) report that 73% of the bulimics they treated had suffered at least one victimization experience, often in childhood. This information is further supported by the work of Oppenheimer, Howells, Palmer, and Chaloner (1985) in which over 66% of eating disordered patients they studied reported an adverse sexual experience. Approximately 80% reported that these events occurred in childhood.

Eating Habits

There are six factors related to eating habits. These are: dieting, obsession with food, ritualization of food preparation, binging, purging, and fear of overeating.

A history of dieting has been associated with the onset of both anorexia and bulimia nervosa. It is felt that adolescents are particularly vulnerable given the normal sensitivity about personal appearance that is associated with this developmental phase. The positive reinforcement received for weight loss is felt to further contribute to the progressive obsession with dieting activities (Garner et al, 1986; Hirschman and Zaphiropolous, 1985; Root et al, 1986; Sours, 1980).

Individuals with eating disorders will often be obsessed with food even though they severely restrict its intake. This may be evidenced in a passionate interest in buying food and preparing meals, and then refusing to eat.

Anorexics are reported to become very ritualistic both in the preparation and consumption of the small portions of food they do eat. This may be evidenced in the meticulous arrangement of food on the plate, or in the compulsive attention to the order in which food must be consumed. During adolescence these obsessions with food and the rituals of eating can be dismissed by parents as teenage fads.

For bulimics, eating habits also involve episodes of binging. Clinical diagnostic descriptions of binging which refer to eating large amounts of food in a short period of time, do not impart an appreciation of the severity of this problem. Drs. Goldbloom and Garfinkel (1988, September) of the Toronto General Hospital have provided this frame of reference. They state that in a binging episode a person may consume up to 6000 calories in one hour. This is equivalent to the caloric intake of one person for three days.

Purging behaviour is associated with both bulimia and severe anorexia, and can have very serious physiological side effects. Purging not only involves self-induced vomiting, but can extend to excessive use of laxatives and diuretics, as well as compulsive over-exercise. An example drawn from personal clinical experience involves a young anorexic who was taking up to 36 laxatives a day. Her medical treatment for anorexia was prompted by an admission for severe dehydration. She had been secretly abusing laxatives for several months and was reluctant to reveal this on admission for dehydration.

Anorexics and bulimics also experience a fear of eating too much. Bulimics particularly feel out-of-control and fear binging. It is felt that this fear may be related to an inability to recognize the physiological cues of hunger, leaving the person feeling unable to rely on internal controls (Root et al,1986, Selevini -Palazozli, 1974).

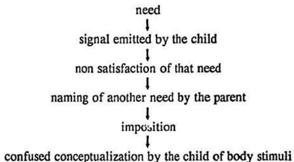
Almost all of the behaviours described in this section have been reported in association with starvation (Goldman 1988, NEDIC, 1988). Garner and Garfinkel (1985)also reported on the Minnesota project carried out by Keys, Brozek, Henschel, Mikelsen, & Taylor, (1950). They studied the effects of induced starvation on 36 normal weight and healthy males. Their study revealed that when their caloric intake was reduced by half, the men experienced obsession with food, food preparation rituals, binging despite the diet, and increased experiences of hunger. In additon, the men reported disturbances in emotional, cognitive, and social functioning.

Distortions of Body Perception

There are three factors associated with distortions of body perception. These are: (a) lack of recognition of the physical manifestations of hunger, (b) distortion of perception of body image, and (c) misperception of the influence of body shape on interpersonal relationships.

Eating disorders are often connected with an apparent inability to recognize the physiological manifestations of hunger. Selevini-Palazzoli (1974) maintains this inability to recognize hunger stems from an early reinforcement to ignore the body's cues. She states that the child is then not able to rely on his/her own body sensations without feeling out of control.

She presents the following schematic of this process:



This conceptualization is further supported by the work of Hirschman and Zaphiropolous (1985). They state that parents should only feed their children based on their childrens' reports of hunger and satiation. They see this "feed on demand" schedule as the baseline for raising children who will not have food or weight problem.

Individuals with eating disorders also have an exaggerated concern with body size and weight. This may be evidenced in strong over-reactions to comments about body size or diet, and/or in a strong denial of any weight loss problem when confronted with such a concern. In anorexia, this is also associated with a gross misperception of body shape and weight, often with specific emphasis on the size of their hips and thighs.

Although not directly identified in the literature reviewed, related to this phenomenon is a misperception of the influence of body shape on inter-personal relationships or career achievements. Body shape appears to be perceived as the over-riding factor in all aspects of life. This comment from an anorexic young woman, drawn from clinical experience, serves as an example; " If my thighs were only two and a half (2 $^{1}/_{2}$) inches smaller my boss would not have become upset with me today." If one refers back to the discussion of cultural influences, it might be argued that this phenomenon is an extreme expression of the socialization of women to believe that power rests in their beauty.

Family Composition and Relationships

The family is a powerful force in the transmission of socio-cultural norms. Through this function it can be expected to have a significant influence on the development of eating disorders. The literature also refers to the relationships within families as connected to the emergence of an eating disorder. The two most significant issues are family composition, and family relationships (Goldstein, 1984; Kog & Vandereycken, 1985; Liebman et al, 1983; Minuchin & Baker, 1978; Selevini-Palazzoli, 1974 ; Root et al, 1986).

Factors related to family composition are: (a)socio-economic status,(b) incidence of weight problems in immediate family members, and (c) incidence of physical illness, depression and alcohol abuse in immediate family members. Factors related to family relationships are: (a) enmeshment,(b) overprotectiveness,(c) rigidity, (d)triangulation, and (e) chronic tension.

Family Composition

Socio-economic status has been correlated with the presence of an eating disorder. Koy and Vandereycken (1985) in their review of the research literature reported that upper class families have been consistently over-represented in eating disorder treatment populations. This association must be viewed in light of recent research that has shown that lower socio-economic groups are increasingly represented in non-clinical populations (Lachenmeyer and Muni-Brader, 1988).

Koy and Vandereycken (1985) also revealed an association between the presence of an eating disorder and incidence of weight control and eating problems in immediate family members. Obesity has been most highly associated with parents of bulimics, as compared with anorexics. Strober, Morrell, Burroughs, Salkin and Jacobs (1985) in a controlled study of anorexic families reported that the incidence of eating disorders in first and second degree relatives was significantly higher than a non-eating disordered psychiatric population. Strober also reported on the work of Gershon and his colleagues, (1983) who showed that eating disorders were 6 times higher in first degree relatives of anorexics, than in a control group.

Koy and Vandereycken (1985) further reported an association between the presence of physical illness, depression or alcohol abuse in immediate family members and eating disorders. This is supported by the work of Root and her colleagues(1986). They present a family model in which substance abuse and depression are a part of the family dynamics connected to the development of eating disorders. Root's proposal will be discussed in greater detail in the following section on family relationships.

Family Relationships

Minuchin and Baker (1978) have studied extensively the patterns of interaction in families where the child has a psychosomatic illness, including anorexia. Minuchin and his colleagues in treating these families refer to the family as a system. The concepts of family interaction used for this study are derived from a systemtic conceptualization and therefore of the family, the basic tenants of the structural family therapy model will be presented as a background to the discussion of the pertinent family interaction patterns (Hoffman 1981; Minuchin & Baker, 1978; & Minuchin & Fishman 1981 Root et al, 1986). These are:

1. The family is an open system, which is constantly changing due to internal and external forces.

2. There is a structure or set of regulatory codes which affects the patterns of interaction both inside and outside the family. These codes are generated

from values, religion, laws, philosophy, and political ideology, and combine to create the unique personality of the family.

3. The family system is dynamic. Individual family members will attempt to maintain homeostasis or stability within the family system. These shifts will have both adaptive and maladaptive consequences for the family.

4. The family maintains a hierarchal structure, with the parental and spousal sub-system in a governing position over the child and sibling sub-systems. Family theorists maintain that the differentiation produced by the normal parent/child hierarchical structure is necessary to the healthy functioning of the family system.

5. The family will move through a series of developmental stages which will result in the family members having to create new skills to match the growth of its members.

The family relationship variables most associated with eating disorders are: enmeshment, overprotectiveness, rigidity, triangulation, and chronic tension. These variables will first be discussed in terms of family therapy theory. The postulated connection of these factors to the development of eating disorders will then be illustrated using Root's (1986) three conceptual models of eating disordered families as a frame of reference.

Enmeshment is understood in the context of family cohesion. Cohesion is defined as the emotional bonds that exist between family members and the degree to which an individual experiences personal autonomy. In **enmeshed**

families there are very close emotional bonds between family members. Of most significance in eating disorders are the emotional bonds that cross generational boundaries and lead to little differentiation of needs and emotions between parent and child. Enmeshment often disrupts the normal hierarchical structure of the family.

Overprotectiveness is reflected in the parents' over emphasis on the family to the exclusion of those outside the family. It is related to enmeshment in that personal boundaries between family members are poorly defined. Members of the family tend to define themselves in reference to the needs of other family members. There is a resulting poor personal differentiation and autonomy, which leads the individual to only feel complete in the family context. Family loyalty will more likely supersede individual needs.

Rigidity refers to an inflexibility in the family system. This may be expressed in stringent rules for conflict resolution and for individual behaviour, or in an equally strict unwillingness to recognize the need for conflict resolution and/or role expectations. Either construct reflects an inability of the family system to adapt to the changing needs of its members.

Triangulation refers to a process whereby a third person is drawn in to help reduce the conflict between two people. While triangulation may be normal and healthy, it can become destructive when family members develop a rigid pattern of triangular interaction. **Triangulation** for the purposes of this study refers to a coalition or covert alliance which crosses generational lines. Often neither the parents nor the child is consciously aware of this process, however

the child experiences anxiety and concern for the marital relationship and alternating feelings of power and helplessness. Closely allied with the concepts of enmeshment, overprotectiveness and triangulation is **chronic tension**. This is a subjective experience and refers to the presence of constant worry or anxiety. These feelings are felt to be a reflection of an overall sense of powerlessness, which is embodied in the family's inability to resolve conflict or to allow development of personal autonomy.

Family Models: An Illustration

Root and her colleagues (1986) have proposed three conceptual models of families with eating disorders. They are: (a) the perfect family, (b) the overprotective family, and (c) the chaotic family. Models (a) and (b) are associated with both anorexia and bulimia nervosa. Model (c) is most highly associated with bulimia nervosa. These models will be presented in the text that follows. Emphasis will be placed on further explicating the family interaction variables just described, as well as highlighting the postulated function of the eating disorder within the family. Each family model will be described using the categories of boundaries, identity, emotional expression, and powerlessness.

The Perfect Family " A Job Worth Doing is Worth Doing Well"

The perfect family presents in a clinical situation as eager, attentive and seeking the "perfect therapy". Clinicians report a sense of unreality about family

members, describing them as "plastic", "robots", "ever-smiling" (Root et al,1986).

Boundaries: While the external representation of the family relationships appears harmonious, the boundaries between family members are **rigidly** set. Emphasis is given to the "right" way to behave. **Enmeshment** exists among all family members, but is most evident in the mother and the eating disordered child. It is felt that the **enmeshment** represents the parents' desire to protect their child from mistakes and to ensure the child makes the "right" decisions.

Identity: The identity of the family is set by the perceptions of others, rather than personal values and feelings. Emphasis is on the external and the search for the **right** way. This **rigidity** creates **chronic tension** and lack of stability.

Emotional Expression: Family members are reinforced to always seek the positive in problem situations. Family loyalty demands that pain and conflict be suppressed or dealt with in ways that are prescribed by **rigid** family rules. **Triangulation** becomes a safe way to diffuse tension.

Powerlessness: The power in perfect families is often unevenly distributed, with the father holding most of the real power. There is also a **rigid** prescription for decision-making which limits the development of personal autonomy, particularly for the female children. Although male children may experience a "false" autonomy created by the **rigid** role expectations for men.

Functions of the Eating Disorder: The Perfect Family

The Perfect Rebellion: The illness provides a legitimate way to break the family rules. This is particularly true for bulimics who often carry out binging and purging behaviour in private.

Boundaries: The eating disorder becomes a way of creating distance from other family members and of creating personal space.

Emotional expression: Anger, pain, guilt, and frustration are all emotions not permitted in the perfect family. The eating disorder provides a focus and outlet for these emotions.

Autonomy: The eating disorder provides a mechanism for complete personal control and delineation of personal identity. It fundamentally reflects the underlying power struggle within the family.

The Overprotective Family "All For One and One For All"

The overprotective family presents in a clinical situation as surprised by the problem. The parents express how much this discovery has hurt them. The person with the eating disorder is represented, and indeed appears, much younger than her age.

Boundaries: There is very little sense of separation between family members. **Enmeshment** is observed primarily between the mother and the eating disordered child, but may also include the father. It is felt that the enmeshment represents the parents attempt to live their lives through the child.

Identity: The family message is that individuals determine their identity in reference to others in the family. This leaves members with confusion about how they will exist outside the context of the family.

Emotional Expression: Negative emotions are suppressed in an effort to ensure that other family members will not be hurt. Outbursts of anger or sadness are responded to with expressions of pain and confusion by family members.

Powerlessness: Autonomy is discouraged, particularly in the youngest child. This child is at greatest risk of developing an eating disorder. Parents may smother the child with attention and affection which interferes with the child's natural progression to adulthood and separation. **Triangulation** of the child in marital conflict becomes extremely easy and the family may indeed present clinically as a "three way matrimony" (Selevini-Palazolli, as cited in Root et al,1980).

Functions of the Eating Disorder: The Overprotective Family

Boundaries: The eating disorder becomes a safe way to create a personal space within the family. This separation is perhaps more greatly marked in the activities of a bulimic, which can be kept hidden from the family for a much longer time than the anorexic.

Emotional Expression: As in the perfect family, the eating disorder provides a channel for unexpressed emotion, particularly anger, given the family taboo about hurting others.

Maintenance of the Marital Relationship: The eating disorder becomes an issue that consistently joins the parents and thus the eating disorder appears to form an important function in maintaining the marriage.

Delays Having To Leave Home: Eating disorders often emerge in adolescence when the child is struggling with separation from the family. The eating disorder serves to delay this separation process and thus delays the perceived hurt for the parents that is associated with the child leaving the family.

The Chaotic Family " The Only One You Can Really Rely On Is Yourself"

Root and her colleagues (1980) maintain that the chaotic family representation is most highly associated with bulimia nervosa and most resembles the conceptualization of addictive families. They report that unlike the rigidity and closeness seen in the perfect and overprotective families, the chaotic family is marked by serious disorganization and distance. Substance abuse and victimization experiences are often more common in these families.

Boundaries: The boundary patterns will change frequently with alternating high expectations or none at all. Contact between parent and child, and husband and wife is often distant.

Identity: There is little sense of " family", due to the family disorganization and distance. Often the eating disordered child becomes the pseudo-parent and/or pseudo-spouse. There is a resulting confusion about identity and autonomy as these roles fluxuate according to parental needs.

Emotional Expression: Anger is the pervasive emotion in the family and is unpredictable and often explosive. Love is conditional and inconsistent. Sadness is often not distinguished from depression.

Powerlessness: All family members feel a sense of powerlessness and lack of control. The father may exert dominance through physical or verbal abuse. **Triangulation** often occurs with the mother **enmeshing** with the daughter in order to cope with the husband's abuse. This child will experience alternating feelings of powerfulness and helplessness as her role is switched within the family.

Functions of the Eating Disorder: The Chaotic Family

Boundaries: Emotional distance and personal space are created by the eating disorder. The bathroom becomes a haven and a place for privacy.

Affection and Nuturance: The eating disorder provides a sense of comfort and predictability, as though the eating disorder becomes a distinct force to be counted on.

Emotional Expression: Emotional expression within the family is often explosive. The eating disorder becomes a safe way to express anger and outrage. It also serves to mask and numb feelings of sadness and loss.

Self Abuse: The eating disorder also serves to carry on the cycle of abuse experienced in the family.

Relinquishing Responsibility: The eating disorder provides a mechanism to escape the parental and spousal functions imposed by the family.

Predictability/Autonomy: The fluxuating role expectations are very stressful. The eating disorder provides a structure that does not exist within the family system. It also promotes a sense of control and mastery.

The family relationship variables of enmeshment, overprotectiveness, ridgity, triangulation and chronic tension appear in each of these family models. Yet the configuration of these variables are qualitatively different for each family model. Root and her colleagues (1986) maintain that these differences have implications for treatment strategies. these differences will therefore be recognized in the analysis of the data for this study.

Summary

Anorexia and bulimia nervosa are multi-determined conditions. The literature points to three constellations of factors as significant in the emergence of eating disorders. These are: socio-cultural norms and expectations, family composition and relationships, and personal characteristics. In this preliminary review, a great deal of consistency exists between the presence of these factors and the emergence of both anorexia and bulimia nervosa, even though each disorder is a unique clinical diagnosis.

One can see that variables related to each of these constellation of factors appear interconnected. For example the personal characteristics of depression, sexual victimization and focus on body size appear to also relate to

socio-cultural issues. While desire for high achievement and response to hunger can also be related to parenting styles. Yet the complexity of these emerging connections does not allow us to see the path from one to the other.

In reflecting on these factors it may be beneficial to view them as similar to Bronfenbrenner's (1979) representation of the hierarchy of human experience as " a set of nested structures, like a set of Russian dolls" (Bronfenbrenner,1979 as cited in Emmet,1985). However it seems that the family structure is pivotal in impacting on the expression of both socio-cultural and personal factors.

RESEARCH METHODOLOGY

Introduction

This is an exploratory study of the association of three levels of human experience with the emergence of an eating disorder. It will examine the socio-cultural, familial, and personal factors associated with the development of anorexia nervosa and /or bulimia nervosa. These factors are then analyzed in the context of the client's perceptions of their eating disorder.

The study is qualitative in nature and explores, through the medium of in-depth personal histories, the life and treatment experiences of women who have been diagnosed as having anorexia nervosa, bulimia nervosa, or both. This study is intended to enrich the social work profession's understanding of clients' perceptions of their eating disorder and its treatment. Consideration is given to the directions indicated for the development of social work strategies for early intervention.

Operationalization Of Concepts And Variables

The variables to be studied are clustered under the categories of:
(a) socio-cultural norms,(b) family composition and relationships, and (c) personal characteristics. Each of these concepts will be operationalized as variables for data collection and analysis.

Socio-cultural Norms

Two concepts are used to study the influence of socio-cultural norms:

1. *Exaggerated emphasis on womens' body size and promotion of thinness:* This concept is represented by statements expressing: a desire for thinness, indications that body size and shape are viewed as important to life satisfaction, and indications that dissatisfaction with body size appears related to comparison with a perceived ideal shape. An example might be " I don't see how it is possible to like myself when my legs are so fat.", " I don't know why my boyfriend puts up with me, even Oprah Winfrey looks gorgeous now that she lost all that weight."

2. *Socialization of women to be passive and to defer to an external locus of control:* This concept is represented by statements which: attribute responsibility for life events to others, express decision-making primarily in reference to the views of others, and express deference to the opinions of others. An example might be " Well my mother always said that I wasn't going to make it in school, and I guess my teachers just don't want me to pass either", "My mother has always said that I was going to have a weight problem, there just doesn't seem to be anything that I can do now."

Family Variables

Family variables are categorized under two headings: family composition and family relationships.

Family Composition

There are three variables related to family composition. These are:

1. *Socio-economic status:* This is defined as the participant's perception of her family's social class, using the subjective categories of lower class, working class, middle class, upper-middle class or upper class families.

2. *Incidence of weight problems in immediate family members:* This is defined in terms of the participant's perception of a weight problem as evidenced in family members expressed unhappiness about body size, or the participant's knowledge of their actual attempts to lose weight. The term "immediate family members" will refer to parents and siblings.

3. *Incidence of physical illness, depression or alcohol abuse in immediate family members:* This is defined in terms of the participant's knowledge of medical treatment for any of these problems. It will also include the participant's own perception of depression or alcohol abuse in immediate family members. The term "immediate family members" will refer to parents and siblings.

Family Relationships

There are five variables that concern family relationships. These are:

1. *Enmeshment between parent and child with an eating disorder:* Enmeshment refers to an extremely close set of emotional bonds between family members, to the degree that there is a lack of personal autonomy experienced in the family system. Enmeshment is reflected in: reports of lack of personal privacy, a perception of the parent(s) as a sibling more than parent, a difficulty in separating personal life goals from parental desires for those goals. Some examples might be: " We never closed the

doors in our house, not even to the bathroom", " Mom tells me all about her problems with Dad", " I don't know what I want to be, but mom always says I really have a special talent for cosmetology and she was always good with applying make-up."

2. *Overprotectiveness of parents towards the family system:*
   Overprotectiveness is reflected in the parents' over emphasis on the family to the exclusion of those outside the family. Family loyalty is expected to supersede the needs of individual family members . Personal boundaries between family members are poorly defined, often with no clear rules regarding age appropriate behaviour.

   Indicators of overprotectiveness are: expression of concern for the family image, references to being told to protect the family image, concern about hurting other family members, and a sense of not fitting in with those outside the family. Some examples might be, " My parents never fought, but sometimes I just get crazy and start yelling for no reason. Mom then starts crying and I end up feeling even worse.", " I went to the school guidance counsellor once, and Dad just blew up when she called home for a parent interview. He said I disgraced the family."

3. *Triangulation of the eating disordered child in parental/marital conflict:*
   Triangulation refers to a coalition or covert alliance which crosses generational lines. Often neither the parents nor the child is consciously

aware of this process, however the child experiences anxiety and concern for the marital relationship and alternating feelings of power and helplessness.

Triangulation is considered present by: references to sense of being caught between both parents when they fight (or fought), a feeling of always being on one parent's side and or , a feeling of responsibility for keeping parents together. Some example might be " I don't know why but every time my parents had a fight I would find myself in the middle, usually agreeing with mom. Funny, you know half of the time I didn't even really agree with her." , "Sometimes I wonder how my parents will survive if I leave home."

4. *Rigidity within the family system, particularly around conflict resolution and role expectations:* Rigidity is expressed in an inflexibility about ways conflict can be resolved, and in an inflexibility about how each person "should" act. It may also be seen in not being willing to recognize the need for conflict resolution or role expectations.

Reflections of rigidity include: references to the family emphasis on "the right way" to do things, a feeling that one had to act in a certain way, or a sense that the individual was only viewed one way within the family. Some examples might be " Dad has the answer for everything, just once I would like to do something without him telling me the right way.", " Mom thinks I'm just a klutz, she won't let me in the kitchen because she says I'll ruin dinner. But I hate her meals, they're so fattening."

5. *Chronic tension:* Chronic tension refers to the constant presence of anxiety. These feelings are attributed to an overall sense of powerlessness in the family. It is a subjective experience and will be operationalized on the basis of the participant's perception of : "being on edge", having to" walk on egg shells", or experiencing a nagging worry.

Personal Characteristics

There are four categories of variables that reflect personal characteristics. They are: personal demographics, personal history, eating habits, and distortions of body perception.

Personal Demographics

There are two variables related to personal demographics. These are:

1. *Sex:* which is defined as male or female

2. *Age:* which is defined by date of birth.

Personal History

Three elements of personal history are relevant to this study:

1. *History of high achievement:* which is based on self-report of drive or felt pressure for high achievement, as well as in documentation of self-reported academic and career accomplishments.

2. *History of depression:* which is defined on the basis of self-report of medical treatment or perception of having a problem with depression.

3. *History of sexual victimization:* which is based on self-report of having experienced sexual contact which was coerced or unwanted.

Eating Habits

Eating habits are important to a study of eating disorders as they are both the focal point of the obsession and the external signal of the problem. There are six variables related to eating habits being explored:

1. *A history of dieting:* which is defined by self report of past or present efforts to control or lose weight. Participants are asked to describe their experiences with dieting and weight control, and to indicate the length of time they have been concerned with losing weight.

2. *A history of purging activities:* which is defined by self-report of present or past involvement in any of these activities: self-induced vomiting; over-use of laxatives, diuretics or enemas; vigorous over-exercise; or fasting.

3. *A history of binging:* Which is defined by self report of: eating huge amounts of food in a short period of time, eating rapidly, eating until physically sick, feeling out of control when eating, and feeling miserable and depressed after binging.

4. *An obsession with food:* Which is defined by the self-report of thoughts that are predominantly preoccupied with some aspect of food or eating. These thoughts may focus on food purchase and preparation of favourite meals,

strategies to avoid food or overeating, contracting with oneself about the foods to be eaten that day. Often the obsession is seen as interfering with ability to concentrate on daily activities.

5. *Ritualization of food preparation and consumption:* Which is defined by self-report of: rigid patterns about the sequence and type of food preparation; strict rules about how the food appears on the plate and the order in which it is consumed; and obsessions with fads about food consumption. One such fad about food consumption is believing that eating an orange slice first will ensure that calories are burned more quickly.

6. *A fear of overeating:* Which is by self report of: feeling extreme anxiety about not being able to stop eating and preoccupation with strategies for food avoidance or consumption.

Distortions of Body Perception

Cognitive distortions, particularly as they relate to body shape are a significant aspect of eating disorders. There are three variables related to the concept of distortion of body perception:

1. *A lack of recognition of the physical manifestations of hunger:* This is defined by the participant's perception of awareness of the body's sensations and signals for hunger. For example, " I never feel hungry or full. I just feel scared when I'm eating.", "My stomach isn't hungry, but my

mouth is." For both bulimics and anorexics, the inability to properly recognize and respond to the physical manifestations of hunger contributed to the overall anxiety about eating.

2. *A distortion of body image:* This refers to the person's inability to accurately compare or represent her body size or shape, based on the interviewer's view of an incongruence between the persons's actual physical size and her verbal description of her size.

3. *A misperception of the influence of body shape on interpersonal relationships:* This is evidenced in expressions that reflect that the interviewee perceives that body size is seen as a primary source of problems in interpersonal interactions. For example, " If only my thighs were 2 ½ inches smaller I would have no problems getting along with my boss."

Data Collection

LaRossa and Wolf (1985) maintain that since the 1960's the professional interest in theory building has led to an increase in quantitative family research. Their review of the Journal of Marriage and the Family between the years 1965-1983 reveals an overwhelming emphasis on quantitative research. Out of a total of 775 articles, 69% were exclusively quantitative. This number increases to 84% when articles that were primarily theoretical are removed from the sample (18%). Of the remaining 13%, only 9% could be considered exclusively qualitative.

Most of the published literature on eating disorders is quantitative. It is also presented primarily from the clinician's experience (see: Bruch, 1978; Emmett,1985; Garner, Garfinkel, Schwartz & Thompson, 1980; Kog & Vandereychen, 1985; Lachenmeyer & Muni-Brander, 1988; Liebman et al, 1983; Minuchin & Baker, 1978; Root et al, 1986; Selevini-Palazzoli, 1974). Cherin (1981) and Orbach (1986) are unique in their concern with the woman's perspective and eating disorders. However Kinoy (1984) is one of the only authors of systematic research from the client's perspective in the literature reviewed on eating disorders.

A qualitative method was chosen for this study in response to this imbalance in the methodology of published research. It was recognized that a qualitative approach would complement and enhance the existing literature reviewed on eating disorders. It was also felt that studying the client's subjective reality, while inherently biased, offers a unique opportunity for social workers to gain insight into the client's view of her situation. This information is fundamental to the social work profession's premise of starting "where the client is" and provides a rich base for meaningful intervention.

Population

Three women were selected to participate in this research. It was decided to study an exclusively female population as most of the literature reviewed has been developed around the experiences of women. It was further recognized that men need to be studied as a unique population.

The participants for the study are drawn from a clinical population. A senior clinician was requested to make the selection of potential participants on the basis of the following criteria: (a) the individual is female and 20 years or older, (b) has been diagnosed as having anorexia, bulimia or both, and (c) has completed the acute phase of treatment. Completion of the acute phase of treatment will mean that while the person might be still undergoing therapy, her weight and cognitive/emotional functioning has stabilized.

This selection process was chosen to ensure that the research did not interfere with treatment, and to also reduce the possibility of negative risks of the research for the participant. This process also ensures access to follow-up therapy should this be necessary.

Potential participants were contacted first through their clinician, either by letter or telephone. Each clinician was given a letter to introduce potential participants to the study. (See Appendix A) The clinician was then responsible for referring any interested individuals. The researcher encouraged clinicians to have their clients make the first contact with the researcher, so that the participant had optimal control over the decision to participate.

Data collection then proceeded in three phases:

1. A brief initial meeting was held to review the purpose and the format of the research. This allowed the participant an opportunity to actually see the researcher and to re-consider her decision to participate. At this time

written consent was presented and obtained. The ethical issues around consent were discussed in a later section. (See Appendix A for the consent form)

2. The primary interview session of three to four hours then took place, in the interviewing rooms at the School of Social Work at Memorial University of Newfoundland. The session was audio- video tape recorded. The researcher followed a non-structured interview format, allowing the participant to present her story without the researcher biasing the information through structured questions. Lofland and Lofland (1984) recommend preparing a very general interview guide that will facilitate discussion during the interviews. The guide also provides a mechanism for taking quick notes of an aspect of the session that seems particularly significant. (See Appendix B) If the participant so wished she may have had a copy of the audio-video tape for review before the final session. This was intended to provide participants with a sense of personal autonomy with respect to the research process, by having an opportunity to provide feedback on the content of their interview.

3. A final shorter session was held to ensure the participant has provided all the information she wished and to clarify any material on the audio-video tape. This also provided the researcher with an opportunity for clarification of any information from the previous interview. Emphasis was be given to terminating sensitively. If at this time the researcher's clinical judgement indicated that the participant had unresolved clinical issues, this was raised and suggestions for counselling referrals made.

Data Analysis

In a qualitative study, data analysis presents one of the most significant challenges to the whole research process. (Lofland & Lofland 1984, Plummer 1983) Data analysis occurred on two levels, data collation and data analysis:

1. Data collation: Each participant's video-tape was reviewed in detail by the researcher. This involved viewing the tapes, completing detailed notes on the content of the interviews and when necessary, partial transcription of the audio-video tape material. Emphasis was placed on recording and understanding each woman's life story independent of the others. The researcher completed this process personally as a way of enhancing the understanding of the information shared, and stimulating the analytic process.

2. Data analysis was conducted on three levels:

   a) a comparison of the responses of each of the participants to establish commonalities and differences

   b) an assessment of the collective responses using the socio-cultural, familial, and personal factors constructed from the literature review as points of comparison. Root and her colleagues (1986) conceptual models of the family was used to situate family-related information. These concepts were intended to facilitate the analytic process and will form a point of reference and a flexible structure for analysis and comparison. Care was taken to ensure that this process did not invalidate the attempt to record the participants' subjective reality; and

(c) consideration of the implications of these results for social work practice.

Ethical Issues

This study is carried out under the guidelines of the Human Subjects Committee of the School of Graduate Studies, and with a commitment to maintaining high ethical standards. The relevant ethical issues for research are: (1) the relative risks and benefits of the study, (2) ensuring confidentiality, and (3) obtaining voluntary and informed consent. Each are discussed below:

1. **Relative risks and benefits:** LaRossa, Bennett and Gelles (1981) have discussed issues related to the risks most often associated with qualitative research. Of primary relevance to this study are: (a) the difficulty in predicting risks in qualitative research, (b) participants may disclose more information than they had originally intended. Each of these issues will be discussed in greater detail in the text that follows:

   a) **The difficulty in anticipating risks.** This issue has been addressed in this study by requesting clinicians to assist in the population selection process. The selection by clinician's not only ensures that participant's are felt to be emotionally stable, but it also ensures a therapeutic backup.

   b) **Participants risk disclosing more personal information than originally intended.** This risk demands a high degree of professional skill on the part of the researcher in maintaining the appropriate distance and neutrality, while still maintaining an atmosphere conducive to discussion of life events. LaRossa and his colleagues (1981) suggest that

to minimize this risk, participants should be informed of other participants' experiences in qualitative research, so that the participant may be prepared for this possibility. This was presented in the information given to participant's prior to signing consent. (See Appendix A)

It was anticipated that this research may have short and long term benefits for participants. These benefits include:

a) the participants may experience **a secondary therapeutic benefit** from being able to tell their life story. The participants for this study will have been through the process of disclosure of the eating disorder and the acute treatment phase. They may then benefit from the opportunity to discuss their eating disorder outside of a clinical forum.
b) the participants may experience satisfaction and an increased sense of control in being able to **indirectly influence treatment directions for eating disorders.** This is particularly important for the eating disordered population, since there is a significant body of literature which proposes that the eating disorder serves as a mechanism for control over life events.

2. **Confidentiality** is crucial in all social science research. Two issues related to confidentiality for this study are:

   a) Ensuring the interview material is for research and not clinical purposes. Since the participants are referred by a clinician and may still be in therapy, the clinician may view the research material as a valuable clinical resource. To reduce this risk, the material is available only to the researcher and will only be released to a clinician with the written and informed consent of the participant.

The researcher will also take the appropriate steps to protect the anonymity of the participants in the published material. All of the study records will be destroyed by the researcher upon University's acceptance of the completed thesis document.

3. **Voluntary and Informed Consent** is also crucial to the research process. The following procedures have been established to ensure voluntary and informed consent.

   The initial contact with the participant was made through a clinician. It was clearly stated that the decision regarding participation in the study will not affect the services provided by the referring clinician. The clinicians were encouraged to have participants make the initial contact with the researcher.

   The preliminary meeting with the participant allowed an opportunity to fully discuss the relative risks and benefits of the study, clarify any ambiguity regarding the research process, review steps to ensure confidentiality, and establish a mechanism for voluntary withdrawal from the study after consent has been given. The onus is on the researcher to act professionally when obtaining such consent and to ensure that there is no overt or covert coercion used.

   A written consent form was developed for this study. (See Appendix A) This form addresses the question of participants' access to the material collected. As indicated previously, the participants were given a copy of any audio-video tapes of interviews for their comments if they so

wished. If desired a written summary of the research findings will be provided and participants were informed that the thesis will be available through the Queen Elizabeth Library.

Pre-test

It is recognized that the success of this type of study depends of the interviewing skill of the researcher. Furthermore since a non-structured interview format was adopted, it is not possible to pre-test an interviewing tool. To overcome these obstacles the following pre-test method was chosen.

Upon acceptance of the research proposal by the Human Subjects Committee, the interview guide and data collection method were used in a trial interview prior to conducting the research. Given the difficulty in locating participant's for this study, the pre-test interview was conducted with a fifth year social work student, who is familiar with eating disorders. The audio-video tape of this pre-test session was analyzed by both the researcher and a supervising clinician.

This pre-test was intended to assess and improve the researcher's interviewing skill, and allowed the researcher to address any methodological weaknesses in the interviewing process. This is important given the small number of participants in the study. The researcher followed the same procedures with respect to voluntary, informed consent and ensuring satisfactory safeguards when conducting the pre-test interview.

DATA COLLECTION

The data for this study was gathered over a three month period. Participants for the research were located using a snowball technique. Clinicians operating in the private practice sector, with a noted interest in eating disorders, were contacted. In total fifteen clinicians were consulted. Ten of these clinicians felt they had clients who might be interested in the study and these people were given written information about the study (See Appendix A). Three clinicians; one psychologist and two social workers , referred the three women who participated in this research.

An initial meeting was held with each woman to discuss the format of the proposed interviews. These sessions were held in the interviewing room to be used for the study, in order to familiarize the participants with the surroundings for the actual interview. Each woman was given a copy of the consent form and the written description of the study, along with the proposed risks and benefits of this type of research. One woman chose to sign the consent form during this interview. The other two brought their consent forms to the first interview. All three women who were interviewed for the study chose to carry on and participate in the research.

Each woman indicated that she was interested in participating in this study because her experience had shown that little was known about eating disorders. Each was most interested in supporting professionals learning more about

eating disorders, as each woman had found many difficulties in seeking treatment. All expressed the wish that by participating in this research they could make it easier for someone to receive help in the future.

The diagnosis for each woman was slightly different. One woman was bulimic and another was bulimic following a period of anorexia. The third woman was defined by her physician as not fitting the DSM-III-R diagnosis for eating disorder, but she presented with symptoms of binging and purging. This woman was included in this study because she saw herself as having an eating disorder and the symptoms she presented were consistent with bulimia. It was felt that it was important in a qualitative study that focuses on the client's perception, to not exclude someone who felt she had an eating disorder because she did not fit the classical diagnosis.

Each session was audio-video taped recorded using the equipment pre-set in the interviewing rooms. The researcher followed a non-structured format, allowing each woman to present her story in her own way. A one page interview guide was carried into each interview, however served only as a reference point in encouraging expansion of topics raised by each participant. No written notes were taken in any of the interviews.

The interview with each woman lasted approximately three hours. One woman chose to have two sessions which lasted approximately one and half hours each. All of the women were given the opportunity to have a copy of the video-taped

session. One woman declined this offer. Another requested a copy, but was later advised by her therapist to defer receiving and reviewing the tape. The third person was given a copy primarily as a memento of the study.

None of the women chose to have a follow-up interview. They did however express an interest in meeting the other participants in the study. The researcher arranged for two of the three woman to meet. The third woman was advised by her psychiatrist to not have any further involvement with the study. The details of this decision are recorded in a post-script to her story in the material that follows.

The information presented by each woman is recorded in the stories that follow. Each woman has been given a different first name. Some identifying information has been excluded or changed to protect the identity of the women and their families. Each story is a summary of the information they provided and is presented using the categories of family, personal, socio-cultural, and treatment issues. This organizational structure is used to facilitate presentation and to provide the reader with continuity in the style of presentation. The emphasis in this process is placed on presenting each woman's life story. No attempt is made to compare stories or to fit information received with issues identified in the literature. This comparison is carried out in the data analysis section that follows. Any comments that are direct quotes from the interview tape appear in the text in quotation marks.

The stories that follow will evoke different feelings for the reader. In fact each story has a distinctive style of presentation that is intended to reflect the

differing styles of these women as they told their stories. Where ever possible each woman's own expressions and descriptions of feelings were used, to further enhance the readers insight and to preserve the uniqueness of each story.

ANNE—"FOOD HAS ALWAYS BEEN A WEAPON"

Anne is the oldest of three children. She is 23 years old and has been married for four years. Anne is presently working part-time, while she explores post-secondary educational options. She started university a few years ago, however her depressions and eating disorder prevented her from completing her degree.

For as long as she can remember Anne has had a battle with food and weight. She describes that during her c[illegible]hood food was used as a weapon; given to provide nurturance and withheld to inflict punishment. She remembers always being overweight and turning to food as a source of comfort. Her bulimia was not diagnosed until three years ago when she was seeking counselling for depression. She indicated that she was in fact relieved when she was diagnosed, as for the first time she felt " credible" in her own eyes. " I had a disease... a wave of relief and gratitude fell over me."

Family Issues

Anne feels that her family life is central to the development of her eating disorder. Her parents married because her mother was pregnant with Anne.

Her mother was 18 years old and in grade 9 at school at the time. Throughout her life Anne has felt that she was not a wanted child and has felt that she was an inconvenience for her parents.

Anne feels that her parents have never been happily married. Her mother has had depressive episodes and periodic problems with drinking. Anne has witnessed her father being verbally and physically abusive towards her mother, which was more prevalent in her early childhood. She feels that people on the outside had no real idea of her home life and she was repeatedly warned by her parents to not discuss family events outside the house.

Anne's parents followed a strict religious faith and were very rigid in their parenting standards. Expression of emotion was not encouraged, and demonstrations of love, anger and sadness were particularly discouraged. Anne feels that she turned to food in order to "squash" the emotions that were building inside her. She describes "cramming cookies" down on top of her emotions to keep them locked in.

Anne has recently remembered more unhappy events from her childhood. Until last year she had repressed memories of being abused as a child by both her mother and father. She recalled these memories in a regression episode. She and her husband had decided to take a week-end away from home, as it had been busy and stressful time. Anne recalls drinking most of the celebration champagne by herself that night. Her husband then witnessed her regression to being a child again. She would not let him touch her and spent much of the evening cowering in the corner, pleading to him as if he were her father, to not

hit her again. The next morning her husband recounted the story; it had been a very upsetting evening for him. Anne then began to remember the abusive events of her childhood.

Both of her parents were physically abusive. Her father however, was the most physical. Her mother's treatment of the children was often more neglectful; however Anne recalls episodes of her mother pulling her by her hair and punching her in the face. Sometimes the abuse would relate to her not finishing her meals. She recalls a specific time where her father took her from the table to a darkened room, where she was beaten with his belt buckle and left for the night. Anne says that often her food would be kept for her for days, until it was too bad to eat. Food was also central in other disputes with her father. Anne was prone to colds and bronchitis as a child. Her father often blamed the frequency of these illnesses on her not finishing her meals.

Anne recalls now that she was physically abused from the age of three until she was seventeen. She said that she was then old enough to tell her father to never touch her again. She is aware that her father also was abusive towards her next youngest sister, as they shared a bedroom. An event that stays with her today occurred when her sister was about three years old. Her sister's mattress support had given way and she and the mattress hit the floor. Her sister started crying and Anne did not wake up in time to settle her down. Her father came in to the room with such force that the door knob went through the wall. He picked up his daughter and threw her against the wall, telling her to stop crying. Anne recalls yelling at her father and also being hit for interfering.

Anne realizes now that her response to the abuse was to become the "perfect child". She felt in that way she could prevent abuse by not giving her parents reason to be upset. She says that despite this she would be outspoken about protecting her sister, as she had the night her bed collapsed. Anne says that the "perfect child" facade also fit with protecting the family's image in the community.

Anne's happiest memories of home life relate to the time she spent with her maternal grandmother, who she felt was always there for her. She would sometimes visit after school and found her grandmother's home to be a haven. She feels that the experience with her grandmother was the only ray of hope in her childhood. Anne also recognizes that food also became a reliable source of comfort. She recalls as a child going to the refrigerator at night and bringing food in her room to eat and perhaps save. She wonders now why no one ever questioned the food that was missing from the refridgerator, as she often ate the left overs from the day's meal.

It bothers Anne now that she was abused. She feels that others, particularly her extended family, knew of the abuse and yet did nothing about it. Her family was viewed as the pillar of the community and she guessed that nobody questioned what was going on. She says that she has been told that resentment really fuels an eating disorder, and she knows that she really resented her father and others in the family who knew that the abuse was going on.

Anne has begun to come to grips with the pain of her family life through therapy. She says that she can now see that life was very difficult for her

father. He felt forced into a marriage with a woman she feels he really didn't love. He was responsible for supporting a wife and child, yet he didn't have a trade, a job or a home. She says he is not a villain and in his own way cared for them. She still feels that he did not have the right to abuse her, but feels she has to let go of it for her own sake. " I have to forgive him or its going to eat me up."

Anne has never confronted her family with her memories of the abuse. She doesn't think either they or she could handle it. When she told them she was in therapy and that her therapist thought she had an eating disorder, they both minimized it. Her mother felt that she just didn't pray enough, and that all she had to do was diet and exercise. Her father generally doesn't believe in what doctors say. While they haven't accepted her eating disorder, she believes her experience has helped her sister who still lives at home.

Anne is concerned about her next youngest sister. She feels that she diets too much. She thinks she has an eating disorder, although she feels her sister likely would not agree. She feels though that her sister is stronger and more assertive than she was and will therefore do better. Her youngest sister she feels has been least impacted by the family experience. She feels this is likely because as the youngest child she is more catered to by the family. Her youngest sister is also different personality wise, and is less challenging of the family system.

Personal Issues

Anne recalls feeling lonely and different through most of her childhood. Much of this she attributes to her being over weight and to the way "fat" children are teased and isolated. She had few friends growing up.

Anne did not have any help throughout her childhood. She remembers overdosing on "speed" when she was 15. (Anne says that this was a narcotic drug prescribed by her family doctor for weight loss.) She had tried to suicide, but her sister found her and took care of her. They didn't tell her parents, because she knew this would only cause further trouble and perhaps further abuse. She tried to kill herself three times that year. She remembers chastising herself for being so weak that she couldn't even kill herself properly. Nobody knew this but her sister. " I felt locked up with my own despair".

Anne left home the day after she graduated from high school. She could not wait to get away from home. She moved into an apartment with three other students. She initially worked while she attended a vocational program, but later attended university. Anne has had depressive episodes throughout her life, but was not diagnosed until she attended university. She has had a long history of dieting, which was felt to be central to her depressive symptoms. Her dieting became more prominent when she left home and shared an apartment with other young women. Everyone seemed concerned about looking good and attracting men, which served to highlight Anne's concerns about her own body shape. She was 150 lbs then and she realizes now that this was really the right

size for her height and frame. She thought however that she was really overweight and began to diet frantically. She went through a cycle of starvation and then started binging.

During this time Anne became secretive about her eating as she was conscious of being heavier than her room mates. As she had at home, she began to hoard food in her room to be eaten later, or would order out food when the others had left. She would often eat incredible amounts of food. She might order a large pizza and several orders of other fast foods, just for herself. She recalls one time standing at the freezer and eating ice cream out of the container with her hands. She recalls that much of her income earned while working went to support her food cravings.

Anne says that her obsessions at the time of binging were so strong that she had come to believe that terrible things would happen if she didn't eat all of the food she could find. She recalls telling herself that if she didn't eat all the food "the sun would go super-nova and everyone would die". (She had seen a program earlier in the week about the sun). She recognizes that it sounds crazy now as she hears herself repeat her story, but at the time this was an absolutely overwhelming urge. Even today Anne says that it is anxiety provoking to not eat all the food on her plate, even if she is not really hungry. For example, prior to our interview we had coffee and a brownie. Anne decided that she didn't need to eat all of the brownie and saved part of it for later. She commented at this point in the interview that six months ago it would have been absolutely impossible for her to leave part of the cookie, even if she really didn't want to eat it.

Anne initially responded to her fear of weight gain following a binging episodes with over-exercise. The whole point of exercising was to burn off the calories consumed in a binge. It was really like a punishment. Her doctor finally told her that she had to give up her extreme exercise regime because her blood pressure was dangerously low, her blood sugar levels were completely off and she was experiencing chronic fatigue. Anne was prepared to give up exercising, but soon needed something to replace it in order to cope with her fear of gaining weight as a result of her eating habits. She remembered reading an article on anorexia and bulimia, which talked about how bulimics used laxatives and self-induced vomiting, in addition to over-exercise. She felt the laxatives were not for her, but tried the vomiting and discovered it was very easy. At the time she saw it as the perfect solution, she could enjoy all the food she wanted without having to worry about gaining weight.

Anne became an expert at vomiting. She remembers having a party in which she was serving a lot of cookies. She described "cramming" cookies in her mouth while in the kitchen. She then went into the living room to serve the remaining cookies to her guests. When serving them she could then say she wasn't hungry. Anne then immediately went to the bathroom and discreetly threw up all the cookies she had just eaten, and returned to the party without anyone knowing or suspecting.

Anne describes this kind of duplicity and secrecy as part of the obsessions in an eating disorder. One must be able to convince others that there is absolutely no interest in food and no need to eat. Anne describes that between ages 18-22 she was totally obsessed with food and weight. Despite this most of her eating

rituals took place in private. She described almost pushing her husband out the door to be able to begin binging. Her whole day centred around, eating, planning for the next time to eat, exercising and purging.

Anne reports that one event brought her condition to a head. One night after a purge she was really anxious and she began to see people in the bathroom walls. Her husband found her cowering behind the shower curtain and was really scared. He said then that he had been doing some reading and he felt she had bulimia. He felt it was time she got some help. At the time she thought he was crazy because she felt one had to be skinny to have bulimia.

Not long after this she had an episode where she ate a whole bag of Fudgeo cookies in about 10 minutes. She was so upset with herself that she called her husband at work and said that she needed help. For Anne it was this kind of "craziness" in eating compulsions and binges that were the most upsetting. She came to worry that perhaps she " really was crazy", because her eating habits were so bizarre and out of control.

Socio-Cultural Issues

Anne feels that societal norms definitely had an impact on her. She was treated differently as a fat child. Her mother seemed to view her weight as a sin. Anne describes "torturing" herself with the fashion magazines that she regularly read as a teenager. She would look at those magazines and see so many pictures of tall beautiful women, that she thought that all women should look this way. She was convinced that there was something totally wrong with her.

Anne realizes that she has lost all ability to judge her own body size. She recalls shopping with her husband on one occasion. In picking out clothes for herself, she often chose items that were 3 to 4 sizes too big. Her husband was a much more accurate judge of clothing size for her. In fact items he chose, which Anne thought were way too small, normally fit her. Anne says she has always had this image of herself as "huge".

She says that it is pathetic that as women we have bought into the media pressure about how we should look. We are saturated with a beauty ideal which she labels as a "subtle form of brainwashing". Anne says " When you are old enough to know you are a woman, you know that you have to be concerned about your appearance, mainly for men, but also for other women". She feels that somehow it is different for men. The men's fashion magazine's do not portray men in the same way. Also men do not seem to compare themselves to the male models the way that women compare themselves to female models.

There was a time when Anne could get very depressed after reading these magazines. She knows of other women who have been similarly affected. She has a cousin who had become so obsessed with her body shape that she dieted herself down to 95 lbs even though she was 5'8" tall. Anne feels that women have to initiate the change regarding body shape expectations, by being more supportive of different body shapes.

These beauty ideals are further reinforced in all the diets that are available. Anne went to Weight Watchers an [illegible]as told that she should be 116 lbs. She was so discouraged because she weighed 150 lbs. She realizes now that 116 lbs

was a crazy weight ideal for her, but at the time it fed right into her obsession. She says that over the years she has spent thousands on diet books, diet programs, exercise classes , and health clubs. In fact as indicated earlier her over-exercising became detrimental to her health. Anne maintains that dieting does not work. She says it is a temporary measure to a permanent problem. She likens it to "putting a band-aid on a gaping chest wound". Anne knows now that permanent relearning of eating habits is the only "sane" approach.

Treatment Issues

Despite the severity of her home life, and the recognition of a childhood problem with food, the crisis that first led to treatment seemed centred around leaving home. Anne was not sure what she wanted to do with her life other than to leave home. She first entered therapy because she was in University and severely depressed. She was tired, smoking, constantly eating and purging. Her battle with weight continued. As she talked with the therapist, she began to feel much better and she decided to discontinue therapy. Some months later she experienced a regression episode, while on vacation. This was the first time that she had conscious knowledge of her abuse. She re-entered therapy and now feels that she has reached resolution around these issues with her family.

It was at this point that her therapist broached the possibility of her being bulimic. His words were initially a shock, but then she described feeling a wave of relief and gratitude. She was not a "fat, weak" person; she had a disease! Her therapist referred her to Overeater's Anonymous (OA) for treatment. For a long time she put off going to OA, as she still felt she wasn't

like them. When she finally raised the courage to go, she felt like she was "coming home". She described experiencing warmth and acceptance in a way that had never existed for her. One of the first things she was told to do was to throw away her weigh scales. She said we give too much power to "a few pounds of metal". For Anne this was a whole new insight.

When Anne reflects on her eating disorder she realize that her battle with food and weight began at a very early age. Food was both a source of comfort and an enemy. Societal norms definitely had an impact on her. She was treated differently as a fat child. Her views about body shape have changed now, but she often reflects that if only someone had been able to tell her that she looked great when she was 18, she might have saved herself a lot of agony. She says that it is ironic that in the five years of starving, dieting and binging she has actually gained 62 pounds.

Anne feels that the OA program is the secret to her present level of control. She knows that she will be battling this for the rest of her life and that she will continue to need the support of this program. She is delighted that for the first time she has lost weight without dieting. Prior to OA she would not have thought this possible.

CONNIE—"FOOD IS THE ENEMY"

Connie is the oldest of four children. She is 28 years old and has been married for four years. Connie is presently employed in a senior clerical position. She

attended university, but despite a good academic standing could not cope with university life. Connie is disappointed that she did not finish her degree and feels that she continues to underachieve professionally.

Connie feels that her struggle with food is really more symbolic of her emotional concerns. She views the dynamics of her family life as being central to the development of her eating behaviour, and sees eating habits as comparable to any addiction. Connie in fact arranged our interview times to allow her to complete her twenty-five kilometres cycling regime prior to our session. She said that if she didn't exercise before hand, she would be anxious during our interview and would not be able to concentrate properly.

As our interview progressed it became evident that Connie is presently still struggling with her eating behaviour. While she has not been formally diagnosed as having an eating disorder, her eating habits over the past two years have swung from being severely restricting, to binging and purging. Connie says that she and her husband can no longer eat together. Her husband will normally bring home fast food to eat, as he does not like to eat her "diet " food. Consequently they most often eat at different times. They rarely go out to eat anymore because she cannot weigh the food, and feels too anxious not knowing how the meal is prepared. They no longer go out with friends for the same reason, nor do they travel. Connie says that they have become social isolates because of her eating behaviour.

This is in complete contrast to the time that they spent together in the six years they were dating prior to their marriage. Connie recalls that they often travelled

and went out to restaurants for meals. She reflects that when she now looks at her wedding pictures, she sees another person. " I look completely different now. So much has happened since. I often long for the way things used to be before we were married."

Connie feels that her eating behaviours are now out of control, and she continues in therapy to address these and other concerns.

Family Issues

Connie's parents married at a very young age and by the time her father was 23 years old, they had three children. Connie feels her father was not ready for the responsibility of a family and consequently was very distant from them. She feels that she really missed her father's presence in her life. Her mother tried very hard to be both a mother and a father; however in Connie's view, the roles are not interchangeable. She sees this loss as very central to her problem with eating now.

Connie recalls that her parents' marriage was also marked by conflict. Her father developed a drinking problem which was the primary source of arguments between her parents. Connie recalls that for the most part the children did not come in contact with their father when he was drinking. Her mother normally "took care of him". Connie feels though, of all the children, she was most likely to become involved in her parents' disputes.

Connie also feels that as children they were affected by her father's drinking problem. She recalls feeling helpless and defenceless, as there was nothing they

could do to control what was happening with their father. She feels that their emotions ran from feeling hopeless, to feeling guilty that somehow they were a part of his reason for drinking.

Connie draws parallels between her father's drinking and her problems with eating. She views them both as a crutch. "They allow you to escape and avoid. That's how I do it."

Connie's mother was the central figure in her early life. While both parents worked outside the home, her mother carried all of the responsibility for raising the children. Connie feels that providing good food and hot meals was an important part of her mother's sense of nurturing. From a very early age food became associated with comfort.

Connie also has a sense that as children they were overprotected by their mother. She recalls that her mother often expressed concern about them becoming involved in activities such as swimming for fear they might hurt themselves. " I knew that we were all that mom had. I often wondered if she would survive without us"

Connie's parents formally separated seven years ago. She said it did not come as a shock to anyone as her parents had been emotionally separated for years. Her father; however, maintains a key to the family house, and he and her mother seem to have an amicable relationship. Connie feels that she maintains most contact with her father of all the children. While she feels a sense of loss

for the things they missed doing together in their early life, she feels that he had his own reasons for being so distant. She feels that her siblings are not this forgiving.

Connie recognizes though that distance remains in her relationship with her father. While she knows she can call upon him for anything, he will not initiate that contact. This remains an area of conflict for her. She feels that she is still looking for a closer relationship with her father.

Connie married four years ago, after dating her husband for six years. She feels that she was not prepared for the responsibility of marriage, nor for how different life would be after she married. She described it as a "real culture shock". Connie had no domestic interests at home, and realizes now that her mother did everything for her. She was not prepared to take on running a home.

In addition to this her husband had a job that required him to work shifts, and for the first time in her life she was confronted with being home alone. She realizes now that she has a fear of being alone. She sees this fear as stemming back to a fear of being abandoned by her father.

Connie describes her husband as having some traits in common with her. She feels he has a low self-esteem, but is very sensitive and has a good sense of humour. He had a difficult early life, and this was part of their attraction to one another. She realizes now though that her relationship with her husband has

created further dependency. She says that, "He treats me like a queen.... it's a problem now because I am becoming incompetent. I went to the bank the other day and didn't know my account number or how to get it."

Connie attributes the dramatic change in lifestyle when she married to the onset of her more serious eating rituals and obsession with weight and body shape. Her husband worked shifts and she was confronted with a lot of time alone. This coupled with the change in expectations and responsibility led to her feeling depressed and overwhelmed.

Personal Issues

As indicated previously, Connie's struggle with her eating behaviour is still very much alive. When Connie was a teenager she was the biggest person in her family, weighing over 200 lbs. She does not have many memories of that time, but she knows that her parents talked about her weight problem. She says she worked hard and did lose a lot of weight. Connie also realizes now that she had attached significance to thinness. She had a perception that being thin would ensure happiness, which surfaced when she first saw the psychiatrist in university.

She recalls becoming really depressed in university which led to her performance deteriorating. She had achieved very well in high school and couldn't understand why she wasn't coping. She recalls seeing a psychiatrist at that time and saying to him, " I used to be really overweight, I got thin and I haven't been the same since." Connie sees that in retrospect that she was only

sixteen, which is about a year younger than most first year students. She feels that in fact she experienced a separation anxiety. This was the first push for independence and she did not feel ready for it. This theme seems to be an important one for Connie as it appeared to surface again around her marriage.

Connie also recalls that her mother was always concerned about her own weight and was constantly experimenting with different diets. Connie recalls that she often went to Weight Watchers with her mother. In retrospect she sees that she tended to go on diet whenever her mother did. It is interesting that Connie feels that going to Weight Watchers is one of the few activities she and her mother did together.

Connie first began to lose a lot of weight about a year after her marriage. She feels the dieting and exercising were her response to spending so much time alone as her husband had been working shifts. Connie became obsessed with her size and shape and would regularly weigh and measure herself. She began being very careful about her food. She created rituals around the Weight Watcher philosophy of measuring, weighing and recording her food. She also began cycling on an exercise bike. Connie is presently up to twenty five (25) kilometres a day. She has already broken one stationary bike through overuse. The store owner when consulted had apparently never seen a bike break down in this way.

Even though Connie lost a lot of weight she was convinced that it is always better to lose more. She soon reached a point where she was always sick and tired. People at work started to talk about her. Some of them called her anorexic.

Connie described her rituals with food, where things have to be weighed and prepared in a certain way. She cuts the crusts off all bread as it tends to weigh more than the recommended number of ounces. She will measure butter and peanut butter in measuring spoons and carefully scrape off all excess before eating. In our interview Connie was smiling as she told me this. She said that she knows this sounds crazy, but also pointed out that she will continue to do it. In fact she feels any change in her food preparation routine would make her feel very anxious.

Connie recognized that she has denied her hunger for so long that she is no longer able to recognize when she is hungry and full. She feels that this contributes to her anxiety, as she does not know when to eat or when to stop. Everything must then be carefully planned. She says that it is particularly distressing not to know when she is full. She recalls sitting at the table asking herself if she needs more and being concerned that she has eaten enough, but not too much.

Connie soon reached a point where she was becoming ill frequently and visiting her doctor's office on a regular basis. He insisted that she would have to soon go into hospital if she did not gain more weight. Connie recalls that this motivated her for a while and she did allow herself to put on a few pounds. Her

doctor also proposed that she see a psychiatrist, and first she was offended. Eventually she agreed to go see him, and she has been in therapy for the past two years. Her psychiatrist sees her eating problem as a manifestation of a deeper emotional problem and that has been the focus of their therapy.

About six months ago Connie and her husband also entered marital therapy. Connie's eating habits had totally isolated her from others including her husband, and her psychiatrist felt counselling would help. Connie recalls feeling very threatened by the proposal of counselling. She recognized that she feared that this would mean the break up of their marriage. In her view, the old fears of abandonment and rejection resurfaced. Just prior to entering marital therapy Connie began binging for the first time.

Connie describes being totally out of control in a binge. She will eat anything that is in the house and has even defrosted food from the freezer to satisfy these overwhelming urges. She knows all of the calories of the foods she eats. She remembered once recording what she ate in one binge, which equalled five thousand (5000) calories.

Connie says that she has now reached a point where her husband will hide some of his favourite foods so that she cannot eat them. Connie described that when she is home alone she has an overwhelming compulsion to find his food and eat it. She described incidents of practically pushing her husband out the door so that she can look for the food and eat it. She described the feeling as an absolute compulsion. " It sounds crazy when I talk about it, yet the binging is absolutely the worst feeling in the world. It is the most awful feeling you can

imagine. It is like you are trying to fill this insatiable void. The more you eat, the hungrier you get. It doesn't matter what you eat, you hardly taste it. I wish I could stay away from it. The binging scares me the most. "

After a binge Connie feels tremendously guilty, particularly if she has eaten her husband's food. She has often called him at work upset with her behaviour, and he too feels upset at her apparent lack of control. She says that she most always binges when she is alone, and that anything could trigger a binge. For example if she felt that she had "cheated" on her diet, or if she and her husband fight. She sometimes views the binge as a form of self-punishment.

Connie uses over-exercise to compensate for her binging episodes; however, this does not prevent the distension of her stomach that often takes place after a binge. She has tried to induce vomiting, but has not been successful and it then takes several days before her digestive tract recovers. In that time she will often experience diarrehea and extreme fatigue. This has recently meant that she loses time from work. Connie describes feeling so guilty and out of control that it is really scary. She says that not that long ago she was so depressed about her eating behaviour that she found herself sleeping much of the time, and having morbid thoughts. She says, " At one point I really wished that I were dead. It seemed too difficult to manage by myself." She wishes she could bring her eating behaviours under control, but fears that this is a distant goal.

Socio-Cultural Issues

Connie feels that the media push to diet and to promote a certain body shape must have an influence in the development of an eating disorder. She has experienced the way people are treated differently depending on their weight, as her husband is considerably overweight. She says that it really bothers her the way her husband is treated. She feels he has been very hurt by the comments and reactions of others.

Connie has a sense that women with weight problems are viewed differently in society than men. She feels that overweight women are viewed as lazy and weak, and generally seen more negatively than overweight men. She recognizes that both she and her mother have spent a lot of money on weight loss programs and diet/exercise regimes. Connie is presently involved in two other exercise activities outside of her cycling.

Connie also feels the media influences regarding appearances leads people to have different expectations of others based on their looks. She says that she is careful to dress well and that her focus on appearance has led her colleagues and superiors to expect more from her. She says the irony is that when she has personally felt the worst, she has perhaps looked her best. For Connie her looks are not a representation of her self-view.

Connie also sees that middle to upper-class families are more at risk for developing an eating disorder. She feels that there are more pressures to

maintain a higher standard of living, as well as easier accessibility to the vast quantities of food needed to sustain binging. She feels the whole pressure for overachievement centres in the pursuit of material things.

Treatment Issues

Connie has examined the factors that she sees as most prevalent to her eating behaviour. She first feels that her lack of internalized sense of self is central to this problem. She feels she doesn't know who she is or what she wants. She feels she is very influenced by the views of others towards her, which allows her to be so controlled by her sense of body shape. She is very influenced by the weigh scales. "If I weigh even a 1/4 of a pound more I am depressed for the whole day. I will review everything I have eaten to find the extra calories. The sad thing is if you didn't show me the scales and you told me that I had lost weight even though I had gained, I would feel absolutely marvellous."

Connie also feels that she has fundamentally feared moving on with her own life. She described herself as fearing success more that failure. She does not really understand this part of herself, but sees it as connected to not letting go of her family of origin, of fearing responsibility, of fearing being overwhelmed. She also recognized that she feels a need to be in control in relationships. She says, "When things get too close, I often begin to distance myself emotionally. There have been times when I have deliberately ended a relationship to prevent being rejected." She feels these issues are fundamental

to her sense of self-despair. She feels terrible having potential that is unused, to never allow herself to do her best. She feels that this issue is central to the resolution of her eating disorder.

Despite this fear Connie recognized that she often carries the blame or responsibility for what happens with others whom she cares about. She has a sense of responsibility for her father and all that he had to face when they were children. She also recognized that she likes to take care of others. She recognized the irony in this, in that she can nurture others, but not herself.

Connie has had a very positive experience with her family doctor and psychiatrist. She feels she would not have made it this far without their help and support. She has recently found that her binging is creating havoc in her life. She has become very distressed by the distension in her abdomen after a binge, which normally occurs at night and when she is alone. A few times her husband has taken her to an Emergency Department. She describes these encounters as most upsetting. " I have met a lot of uncaring people. Once I came to Emergency and asked to see someone from Psychiatry. The doctor told me the problem was all in my head and to go home, take whatever medication I was on, and call my doctor in the morning.... After he left I started crying. I knew there wasn't a lot they could do for me, but I really needed to talk to someone."A nurse there put me in a room and arranged for someone to come down from Psychiatry to see me."

Connie reached a point where her psychiatrist told her to stop going to Emergency, as there was nothing that anyone could do for her there. She said " I know that no one can stop these binges for me, but I just do not know what to do for myself."

Post Script To Treatment Issues

The day after my interview with Connie I received a call from her saying that she had a bad binge after our session. She wanted to let me know this as she felt it might be significant to my research. She had not felt upset during or after the interview, and was puzzled by the binging response. She agreed to consult her psychiatrist. I later received two more calls from Connie, once late in the evening after she had finished a binge. She was home alone and was upset. As our discussion progressed, I questioned Connie as to whether she was actually looking for help from me regarding the binging. She indicated that she was not sure what she was looking for.

I met with Connie and her husband the next day. I stated that I felt that she was seeking more direct help for her binging behaviour. Connie's husband confirmed that he was very worried about her. He was also concerned about my involvement as they have not told anyone except Connie's family about her eating behaviour. They did not want anyone else to know about it. I sought and obtained permission to contact her social worker who had referred Connie to the study. We agreed that it was not in Connie's best interests to take and view

the video-tape of our session as had been previously discussed. We also agreed that Connie would discuss viewing the tape with her social worker and psychiatrist, and we would be guided by their decision.

We also decided that we would defer any follow-up interviews until after she had these sessions. Connie was to initiate this follow-up contact. I reassured her that she should not feel obligated to see me again, even though this was part of the original plan. I stated that Connie had given me a wealth of information and had been very open in sharing her life story.

I later contacted Connie's social worker to relate the concerns raised with me following our interview.

I have since briefly talked with Connie's social worker to consult on the advisability of Connie joining a meeting of the research participants. In consultation with Connie's psychiatrist they felt it was not in her best interests at this time. To date I have not heard from Connie.

DIANNE—FOOD IS LIKE AN ADDICTION

Dianne is 31 years old. She is the third of five children. She has two older sisters and two younger brothers. Dianne has a University degree, but feels her career choice was made more because of the influence of others than because of her own interest. She has recently married for the second time. Dianne feels that she is now more content than she has ever been in her life.

Dianne first developed anorexia at the age of 21 years. She later became bulimic. Her weight went down to 87 lbs and she stopped having menstrual

periods for almost four years. At the height of her bulimia she might have had as many as 20 binge/purge episodes a day. Dianne feels over the past year her life has really come together and both her anorexia and bulimia are well under control.

Family Issues

Dianne's family lived in a small community for 10 years and the move to a larger centre was a difficult adjustment for the family. Dianne's most prominent memories of childhood centre around her mother's development of depression and her older sister's drinking problem. She has a sense that her sister's drinking developed first. Her sister was quite young, between age 10 and 14 years old, when she began drinking and coming home drunk. Dianne's parents rarely drank and she recalls that her sister's drinking totally disturbed the household. The family began to experience fighting and disagreement.

Dianne recalls as well that there was a lot of shame and guilt within the family about her sisters's drinking problem. She feels that this also coincided with the beginning of her mothers' depressions. Her mother's depressions became severe enough to require a series of hospitalizations over the next several years.

Dianne says that she was a young teenager (12-13 years) when her sister and mother developed these problems. She recalls feeling very responsible for the household, such as cooking, cleaning and doing laundry. She also was very

cognizant of how her sister's behaviour disturbed the household and was careful to not disrupt things. " I was always trying to be good ... to not be like my sister...everything had to be perfect."

Dianne feels her mother's depressions had an impact on their relationship. Dianne recalls that her mother would be cool and distant towards them. She said that in some way she felt responsible for the depression and recalls trying to make her mother feel happy. Despite these efforts her mother's moods would swing, and so would her responsiveness to them as children, leaving her feeling that her mothers' reactions were totally out of her control.

Dianne recalls the shame centred around their family because of her mother's depressions. She recalled maintaining a certain front outside the family, while inside feeling as through she was "tied up in knots". One time she tried to describe to her father how she felt about need to "keep up a front". Even though he said she didn't need to feel this way, Dianne said this was not a comfort. She said this only heightened her confusion because she just didn't know how she should be feeling.

Dianne says she eventually created a series of "masks", one for every occasion. She then had the perfect response, how to act and what to say for every situation. In the meantime there was no outlet for the emotions that were building inside her. There was nowhere to vent her feelings of confusion and anger,and nowhere to gain insight as to what the feelings meant. In many ways Dianne found her early home life confusing, particulary when she started comparing her life with those of other families she knew.

Dianne recalls that her sister left home when she was about 17 or 18 years old. She said there was an immediate sense of relief in the household. Despite this her mother's depressions continued. Dianne recalls two or three Christmases where her mother ended up in hospital with depression. She took on the responsibility of buying gifts and preparing the Christmas dinner for the family.

Dianne feels that despite her family's problems there were also pleasant times in her family life. Dianne has a recollection of times when her parents were loving and caring. While her father tended to be a quiet man, who did not express many opinions or emotions, he would often just give her a hug and a kiss. Dianne feels on reflection that perhaps both her father and her mother had inferiority complexes and were consequently shy and had more difficulty expressing emotions.

Dianne recalls that finishing high school was a very confusing time for her. She had no idea what to do, and there was little direction from home. She ended up following a career path that was similar to many of her friends, as it seemed like the easiest thing to do. She left home to attend school, but recalls still carrying the shame of the life at home.

In Dianne's first year of school her mother was diagnosed as having cancer. She recalls being flooded with emotions and yet not knowing what to do with these emotions. She felt anger at her mother, and guilt for the anger. She does not know what to and so she again created a "mask" that everything was just fine.

Her mother had surgery and seemed to recover well. To Dianne's surprise her mother also experienced a dramatic change in her emotional state. In her view her mother had become a completely different person. Her depressions lifted, and for the first time Dianne feels they had a close relationship. She feels that it was more a friendship type of relationship, with a lot of sharing of personal experiences. She recalls being up for hours talking to her mother about her life as a young women and sharing stories with each other about relationships . The next two years were very special for them. Her mother did have a second surgery in which no cancer was found, and they both felt that she was healed. During this time she and her mother had experienced a faith healing to which they attributed the success of her mother's second surgery.

After graduation, Dianne left her home community to find work. She recalls being really surprised that her mother had prepared a going away party of her. Shortly after she left home her mother had a third surgery. She felt confident that her mother would recover again. She was shocked wh n she received the call that her mother had only a month to live. She also felt hurt that her father had not told her that her mother had been deteriorating. When she returned home she was disturbed to see how her mother had lost weight. She knew she was dying.

Her mother's death is still very difficult for Dianne. There is a sense of a double loss, in that she and her mother had only recently re-discovered each other. This has made her death much more difficult for Dianne to reconcile. She recalls that for a long time she was very angry at God for not healing her mother a second time. "He did before. Why not now?"

After her mother's death Dianne buried herself in work. She did not want to feel anything, and did not allow herself to grieve. She closed out all emotions and even fantasized that her mother was still back home. One year later she received a call from a high school friend. Her friend had been diagnosed as having cancer and wanted to discontinue her chemotherapy. She wanted Dianne to go home with her and to help take care of her. Dianne went with her and stayed with her until she died.

Dianne recalls allowing herself two days to grieve and them she went back to work, although this time she stayed in her home community. At about this time Dianne re-started a relationship with a previous boyfriend. She had ended this relationship because he wanted to marry her. She feels that she allowed them to come together again out of a need for comfort.

The following year her father re-married. She said nothing was discussed about the marriage, or whether the children felt the marriage was too soon after her mother's death. Her step-mother had four children and Dianne was living in the basement apartment with her brother and sister. She said they had no idea about step-families and had expected things to stay the same. She found her step-mother cold and felt that she did not want them upstairs. Ultimately, she felt totally removed from the family.

Around this time her relationship with her boyfriend ended and depression began to set in. Dianne recalled not wanting to feel anymore pain. She made a "pact" with herself that nothing else would hurt her; that she would not let anyone else into her life. At about this time, Dianne started to lose weight. She

lost about 15-20 lbs and her weight loss was soon noticed by others. She also began to be careful about her weight and shape. She recalls feeling, "Well I've lost all this weight, I might as well keep it off."

Dianne later began another relationship and cancelled plans to move away to work, so that she could move in with this man. She felt the relationship was not bad, but recognizes now that everything was very controlled on her part. She described feeling that she could not let her boyfriend see what she was really like. Dianne eventually married this man, even though she sensed that this might not be the right thing. For her it was important to have someone who cared.

Dianne described herself at that time as "aching throughout". Having no idea of who she really was, or what she really wanted, and yet trying to be someone all the same. Despite this personal lack of focus, Dianne was performing well at work. She in fact was promoted to a supervisory position. She feels her obsession with food and weight was then at its height. She recalls that although she was 87 lbs she could look in the mirror and see "globs of fat" on her body.

About a year later her sister sent her some information on anorexia. At the time she thought this was crazy, but in the back of her mind she was beginning to see that she needed help. She began to do some reading on eating disorders, but was afraid to seek help. She describes feeling a total shame, guilt, and fear; particularly about telling her husband. She was worried he would leave her. Still she had reached a point where she was questioning whether she could live the rest of her life this way.

Dianne eventually did discuss her eating disorder with her husband; however their relationship could not withstand the turmoil of her search for treatment. Her husband eventually left her. Dianne recalled feeling that she deserved this. She also reverted back to her old survival mechanism of burying her feelings. She described herself as becoming "really cold on the outside, while dying on the inside". Anorexia and bulimia became a substitute for feelings. She felt this was the only way she knew how to deal with anything in her life.

Dianne also had to face the shame of disgracing her family by being the first one to divorce. As in the past she moved away from home and indeed moved outside the Province. She was away for six weeks before she let her family know where she was. She was feeling so much pain, shame and guilt that she really didn't care what anyone thought. She realizes now that her moving was the beginning of the search of help.

Personal Issues

Dianne recalls feeling different from a very early age. She describes herself as always being shy and introverted. She jokes that she probably went all the way through kindergarten without opening her mouth. Dianne recalls feeling a lot of pressure in school to fit in and to not appear different to others. She feared being singled out in class and soon learned how to present herself so that she did not stand out.

Dianne feels weight and food did not become an issue for her until she became depressed in the year following her father's re-marriage. She had never been overweight, and beyond carrying much of the responsibility for cooking the family meals, food was not really an issue at home.

Through her treatment process Dianne recognized that she had difficulty accepting how things were in her life. She feels that she had a certain standard and expectation for people, and held resentments if they did not live up to them. She knows that she particularly felt this way about her early life with her mother. Dianne also feels that some of this ties into her own sense of perfectionism and her need to do things the right way.

Dianne feels that she always had a inferiority complex. She feels that some of this centred in her shyness, but also stems from her parents having inferiority complexes. Coupled with this was a sense of herself as needing to meet the ideal she perceived others held for her. This left Dianne experiencing an internal void, a lack of internalized sense of self.

Dianne feels that food and its control became her survival mechanism. It was the one thing she could rely on. It also made up for her inability to cope with her emotions. For Dianne it was as if experiencing emotions was a threat to her personal safety that was to be avoided at all costs. The anorexia and bulimia served to be effective distracters.

For Dianne her anorexia and later bulimia extended over a seven year period before she began to seek help. Her initial weight loss was associated with depression. From there she became conscious of maintaining the reduced

weight through food restrictions and exercise. Over a six month span Dianne's weight went from 120 to 87 pounds. This represents an 18% loss of weight. Dianne believes that the biochemical changes associated with the dramatic weight loss help to feed into the food and body shape obsessions that developed around that time. She recalls that one of her colleagues had commented on her weight at that time and responding to her by saying, " Too skinny? Don't be so foolish I could lose another 10 lbs! " She recalls that the sensation of being "over-full" was particularly anxiety provoking. However, Dianne had reached a point where she felt "over-full" after eating an apple for lunch. This is when she began self induced vomiting.

For Dianne binging episodes occurred after she had developed a pattern of self-induced vomiting. Dianne feels it is hard to describe the obsession with food and weight, because it sounds "totally crazy" to someone who has not experienced it. Even now as she describes things she did, she finds it hard to believe. For her the binging and purging episodes became the most disturbing. Dianne recalls that if she were off from work for several days and had no social plans, that she could binge and purge up to 20 times a day. She said at one point she became so desperate that she began to eat out of the garbage. She said it is hard for others to understand that kind of desperation. In fact, she also began to question whether she was really "crazy".

As the bulimia and anorexia progressed socializing became a nightmare. Dianne found that she always needed somewhere to get rid of her food. This was an overwhelming concern. Dianne feels that the " craziness " of the bulimic behaviour further reinforced the secrecy because of the shame and guilt one

feels after a binge. How can you tell a colleague or friend that you needed food so badly that you ate out of the garbage last night? She found herself becoming very manipulative so that she would have food enough to binge and time alone without anyone suspecting what she was doing. She recalls staying at a friends apartment and carefully replacing all the food she ate so they would think she hadn't eaten anything. The facade to the outside was a very important part of maintaining the eating disorder.

Dianne also feels that she probably also had a problem with alcohol. She was never a heavy drinker, but came to recognize that her pattern of drinking was such that alcohol often helped her to cope. She also remembers that after abstaining from alcohol for a period of time, she was placed on a medication by her doctor that had 20% alcohol base, although she was not aware of this at the time. Within the first day of being on this medication Dianne indicated that her previously conquered anxieties and fears dramatically returned. She feels convinced that there are parallels, if not links, between eating disorders and alcohol addiction.

She realizes now that the anorexia and bulimia masked a greater personal dissatisfaction with life. She felt that she was still searching for inner fulfilment and nothing seemed to be able to satiate that need. This dissatisfaction also seemed to centre in her sense of perfectionism, for herself and others. Dianne came to feel that no one, not even she could meet those standards.

Socio-Cultural Issues

Dianne did not express a sense that societal pressures had played a part in her eating disorder. She recognizes that there is an impression that thin is better, and this surfaced when she first lost weight during a depressive episode. She feels as well that women in general are conscious of their appearance. She says that even though she has resolved her eating disorder that she will always be aware of her figure. She sees this as normal for women.

Dianne also recognized that she has spent a lot of money on health clubs over the years. She sees that the promotion of exercise and fitness fed into her obsession with weight and shape. She said that at the height of her anorexia and bulimia, that she "lived" at her health club.

Treatment Issues

Dianne has had a long journey to reach the point of control she presently enjoys with respect to her eating disorder. Her first treatment contact was with a psychiatrist. She was given medications which she did not find helpful, and she discontinued treatment after a few sessions.

Shortly after the break-up of her first marriage, Dianne began to recognize that she had a problem. Her sister had sent some articles on anorexia which she initially dismissed, but which ultimately led her to do more reading. In the following seven years Dianne moved jobs and locations four times. With each move she felt a step closer to resolution of her problems.

When Dianne was at the height of her anorexia and bulimia she began to see a psychiatrist again. She was given more medication for her depression, which she didn't want and threw out. At this point Dianne was really discouraged because she felt this was not the kind of help she needed. While visiting a friend one week-end, she saw an advertisement for an eating disorders clinic. She called the clinic and described her symptoms. They confirmed that it sounded like she had an eating disorder and they suggested she begin with Overeaters Anonymous (OA)in her home community.

Dianne describes being so excited that she left her girlfriend's home early to return home to the meetings. She described feeling a little out of place in the group, because most of the people were overweight. However she immediately felt a warmth from the members and joined up with a sponsor that night. She described feeling an almost instant relief. The anorexia, binging, and purging stopped for almost a full year after joining the OA group. Dianne recognized, in retrospect, that at this point she had not realized the magnitude of her eating disorder. She initially felt that as long as she gained back her weight and stopped binging and purging, she would be cured.

Dianne returned to the Province two years later. She tried to join the Overeaters' Anonymous group here, but found it to be smaller and less well developed than the group she was used to. She decided to try coping on her own. Dianne soon found that her depressions returned and so did the food and weight obsessions. She was really scared that she was back on the same "merry go round". She soon found that the depressions escalated and she in fact started to have anxiety attacks. She began seeing a psychiatrist again, but found he had

absolutely no concept of her eating disorder. She fought with him for two years not to go on anti-depressants, but finally relented as she felt there was no other help possible. After six months she felt the medications had not been helpful. She began looking else where for help.

Dianne saw a psychologist for about a year. She found this beneficial to a degree, but she was still frustrated by the periods of depression, anxiety and bulimia. She wanted to get rid of the symptoms altogether. She went to meetings of Adult Children of Alcoholics (ACOA), as her sister was an alcoholic. She found some help, but still felt there was something missing.

Last December she felt that she hit rock bottom. She had been working long hours away from home. She had ended another relationship in which she felt she was giving more than receiving. She felt completely depressed and ready to give up on life. Out of desperation asked her sister if she could join Alcoholics Anonymous (AA). Her sister found her a sponsor, who agreed to help if Dianne also gave up drinking. At that point she didn't care, she felt this was her last chance for help.

Dianne became very involved in the twelve steps of the AA program. With her sponsor she worked on each step. She began to see how her resentment for life events and her inability to accept people for who they were, fuelled her eating disorder. Linked with this was her sense of perfectionism, which made it more difficult for her to let go of these expectations. Dianne spent time looking at her own behaviour and writing out her character flaws. She said this was the

hardest thing she has ever had to do, as thoroughout her life she had externalized responsibility. She had finally found an outlet for the emotions of hurt, anger, and regret that had accumulated over the years.

Dianne is now at a point where she feels free for the first time. She has worked hard to let go of all of the past hurts and has tried to take responsibility for her part in the troubles of her past. She feels that she still very much needs the support of her AA group and will attend 2-3 meetings a week. She feels that her eating disorder is something that she must cope with on a daily basis, with a trust in a higher being who will help her through. She says there are still times when some of the old concerns return, like being anxious when she is over full, but now she is able to "ride it out".

For Dianne this resolution was most signified by her peace of mind. She says that she no longer looks to others for satisfaction and is much more tolerant of herself and others. Dianne now holds a lot of hope for the future.

DATA ANALYSIS

In a qualitative study the data analysis component presents a significant challenge. The analysis began with a collation of the data and continued with an examination of the content of the collated data. Content analysis was conducted focusing in three directions:

a) A discussion of the commonalities and differences between each woman's story and between the storys and the concepts and variables identified in the literature.

b) A discussion of the insights provided by the data and a re-consideration of the concepts and knowledge drawn from the literature. This section will focus on analyzing the data in relation to the literature and will contribute to the social work knowledge about eating disorders.

c) An examination of the implications of these results for social work practice.

A. Comparative discussion of each woman's story and the variables identified in the literature.

Despite the differences in diagnosis, there were many common issues expressed by these women. All felt their eating disorder was symbolic of more deep-seated emotional problems. Each saw her family experiences as being a significant component in the development of the eating disorder. Each expressed very similar obsessions and rituals with respect to body shape,

weight, and control of eating. Finally two of the three women felt that socio-cultural pressures regarding thinness and the female shape, had a significant impact on them.

In the discussion that follows each woman's story will be further analyzed with respect to the commonalities and differences between each story, and between the stories and the concepts and variables identified in the literature. Tables have been used to facilitate this comparative analysis. Of the twenty-five variables presented, seventeen were present in each participant's story. Six of the remaining eight were present for two out of the three women. Anne and Connie, who presented with the most similarity in their struggle with weight and eating behaviour, were consistent in twenty out of the twenty five variables.

Socio-cultural Issues:

Of the three women, Anne and Connie felt the most strongly about socio-cultural issues. They felt there were pressures on women to be thin. As children they had been perceived by their families as being overweight, and as teenagers they saw the television and print media portraying a stereotyped ideal of the female shape. Anne particularly recalled being convinced that all women should look like the fashion models in magazines. Connie has also seen how her husband has been treated as an overweight man. She feels that society generally views overweight people negatively, and that overweight woman are more negatively viewed than overweight men.

All of the woman felt that there is a pressure on woman to be attractive, especially to men. They had each spent a great deal of money on diet programs, fitness classes, and health clubs. They recognized that their reason for participation in these programs was to lose weight, and improve muscle tone and body shape. Anne and Connie felt that women "buy into" the pressure about appearance and further perpetuate this pressure by also being critical of other women's appearance.

Anne and Connie connected thinness with personal happiness. Each felt the solution to their life problems was to be thinner. Each felt controlled by the weigh scales and the loss or gain of weight dramatically affected their view of themselves.

In Table I that follows, socio-cultural issues raised in the literature are compared with each woman's life experience (See page 97).

The second socio-cultural variable raised is deferral of control to others. It is interesting that while each woman's story supports this issue, the women did not connect it to the socialization of women in general. Rather the issue of deferral of needs to others and loss of control over life events, were more seen by them in a personal and family context.

Each woman reported feeling out of control of life events, particularly during her childhood. Anne could not control the abusive episodes, despite her attempt to be the "perfect" child. Connie felt helpless and out of control of her father's

Table I Socio-cultural Factors

This table presents the socio-cultural factors studied and indicates the presence of these factors with a (√). Descriptive information has been included to provide greater detail.

Variable / Name	Focus On Body Size and Shape	Defer Locus of Control
Anne	√ Present pre-symptoms of ED - dieted - read fashiod magazines - always felt "huge" - over-exercised	√ - lack of well developed sense of self - felt pressure to be "perfect child" - felt out of control with respect to family abuse
Connie	√ Present pre-symptoms of ED - dieted - worried about weight - felt thin was better - over-exercised	√ - lack of well developed sense of self - overprotected at home and in marriage. 'treated like queen'. - felt out of control with respect to father's drinking.
Dianne	√ *Not present pre-symptoms of ED - dieted - concerned about being fat - over-exercised	√ - lack of well developed sense of self - felt pressure to be "perfect child" - felt out of control with respect to sister's drinking and mother's depressions

* Dianne did not have a sense of experiencing pressure about body size and shape, prior to the onset of her anorexia.

drinking episodes and worried he may abandon the family. Dianne felt out of control of her mother's depressions and confused when her mother did not respond to her attempts to make her happy.

Each woman described a lack of sense of self which seemed to be related to her perception of having to present a particular image. In a sense they each appeared to be sacrificing themselves as individuals to protect the family image, or to meet the family's perceived expectations for them. None of the women attributed this type of self-sacrifice to the role of woman in society in general, as has been proposed by the literature.

Family Issues:

Each woman saw her family life and her relationship with her parents as central to the development of her eating disorder. Of most significance was their parents' inability to meet their nurturing needs as children, which was expressed as their parents not being emotionally available.

While all of the women felt that family issues were the most important factor in the development of their eating disorder, the degree of concordance with variables identified in the literature was the lowest. In Table II that follows one can see that only three of the nine family variables were present for all three women. Five of the remaining six variables were present for two of the three women (see page 99).

Connie was the only participant to express a connection with social class and the development of her eating disorder. She felt that coming from a family that

Table II Family Factors

This table presents the family factors studied and indicates the presence or absence of such factors with a (√) or an (X) respectively. Where appropriate descriptive information has been included.

Variable / Name	Family Composition				Family Relationships				
	Social Class	History of Weight Problems in Immediate family	History of Depression in Immediate Family	History of Alcohol Abuse in Immediate Family	Enmeshment	Over-protective	Rigidity	Triangulation	Chronic Tension
Anne	• Father self-employed, no formal post-secondary education • Mother not employed outside home	√ • Younger Sister	√ • Mother	√ • Father • ? Mother	X • Presented as distant and disengaged family	√ • Had to present a good image to the community	√ • Father dictated right way	√ • Caught in conflict between parents and younger Siblings	√ • Threat of verbal & physical abuse
Connie	• Both parents professionals in management positions	√ • Sister and Brother • Mother	X • ? Father in association with drinking problem	√ • Father	√ • Very connected to mother and, in later years, to her father	√ • Mother sheltered children • Aware that mother tried to compensate for missing father	√ • Mother had established routines, in response to demands of "single parenting"	√ • Felt responsible for father's drinking	√ • Threat of father leaving and alcoholic episodes
Dianne	• Father Self-employed • Mother in para-professional position	X • No Report	√ • Mother	X • Not in immediate Family • Significant history in extended family	√ • Always connected to concerns of mother and family in general	√ • Felt Need to project good image to community	X	√ • Caught between mother's unavailability and of sister's drinking	√ • Mother's depressions and sister's drinking

$\frac{3}{9}$ Consistent for all three participants

$\frac{3}{8}$ Removal of social class which was not directly asked

was financially well off meant that there were greater pressures on the children to succeed. She also felt that from a practical standpoint, one needed to have good financial resources to sustain the expenses of regular binging activities.

A history of weight problems and depression in the immediate family was evident for two of the women. It is interesting that weight concerns were present in the families of the two women who struggled with being overweight prior to their eating disorder. It is of further interest that the people identified as experiencing depression within the family were also women. Both Dianne and Anne felt their mothers' depressions had a tremendous impact on their sense of family life, as their mothers were distant and emotionally unavailable. For Anne this emotional unavailability was also experienced as neglect.

Alcohol abuse was a consistent factor in the disruption of the home lives of all of these women. It is significant that Dianne in the course of seeking help, found herself joining the AA programme that her had sister attended. She felt through her work with AA that she too had a problem with drinking. She now feels that alcohol consumption exacerbated her compulsions around eating.

All three women felt that the dysfunction of relationships in their family had a significant impact on them and the development of their eating disorder. In examining these family relationship variables separately, three of the five variables were evident in families of all three women. Both of the two remaining variables were present for two of the three women. The following

discussion will initially focus of the presence of these variables in the women's stories. An analysis will then be conducted using the family models by Root and her colleagues (1986) to further explicate these variables.

The open-ended interview style made it difficult to determine the presence of **enmeshment.** It was most evident in Connie's presentation of her family and her early relationship with her mother. It is interesting that Connie is the only sibling in her family who is struggling for a closer relationship with her father. She seems to still be very "in-tune" to issues in her family of origin. Dianne's later relationship with her mother also appeared **enmeshed.** This relationship became very close, and it seemed to be more like a sibling relationship than a mother-daughter one.

An **overprotectiveness** about the family was strongly felt by all of the women, and each worked to present a good facade to those outside. They were all **triangulated** in the conflicts that existed within their family. All felt similtaneously responsible for what was happening with their parents and out of control of those events. All experienced a **chronic tension,** which was connected to the dysfunctional family relationships, the need to present a positive picture to those outside, and the inability to control what was happening inside the family.

Anne experienced the most **rigidity** of all of the women, which she connected to her parents' religious orientation. One had the sense that for Connie life was closely ordered, perhaps as her mother's way of coping with being a single

parent. Connie certainly felt that she did not fully mature in her home environment. One senses that her early life was perhaps chaotic and that in response Dianne became **rigid** in her own routines.

Family Models: An Illustration

Table III Family Models: Root, Fallon and Freidrich (1986)
In the table that follows each woman's family life is discussed in the context of each family model. The proposed family model for each woman is highlighted for ease of identificiation.

Variable / Name	Perfect Family	Overprotective Family	Chaotic Family
Anne	Anne's family life experience, was different from how she was told her family should look to the community. She was pressured into not discussing the abuse. There were rigid rules about how she should behave. She became the perfect child and food became the perfect addiction.	Anne's family experience did not match this model. The only parallel was her concern for how her family was seen in the community.	**This model most closely represent's Anne's family experience. Her parents were emotionally distant and abusive. She was triangulated in conflicts between her father and sister. She experienced rigidity in family roles and chronic tension.**
Connie	Connie did not comment on whether she felt pressure to portray a certain view to the community during her early family life. Her family life seemed much like that of the overprotective family.	Connie's family experience most matched this model. She had an enmeshed relationship with her mother, and felt triangulated in the conflicts with her father. She felt she was not ready to leave home. She remains protective of her family life experience.	**There may have been times when Connie's family experiece matched this model because of her father's drinking. However her mother's strong presence seems to give the family a stability that is not indicative of this family picture.**
Dianne	Dianne's family life experience was different from how she perceived it should be. She felt a pressure to portray a perfect family picture to those outside. She described having a mask for every occassion.	This model most represented Dianne's life after her mother's remission from cancer. She and her mother developed an enmeshed relationship. She also continued to be protective of the family image.	**Dianne's life, through her teen years, matched many aspects of this model. While there was no presence of abuse, her mother was distant and not emotionally available. Dianne became triangulated between her mother, the family, and community. She became a pseudoparent. She experienced chronic tension.**

In examining these families in relation to the family models proposed by Root and her colleagues (1986), one can better understand the lives of these women. The models provide both a context and a frame of reference for the connection of such seemingly diverse family experiences and the development of an eating disorder. Through this examination an interesting feature emerged. Each woman felt a strong need to present the facade of a **perfect family**, while their actual experience was very different. This phenomenon was most evident in Anne and Dianne's description of their family life, both of whose actual experience most fit the **chaotic family** model.

Connie's discussions were more focused on the present. She continues to be concerned about presenting a "good" image. She has not told anyone of her eating disorder besides her parents and her sister, who were invited to a therapy session. Her husband's family does not know of her binging and purging activities, and she is anxious that they not find out. Connie's discussions of her present life and her comments about her early life most matched the **overprotective family**.

Dianne's story was initially difficult to situate in these models until it became evident that she had at least two distinctive family experiences. The most significant demarcation was her life before and after her mother's treatment for cancer. Prior to this treatment Dianne's mother had been distant and unavailable as a mother. Her oldest daughter was out of control with respect to drinking and family life was very disrrupted. While Dianne's family does not

fit the abusive component of the **chaotic family**, it best represents the emotional distance and disorganization that seemed to have marked her teenage years in this family.

Although Dianne was not living at home after her mother's treatment for cancer, one senses that her relationship with her mother after this time had a profound effect on her. This relationship seemed to be best symbolized in the presentation of the **overprotective family**, in that Dianne and her mother experienced a close and perhaps enmeshed relationship. Although Dianne enjoyed a closesness during that time, she felt that the relationship was fragile and in need of protection. One senses that Dianne would have liked to confront her mother on the loneiness of her childhood and to discuss with her the many conflictual emotions she experienced.

These family models allow for the unique expression of the identified family variables which gives them a life and context. The reader, and perhaps the clinician, is able to go beyond the confines of static definitions of family relationships to a more dynamic and interactive view. **Overprotectivenss, triangulation, and chronic tension** were consistently present for each woman despite other configurations of the family. These issues seem to be most central to their pressure to exhibit the facade of being in the **perfect family**. This connection will be examined in greater detail in a later section.

Personal Factors:

One is struck by the consistency of each woman's story in the discussion her obsessions with food and body size. In fact they each used very similar words to describe the overwhelming compulsion to binge, and the extreme nature of their obsessions and eating behaviour. Each emphasized that people who have not experienced an eating disorder would not truly understand these issues. This is particularly significant as Connie has not been formally diagnosed as having an eating disorder, yet her presentation was very similar to the other women.

Each woman saw her eating disorder as being symbolic of a larger emotional problem. Connie described her binging episodes as "filling an insatiable void", while Connie and Dianne described binging episodes as a way of coping with their emotions. All felt that the eating disorder served to distract them from the emotional issue they needed to address.

Like most of their mothers, each of these woman have been battling depression since adolescence. In fact each woman's first search for help was centred around treatment of depression. The presence of depression can be understood in the context of their unsettled family lives, and yet each woman felt that her high personal standards and sense of not having achieved to those standards was also significant.

In Table IV that follows, personal factors identified in the literature are compared with the life experience of each woman.

Table IV Personal Factors

This table presents the personal factors studied and indicates the presence or absence with a (√) or an (X) respectively, where appropriate descriptive information has been included.

Variable / Name	Demographics		History			Eating Habits						Distortions of Body Perception		
	Sex (controlled)	Age	High Achievement	Depression	Sexual Victimization	Dieting	Rituals	Obsession	Binge	Purge	Fear of Overeating	Recognition of Hunger and Satiety	Distortion of Body Image	Distortion of Influence of Body Shape
Anne	F	Present 24 Onset 15	√ • Need to be perfect child • Presently feels under-achieving	√ • Saw psychologist	X • Physical abuse	√ • Since late childhood	√ • Food Preparation	√ • Food and Weight	√	√ • over-exercise • later self-induced vomiting	√	√ • No influence on when or how much to eat	√ • Always saw self as huge	√ • Needed to be thin to be happy
Connie	F	Present 28 Onset 24 ? a weight loss as a teen	√ • High personal standards • Underachieving	√ • Saw and still seeing psychologist	X • not reported	√ • Since early adolescence	√ • Food Preparation and consumption	√ • Food and Weight	√	√ • over-exercise • has tried to induce vomiting	√	√ • Anxious because cannot tell	√ • Over-estimated weight	√ • If lost weight felt fabulous • Gained weight, depressed
Dianne	F	Present 31 Onset 21	• Perfect child • High standards for self and others √	√ • Saw at least 3 psychologists	X • not reported	√ • During eating disorder	√ • Food Preparation and consumption	√ • Food and Weight, after anorexic period	√	√ • over-exercise • self-induced vomiting	√	√ • denied hunger • Amount of food little influence on satiety	√ • During anorexia felt fat at 87lbs	√ • Felt need to lose more weight, anorexic process

$\frac{11}{14}$ Present for all three participants.

$\frac{10}{13}$ With removal of sexual victimization variable which was not directly asked.

When comparing these women's stories with the personal variables identified in the literature, six of the nine variables were present for all of the women. All of the remaining three variables were present for two of the three women. Of particular interest in this discussion are two factors not directly identified in the literature that were expressed by all of these women. They are, a lack of an internalized sense of self, and suicide ideation.

Each woman reported feeling "different" and felt she did not fit in easily with others. For Anne and Dianne this was recognized at a very early age. Each woman reported a poor sense of self, both with respect to self-esteem and personal identification. Each felt that they were not performing to their potential, and there was a quality of self betrayal in each woman's discussion of her education and career. Their underachievement in the face of high personal standards was confusing for each of the women. This confusion is embodied in Connie's statement that she feared success more than failure.

This lack of an internalized sense of self may also be understood in both a familial and socio-cultural context. Each women presented a sense of responsibility for family life events that were ultimately out of her control. Each also felt a need to maintain an external facade that the family was okay. Finally each woman expressed a sense of societal pressure about how a woman should look. There were strong external pressures on these women which they saw as having impacted on their perceptions of themselves.

Of further significance is that each woman reported at least one episode of suicide ideation, and Anne reported three actual attempts to commit suicide.

The suicidal thoughts were seen in the context of depression and most frequently surfaced in association with a despair in being unable to control the binging and purging cycle. Each felt a sense of hopelessness and described feelings of; "it hurt too much to go on ", "wishing the pain would just end" and " wanting to end it all".

The report of suicide attempts and suicide ideation reflects the level of despair and detachment felt by these women. They each reported being concerned and disturbed by these thoughts and each went through a time where she questioned her own sanity. Ironically the depression and suicidal thoughts also seemed to help break down their denial about their eating problem. It was at this point of despair that all began to seek help. It was as if they needed to "hit bottom" before they could be receptive to help.

Summary

The process of comparing these women's life stories, both with each other and with the variables in the literature, further highlights how these personal, family and socio-cultural issues are intricately interwoven. A closer examination of the personal factors reveals that many are rooted in familial and societal issues. Furthermore, some family variables can also be connected to socio-cultural expectations. This apparent interweaving of variables will be explored in greater depth in the next section, drawing on the insights provided by this data in light of the concepts identified in the literature.

B. A re-consideration of the data and the knowledge and concepts drawn from the literature.

The challenge in understanding the developmental processes for eating disorders is in moving past the strange and fascinating behaviour. In many ways researchers and clinicians have mirrored the dilemma of the eating disordered person, in that the eating rituals have often distracted from the underlying issues that need to be addressed. This discussion attempts to bring together the collective wisdom of the existing literature and the information provided by the women in this study.

Socio-cultural Expectations

Socio-cultural expectations affect individuals and families, and yet the intangibility of these factors often make them hard to identify. Societal pressures predispose women to be more focused on body shape and attractiveness than men. They are encouraged to be passive and to defer to the needs of others. Self-satisfaction is externalized, therefore self-determination is exercised through the control of external events, such as the control of food.

These associations are hard to see in the everyday lives of people and families. It is not surprising then that the women in this study most strongly connected societal pressures with the idealized portrayal of the woman's body in the media, and not with the socialization and role expectations for women. Yet these secondary issues were evident their stories, they were just expressed in more subtle and indirect ways.

One of the consequences of the socialization to be passive is that one must find indirect ways to express personal views and emotions. Furthermore authors such as Orbach (1986) and Root and her colleagues (1986) maintain that this type of loss of control contributes to the development of depression.

Depression and an inability to express emotions were consistently identified by the women in this study as being a significant issue in the development of their eating disorder. Furthermore, two of the three women indicated that their mothers experienced depressions which interfered with their ability to nurture their daughters.

A further consequence of this socialization of women is that they may be more at risk of becoming triangulated in the conflicts of the family and the marital relationship. The desire and expectation for women to be self-sacrificing means that even at a young age they may be drawn into conflicts as a way of preserving the family. All of the women in this study had been triangulated in family conflicts and felt a responsibility towards maintenance of the family. Each of the women identified that they felt out of control of these life events and that mastery of eating helped to substitute for this lack of control.

Finally, societal structures continue to permit violence in families and women are more likely to be the victims in this violence. Furthermore, the recent literature (Root, et al, 1968; Oppenheimer, et al, 1985) also points to sexual victimization in association with eating disorders. None of the women reported any victimization experiences , however one woman identified physical abuse as being present in her home life. She felt this abuse had a profound affect on

her and was connected to her development of an eating disorder. While abuse may be seen as a variable of the family, it must also be understood in the context of societal structures that place women more at risk to be victimized.

Family Composition and Relationships

The family is a pivotal component in personal development. It is the place for nurturance and caring, and it is also the forum for transmitting the values and beliefs of the culture and the family. Parents bring to a marriage their own family experiences and beliefs which become blended with societal expectations, such that each family's life has a distinctive character.

The family models proposed by Root and her colleagues (1986) served as an excellent medium through which to see both the common and the unique aspects of the families described in this study. Through the use of this model the seemingly diverse experiences began to reveal a common thread, without diminishing the specific character of each family. Triangulation, overprotectiveness, and chronic tension emerged not only as common issues, but as a significant pattern in the web of the development of the eating disorder.

The family models also served to emphasize how each woman's perception of her life experience differed from her actual experience. All of the women felt a need to portray the perfect family, yet their actual experiences were more indicative of the chaotic or overprotective families. The source of this pressure

to reflect a perfect family may not have only come from within the family, but may have also been experienced by these women as their family not meeting a perceived ideal.

These women were puzzled by their family life and they continue to search for the answers which will help to make sense of their experience. Anne remains hurt by her abusive experiences and the hypocrisy of her father. Connie continues to seek a closer relationship with her father and to understand why he was not able to be available to them as children. Dianne remains conflicted about her relationship with her mother and still seeks an understanding of her mother's depressions and distance in their early life. All of the women saw their unresolved emotional issues as centred in this family experience.

Personal Characteristics

That these women survived and developed is a tribute to their strength as individuals. It is in this sense that they are truly unique women. However their eating disorder was viewed both by them and by many of the professionals who treated them, as belonging uniquely to them. The bizarreness of their behaviour and the consequent shame and guilt attached to the behaviour, caused these women to be very isolated even within their family and marital relationships. This isolation no doubt further reinforced the view that they somehow "deserved" the eating disorder.

The previous discussion of socio-cultural and family issues reveals that many of the variables ascribed to the individual are rooted in the family and ultimately

in society. In fact when one removes these factors such as; sex, high achievement, depressions, victimization, dieting, obsession, and distortions of body perception, one is left with the eating and purging rituals. Yet even these rituals have also come to be understood in the context of imposing control over life events.

Two variables not directly raised in the literature, but consistent in the presentation of each women's story were, a lack of internalized sense of self and suicide ideation. These were two pivotal issues for each of the women in the emergence of the eating disorder.

The lack of sense of self was in many ways symbolic of how out of control these women felt in their lives. The journey to self-discovery was perhaps the most painful part of their search for help. This is embodied in Connie's story as she is still very much struggling with her eating rituals. Her search for a sense of self continues to be a difficult and bewildering process. Her intelligence and ability to be introspective perhaps only add to this confusion as she, and no doubt others, find it difficult to understand why she should be struggling at all.

Through each woman's story there was a overwhelming sense of loneliness and isolation. Their family lives, the sense of opportunities missed, the uncertainty about who they were and what they wanted, combined to create "an insatiable void" in their lives. While their eating disorder came to be seen by others as desperate, their despair was somehow missed. One senses that no one knew of

their suicide ideation or how difficult living had become for them. Anne's younger sister was aware of her attempt to overdose, but both were powerless to seek help as this would mean admitting their family had a problem.

Summary

For all of these women, leaving home provoked a crisis which brought them in contact with treatment systems. They also felt that their high personal expectations, and their consequent disappointment with their families "fuelled" their eating disorders. All of the women also felt a responsibility and an inability to control the conflicts which occurred in their homes. Each of these processes first appear to be only connected only to the family; however the discussion in this section also revealed connections with socio-cultural expectations. This reinforces the initial assertion from the review of the literature that the constellation of factors should be viewed as a set of "nested structures, like a set of Russian dolls" (Broffenbrenner, 1979).

The crisis on leaving home was symbolic of the poor internalized sense of self expressed by these women. Their sense of self was determined in relation to others in the family and thus their frame of reference for self no longer existed once they left home. This conceptualization of the role of the eating disordered person is represented in the literature as an overprotective stance within the family. While their sense of self is rooted in perceived family expectations, it also connects with societal expectations for women to both act and appear in idealized ways.

The women in this study felt that their perfectionistic tendencies combined with the lack of outlets for emotional expression, created resentments and dissatisfaction that in turn, "fuelled" their eating disorder. While these qualities are clearly expressed by the individual, the perfectionism and inability to express emotions, are rooted in both the unique dynamics of the family and the societal pressures on women.

Finally, the eating disorder is also seen as symbolic of the women's struggle to gain mastery over her life. In both the literature and in the lives of the women in this study, the struggle to control life events is seen as central to the emergence of an eating disorder. Triangulation in family conflicts, an overprotectiveness which led to the portrayal of the "perfect" family, and the chronic tension experienced by ultimately being out of control of these events, are seen as the significant contributing factors. While these issues are clearly the experience of the family, they must be also understood in a societal context where women are prescribed to be nurturing and self-sacrificing.

These assertions are not meant to diminish the uniqueness of the individual. We are all different by the very nature of biology and the unique combination of our parents' genetic fabric. Rather this is an attempt to broaden the view of the developmental processes for eating disorders and to challenge our fascination with the strange eating behaviours. In this context the depression, suicidal thoughts, and bizarre eating habits experienced by the eating disordered person, come to be seen as not centered in the individual, but in the context of family societal pressures.

This context broadens the view of the origins of the problem and also allows for a greater span of intervention strategies. These strategies will explored in the following section.

C. Examination of the issues for social work practice:

Each woman in this study expressed frustration and despair in her struggle to become well. All of the women felt that their eating disorder was not understood by the professionals they met. Each woman therefore felt that professionals needed to better inform themselves about the symptoms and treatment interventions for eating disorders. Dianne particularly felt that her professional contacts only increased her sense of frustration and helplessness. Connie, while satisfied with the treatment received by her doctors, had some demoralizing experiences in emergency treatment. In many ways these women progressed in spite of the treatment systems, rather than because of them.

The previous analysis also poses a challenge to the social work profession to provide intervention strategies that move beyond the behaviour of the individual. The profession's orientation of viewing the person in the context of a family and a community, means that it is uniquely equipped to meet this challenge. Yet two social workers who referred participants for this study, had not been involved in the treatment of their client's eating disorder. Rather, their treatment was focused on emotional, marital, and family issues. However one social worker expressed concern that she was not professionally equipped to directly address the eating behaviour. Her client sought this treatment through a psychiatrist.

There is tremendous shame and guilt experienced about the eating behaviour. Consequently there is a high degree of denial and secrecy which makes identification of the eating disorder difficult. It appeared that for the women in this study the prompting of relatives served to lead to questions about the eating disorders. Anne's husband first raised the question of bulimia, Dianne's sister sent her reading material on anorexia and Connie's colleagues began whispering "anorexia". All of the women had immediately dismissed any such possibility, but were later able to see that these questions matched some of their own unspoken misgivings.

The prevalence of depression in this population, was confirmed by the experiences of the women in this study. This means that the professional is more likely to first be referred a woman who is seeking help for depression. For the women in this study their eating disorder emerged as either a secondary problem, or was seen as connected to the depressive symptoms. For Dianne this was a frustrating connection, as she felt the symptoms of her eating disorder were ignored.

Alcohol abuse was identified in the literature as present in eating disordered families. However for the women in this study it impacted on their lives in a more significant way than is imparted by the literature. Alcohol abuse was seen as a major contributor to the disruption of their home lives. For Anne and Connie, it seemed to interfere with the ability of their fathers to be stable or nurturing figures. Dianne felt through her treatment experiences that she too had a drinking problem. She felt in retrospect that alcohol use exacerbated her eating obsessions.

Societal pressures and expectations for women appeared to connect to many of the issues seen as significant in the development of eating disorders. Of interest is the fact that the women in this study who were most impacted by the media portrayal of women had been overweight as adolescents. They also came from family backgrounds where weight control had been a problem. It appears that overweight women may be more susceptible to these external pressures and more likely to have well established dieting rituals before the onset of the eating disorder.

Each woman felt that they needed two levels of treatment, one that specifically addressed the eating behaviour, and another that examined the underlying emotional issues. Too often treatment approaches they had experienced had not directly addressed the eating behaviour and this led to an increased sense of hopelessness.

Anne and Dianne felt that the self-help mechanism, particularly through Overeater's Anonymous, was an essential component to treatment. Each felt the guilt and secrecy she experienced could only be overcome in a milieu where there is complete understanding. They also felt that this was the only place where they could receive the support they needed to give up their binging and purging behaviour.

This may also be reinforced by Connie's experience. She feels she needs more help in controlling her eating behaviour, and feels great despair that she will not be able to bring them under control. She feels guilty about imposing on others for support, yet feels that she needs more direct help if she is gong to

conquer the binging and purging behaviour. To date her psychiatrist has not supported involvement in Overeater's Anonymous, and while Connie did attend one meeting she felt the program was not for her.

Each woman felt that social workers could be most helpful in dealing with the emotional issues stemming from family and marital life. The challenge for the social work profession will be to frame treatment interventions to include the broader view of this problem.

CONCLUSIONS AND RECOMMENDATIONS

Anorexia and bulimia nervosa are multi-determined conditions. The literature points to three constellations of factors as significant in the emergence of eating disorders. These are: socio-cultural norms and expectations, family composition and relationships, and personal characteristics. It was felt that these factors are consistent with the social work perspective in its focus on the individual in the context of a family and community.

This study explores three women's experiences with the emergence and treatment of an eating disorder. A qualitative method was chosen as most of the published literature on eating disorders is quantitative, or presented from the clinician's perspective. It was felt that studying the client's subjective reality, while inherently biased, offers a unique opportunity for social workers to gain insight into the client's view of her situation. This information is fundamental to the social work profession's premise of starting "where the client is" and provides a rich base for meaningful intervention.

The study examines, through the medium of in-depth personal histories, the life and treatment experiences of women who had been diagnosed as having anorexia nervosa, bulimia nervosa, or both. It was decided to study an exclusively female population because the literature was built mainly on the experiences of women. Participants were located through local private practitioners using a snowball technique. Interviews were conducted by the researcher using a non-scheduled interview format, which focused on allowing each woman to tell her life story.

Data collation was conducted by the researcher in order to facilitate later analysis. Data analysis was conducted on three levels: (a) a discussion of the commonalities and differences between each woman's story, and the concepts identified in the literature, (b) a discussion of the insights provided by the data and a re-consideration of the concepts and knowledge drawn from the literature, and (c) an examination of the implications of these results for social work practice.

The comparison of each woman's story revealed a high degree of consistency. This was particularly evident in the descriptions of their obsession with food and body shape, and in their view of eating disorders as distracting from more deep-seated emotional problems.

The examination of the participant's responses in relation to the variables presented in the literature, also revealed a significant degree of consistency. One deviation was evident in the presentation of socio-cultural issues. While the participants felt that they did experience a loss of control in their lives, they did not attribute this to socio-cultural pressures. Most saw this as a reflection of personal and family pressures.

There was a lower degree of internal consistency with respect to family variables as only three of the nine variables were present for all women. However three of the five family relationship variables (overprotectiveness, triangulation and chronic tension) were present for all three participants.

The family models proposed by Root and her colleagues (1986) were seen as an effective tool for analyzing family relationships. Two families were seen as

primarily chaotic, while the third was seen as overprotective. One participant was given a secondary family model assignment, as there had been significant changes in her family life. All of the women experienced a pressure to present the facade of a "perfect" family, while the internal family experiences were different.

The analysis also revealed two consistent issues which were not directly raised in the literature. These were: (a) a lack of internalized sense of self, and (b) prevalence of suicide ideation.

Implications for Social Work Practice

This study revealed a great deal of frustration with health care professionals. The women interviewed progressed more in spite of the professional help they received, than because of it. All felt that professionals needed to be better informed about eating disorders. Two of the three women felt strongly that a self-help component was essential to treatment. Each felt that social workers could be most helpful by addressing the emotional concerns underlying their eating disorder. By being sensitive to the underlying emotional issues, social workers may also be effective in initiating early intervention.

The secrecy, shame, and guilt, coupled with the masked presentation in depression make this population difficult to identify, particularly if weight loss is not an issue. Social workers concerned about early intervention with this population must be sensitive to the other more subtle signs, such as concern with body shape, over exercise, an overconcern about food, and perfectionism.

Alcohol abuse was present in all of the families and was seen as a significant part of the family disruption. Social workers in their intervention with alcoholic families will need to be aware of this association and may need to more actively screen for eating disorders in the children.

These women all sought medical treatment for the physical side effects of their eating behaviour, such as low blood pressure and fatigue in over-exercising, and severe weight loss. However their eating disorder was either not identified or not explored during this contact. In fact Connie and Anne were instructed to give up the over-exercise, which led each seek to replace the over-exercise with equally self-injurious behaviours, as their binging continued. Anne chose self-induced vomiting. Connie ended up seeking treatment through emergency departments as she was unable to induce vomiting.

This further reinforces the need for professionals to be sensitive to the subtle cues that may indicate a larger problem. Since exercise and fitness are viewed as healthy, it is often difficult to view exercise as potentially destructive and self-injurious.

Eating disorders are seen to represent and perhaps distract from more deep-rooted emotional problems. All of the women felt that these problems were centred in their families. Each woman felt that they needed two levels of treatment, one that specifically addressed the eating behaviour, and another that examined the underlying emotional issues. Too often treatment approaches they had experienced had not directly addressed the eating behaviour and this led to an increased sense of hopelessness.

Anne and Connie felt strongly that professionals should support use of self-help groups such as Overeater's Anonymous. Each found that she experienced true understanding in the milieu of others who had been through the same problems. The eating behaviours appear take on a life of their own that requires treatment, in addition to the underlying emotional problems. All of the women felt that they needed the very active support provided by the self-help group in order to give up their eating rituals. This support came from having a sponsor who is available twenty-four (24) hours a day.

The women also felt that they had difficulty with emotional expression, which impacted on their ability to form close relationships. Connie and Dianne reported being very controlled in relationships and feared abandonment. Dianne's first marriage ended in divorce when the relationship could not withstand the turmoil of her search for help. Connie is presently in martial therapy and concerned about the impact of her eating disorder on her relationship with her husband.

Recommendations for Further Research

This study provides a rich base of information that may be followed in both quantitative and qualitative research methods. Certainly the participants in this study felt that there was room for more research and knowledge, particularly from the client's perspective.

It would be helpful to understand the prevalence of eating disorders in Canada and Newfoundland. To date these numbers are not available. It would also be

important to do more longitudinal studies to determine the proportion of sub-clinical eating disordered individuals who later develop clinical diagnosis, and to determine if there are distinguishing factors for this group.

Socio-cultural factors require a more in-depth analysis as they appear to permeate all aspects of these conditions. These women felt they were strongly impacted by media portrayal of an idealized body shape. They however did not report that issues of loss of control, and deferral of control to others, as centred in societal values. These factors were mainly seen as reflective of their family lives and who they were as individuals within that family structure.

It will also be significant to study a group of men to understand the unique aspects of their conditions, as well as to further explore the impact of socio-cultural norms.

Family relationship issues need to be examined in a more controlled way, perhaps using the family models presented by Root and her colleagues (1986) as a framework for examining family relationship variables. One wonders how the stories of parents and siblings would differ from the perspective of the individual with an eating disorder, and how these perceptions would compare to clinical observations.

Connected to this, is a need to explore treatment methods, particularly for social workers. It is clear that family and socio-cultural issues will be of particular interest to the social work profession. Investigation of family issues

may be directed towards the efficacy of family intervention approaches. While socio-cultural pressures may be addressed through an examination of prevention strategies, such as public education programs.

Limitations

These implications and recommendations must be viewed in the context of the limitations inherent in this study. The qualitative approach, while providing rich information, presents only the subjective view of the individual participants. The stories reflect the collective memories of the women interviewed and the information may be incomplete or perceptions influenced by the passage of time.

The small number in the sample population and the method used for locating the sample, further limit the generalizability of this data.

The non-scheduled format for data collection, while allowing expression of subjective reality, was open for bias in interpretation by the researcher. Furthermore the data analysis process relied on the judgements of the researcher and while there were objective criteria used to facilitate analysis, the possibility of researcher influence remained.

These limitations not withstanding, there is a wealth of data provided by this study which can be used to both inform social work practice, and to highlight future research needs.

APPENDIX A

Introductory letter and consent form

Dear________________:

Ms.Beverley Antle is a graduate student in the School of Social Work at Memorial University in Newfoundland. She has approached us for assistance with her research project which is part of the requirements for her Master's degree. She is interested in studying anorexia nervosa and bulimia from the client's perspective.

Ms. Antle will be interviewing a total of four women. We are approaching you regarding this research because we thought you would be interested in this project. We have enclosed a brief outline of the goals of the research and what would be involved should you choose to participate.

You are under no obligations to participate in this study. If you choose to not to be referred, simply let our staff member know when he/she calls.

Thank-you.

Sincerely,

Outline of Research Goals and Methods for Potential Participants

This is an exploratory study of the relationship between social, family and personal experiences and the development of an eating disorder. The study is focused towards the clients' perceptions of their life experiences and the development of an eating disorder, as well as the clients' feelings towards past treatment experiences.

This research is intended to improve social work strategies for treatment, through a greater insight into the feelings, attitudes, and experiences of the client. Emphasis will be given to developing strategies for early intervention.

This information will be obtained through personal interviews. Ms. Antle will first contact anyone who has expressed an interest in participating and arrange for a meeting. This will allow participants to actually meet Beverley, as she will be conducting all of the interviews, before making a final decision about participating. Anyone who is interested will be asked to sign a consent form in order to participate.

Some risks related to this research approach have been identified. Previous studies show that one of the major risks associated with this kind of study relates to problems of ensuring that participants cannot be identified in the written report of the research. Ms. Antle will be preparing the results of this study so that personal identifying information will not be included, and so that personal comments cannot be attributed to a particular individual.

A second potential risk is that participants' may find they report more information during the interviewing process then they had originally intended. Participants may also re-experience unexpected feelings and emotions in relation to past events or behaviours. It is felt that both of these risks can be reduced by presenting participants with this information prior to the study.

There may also be benefits for participants in this research. They may derive a secondary therapeutic benefit through being able to relate their life story. In addition, participants may experience a sense of satisfaction in contributing to professional research and treatment directions.

Ms. Antle will be available in the initial meeting to review the study in greater detail and to further discuss the potential benefits and risks of this research.

The study will consist of two parts:

1. an initial interview that will be audio-video tape recorded. Beverley will not be following a strict questionnaire and therefore emphasis will be placed on participants being able to tell their life story. If participants wish, they will be given a copy of the audio-video tape for their review before the final interview.

2. a second "review" interview will be held to clarify any information given in the first interview and to answer any questions or concerns. This interview will be approximately one to one and a half hours.

The timing and number of interviews may be re-negotiated prior to the first interview.

All information will remain confidential. In the final report, all personal information will be written so that individuals may not be identified. Upon acceptance of the thesis by Memorial Unversity of Newfoundland, the audio-video tapes and any written transcripts will be destroyed. The thesis will be available in the School of Social Work and the Queen Elizabeth Library at Memorial University.

Consent to Participate in Research

In signing below I acknowledge that I have read and understand the following information regarding this research.

1. The purpose of this study is to gain a greater understanding of anorexia nervosa and bulimia nervosa from the client's perspective.

2. Beverley Antle, the primary researcher, is a professional social worker and this study will serve as part of the requirements for her Master of Social Work Degree.

3. The results of this study will be kept confidential and will be reported in a way that the women involved will not be identifiable. Upon acceptance of the thesis by Memorial University of Newfoundland, the audio-video tapes and any written transcriptions will be destroyed by the researcher. The thesis document will be on file in the School of Social Work and the Queen Elizabeth Library at Memorial University.

4. The risks and benefits associated with participating in this project have been satisfactorily described by the researcher, both verbally and in writing.

5. Participation in this study is completely voluntary and I may withdraw at any time. Furthermore, the choice to participate will not affect in any way my relationship with the referring person and/or agency.

6. In agreeing to participate in this study, I will be available for two interviews. The first interview will be a approximately three hours and may

be broken down into two interviews. The second interview will be approximately 1-1 1/2 hours. The first interview will be audio-video tape recorded. I will be provided with a copy of the tape and may provide feedback and clarification to the researcher.

Signature________________________ Date ______________

Witness _________________________ Date______________

APPENDIX B

INTERVIEW GUIDE

INTERVIEW GUIDE

PERSONAL

- demographics
- high achievement
- depression
- victimization

FAMILY SOCIO-CULTURAL

-socio-economic status
-history of affective, addictive
- depressive, and eating disorders
- enmeshment
- overprotection
- triangulation
- chronic tension

EATING HABITS

- dieting
- fear of over-eating
- ritualization
- binging/purging
- food obsession

BODY- CONCEPT
- perception of size
- perception of hunger
- influence of body size
- fear of fat

TREATMENT EXPERIENCES

- actual
- most/least helpful
- family reaction
- sources of support
- comments for SW

SELF-CONCEPT

- influential factors
- previous goals/now
- role of ED
- now vs then

- shape/thinness
- published diets
- locus of control

RETROSPECTIVE

- personal theories
- early signs
- changes since ED
- suggestions for SW

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