Toward a Multi-factorial Model of Eating Disorders: Integrating the Patient's Perspective

by

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For my family.

Table of Contents

Acknowledgments

So many individuals have contributed to the creation of this work, in large ways and small, knowingly and unknowingly.

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Introduction

Eating Disorders: An Integrative Approach

When I set out to study factors involved in the etiology of, and recovery from, eating disorders, I sensed that the clinical entity I had chosen to research was only the tip of the phenomenological iceberg. My own experience told me, and subsequent research confirmed, that full-blown eating disorders are the extreme expression of a more pervasive process underlying women's development in Western society. This process, which accelerates at adolescence, is characterized by a loss of subjecthood, a muting of voice and disconnection from the self which, to a greater or lesser extent, marks us all as we enter adulthood. In the vast majority of women, the experience is reflected in disturbed body image, in a preoccupation with weight, size and appearance that drains energy and creativity. In young women who go on to develop an eating disorder, the process results in a wholesale loss of voice and diminution of self that is literal as well as figurative.

Why is it, then, that of all women who are subject to this process only a fraction, albeit a substantial fraction, go on to develop a clinically-definable eating disorder? As Erik Erikson has noted, the crucial question concerning a neurosis has always been whether the cause of the disturbance lay within the individual, or in his or her society (Erikson, 1963). In the area of eating disorders, both schools of thought have been endorsed by various theorists: Those who implicate factors within the individual cite physiologic and endocrine disturbances, psychoanalytic factors and pathological family interactions; those who would attribute the cause of eating disorders to society describe a pathological focus on women's appearance, pressures on women to

be thin, and competing expectations of traditional femininity and "male" success. The literature in this area is now so diverse and contradictory that it is difficult to see the proverbial forest for the trees, or, more precisely, the clinical entities for the theories which seek to define them.

What becomes clear, after three decades of research on anorexia and bulimia, is that these disorders, like neurotic symptomatology in general, are highly overdetermined (Erikson, 1963) The development of an eating disorder represents a confluence of factors within the individual, both physiological and psychological; between an individual and her family; and between her and the larger society with which she daily comes in contact. As Naomi Wolf notes in her essay, *Hunger*, "There is a disease spreading," and it is a disease so selective in the demographics of its victims that it is impossible to dismiss its sociocultural context (Wolf, 1991, p. 179). Nonetheless, we do a disservice to women afflicted with eating disorders if we fail to appreciate interactions between self and society, the way in which vulnerabilities in certain persons or groups of people may cause them to be more susceptible to social forces.

This work represents an attempt to develop a holistic, integrative model to describe the etiology and course of anorexia and bulimia nervosa. The research described consists of interviews with former patients treated for eating disorders at Stanford University, who were seen initially between 1985-1991. These interviews are used to explore a) commonalities and differences in the experience of women with eating disorders, and b) factors involved in recovery. It is critically important to understand both processes influencing all women, and variation in women's response, in order to mount strategies effective for both prevention and treatment of eating disorders.

A Feminist Research Perspective

The research described in this thesis is grounded in the principles of feminist scholarship, both methodologically and epistemologically (Fonow & Cook, 1991). The qualitative design of the interview study reflects a personal commitment to the goals and methods of feminist research. I was particularly concerned that the interview avoid the following problems found in traditional research:

- The illusion of objectivity;
- The imposition of categories, and the distortion of subjects' voices to accommodate these;
- The exploitative, hierarchical relationship between researcher and research subject.

Objectivity

"The requirements of...correctness in practical judgments and objectivity in theoretical knowledge...belong as it were in their form and their claims to humanity in general, but in their actual historical configuration they are masculine throughout" (Simmel, 1926, quoted in Horney, p. 200).

Feminist critiques of traditional methods reject the notion that scientific research is value-free. Keller has suggested that the high regard in which objectivity is held in the scientific community reflects the underlying bias of male scientists, whose psychosocial development has been based on concepts of separation and distance (Keller, 1985). Keller, with others, has noted that quantitative data methods reflect traditionally "male" values of objectivity, separation and distance (Jayaratne & Stewart, 1991). When these values are applied to interview methods, there emerges a reductionistic

approach that results in the objectification of the person being interviewed, and obfuscation of that individual's experience.

Feminist researchers reject this approach on two counts. First, they note that objectivity in research is in fact not attainable. Scientists inevitably bring personal motivations, interests and theoretical schemae to their research efforts. A geneticist studying intelligence is inclined to look for heritable causes; a sociologist seeking to unravel differences in math performance between men and women will tend to look for environmental (e.g., parental and teacher) influences.

Second, feminists suggest that, even were it possible, objectivity would not be desirable, since women's subjective experience has been largely ignored through the emphasis on quantification and objectivity. Instead, the process of interviewing women should serve as a means to give voice to their experience, as "a strategy for documenting women's own accounts of their lives" (Oakley, 1981, p. 48).

The restoration of voice, while applicable for all research participants, is particularly important for women who have suffered from eating disorders. Frequently these women have little sense of efficacy or self-worth, and typical quantitative studies, which require no more self-expression that is revealed by a Likert scale, may perpetuate a sense of ineffectiveness. The interview, therefore, was designed to allow women to express their perceptions, convey their experiences, and offer their own insights into the problem of eating disorders.

Self-Fulfilling Categories

"As a researcher, I have learned that critical areas demanding attention are frequently those where I think I already know what the woman is saying.

This means I am already appropriating what she says into an existing schema, and therefore I am no longer really listening to her" (Anderson & Jack, 1991, p. 9).

Any interview that is not entirely open-ended runs the risk of creating self-fulfilling categories: that is, of creating categories into which subjects' responses are fitted, more or less appropriately. An awareness of this danger guided my attention to the development of hypotheses and categories.

While the interview was designed to be somewhat open-ended, it was not entirely without structure. The aim was to suggest general areas of relevance for exploration, without imposing categories which did not reflect my subjects' experience. Thus, I did formulate tentative hypotheses, but I tried to remain open to other associations that would emerge from the data. My approach approximated that offered by some feminist researchers: "To the greatest extent possible, one strives to allow the categories to emerge from the data themselves, rather than from a pre-conceived theoretical or empirical framework" (Jayaratne & Stewart, 1991, p. 93).

Hierarchy and Reciprocity; An Action Orientation

"The goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her personal identity in the relationship" (Oakley, 1981, p. 41).

Traditional methods have also been criticized for their tendency to create a hierarchical relationship between researcher and subject, in which a power differential operates to insure that the imparting of information is a one-way process. The interviewee responds to the researcher's questions, but is not permitted to depart from the planned format nor to pose questions of

her own. Moreover, the subject is not involved in the interpretation of the results, and may indeed never learn of the researcher's analysis.

In my interview, I attempted to minimize this research hierarchy. Whenever practical, the 45 to 60-minute interviews were conducted in person, preferably at the interviewee's home. If this was not possible due to geographic distance, we spoke over the phone at a mutually convenient time, when privacy could be insured. When questions arose about the nature of the study, my role in it or my personal motivations for research, I answered these as completely and honestly as I could.

I communicated to each interviewee that her perspective was greatly needed in eating disorder research, and was greatly appreciated by me, personally. I also assured each participant who expressed an interest that I would be pleased to share the results of the study, particularly the interview data, with her. Lastly, I assured each person that if she had more questions or would simply like to discuss the issues we'd raised further, I would be happy to talk to her.

In addition to reducing the research hierarchy, a feminist research orientation implies that research should serve an empowering role for its subjects (Pesquera, 1993). I anticipated that my research would prove helpful to my subjects in several ways: First, by restoring to these women some of their lost voice and subjectivity, I would be countering some of the disempowering effects of their illness. Second, I hoped that, through the results of the interview data, they might benefit from the insights of other women with eating disorders. Finally, I anticipated that my research would have implications for the reformation and improvement of eating disorder treatment programs.

The text of this paper presents the research data in the context of past observations and theory about the etiology and course of eating disorders. The First Chapter describes the clinical and demographic features, treatment and outcome of these disorders. The Second Chapter characterizes the major theories regarding the etiology of anorexia and bulimia nervosa. Chapter Three consists of a description and analysis of the open-ended interviews with young women who have been treated for eating disorders. In the Fourth Chapter, I discuss the implications of the interview data for treatment and prevention of eating disorders, as well as for future research directions.

Chapter One

Eating Disorders: Characterization and Contextualization

A Historical Perspective

The first description of anorexia nervosa is usually ascribed to two 19th century physicians, who independently observed a peculiar phenomenon occurring among young women in France and England. In 1873, British doctor William Gull noted a constellation of features that included emaciation without an organic cause, a conscious choice to refuse food, and denial of illness; he also observed that the syndrome, which he called "apepsia hysterica," afflicted young women age 15-23 almost exclusively (Gull, 1868, 1873). At approximately the same time, Ernest Lasegue described the identical phenomenon among young Frenchwomen. However, Lasegue emphasized that not only did his patients express no desire to eat, they also exhibited a frank aversion to food (Lasegue, 1873).

For both Gull and Lasegue, it was evident that the illness which came to be known as anorexia nervosa was a non-organic process. According to Gull, "the want of appetite is due to a morbid mental state," and a "want of mental equilibrium," to which his young patients were particularly susceptible (Gull, 1874, p. 7). Although the role of biological influences in eating disorders continues to be debated (see Chapter Two: Medical Theories), anorexia and bulimia are widely regarded as primarily non-organic phenomena with multiple etiologic factors (Herzog & Copeland, 1985).

Clinical Features

The clinical phenomena of anorexia nervosa and bulimia nervosa comprise a spectrum of behaviors. At the extremes, restrictive anorexia nervosa and bulimia appear as distinct entities; however, there is frequently overlap between the syndromes. Nevertheless, it is useful to describe the two types, their salient features and the populations affected.

According to the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994), the defining feature of anorexia nervosa (AN) is the refusal to maintain one's body weight within 85% of normal for age and height. Patients may achieve weight loss through diet and exercise alone (restrictive anorexia), or additionally through self-induced vomiting and laxative or diuretic abuse (bulimic anorexia) (Herzog & Copeland, 1985). The weight loss is often accompanied by loss of menstrual periods (amenorrhea), hyperactivity and decreased body temperature (hypothermia). Other physical findings may include a slowed heart rate (bradycardia) and hypotension, or low blood pressure, anemia, and the appearance of a fine, downy hair over the body (lanugo). Impaired renal function and cardiac irregularities are potentially life-threatening complications (APA, 1994). In addition, anorexia is characterized by specific psychological disturbances, including an intense fear of gaining weight, distorted body image, feelings of ineffectiveness, a need to control one's environment, inflexible thinking and emotional restraint (APA, 1994; Johnson, 1991).

Bulimia nervosa (BN) may occur in women of normal weight, or in those whose weight is above or below a normal weight range. The syndrome is characterized by recurrent episodes of binge eating-- that is, the consumption of more food than most individuals would consume under

similar circumstances, within a circumscribed period (usually two hours) (APA, 1994). The person characteristically feels a loss of control over eating during the episode, and binges are followed by various measures taken to prevent weight gain, including self-induced vomiting (80-90% of individuals), diuretics, laxatives, enemas, fasting and excessive exercise. The bingeing and compensatory measures must occur at least twice weekly, but may occur as often as 40 times per day (APA, 1994; Johnson, 1991).

Like women with anorexia, those with bulimia may have irregular menses. Other common physical findings include an erosion of dental enamel and swollen parotid glands due to self-induced vomiting, hypotension and electrolyte imbalance, particularly low potassium (hypokalemia). Potentially fatal complications include esophageal tears, aspiration, gastric rupture and abnormalities of cardiac muscle (APA, 1994; Herzog & Copeland, 1985).

Treatment

There appears to be no clinical consensus regarding the treatment of eating disorders (Herzog et al., 1991). Nevertheless, most clinicians advocate a combination of individual psychotherapy, nutritional counseling and medical management, with or without family therapy, group therapy or medication (Herzog et al., 1991).

Patients with anorexia may begin the treatment process with a hospital admission, to initiate weight gain. Strategies used for weight gain are varied, but in general a steady gain of 1-2 kg/week is advocated (Hsu, 1990). Recently, economic factors have begun to limit the availability of inpatient treatment for all but the most acutely ill patients: One study showed that a majority of women seeking insurance coverage for inpatient treatment of eating

disorders were denied reimbursement, were offered short-term or selective treatment only, or were prematurely discharged because of the limits of their coverage. Insurers also denied coverage to women who had sought prior outpatient therapy, on the grounds that the eating disorder was a "pre-existing condition" (Kaye, Enright, & Lesser, 1988).

The goals of individual psychotherapy frequently reflect the perspective of the therapist regarding the pathogenesis of eating disorders. According to Bruch, the patient's preoccupation with her weight should be viewed as concealing underlying feelings of ineffectiveness and self-doubt (Bruch, 1973). The goals of psychotherapy should therefore be to recover self-awareness and internal perceptions, and to re-establish the development of her personality (Bruch 1973, 1978).

Family therapy is often used, particularly with younger anorexic patients. Traditionally, the goals of family therapy have been to identify dysfunctional patterns and replace these, insofar as possible, with more healthy communications (Hsu, 1990). A different approach to family therapy involves the use of a "textual" or narrative analogy (White & Epston, 1990). In this methodology, family members are invited to "externalize" the problem at hand, thereby separating themselves from it and allowing them to envision different possibilities for themselves and their inter-relationships (White, 1988/89).

Medication, most often anti-depressants, is used in the treatment of one-third to one-half of eating-disordered patients not diagnosed with a concurrent depression (Herzog et al., 1991). Clinicians are more apt to use medication for patients with bulimic symptoms, and the tricyclics and MAO inhibitors are the drugs most frequently prescribed. Nevertheless, reports of their efficacy are indeterminate (Yates, 1989).

Outcome

The course of eating disorders may be assessed in terms of its acute, intermediate-term, and long-term outcomes. Acutely, most patients improve with therapeutic intervention, although as many as one-half of hospitalized anorexic patients relapse within a year (Hsu, 1979). However, the intermediate and long-term prognoses are less clear.

At least 40 studies addressing the intermediate-range (2-10 year) outcome of anorexia and bulimia nervosa were conducted between 1954 and 1986, yielding markedly different estimates of recovery. Among patients with anorexia nervosa, for example, reports of recovery rates have ranged from 17% to 77%, while mortality ranged from 0% to 22% (Herzog et al., 1988). Most reviews indicate that about one-third of women with anorexia or bulimia continue to have a diagnosable eating disorder at follow-up (Herzog et al., 1988). One factor complicating the assessment of outcome is the natural history of eating disorders. Over time, some anorexic patients who have regained weight will develop bulimia (Hsu, 1990). Others who are apparently recovered will eventually relapse after a long interval (Theander, 1985).

The observed variability is also partly attributable to variations in study design and measures of outcome. (Herzog et al., 1988; Steinhausen & Seidel, 1993). Studies differ in the length of time at follow-up, the diagnostic criteria for an eating disorder, retrospective versus prospective design, and follow-up method. In addition, not all studies have defined "recovery" and among those that have, the definitions are variable. The indices most commonly used to measure outcome include chronicity and mortality, normalization of weight, restoration of menses, normalization of eating behavior, absence of

vomiting, psychosocial and psychosexual functioning, and employment status (Herzog et al., 1988).

Among 22 studies published between 1981 and 1989 on the intermediate outcome of anorexia nervosa, 59% of former patients were within a normal weight range at follow-up, while 41% were underweight (Steinhausen et al., 1991). Slightly fewer patients had resumed normal menstrual patterns (55%). In studies which assessed this parameter, normalization of eating behavior occurred in 44% of former patients (Steinhausen et al., 1991). A number of studies have shown that, several years after hospital treatment and normalization of weight, most anorexic patients continue to restrict their diet and to consider themselves overweight (Yates, 1990).

Measurements of psychosocial functioning suggest a troubling pattern: Whereas employment and educational status is normal in two-thirds of patients at follow-up, interpersonal relations fare less well (Herzog & Copeland, 1985). In a recent study of 60 former adolescent patients at a mean of 58 months follow-up (Steinhausen & Seidel, 1993), only about half of these had developed a positive attitude towards sexual matters. Forty percent of treated patients are chronically depressed and 22% have unsatisfactory social relationships (Nussbaum et al., 1985). Despite this evidence of chronic psychosocial impairment, the parameters used to assess social and sexual function are notoriously ambiguous and variable (Steinhausen et al., 1991). For example, indices of social functioning have sometimes relied solely on the criterion of marriage, ignoring the importance of intimate relationships outside marriage, as well as differences in sexual preference.

A number of studies have also attempted to identify factors prognostic of outcome from eating disorders, and here, again, there is wide variability.

Factors which have been implicated in outcome have included age at onset, duration of symptoms, socioeconomic status, type of eating disorder, and pre-morbid behavioral and eating abnormalities (Steinhausen & Seidel, 1993). However, all of these factors have proven inconclusive in other studies. In the study of 60 adolescents cited above, only lower body mass index on admission was found to be correlated with poor outcome (Steinhausen & Seidel, 1993).

The long-term outcome of eating disorders is little understood. Although it was previously thought that four years was a sufficient time interval for the disease to run its course, it now appears that the sequelae may continue to evolve over many years (Hsu, 1990). Two recent long-term (20-year) studies of anorexia reveal that mortality increases over time, and that chronicity decreases chances of recovery (Russell, 1989, cited in Hsu, 1990, p. 199; Theander, 1985). In one study, mortality at 33 years was 18%, and the most common causes of death were complications of starvation and suicide (Theander, 1985). The likelihood of recovery diminished with the chronicity of disease: Those patients who continued to be ill after five years generally had a poor outcome, and recovery after twelve years of illness was unlikely (Theander, 1985).

Demographic Features

Rare before 1960, the incidence of eating disorders in the U.S. and other Western societies has recently risen appreciably (Kendler, et al., 1991; Lucas et al., 1991). Anorexia and bulimia now affect as many as 5-10% of adolescent girls and young women (Herzog & Copeland, 1985). In a recent study of students at two colleges and one secondary school (Pope et al., 1984), the incidence of anorexia nervosa was found to be between 1-4.2%. Bulimia

nervosa afflicted an additional 6.5-18%, depending on the criteria used (Pope et al., 1984).

Eating disorders continue to be primarily a problem of young women. Ninety to 95% of those affected are female, and the majority of cases begin between the ages of 13 and 30 years. Anorexia has a bimodal onset, often beginning between 13-14 years or 17-18 years of age; bulimia usually appears slightly later, between 17-25 years (Herzog & Copeland, 1985).

Cultural Factors

Cultural and socioeconomic factors appear to play a significant role in the occurrence of eating disorders. Comparisons of African-American and Caucasian teenagers have shown that white female adolescents are much more concerned with thinness and dieting than their black counterparts (Hsu et al., 1982). Meanwhile, individuals of a higher SES have an increased risk of both clinical eating disorders and subclinical eating pathology (Anderson & Hay, 1985; Dwyer & Mayer, 1970).

Although eating disorders have been uncommon among racial minorities in this country, studies suggest that the incidence is rising among African-American (Hsu, 1987), Asian (Lacey & Dolan, 1988), Hispanic (Pumeriega, 1986), and Native American girls and young women (Rosen et al., 1988). The increase in cases among minorities appears to be tied to socioeconomic status and educational attainment (Anderson & Hay, 1985).

In a recent study of Native American girls who developed anorexia, Yates (1989) found that all the patients came from traditional families who had moved off the reservation, and who had high expectations of their children in terms of achievement. Yates suggests that "The painful thinness

of these anorexic girls seemed to be a repudiation of the image of the traditional woman on the reservation" (Yates, 1989, p. 816).

A recent analysis of seven black and Hispanic patients revealed that all patients came from families who belonged to the upper middle class or were upwardly mobile (Silber, 1986). The black patients attended highly-competitive, largely Caucasian schools where there was no black peer group. These individuals expressed disappointment about the fact that they had "big" bodies, and felt responsible for "correcting the image of blacks." The Hispanic patients had similar backgrounds; in addition, they were also recent immigrants to the United States (Silber, 1986).

These studies suggest that loss of cultural identity, membership in white peer groups, and pressures toward educational achievement and social advancement may be implicated in the rising incidence of eating disorders among non-Caucasians. Among immigrant women, a loss of cultural traditions and affirmations of the female body may cause adolescents to adopt mainstream standards of appearance. As Yates has suggested, the fact that these girls may now view their traditional mothers with embarrassment or disgust may trigger the onset of an eating disorder (Yates, 1989). For black women joining a white peer group, a similar process of "immigration," acculturation and loss of cultural affirmation may be occurring. Indeed, one might extend the analogy of immigration to the emergence of eating disorders among women of any racial group, who enter into previously male domains of achievement, leaving their more traditional mothers behind. In this context, I turn to past and current thinking about the etiology of eating disorders.

Chapter Two

Theories of Etiology

Current thinking about the pathogenesis of eating disorders runs the gamut from neuroendocrine hypotheses to dysfunctional family patterns and sociocultural influences on women to be thin. Despite some overlap, the theories are grouped generally into those favoring an internal (individual) cause, including biological, psychodynamic, and family interactional models; and those favoring external causes, including behavioral and feminist approaches. Because a multi-factorial model is currently favored, I will briefly review the major etiologic theories, beginning with the most individual explanations.

1.) Medical Theories

A biological basis for eating disorders was postulated in the early part of the century, when Morris Simmonds, a German pathologist, noted that lesions of the pituitary gland resulted in cachexia that looked much like the clinical syndrome of anorexia (Simmonds, 1914). Subsequent research was directed towards finding an endocrine cause of eating disorders, implicating possible cerebral, pituitary and hypothalamic factors.

By the 1950s, however, biology had been consigned to a permissive, rather than a causative role in anorexia. According to Fries, a biological factor "may best be expressed in terms of predisposing diencephalo-hypothalamic vulnerability rendering some women more susceptible to non-specific stimuli such as emotional stress and/or weight loss" (Fries, 1974, p. 70). Among the biochemical abnormalities implicated in the etiology of anorexia nervosa are increased endogenous opioid activity, which may suppress

appetite, abnormalities in central nervous system neurotransmitters and metabolites, and increased cortisol production (Herzog & Copeland, 1985).

Eating Disorders and Depression

One observation suggesting a biochemical basis for eating disorders is the apparent association between eating disorders and affective illness. As many as 60% of patients with eating disorders may meet clinical criteria for depression. Indeed, anorexic patients on follow-up are more likely to suffer from depression than from anorexia nervosa (Cantwell et al., 1977; Cooper & Fairburn, 1986). It has thus been suggested that anorexia and bulimia nervosa constitute variants of an affective disorder (Katz, 1987).

Family studies support a link between depression and eating disorders, as there is an increased prevalence of affective disorders among the first- and second-degree relatives of eating-disordered patients (Gershon et al., 1984; Hudson et al., 1983). There is also some neurochemical evidence: Low levels of metabolites of serotonin and norepinephrine have been reported in patients with anorexia nervosa, suggesting a deficiency in neurotransmitters similar to that seen in depression (Biederman et al., 1984; Kaye et al., 1988). Finally, antidepressant medications have been found efficacious in treating eating disorders, although mainly with bulimic patients (Mitchell, 1989).

These findings point to a relationship between affective illness and eating disorders. However, other factors tend to cast doubt on the presence of a direct link between the two. The majority of eating-disordered patients are not clinically depressed, and in those individuals with dual diagnoses, the affective and eating disorders often differ in time of onset and resolution of symptoms (Walsh et al., 1985). Among the patients interviewed for the present study, depressive symptoms did not correlate with the presence of an

eating disorder; of seven depressed individuals, four currently had an eating disorder, while three did not. This finding lends support to Hsu's suggestion that, rather than constituting a variant of affective illness, eating disorders may develop in a person predisposed to affective disorders, who undertakes strict dieting. Thus, a predisposition to affective illness may be one risk factor in the development of an eating disorder (Hsu, 1990).

Other Psychiatric Diagnoses

The lifetime incidence of anxiety and obsessive disorders is also high in eating-disordered patients (Toner et al., 1986). The obsessive features of eating disorders, as well as the fact that dysregulation of serotonin is reported in both patients with eating disorders and those with obsessive-compulsive disorder, have led some authors to propose a link between these two clinical entities (Rothenberg, 1986). However, the evidence supporting neurochemical changes is not definitive. Once again, it is suggested that obsessive or anxious personality features may be predisposing, though not causal, factors in the development of eating disorders (Hsu, 1990).

Psychophysiology: the Effects of Deprivation

A further complication in assessing the role of biological factors in eating disorders is the reciprocal effect of starvation and disordered eating on metabolic and neuroendocrine functioning (Herzog & Copeland, 1985). According to one author, all the observed metabolic and biochemical derangements, including temperature dysregulation, suppression of menses, and gastrointestinal slowing, may be attributed to malnourishment. "Every positive observation has proven on follow-up after treatment to be a

symptom of the food restriction and starved state and thus a result rather than a cause of the behavior" (McHugh, 1989, p. 7).

Starvation may also induce the psychological changes observed in anorexia. During World War II, a study of male conscientious objectors strongly suggested that chronic food deprivation could be the cause, rather than the result, of psychological disturbances (Franklin et al., 1948). In the course of a long-term, semi-starvation diet, volunteers became intensely preoccupied with food, recipes, cookbooks and menus. Some men developed elaborate rituals, prolonging for up to two hours the process of consuming one slice of bread; others demonstrated episodes of binge eating. Social withdrawal was evident, as were impaired concentration and mood swings.

It has been suggested, moreover, that the less extreme deprivation which characterizes "restrained eating" may also be linked to disruptions of the psychophysiological mechanisms controlling satiety, leading to a further inability to regulate food intake (Tuschl, 1989). Both normal children and normal-weight, non-eating-disordered adults demonstrate a remarkable ability to regulate their energy consumption, given a wide range in food availability. In studies of children who were given high- and low-caloric density drinks as preloads to a meal, the children consistently adjusted their subsequent food intake downward and upward, respectively, to arrive at a constant energy balance (Birch, 1985, 1986, 1989).

Patients with eating disorders, however, demonstrate an inability to recognize hunger and satiety (Halmi et al., 1989). It has been theorized that the vigilance imposed by restrained eaters interrupts physiological mechanisms of satiety, overruling these with cognitive decisions. Internal cues are thus replaced by external cues regarding caloric content and "permitted" foods (Ogden & Wardle, 1990). To test the importance of internal

and external satiety mechanisms, researchers compared post-ingestion sense of fullness and estimated caloric content of high- or low-caloric density drinks among restrained and non-restrained eaters. They found that although both groups were responsive to internal cues, the restrained eaters were considerably more influenced by the believed content of the drink they had consumed (Ogden & Wardle, 1990).

The theory that impaired perception of satiety occurs in women with eating disorders has not yet been proven, but it remains likely. A mechanism which has been proposed to account for such a disruption is the increased intake of low-calorie sweeteners and "fake fats" which characterizes dietary restriction. In one study, young women who were classified as restrained eaters on the basis of questionnaires demonstrated a strong tendency to avoid fat, and an increased preference for defatted foods and artifical sweeteners (Tuschl, 1989; Tuschl et al., 1990). Tuschl hypothesizes that the replacement of calorie-rich foods with low-calorie substitutes may not only generate a cognitive sense of deprivation, but may actually disrupt the physiological mechanisms of satiety. "Uncoupling the sensory characteristics of food from its caloric content, such as occurs with the use of artificial sweeteners and other calorie-reduced ingredients, may lead to paradoxical effects on the sensations of hunger and satiety" (Tuschl, 1989, p. 107).

The biological determinants of eating disorders, then, are intimately related to cognitive and behavioral aspects of disordered eating. Indeed, it may not be possible to disentangle cognitive restraint from the disruption of the delicate physiological regulation of hunger and satiety-- to determine the point at which the restrained eater becomes "out of touch" with the physiological perceptions that have previously guided her approach to food. Whether cause or effect, however, or a combination of both, a disconnection

to internal feeling states is characteristic of women with eating disorders. This loss of interoceptive awareness is a central feature of Hilde Bruch's work on the psychodynamic development of eating disorders, to which I now turn.

2) Psychodynamic Models

The psychodynamic model of eating disorders has its roots in classic Freudian theory. As in hysteria, a 19th-century syndrome bearing remarkable similarities to anorexia, the rejection of food in anorexia was seen by early theorists as a repudiation of sexuality and a fear of "oral impregnation" (Waller et al, 1940). More sophisticated formulations of this model emerged in the 1970s; according to Crisp, anorexia represented a "maturational crisis" characterized by an intense fear of developing a female body. The intent of the anorexic girl was therefore not to control her intake of food, but to return her body to a pre-pubertal weight and shape (Crisp, 1970, 1974, 1979).

Another kind of maturational crisis was postulated by Hilde Bruch. Bruch suggested that anorexia comprises a "struggle for control, for a sense of identity, competence, and effectiveness," in young girls who possess an inadequate sense of mastery (Bruch, 1973, p. 251). For Bruch, this "lack of awareness of living one's own life" was linked to another central feature of anorexia, the inability to recognize hunger. She postulated that a parent's failure to respond appropriately to a child's biological needs resulted in the child's failing to learn how to appropriately identify and satisfy her own needs, and thus to an inadequately developed sense of self. For example, a "good parent" provides careful attention to a child's expression of hunger, and satisfies that need. But if a parent instead provides food as a pacifier or reward for good behavior, or withholds food as punishment, "he will grow up confused and unable to differentiate between various needs, feeling

helpless in controlling his biological urges and emotional impulses" (Bruch, 1973, pp. 57-8).

Bruch suggested that the inability to identify hunger could manifest as anorexia if the child later experienced uncomfortable emotions that were displaced onto the need for food. "These patients...misperceive, their bodily sensations so that the nutritional function can be misused in the service of complex emotional and interpersonal problems" (Bruch, 1973, p. 50).

The model proposed by Bruch posits that internal awareness of bodily sensations is learned, and that disturbances in the acquisition of interoceptive awareness may lead to eating disorders. However, the research on self-regulation of energy intake among young children suggests otherwise. As an alternative to Bruch's theory, interoceptive awareness may be innate, and may be *unlearned* in the course of female development, under the influence of factors which serve to distance a woman from her body.

Object-Relations Theory

Like Bruch, Italian psychoanalyst Mara Selvina Palazzoli (1967, 1969) has construed anorexia as a disturbance of "body cognition," with an attendant inability to recognize internal states and desires. Like Crisp, Palazzoli also believed that the female body took on the role of a phobic stimulus for anorexics.

Palazzoli employed object-relations theory in her approach to the etiology of anorexia, arguing that the pre-anorexic child came to identify her anxiety and dissatisfaction with the primary object-- her mother-- with the mother's body or corporeality. "The body of the anorexic does not merely *contain* the bad object but...*is* the bad object..." (Palazzoli, 1974, p. 87). It is particularly at puberty that anxiety takes expression in anorexia, because the

pre-anorexic girl, who has been encouraged to be dependent and submissive, is unable to achieve the autonomous identity of an adolescent. At this point, "because of the development of the breasts and other feminine curves, the body is experienced concretely as the maternal object...(and)...the patient considers and experiences her body as one great incorporated object which overpowers her and forces a passive role upon her" (Palazzoli, 1974, p. 90).

Palazzoli astutely identifies the meanings anorexic girls associate with developing a female body, which is perceived as a "receptive-passive object" (Palazzoli, 1974). With Bruch, however, she concludes that this perception stems from inadequate mothering and failure to develop an autonomous personality. She largely neglects the social context of anorexia, a context in which the female body is visibly construed as passive, and the feminine personality is frequently portrayed as dependent and compliant. Moreover, she neglects important recent contributions to our understanding of female adolescent development.

Female Development: A Relational Model

Traditionally, female adolescents have been thought to resemble their male counterparts in terms of the goals and struggles of puberty. It was supposed that, like boys, adolescent girls were striving to achieve separation from the family, individuation and autonomy (Zilbach, 1993). In her reworking of Freud's Oedipal phase, however, Chodorow (1974) has observed that the organizing feature of a girl's identity is continuity. For a girl, "The development of her gender identity does not involve a rejection of this early identification (with the mother), however. Rather, her later identification with her mother is embedded in and influenced by their ongoing relationship..." (Chodorow, 1974, p. 51). In this light, girls' development may

have less to do with autonomy, and more to do with inter-relationships and integration, than was previously supposed.

The traditional configuration of adolescence as a time of autonomy and separation thus poses definitional and practical difficulties for girls. As Apter puts it, "A girl undergoes the first separation/individuation phase without actually separating, without drawing distinct self-boundaries, especially boundaries between herself and her mother" (Apter, 1990, p. 58).

Adolescence and Role Conflict

Apter calls for a rewriting of the standards of female development. "We need accounts of adolescence which accomodate this continuing bond, in which independence is not seen as rank autonomy...and in which self-interest is not at odds with binding attachments..." (Apter, 1990, p. 57).

However, such an account is clearly at odds with standards of autonomy which dominate the academic and professional worlds, and which girls encounter early in the course of their education. As they reach an age when the relational identity they have known conflicts with normative expectations of (and their own desire for) autonomy, girls may experience a crisis of integration that is empirically characterized by a loss of self-esteem, increased incidence of depression, and drop in confidence and academic achievement (Orenstein, 1994).

The psychodynamic theories contribute to our understanding of the etiology of anorexia by focusing on the meaning of the female body for the adolescent girl, and by identifying the absence of body awareness that is so central to the illness. However, these theories all see the central problem in anorexia as women's inability to acquire a sense of self, acknowledge their desires and achieve their autonomy. They fail to recognize that the problems

of anorexia-- dependence and suppression of desires-- are part of the normal socialization process of young women. The family-oriented, and to a greater extent, the behaviorist theorists, add this social context to the understanding of eating disorders.

3) Family Interactional Model

The family interactional model was formulated in the 1970s by Salvador Minuchin, who rejected the strictly patient-centered, "linear model" of the development of eating disorders. According to Minuchin, the family of an anorexic patient behaves in a stereotyped, rigid pattern, repeating behaviors that have proved ineffective. Thus, Minuchin wrote that "anorexia nervosa seems equally valid as a diagnosis of the family system," and he coined the term "anorectic family" (Minuchin, 1978, pp. 9, 51).

Minuchin observed that the family of the anorexic girl shares many of the features of other "psychosomatic" families: namely, enmeshment, overprotectiveness, rigidity, and lack of conflict resolution, with the anorexic child frequently involved in unstated conflict between the parents. He suggested that the child raised in such an enmeshed household "learns to subordinate the self, and that her psychological and physical autonomy are constrained within an atmosphere of overprotectiveness. Open conflict is avoided, and the illness itself may become a focus of the family and subsequently used in the goal of conflict avoidance" (Minuchin, 1978, p. 61).

Finally, Minuchin observed that the anorexic child is often "recruited" to take sides in parental disputes. In one family therapy session, a girl with anorexia tells her father, "I don't think you respect Mom enough as a person." To her mother she says, "You let him treat you like that. You accept your role as someone who just cooks the dinner." Minuchin uses this

exchange to illustrate his conception of the anorexic family as enmeshed and fraught with "cross-generational coalitions" (Minuchin, 1978, p. 66).

Minuchin's perspective is helpful on two levels. First, it acknowledges that family dynamics considerably more complex than "inadequate parenting" may influence the development of an eating disorder. Additionally, Minuchin points out some of the central psychological dilemmas of eating disorders, including a need to avoid conflict and to suppress unpleasant feelings. He also notes that girls with anorexia are sensitive to inequality and disrespect between their parents.

Minuchin's formulation, however, falls short in that he does not consider the sociological implications of his observations. He does not ask *why* his patients are unable to express conflict and angry feelings. He does not remark on the content of the exchange between his patient and her parents: namely, that her father does not view her mother with respect, and that the mother allows herself to be devalued within the relationship. This omission is particularly relevant in light of Bruch's earlier observations of anorexic families, in which the mothers were often frustrated career women who were "submissive to their husbands in many details" (Bruch, 1978, p. 26). It is even more relevant in light of recent research, described below, which suggests that eating disorders may be related to fathers' attitudes towards mothers' roles and achievements.

4) Behavioral Theories

Eating disorders are remarkably age- and gender-specific clinical phenomena, affecting predominantly adolescent and young adult women. They are also immersed in a unique historical and cultural context, in which traditional expectations on women are at odds with modern opportunities

and values. Indeed, it has been observed that syndromes similar in many respects to anorexia, such as chlorosis, neurasthenia and hysteria, have emerged throughout history at times of significant change in women's roles (Perlick & Silverstein, 1994). Behavioral theories of eating disorders emphasize the importance of sociocultural influences on women's development in the etiology of eating disorders.

The Thin Ideal

The pursuit of thinness has indeed become a cultural obsession (Seid, 1988). The last few decades have witnessed an explosion in diet-related books and articles, an insatiable quest for fat-free, low-calorie products and the rise of ever more drastic means of weight reduction, from liquid diets to liposuction. A 1986 survey revealed that 90% of Americans thought they weighed too much, and 25% were on a diet on any given day (Gallup Survey, 1985). However, the burden seems particularly heavy (ahem) for women. A 1988 study of normal-weight college freshmen found that only 15% of both sexes were satisfied with their weights, but that only women were interested in trying to reduce (Haynes, 1988). In 1984, research conducted by Wooley and Wooley in cooperation with *Glamour* magazine revealed that 75% of respondents thought they were too fat, although only 25% were actually over the weights recommended by Metropolitan Life Tables (Rubin, op. cit. Chernin, 1981).

Images promoting the thin ideal include children's dolls, magazine advertisements, television programs and commercials, and movies, and studies have shown that exposure to such images may cause girls and women to identify with them (Pedersen & Markee, 1991). For example, despite her advanced age, Barbie, in all her incarnations, remains the most popular

fashion doll on the children's toy market. The dolls' proportions, however, are markedly unrealistic; when assigned a standardized height of 5'6", taller than the average American woman, various Barbies assume a waist size of 17.0-23.3 inches, bust circumference of 26.4-32.0 inches, and hip measurement of 26.9-32.3 inches. When the bust measurements are standardized to 36 inches, the dolls' projected heights range from 6'2" to 7'5" (Pedersen & Markee, 1991).

The thin ideal is also actively promoted to adult women. In their 1980 analysis, Garner and Garfinkel observed that the weight of winners of the Miss America pageant declined by an average of 0.17 kg (0.37 lb.) per year between 1959-1978 (Garner et al., 1980). After 1970, the pageant winners were almost invariably thinner than the average contestant, and weighed only 84.6% of national norms for their age, height and sex. The authors thus concluded that "the apparent increasing prevalence of anorexia nervosa and related eating disorders may well be linked to current cultural demands on women to be thinner" (Garner et al., 1980, p. 484).

Female Adolescent Development and The Pursuit of Thinness

In *The Obsession: Reflections on the Tyranny of Slenderness*, Kim Chernin (1981) describes a scene that takes place in the exercise room of a tennis club. Two girls, perhaps ten or eleven years old, both thin and gangly, enter the room and, after playing for a few minutes under the hair dryer and on the treadmill, move to the scale. The taller girl climbs on and looks down. She sighs and shakes her head, precociously. The younger one takes her turn. "Oh God," she groans, "Would you believe it? I've gained five pounds" (Chernin, 1981, p. 21).

Chernin's poignant description demonstrates, of course, that even pre-pubertal girls are influenced by our cultural idealization of thinness. Indeed, in 1986, researchers at UCSF observed that a full 50% of 4th grade (9-year-old) girls had put themselves on diets (Stein, 1986). Why are girls particularly susceptible to dissatisfaction with appearance, weight and size? It is possible that both physiological and cultural factors are implicated.

The female body, it has been noted, is less conducive to self-knowledge from an early age than is the male form (Cross, 1993). Except for the vulva, female genitalia are not available for external perception, and there is little discernible motility involving them. Thus, "The girl has to rely more on diffuse proprioceptive messages, as well as on intellectual learning, than her male peers" (Rosenbaum, 1993, p. 63).

With less objective self-knowledge to start, a girl finds that her body changes qualitatively more than her brother's during puberty. It has been suggested that, with these changes, girls may experience a loss of speed or agility that increases the sense of alienation from their bodies. "The relatively taut and muscular body of latency has become softer...balance, speed, strength and agility may all diminish, at least temporarily, giving rise to feelings of vulnerability and of a general lack of physical ineffectiveness" (Cross, 1993, p. 44). This is especially likely if girls stop being as physically active as they previously were; in a recent study, adolescent girls who were regularly active in sports felt better about their bodies (Rosenbaum, 1993).

A girl arrives at a fragmented, objectified view of her body as she discovers that most of the rest of the world knows more about that body than she does. The gynecologist probes in places she has not seen and about which she may be unclear. The media offer advertisements for products she may or

may not need-- douches, sanitary napkins, panty liners, hair removers -- how can she know?

Cultural images contribute to and sustain the process of self-objectification. As one therapist observes, his experiences with female patients "have led me to question whether it is possible for women not to feel pathologically self-conscious- for them ever to feel comfortable with their bodies in a culture that is...flooded with idealized images of women's bodies..." (O. Wooley, 1994, p. 19). In this light, it has been suggested that eating disorders represent an attempt to re-establish ownership of the body, "to perceive it as self (not other), known (not uncharted and unpredictable), and impenetrable (not invaded or controlled from the outside)" (Cross, 1993, p. 54).

For both boys and girls, the physical changes of adolescence have considerable impact on relationships, social status and self-image (Petersen, 1988). There is a large body of data to suggest, however, that the impact of physical development is largely positive for boys, whereas for girls it is mainly negative. With maturation, boys' mood and body image improves, while girls experience diminished feelings of attractiveness and depressed mood (Petersen, 1988; Sugar, 1993). Girls who mature early have poorer body image than their less mature counterparts; they are less satisfied with their weight and more likely to have eating problems throughout adolescence. Among a recent sample of middle-school girls in California, higher stage of physical maturation at a given age was significantly associated with an increased incidence in meeting the criteria for an eating disorders (Killen et al., 1992). It has been suggested that the divergence in mood and body image is related to cultural valuations of male and female bodies: "Because puberty is associated with an increase in adiposity in a culture that values thinness,

girls who mature early may be particularly susceptible to unhealthy weight-control behaviors" (Killen et al., 1992, p. 323).

Objectification and Sexualization

In a variety of ways, women become accustomed to being conscious of how their appearance affects others, especially men. The pornography industry grosses $7 billion per year world-wide, and some 165 pornographic publications are bought and read by 18 million men (Wolf, 1991). Pornographic images, it has been noted, serve not only to objectify the human body under consideration, but to fragment it: "...porn's attention to bits of bodies is never random. Pornography is preoccupied with what it regards as the signifiers of sexual difference and sexuality...It is much more often the female body and its representation which receives this kind of treatment" (Kuhn, 1985, pp. 36-7). The preoccupation with representations of women prevents women from feeling in control of their own sexual experience. "Both men and women," Wolf writes, "eroticize only the woman's body and the man's desire" (Wolf, 1991, p. 127).

This preoccupation, even with images that are not strictly pornographic, also contributes to women's experience of themselves as objects. As John Berger has observed, "(A) woman's self (is) split in two. A woman must continually watch herself. She is almost continually accompanied by her own image of herself...From earliest childhood she has been taught and persuaded to survey herself continually... Thus she turns herself into an object- and most particularly an object of vision- a sight" (Berger, 1972, pp. 46-7).

Childhood sexual abuse has sometimes been implicated as a factor in the etiology of eating disorders. Some studies have reported a higher

incidence of abuse history among women with eating disorders, while others have observed higher scores on eating disorder inventories among survivors of sexual abuse. Still other studies, however, have failed to confirm the correlation between abuse and eating disorders. Overall, it appears that approximately 30% of patients with eating disorders have a history of sexual abuse in childhood-- about the same percentage observed in the general population (see Connors & Morse, 1992, for a review).

For some women, the experience of sexual abuse may be closely linked to the appearance of an eating disorder, as was the case for one young woman who began to starve herself in order to become physically unappealing to her abusive brother (Connors & Morse, 1992). In other instances, however, sexual abuse may serve as a contributing cause which serves to diminish a sense of self-ownership and bodily integrity. Thus, "(Sexual abuse) may best be regarded as a risk factor in a multidimensional approach to the etiology of eating disorders" (Connors & Morse, 1992, p. 9).

Female Passivity

Cultural norms promote the ideal of a woman who is not only physically thin and beautiful, but who additionally is passive and compliant. Such norms are promulgated in movies, books and television shows which portray few women characters in the most active roles, preferring to cast women as adjuncts to males. Children weaned on *Speed Racer, Superman* and *Star Wars* learn that women are to be taken care of, protected, fought over. They may be brave, but they rarely initiate action; they are more often the object than the subject of an adventure.

Children often receive the same message from books: Heroic men *make* things happen, but for women, it is usually their beauty which causes

things to happen *to* them. Naomi Wolf describes such a contrast between two young protagonists, Stephen Dedalus in James Joyce's *Portrait of the Artist as a Young Man*, and Tess in Thomas Hardy's *Tess of the D'Urbervilles*:

> Stephen is in his story because he's an exceptional subject who must and will be known. But Tess? Without her beauty, she'd have been left out of the sweep and horror of larger events. A girl learns that stories happen to beautiful women, whether they are interesting or not. And, interesting or not, stories do not happen to women who are not beautiful (Wolf, 1991, p. 44).

The process of learned passivity, however, may begin much earlier. Studies of boys' and girls' play reveal that as early as 18 months, male infants receive more positive responses from their parents for large-motor play, such as running, jumping and sliding, and for using male-typical playthings such as building and transportation toys, than do girls (Fagot & Hagan, 1991). By age five, male and female children are already channeled into different physical activities, with females excelling at tasks involving balance, while their male peers are learning how to move themselves, and objects such as balls, through space (Morris et al., 1982). Messages about the types of activities that are considered "appropriate" for girls significantly impact the way they come to relate to their bodies as more or less effective than boys'. And, too often, these messages may contribute to girls' distrust of their bodies, and sense of ineffectiveness. As Bennett has noted, "For less-than-well-skilled females, the accompanying and internalized meanings breed lack of confidence, lack of understanding of self in relation to the environment, and lack of control over one's own physical destiny...it reinforces women's view of self-as-object rather than agent" (Bennett, 1987, p. 371).

Behavioralists add an important perspective to an understanding of the etiology of eating disorders. They situate the problem within the context of a culture which persists in promoting unrealistic physical images of

women, which encourages women to view their bodies as objects rather than subjects, and which rewards women for being quiet and non-confrontative.

The chief deficit of the behavioralist theories, however, is that they are somewhat outdated. Although the cultural forces they cite are still very much in effect, these forces are now countered by increasing opportunities as well as new expectations on women to be as forceful, successful and independent as men. In the context of the "Superwoman" image, women face a different set of obstacles in maintaining connection with themselves.

5) Feminist Perspectives

Like behavioralists, feminist theorists locate the causative factors of eating disorders within the context of the larger society, and they characterize anorexia and bulimia as the unfortunate but not unexpected consequence of normal female adolescent development. Eating disorders, it is suggested, emerge during adolescence because this is when girls' learned insecurity and low self-esteem clash with cultural expectations of their success, or when traditionally female and male qualities and values come into conflict. Thus, the term "gender ambivalence" has been coined:

> During periods of great change in gender roles, large numbers of women aspire to achieve in highly respected areas traditionally reserved for males...They are thus faced with one of two problematic situations. If their mothers are also non-traditional, the daughters may identify with them, at the same time observing the great limitations placed upon the mothers because of their gender. If their mothers are traditional, the daughters may be socialized to devalue the roles played by the mothers and may confront difficulties in identifying with their mothers. In either case, their sense of self-worth as adult females suffers (Perlick & Silverstein, 1994, p. 90).

Adolescence: A Historical Context

Historically, adolescence has indeed been a time of role-related crisis for young girls, not infrequently resulting in somaticized illness. As far back as the 4th century B.C., the Hippocratic texts described a "disease of young women" that began about the age of menarche and was characterized by wasting, amenorrhea, depression, vomiting, anxiety and suicidal ideation (Lefkowitz & Fant, 1982; Littre, 1853). By the 17th century, a "new" disorder emerged, chlorosis, that included many of the identical features. As one physician noted, "Many young women, as their frames develop, fall into a panic fear of obesity, and cut down on their food" (Allbutt, 1901, p. 485). Similarly, the 19th-century disease known as neurasthenia affected young women under age 25 and was characterized by vomiting, refusal of food and a wasted appearance (Deale & Adams, 1894).

During the 19th century, hysteria emerged among a similar population, and with similar features, as modern-day anorexia. Sigmund Freud and Josef Breuer detailed the symptoms of hysteria, including "chronic vomiting and anorexia, carried to the point of rejecting all nourishment..." (Freud & Breuer, 1893, p. 38). Moreover, they described their (female adolescent) patients as possessing "a powerful intellect," and as "lively, gifted and full of intellectual interest." The girls were often characterized as taking after their fathers in terms of their intellectual abilities (Freud & Breuer, 1893-95, pp. 55, 284). In much the same way, Hilde Bruch would later note of her anorexic patients that "it is significant that the fathers value their daughters for their intellectual brilliance" (Bruch, 1978, p. 25).

Freud and Breuer observed the centrality of adolescence and especially, sexual maturation to the emergence of hysteria (Freud & Breuer, 1893-95). Though they conceived of the illness as a pathological response to

maturation, they recognized that, for bright young women, adulthood did indeed imply a loss of intellectual stimulation and camaraderie, and an acceptance of household duties and spousal support. Thus "The girl senses in Eros the terrible power which governs and decides her destiny and she is frightened by it" (Freud & Breuer, 1893-95, p. 290).

The modern adolescent girl is not constrained to traditional feminine duties. Nevertheless, the female body may take on symbolic meaning for the adolescent struggling to retain her connection to her mother while incorporating values of independence, accomplishment and autonomy that may be more like her father's. The apparent incongruity between a female body, with all the potential for objectification and exploitation that implies in our society, and traditionally "male" achievement and respect may provide a psychological trigger for the development of an eating disorder.

Gender Ambivalence

How, exactly, is gender ambivalence related to the development of eating disorders? It has been previously noted that the pre-anorexic adolescent is a high academic achiever who often identifies with her father's career goals and sees her mother as ineffective, thwarted or repressed (Boskind-Lodahl, 1976; Bruch, 1978). It was thus hypothesized that women predisposed to eating disorders were those who were more apt to identify with a masculine gender type. However, recent studies suggest that the relationship between gender role identification and disordered eating is not so clear-cut. Instead, it appears that the important criterion seems to be not whether women identify with a masculine or feminine gender type, but whether they view society as respectful of women's roles, and to what extent

they perceive their own goals as concordant with societal expectations of them as women (Thornton et al., 1991).

In a study of women attending a state university (Silverstein et al., 1988), it was found that eating disorders were more prevalent among those who had experienced their families as unsupportive or disparaging of women's achievements. Disordered eating was particularly likely to occur among women who felt that their mothers were not happy with the career choices they had made, and who believed that their fathers thought their mothers unintelligent.

The Superwoman Ideal and Self-Esteem

In a similar vein, adherence to a "superwoman" ideal has been proposed as a risk factor for eating disorders. Endorsement of this ideal is measured by asking a woman to classify various roles and attributes, including daughter, student, romantic partner, leader, friend, physically active, and physically attractive, as more or less important. The greater the number of roles classified as extremely important, the higher the "superwoman index" (Thornton, 1991). Several studies suggest that women who more closely adhere to the superwoman ideal are at greater risk for eating disorders (Steiner-Adair, 1986; Timko et al., 1987).

Steiner-Adair (1986) has extended the superwoman model to address the relational nature of female development. In her interviews with young women, Steiner-Adair identified two lines of adolescent development: The Super Woman, who is oriented toward achievement and image, and the Wise Woman, who similarly seeks achievement, but who is motivated by self-fulfillment and a belief in herself. Both groups were concerned with dieting, but when Steiner-Adair examined the eating behavior of these

adolescents, none of the Wise Women were in the eating disordered-range, while eleven of the twelve Super Women fell into this range. Steiner-Adair hypothesized that, as young women negotiate the transition to an achievement-oriented, autonomous image of themselves, they require affirmation that their relational development is still of value in order to retain connection to others and to themselves. Thus,

> Wise Women who reject the cultural image of the Super Woman are able to envision an ideal of adulthood that makes connectedness to self and others central...Super Women who identify with the cultural image of an autonomous, independent woman are unable to hold for themselves a vision of adulthood that integrates the relational aspect of themselves (Steiner-Adair, 1986, p. 106).

Steiner-Adair's analysis suggests a crucial link between women's psychological development and the occurrence of eating disorders:

> It is possible that eating disorders emerge at adolescence because it is at this point in development when females experience themselves to be at a crossroads in their lives where they must shift from a relational approach to an autonomous one, a shift that can represent an intolerable loss when independence is associated with isolation (Steiner-Adair, 1986, p. 107).

The author postulates that the rejection of a relational identification takes expression in the rejection of the female body which is manifested by women with eating disorders. In this way, she suggests that anorexia represents a sort of symbolic protest against a society which idealizes women who are thin and quiet, and denies them the freedom to retain connection to themselves and their experience (Steiner-Adair, 1986). I would extend this analysis in noting that, for many women, the connection to experience and emotion has been systematically undermined throughout their development.

Connection and Disconnection

Disconnection from internal feeling states, both emotional and physical, has been linked to anorexia, bulimia, and compulsive eating. As Hilde Bruch first noted, girls with eating disorders are frequently unable to identify not only hunger but many internal feeling states -- such as fatigue or cold (Bruch, 1973). In her essay, "Women's Anger and Compulsive Eating," Bunny Epstein notes that over-eating serves a function in separating a woman from her feelings:

> A compulsive eater in flight from her anger will not actually know she is angry. Hand in hand with noshing or bingeing, she may project her anger in a way which produces anger in others and at the same time proves that she is helpless... By projecting her anger, a woman can hide it from herself (Epstein, 1987, p. 34).

For women with bulimia, bingeing may provide a way of "anesthetizing" themselves against unpleasant emotions. As Millman quotes one woman: "Binges you don't even taste. I pig out to avoid thinking of something else. Binging happens when I have experiences I don't want to remember, feelings I don't want to keep" (Millman, 1980, p.141).

How is it, then, that these women have become so uncomfortable acknowledging and expressing difficult feelings? Just as they unlearn connection with their physical selves, women and girls may lose touch with their emotions, if they are subject to pressures to suppress feelings, to get along and be "nice."

Peggy Orenstein's recent study of eighth graders at two California middle schools suggests that girls are unwittingly silenced by their well-meaning teachers. Boys, she observes, consistently fight for, and get, more of the teachers' attention, by insistently thrusting a hand in the air, shouting "I know!" and talking and clowning in class. At one school, boys received

about five times the attention in class that girls did, and this ratio is actually better than the average reported at many other schools (Orenstein, 1994). By adolescence, Orenstein notes, "Girls have learned to get along while boys have learned to get ahead." And girls are attuned to what is expected of them: "Teachers like us because we're nicer, quieter, and better behaved" (Orenstein, 1994, p. 35).

In their study of students attending the Laurel School for Girls in Cleveland, Ohio, during the years 1986-1990, Lyn Brown and Carol Gilligan have described a paradox: On the one hand, the girls with whom they talked became more mature, independent, more aware of differences and differing perspectives, over the course of several years. On the other hand, these same girls became less attuned to their own feelings, and less willing to express themselves freely (Brown & Gilligan, 1992). As the authors suggest,

> If we consider responding to oneself, knowing one's feelings and thoughts, clarity, courage, openness, and free-flowing connection with others and the world as signs of psychological health, as we do, then these girls are in fact not developing, but are showing evidence of loss and struggle and signs of an impasse in their ability to act in the face of conflict (Brown & Gilligan, 1992, p. 6).

Brown and Gilligan observe that, as they matured, their subjects became less willing to argue, make demands, and engage in conflict. They began to censor their emotions, first in their expression, ultimately in the very recognition of feelings. Over the course of several years, the phrase "I don't know" became ever more prominent in the language of these young girls (Brown & Gilligan, 1992).

In second-grade, for example, Lidia knows that her opinion is worth listening to. When "my mom...doesn't answer," she explains, "I have to yell. Then she gets to hear me." At the same age, Lauren stands up for herself when another student intervenes between her and the computer. "I had (the

computer) first," she says, "and I just left to put my spelling book away and stuff. And when I came back, (another girl) was there...and she said, 'Well, I got here first,' and I'd say, 'No, I did'" (Brown & Gilligan, 1992, p. 44-6).

Already, however, these girls are learning that open expression of their feelings is frowned upon by adults, particularly adult women. When Lauren argues with her classmate, the two are told by their teacher that they must work together on the computer, or neither of them may use it. The authors note that, in this way,

> Voicing feelings brings these girls in conflict with... adult women who have learned how to cover their own feelings and hide what they know. Listening to seven- and eight-year-old girls, we hear a beginning awareness that parents and teachers-- and in some instances even the girls themselves-- use the injunction "to be nice" as a way to control girls' expression of feelings and thoughts and, in this way, to orchestrate their behavior, to keep them from saying too much or speaking too loudly (Brown and Gilligan, 1992, p. 52).

Thus, feminist authors hypothesize that girls are unwittingly socialized to suppress and deny their appetites and feelings, when these are not in accord with expectations of propriety. Under the influence of social forces which encourage objectification and passivity in women, the suppressed feelings may quickly disappear beneath the surface. The woman with anorexia or bulimia who cannot tell if she is hungry or full may not be aware that she has also lost the ability to feel or express anger. Women who learn, as a matter of course, to suppress their anger, passion, energy and creativity, who cease to express their bodies and voices in order to comply with standards of "niceness," are at great risk of losing touch entirely with their own experience. And at the root of eating disorders is the failure to attend to, and trust, what one feels.

Chapter Three

The Voice of Experience: Interviews with Former Patients

The Open-Ended Interview

The perspective of patients treated for eating disorders has been largely excluded from outcome research. In order to incorporate the experience of women recovering from eating disorders, I designed a semi-structured interview questionnaire, which was initially piloted on a self-selected sample of female medical students of approximately the same age as the Stanford cohort. I then administered the questionnaire to 14 subjects from our population of respondents. Twelve of the 14 interviews were included in the analysis; two were excluded because of incompleteness and the presence of confounding diagnoses. At or near the time of interview, the subjects were also evaluated using a standard measure, the Structured Clinical Interview for the DSM-IIIR (SCID), to determine the presence or absence of a current eating disorder, or other psychiatric disorder.

The open-ended interview was designed to explore, from a feminist and sociocultural perspective, several areas which have been implicated in a multi-factorial model of eating disorders, including gender ambivalence; difficulties with conflict; lack of interoceptive (body) awareness; and adherence to societal ideals for women. The questions emerged from my personal synthesis of discussions, writings and research on female psychosocial development, changing expectations for women, and psychological characteristics of patients with eating disorders. In addition, the patients' experience of the illness was sought in a separate section. The common thread uniting these diverse areas is, I believe, a loss of connection

with internal feeling states and standards of self-worth that is evidenced by women with eating disorders and may return with recovery.

The data presented here are intended to be descriptive; studies using a control population should be untaken to further explore a causal connection between the findings of this paper and the occurrence of eating disorders. I suggest that many of the subjects' experiences may be applicable to a large number of women, and it is the presence of multiple influences or predisposing factors that may cause some women, and not others, to develop an eating disorder. Nevertheless, I believe it is useful to make some observations about commonalities, as well as differences, in the experience of women with eating disorders. Comparisons among recovered and non-recovered patients may provide additional insight into the factors involved in recovery.

The Structured Clinical Interview (SCID)

All subjects were interviewed using the Structured Clinical Interview, an instrument which permits assessment according to diagnostic criteria for the DSM-IIIR (Diagnostic and Statistical Manual of Mental Disorders, 3rd ed., revised). Deleted from the measure were those portions pertaining to psychotic disorders, personality disorders and substance abuse. Subjects were evaluated for the presence or absence of a mood disorder (major depression, bipolar disorder, dysthymia), anxiety disorder (obsessive-compulsive disorder, panic attack, social phobia, agoraphobia, generalized anxiety disorder), and eating disorder (anorexia nervosa, bulimia nervosa). The interviews were conducted by myself and another researcher, and results were cross-checked by a third researcher to enhance reliability. The results of the SCID are presented below.

Results of the Structured Clinical Interview for the DSM-IIIR (n=12)

Current Age	18-25 years
Average Time Since Diagnosis	8 years
Ethnic Identification	10 White, 1 Hispanic, 1 "Other"
Presence of Current Eating Disorder	6 (50%) 4 Anorexia Nervosa 2 Bulimia Nervosa
Presence of Current Mood Disorder	7 (58%)
Presence of Current Anxiety Disorder	5 (42%)

Discussion

The SCID data are concordant with previous studies which have shown a high prevalence of both eating disorders and co-morbid diagnoses at follow-up (Smith et al., 1993). As noted, most studies report continued illness in one-third of patients, and the finding that one-half of patients meet criteria for an eating disorder is not atypical (Steinhausen & Seidel, 1993).

The high proportion of patients meeting criteria for a mood disorder, either major depression or dysthymia, and anxiety disorder, such as obsessive compulsive disorder, is also consistent with earlier findings (see Chapter Two: Medical Theories). The mean age among recovered patients (22.7) was similar to that among non-recovered patients (21.7). Following is an overview of the current diagnostic status of the 12 respondents, whose initials have been changed for purposes of confidentiality.

Interviews with Former Patients: Assessment of Current Status

Initials	Code no.	Age	Follow-up Status
A.E.	005	25	recovered
R.D.	022	25	recovered
E.F.	027	25	anorexia
N.K.	029	21	anorexia
A.K.	035	18	bulimia
L.D.	036	21	anorexia
K.H.	062	24	anorexia
M.D.	137	20	recovered
A.O.	175	24	recovered
D.A.	218	21	recovered
H.C.	253	21	recovered
E.R.	261	21	bulimia

The Interview: Exploring Connections

In the remainder of this chapter, I present a discussion of the questions and hypotheses explored in the open-ended interview, in the context of the responses offered by the subjects.

1.) Gender/Family

"I'd like to ask you some questions about your family."

1. What did your mother do, in terms of work, while you were growing up?

2. What did your father do, in terms of work?

3. What do you do?

4. What are your work-related goals?

5. What are your other goals, in life?

6. Do you feel these goals are more like your father's or your mother's? (Follow-up)

7. Are *you* more like your father or your mother? (Follow-up)

8. Was it your perception that your mother's work was respected in the family?

9. Your father's work?

As previously noted, gender ambivalence, or a perceived conflict between personal goals and societal expectations for women, has been implicated in the etiology of eating disorders. In exploring this association, I was particularly interested in learning how these women perceived the nature of their parents' work; whether they thought their mothers enjoyed their work and whether this work was valued; and whether the subjects identified to a greater extent, professionally and personally, with one parent than with the other.

Hypotheses

• Women with eating disorders may have perceived their mothers' work as less respected than their fathers' work.

• These women may perceive their mothers as having foregone personal or professional goals.

• Women with eating disorders may associate personal and professional reward with masculinity, and be more likely to identify with their fathers' goals than their mothers'.

Results

Mother's Work

Among the interview subjects, two reported that their mothers had been housewives while they were growing up; three said that their mothers had worked as teachers; and six answered that their mothers had worked as secretaries, office managers or administrative assistants. The mother of one participant was a physician. About half the daughters of working mothers reported that their mothers had not worked when they were very young.

Two-thirds of the women expressed that their mothers either had not found their work rewarding or had aspired to other goals for themselves. One woman said that her mother, an office supervisor, had wanted to be a lawyer. Another, whose mother had been a teacher in New England and was now a secretary, said she had wanted to continue teaching. Another woman noted that her mother had artistic aspirations but lacked confidence in her abilities. Still another, H.C., said her mother had aspired to many things, but was turned away by barriers against women's achievement:

> ...my mom had a lot of ideas, but when she was growing up women weren't encouraged to do a lot of the things she was interested in doing so I think she modified her goals slightly.
>
> *In what way?*
>
> Well, she wanted to be a pilot, and she was told she couldn't because she was a girl. Something that large down to something as small as she wanted a newspaper route, and they said girls can't have those so she couldn't do that either. So in that way she kind of tempered her ideals for having, you know, being a real career woman, whereas my father, of course, was able to do that. And I'm more like him in that way, in that I can pursue that. (253)

Another theme that emerged was a perception by daughters that their mothers were pursuing careers vicariously through them. The woman whose mother had wanted to be a lawyer noted that "I feel like my mom's trying to live her life through me, like how she wanted it to be, so she's like so involved in my life when it comes to school." Another woman, A.E., put it this way:

> I feel like I'm compensating for what she didn't accomplish...like I'm trying to accomplish what she's always wanted to accomplish and that was always, you know, she was never able to really get where she wanted to get...She doesn't want me to be in that same boat so she'd like to see me succeed. I'd like to see myself succeed and not end up like her... (005)

Most women reported that their mother's work, whether in the home or outside, had been respected in the family. Some answered that it was "differently" respected, others said it might have been appreciated more. Most, however, denied that their mother's work was less valued than their father's. In almost every case, however, mothers were perceived as enjoying their work less, or in compromising their aspirations to a greater degree than

fathers. The perceived difference is reflected in women's reports of how they view their own goals and personalities.

Goals and Self-Identification

About half of the women interviewed described their goals as more like their fathers' than their mothers'; the remainder said their goals were like both parents, or neither parent. One women, whose goal was to be happy, said this goal was more in keeping with her mother's attitudes.

Among women who identified with fathers' goals, the specific goals most often cited were having a successful career, enjoying one's work, and "always looking for something more." The same themes were reflected in women's self-descriptions, as characterizations sorted out along traditional gender lines.

Many women described themselves as being like both parents, in different ways. In explaining how they were like their fathers, women cited factors like perfectionism, constant striving, stubbornness, intellectual pursuits, self-understanding and personal reward. In contrast, they were like their mothers in being sensitive, anxious, insecure, careful of feelings and concerned about others. Thus these women, most of whom expressed the desire to have a career, associated qualities of achievement and personal job satisfaction far more with their male parent. They associated their emotive qualities, both positive and negative, more with their mothers.

Discussion

These results suggest that some women with eating disorders have experienced their mothers as having less-rewarding professional lives and/or as having abandoned personal goals. In addition, these women may view

their own desires for professional reward and achievement as embodied more by their fathers' lives than their mothers'.

What is the relationship between women's striving for achievement and eating disorders? As discussed earlier, the phenomenon of "gender ambivalence" has tended to emerge at times of a change in women's roles (Silverstein et al., 1988, 1990). I would suggest that goal-oriented women are at increased risk for eating disorders if they are unable to integrate their achievement goals with a female identification (gender ambivalence). That is, if they perceive the most-valued qualities of themselves as essentially male qualities, then it will be difficult for them to reconcile themselves to femininity. Viewing femaleness as incompatible with their goals, and having the choice, unlike their mothers, to pursue those goals, many women may reject their female bodies.

2.) Conflict

"I'm interested in your experiences of conflict with other people."
1. Could you describe a conflict that occurred in your family? (Follow-up)

2. How was conflict or anger generally handled by members of your family? (Follow-up)

3. Can you tell me about a recent interpersonal conflict, how you felt about it and what you did? (Follow-up)

4. Thinking back 5-10 years ago when you were first coming to clinic, how do you see yourself handling conflict now as compared to then?

5. Can you describe a conflict that you had with staff while you were in treatment at Stanford? How did you feel, and how did you think it was handled?

An inability to deal appropriately with conflict is characteristic of people with a psychosomatic illness. As noted above, Minuchin has described the families of women with anorexia as fraught with unresolved conflict, with the woman herself often embroiled in parental disputes. The feelings of

frustration and ineffectiveness which stem from an inability to resolve disputes are manifested in her eating disorder, which serves to shift the focus away from pre-existing conflicts (Minuchin, 1978).

In order to explore this theory, I asked the research participants how they had experienced conflict in their respective families. In addition, I was interested in exploring another aspect of conflict: the presence and acknowledgment of angry feelings.

As has been discussed, anger is an integral part of syndromes of compulsive eating, anorexia and bulimia (Epstein, 1987). Women and girls who are socialized to suppress anger as well as other unacceptable feelings may cover these feelings with eating symptomatology, and ultimately lose touch with them. I wondered, then, whether the women with whom I spoke had experienced their mothers as unable to express anger or other feelings. I hypothesized that women in the throes of an eating disorder, who are out of touch with both physical and emotional sensations, would have a difficult time recognizing or expressing anger. By extension, I thought that an improved ability to recognize and express anger would correlate with the extent of their recovery.

Finally, other studies have suggested that eating disorder treatment protocols tend to replicate the frustration and sense of ineffectiveness experienced by eating disorder patients in their homes (Maine, 1985). I was interested in learning whether or not their treatment at Stanford had had this effect for these former patients.

Hypotheses

- Conflict at home was experienced by these women as poorly resolved and frustrating.
- Mothers of women with eating disorders were less able than fathers to communicate anger.
- The ability to recognize and express anger improves with recovery from an eating disorder.
- Conflicts with staff in treatment programs replicated the frustration experienced at home around conflict situations.

Results

Conflict at Home

Conflict at home took a variety of forms for the research subjects, from open fighting to tight-lipped silence. In five cases, conflict was experienced as hidden, unacknowledged; in several other instances, one or both parents were perceived to have "their minds made up," precluding discussion. In still other cases, physical threats or financial coercion were used by parents (usually fathers) to control daughters' behavior and stifle the airing of disputes. A common theme among the participants, however, was the experience of family conflict as frustrating and irresolvable, as the following excerpts indicate.

Asked to describe a family conflict, D.A. related the way her step-father terrorized her sister and herself, silencing them with his physical threats.

> Well, the one that's most memorable is my mother and I arguing about something...and then, either my Mom saying that she was going to involve my stepfather, or himself involving himself. He would involve himself, and then that took every power away from me because I was afraid of him. So then I wouldn't have a voice anymore.

What would happen to the conflict when he came into the picture?

> It would usually get pretty ugly, like he would get this mean, scary face where he would clench his teeth and he just looked like he was about to rip me apart, and sometimes there were times when he wouldn't touch me at all, and he would just talk to me really close in my face, and then other times he might hold my shoulder or the back of my neck or something, or my hair...And then, you know, eventually I would say whatever he wanted me to say because I was scared, and that usually would be how it was diffused. (218)

Silenced by her fear, this young woman experiences herself as powerless in the face of family conflict. Her frustration is exacerbated by the fact that her step-father never physically harmed her, as she explained, "Both my sister and I have confronted him as adults, and he says, 'But I never hurt you girls.' So it's like it never happened."

Another way that conflict may be diffused is avoidance and denial. Asked how conflict was handled in her family, A.O. explained:

> No one talks afterwards. There is no resolution to the conflict. Nothing is really solved. There is like a period for, maybe, about a couple of weeks, where there is very blunted, restricted conversation...No one talks to anyone.
>
> *So, is anger expressed at all?*
>
> No, it is usually, if it is expressed it is expressed in very childish ways, through not talking or through the slamming of a door. "I'll eat later, when no one is around," that kind of deal. It is never, "I am angry with you." It is never expressed openly and directly. (175)

In this case, it is the failure to acknowledge conflict, rather than the presence of a physical threat, that creates an environment of frustration for the subject. As she observes, unexpressed anger may insidiously be turned

into eating pathology, as someone decides to "eat later, when no one is around." Unable to communicate her anger verbally to her parents, the daughter unleashes it on herself, hoping at once to illustrate her distress and create distress for them.

Mothers and Conflict

A third of the women interviewed offered that their mothers did not express anger or did not stand up for themselves in disputes. However, even when mothers seemed able to express anger, they were still sometimes seen as denying other feelings. This was true in the case of E.R., a woman with bulimia, whose mother had herself struggled with weight and food issues:

> Actually, my Mom is like, she's like, always says what she feels no matter if it's blunt or it's bad or it's good. My Dad just takes things in and doesn't actually talk about his feelings, but my Mom has a lot of feelings I know like deep down inside that she hasn't dealt with and that she hasn't expressed. I mean she's expressed to me like things that happened to her in her childhood and stuff but she just denies them and things that happened like, like what happened with me with the whole bulimia thing. (261)

E.R. recognizes a discrepancy between her mother's open expressions of anger and her unwillingness to recognize her own problems as well as her daughter's illness. Attempts to overcome these barriers meet with disaster; E.R.'s mother thinks her bulimia is a "phase," and telephone conversations between mother and daughter often end with the crash of the receiver by either party. And the young woman acknowledges that her inability to communicate with her mother contributes to her problems with food, as I discuss below.

Ability to Acknowledge/Express Anger

Improved tolerance for anger, and ability to deal with conflict, was described by most subjects (although some individuals were hard pressed to think of conflict situations). In addition, more open recognition and resolution of conflicts correlated with the absence of an eating disorder as diagnosed by the SCID.

A young woman with bulimia, A.K., who says that "I don't get into many disagreements with people," describes a situation where a friend of hers has just been maligned in the context of a group meeting:

> I just got really upset because the person he was talking about I knew pretty well. She was a really nice person, and I was really upset that he did that, that he badmouthed her like that. But I didn't think I expressed very much anger, but I guess that I did because afterwards one of the other people who was there came up to me and said, you know, you looked really angry. What's the problem? And so I told him what was going on, and I think that the guy I talked to talked to the guy who was badmouthing the girl, because I got an apology from him. It was kind of like, oh, I didn't know you knew. (035)
>
> *So you didn't actually say anything at the meeting?*
>
> No, I didn't. I couldn't.

In this case, the subject knows she is angry, but does her best to conceal it. Although she very much wants to stand up for her friend, she is unable to express her feelings until confronted by another member of the group. In the presence of a neutral party, she can communicate her anger, but not directly to her friend's abuser.

E.R., whose problematic relationship to her mother was described above, recognizes that her bulimic symptoms are closely linked to her inability to tolerate conflict with her mother.

What do you do when you feel angry?

I don't know. I like just don't talk to her...And then I've tried to like fix it because I'm one of those, like, I'm the kind of person who when I get in a fight with someone, I just can't leave it alone...I have to fix it. I have to make it better. And I can't. And this is something, this is one thing in my life that I can't make better. It upsets me.

So what do you do about those feelings? What do you do when you get angry and you can't resolve it?

I like turn to food, or that's when my whole bulimia thing starts coming up again. It's like I don't know why. It's not even like I'm mad or I'm gaining or losing weight, it's more like emotions. It's something that I can't control, you know? Like, I mean, I turn to food. And then, you know, I feel that like bingeing and purging, it makes me feel better. Then, in the end, it doesn't. (261)

Although E.R. says she doesn't know why the "whole bulimia thing starts coming up again," she does connect it to the presence of emotions she cannot control. As she observes, conflict and angry feelings are not always within one's capacity to assuage; it is not always possible to "make it better." And yet, conflicts are an inevitable part of life. For someone who cannot tolerate the existence of a disagreement, one recourse may be to seek a form of control over the body that is ultimately self-defeating.

In contrast, several women who no longer have an eating disorder reported an improved ability to recognize and express their anger. One woman, A.E., who was in treatment ten years ago, said her method of handling conflict has changed since that time:

> I definitely didn't express anything...then I think I was just too concerned about what people thought. Now I'm still concerned about what people think, but I'm not as much as I used to be. I mean, it doesn't bother me if somebody doesn't like me for what I think...I'm much more aware of if something's bothering me and how I should express it. (005)

Similarly, the young woman who felt afraid of her step-father describes the change in her ability to deal with anger, linking it to the resolution of her eating problems:

> When I do get angry now, I can *be* angry. I *feel* when I feel angry. I can feel it, and if I need to yell or whatever, I can do it. Then, I was always--I couldn't say everything I needed to say.
>
> *Why?*
>
> Because there was always the threat of my stepdad being involved and so I mean I, you know...vomiting is a really violent act, you know, and I felt really good after I'd throw up. I felt really powerful. I liked it a lot, and I think that that was how I was exposing my anger. (218)

Whereas subjects who continued to suffer from eating disorders did not often recognize anger in themselves, the last two women admitted that they get angry and are comfortable communicating their anger. Notably, these women describe not only a new ability to express anger, but also to *feel* it. As Brown and Gilligan have suggested, a diminished ability to tolerate difficult emotions may be part of the normal process of girls' socialization, as they learn that they are rewarded for being "nice" and careful of others' feelings (Brown & Gilligan, 1992). In women who develop eating disorders, the ability to tolerate anger may be not only suppressed, but subjugated entirely to the desire to please others. This phenomenon is illustrated by the words of one woman, H.C., who notes that when she was sick with anorexia,

> I just tried to make everything perfect, like anticipating what other people were thinking or feeling and trying to accommodate for that, and I can't even give a solid example, but it was like I spent a lot of time trying to figure out what other people were thinking and how they'd react, and I'd make sure that I didn't upset them. (253)

Given the central role of anger in disorders of eating and in female socialization generally, it seems that recovering the ability to feel and express this emotion is an important factor in recovery from an eating disorder. Whether the return of the ability to tolerate anger contributes to, or follows from, recovery, is a question for future exploration. As H.C. notes, her own recovery correlated with an increased attention to her own feelings, rather than others': "Now, I know that it is impossible to figure out what other people are thinking and feeling and so I don't try. It's a waste of brain time."

Conflict in Treatment

Several themes emerged from the former patients' comments about experiences of conflict in treatment. First, a majority of those interviewed mentioned that during conflicts with staff they felt a loss of control, personhood or voice. They felt that they were not taken seriously, or were not heard by staff members. Whether or not this perception was shared by the staff, the fact that patients perceived a further loss of control is a matter for concern, given that the need for control is a central feature of eating disorders.

Second, several women noted that while they were unable to resolve conflicts with staff, they were able to "get back" at the treatment team by deceptive and self-destructive means.

Finally, most of the former patients reported that they had been compliant while in treatment, avoiding open conflict. However, a minority recalled asserting themselves during treatment.

R.D., who was hospitalized at age 15, describes a situation where, on the day she was to leave, the doctor told her she could not go until she signed a contract (to gain additional weight).

> I was really mad because I felt he was cheating me out of...he made a promise to me that I could go if my parents would come and pick me up. And then he said, "no, you can't go anymore."
>
> *Do you remember how you felt?*
>
> I felt completely trapped! I felt really claustrophobic and very, very anxious. Like I had suddenly lost complete control of everything. (022)

Similarly, A.K. recalls a situation in which she and her hospital roommate had asked for permission to photocopy her term paper on the staff copy machine. However, when they went to use the machine, they were told that only the roommate had been granted permission, and so the subject would be punished by having to sit on her bed for a period of time. She remembers feeling that the staff did not listen to the girls' explanation of the fact that they had asked for and been granted permission together: "I thought it was very unfair. I don't think they were communicating very well, either among themselves or to us."

Still another interviewee, A.E., remembers a conflict over her goal weight, during which she felt that she was not taken seriously by staff.

> A lot of times what would happen is they would say, oh, A--, you don't know what you're talking about. You're at a low weight where you can't think clearly, and I remember thinking, oh, my God, they don't think I'm thinking clearly? What is this? I'm thinking perfectly rationally...I wish they would have just listened, just kind of sat down and listened instead of objecting all the time, and saying well, you're not in a clear state of mind.
>
> *Do you think you were in a clear state of mind?*
>
> I do actually. To this day I think I was. (005)

A.E., like other patients, took out her anger and frustration by thwarting treatment efforts. A.E. would water-load (consume a large volume of fluid to increase her apparent weight) before her weight was taken; other women report skipping clinic visits and lying to their parents about where they'd been, or escaping staff supervision in order to vomit.

Many patients reported that, while in the hospital, they were very compliant and docile. This may be due in part to the nature of their situation as minor psychiatric patients; in part it may be due to the nature of their illness, which is characterized by an overriding need to please others. However, some former patients recall going to some effort to make their opinions heard. Would the ability to communicate one's position be a prognostic feature for recovery?

R.D., who had a conflict with her doctor over signing a contract, recalls that she enlisted the help of another staff member.

> I remember getting very mad, and screaming and crying. And finally, I got-- I don't know what this nurse's name was, but finally I convinced her to be on my side and help me. And she kind of helped me get through it all.
>
> *What happened?*

> Well, I got a lot more stuff. I got to control more what I got to eat, and to control more when I got to see my parents. (022)

R.D., who is currently recovered, expresses both relief at being listened to by this nurse and a sense of accomplishment at having some control restored to her. It is the first time in her description of her treatment experiences that she mentions feeling in control.

It appears that, for some patients, the treatment environment contributes to the perceptions that they have no control over their lives, and that their voices are not heard. Although many patients acknowledge that they may not have known what was best for them at the time, they still wanted to feel that they were taken seriously as persons and granted a measure of control over the process of their recovery.

These interviews also suggest that patients who perceive no possibility of negotiating conflict with staff may resort to subversive ways of exerting control, like vomiting and evading treatment. In this way, poorly resolved conflict in treatment may perpetuate the patient's sense of ineffectiveness and her self-destructive behavior. As will be discussed later, treatment programs should be changed to encourage open resolution of conflicts and to validate the patient's need for respect and autonomy.

3.) Body Awareness

"I'd like to explore your relationship to your body."

1. How do you currently feel about your body? (Follow-up)
2. Do you feel like you are aware of when you are tired or restless? warm or cold? hungry or full?
3. What kinds of things make you feel good about your body? (Follow-up)
4. How do you feel treatment affected your feelings about your body?
5. Have your feelings about your body changed since treatment?

Deficits in recognition of body sensations, termed interoceptive awareness, are a constant feature of eating disorders. In this section, I was interested in learning about various aspects of patients' interoceptive awareness. First, I wondered if better outcome was associated with improved awareness of sensations such as fatigue, temperature, and particularly hunger and satiety. I also wondered whether women now experienced a different relationship to their bodies; for example, whether they were now using internal cues such as hunger, rather than external cues, such as calorie allowance, to regulate their food intake.

Additionally, I hypothesized that women who derived self-esteem from internal rather than external cues would be more likely to have recovered. I supposed that such women would report feeling good about their bodies when physically active, whereas less recovered women would feel good when they received external affirmation of their worth, such as a compliment or a small size or weight measurement.

Lastly, I wondered whether these women had experienced their treatment as facilitating attendance to internal cues.

Hypotheses

- Outcome would be correlated with improved recognition of internal sensations, particularly hunger and satiety.
- Women who associated feeling good about their bodies with being active would be more recovered than those who relied on passive, external cues like size and weight measurements.
- Traditional treatment programs would not be perceived as promoting interoceptive awareness.

Results

Ten of the twelve women interviewed reported either negative or equivocal feelings about their bodies. The most common complaints were of feeling fat, dissatisfaction with particular body parts (thighs), and wanting to be smaller. One woman with anorexia noted that she sometimes hated her body because it was "bony and gross and disgusting." Another woman said that although she was "never totally satisfied," she felt pretty good about her body. Only one individual reported feeling definitely good about and liking her body.

Internal/External Cues: Hunger and Satiety

There was an observable correlation between current status with respect to an eating disorder, and the degree to which individuals reported recognizing internal cues of hunger and satiety. All women currently in remission reported that they were able to tell when they were hungry and full. One of these women added that although she recognized feeling full, she sometimes ate when not hungry.

> I can tell, but sometimes I eat past that time or I eat when I'm not hungry. But I can tell when I am hungry and when I am not. I couldn't tell it for a long time, though, and then it came back to me. (022)

In contrast, all currently symptomatic women did not recognize hunger, satiety, or both. Several women said they never felt hungry, but ate according to the time of day and a schedule of allotted calories. As E.C., who currently has bulimia, explained:

> Every day, when I wake up in the morning, I think about what am I going to have for breakfast and I plan it all out either in my mind or, most of the time, I write it down, and I try to calculate how many calories I have every day, and I try to stick to that. You know, it's not just like, what do you *want* for lunch today, you know? It's not that. You know, it's like I already *have* what I'm supposed to have for lunch. (261)

This young woman clearly identifies the problem in her current approach to food: For her it is not a question of "what do I *want* for lunch today?" but rather, "what am I *supposed to* have?" The inability to attend to the needs of her body also extends to her failure to experience satiety:

> *After you've eaten, do you feel full?*
>
> No, well, I mean I *should* feel full, but I like, because I've made out my schedule, I should be feeling full...I'm full now because I ate what I'm supposed to eat, not because I'm feeling full. (261)

Another woman with anorexia, K.H., who finds it difficult to tell when she is hungry, has in the past resorted to an elaborate system of external cues:

> I used to have this system of three growls and then you could go ahead and eat. Like three phases of growling, you know, 'cause like your stomach growls and then it settles down for like maybe an hour and then it growls again. And I would like, wait three of those and then I'd say, oh, okay, I can go ahead and eat. Um, now I don't think I do that, but I still wait until my stomach is really growling. (062)

As in the previous case, K.H. is aware of a deficit in her perceptions of hunger and satiety. She explains that without some external gage she cannot tell if she is hungry or simply "mentally hungry," and that eating when only mentally hungry might cause her to get fat.

Others similarly report overriding physical sensations with cognitive control. A young woman with anorexia, N.K., describes the progressive loss of sensation through her illness:

> No, I don't really get hungry. I eat just because it's time to eat. That's the hardest part, for me.
>
> *Has it changed at all?*
>
> I mean, I think initially when the disorder started I was hungry all the time, but you just deny it. Now it's gotten to the point that I don't feel it. I just put the calories down. (029)

Women with both anorexia and bulimia report an inability to recognize physical sensations of hunger and satiety that has developed over the course of their illness, perhaps through the substitution of cognitive control (e.g., denial of hunger) for internal perception. As has been suggested earlier, other factors that may contribute to the loss of interoceptive awareness are the consumption of diet products and low-calorie foods (Tuschl, 1989). Indeed, one young woman with anorexia explained that "I think I'm full, but...maybe I just ate a whole big bowl of salad and so I didn't really eat enough calories or something." Most likely, there are several mechanisms causing women with eating-disorders to lose touch with internal perceptions; once these perceptions are no longer deemed trustworthy, a cycle is begun in which cognitive control is substituted for physical sensation.

Internal/External Cues: Feelings about Body

Several women reported that nothing currently made them feel good about their bodies. Contrary to predictions, the most common positive factor

reported by women, irrespective of current diagnosis, was exercise. The actual source of satisfaction derived from exercise, however, varied among the women. Some reported that they enjoyed working out because they felt like they were "burning fat" or "burning up calories." Others said they enjoyed being able to outdo someone else, or the feeling of being "on track."

Five women reported that being complimented, fitting into small size clothing, or losing weight made them feel good about their bodies. Three of these subjects were currently symptomatic. As K.H. explains,

> Unfortunately, when I lose weight I'm still happy, so that kind of makes me feel good about myself. Or when I go to a store and I try on a size and it's under what a person who's my height and age and stuff would be, that'll make me feel good about it. (062)

Thus, the use of external cues to provide satisfaction with their appearance was characteristic of women still suffering from eating disorders. On the other hand, it is difficult to determine if attention to internal cues, such as pleasure in physical activity, is more applicable to women in remission. One reason for this is the difficulty of determining who among the subjects enjoyed exercise for its physical pleasure, and who enjoyed feeling in control and expending calories. Another possibility which should not be overlooked is that women with eating disorders as well as those who are healthy may in fact enjoy exercise for both reasons. For women still suffering from eating disorders, exercising may provide a period of time when they actually are aware of their physical sensations. As one woman with anorexia said, during exercise, "I can feel my body."

Treatment Experiences and Body Awareness

In a recent study of women who had recovered from anorexia, Margo Maine (1985) found that the majority felt that their treatment (inpatient and outpatient) dealt inadequately with their feelings about food and their bodies. This finding was supported in the present study, as three-fourths of the women reported that their clinic or inpatient treatment had not been helpful in improving how they felt about their bodies. The most prominent criticisms of treatment were: the focus on "a number," without regard for how the patient might feel about her body at a given weight; the presence of competition engendered by patients who were at lower weights; and the perception of mixed messages from nursing staff who were themselves concerned about their weight.

An emphasis on the "medical" approach to treatment was described by several former patients, as R.D. explains:

> When I was there it was all a number on a scale...They didn't emphasize how you looked, at all. I mean, they told you if you looked really sick, but they never told you when you looked good. (022)

Another aspect of the medical approach deemed unhelpful by some was the extensive measuring of food and caloric content. A.E. commented that the requirement of keeping a "diet plan" seemed to amplify her obsession with measurement:

> ...I think when I got out, I was more caught up in that than I was before I had gone in because they measure everything....I remember thinking at the time, this is unhealthy...I thought it was very unreasonable to do that because it was really perpetuating things for me, because I was already caught up in that. (005)

Comparisons with other patients were perceived as unhelpful by several respondents. M.D., who was treated for anorexia recalls,

> It was sick. I mean, there were girls there who were more underweight than I was, and it made me feel worse about myself because I thought I should be as skinny as them. It was terrible. (137)

Women with eating disorders are extremely aware of the appearance, weight and eating habits of other people. Another aspect of treatment considered detrimental to body image was the existence of "mixed messages," particularly in the inpatient setting. A.E. reported that, during her hospitalization for anorexia, the nurses on the unit would sometimes discuss their concerns about their weights in front of patients. In addition, on one occasion the staff rented a particularly unhelpful video:

> ...Once they rented the movie *Perfect* with Jamie Lee Curtis and John Travolta, and that's like the ultimate anorexic nightmare. You don't want to see Jamie Lee Curtis with this beautiful body. I mean, everything you want to have, and the doctors are telling you you're not built like that...That's something you have to deal with later on, but, you know, at the time, when you're trying to focus on feeling better about yourself, that doesn't exactly help. (005)

Several women reported that their treatment had been somewhat helpful in how they felt about their bodies. One young woman with anorexia said that, while in the hospital, she had felt better about her body because she was around others who felt as she did; but after leaving the hospital those feelings evaporated. Another woman attributed her improved body image to the weight gain, itself.

Finally, positive role models were perceived as crucially important by one participant. D.A., now recovered from bulimia, says that her self-image changed only after she left formal treatment and joined a support group:

> The group therapy work that I did had a huge impact on my body. I was still, when I went there, I was still comparing a lot. I remember I would sit in like the quad area of school and just look at people walking by and decide who had bigger thighs or smaller thighs or just stuff like that. I would do that a lot. Then I started going to this group, and people who were heavier than me and felt good about their bodies, and I learned that it was all totally upstairs and all I wanted to do was feel good about myself, and I knew I just needed to decide to, just decide to accept my body... (218)

These data suggest that eating disorder treatment programs fail to adequately address patients' feelings about their bodies, dismissing such feelings as mere symptoms of an underlying disturbance. Many patients found their treatment unhelpful in how they viewed their bodies, criticizing especially the presence of mixed messages and an emphasis on quantificatio (counting of calories and pounds) rather than attention to body awareness and internal perceptions.

On the other hand, positive role models-- exposure to women who were comfortable with their bodies-- was perceived as helpful by at least one participant. These findings offer some insight into the changes in internal awareness that accompany recovery from eating disorders. Additionally, they highlight specific avenues of reform for treatment programs, as I discuss later.

Changing Body Attitudes

Maine's study of women who have recovered from anorexia suggested that the recovery process was characterized by an increasing acceptance of

oneself and one's body (Maine, 1985). Similarly, many of the women I interviewed said they were now more accepting of, although not yet satisfied with, their bodies. This finding was largely correlated with the degree of recovery; all of the currently symptomatic women reported dissatisfaction with their bodies, while recovered subjects expressed more equivocal feelings, often of resignation. Perhaps most accurately, the shift towards increasing acceptance may be described as a continuum, as many still-symptomatic women reported a slowly-changing body image.

One young woman with anorexia, N.K., described how she vacillates between liking her thin body and hating it:

> There's times when I just can't seem to look at myself in the mirror. I just feel so bony and gross and disgusting, but there are other times when that feels good, that it feels like there's some control. So it shifts back and forth, whereas before, I didn't see anything wrong with feeling bony or being underweight. (029)

Another woman with anorexia described the evolution in her feelings about her body, explaining that she used to admire a completely emaciated co-worker. Several years later, she found that image less desirable, although she still wanted to be "super-skinny." Today, she questions that preference, as she wonders aloud, "well, *do* I really want to be super-skinny, or do I just, you know...oh, I still haven't figured it out." (062)

Typical of the recovered women still struggling with their body image was H.C., who explained:

> I wouldn't say we're friends in any way. I would like it to be smaller...It's more like being stuck with a step-sibling that you don't especially like, but you know you have to live with. You try to get along. (253)

Two women, now recovered, say that they have come to accept their bodies:

> ...I'm happy with what I have now, you know. I mean, this is my body, and there's nothing that's going to change that. (137)
>
> I'm way more loving and accepting of myself. I'm a lot nicer to myself. (218)

Another aspect of recovery was a shift toward internal standards of body satisfaction. One recovered woman, R.D., explained that she now focuses on appearance, rather than numbers:

> I care more about how I look now than what the number is on the scale. More...is everything in proportion, rather than how much do I weigh. (022)

H.C. described how her attention to her internal signals of hunger and satiety returned when she started college. In her college dormitory, extensive external controls were no longer possible:

> I couldn't know calories or measure everything or make it all myself. I couldn't count exactly the way that I could when I was at home. And that helped because-- it pissed me off because I couldn't keep to my regimented pattern-- but it forced me to use another tool and that was going back to the original one of my body... (253)

These responses suggest that the process of recovery from eating disorders is accompanied by increasing self-acceptance, and attention to internal signals, standards and desires. Together with the findings from the previous section, these data suggest that treatment for women with eating

disorders should include promoting interoceptive awareness and self-acceptance, and providing patients with role models who can reinforce these attributes.

4.) Politics

"I'm interested in how you think society views women."
1. How do you think our society wants women to be? (Follow-up)

2. What do you think is society's image of the ideal woman?

3. What is your own image of the ideal woman?

Clinicians have long noted the correlation between achievement orientation and eating disorders (Bruch, 1973). Recently, some investigators have reported a relationship between adherence to a "Superwoman" ideal and eating disorder prevalence (Steiner-Adair, 1986; Thornton et al., 1991). The Superwoman, as noted earlier, represents an image of a woman who excels in a number of areas, including work and academics, physical appearance and attractiveness, and family roles.

However, the relationship between the Superwoman ideal and eating disorders may be somewhat indirect. In one recent study, eating disorder risk was increased among women with a higher Superwoman index who also adhered to a strongly feminine or masculine gender type, but there was no increased risk among women with a high Superwoman index who were androgynous or undifferentiated in their gender identification (Thornton et al., 1991). The author suggests that the absence of a rigid gender identification among androgynous and undifferentiated women may allow these individuals to respond with more flexibility to situations requiring traditionally masculine or feminine traits.

As previously discussed, Steiner-Adair has observed a higher eating disorder risk among young women age 14-18 who associate with a Superwoman ideal without separating their own values from those of society (Super Women). In contrast, young women who recognize new roles and expectations of women in society, but who are able to distinguish their own values from society's, are at no increased risk (Wise Women). As she suggests of the Wise Women respondents, "Inherent in the process of being able to take a stand apart is the capacity for reflective thinking about the self, which comes through an emphasis on self-awareness" (Steiner-Adair, 1986, p. 105).

In keeping with these observations, I hypothesized that the expression of a personal ideal which focused on satisfaction and relatedness, and which differed from societal ideals, would be correlated with better outcome. Recovery would thus be associated with increased attention to internal satisfaction and reward rather than fulfilling societal expectations, and on reintegration of relationships, rather than autonomy.

Hypothesis

- Recovered patients will identify personal ideals for women which are self- and relationship-oriented and are distinguished from those of society.

Results

Societal Ideals for Women

The questions about societal and personal ideals for women posed in the present study were similar to those used by Steiner-Adair. The patterns of response, however, were somewhat different.

Societal ideals were fairly consistent among the respondents. The prevailing pattern cited was indeed of the Superwoman (four women used this word), who was "perfect," and could "juggle everything," including career, family, and appearance. "To be a Ph.D. candidate who looks like Pamela Anderson," was the succinct answer of one respondent. Indeed, appearance was considered most central to the societal ideal, and 11 of the 12 subjects said society wanted women to be thin. Other features considered important to societal ideals were large breasts, self-presentation, weakness or frailty, and deference to men. As D.A. put it:

> I think society likes women to be very caught up in their presentation of themselves and that's really important-- that first look of a woman is like the most important. I don't think society puts enough emphasis on who's inside. (218)

Several women, including K.H., articulated the Superwoman ideal, with looks as the pre-eminent feature:

> Well, I think that on one hand, the ideal woman has a body like Cindy Crawford...I think now it's that she has the ability to go out there and work, and be super-success story in the workforce, and then come home and be able to be super-mom. And then still not cross over an imaginary line of femininity. She's supposed to be assertive, yet not assertive so that she's not feminine anymore. (062)

Another subject, J.R., commented on what she considered the "conflicting messages" presented of women.

> I feel like, you know, they want us to be pencil thin, but still have big breasts, and still have lots of energy and, you know, be able to do all kinds of things, be superwoman. You know, you see these commercials on T.V. with this, you know, really thin model eating potato chips and drinking soda. That doesn't work, you know? (027)

In discussing society's ideals of women, the subjects noted the primary importance of appearance and thinness, even as they remarked on other expectations such as being successful and having energy to do things. They were aware of the incongruence between the restraint required to stay thin and the other goals which are expected of them; between demands to be assertive, yet not too assertive. The degree to which the subjects identified themselves with these irreconcilable expectations of women may suggest a link to eating disorders.

Personal Ideals for Women

The question, "What is your own image of the ideal woman?" evoked unanticipated responses. Unlike Steiner-Adair's subjects, most interviewees were able to identify an ideal woman who was self-aware, self-satisfied, and tolerated her imperfections. This difference may be due to my subjects' older age, their time in therapy and/or their personal searches for self-acceptance. However, a difference emerged among the respondents in terms of how well they were able to apply this ideal to themselves.

Several women described an ideal woman who was happy with herself, yet did not themselves identify with this image. As one woman with anorexia, L.D., put it:

> I think, caring and funny, and a lot of it I can say and tell everybody else, you know what I mean? Like, it's the inside that counts. If a friend comes to me and she's really upset about maybe the way she looks, it's the inside that counts, you know? God made you who you are, and stuff like that, but I don't take that to (apply to) me. It's like not practicing what you preach. (036)

Similarly, E.R. described an ideal woman as one who was self-contented, yet this was not the standard by which she judged herself:

> I think the ideal woman should be how they want to be and what makes them happy as a person...with me, personally, I guess I just want to be happy, but being happy includes all the being successful, just like how our society views people...Like I think I need to be all those things, but another person, another woman can think that, you know, what they're doing is great, and you know, they're confident in what they're doing. They're confident even though they are overweight or they're not the prettiest person. That's the ideal woman in their eyes.
>
> *But not for you?*
>
> Not for me. (261)

It was difficult to assess the correlation between recovery and identification with a self-accepting ideal, since some subjects failed to specify whether or not they identified with their ideal. However, among Maine's subjects, self-acceptance was a key factor in recovery (Maine, 1985). And indeed, several women I interviewed said they hoped that they would eventually be able to apply their image of a self-accepting woman to themselves.

In general, then, it seems plausible that recovery may be associated with an ability to identify with ideals of self-satisfaction and relationship to others. The degree to which women are able to identify with an ideal of happiness, personal satisfaction and acceptance, rather than applying to themselves external standards of appearance and achievement, may represent a spectrum in psychological recovery.

5.) Experience of Illness

"I'd like to know about how you have experienced your illness and treatment."

1. What have been the effects of this problem on your life? (Follow-up: Has anything good come out of it?)

2. What have been the effects of this problem on your relationships with others?

3. What factors do you think contributed to the development of this problem, for you?

4. What factors have helped you in managing or overcoming the problem?

In this section, I was interested in learning about the impact of having an eating disorder on the lives of these women. As previously noted, outcome studies have largely excluded the patients' perspective, and have often focused on physical parameters and diagnostic criteria, such as weight and restoration of menses. Though these parameters are certainly relevant, they in no way assess more subtle issues such as the quality of relationships and degree of social satisfaction.

Those studies which have inquired into such "soft" parameters have tended to note that impairments in intimacy and relationships may occur after work and academic functioning are restored (Herzog et al., 1988). Therefore, I was interested in learning whether these women had experienced the problem as affecting particularly their ability to form close relationships.

The exclusion of patients' perspective from outcome studies also means that little is known about what aspects of treatment, or what informal therapeutic influences, are considered helpful by recovering or recovered patients. Maine's study of recovered women suggests that the process of recovery is an individual one, that formal treatment may be inessential, and that among the most helpful factors is the establishment of an intimate,

empathetic relationship with someone (a friend, family member or psychotherapist) which fosters valuation and acceptance.

An additional aspect of Maine's study was the finding that the women often described making an active decision to get better. Some recalled that the decision to take responsibility for themselves had followed a moment of crisis, as Maine explains:

"For some this decision emanated from their panic when suddenly they no longer had the strength to walk or when they wanted to eat, but could not. Doctors, hospitals, and their families had failed to convince them of their endangered status; they had to experience this themselves and actively decide to recover" (Maine, 1985, pp. 52-3).

Similarly, in a qualitative study of long-term outcome among patients with anorexia, Hsu found that women often described making a conscious decision to get well, and that they often cited a precipitating factor, such as 'hitting bottom,' becoming pregnant, or having a husband threaten to leave (Hsu et al., 1990).

Based on these findings, I wondered whether the recovered subjects I interviewed could identify a precipitating experience, or a conscious decision to get well. I also hypothesized that relationships, and not formal treatment *per se*, would have been experienced as most helpful in recovery.

Finally, I was interested in learning what factors my subjects felt had contributed to the onset of their illness. Given the apparently multi-factorial nature of eating disorders, I had no expectations of what these women might have perceived as inciting causes.

Hypotheses

- Social and intimate relationships would be perceived as having been particularly impaired among women with eating disorders.
- Recovery would be associated with an active decision to get well, especially following a particular event or experience.
- Factors associated with recovery would include the establishment of a supportive relationship, in or out of formal treatment.

Results

Factors Contributing to Illness

Each woman had to some extent contemplated the causes of her eating disorder, and in each case, the perceived causes were different. However, several themes were apparent among the responses. These may be grouped into what I will refer to as chronic, or personality factors, and acute or subacute events.

Among the former category, several women said they believed they had developed an eating disorder partly because of the obsessive or addictive nature of their personalities. For one woman, an obsession with weight loss provided a relief from other obsessive thoughts that had previously occupied her mind. Another woman noted that a tendency to addictive behaviors runs in her family, as her sister has had problems with drugs. For her, as for many other women, the eating disorder emerged at a time of change:

> ...I have an addictive personality and an obsessive personality to begin with, and I think that my eating disorder is just one of the ways it manifested itself...It was a changing point in my life in terms of, you know, going from grammar school to junior high, and the times in my life when I've had the most difficult time with it have always been times of change for me... (027)

Another personality trait cited was, not surprisingly, that of the "good girl," intent on pleasing others. For A.O., as for the woman quoted above, developing anorexia was an acceptable way to rebel:

> I think that someone (once) asked me, "why did you choose anorexia? Why did you become anorexic, instead of becoming addicted to drugs, or something?" It was because I was the good girl and I wasn't involved in that kind of scene... (175)

Despite some consistency in personality traits, the acute precipitating causes of illness varied among the respondents. In a few cases, a single "trigger" event could be cited; in other cases, more subtle pressures on appearance were described. Notably, about half of the women related the illness to a change in schools or a desire to remake their image among their peers.

An example of a single "trigger" event was described by K.H., also a "good girl" who explains that her anorexia "was kind of a safe way for me to rebel." K.H. had felt pressured about her weight as a child, but her illness began after a specific incident at school:

> Everybody was being weighed, and (the teacher) was shouting out all these numbers, for weights. And then when I got up to the scale, she like whispered it in my ear, and I was like, wait, I wanted my number yelled out, too. But then I realized, oh, wait, there's something wrong here, you know? I'm an 80, I'm not, like, a 60. And then I thought, Oh, God... (062)

Several other women described feeling that their parents had been critical of their appearance or their diet. In some cases, pressure was related to achievement expectations, rather than appearance. In either situation, the

eating disorder seemed to emerge as a way of re-establishing control or refuting parental expectations.

The desire to change one's image, often coinciding with joining a new peer group, was a frequently cited theme. H.C., now recovered, linked the onset of her illness to starting boarding school:

> ...between 8th and 9th grade I said, okay, this is my chance, a new group of people, they've never seen me...and they don't have any ideas about me, and if I can lose weight this summer I can start totally fresh and I'll never have to be the fat kid, which was an incredibly enticing idea to me. (253)

Clearly, many young people diet without succumbing to an eating disorder. However, as H.C. suggests, weight loss may become an end in itself, if an individual feels rewarded by little else in her life. For H.C., dieting "spiraled downward" into anorexia when, in spite of the fact that she was no longer teased about her weight, she continued to feel lonely and homesick at school. Similar accounts were related by other women:

> It started in the summer of 8th grade. I had moved from a different place to junior high...I thought if I lost weight, people will like me more...It got out of hand. I started finding myself eating over getting upset. (137)

> We moved to Novato...and I was trying every which way to fit in...and I had just started on a diet, you know, thinking that, oh, it's the pretty, skinny girls and cheerleaders who have the boyfriends. So I just dieted a little, and it just escalated. (036)

The vivid descriptions offered by these women lend support to Hsu's hypothesis regarding the relationship of eating disorders to affective illness and personality features (Hsu, 1990). It seems reasonable to assume that a

socially-approved behavior, like dieting and weight loss, might "escalate" into a full-blown eating disorder at times of stress, in individuals susceptible to depression or compulsive behaviors. The appearance of an eating disorder might therefore require several separate events, including: an underlying susceptibility; a stressful change in environment; and the perception that dieting may serve as a means of coping with the problems at hand. Such a formulation offers promise for multiple avenues of intervention and prevention, as I discuss in the next chapter.

Effects of the Problem

As expected, the largest category of effects cited by the subjects was that of social isolation. Five women discussed their withdrawal from others during the illness, and the difficulty they continued to experience in terms of establishing new relationships. The problems in relationship will be addressed later; for now, I will focus on the immediate problem of social isolation.

Several women described their progressive isolation as stemming from a need to control their environment, particularly their food intake. L.D. spoke of missing out on social opportunities, because of a fear of the "change in my routine."

> A lot of things center around food, and I avoid everything possible like that--socializing around food, or sitting, maybe going on a trip, and I'd say no. I'd be too scared to do that because it would be a change in my routine. I have a certain kind of routine that I do, and it sounds really dumb, but, you know, when something gets in the way of it, I get really anxious. (036)

Another woman, E.F., spoke of a similar anxiety:

> It's always hard, because I couldn't just go out with someone. I was always, you know, concerned about counting my calories and what I was going to eat and this and that, and so it made spending the night at someone's house difficult or going away for the weekend impossible...It's like since my eating disorder I've sort of become like a recluse. (027)

E.F., who has suffered from anorexia since age 12, also cited the physical effects of having the disorder:

> Well, physically, I'm not as tall as I would have been. I have osteoporosis. My bones are like those of somebody who is like seventy. I've never menstruated on my own. (027)

Several women characterized the effects of the problem on their lives as exhausting and depressing. As N.K., a woman with anorexia, explained:

> (It) sort of drains you, physically, emotionally. There are times when you just don't want to deal with it anymore. Sometimes, I try to look at it as a challenge to try and overcome it, but other times, it really feels like it's holding onto me. (029)

A.O., who has struggled with eating disorders for nearly a decade, offers this perspective:

> I feel like it has really ruined my life, to a degree. Ever since then, there hasn't been a day when I haven't thought about how I look. When others look at me, what do they see? I haven't been comfortable with myself...I feel like I haven't eaten normally in ten- eight years, eight or nine years. I feel like I haven't had a decent, normal eating day in about nine years. (175)

This young woman, like others, describes the illness as something which is outside of herself and holding onto her tenaciously. She relates her fear that she will never be free of its grasp:

> I feel like I am never gonna...Sometimes, I think it is going to be on my mind every single day for the rest of my life, because it has been for the past eight or nine years. It has been. What is not going to keep it on my mind for the next twenty years? That scares me. That thinking scares me, and it bothers me. (175)

Even women who are clinically recovered describe lasting effects of the problem on their lives. One recovered woman, A.E., relates the following:

> Well, it never leaves you. You always have some sort of characteristics that stay with you. You know, you think about exercising, freaking out in certain situations, you know, when I get around my family, I get nervous about that because I'm afraid they're looking at what I'm eating, what I'm doing. I mean, I think it just never goes away. (005)

These women describe fairly long-term, significant life effects of having an eating disorder. Given the perception of constant struggle, draining of energy, and sense of discomfort expressed here, it is not surprising that some studies have reported impaired relationships and intimacy at follow-up.

Effect on Relationships

All subjects reported that the disorder had, at least for some time, impeded their relationships with others, particularly intimate relationships. Half of the subjects expressed an absence of, or difficulty in maintaining, romantic relationships. When romantic relationships (exclusively with men, in this sample) were established, these were seen as having a powerful influence, both positive and negative, on the subjects' self-images.

The women cited several factors as interfering with relationships, including: a need for secrecy and control; insecurity about body and appearance; and difficulty in dealing with intense emotions. As the need for control leading to social withdrawal has been considered above, the latter two factors will be the focus of this discussion.

A.O., now recovered, describes the difficulty she has had in relating to men since her illness:

> I think it has really impacted my relationship with men...I have never had a boyfriend. I have never had any kind of real relationship with a guy... And, of course, I think something is wrong with me and what is wrong with me? So, it must be that, maybe, I look too big in that outfit, or, I don't know... (175)

Similarly, H.C., also recovered, explains that she has had few relationships because of her insecurity about her appearance:

> ...As far as boyfriends, it's been hard, just because I don't think of myself as an attractive person and...it just takes me a really long time to feel comfortable with someone who compliments me or to ever believe it. (253)

Another prominent theme was the desire to avoid the emotional costs of intimate relationships. A woman with bulimia, E.R., describes how she had been involved in a serious relationship, but had broken up with her boyfriend because "I gave so much into the relationship, and I mean I couldn't deal with it anymore...

> After that relationship I haven't had a boyfriend. Actually, at this point in my life I have no time to even date someone. I say that and it's sort of like an excuse because I don't want to deal with emotions. You know, like going out with a guy or just even if I like them, I try to avoid it...I don't want that type of, I just don't want an emotional thing like that with a man. (261)

M.D., now recovered from bulimia, explained that she still could not tolerate the difficult emotions that go along with intimacy:

> I don't get very close to people at all.
>
> *How come?*
>
> I don't know. I don't think I know how to handle, I mean, a relationship. I just can't handle making people upset and dealing with that, and so I try not to get too close to people. I don't want people to get very close to *me*. (137)

The fear of tolerating difficult emotions appears to linger for some time, interfering with the establishment of close relationships. This finding is not surprising in view of the fact that so many women with eating disorders express difficulty dealing with conflict, as well as in recognizing their own emotional states. As Brown and Gilligan have suggested, it may be that the socialization process discourages women from identifying with and expressing difficult emotions (Brown & Gilligan, 1992).

Effects of the Illness: Growth and Empathy

Several women commented that, in addition to the negative effects, some good had emerged out of their experience with an eating disorder. Three themes were prominent in these remarks: an increased understanding of oneself, empathy for others, and improved family communication.

One recovered woman noted, for example, that her experience with eating disorders had inspired her to pursue psychology as a career. In addition, she has been motivated to educate other people about eating disorders. Another recovered woman, H.C., observed:

> It's made me tremendously more empathetic. My two closest friends, one is 27 and one is 23, both have had eating disorders off and on. We didn't become friends because of that. It was just that through the friendship we found out and we've all been incredibly helpful and supportive of one another. And it's made our friendship even stronger. (253)

The re-establishment of relationships described by these women may be one road to recovery from eating disorders, as is discussed below.

Overcoming the Illness

As expected, over half the women cited supportive relationships-- with therapists, friends and boyfriends-- as factors central to their recovery. In addition, several of the recovered women described a precipitating event which motivated their making an active decision to recover. For example, A.E. described how she had unexpectedly gained weight during college, and as a result had had to shift the focus of her control from her weight to other things in her life.

> I mean, I didn't have any control over my weight anymore...so it was the studies I was concentrating on, as well as relationships with friends...(005)

Another woman, D.A., explained that she had "decided" to get over her illness as a result of her experiences in her support group.

> ...I decided that I didn't want to obsess about this anymore, at the point where I decided that I wanted to feel good about myself.
>
> *What made you decide that?*
>
> I think seeing other people feeling good about themselves and what that was like. (218)

Lest it be construed from this last response that the decision to recover is readily at women's disposal, it should be emphasized that these subjects struggled for years with an eating disorder before finding the ingredients crucial to their decisions. In some cases, the event that triggers the recovery process may be somewhat more concrete, as M.D. explained:

> I swear to God the last time I threw up was the day I found out I was pregnant. That was the last time I did it because I could not do that when I was pregnant. I thought I would miscarry the baby. And I promised myself that I would never do it again afterwards because I couldn't raise my son the way I was before. I was just totally sick. (137)

Several women who are still in the recovery process described a similar sense of needing to take control over their lives-- rather than their bodies. One woman with anorexia, E.F., related this realization as follows:

> I'm almost twenty-six, and, you know, if I want to live my life out like this it's my decision, but I'm also realizing that I'm missing out on a lot of things in life. (027)

Or, as K.H., also suffering from anorexia, put it:

> I think one of the biggest things that I've learned, it's just that, I need to be responsible for *me*, I'm not here to take care of other people...it's taking control, I guess, instead of trying to starve yourself to get control. (062)

Whereas these young women seem to be arriving at a slow realization of a new way to take control of their lives, E.R. said that she felt as though she needed a "wake-up call" before she could put a stop to her bulimia:

> It has to stop...And at times I feel like I can't do it, but I know I can do it because I'm a strong person, and I realize all those things that have happened to me, and that it's just a matter of me taking control and, you know, saying this has to stop. This is going to stop, but I always say that, though. So I mean, I feel like something drastic has to happen to me in order for it to change my mind about some things. (261)

These reflections suggest that recovery from eating disorders requires both a supportive relationship and an active decision on the part of the individual patient. In many cases, this decision may follow an inciting event which makes a crucial, threshold impact on the psyche. For each individual, however, the necessary event may be different: One woman interviewed was motivated by the understanding that she was physically endangered, while another cited the realization that she had pushed away the people closest to her. Given these variations, treatment programs should be designed flexibly to help each individual achieve the motivation necessary to initiate her own recovery.

Chapter Four

Future Directions: Implications for Treatment, Prevention, and Research

The View from Here: A Multi-factorial Model of Eating Disorders

The voices of women who have suffered from eating disorders attest to a model of the illness that is both etiologically and experientially complex. Each individual in the present study was exposed to a unique combination of family, social and biological forces which may have contributed to her developing an eating disorder. At the same time, these interviews also suggest common experiences among women with eating disorders which may shed some light on the etiology of the problem.

A central feature of these women's experience was a disconnection from the self. This was diversely manifested as an inability to: 1) acknowledge anger or express it openly; 2) identify and trust internal signals of hunger and satiety; and 3) attend to internal standards of success and happiness. In each case, the women had substituted external standards such as approval from others, a calorie allowance, or societal norms and ideals, in place of their own emotions, physical sensations and personal goals.

As discussed earlier, the process of "normal" female socialization may contribute in various ways to the disconnection experienced by these women. Pressures to suppress discordant feelings, to contain appetites, and to value appearance over competence are all likely to inhibit access to feelings and desires. Women who lose touch with their feelings can no longer trust their responses either to emotions or physical sensations, and are thus susceptible to the tyranny of self-control, rigidity and isolation that is characteristic of eating disorders.

A related theme among the interviewees was a perceived dissonance between a female role, as represented by one's mother, and intellectual or professional achievement and reward. These women, by and large, did not view their mothers' lives as embodying the public success and personal satisfaction to which they themselves aspired. This, too, represents a disconnection from the self, through the rejection of the female aspects of oneself, including, perhaps, emotional availability as well as physical attributes.

Recommendations for Treatment

The interviews with former patients point to strategies for both prevention and treatment of eating disorders. Based on our current understanding of etiology, efforts at intervention, both primary and secondary, should involve:

1) maintaining or re-establishing connection to the self; and
2) fostering integration of diverse female roles.

I first discuss the applicability of these concepts to treatment of eating disorders, turning later to strategies for prevention.

Re-establishing Connection to the Self

The interviews with former patients reveal that recovery from an eating disorder is associated with the return of the ability to identify and attend to both emotional and physical sensations. Treatment programs, both inpatient and outpatient, should therefore be directed at developing such interoceptive awareness. Though the following recommendations are directed toward hospital-based treatment programs, the majority may also be adapted for use in individual therapy.

1) Increased attention to awareness of internal states of hunger and fullness.

Traditional eating disorder programs may replicate the patterns of caloric regulation imposed by women with eating disorders, themselves. According to one author, the main concern of treatment is cognitive, not sensory: The goals are to help patients *understand* their nutritional and energy needs, without regard for *experiencing* physical sensations of hunger and satiety (Hsu, 1990).

Yet it has been noted that "Women with eating disorders are often dissociated from their bodies (Goldner, Cockhill, & Bakan, 1990). They need opportunities to feel fullness and hunger, and the attending feelings of emptiness, deprivation and satiety" (Sesan, 1994, p. 257). Inpatient and outpatient programs should therefore encourage patients to attend to internal cues in deciding when, and how much, to eat. Once they are out of medical danger, patients should be encouraged to monitor their feelings, and should be rewarded for how well they respond to internal signals, rather than how well they follow a prescribed diet.

Interoceptive awareness may be fostered through other means, as well. Physical activity has been proposed as an effective therapeutic means of strengthening connection with the self. Some therapists recommend the use of guided imagery in women with eating disorders, for "mapping the landscape of the self" (Hutchinson, 1994, p. 158). Other techniques for recovering a sense of self might include yoga and meditation exercises, journals and artwork.

2) Develop the ability to recognize anger and other emotions, and teach constructive ways of dealing with conflict.

Inpatient eating disorder treatment programs have been described as "perpetuating a pattern of oppression by rigidly controlling women's behaviors and actions and inadvertently "silencing" them once again" (Sesan, 1994, p. 256). In the present study, conflict situations in treatment often contributed to patients' perceived loss of control and ineffectiveness, with the result that some women used subversive measures to "get back at" staff. Rather than punishing assertiveness, treatment programs should be designed to foster individuals' ability to identify and express their feelings. Constructive ways of voicing and resolving conflict should be practiced by patients and modeled by staff members.

3) Positive role models who foster self-acceptance.

Women recovering from eating disorders need to be exposed to female role models who can accept themselves and who can encourage patients to reject societal standards and ideals. This perception was expressed by one interviewee, who described a particularly influential staff member:

> One of the people I respect a lot is R.S...I guess because...she accepts her body for what it is...She's successful, and she's happy with herself. I think that's the biggest thing. She accepts herself. (027)

4) Attention to social and cultural factors on women, with the opportunity for political action.

In Maine's study of recovered patients, an awareness of social and cultural forces influencing women was perceived as helpful in the recovery

process (Maine, 1985). In recent years, some eating disorder programs have indeed incorporated discussion of sociocultural influences into their protocols (Sesan, 1994). Few, if any, however, have adopted an active political stance for women with eating disorders.

Such a stance, however, might have therapeutic value for patients with eating disorders. Indeed, one subject, A.E., described her wish that patients had been able to take an active role in countering images of women:

> What would have been good is like where you had a project where you wrote a letter to some of the advertising agencies or even modeling agencies, like a modeling agency in New York, and saying, look, here're the statistics. We have fourth-graders who are dieting, so think about it, and you are perpetuating it, and don't deny it. (005)

Political activism may benefit patients, both by enhancing their sense of personal effectiveness, and by encouraging them to identify and reject prevailing stereotypes of women.

5) Helping patients to locate personal motivating factors, and encouraging the process of making an active decision to get well.

As in previous studies, many of the recovered women I interviewed felt that they had arrived at a very personal, active decision to get well. No two women shared the same motivation; as one recovered woman wrote in a letter, "Everybody needs something special in their lives. Not everybody will be the same." Treatment efforts should therefore be directed at discovering individual motivations for recovery. Patients should be helped to explore the value of their lives and to identify reasons for taking care of themselves and being healthy.

Integrating Female Roles

Women with eating disorders appear to experience conflict over a female gender identification and achievement goals. Treatment programs may help to counter this dissonance in the following ways:

1) Provide female therapists as role models who integrate traditional and non-traditional goals.

Susan Wooley has noted that the female therapist can serve as a counterpoint to traditional therapeutic distance and objectivity (S. Wooley, 1994). Women therapists, who share some of their female patients' experiences, should diminish boundaries between themselves and their patients, modeling an awareness of feelings and a connection to others. As role models, they demonstrate that professional reward is compatible with rewarding relationships and self-knowledge.

2) Foster communication and understanding between mothers and daughters.

Mothers have frequently been blamed for psychosocial illness in general (Caplan, 1986) and eating disorders in particular (Bruch, 1978). It has recently been suggested, however, that repairing and affirming mother-daughter relationships may be important to patients' recovery (Rabinor, 1994). Given the significance of gender role conflicts among patients with eating disorders, it follows that healing this primary relationship should contribute to a reintegration of the feminine and masculine aspects of oneself.

Daughters can be helped to achieve a new understanding of, and respect for, their mothers, in a number of ways. A therapist can help a patient see how her mother's strengths have allowed her to cope with life challenges

and personal struggles. A daughter who views her mother's unrewarding job as an active decision to help support her family may respond differently than one who sees her mother as having forfeited her dreams. Daughters can come to appreciate the circumstances differentiating their mothers' lives from their own, and the resilience and ingenuity with which the older women negotiated their situations (Rabinor, 1994).

Mothers can also be helped to see the influences on their daughters' lives, and to develop new roles for themselves as their daughters mature. Mothers and daughters may enter therapy together, in some cases. Finally, group exercises can encourage women to affirm their relationships as mothers and daughters (Rabinor, 1994).

3) Establish and promote a supportive therapist/client relationship.

Given the fact that eating disorders are characterized by difficulty with close personal relationships, and that recovered women cite the importance of such relationships to their recovery, work on relationships may be viewed as central to the treatment of eating disorders. Therapists of women with anorexia and bulimia should seek to establish strong, supportive relationships with their clients, in which women can become comfortable tolerating the difficulties encountered in relationship.

Additionally, narrative forms of therapy can serve as a means for restoring subjectivity and voice to women with eating disorders. Therapists taking a narrative approach encourage clients to envision other, non-problem-oriented realities through a process of "externalization," thus allowing for "the re-authoring of lives and relationships" (White & Epston, 1990, p. 17). This approach counteracts the positivist method of traditional

encounters, and empowers individuals to take a more active view of their situation. As White and Epston have noted:

> Through this process of externalization, persons gain a reflexive perspective on their lives, and new options become available to them in challenging the "truths" that they experience as defining and specifying of them and their relationships. This helps them refuse the objectification or "thingification" of themselves and their bodies through knowledge (White & Epston, 1990).

Primary Prevention of Eating Disorders

In theory, attempts at prevention of eating disorders may occur on an individual and a societal level. It may be possible to identify girls who demonstrate a tendency to depression or compulsive behavior, and to help these individuals cope with times of stress or change around adolescence, to prevent them from communicating their distress through their bodies. However, it seems vastly more effective to take aim at the social climate in which eating disorders emerge.

A few eating disorder prevention programs have been targeted at the junior high, high school, and college levels. These programs have generally been concerned with educating students about the harmful effects of unhealthy weight regulation, and the identification of sociocultural influences promoting dieting and thinness. (Carney & Veilleux, 1986; Killen et al., 1993). However, the only long-term controlled effectiveness study of these efforts to date reported no significant benefit in eating attitudes and weight regulation practices among California middle school students (Killen et al., 1993). This finding suggests that sociocultural influences might already be firmly entrenched among middle school girls, requiring a) interventions at a primary school level; and b) more intensive interventions with older children at high risk.

In designing preventative strategies, the aims of treatment are also applicable. Young girls should be helped to maintain a connection to self, and to integrate multiple roles for themselves as women. These processes may be facilitated by reversing the silencing of female voices that occurs in school classrooms, by enhancing a sense of effectiveness through participation in sports, and providing as role models women who attend to and express their own feelings and desires. With the guidance of women teachers or group leaders, girls may be encouraged to examine role prescriptions and cultural ideals of beauty, and to reject those prescriptions they find to be unhealthy or unsatisfying (Shisslak & Crago, 1994).

Such a strategy for prevention will not eliminate the sociocultural climate in which eating disorders have come to flourish. It may not be immediately possible to change rigid role expectations, physical ideals and societal norms for women-- that will take a few more years. In the meantime, we can preserve the physical and emotional health of our girls and young women by reminding them, and ourselves, to remain connected to the self.

Postscript: Directions for the Future

The interviews described here reveal both commonalities and differences in the experience of women with eating disorders. Because the perspective of patients themselves has rarely been sought, this research represents an initial attempt at a contextualized understanding of the problem. There are, however, limitations to the current study, which may be overcome in future research.

First, the population of former patients interviewed was relatively small. The women were recruited by mail, creating the possibility for bias in self-selection. It seemed most likely that such a bias would lead to an over-representation of more recovered patients or those who retained a connection to Stanford. However, the women were quite varied in both the degree of their recovery and the relationship they had to the Stanford community.

Future efforts should be directed, in part, at documenting women's accounts of their illness and recovery. Larger numbers of subjects should be recruited, and through different methods; for example, non-clinical populations may be contacted through advertisements in newspapers and magazines. Additionally, comparisons should be made between women with and without eating disorders with regard to the themes explored in the current study, including gender ambivalence, attention to internal cues, and difficulty with conflict. As discussed, many of these experiences may be common to women generally, and such comparisons may help to elucidate underlying risk factors in the development of an eating disorder.

Finally, future studies should extend Maine's (1985) effort to determine what forms of treatment women with eating disorders find most helpful. In particular, the efficacy of narrative therapy should be compared with that of more traditional methods.

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