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INDIVIDUAL AND CONTEXTUAL FACTORS
HIGH ABILITY WOMEN
UNDERSTAND AS BEING ASSOCIATED WITH THE DEVELOPMENT
OF THEIR EATING DISORDER

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2001

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ABSTRACT

The purpose of this study is to understand how individual characteristics and traits in high ability women with eating disorders interact with contextual factors such as the family, social context and culture. The participants in the study are four high ability women. Three at the time of data collection, have been suffering from an eating disorder and one participant has been in recovery for a number of years.

The qualitative design of the study allows for the emergence of common themes among the participants. Through in-depth interviews, experience sampling methodology and artifacts an understanding emerges of the individual and contextual factors that each perceived was associated with the development of her eating disorder. Results of the study indicate that high ability women possess the following individual factors that contribute to the development of their eating disorder: caring and nurturing others but not themselves, hypersensitivity, over-excitability, perfectionism, harm avoidance, reward dependence, shame, guilt and a sense of ineffectiveness and the lack of an identity. The most significant finding of the study is that individual factors in all the women were discordant with the family context in which they were raised. Specifically, the family features of emotional inexpression, a high achievement orientation, an enmeshed style of parenting and a chaotic environment. The poorness of fit between each woman and her family was associated with the development of her eating disorder. Finally what emerged from the present study was that the reciprocal interaction among individual and contextual factors explained the development of each woman's eating disorder. The concluding chapters present and discuss the common themes that emerged regarding the factors which interacted in each woman's life, leading her to turn to an eating disorder in order to cope. Recommendations are made to educators, psychologists and

parents to work to create a goodness of fit in the lives of all women, in particular those with high abilities.

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DEDICATION

I dedicate this thesis to my mother, father and brother.

Thank you for your unwavering love

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INDIVIDUAL AND CONTEXTUAL FACTORS HIGH ABILITY WOMEN UNDERSTAND AS BEING ASSOCIATED WITH THE DEVELOPMENT OF THEIR EATING DISORDER

Chapter One: Introduction

We come into this world with natural predispositions; this is what makes us unique, different from one other. As we move through the world our natural tendencies affect how we perceive and act towards the world. Individuals influence the contexts they interact within. In turn the contexts influence the individual. There is a reciprocal interaction among these influences. In the case of eating disorders, the interaction of both individual and contextual factors seemed to explain the development of this illness.

Four women, Hazel, Pat, Sheila and Catherine share similar natural individual characteristics. As children they were precocious, perceptive, sensitive and introverted girls. All were model children. As adults and adolescents they were high ability women. Two are published authors and two are honour role students. Hazel is seventeen; in the past three years she has been hospitalized three times for her anorexia and bulimia. She is currently struggling to stay alive. Pat is eighteen. She has never been admitted into the hospital for her anorexia. She faces the reality that she is only a few pounds away from entering a hospital. Sheila is a thirty-three year old woman who had anorexia and bulimia for ten years and has now been in recovery for eight years. Catherine's anorexia began when she was fifteen. She is now fifty and struggles off and on with the illness.

Despite their promised and/or demonstrated potential, they have felt/or feel self- contempt and shame at the core of their being. The outside world looking in sees mainly their accomplishments, strength and courage. These women have what others desire and admire. Each

was born with unique gifts which have allowed them to achieve but these same gifts have been the source of great suffering.

Sheila, Catherine, Hazel and Pat's natural tendencies have been reciprocally influenced and shaped by the contexts they have interacted within. Unfortunately all have experienced a poorness of fit between their natural predispositions and the contexts in which they were raised. Thomas and Chess (1977, 1980, 1981) and Lerner and Lerner (1983) argue that adaptive psychological and social functioning is the result of a person's natural individual characteristics, fitting or exceeding the demands of a specific context. A goodness of fit is achieved when a person's natural individual characteristics match most of the demands of the contexts in which they interact (Lerner, 1987). The women in this study have not always received support, validation or positive feedback from those contexts and this has in part provoked a poorness of fit. As a consequence, their development has gone awry.

All four women have doubted their abilities. The four were born with gifts, but experience shame and guilt because they possess them. All are highly accomplished women. Their achievements are remarkable they have been successful in periods of profound emotional turmoil and at times when physically they were often near the point of death. Through their stories emerged an understanding of what factors interacted in each of their lives to effect the development of their eating disorder.

As this is being written women everywhere are suffering in silence. Young girls are sitting in classrooms dizzy, unable to learn because they have waged a war against their very essence. What is happening? Why are so many of these girls the brightest and most capable? (Garner, 1991). I hope the story of these four women will provide insight. What factors interact to lead to anorexia and

bulimia? Understanding carries the promise of change. Once the pieces of the puzzle are found, we can help create a complete picture. This study makes an effort to locate some pieces of a complicated puzzle.

This qualitative study gives four women a forum to tell their story of the factors they understand as being associated with the development of their eating disorder. Through in-depth interviews, the experience sampling method and artifacts, each woman's story is constructed. This study describes how different individual and contextual factors at different points in the life span of these women have shaped the development of their lives.

Research Background

My research has always been undertaken with the goal of educating people about the obstacles women face throughout their life-span. The training and research at the M.A. level gave me a specific understanding of the psychology of high ability women. My current research interest arose from my M.A. work. I was struck with the insight that some high ability women shared similar natural characteristics to women with eating disorders (ED). From my previous Psychology training I became aware that women with ED are often described as highly intelligent, conscientious and often A+ students. Recently, a high school counsellor spoke of the prevalence of ED in her school. To my horror she said, "Girls don't eat lunch. Those that do, stand outside in a long line to the girls' bathroom. They take turns ridding themselves of their lunch".

My purpose is to help young women, including those who are not eating or are lining up outside the bathroom stalls. These same girls will sit in my classroom. They may be the brightest students, but how can I nurture their abilities if they are self-destructing?

My intent is to make a contribution, to share insights on how educators and society can

help smooth the path of female development. The study will lend understanding to the individual and contextual factors that effect the onset of an ED in high ability women.

Statement of the Problem

Eating disorders have increased over the past 30 years. More than 90% of cases occur in women (DSM-IV, 1994). By age 18, 80% of women have engaged in dieting (National Eating Disorders Information Centre, 1998). The setting conditions that predispose the individual to an ED (e.g., natural temperamental dispositions, personality, developmental level, emotions, the family context, social network and culture) are complex.

The high ability woman faces unique obstacles. She has profound introspective tendencies, a sense of idealism and justice (Clark, 1997; Piechowski, 1994). Typically she places high expectations on herself, has heightened sensitivity and experiences asynchronous development (Clark, 1997; Piechowski, 1994). Obstacles that high ability women face may be discouragement from parents to pursue their goals, sex discrimination, ambivalence from peer group and the “superwoman” complex which refers to women who try to be perfect in all their roles (Kerr, 1994; Leroux & Butler-Por, 1996; Noble, 1997). However, no research has studied ED in high ability women. Studies have shown that culture, personality, temperament, family and social networks interact to place women at risk of developing an ED (Smolak, Levine & Streigel-Moore, 1996).

Purpose of the Study

The intent of this study is to gain a better understanding of the individual and contextual dynamic interactions across the life-span that may be associated with the development of an ED. Women with ED provided an account of the individual and contextual factors that were associated with their ED. The study is guided by a social constructivist perspective. The methodology is

grounded in phenomenology. In-depth interviews, the experience sampling methodology (ESM) and artifacts, are used to understand "the place where culture and individual psychology intersect" (Pipher, 1995, p.26). The study documented the stories of four women. It provides a holistic understanding of the emerging intra-individual and contextual factors reported by the participants at different phases of their life-span that are associated with an eating disorder.

This study goes beyond looking at the phenomena of ED in a positivist manner. The research methodology and data collection methods "share the goal of understanding the complex world of lived experience from the point of view of those who live it" (Schwandt, 1994, p.118). Women bring individual characteristics that may interact with contexts to increase vulnerability to ED. The study will elicit an understanding of what individual and contextual factors are associated with an ED. The implication, thus, is educators can then respond by modifying teaching methods and educational contexts to individual differences. The obstacle's women face throughout their life-span provide insight to educators of the psychology of the learner and the issues women face at times of their lives. This information can then be shared with other women, to help build their resiliency and to help negotiate the obstacles they confront when faced with the development of an ED.

The second chapter presents a review of the literature. The chapter begins by tracing the history of anorexia and bulimia nervosa. The current status of eating disorders is discussed. Next, research of the factors depicted within the theoretical framework are commented upon. The third chapter discusses methodology. The participants, the research paradigm, the sources of data, the procedures undertaken to collect data, the transcription, analysis of data and the criteria to establish the quality of the data are presented. The fourth chapter presents the findings of the study. Three sources of data, in-depth interviews, ESM data and artifacts, are inter-woven to present a picture of

what individual and contextual factors four high ability women understand as being associated with the development of their eating disorder. Chapter five deals with the analysis of the findings. A between-case analysis of each participant is presented first. Then, a within-case analysis is outlined. The chapter concludes with the identification of the factors that effect the development of each woman's eating disorder on an individual basis and which factors they commonly share.

Finally, chapter six discusses the implications of the current study. Recommendations are offered. In summary, the goal of this study was threefold: firstly, to understand what temperament and personality characteristics appear in high ability women with eating disorders; secondly, to understand the contextual factors that effect the development of eating disorders in high ability women; lastly, how individual characteristics interact with contextual factors such as family, social context and culture in high ability women with eating disorders to effect to the development of their eating disorder.

Chapter Two: Literature Review

The objective of this chapter is to provide a review of factors that are associated with the development of ED. A historical overview of ED is presented first. Then the current information regarding anorexia and bulimia is discussed in order to outline how ED are presently understood by clinicians and researchers. Lastly, factors that interact and are associated with the development of ED are reviewed. These include: (a) individual factors such as temperament, personality, emotions, developmental level, the psychology of female development and high ability women; (b) the family; (c) the social network; and (c) the culture.

A Historical Overview of Eating Disorders

Deliberate starvation can be traced back to ancient Greek and Egyptian cultures. Fasting to the point of death was not uncommon in ancient religions and Gnostic sects. Fasting was thought to separate one from the evil, material world (Bemporad, 1996; Jonas, 1958). In the fifth and tenth century invasions, plagues and food shortages destroyed the Greek-Roman Civilization. During this time deliberate starvation was rarely reported (Bemporad, 1996). In the Middle ages and Early Renaissance, that is, from the thirteenth to seventeenth century, voluntary starvation was observed among European women (Bell, 1985; Brumberg, 1988).

In 1694, the English translation of Richard Morton's *Treatise of Consumption* was published. This was the first medical account of anorexia nervosa (AN). Morton's account was followed by two other publications: in 1767, Robert Whytt and then in 1768, De Valangin wrote about AN (Garner & Garfinkel, 1997). In 1860, Marcé argued that willful starvation was a function of psychiatric not physical causes (Garner et al., 1997). In 1873, Lasègue outlined the medical and

psychological stages of hysterical anorexia and in 1874, Gull, a physician, presented cases of patients with anorexia that he had treated (Garner et al., 1997). Following his publication, in the course of sixty-three days, eleven articles on anorexia were published in the *Lancet* (Adams, 1888; Edge, 1888; Hovell, 1888a,b; Mackenzie, 1888; Myrtle, 1888; Playfair, 1888; Robinson, 1888; Wilks, 1888). Eight of these articles referred to young women suffering from AN. Between 1825 to 1893 Charcot wrote papers published collectively as *Isolation in the Treatment of Hysteria*. In one paper Charcot presented the case of a 13 year old girl who was in the terminal stages of starvation. Charcot believed isolation was necessary to treat hysteria. He argued that parental influence on children was destructive, but Charcot did not state the reasons for this assertion.

In the late nineteenth century and early 20th century, clinical reports of anorexia became more common. Anorexia nervosa was attributed to psychological problems. For instance, Pierre Janet (1929) argued that women starved for two reasons: they were afraid of becoming obese and they feared maturing sexually (Silverman, 1997). Discussing why nineteenth century women refused to eat, Blumberg (1988) indicated that young girls from middle class homes turned to food as a means of expressing their emotions.

Some researchers attributed anorexia to physical pathology. For instance, Simond published in 1914 a paper which argued that anorexia was a function of pituitary pathology. His thesis dominated medical opinion for a period of time. Then in 1930, Berkman presented case studies of 117 patients with AN. He provided a psychogenetic interpretation for the illness. The same year Venables (1930) described the psychological etiology of anorexia in nine patients. As a result of Berkman's and Venable's research, Simond's thesis was dismissed. A few years later in 1936, John Ryle wrote that AN was the result of "a psychic trauma or a foolish habit or some combination

of the two" (Garner et al., 1997, p.99). In 1940, publications surfaced arguing that AN was a function of symbolic or unconscious fantasies (Thoma, 1967).

It is beyond the focus of this study to review all the research that has explored the work conducted on anorexia. However, the work by Hilda Bruch, a clinician and researcher is crucial because it offers a systematic profile of anorexia. In 1978 Bruch published *The Golden Cage: The Enigma of Anorexia Nervosa*. Based on clinical work with eating-disordered patients, she developed a profile of the anorectic: in childhood she was typically good, quiet, obedient, eager to please, helpful, precociously dependable, and excelled academically. Bruch argued that the ED surfaced in adolescence when the need to be self-reliant and independent arose. The need to act autonomously was difficult because the girl who went on to develop an ED functioned by meeting other's needs in childhood and hence found it conflicting to extricate herself from this pattern (Bruch, 1978).

Bruch further concluded that the woman with anorexia strove to meet others' expectations because they were convinced of not being good enough. Early in life the person with anorexia received the message and came to believe that she was ineffective. As a consequence, she had lived with a constant fear of not being respected, never developing a sense of conviction of who or what, she was. Therefore, a sense of identity was not established. The act of starvation instilled pride, power, a sense of accomplishment and control (Bruch, 1978).

To summarize this section, anorexia is an illness that has been reported in young women for centuries. Opinions about the etiology of the illness have been debated. Bruch's work influenced the current conception of AN.

Bulimia nervosa has also been observed throughout history. Since antiquity overeating and induced vomiting has been reported among Egyptians and people who were devoutly religious.

Historically, medical advice encouraged people to vomit. For example, Hippocrates advised people to vomit twice a month. However, these early accounts rarely reported the motivation for vomiting, as for example the desire to lose weight (Russell, 1979). Since the late 1800's physicians have written case reports of patients with “bulimic like” symptoms. Most of the early reports spoke of bulimic symptoms in cases of anorexia or other medical conditions (Johnson & Connors, 1987). Russell (1979) cited three historical cases that mirrored the current diagnosis of BN. He argued that Janet (1903), Wulff (1932) and Bingswanger (1958) treated women with bulimia. In all three cases symptoms consistent with BN were present: overeating, using compensatory behaviours to control weight [vomiting, castor oil, etc] and fear of becoming fat (Russell, 1979).

Binge eating and self-induced vomiting were also described in a number of clinical case studies (Brissaud & Souques, 1894; Deutsch, 1941; Gilles de la Tourette, 1895; Girou, 1905; Gungi & Stichl, 1892; Janet, 1929; Meyer, 1938; Noguès, 1913; Rahman, Richardson & Ripley, 1939; Zutt, 1948). However, historical accounts did not document the morbid fear of fatness and self-induced vomiting with the goal of losing weight, all necessary symptoms which indicate the presence of BN according to the current definition (Parry-Jones & Parry-Jones, 1991; Russell, 1979; VanDeth & Vandereycken, 1995).

During the 1950s bulimia was believed to stem from the problems that obese people experienced (Hamburger, 1951; Stunkard, 1959). In the mid-1970s reports of bulimic behaviour, fear of becoming fat and restricting caloric intake began to appear among normal weight populations. These cases bore resemblance to what, in 1980, was given the diagnostic label “bulimia”. For instance, Brusset and Jeanmet in 1971 wrote about patients who would overeat, then abstain from food, vomit or abuse laxatives.

In 1976, Boskind-Lodahl writing about bulimia in a normal-weight population of young women, indicated that his patients shared many of the same characteristics as those with anorexia: feelings of helplessness, a distorted body image and a fear of gaining weight.

Russell (1979) was credited as the first to refer to bulimia as a variant of anorexia. In his study of 30 patients, self-induced vomiting was used to compensate for overeating. Patients had uncontrollable urges to eat followed by a fear of becoming fat. These constellations of behaviours Russell argued, meant there was a need to develop a new diagnostic criteria under which these symptoms could be grouped. In 1980, the Diagnostic Statistical Manual (DSM) Third Edition, included a new psychiatric disorder, “bulimia”. However, it was not until DSM-III-R that the term “bulimia nervosa” was introduced (APA, 1987).

To conclude, this section highlighted historical accounts which suggest that anorexia and bulimia are not new disorders. Throughout history medical opinion regarding the etiology and function of ED has varied. The next section discusses the current state of knowledge regarding eating disorders.

The Current Picture of Eating Disorders

The prevalence rate of AN between late adolescence and early adulthood ranges between 0.5% to 1.0%. The mean age of onset is 17 with peaks at 14 and 18. In excess of 90% of individuals diagnosed with AN are women (DSM-IV, 1994). Anorexia has the highest mortality rate of any psychiatric illness. Ten percent of patients admitted into a hospital will die (DSM-IV, 1994). The clinical diagnosis of AN and BN as stated in DSM-IV have been used in the present study (See Appendix A). A person with anorexia makes a conscious decision to remain underweight or avoid gaining weight. Weight loss is achieved through a reduced intake of food. Initially foods high in

calories are eliminated, then all types of food are restricted (DSM-IV, 1994). The fear of becoming fat remains even after significant weight loss is achieved (DSM-IV, 1994). Therefore, the person with anorexia does not relinquish control over her eating and exercise because her belief system is that weight gain will follow. The anorectic's self-esteem is affected by her perception of body shape and weight. Weight loss typically is perceived as an achievement and as evidence of self-discipline (DSM-IV, 1994).

In adolescence and young adulthood the prevalence of BN ranges between 1% to 3%. The onset of BN typically begins in late adolescence or early adulthood. Approximately 90% of patients diagnosed with BN are women (DSM-IV, 1994). DSM-IV defines the current criteria used to diagnose BN. A binge refers to eating in a discrete period of time "less than 2 hours" an amount of food greater than most people would eat in the same period. Binge episodes are triggered by dysphoric mood states, stressors or hunger after a prolonged period of food restriction. People with bulimia report feeling ashamed of their eating habits. Binge eating and vomiting are done in secrecy. Following the binge-purge, individuals self-criticize, feel depressed and report a loss of control (DSM-IV, 1994). Bulimia nervosa is not diagnosed when body disturbance is seen exclusively during episodes of AN. People who meet the criteria for both AN and BN are given the diagnosis anorexia nervosa, binge-eating/purging type (Garner, 1997).

Generally, individuals with BN fall in the normal weight range. Some are slightly underweight or overweight. Many people with bulimia prior to the disorder are overweight in relation to their peers (DSM-IV, 1994). The diagnosis of an ED is often reported as being accompanied by the diagnosis of another psychiatric disorder. Such a statement must be read with caution. For instance, studies have cited different prevalence rates of personality disorders,

anywhere from 27% to 93% in people with ED. The discrepancy has been a function of many factors. Studies use different diagnostic assessment methods; longitudinal research and controlled comparison groups are missing (Skodal, Oldham, Hyler, Kellman, Doidge & Davies, 1993). In chronic cases of ED there are life-threatening consequences associated with starvation and/or vomiting.

Symptoms associated with Eating Disorders

Physical Symptoms

The extreme reduction of fat intake and other nutrients causes dramatic effects on the body, such as the cessation of menstruation. Lanugo, a fuzzy layer of hair develops over the body. Bald spots appear, hair becomes brittle and loses its shine (Sadker & Zimmer, 1987). The person with anorexia has a low basal temperature; she always feel cold (Dally & Gomez, 1979). Other symptoms include dry skin, irritability, inability to sleep, anaemia, cardiovascular problems, dental problems, swollen salivary glands, stomach pains and excessive energy (DSM-IV, 1994).

Cognitive Symptoms

People with ED report a number of distorted perceptions, such as denying they are underweight, feeling fatigued, vomiting, being emotionally upset, experiencing personal problems in relationships, lacking peer group affiliations, needing medical treatment and denial of bodily sensations and hunger (Crisp, 1965; Bruch, 1988). The central cognitive disturbance in those with anorexia and bulimia is a distorted body image (Garner et al., 1997). They have difficulty distinguishing between a normal healthy body weight and a desired weight (Bruch, 1988).

Another erroneous belief held by people with ED is that they are defective (Bruch, 1962). Both those with anorexia and bulimia believe that they have no control over life, and that it is

dangerous and/or not useful to tell others how they feel. They hold the belief that others will not understand or be sympathetic to their needs or opinions. They are convinced that people are incapable of responding to or meeting their emotional needs. People with anorexia and bulimia often believe that others are judging them. Asserting one's desires, ideas or wants is believed by some people with ED to elicit anger or risk alienation (Garfinkel & Garner, 1982; Garner, 1986).

Superstitious thinking (the assumption that two things are related when in fact they are not related) is noted in people with ED. For instance eating a small amount of "fattening" food results in weight gain (Lingswiler, Crowther & Stephens, 1989; Zotter & Crowther, 1991). In addition, their thoughts are characterized by "negativism" (Bruch, 1988; Zotter et al., 1991) and most often focus upon failure and a sense of inevitable doom (Polivy & Herman, 1983; Robin, Gilroy & Dennis, 1998).

Behavioural Symptoms

People who have ED display common behaviours, such as being preoccupied with food (Bruch, 1988; DSM-IV, 1994). Typically, a person with an ED finds it distressing to eat in public or in front of family and as a result many avoid social situations where they are expected to eat (DSM-IV, 1994). Another behaviour in people with ED is the inability to express their emotions (Bruch, 1988; DSM-IV, 1994; Vitousek & Ewald, 1993). Characteristics include denying themselves anything pleasurable (Garner & Bemis, 1985; Goodsitt, 1985; Strober, 1991), lack of spontaneity and a restrained demeanour (DSM-IV, 1994; Slevini-Palazzoli, 1978).

Over-conscientiousness (Bruch, 1988; Crisp, 1965) and hyperactivity are also witnessed in the strong drive and determination in which people with ED engage in activities such as exercise and studying (Bruch, 1988). Yet another behaviour of eating-disordered women is the need to control

their environment. Control is manifested by becoming over-involved in solving other's problems, maintaining a rigid routine and surrounding themselves with simplicity (Pipher, 1995; Vitousek & Hollon, 1990; Vitousek & Ewald, 1993).

Individual Factors

Female Psychological Development

More than 90% of ED cases occur in women (DSM-IV, 1994), thus it is important to discuss factors in the psychological development of a woman that differ from that of a man. In a *Different Voice*, Gilligan (1982) wrote that for women, intimacy, caring and being responsible for others is linked to identity formation. When a woman is confronted with the need to choose between her own desires versus those of others, she will most often sacrifice her own needs to avoid disrupting her relationships with others.

In 1992, Gilligan and Brown concluded that a woman's well-being is associated with a need to be connected with the world. Women feel connected when they experience good quality relationships. Gilligan et al. (1992) uncovered that before puberty, girls are willing to go against society's expectations, speaking their minds when they deem it necessary. This tendency changes as girls enter adolescence. The need to please others is so strong that girls often say and act in ways which are not congruent with how they feel (Belenky, Clinchy, Goldberger & Tarule, 1986). In an earlier study Gilligan et al. (1992) studied adolescent girls in a private school and revealed that girls perceive a "good woman" as someone who is willing to take care of others to the point of self-sacrifice. Women begin to separate what they felt from what they believed. Women lose their authentic self and their identity (Belenky et al., 1986). Because adolescence is a period of development when girls were at greatest risk of losing their identities, the struggle that adolescent

girls face is the need to remain connected to who they are and to resist the need to be what others expect them to be. Unfortunately, the need to belong to their peer group more often overtakes the adolescent girl's needs to be true to herself. As a consequence, a false image is projected to the world.

The preoccupations of being what others expect is exhausting and women continue to experience a loss of connection with their thoughts and feelings (Gilligan et al., 1992; Gilligan, 1982). The psychological development of women becomes intricately linked to what people say, think and believe of them. Too often women become preoccupied with a need to be perfect and to respond to the needs of others (Belenky et al., 1986; Gilligan et al., 1992). In a similar vein, Stern, (1990) talked about the value women place on relationships with others. He argued that throughout female development, the importance of strong relationships does not change. There exists a fusion of identity and intimacy in women. This is why women may feel threatened at the thought of losing a relationship (Gilligan et al., 1992). Some researchers postulate that Western culture does not support healthy female identity development (Brown & Gilligan, 1992; Steiner-Adair, 1984). Since girls develop their identity in the context of relationships, they may be vulnerable to external opinions and expectations (Gilligan et al., 1982b). This may increase their vulnerability and risk of an ED.

In addition, if cultural expectations press a narrow definition of what is beautiful in women (i.e. thinness), girls may be more influenced by these external constraints. If a girl lives in a culture that promotes a specific body ideal and she falls outside this norm, she jeopardizes her ability to form relationships with her peers (she may be rejected because she does not have the "look"). As Steiner-Adair (1990) stated, research in ED overlooks the importance adolescent girls ascribe to maintaining

relationships and how this affects a woman's drive to meet a certain body image. By achieving the perfect body she will secure approval and hence secure interpersonal relationships that are crucial to her well being.

From the work in female psychological development, we see that women have a need to care for and nurture others. Moreover, they may abandon their own needs for others. However, to my knowledge none of these authors discussed how certain temperamental or personality characteristics may exacerbate these tendencies. Because women with ED are typically referred to as over-compliant, as wanting to please others and abandoning their own needs, I wonder if these tendencies arise simply as a function of female psychological development or do temperament and personality play a role? This relationship needs to be examined. The discussion now turns to the role temperament and personality has in the development of ED.

The Distinction between Temperament and Personality

Temperament and personality are two interdependent individual factors that will be examined in women with ED in the present study. There seems to be no universal agreement on what constitutes a temperamental disposition. Temperament in this study is operationally defined as "any moderately stable, differentiating emotional or behavioural quality whose appearance in childhood is influenced by inherited biology" (Kagan, Accus & Seidman, 1993, p.xvii). For example, the intensity and vigor a person displays in relation to fear constitutes a temperamental disposition. The primary focus in studying temperament is not the motivation of "why" a person responds with fear, but "how" the reaction of fear is experienced (i.e. intensity). Temperament is a constant but moderate determinant of behaviour and emergent personality. The context, life experiences and biology interact to affect its actualization. Temperament provides insight into individual differences

in how people react to similar social and/or physical situations (Lerner, Lerner & Zabski, 1985).

Personality differs from temperament in that it is not an inborn trait, but develops as a consequence of social interaction. The operational definition of personality used in this study is “the composite of those enduring psychological attributes which constitute the unique individuality of the person, and which are expressed in diverse behaviours in different life situations” (Thomas & Chess, 1989, p. 250). Taking the example of a child who responds with fear to a situation, the focus in studying personality is on what the child does (the content of behaviour) or on the why (the motivation for the behaviour), or on how they do it (Lerner, 1986).

Berger (1982) summarized the theoretical difficulties in distinguishing between temperament and personality. He stated that there is no clear consensus distinguishing the difference between temperament and personality. Different theorists identify different temperamental and personality dimensions. Despite these inherent difficulties the following issues emerge about temperament: genetic factors play a primary role in determining temperament; temperamental traits focus on stylistic elements of behaviours; temperament is present at birth; it excludes cognitive attributes of behaviour, attitudes, values and motivations (Angleitner & Riemann, 1991). Some common factors regarding personality are the following: it is a result of the social environment; it is not present at birth; and personality makes reference to the “why” of behaviour (Strelau, 1987).

Significant Researchers in Temperament

Thomas and Chess devised the New York Longitudinal Study (NYLS) in 1956 to study the role of temperament in the development of personality. The NYLS is still ongoing, studying 132 subjects who were children in 1956 and who are now adults. To date, observations gathered through the NYLS have found that the temperamental dispositions of activity level, threshold, intensity,

mood, and distractability observed in childhood remained relatively constant in adulthood. The NYLS also has lent evidence that temperament has an impact on how a person adapts to life (Thomas & Chess, 1989). As a function of a child's individual characteristics these manifest behaviours elicit different reactions from others and these in turn reciprocally affect the child. It is the interaction between the child, others and the social context in which they interact which trace the course of development. Thomas and Chess (1984) noted that when a person interacts in a context that is suited to the temperament, she/he is more likely not to experience problems in their development. This phenomena is termed the principle of "goodness of fit". In essence, a goodness of fit is achieved when the opportunities, expectations and demands of the environment are in agreement with a person's individual characteristics, including temperament. When a goodness of fit is achieved, it is associated with optimal development. Whereas, a poorness of fit generates a mismatch between a person's individual characteristics and the environmental contexts, so that maladaptive functioning is more likely to occur (Keogh, 1986).

Despite the positive contributions of Thomas and Chess's work, limitations have been noted. They advocated that temperament reciprocally interacts with other factors to affect expression, but they failed to outline in detail how individual differences in emotion, developmental level, personality and temperament reciprocally interact with one another. Yet another prominent researcher in temperament is Richard Lerner. His perspective on temperament is similar to that of Thomas and Chess's (1984), but posits that temperament refers to how a person does something naturally. Lerner (1986) conducted numerous studies demonstrating that temperament plays a significant role in how people adapt in life. Lerner and colleagues found that when a "goodness of fit" is achieved, development that is adaptive is more likely to occur. For a review of his work,

numerous writings are listed (Lerner et al., 1983; Lerner, 1984; Lerner, 1987; Lerner, Nitz, Talwaz & Lerner, 1989). The personal and contextual factors that have been shown to reciprocally interact to affect development are summarized in a theoretical framework by Lerner (1984).

Temperament and Personality in Eating Disorders

Studies have suggested that there may be a genetic disposition contributing to the development of AN and BN (Holland, Sicotte & Treasure, 1988; Hsu, Chesler & Santhouse, 1990; Strober, 1991). Other studies have suggested it is difficult to ascertain natural pre-morbid dispositions when people are physiologically starving themselves (Garner & Garfinkel, 1997; Casper et al., 1992). The position taken in this study is that some traits are innate (temperament) but others are a concomitant of transactions interacting within a social context (personality).

Most studies which have examined temperament and personality in people with ED present several limitations. The majority do not define if they are studying temperament or personality. Some studies assume that temperament and personality are equivalent. Another limitation of these studies is the lack of consensus on the criteria used to determine if a characteristic observed in a person with ED is a temperament or personality disposition. Therefore, in a focused review of the literature, with the exception of studies done using the Tridimensional Personality Questionnaire (TPQ), few have examined temperament and personality as a composite entity in women with ED.

The TPQ temperamental dimensions.

The first set of studies reviewed are based on Cloninger's psychobiological model of personality. Cloninger's research focused on temperament and personality in people with ED. He clearly defined temperamental dispositions as an element which falls under the broader term of personality. The model outlined three temperamental dimensions: novelty seeking (NS), harm

avoidance (HA), and reward dependence (RD). In a series of studies, persistence has emerged as a fourth temperamental dimension (Cloninger, Brohman & Sigvardsson 1991; Cloninger, Svrakic & Przybeck, 1993). In other studies it has been seen as an element of RD (Bulik, Sullivan, Joyce & Carter, 1995a; Brewerton, Hand & Bishop, 1993; Casper, Hedeker & McClogh, 1992).

Novelty Seeking refers to the activation and inhibition of behaviours. For instance, the amount of explorative activity in response to novelty, a tendency to lose one's temper and purposive avoidance of frustration. A person who scores high on NS shows exploratory excitability, impulsiveness, extravagance and disorderliness. *Harm Avoidance* refers to inhibition in engaging in behaviours such as pessimism, worry in anticipation of future problems or the passive avoidance of behaviours (i.e. fear of uncertainty). A person who scores high on HA engages in anticipatory worry, fatigability and fear of uncertainty. *Reward Dependence* refers to the maintenance of behaviours in response to signals of reward (especially social ones). A person who scores high on RD is sentimental, attached and dependant (Cloninger et al., 1993).

A number of studies have used the TPQ or elements of it to study temperament in persons with ED. The following section reviews only the empirical studies that have used the TPQ because it is the only instrument to my knowledge that has been used to study temperament in people with eating disorders (ED).

Empirical studies using the TPO.

The TPQ was one instrument used by Casper et al. (1992) to study temperament in 50 women with ED. All the eating-disordered participants indicated higher NS, HA and RD than the control groups. Another study conducted by Brewerton et al. (1993) used the TPQ with 147 individuals with ED. Regardless of the type of ED, the participants rated high on HA and

shyness, meaning anticipatory worry, fear of uncertainty, shyness with strangers and fatiguability. Only people with BN (with or without AN) had elevated NS scores, and rated high on exploratory excitability. People with anorexia scored higher than those with BN on RD (sentimentality, attachment & dependence). A study by Kleinfield, Sunday, Hurt and Halmi (1994) used the TPQ to examine temperament in ED. The participants were divided into an experimental group: 97 women with an ED and a control group of 51 women. The results indicated that the women with restricting anorexia (in the current episode of AN, the person has not engaged in binge-eating or purging), scored low on NS. In contrast those with BN, AN with features of bulimia scored high on NS. The women with BN had higher NS scores than the controls. People with restrictor anorexia scored lowest on NS and highest on persistence.

Bulik, Sullivan, Welzin and Kaye (1995b) studied temperament in 30 women with AN: 22 with BN and 20 with AN and BN. Women with AN scored higher on reward dependence (RD) while those with bulimia scored higher on novelty seeking (NS). In contrast, the person with anorexia binge-eating/ purging type (those who in episodes of AN engaged in binge-eating or purging) scored higher on HA. The RD individuals were sensitive and needed others to give them signs of praise and reward. Similar results were found by (Cloninger, 1986, 1987). Reward dependent individuals were hypersensitive to rejection or disapproval and therefore avoided harm. Bulik et al. (1995a) studied differences in temperament and personality in 76 women with BN, some suffering from personality disorders. A temperament and character inventory (Cloninger et al., 1993) rather than the TPQ was administered to participants. In regards to temperament, it was found that those with BN with a personality disorder scored higher on HA.

To conclude studies using the TPQ or elements of it have furthered understanding about

dispositions in people with ED. The studies using the TPQ have lent insight into the neurological basis involved in temperament and personality, indicating there is a large genetic component because it assesses temperamental dimensions that are biologically based. Cloninger and colleagues delineated clearly the temperamental profile of people with BN and AN, hence the TPQ is useful in assessing the difference among sub-groups of eating-disordered individuals. These studies also help identify temperament and personality dispositions because they operationalized them. Generally, the studies highlight that people with BN have a natural tendency to seek out experiences that create excitement, whereas those with AN have a temperamental disposition towards restraint in behaviours and emotions, being interpersonally insecure, holding conventional values and scoring low on NS and high on RD.

However, there are several limitations to these studies. First, all are done using only a quantitative methodology. Therefore how temperamental predispositions manifest themselves is missing. Second, some studies using the TPQ see persistence as a fourth temperamental dimension whereas others see it as an element of reward dependence. Therefore, the results of studies using the TPQ cannot be compared to each other because the analysis of the TPQ used is different. Other empirical research has studied the same temperamental and personality dispositions as Cloninger, but used different terms. They are discussed next.

Impulsivity.

Several studies have suggested that impulsivity is high in people with bulimia (Hatsukami, Mitchell, Eckert & Pyle, 1986; Lacey, 1993; Lilenfeld, Kaye, Greeno, Merikangas, Plotnicov, Pollice, Rao, Strober, Bulik & Nagy, 1997). Waller, Sheinberg, Gullion, Moeller, Cannon, Petty, Hardy, Orsulak & Rush (1996) suggested that impulsivity is related to control

problems in people with ED. These same researchers argued that high arousability and impulsivity share a biological etiology.

Impulsivity in people with ED has a detrimental effect on a person's ability to adapt in life. Palme and Palme (1999) characterized people with bulimia as impulsive, moody, anxious, intolerant of monotony, suspicious and tense. These characteristics may be associated with the bulimic's inability to adjust to new contexts. In another study of 245 individuals with ED, most indicated an inability to deal with things, being impulsive, hyperactive and becoming easily bored (Cumella, Wall & Kerr-Almeida, 1999). Those with BN rated high on impulse control problems, low on tolerance and aspirations, procrastination, frustration, family and school conflicts, impatience, defiance, interpersonal exploitation and a tendency to externalize blame. A temperamental disposition related to impulsivity is exploratory excitability which has been reported in people with ED. Excitability is associated with high arousal and a propensity towards impulsivity. In a study of 25 women who possibly had abnormal eating patterns, a tendency towards high arousability was found (Brassington, Welter, Lucero, Bramlette & Hicks, 1992). In a similar vein, Shaw and Steinberg (1997) found 28 women with bulimia scored low on general rhythmicity and task-orientation, both characteristics indicative of being easily excited. Yet another disposition among some individuals with eating disorders is reward dependence.

Reward dependence.

Behaviours such as over-compliance, perfectionism and industriousness have been observed in people with ED. These behaviours may be motivated by the need to avoid harm. If a person behaves in a manner that secures approval from others the probability of rejection and harsh criticism decreases (Bruch, 1988). Similarly, Casper et al. (1992) studying 50 women with ED, revealed that

they scored higher on self-control, inhibition of emotionality and conscientiousness. They concluded that people who were controlling and reserved might have an increased risk of developing AN. Characteristics in individuals with AN and BN were also studied by Shaw et al. (1997). Of the 65 participants with ED, those with AN were task-orientated, had a high attentional focus and were persistent.

Garfinkel et al. (1982) reported women with AN when compared to those with BN were more serious, conscientious, concerned with doing what was right, controlling their emotions and living in an orderly predictable manner. Some of the women with ED expressed a concern for social conformity (Millon et al., 1982). Clinical reports have described people with anorexia as reserved, constricted, and compulsive (Garfinkel et al., 1982; Johnson & Wonderlich, 1992; Vitousek & Manke, 1994). Harm avoidance has also been noted in people who have anorexia and bulimia.

Harm Avoidance.

The need to secure external approval underpins the desire to avoid harm in women with ED (Keck et al., 1986; Shisslak et al., 1990). Shisslak et al. demonstrated people with ED had low self-esteem and could only obtain a sense of personal effectiveness through external sources. In their research, restrictor anorexics presented a “defensive” personality profile which suggested a denial of their emotions (i.e. having psychological problems). Denial of emotions prevents others from getting too close and hence may be indicative of an active desire to avoid harm. On a similar note, Pryor et al. (1998) observed the personality style of avoidance in people with ED. As a group, the adolescents with ED’s were shy, feared rejection and felt safer keeping a distance from people (Millon et al., 1982; Pryor et al., 1998). Other studies have observed an avoidant personality style among eating-disordered individuals (Johnson & et al., 1992; Pryor et al., 1998; Vitousek et al.,

1994). Perfectionism is one of the most common dispositions seen in people with eating disorders.

Perfectionism.

One of the most common characteristics in clinical and empirical reports of women with ED is perfectionism. (See Blatt, 1995, for a review). Hewitt, Flett and Ediger (1995) found that self-imposed perfectionism was associated with anorexic tendencies and attitudes. Other studies reported similar results (Eisele, Hertsgaard & Light, 1986; Garner, 1986).

Restraint is often associated with perfectionist tendencies. For instance, Pryor et al. (1998) noted a tendency towards control, caution, reflection, rationality and planning. In a study of 715 high school girls, Steiger, Leung, Puentes-Neuman and Gottheli (1992) uncovered that the girls with ED symptoms scored high on perfectionism. There have also been studies that suggest that perfectionism is not a function of the ED. One such study by Scinivasagam, Kaye, Plotnicov, Greeno, Weltzin and Rao (1995) described 20 women who had recovered from an ED. The women continued to show an obsessive need for order, exactness, symmetry, that is perfectionist tendencies. The recovered women also had elevated scores on concern over making mistakes, high personal standards, doubting their actions, organization and overall perfectionism. Recovered and currently ill patients had similar concerns including a need for symmetry and exactness. Weight loss only intensified these concerns. People with ED do not show perfectionistic tendencies exclusively during their illness. Studies demonstrated that people with ED before and after the illness still showed perfectionism and behaviours associated with it (Bruch, 1981; Davis, 1997; Hewitt et al., 1995).

In 1981, Strober portrayed those with anorexia as rigid, conforming, controlling, traditional, self-disciplined and conscientious. Typically, eating-disordered individuals were seen as socially

withdrawn, timid, moralistic and perfectionists (Gamer, Garfinkel & O'Shaughnessy, 1985). Strober argued the results of his study support the assertion there are some common natural personality and individual traits in women with ED. The disposition of hypersensitivity has been noted in studies examining those with eating disorders.

Hypersensitivity.

Hypersensitivity appears to be inherited and refers to a greater awareness of subtleties in one's surroundings and emotions (Aron, 1997). Each person's nervous system is affected differently by stimuli in her environment. However, any predisposition, including hypersensitivity, is affected by what transpires in the environment. When referring to studies in temperament, empirical research lends evidence to the notion that there is a hypersensitivity dispositional trait. Kagan (1994) differentiated the inhibited and uninhibited child. The former shares a striking resemblance to what Aron refers to as the highly sensitive person. Kagan postulated that the inhibited person has a more reactive nervous system than the uninhibited child. Physiologically, inhibited children display more rapid heart rates, high concentrations of cortisol and high diastolic blood pressure. This lends evidence to the higher reactive nature of the nervous system in inhibited children, analogous to the over-excitability nervous system noted in highly sensitive people. Specifically, the sensitive individual has an internal disposition to react strongly to external stimuli. Another natural characteristic of the inhibited and sensitive person is difficulty in adapting to change. Both the inhibited and sensitive person need time to feel relaxed in new contexts. Both show a propensity towards conscientiousness and perfectionism (Aron, 1997; Kagan, 1994).

Characteristically, highly sensitive/intuitive people are aware of the subtleties in their environment, easily affected by people's moods and are conscientious by nature (Clark, 1997).

When confronted with too much stimulation, they have a tendency to withdraw. Sensitive people are described as having a rich and intricate fantasy life and a deep affinity for music and art. They report becoming overwhelmed when too many things must be done in a relatively short period of time. For many highly sensitive people, adapting to life becomes difficult; therefore, they plan out their lives in an effort to circumvent situations that are overwhelming or upsetting (Aron, 1997).

Possessing a hypersensitive disposition can be positive in that it generates a deep empathetic understanding. However, this can also lead to problems. Someone who is hyper-sensitive has difficulty censoring incoming information. Therefore, the highly sensitive person has a tendency to become easily over-aroused. They have a qualitatively more intense reaction to stressful life events. What is less arousing for others is over-arousing for them (Aron, 1997).

They are overwhelmed amidst prolonged stimulation. When the feeling of being overwhelmed begins, the person feels anxious, frazzled and wants to retreat. The highly sensitive person is also described as socially introverted (Aron, 1997). Moreover, Aron (1997) cited other problems associated with being highly sensitive. She noted,

Being sensitive to the discomfort, disapproval, or anger of others probably makes you quick to follow every rule as perfectly as possible, afraid to make a mistake. Being so good all the time, however, means ignoring many of your normal human feelings-irritation, frustration, selfishness and rage. Since you were so eager to please, others could ignore your needs when, in fact, yours were often greater than theirs (Aron, 1997, p.74-75).

The behaviours, experiences and emotions of the highly sensitive person have also been used to describe people with ED. In 1998, Collier-Gagnon wrote about her daughter Gen who suffered and eventually died from AN. She wrote about the sensitive disposition that she observed in her daughter since infancy:

In retrospect, my daughter Gen was always super-sensitive. As an infant, too much stimuli, whether emotional or physical, bothered her. As a child, she loved adventure and fun, but she experienced sorrows and joys at extreme ends. She often needed comfort. It was as if some “psychological skin” was not intact and she had no protection from the outside world. In the angst of adolescence, this predisposition became acutely painful...(p. G1-2).

In the *Ottawa Citizen* (Bohuslawsky, 1998) cited an eating disorder specialist. He said of those with eating disorders, “as a group they are intelligent, educated and sensitive” (p.2). The heightened sensitivity observed in women with ED, may also be in part a response to how they were raised. Bruch (1973) argued that girls with anorexia commonly have been taught from a young age to be responsive to others’ needs and perceptions rather than their own. They become over-sensitive to the desires of others (Duke & Slade, 1988). People with ED scan the environment to ascertain how they are being perceived or judged. This behaviour may be indicative of hypersensitivity. Bruch (1978) comments “there is much preoccupation with what one will look like, what people will think, and with the image they must maintain” (p.32).

In a similar vein, Claude-Pierre (1997) says those who have a predisposition to heightened sensitivity may be at risk of developing an ED. For some the hypersensitivity is so great that it leads to accepting responsibilities beyond their age level. Bingswagner (1958) indicated that the level of hypersensitivity among persons with ED was so deep that it moves them to try and improve the plight of others. When this is not possible, the sensitive person has difficulty accepting this reality. Orbach (1986) suggested that when one is sensitive, it is difficult to distinguish perceptive awareness from responsibility. She suggested a woman with AN is incapable of distinguishing between these two: her awareness of emotions and sensations, and her responsibility to do something about what she perceives. In some ways the

person with anorexia finds it impossible to say “no” to others. Once again her hypersensitivity to the plight of others leads to feelings of extreme guilt and shame if she refuses or is unable to help.

People with anorexia are also described as having a heightened capacity to gather information from the environment. They have an intuitive ability to ascertain the relationships among people in a group, being very perceptive to the needs and feelings of others (Bruch, 1988). Hypersensitivity to others is apparent in many with anorexia who ascribe to the notion that they must deny their own needs in the service of others (Bemporad, 1988; Garner et al., 1985; Mogul, 1980; Segel & Blatt, 1993; Strober, 1997).

Studies that have examined temperament and personality in people with ED have identified impulsivity, exploratory excitability and high arousability as being present. This constellation of traits appears to occur more often in women with BN. Studies indicate women with ED are concerned about what others think about them. Women with AN are over-compliant, extreme conformists and inhibit the expression of emotions. These behaviours secure acceptance and approval from others. This suggests one is reward dependent. Women with ED engage in many avoidant behaviours. They try to avoid confrontation, and mask their emotions. When confronted, they appear at times to be defensive. The studies reviewed suggest that women with ED are perfectionists, restrained and self-disciplined.

The limitations of these studies is that most have been done using a quantitative methodology or are based on clinical reports. This suggests that there is a need for qualitative studies. To my knowledge the studies reviewed here also did not examine in detail how temperament and personality interacted with different contexts. Specifically, do certain

combinations of individual and contextual factors affect the development of an ED?

Eating disorders often affect girls with high abilities (Garner, 1991). When reviewing the literature one is struck by the observation that some high ability women share similar temperamental and personality characteristics with women with ED. The following section reviews the temperamental and personality dispositions in high ability women that mirror those found among those with ED.

Temperamental and Personality Dimensions in High Ability Women

Gilligan (1990) among the women she interviewed observed that AN arises in women who are often well-educated or appear to be destined for success. High ability women demonstrate characteristics and traits such as over-excitability, hypersensitivity and perfectionism that have been implicated as being associated to the development of ED's. The following section discusses the characteristics noted in high ability women that mirror those observed in women with ED. It is suggested that some of these temperamental and personality characteristics may increase their vulnerability. Over-excitability and hypersensitivity appear to be more temperamental in nature whereas perfectionism reflects a personality characteristic.

Over-excitability.

Davis and Rimm(1997) described high ability individuals as very excitable. They have an extraordinary amount of energy, drive and restlessness. Similarly, Clark (1983) indicates the high achiever is intense, shows emotional depth, and has an alert mind. The intensity can be seen in the high achiever's intellectual quest for knowledge, their curiosity and the concerted effort they exert in all their pursuits (Davis, 1997). An over-excitable nature is linked to novelty seeking. The intense emotions felt by high ability individuals are offered as

additional evidence of their highly excitable nature.

A body of literature documents over-excitabilities (OE) in high ability individuals. High ability individuals are intense and precocious (Kerr, 1994; Lovecky, 1994; Piechowski, 1994; Silverman, 1994). Dabrowski (1937, 1967) conceptualized the concept of OE and observed that high ability people repeatedly demonstrated over-reaction to external and internal stimuli. He asserted that the OE are innate and differentiate into five dimensions: psychomotor (tendency to be active and energetic); sensual (awareness of and response to sensory stimuli); intellectual (quest for knowledge); imaginal (vivid imagination); and emotional (deep feelings). Piechowski and Miller (1994) reported that high ability individuals scored high on the five OE. Other studies confirmed that high achievers score high on one or more of the OE (Ackerman, 1997; Lewis, Kitano & Lynch, 1992; Piirto, 1994; Silverman & Ellsworth, 1981; Sowa, McIntire, May & Bland, 1994).

Lovecky (1994) highlighted the intellectual curiosity, absorption and fascination with ideas and words in high ability individuals. Another study noted also high absorption and the effort placed forth by high achievers in solving problems (Caruso, Mayer, Zingler & Dreyden, 1989). High achievers have also been described as being unable to stay still unless they are absorbed and interested in something. The need to be stimulated was so intense they will create obstacles to stimulate themselves (Sowa et al., 1994).

High achievers as well as women with ED seek novelty in order to remain stimulated. Characteristics such as over-excitability, impulsivity, exploratory activity and, a tendency to become easily bored have been noted in women with ED (Bruch, 1978; Leon, Fulkerson, Perry & Cudeck, 1993). Similarities between the two groups are quite striking.

Hypersensitivity.

High ability people are described as sensitive (Clark, 1997; Roedell, 1984; Silverman, 1994; VanTassel-Baska, 1989). Cruickshank (1963) described them as capable of sensing a great deal of input. This hypersensitivity renders the person very perceptive (an element of sensitivity) to the feelings of people and verbal and nonverbal cues in the environment are picked up quickly (Aron, 1997). Such hypersensitivity to social response may exacerbate how people experience criticism. In response, people may isolate themselves. However, being acutely aware of the interpersonal dynamics often makes super-sensitive people good confidants, leaders and social activists, often at the expense of self-nurturance (Cruickshank, 1963).

Miller (1994) claimed that the high ability individual's hypersensitivity enhances her intuitiveness and ability to empathize with other people, but puts her at risk of emotional disturbance because it functions as a radar, making one aware of others' emotional needs. Hence, high ability people are often incapable of tuning out others' needs and therefore run the risk of not responding to their own needs. In a similar vein, VanTassel-Baska (1995) referred to high ability people as those who possess an aesthetic and emotional sensitivity. From a young age they seem aware of the nuances in people's language and behaviours.

Their hypersensitivity is evident in many ways. Their feelings are hurt easily. They are compassionate towards others, become easily upset and are often moved to tears. They have a tendency to respond in an intense manner to criticism (Silverman, 1993). Whitmore (1980) reported that highly able people who are sensitive may misperceive social rejection even when this is not intended. As well, extreme sensitivity in high ability individuals may exacerbate

reactions to the normative problems of development (Roedell, 1984; Whitemore, 1980). Moral sensitivity is also noted in high ability women (Clark, 1997). Sensitivity is more acute when injustice or hypocrisy are manifest.

Clark (1983) argued that the high ability person seem often different on the affective and intuitive level, because of a rich and intense emotional life. A heightened self-awareness, idealism and sense of justice seem ever-present, which leads to a greater moral and ethical awareness. Clark (1983) proposed two kinds of sensitivities in high ability individuals: first, to the expectations and feelings of others, and second, to inconsistencies between one's ideals and behaviours, underlying inconsistencies within oneself. Lovecky (1992) described sensitivity in high ability individuals as an in-depth ability to feel and identify with others who are empathetic human beings. Levine and Tucker (1986) also concluded that the high ability person was capable of profound empathic understanding, likely to reflect a heightened sensitivity to the feelings and stress that others experience.

Silverman (1994) also spoke of moral sensitivity in high ability individuals. In her clinical practice she witnessed high ability individuals with moral sensitivity so profound, it moved them to action. She further described an innate sense of what is wrong and right which led to acts of altruism and compassion.

Acts of compassion include speaking against injustice, befriending and protecting vulnerable children (i.e. disabled). The high ability individual's hypersensitivity causes her to experience a high level of distress when others are hurt. Another characteristic similar to hypersensitivity is empathy which has also been observed in high ability people (Lovecky, 1992; Roeper, 1982; Silverman, 1993).

A multi-faceted perspective of sensitivity in high ability people was proposed by Mendaglio (1994). He identified two types of sensitivities, namely intrapersonal and interpersonal, each with a cognitive and affective component. Intrapersonal cognitive sensitivity refers to self-awareness and sensitivity directed towards others. Mendaglio (1994) argued that intrapersonal sensitivity is more often present in the highly able person. Other researchers have noted the intuitive and introspective tendencies of highly able individuals in regard to their sensitivity (Piechowski, 1994; Pirtó, 1998). A higher awareness may lead to greater reactivity or emotional distress (Luthar & Ripple, 1994). Roedell (1984) concluded that the high ability person was thus more vulnerable.

Women with ED are often characterized as sensitive. This trait can lead to intense reactions to criticism and efforts to meet others' expectations. Eating-disordered individuals are also very attuned to their surroundings, hence often become overstimulated (Blatt & Scichman, 1983; Christodoulou & Rose., 1995; Strober, 1991).

Perfectionism.

High ability individuals are referred to as perfectionists in their achievement orientation (Clark, 1997; Delise, 1992; Kerr, 1994; Lovecky, 1994; Silverman, 1994). The quest for perfection may lead to difficulties. Miller (1994) discussed how highly able people are portrayed as having a positive sense of themselves. High achievers are praised, admired and envied because of their abilities and successes; however, it is not uncommon for high ability people to feel empty or alienated from themselves. These feelings surface each time they fail to meet the high standards they set for themselves. Feelings of failure or not fulfilling their obligations surface which then trigger negative emotions. Perfectionism can be positive when

it motivates people to pay attention to detail and allows them to produce extraordinary accomplishment. However, it can be counter productive when a person derives satisfaction only when what she/he achieves perfectly (Parker & Adkins, 1995; Sowa et al., 1994).

Perfectionism and high achievement orientation have been repeatedly observed in women with ED (Clark, 1997; Claude-Pierre, 1997; Garner, 1991; Hewitt et al., 1995; Pryor et al., 1998; Silverman, 1997; Steiger et al., 1992). High ability women may project their tendencies towards perfectionism and high achievement onto their bodies and the pursuit of a thin beauty ideal. Consequently, the stress associated with trying to meet unrealistic expectations may be associated with the development of an ED (Bruch, 1988; Garner et al., 1985). A body of literature links adherence to the superwoman ideal and a heightened vulnerability to developing ED (Dryer & Tiggemann, 1996; Kenny & Hart, 1992; Thornton, Leo & Alberg, 1991). The superwoman can be characterized as someone who has an increased concern about her physical appearance, has a heightened interest in maintaining interpersonal relationships, all the while maintaining a level of independent achievement and successful performance in many diverse roles. The quest for this ideal is related to eating disorders. Research has established a relationship between high achievement, striving in multiple roles and an increased vulnerability to developing ED. For example, Timko, Streigel-Moore, Silberstein & Rodin (1987) found that the traditionally feminine emphasis on appearance, combined with the contemporary desire to achieve in multiple roles, is significantly and positively related to ED symptoms. Steiner-Adair (1984) revealed that girls who scored high on disordered eating rated high on adherence to the Super Woman ideal. These same girls held the belief that the ideal woman is successful, independent, thin, and beautiful. The girls who

did not score high on ED symptoms are characterized as “wise women”. The “wise women” recognizes that society pressures them to adopt an image of the ideal woman. They reject the stereotypical views of women and maintain a sense of connection and interdependence in their relationships.

An ideal body shape is associated with success. Superwomen seem to associate femininity with multiple roles and place a strong value on physical appearance (Hart & Kenny, 1997). However, trying to excel in many roles for which one is not prepared can lead to stress and anxiety and thus vulnerability to developing an ED. Female college students who considered many roles as central to their sense of self, scored higher on eating disordered measures compared to those who did not try to achieve in as many roles (Thornton et al., 1991; Timko et al., 1987). Boskind-Lodahl (1976) characterized the patients she saw who have an ED as demonstrating a need to achieve in many domains, including academics. People with a high achievement orientation may sublimate their high achievement expectations to their appearance. Success in the high ability girl is often essential to her feelings of self-worth (Silberstein, Streigel-Moore & Rodin, 1987). The high ability woman often attempts to fill multiple roles and prove herself always diligent and persistent (Kerr, 1994; Silverman, 1994). Perhaps, these high demands increase her vulnerability to developing ED.

The current North American culture conveys that beauty is equated with competence and happiness. What is beautiful is a thin body. Therefore, high ability women may sublimate their work ethic and perfectionist tendencies towards achieving a thin body ideal that consequently conveys competence. Silverstein, Perdue, Petersen, Fabtini and Vogel (1986) suggested that the changing standard of bodily attractiveness towards a slimmer and less

curvaceous body is related to women's increasing concern about intelligence and professional competence. These two themes can be viewed within the general context of sex roles, whereby both femininity on the one hand and non-traditional sex-role aspirations on the other have been associated with ED (Dyer et al., 1996; Paxton & Sculthorpe, 1991; Silverstein, Carpmann, Perlick & Perdue, 1990). Following on studies cited earlier, Brown et al. (1992) argued that a woman's identity development is related to relationship and connectedness with others. High ability women echo the need for connectedness and relationships (Leroux, 1994). However, our North American culture values success and autonomy over relationships. High ability women who interact in contexts that place a high value on success and performance may thus sacrifice healthy identity development and embrace the erroneous stereotypical ideal of the "Superwoman" (Silverstein et al., 1986).

In summation, high ability women engage in novelty seeking, are perfectionist and are sensitive. The similarities in natural temperament and personality characteristics between ED and high ability individuals raise the possibility that the latter may have a susceptibility to developing an ED. Strober (1992) and Bulik et al. (1995b) stressed the importance of studying temperament, personality and how they interact with contextual factors to influence behaviour. Thus far, no study dealing with ED specifically has examined ED in high ability women. Garner (1991) who reviewed the literature, posited that key characteristics and setting conditions present in gifted adolescents may make them vulnerable to the development of ED. However, he did not conduct a study to ascertain if, in fact, there is a relationship between the two factors. A summary of the common characteristics observed in high ability women and those with ED is presented in Appendix B. It builds an argument for the possibility that

because high ability women share many common temperamental and personality characteristics with people with ED, this may increase their vulnerability to developing an eating disorder. Temperament and personality constitute the individuality of each person. The emotions a person experiences are also a factor which has been implicated as being associated with the development of ED.

Emotions

Emotions are a component of temperament (Derryberry & Rothbart, 1984; Strelau, 1987). Goldsmith (1993) argued that any definition of temperament should define emotion as part of it. He wrote,

However emotions are defined, a view that would probably achieve consensus is that emotionality can be manifested as brief states as longer but still transitory moods, and as traits or patterns of expression that characterize an individual over significant periods of the lifespan (p.354).

There is an interactional dimension to emotions: the intensity and the quality of emotional reactions is reciprocally affected by the environment (Izard, Kagan, Zajonc, 1988). Hence, when studying emotions, the context in which they occur needs to be ascertained (Izard et al., 1988). Two of the most salient emotions in people with ED are shame and guilt (Johnson & Larson, 1982; Kaufman, 1991). The phenomenology of shame and then guilt are reviewed and how shame and guilt present themselves in those with ED is examined.

The Phenomenology of Shame & Guilt

Shame has been described as a feeling as opposed to a thought. Kaufman (1991) described shame as a “sickness within the self” (p.5). Feelings of indignity, defeat, inferiority, alienation and transgression are triggered by shame. When shame is chronic, it can lead to a

disturbed sense of self that thwarts the development of identity (Kaufman, 1991). Phenomenologically, shame is experienced as a feeling of being exposed, despised and worthless. The core of the self feels exposed. When people live with shame, they feel as though they are always being watched. As a consequence they scrutinize their every action (Kaufman, 1991).

Guilt arises from being disappointed in having transgressed an internal value or code of behaviour one holds. The object of guilt is a person's actions not the entire self as in shame. The affect of guilt is the same as in shame, but felt and experienced with less negativity. In guilt the person feels redemption is possible, that they can correct their actions and rid themselves of the guilt (Kaufman, 1991; Lewis, 1992). Phenomenologically, guilt is experienced as self-contempt, self-blame and disappointment in oneself (Kaufman, 1991).

Shame and guilt in eating disorders.

Shame is the central emotion experienced by people with ED. Research with eating-disordered individuals has not always discerned the difference between guilt and shame. Shame and guilt are often mistakenly used interchangeably. Shame is an internal experience of the entire self. Guilt focuses on one's actions or failure to act (Kaufman, 1996; Sanftner et al., 1995). Many theorists have suggested that ED stem from disorders of shame (Bybee, Zingler, Berliner & Merisca, 1996; Kaufman, 1991; Sanftner et al., 1995). A person with ED experiences herself as deficient, worthless, disgusting and as a failure. The ED serves to exacerbate the level of shame she experiences. Kaufman (1991) suggested that people binge on food in order to deal with their shameful interpersonal needs. Because the person has rejected an element of herself, she feels empty and void. Bruch (1988) supports Kaufman's

assertion. They both argue that people with ED experience a sense of 'emptiness'. They have an intense longing to be wanted, loved and admired, but believe they are worthless and therefore their needs do not deserve to be met. Their sense of shame is dealt with by turning to food. The shame is projected onto eating, but its antecedents dwell within the self. The act of binging on food or not eating is a function of displacing a deeper, internal sense of shame experienced about themselves. The problems experienced in relation to food increase the level of self-contempt and disgust the person with ED already feels about herself (Kaufman, 1991).

Most who develop ED believe they are not as good compared to others and they are failures, inherently shameful and therefore not worthy of anything pleasurable (Bruch, 1978).

Sanftner et al. (1995) argued that if a person feels shame, she experiences this emotion in relation to aspects of herself (i.e. bodily shame). Shame can originate from a failed dieting attempt or a response to behaviours (i.e. self-induced vomiting). A study conducted by Sanftner and Crowther (1998) compared 37 women who binge, with 41 who do not. Those who binge experienced greater variability in their moods and reported a high level of shame. The intensity of their shame increased prior to each binge episode. As early as 1958 Bingswanger alluded to the experienced level of shame in Ellen West, a woman who suffered from AN: "she feels herself to be absolutely worthless and useless...degraded ...cowardly, wretched creature" (p.242).

Silberstein et al. (1987) noted that patients in her clinical practice who suffered from BN experienced shame at multiple levels. For example, some experience shame when they compared their natural body size to their ideal. For some the level of shame was so intense that they withdrew from social interaction. These feelings then serve to trigger a binge. Binging

and purging provoked shame and keeping the practice a secret exacerbated the level of felt shame.

Guilt is another common emotion displayed by those with ED. Bruch (1978) wrote the following about women with ED: “ [they feel] guilty for not living up to what they are supposed to be, guilty for having thoughts or doing things” (p.129). She further stated that girls with ED are cloaked in shame and guilt. When those with ED experience anything gratifying, they feel guilty. This sense of guilt is most evident in their relationship to food. The intense level of guilt leads the person with ED to engage in all kinds of self-punishing behaviors (i.e. denying herself sleep or working excessively) (Bruch, 1978). Allen, Scannell and Turner (1998) compared 17 women with BN. They report experiencing intense guilt when they fail to live up to their standards of perfection. This has been found in other studies (Bybee et al., 1996). Studies that have examined shame and guilt in people with ED have highlighted their role in the illness. However the studies reviewed have neglected the “situated” nature of the appearance of these emotions. The developmental level that the person is situated in will influence when and how the emotions of shame and guilt are experienced

Developmental Level

Each transition in the life-span is difficult. Change in underlying structures (psychology) and normative obstacles (for example, onset of puberty) present stressors that necessitate further change (Brown et al., 1992). Transitions in the life-span have been studied by examining triggers specific to different phases in life. Triggers cause individuals to initiate questioning of existing psychological structures, beliefs, views and emotions (Smolak et al., 1996).

Eating disorders most often begin in adolescence (DSM-IV, 1994; Gandour, 1984; Levine, 1987). The four participants in the present study developed their ED in adolescence. For adolescents, the quest begins when they question and test the beliefs and values of their society. A common struggle is to act authentically and to abandon behaviours that do not reflect one's true self (Smolak et al., 1996). The high ability individual's struggle to establish her identity may begin earlier due to her advanced development. Hence she may confront the struggle with identity when she is not psychologically ready. This may increase stress and make the transition into adolescence more difficult for the high achiever. Cumulative stressors can disrupt a person's development (Sharpe, Ryst, Hindshaw & Steiner, 1997).

Adolescence is a time when multiple obstacles, cognitive, physical and social, arise. Many of these obstacles are risk factors for the physical and psychological well being of adolescents (Graber, Brooks-Gunn, Paikoff & Warren, 1994). Research indicates that stress plays a crucial role in the development and maintenance of ED (Cattanach & Rodin, 1988; Wolf & Crowther, 1983). Some of these stressors are related to experiences normal to all adolescents including puberty, dating, higher academic demands and the transition from elementary to junior high school (Levine & Smolak, 1992).

The timing of puberty affects adolescent girls' body image. All adolescents experience at different times the same physical changes, but recent literature suggests that early maturing girls are more dissatisfied with their bodies, whereas late maturing girls are more satisfied (Graber et al., 1994; Leon, Keel, Klump & Fulkerson, 1997). In late adolescence early maturing girls are often shorter and heavier, whereas late maturing girls are taller and thinner. Thus, the late maturing girls have body types that are more congruent with the cultural

feminine ideal of beauty (Graber et al., 1994; Tobin-Richards, Boxer & Petersen, 1983). Some studies assert that early onset of puberty is a risk factor for chronic and transient eating problems (Graber et al., 1994). For a high ability girl who senses the value society places on physical attractiveness, it may offer another venue to display her competence and hence she becomes vulnerable to abusing her body. However, when the cumulative developmental obstacles of puberty occur simultaneously, there is a greater risk of disturbed eating symptomatology (Brooks-Gunn & Warren, 1985; Swarr & Richards, 1996; Tobin-Richards et al., 1983).

During adolescence there is a normal concern about appearance (Gralen, Levine, Smolak & Muren, 1990). Girls focus on weight and their desire to be thin (Graber et al., 1994). The adolescents' concern with appearance is more than an indication of vanity. Adolescents recognize the role that physical attractiveness plays in gaining approval, being successful and obtaining acceptance from society and especially the opposite sex (For review see Rodin, Silberstein & Streigel-Moore, 1985). It may be that the heightened sensitivity, demonstrated by some high ability girls makes them more perceptive to the opinions others have of them and may be more affected by negative comments regarding their body image. Hence they decide to alter it.

When rapid physical and situational changes are occurring simultaneously, adolescents differ in their abilities to adapt to change. Several factors reciprocally interact to affect successful adaptation and these include: the number and spacing between changes, life experiences, gender, environment and natural temperamental dispositions (Garmezy, Masten & Tellegen, 1984). An increase in body fat takes place in early adolescence and girls become

dissatisfied with their weight and may begin to diet (Killen, Hayward, Litt, Hammer, Wilson, Miner, Taylor, Varady & Shisslak, 1992). Dating elicits self-consciousness about one's body. Generally, adolescent girls, in contrast to adolescent boys, are more ashamed of their bodies and feel less attractive. The dissatisfaction is often focused on weight (Smolak et al., 1996).

Yet another normative change in adolescence is one's relationship with the peer group. One salient concern associated with going through puberty is moving from elementary to junior high (Attie, Brooks-Gunn & Petersen, 1990; Fabian & Thompson, 1989). The peer group becomes a referent group that one evaluates oneself against (Rodriguez-Tome, Bariaud, Zardi, Delmas, Jeanvoine & Szlagyi, 1993; Rosenbaum, 1993). Peer interactions may function as antecedents to the development of ED in many ways including: influencing attitudes towards body size; beauty ideal standards and dieting methods which are shared and rewarded through the peer group (Garner, 1991). In addition, establishing new peer relationships in junior high has been linked to an increased focus on physical appearance and weight including ED (Hill & Pallin, 1998). The changing body of the adolescent evokes reactions from the peer group which in turn affects how they feel about themselves (Lerner et al., 1985). Adolescent girls report that with the onset of dating, they experience dissatisfaction with their body shape, specifically their weight (Gralen et al., 1990; Richards, Boxer, Peterson & Albrecht, 1990). Perceiving oneself or being perceived by others as attractive is associated with better social adjustment, performance, positive peer relationships, better teacher ratings and school grades (Brooks-Gunn & Petersen, 1983). Hence, adolescent girls who have a poor perception of their physical attractiveness may experience less positive experiences in these same areas. This in turn may elicit anxiety, stress and uncertainty. Cumulatively, this may be associated to a lower

sense of self-worth or even shame. Such feelings and beliefs place women at greater risk of developing an ED. Although the majority of ED cases begin in adolescence, the illness can begin or continue at any point in the life-span (Gupta, 1990; Hsu & Zimmer, 1988). Moreover, women who have ED at an earlier point in their life-span may re-experience its onset at a later stage in their lives (Beck, Casper & Andersen, 1996; Dally, 1984).

Body image dissatisfaction and the preoccupation with weight remains consistently high in western women after adolescence (Pliner, Chaiken, & Flett, 1990; Rozin & Fallon, 1988). Allaz, Bernstein, Rouget, Archinard and Morabia (1998) examined 1,053 women aged 30-74 in a non-clinical population. In general, most women, regardless of their age, indicated a dissatisfaction about their weight. Most tried dieting, although they have a normal weight. The women indicated that they still felt the social pressure to remain thin.

The factors that are associated with the onset or maintenance of ED differ at various phases of the life-span. They include pregnancy, the birth of children, marriage, divorce, the death of a loved one, fear of aging (such as change in physical appearance) and the transition into different environments (Dally, 1984; Hsu et al., 1988; Price, Giannini, & Colella, 1985). A low sense of self-esteem, the notion that one is worthless, the absence of a stable identity and natural personality characteristics continue to affect the maintenance of ED (Beck et al., 1996; Dally, 1984; Gupta, 1990).

Some factors such as temperamental dispositions and personality consistently are associated with the maintenance and development of ED (Bulik et al., 1995b). Other issues make a more transient contribution to the onset and continued expression of ED, such as the transition into junior high (Killen et al., 1992). Therefore, a life-span perspective is needed to

ascertain what stressors at different levels of development are associated to the continued expression of ED. Gralen et al. (1990) showed that the onset of menarche and dating when occurring together, increases the likelihood of eating-disordered behaviour. Levine et al. (1992) looked at what specific factors in adolescence place girls at risk for developing ED. Tobin-Richards et al. (1983) developed a biopsychobiological model which examines the interaction between biological, social and psychological factors, but not the reciprocal interaction between individual factors and contexts. Other studies have also failed to examine this relationship in the development of ED (Fabian et al., 1989; Graber et al., 1994; Gralen et al., 1990; Gupta, 1990; Hill et al., 1998). Another short-coming of the studies reviewed, with the exception of Gupta (1990), is that all were done from a quantitative perspective. The richness of description offered by a qualitative approach is absent.

In essence, when girls enter puberty, weight dissatisfaction, dieting and abnormal eating patterns emerge. Following puberty, girls' body image satisfaction declines rapidly and feeling fat is the most salient concern girls have regarding their physical appearance (Gralen et al., 1990; Rosen, Silberg & Cross, 1988). Research shows that preoccupation with body weight is occurring at even younger ages. Research also suggests that among 9 and 10 year old girls there already is a preference for thinness which is accompanied by reports of dieting (Hill, Draper & Stack, 1994; Hill & Robinson, 1991; Hill & Bhatti, 1995). However, the most frequently cited age for the onset of ED in western cultures is still between early to late adolescence (DSM-IV, 1994). The individual factors that are associated with the development of ED have been discussed. It remains to examine the life contexts of the women, most specifically their families. Research has shown that family dynamics are associated with the

development of ED.

The Family

It is beyond the goal of this study to review all the studies of the family dynamics in which women with ED have been raised. Rather, a focus is placed on reviewing the values, methods and expectations of parents of women with ED. The families of women with ED are not homogenous, but some common features prevail. The characteristics of some of these families magnify cultural ideals (Garner, 1997). A pattern of enmeshment, emotional inexpression, rigidity and overprotectiveness has also been observed in the families of women with ED (Blouin, Zuro & Blouin, 1990). Children raised in these contexts are hyper-obedient to the wishes of others, highly dependent and have a difficult time differentiating themselves from the family unit (Bruch, 1978). Other characteristics in eating-disordered families are the inability to freely express emotions (Hodges, Cochran & Brewerton, 1998), and high conflict (Hart et al., 1997; Hodges et al., 1998; Strober, 1981).

A high achievement orientation and lack of emotional expression are characteristics common in the families of both those with anorexia and bulimia (Garner, 1997). Enmeshment is typically seen in families of those who suffer from anorexia. A chaotic family climate is most often present in the families of those who suffer from bulimia or anorexia subtype purging type (Humphrey & Stern, 1988).

High Achievement Orientation

The families of those with anorexia and bulimia are said to ascribe to a high achievement orientation (Bruch, 1978, Garner et al., 1982; Selvini-Palazzoli, 1978). Kaslow (1996) has studied 16 families in which one member had ED. These families placed a high

focus on achievement, perfection and had an excessive concern with appearance and perfectionism (Minuchin, Rosman & Baker, 1978; Strober, 1981). The values that the parents held had a profound impact upon their children. Dally (1984) studied 50 women over twenty who have ED. All were dependent emotionally on their parents. Moreover, the women continued to subscribe to and function in a manner consistent with their parents' stated values and beliefs. Laliberté, Boland and Leichner (1999) conducted a series of studies, and concluded that disturbed eating behaviours were more prevalent in families that placed an emphasis on achievement and social appearance. This high achievement orientation is also echoed in studies by Root, Fallon and Friedrich, (1986) Humphrey et al., (1988).

Enmeshment

Enmeshment is commonly observed in the families of those with anorexia (Bruch, 1973, 1978; Garner et al., 1982; Goodsitt, 1985; Johnson et al., 1987). Enmeshment posits that members within a family act as a unit rather than as individuals. It has been noted that a child raised in an enmeshed family system may interfere or intervene in parental conflicts. Coalitions against one parent are common. On the one hand, children raised in enmeshed families are asked to act responsibly and assume responsibilities beyond their years (Bruch, 1978). On the other hand, the parents are over-involved and protective of their children. Over-involvement has been associated with increased vulnerability to the development of ED (Bruch, 1973; 1978; Johnson et al., 1987; Minuchin et al., 1978). Meyer and Russell (1998) studied 95 adolescents and found those who are co-dependent upon their families have a higher degree of ED symptoms and showed greater difficulty separating from their families. Parental separation is predictive of ED vulnerability (i.e. lack of introspective awareness, social

insecurity). As well, a sense of ineffectiveness and powerlessness within the family system were often reported by women with ED (Bruch, 1988). This may stem from the lack of autonomy that they experienced in their families.

When they reach adolescence, children who are raised in over-involved and over-protective families may not be prepared to deal with the obstacles. Some individuals with ED experience problems with autonomy and identity; others experience difficulty separating from their parents (Friedlander & Siegel, 1990; Strober & Humphrey, 1987). The paradox is that children raised in enmeshed families vacillate between hyper-maturity and infantilism (Bruch, 1988).

Emotional Inexpression

Emotional inexpression is yet another characteristic observed in the families of those with anorexia and bulimia. Those with ED report feeling distant from their parents. Their relationship to their parents is characterized as one of poor communication and little warmth and empathy (Calam, Waller, Slade & Newton, 1990). In one study, those with bulimia described their families as disengaged and as placing little focus on self-expression (Johnson, 1985). Some eating-disordered individuals described their upbringing as constrained. Their parents did not encourage or tolerate the expression of feelings (Hodges et al., 1998; Minuchin et al., 1978; Strober, 1981). As a consequence, the eating-disordered person learned to suppress her emotions. Interestingly, hiding one's feelings has been associated with greater vulnerability to the development of ED (Bruch, 1978).

Chaotic Family Life

The homes of people with bulimia or with binge-eating/purging type anorexia have been described as chaotic. Their families are depicted as hostile, openly conflictual, disorganized, less nurturing, supportive and understanding than anorexic families (Garner et al., 1985; Humphrey et al., 1988; Selevini-Palazzoli, 1978; Strober, 1981; Strober, 1997). Some women with bulimia or bulimia-anorexia perceive their parents as being unreceptive to their needs. It has been suggested that BN serves a self-soothing mechanism in families where parents are insensitive or unavailable to meet the eating-disordered individual's need (Smolak & Levine, 1993).

As a group, these studies have lent insight into some of the family dynamics of women with ED. The shortcomings of most of the studies is that they do not examine the interaction between individual characteristics and the family context in the development of ED. For example, although Hodges et al. (1998) discussed the climate in eating disordered families, they did not discuss how the ED person's temperament or personality affected her interpretation and reaction to these contexts. On a similar note Shisslak et al. (1990) listed individual characteristics women with ED have, but again they made no effort to discuss how these interacted within the family context. Also most studies have been done using a quantitative methodology: further qualitative research studies would strengthen their conclusions. The person with ED does not only develop within a family network, but also in a school network. This is the focus of the next section.

Social Context

The school context as well has been implicated in the development of ED. School contexts that foster academic competition relate success and competence with a thin body ideal (Dryer et al., 1996; Striegel-Moore, 1997). Women in private school versus those in a public co-educational schools, are more dissatisfied with their bodies, ascribe to a thinner body ideal and are preoccupied with their weight (Tiggemann & Pennington, 1990; Paxton, Wertheim, Gibbons, Szumukler, Hiller & Petrovich, 1991). Such studies reinforce the notion that certain school contexts may increase vulnerability in the development of ED. Dyer et al. (1996) raised the question: what are the specific elements of certain contexts which place adolescent girls at risk for the development of ED? Do highly competitive academic contexts contribute to the adherence of a thin body ideal?

Some research suggests that the onset of ED is associated with increased academic expectations. The onset of ED in a study of eleven to fifteen year old girls coincided with placement exams (Dally & Gomez, 1979). Clinical reports of girls with ED described them as being intense, active, excelling in academics and being conscientious students who earn high marks (Bruch, 1978). It is likely that girls who hold high academic expectations of themselves when confronted with academic obstacles (such as exams), experience an extreme amount of anxiety and stress associated with the need to perform exceptionally well (Bruch, 1988).

These studies highlight factors within the school context which have been implicated as being associated with a vulnerability to the development of ED. Other research links multiple developmental occurrences such as dating and the onset of menarche occurring at the same time as being associated to increased ED vulnerability. None of these factors links how

individual personality and temperament impact on the developing girl. In addition, how factors in the family interact with the school context fail to be included. For instance, if a girl has a high achievement orientation, comes from an over-involved family and attends a school that values the same achievement, is it likely this interaction of factors may increase her vulnerability to developing ED?

All the social networks discussed are situated within a larger context, a socio-cultural milieu. What follows is a discussion of the socio-cultural factors implicated as effecting and influencing the development of ED.

The Culture

Sociocultural factors influence the development of eating, dieting and body image (Akan & Grilo, 1995). Eating disorders are not solely the result of sociocultural factors, but as Bordo (1997) argues, they are one of "a series of cultural interconnections and intersections" (p.424) that reciprocally interact with other factors and are associated with the development of an ED.

The incidence of ED has been increasing over the past thirty years in Western cultures (American Psychiatric Association, 1994; Gellman, 1988). Caucasian women express greater body dissatisfaction than women in other ethnic and cultural groups (Ammaniti, Ercolani & Tambelli, 1989; Ferron, 1997; Mukai, Kambara & Susaki, 1998). Several studies have highlighted that ED are more common in Western countries (Akan et al., 1995; Furnham & Baguma, 1994).

Other studies have documented that Caucasians in general show a higher level of concern regarding weight and body image than African-American women (Ahmad, Waller, &

Verduyn, 1994). Moreover, Caucasian women and adolescent girls in the United States tend to express greater body dissatisfaction than women in other ethnic or cultural groups (Mukai et al., 1998). A comparison of American and French adolescents revealed that American adolescents who are dissatisfied with their appearance adopt behaviours that place their health at risk (e.g. unbalanced diets) in order to achieve their idealized body (Ferron, 1997). On the other hand, 75% of the French adolescents understand that their body and physical appearance have a genetic component and do not readily expect to change their body size. The American adolescents believe that they would be happier and find life easier if they were to have a flawless body. Dolan (1991) concluded when women from more weight-tolerant culture are assimilated into Western cultures, they become more fearful of becoming fat and eating disorder symptoms proliferate. This is supported by Root et al. (1986) and Furham et al. (1994) who found that students who are highly acculturated have a greater risk of developing disordered eating symptoms. Despite different prevalence rates among different cultures, research indicates that disordered eating has begun to change from a disease of young, white, middle class girls and women to a more equal-opportunity affliction, especially in Westernized societies (APA, 1994). Concern over weight among women is such a common occurrence that it has been referred to as a 'normative discontent'. Many contemporary women hold an unrealistically thin body ideal (Lamb, Jackson, Cassidy, & Priest, 1993; Mallick, Whipple & Huerta, 1985; Raudenbush & Zellner, 1997).

Eating disorders are "multidimensional disorders" (Garner et al., 1997). Attitudes toward beauty have changed. The slender body as a beauty ideal for women is a contemporary issue. In the last 20 years the culturally desired average weight for age, height, waist and hip

size in women has decreased, and preference for a thinner body has emerged (Garfinkel et al., 1982; Wiseman, Gary, Mosiman & Ahrens, 1992). These messages are transmitted via the media. From an early age women are the recipients of messages telling them something is wrong with the way they look (Lictendorf, 1988). There seems to be an association between media images of thinness and ED's (Harrison, 1997; Ogletree, Williams, Raffeld & Mason, 1990). The most successful and beautiful protagonists in the media are often portrayed as thin, self-controlled and successful (Garfinkel et al., 1982; Harrison, 1997). A belief in perfect self-control and perfect thinness can have severe repercussions upon the psychological well-being of women (Ferron, 1997). When girls desire to change their looks, their self-esteem declines, which is associated with the onset of eating disorders (Lundhom & Littreil, 1986; Ferron, 1997; Richards, Boxer, Petersen & Albrecht, 1990).

Body dissatisfaction is the domain of women (Rosen, Gross & Vara, 1987). Society places a great deal of pressure upon women to be attractive. They are more often judged by their physical appearance than men (Fallon & Rozin, 1985). Feminine stereotypes conveyed through sociocultural factors have also been implicated with the rising prevalence of eating disorders. Streigel-Moore (1992) argued that the more a woman sees herself as feminine, the more she will define herself based on her physical appearance and relationship to others. This makes her more vulnerable to ED.

Femininity refers to the subjective feeling of having characteristics regarded by the culture as feminine. Two stereotypes of femininity in Western culture are the need to be interpersonally orientated and to be beautiful. It follows that because women are interpersonally orientated, a large part of a woman's identity is formed through her relationship

with others. It is not surprising then that women are affected by what others say or think. Even if she is a high achiever, seeking approval and avoiding disapproval are crucial. Women who are beautiful are treated more favorably by society. Therefore, if a woman's identity is linked to relationships, what people say and think about her has a strong impact. Women may develop the belief that the more beautiful they are, the more likely they will elicit positive responses from others (Gilligan, 1982; Silverstein et al., 1986). Not all women who dislike their body go on to develop ED. An exploration of the individual factors which make it more likely that a woman will be influenced by societal messages should be examined. There is strong evidence that factors in Western culture increase a woman's vulnerability to the development of ED; however, not all women in Western culture develop an ED. Temperament, personality, age, the psychology of female development, the characteristics of high ability people, the family dynamics, social network and culture all reciprocally interact to lead to the expression of eating disorders (Gardner, 1997).

Rationale for the Proposed Study

ED is a complex phenomenon. Many different factors interact to lead to its expression. Many studies have examined one or two factors which are associated with ED's. To my knowledge, few studies have attempted to examine the complex interplay of individual and contextual factors that interact and are associated with the development of an ED.

The studies contributing to our understanding have been mainly conducted using quantitative strategies. As Hepworth stated (1994):

Given the complexity of social issues that are associated with eating disorders, it is suggested here that qualitative methodology can provide useful research techniques to develop theorization of the processes that occur prior to the onset of eating disorders (p.180).

The present study uses a qualitative methodology and a theoretical framework to examine the interaction among many factors that are associated with the development of ED in high ability women. Examining the factors that exacerbate or protect women from the development of ED entails an understanding of biological, psychological, interpersonal and physical components of the context in which women are situated (Lerner, 1996).

Life-Span Perspective

The life-span perspective is, according to Baltes (1987), “a framework emphasizing the core process of human development. It involves integrative relations between the developing individual and the multiple levels of the changing context, including history, within which a person is embedded” (p.611). The life-span perspective states that human development is incomplete and unfolding throughout the life-span (Baltes, 1994; 1997; Baltes & Graf, 1996). Because human development is incomplete, there is no ideal stage in the life-span to begin to study development. There exist multiple points of entry for studying development. Processes of changes do not only originate at birth but also in later periods of the life-span. Developmental tasks entail problems, obstacles and adjustments to situations that arise from both biology or society (Baltes, 1987; Havinghurst, 1973). Studying individual life trajectories can provide information about the ongoing development because they link social and psychological processes which the person experiences over a large portion of the life-span (Baltes, Lindenberger & Staudinger, 1997).

The life-span perspective affirms that there are multiple sources of influences that determine development. The life-span perspective constitutes the theoretical framework for

the study for several reasons. Natural individual characteristics and contexts have a different impact depending on the phase in the life-span of the individual. The development of eating disorders in women occurs at all times of development. The life-span perspective looks at the changing relationships between a developing person and his/her evolving context (Lerner, 1987). Women with eating disorders develop in a family, community and society, all of which are ever changing (Lerner, 1996).

Changes among the above factors constitute development. Moreover, each factor is embedded in an historical time, culture, community and society that are continually changing (Lerner, 1996). The life-span perspective thus offers an avenue to study the individual differences and similarities of women who have developed an eating disorder.

Lerner (1984) developed a general descriptive model depicting the relations involved in individual development (Lerner, 1987; Thomas et al., 1989). The developmental contextual model acknowledges that biological change is rooted in evolving sociocultural factors. However, it also considers how biology contributes or constrains the psychosocial functioning throughout the life-span. Lerner's model helps ascertain how intra-individual and interpersonal changes at different points in people's lives reciprocally interact (Lerner, 1987). Figure 1 (p.60) is a modified version of the individual-context relations model. It is the theoretical framework which guides this study. The individual and contextual factors identified in the model are those that have been empirically identified and have been shown to influence development through the reciprocal interaction and bi-directional relationship between components (or levels). The factors discussed above are depicted in Figure 1 which is a modified version of this model and is the theoretical framework that underpins this study.

The framework outlines factors in childhood, adolescence and adulthood that impact on life-span development.

To demonstrate the use of this theoretical framework, let us consider ED in women. Studies have demonstrated that specific individual characteristics, temperamental traits (Bulik et al., 1995a; Brewerton et al., 1993), personality dimensions (Suzuki, Higuchi, Yamada & Komiya, 1994), developmental level (Dally, 1984; Smolak et al., 1996), emotions (Johnson et al., 1982; Kaufman, 1991), the psychology of female development (Pipher, 1995; Steiner-Adair, 1990) and characteristics of high ability women (Garner, 1991) are associated or may be associated to the development of ED. Moreover, other research has shown that the family context plays a role in the development of ED (Hart et al., 1997; Shisslak et al., 1990). Yet other work links elements of the social context such as peers (Garner, 1991; Rodriguez-Tome et al., 1993) and the school environment (Dryer et al., 1996; Streigel-Moore, 1997) as playing a role. All the above mentioned factors are situated within a culture (Akan et al., 1995; Pate, Pumariega, Hester & Garner, 1992). Hence, to understand the development of ED in high ability women, these individual and social contextual factors must be examined. The theoretical framework outlined in Figure 1 proposes a comprehensive framework of this reality.

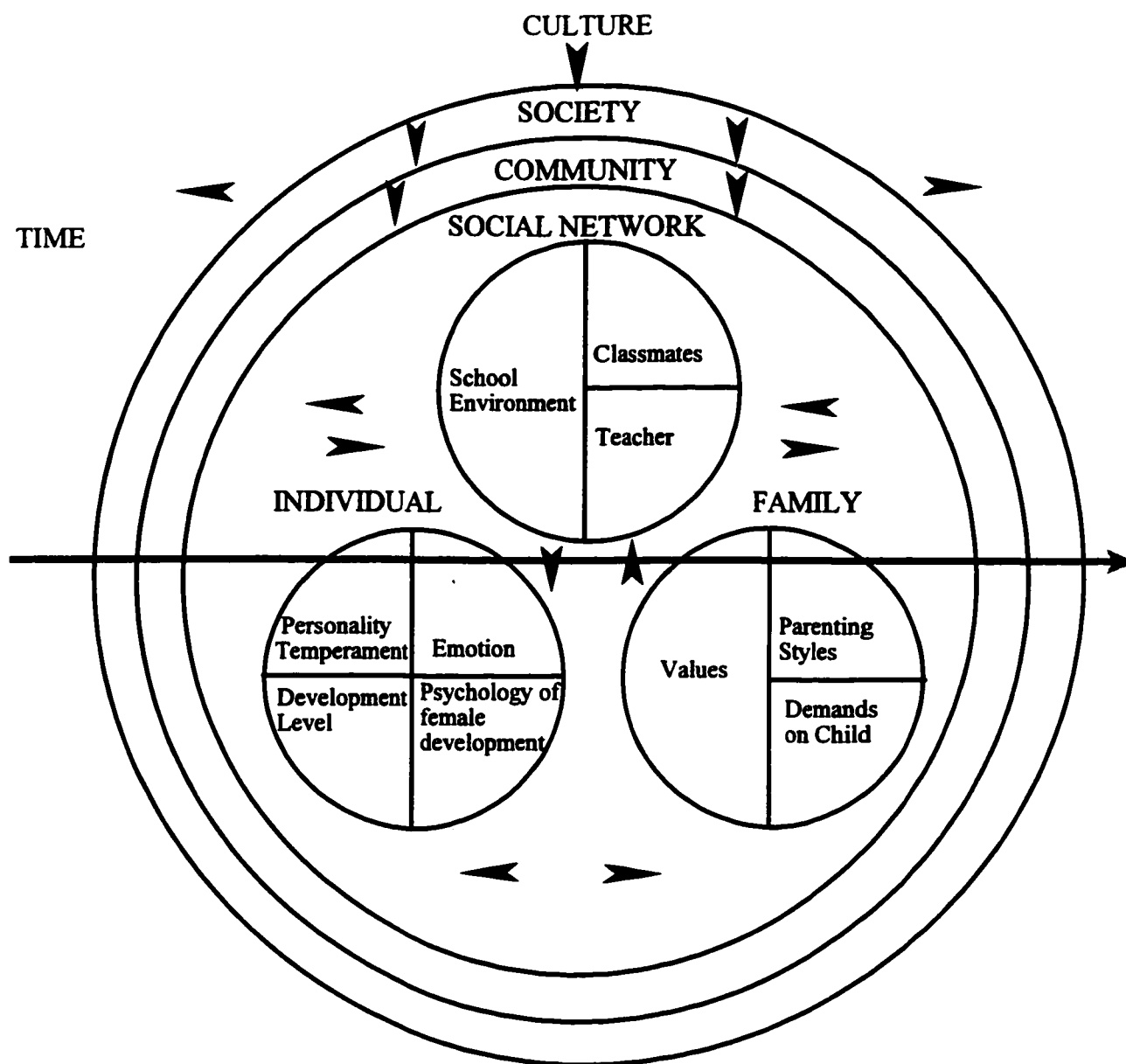


Figure 1: Theoretical Framework

A Dynamic Interactional Model of Development modified from L. Lerner (1984)

Through an examination of the research literature on eating disorders, what has emerged is that many factors interact in the development of an eating disorder. This chapter has also argued that there is a need to conduct research in high ability women with eating disorders. Moreover, few studies have attempted to study the interaction among factors implicated in the development of anorexia and/or bulimia nervosa. The present study addresses these gaps in the research literature. Chapter three discusses the methodology upon which the study has been built.

The critical examination of the research literature has revealed no study that has examined eating disorders in high ability women. Moreover, few studies have examined the reciprocal interaction between the individual and contextual factors that are associated with the development of ED's. Therefore, the following research questions guide the present study:

- (1) What temperament and personality characteristics appear in high ability women with eating disorders?
- (2) What contextual factors are associated with the development of eating disorders in high ability women?
- (3) How do individual characteristics interact with contextual factors such as the family, social context and culture in high ability women with eating disorders to affect the development of their eating disorder?

Chapter Three: Methodology

The preceding chapter established the need to study the individual and contextual dynamic interactions in certain phases of the life-span that are associated with the development of eating disorders in high ability women. Findings can contribute to our understanding of what factors are associated with the onset of eating disorders at different phases of the life-span and the coping mechanisms women use to deal with their illness. This chapter begins by describing the rationale for using a qualitative research design in the present study. Following this, case study methodology is described. The chapter also presents the research paradigm. The inquiry is guided by phenomenology. Next, research procedures, data collection methods, analysis and transcription process and goodness of data are highlighted. The ESM method is also fully described.

An in-depth inquiry is needed to be undertaken in order to understand the individual and contextual factors that reciprocally interact and lead to the development of eating disorders. A research genre and methodology was chosen that is systematic and flexible. The qualitative genre and case study methodology fulfill these requirements. Lastly, the philosophy behind qualitative research and how it complements my research is presented and then the rationale for using case study methodology is addressed.

Qualitative Research

There is much discussion on the philosophical issues related to qualitative research. A few points will be discussed as they relate to the present study. I ascribe to the notion that knowledge is constructed by each individual in unique and different ways; therefore, I reject the notion that there is 'a truth'. I believe that multiple truths exist (Guba & Lincoln, 1994). This belief must be aligned to a research methodology that helps uncover and comprehend multiple realities. The qualitative research paradigm provides the means to explore the personal narratives of selected

women regarding the development of their eating disorder. Qualitative research focuses on discovery, insight and understanding, advocating that humans are the best source from which to collect data (Merriam, 1998).

I believe that varied dimensions of a phenomenon can best be understood by the people who experience it. Stake (1995) pointed out that interpretation is the hallmark of qualitative researchers. The priority in qualitative research is on interpretation, not on establishing cause and effect. The objective of the present study is not to examine the association between specific individual and contextual factors in women with eating disorders. Rather, the objective is to study how each woman feels, how she interprets or understands events, and how characteristics (natural dispositions and personality) may have been associated with the development of their eating disorder.

Qualitative methodology is descriptive. As Merriam (1988) stated, “words and pictures rather than numbers are used to convey what the researcher has learned about a phenomenon. In qualitative research “there are likely to be researcher descriptions of the context, the players involved, and the activities of interest. In addition, data in the form of participants’ own words, direct citations from documents ...and so on, are ...to be included to support the findings of the study” (p.8). Qualitative research is used when the cause of behaviour cannot be controlled or when factors are embedded in the phenomenon. Moreover, qualitative research focuses on the gestalt of phenomena. It is both holistic and contextually developed (Merriam, 1988; Schwandt, 1994). In order to understand an eating disorder, there is a need to capture the dynamic interaction among many factors. Recreating the entire context in which eating disorders emerges is the best strategy to attune the reader to each participant. Moreover, providing a thick description of all the factors that interact places each woman's experience in a sociocultural context. Case study is one method

that can be used in qualitative research. In the next section the characteristics of case study methodology will be addressed.

Case Study Methodology

The research method needs to be congruent with the philosophy of the researcher and serve the research questions. According to Adelman, Jenkins and Kemmis (1983), the case study method allows one to focus an inquiry around an instance. The unit of analysis for case study can be an individual. Bromley (1986) stated, "the case study allows one to get as close to the subject of interest as one possibly can" (p.23). Therefore a methodology is needed that can provide a framework to explore in-depth the lives of women with eating disorders. Many contexts and factors need to be examined fully. To do justice to the phenomenon in the period available, only a few participants can be studied. Therefore, case study methodology provides a framework to focus an inquiry on the lives of four women with an eating disorder. I am interested in what the participants voice about their lives. Case study methodology provided a venue to use personal narratives.

Stake (1995) discussed the descriptive and heuristic qualities of case study methodology. The descriptive qualities of the case study are that it portrays the complexity of a situation and the impact of natural personality characteristics. Vivid materials using quotations and interviews coming from various sources are explored. The descriptive qualities of case study methodology help situate the complexity of anorexia and bulimia nervosa in the examination of the interaction between biology, psychology and the sociocultural environment. The case study method facilitates the exploration of the impact natural dispositions have on the development of eating disorders through the use of narratives, journals and artifacts to collect data.

Stake (1995) also summarized the heuristic value of the case study methodology. Case study methodology helps establish reasons for a problem in highlighting the background of a

situation, and its mode of opposition. Case study also resonates with each person's lived and situated experience. Given the heuristic qualities of the case study, a forum exists to ask participants to interpret why they have developed an eating disorder. The life history of each participant can be traced. This lends understanding and background information that has helped me to be sensitive to the story of each participant and to obtain information that is contextual. The research paradigm guiding this qualitative study is discussed next.

Social Constructivism

A social constructivist perspective has been used to guide the research. Ontologically, social constructivism argues that "realities are apprehendable in the form of multiple, intangible mental constructions....and dependent for their form and content on the individual person or groups holding the constructions" (Guba et al., 1994, p.110). Phenomena are best understood by the people who experience them. Reality is constructed differently by each individual. In the present study this emerges in how each participant understands the development of her eating disorder. Social constructivism postulates that what is "objective knowledge and truth is the result of perspective. Knowledge and truth are created, not discovered" (Schwandt, 1994, p.125). Based on their experience participants lend understanding to the personal and social factors that entered into the picture of their eating disorder. Therefore, a social constructivist perspective has been chosen because it places emphasis on the "world of experience as it is lived, felt, undergone by social actors" (Schwandt, 1994, p.125).

The epistemological perspective is transactional and subjectivist, meaning "the investigator and the object of the investigation are assumed to be interactively linked so that the 'findings' are literally created as the investigation proceeds" (Guba et al., 1994, p.111). Knowledge is created by a close and prolonged interaction between the researcher and participant. An in-depth interaction

is achieved with participants through interviews and experience sampling data. The methodological perspective is hermeneutical and dialectical. Guba et al. (1994) argued that "constructions can be elicited and refined only through interaction between and among investigator and respondents" (p.111). The factors that were associated to each participants' eating disorder are co-constructed by the researcher and the participant. Hence, the conclusions rendered are themselves a creation of the inquiry process (Guba et al., 1994). A phenomenological perspective is adopted in this study.

Phenomenology

The proposed study is guided by phenomenology. First, phenomenology seeks to understand the meaning which a phenomenon has for the participants experiencing it. The objective is to understand the essence or the central underlying meaning of the phenomenon (Creswell, 1997; Giorgi, 1997). The interest is in 'asking women with eating disorders to provide meaning/understanding of the personal and contextual factors that are associated with their eating disorder. The majority of research on eating disorders has been guided by a positivist paradigm. A limitation of research conducted from a positivist paradigm is that women who have or had an eating disorder are not given an opportunity to convey their understanding of the development of their illness. The proposed study will be guided by a qualitative perspective which values and gives presence to the voices of women who have experienced an eating disorder.

Secondly, with phenomenology, the object is to uncover the essence of the phenomenon (Giorgi, 1997). In the proposed study, I am not only interested in the events that occurred in the lives of woman (i.e. puberty, family dynamics) in and of themselves. My focus of inquiry is also on how events have been experienced by each woman with a eating disorder.

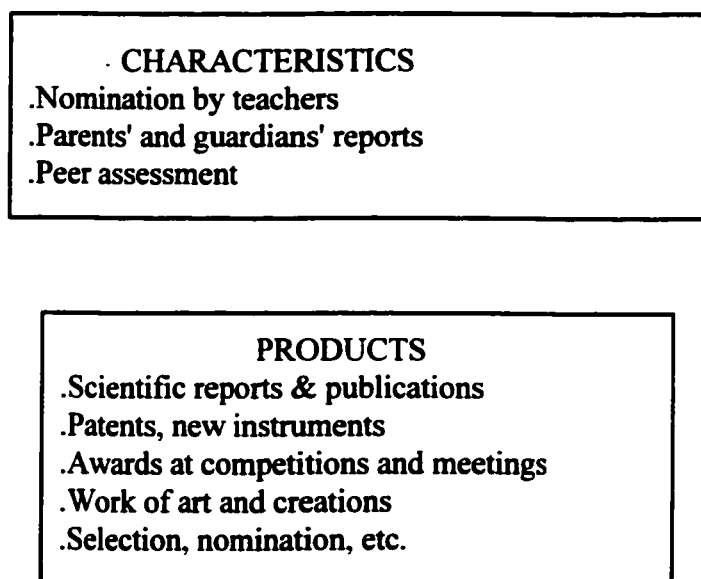
Procedure

Participants and setting.

In-depth inquiry was conducted with three women who have an eating disorder and one woman who has recovered from an eating disorder. The sample size of four was chosen to capture in depth information (Morse, 1994; Polkinghorne, 1989). The interviews took place at the most convenient location for the participant; in one case the participant's home and in three cases the researcher's office. The participants were recruited by advertising for research participants in various clinics and support groups for women with eating disorders. The participants were purposively sampled according to the following criteria: self-diagnosed or diagnosed by a medical professional as having an eating disorder; were women; were not currently residing in a hospital for treatment of the eating disorders and were high ability women. An attempt was made to obtain participants from different ethnic backgrounds and at different phases in the life-span.

For the purpose of this study, high ability was defined as evidence of high performance capability in areas such as intellectual, creative, artistic, or leadership capacity, or in specific academic fields (Gifted and Talented Education Act, 1994). To ascertain if the participants met this definition an assessment method was needed. When referring to the term assessment, it means a researcher determined if particular characteristics a person possessed qualify them to be included in a population (i.e. high ability). It is therefore always subjective. There are two forms of assessment: (a) assessment of the developmental level of a person's natural characteristics (abilities, personality, motivation etc.); and (b) assessment of a person's material products (scientific work, technical patent, poem, painting, acting, musical abilities) (Koren, 1994). In this study the assessment criteria used are presented in Figure 2 to identify women who were high achievers.

Figure 2 : Identification Measures



Assessment of identifying high achievement (Modified from Koren, 1994). For a complete assessment profile for each participant see Appendix C. Sheila and Catherine gave permission for their real names to be used in the thesis. Both Hazel and Pat wanted pseudonyms used. All the participants' wishes were respected.

Researcher's qualifications.

In qualitative studies the researcher is fundamental to the paradigm (Guba et al., 1985; Marshall & Rossman, 1998). I have a degree in Psychology. I have obtained training in qualitative research in graduate courses, conducting interviews and focus groups with adolescent girls. Classes in clinical and counselling psychology have taught me the skills of interviewing and how to establish rapport. I undertook a four-month internship in an outpatient psychiatric ward and in this capacity, I assessed and counselled people with various mental disorders, including two women with eating disorders. My past research has been with abused children and resilient women. For my M.A. thesis, I conducted interviews with 12 women. My course work and past research

documents my ability to establish and maintain rapport, trust and ethical principles.

Recruitment.

All potential participants were contacted by telephone and a time and location for a contact visit was arranged (Seidman, 1991). The contact visit had three goals: to convey that I respected and believed that each potential participant had valuable information to contribute to the study; to become familiar with the participant's setting before the interview; and to help me determine if the participant was interested in the study. During the contact visit, the nature of the study was explained and participants were reassured that what they had to say was important. Requirements of participation were outlined. Potential participants were asked if they were interested in taking part in the study, and their rights were described. At the end of the contact visit, all participants were asked for contact information. The participants were selected according to the criteria outlined on pages 67 and 68. The women who came to the contact visit were later contacted by telephone to inform them if they were selected to take part in the study. Where applicable, the parents were contacted via telephone to inform them of their daughter's participation in the research project. When the participants were contacted at this point two appointments were arranged, one to introduce the Experience Sampling Method and another for the first interview. The parents of the participants under 18 years of age were sent a consent form to sign prior to their daughters attending the meeting that explained the ESM method (See Appendix D).

At the second contact meeting the ESM method was introduced. The ESM sampling process took place before the interviews, the rationale being that if clarification was needed on any points of the ESM data collected, there was an opportunity to ask for it during the interviews. At the outset of the first interview the purpose of the study and what was expected from the participants were reiterated. All participants were asked to sign a consent form (See Appendix E)

and permission was asked to use a tape-recorder. Participants were informed that before any transcripts were used, they would be sent a copy to ensure the accuracy of what was reported. The second and third interviews were scheduled at the completion of the first interview.

In-Depth Interviews

The present study used in-depth interviewing with open-ended questions. Three 90 minute interviews were conducted. Interview one was a focused life history. The goal was to "put the participant's experience in context" (Seidman, 1991, p.11). A storyline of the experiences that occurred in each woman's life-span emerged. Therefore, these past experiences provided a context for the current experiences of each woman's eating disorder. The goal of the second interview was "to concentrate on the concrete details of the participant's present experience in the topic area of study" (Seidman, 1991, p.11). An attempt was made to place experiences within the contextual settings in which they occurred. Interview three aimed to obtain reflection and meaning. Participants were asked to reflect on the meaning of their eating disorder. Seidman (1991) says that "making sense or making meaning requires that the participants look at how the factors in their lives interacted to bring them to their present situation" (p.11). In the third interview, participants were asked to ascribe meaning and examine what factors in their lives interacted and led to the development of their eating disorders. When possible, the three interviews were spaced three days apart. The short period of time between interviews reduced the impact of possible idiosyncracies between interviews (Seidman, 1991). For the interview guide, see Appendix F.

Experience Sampling Methodology (ESM)

What is the experience sampling methodology? How can it inform educational research? The experience sampling methodology (ESM) obtains data by asking participants to provide self-reports about their internal and external experiences. The participants carry electronic pagers that

beep or vibrate when the researcher pages them. On average, participants are asked to carry the electronic device for one week. During this period the researcher will ask the participants to keep the beepers on for a specific duration of time in the day usually between 8:00 a.m to 10:00 p.m. (Johnson et al., 1982). Each participant is beeped once every two hours (Johnson et al., 1982). When they receive the page, participants are asked to fill out an experience sampling form (Csikszentmihalyi & Larson, 1987). A new experience sampling form is filled out each time the participant is paged. The ESM form is designed to obtain self-reported thoughts, activities and feelings. In addition, participants are asked to report where they were, if they were alone or with others and the activities engaged in when beeped (Kubey, Larson & Csikszentmihalyi, 1996).

The ESM yields an abundance of data regarding the daily lives of each participant (Kubey et al., 1996). On average, participants are beeped about six to nine times a day. However, depending on the researcher's goal, the number of pages sent out and the amount of time the electronic pager is carried can vary (Kubey et al., 1996). The ESM has been used with psychiatric patients (Johnson et al., 1982), adults (LeFevre, Hedricks, Church, & McClintock, 1992), people with eating disorders (Johnson et al., 1982), adolescents with eating disorders (Swarr et al., 1996) and "normal" adolescents (Csikszentmihalyi & Wong, 1991; Lee, 1994; Raffaelli & Duckett, 1989; Larson, 1989).

Carrying a pager that beeps raises some ethical concerns. First, is the ESM method obstructive? Does it draw attention from other people in the environment? Second, does filling out the self-report form interfere with the daily functioning of participants? Larson (1989) used the ESM to study the daily lives of 463 adolescents. Sixty-five teachers were asked to rate the quality of work of 138 of the adolescents who took part in the study. The teachers reported that in 92% of the cases the time the students needed to answer the self-report forms did not affect the

quality of their schoolwork. Moreover, 86% of the teachers said that the beeper did not attract any attention from the other students in class. According to Kubey et al. (1996), the self-report forms take less than two minutes to fill out so intrusion on the participants' daily activities is minimal. In addition, participants are instructed that if they are unable to fill out the self-report form when paged, they can do so when it is possible. To avoid attracting attention, depending on the setting, participants have the option of carrying electronic pagers that vibrate to disguise the fact that a respondent is taking part in a study, therefore, not disturbing or eliciting attention from others.

Two further things can be done to ensure younger participants feel at ease taking part in studies using the ESM. First, adolescent participants can be provided with stickers to seal each self-report after it is completed. Second, they can be instructed that if they are beeped when engaged in activities that are embarrassing, they can substitute what they are doing to something similar for example going to the rest room could be changed to washing their hands (Larson, 1989). However, in the present study none of the women indicated that they felt the need to disguise what they were doing.

The Data Elicited

Kubey et al. (1996) state that experience entails internal and external elements. The internal element refers to how a person thinks and feels. In contrast, the external element revolves around the events, environments and behaviours which transpire in the course of a day. The ESM reinforces the notion that to obtain an accurate description of a respondent's daily life an account of the inner subjective experience needs to be examined i.e. how a person feels and how they are affected by what they do as well as the external context i.e. historical context, location, environment in which a person lives. In essence, human experience can only be understood by examining the reciprocal interaction between the individual and the context in which they are situated in.

The ESM form also asks for information about the context the participant was in when paged. When beeped, participants are asked to answer the following questions: Where are you?, What are you doing? Whom are you with? (Hurlburt, 1997, p.942). Moreover, the ESM self-report form obtains data about the respondent's internal state of mind. Participants are asked to answer questions about what they are thinking, feeling, and how the environment they are in impacts the way they feel (Hurlburt, 1997). The ESM form asks participants to fill out a Likert scale rating the following: (a) moods (cheerful, secure, social, relaxed, calm, and friendly); (b) four activity motivation scales (I like to do this, I feel active, I am in control, and I can concentrate on this) and; (c) three physical concern factors (I feel hungry, I am tired, or I am not feeling well) (Hurlburt, 1997). The ESM form can be modified to suit the researcher's needs. Therefore, the ESM elicits data about the internal and external elements of the participants' experiences.

In this study, participants were asked to carry electronic pagers for three days: a Saturday, Sunday and a weekday. Three participants agreed to this request. The one exception was a participant who carried the beeper for two weekdays and a Saturday. She did not want to carry a pager on a Sunday because this was a day she spends with family and does not work. The objective was to accommodate each participant, so that carrying the beeper and answering the ESM forms caused the least amount of intrusiveness, thus being flexible to the participant's request. The women did not carry the beeper in the same week. Rather each participant carried the beeper for one week. The first week Sheila carried the beeper, then Catherine, Hazel and Pat. The beeper was turned on at 8:00 a.m. and turned off at 10:30 p.m. The two adult participants were beeped once every two hours (Johnson et al., 1982). The first page was sent at 10:00 a.m. and the last at 10:00 p.m. The two adolescent girls were beeped once every two hours. The first page was sent at 10:00 a.m. and the last at 8:00 p.m. It was concluded that 10:00 p.m. may have been too late to page

adolescents; therefore, unlike the adult women the adolescent participants were not paged at that time. When the page was received, an ESM form was completed (See Appendix G). A new form was filled out each time that the participant was paged.

Validity

The Experience Sampling Method has good ecological validity because it obtains self-reports from respondents as they interact prospectively in their natural environments. Hormuth (1986) argued that studies that use the ESM "seek to attain ecological validity by randomly sampling participants as they move through their natural environments" (pp.264-265). The validity of the ESM has been supported by some research. Larson (1989) conducted a study using the ESM with 483 adolescents between nine and fifteen years of age. Completed ESM forms were obtained by 80% of the participants. The remaining 20% of reports were not filled as a result of malfunctioning beepers, decreased motivation, accidentally forgetting the beeper at home or leaving the beeper at home because it could not be taken to certain events, i.e. outside city limits.

In order to assess the validity of what was reported, Larson (1989) obtained information from a set of 37 parents and students. The parents were asked to comment how the adolescent appeared to feel on the occasions when they were beeped in their presence. The parental ratings positively correlated with students' own ratings on their moods on the self-report forms in 24 cases and incorrectly in 11 cases. Moreover, Larson (1989) asked students to report how accurate they perceived that they had been in what they reported on the ESM forms. A large percent of the respondents reported they answered the questions truthfully even when they felt uncomfortable reporting certain things such as interactions with the opposite sex which they still reported. Based on these findings, Larson (1989) concluded that the ESM is valid and reliable. Criterion-validity is established by researchers who compare responses on one instrument with responses on some

other independent external criteria. If the response to the external criteria goes in the expected direction, then criteria validity is established (Fraenkel & Wallen, 1995). The criterion-validity for using the ESM has been documented by Johnson et al. (1982). Moreover, concurrent validity for the ESM has also been documented (Delespaul, Reis, and De Vries, 1995; Dijkman-Caes & Delespaul, 1995).

Advantage of Experience Sampling Method

The ESM collects data in which participants are asked to report what they are currently experiencing internally and externally. Participants are asked to report information at the moment it is happening. Unlike other data collection methods such as interviews and questionnaires, information is not collected retrospectively, therefore, the probability of degradation of memory among participants decreases. Another advantage to using the ESM is that it decreases observer intrusiveness. For instance, ethnographers seek to obtain information by interacting or observing participants in their natural setting. The ESM can obtain information about the daily life events of participants and the context in which they interact without causing intrusion. The potential impact the researcher has if observing participants in their natural setting cannot be discounted. The researcher's presence can effect the behaviour of participants and/or other people in the environment. The ESM alleviates such a possibility.

The ESM forms ask questions that uncover subjective feelings. Therefore, the researcher has a better opportunity of gaining information regarding the following: what a respondent thought; what behaviour they engaged in; why a thought emerged; why participants behaved a certain way; and how the environment reciprocally interacted with the individual to lead to an action, thought or emotion. Furthermore, the ESM also focuses on the context of the experience (the social and environmental factors that impact thinking, feelings, etc.). As well, a great deal of data can be

collected on cognitive factors in many different contexts (Hurlburt, 1997). Lastly, the ESM method is atheoretical. It can be used with any population that can read and write. The ESM can also be used with different methodologies and it can be used as a primary source or secondary source to collect data (Kubey et al., 1996).

Limitations of ESM methodology.

Despite the precautions ESM researchers take (e.g. having a pager vibrate instead of beeping), the possibility that unwanted attention may be directed towards the participants is a reality. This potential for attracting attention in past work has shown to be minimal; nevertheless, it is a valid risk and hence participants need to be informed of its possible occurrence. A second limitation with the ESM is the lack of control the researcher has. It is impossible to try to speculate in advance the type of data that will be obtained because participants are sampled every two hours regardless of where they are or how they are feeling. Hence, the participants may be paged at inconvenient times (i.e. they may be in a hurry and not respond to the ESM page) or may respond in a very desultory way. However, the lack of control is outweighed by the advantage of obtaining information that is not contrived or selected, as people interact in their natural environments (Hurlburt, 1997).

How the experience sampling method informs the research.

The present study focusses on understanding the interaction between contextual and individual factors in high ability women with eating disorders. As young girls enter adolescence they experience biological, cultural, emotional and behavioral changes. When childhood is left behind, a large number of adolescent girls lose their voice, sense of self-worth and confidence (Friedman, 1998). In order for educators to understand why these events happen we need to examine the subjective reality of young girls' lives while they are in adolescence. The ESM data

helps elicit information in adolescent girls that will answer the research questions posed in this study. The ESM asked participants to self-report how they experience the world during the developmental stage of adolescence, young adulthood and middle age. A woman's life is filled with daily activities and interactions in the world. In order to understand each woman's life, it is crucial to obtain as much information as possible about the activities and interactions she experiences daily in her life (Bronfenbrenner, 1979; Savin-Williams & Demo, 1983). The ESM attempts to provide an account of the subjective reality that unfolds in each woman's life (Kubey et al., 1996).

Educational researchers try to understand the reasons young women are experiencing difficulties in adolescence. However, adult researchers are far removed from the developmental stage of adolescence. Adult educational researchers do not interact in the same environment adolescents do. Moreover, adult goals, thoughts and priorities differ from those of adolescent girls. Furthermore, even though all educational researchers have experienced adolescence, they did so in a different sociocultural context and historical time. The ESM has the potential to transport educational researchers into the current lives of adolescent women in an unobtrusive manner.

The experience sampling form's goal is to have the women self-report how they think, feel and experience the world. However, the ESM goes beyond ascertaining the internal states of participants. It also elicits information about the actions, activities, interactions and sociocultural context in which thoughts and emotions are felt. The ESM provides insight regarding the context in which the subjective experiences of women occur. In this way educational researchers can track and ascertain the specific sequence of factors which lead to certain emotions and behaviours. The ESM focuses on the experiences of participants as well as their behaviours. The actions people take as a consequence of what they feel, think and believe are revealed. The ESM lends

insight because it uncovers the behaviours women with eating disorders engage in and it focuses on how the decisions to pursue specific activities are related to internal feelings, thoughts and motives (Kubey et al., 1996).

Larson and Richards (1994) stated that ESM facilitated the creation of an emotional photo album of a person's life. The implication for educators is that we can discover the times, locations and interactions where people feel happy, sad, fulfilled or discontent. For instance, if the ESM provides information that the moods of adolescents girls with eating disorders' tend to be lowest during certain periods of the day, educational researchers can examine where the adolescent girls were and what they were doing at that point in time. Obtaining this information can help educational researchers determine what are the various elements that are associated with the low affect being observed at a specific point. The ESM pages participants at random times throughout the day. Therefore, the mood fluctuations in the typical day of an adolescent female can be uncovered in a great number of contexts, interactions and activities. The switching of moods can be traced and linked to specific events (Larson et al., 1994). The experience sampling method has been used extensively in many universities. However, to the best of my knowledge, this study is the first in the Faculty of Education at the University of Ottawa to use ESM methodology. Therefore, this thesis makes a novel contribution and sets a precedent for using a unique data collection method.

Artifacts

When participants were contacted, they were asked to bring to the first interview any thing they thought would help tell their story or convey who they were. Participants brought autobiographical novels, newspaper articles, certificates of achievements, photographs and poems. All the artifacts women brought to the interview were used in the study. The artifacts helped the

women reconstruct their experiences and are presented in more detail in chapter four.

Researcher's Journal

During the data collection phase, a detailed journal was kept to note what I was learning, patterns and themes I saw emerging, and my developing rapport with the participants. The interaction I had as a researcher with participants influenced my insights, reflections and research decisions. I outlined problems and emotions I experienced. I also periodically reflected on the ongoing assumptions that I brought to the research (Bogdan & Biklen, 1992).

Data Analysis

In-Depth Interviews

The interviews were phenomenologically analyzed. The goal was "ferreting out the essence or basic structure of a phenomenon" (Merriam, 1998, p.158). Analysis of the data began after all three interviews were conducted with each participant. The interviews were tape-recorded and transcribed verbatim. The interview data were reduced to the elements that were most significant. Reduction was done inductively, with an open approach to the transcripts that ensured that I would note the emerging themes from the text. Reducing transcripts began by the reading and bracketing of the material. At this stage, I was aware that I was interpreting and structuring meaning from what the participants were saying. Seidman's (1991) suggestion was followed: "mark what is of interest to you as you read. Do not ponder about the passage. If it catches your attention, mark it. Trust yourself as a researcher" (p.90).

The analysis occurred in two steps. First, profiles of participants were created. The profile helped me to take what was learned from the participants and to create a story so the information would be conveyed to the reader (Mishler, 1990). Second, the analysis made thematic connections. All the transcripts were read through several times. The transcripts were divided into units (e.g. all

the passages that allude to cultural influences), categorized according to dominant themes and patterns that emerged from the interviews, and given a descriptive label (e.g., categories that discuss family relationships may be given the label 'family influences'). These categories with descriptive labels were filed.

Next these files were reread. The significant events and experiences in the categories were highlighted and retained. Less significant ones were set aside. Lastly, the highlighted sections in the categories with descriptive labels were woven together. The goal was to represent what individual and contextual factors women understood as being associated with the development of their eating disorder and how (Seidman, 1991).

In order to portray logically the participants' narratives, words were added to make transitions between passages or paragraphs. In some passages, words were added to indicate which words were not the participants and these were placed in brackets (i.e.,[]). When sections were omitted from the interviews a series of periods (i.e.,...) were used to indicate this (Seidman, 1991). In the following chapters all the quotes taken from the interview are written in italics. All the quotations from any novels written by the participants are presented in a free-standing paragraph.

Analysis of ESM and Artifacts

The ESM sampling forms were analysed for the dominant patterns. Following this, all the ESM self-reports were reread collectively with the goal to label the characteristics that emerged repeatedly from the self-reports. Finally, a complete description of the salient themes and patterns that emerged from the ESM report was presented (Hurlburt, 1997).

The artifacts were used to triangulate data. The analysis of artifacts looked at the types of patterns, reoccurring behaviours or actions that supported or contradicted the interpretation made by the researcher in the analysis of ESM data and in-depth interviews (Creswell, 1997; Eisner,

1991). The objective of triangulation was to provide extra information to validate arguments which were proffered by the researcher (Stake, 1995). For instance, books about personal experiences of eating disorders were used in the study for additional data analysis.

Criteria to Assess Goodness of Data

Qualitative research attempts to achieve an in-depth understanding of the phenomena. Qualitative researchers try to establish trustworthiness by meeting a specific criterion. In this study three data sources were used: in-depth interviews, ESM data and artifacts (i.e. personal diaries, books, other written material) that were triangulated. Triangulation is not a tool of validation, but an alternative to validation (Denzin, 1989). To validate the quality of research, Guba et al. (1994) suggest qualitative researchers use truth value for internal validity, transferability for external validity and consistency or reliability. Each of these is discussed in turn. Merriam (1998) argues that qualitative researchers attempt to describe and explain the world. Any event can be interpreted in many ways, therefore, one does not establish reliability in the traditional sense.

To establish consistency, the following needed to be done: (a) explain the assumptions and theory underlying the study, (b) explain my position as a researcher in relation to the participants, (c) describe the criteria used to select participants and the context in which the research was undertaken (Goetz & LeCompte, 1984). The suggestions of Goetz et al. were followed, namely that a researcher needs to be open and honest with the readers about all the decisions made in the research process. This was done through the research journal and by articulating the philosophical stance the researcher brought into the study. In addition, once I had written each participant's case, I sent them a copy. I asked each woman to verify whether or not her story had been described accurately.

Yin (1984) argued that a case study is trustworthy if the following elements are included:

three interviews were conducted with each participant. The interviews were tape-recorded and transcribed verbatim. The interview data were reduced to the elements that were most significant. Reduction was done inductively, with an open approach to the transcripts that ensured that I would note the emerging themes from the text. Reducing transcripts began by the reading and bracketing of the material. At this stage, I was aware that I was interpreting and structuring meaning from what the participants were saying. Seidman's (1991) suggestion was followed: "mark what is of interest to you as you read. Do not ponder about the passage. If it catches your attention, mark it. Trust yourself as a researcher" (p.90).

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In order to portray logically the participants' narratives, words were added to make

Chapter Four: Findings

To understand a person's life story is to know where she has come from, what she has lived through and where she finds herself today. Telling one's own life story is not as difficult as telling someone else's'. Each one of us knows our own story because we have lived it. I have learned through this research that if I ask the right question, listen to the answers and piece together artifactual mementos of lives, I become a medium through which four women can convey their story to others. The intention in this chapter is to illustrate what I, as a researcher, have been privileged to hear. It is only with the help and trust of Hazel, Emily, Sheila and Catherine who believe in my ability to tell their story, that this chapter has been written. Through in-depth interviews, ESM data and artifacts, these four women have told their stories. The first adolescent interviewed is Hazel.

Hazel: The Man in The Glass

Hazel is of a high ability 17 year old girl who reveals the individual and contextual factors that were associated with her eating disorder. First, Hazel's life before the eating disorder is described. A focus is placed upon her mother's and father's parenting styles and the demands Hazel's parents exert upon her. Following this, the onset of the eating disorder is discussed. Hazel's natural dispositions are outlined with the goal of demonstrating how they, in part, were associated with the development of her eating disorder. Then, Hazel discusses her daily life with an eating disorder. Lastly, the function the eating disorder serves for her is outlined.

Hazel was sampled on a Saturday, Sunday and Tuesday. She was beeped every two hours. The first page was sent at 10:00 a.m. and the last page at 8:00 p.m. I weave the three sources of data, the interviews, artifacts and ESM data to convey Hazel's story.

Hazel has both anorexia and bulimia. She has been hospitalized three times for her eating disorder. The interviews took place just days after she was discharged from the hospital. Hazel is a young girl who is eager to please. During the contact visit I explained what would be required of her should she choose to participate in the study. Several times during the initial description, she interrupted me as the details of the study were outlined, saying, "You don't have to explain anymore. I want to do this". Hazel was told it was unethical not to outline what was required of her if she should take part in the study. She needed to be informed of any potential risks as a consequence of her participation in the study.

From the onset the intention was not to mislead Hazel. When Hazel was told that part of the study would entail carrying a beeper, a huge grin crossed her face. She thought carrying a beeper would be fun. At that point it was evident she wanted to take part in the study, but things still needed to be clarified. Hazel was informed that parental consent for her to take part in the study was needed. In addition, because she was under the care of a child psychiatrist, I felt that I needed to provide him with information about what Hazel would be asked to do in the study. Hazel was informed that her participation in the study was dependent upon obtaining consent from her parents and doctor. If Hazel's doctor felt her participation in the study would have negative repercussions, she would not be invited to participate. At the time of the data collection, Hazel was not yet eighteen. Therefore, obtaining consent for her to take part in the study involved several meetings with her parents. Hazel's parents readily consented to her participation in the study because they thought Hazel's participation would be beneficial. Both Hazel's mom and dad hoped she would obtain insight about her eating disorder. Hazel's doctor also thought her participation in the study would be beneficial.

Once all the consent forms were obtained, Hazel was contacted and the days she would carry

the pager were arranged. Hazel completed the ESM portion of data collection when she was sixteen. Originally the interviews were scheduled to be conducted a week after the ESM paging was done. However, the interviews had to be postponed. Hazel's health deteriorated so drastically that she was admitted to the hospital. The evening before the first interview, I called Hazel to remind her that we had an interview scheduled for the next night at 7:00 p.m. Hazel confirmed this, so we concluded the conversation expecting to meet the next evening.

The following day at approximately 5:00 p.m. Hazel's mother called and left a message telling me Hazel had been admitted to the hospital. Her mother told me that if I still wanted to do the interviews I could see her in the hospital. However it was decided that interviewing her in the hospital was not in Hazel's best interest. Later when I spoke to Hazel's mother she went into detail explaining what had transpired. Someone at school had seen Hazel vomiting blood, her mother took her to the hospital, and the doctors found that she was having irregular heart beats, so she was admitted.

Several weeks later when the interview was rescheduled Hazel was discharged from the hospital. She had lost a considerable amount of weight, her skin was pale and her hair unkempt. Similar to Sheila and Catherine, Hazel was asked to bring any artifacts such as awards, journals or poems that would help tell her story. Before one of the interviews she gave me a wealth of artifacts. In fact, Hazel had a black leather portfolio case where she kept a record of all the awards she had received. They included honour roll awards and certificates testifying to her participation in numerous activities such as an enrichment mini-course program at University and public speaking, to mention a few.

Hazel is a high ability girl. Her average in grade nine and ten was 88% and in grade eleven was 90.5%. Hazel indicated that she excelled in drama, music and math with a 94% average

in high school. She reported having been a group leader in the YMCA and an aqua-leader (instructing children how to swim). Hazel is very creative, especially in drama. In grade nine, despite suffering from anorexia, she obtained the lead role in her high school play. Hazel also indicated having received recognition for: a school drama club, after school care for children, piano, extracurricular young drama players, swimming lessons, teaching drama to children, the yearbook club, volunteering at a library choir, music theory, band, the youth ministry, volunteering at a summer camp for children with special needs, the ski team and softball team. She also received medals for softball, public speaking and drama class. The artifacts and the information on the contact form indicated that Hazel was a female with high abilities. All the artifacts Hazel gave me can be seen in Appendix H.

The interviews were conducted at her home. The week we met for the interviews she was on home hospital. This meant that Hazel's doctors felt she was not medically stable and could not return to school. The two days prior to the first interview she had spent at home with her parents.

When I arrived for the first interview, both Hazel and her mother indicated they needed a break from each other. Hazel's mother took the opportunity, while I was conducting the interview, to step out. Hazel's mother told me since her daughter developed the eating disorder, she felt like she was caring for an infant. She was not free to come and go as she liked. At the time of the interviews, Hazel had to be monitored on a 24 hour basis because her health was in danger.

Hazel was eager to start the interview. We went upstairs to her bedroom. Her room looked like one that a six year old child would have. She had many stuffed animals and toys that she had saved. Above her bed Hazel had displayed awards, medals and trophies. The room was neat, organized, but simple. She herself seemed so plain, almost as if she wanted everything to remain uncomplicated. It was impossible to ignore how thin Hazel was. She complained of feeling cold

but would not put on a sweater, almost as if she were purposely trying to punish herself by refusing to be warm. Hazel sat on the floor to begin the interview and I followed her lead.

Life Before the Eating Disorder

Hazel was told that the goal of the first interview was to obtain a sense of her life before she developed the eating disorder. I explained to Hazel that this meant conveying what her family was like. She began by telling me that throughout her life she has felt: *they [her family] are...hard to communicate with...they don't listen...and whatever I say they always tell me...how I am feeling or how I should feel...my parents shut me down (Hi,1).*

Hazel perceived her parents as exerting pressure on her to achieve *...my parents are really demanding and they put a lot of pressure on me (Eii,2)... They say they don't have too many expectations on me with school and everything. [They] really don't care like if it's a 99 or a 69. They don't really care whatever my marks are. But they have a subtle way of saying they are not pleased with what I am doing, how I am doing it, or becoming a person. I think my parents are a big thing [that contribute to the eating disorder] and my brother, cause he's so perfect at everything. He's like a doctor so....he's ... really smart (Hiii,4).*

Hazel's appraisal of her parents was unclear. Two questions arose: Did Hazel's parents exert demands on her, or did Hazel herself feel that she needed to do everything perfectly in order to please them? The latter question arose because Hazel indicated several times that her brother had excelled in school. Hazel compared herself in relation to her brother: *[I am] not important; he's the perfect one. A really high achiever and he has a lot of friends. He's a doctor...well he's a medical student... he has a lot of friends ... he's more important [to my parents] and everything he does is better... Before, I was the special one, before everything happened (Hi,2)... When I was young, he was the rebellious bad child and so my parents would always say 'oh you're the good*

one' but then he moved out and then I became the teenager and he became the favourite (Hi,2). I am not important (Hi,1)...he's always been...the good one (Hii6). What is clear is that Hazel excels in academics and extra-curricular activities.

Hazel interpreted her parents' reaction to her brother's achievements as evidence that she no longer held the 'special child' position in the family. Hazel experienced herself as worthless in comparison to her brother. It appeared that within the family unit she felt devalued. To ascertain Hazel's mode of behaviour in relation to her parents Hazel was asked how her parents would describe her before the eating disorder began. She replied, *I was really cheerful, very obedient and...did anything [so they would say] very responsible...very affectionate...really tidy, everything had to be in order (Hi,3).* Previously, Hazel had told me her parents did not see her as obedient but she indicated the opposite. To clarify, what she had said I reminded her of this discrepancy. Hazel said she perceived that even though she was obedient, her parents acted as if she weren't. Hazel recounted : *when I was really young my parents would always yell at me. They would send me to my room and forget about me. They wouldn't come and talk to me or anything (Hi,3).* This sent a clear message to her *that I wasn't important and that they were abandoning me (Hi,3).* One great fear of Hazel's was that she would be abandoned . She believed it was a natural eventuality because she was bad and therefore unlovable.

Before the interviews began, Hazel shared that she had been adopted. Perhaps the fear of abandonment stemmed from being abandoned at birth. To explore this implicit hypothesis, Hazel was asked how old she was when adopted. She gazed down to avoid eye contact and replied: *[At] twelve days old (Hi,3).* Her body language indicated that she was ill at ease speaking about this issue. It was paramount not to cause any distress, so I did not probe further.

It is revealing that Hazel in the ESM reports wrote about her fear of being abandoned. For

instance, on Saturday at 6:00 p.m. when paged, Hazel wrote in the ESM form: *I feel really guilty because every time I workout I have to lie to everybody. I'm scared that one day they'll catch me and throw me in the hospital and totally abandon me (ESM Entry)*. Sunday at 10:00 a.m. she reported: *I was telling my favourite aunt that I was going to miss her. At the time of the page I was thinking that my aunt was abandoning me. I feel I am not at all living up to my own expectations. I am lonely, ashamed, sad and weak (ESM Entry)*. Although Hazel did not seem to want to discuss her fear of abandonment in the first interview, it surfaced as an issue in the ESM reports.

Up to this point in the interview, the social context that was explored was her family. Before the development of her eating disorder, the other prominent social context in her life was the school milieu. My objective was to obtain information about how she interpreted her experiences in relation to her teachers and peers and how these people in turn perceived and acted towards her. Hazel was asked to reflect upon how her teachers would describe her before she had the eating disorder. She stated: *I was ... really obnoxious (Hi, 4)*. Hazel indicated that as a child she was kind and cheerful, yet she said her teachers had an unfavorable opinion of her. Again, in the conversation it appeared that Hazel had a misconception about how she was perceived by others. To clarify how she was obnoxious, she was asked if she was disruptive and unkind to others in school. She responded: *[I was really cheerful...I was more like that at school...[In] elementary school I had a whole bunch of friends and...everybody [my friends] were nice and I was bad (Hi, 4)*. It was perplexing: if Hazel was obnoxious why did she have so many friends? Hazel did not really clarify why she believed her teachers saw her that way.

I continued and asked Hazel if she could provide a concrete example that illustrated why her teachers felt she was bad. She recounted: *in grade four once... this girl in my class... we were in gym and she laughed... I always got in trouble with this teacher. I was trying my really, really*

best not to laugh at the joke [then] Lisa laughed out loud ... and I yawned at the exact same time as she laughed, so it looked like I had laughed and I was sent to the office and was blamed (Hi, 4).

Hazel interpreted this teacher's behaviour towards her as evidence that she was bad and obnoxious. However, most would not have interpreted the teacher's reaction towards Hazel in this same light. The teacher apparently had misunderstood a situation and mistakenly accused Hazel of acting inappropriately in class.

It is understandable how such a mistake could send a child the message that she was being treated unfairly. However, it was difficult to understand why a child would blame herself for a misinterpretation someone else made as validating that she was bad. In reality Hazel's teachers did not perceive her as a bad child. She related: *...now I go back to visit them...they say 'oh you were...such a nice little kid' and I was like, 'no I wasn't'...I think [some] thought I was really obnoxious...I didn't...listen much...I got in trouble a lot (Hi4).* Hazel indicated that her teachers said they don't recall her as being the 'bad girl', yet she still believed they did feel this way towards her. Perhaps Hazel in part, responded negatively to the situations she recounted because she was emotionally sensitive, albeit immature in interpreting the experiences.

To clarify how Hazel responded to other events within the school context she was asked to discuss other experiences and memories she had of school life before the development of the eating disorder. She stated, *they [my memories of elementary school] were usually good...I acted [in drama] a lot...in grade four I had a friend and we were always acting...in grade three I had my favourite teacher...she came to my house once... (Hi, 5).* It appeared that some of her memories of elementary school were positive, but on the whole she recalled negative memories connected with elementary school. Hazel remembered an event from grade one: *[I had a teacher] she would ... [say to our class] 'the other two classes are so well behaved and so nice and you [the class] can't*

listen' ...she wasn't very nice... (Hi,5). The teacher's comments were not addressed to her. However, when recounting this story Hazel seemed to have interpreted that the teacher's comments were directed specifically to her. This perhaps lent evidence that Hazel was hypersensitive by nature. Did this cause her to respond emotionally to any situation, particularly circumstances in which any sign of anger or criticism was present?

Hazel recalled another negative experience in kindergarten: *until grade six [I had good memories and experiences of school]... except in grade one, two and kindergarten cause I got in trouble a lot (Hi,7). I didn't do anything, the teacher was really mean... this one time the teacher invented a new game [where a] witch would hide in the middle of the [game] and pop out when you would count and when the witch heard her favourite number she would pop out and when the witch popped out, I screamed and ran because I was scared. Screaming and running was totally out of the question in kindergarten class (Hi,7). I replied " In kindergarten?" She said, we weren't allowed to scream or run so I was sent to the bad girl chair... It was a horrible chair... That was ... the first time I felt horrible... I had to go in front of my friends and everybody saw me going to the bad girl chair and then I went there and fell asleep and I remember... going home and sitting in the booster seat and we were having supper and I wouldn't talk and I don't think my parents even noticed. I think that was the first time I ever kept anything to myself...[I was four] (Hi,7).* In recounting this incident, Hazel avoided eye contact.

The following extract summarized Hazel's school experience: *...everybody was nice and I was bad... (Hi,4)... I [didn't] fit in anywhere (Hi,8).* Before the onset of her illness, Hazel interpreted people's negative comments and behaviours as always directed towards her. She believed people acted in this manner towards her because she was a bad person. Hazel still responded in this manner. Whenever anyone was angry no matter in what context, if she was present, she felt the

anger was directed towards her. For example Saturday at 4:00 p.m., Hazel was in drama rehearsal and self-reported: *The same teacher got mad at all of us because we weren't having enough fun on stage. I felt like I wasn't trying hard enough and that even though the teacher was directing her criticism to everyone, I thought that she was really only focussing on me. This incident has effected my mood since the last time I was paged (ESM Entry).*

In the interview conversation she recounted another incident: *when I was young (Hi,9)... I would always get in trouble for everything. I remember I had this really good friend and I was playing [a] game in my backyard with a piece of wood and I was trying to cut it ... I accidentally whacked his hand [my friend's]. Our neighbour saw it and thought that I was doing it on purpose and so he told my parents and I got in a lot of trouble (Hi,9).* Thus, the slightest gesture of reprimand, anger or frustration directed towards her was interpreted as evidence that she was bad, shameful and guilty. Perhaps, her response in part was affected by her natural hypersensitivity. The ESM self reports were filled with emotionally draining reactions. For instance, on Saturday at 2:00 p.m. she reported: *At the beginning of [drama] rehearsal, the teacher got mad at me in front of everyone because I wasn't facing the audience (ESM Entry).* The second day of sampling was a Sunday. Hazel again provided evidence of her hypersensitivity. At 12:00 p.m. she wrote: *Someone said I looked good and I interpreted this to mean that I looked fat and needed to lose weight. Later that same day she reported: It's Sunday 8:00 p.m. My friend was supposed to call to tell me the time she would come for a sleep over. My friend forgot and then when she did call at 7:45 p.m., her parents thought is was too late to come over to my house. I feel sad, weak, closed and confused (ESM Entry).*

Again, on Tuesday at 10:00 a.m., Hazel reported: *I am sad, drowsy, weak, passive, tense, detached and confused. I am in accounting class. My regular teacher has been replaced by*

someone who isn't as nice. One of my friends had told me I was not part of their group (ESM Entry). Hazel experienced negative mood states following such incidents. To illustrate, she reported on Tuesday: *I was paged at 4:00 p.m. I responded at 5:45 p.m. My friend told me I was looking fatter, so I feel disgustingly fat. This is killing me (ESM Entry).* Hazel's hypersensitivity to negative comments became so intense that it led to self-destructive behaviour. For example, when Hazel was paged on Sunday at 6:00 p.m., she was vomiting in the bathroom. She self-reported: *I was recalling nasty things people had said to me in the past ... that I look like a pear and look at what I had done to my family (ESM Entry).* Hazel reacted intensely to life events and dealt with these emotionally-laden events by engaging in her eating disorder.

In conclusion before Hazel developed the eating disorder she found it hard to communicate with her parents. She felt unimportant. Hazel perceived that her brother was the favourite child. In the family he was a high achiever who did well in school and had a lot of friends. In relation to her brother Hazel felt inferior. Hazel always felt that her parents exerted pressure on her to achieve. However, at times in our conversation Hazel indicated otherwise. The picture that emerged of Hazel as a child was one of an obedient, cheerful and affectionate little girl. Despite this outward appearance she revealed that she had been a very unhappy child. Hazel said that her parents perceived her as a cheerful and obedient child, but she also felt that her parents were always displeased with her. Contradiction often arose between what people said about Hazel and what she perceived about herself. Hazel's first memory of suppressing her feelings happened when she was four.

In reference to school experiences, she reported numerous negative events. Although generally she indicated elementary school was positive, she recalled only negative memories. When we were speaking of her school experiences, I again noted she perceived that the teachers did not

like her even though she recalled incidents where it was clear the teachers did not perceive her as bad or unruly.

The Onset of the Eating Disorder

The first interview provided me with an understanding of what Hazel was like before the eating disorder. As we began the second interview, the goal was to focus on the onset of her eating disorder, what life was like living with this illness. At the time of the interview, Hazel was struggling with anorexia and bulimia on a daily basis. The interview began by asking Hazel her first memories of the eating disorder. Hazel recounted two stories that she connected with the onset of her illness. The first happened in grade eight: *... our class had this ... lunch and I remember between three of my friends they ordered two large pizzas... When the pizza came ... my friends each had seven pieces... and I had half a slice. I was hungry, but I didn't feel I should eat. I didn't even know that I was doing it [restricting] but...I didn't eat (Hii, 1).*

Hazel told a second story: *I remember... in New York with my aunt... [she gave me] good cookies... they were really 'gooey' and there were twelve (cookies) ...I really liked them... I had like five of them... My cousin asked to have some [cookies] and he...[asked my aunt] ' Can I have as many as she did?' and my aunt [said] 'No you can't eat nearly as much as she did' and I felt really bad (Hii,1).* When Hazel was asked to talk about how she felt about these events, she replied, *I think I felt guilty...that if I was going to eat then I was going to feel bad afterwards...I felt really bad and guilty(Hii,2).*

Soon after these two incidents Hazel was diagnosed with anorexia. She began to associate eating with guilt. She felt unworthy and believed she could not allow herself to eat. Hazel's feelings of self contempt appeared before the eating disorder. When her aunt commented on the number of cookies she had eaten, it exacerbated her negative feeling towards herself. Hazel was

hyper-sensitive to criticism and her aunt's behaviour only reinforced the negative opinion she already held of herself.

What other factors during grade eight could have been associated with the development of her eating disorder? In early adolescence, she was still adjusting from the transition of elementary school into junior high and this transition had been difficult for a number of reasons. One of the central difficulties Hazel faced was in the relationships with her peers. Her friendship patterns changed as she entered junior high: *I was ...always a one person best friend...then in grade seven...I had to change schools from elementary school...I was in immersion...so I ... distanced from all my friends...it was really hard...then I became friends with this one girl...she wouldn't just be my friend like alone...then I went with this other girl who had no friends so that at least I would have a friend one on one... (Hi,6) ...In grade six I felt free I think...everybody was really close in grade six (Hi6).*

The role Hazel's peers played was pivotal in early adolescence. In reference to her friends Hazel indicated, *I needed to have them, I don't know what I would have done. I always needed people around and if I wasn't with someone all the time, I would be unhappy... I always needed a friend. In grade six it... was okay if one of my friends wouldn't do something with me ...I remember in grade four I went through three different friends in the same year ... in grade seven that would have killed me...In grade seven I needed somebody with me and I thought that if they [friends] would have left, I would never have anybody... (Hi,8) I would have thought I would always be alone...in grade seven. I thought that if I would lose someone, I would always be alone ...if my best friend would have said it to me (she didn't want to be my friend), it would have killed me. I always needed someone really badly all the time but the difference was that if a person did that (left me), it would kill me (Hi,9).*

Another difficult change Hazel had to cope with was the late onset of puberty. In relation

to her peers, Hazel felt she was not developing at the same rate. Hazel said, *I moved schools, [before] I was...always chosen first for teams in gym...but then in grade seven everything changed...I wasn't as strong in sports...as I was before...because everybody developed...I was always short...everybody got stronger and I was still ...really small so I would never be chosen first (Hi, 11)*. Hazel believed that her peers related to her differently in junior high because she was not maturing physically; she was different. All these changes made it difficult for Hazel to adjust in early adolescence and this was expressed through her fear of leaving her childhood behind:... *I used to love dolls...I used to play with them all the time and then my parents said, 'you have to give up your dolls...[they] are for little kids and you're not a little kid anymore. You're going to have to grow up' (Hi, 11-12)... everybody was...encouraging me to give it up [my childhood] (Hi, 12)*. This fear made her transition into adolescence painful.

Dispositions that are Associated with the Eating Disorder

Because Hazel was still struggling with an eating disorder, there was the opportunity to gain insight into what natural characteristics were associated with her illness. One disposition Hazel highlighted was her hypersensitivity...*I think that I know how other people are feeling...without...meeting them...I ... have a feeling of how they are feeling...I am sensitive too...everything hurts or is really good (Hii, 2)*. She explained how being sensitive affected her ...*if I say hi and somebody doesn't say hi back...they could just be worrying about something else, but I perceive it as...they are trying to hurt me...I always take things inward...(Hii, 2)*. In the ESM forms and in the interviews Hazel provided more evidence. The slightest glance or word would ignite self-denigration. This was confirmed when Hazel stated: *[being sensitive] it's a good thing and a bad thing...I know a lot of people I don't want to hang around with...but it's hard [being sensitive] because...if someone does something even if it's not intentional, that hurts me...I take it*

really personally (Hii3).

Her hypersensitivity affected her perception of the world as well: ... *I think that there's a lot of problems now... I don't understand why people have wars...are mean...and I think a lot of people can do...cruel things to other people...I think that the majority of people can be really cruel and... not as sensitive as I am (Hii,3).* It appeared that she experienced the world as menacing and frightening, a place where people hurt each other. She was most careful in her interactions ... *I think I'm more cautious. I know ...now that people can be cruel and so I am more cautious...[with people] (Hii,3).* When asked to clarify what she meant by “cautious”, she stated: *I don't want to be hurt because I know I can be hurt very easily (Hii,3).* Already at seventeen she had experienced too much pain... *like cutting [self-injuring] ...being sad all the time ...and being abused...people have hurt me (Hii,4).*

Her hypersensitivity was a double edged sword; she was intuitive, but also vulnerable. She did not have the ‘psychological skin’ she needed to protect herself when negative comments were directed towards her and she sensed the subtleties that others might miss. The result was she had a potential to become overstimulated because she was so in tune to everything in her environment. Hazel was extremely cognizant of everything that unfolded around her, therefore, she experienced an abundance of information and stimuli continuously.

Living with Anorexia and Bulimia

Hazel poignantly outlined the horror and pain of her present existence. She explained what her daily routine was like at home from the hospital, unable to attend school. *You're dreading to eat breakfast and going to school. So you're trying to figure out ways to ... not eat breakfast (Hii,5)...*[In]...*the morning I try to skip breakfast..[but if] my parents catch me [they] try to make me eat. To make me feel even worse (Hii7).* When Hazel was coaxed into eating, she reported in the

ESM forms, a loathing of self. For example, on Saturday at 8:00 p.m. Hazel self-reported : *I had to eat supper with my family and I feel gross, fat and out of control. This has affected my overall mood state (ESM Entry). [Even if] my parents don't notice [I'm not eating]...[they] are always usually mad at me first thing in the morning for nothing.* For instance Hazel reported: *You paged me at 4:00 p.m. but I answered the page at 5:45 p.m. I had to make supper and my mom was getting mad because I'm stupid with food... (ESM Entry)...They yell at me for nothing...(Hiii,4).*

Hazel felt she had no control in her daily life ... *I'm forced into all these anti-anxiety pills... I don't want them. [If they make me eat] then I feel even worse cause after I eat I feel really bad... I think everybody is invading my privacy...(Hiii,4). After the morning... I try to skip lunch (Hii,4). [When they force me to eat]...they [my parents] usually watch me ...two hours after meals...so I can't purge anymore... I feel...really violated...I feel worse at dinner because we all eat together...I cook something very early so I don't have to eat with them... I feel really anxious eating with them because they are watching me the entire time (Hii, 5-6). Then I have to go to bed. [Before bed I] usually get anti-anxiety pills again... I have to have them and then I sleep (Hii,5-6).*

I asked Hazel if her daily routine was different when she attended school. She indicated her morning routine was the same as on home hospital, but added: *when I go to school... I usually purge. Everybody is watching me at school too, all the teachers, because my parents told all the teachers [I have an eating disorder]...At lunch time I have to go to student services and they watch me eat... (Hii,7). I'm like a child...I don't think it's fair for them to do it... I'm seventeen...next year I will be an adult. I can make choices for myself (Hii,8)... [Even at school] my parents told [everyone I had bulimia]. The guidance counsellor told all the teachers not to let me go to the bathroom [so I won't purge]...(Hii,9)... The teachers, all my classmates now know [I have an eating disorder] ...Everyone is always focussing on me. Making me more anxious. It's making me*

restrict even more... (Hiii,4).

Hazel's peers knew about her eating disorder and were concerned about her well-being, but at times Hazel found this intrusive. For example, she self-reported, *You beeped me on Tuesday at 12:00 p.m. I was in the bathroom at school throwing up so I filled out the ESM form at 4:00 p.m. At the time of the page I was trying to throw up when no one was around. I was thinking I needed to throw up more than I was. I am very self-conscious. I do not feel at all good about myself. My stomach and throat are killing me. When I was throwing up, my friend wouldn't let me go to the bathroom alone because she knew what I would do, so she went with me to the bathroom. I "had" to throw-up (ESM Entry).*

At the time of the interview Hazel's privileges had been revoked because she had not been complying with her doctor's orders. Hazel felt "captured" and the loss of privileges was preoccupying her mind. For instance, on Saturday at 8:00 p.m. Hazel self-reported: *My parents are not allowing me to take piano lessons and I have no control over that decision (ESM Entry). ...I hate it when they [my parents]... bribe...[they say] 'if you want to do this you need to eat'...I hate it when people do that...they [my parents] have taken away my music...(Hii,9)...[They say] I'm not going to be able to go to Spain [on a school trip] and not... go to school...(Hii,5-6). My parents, they are forcing me to do things I don't want to do (Hiii,4).*

When speaking of her daily life, she felt helpless and manipulated by her parents. The relationship between Hazel and her parents was strained. Wrapping her arms around her thin shoulders she said, *I think ...they [my parents] think I'm really weak . That I can't do anything right. I'm selfish and... I don't have any idea of how much I'm hurting them. I do... know I'm hurting them but... I don't want to. I really, really don't want to... They have to understand it's not their fault [I have the eating disorder] but they don't... I feel really guilty and [I] think they [my*

parents] think I'm being the bad daughter and rebellious (Hii6)... I feel guilty all the time. Whether I'm eating [or], not eating [I am] making my parents disappointed [or] making me disappointed...All... they [my parents] talk about is how I can't do anything right and how I am ruining the family (Hii, 5-6). On another ESM form, Hazel reported feeling guilty about how her eating disorder was causing pain for her parents. She wrote: *You paged me on Sunday at 4:00 p.m. but I filled out the ESM form at 5:45 p.m. My aunt and uncle were at my house and my parents were happy, but now that they are home alone with me, they are sad. I feel very guilty (ESM Entry).*

Hazel's relationship with her parents was different now that she had the eating disorder. Before the illness she said, *we used to do everything together...now if I say something [when we are together] they [my family] change it completely so it works for them and [I feel] what I say [is] not important (Hi,2).* Perhaps this was why Hazel felt a great need to interact with her peer group. Her desire to be with friends was evident in many of her ESM reports. When she felt sad and alone, she indicated she wished she were with her friends. On Saturday at 12:00 p.m. feeling lonely, ashamed and confused, Hazel reported: *I would like to be spending time with my friends swimming or skating (ESM Entry).* On Sunday at 2:00 p.m. Hazel wished she could be with her peers and she wrote: *You paged me at 2:00 p.m. but I filled out the ESM report at 2:55 p.m. I wish I was doing something else, skating with my friends because I feel sad, weak, lonely and ashamed (ESM Entry).* An hour and five minutes later on the same day she indicated: *It's 4:00 p.m. I filled out the ESM form at 5:45 p.m. if I had a choice I still wish I could be with my friends skating (ESM Entry).* The last page was sent on Sunday at 8:00 p.m. and Hazel was feeling sad, weak, lonely, ashamed and confused. She reported: *If I had a choice I would be with my friend having a sleep over (ESM Entry).* When Hazel didn't eat or when she vomited, she was not allowed to see her friends. This was particularly difficult for Hazel to cope with.

As a consequence of her eating disorder, Hazel lost her freedom and privileges. However, she still was unable to abandon her eating disorder. The eating disorder served some role for Hazel and in order to understand this, she was asked, “Tell me how you think and feel when you are not eating” Hazel said, *I feel better I feel stronger...when I am eating I feel weak and selfish (Hii, 4).*

On Sunday at 12:00 p.m. Hazel self-reported: *I am eating lunch in the basement, alone while watching television. I am thinking how selfish I am and that I will have to do a lot of exercise to compensate for the calories I am eating. I feel self-conscious, not at all good about myself, not in control of the situation and not living up to my own expectations but living up to others. I feel lonely, ashamed, closed, tense, drowsy, sad, weak, passive, detached, bored and confused. My stomach feels gross because I have just eaten and I feel the need to throw up. Eating is not at all important to me. But it is more important to others (ESM Entry).*

When asked how she felt when eating, her reply was: *ugly, fat, shameful and not deserving (Hii, 4).* In her ESM forms Hazel reported feeling awful while eating or after having eaten. For instance, on Saturday at 12:00 p.m., she disclosed: *I feel pain and discomfort, my stomach feels gross cause I'm eating and my back hurts (ESM Entry).* Once again on Sunday at 8:00 p.m. she reported: *I feel physical and emotional discomfort, my stomach is hurting because my mother forced me to eat more than I wanted (ESM Entry).* Her feelings when eating were that she was shameful, guilty, disgusting and worthless. The contradiction was apparent.

Hazel initially had anorexia, but now was also bulimic. How she felt before purging provides insight into the function this act played in Hazel's life. When she was asked, she confided: *really overwhelmed...really anxious (Hii5).* In the act of purging she experienced herself as *disgusting... and...relieved...I know I am hurting myself so I want to stop but I don't think I can (Hii, 5).* After the purge, emotions abounded: *I feel shaky...but I think the world feels like an easier*

place to handle [because] before the purge, I am anxious and uptight and then after I'm relieved...[it lasts]...for five minutes. [I.also] can't feel feelings right after I purge (Hii,5).

Several of the ESM self-reports illustrated the emotional experiences just before and during bulimic episodes. For instance, on Sunday at 2:00 p.m. Hazel wrote: *I filled out the ESM report at 2:55 p.m. I just looked in the mirror, I feel disgustingly fat and this has affected my mood. I was thinking how much I wanted to throw up. I feel very self-conscious, not at all good about myself not living up to my own and others' expectations of me. I feel very lonely, ashamed, closed, drowsy, weak, passive, bored and confused (ESM Entry).*

Feeling bad about herself and anxious when paged again at 6:00 p.m. on Sunday, she reported: *When you paged me I was in the bathroom throwing up, so I filled out the ESM form at 6:30 p.m. After vomiting I was running water in the bathtub so my parents wouldn't hear me. I was also trying to make my eyes, cheeks and hands look like I hadn't thrown up. I was thinking how selfish and horrible I felt for having vomited. I feel self-conscious, bad about myself and not at all in control of the situation. When paged I felt somewhat happy, weak, passive, lonely and very ashamed. My mouth and stomach are burning a lot.*

When Hazel experienced feelings of worthlessness and self-contempt, she turned to purging in an effort to relieve these negative emotions. Hazel engaged in behaviours that threaten her life. The eating disorder resulted in her losing her privacy. However, at the time, not eating and/or purging were the only ways Hazel could deal with her feelings. Since she felt anxious, disgusting, shameful, bad, not deserving and guilty, not eating or purging soothed her. Hence, it was difficult for her to abandon these destructive behaviours. Feelings of guilt and shame were dominant, however the eating disorder only served to magnify these feelings. Hazel spoke of the guilt and shame that dominated her life:.... *I feel really bad I feel...I don't deserve a lot...[now] if I get gifts...I*

feel very awkward...I don't deserve it...I feel really bad (Hii2). She loathed herself. she was convinced she was bad and therefore deserved nothing that brought her pleasure. Yet, Hazel's life was dominated by the desire to do everything perfectly. In the ESM reports her quest for perfection was obvious. For example, on Saturday at 4:00 p.m. she reported: *I was at work where I host birthday parties for children. I filled out the 4:00 p.m. ESM report at 7:00 p.m. When paged I was distributing pizza to children, trying to impress the parents by being super nice...plus I was trying desperately not to screw up while speaking French. During the birthday party, one of the kids said I wasn't speaking French very well. I feel weak, ashamed, confused, tense and competitive. I do not at all feel satisfied with my performance (ESM Entry).*

Hazel wrote a poem that captured how she tried to please everyone else, but was unable to please the person who really mattered, herself:

The Man in the Glass

When you get what you want in the struggle for self
 And the world makes you king for a day,
 Just go to the mirror and look at yourself
 And see what that man has to say

For it isn't your father or mother or wife
 Whose judgement upon you must pass
 The fellow whose verdict counts most in your life
 Is the one staring back from the glass

You may be like Jack Horner and chisel a plum
 And think you're a wonderful guy
 But the man in the glass says you're only a bum
 If you can't look him straight in the eye

He's the fellow to please-never mind all the rest,
 For he's with you clear to the end
 And you've passed your most dangerous difficult test
 If the man in the glass is your friend

You may fool the whole world down the pathways for years
 And get pats on the back as you pass
 But your final reward will be heartache and tears
 If you've cheated the man in the glass

How did Hazel deal with the demands of life? What strategies did she use to deal with her insidious illness, particularly, in school when starving and/or vomiting more than six times a day? Coping was a daily struggle for Hazel ... *I try my very best with my friends...I...go to class...I do quizzes ...and I can't concentrate...I try to talk with my friends, so they don't think I'm trying to hurt myself...(Hii,8)*. The focus of Hazel's thinking was always about the external, not her internal state of mind at play in her life.

Through our conversations and the ESM reports it was evident that the eating disorder overwhelmed her life. In school it was difficult for Hazel to concentrate. She experienced extreme anxiety if she were not engaged in some behaviour which was conducive to losing weight. She said, *Between classes I usually run upstairs...so I can exercise...I feel better [in the] next class [if I exercise]... (Hii,8)*. Hazel self-reported that the need to exercise also preoccupied her mind . For instance, she reported: *It's Tuesday. I was sampled at 2:00 p.m. but responded to your page at 4:00 p.m. I was at school in English class listening to the teacher. At the same time I was shaking my legs to try and burn off calories. I had thrown up so I hurt myself. I am feeling a bothersome level of physical and emotional pain (ESM Entry)*. The need to exercise was so great Hazel even lied to be able to do it. For instance, on Saturday at 6:00 p.m. *I was waiting to be picked up from work by my parents. I lied to my parents, told them I was working when instead I was exercising. I was thinking that I should have exercised more and was weak for not doing it. But, I also feel good about myself, I am experiencing severe physical and emotional discomfort because I was exercising too much and my legs are hurting. The activity (exercise) was very important to me. I also weighed*

myself...I lost weight. I feel totally huge like I shouldn't exist and I'm much too fat and disgusting to be seen in public (ESM Entry).

When Hazel achieved her goal of not eating, she felt better. Hazel said, *At lunch time I have to go to student services and they watch me eat....most of the time I'm pretty good at hiding things [food] and I don't eat everything so I don't feel bad in the afternoon. But if I have to eat everything I feel really gross...(Hii7)... Then [after lunch] I go to class...depending if I've eaten or not I feel better or worse (Hii,8).*

To conclude the eating disorder began when Hazel was fourteen. She experienced herself as bad and not deserving. By nature she was sensitive and therefore her feelings were easily hurt. Hazel experienced the world as hostile, bad and frightening, therefore, she was cautious how she interacted in the world. At the time of data collection Hazel was on home hospital and was monitored twenty-four hours a day. Her life revolved around trying to not make others aware she was starving and/or bingeing. Hazel felt her parents and other people in her life, teachers, neighbours, etc., have always experienced her as a bad person. The anorexia allowed her to feel strong and powerful. In contrast, when she was eating Hazel experienced herself as ugly, shameful, fat and not deserving. The purging served to relieve the anxiety. High achievement in school and, extra-curricular activities was the only way Hazel was able to feel good about herself. What follows next is a discussion of the function that Hazel's eating disorder served.

The Eating Disorder's Function

The second interview abounded in information about what life is like when in the throes of an eating disorder. The last interview focussed on eliciting reflection, specifically in relation to the precipitating factors leading to her eating disorder and the function it continued to play in her life. Hazel had been under the care of a psychiatrist for some time, so she was quite insightful about

her eating disorder. She indicated many reasons why the eating disorder began: *...a lot of stress from parents and friends and anxiousness...in grade seven having to give up some of my friendships...(Hiii,1) [plus] I never liked change, I hated change and dislike whenever anything changes ... I freak out that's why I think it's so hard ...when my cat died [and] when my friends leave...it was really, really hard for me to change schools. This whole year is going to be weird (because I'm moving homes). [When change happens I feel]... someone is taking something away from me that is mine. (Hiii,3). Especially when they [my parents] took away my cat from me without even telling me... [they] brought it back to the Humane Society and they told me later that they had to put her down and I felt really, really bad. I thought that was really mean and then I got even... worse... (Hiii,3).*

Hazel's inability to accept and adapt to change was apparent in many of the ESM reports. For instance, her cat had died many years earlier, but she still experienced profound sadness when she thought about her and desired to be reunited with her. For example, on Sunday at 6:00 p.m., Hazel was in the bathroom vomiting, therefore she filled out the ESM form at 6:30 p.m. She reported: *I wanted to be with my cat who died (ESM Entry)*. On Tuesday she wrote: *it's 2:00 p.m. but I answered your page at 4:00 p.m. I was at school. If given a choice I would be with my cat who has died (ESM Report)*. Later that same day: *You beeped me at 8:00 p.m. and I answered the ESM form at 8:30 p.m. I wish I was with my cat who died (ESM Entry)*. Anticipated change was just as terrifying for Hazel. For example on Sunday at 4:00 she reported: *I filled out the ESM form at 5:45 p.m. I was thinking about the move my family is going to make. I have so many friends and memories here and I don't want to move...but it is totally out of my control. I feel quite weak and ashamed (ESM Entry)*.

The eating disorder helped her deal with life...*to get control and to relieve anxiousness*

sometimes...if I need distraction, it takes away all my problems and gives me one thing to focus on instead of having to worry about a whole bunch of stuff (Hiii,2). She had been suffering from an eating disorder for three years. The eating disorder had always served the same function: it helped her deal with life . She said, *it started ...because I knew I wanted to get away from that girl Kim...I wanted to get away from her because she had no other friends and everybody was ignoring me...I really felt abandoned and so I wanted to get away from her, but I had no idea how to do it...I didn't want to hurt her feelings...she had nobody else to turn to...I started not eating...to lose weight...so that my parents would notice something was wrong they would do something about it (Hiii,2).* I asked, "You couldn't tell them?" She firmly replied, "No" (Hiii,2).

Hazel returned to her cat's death....*I think the biggest thing is when my cat died...that's when I stopped eating a couple of days after...[I was in] grade eight ...I blamed myself (Hiii,2) [for the cat dying. She had] diabetes. But I was clipping her claws and...it [her claw] started bleeding because I...cut a bit too much of it [the claw] ...after, she just kept getting worse...then she got diabetes and died, but it wasn't until I clipped her toe that she started getting sick (Hiii,3).* Perplexed, I asked, " Why did you chose not eating as a method to deal with the feeling you felt that you hurt the cat?" Hazel replied, *the reason why we put her down was because she was not eating ... she didn't eat because she knew she was in pain and she had to go... So I felt like it was my fault... I felt I deserved not to eat, too (Hiii,3).*

It was difficult to follow her reasoning, so Hazel was asked if she didn't eat because of the pain of the clipped toe or before that. Hazel responded: *No, when she was really sick with diabetes she weighed like four pounds...I think the biggest thing [that was associated with my eating disorder] was my cat (Hiii3)...then my parents...plus... trying to be perfect all the time...(Hiii,4).*

Hazel next introduced the theme of perfection. Her need to achieve perfection dominated

her life. Nothing she ever did met her expectations. This belief system was seen in many of the ESM reports. For example, on Saturday at 2:00 p.m. she reported, *I was late for drama and then for work. So I completed the ESM form for my 2:00 p.m. page at 6:30 p.m. At 2:00 p.m. when you paged I was in drama practice. I was worried about being late for work. I was thinking in drama practice, "I wasn't doing a good job". I feel very self-conscious, not at all good about myself and not in control of the situation. I feel drowsy, ashamed, tense, competitive, confused and detached. If given a choice, I would be putting on the play, rehearsing in front of an audience, and I would be cast in the lead role (ESM Entry).* Later the same day at 8:00 she reported, *I am on the phone, in my room alone. I am worried about remembering everything for drama (ESM Entry).*

On Tuesday, a school day, Hazel carried the beeper and on one page she revealed her expectations: *It's 12:00 a.m. I was in the bathroom at school throwing up so I filled out the ESM form at 4:00 p.m. Just before the page I had received my chemistry test back. I got 77%. This has affected my mood (ESM Entry).* Again at 2:00 p.m. Hazel was thinking about how badly she was doing in school: *At 2:00 p.m. I was at school. I was thinking that this school semester is going to be hard and that I am stupid because I got 77% on my Chemistry test. I feel self-conscious, not good about myself and not in control (ESM Entry).*

Most of Hazel's words indicated that her eating disorder arose because she felt self-contempt and fearful of change. She spoke of how the family and the school context interacted with her natural dispositions at the onset of her eating disorder. However, up to that point Hazel had not yet identified any role the sociocultural context played in the development of the eating disorder. She was asked if she began to not eat and/or vomit because she wanted to look thin and beautiful. Her answer negated the influence of sociocultural pressures: *...it's more about ...feeling [what's] going on in the inside...it has nothing to do with that [the magazines, fashion] ...cause no matter*

how much weight I lose, it doesn't really make a difference (Hiii,5). Before the interview ended Hazel was asked to communicate anything else she was feeling. Her concluding statement strengthened the belief that Hazel was an unusually caring human being: *...I don't think the eating disorder is anybody's fault...it's...nobody's fault, it's like a disease ...it's important to be patient...(Hiii,5).*

Despite Hazel's young age she was quite reflective on what she had come to understand about her eating disorder, namely, dealing with stress, parental expectations, perfectionism, the loss of friendships and changing schools. Hazel's sensitive disposition made it harder for her to accept some of life's experiences. Based on what Hazel shared it became evident that the eating disorder helped her deal with life. The sociocultural environment had reportedly played less of a role in the development of the eating disorder as Hazel indicated her eating disorder was a result of pervasive inner feelings.

Hazel shared with me a second poem which illustrated her battle against the eating disorder. She desperately wanted to abandon her illness, but knew it will be the most difficult fight of her life because it is a war she has to wage against herself.

Swimming in an ocean
 You find yourself all alone
 You're free from all distractions
 From the doorbell and phone

 You start to think about the present
 About the future and the past too
 You think about your family and friends
 And you begin to wonder what's in store for you

 All of a sudden you begin to shake
 For your body's in need of some air
 You're not sure if you'll make it up in time
 And you realize that you really want to get up there

You push with all your might,
 Your arms and legs begin to hurt
 You feel your face become blue
 As you look around and see all the dirt

There's pollution all around you
 As bubbles rise from your nose
 Your body's in desperate need of air
 And you find yourself missing the sound of the crows

You realize that life is so fragile
 And can be destroyed so easily
 Right now all you need is a hug
 As you push your way up dizzily

As finally you begin not to hear any noise
 And you begin only to see black
 Your lungs are finally relieved
 As air fills up those precious sacs

Slowly you make your way to the shore
 As your friends begin the cheer
 You find yourself free from all guilt
 As you realise that this nightmare's over with a tear

.You're back to your old self again
 Your parents reach out and take your eleven year old hand
 You begin to laugh and to sing
 As your toes touch the gentle warm sand

The colours of the world are so beautiful
 They're colours you looked past before
 With your family and friends in place
 You find yourself again with the life you adore

Hazel's story provided a general overview of the issues that she believed were associated with the development of her eating disorder. The next case introduced is Pat's. She is an adolescent girl who is currently suffering from anorexia.

Pat: Going to the Edge Three Times a Day

Pat's account of her eating disorder is woven from three sources of data: interviews, artifacts and ESM data. For the ESM data Pat was sampled for three days, a Saturday, Sunday and Friday. She was paged every two hours for three days. The first page was sent at 10:00 a.m. and the last one at 8:00 p.m.

At the time of data collection Pat was an eighteen year old girl with anorexia nervosa. In school she was a high ability student, had a ninety percent grade point average and had been on the honour roll. She received special recognition for her music and volunteer work and was the section leader in her high school band. Her creative talents included drawing and painting. She excelled in English literature and kept a journal.

I attempt to voice Pat's understanding of the individual and contextual factors that led to the development of her eating disorder. Then, Pat's family life before the development of her eating disorder is pursued. Subsequently, Pat describes the onset of her eating disorder. Following this her present struggles with the illness are outlined. Pat's knowledge about her illness is then presented. Pat talks about how the eating disorder allows her to flee from herself. Finally, the sources of refuge Pat uses to deal with her illness are discussed.

Life Before the Eating Disorder

We began the first interview with the objective of obtaining information about what Pat's life was like before the eating disorder. Pat was asked to think back to her childhood, what was it like? She stated ... *I don't remember much from my childhood. I don't know if that's selective or sub-conscious... cause I didn't want to remember...(Pi,2).*

Pat did recall that since a young age her mother had been the primary caregiver.... *It's always ... been my mom, my sister and I... My father was there. My parents didn't get divorced until*

much later, but he [my father] wasn't really much at home. He was working, he was providing for the family. My mom took years off to spend with my sister and me... She was always at home... I didn't see too much of my father even back then ... (Pi,1).

Pat did not want to convey the impression that her father was a bad parent. She stressed *...these are good memories that I have with my father... [He would] play [the] guitar at [my] birthday parties ...* However, she said, *there's only a few memories like that. Nothing really close as a family (Pi,1).*

Pat vividly recalled what life was like for her following her parents' divorce. *I was almost six years old... when my parents divorced (Pi,1)...I think there had already been periods of time where my father wasn't living at home... I just don't remember. I [do] remember one night I had a bad dream ...[so I went] to my parent's room. My father was there and I said "I had a bad dream" and he said "crawl in". [I didn't see my mom so I asked] "Where's mom?" He said "She's out". I remember it being dark and late and my mom usually didn't go out...(Pi,2)...it scared me...She had probably left because they had a fight or something (Pi, 2).*

With the divorce, the family context and dynamics changed ... *We [my mom, sister and I] had to move. [We went] to a smaller house because we couldn't afford our new house [the one we were living in with my dad]...(Pi,3). My father was forever moving from apartment to apartment...Even when we went to visit him, we weren't ... settled there because he was still moving and unpacking...(Pi,3). We [my sister and I] had to spend equal time between the two houses...(Pi,3).*

Pat indicated that the divorce of her parents was a time of tremendous change, emotional distress and confusion. Following the divorce, she was put in a position she was unprepared to deal with. As a child she said, *I was always... put in the middle... I was... the messenger [I remember*

wanting to shout] ... "Don't kill the messenger" ... But, that's... what it turned out to be. They would always ...pump me for information about each other... Not that they meant to do it. They were curious and they didn't really know how to come out and ask...there was never an intention [to hurt me]...(Pi,3).

After her parents' divorce Pat assumed roles unusual for her age. *My father was not a good cook... I remember going over and we would have Kraft dinner or we would go out for dinner... That was the ... pattern for awhile, so I learnt to cook early or at least help in the kitchen... I enjoyed it. I [also] helped out my mother at home...(Pi,3).*

In addition to the changes and added responsibilities she confronted after the divorce, she felt an overwhelming concern for their well being, especially her mother's...*[I] felt... responsible to keep both parents... happy... My mother she had a really hard time... it was my father who left and who wanted the divorce. It was a big mess...(Pi,4).*

Already at the age of six, Pat was a precocious, perceptive child, who was aware of her mother's unhappiness and loneliness. *After my parents split up my mom would have friends in the house. She wouldn't go out often...When she did she would only be gone for a couple of hours at a time...My mother, it took her a long time before she dated...(Pi,17)...I ended up being my mother's half, like her other partner. I was very overprotective of her and still am... (Pii,9)*

She was also sensitive to her mother's sadness. Being a caring child she tried to make her mother's life easier. This was never intentionally expected by her mother, it was just how Pat responded to the situation. As a child she recalled the sacrifices and difficulties her mother experienced. *She [my mom] had two kids. She was more responsible for us than my father . My mom, she didn't have job... because she took all that time off with me and my sister. ...[After my Dad left she had to] find a job... enough money... She was really protective of us... [after the divorce].*

I ... took on the parental role of my sister ... I tried to keep her happy...(Pi,4). Pat as a child was a serious, responsible young girl who assumed adult responsibilities.

To obtain a clear picture of Pat's childhood she was asked about her school experiences. Pat discussed the difficulty she had in adapting to school. She attributed this to a number of reasons ... *I was used to having my mom around ... because I was premature... She [my mom] was always there when I was little... Whenever I would cry she would be right there because she would be so afraid something would happen...(Pi,5)... She was very protective of her kids...(Pi,5).* Going to school was hard for me [I bonded with my mom more] because I didn't make friends ...easily (Pii,9).

Adapting to school was also difficult because of Pat's naturally shy disposition....*I was too quiet and ...loved to read books... I kept to myself a lot ... I wouldn't go out and play with the other kids. Sometimes I would just want to be by myself and do my own little thing...(Pi,6)...*She recounted an event of how her shyness affected her behaviour in school. *In kindergarten... we used to have free time ... Sometimes I would play with the other kids, but most times I'd go off into the little corner and read my book. Sometimes I'd cry because I'd miss my mom. I'd want to go home... I was always ...shy in the younger grades...(Pi,5)...*We used to have carpet time ... *I remember I used to be part of the circle. .. Sometimes I wouldn't say much, so that's like my own way of retreating into my own mind ... (Pi,5).*

Pat craved solitude and felt uncomfortable in social situations. She found it was difficult to socially interact with her peers. Moreover, her natural tendency to withdraw into herself restrained her from talking in group settings. Pat's elementary school teachers saw her as shy, introverted and sensitive...*every report card...I always got 'too quiet in class'...not outspoken enough' (Pi,4).*

Pat's family moved often. This made it more difficult for her to make friends. *It took me a long time to make friends ... We were always moving around a lot ... I was always really quiet with them [my peers]... [I would] feel them out in the beginning ... (Pi,8).* Pat's peer group played a minor role in her life before she began junior high. She alluded to this fact...*I can remember like one or two [friends] who I was close to...I remember people who travelled with me through the grades but two or three at the most in elementary school...(Pi,13)...I don't really remember specific friends I had...(Pi,12).* Each geographical move proved difficult. She said, *...we...moved every two years. You...get settled and then... you get used to it...I guess...(Pi,14).* Her manner of speech (i.e. barely audible) made it evident that the various moves had caused problems.

During Pat's childhood her mother was employed as a teacher and at times she worked in the same school that Pat attended. Her mother would socially interact with her teachers and hence Pat met her mother's colleagues more than her peers. *I was exposed ...[to] people mostly in the teaching profession... [My Mom] became really good friends with [the]... people whom she worked [with]...(Pi,17).* These early experiences made it easier for Pat to interact with adults rather than children. *[As a child]... I was... more comfortable with teachers. I had a different relationship with teachers than most students because my mom was in the teaching profession... Teachers interacted with my mom or came to the house ... (Pi,12).* [In school]...*I was always with a teacher. I have always been more comfortable with adult figures because I have grown up around adults...(Pii,2).*

However, Pat recounted that her memories of elementary school were not positive ...*In elementary school for awhile it seemed... negative because I wasn't really good at a lot of things (Pi,13)...I wasn't [a] particularly good student. I would get...C's and D's...I wasn't a stellar academic student ... (Pi,11).* *I wasn't good at spelling... and math... In grade six or five we would do math minutes where you have to do 50 questions in one minute.... I couldn't do that. I would get like five*

done at the most...(Pi,13). However she did excel in reading: I remember I could read before everyone else...(Pi,11)...I was always reading early. I loved to read a lot... and I like to write things (Pi,11)...I read so many things. I've read all the Anne of Green Gables and Emily of New Moon [books] (Pi,11)...

Pat was asked why she loved to read. [Reading books was] *something different... I couldn't do much in my own life. I didn't really go very far from my own space...[Books] helped me to see what else was out there. I could go off into my own little space in my head. You make friends in books ... (Pi,11). Perhaps, she found in books the comfort, company and understanding she could not in her peer group. Pat was also a child prone to fantasy and imagination...I had an imagination...I was always doing weird and crazy things...(Pi,6)... [I was] into ... making up my own stories. I loved Barbies... (Pi,6)... [I was always] doing my own little imaginative things ... (Pi,17).*

While in elementary school the composition and dynamics of her family changed. From a unit consisting of three people, herself, her mother, and sister, a new male partner entered into the family. This time in Pat's life was a most difficult transition. In telling her story Pat said *in grade five we moved down here [to Ottawa]...We started living with my mother's significant other (Pi,17)...I was used to being the other half of my mother, the other parent for a long time. My stepdad assumed that role, so I got defensive, easily argumentative... (Pii,6).*

All the while a number of other changes also occurred. Pat became more aware of her body. *I was a fat pre-adolescent [i.e.] like when I was 10, 11 and 12. I would say I was fat. My mom says I wasn't ...but I wasn't developing and a lot of girls in my class were already developed. They had the breasts ... I would look at them and [think I didn't look as good so] I would wear my sweatshirt and sweat pants to school. I was ...chunky (Pi,15)...Before junior high school, in grade six, I started noticing all my friends were tall and thin. Their bodies had already matured. Mine was going slower...(Piii,4)...* The difference between Pat's body and that of her friends became more salient

following a critical incident in grade six ...*[There was a boy], he liked me for a little while but as soon as my other friend came along (she was taller, prettier and had breasts)... he just ... went for her (Pi,17). She was tall so it didn't look like she had the excess baby fat... She was just taller and I'm short. She was proportioned better compared to me... They [the taller, prettier girls] always had the boyfriends... They had the looks and [got] the things they wanted(Piii,5)... I was always one of the really small kids in my class...(Pi,4). I got the message...I wasn't really good enough. I was the short, chunky kid (Pi,17)...* Amid these turbulent times Pat was preparing to make yet another change, the transition from elementary school to junior high. In preparation Pat went to visit the junior high she was going to attend. She saw the honour roll and wanted to be on it. From junior high onwards Pat's identity became fused with her grades. Pat provided several artifacts that speak to her academic achievements (See Appendix I).

The first interview provided a wealth of childhood information. Pat's mother had always been the primary caregiver. Pat remembered seeing little of her father when her parents were married. When she was six, Pat's father divorced her mother. The demise of the marriage was difficult for Pat's mother. She experienced financial and emotion strain. The family moved often, making it difficult for Pat to establish friendships.

According to Pat, her parents unintentionally cast Pat in the role of mediator. Both parents would ask her to divulge information about one parent to the other. Pat experienced herself as "the messenger" and this role was overwhelming. After her parent's divorce, Pat, of her own volition, assumed a lot of responsibility. She believed it was her task to ensure her mother's, sister's and father's well-being. For Pat's mother, the world revolved around her children. She was very overprotective of them. She felt that this closeness to her mother made it difficult for her to adapt in school and to make friends. She had always been more at ease with adults. As a child she was

withdrawn, shy and imaginative. She lived a vivid, inner world. Pat claimed she was not a top student, but she excelled in reading. In grade five her mother moved in with her step-father. This was a difficult time for Pat because she had to relinquish her role as the other partner within the family context. Her step-father assumed the role that she had held for years. Pat did not easily accept her changed position within the family.

When she began grade six, Pat noticed she was not developing at the same rate as her peers. She perceived herself as short, chunky, small and fat. As a consequence, she assumed she wasn't good enough. Therefore, she concluded if she could obtain high grades, perhaps she could feel better about herself. From that point onwards Pat began to focus on her grades and her goal became to excel academically.

The Onset of the Eating Disorder

In the first interview Pat travelled back in time to explore what her life was like before she developed her anorexia. The objective of the second interview was to elicit an understanding of the onset of her eating disorder and life since that time. She was asked to share the first memories of her eating disorder. Pat believed the anorexia *started around grade seven or eight (Pii, 1)*. She stated ... *I had no idea what an eating disorder was. I just wasn't hungry. I didn't think I ... needed food. It was ... the last thing on my mind... I just wasn't hungry. I guess that was my excuse for the longest time...I truly believed it... When people started pointing out that was just an excuse, I [began to think] I had a real problem. [At first] I just didn't believe it...[I would think] I'm not hungry...[The] more I found out about eating disorders, the more I tell myself that's an excuse for something (Pii, 1).*

Pat had precise recall of how she felt when her eating disorder began. She reported, ... *I wasn't intentionally trying to lose weight. I just stopped feeling good all the way around. I just wasn't hungry...(Pii, 1). [I was]... feeling ... confused. I didn't know what an eating disorder was when I was*

first diagnosed... I just believed I wasn't hungry...[People say I began] because [I] wanted to be pretty or a super model. I say "No, that's not why!" (Pii,8)... It [the anorexia] wasn't a quest for thinness or to be part of a certain group or anything... I [just] went along with it...(Pii,1) . [At first]...it wasn't bad enough to be considered an eating disorder. There was always someone worse off than I was... [I would think] "Well, mine isn't really that bad". The biggest thing I remember was [people] trying to make me eat. At first nobody really understood it... I wasn't doing it as a drive to be thin or anything. I just wasn't hungry. I do use that as an excuse... but I don't know what it's an excuse for (Pii,3).

Pat saw the eating disorder as something that just developed as she went about her life. She claimed that this was a time where many other things were taking place in her life. Therefore, eating wasn't a priority. Pat was asked to elaborate on this point. *I was always busy doing something. I was involved in music... I was doing [something] all the time. I was helping out on my lunch hour. I didn't really go out for recess with [the] other kids. I always made sure I had something to do... There were just other things going on at lunchtime which filled the time...(Pii,1)... In junior high I used to go in at lunch and help the home economics teacher. I would fold towels and clean up ... In grade nine ... music [band practice] was at lunch time...Therefore, I didn't have to go in the cafeteria. I didn't have to talk to other people...(Pi,18)... [I would] help in the family studies room at lunch...I always had something to fill in the time (Pii,2).* Pat would fill her days, keep herself busy, particularly at times in the day that were associated with eating. Staying busy helped her keep her mind off food which made restricting her food intake easier.

While dealing with anorexia, Pat changed high schools. *In grade ten I had to go to a different high school [than] ...the one I am presently [at] (Pi,14). I fought it the whole way. My first half a year at my new school I didn't want to make any friends because [I was determined to send the message*

to my parents] I'm going back, you can't keep me here. This is not what I want...I isolated myself so much because I wanted to be somewhere else...(Pi,15). Typically an adolescent forced to change high schools would have difficulty adapting to such a change. In Pat's case the difficulty was compounded by a number of factors. Within a short period of time she had experienced many changes in her family structure and dynamics. Pat was in a period where she felt self-conscious about herself physically. Coupled with her tendency towards introversion and shyness, the transition to a different high school was particularly stressful.

Living with Anorexia

The conversation switched to how she currently felt. At the time of the interview Pat was struggling daily with anorexia. Pat spent some time telling me how the anorexia had affected her entire life...*I have band three mornings a week... I get up relatively early... at six but I'm awake at 5:30 a.m. or 5:00. Sometimes. I don't sleep very well ...so I tend to be awake and ready before everyone else. I get impatient because I like to be ... early ... I don't like to walk in late [where ever] I am going. My mother always wants me to eat something in the morning but it's harder to eat in the morning... I find anyway.* On Saturday at 10:00 a.m. Pat self-reported feeling awful before music practice began, *I felt nausea, weak and dizzy. I had eaten breakfast... this feeling had not happened for a long time (ESM Report).* She recounted, *I'm grateful for the band mornings. I don't have to usually eat or she'll [my mother] make me take something with me ... so I don't end up eating. In the morning that makes it easier because then I am past the hungry stage...(Pii,6) ... If I can get past it, I can get out of my house in the morning without eating something, then I don't have to worry. The issue [eating] goes away until lunch and then if I can make it through lunch without eating anything... [The issue is] gone until dinnertime. Then if I do eat something I might think about it a little bit too long... There is always the point around lunch time. I tend to get more anxious...if people notice [I'm not eating]...(Pii,8).*

I'm [usually] not hungry at lunch, then I go through the regular school day... It's always hard to concentrate in classes... I find after lunch I really lose concentration because I haven't eaten breakfast or lunch... I will have a juice box, just to have something... I fill up on juice or water... In the afternoon classes it gets harder to concentrate and more so now . I've been getting dizzy spells (Pii, 7). Another physical effect was reported on the ESM form. On Saturday at 4:00 p.m. when paged she reported *I am home alone. I just went to the grocery store and shovelled the snow. I am thinking how weak and out of shape I am. I just shovelled a little bit of snow but I feel very tired and weak (ESM Report).* Pat lived in a state of constant stress anticipating the time she next needed to eat. Repeatedly she used the phrase "Going to the edge three times a day" to express how she felt during and before each meal. This expression was important because it captured the essence of Pat's difficult relationship with food.

Pat continued to explain her daily routine once home from school. *I know at home I have to eat dinner because my mom is there. She watches me and she makes me eat. She makes me physically sit there. Eventually if she gets fed up enough, she will try to force feed me (Pii,6)... [Eating has] become a chore it's like... "going to the edge three times a day" (Pii, 7).* On Saturday at 2:00 p.m. when paged at home with her mother, stepfather, sister and uncle, she was helping to prepare lunch and trying to decide what to eat. She wrote, *it's lunchtime. I am hungry, but I am having a hard time giving myself permission to eat something. I'll just probably have something small. It's like going to the edge three times a day. I feel very self-conscious, not at all good about myself, ashamed, passive, detached, closed and tense. What is affecting my mood is that it is lunch time and because I am at home my mom will make me eat more than I want. My mother does not understand me and I wish my mom would let me control my own eating. These are the times I wish I could binge and purge, but I've tried and I can't (ESM Report).*

Eating evoked intense anxiety and distress. She felt conflicted when she did not eat: *there are*

two distinctions. One is I know I have the self control and I can do this. Then at other times it's well, you don't deserve it [to eat]. On Friday at 12:00 p.m. when paged, she was wandering the halls during lunch hour. She was talking with friends and giving her lunch away. I feel like I'm going to the edge three times a day. I want to eat but I deny myself that pleasure because I feel I don't deserve food. When paged I was feeling self-conscious, not at all good about myself or in control of the situation. I feel lonely, ashamed, sad, tense and very closed (ESM Report). She added, ...Sometimes when I'm not eating I feel good about myself. I know I can control that aspect. I know it's my own choice. I have the willpower. Sometimes when I'm not eating I feel really bad because I know I should be eating ... It's a control thing. When I can't control anything else [I control my eating]. When things are going on in my life and I just can't handle anything else at least I can control what I eat, when I eat and if I eat (Pii,5). In this last statement she expressed that the only thing she believed she exerted control over in her life was her food intake. As she was describing her daily routine one noted the frustration she felt when her mother forced her to eat.

Pat also addressed her present relationship with her parents. In reference to her father she said...*The really sad thing is ...we're not overly close... (Pi,6)... That's not overly his fault now [that my parents] separated ...We moved three days away [from my dad] ...I don't see him very often. When I do, he tries to talk about the eating disorder. The first question he asks is "What is your mother doing to make you feel that way"?...I just completely blow up at him...They still do that, [my] parents shift the blame on each other and that bugs me (Pi,6). [But my father] he is just recently starting to realize how important some things are in my life like music and school (Pi,6). [He] knows I have the eating disorder...[but] he doesn't ... understand that much about it (Pi,6)...*

Pat was careful not to ascribe blame onto her father for the distant relationship between them. In part, Pat viewed her remote relationship with her father as linked to having been physically

separated for a long period of time. She resented any comment, even from her biological father, which would blame her anorexia on her mother. It was no surprise that Pat saw her relationship with her mother as much closer than that with her biological father. She nevertheless worried about how she had affected her mother. *Sometimes I think she [my Mom] thinks I am doing it [not eating] as a way of control... She doesn't blame me for this [the anorexia]...(Pii,6). My mom worries about me. [For example] ... my mom says to my little sister "take care of your little sister", meaning me. She, my sister ends up talking for me now and... taking care of me. The roles have ... completely shifted (Pi, 7)... Our roles are reversed now... When I was little I always used to talk for my sister ... I would want to... protect [her]... I would always talk for her. My mom would have the hardest time to get my sister to say things...(Pi, 7). Pat's mother recognized that her daughter was experiencing a lot of distress and she had enlisted the help of Pat's younger sister. Pat introduced her sister in our conversation. She confided. *[My sister would] think [I'm one of] the boring bookish losers. Not one of the cool people... Weird I guess (Pi,8)...Maybe a little to quite... boring because I like to read books...She would describe me like other people would on the outside looking in (Pi, 8).**

How did her friends see her? Pat indicated that most of her friends didn't know that she had an eating disorder so *...they [my friends] would consider me quiet. But once they get to know me I ... voice my opinions... (Pi,8). My closest friends would say I am... goal orientated ... Really strong on getting the grades... [but I] put relationships first... I would try to be there [for them]... I am a support for them [my friends]...I am just somebody they can go to if they are having problems. I am always there to support them . [I am] solid. Even if I wasn't solid I'd be more solid than most other people would be (Pii,6).* It seemed that Pat's friends did not realize the emotional distress she was experiencing. Rather Pat projected dependability and stability.

She explained an incident that illustrated how reliable a person she was: *I met my best friend...*

in grade nine... in a bus accident. We had to jump out [of the bus] ...I found her [my best friend] she was crying... saying " I can't move my leg. I can't walk. " ... I started doing first aid on her ...some people ... completely broke but ... I'm always good in those situations.(Pi,11). We have been best friends ever since (Pi,9)... Pat continued: They [my friends] wouldn't understand I had problems... Sometimes I would like someone to ask me how I am and answer honestly...(Pii,5). Sometimes I just want to go where I can live, not pretend I have any personas or masks...(Piii,2)... I don't usually share. I feel weird or bad for sharing ...(Piii,6).

Any situation where Pat ran the risk of having to talk about herself was anxiety-ridden, in part because it might have forced her to reveal herself. On Friday at 4:00 p.m., she was waiting to see a doctor who specialized in eating disorders and subsequently she filled out the ESM form at 7:00 p.m. Pat wrote: *I am nervous about seeing the doctor about weight gain and loss. I feel very self-conscious, not at all good about myself and not in control of the situation. I feel very tense, ashamed, closed, sad, detached and confused (ESM Report)...Sometimes I mask my personality to conform to what others want. It changes or what I present changes (Piii,1).* She felt she needed to maintain a facade. When asked, why, she responded...*It's safer that way... nobody gets too close to me...(Pii,5).* On Friday at 12:00 p.m. when paged, she was feeling distressed because she feared someone would see beyond her facade and discover she had an eating disorder. *I want to tell my teacher that I want to write my essay on eating disorders, but I am afraid he will figure out I have an eating disorder (ESM Report).* Perhaps Pat did not want people to get close because she feared they would discover how unworthy she believed herself to be. She indicated she had a negative concept about herself *...I don't really have a good opinion of myself... [I feel] worthless. I shouldn't be here. I shouldn't have things. [I feel] a lot of guilt, just a feeling [of not being] adequate and shameful (Pii,4).*

Part of Pat's present struggle included dealing with the guilt she felt in relation to everything

she did. The guilt initially felt had become intensified with the eating disorder. [When I] ... *restrict [eating] it feels good ... [but]... I might be really hungry, but I can't eat. It is so frustrating. I feel so selfish (Pii,5).* Feeling self-centered then evoked childhood memories...*When I was younger I was more ... I want to say more selfish but I don't know if that's quite the [right] word. I was more into myself. What I wanted ... (Pi,13).* Even as a child she felt guilty. For instance, she told me,.... *I was always getting presents. [Also at] ... Christmas... there was tons and tons of presents. I just felt so guilty [while looking at the pictures I was] thinking "Oh my God, look at all the stuff I used to have!"... Even back then I think I felt a little bit of that [guilt] because I would always be the [kid that] would let others come over and play with my toys... (Pi,13).* While on this train of thought, Pat returned to the theme of the guilt she experienced in relation to food: *There is [also] the feeling of guilt, you say to yourself "You just polished off three brownies" you didn't have the will power not to eat the three brownies (Pii,8).*

These feelings resembled what she experienced on Friday night when beeped: *I am in my room alone procrastinating over my homework. My mother, stepfather and uncle are in another part of the house. I am eating cheesies and I feel I shouldn't be doing this because I just ate at Mc Donald's. I feel self-conscious, ashamed, excited, closed and tense. What has affected my mood is the fact that I ate Mc Donalds for dinner and now I am eating chezzies (ESM Report) .* Again on Saturday at 6:00 p.m. guilt was replayed. She reported: *I just finished eating dinner with my mother, stepfather, sister and uncle. My mind was on food. I had eaten a full plate of spaghetti, garlic toast, a piece of pie and at lunch a grilled cheese sandwich, 15 chips and 2 chocolate kisses. I am thinking about going out with my friends, but I feel fat and that I ate too much. I felt that I had to eat dinner so I feel very self-conscious. I do not feel at all good about myself, or in control of the situation. I am not at all living up to my own expectations but up to others. I feel tense, ashamed, detached and closed. If I had a*

choice I would be by myself doing anything other than eating (ESM Report). Pat said she also felt guilt because my mom wants me to eat. I feel guilty because I know she feels bad [when I don't eat] (Pii,8). For instance, on Friday at 6:00 p.m. she reported I was at a health food store with my mother so could not fill out the ESM form until 7:30 p.m. I was thinking about the meeting I just had with the doctor and about the calories in food. I am thinking about my mother. She is upset about what she was told by the eating disorder specialist . I lost weight and the doctor said I am close to being admitted into the hospital. I feel I can't control the fact I have lost weight but I feel bad that I was the cause of my Mom's pain. I feel self-conscious, not at all good about myself, ashamed, closed and tense. I feel drowsy, irritable, lonely, detached and confused (ESM Report). Pat felt guilty about so many things [I also feel guilty because I] don't have money to waste and I feel bad every time I do waste food...(Piii,9). She experienced guilt if anyone did anything for her or if she permitted herself the slightest indulgence.

Pat was also engulfed by shame. *[Having the eating disorder I feel] shame [because I am] doing something although I know its wrong...(Pii,8)...[I have a] gut wrenching feeling that makes me feel...suzzy...(Pii,9). Pat spoke about herself with self contempt. She had a particular distain for her appearance. Physically I don't see myself as fat...Then some days I just look and go " yuck". It's not what [I] want it to be...(Pii,3)... Now I think about food more... than I used to. I think more about body size now. I compare myself with other girls...(Piii,5)...I look more critically at girls since I was diagnosed with the eating disorder...(Piii,6). For example, on Friday at 12:00 p.m. she reported I was looking at all the girls in my class and my friend, they are skinny and I feel fat and self-conscious around them. I feel worthless and nervous. I can't be around them long, even though they are my friends (ESM Report).*

At this point in her life the anorexia had become entrenched ...*I'm really paranoid. I am just*

always afraid...(Pii,4)...You're always worried about people finding out your secret, how they are going to judge you and perceive you...(Pii,9)...I just I don't want to be judged on that. I just don't want to be judged for having an eating disorder. I don't want any pity...(Pii,4) I don't want people to feel sorry for me because I ... don't feel sorry for myself (Pii,4)...I'm really paranoid [about someone finding out]...I don't want anybody to feel guilty or bad because of me...(Pii,10).

The onset of Pat's anorexia appeared when she was in grade seven or eight. At that time she indicated not feeling good about herself. The anorexia, she claimed, just occurred and she passively went along with it. She recalled not feeling hungry or thinking about food. In the beginning she did not think she had a problem with eating. It was only when people told her she was losing a lot of weight she realized something was wrong. She remembered always keeping herself busy especially during lunch time which helped her not think about food.

Grade ten was a difficult year for Pat. She changed high schools. Pat did not want to move. In protest for the first half of the year in her new school, Pat isolated herself and was unwilling to make friends. Her current life was dominated by the anorexia. On a daily basis she tried to avoid eating, even though her concerned mother forced her to eat at times. The repercussions of not eating affected her ability to concentrate in school. She often felt dizzy. Pat reported that when she was not eating she felt a sense of control and willpower, but also contempt for the anorexic activities. Her relationship with her biological father was limited. He did not understand why she had an eating disorder. Her mother worried about Pat and was protective of her. Pat's sister was more outgoing and saw her sister as 'bookish'.

Pat believed that her friends perceived her as quiet, goal oriented, shy, solid and caring. She had one close friend. In the presence of most people she wore a mask she desperately wanted to shed, but feared the consequences if she did. Pat shared a poem which illustrated her hidden self:

The Mirror has Two Faces

The mirror has two faces
Reflecting reality, but not what dwells within
The perfect illusion, capturing only what others
Want to see

Come closer to the mirror
Look beyond the presented package
Feelings of anger and sadness deep within my soul
Is the burning rage reflected in the soft pools of my eyes?

Damn you for being so much like myself
You seem to understand, yet you don't see what I see
I can't let you in, for your gentle touch will shatter my fragile heart

Drowning in sorrow, stumbling blindly through my tears
Reaching for something beyond my grasp-something that isn't even there
Fear, shame and hatred rise in my throat, burning like the flames of hell
Not even the tears of despair can soothe them

There is nothing left to see here
Only a reflection, picture perfect on the outside
now smashed into a million pieces, each one identical to the last
Peer deeper into the abyss and you will discover that the mirror has two faces

Dispositions that are Associated with the Eating Disorder

The inquiry shifted to the critical incidents and experiences Pat believed were associated with her anorexia. *My parent's divorce had something to do with it. That's where a lot of my stress came from. (Pii,9). A lot of change; I moved around a lot...(Piii,1). Change of life, change of style... switching schools... With the divorce I took on a lot of different roles...(Pii,9).* When asked if she wrote an autobiography about her eating disorder what would the titles of the chapters be, she responded, *Coming into knowledge of it ...total chaos and confusion... feelings [of] guilt, anxiety, stress and shame...(Pii,8).*

Regarding personal factors that may have been associated to the development of her eating

disorder, she said *What I think personally [is the eating disorder has more to do with] personality...(Pi, 7)....I am a normal teenager, a little too over concerned about things that I shouldn't be concerned with (Pii,6)...I'm more sensitive to things that go on around me than others... It physically hurts me to see somebody in pain... I can feel what someone else is feeling. It physically hurts...(Piii,1)*. Pat was inherently hypersensitive, picking up the subtleties and nuances in her surroundings, profoundly affected by the suffering of others.

Pat was also a very compassionate human being. She spoke out if someone tried to hurt others. However, she did not believe she deserved the same benefits. The following statement illustrated her belief system: *...if I find someone is not being treated properly...[I say] they deserve to be treated better. It doesn't matter [about me] I could be walked all over. It wouldn't matter. I would just take it (Pi,8)*. Pat felt she did not deserve to be treated fairly which was indicative of the level of self contempt she held for herself.

Pat also spoke of behaviours that reflected a predisposition to introversion. She felt very anxious when interacting within a large group. *[I get]...really nervous...[when more than] four or five [people are in a room] it's getting there [to the point I do not feel comfortable]. Anything past [a few people] I become more of an observer, listener than a participant (Pii,2)... I do withdraw just to breathe for ten minutes...It's a way of rejuvenating...Getting back into my own space.(Piii,2). I'm not good with a bunch of people around... I have to be in my own space (Pii,2)*.

There were instances when Pat was paged that she indicated she felt overstimulated when too many people or things occurred. For example, on Sunday when paged at 10:00 a.m. she was at work serving customers: *I feel worried, I am serving customers. It's getting busy and I am afraid of making a mistake on an order. I feel drowsy, weak and tense. If I had a choice I would be by myself (ESM Report)*. Pat was most comfortable in small groups. On Saturday at 8:00 p.m. when beeped she wrote

on the ESM report *I am with two friends. We are talking and spending time together. I enjoy doing this. I feel somewhat self-conscious, but good about myself. I am feeling sociable, happy, active, involved, excited and relaxed. Spending time with my friends is very important to me. I wouldn't want to be doing anything else. Going over to friends I feel better, more relaxed in the company of those who know me (ESM Report).* The greater number of people in a room the greater was her level of arousal. Pat coped with over-arousal by retreating and withdrawing for a period of time.

Another source of anxiety was the expectations she placed upon herself ...*Stress, well there is the usual stress, school, you know, make the grade or at least pass. Your grade reflects what type of student you are and how well you do... Everything is stress...(Pii,9).* Many of the ESM reports reflected how negatively she felt when she did not meet the expectations she set for herself. For example, on a Friday at 2:00 p.m. she was beeped while she was in class and she wrote, *I just got back two marks from quizzes I had written. I failed them, so now I feel stupid and that I cannot pass or finish the two OAC classes I took because I am not mature or smart enough. I shouldn't be here (ESM Report).* Pat lived in constant fear that she would fail at whatever she attempted. Pat also wrote *I was writing a quiz in class with 26 other students, so I filled out the ESM form at 2:35 p.m. When you paged me while doing the quiz I was thinking why did I take OAC English? Did I think I would do a good job or get a good mark? I feel self-conscious, not good about myself and not in control of the situation. I am ashamed, sad, closed and tense. I also feel weak, lonely, detached, and competitive (ESM Report).* On Saturday she was beeped at 10:00 a.m. and reported *the beep came at 10:00 a.m. but I could not answer the ESM form until 12:30 p.m. I was in music rehearsal at the time of the page. I was worried because my instrument was not working properly and I thought I was going to throw the sound of the entire orchestra off. I feel self-conscious, weak and tense (ESM Report).*

The role the sociocultural context and peers played in the development of Pat's eating disorder

had not yet entered into her reflections. Since a significant portion of Pat's life was spent interacting with her peers, she was asked what role she felt her peers had in the development of the eating disorder. Pat responded: *...I don't really know if they contributed much... (Piii,2). I don't have the eating disorder because I want to be thin or accepted. [But] that [must have] had an effect on me. A lot of my friends were athletically built and they were pretty good looking more like the magazine type, I guess that contributes... (Pii,9). They contribute now. Some of my friends that do know [I have an eating disorder] they tell me to eat...[My friends] are overly concerned or don't understand completely why I don't eat...Then I feel bad because they are only happy when I eat something. That's how they contribute to the eating disorder now...(Piii,2).* Pat felt her peers did not have a direct influence on the development of her eating disorder. However, she said that simply being in the presence of her peers, she felt less attractive. Some of her friends monitored how much she ate and this caused further stress for her.

Pat was asked specifically what role the media had in influencing or contributing to her eating disorder. Pat said, *You're bombarded with images of society and not that I am saying I conform to them, but that's there. (Pii,9)... I believe media has an impact, it contributes to an extent... It plays a part but it's not one of the main factors (Piii,3)... I... think... society plays a role, it has contributing factors... [I] can't just nail it and go, it's because of our culture and society. It's not, because other people, different circumstances, different cultures, background societies can be affected...(Pi,7) [but] they send the message you have to be able to play the game. Look good and act how society wants you to act to get what you want... (Piii,5)...* Pat lived in a cultural milieu that glorified a thin body ideal. Although she indicated this alone did not contribute to her anorexia, the mere fact she was exposed to this ideal has had an impact upon her. Pat witnessed the advantages ascribed to people who meet the beauty ideal that society sets.

The Eating Disorders' Function

Anorexia served a purpose in Pat's life. *[I use the anorexia] as a way of dealing with everything else...like putting on make-up . It's just like you put on something else, that's my way I guess (Pii,3)...I know it's a defence mechanism... It's a control thing. It spirals out; I just can't seem to get control over it. When I don't eat for three days then I feel at least I control something. I can control my food intake... (Piii,4). It [the eating disorder] has been part of my identity; at least if I don't belong anywhere, I have an eating disorder (Piii,4)....I am discovering more about eating disorders...(Pii,6). [I realize]... when I'm by myself just thinking about myself, that's something I don't deal with very well. (Pii,3)...I know [a lot] of stuff is here [inside me]. I know that I should probably deal with it, but I don't want to... (Pii,3).*

She had difficulty dealing with her feelings, often trying or wishing she could run away from them. For example, on Friday at 6:00 p.m. after she was told by the doctor she was close to being admitted into the hospital because of her low weight, she reported *I would like to be by myself to digest all the information the doctor gave me. I want to be clearing my mind, shutting off my feelings and practising being numb (ESM Report)*. On Friday at 8:00 when paged she wrote: *my uncle is here and he asked me about my eating disorder, but I don't feel like talking about it (ESM Report)*.

Pat struggled to deal with her thoughts, feelings and perceptions of herself. She was afraid to confront what resided within, so often chose to run away from herself. The eating disorder gave her a semblance of control over her life. For instance, on Sunday at 12:00 p.m. when paged, she was contemplating her future *I am still at work but it has slowed down, I am doing some homework. There were a few customers in the store. My homework assignment is to write about where I will be in the next ten years. I have so many dreams and hopes but I don't know if they will come true (ESM Report)*. The anorexia had become so entrenched that it was limiting her future visions.

Life continued to be a daily battle for Pat. When asked how she coped, she said: *I like reading, it is my escape, a relaxation...(Piii,7)*. Consistently, Pat reported that when she was experiencing negative mood states, she wished she were reading. Pat reported this on Saturday at 2:00 p.m. At that time she was feeling anxious about having to eat with her family: *If I had a choice I would be myself eating small amounts of food, relaxing and reading (ESM Report)*. Later the same day at 4:00 p.m. Pat indicated she wished she was doing something else, such as reading by herself. Again on Sunday at 10:00 a.m. Pat, at work and feeling tense, reported she wished she were at home reading instead of doing what she was.

In the ESM reports music emerged also as a source of refuge. When she was experiencing negative mood states Pat indicated the desire to be playing music. For instance on Friday at 2:00 Pat wrote on the ESM form: *I am in school, but if given a choice I would be by myself playing music (ESM, Report)*. When playing music, Pat experienced positive mood states. For example, on Saturday at 12:00 p.m. she was in music practice, so responded to the page sent at 12:30 p.m. On the ESM form she reported: *I was thinking I was playing very nicely. I feel very good about myself and the situation. I am living up to my own and others' expectations of me. I feel happy, active, excited, proud, alert, involved, cheerful and weak. Our conductor had taped the last concert and played it back to us. I was happy with how it sounded. Practising music is very important to me. I feel I am doing quite well at it and I do not at all wish to be doing anything else (ESM Report)*.

Pat also said she coped by taking things as they arise in life....*I think I just take it as it comes and deal with it anyway that I know how. Whether it be eating, not eating [or] writing it out. I keep a journal. I write in my journal when I can't talk to anyone else... [I think] if I talk to people about the eating disorder [it] shows I am weak. I have my own problems. If I write [what I am feeling] I am not making anyone else feel guilty for my thoughts...(Pii,10)*.

To recapitulate, three positive sources of refuge were used to deal with her anorexia: reading, writing and music. Pat also used food to cope with life. Pat believed that her interpretation of experiences in life have had a significant contribution in the development of her eating disorder. Consistently, throughout the interviews, Pat stressed that no person other than herself held responsibility for her condition. The interviews ended on a note of optimism. She confided that her participation in the study had caused her to reflect more upon how her anorexia developed and what need it fulfilled in her life. She whispered,...*hopefully I am on my way to recovery (Pii,6)*. The next case presented is ¹Sheila Mather a woman who has been recovered from an eating disorder for eight years.

Sheila Mather: Leaving Food Behind

Sheila wrote in her autobiographical account of her life: "My eating disorder began when I was 15: my recovery began in 1992 when I was 25...My eating disorder started...in grade 11 but I felt the pain that drove me toward food for many years before that" (Mather, 1997, p.i). What follows is the story constructed of the individual and contextual factors that are associated with Sheila's eating disorder. Sheila is introduced first. The presentation of the findings first reports the relevant family network, natural temperamental dispositions and school network before the onset of her eating disorder. Then, the setting conditions during the course of her eating disorder are voiced. Finally, what Sheila has come to understand about her eating disorder is presented. This structure for presenting the findings was chosen in Sheila's case because she was the only participant who had recovered from an eating disorder. Therefore, the goal was for the reader to be able to compare and contrast how the setting conditions before, during and after the eating disorder affected her.

¹ Sheila Mather is the author of *Leaving Food Behind*.

At the time of our meeting Sheila was a 33 year old single women who had been in recovery from an eating disorder for eight years. Sheila was an extremely busy person, so we planned the dates to enable her to carry the pager and come to the interviews two months in advance. Sheila was an exceptional, high ability woman. It was rare to encounter someone as driven and accomplished. During our first conversation, I invited her to bring along any mementos, photos or other artifacts that would help me to better understand who she was.

Sheila and I decided that the first interview would take place at the University. Promptly at 10:00 a.m. she arrived. She was tall, had long blond hair, was well dressed and mannered. However, what struck one most was the aura of someone being relaxed and comfortable about who she was. As we sat down to begin the first interview, Sheila gave me some articles she had written. The first article had been published in the *Timmins Times*. It was an account of Sheila's struggle with her eating disorder. The second article appeared in *Personnel Excellence Magazine* and was entitled *True Beauty*. She was uncertain what else I wanted as artifacts. I responded, "Anything you want to share". As the interviews progressed and our relationship grew, Sheila shared a wealth of artifacts (See Appendix J). Through these personal effects I came to understand that Sheila travelled and did speaking engagements both in person, through television and print, talking and sharing her story. Another artifact Sheila gave me was a brochure which listed the services she provided through her company *Mather Publications*.

One of the artifacts held a particular significance. When Sheila was recovering from a ten year struggle with anorexia, bulimia and binge eating Sheila wrote *Leaving Food Behind*, an autobiographical account of her illness and recovery. Sheila was also the president of her own publication company. She ran workshops for women to help them cope with their eating disorder. She brought to the interview a resource book she had developed to help these women entitled

Woman's Workshop: "Leaving Food Behind".

Sheila also shared creative business cards that she designed and produced through her company. They were very original art pieces. Sheila held many leadership roles in various associations. She had received awards and recognition for her work in many organizations. Her talents extended to music. She played guitar and sang. Being privy to this information I knew that I was dealing with a woman that could easily be referred to as a high ability person. This conclusion was further supported by artifacts from Sheila's childhood. As an adolescent girl she wrote poems and journals. She received awards for sport competitions. She had been captain of the basketball team. Sheila told me that her average GPA in high school was a B and she achieved this without really trying. Maintaining a GPA of B while dealing with a life threatening medical illness was a remarkable accomplishment. Based on what Sheila had said and the artifacts she had given me, she fulfilled the requirements outlined in Figure 2 to be identified as a high ability woman. For a detailed summary of the assessment criteria used to determine if Sheila was high ability, see Appendix C.

Life Before the Eating Disorder

The interviews began with the goal of understanding Sheila's family history and to come to know what Sheila was like before the eating disorder began. She began her story by revealing that she had been abandoned at birth and that this has played a role in how she related to the world for years:

The first 23 days of my life shaped the way I related to myself, to others...my twin sister and I were put up for adoption and adopted into the same family... We remained in the hospital for 13 days. I remained for an additional 10 days. For the first 23 days [of] my life I was alone (Mather, 1997,p.37)...I lived in an incubator...I concluded that I could never survive abandonment...I didn't trust anyone...(Mather, 1997, p.38)

Curious about her adoptive family I asked her to describe her family to me in as much detail as possible. She responded: *the [family] ...hierarchy went John, Joey, myself, my twin sister Lina ...and*

Sue..[the first] four of us were adopted. [When] I was seven... my mom left (Si1). Sheila had brought up a critical incident. If probed, she would offer more information. When asked about her relationship to her adoptive mother, she replied: My relationship, with my Mom...I remember never being able to ask her for anything, I remember really wanting to ask her for help...and knowing that I couldn't...(Si1,2). Sheila recounted an incident: [I was about six and a half]...I remember getting a cookie from [my Mom and]...feeling ...she loves me... I was crying because I didn't want to go to bed and she brought me a cookie...(Si2). Sheila spoke about this incident in her autobiography.

I could feel the love that came with the cookie...later, I would often binge on that kind of cookie...(Mather, 1997, p.52).

As Sheila was speaking she conveyed how she had been raised by her mother who was unable to openly express love to her own daughter. Her father's parenting style was not different. When asked , "What was your relationship with your father was like?", She said: My relationship with my Dad...I can't describe it as a two-way...relationship...that just wasn't there. I didn't have a relationship with him as a child...as a teen...[and] as an adult (Si1)... at home nobody spoke...[there] was negative emotional support...Dad drew emotional support from his children (Siii4).

In her autobiography she alluded to having been emotionally abused by her family:

When I did something wrong and was told 'you dummy, that's not how you do it' or 'how stupid can you be?' (Mather, 1997, p.42). [The message I incorporated was] 'Why am I so bad? Why do I cause all this yelling?' (Mather, 1997, p.41).

In the interview Sheila confirmed: [There] was constant verbal abuse...[For instance]...[we were told] we were all idiots...stupid...[We] could...[not] do anything right...There was no sense of boundary...the [siblings] shared rooms...We were financially strained...[there] was a lot of anger and disharmony...chaos and unhappiness...(Si1)...We didn't have a maternal anchor in the house...My

brothers and sisters were ...(except my younger sister)...really angry...acting out so they were destructive. My brother was stealing...raiding everyone's room, it was just horrible...(Si2)...With my brothers and sisters there was no harmony...We had family dinner...and there would be a lot of arguing...(Sii8) There wasn't...much in the way of laughing and joking...Between age[s] twelve to fifteen...we were all individually trying to survive and we all did our own things...(Si2)...I had my sports (Si7)...my two older brothers...were very rebellious. The oldest ...[was] into drugs...the second one...was just partying...(Si7).

The environment in Sheila's home forbade the expression of emotions. She had no parental figure she could confide in; therefore, as a child, she never told anyone how she felt. Talking about what her family context was like, she said: *it was very hectic...we moved every year to two years. We moved eleven times by the time I was fifteen...there was never a foundation... (Si1).* Sheila recounted in *Leaving Food Behind*:

I began... life in Toronto with...[my]...adoptive parents, and a brother...the next year we moved to the East coast, and lived in New Brunswick and Nova Scotia for five years (Mather, 1997,p.39). We [then] moved to Schreiber, Ontario for a year (Mather, 1997, p.52)...A year later, our family moved to Terrace Bay...I was seven years old (Mather, 1997,p.52)...I remember feeling very unhappy and insecure. I never knew when our family would move again (Mather, 1997, p.52).

Lacking emotional support, having been abandoned and living in a hectic ever changing family context placed demands on Sheila as a child. In order to understand how Sheila's natural dispositions affected how she perceived what was occurring within the family context she was asked questions that would provide information about her personality and natural dispositions. To understand how Sheila responded to the demands placed on her, there was a need to obtain a sense of Sheila's natural personality dispositions. Therefore when asked how the people closest to her would describe her before she had the eating disorder she responded, *Sensitive soft...my siblings would laugh at me*

because I was too soft ...just soft, way too sensitive, hypersensitive... I would take what they [people] said personally and respond to it...[I was] very emotionally sensitive...my feelings could get hurt very easily...(Si3). Sheila herself commented that *my temperament was...highly sensitive (Siii1).* Being sensitive meant being very perceptive to rejection or disapproval. Her inability to tolerate not being liked may have been associated to how she behaved and responded to the demands she faced as a child within the family context.

The behavioural repertoire Sheila adopted was that of a responsible, compliant and selfless little girl. Since early childhood Sheila said her father saw her *...as a good girl...that's how I was accepted...I didn't get yelled at as often if I was a good girl...(Si1).* Certainly, the behaviour of her father influenced the way she behaved within the family context. As a child Sheila responded to the family dynamics by becoming a perfect little girl. What she told me next lent further insight into how her natural dispositions also influenced her mode of behaviour. She said: *I took over... at ten years old, I made the decision to take over...[When] we moved...I unpacked everything...I cleaned the house...I cooked...it was just like I...[finally]...mattered, I finally got this great praise...I felt good. I got validation and felt as though I mattered...(Si2)...that went on for the next five years...I...took the avenue of taking care of the family...(Si2)...Cleaning the house...was like putting on make-up, it was something I did to look better...I was validated...I was driven by the response, by...being accepted (Si8).* Up to age fifteen, taking care of the family gave her a sense of grounding. Sheila spoke of this time in *Leaving Food Behind :*

I took care of others....by putting other people's needs first, I abandoned my own...I tried to be super-responsible at home...I cleaned the house, baked desserts...I was told that I was 'a thoughtful young lady who put other people first'. I loved getting that recognition (Mather, 1997, p.8).

We see that by nature Sheila was a caring person. Hypersensitive to rejection, perhaps

these natural tendencies were associated to how Sheila responded to her family context.

Several times in the interviews Sheila mentioned that as a child she would be compliant, placing others' needs before her own. When she did not, she experienced tremendous guilt. Sheila often commented in her autobiography of how easily she could be made to feel guilty:

...[we were] given two pieces of bubble gum each...When my father asked if anyone had a piece of gum, my sister said yes and passed it to him...my mother asked for a piece. I didn't have one for her. I could have died. I felt so awful and selfish...extremely guilty...I felt completely responsible for everyone (Mather, 1997, p.45).

Because Sheila was caring and oversensitive, this may have been associated with her belief that she needed to take care of everyone. Her parents did not provide understanding and unconditional acceptance of their children. As a young child Sheila experienced guilt over events she had no control over. When her dog, died she felt responsible. She wrote in *Leaving Food Behind*:

My dog had been killed....if only I had stayed in that night, I thought, she wouldn't have gotten away and run across the highway. I could have saved her, but now it was too late...(Mather, 1997, p.91).

Again, as a consequence of being naturally sensitive, Sheila reacted in a particular way to life events. The intensity of her reaction to her dog dying was influenced in part by her temperament. While speaking about natural dispositions Sheila expressed *I was intuitive from birth* (Si5). In her autobiography she wrote:

Certain people, places and things caused me to respond in certain ways...when someone turned up their nose at me, I got the message...I was disgusting, I was very perceptive (Mather, 1997, p.32).

As the conversation continued, Sheila revealed that natural dispositions of hypersensitivity and intuitiveness affected how she experienced the world: *[The] intuitive part of me could sense the disharmony, could sense the anger...I knew all these things, I felt all of these things...I used to wish I could just move along life superficially and just not respond...I loved that I cared so much, but it's very*

hard to care so much...to be so compassionate, to be so caring...(Siii1).

Sheila's natural disposition affected not only how she experienced things but also was associated to how things unfolded in her environment. Her natural dispositions seemed to have been misunderstood within the family. Her parents responded to her hypersensitivity negatively. She recounted: *I would get punished which was a result of being so sensitive (Siii1).* Sheila's siblings also didn't seem to understand her and this hurt her terribly. *[My siblings]...they thought I was weak...they used to laugh at me...[there] was...just a lot of mocking and laughing... (Si3):*

Sheila wrote in *Leaving Food Behind* about her hypersensitivity. Someone's actions or words could bother me for an entire day...[I] appreciate how sensitive I was...(Mather, 1997, p.78). I was (and still am)an extremely sensitive person who felt the slightest frown, smile, movement or word of everyone around me (Mather, 1997, Preface).

Sheila reacted with great intensity of emotion when she perceived any sign of rejection or criticism from others. Unfortunately she found herself in a family that would behave in ways that would evoke these behavioural responses. Therefore, the family context and her natural dispositions did not complement each other. Sheila revealed a third natural disposition, that is, over- arousal. She indicated: *I was easily excited too, so I had extreme emotions (Si3).* In *Leaving Food Behind* Sheila wrote about the intensity to which she responded to emotions:

Overcome with anger, I pushed the gas pedal to the floor. My Camaro Z28 shot out of the traffic like a bullet... Everyone was driving me nuts! So with my car [and] I bolted out of it...I was driving on the open highway, outside the city, yet I was still fuming. I grabbed my hair and tugged. I wanted to scream at the top of my lungs, I felt like I was going to explode at any moment (Mather, 1997, 81).

We had talked about Sheila's natural dispositions and how they affected the way she interacted within different contexts. Not being understood by her family was not the only thing that caused Sheila pain. Her family's response to her natural tendencies affected the way she perceived herself. Even before the onset of the eating disorder Sheila held the belief that there was something

wrong with her. She recalled an incident that typifies her belief system: *when I was nine my girlfriend and I were sitting on a stone...I noticed that when I sat down my legs spread much wider...I thought there was something wrong with me...I was very muscular...I must have been born muscular...I saw it as something wrong, something different...I felt I needed to lose weight ...around ten or eleven...at camp...I remember looking at the other girls and noticing that my legs were larger... (Si1)*. From that point onwards Sheila embraced the notion there was something wrong with her body, specifically her legs. She wrote in *Leaving Food Behind*:

...I was afraid that my boyfriend would be "grossed out" by my legs, and that he would reject and abandon me. From that point on, I was very aware of the size of my legs (Mather, 1997, p.54).

Sheila was sketching a picture for me of a young child being forced to move repeatedly. A little girl of seven left behind by her adoptive mother and then by different surrogate women moving in and out of her life. After, her adoptive mother abandoned her, Sheila's father married again six months later and the second wife eventually also left. As the conversation progressed, Sheila revealed how these experiences took a toll on her childhood. As Sheila talked what emerged was: *There was a traumatic loss...at every move...at age five moving and losing a friend...then again at age seven...age eight...age ten (p.Si6)*. In *Leaving Food Behind* Sheila said, *I couldn't deal with these feelings...I felt the same pain every time I moved... (p.54)*. It was no surprise that Sheila developed the eating disorder soon after she moved to another city.

The Course of the Eating Disorder

At fifteen Sheila moved again, She became unable to deal with all the emotions she was experiencing. She said, *I had two very close friends from age ten to fifteen...when we moved here[to Ottawa] the pain of leaving them was too much... (Si5)*. The outcome was that the last move created a lot of uncertainty and pain for Sheila. It made it difficult for her to adapt to new situations and

environments. In addition, within the family dynamics, there was no parent to confide in, so Sheila dealt with her emotions by turning to food. When Sheila was asked to focus on when the eating disorder began, she spoke of this time when she was fifteen and travelling to Ottawa. She explained: *When our family moved to Ottawa...I ate throughout the entire move... I didn't realize [then that it] was to get grounded...I was...terrified about what was happening, of losing everything...my boyfriend, student council...[being] captain of the basketball team...Everything [was being]...torn away from me so I was eating and I gained weight... (Sii2).* She adds: *I hated...Ottawa...(Si5)...their role [my two close friends] was key and it was too painful to ...[try to have] that type of relationship...[again]...to find someone here. I...never met anyone [in Ottawa]...that I felt that kinship...[with] (Si6).*

Once again because she was by nature sensitive, losing close friends had a negative impact on her and coupled with her inability to adapt easily to new environments, she experienced a high level of negative emotional distress. In response to the distress, Sheila felt she gained weight during the move to Ottawa. Her father's reaction to her weight gain scared Sheila. His reaction was unforgettable. *My Dad noticed I had gained weight so that was very...traumatic...so I lost [the weight] I knew I had to lose weight because I felt really, really ugly... (Sii1)....* In *Leaving Food Behind* Sheila recounted how she felt when her father noticed the weight gain:

....my sister commented 'Dad has just noticed how much weight you've put on'!...I just wanted to die. He could have noticed anything but my weight. Nothing could have been worse...I felt horrible, ugly, gross and...unlovable. I...[was] so terrified that he would reject me. Right then, I knew I had to lose weight...I felt like my shame had been exposed....I couldn't let my dad reject me. I had to get rid of this ugliness, this weight...I knew what I had to do... (Mather, 1997, p.62)

I went on my first diet...skipped lunch... and stopped eating dinners...I lost 20 to 25 pounds in a couple of months... (Sii1). When asked if her father noticing her weight gain was devastating to her, Sheila responded: *yes, because there was no closeness. The only thing he always praised [me was] for*

was being ...pretty...When he said that [I had gained weight] it was as though...the love [was] going to be cut off. The only thing that mattered was...[how] I...looked...(Sii2). One must wonder if Sheila had a father who unconditionally loved her and if she were not, so sensitive, would she have begun to diet? Did the eating disorder develop as a consequence of the particular combination of individual and natural contextual dispositions which conflicted with each other in Sheila's case?

As Sheila's eating disorder became entrenched, so did her sense of shame. She said, *I had no place in it [the world]...because I was so incapable of doing anything that was worthwhile...I felt invisible but not quite...invisible enough...I felt utter, utter shame...it was horrible...existing...(Sii4).* In *Leaving Food Behind* Sheila wrote:

I...hated a part of myself. I....rejected myself...I was stupid...I was ugly....My emotions were shameful and disgusting...I didn't belong to anything (Mather,1997,p.2). I didn't deserve to be happy, to succeed, to do what I wanted, or feel good about myself. I felt stupid, too weak to excel at any-thing. I felt...useless, incapable of learning...I was sure that other people could see my shamefulness...To lessen my shamefulness, I did everything I could to become the embodiment of what others wanted-a pretty, slim, happy, kindhearted young women..I was like an actress (Mather, 1997, p.12).

When Sheila lost a lot of weight in a short period of time, her parents did not notice this loss. She commented, *[My] parents were not present...My Dad was...rarely home...When he was home I was up in my room...[so] there was no...contact...(Sii5).* As a child Sheila was left to care for herself. Even during the active phases of her illness, when it became evident she was ill, her parents never noticed. The anorexia continued for a period of time . Sheila then turned to bulimia because starving became too difficult. Although, she purged regularly, her parents never discovered she had an eating disorder. Sheila candidly told me: *I can say that after most dinners I purged. I would go upstairs and we [kids] had the upstairs pretty much to ourselves....It was ...very lonely...sad and..isolated...(Sii8)...I knew that I was alone (Siii1).*

Sheila's parents lack of response to her eating disorder made her realize that *[the family] didn't care, they didn't respond...[and I thought] now I am really...alone...[My parents gave me]...complete invalidation...no acknowledgement whatsoever...(Siii1)....At home nobody spoke...[there] was negative emotional support...Dad drew emotional support from his children...I had no idea that I was not getting emotional support...that I needed...emotional support...I have to say that when you go from 140 to 113 pounds...[that's]...a red flag...but nobody stepped forward and said 'Are you okay?'...[It] was a very loud response...'I can't help you'(Siii4)*. Sheila's sense of being alone intensified as the years progressed. The companion which she could rely on was food. When she needed love, she turned to bingeing. Sheila's parents couldn't or wouldn't provide her with love so she found it in food. All the pain and hurt Sheila experienced were dissociated from her when she gorged on large amounts of food. But the feeling of love and peace quickly dissipated after each purge. She alluded to this in *Leaving Food Behind*:

I was alone...when a binge had to end. My fill of love was over...I could no longer make the pain go away...[it] would surface like a rocket...sharper and stronger than before my binge. Then I'd purge, all the love...I didn't stop purging until...I felt numb...I felt so sad...so alone...I felt such shame...(Mather, 1997, p.70).

The isolation and pain of feeling alone intensified as the bulimia progressed and became entrenched in Sheila's life. In *Leaving Food Behind* she recounted the experience after each binge and purge episode:

I looked at myself in the mirror with utter disgust. I had done it again-binged...I felt so weak...pathetic...shameful...The more food I got rid of, the more relieved I felt..When I had finished, I looked at myself in the mirror...I was...exhausted....Ashamed....something [was] wrong with me. I felt "shame" right down to my core....I felt shame for so many things (Mather, 1997, p.11).

The eating disorder became a vicious cycle. Sheila needed to find a mechanism to cope with the

negative emotions she felt. She coped by bingeing. However, the purge that followed after each binge only reinforced her belief system that she was shameful, unworthy and not loveable. Sheila began the eating disorder in part because she felt shameful. The eating disorder only served to increase her dependence upon the eating disorder and in turn, increased her shame.

Whatever her weight, she could never rid herself of the intrinsic sense of worthlessness and shame she felt. The eating disorder only worsened her shame-based identity. Sheila said, *Right before I would purge I felt so sad...like a grief experience each and every time and that was coupled with utter shame...the shame was so strong it was...utter disgust for who I was and that I had done it again...(Sii5)*. The level of self-contempt Sheila experienced engulfed her. Her daily life was marked by pain. As an adolescent, *I would walk home from school...binge and purge...followed by watching television...sitting outside...with [my] sister...and just being very, very, very lonely, very unhappy and...just feeling this weight...my sister...[would] go out...I would play my guitar and just be really unhappy...(Sii8)*. *I [was]...extremely lonely, yet I felt that I deserved that ...[it] was just a natural eventuality because I [was] not a good person...(Sii10)*. Sheila wrote three poems about how she perceived herself while suffering from bulimia and anorexia. One of her poems, presented next, conveys the complexity of her inner thoughts.

Confusion

To go here or there
to say yes or no
the answer unknown
is which way to go

Decisions become difficult
thoughts are unclear
uneasiness takes over
insecurity fills in

These feelings inside me

cause anger and pain,
 unnoticed by others
 grow stronger by day

The good from the bad
 the right from the wrong
 are undistinguishable unknown

The doors which block reality
 the air that surrounds me
 the complications involved
 must settle down

The point expressed
 in this little passage
 deals with the confusion
 I'm coping with unsteadily.

Early in life, Sheila's parents made it clear that if she wanted to be accepted she needed to behave like a good girl. She knew that she was not unconditionally loved. She said, *to be... loved...I knew at the time...everything was conditional...Based on what I did and not who I was...(Si8)*. The message Sheila incorporated was that, if she was not loved unconditionally by her parents, something must be wrong with her. This perhaps activated the belief system she adopted, that she was not good enough. Sheila believed she was fundamentally deficient and that meant she needed to conceal her authentic self. This was precisely what she did. She wrote in *Leaving Food Behind*:

I began most of my sentences with 'I just'...as in 'I just thought'...or 'I just needed'...if I justified all my feelings, thoughts and actions I would reduce the chance of shame, judgement, rejection or guilt (Mather, 1997, p.9-10).

During our conversation it became quite evident how Sheila experienced life as a false self. This awareness re-emerged: *I remember seeing people who were happily expressing themselves...I remember thinking, is she ever lucky to be able to do that...I hated the fact I couldn't...I felt like nothing*

*on the ground...compared to this one girl who was...loved and ...popular...She just seemed so natural...She was the personification of what I wanted to be. I wanted to be...happy...loved.... popular...good in sports... and smart...she had everything I didn't have, for the exception of being good in sports and being pretty...(Si8). I...never experienced me...It was always a show. I was always playing a role...I longed to be able to answer a question honestly... There was...no authentic core, no place where I could go to...everything was outside of myself...I was so disconnected...that I drew from the exterior and just said what I thought they wanted to hear...People with an eating disorder...are able to... become the chameleon that we are, that we feel we need to be...I just said what everyone else wanted to hear. Nothing came from me, nothing...(Sii4)...For years...I would interact, be the life of the party...but none of that was real [I] just did what I thought everyone else wanted me to do. I said what I...thought they [people] wanted me to say and very little [of me] came to light (Sii4). Sheila in *Leaving Food Behind* stated:*

Other people's thoughts, feelings, preferences and judgements were much more important than my own... (Mather, 1997,p.3)...I always said things I thought others wanted to hear. I rarely disagreed with people... (Mather, 1997, p.9).

When Sheila was asked, "Why in your mind did you think you needed to say and do what everyone else wanted?", she stated , *I wanted people to like me and I wanted people around me...I wanted to be loved...I wanted people to like me...I wanted to belong and I didn't think I could ever be loved for who I was...(Sii4).* In *Leaving Food Behind* Sheila reiterated this theme:

I rarely expressed my own ideas, opinions or desires...If ever [I] let myself show my true self, I'd never be loved...I strove to be perfect...to be the best at everything I tried...I struggled to appear perfect on the outside I had to win at everything...I craved attention and desperately wanted to be the light of everyone's eyes (Mather,1997, p.13).

Sheila believed she was flawed, that something was intrinsically wrong with her. In order to

compensate for her perceived worthlessness, she embraced the notion that she had to be perfect. During the eating disorder, Sheila became a perfectionist. She spent some time recounting how this belief system played itself out in all areas of her life: *I always had to excel...in what I was doing...I worked part time at Zellers while I was going to school...I was fastest on the cash [register] (Sii9)*. Even as a young child she incorporated this mode of behaviour into her life. *In grade four it was flashcards...[I had to] beat everyone in flashcards..(Sii10)*. *At birthday parties I would want to dress in my best clothes...(Si3)*. In order to be accepted by her parents, Sheila felt she was not permitted to make any errors. She said, *I had no idea that someone, a peer of mine, would have been told by [their] parents that you're good, just try and be the best that you can...I didn't know that even existed (Siii2)*. However, nothing Sheila did was perceived by her to be good enough. Hence everything she did inevitably was interpreted as a failure. This only served to fortify her belief that she was defective.

In adolescence and adulthood, Sheila displaced the drive for perfection onto her body. She drove herself to have the perfect physical appearance. Perfection meant *I had to be the skinniest and the most attractive (Sii12)*. In her autobiography she wrote:

If I was ever to be loved...I would have to change...that meant losing weight...(Mather, 1997, p.12)...[Sheila longed for the approval and acceptance of others...I had] a need for perfection...(Mather, 1997, p.29).

Tracking this belief I asked her: "Your desire to be perfect, where do you think that came from, what needs [did] that serve? As her illness progressed, her sense of worthlessness did also. Her need to be perfect served an adaptive function during the years of her eating disorder. She said, *I needed to matter...I needed to prove to other people and myself that I wasn't horrible...It gave me a sense of being, a sense of accomplishment, a sense of worth...you grabbed onto...(Sii10)*. *I was desperate not to be abandoned...I thought that I could achieve safety, security and people....around me. One way was*

to be slim and beautiful...(Siii2). She wrote in Leaving Food Behind:

I believed that if I was ever to be loved by someone, it would be up to me to make it happen. I would have to change the way I was and that meant losing weight (Mather, 1997, p.12)

Perhaps, if her family had provided her with a home where she felt safe and accepted, Sheila would not have developed the belief system that to be loved meant being perfect and being perfect meant being slim and beautiful. Up to this point we talked about her family and some of her life experiences, but Sheila had not offered any information about memories surrounding school, classmates and teachers after the onset of the eating disorder. Therefore, the issue of school was brought up. As soon as school was mentioned, she responded, *I hated school...from the day I started until the day I left...I felt like I was in prison...I always felt stupid, so I didn't try... (Si4)*. This is further illustrated when she wrote in *Leaving Food Behind*:

School was...[a] stressful environment (Mather, 1997, p.50). I struggled in school, I couldn't concentrate and didn't want to...(Mather, 1997, p.51)...I was focussed on surviving...I didn't care about being educated. I cared about surviving, and not being abandoned...Feeling incompetent and inferior to others in every way but in appearance. In this area, I believed I had a chance....if...I could be pretty and slim...(Mather, 1997, p.56). I worried about how I looked when I was in class...(Mather, 1997, p.60)

Sheila believed she was inherently deficient, therefore incapable of learning. The only way Sheila could be accepted was by achieving perfection in her physical appearance. She could not change internally what was deficient, but could alter externally what was wrong with her. Therefore, Sheila waged a war against her body. School context reinforced the belief she held that if she changed her external appearance, she would be validated and accepted. Sheila believed this would then compensate for her inherent worthlessness.

I was 13...I felt overwhelmed...I was... shy and nervous... Inferior...I had heard that if a person was pretty and slim, they would be popular...I was so relieved to be attractive...How people saw me really mattered to me...I began to notice that guys

watched me...Girls who were overweight were ridiculed and laughed at...They were shamefully rejected by my peers...I'd die if that ever happened to me (Mather, 1997, p.58).

School context played a role in the development of Sheila's eating disorder. Her peers rewarded girls who were physically slim and beautiful and shamed those who were not. As an adolescent Sheila was desperate not to be rejected, exposed as the shameful person she knew herself to be. Therefore, she became the embodiment of what was considered desirable in that context. Sheila said her peers perceived her as *the ideal person, a personification of the perfect woman...in control...smart...tall...blonde and slim...I looked the part...(Sii6)*.

Sheila was popular in school but her good friends did not really have an emotional connection with her. Typically, these good friends were *very surfacy, I had nothing to say to them...most of them were gossipers...(Si5)...our attitude was party...do well in sports...(Si6)*. In speaking about her peers, Sheila indicated that she had two sets. Ones that were very close and others that were not. She said, *I had friends but...only one or two close friends...usually one at a time...[In] high school ...I was very popular...[but] still had one or two close friends...(Si4)*. She characterized her relationship with her close friends as *equals...I never ever got a sense that I ought to be saying something right...[My close friends] were my emotional support...they reinforced who I was...(Si5)*. In her close friendships, Sheila was able somewhat to shed her persona. In fact, she said, *in my very close relationships, I was as authentic as I could possibly be...[not] completely me...because I was trying very hard to just...be loveable, someone who would matter... (Si7)*

As we were talking about Sheila's experiences with school, the theme of perfectionism resurfaced. Sheila explained how in school nothing she ever did eliminated the constant belief she held about herself that she was bad and worthless. No matter what she accomplished, it was never enough to override the self-contempt she held about herself. Perfectionism extended into her

schoolwork. Sheila did have times in school where she excelled, but she was incapable of recognizing her accomplishments: *[In school] I never tried ...I remember once trying and doing extremely well and thinking, well, this is weird. But of course I thought [because I did well it] was a fluke...(Si4)...[I often] took the leadership roles...[in school]...and did well but...I assigned [it] to fluke (Sii6)*. In her autobiography she revealed that her drive for excellence stemmed from a need to achieve a sense of worthiness. She wrote in *Leaving Food Behind*:

I [won] the highest award in the scholastic physical education program....I participated in every school sport I possibly could...I was on the junior basketball team...I finally felt included, part of something...[because I was a good athlete I] gained a great deal of attention ...as an athlete, I had found a very important part of my identity...my coaches [praised me]...I felt validated and worthy. I tried to play my best, to please my coaches...when I didn't play well, I felt shameful (Mather, 1997, p.59).

Again, when Sheila succeeded at something she said she felt worthy; when she didn't excel, she felt shameful. Her sense of worthiness was transient and dependent on external praise. Intrinsically, she did not have a sense of worthiness. There is a paradox here: although Sheila excelled, she didn't derive any intrinsic joy or pleasure from her achievements. Within the school context, Sheila's relationships with her teachers were limited: *I didn't really get close to teachers because I felt ashamed and so stupid...I believed they could see I was stupid... (Si4) My teachers perceived me as being very capable but I thought I am just fooling them...(Sii6)*. In *Leaving Food Behind* she revisited this theme,

[I had] this insidious fear that I would be found out...I was besieged by the message 'I doubt you can do it'...(Mather, 1997, p.68).

What surfaced once again was a paradox. Sheila had said she wanted people around her, but she maintained a distance from people she could have confided in. Sheila had a desire to be loved and accepted, yet she felt so worthless and shameful that she believed she was

unloveable. Perhaps she feared if people got too close to her, they would discover that she was as worthless as she believed herself to be.

When asked if the school context was associated in anyway to the development of the eating disorder, Sheila replied: *No, not really* but then revealed the following: *in the school context...nobody said you can do it and nobody said it's okay as long as you try, nobody said you are good just because you are here...in school [no] teacher...[said] that to me...(Sii2)*. No teacher recognized the psychological state Sheila was in, no one mentored her or walked her through the difficult times she was experiencing. Perhaps, this was not a shortcoming on the teachers' part because Sheila was skilled at hiding her feelings from others.

There was a large disjunction between what Sheila projected on the outside, that is beautiful, poised, popular and competent, to how she felt on the inside, disgusting and shameful. Sheila said she hated herself when she had the eating disorder. She further gave me a sense of what that meant. She indicated: *I couldn't understand why I [didn't] have the ability to be smart [and] capable*. As Sheila spoke she made a gesture with her hand. She indicated with her hand that she felt she was about a centimetre high. This was how small she experienced herself to be.

At the age of seventeen, Sheila's sense of being worthless was affirmed even more when her father informed her she had to leave home. He said, *you are going to have to...move out and if you are not, we are going to be looking for a place [apartment]...for you...* (Sii7). Sheila complied with her father's request. She left home. She said, *I saw them [my parents] four times in the next couple of years...(Sii5)*.

The years that followed were full of isolation and guilt. She lived inside her own world. She said, *I'd tape soaps every day, so I would watch soaps and go to bed and read and those were [my] days... (Sii10)*. She vicariously lived through fictional characters on television because they weren't real

people and she did not have to risk being hurt. As time went on she became more withdrawn and isolated from society. Sheila added in *Leaving Food Behind*:

...the characters [in the soap opera] were very real to me...I wanted to feel from the real world without the risk (Mather, 1997, p.26)

Sheila was raised in many communities during her childhood. Up to the age of one year old, she was raised in Toronto, after which point, for the next ten years the family lived in Nova Scotia, New Brunswick, Schneider, Ontario and Terrance Bay. At ten, she moved to South Porcupine and five years later, moved on to Ottawa. The family constellation was chaotic, not only because of the geographical moves, but also due to the inconsistent maternal figures in Sheila's life. Sheila was abandoned by her biological mother at birth, then at seven by her adoptive mom. For the next 10 years, Sheila's father introduced different partners in the household. The consistent parent was Sheila's father. However, we get a picture of him as being emotionally distant from his children. Specifically, in relation to Sheila, he wished her to be a good girl and placed demands on her to be so. She responded by seeking to become perfect at everything. She felt that her authentic self was not good enough, so she adopted a persona: she played a role. Sheila believed that she had to be perfect in order to be accepted. She felt the need to prove her worthiness, but she believed she was a shameful being. In the family she was alone emotionally and therefore this created a need to find love and acceptance outside her family unit.

Sheila's natural dispositions appeared to be hypersensitivity, over-arousal and intuitiveness. These natural dispositions were not recognized by her parents and siblings. Sheila's experiences in the family context and her temperament reciprocally interacted to mold a fixed behavioral repertoire. The focus of the conversation to this point had been on what life was like for Sheila before and during the eating disorder. At the time of our interviews Sheila had been eight years into recovery. What other

interactional factors brought about the development of the eating disorder?

The Function of the Eating Disorder

Up to that point Sheila had discussed the progression of her illness from age 14 to 25 years, that is, 10 years of bingeing and purging. What follows are Sheila's reflections about her ten year struggle with her eating disorder. Looking back, Sheila came to the realization that when she was suffering from her eating disorder she believed that nothing she did was good enough. The level of self loathing became intense and Sheila directed it towards her body. Sheila spoke willingly about her tormented relationship with her body: *like I said I hated who I was and I'll get more specific, I hated my body. I absolutely hated my body...I was so self-abusive...I knew at the time I believed I deserved it...I would over-exercise...starve... and binge (Si8)*. As Sheila spoke, she explained the level of self-hatred she had for herself. Sheila dealt with her emotional pain by self-injuring her body. This was the ultimate form of self betrayal, waging a war against oneself.

Sheila remembered how she felt or experienced herself when she had the eating disorder. She said, *ugly...really shameful...I was living a disgusting secret...[If] anyone found out..I would just be...exposed...revealed to be the disgusting person I knew I felt to be...I felt completely worthless...(Sii3)*. Sheila realized that the level of shame she held was high. In *Leaving Food Behind* she recalled the experience:

I judged myself the hardest of all...I lived a shame-ridden, fearful and painful life...I lived to hide my shamefulness, from others to be worthy of being loved...my body weight had become the symbol of my shame...I was complimented when I was slim, rejected when I wasn't (Mather, 1997, p.14)

Sheila was engulfed by a sense of shame and self-disgust. She was self-conscious and believed that she was inherently worthless, so she became very attuned to any sign of rejection. In addition, Sheila came to understand her hypersensitivity to what others felt and said about

her. Her hypersensitivity intensified as her eating disorder developed. Sheila would respond to being emotionally hurt by withdrawing. Each time Sheila felt something negative was being said or thought about her, it validated that she was flawed. She told me, *if someone said 'you're stupid' I would just close up...(Si3).*

The eating disorder helped Sheila cope and was in part a search for control. When Sheila was asked, "How did you feel when you were not eating, bingeing or purging?" her reply was, *When I was not eating I felt...totally in control. I felt euphoric...powerful... strong...I had all kinds of energy...the biggest thing was that I felt totally in control...it was really great to feel that solidness, the strength...when I was bingeing I felt...weak...[but]...I also felt so good...because there was no fear, no shame, no worries, no anything...it was like [being] intoxicated because I was not present at all, not even aware...(Sii5).* In referring to the issue of control, Sheila, in *Leaving Food Behind*, concluded:

I tried to instill order by controlling my body...by starving myself...I could convince myself I was in control... (Mather, 1997, p.3). My life was about controlling everything and everyone in it (Mather, 1997,p.6).

Perhaps Sheila needed to believe she could control her body because the pain of being unable to control the disgust she felt for herself was overwhelming. When asked how she coped with the demands of life after she developed the eating disorder, she responded: *I didn't, I ate...ate or starved...all I did was [think] about [my] body (Sii11).* The bingeing, purging and preoccupation with weight became Sheila's life. Bingeing and purging were functional behaviours. Sheila described this in her book:

Before each binge, I'd feel desperate, overwhelmed. I'd exclaim, Oh God, I can't stand it! Get me away from here! I need food! Food would relieve my pain on contact. Food was my rescuer. It seemed almost human. When I needed relief, I had to binge (Mather, 1997, p.25)

She perceived a sense of control when bingeing. In her autobiography, Sheila recreated one of her binge episodes:

Vanilla cream cake...my next bite...I felt strong... I could...conquer the world...pain came up when I acknowledged "reality" ...reality is experienced in the present...and I hated the present...I felt alone, scared and unsafe... I couldn't stand to feel more fear, shame or guilt (Mather, 1997, p.23)

In reflection, Sheila indicated that her level of self-contempt intensified with each binge and purge episode. Her self-hatred became so great that she found it impossible to do anything for herself.

She wrote in her autobiography:

I felt very guilty for wanting or needing anything for myself. It seemed to me that satisfying a want or need would always be at the expense of others...I always put the needs and wants of others before my own. I longed to take care of myself but I couldn't bear the guilt. In my mind, someone else had to lose if I gained (Mather, 1997, p.8).

Sheila also wrote in *Leaving Food Behind* of her inability to enjoy simple pleasures:

I would not buy myself that purse...I wasn't worthy of having [it]...I could buy the purse for my sister...I went right back to the store and bought the purse for her...I was 19...I knew how to restrict...my other desires...[Buying] that purse for myself...[I] would...feel too guilty...(Mather, 1997, p.7).

Sheila had come to the realization that during the years of her anorexia and bulimia she sabotaged her own well being because she was guilt-ridden. She mentioned in *Leaving Food Behind*:

I felt guilty for having things, for doing things, for trying things, for showing confidence...I never wanted anyone to be envious of me. I felt guilty for being pretty, having nice hair and clothes, being able to sing, working at an enjoyable job, making money or getting a promotion. I would often ruin or downgrade my opportunities so that this wouldn't happen (Mather, 1997, p.9)

Sheila believed that she was undeserving of any pleasures. Because she was so bad she did not

have the right to experience pleasure or happiness. It was no surprise that Sheila felt she didn't belong, she felt unloved. She conveyed the following: *I felt so empty...I didn't know the word feel...I felt unhooked...I felt like a free radical...(Sii9)*. In her autobiography she revealed how disconnected she had become from herself.

My own body was foreign to me...I felt like a stranger in my own skin...so mentally and emotionally split...so estranged from my own body...I can't recall a time since I was seven that I really acknowledged my body was mine (Mather, 1997, p.1-2).

The focus of Sheila's hatred was still her body and specifically, her legs. She explained in her autobiography why she hated them:

I stood before the mirror and stared at my legs in utter disgust...I hated my legs...They were the reason for all the pain in my life...The cause of all my feelings of my rejection and abandonment (Mather, 1997, p.1-2).

Sheila had been rejected by her birth and adoptive mother. Being abandoned lead her to conclude that something must have been wrong with her. Sheila came to believe that her legs were so disgusting that they were the reason she had been abandoned.

At this time Sheila felt she *just hated who I was...(Si7)*. In her autobiography Sheila wrote:

...I hated who I was, didn't care [about] myself and never trusted myself...I [didn't] have a relationship with myself ...I was a perfect stranger [to myself] (Mather, 1997, p.41)

To cope, Sheila needed to find something that would fulfil her emotional needs. She found it in the eating disorder, *that the sense of grounding...food later did [that]...(Si3)*. *I was not in...connection with my...senses except sense of taste, that was the only thing that kept me linked...Beginning of every binge everything tasted so good...food...I never experienced me...(Sii3)*. It became evident what food symbolized to Sheila. *Food anchored me...it was like a core grounding...I felt safe...I felt connected, I felt as though I would survive as long as food was there...with food I felt*

a connection like being connected to mother through the umbilical cord...nothing else gave me that...sense of safety, security...that I wouldn't starve... (Siii1). Sheila again in *Leaving Food Behind* revealed:

I made myself very busy...I had to stay one step ahead of my feelings...A painful emotion arose...I wouldn't let myself have a chance to feel it...all I had to do was eat...Eating I felt connected...I felt wonderful, lovable...serene...Before each binge I'd feel desperate, overwhelmed...food would relieve my pain on contact...my rescuer... (Mather, 1997, p.25)

When Sheila ate, she soothed herself temporarily from her emotional pain. Sheila's life began to be orientated by her need to binge and purge. As the illness progressed, her daily routine was long hours of work and then binging and purging at home. The level of her shame became exacerbated. To protect herself from the gaze of others as her eating disorder advanced, she isolated herself even more. She said, *I grew more...isolated and I liked that isolation...it was safe (Siii3).* Sheila tells us in her autobiography:

By isolating myself I didn't risk exposure to pain, being alone was safe...I stayed safe in my house as much as I could...(Mather, 1997, p.26)

One theme did not surface up to this point in our interviews; that was, the role of the socio-cultural milieu. When Sheila was asked how she felt the general culture was associated to the development of her eating disorder, her response was intriguing...*you know it's hard to say whether it was or wasn't because I felt these things [cultural messages] because I felt...alone...The way I thought that I could...have people around me...was to be slim and beautiful...I think that if I had felt safe in the world and truly loved...had somebody [been] there for me, I don't believe I would have responded to what the world was saying... (Sii2).* The socio-cultural milieu did play a role in that Sheila's weight loss was reinforced: *I was fifteen...[I lost weight]...but I was barely even big...people noticed me and people*

said 'oh you look great' and in hindsight...if I look at the pictures I was just so disgustingly skinny, but people were saying 'you look great, you can do modelling'...I was getting this approval and the attention I was dying,... so I thought, I am just going to stay with this...(Si, 1, 2).

Sheila has been free from an eating disorder for the past eight years. The conversation switched to the process of recovery, including the coping strategies she had adopted. The ESM data provided information on how Sheila lived her life now that she did not have an eating disorder.

Recovery

Eight years into recovery Sheila came to understand that her natural dispositions were associated to her eating disorder. She alluded to this in reference to her recovery:

I finally felt safe in my own skin (Mather, 1997, p.127)...I knew I was sensitive to other people's energy and I made an extra effort to appreciate my sensitivity. I tried hard not to respond to a person's mood, speed or vibration...I decided to live at my own speed (Mather, 1997, p.131-132)

Sheila came to understand how she tended to react in situations, making an effort to modify her response to situations or people to lessen her level of distress. When Sheila was recovering, she did a lot of reading and writing. To deal with the eating disorder, she said, *I read...about every psychology book I could get my hands on that resonated with me... (Siii3)*. In her autobiography, Sheila stated:

Throughout my recovery...books...were available to me exactly when I needed them (Mather, 1997, p.iv).

Sheila embraced reading and writing, she said, because *I was trying to figure out what was going on [with me]...(Siii3)*. Writing in many ways saved Sheila's life. She spoke of this in *Leaving Food Behind*:

...I had just completed the outline of a book...An hour earlier the thought of writing this book had let itself into my mind....From deep inside me, I knew that it would be

written...My journey of recovery through it, I became me, my soul (Mather,1997, preface).

Sheila was the one participant who had recovered from an eating disorder. Therefore, the ESM forms reflected Sheila's post-recovery phase. This was unique to her case and was reinforced by the ESM Methodology. Sheila carried the pager on Wednesday, Friday and Saturday. Initially all the participants were asked to carry the beeper on a Saturday, Sunday and one week-day. However, Sheila said Sunday was family day and she preferred not to carry the beeper. Sheila was beeped every two hours, for three days: the first page was sent at 10:00 a.m. and the last page at 10:00 p.m. As Sheila was in the post-recovery phase, many of her ESM reports were similar. Typically, Sheila was in a positive mood state. Most of the pages found Sheila working or relaxing. In presenting the ESM findings for Sheila, the reports were reduced to the elements that represented her inner subjective experience. The ESM forms were not presented in their entirety in the text because they were redundant. On the first day of paging Sheila was in a positive mood state. She indicated feeling consistently alert, happy, cheerful, strong, active, sociable, proud, involved, excited, open, clear, relaxed and cooperative. In addition, consistently she was engaged in activities she wanted to be doing and therefore feeling good about herself. The following is an abbreviated version of the self-reports Sheila completed during the three sampling days.

It's Wednesday 10:00 a.m. Right now I am sipping coffee at Starbucks waiting for two women I am working with to raise awareness of eating disorders. I am thinking about what to say and reading information about eating disorders. I am thoroughly enjoying what I am doing and it does not occur to me to be doing anything else.

11:55 a.m. I am working in my home office, alone. If I had a choice I would be with my twin sister talking. She's experienced an emotional situation at work.

1:45 p.m. *I'm alone in my home office. I am envisioning the next step in the publicity to raise awareness for eating disorders. I can't think of anyone I would want to be with right now. Although I would like to be swimming in a warm pool-it's cold outside!.*

4:00 p.m. *I am looking outside my home office window that faces north. I am thinking how prompt your beeps are and that as I sit here alone how grateful I am for the sunshine today since it seems to have contributed to my vigour and pace positively. If I had a choice I would be with a girl who wrote poetry to me-she's suffering with bulimia.*

6:00 p.m. *Right now I am with my roommate in my home office. I am feeling very satisfied at my level of productivity today. I thoroughly enjoy the company of my roommate.*

8:00 p.m. *I am in my den at home with a friend. We are sitting on the couch talking, listening to soft music and laughing. I am thinking how interesting my friend's story is. He is describing how he managed a complete conversion and trained several people to do so also. I would not want to be with any one else right now, I am having a terrific experience.*

10:00 p.m. *I am lying in bed alone. I just finished writing in my journal and I am about to read but feel very sleepy. If I had a choice I would be with a handsome man. Yet, I'm very happy now.*

The second day of sampling, Friday

10:05 a.m. *I am alone in my home office. Working on a fundraising project for eating disorder awareness group. I am thinking how much work I still have to do.*

12:08 p.m. *I am alone in my home office reading and sending e-mails. I am glad that it is Friday. It's been an extremely busy week. If I had a choice I would like to be with my twin sister doing anything.*

1:45 p.m. *I am at my sister's house. It's my nephew's birthday and I brought over his*

presents. My mother is also here. We are watching my nephew play with his new toys.

4:00 p.m. I am working alone in my home office. I would like to be with my twin sister going out for dinner.

6:00 p.m. I am alone in my home office composing a newsletter. I'm thinking about how much I enjoy doing this.

8:00 p.m. I have stopped working and I am at home in my den with a friend. We are having a glass of wine together and talking about how meaningful our careers are to us. I am thinking how great it is that it's Friday night.

10:00 p.m. I am in bed alone about to read and go to sleep. I just finished writing in my journal. I am smiling thinking about how wonderful the evening has been. I would like to be with a partner or soul mate.

On the third sampling day, Saturday

10:00 a.m. I am at home cleaning. I would prefer to be with my girlfriend helping her decorate her new home .

12:00 p.m. I am still at home alone uncluttering my home. I am singing to the music I have on a fairly high volume. I would like to be with my girlfriend Lisa.

2:00 p.m. I am in my car alone driving to the library to drop off books. I am thinking how great it feels to have just dropped off three large bags of stuff at the Salvation Army.

4:00 p.m. I am at home alone reading about Feng Shui and placing crystals in unsuspecting positions around my clean house. I am also listening to music and singing. I am debating about whether to get together with friends tonight or stay home. I would like to be with my friend.

6:00 p.m. I am home alone. I am looking around feeling very satisfied and loving my surroundings. If I had a choice maybe I would like to be with my friends playing guitar and singing

yet I'm very happy to be with myself.

8:00 p.m. I am at home in my den watching television with my roommate. I am thinking how great it is to be home with my roommate just relaxing. I decided to stay in and I'm so glad I feel very relaxed.

10:00 p.m. I am in bed alone. I'm usually asleep by now when I stay in on a Saturday night. I am reading and thinking how sleepy I am. I would like to be with a tall, dark and handsome man! Okay, just kidding since he would be loving, kind, compassionate, sensitive. If he was handsome too, fantastic!

To summarize: consistently, every time Sheila was beeped she described positive moods. The majority of the time she was content and doing what she wanted. Repeatedly, Sheila reported feeling good about herself, in control of the situation and living up to her own and others' expectations. Not once did she indicate feeling any level of discomfort. The report revealed that Sheila spent a great deal of time alone; however, this suited her. The incidents reported as affecting her mood between pages were always positive. Most likely this was a function of the fact that she had been eight years into recovery when she filled out the ESM forms. Regarding the ESM forms, she was worried that she didn't provide valuable information to me through the ESM forms. She said they were very boring because she no longer suffers from an eating disorder. I reassured her that what she felt and did on a daily basis would give me insight into how she had created a life conducive to her well-being. Through the ESM forms one could see what natural dispositions remained since early childhood and how these affected the way she related to the world.

²Catherine Joyce is the last case presented. She is a fifty year old woman whose anorexia began

² Catherine Joyce is the author of *Locked Rooms*, *The Unknown Share* and *Know Thy Place*

in adolescence and still affects her at times.

Catherine Joyce: Getting Down to the Bone in Life

What follows is the story constructed through the interviews about the individual and contextual factors that were associated with each woman's eating disorder. Catherine is introduced, then her family is described. A focus is placed on her mother and father's parenting styles and the demands they exerted upon Catherine before the appearance of her eating disorder. Following this, Catherine's natural dispositions are outlined with the goal of demonstrating how her natural tendencies were ill matched to those of her parents. Throughout this chapter findings from the interviews, artifacts and ESM data are used. Catherine carried the beeper for three days, a Saturday, Sunday and Monday. She was beeped every two hours, for three days. The first page was sent at 10:00 a.m. and the last page at 10:00 p.m. An attempt has been made to weave the three sources of data to convey her story.

Catherine was a fifty year old woman who suffered from anorexia on and off since the age of fourteen. To this day the anorexia still comes and goes, in her own words, as an impulse/enthrallment. The first interview took place at the University. It was decided to meet at the entrance of one of the University buildings. Catherine was a tall woman who looked much younger than her age. Standing, there alone, she appeared apprehensive, ill at ease by herself among other students. I quickly went up to her and escorted her into my office to begin the first interview session. I motioned her to sit down and as she was doing so I asked if she was feeling worried about her participation in the study. In our conversation, Catherine said that up to this point in her life she had not publically spoken about her anorexia. I assumed her apprehension that morning revolved around this issue, but this later proved to be a false assumption.

Recently, Catherine had read a doctoral thesis on eating disorders in which the author had

argued that women developed eating disorders because they wanted to fit the cultural ideal of beauty. Catherine was questioning herself on whether she was a 'true anorectic' because her anorexia had no relation to wanting to be physically beautiful. Rather, her eating disorder had been a response to a spiritual quest. She told me she needed to know if I thought women engaged in disordered eating because of cultural influences. The guiding premise throughout my interaction with the women in my study was to not mislead them. So I answered honestly, that at this point no data had been collected but each woman's experience with her eating disorder was going to be used to lend understanding to what was associated with the development of her eating disorder. The intention in the thesis was to allow each participant to voice her understanding of what was associated to the development of her eating disorder.

Catherine's apprehension disappeared. She handed me a gift, one of her novels entitled *The Unknown Shore*. I had previously bought and read her first novel *Locked Rooms*. For a decade, Catherine has written a series of novels in which the central character is a girl named Molly. Catherine revealed that it was only recently that she had come to the realization that she wrote about her anorexia through these novels. When reading *Locked Rooms* it became evident that through Molly, Catherine wrote about her own eating disorder. Therefore, how Molly's emotional state is depicted in both novels is semi-autobiographical. Writing the novels has served as a means of working through her anorexia. Catherine stated, *When I wrote these books... I didn't know any of this, I knew about the not eating part but I changed it with Molly into obesity, but I thought I was just playing with a metaphor...it was a metaphor for a psychological state. It's been since that time with Joan [one of the anorectic adolescent girls Catherine has worked with] when I wrote first directly with the personal I, [that I realized] oh my God! I knew about these metaphors...[but] I didn't know it was a problem [not eating]. I [just] wrote about Molly from the motive and perspective of how it felt to me. Looking back.. I mean I have*

learned so much in this one short year ...from [working with] the girls at [the eating disorder clinic](Eii, p.11).

In *Locked Rooms* and *The Unknown Shore* two characters, twin sisters Molly and Claire Beamish, are central. Molly as a child is thin and there are references in *Locked Rooms* that suggest as a child she unknowingly had anorexia. Molly is depicted as an inner, intense and lonely character. Claire is Molly's twin sister who successfully negotiates her way in the world. As an adult, Molly once a slim child, becomes an obese recluse, shut away from the world in her family's country farm house. In *Locked Rooms* there are several scenes where Catherine, as she said, "plays with the metaphor" of obesity and starvation. For instance, Molly recalls the struggle of not wanting to eat as a child. She says to her mother:

Would it be okay if I didn't come down for dinner? I'm not usually hungry at night' (Joyce, 1998, p. 100)... 'What do you mean-you're not eating?'... 'I'm just not hungry' (Joyce, 1998, p.101)... Sent home from Ashworth at Christmas because sometime last autumn, in her final year, she stopped eating... (Joyce, 1998, p.182-183).

As a an adult, the other twin, Claire, is a housewife. She is married to a doctor, has two sons and lives in a beautiful home. Nevertheless she has difficulty eating. There are several references in *Locked Rooms* that illustrate this. For instance, Claire recalls as a child being forced to eat and now as an adult not wanting to. She says,

That's enough. No, mother, that's enough. Trying to make her fat. She is sick of every woman in her life wanting to make her fat-as if they hate the thought of her not eating, not complying, or not being as they are, undisciplined, unruly, self-indulgent. She is not going to end up like her twin sister, trapped in self-defeat (Joyce, 1998, p. 69)...she cannot eat. [When she tries to eat] there is a tightness about her throat... (Joyce, 1998, p. 148)...

Often Catherine through Molly and sometimes Claire, spoke about her anorexia. Scenes from both *Locked Rooms* and *The Unknown Shore* elaborate on issues Catherine discussed in the interviews. Later in this section excerpts from the novel are highlighted. In addition to the novels, information was

gathered through other artifacts such as writings, poems and a curriculum vitae. In one of the interviews Catherine brought a folder containing artifacts. Looking through them it became evident she was a high ability woman. Academically she obtained a first class honours B.A. in English and while on a full scholarship, a Master's degree. She is the author of a series of novels and poems and owns a publishing company. Catherine's professional work has also centered on teaching the process of creative writing. Since 1971, she has taught and continues to teach various writing workshops. She has also worked as a free-lance writer. Catherine has received special recognition for her novels, poetry and film scripts. Her leadership roles included teaching and spiritual exploration work through writing. She was also the recipient of numerous grants including an Ontario Arts Council Grant and an Explorations Grant for fiction from the Canada Council. All the artifacts Catherine provided can be seen in Appendix K.

Life before the Eating Disorder

The interviews were conducted when she was fifty years of age. The objective of the first interview was to travel back in time. The questions that framed the dialogue were: Who was Catherine before the eating disorder? Where did she come from? What was her family like? In order to obtain information about her family context, Catherine was asked to reflect on her childhood: *[I was] the second oldest of four children, raised in an upper middle-class family (Ei1)...[We had] various animals...Animals are very, very important to me... (Ei1). It was a family of tremendous discipline...Everything went like clock work...At the beginning of the day you had a list of your tasks and you had to do them all. We were raised to be highly disciplined, very obedient, accomplishment, achievement oriented types...The unspoken law [was] 'Nothing is ever good enough'...My parents drove themselves and equally we [the children] were driven...it was a ethos... of perfectionism...(Ei1).* In a scene from *Locked Rooms* Catherine and her father are fishing together. The scene illustrates how even a leisure activity becomes a test of competence. Molly's father says,

Did you catch it? Now you try. Sit up. Come on, sit up. You'll never do anything right cowering like that in the bottom of the boat. The rod's light as air. Any child can do it. Now think. Already the moment has shifted. What has been a gift of rare attention is now turning into a test of competence (Joyce, 1998, p.24).

Catherine's parents valued excessive discipline and were achievement oriented. Her parents' values placed heavy demands on her as a child. From a very young age she came to believe that nothing she ever did was perfect enough to please them. She said, *the focus was on mind achievement, perfectionism...not heart...not relaxation...not cosiness, not a lot of physicality. I don't remember being hugged... (Ei1)*. In *Locked Rooms* Catherine wrote about the pain she experienced because her parents did not express their emotions. Molly tells us about her father and mother:

He is indifferent as usual to her presence...Oh stop. Stop! Speak to me. Don't go by. Oh please, Dad, don't go by and leave me here in the darkness, don't leave me with this awful sense of having done something wrong....will she ever be free?...(Joyce, 1998, p.89).

Catherine's parents did not provide any emotional support and appeared to have been incapable of responding to their daughter's emotional needs. Catherine's parents exerted great demands and expectations upon their children. Both parents engaged in practices that conveyed specific messages of what was expected and valued within the family.

Catherine's father modelled discipline and achievement. He was a successful surgeon who was up at *the crack of dawn*. *My Dad was...in the OR...[he] walked to work...ran up and down the stairs of the hospital...[he was a] phenomenal athlete...[but] dropped dead at 56 of a heart attack..truly your Type A...(Ei1)*. In several passages in *The Unknown Shore* Catherine wrote about Molly relationship with her father. The relationship seems analogous to hers with her father. Molly saying,

There was a silence about her father...it vibrated through to the core of her being. A

vortex of silence that echoed with one unspoken question whenever he passed-And you? What have you done with your day?...A battery of achievements she could never equal...(Joyce, 1997, p.60).

Catherine described her mother as a woman subscribing to a value system concerned with the image she projected to people. *My mother was very exclusive and she would never invite anybody to come in [to the house]. She didn't want any drop-in company, we were not allowed to have our friends there and [we] were definitely not allowed to have friends over in the city. She was a very controlling person (Ei5). My mother was the epitome of what she would regard as [a person having] impeccable taste...one of her lines was "we don't keep up with the Joneses, we are the Joneses"...and I wasn't a Joneses by nature...(Ei,1,2). She grew up...in an unreal world with lots of wealth...she was a true princess (Ei1).* During the interviews, Catherine's mother was portrayed as very controlling and aristocratic. Molly's mother is depicted in the same manner. In a scene in *Locked Rooms*, Molly's mother says,

I've told you. I won't have either you or Claire associating with those children. You're known by the company you keep (Joyce, 1998, p.111).

This last statement provided insight into Catherine's natural personality, the need to be authentic. She was unconcerned about having to maintain a facade like her mother. Therefore, there appeared to be a mismatch between Catherine's natural disposition and her mother's. Catherine's relationship to her mother was also distant. In *Locked Rooms*, Molly's mother shares a striking resemblance to Catherine's. Molly describes one of her mother's daily rituals:

So often she'd come upon her in late afternoon, sitting before the vanity, arranging her hair. Daily, at four o'clock, she would bathe and dress for dinner; the careful selection of dress and shoe, of clasp for hair, the discreet dusting of powder across her nose-her mother could spend hours before the mirror (Joyce, 1998, p.85).

Through my conversation with Catherine and reading her novels, I constructed a visual picture of Catherine's mother. Catherine depicted her as an elegant, well mannered, impeccably groomed

woman, raised to portray a certain image to the world. She had tried to pass this value system onto her own daughters. But, Catherine said, 'I wasn't a Joneses by nature'. She must have felt stifled and forced as a child to adapt to a value system far removed from her own. This theme was alluded to in *Locked Rooms*. Molly narrates how she feels when her mother invites Molly and Claire to her room:

Through the closet doorway she can smell the faint scent of lavender stitched into padded sleeves of hangers or tucked away among lingerie covered with tissue paper on the shelves; in her mind's eyes she can see plastic covering the shapes of things which are never worn. New clothes arrive. Continually. Molly and Claire are invited to see them, ushered into the closet as if into a museum...they listen again and again to stories of growing up in a family of wealth and privilege....Often Molly wants to leave in the middle of a story. To run as far and as fast as she can-out into the fresh, clear air. Today, she listens wearily to the voices amid the plastic and silk (Joyce, 1998, p.80).

Catherine's parents rarely praised her. It seemed that nothing she did was good enough. *I lived in what I thought was a nice, normal, happy family-the perfect family, as everyone always said (Joyce, 1999a, p.1).* However, in relation to her family she saw herself *as invisible... not wanted or even noticed, but having to live up to family expectations whether we wanted to or not, be always cheerful, bright, cooperative. I wanted to be liked and appreciated. I grew up in a home where everything was in its place. The floors were so clean you could see your reflection in the polished surfaces. Everything was tastefully decorated and perfect. My parents were perfect... (Joyce, 1999a, p.1).* The need to be perfect was also found in *Locked Rooms*. In the following scene, Claire is talking to Molly about their mother,

You remember how Mom was-everything had to be just so. I used to think...unless I was perfect...I would never be loved(Joyce, 1998, p.258).

Molly reflects on how she felt in relation to her mother,

Everything her mother touches turns to perfection: her hands like machines operate hour after hour, all day long. Claire can't keep up with them. Who could? Not Molly, who never bothers to try, always off with a book to one of her hiding places...(Joyce, 1998, p.134)

Catherine was sensitive, therefore, she picked up subtle cues, messages her parents and the environment sent. Being highly intuitive did not always work in Catherine's favour. She could never ignore the expectations others exerted upon her.

Dispositions that are Associated with the Eating Disorder

The insights about Catherine's natural disposition (authentic, genuine, sensitive and unconcerned with material possessions) stem from a number of things. The artifacts Catherine brought to the interview indicated that she has been an extraordinary woman. A large part of her life she has dedicated to writing and teaching "the inner imagery that flows through [one's] mind" (Joyce, 2000, p.1). She loved books, drama and art.

Catherine was a feeling, creative inner child. As a young girl she was naturally drawn to adventure and fantasy. She said, *I was a very inner child (Ei2). From the time I was little I was afraid of losing my head... I knew my perceptions were true... I had a recurring dream of having to be forced to go down a funnel...I wanted to protect my head...[I would think]...just let me protect my head, take anything else away from me but don't take away from me my head...my imagination...thoughts...this inner landscape that is so rich and multi-layered...I could be quite happy living all alone with that and my books (Eii6).*

As a child she literally lived in her own world. She was a day-dreamer, a writer who had a voracious appetite for books. She was a sensitive, precocious child, aware of her own emotions and those of others. She said, *I was always caught in the drama of the emotion I had...vivid memories of the emotional scenes...I can't remember exactly what happened but I know exactly how I felt, what I thought the inner dynamic was...playing itself in my head (Ei2). I was a a very soft child...very cuddly, munchy...child I was a very out of it child... not all there ...I wasn't reliable, in the sense, that I wasn't predictable, I'd be off doing the unpredictable... (Ei3).*

I asked Catherine how her parents responded to her natural dispositions of being introverted, emotional and sensitive. Catherine commented that her parents were far removed from understanding her. The focus in the home was on achievement and accomplishment. Her parents were not pleased with her tendencies: *As a child [I] would be punished severely for being selfish, for being...concerned with my own things... (Ei3)*. Her interests were different from her parents. Her parents had been unable to understand their daughter's natural disposition and natural personality. Catherine described herself as an imaginative child, similar to Molly, but this was not a behaviour tolerated by either parent. This was evident in a scene in *Locked Rooms*:

Molly rises early, skims downstairs to the living room where she pushes the doors shut, angles the furniture back against the walls, seals the curtains...a garden of palms where the three boys sing as she dances-Pamina in search of light... her mother comes in. Strolls across to the record player and lifts the needle...she takes apart the imagined scene. Molly looks up...at her mother...'Believe me, there'll be none of this tiresome charade when you go off to private school in September. You will be on your own' (Joyce, 1998, p.10-11).

Almost as if she has to hide this part of herself from her mother and father, Molly dances secretly, behind closed doors while her parents sleep. The beauty of Molly's world is instantly destroyed by her mother's appearance in the living room. Catherine, through Molly *In Locked Rooms*, illustrated the disdain Catherine's mother had for her daughter's behaviour. Molly's mother says,

You know, sometimes I think you do all this quite deliberately. Her mother's voice is low. The time you waste... No! It is not funny. It is never funny. It is only a blessed nuisance (Joyce, 1998, p.31).

Catherine's propensity towards imagery was vivid and she ascribed importance to it. For example, on Sunday at 10:03 p.m., Catherine wrote in the ESM form *I feel alert, happy, cheerful, strong, active, proud, involved, excited, open, clear, relaxed and cooperative. I am in bed writing in my journal about my dreams. My son and husband are in another part of the house. I am focussing on*

my dream images, I have recorded them and I am now reflecting upon them. I need to stay connected to the energy in the dreams because they are a source of inspiration for me. Recording my dream images is very important (ESM report). As an adult she no longer had to contend with her parents' response to her natural tendencies. However, as a young child she had to. As a result of being misunderstood by her parents Catherine developed an inner doubt, shame or guilt over her propensity to be drawn into the 'emotional drama' of life. *My biggest memory is always thinking...have I forgotten something...So my childhood was one of anxiety, based on did I do what I was supposed to do when I was supposed to do it or have I forgotten...That created an inner anxiety about the outside world (Ei2).*

Catherine at fifty still struggled with this inner anxiety. Many of the ESM reports illustrated that when Catherine was not doing something concrete, achieving something, she became anxious. For example, at midnight on Saturday Catherine wrote, *I feel weak, passive, detached and bored. I am ready to have 'alone time'. I am feeling restless doing meaningless tasks. What has affected my mood is that I have been too long in "meaningless" mode. It is very hard for me to relax without getting down to something concrete and significant such as writing. I find I can subvert myself by being 'lazy' and 'unfocused' for too long at any one time. I prefer to be alert and to get a grip on my activities (ESM, entry).* On Monday, she was feeling uneasiness because she was unable to accomplish what she set out to do (In the morning, events transpired that kept her from her work). At 10: 06 a.m. she wrote, *It's Monday I feel alert, happy, cheerful, strong, active, sociable, involved, excited, open, clear, relaxed and cooperative. I am in the kitchen alone attending to various business and household tasks. I am thinking about my brother and sister-in-law. I just spoke to them on the telephone. I feel somewhat self-conscious. I feel slight physical or emotional discomfort and slightly restless to get on with my work (ESM entry).*

Later that same day she was still struggling with an inner anxiety because she had not completed her work: 2:05 p.m. *I feel alert, cheerful, strong, active, involved, open, clear and cooperative. I am all over the house doing things. I just sat down in the kitchen to complete the ESM form. I was making phone calls, organizing my writing work, making cookies for my evening class and thinking about new projects. I was thinking about all the things I wanted to be doing and feeling a buzz of pressure to do many things but I am aware the day is passing too quickly and that I have not accomplished as much as I desire. I am somewhat self-conscious. I am not quite living up to my own and others' expectations of me. I feel a slight sense of physical or emotional discomfort because I can not get past details of work that are meaningless so I can get down to concrete work. What I am doing is somewhat important, but I somehow wish to be doing something else (ESM entry).* Catherine indicated that she was able to feel relaxed when she had completed the work she had set out to accomplish. She wrote on Saturday at 6:06 p.m. *I feel alert, happy, cheerful, sociable, open, clear and relaxed. I am in the kitchen with my son and husband trying to relax. I am putting away the laundry, filing teaching materials, looking at photographs, printing my students' poems. I am relaxed after having completed my day's work. I feel very good about myself and I am living up to my own expectations. Now that I have completed my work I feel much better and can relax (ESM entry).*

From the ESM reports and the interviews it was apparent that Catherine has incorporated the need to be achievement-oriented into her adult life. However, she experienced great distress in doing so. It was unclear whether Catherine had a natural tendency to being achievement-oriented or whether it was a consequence of her upbringing. Catherine indicated that her natural dispositions were ill-fitted to her parents. She was not understood by her family, so she sought solace in books. *In the family construct I was the introvert... (Ei1) As a consequence I felt alone...like I lived...in a daydream which suited me fine and I would read the same books over and over again. I had favourite writers (Ei3).*

Catherine touched on the impatience Molly's father has towards his daughter's mode of behaviour. In *Locked Rooms*, Molly is standing in front of her father and he says,

'What's that you're hiding?' 'I-it's a-it's just one of the art books- ...There's a painting by a man....here it is see-on this page?' 'Put it away.... You cannot afford to be a romantic in this life! You must be a realist! Put it back! Now!' (Joyce, 1998, p.57-58).

Catherine seemed to have an inborn keen awareness of emotional overtones to life events. She could sense the unfolding drama of her life which she could never permanently hide from by reading. Therefore, she was profoundly hurt by her parents' lack of understanding. She wrote:

I was not an intellectual child by nature. I was a feeling child, aware of everything unspoken around me, aware of my mother's hostility, my father's distance and preoccupation, the unacknowledged ideal that children were a bother but if they behaved themselves and made the family proud, then they would be accepted, perhaps loved (Joyce, 1999a, p. 2-3).

Catherine provided insight into the dynamics of her family, the values, goals and priorities they held. She was not understood within the family context. Consequently, as a child she felt lonely and disconnected. Catherine's natural disposition were ill-matched to her parents so she elicited reactions of disapproval from them. Catherine in turn, responded to her parents' reactions by withdrawing further into herself. Catherine's experiences and natural disposition reciprocally interacted within a specific context. Her family was a microsystem in a larger cultural macro system. In the interview it was necessary to situate everything Catherine had already said. Therefore, I asked her to describe the community she was raised in. Catherine spoke of living as a child in two different communities. [Growing up I lived in] *a split community...[in] the winter time... we were in the city and [in] the summertime ... we were in the country. The city world was very disconnected from me ...it was a who's who world with that kind of value system (Ei5). [In the city we lived in] this pristine...monstrosity...my mom wanted this showcase home...and I never [felt]...settled [there] (Ei 5, 6). The summer time world*

was totally different, we moved every summer ... up to the country...we...had [the] outdoor world, it was a very cosy wonderful world...(Ei5). The country provided an escape for Catherine and her sister. As children we would go off...into the world and have adventures...we had this underground world in the country where we could escape (Ei5). When Catherine was asked if as a child she had lived in two disconnected communities, she responded: *yes, two disconnected [communities], like light and dark (Ei5).* Based on what Catherine said it appeared that her natural disposition fit the life style of the country rather than the city. She seemed to adapt better when living in the country setting. In both *Locked Rooms* and *The Unknown Shore*, Molly's love for the country is featured. Through Molly, Catherine explains her affinity to nature and how it speaks to her. She also recounts how country living is difficult to leave:

The landscape soothes, the fields as familiar as the delicate transparency of her own skin... The land. Her life. Both solitary. Worlds set apart. Not a clock ticking (Joyce, 1998, p.12). How she hates to leave-the mountains...(Joyce, 1998, p.79).

Catherine still to this day finds solace in nature. This was apparent in the ESM reports. For instance on Sunday at 12:03 p.m. she indicated, *I feel alert, involved, clear and cooperative. I am in the living room with my husband. When you paged me I was filling out the 10:00 a.m. ESM form. I am still worried about my son getting home and I am writing a list of things I have to get done. I am thinking how peaceful the snow looks and how I wish I could go out in it with my dog to get some exercise. I do feel a slight level of physical and emotional pain, the anxiety of my son returning home has lessened (ESM Entry).* Catherine recognized that escaping into nature would help her cope with the uneasiness she was feeling. When she was unable to do so, she felt a level of discomfort. For instance, later the same day, on Sunday, at 2:06 p.m. she wrote *I am feeling slight physical/emotional discomfort. I am looking forward to my walk and feel some discomfort because I didn't take one the previous night. I crave exercise. I would like to be taking a long walk with my dog or swimming (ESM*

entry). Finally , when she is able to go outdoors, her mood changes as she indicates, *It's Sunday 4:05 p.m. Having gone outdoors for a walk and shovelling has "invigorated" me (ESM entry).*

Catherine grew up in a family of four children. The family milieu was one of discipline and achievement. The father was a successful surgeon and her mother a woman concerned about image. Catherine self reported on the ESM forms feelings of distress if she was not working or doing something concrete. Catherine was an inner, imaginative child. She preferred the company of books rather than people. However, Catherine's family did not understand her behaviour. Her parents perceived her as selfish, not adhering to the family code of discipline. The mismatch between herself and her parents created an inner anxiety about what she did and who she was. Catherine was a sensitive child. She was keenly aware of the conflict between her natural dispositions and the family in which she was being raised. As a child she lived in two different worlds. In the winter Catherine lived in the city where she never felt settled. In the summertime she moved to the country where she felt free and at peace. Nature still has a calming effect upon Catherine as she often reported this in the ESM reports.

The Onset of the Anorexia

How did this young girl become a person with anorexia? To answer this question, the conversation switched to the development of the eating disorder. It was at fourteen that Catherine first began her anorexia: *in high school I began [not] eating...in grade ten when I was 14...it usually occurred in the coldest winter months...exam time...that psychological stress of achieving things...The more pressure I felt, the less I would eat (Eii1).* Catherine wrote:

By the time I got to high school I was feeling overwhelmed with all the things I had to be good ...Every night, before I went to bed, I would lie awake going over my day, picking out the parts that I thought were bad and worrying whether I could change them for the better. This ritual of wondering and worrying and telling myself the stories of my day began as a small bedtime ritual when I was a child. By the time I got to high school it was keeping me awake for hours. I couldn't fall asleep until I noticed and remembered everything. I berated myself for the smallest oversight... I felt-no

matter how hard I tried nothing would ever be enough to please my perfect parents. But I was determined to try (Joyce, 1999a).

As Catherine entered adolescence she not only felt strong family expectations, but also had to deal with issues of adolescent development. In Catherine's case because she was a perfectionist, trying to fulfill all the demands placed upon her was difficult. Whether her perfectionism was a natural disposition or one that was cultivated by her family is uncertain. What was clear was that the striving for perfectionism had ramifications for Catherine. *My biggest problem has always been perfectionism(Eii8)*. She wrote:

I was a child who wanted to do everything right, to make everything better. I wanted to do well in school and make my parents happy, especially my father (Joyce, 1999a, p.1).

Although Catherine is now a grown woman with her own family, she still struggles at times with the feeling that nothing she does is good enough. For instance when paged on Saturday at 2:08 p.m. she wrote in the ESM report *I feel irritable, weak, passive and withdrawn. I feel somewhat self-conscious because I am not getting my work done and also because I have worked myself up into an anxiety, a fear of failure. I am not at all living up to my own expectations. I feel slight physical discomfort and pain due to the disparity between the goals I set for myself and life as it evolves with all its randomness and chaos. I can get into robot mode too easily (ESM entry)*.

In childhood her persona of perfectionism extended to the school milieu. *I was your classic good girl. I loved school, not [the] social side (Ei3)...I was always a student ...You could call me 'a goody two-shoes'...I looked forward to school...I loved books...I got along well with my teachers...I was polite, obedient child...always got my work done...(Ei3)*. However, as an adolescent, her disposition towards perfectionism, exacerbated by her parents' stress on achievement and the multiple changes she was experiencing, led to her being overwhelmed and over-aroused with life's expectations. In response,

Catherine coped by further withdrawing into herself. Complex inner thoughts and emotions led her to isolate herself. As the anorexia developed so did a life ritual. *When things got complicated* [meaning the logistics of real life] ...*I couldn't negotiate the path...I spent my life withdrawing (Eii9)*. This is still a pattern of response she engaged in. For instance, on Saturday at 12:08 p.m. she answered a page and wrote, *I feel confused and tense. The phone is ringing and as multiple extraneous demands pile up I find myself getting a headache as I try to clear a path to my own priorities...Perhaps working alone is a response to stimulation overload...Trying to be all things to all people and situations is a negative impulse that I still struggle with (ESM entry)*.

The inclination to withdrawal during her adolescent years initially made it difficult to establish close friendships with her peers . *I had a hard time with my classmates...I would appear a certain way but I wasn't like that. [They had to get to know me because] the distinction was always causing me problems...I was this inner person...I rarely...connected easily (Ei3)*. *My peers, I think they thought I was very bright but missing a few screws...(Ei4)*. Catherine became overstimulated, often unable to handle the complexities of adolescent life, so she withdrew. However, this behavioural response affected the perceptions of her peers. Catherine in turn, being highly sensitive, was aware of how her peers perceived her. In many ways this may have increased her level of self consciousness of being very different from her peers. It may have validated her erroneous belief system of not being good enough.

Up to the age of eighteen Catherine continued to restrict her food intake. Her weight fluctuated. Her parents noticed her odd relationship to food. It was regarded as silly. Up to this point neither she nor her parents knew she was suffering from an eating disorder. At eighteen she left home and moved to Kingston to begin a baccalaureate degree. It was during this time that her anorexia intensified. *I was living alone at Queen's...I was responsible just for myself (Eii1)...I got into this nuttiness [not eating]. It was when I lived alone (Eii4)...[in University when] my roommate [left] I fell back into the [old]*

pattern (Eii4). Catherine wrote in an autobiographical text:

I would spend hours in my apartment, worrying over what I would wear to class, not even wanting to have a body to clothe and yet wanting to be so perfect, so elegantly dressed (if it had to be part of me at all), that I would be exhausted with trying to decide on clothes.

Then I needed to run to class or I would be late... By my second year, I had lost so much weight. I was a stick-so thin, when I turned sideways, you could hardly see me... Each time I ate only one slice of cantaloupe, I felt virtuous and good. Each time I ate a slice of bread, I felt terrible and bad. My body became the field of battle on which I acted out the war and confusion of my own feelings. I never felt I could give up this battle. I never felt I could just relax and lie down and say No, I am not going to try anymore (Joyce, 1999a, p. 2-3).

Catherine shared four poems she wrote when she was twenty and twenty-one (1969, 1970).

She was in an intense phase of her anorexia. One poem is presented here; the other three are found in Appendix (K).

Poem for Tomorrow
December 1970

time stops tomorrow
at five a.m.
the present will be shaped
by the replay of history

but I have only the litter
of years to recall-
old bones bleached white
and dry, light-edged
tin cans curved silver
and blue, pale
from the earth tin
limbs glow yellow
mould in my mind

I can feel the dust
forming on my fingers
touch the chips of bone
and steel and skin
my mind reels in the hollow

walled silence of the past
 I babble in a lost language
 my tongue encrusted
 with discarded words
 that arch and heave
 up
 from mire of memory

the alarm rings
 five o'clock
 my lips are thick
 and caked with dreams

why go on?

Catherine described how she felt during the acute phases of her anorexia: *It was almost a relaxation form. [If] I had [not] eaten that day I felt...a peace, if I did eat I felt...out of control. I had this tremendous power...I wanted to be a ray of sunshine...I just wanted to be...like spun steel...I felt a tremendous power...like euphoria...[at] the initial phase...then you experience incredible aches and pain (Eii1). I would feel heavy if I was eating: when I was not eating I would feel light...it was a form of...inflation...being thin...I had this...sense of radiance inside me (Eii3).* These same feelings still recur whether she is eating or starving. This became evident when she was paged on the Sunday. At 8:00 p.m. she wrote, *I feel alert, happy, cheerful, strong, involved, open, clear, relaxed and cooperative. I am in the living room sitting with my husband talking about anorexia. I am reflecting that when I feel relaxed, I eat, but then when I put on weight I get sleepy and less driven. That feels good for one day or so, but then I desire the feeling of being tense, of being the "go, go self" again who works all day and never eats. I recognize there is a pattern to my behaviour. I will not eat and work constantly for three or four days and then I begin to eat as I relax again. This is a pattern of behaviour. I do feel quite self-conscious right now... Talking and reflecting about anorexia is important... I am in a relaxed mode, this is odd for me. I am aware of how little I relax and I notice my work/don't eat cycle, but I really*

want to embrace relaxation (ESM entry).

The eating and starving became a routine way of living and took over Catherine's life for a while. Her eating disorder was associated to her difficulty in establishing friendships in high school as well as in university. She had some very good, deep friendships, just not many. She was hardly eating, always running off doing something. She was a woman in constant motion. *I think they [my friends]...thought I was odd...the word anorexia wasn't known...[my friends thought] 'well you know her she's nutty'[about food] ...my friends...accepted the fact [that] my behaviour was strange...they just didn't know what to do (Eii4).* Catherine was not overly open and sociable with her peers because she was an introvert. Catherine was often alone by preference in her university years. However, she did not feel lonely or left out; she liked being alone.

Catherine withdrew in all areas of her life at this time. Although an excellent student, she had a tendency to become easily over-aroused which had ramifications in her personal and professional life. For instance, she said she longed to be a poet but did not seek any mentors. *I stayed away from most of my professors and I basically lived by myself (Ei4).* Because of this search for solitude, people did not really know who she was. She said, *I had a poet professor for whom I was...the muse...in a sense I felt myself being devoured...I didn't exist in that relationship. I [was] just a muse but I didn't have any boundaries...[this] poet...published two novels about me, three books of poetry...and I am not there...I'm just the poetic inspiration...but I, me, this person [Catherine points to herself] I am not there (Ei4).* The isolation she experienced appeared to exacerbate her eating disorder. She observed that, during the intense phases of anorexia, *...in my final year [of university I] was living alone, my good friends were gone...I was more isolated...* She fainted on a street corner. Her friend brought her to the hospital. Catherine wrote in an autobiographical text:

I remember lying huddled under a sheet on a stretcher. A young doctor came in to

examine me, poking and prodding my back and stomach and chest. He said very matter-of-factly, 'You know you are eating your own organs' and he left (Joyce, 1999a, p.3).

Catherine's physical health had reached a potentially life threatening point. She was starving herself to death. Catherine was forced to leave university and return home. *My parents...they had seen me in high school being difficult...not eating with the family...the anger they felt...after I had been in hospital...they were just fed-up ...I was quite used to their...impatience, disdain for my issues (Eii3).*

Catherine further wrote:

My surgeon father took one look at me and clicked his tongue with impatience. 'I see people everyday of my life who are struggling to live and here you are playing with Death as if it's an idle game'... He was disgusted with what he called my 'obsession' with myself... (Joyce, 1999a, p.4). With his words, my father took away my beautiful dream. He took away my power. He stripped the glory of Anorexia from me and made me feel ashamed. He made me feel like a total bother, a complete stupidity, a selfish, ungrateful child.(Joyce, 1999a, p.4). My mother as the perfect one...had nothing to say to me... (Joyce, 1999a, p.4).

Catherine's parents reacted to her illness by telling her she was selfish and they were disappointed in her. The following quote from *Locked Rooms* was indicative of Catherine's father's reaction to her refusal to eat. Molly's father sees her not eating and says,

Oh, suffering Christ! Her father clicks his tongue with impatience. If you're not eating, if you're not going to join us like a civilized person, then be off with you! I've had just about enough of this ridiculous charade!(Joyce, 1998, p.183)

Her parents made no attempt to understand the reasons Catherine was starving herself.

Catherine responded by leaving home. Catherine wrote,

I didn't stay long at home. I couldn't bear to be there under their watchful eyes...I went back to University and began the battle of my life... I was terrified and ashamed. I began to eat-slowly, painfully-but with the same blind fear with which I had fallen into Anorexia. A terror of not being loved. A terror of not being perfect. Of not being the wanted child. Of somehow being wrong in my deepest being. I had a strange sense of being evil. Evil in ways I couldn't understand. I didn't know why and I didn't know how

to make myself better. I didn't know how to talk or tell anyone of the fears and confusions that haunted my life...(Joyce, 1999a, p.4-5).

As Catherine was waging war against the anorexia she continued to accomplish incredible things. She returned to university and completed a first class honours degree in English. At twenty-two, she began an M.A. in English on a full scholarship at York University. She completed her M.A. at the age of twenty-three. Throughout her adult life Catherine has continued to struggle on and off with her anorexia, but she has still managed to create a life for herself. She has dedicated most of her adult life to various literary pursuits and to teaching. Between age twenty-three and twenty-four she taught English and Journalism abroad, then returned to Canada where she taught in Northern Newfoundland for 6 months. She returned to Toronto and for a number of years worked as a script writer and researcher for a major Canadian Television network. Between ages twenty-three and thirty she was a freelance writer and taught creative writing at a local college in Toronto. At thirty-one she returned to Ottawa and for four years wrote short stories. At thirty-five she returned to the Maritimes to teach and she got married. By age thirty-six she was back in Ottawa and for the next three years was a full-time mother but was also teaching creative writing and studying art and design. It was at age thirty-nine that she began to write her first novel, *Locked Rooms*, all the while working as a free lance writer. At forty-one she was the recipient of a grant from the Canadian Council and completed her first novel, *Locked Rooms*. The next year (1992) saw her writing another novel in the Waneva series *Fugue in Winter* and lecturing on how to write fiction. At forty-four (1993) she rewrote *Locked Rooms* and worked as a writing teacher in a local school. In 1994 *Locked Rooms* was published. A year later she wrote another novel *The Unknown Shore* (1995-1996) and was still teaching creative writing. In 1997 *The UnKnown Shore* was published. Her fourth novel *And Know The Place* was written in 1999 and published in September 2000. Over this last year (1999-2000) she has begun to teach creative writing

workshops to girls with anorexia and bulimia nervosa.

Reflections of Factors Associated with the Eating Disorder

Catherine was fifty years old, and although she had been struggling with anorexia since the age of fourteen it was only in the last year that she has talked about her anorexia to girls with eating disorders. The emotional insights narrated by a fifty year old woman have been pondered since she was a teenager.

Catherine wrote about how she felt about herself during the years of her illness . The depth of emotional pain she experienced was conveyed in Catherine's writing:

There is a deep grief in the heart of all anorexics/bulimics. The world and they themselves are not what they would wish. They live lives haunted by a sense of failure. They are hounded by guilt and a strange sense of evil that does not make sense to those around them (Joyce, 1999b, p.1). We see ourselves as not independent but needing to be hugged and cared for and loved and accepted as we are-we are unable to express how we feel (really feel) but we are terrified of being abandoned or cast away as too selfish, stupid, willful to be bothered with... Feeling this way Catherine says, inside we [people with eating disorders] feel punished enough by this voice that drives us to run and never eat, never rest...not avoiding life but being drawn to death, to escape, to find some final rest where our minds can stop, we can be free as we were as a children-We don't want the world as it has been presented to us: it has no meaning (Joyce, 1999b, p.1).

Some of the feelings that were present in the earlier years of Catherine's anorexia still plagued her. *I drove myself...physically I stopped eating...to strip myself down to the bone...I wanted to be like this radiant spirit thing...I still fall into this longing. That's almost an answer to the feelings of shame and guilt [I feel]...the feeling of somehow being evil...I often felt...that sense of evilness (Eiii,2). It's a bit of pathology that lingers...it's connected to shame and guilt...weakness (Eiii,3).* At fifty she still experienced a sense of guilt and shame about herself. She wrote:

Anyone dealing with Anorexic/Bulimic young people must keep in mind that these girls are in a prison. Every time they eat, they feel a punishing guilt for having 'failed' Anorexia. (Joyce, 1999b, p.1)...

Catherine indicated that her eating disorder was also a response to her inability to cope with life. She said, *I began to worry about coping. I had been in this bubble...I had this sense of ecstasy and power...I began to worry...[if]...I could cope with the demands of the real world and still maintain this person I wanted to be...The eating disorder was symptomatic of that...[when] I got on overload I found...that I [had] a hard time swallowing (Eii8)*. She had wanted to pursue a doctoral degree, but thought she would be unable to negotiate her way in an academic environment. As she stated *I...thought I would become an academic ...[what] happened to me with the anorexia was the recognition of the disjunction between the way other people coped with the demands of the world and...[how] I coped...I became conscious of ...stimulation overload...I began to withdraw...I stopped my academic path (Eii9)*. Her natural disposition led her to become easily over stimulated (meaning she became over aroused physiologically) and unable to cope with the intensity of her emotions. Withdrawal was her response.

Catherine identified her inability to handle stimulation overload as being associated with her eating disorder. Often when she was unable to decrease her level of arousal, eating became difficult. The natural tendency to become over-stimulated was noticeable in many of the ESM reports. When Catherine became over- stimulated she indicated experiencing predominately negative mood states. Saturday was a ESM paging day where these tendencies were apparent. At 12:00 p.m. *I feel irritable (not visibly but inwardly), weak, passive, detached, bored, confused (jangled) and tense. I am in the kitchen with my husband, son and his friend. When beeped I was cleaning up after breakfast. To get away from the noise I went into the living room to fill out the ESM report. Simultaneously, the laundry is being done, I am preparing a stew for supper, planning the activities of the day who will do what and the dog is demanding to be walked. I feel too much is happening. I am trying to get to my own work*

(preparing teaching lessons) but too many things are demanding my time. This is not a new feeling, this thought is a constant in my life. I am feeling self-conscious, not at all in control of the situation and not living up to my expectations. What I am doing is not at all important to my overall goals. I very much wish I could do something else. Specifically working by myself preparing my teaching materials, basically doing one thing at a time (ESM entry).

A few hours later Catherine was still fighting to deal with the multiple demands she was experiencing: *It's 2:08 p.m. I feel irritable, confused and tense. I was not feeling calm when you beeped me. I was trying to get work done and was struggling to find the time to do so. Therefore, I responded to the page at 2:36 p.m at which time I was in the downstairs office working on the computer. To answer the ESM form I moved away from the computer area so I would be less distracted. While working I was doing laundry, talking to my son and the dog was still waiting to be walked. My husband has gone out to do the groceries so life has calmed down...this eases my path. I can't believe how frazzled and disconnected I have become since the previous page. This prioritizing of energy does take time and focus because when too much is happening, I get paralyzed and can't cut a path to what I want and need to do (ESM entry).*

Her tendency to withdraw made it difficult for others to relate to or understand Catherine. When asked what her relationship with other people had been in the active phases of the eating disorder, she mused and then replied, *I was very alert to what I loved but tuned out [the] things that did not interest me...before...the anorexia I really cared about people, I really cared about my girlfriends...I remember everything about them (Ei5) but I was a non-existent person [to my friends]...I absorbed everybody but I didn't know that was what I was doing (Ei5).* Indeed, Catherine held values of asceticism and modesty. Values different from her peers: *my roommates at university were powerhouse women...very ambitious...loved the things of the world...were consumers...had a...sense of their path out in the*

world...mine was an inner path...I didn't capitalize on openings [career opportunities] I would...ignore them...as if they weren't meant for me...I wasn't thinking [about]...the outside world...that was separate from my inner space (Eii3). Catherine's value system and goals in life were different from her peers. She still holds this value system. Catherine was paged on Monday at 10:04 p.m. She had just finished spending the night talking, teaching and sharing with other women their dreams and goals in life. What she reported typifies the values she ascribed to: *I feel alert, happy, cheerful, passive, sociable, proud, detached, open, clear, relaxed and cooperative. I am cleaning up, the class has just left. How much I wish this kind of communication was at the centre of life rather than the race for money, success, power and technical achievement (ESM entry).*

Catherine stated, *I had tremendous drive to get at the truth but I [didn't] care whether or not...I [got] the golden crown (Eii9). The world had another perception and value system than mine...I was...like a nun...with a concept of devotional respect. When I didn't eat I was in a state of devotion, purity...integrity, authenticity, clarity of being radiance clarity of perception. I wanted to write the purest poem...that encompassed all of knowledge (Eii3). If I start naming it more directly I recognize that there's a kind of pathology here...I was just trying to cope with the intensity of my inner life (Eii6).* Her intense mind set is often perplexing. She wrote, *Sunday 10:00 a.m. I feel drowsy, sad and weak. I did not sleep well the previous night and this has affected my mood. I dreamt and was thinking a lot about anorexia and what it is about. My mind has been "racing" all night and therefore I woke up feeling tired, "groggy", with no voice (ESM entry).*

She related the development of the eating disorder to a number of factors. First of all, she identified her natural disposition as being associated to her anorexia. She said, *I would identify my temperament as...the single most important factor over 50 years of a behaviour that recurs [anorexia]...so...what happens is an ultra sensitivity to the world...the world expectations create a kind*

of shame in me, create a kind of guilt over not living up to what it is that the outer world wants...it is not known or ...understood...there is no place for my soul (Eiii, 1). How her natural disposition made her feel different was often articulated in her novels. As Molly says:

....sometimes at night I get a feeling of claustrophobia; of being smothered by my own personality...the world seems a prison where I lie fettered by the chains of my senses and blinded through being myself (Cyril Connolly as cited in Joyce, 1998b, p.8).

Another natural disposition, over-arousal, has made it difficult for her to adapt to life. She reflected, *going back to temperament, the lack of fit...my inability to handle stimulus...[the] anxiety and the rituals of the eating disorder calm you...create a routine...create a focus for the confusion...Those rituals became...a liturgy in a religious sense...you follow this discipline...anchor yourself...I...felt like a fragment in outer space, other people seemed...adept at handling the world but for me... with this...hyper-overload...the eating disorder...comforted me...made me feel a sense of control...It gave me a sense a place...it shaped my day...in the outer world sense (Eiii,3).*

According to Catherine her natural disposition per se did not lead to the development of the eating disorder, but it did in conjunction with the social context and the family. This became clear when I asked Catherine to tell me the critical experiences and memories that arose in reference to her eating disorder: *the most critical thing...is the lack of fit between my temperament and my family...I went into myself more because of that lack of fit...I sought out spiritual understanding from an early age because of a not understood spiritual path...I sought out books...Perhaps...[had] I been in a family where being an introvert...being imaginative...being sensitive [was normal] the family construct for me was pivotal (Eiii,3).* Not only did her family not understand Catherine's natural disposition, but according to her, the larger social cultural context also was ill suited to Catherine's natural personal characteristics.

Catherine said, *[the] lack of understanding of my personality type...how inhospitable the world is to that personality type. We live in a world of extraverts, rationalists...people who deal on a sensation side of life...People with intuitions are often...regarded as witches...I ended up feeling more alien...more misunderstood...more guilty...more shame filled...The world is not always open to different ways of perceiving... so I ended up double guessing myself, my instincts and feelings... I retreated into the solitude...My journey in the world has been a struggle to wrest a blessing from the culture for the kind of human being that I am...I want the world to understand...I believe anorexics are walking emblems to the world of soul longing (Eiii5).*

Catherine indicated the world around her did not understand or value her belief system, values and natural tendencies, so she came to perceive herself as guilty and shameful. If Catherine had been raised in family and context that understood her natural disposition, perhaps she would not have developed these feelings. It is no coincidence Molly says she feels many of the same emotions. Molly feels:

The cold of shame. Silence and shame (Joyce, 1997,p.47). Shame she was beyond caring into pure longing...exhausted with fear and disgust... (Joyce, 1997, p.91).

Molly says:

Whatever inside drained me of all conviction, whatever shamed me into further corrupting my life, whatever unconscious, implicit demand was structured into me, imprinted from the very beginning that somehow I must sacrifice myself over and over as a way of being, not being in the world-it is ending...(Joyce, 1997, p.232).

We talked about natural individual characteristics and experiences that were associated with the development of Catherine's eating disorder. However, the role she felt the culture had in the appearance of her illness had not been discussed. Eating disorders are often said to arise as a response to Western cultural expectations that women should be slim and beautiful. However, according to Catherine the culture seemed to have played a minor role in the development of her eating disorder. *It*

wasn't about culture...I never cared ...[if] I was physically attractive. This [anorexia] was purely a longing for spiritual radiance and transcendence ...if I... could...have just taken my body off to get down to the bone....that would have been the goal....anorexia as I have read...didn't seem to have anything to do with me...I wasn't trying to look like a model (Eii6).

When Catherine was paged on Monday at 12:12 p.m. she was contemplating the meaning of anorexia in her life and how different it was from the meaning popular culture ascribed to anorexia. She wrote in the ESM form: *I feel alert, happy, open, clear, relaxed and cooperative. I am with my husband having lunch and looking at old photographs... when both of us were younger. My husband comes home each day for lunch. My husband is in many ways my life line. As he says, just now, without him, I would forget to eat. I am thinking so many thoughts. Am I a true anorectic? Because my behaviour is not a response to wanting to be the perfect thin beautiful woman. It is more a quest for the euphoria/visionary world starvation brings. I am also looking at and thinking about the photographs of my teenage years when the anorexia began. I am also thinking about my life at home and then being alone at University, not eating because no one was there to make sure I did. I feel self-conscious, in that I am laughing at myself. I feel quite good about myself, somewhat in control of the situation, quite living up to my own and others' expectations of me. I feel a slight sense of physical\emotional discomfort. Anxiety about not finding any photos of myself, that I could not locate any of myself when in the anorectic phases. Looking at pictures of my younger self is not very important to me. I prefer not to be preoccupied with thinking about myself when in the anorectic periods of the past or present. Despite the fact that I write about such mind sets in all my books. Sometimes I just want a holiday from figuring such things out. These various thoughts have affected my mood including the thought I may not be an anorectic. Primarily because my anorexia is about a nun's spiritual longing for transcendence, I pour this into my writing. The battle field of the body in any extreme state was very*

short-lived for me. The true battle has been in my heart or soul, to live, to incarnate, to give back. That's where my writing and teaching come from, the longing to be of use, to give back from whatever wounds we all share in this culture. My obsession has not been with being the 'model thin' attractive stereotype: it has been a spiritual journey. The more I read about anorexics perhaps (given the disparity of motives) there are many, many types (ESM entry).

The culture's role...was [a] backdrop...I was...and am...aware that women...in our culture...are supposed to be thin...I was not living on the culture's terms. I was not a child that wanted to be popular. I didn't care if I was beautiful and attractive to men...but the culture of perfectionism does have a part to play (Eiii,2). Catherine further made her point by referring to a thesis on eating disorders. She said [the] premise [of the thesis was] that our culture and socio-economic patriarchal system is the ground for anorexia...the impetus of anorexia...[for] women to survive that system they must have the perfect body... get the perfect mate who is wealthy and powerful...[has] a secure job...[so] they can compete...I could [not] identify...because she [the author] doesn't deal with the concept of this inner longing...authenticity...purity...finding who you are...in relation to the external world (Eii7).

The Function of Anorexia

The true essence of what Catherine's anorexia nervosa signified was conveyed in the following words: *Anorexia was for me soul hunger...a transcendent awareness...I could be part of all things and my body and my physicality and my living in the world as the world was constructed... was a betrayal of soul...soul longing...If I could have no body, then I could climb up into my soul...and be the person I wanted to be (Eiii, 3). My image of myself, I wanted to be so thin...so pure and...unsullied...by the things of the earth. I...wanted to be spirit, so the closest I could get to spirit was to not eat...as if I was nobody at all...It was...a desire to get down to no body (Eii1). I wanted to be so pure...radiant is the*

word...there's a kind of radiance...at the core of the purity...integrity (Eiii,2).

Catherine continued with a metaphor [although she is not Roman Catholic]: *[I] connect it to being a nun for me, there is a religious component to anorexia...I got into anorexia, then [with] the intensity which...happens at puberty, the intensity of my emotions [became] this desire for transcendence...I [wrote] poems...about nails in your palms...like [the] crucifixion...the fear...was so fierce...It was...about being a nun wedded to a discipline, a spiritual discipline. Not eating was...like living on the edge...I was reading, I had a hunger to know...I would read Plato or...George Eliot...it was my food...At the same time I was cutting back on eating...I remember this blue dress...looking at myself in the mirror... the neck was low and I saw my collarbone...I thought oh great...it's beginning. [If] I could melt my flesh to get into this place where this hunger was...it became manifest in the bone structure...[it] was important to me to get down to the bone...getting down to the bone in life...to see it metaphorically is the essence of my quest (Ei6).*

Molly in *Locked Rooms* describes her inner experience of having anorexia in the following manner:

Her body is air. Transparent as water. Hasn't she longed for this clarity? Body stripped to essentials as if her soul were beating upward into the light, unimpeded by the darkness of matter, by the never-ending sense of falling short of the mark...the haunting awareness of deficit...she now feeds on hunger. It is purification...it does not matter any more if they do not understand...(Joyce, 1998, p.200)

The eating disorder was a means for Catherine to deal with her sense of unworthiness. *The eating disorder was [the] outer manifestation...of a need inside me for a ritual of paying attention to this discipline...stopping eating helped me stay close..."to cleave to" the spine or the essence of what I wanted to become. When I would eat and relax I would get sleepy and I would fall away from the edge...from the discipline...the longing to be, [to follow a] mystic discipline, [the] not eating, driving [myself] physically helps you to climb up into a spiritual place...you are at one with the universe...I*

wanted to be truth, light...in some ways a saint...The eating disorder was the outer manifestation in behaviour of an inner discipline that I was following in my soul...but before puberty [I] didn't act it out...I was a child who identified with nature so completely as a kid...the longing, the soul longing to be reunited... with nature(Eiii,2). Catherine wrote:

Anorexia is like a beautiful dream. When I was young I wanted to live in that dream landscape so much. I wanted to live in a world where I could control the strange and frightening changes that were always happening to me. I wanted to return to a place where it would be okay if I was still small and young and didn't know everything, but would be loved and taken care of despite my failings. I didn't want to grow up. I wanted to be a beautiful little girl forever. (Joyce, 1999a, p.1).

In our conversation Catherine told me, not eating is part of that...feeling of lack of agency at the core of my being. I have a sense of agency on the spirit side...it comes out in my writing but the eating disorder is a residue of my lack of agency...[In real life] the disjunction recurs at weakened times...there is a kind of contamination...I can fall into that [anorexic] space by influences...I don't always recognize (Eiii,3).

Catherine explained in her writing:

Anorexia [persists] as a disease that recurs, you are never really finished with the battle. It haunts you all your life. You must keep listening to this still small voice that wants you to live:...(Joyce, 1999a p.3). Giving up anorexia was the hardest thing I ever did. It had been my companion, my soul-mate, my only feeling of being in control, of having any power at all...(Joyce, 1999a, p.5).

At fifty, Catherine still found it difficult to eat when she was feeling stressed. For instance on Sunday at 6:06 p.m. she wrote:... I am thinking about the book on anorexia I have just been reading. How terrible the stranglehold of anorexia is...how lucky I am, that [although] I do fall into "robot mode", I can catch myself...I eat regularly as long as I am not too stressed: I continue to eat (ESM entry).

The lure of anorexia was powerful. Despite the weakness from not eating Catherine wrote about the sense of power she had experienced with the anorexia. Molly describes it as:

Air. Nobody can touch her. Or hurt her. She is air. Dancing is her element (Joyce, 1998, p.202).

In retrospect, the sense of power and control anorexia provided, helped Catherine deal with the feelings she was experiencing. Catherine wrote:

When I look back and see that frightened young girl, I know now that all she needed was ... a circle of arms to hold her while she let go the terrible demands of being perfect...She needed to be loved as she was, confusions and anxieties and all, without being told she was being stupid and stubborn and idle in her love affair with anorexia.(Joyce, 1999a, p.5)

Catherine wrote how anorexia was an illness that has a firm grip over those who experience it.

We see ourselves trapped in a prison of control-when we eat, we feel we've failed this rigorous system of perfection that has us in its power... not to be thin means we have failed... Following necessary rituals in our day and in our relationships to food we must eat at certain times, certain types of food, in certain amounts, this is a sacred, holy ritual that we deviate from at our peril (an overwhelming sense of failure)...Anorexia is like a lover whom we fear and yet love and obey it... (Joyce, 1999b,p.2). It was as if I lived inside a glass bubble. No one could hear what I was saying....Out loud I was saying nothing, but I was screaming inside...My anorexia...[had]... the power to hold my hand like a stop sign and say "No, I don't want to live if I cannot live as purely and innocently as I long to" ... (Joyce, 1999a,p.3)

At times Catherine still struggled with her illness. However, because she has lived for decades with the illness, she has developed coping mechanisms. Catherine identified the coping strategies she uses to deal with her eating disorder... *solitude, withdrawing...because it was all too much (Eiii3) and writing is a way of opening up my mouth, my throat, to hear my own voice(Ei4)*. Catherine began to write because she needed a venue to express her inner thoughts. Catherine said, *nobody understood her but this created the writer in her...(Ei3)*. *Retreating into fiction and poetry...was the right path for me (Eii9)*. *My true gift is in the*

articulation of complicated states of being...God was very good to me in that he gave me the very obstacle that woke me up to who I am inside...that's what saved my life because writing became the tool that got me out of the cycle [anorexia] (Eii9). Writing is so great ...other than my [own personal] family [it] keeps me sane (Ei5).

Writing was a significant priority in Catherine's life. On all three ESM sampling days Catherine reported feeling peaceful, not overstimulated and in only positive mood states when writing. For example, she wrote, on Monday at 8:30 p.m.: *I could not answer your page at 8:00 p.m. so I am responding to it at 8:30 p.m. I was teaching a writing class to women. I was mainly trying to teach them how to write so they can express themselves. As I was teaching I was thinking, I was not at all self-conscious and I felt very good about myself, in control of the situation and living up to my own expectations. I was feeling a sense of euphoria. If anorexia is an addiction that allows you to see visions so is writing. Teaching writing is also an obsessive state where you can live on the knife's edge of awareness happily (ESM entry).*

Later that same day Catherine reported: *It's 10:04 p.m. I feel alert, happy, cheerful, passive, sociable, proud, detached, open, clear, relaxed and cooperative. I am cleaning up; the class has just left. I feel very good about myself, quite in control of the situation and very much living up to my own expectations. I am feeling very peaceful because I just experienced a wonderful writing class and thoroughly enjoyed it (ESM entry) .*

On Saturday when writing Catherine was fulfilled and at peace at 2:06: *I feel alert, happy, cheerful, strong, active, proud, involved, excited, open, clear, relaxed and cooperative. I am in the living room alone. I am thinking about my students' poetry. I finished reading it and e-mailing the students comments about their poems. I do feel somewhat self-conscious but feel quite good, in control of the situation, living up to my own and others' expectations of me (ESM entry).* Two hours later on the same day she was still writing and in a positive mood state 4:08 p.m. *I feel happy, cheerful, strong, proud, excited, open, clear, relaxed and*

cooperative. I am in my home office alone working, thinking and writing. I am not self-conscious at all. I feel very good about myself, in control of the situation and living up to my own expectations. What has affected my mood is that I am finally able to do my work (ESM entry).

Writing is Catherine's life work. On the Sunday she was engaged in it once again. She wrote on the ESM form 4:05 p.m. *I feel alert, happy, cheerful, strong, active, sociable, proud, involved, excited, open, clear, relaxed and cooperative. I am in the living room reading and preparing class materials. I am feeling very good about myself, very much in control of the situation and living up to my own expectations. This activity is very important to me and I do not at all wish to be doing anything else. I am very satisfied with how I am doing (ESM entry).*

Writing was something that facilitated Catherine's well being. On two sampling days when she was struggling to find the time to write, she experienced discomfort. For example on Saturday at 12:08 p.m. she wrote: *I feel passive and irritable; I am having a hard time getting my work done. I would like to be alone, writing and preparing my teaching materials. I love my writing/teaching work and I dislike the feeling that I may not have the time to do it as well and as deeply as I would like. I am having difficulty finding the time to sit down and work. This is affecting my mood (ESM entry).* Similarly, on Monday when paged at 2:05 p.m., Catherine was experiencing negative mood states because she was not writing. *If given a choice I would be writing fiction or swimming. What has affected my mood state is that I have hit my afternoon slump. I dislike feeling the sense of low energy (ESM entry).* The coping strategies Catherine used are reading, writing and spending time alone.

Having elicited information about the coping strategies Catherine used to deal with her anorexia, the focus of our conversation shifted to the role she had in the development of her anorexia. The anorexia had been Catherine's companion for years and when asked what her role and responsibility were in the development of the eating disorder, she said: *my...participation in [my] own corruption...being*

complicitous...self-subversive...not questioning the soul longing...not questioning the behaviours...I surrendered to those rituals (Eiii4). In some ways Catherine believed she was ultimately responsible for her eating disorder.

Catherine's eating disorder began when she was fourteen. In adolescence she became overwhelmed with the psychological stress of needing to achieve. Being a perfectionist, sensitive and having a propensity to become easily over-aroused was associated to her eating disorder. The ESM reports revealed that Catherine was still prone to over- arousal and when she experienced it she reported negative mood states. The single most important factor she identified as key to her anorexia was the lack of fit between her temperament and her family's values and expectations. The eating disorder gave her a sense of power and control. Anorexia was also a form of relaxation for her. In the ESM reports Catherine reported that not eating still gave her the same feelings it did when she was fourteen. Moreover, she self-reported that when she felt stressed, it was difficult for her to eat. During her second year of university she was told by a doctor that she was starving herself to death. As a result she left school and returned home. Catherine did not stay home long and returned to school. For the next thirty years she continued to struggle intermittently with anorexia. Despite this, Catherine is a very accomplished woman. She has written several novels and taught creative writing since 1971. On every ESM sampling day Catherine reported writing and when so doing she was always in a positive mood state. Catherine said that her anorexia was not a result of a desire to be beautiful, but rather it was part of a spiritual quest.

To conclude this chapter has presented the stories of four women Hazel, Pat, Sheila and Elizabeth. Through in-depth interviews, ESM data and artifacts each woman's understanding of what individual and contextual factors were associated to the development of their eating disorder has provided. Chapter five will discuss the results that emerged in the study.

Chapter Five: Discussion

The previous chapter presented the stories of the four participants. Each woman's voice was given centre stage. The first level of analysis, within case, unravels the grounding of each story. The second level of analysis, between case, will provide the gestalt of these stories through a discussion of common themes and patterns of the four stories. The observations made stem from the data provided by the participants. In the four cases there appeared to be a negative interactional process between the participants and their families, which seems to have played a role in the development of their ED. This negative interaction process is referred to as a poorness of fit between the participants' individual characteristics and their family context. In the within case analysis we reflect on the poorness of fit of each story.

Section I: Within Case Analysis

Hazel: The Man in the Mirror

Individual factors.

Over-excitability and hypersensitivity seem to be core features that influenced the development of Hazel's ED. Hazel as a highly able female has a temperamental predisposition to being intense and impulsive. Her propensity to seek stimulation may be linked to her over-excitability nature. Prior to the onset of her ED, Hazel pursued everything that she did in an intense manner. Her over-excitability cannot solely be explained as a function of her ED. Hazel is intellectually curious and this inquisitiveness motivates her to exert herself in everything that she undertakes. Hazel's intense nature facilitates her ability to pursue the rituals associated with her ED. She has the capacity to not eat for a number of days. Hazel can also tolerate the physical pain that arises from her self-induced vomiting. Her intense nature equally allows her to exercise for hours. Hazel's extraordinary energy, in essence, supports her quest to

remain unrealistically thin.

Hazel reported engaging impulsively in self-induced vomiting and self-injury. When Hazel is incapable of tolerating negative affect, she describes herself as becoming overwhelmed emotionally and engages in these acts. The intensity that Hazel brings to life causes problems as she exerts herself in an extreme manner in everything she does, hence exacerbating her natural disposition towards over-excitability. Hazel indicates that she becomes easily over-stimulated and over-aroused. The ESM forms document how the expectations that Hazel sets for herself cause extreme anxiousness which she copes with by purging.

Hazel's over-excitability also makes adapting to change difficult (Aron, 1997; Kagan, 1994). The transition to puberty was an unwelcome change. Hazel became overwhelmed with having to change schools, losing friends, and dealing with her body physically maturing. When entering adolescence she felt that she was being forced to leave childhood behind. The ED developed when all these changes were occurring. It appears that Hazel may have a propensity to stimulation over-load. Her illness, she reports, helps her to cope when too many things are occurring at once.

Hypersensitivity was another individual factor that played a role in the development of Hazel's ED. Hazel intuitively feels what people are feeling. She says that her hypersensitivity is both a positive and negative trait: positive because she can feel things profoundly and negative because she is unable to turn her emotions off. Hazel recognizes that her hypersensitivity means that she can be easily hurt and therefore she acts in ways to protect herself. Hazel's hypersensitivity also means that she is aware of others' suffering as she is very perceptive to verbal and non-verbal nuances in the environment (Clark, 1997). Miller (1994) argues that persons with high abilities possess a hypersensitivity which makes them empathetic and unable to accept injustice and others' suffering. This lends insight to why Hazel is unable to comprehend and come to terms with why people are mean and wars exist. In an informal discussion, Hazel's parents indicated that they do not exert academic expectations on her, however, being perceptive, she feels that their actions and words

convey the opposite. Her sensitive nature leads to intense negative reactions to criticism, recalling vividly painful events that occurred years earlier. Many of the incidents that Hazel recalled were ones where she was not criticized explicitly but implicitly. Through the ESM reports it was obvious that Hazel is still unable to cope with any sign of criticism.

Hazel also reacted in an intense manner to life events that she perceived as symbolizing abandonment. For instance, she was not able to accept the death of her cat. When her aunt who was visiting her family returned to her home, she felt that she was being abandoned. Hazel said that if she lost a friend it would have been so difficult to accept that she would consider killing herself. Being aware of the emotional nuances around her, caused Hazel to feel overwhelmed. In addition, her sensitive trait makes adapting to change difficult. As a result, Hazel is often in a state of anxiousness and stress.

Perfectionism interacted with other factors in the development of Hazel's ED. Hazel expressed a propensity towards perfectionism and a high achievement orientation. Trying to be perfect in everything is a means that Hazel uses to feel good about herself. As a child she indicates being praised by her parents and teachers for being obedient. This validation counteracted Hazel's belief that she was bad and shameful. Hazel did not have an internal sense of self-worth and she did not feel good about herself; therefore her sense, of self-efficacy appears to be rooted in others' perceptions of her.

Hazel feels that she needs to be perfect to secure the acceptance of her parents. She measures her achievements against those of her brother. In comparison to him she feels less important and worthy. Hazel commits herself to academic excellence but she exerts unrealistic expectations upon herself. On one ESM form when receiving 77% on a quiz she reports feeling disappointed and then dealing with her emotions by vomiting.

When Hazel falls short of meeting her expectations, she reports feeling ashamed and confused. *The Man in the Mirror* is a poem that Hazel wrote in which she conveys the burdens that she experiences by

trying to meet everyone's needs to the point that she negates her own. For instance, although in emotional pain Hazel will not confide in her peers because she does not want them to worry. Unable to share what she is feeling with others, Hazel turns to her ED to cope. Hazel revealed she does not feel intrinsically good and worthy about herself. When she accomplishes something she feels a temporary sense of satisfaction but it dissipates. Feeling good about herself is dependent upon meeting the next goal. The incessant need to be perfect at everything is stressful. The role Hazel's family had in the development of her ED is discussed next.

The family.

Hazel does not state that her family rejected emotional expression. However she does indicate as a child feeling unable to share with her parents what she was feeling. Unlike Catherine and Sheila, Hazel did not say that emotional inexpression was a contextual factor that was associated with the development of her ED. Hazel perceives that her family ascribes to a high achievement orientation. Hazel feels that her parents exert pressure on her to achieve academically. Hazel's brother is a doctor so she felt her family valued academic accomplishments although she does not say it outright. Hazel excels at many things. Despite her achievements she never experiences a sense of satisfaction from her accomplishments. She feels that her parents' love is conditional. Because she is praised for her achievements it is a means through which she secures validation. Therefore, the high achievement orientation that Hazel understands her family ascribes to is a contextual factor which seems to be associated with the development of her ED.

Based on Hazel's description of her family it appears that her parent's have an enmeshed style of parenting. Enmeshed families are excessively close and as a result there is a lack of autonomy and independence among the members. Hazel indicates that her family has always been close. As a child she remembers that they did everything together. Those raised in enmeshed families report feeling ineffective and powerless (Caskey, 1986). Hazel feels this way in relation to her family, but also feels that they do not value her because they do not listen or acknowledge her ideas. Hazel perceived herself as ineffective, non-existent,

and not important within the family unit. Hazel has always felt ineffective. She recounts incidents when as a child she was mistakenly blamed for things that she didn't do. She wouldn't assert her innocence, believing it fruitless. Hazel's sense of helplessness made negotiating the tasks of adolescence difficult. Hazel decided to stop eating partly because she felt unable to end a friendship. She stopped eating hoping her parents would notice and ask what was bothering her. Hazel's behaviour is typical of children raised in enmeshed families. They vacillate between claiming they desire autonomy and independence but act in an infantile, powerless manner (Bruch, 1988).

In enmeshed families, the parents tend to be over-protective. The children raised in these families have been sheltered and have difficulty accepting the realities of life (Calam et al., 1990). For example, Hazel feels that she has no autonomy, independence and control over her life. She said that her ED gives her a sense of control over life. When she can control what she eats, Hazel feels that she is exerting her autonomy. Her ED becomes exacerbated when she feels her parents are exerting power over her. For instance, when Hazel's parents told her that they were going to move, feeling she had no power over her parents' decision, she exerted herself by intensifying her unwillingness to eat. Unable to express the anxiety and fear associated with the up-coming move, Hazel communicated this to her parents through her ED.

Hazel has made decisions that have placed her health at risk. The predominant struggle that she presently reports is dealing with her parents' dissatisfaction about her unwillingness to eat. Hazel speaks of how she feels her parents are controlling everything in her life. They reportedly tell her what and how much to eat. If she does not comply, privileges such as spending time with friends and permission to attend extra-curricular activities is denied. Hazel feels that her parents are treating her like a child and that they do not have a right to make decisions for her. She feels that they are unfairly exerting power over her.

Hazel feels unimportant in relation to her family. Children raised in an enmeshed family have been in a protective environment where their parents have always made decisions for them (Bruch, 1988). Based

on the descriptions Hazel provided of her family, it appears that she has not had the experience of expressing her autonomy and hence her difficulty making decisions for herself. If this is the case it may explain in part why Hazel feels ineffective and powerless. The ED began as an attempt to secure a semblance of control but Hazel indicates the opposite has happened. She mentions that she is presently not free to make many of her own decisions. She continues to use her ED as a protest against being controlled by her parents. Therefore, Hazel's description of her family context fits with those of an enmeshed family (Minuchin et al., 1978) and seemingly it is a factor that is associated with the development of Hazel's ED. As a function of the poorness of fit between Hazel's individual characteristics and her family context Hazel perhaps came to experience herself as shameful and guilty. These emotions may have been associated with the development of her ED.

Emotions

Shame and guilt.

Kaufman (1991) argues that if there is a severance of trust between a parent and a child, shame is triggered. Hazel was abandoned at birth and adopted when she was a few days old. In Hazel's case abandonment signifies a form of rejection; it appeared to convey to her that she had been left behind because something was wrong with her. Hazel provided evidence that at age five she felt bad in relation to her peers. Feelings of inferiority in comparison to others is indicative of shame (Bruch, 1978; Kaufman, 1991). The antecedents of Hazel's shame appear to be related to the relationship that she has with her adoptive parents. Hazel feels that she is ineffective in relation to them. She believes that what she feels or thinks is of no consequence to her parents, and as a result she does not share her feelings with them. Several other events occurred in school that exacerbated her level of shame. She speaks of many instances in elementary school where she was publically blamed and pointed out as having done something wrong. Such incidents appear to have contributed to Hazel's sense of shame. It caused painful emotions. Not talking about how she felt left Hazel carrying these emotional wounds. As well as the erroneous belief that something was bad about

her seems to have precipitated such a response from teachers.

Now that Hazel has an ED she feels everyone is monitoring what she eats and how she looks, hence she feels self-conscious. Already feeling shameful, being monitored by others has made Hazel extremely aware that people scrutinize her actions. She reports being in a continuous state of anxiety. Hazel's sense of shame has become chronic. In the ESM forms she reports feeling ashamed even when not in the presence of others. Hazel's body weight has become a source of shame. When she entered puberty she experienced herself as small and not strong in comparison to others. She was unable to eat in the presence of others because it was a shame inducing act. Moreover, the act of purging leaves Hazel feeling a sense of self-loathing and disgust for engaging in such a demeaning, humiliating act. Purging is the only means through which she can lessen her feelings of anxiety, but it triggers feelings of shame which then lead to the next purge. The other prevalent emotion that Hazel experiences is guilt.

Lewis (1992) indicates that guilt happens when someone violates an internalized value of what is right and wrong. Hazel feels that she is morally obliged to make her parents happy. Having an ED causes her to violate this value. Hazel also feels guilty because she is the source of her parents' pain. Interacting in the world with feelings of shame and guilt, Hazel feels worthless in comparison to others. Therefore, shame and guilt appear to be two individual characteristics that were associated with the development of Hazel's ED.

Poorness of Fit

There seems to have been a discordance between Hazel's individual characteristics and the family context in which she is being raised. This may be associated with the development of her ED. Hazel has a temperamental predisposition towards hypersensitivity so she is attuned to her parents' expectations of her. She feels that their love is conditional. To secure her parents' love she felt that she had to be the embodiment of the perfect child. When she acted as a responsible compliant child, Hazel was praised. Indirectly, when

parents' support the display of an artificial persona they reinforce the belief in their children that to secure parental approval they have to be perfect (Bruch, 1981, 1988).

Hazel feels that her parents are disappointed in her because she feels that they criticize her. Hazel feels ineffective, intruded upon, and misunderstood because she perceives that her parents negate what she says. Hazel interprets her parents' behaviour towards her as evidence that she is incapable of negotiating her way through life. As a consequence, Hazel feels that she has no control over her life. In addition, having a hyper-sensitive nature, the rare times that Hazel identifies that her parents have yelled at her has left a negative impact; she conceives that nothing she does is right according to them. This reinforces her feelings of worthlessness and shame. Hazel depicts the family climate as deficient in emotional expression. If this is indeed the case, perhaps Hazel's parents may not be attuned to their daughter's hyper-sensitive nature. In essence there seemingly is a poorness of fit between Hazel's hypersensitivity nature and the style of parenting that she reports her mother and father use.

Over-excitability is a temperamental trait ill-suited to Hazel's family context. Hazel's predisposition towards over-excitability causes her to pursue all her quests with a marked intensity. Her parents' reported emphasis on achievement fuels Hazel's tendency to do things in an extreme manner. Hazel places unrealistic expectations upon herself. If Hazel had believed that her family provided her with unconditional love and validated her, she might not have developed a sense of shame and guilt about herself. If Hazel was not temperamentally hyper-sensitive she may not have reacted to her parents' criticism with such intense negative emotions. If Hazel believed that her family valued emotional expression, she perhaps would have been able to seek comfort from her parents, and not feel that she needed to hide her feelings. Being over-excitable and a perfectionist, Hazel's understanding of the family climate exacerbated her tendency of placing unrealistic expectations upon herself. Therefore, the poorness of fit seemingly is most profound between Hazel's temperament and her family context. This mismatch possibly was associated with the development

of her ED.

Pat: Going to the Edge Three Times a Day

Individual Factors.

Over-excitability and hypersensitivity appear to be associated with the development of Pat's ED. Our discussion turns to these predispositions. Pat appears over-excitabile and intense. Over-excitability is a temperamental trait that makes adapting to change difficult (Cloninger et al., 1993). Having a predisposition to high arousal, the level of anxiety that accompanies change is amplified. Pat experienced a number of changes in her life including her parents' divorce, altered living arrangements, the introduction of step-parents, and puberty. These changes were experienced with increased anxiety and intensity.

Over-excitability appears to cause Pat to exert herself excessively in her academic pursuits and eating rituals. The intensity that she brings to these tasks may be indicative of a temperamental bias to seeking stimulation. This commitment to goals is noted in persons with high abilities (Clark, 1997). When she is exposed to a lot of stimulation Pat becomes tense and anxious. As a young child she recounted having difficulty making friends because she preferred solitude and quiet. When in the presence of many people, Pat mentions that she becomes physiologically over-stimulated. Over-excitability seems to be an individual factor that is associated with the development of Pat's ED. Yet another individual factor observed in Pat is hypersensitivity.

Pat has a predisposition to being hyper-sensitive. She is aware of subtleties in her environment and is unable to ignore emotional information (Aron, 1997). From an early age, Pat has been aware of her biological father's emotional and physical absence. She was equally aware of problems in her parents' marriage. Pat's parents divorced when she was six. From that point onwards she believed it was her responsibility to ensure her parents were happy. Bruch (1973) observed that those with anorexia are over-sensitive to their parents' needs, and they often ignore their own (Bruch, 1973). Pat was completely focussed

upon her parents' well-being and she iterated that she did not deal with the emotions she experienced following her parents' divorce. Seemingly, unable to identify her own needs, she could not nurture herself.

Pat is aware of her mother's financial and emotional struggles following the divorce. Wanting to lessen her mother's burdens, Pat assumed of her own volition, responsibilities typically reserved for someone in a parental role. Pat takes on responsibilities inappropriate for her age. Claude-Pierre (1997) argues that those with ED assume roles which they are emotionally unprepared to deal with so they become overburdened. Pat expresses being overwhelmed because she held the belief that she is responsible for the well-being of her mother, father and sister. Being aware of the problems her mother is experiencing, Pat stated that she couldn't further burden her by sharing what she experiences.

Pat's responsivity to others' emotions, coupled with an empathetic nature, reveals her tendency to feel obligated to help others resolve their problems. Orbach (1986) argues that those who are overly attuned to the needs of others are unable to recognize that they are not responsible to improve everyone else's plight. When Pat was aware someone else was being judged or treated poorly she would take steps to defend the person. However, if Pat is treated unfairly she is unable to fight for herself. As a consequence, based on what Pat shared, it seems people do not respect her boundaries. Although Pat was not outwardly criticized by her parents or peers, she nevertheless does not feel good about herself and reacts intensely to any indication of rejection. A heightened emotional response is noted in highly able individuals. This hypersensitivity may be conceived as an individual trait that was associated with the development of Pat's eating disorder. Similar to Hazel perfectionism played a role in the onset of Pat's ED.

Pat feels that she is not a worthy person. Her propensity towards perfectionism became a means through which she could temporarily escape feeling bad about herself. To compensate for how negatively she feels about herself, Pat tries to be perfect in everything she does. As a child her perfectionism led her to be compliant and responsible. To further counter-act her negative feelings at the onset of adolescence, she

made a decision to excel academically. Her academic achievements were undertaken to counter-act her sense of worthlessness.

The need to be perfect at everything causes a great deal of stress and constant worry about making mistakes. For instance, in many of the ESM forms Pat reports experiencing anxiety each time that she is doing something. Pat's personal standards are so high that everything she does is anxiety provoking. Living like this makes functioning in life difficult. Any failure is perceived by Pat as evidence that she is worthless.

Therefore, perfectionism presented itself as a possible individual factor that was associated with the development of Pat's eating disorder. The role Hazel's family had in the development of her ED is discussed next.

The Family.

As a child Pat reported feeling she could not share with her mother what she was experiencing for fear of burdening her. Catherine and Sheila provide evidence that their families were emotionally inexpressive this is not the case with Pat's description of her family. The dynamics of Pat's family reportedly changed after the divorce. Her mother went back to work. Pat was aware of the added responsibilities that her mother faced. There was a change in Pat's living arrangements and she had to divide her time between the homes of two parents. Change occurred again when her mother introduced a new partner into the home. Once again parental roles and the daily routine in Pat's home was altered. These changes cumulatively caused a great deal of confusion and uncertainty. The divorce of her parents, Pat revealed, led to over-stimulation along with the reported chaotic nature of her family context. This individual factor seems to have been associated to the development of her ED.

Patterns of enmeshment within Pat's family also appeared. Pat described her family as being comprised of her mother, sister, and herself. Although her father was part of the family for a number of years and later her step-father became a member of the family, Pat does not refer to them as occupying a place in

the family unit. Before her parents' divorce, Pat shared that her father was rarely present. In contrast, Pat related her mother was a constant presence. Although Pat does not directly say she was her mother's confidante before the divorce, it can be inferred from other things that she said. For instance, Pat was aware of the tension between her parents while they were married. Based on what Pat shared, it emerged that her mother spent most of her time with her children. During this time, Pat perceived her mother to be unhappy and she responded by trying to become her mother's emotional support system. Pat does say that following her parents' divorce she was her mother's partner, in that she assumed the emotional role and responsibilities that she feels should have been fulfilled by her father.

Following the divorce, Pat felt the relationship between her parents was not congenial. Pat understood herself to be the mediator through which the two communicated. She found this role overwhelming. She recalls feeling like a messenger but she was unable to tell her parents that she was emotionally overburdened. Bruch (1988) writes that those who develop an ED as children assume a position in the family of responsibility. Often they want to make their parents happy, but are afraid this is too unbearable a demand for them to fulfill. Pat felt this way but was unable to express it to her parents because she did not want to further burden them, believing they were already coping with many problems.

Pat insists that her parents did not intend to cause her distress. Repeatedly in the interviews she is "conflicted" talking about the role her parents played in the development of her ED. It was important for Pat to feel that I understood that she does not hold her parents responsible for her ED. We find this tension in the literature on women with ED. There is a tendency to be overly concerned with the emotional well-being of their parents and such women do not blame their parents (Bruch, 1988).

Following the divorce, Pat alleges her mother's life became more focussed on her children. For a period of time, her mother rarely participated in social outings. Friends would come to the house. The picture emerges of a mother who was very concerned about her children but, as Bruch (1988) describes such women

as mothers having no personal life of their own. The result is over-involvement with their children. If Pat was raised in an enmeshed environment, she had no opportunity to assert her independence and test her abilities. Pat did say that her mother had always been over-protective. This dependence provokes problems in every phase of development. For example, when Pat began school she experienced a great deal of distress because she missed her mother. Her anxiety of being away from her mother did not dissipate. She had been used to being in the presence of adults, therefore, Pat found it difficult to make friends and be comfortable with her peer group. Being raised in an enmeshed family, children are not given the proper tools to negotiate their way through adolescence as they tend not to be able to make independent choices and function autonomously.

During the data collection phase, Pat was struggling with her anorexia. She was having great difficulty eating. She was continuously preoccupied with how she could avoid eating in the presence of her mother. When at school she found it easier to restrict her intake than at home. The ESM forms document that each time Pat is forced to eat she feels ashamed, guilty, not good about herself, anxious, and not in control. Eating has become a chore, something she must do. The sense of ineffectiveness that she feels in relation to controlling what she eats is ever present. Bruch (1988) reported that in enmeshed families the person with the ED tries to exert control over her life through the ED because she feels this is the only means through which she can exert her independence. Pat clarified that when she feels that she cannot control anything else, she knows that she can control what she eats and this gives her a sense of power.

Based on Pat's description of her family, it appears that she was raised in an enmeshed family; thus, this may have played a key role in the development of Pat's ED. As a function of the poor fit between Pat's individual characteristics and her family context, Pat may have come to experience herself as shameful and guilty. These emotions seem to have been associated with the development of her ED.

Emotions

Shame and Guilt.

The origins of Pat's shame are more difficult to ascertain than for the other three women. As previously mentioned, Pat is the least insightful about her ED since she has just recently begun to reflect on what it means. Pat does not provide any evidence that her parents criticize, reject, or place expectations upon her, all of which are reported sources of shame. What is known is that early in life Pat felt the tension between her parents and was aware of her mother's unhappiness after the divorce. However, Pat did not share with her parents that she was experiencing these emotions; therefore, they could not help her. Shame can originate when a child's needs are not responded to by their care-takers (Kaufman, 1991). Both of Pat's parents, particularly her mother, may have been in so much emotional distress that she was unable to see Pat's mental anguish.

Entering adolescence, Pat already felt ashamed about herself and then a pivotal event reinforced this feeling. Born pre-maturely, she has always been small in stature compared to her peers. The growing awareness of her body coincided with being rejected by a boy because she was not physically developed. From that point onwards, Pat developed a sense of shame about her body and soon after, her ED began. Pat feels ashamed of her ED. She is hyper-vigilant to hide her AN. She believes having an ED signifies weakness and because she wants people to see her as solid and dependable, she will not share what she is feeling. Pat says that she adopts different personas depending on whom she is interacting with and she wears a mask because of this shame. The source of Pat's present guilt is also her ED. She repeatedly reports in the ESM forms of feeling guilt because her ED is causing distress for her mother. Guilt arises when a person is disappointed in themselves or when they feel that they have violated an internal code of behaviour (Kaufman, 1991). Pat believes that she should not be the source of pain for others and hence, feels guilty for transgressing this code. Those with ED do not feel worthy of all that they have been given and experience

remorse in joyful occasions (Bruch, 1988). Speaking of her childhood, Pat says that she feels guilty because she was given material things. Her current level of self-loathing prevents Pat from accepting help for her ED because she believes she is not deserving.

Poorness of Fit

There appears to be a poorness of fit between Pat's individual characteristics and the family context in which she is being raised. Pat is hypersensitive and indicates being fully aware of the problems in her parents' marriage. It is plausible that had Pat not been hyper-sensitive she would not have sensed everything so intensely and therefore, may have not felt the need to improve her parents' plight. Pat felt she was the mediator between her parents. Being the mediator exacerbated the level of stress that she was experiencing. Pat indicated that she and her mother have always been close to each other. If Pat was raised by a mother in an enmeshed relationship this could have increased her knowledge of her mother's distress. Perhaps, if her mother had been aware of Pat's disposition, she may not have turned to her as a confidante. Likewise, if Pat had a different temperament, she may not have been as emotionally affected by her mother's distress.

Pat has a predisposition to being over-excitabile that makes adapting to change difficult. The enmeshed style of Pat's reported upbringing exacerbates her inability to deal with change. As a result Pat has not learned to assert her independence and function autonomously. This makes any transition that Pat experiences more traumatic. For instance entering school was difficult for Pat. She was confronted with the need to make friends and function without the presence of her mother. Likewise, Pat's transition into adolescence presents her with the need to act independently. Had Hazel felt that she had been given the opportunity to test her abilities, she would have learned skills which would have helped counteract her natural disposition so when confronted with change, she might cope better.

The events that transpired in Pat's home led her to assume inappropriate roles for her age. Had Pat not been over-excitabile or had the family context been different she may have not pursued or felt

responsible to assume such demanding roles. Within the family unit there were reportedly many difficult life changes. Therefore, the seemingly poor fit between Pat's temperament and her family context is profound. This mismatch could be associated with the development of her ED.

Sheila: Leaving Food Behind

Individual Factors.

How over-excitability and hypersensitivity may be associated with the development of Sheila's ED is discussed. Sheila presents herself as intense and impulsive. Every aspect of Sheila's life, including work, food, emotions, and behaviours is undertaken in an excessive manner. Although recovered, Sheila still pursues everything with intense energy. The ESM reports document the intensity that she brings to her life. The need to remain stimulated and the intensity with which she engages in activities, is excessive. Sheila's intensity mirrors that of high ability individuals who pursue their goals with a passion. She wanted to be thin, popular, smart, and accepted. She was committed to her goals and would not relinquish what she wanted. She is capable of sustained persistence in order to achieve her goals (Caruso et al., 1989; Lovecky, 1994). Impulsivity is common among those with BN and Sheila's impulsive nature made adjusting to change difficult. Unfortunately, her life has been full of change. She lost two maternal figures. In addition, her family moved often, so Sheila lost friends and changed schools repeatedly.

Sheila's mode of behaviour suggests a predisposition towards over-excitability, intensity, and impulsiveness. These traits make it difficult for her to adjust to change and then stress ensues. Coupled with Sheila's tendency towards exertion and excess, her stress level is compounded. Being over-excitabile appears to be an individual trait that seems to be associated with the development of Sheila's ED. Yet another individual factor observed in Sheila is hypersensitivity. Hypersensitivity is a trait that transpires in interpersonal awareness (Mendaglio, 1994). Sheila states that from birth she has been intuitive and sensitive. This causes her to respond with intense emotions to every event in her life. Having a heightened emotional

response, Sheila responds to criticism in an extreme manner. She reported experiencing emotional abuse which left her feeling stupid and shameful. Sheila indicated she was ridiculed for her hypersensitivity. Her father noticed Sheila's weight gain which had a lasting adverse effect upon her. According to Sheila, being introspective and intuitive caused difficulties. She was aware of the nuances, both verbal and non-verbal, expressed by others. Any glance or comment made by others she couldn't overlook. Being intuitive and empathetic, she felt compelled to improve the plight of others. When unable to act effectively she had difficulty reconciling with this reality and as a consequence experienced profound sorrow. Sheila's awareness of the emotional drama in her family meant that she could not censor incoming information, so she became easily overwhelmed. Unable to deal with criticism and ignore the emotional nuances in her environment, Sheila seemed to be in a constant state of over-stimulation. Similar to Hazel and Pat perfectionism played a role in the onset of Sheila's ED.

Sheila has a propensity towards perfectionism. The expectations that she placed upon herself were unrealistic. She reports being the model daughter, thoughtful, caring, and demanding nothing. As an adolescent, her perfectionism extended to her body, sports, and relationships with her peers. Sheila extrapolated her quest for perfection to her body. Having a propensity to over-excitability seems to have been associated to the rate and intensity in which Sheila pursued perfectionism. Sheila reported that her father only validated her achievements. Sheila's tendency towards perfectionism may have been exacerbated by his mode of reported behaviour. Sheila derived little satisfaction from her accomplishments. They were a means to avoid rejection and secure approval. Trying to perfect everything caused a great deal of anxiety in Sheila. The role Sheila's family had in the development of her ED is discussed next

The Family.

Sheila indicated her parents showed no emotional affection for their children. She describes, her father, as physically present but emotionally absent. Lack of warmth and empathy on the part of a parent is

often noted in eating disordered families (Calam et al., 1990). According to Sheila, when her father did express affect, it was negative. She said, he told her that she was dumb, stupid, and incapable of doing any thing right. Sheila had been abandoned twice by two maternal figures. She needed support, understanding and someone with which she could share her feelings with. Unfortunately, as Sheila surmised, her family context did not provide these supports. Hence, Sheila never dealt with the sense of loss and confusion from being abandoned. Unable to talk to her father about why her mother had left, Sheila came to the conclusion that she must have been bad, or that something was wrong with her that caused her to be abandoned. She revealed, her father's emotional abuse only served to reinforce what she felt about herself.

Sheila is naturally sensitive and emotional. When she ventured to express herself, she reported being ridiculed by her siblings and parents. Sheila incorporated the message that her natural predispositions were shameful. Once again, Sheila perceived being sent the message that there was something wrong with her. She came to believe that her emotions and perceptions were wrong. As a consequence, she rejected them and began to hide her true self. Sheila depicts her family environment as chaotic.

Confusion in Sheila's life began in her early years. She was abandoned at birth. After 23 days she was adopted. Sheila was raised in a large family. There were six children. At seven Sheila's adoptive mother abandoned the family. Her father was left to raise six children. The climate in the home, according to Sheila, was chaotic. There was a lot of yelling and fighting. Surrogate maternal figures moved through Sheila's life. In addition, every two years the family would relocate and they were financially strained. Among the members of the household, Sheila said, boundaries were missing. Siblings would freely enter each other's rooms and destroy belongings. Within the home, there was a lot of anger. All the children were unhappy and trying individually to survive. Sheila described her family as hostile, conflictual, and disorganized; characteristics seen in the families of those with bulimia (Strober et al., 1987).

Another feature of a chaotic home environment is that it does not support or care for its members

(Garner et al., 1985). For example, when Sheila lost 20 to 25 pounds in a month and then developed bulimia, she reported that her father did not notice. His lack of response confirmed for Sheila that she was emotionally alone with no family support network to help her negotiate her path in the world. Sheila responded by trying to secure the presence of other people around her. As an adolescent, she turned to close friends for emotional support. As a perceptive person, she was aware that her peers valued people who were attractive and popular. She became the personification of the perfect woman and, in this way, she believed that she could secure the presence of others. The need to always have someone around arose in Sheila, perhaps, as a consequence of not having felt unconditional love from her family. As Sheila entered adolescence, fears and anxieties prevailed. In childhood, she had experienced a number of traumatic events that she never dealt with. At 15, she moved to another environment and became emotionally overwhelmed with no adult figure to support her. Perhaps had Sheila been raised in a family that was stable, she would have had the support that she needed to discuss what she felt and tend to her own emotional wounds. The high achievement orientation Sheila's family ascribed to seems to have contributed to the development of her ED.

Love, Sheila indicated, in her family was conditional so she learned what to do in order to secure it. She reported being validated by her family for her accomplishments. According to Sheila, her father's mode of behaviour served to reinforce her belief that to be loved meant that she needed to be perfect. The perceived value placed on high achievement was associated with the development of Sheila's ED. She said others' praised her for doing well in school, excelling in sports, and leadership roles. Partly, the poor fit between Sheila's individual characteristics and her family context seems to have caused Sheila to experience herself as shameful and guilty. The reported value that Sheila's family placed on a high achievement orientation also appears to have been associated with the development of her ED. Shame and guilt were emotions that played a role in the development and maintenance of Sheila's ED.

Emotions

Shame and Guilt.

Since childhood, Sheila felt a sense of shame about herself. First, Sheila indicated her sense of trust was severed when her birth mother abandoned her. According to her the second and more profound severance of trust occurred when she was seven and her adoptive mother left her. Sheila embraced the notion that something was wrong with her because two mothers had left her behind. Sheila's sense of shame could have been cultivated by how her parents related to her. Both parents reportedly did not provide unconditional love. They accepted Sheila only when she behaved as a model child. Mostly, Sheila recalls she that was yelled at, belittled, criticized and told nothing she did was good enough. Being treated this way added to Sheila's belief that something was wrong with her. Emotional expression was according to Sheila not valued in her family. So when she reacted emotionally Sheila shared that she was mocked, ridiculed by her siblings, and punished by her parents. Being treated this way further solidified Sheila's belief that something was wrong with her. She came to believe that she was worthless and shameful. When the shame became chronic, her sense of self was thwarted. Sheila became disconnected from herself and from her core beliefs. The other prevalent emotion that she experienced was guilt.

A sense of guilt surrounded Sheila. As a child she felt guilt because her dog died, her siblings spent too much money, and because her family was unhappy. Sheila believed that it was her responsibility to prevent all these things from happening, and when she couldn't, guilt ensued. Guilt also arose when Sheila experienced pleasure. She believed herself to be a bad person and hence undeserving of pleasure. Sheila consciously denied herself the things that brought her enjoyment. This meant she was incapable of appreciating her qualities, such as her beauty, intelligence, and compassionate nature. She believed these gifts had to be atoned for because she felt not worthy of them. In light of the literature which reported feelings of guilt observed in people with EDs, behaviours such as over compliance, self-denial, self-control and

being reserved were evident (Casper et al., 1992; Pryor et al., 1998; Strober 1980). Sheila interacted in the world with a sense of shame and guilt. Living with these emotions, she experienced herself as worthless in comparison to others. Shame and guilt were two individual characteristics that appear to have been associated with the development of Sheila's ED.

Poorness of Fit

The mismatch between Sheila's needs and her family seemingly appear to be pervasive. Sheila reported in her home, positive emotional expression was absent. She felt her parents did not provide unconditional love and the only way that she could secure it was through her accomplishments. She was ridiculed for being sensitive. Perceiving being abandoned twice and experiencing verbal abuse left emotional wounds. Sheila's temperamental disposition of hypersensitivity appeared ill-suited to her family context. Being interpersonally sensitive, intuitive, and introspective, Sheila was aware of the constant emotional turmoil in her family. Hyper-sensitive, she responded to the negative events that took place in the household with a heightened intensity and perceived a need to atone somehow.

The reported family context was chaotic. Sheila's over-excitability meant that she was predisposed to being intense and impulsive. The constant chaos caused stimulus over-load. Therefore, the climate of her home may not have been well suited to her innate tendencies. The family context surfaced as being crucial in the development of reward dependence, harm avoidance, and perfectionism all of which emerged from the data as thwarting her development. Because she wanted to secure approval, Sheila tried to perfect herself. This meant that Sheila denied her own needs and developed a persona. Being hurt often as a child, she became driven by the need to avoid harm. Part of avoiding harm meant hiding her emotions, thus, Sheila never dealt with anything she felt. It was stated by Sheila that her perfectionist nature was rewarded by the family. She was praised and validated for her accomplishments and work ethic. Supposing this was the case, the family may not have helped Sheila to set appropriate expectations so that she would not become burdened

by the need to be perfect at everything. Her guilt and shame also arose from the way that she was treated in her family. To deal with these emotions, she developed a number of defensive strategies that rather than helping her cope, caused more harm. As she entered adolescence, Sheila indicated that she did not have a stable anchor in her family. The uncertainty of adolescence, coupled with all that had transpired and how it had left her feeling reached a threshold. She responded by turning to an ED to cope with her emotions.

Had Sheila felt her family provided her with unconditional love and accepted her as she was, she might not have developed a sense of shame and guilt about herself. Had Sheila not been hyper-sensitive, she might not have reacted to the reported chaotic family climate with such intense negative emotions. Moreover, had she believed that her family was supportive, Sheila may have been able to seek comfort from her parents and not feel that she needed to hide her feelings. Being over-excitabile and a perfectionist, the family climate appears to have exacerbated the tendency Sheila had to placing unrealistic expectations upon herself.

Catherine: Getting Down to the Bone

Individual Factors.

How over-excitability and hypersensitivity may have been associated to the development of Catherine's ED is discussed next. Catherine demonstrates intensity and curiosity in all aspects of her life. One form of her intensity is her quest for knowledge. Catherine is a voracious reader who has always had a hunger to understand. From an early age, she had a propensity to retreat from the world through books.

Over-excitability led to excess in every area of Catherine's life including reading, writing, food habits, emotions, and behaviours. Her intensity can be observed in her ESM reports. She becomes so immersed in her writing and/or thoughts that she forgets to eat. As a child, her imagination was so intense that she would get lost in her own world and, as a consequence, could not negotiate the pragmatic aspects of life. This behaviour mirrors the over-excitabile imagination noted among high ability individuals (Piechowski, 1994). Catherine's adherence to a spiritual quest, rituals of not eating and denying herself anything pleasurable

seems also to be linked to her intense nature. Anorexia for Catherine is a form of excitement. When not eating, she alludes to experiencing an inner intensity which she describes as “living on the edge”. Feeling this way she can work vigorously and at a productive pace. When she eats, the sense of over-excitability lessens and so does her level of productivity. Catherine reports in the ESM forms that being relaxed is an uncomfortable state for her. In contrast, when not eating she feels a sense of impulse/enthrallment. The natural need to remain stimulated can be seen as lending evidence to her temperamental disposition towards over-excitability.

The intensity with which Catherine does things has caused problems . She decided not to pursue a Ph.D. because of her inability to cope with stimulus overload. She seeks excitement but becomes physiologically overwhelmed by it. In the ESM forms, she reports feeling jangled, tense, and anxious when a number of things take place simultaneously. At such times, she finds it difficult to eat, her throat constricts and she cannot swallow. Her over-excitability and intensity have made coping with the logistics of life difficult. She becomes over-aroused and stimulated physiologically when too much is transpiring in the environment. The rituals of anorexia help calm her. Yet another individual factor observed in Catherine is hypersensitivity.

Catherine indicates that her hypersensitivity played a significant role in the development of her ED. Catherine believed that she was not what her parents wanted. At an early age, she felt the stress and anxiety of trying to become someone that she thought her parents would approve of. Catherine is introspective and intuitive and seems to have felt that her parents presented artificial facades. She sensed that her mother and father were discontent. Had Catherine not been born hyper-sensitive perhaps she would not have reflected nor understood as profoundly the emotional nuances in her family. Catherine’s highly perceptive nature left her feeling smothered and overtaken. She would lie awake at night worrying about things people had said to her.

As a child Catherine revealed she was criticized for being imaginative. This left her feeling ashamed about her natural dispositions. She was further emotionally wounded by her parents' belief that the anorexia was a selfish act. In truth, Catherine iterated that her AN is a means of coping with her sense of worthlessness. Catherine has always been drawn to literature especially poetry. Nature provides solace so as a child to escape the family climate, she would run to the outdoors. The ESM reports document that Catherine still seeks comfort in nature when in distress.

Catherine articulates that she has difficulty adapting to the world because of its value system (ambition & materialism) that is incongruent with her value system (truth & integrity). Catherine's AN is a means through which she can reject that which is worldly. She said that her illness is a spiritual quest which allows her to remain committed to her value system. Catherine's ED appears in part to have developed because it was a means through which she sought solace from not having her emotions and imagination understood. Perfectionism interacted with other factors in the development of Catherine's ED.

Catherine reports that she feels her propensity towards perfectionism was exacerbated by her family. Moreover, she felt driven by her parents to achieve and Catherine believed it was the only means by which she could secure acceptance from them. Her parents she felt modelled perfectionism. Her mother is described as industrious, well-mannered, and beautiful. In addition, her father was a successful surgeon and a outstanding athlete. No matter what Catherine accomplished, she believed it was never enough for her parents but she continued to try and fulfill their expectations. The perceived pressure to be perfect instilled a fear and anxiousness in her. She became overwhelmed by all the things she thought that she needed to perfect.

Conscientiousness and discipline are behaviours that Catherine indicates were taught to her in childhood. As an adult when she is not doing something 'productive' Catherine feels uneasy. The ESM reports provide evidence that Catherine has a strict writing routine that she has difficulty deviating from.

When she is unable to accomplish what she sets out to do, she feels tense and frazzled. Catherine's disciplined nature may have been associated with her anorexia. She sees eating as an undisciplined and indulgent act. For instance, when eating Catherine refers to herself as being in 'meaningless mode'. In contrast, when she is not eating, she feels that she can work and accomplish more. Attempting to be perfect in everything seems associated to Catherine's stress and anxiety and made coping with the logistics of life overwhelming. The role Catherine's family had in the development of her ED is discussed next

The Family.

According to Catherine, her parents did not demonstrate any affection. Her mother was physically present but emotionally unavailable, interacting with Catherine only at a superficial level. Catherine's father was a busy surgeon who, when at home, Catherine felt he kept an emotional distance from his children. The lack of warmth and empathy is typical in the families of those with anorexia (Bruch, 1981; Calam et al., 1990). Catherine's parents were depicted by their daughter as hiding behind a veneer. They were perceived as an aristocratic, well- educated, cultured, and a happy family. Catherine describes her parents as not wanting others to see them as anything less than perfect. The portrait of her parents emerge as people ill at ease and incapable of acknowledging their own feelings and, hence, perhaps uncomfortable with Catherine's propensity towards emotionality. Perhaps they also feared that Catherine was able to penetrate their veneer and see what they did not want exposed. Therefore, her parents conveyed that they did not tolerate the expression of emotions. Being hyper-sensitive, Catherine was prone to react with intense emotions to life events. Aware, that her parents did not condone emotional expression, Catherine suppressed her feelings believing that they were something to be ashamed of.

When Catherine's AN was discovered by her parents, their reaction left Catherine feeling misunderstood. She needed her parents to tell her that she was loved even if she wasn't perfect. According to Catherine, had her parents recognized and valued emotions, they may have understood that her AN arose

because she did not feel good about herself. The high achievement orientation Catherine's family ascribed to seems to have contributed to the development of her ED.

Catherine's parents are described as ascribing to a high achievement orientation. Everything in her home was a test of competence. Her parents valued discipline and believed a person's worth was measured by her accomplishments. Catherine felt none of her achievements were good enough to please her parents. This left her believing that she was worthless and a failure. The reported high achievement orientation instilled in Catherine as a child seems to still influence how she behaves today. Other studies have found that women who have recovered from an ED continue to function in ways that their parents would approve of (Dally, 1984). Catherine has chosen as her life's work to be a writer but she feels a sense of guilt about this decision because it is something she believes her parents would not see as an accomplishment. Catherine still experiences a sense of shame if she is not achieving something. In the ESM forms, she reports feeling guilt even when relaxing. The anxiety and stress of trying to achieve surfaced as possible emotions that may have been associated with the development and maintenance of Catherine's ED.

The description Catherine provides of her family is one of enmeshment. It appeared to function as a unit. Her parents reportedly expected their children to ascribe to the same values and goals that they held. It seems that Catherine's parents did not value their children's individuality. If this was the case, they may have been unable to acknowledge Catherine's nature and negated her propensity towards being imaginative and emotional. In this way, they did not support Catherine's autonomy. This is a common tendency in enmeshed families (Friedlander et al., 1990; Strober et al., 1987). Catherine speaks of being raised in a constrained environment where she felt unable to express herself. Catherine's mother is described as very controlling. According to Catherine, she dictated what her children did and with whom they were allowed to associate. Again Catherine believed that she was not permitted to express her individuality and this left Catherine feeling powerless and ineffective within her family context.

Entering adolescence, Catherine confronted the need to establish an identity. She became overwhelmed because she had no experience in expressing her opinions, beliefs, and values. The ED developed partly as a response to the stress, anxiety, and sense of powerlessness that she felt within her family context. Catherine believes that she was never encouraged to express her individuality and, as a consequence, she did not develop an identity which made adapting to adolescence difficult. The obstacles of this phase of development appear to have been dealt with through her ED. Partly, the poorness of fit between Catherine's individual characteristics and her family context, led her to experience herself as shameful and guilty. The role emotions had in Catherine's ED are discussed next.

Emotions

Shame and Guilt.

From a young age, Catherine felt a sense of shame about herself. She believed that she was evil. Catherine's sense of trust in people may have been severed because she felt her parents failed to provide unconditional love, along with ridiculing and criticising her for being emotional and imaginative. Temperamentally, Catherine was a sensitive child. Her parents are depicted as demanding that she deny this element of herself. As a result, Catherine alluded to the fact that she came to see her predispositions as shameful and therefore, suppressed them. In this way, she rejected and disconnected from parts of her true self.

Catherine wrote of being "hounded" by a sense of guilt, because she believed that she violated and failed to fulfill the values or code of behaviours instilled by her parents. She experienced guilt for being self-indulgent, for doing things that brought her pleasure such as writing, reading, and being imaginative. Catherine's sense of guilt extrapolated to eating. When she did eat feelings of being self-indulgent and selfishness arose. This vicious cycle perpetuated itself. Guilt arose each time Catherine experienced pleasure. Believing she was bad and evil she felt that she was not deserving of anything that brought her satisfaction.

This caused her to sabotage many things in her life. To this day, she has not profited or claimed her talents or the rewards associated with her hard work in part because she still feels undeserving of them. Catherine continues to interact in the world with a sense of shame and guilt. She often feels worthless in comparison to others. Although a mature woman she cannot completely rid herself of these emotions.

Poorness of Fit

Catherine's parents are described as practical, achievement orientated individuals. Catherine believed that they did not value the expression of emotions. She did substantiate this claim by saying that she did not receive any physical or emotional affection from them. There appears to be a mismatch between Catherine's hyper-sensitive nature and her parents reported lack of emotional expression. Those who are hyper-sensitive are able to understand the emotional nuances in the environment. Being perceptive, Catherine felt that her parents did not unconditionally accept her. She understood that to secure their approval she had to fit her parents' image of what she should be. This meant suppressing her feelings. Being intrapersonally sensitive, it was hard for her to reconcile with the fact that she was presenting a false persona to the world.

Catherine's parents' reportedly lack of conditional acceptance may have lead her to develop the personality characteristics of reward dependence, harm avoidance and perfectionism. Like Hazel, Pat, and Sheila, the stress and anxiety of feeling the need to secure approval from her parents caused Catherine to be in a constant state of anxiety and worry. Catherine was also driven by the need to avoid harm. Fearing rejection she had a difficult time getting emotionally close to people. This left her with no emotional support system. Catherine was a perfectionist and her family construct is described as exacerbating this tendency. When she reached adolescence, Catherine felt overwhelmed with the intensity of her emotions. She felt that had her parents valued emotional expression, they would have been attuned to her feelings.

There also appears to be a discordance between the values Catherine held and those of her parents. Catherine describes her parents as concerned with wealth, image, and achievement. Catherine rejected the

value of materialism; her quest was for an inner truth. As a child, Catherine felt forced to act and behave in ways incongruent with who she wanted to be. She reported that her mother controlled who she could associate with and Catherine indicates that she tried to instill in her children that her family held a nobler place in society. It seems from Catherine's depiction of her mother that she was incapable of entertaining the thought that her daughter could have a different belief system than she did. Catherine reported as a child she felt trapped in a home that valued the opposite of what she did.

Believing she was not unconditionally accepted by her family, Catherine came to believe that she was shameful and guilty. To cope with these emotions she developed a number of scripts which rather than helping her cope with life, caused greater shame. Had Catherine felt that her family could have provided her with unconditional love and accepted her as she was, she may not have developed a sense of shame and guilt about herself. Had Catherine not been hyper-sensitive, she may not have reacted to her perceived parents' rejection with intense negative emotions. If Catherine's family had been more emotionally expressive, she may have been able to seek comfort from her parents and not feel that she needed to hide her feelings. Therefore, being over-excitabile and a perfectionist, the family climate seems to have exacerbated the tendency Catherine has to placing unrealistic expectations upon herself.

Section II: Between Case Analysis

Portraits of Four Persons with Bulimia and Anorexia

Sheila was the only participant who had recovered from her ED. She was not diagnosed with BN/purging type but provided evidence that she would have met the DSM-IV criteria for this disorder. Pat and Catherine also were not formally diagnosed but met the criteria for AN/restricting type. A psychiatrist diagnosed Hazel with AN/ binge-eating/purging type. When eating Sheila lacked control and ate in a short period of time an inordinate amount of food. She used compensatory behaviours such as self-induced vomiting and excessive exercise to avoid weight gain. Her self-evaluation was influenced by her body shape

and weight. She engaged in bulimia even when not in phases of anorexia.

Hazel, Pat, and Catherine met the criteria for AN. They refused to maintain an appropriate body weight in light of their age and height. All had an intense fear of being fat. Although emaciated, all at some point in time thought they were fat because they had a distorted body image. None indicated they had amenorrhoea; however, given their body weight it is likely at some point they experienced it. Hazel had BN/binge-eating/purging type because in periods of restricting she would purge and/or binge and use laxatives. Pat and Catherine had AN/restricting type because they did not binge, purge or use laxatives.

The four sustained physical symptoms such as problems sleeping, being underweight, feeling weak and dizzy. All, with the exception of Pat, indicated suffering from sore bones and feeling cold. Pat was less forthcoming with information because she had only recently began to acknowledge that she suffered from an ED. Sheila and Hazel experienced symptoms associated with BN such as stomach pains (bleeding) and sores in their mouths (from repeated vomiting).

Persons with EDs present cognitive distortions. As a group the women denied being underweight. They ignored body signals. All believed that revealing their emotions was dangerous. The majority of their thoughts focused on the worst possible outcome of any situation. These same distortions and symptoms are seen in others with EDs (Bruch, 1988; Crisp, 1965; Brownell & Fairburn, 1995). The behavioural symptoms these women displayed were the following: a preoccupation with anything associated with food, over-hyperactivity (occupying their days by keeping busy), having difficulty eating in the presence of others, and denying themselves anything pleasurable.

Individual Factors

There exists psychological elements associated with being a woman: the need to care, nurture and to relate. What follows is a discussion of how these elements may have been associated to the development of each woman's ED.

Female Psychological Development.

Women have an ethic to care and nurture others (Gilligan, 1982). The family dynamics reinforced this tendency in Sheila and Pat. When Sheila's six siblings were left with no maternal figure, she assumed the caretaker role. When Pat's parents divorced, she took over her father's position in the family, feeling responsible for her mother and sister's happiness. Fulfilling the wishes and/or needs of others is common in those with ED (Bruch, 1978). In some women the nurturer role overtakes their need to care for themselves particularly in adolescence (Belenky et al., 1986). From an early age the women were adept at denying their own needs. This tendency increased in adolescence and appeared as a function of feeling worthless and shameful. These feelings fuelled each woman's need to please others because it appeased their sense of not being loveable.

For women, having quality relationships is fundamental to their sense of well-being (Belenky et al., 1986; Gilligan, 1982). For Sheila and Hazel, when the threat of a relationship ending arose, so did the fear of abandonment. This trepidation seems to have been rooted in their perceiving rejection and abandonment as children. Catherine felt that her parents did not accept her unconditionally. To secure a relationship with her parents she tried to become the embodiment of what they wanted. This meant that Catherine believed she had to hide her authentic self, part of which were her emotions. Catherine did not share what she felt with her parents because she feared being punished for being sentimental. On the other hand, Pat's relationship with her mother was excessively close; Pat felt she was an emotional support system for her. Pat did not confide in her mother or others because she did not want to burden anyone.

Elements of female psychology such as caring, nurturing, and relating are part of healthy female development but women should not abandon their voice, their authenticity. However, in the four cases, the women chose caring, nurturing and relating for the purpose of securing the approval of their families and/or others at the cost of neglecting self; their own well being. As a consequence, they did not nurture themselves

and experienced anxiety associated with the perceived responsibility of having to meet everyone else's needs.

In this study, temperamental predispositions were ascertained by an examination of the behavioural quality of emotions and actions during the childhood years (Kagan et al., 1993). Personality characteristics were identified when demonstrated behaviours or emotions were mostly a function of social interactions and life experiences (Thomas et al., 1989). With these caveats in mind, what follows is a brief discussion of the common temperament and personality dispositions observed in these women. In the within case analysis, the temperament and personality of each participant is profiled because they emerged as two of the most significant individual factors that seem to have influenced each woman's ED.

Temperament and Personality.

The four women presented three common personality characteristics: reward dependence (RD), harm avoidance (HA), and perfectionism. All four women also possess the temperamental dispositions of over-excitability and hyper-sensitivity. How each of these are associated with their ED is discussed next.

Reward dependence appeared as a personality characteristic because its development seems to have been a consequence of the dynamics within the family context. Sheila and Catherine outwardly expressed that as children they did not receive unconditional love from their parents. Both reported being validated and acknowledged for behaving as model children. Likewise, Hazel believed that her parents expected a lot from her and were not pleased with her. Pat, in part, was compliant, kind and a good student because it was a source of pleasure for her mother. Bruch (1988) observed that those with ED are praised for being model children and parents reinforce their daughters' belief that to be loved and accepted they have to be perfect. Holding such a belief system was associated with the women engaging in behaviours that would secure approval. This coincides with other research that found such belief systems in persons with eating disorders (Casper et al., 1992; Shaw et al., 1997; Strober, 1981).

Individuals with ED have a profound dissatisfaction about themselves (Bruch, 1988). Hence, any source of external approval serves to counteract the negative feelings that they hold of themselves. In this way being acknowledged and praised by others was a source of reward for these women but in a transitory way because they did not have an inner sense of worth. Therefore, each felt the need to be continually acknowledged which motivated them to repeat past behaviours that were rewarding. The four women were hyper-vigilant to avoid demonstrating any behaviour that would not secure approval. They rarely shared their feelings for fear of being rejected. As children they reported not being encouraged to be honest or to communicate what they were feeling and in this way they were reinforced for presenting a persona or artificial front (Bruch, 1988). This occurred in all four women as they refrained from showing their parents how unhappy they were. Problems arose and since they did not share their feelings, they were never validated for what they honestly felt. Part of healthy childhood development involves parents sending the message to their children that they are understood, that their feelings are valued and important. The women described being raised by parents who did not welcome their feelings. They became adolescents and adults who held pain and anger because they felt their emotions were not acknowledged. As adults the women did not learn to recognize their intrapersonal needs and, hence, were in a constant state of confusion because they were not in tune with their emotional needs. These four women could not satisfy their emotional needs because they were unable to acknowledge them. The result was a cumulative build-up of negative affect. Once the women reached adolescence having no sense of self, they felt ineffective and unable to make decisions on their own. Feeling overwhelmed and experiencing negative affect, each dealt in her own way with these emotions through the ED. They developed into adults who felt they had not been treated as autonomous independent people.

Harm Avoidance (HA) is a temperamental predisposition. In all the cases, HA appeared as a personality characteristic because its development was a consequence of life experiences and dynamics within

the family context. These four women experienced traumatic events at a young age that left them emotionally hurt and fearful of the world. Sheila perceived being abandoned by two maternal figures. Catherine felt she was rejected by her parents. Hazel felt psychologically abandoned and conditionally loved. Pat was affected deeply by her parents' divorce. The families of women with ED seem not to encourage the expression and affirmation of the autonomy of their children. As adults, the women felt a sense of emptiness and uncertainty about themselves because they did not develop a positive sense of self-worth and felt helpless (Bruch, 1988). They lacked an internal sense of self-worth and so they interacted in the world in a manner to avoid experiencing rejection or criticism from others.

All four women believed it necessary to deny their emotions in order to avoid harm. Sheila and Catherine believed that their parents did not tolerate the expression of emotional affect. When Sheila reacted emotionally, she reported being ridiculed and mocked. Catherine indicated that she was told that she was selfish and silly. Hazel feared telling her parents how she felt because they would abandon her. Pat hid her emotions because she wanted to be seen as solid and reliable. Pat believed if others were privy to her true emotions, that they would see her as weak and this would make her vulnerable to being hurt. The need to keep emotions hidden led these women to keep an emotional distance from others. They believed that this would circumvent the threat of being emotionally hurt. All were over-compliant to the wishes of others and did not make excessive demands on their parents. These behaviours appear to have been motivated by a fear of being rejected. Behaving in such a manner, they seemed to live their lives making others feel better rather than themselves. In addition, they believe that they had no rights as individuals other than to please people (Bruch, 1988). The result was that these women did not do things to care for themselves. Because they believed that they had no rights, they lacked boundaries, so were often taken advantage of emotionally or academically. For instance, Catherine's intellectual ideas have been stolen by professors and colleagues. These women experienced the imposition of others' wishes, values and beliefs. Unfortunately the behaviours

adopted by the women to avoid harm provoked further abuse. To cope with repeated emotional pain, they turned to an ED.

Perfectionism was another personality disposition that was associated with the development of an ED in all these women. Each imposed high personal standards on herself. Academic achievements were part of their quest for perfection. All were model and obedient children. Their achievements were representative of high ability individuals. Hazel, Pat and Sheila wanted others to see them as perfect in relation to their peers. This motivated their quest to achieve in many fields. A desire for control was also associated with perfectionism even in relation to their ED. The ED made life more predictable and it created a routine and a semblance of control in the lives of each woman. They were highly efficient in all they chose to do.

Being perfectionists, these women were in a constant state of fear and worry over making mistakes. Invariably when failure occurred, they could not cope. Shame and guilt followed. Feeling this way was associated to their need to rid themselves of these emotions. The ED was the means that they used to blanket their feelings. Self-discipline and conscientiousness are also associated with perfectionism. These four women worked countless hours and exerted intense effort in every one of their endeavours. The ED itself was a disciplined act made possible by the many talents that the women utilized every waking hour.

Many of the behaviours and emotions that the women demonstrated can also be attributed to their high abilities. Like most high ability people, these four women were perfectionists. They were successful in many of their undertakings. Although they were praised and admired, none derived a sense of self-satisfaction from their accomplishments. Many high ability women have difficulty recognizing their talents and attribute success to luck, hard work or fluke (Clance, Dingman, Reviere & Strober, 1995). In these four women, the quest for perfection was a mode of behaviour that helped secure approval and/or love. Each of the women extended the quest for perfection to her body. Attempting to alter their bodies' natural shape only

served to increase the level of stress each experienced.

As high achievers, these women ascribed to the superwoman ideal. Each strove to be successful at school, work, home and extra-curricular activities. Timko et al. (1987) argued that trying to perfect one's appearance and the desire to achieve in many diverse roles causes a high level of negative stress. This seems to be the case in these four women. The ED seemed to help them cope with the self-induced stress.

Cloninger et al.(1993) stated that excitability is indicative of novelty seeking (NS). A NS person is by nature over-excitabile, impulsive, intense and extravagant. All four women demonstrated elements of this disposition. Over-excitability presented itself as a temperamental disposition because it was observable from childhood on. Cloninger et al. (1993) use the term NS whereas I have chosen over-excitability because it captures the phenomenology of how the women felt when they became physiologically over-aroused.

Some behaviours associated with over-excitability manifested themselves differently in Sheila and Hazel who both engaged in bulimia. Excitability and impulsiveness are most observed in those with bulimia (Lilenfeld et al., 1997; Suzuki et al., 1994). Sheila demonstrated these tendencies in the most pronounced ways. Pat, Hazel and Catherine appeared rigid, reflective, reserved and regimented; all behaviours in stark opposition to a person who rates highly on NS. These characteristics are most often present in those with anorexia (Cloninger et al. 1993; Garner et al., 1997). The data obtained in this study did not entirely conform to Cloninger's formulation of NS. Sheila and Hazel were impulsive and Catherine and Pat were not. This distinction is common between those with BN and AN.

All four participants demonstrated exploratory excitability. This finding was contrary to some research findings. The discrepancy between the findings of this study and that of Cloninger et al. is likely a function of a difference in the definition of what constitutes excitability. Cloninger et al. (1993) see excitability as the activation of behaviour versus inhibition. The activation of behaviour is an element of excitability, however this does not mean that inhibited tendencies exclude the possibility that people are excitable.

Catherine and Pat inhibited their behaviour in certain contexts, while at other times they reacted very intensely. For instance, at home Catherine was withdrawn and quiet because she felt that any expression of individuality would not be condoned by her parents. In contrast when writing, she was in an absorbed state and energetic. In our four participants, over-excitability presented itself as high arousability to external stimuli. Cloninger et al. (1993) do not discuss arousability as an element of NS.

The act of bingeing and/or purging is in itself an impulsive act. Both Sheila and Hazel were unable to tolerate negative affect and induced vomiting to deal with their emotions. Impulsive behaviours were reported by both women. Sheila drove recklessly and Hazel indicated that she self-injured. Both behaviours arose when they felt desperate and in severe emotional turmoil. Anxiety seemed to precede self-injurious behaviours. The act of hurting oneself had a calming effect; it was cathartic and a means through which anxiety was relieved (Pipher, 1994). Pat and Catherine did not seem to show impulsive tendencies. Persons with anorexia/ restricting type are more cautious (DSM-IV, 1994). However, both Pat and Catherine were over-excitabile. Confronted with intense stimulation, they would become physiologically overwhelmed. Since childhood, Pat felt uncomfortable and withdrew when in the presence of many people. Similarly, Catherine would react to over-stimulation by seeking solace in nature or in her imagination. When she experienced stimulus over-load she felt frazzled and anxious.

Sheila and Hazel also became over-aroused by external stimuli. They all reported what Buss & Plomin (1984) referred to as behavioural arousal. Their reaction to external events was high excitability. Sheila, Hazel and Catherine pushed their bodies to exhaustion when exercising. All four had a number of projects and activities going simultaneously. Pat, Hazel and Catherine spent countless hours studying. Each, when over-aroused may have experienced a physiological change in their bodies (Buss et al., 1984). Repeatedly the women indicated experiencing anxiety, tension and an overall level of discomfort when too much was occurring in their environment. To cope, they withdrew. For each of these women, the rituals associated

with their ED was calming.

Over-excitability is a by-product of physiological starvation (Bruch, 1973), but each of our participants reported behaviours indicative of over-excitability before the onset of their ED. Over-excitability perhaps was exacerbated by the effects of starving and/or bingeing. Over-excitability in high achievers can be seen in the extreme level of energy that they bring to their lives (Clark, 1997; Davis, 1997; Piechowski et al., 1994). Our participants demonstrated this propensity. They drove themselves relentlessly. The excess of energy fuelled their accomplishments and quest for perfection. The intense energy also drove each woman to engage in destructive behaviours. They exhausted themselves in various venues of their lives (i.e. work, relationships and achieving the perfect body). The innate extraordinary amount of energy was channelled into their ED.

An intense mind is also associated with over-excitability. These four women were intellectually curious, had precocious minds and a propensity toward reflectiveness (Davis, 1997). The tendency to think, ponder and question made adapting to change and life more difficult for each woman. Being easily excited, they appeared as being always in overdrive, overwhelmed and stressed. The poor fit between this temperamental predisposition of over-excitability as lived in their family context appeared to have been associated with the development of each woman's ED.

Hypersensitivity is an element of temperament (Cloninger et al., 1993). Like over-excitability this appeared as an extreme sensitivity in these four women. The four women manifested a low threshold when coping with criticism and negative affect. It can be argued that the women were hyper-sensitive because they felt poorly about themselves. However, all demonstrated the propensity towards hypersensitivity before the development of their ED. Moreover, hypersensitivity extended beyond responding to criticism. Since childhood some reported being empathetic and intuitive to the emotions of others. The four women were raised in homes where they reported open communication was absent. In such a context children learn from

a young age to infer what their parents or siblings are feeling and thinking and thus may develop a heightened sensitivity (Bruch, 1988). This does not exclude the possibility that the women were born with a predisposition to hypersensitivity which was further reinforced because of the dynamics in the family. Research suggests that those with ED are raised in homes where members of the family do not openly discuss what they are feeling. As a result the children raised in these homes learn to be perceptive to the emotional nuances in their environment (Bruch, 1988, 1978).

Pat, Hazel, Catherine and Sheila reported possessing all the traits that Aron (1997) lists as indicative of sensitivity. They reported an acute awareness of subtleties in their environment, being affected by others' moods, the desire to withdraw when too much stimulation was occurring, a rich/ imaginative inner life, unpleasant sense of arousal when confronted with a number of things to do in a short period of time, and difficulty accepting change. They were also shy. These behaviours and feelings were experienced by the four women before and after the onset of the ED and for Pat, Catherine and Sheila since early childhood. This provided evidence that hypersensitivity among the four women seems temperamental in origin.

Being hyper-sensitive made negotiating the path through adolescence more difficult for all these women. Their ED appeared to have been partly a response to being overwhelmed with the tasks associated with the adolescent experience. For sensitive people, life is more difficult because they are acutely aware of life events: disharmony, criticism and others' emotional pain. For the hyper-sensitive person it is almost impossible to not be affected by the emotions of others (Aron, 1997). Hazel and Pat were disturbed by the feeling of others towards them. Sheila indicated that she was sensitive and intuitive from birth. Catherine revealed that since childhood she was cognizant of the emotional drama unfolding around her.

These women responded emotionally to any indication of rejection or criticism. They were intuitive and capable of sensing the subtle nuances in their environment (VanTassel-Baska, 1995). At a young age these women were intensely aware of the emotional drama unfolding around them, especially within the

family context. Their feelings were easily hurt (Silverman, 1997). Sheila reported that she was subjected to verbal abuse; Catherine could never do anything to please her parents, Pat feared being judged; and Hazel felt that she was a disappointment to her parents. Due to their hypersensitivity, each criticism caused emotional pain.

Yet another characteristic among these women is their compassion. They are highly attuned to the suffering and emotions of others (Silverman, 1997). The four women had a profound ability to empathize and feel another's pain. This tendency caused them to feel responsible for others' needs at the expense of their own (Miller, 1994). These women neglected their own needs for others and when unable to help, they experienced a great deal of guilt. Possessing a sensitive disposition made adapting to life events, especially in adolescence most difficult. These women were aware of the inconsistency between how they behaved externally and how they felt internally. The knowledge of this discrepancy appeared to occur because the women possessed an intrapersonal cognitive sensitivity, an intense self-awareness.

Emotions.

Shame was the prominent emotion experienced by the four women, followed by guilt. In the within case analysis, how shame and guilt arose and presented in each of the women was discussed in detail. The four women described themselves as insecure, incompetent, not worthy of love and acceptance. Feeling this way about themselves, each developed defending strategies to cope with these emotions.

Kaufman (1996) proposed the theory that when individuals feel ashamed, they develop defending strategies to deal with their sense of shame. One defending strategy the women used was perfectionism. By trying to be perfect, each tried to compensate for an inherent sense of defectness or worthlessness. The struggle for perfection was a strategy the women used to turn themselves into something where every perceived defect was eliminated.

Perfectionism was a defending strategy and a personality characteristic that the women adopted

because their extraordinary achievements, particularly academic pursuits, provided compensation for the sense of inadequacy that they felt about themselves. The perfectionist stance included pleasing and meeting others' needs and setting unrealistic standards of physical attractiveness (Bruch, 1978; Garner, Olmsted, Polivy & Garfinkel, 1984; Sadker et al., 1987). A second defending strategy the women used was internal withdrawal. This strategy was self defeating. When people internally withdraw, the belief is that by not exposing themselves they are less likely to experience events where they will be shamed again. Presenting a false self to the world was an element of withdrawal that Pat, Hazel, Sheila and Catherine all demonstrated. There were a number of reasons why they choose to do so. In their families they felt no encouragement, in what they communicated. Catherine and Sheila reported that their parents deliberately sent the message to their children that they had to maintain the image of the perfect family. Similarly, Pat and Hazel communicated that their family sent the same message but in a more indirect way. It seems that these parents were unaware that their children were unhappy since they presented a happy persona. By praising their daughters for being 'good', this was perceived by the women as reinforcement to present a facade. In this way, those women felt ashamed of themselves. They felt inferior and worthless in relation to others. Therefore, any expression of behaviour or emotion that stemmed from 'the self' was judged by the women to be wrong and if expressed, they were convinced that they would be rejected and/or abandoned. This was part of their motivation to maintain an artificial front. However, the penalty for this defensive strategy was further loss of authentic self in each woman.

Those who have an ED have been described as wearing a mask to conceal their authentic selves. The result is that the image presented to the world is far removed from what they experience internally (Bruch, 1981; Casper, 1983). For example, how the women perceived themselves stood in stark contradiction to how others perceived them. People would describe them as bright, successful, admirable, kind, cheerful, considerate, and helpful but they experienced themselves as frauds, disappointing others and as failures.

The degree of self-hatred was so intense in these women that they felt the need to hide. By presenting a perfect image to the world, the women did not allow themselves to show imperfections. A perfect self was presented in order to prevent negative evaluation. Hazel, Pat, Catherine, and Sheila periodically isolated themselves from external contact because they feared their level of shamefulness or inferiority was visible to everyone. Moreover, because a false self was presented to the world, the four were hyper-vigilant to ensure their persona was not penetrated. Perfectionism, internal withdrawal and presenting an artificial front is counter-productive to positive development. These defending strategies increase the level of stress and anxiety. Each of the women experienced them.

Kaufman (1996) identified shame complexes as secondary reactions to shame, reactions that mask one's shame. They were employed in many of the interpersonal situations and relationships of these women. The women in the study reported feeling scrutinized and were preoccupied with how they appeared to others. Hazel, Pat, and Sheila reported, while in school, that they were worried that people thought they looked fat. When at work, they were preoccupied about being evaluated on their performance. At home, Catherine felt that she was always under the suspicious eyes of her mother who watched her every move so that she did not waste time. All four women struggled to act spontaneously. Stress and anxiety ensued.

Shyness is yet another shame complex state. A person who is shy feels exposed in the presence of others and in response may withdraw and behave in a restrained manner. Sheila although outwardly social, indicated that she suffered from profound shyness in some social situations because she feared saying or doing something that would cause her embarrassment. Catherine was a withdrawn child who preferred solitude. In the presence of some people, she withdrew and censored what she said for fear of being judged negatively. Hazel did not talk about shyness, but Pat clearly stated that she was a shy child who found interacting with her peers difficult. For all these women shyness appeared when they were concerned about being perceived and evaluated by others (Leary, 1986). Believing themselves to be worthless, it heightened

their sense of shyness.

One of the central problems of our participants concerns their identity formation. When shame became internalized, each woman's identity was profoundly affected. According to Kaufman (1996), identity is comprised of core beliefs that people hold of themselves. The beliefs that the women held pierced the essence of their self and hence impacted on their sense of identity. Our participants identified with how others treated them and they acted towards them accordingly. The four participants were told that their perception of things was wrong. Given their reports of parents' over-involvement and in some cases alleged controlling behaviour, these women developed as children the belief that they were incapable of negotiating successfully their path in the world. Instead they internalized negative beliefs about self.

Self-blame was an identity script Hazel, Sheila, Pat and Catherine incorporated. In Sheila and Catherine's case, both indicated they were humiliated for being sensitive. Hazel felt her family denounced her when she expressed her own opinions. Each of these women felt that they failed to live up to her parents' ideals. Another identity script was also developed, that is, comparison-making. All four women did not feel worthy and some compared themselves to others. They saw themselves as different in a significant way. Some of these women felt they differed from others because they were fat. They feared not being as worthy as they believed that they should be and came to identify fat with personal dissatisfaction. Hazel, Sheila and Pat repeatedly compared their bodies in relation to others and always interpreted their physical appearance as inferior. This finding is confirmed in the research literature on physical appearance (Bruch, 1978; Garner & et al., 1982; Sadker et al., 1987). Catherine did not compare her body to others, but she did compare herself to her parents and believed that she was not as competent as they were. Hazel, Pat and Sheila thought that they were not as smart as others. Hazel felt inferior to her brother.

Another identity script encountered in the participants was self-contempt or rejection of self. When contempt is intrapersonally focussed, it produces highly critical attitudes towards the self. This can be

observed in people with EDs who use self-contemptuous words to describe themselves. The self-loathing is often directed towards the body (Bruch, 1978; Cash & Brown, 1989; Duke et al., 1988; Garret, 1998). Our participants used self-abusive words to describe themselves such as disgustingly fat, obnoxious, stupid, gross, selfish, horrible, not good enough, evil, loser, worthless, self-indulgent or deficient. Disowning the self was another identity script of the participants. Pat had no sense of self as she defined her identity was her eating disorder. Sheila felt disconnected from her body. Catherine saw her body as a hindrance and wanted to strip herself of her flesh to get down to the bone. Hence she did not identify her body as a part of her being. Hazel dissociated from her feelings. Common among those with EDs is that they split off elements of themselves which they perceive as problematic (Bruch, 1978).

The identity scripts of self-blame, comparison-making, self-contempt, rejection of self and disowning elements of oneself served to further confirm the feelings of worthlessness and shamefulness. These beliefs were associated to their ED because the illness was a means to escape the negative belief systems that the women held of themselves. The transition to adolescence for the four women was a traumatic period of their lives. A discussion of the common themes during this transition period will help us understand better the inner life of these four women.

Developmental Level.

Pat, Hazel, Sheila and Catherine developed their ED in adolescence. This is consistent with what is reported in the scientific literature (DSM-IV, 1994). Many life experiences, prior to that age, were associated with the development of their ED. Each entered adolescence with an overwhelming sense of shame about herself. Hence, the normal obstacles confronted in adolescence were exacerbated. Some reported they experienced problems within their homes. It seems that the accumulation of stressors led each woman to turn towards an ED as a coping process. Previous research has shown an association between cumulative stress and EDs (Graber et al., 1994; Sharpe et al., 1997). All adolescents have a fear of being judged, rejected and

criticized. In the four cases, other things had taken place within the women's lives to reinforce this overwhelming fear.

Adolescence was anxiety provoking for all four women. Their emotions were heightened, not only because of the physical changes taking place in their bodies, but also perhaps because they were temperamentally prone to over-excitability. Entering high school, they felt over-burdened with the abundance of things that they thought they had to perfect. Unable to cope, the four responded by turning to an eating disorder. The illness began slowly in the four cases. It was a means that gave each woman a sense of control over her life. They felt shy and inferior, and also were attuned to how other people saw them. The heightened intuitiveness and hypersensitivity made them very aware of their environment.

The women seem to have been raised in a manner that did not prepare them to deal with the changes that took place in adolescence. As children, these women reported they were never encouraged to assert their independence. Their entire lives were dominated by the need to please their parents and, hence, they had no practice in determining what they wanted from life. Because they had not been given the fundamental tools as children, they found it difficult when confronted in puberty with the need to come to a self-integrated view of themselves. The need to please others was a childhood rule that they continued to hold as they entered puberty hence, making adapting to this phase of development difficult. Fearing that they could not meet others' expectations, these women were unable to come to differentiate the difference between their true and false selves. This part of healthy adolescent development was thwarted in all of them. These four women also entered puberty with a sense of ineffectiveness about themselves. It made it impossible for them to make independent decisions because they feared making wrong ones and hence not being respected, or worse, ridiculed. Adolescents are self-conscious about their physical appearance at some time. Prior to this phase of development, these four women experienced themselves as shameful and worthless in comparison to others. As such, the level of self-consciousness experienced by each was intensified.

Hazel, Pat, Sheila and Catherine were ill-prepared and did not have the necessary tools to negotiate their way through adolescence. The level of stress and anxiety associated with adolescence was exacerbated and they coped with this by turning to an ED. Let us now turn to the family dynamics in each woman's home and discuss its contribution to the development of their ED.

The Family

The family unit acts as the formative social system for communicating belief systems to its members. What is learned in the family affects how a person behaves and perceives the world. In the within case analysis, the poorness of fit between the family and individual factors are discussed. There were common themes found among our participants' families such as a high achievement orientation, enmeshment and emotional inexpressiveness. The following statements are based on what each woman reported. Consistent with social constructivism, the focus of the research was to understand the participant's reality. Missing from the discussion is parents and others' perceptions of what transpired in the development of each woman's eating disorder.

Catherine's parents valued high achievement, discipline, and a strict work ethic. Sheila was validated when she did things for her family and she was praised for her accomplishments. Hazel felt pressure to equal her brother's academic accomplishments. Pat did not openly state that her parents had high achievement expectations of her. Perhaps, Pat saw her accomplishments as validation for her mother that she was a good, successful parent. Common among the women was that they intrinsically held a high achievement orientation because it was the only means that provided them with a sense of validation and self-worth in the eyes of their parents.

A common element among Pat, Hazel and Catherine was that they reported that their mothers were overly involved in their lives. Not having a separate entity, Pat grew up feeling it was her responsibility to be her mother's confidante. Catherine's mother was depicted as not emotionally close to her children, but

was nevertheless over-involved. She was described as controlling and seeing her children as an extension of herself. Hazel felt that her parents did not acknowledge or value her. Sheila's family was an exception. The pattern of excessive closeness is often noted in the families of those with AN rather than BN. Sheila assumed the roles that she did because it was the only way by which she could secure attention from her father.

One of the commonalities found among the families of the women was that they were emotionally inexpressive. Sheila and Catherine's parents conveyed that emotions were kept to oneself. Hazel and Pat said that their parents did not outwardly state that emotions were not acceptable, but they unintentionally invalidated them. Because the women perceived things were not freely discussed in their homes, both women interpreted this to mean emotions were unacceptable. These women perceived the undercurrents of the emotional drama in their homes and not having anyone to discuss it with, they dealt with their emotions through the ED. Humphrey et al. (1988) indicated that families of bulimics are deficient in self-regulatory and self-caring; they are conflictual and openly hostile. This profile was observed in Sheila's family who did not nurture each other and when feelings were expressed, they were negative. There was constant verbal abuse and fighting. The home was disorganized, pseudo mother figures moved in and out, and the siblings were in emotional turmoil. In contrast Pat, Hazel, and Catherine's family fit the profile of anorexic families in that they presented "a facade of perfection, self-sacrifice, and love" (Humphrey et al., 1988). In their homes, there was underlying tension and unhappiness among members of the household but it was not talked about. It was hidden by presenting an artificial veneer to the outside world.

The effect of being raised in a family that values emotional inexpression may have been associated with a number of problems. Firstly, it could have communicated that emotions were something to be ashamed of. Secondly, the girls raised in such families felt that they could never act authentically, or develop a true persona, hence, never discovering their true identity. Thirdly, when obstacles or uncertainty associated with various phases of development arose, the girls felt that they could not confide or elicit support from their

parents. This made adapting to life experiences more difficult.

The Social Network

For all four women, the social network and the school culture interacted with other factors to affect the development of their ED. Hazel, Pat, and Catherine were exceptional students. All obtained high grade point averages and had been the recipients of academic awards. Sheila did not excel scholastically but maintained a B average. She did excel athletically and in leadership roles. As a child, Sheila reported that her parents told her she was stupid and dumb. She came to believe this about herself, and therefore, did not exert a great deal of effort in school. Sheila's home environment appears to be the most unstable of the four cases. She moved often and had to adjust to new teachers, schools, routines and friends. Therefore, school was an inhospitable environment for her. These four women were unable to appreciate or acknowledge their achievements. Although they excelled at many things, each felt that she did not meet the expectations that she set for herself or others set for her.

Relationships with teachers were non-existent. All restricted interacting with their teachers for fear of being discovered as stupid, shameful and worthless. They were recognized, however as being highly capable students. Sheila and Catherine's teachers were not aware that they had an ED. Most of Hazel's and some of Pat's teachers knew of their ED but didn't know how to help them. Hazel talked the most about how she was negatively affected by what teachers would say. Hazel repeatedly felt that her teachers were angry with her, when in reality this was not the case. Hazel believed herself to be bad and this was why she thought that her teachers disliked her. The ED affected the women's ability to concentrate in school. Some reported feeling dizzy and weak at school as a consequence of bingeing/purging and/or starving. Yet they still pushed themselves to academic and extra-curricular heights. None of the participants commented on whether their school instilled competitiveness. Therefore, the association between academically competitive school contexts and the development of an ED cannot be discussed. However, all four women indicated that their

desire to achieve academically increased the stress and anxiety that they experienced and this was associated to their ED. They appeared to be naturally competitive, forcing themselves towards ever higher self imposed goals.

As Hazel and Pat were the two adolescent participants, the interactions with the school network were discussed more often than in Sheila and Catherine's case. Hazel, Pat and Sheila indicated that they had one or two close friends. Because they had inner doubts about themselves, they had a fear of not being liked. As a consequence, they lacked the tools to establish authentic relationships with others. Even with their close friends, each of the women tried to be as authentic as possible but still were unable to be completely themselves.

Friends did not play a large role in the lives of the four women when they were children. Sheila's childhood was one of constant change and establishing friendships in her early years was difficult. Hazel had many friends in elementary school. Yet, it was unclear if these relationships were satisfying because she reported feeling bad in relation to her peers. Pat as a child found it hard to make friends. She was a quiet inner-focussed child who preferred to spend time alone reading books. She was excessively close to her mother which made it difficult for her to be away from her and establish relationships with others. Catherine had limited interaction with peers because her mother apparently restricted with whom she was permitted to be with. When Hazel, Pat and Sheila made the transition to junior and/or high school, a change in how they related to their peer group occurred. Hazel and Sheila were separated from friends and this appears to have impacted upon the development of their ED. The women did things to please others, therefore, within their friendships they feared being free and open. Expressing their ideas was difficult because they worried that by so doing they would be rejected. In adolescence they did not establish friendships that were nurturing. The need to be validated by the peer group was most salient in Sheila and Hazel. Both felt they were not given enough attention at home, so they sought it out in their peer group.

As adolescents, these women compared their physical appearance to that of their peers. Hazel and Pat at the onset of puberty felt that they were not physically developing at the same rate as their peers, and therefore, felt bad about their appearance. Both Hazel and Pat reported feeling less attractive than their peers. Sheila wanted to be the smartest, prettiest and most popular girl. Catherine did not say that she compared herself physically to her peers, but did indicate feeling evil in her family and different in relation to others. Hazel and Pat alluded to interactions with their peers. Some of their friends knew that they had an ED, so at times they felt anxious eating in the presence of others. Sheila stated that her peer group in adolescence conveyed the message that being physically attractive was important. Hazel and Pat were aware of what the peer group valued because they both were concerned with how others would evaluate their appearance.

At various points in their lives, all four women isolated themselves from social interactions. Isolation was motivated by not feeling good about themselves, the fear of rejection or criticism, or the need to have time alone to cope with the intensity of their inner lives. For all the participants junior high and/or high school was distressing. The demands of trying to excel academically, being popular and perfecting their bodies increased the women's level of stress.

The Culture

According to three of the women, the culture played a role in the development of their ED. However, the four women believed that it was their emotions that played the pivotal role in the development of their illness. Some acknowledged that they were affected by the Western Culture's values of being thin and attractive. The culture did reinforce their quest to lose weight but all felt that the desire to be thin was not a response to wanting to look like a model. Rather, it was the acceptance and validation that drove some to remain thin.

Catherine was the one woman who acknowledged that the premium her culture places on having a strong work ethic was associated with her ED. The knowledge that achievement was valued drove all the

women to seek a sense of worth through their accomplishments. However, no matter their accomplishments, the feelings of shame remained and no accomplishment was enough to change the way that each felt about herself. The other way that the culture was associated to each woman's ED was the disparity between their value system and those held by society. Each of the women felt that the world was a frightening place where people were not as kind and sensitive as they. Western culture values achievement, monetary gain and self-interest. The women were sensitive and altruistic. Each was concerned with understanding the essence of what it means to be human. Western culture does not value such things. Hence, the women felt that people did not understand them and they were essentially alone. Their quest has not been for success and accomplishments so their journey in life has not been acknowledged. This fostered shame. Each questioned if they were different and abnormal because their beliefs were at odds with what society claimed was important. As Catherine articulated, her struggle with anorexia is symbolic of trying to wrest a blessing from the culture for the kind of human being she is. She concluded by saying "*...I want the world to understand...I believe anorexics are walking emblems to the world of soul longing*" (Siii, 5). To conclude, this study revolved around the following research questions and findings:

1. What temperament and personality characteristics appear in high ability women with eating disorders?

Mirroring female psychological development as identified in the literature, all four women had a need to care and nurture others. Trying to meet everyone's needs, the women lost touch with their own. Suppressing their emotions and the stress that they experienced led them to turn to an ED in order to cope. All four women showed evidence of over-excitability and hypersensitivity. These two temperamental predispositions were also individual factors that were associated with the development of their ED. Over-excitability in order to cope with the sense of over-arousal to emotions or stimuli, they turned to the ED as a means to cope. The act of bingeing/purging or starving temporarily relieved them of feelings of anxiousness.

Hyper-sensitive, the women were attuned to everything around them, unable to censor incoming emotional information. Everything that transpired in their lives was responded to with intense emotionality. Their nature was one in which they sensed others' pain and felt an obligation to respond. The result was that they became emotionally overwhelmed and the chosen method to cope was turning to an ED.

The personality characteristic of harm avoidance was an individual factor that was associated with the development of each woman's ED in several ways. Feelings of low self-esteem and a sense of ineffectiveness meant that the women did not feel good about themselves. In order to avoid harm (criticism), they wore masks and denied elements of themselves (i.e. emotions). To avoid criticism and feeling bad, these women experienced the stress of trying to secure acceptance from everyone and hiding their true selves increased stress and left them with no person to confide in emotionally. To deal with these realities they turned to an ED.

Yet another personality characteristic, reward dependence, was an individual factor that was associated with the development of each woman's ED. All felt that they were not worthy of unconditional love because they experienced themselves as shameful. Their lives were dictated by the philosophy of adapting their behaviour in order to secure approval and acceptance. This exacerbated the level of stress that they experienced. The personality characteristic of perfectionism was another individual factor that was associated with the development of each woman's ED. Their quest for perfection was driven by the belief that they were worthless. Becoming the embodiment of perfection, the women believed, would help them compensate for their deficiencies. Once this was achieved, each thought that she would secure approval and prevent abandonment. However, it was an ill-fated attempt because they were incapable of seeing their worth despite their achievements. In essence, perfectionism was a personality characteristic developed out of a motivation to prove to others that they were not as bad and shameful as they suspected themselves to be. The intensity of trying to perfect everything meant that the women placed unrealistic expectations upon

themselves. This exacerbated their stress level and the ED was used to help them cope

Being high achievers, they had a predisposition towards over-excitability and it was an individual factor that was associated with the development of their ED. Some experienced a number of traumatic events in their lives and, coupled with their highly excitable nature, they responded with great emotional intensity. The intense energy and relentless drive forced each to extremes of behaviour. The combination of all these factors caused the women to become over-stimulated, unable to deal with what transpired in their lives. The ED was a means by which they chose to cope. Being high achievers, all had a predisposition to hypersensitivity. It was an individual factor that was associated with the development of their ED because they were constantly aware of the undercurrents of the emotional drama around them. More vulnerable and at risk because they were emotionally over-stimulated, this was associated with their stress that was dealt with by turning to an ED.

All were ashamed of their emotions. Guilt was always present and believing themselves shameful, they were unable to accept any pleasure. They responded by developing the defending scripts of perfectionism and internal withdrawal. These scripts increased their stress level because they set unrealistic expectations and were vigilant to ensure no person had access to their true emotions. The shame complexes made life more stressful. They were always self-conscious in the presence of others. The identity scripts served to distance each woman from herself.

The developmental phase the women were in when their ED began was another factor that was associated with the development of their ED. Adolescence is a time of stress and unpredictability. In each case, because of temperament, personality, emotions, and the life experiences that had transpired before, trying to negotiate their way through adolescence compounded their stress. This is why each woman's ED began in adolescence; it was a response to coping with the complexity of life. The discussion now turns to the second research question.

2. What contextual factors are associated with the development of eating disorders in high ability women?

The family was a contextual factor that was associated with the development of each woman's ED. The families of the women valued emotional inexpressiveness. All the women felt unable to talk about their feelings to their parents. Some of the women perceived sharing their emotions was a selfish act that would burden their parents. Moreover, a value on high achievement orientation was reported as being held by Hazel, Sheila, and Catherine's family. The women felt from an early age their parents' love was conditional, based on what they accomplished. The stress and anxiety of trying to meet their parents' sensed expectations was associated with the development of their ED. For Hazel, Pat, and Catherine, their parents' enmeshed style of parenting also was associated with the development of their ED. These women felt ineffective. The ED was a means to exert a semblance of control over their lives. The perceived chaotic nature of Sheila and Pat's families led to many changes that were not dealt with by the women. The disturbances in their homes were associated with the development of their ED.

The social network also played a role in the development of the women's ED, however, not as significantly as the family network. With all the women, the peer group served as a reference group for comparison. The value of appearance ascribed to by the peer group only served to reinforce the importance of being thin and attractive. Some of the women had no emotional support system at home or with peers, so they were emotionally alone. All the women wore a mask and were unable to reveal their authentic selves to their peers. Therefore, they did not have genuine peer relationships and a support system to confide in. The lack of close confidantes to share the complex emotions that they were experiencing was associated with the development of their ED.

Teachers played a minor role in all the women's lives. Through inattention, they contributed because they reportedly were unaware of the girls' sensitive nature and that each was in need of support. Lastly, all

the women ascribed little value to the culture playing a role in the development of their ED. They unanimously indicated the culture of thinness and perfectionism influenced them but did not cause their ED. The ED was a function of the emotions they were experiencing. The findings in reference to the third research question are discussed next.

(3) How do individual characteristics interact with contextual factors such as the family, social context, and culture in high ability women with eating disorders to affect the development of their eating disorder?

The poorness of fit between the temperament and personality of each woman to that of her family was the most significant factor that was associated with the development of each woman's ED. The temperamental traits of over-excitability and hypersensitivity as well as the personality characteristic of perfectionism were ill suited to the family climate. The families of the four women reportedly valued emotional inexpression. This was ill-suited to Pat, Hazel, Sheila, and Catherine's hyper-sensitive natures. Each felt things in an intense manner that at times lead to feeling confused and overwhelmed. Not having anyone to share these feelings with, the women developed an ED in part to cope with them. In addition, because some felt their parents did not value emotions, they were ridiculed for being sensitive and therefore the women came to believe their innate predispositions were shameful.

The chaotic nature of some of their homes meant change was a constant part of Sheila and Pat's life. Such an environment was ill-suited to those who have an innate temperamental predisposition towards over-excitability because it caused the women to become easily over-stimulated and overwhelmed. The enmeshed nature of some of the participant's homes was also ill-suited to their temperament. Being hyper-sensitive the women were already emotionally attuned to the problems within their family context. This family environment stifled autonomous growth. Coupled with an already hyper-sensitive nature, the women became overwhelmed with emotional contradictions and felt there was not a solution beyond the ED.

The reported high achievement orientation in the families was ill-suited to the perfectionistic nature of the women. The families that valued achievement sent the message that the need to accomplish things was important. This increased the level of stress and anxiety experienced by some of the women. The family unit also did not help the women develop realistic expectations for themselves since no successful achievements were ever considered good enough for these women. The only avenue for relief appeared to be the eating disorder.

This chapter discussed the common individual and contextual factors that were associated with the ED in each high ability participant in the study. It began with a within case analysis and then a between case analysis . Furthermore, it discussed how a poorness of fit between each woman's individual characteristics and the family context is associated with the development of her eating disorder. Chapter six provides a summary of the findings and makes recommendations to deal with the development of eating disorders among high ability women.

Chapter Six: Summary And Implications

The previous chapters described and reported the individual and contextual factors that four high ability women understood are associated with the development of their eating disorder. Through in-depth interviews, ESM methodology, and personal artifacts salient findings emerged.

Specific **individual** factors seem to be associated with the development of each woman's eating disorder. One such individual factor was the ethic these women were socialized to conform to, that is, the need to care and nurture others. They met everyone's needs but their own. Moreover, a second individual factor was the temperamental predisposition of hypersensitivity. These women responded with intense emotional reactions to life events. They became overwhelmed and coped through their eating disorder. Similarly, a third individual factor was the temperamental predisposition of over-excitability. All four women became over-stimulated and physiologically over-aroused. They soothed and calmed themselves through their eating disorder. A fourth individual factor was the personality characteristic of perfectionism. The women set unrealistic expectations on themselves which increased the level of stress and anxiety that they experienced. They coped through their eating disorder. Next, the personality characteristic of harm avoidance emerged among the participants. They hid their authentic selves to secure approval from others. The stress and anxiety of maintaining an artificial front was dealt with through their eating disorder. In a similar vein, a sixth individual factor was the personality characteristic of reward dependence. All four women needed constant external acceptance this need increased their anxiety to be perfectionists. The participants became overwhelmed and coped through their eating disorder. A seventh individual factor was the overwhelming presence of shame. The source of their shame was internal but it manifested itself through bodily shame. To cope with these emotions the women developed defending scripts which increased the stress and anxiety that they experienced which they then coped with through the eating disorder. In addition

to shame guilt emerged as an eighth individual factor. The women did not feel worthy and hence believed they did not deserve anything that brought them pleasure. Each time they were given gifts, complements or praise they experienced guilt. Lastly, a ninth individual factor was feelings of ineffectiveness and the lack of an identity. When they entered adolescence the women lacked the tools to negotiate the obstacles associated with this phase of development.

Specific **contextual** factors that emerged as being associated with the development of each woman's eating disorder. The family context played a key role in the eating disorder. Specifically, the family features of emotional inexpression, a high achievement orientation, an enmeshed style of parenting and a chaotic environment provided a lethal combination for these highly able women. A second, yet not as significant contextual factor, was the peer group. In some of the cases the peer group reinforced the value placed on appearance and hence supported each woman's quest for thinness. A third, yet also not a significant contextual factor, was the school environment. The stress of trying to achieve personal academic goals was associated with each woman's ED.

The significant finding of this study lies in the poorness of fit between each high ability woman's temperament, personality and the family construct in which she was raised. Hypersensitivity was ill matched to the family features of emotional inexpression and enmeshment. The four participants were unable to share what they felt. They worked hard to avoid revealing what they felt to their parents and hence were always emotionally alone. Over-excitability was ill matched to the chaotic nature of the family context. These four women were over-excitabile and the family climate exacerbated this tendency to the point they became over-stimulated and turned to an eating disorder to soothe themselves. Perfectionism was ill matched to the high achievement orientation of the family context. They developed a contrived self in order to compensate for their inherent sense of worthlessness. By so doing, they abandoned their selves and never developed an authentic identity. In each of these women, the eating disorder developed as a means to cope with shame and

guilt, intense emotions, over-stimulation and over-arousal, stress and anxiety as well as a sense of ineffectiveness.

Contributions to Understanding Eating Disorders among High Ability Women

Eating disorders develop as a consequence of an interplay of factors. The present study is the first that has attempted to understand factors that are associated with the development of eating disorders among identified high ability women. Thus it makes a novel contribution to the scientific community. Significant was the finding that the hyper-sensitivity, over-excitability and perfectionism were associated with being a high ability individual and came into conflict with family constructs of emotional inexpression, chaotic life style and high achievement orientation. We now understand that there may be a core set of individual and contextual factors in high ability women that, when present, may place them at risk for developing an eating disorder.

Previous research studies have looked in isolation at individual and/or contextual factors among those with eating disorders. We argue that individual and contextual factors did not act independently to affect the development of their eating disorder. Rather, it was the reciprocal interaction among individual factors, family context, social network and the culture that lent understanding to each woman's eating disorder. To understand why an eating disorder developed, the interplay of individual and contextual factors must be examined to obtain a full picture.

Most salient we now know that there exists a poorness of fit between the individual characteristics of each woman and her family context that was associated with the development of her eating disorder. This finding reinforces the importance of promoting a goodness of fit between a child and the family context in which she/he is being raised. A person's characteristics need to match most of the contexts in which they interact. Without this, maladaptive development, including the development of an eating disorder, may occur. Lastly, the study used a qualitative paradigm. It demonstrated how through rich and thick description,

participants' voices are respected and given center stage in explaining and lending insight to the phenomena under study. In this case the in-depth interviews, ESM data and artifacts provided a means for the reader and researcher to immerse themselves in the lives of the four women. In this manner we came to better understand them and what was associated with the development of their eating disorder. We are humbly grateful for their trust and willingness to share their ideas.

Recommendations

Educators, psychologists and parents need to be informed that both individual characteristics and contextual factors place high ability women at risk of developing an eating disorder. High ability women must find themselves in environments that are conducive to supporting their temperament and needs. Several recommendations are offered to those who interact and educate high ability women. Such women may give so much to others that they ignore their own needs. Before women enter adolescence they should be educated that to nurture does not mean that they have to abandon their own needs. Moreover, women should be educated that in any relationship, they should feel able to openly express their emotions. In addition, professionals and parents need to develop skills to identify temperament and personality characteristics among high ability women and then engage in parenting styles and teaching practices that are conducive to promoting the best of these characteristics. This study demonstrated that over-excitability, hypersensitivity, reward dependence, harm avoidance and perfectionism when coupled with specific dynamics in different contexts was associated with each woman's ED. Those involved with females' care and education should be informed about the following issues:

1. High ability women with EDs developed reward dependence in part because they believed their parents' love was conditional. The women believed themselves to be worthless and thus sought external validation. At an early age high ability women need to be given opportunities to develop an internal sense of self-worth and should be told by their parents that they are unconditionally loved. Recognition and love

need to be given for who they are, not what they do.

2. High ability women with EDs manifested harm avoidance. Hyper-sensitive, they experienced childhood events (i.e. abandonment) with emotional intensity. Because the women had no adult to share their feelings, they never dealt with their emotions. This left the women emotionally hurt and fearful of the world. Those in contact with young women who are sensitive should be aware how they perceive and experience events (i.e. death, change and, loss). Adults need to provide emotional support and convey the message that people should always have the freedom to openly express what they are feeling.

3. High ability women with EDs are perfectionists. They often set unrealistic expectations for themselves and assess their worth based on their accomplishments. Care should be given not to reinforce this tendency. Rather we should impress high ability women that they are valuable and loved regardless of what they achieve. They should be also helped to set realistic expectations and learn to deal with criticism in healthy ways.

4. High ability women with EDs may have an over-excitible disposition. They have a need to be stimulated, but when they are exposed to a great deal of stimulation they may become overwhelmed. At a young age such individuals need to be aware of their tendencies and learn to control their commitments. They need to learn skills to help them reduce over-reaction to stimuli. Since events in life that entail change may cause distress, an effort should be made to ensure that much change and stress is moderate in their lives. A stable, predictable home and school environment where chaos is kept at a minimum is best suited to those who are over-excitible.

5. High ability women with EDs are hypersensitive. Because of their heightened emotional responses to life events and criticism, they need encouragement to discuss and share their feelings. Parents and educators must never invalidate or mock what they feel or perceive. Knowing that criticism is difficult to accept for the highly sensitive person, others should always use vocabulary that is constructive and positive.

6. The highly able sensitive women with EDs are aware of subtleties in their environment and become easily overstimulated. Therefore, they should not be exposed to emotional information inappropriate for their age. They need to know that they are not responsible for the well-being of adults or others in their environment.

7. Highly sensitive women with EDs may become physiologically over-aroused when exposed to excessive external stimuli. They need help to understand that in times of change and stress they may become overstimulated and therefore need time to adjust. Schools and homes are advised to make modifications to limit the amount of stress to which they are exposed.

8. Women with EDs feel shameful and guilty because they experienced themselves as deficient, worthless, disgusting and as a failure. Care should be provided to ensure they do not say or engage in behaviours that cause them to feel bad about themselves. For instance, allow choices or room for healthy experimentation, but always provide unconditional acceptance so that children feel loved no matter what they achieve.

9. High ability women with EDs may find it difficult to cope with the changes occurring in adolescence. Therefore, there is a need to educate women, parents and teachers that when girls enter adolescence the changes they are under-going may be very distressing. An effort needs to be made to curtail any additional stress placed upon adolescent girls. Knowledge of the potential stressors and the interrelatedness of individual, family, social and cultural factors will help professional and parents recognize those that cultivate the onset of bulimia and/ or anorexia.

10. The women in this study came from families who voiced a high achievement orientation. As such they came to believe that their worth was dependent on what they accomplished. The women felt constant stress and anxiety trying to meet their parents' expectations. Parents should model and educate children that they need to have an internal sense of validation, that they are worthwhile regardless of their

accomplishments.

11. Some of the high ability women with EDs came from families that were enmeshed. They assumed roles inappropriate for their age and did not see themselves as separate entities from their parents. Therefore, some of the women entered adolescence without the necessary tools to negotiate their way through that phase of the life-span. Parents should treat their children as individual, autonomous people. As children develop, they need to be given opportunities to build their self-confidence and to act autonomously with appropriate, safe boundaries.

12. The high ability women in this study came from families where emotional expression was often missing. They felt that they could not talk about what they were experiencing. Families should model and encourage their children to engage in open and honest communication. Opportunities for free expression are paramount.

13. Some of the high ability women with EDs came from families that experienced constant change and instability. Parents should be aware that when chaos is a regular part of a child's life, it can cause maladaptive development. The women in this study said that the social network and the culture conveyed the message to them that being thin, beautiful and accomplished was valued. This value system reinforced each woman's propensity to place unrealistic expectations upon herself (i.e. body weight, academic achievements). As a culture we need expand our efforts to ensure that a woman's value is not related to her body and to her achievements. Changing our value system of what are important attributes for a woman to possess should be addressed.

In essence, this study does not conclude that high ability women have an increased vulnerability to developing an ED. However among the four women with EDs in this study there were a number of commonalities that were representative of individuals classified as highly able. Women with EDs are often seen as intelligent and gifted. Therefore, future research is needed to ascertain if being a high ability female

places one at greater risk for developing an ED. This study has contributed to our understanding of what women with EDs understand contributed to their illness nevertheless it does have its limitations.

Limitations and Future Considerations

One limitation of the present study was that it used a small sample of four women, therefore, the findings cannot be generalized to all high ability women or all women with eating disorders. A second limitation of the present study is that it only used information provided by participants to ascertain the presence of temperamental dispositions. It remains for future studies looking at temperament in high ability women with ED, to collect data from parents about the temperamental traits that they have observed since infancy. Conducting longitudinal research with infants who show temperamental propensities towards hypersensitivity and over-excitability would also be most appropriate. A final limitation of the present study was that it did not include a control group. Future research could study both women with ED identified as highly able as well as those who have not been identified as high ability in order to understand if indeed the latter group has a heightened vulnerability to developing an ED.

Throughout the present research I was committed to allowing the voices of the women to prevail. Consistent with this notion I took steps to provide Hazel, Pat, Sheila and Catherine the opportunity to be active collaborators in the telling of their story. However, as a researcher I brought bias into the research. Ultimately I choose what data to include and exclude in order to tell each woman's story. Each reader may make their own interpretation into the women's words.

To conclude, the high ability women who took part in the study indicated individual and contextual factors interacted to affect the development their eating disorder. This study explored how the individual factors of temperament, personality, psychology of female development, emotional and developmental levels interacted with the family context, social network and culture in the lives of the high ability women with eating disorders. The qualitative study allowed for the emergence of common themes among the four women.

Future research should explore further how individual, family, social and cultural factors in high ability women with eating disorders. This information can then be shared with women at different phases of development, which may increase their resiliency to negotiate the obstacles they face which are associated to the development of eating disorders

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Appendix A

The Clinical Diagnosis of Bulimia Nervosa

According to DSM-IV (1994), to be diagnosed with BN the following criteria must be met,

A .Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

(1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.

(2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics or other medications;fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviours both occur, on average at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify Type

Purging Type: During the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Nonpurging Type: During the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviours, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas (1994, p.549-550).

Appendix A

The Clinical Diagnosis of Anorexia Nervosa:

According to the DSM-IV (1994) the following criteria must be met to be diagnosed with anorexia nervosa.

- A. A refusal to maintain body weight at or above a minimally normal weight for age and height (e.g. weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
- B. Intense fear of putting on weight or becoming fat, even though underweight.
- C. A disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
- D. In post menarcheal females, amenorrhoea, i.e., the absence of at least three consecutive menstrual cycles.

A woman is considered to have amenorrhoea if her periods occur only following hormone, e.g., estragon, administration.

Specify Type

Restricting Type: During the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behaviour (i.e. self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Binge-Eating/Purging Type: During the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics or enemas) (p.544-545).

Appendix B
Summary of Temperament and Personality in AN & High Ability Women

<u>Eating Disorders</u>	<u>High Ability Women</u>	<u>The TPO Temperamental Dimensions</u>
Avoidant personality, shy, fear, rejection, keep a distance (Pryor et al., 1998; Jhonson et al., 1992; Vitousek et al., 1994; Brewerton et al., 1993; Bulik et al., 1995a, 1994). Defensive (Shisslak et al., 1990) Interpersonal distrust (Scrivasagan et al., 1995) Avoid confrontation (Keck et al., 1986) Extreme worry, irritability & emotional disturbance (Tellegen, 1982) Minimization of displayed affect (Strober, 1980) Timid (Tellegen, 1982) Inhibited shy (Brewerton et al., 1993) Socially introverted (Shisslak et al., 1990) Socially withdrawn (Cumella et al., 1999)		<u>Harm Avoidance</u> HA1: Anticipatory worry vs. uninhibited optimism HA2: Fear of uncertainty vs. confidence HA3: Shyness with strangers vs gregariousness HA4: Fatigability vs vigor

Appendix B
Summary of Temperament and Personality in AN & High Ability Women

<u>Eating Disorders</u>	<u>High Ability Women</u>	<u>The TPQ Temperamental Dimensions</u>
Interpersonal Insecurity (Strober, 1980) Reward dependence, serious, rule-conscious, do the right thing (Brewerton et al., 1993; Bulik et al., 1995a; Christodoulou et al., 1995) Hypersensitive to rejection/disapproval (Blatt et al., 1983; Strober, 1991) Sensitive to abandonment, depression triggered by sensitivity (Brewerton et al., 1993) Compulsive, serious, conscious of rules (Christodoulou et al., 1997) Persistence despite frustration and fatigue (Cloninger et al., 1993) Industriousness (Strober, 1980) Dependence (Brewerton et al., 1993) Insecure (Strober, 1980; Brewerton et al., 1993) Perfectionism, Constentious, Exactness, Responsible, Self-Control, Compulsive, Self-Regulatory, Need to Conform (Srinivasgan et al., 1995; Steiger et al., 1992; Strober, 1980, 1981; Cumella et al., 1981)	Conscientious (Clark, 1997; Kerr, 1994) Perfectionism, high achievement orientation/expectations (Silverman, 1991, 1994; Delise, 1992; Kerr, 1997; Webb et al, 1983; Clark, 1997; Silverman, 1993) Hypersensitivity (Silverman, 1994; VanTassel-Baska, 1989; Clark, 1997) Introspective & Intuitive (Piechowski, 1997a; Clark, 1997; Piirto, 1998) Persistence (Clark, 1997; Piirto, 1999; Kerr, 1992).	<u>REWARD DEPENDENCE</u> RD1: Sentimentality vs insensitiveness RD2: Persistence vs irroluteness RD3: Attachment vs detachment RD4: Dependence vs independence

Appendix B
Summary of Temperament and Personality in BN & High Ability Women

<u>Eating Disorders</u>	<u>High Ability Women</u>	<u>The TPQ Temperamental Dimensions</u>
Novelty Seeking (Brewerton et al., 1993; Bulik et al., 1994) Easily bored (Cumella et al., 1981) High arousal (Brassington et al., 1992) High irriability (Waller et al., 1996) Venturesome (Fahy et al., 1993; Bulik et al., 1994; Fichter, Quadflieg & Rief, 1994; Brewerton et al., 1993) Immediate satisfaction (Palme et al., 1999) Impulsivity (Steiger et al., 1992; Lilenfeld et al., 1997; Waller et al., 1996; Fahy et al., 1993; Plame et al., 1999; Cumella et al., 1981; Fichler et al., 1994; Leon et al., 1993; Casper et al., 1992; Brewerton et al., 1993; Suzuki et al., 1994) Low persistence, self-directedness, low tolerance, frustration , procrastination (Cumella et al., 1999) Low self-directedness (Gendall, Sullivan & Bulik, 1998)	Intense, Excitable & Impulsive (Clark, 1991; Delise, 1992; Lovecky, 1994; Piechowski, 1997a) Precocious Behaviours, Hyper-maturity (Piechowski, 1997a; Lovecky, 1994) Genuine Boredom (Vail, 1994) Over-excitabilities (Delise, 1992; Lovecky, 1994; Piechowski, 1997a; Vail, 1994)	<u>NOVELTY SEEKING</u> NS1: Exploratory excitability vs rigidity NS2: Impulsiveness vs reflection NS3: Extravagance vs reserve NS4: Disorderliness vs regimentation

Appendix B
Summary of Temperament and Personality in BN & High Ability Women

<u>Eating Disorders</u>	<u>High Ability Women</u>	<u>The TPO Temperamental Dimensions</u>
Avoidant Personality Style (Pryor et al., 1998; Bulik et al., 1995a; Brewerton et al., 1993; Gendall et al., 1998; Keck et al., 1986) Restraint (Nagelberg, Hale & Ware, 1984) Anxiety, tension (Palme et al., 1999) Extreme worry emotional disturbance (Tellegen, 1982) Difficulty adjusting to change (Fichter et al., 1994) Shyness (Brewerton et al., 1993) Social withdrawal (Cumella et al., 1998) Social anxiety (Lilenfeld et al., 1997)		<u>HARM AVOIDANCE</u> HA1: Anticipatory worry vs uninhibited optimism HA2: Fear of uncertainty vs confidence HA3: Shyness with strangers vs gregariousness HA4: Fatigability vs vigor
Rule Conscious (Christodoulou et al., 1995) Sentimentality (Bulik et al., 1995a) Sensitive to other's approval (Blatt et al., 1983) Persistence (Christodoulou et al., 1995) Perfectionism/Conscientious/Exactness/ Responsible/ Self-Control/ Compulsive/ Self-Regulatory/Need to Conform (Gendall et al., 1998; Palme et al., 1999; Stegier et al., 1992; Cumella et al., 1999; Scrinivasagam et al., 1995; Eisele et al., 1986)	Conscientious (Clark, 1997; Kerr, 1997) Perfectionism, High Achievement Orientation/Expectations (Silverman, 1991; 1994; Delise, 1992; Keer, 1994; Webb et al., 1983; Clark, 1997; Delise, 1992; Kerr, 1997; Silverman, 1993) Hyper-sensitivity (Silverman, 1994; VanTassel-Baska, 1989; Clark, 1997) Introspective & Intuitive (Piechowski, 1994; Clark, 1997; Piirto, 1998) Persistence (Clark, 1997; Piirto, 1999; Kerr, 1997)	<u>REWARD DEPENDENCE</u> RD1: Sentimentality vs. insensitiveness RD2: Persistence vs irresoluteness RD3: Attachment vs detachment RD4: Dependence vs independence

Appendix C
Assessment of High Ability

HAZEL

Characteristics

1. Nomination by teachers

- Honour roll for a number of years in high school 1997,1998, 1999(received by students with an average of 80% or higher)
- Won Religion in Life Certificate, 1994
- Won a position to attend enrichment mini-course program at a University

2. Parents' and guardians' reports

- As a young child very intelligent and bright

3. Reports by club leaders

- While in grade junior high completed course offered by the University of Ottawa introduction to engineering and science
- Nominated and chosen as Patrol leader in girl guides
- Chosen to be leader for YMCA aqua-leaders
- Leader in youth ministry

4. Specific ability tests

- High Academic Marks (94-95%)

5. Creative ability tests

- In drama club (in school)
- Year book club
- Attained a high level of achievement in piano
- Young players (drama association)
- Attained a high level of achievement in swimming
- in the high school band (plays the trumpet)

Products

1. Awards at competitions and meetings

- School award for outstanding co-curricular involvement in track and field, variety/talent show, ski club and public speaking
- Reacher finals in public speaking at public speaking festival

Appendix C

Assessment of High Ability

- Board finals competition in public speaking in 1995, 1996, 1997, 1998, 1999 in French
- certificates for drama club, young players, swimming lessons, band, choir, youth ministry team, volunteering with kids with special needs. Medals for softball and drama class.

2. Work and art creations

- Lead role in a high school play
- Written poems

PAT

Characteristics

1. Nomination by teachers

- has been referred to as high ability

2. Parents' and guardians' reports

- Nothing Provided

3. Reports by club leaders

- Nothing Reported

4. Specific ability tests

- High academic marks (85-98%)

5. Creative ability tests

- Section leader in high school music band

Products

1. Awards at competitions and meetings

- Honour Role Certificate for a number of years.

2. Work and art creations

- written poems
- paints and does sculptures

Appendix C

Assessment of High Ability

SHEILA

1. Peer assessment

- Been referred to as gifted, highly able

Products

1.Publications

- Wrote a novel: *Leaving Food Behind*
- Published Articles: *True Beauty, 1999 & Former Timmins Resident Brings Hope*
- .Wrote a self-help workbook for women with eating disorders

2.Awards at competitions and meetings

- Received awards in school sports, community involvement and leadership roles
- Nominated President of Public Relations for Toastmaster's

3.Work and art creations

- Creates graphic designs (i.e. business cards and brochures)
- Created and maintains a web site
- Plays guitar
- Sings and sews

CATHERINE

Characteristics

1. Nomination by teachers

- Referred to as gifted and highly able
- A+ average in undergraduate and graduate school

2. Peer assessment

- Superior evaluation for written and writing workshops by literary colleagues and participants

Appendix C

Assessment of High Ability

CATHERINE Products

1.Publications

- And Know The Place*
- Fugue in Winter*
- Locked Rooms*
- The UnKnown Shore*
- Published a number of poems*

2.Awards at competitions and meetings

- Recipient of a one year *Explorations Grant* for fiction from the *Canada Council*
- Recipient of a one year grant *Gloucester Arts Council*

3.Work and art creations

- Writing workshops for Adults
- Writing workshops for students in alternative high school program
- Writing workshops for girls with anorexia and bulimia nervosa
- Writing workshops in a hospital for people with mental illness
- Manuscript evaluations for other writers
- Artist in a school program,
- Lecturer
- Writing research profiles for the Annual Report of the Social Sciences and Humanities Research Council (SSHRC)
- Editing and proofreading guides for Japanese industries
- Free-lance writer for a number of companies
- With CIDA developed teaching materials
- Policy Analyst
- Editorial consultant for journal
- Speech writing for members of Parliament

Appendix D

Parent Consent Form

**Principal Investigator: Maria Assunta Cuffaro Affiliation: Doctoral Student, University of Ottawa
Telephone no:(613) 226-2291**

Whenever a research project is done with human participants, the written consent of the participants must be obtained. When the participants are under eighteen, the written consent of the legal guardians must be also obtained. This does not mean that the project in question involves a risk. In order to protect the rights and well-being of participants, the University of Ottawa and the research funding agencies have made the signing of a consent form mandatory.

The purpose of the study is to understand your daughter's experience with an eating disorder specifically to understand if high ability women have a heightened vulnerability to the development of an eating disorder. Women bring individual factors (i.e. personalities) that may interact with environments to increase vulnerability to eating disorders. The study will try to understand how individual factors (i.e. personality) and environments (i.e. school) interact to lead to the development of an eating disorder.

I am asking for your permission to allow your daughter _____ to take part in this study. All the participants who take part in the study are high ability women with an eating disorder. Approximately four or five women spanning in age between sixteen to seventy will take part in the study. None of the participants with an eating disorder are currently hospitalized. If you agree for your daughter to participate, her participation will consist of attending 3 contact visits (two will be 15 minutes each and the third is 20-30 min). The first contact visit will last 15 minutes. Participants who do not meet the criteria for inclusion in the study will only take part in contact visit one. To obtain participants, I posted recruitment letters explaining my study in various clinics and support groups for women with eating disorders. All the participants who call me by telephone and indicate they are interested in taking part in the study I will telephone and arrange a time for the first contact visit. The location of all the contact visits will be at the University of Ottawa in my office. During the first contact visit, potential participants will be asked to fill out a questionnaire asking demographic questions.

The participants who meet the following criteria will be chosen as participants (a) have experienced or are currently experiencing anorexia nervosa or bulimia nervosa as diagnosed by a mental health professional or themselves (b) if they are currently suffering from an eating disorder they are not living within a hospital setting and (c) show evidence that they are high ability women. Once the participants who meet the criteria are selected, I will send a letter to all the participants informing them if they were selected or not selected to take part in the study and explain the reasons for my decision.

Appendix D

Parent Consent Form

I will telephone the participants chosen and set a time for a second contact visit that will last 15 minutes. During the second contact, visit the experience sampling methodology (ESM) will be introduced. Once all the data is analyzed I will mail participants a summary of the results. The participants will be asked to review the results to ensure that I have said what is truthful. When the participants come for the third interview, they will be asked to go over the omissions or corrections they made on summary of the results. One week after this I will telephone the participants to set an appointment for a third contact visit that will last approximately 20-30 minutes.

Participants will also be asked to attend 3 interviews (90 minutes each). The interviews will be scheduled 2 to 3 days apart and will take place at the University of Ottawa in my office. The goal of the first interview is to obtain information about each participant's life history. The goal of the second interview is to concentrate on the specific details participants presently experience regarding their eating disorders. Interview three aims to obtain reflection and meaning. Participants are asked to reflect on the meaning of their eating disorder.

Your daughter's participation will consist also of carrying a pager for 3 days (One weekday, and one Saturday and one Sunday). She will be asked to answer to the pager between 8:00 am to 10:00 pm. She will be asked to respond to each page by filling out a questionnaire asking what she was doing, who she was with and how she felt when paged.

Carrying a beeper for three days may cause a great deal of intrusiveness since you daughter will be paged seven times a day. The times you will be paged are 10:00 a.m., 12:00 p.m., 2:00 p.m., 4:00 p.m., 6:00 p.m., 8:00 p.m and 10:00 p.m. Due to the nature of the questions perhaps a sense of uneasiness or discomfort may occur regarding some of the questions asked in the three interviews. These questions may lead to the recall of specific negative life events that have happened to them. In addition carrying a beeper and may draw attention. However, the beeper method has been used with adolescents and adults with eating disorders and has been found not to be intrusive. However, if the participant feels any discomfort they can turn off the pager. The beeper has a vibration signal so when the participant is paged no one can hear the beeper. A list of resources is attached to the consent form in case participants have any negative emotional reactions stemming from questions asked to them.

All the information obtained will remain confidential and will only be available to myself and to my thesis advisor. The names and any identifying characteristics of the participants will not be used in any discussions or print matter. The response to interviews, the beeper and analysis of this information may be part of the final Ph.D. thesis, future academic publications or professional presentations. Throughout the study any data obtained from participants will be filed at my home in a safe location with only myself having access. Once the final thesis is submitted and defended all the information collected will remain in a safe location at my home. I will keep the data for five years and then will destroy it (using a paper shredder) myself to further ensure confidentiality.

Appendix D

Parent Consent Form

The benefits of the proposed study for participants is that it may help women who are currently suffering from an eating disorder gain insight about what their eating disorder means. Moreover, through dialogue with the researcher the participant may feel telling her story is therapeutic and this may carry the potential or desire to recover or seek treatment.

I understand that the contents will be used only for the Ph.D. thesis, academic publications or professional conferences purposes and that my daughter's confidentiality will be respected.

I am aware that my daughter is free to withdraw from the project at anytime, before or during an interview, refuse to participate, and refuse to answer questions without consequences.

I have received assurance from the researchers that the information my daughter will share will remain strictly confidential. I will be sent an summary of the results.

Any information requests or complaints about the ethical conduct of the project may be addressed to the Research Ethics Board (562-5800, ext.1787). If I have any questions, I may contact Professor Janice Leroux, Tel:(613) 562-5800 (ext.4159). There are two copies of the consent form, one of which the participant may keep and one which the researcher will keep.

Parent's signature

Date

Researcher's signature

Date

Thesis Director

Date

I, _____, am interested in collaborating in the study _____ conducted by Professor Janice Leroux and Ph.D. student Maria Assunta Cuffaro of the Faculty of Education of the University of Ottawa.

Optional: I wish to receive a summary of the findings of this study which will be available on August 2000 (approximate date) at the following address:

Appendix E

Participant Consent Form

the research funding agencies have made Principal Investigator: Maria Assunta Cuffaro Affiliation: Doctoral Student, University of Ottawa Telephone no: (613) 226-2291

Whenever a research project is undertaken with human participants, the written consent of the participants must be obtained. When the participants are under eighteen, the written consent of the legal guardians must be also obtained. This does not imply, of course, that the project in question necessarily involves a risk. In view of the respect owed the participants, the University of Ottawa and this type of agreement mandatory.

The purpose of the study is to understand your experience with an eating disorder. If I agree to participate, my participation will consist essentially of attending 3 contact visits (two will last 15 minutes each and the third will last 20-30 min) and 3 interview sessions (3-90 minutes each). The sessions have been scheduled 2 to 3 days apart. I will be asked to answer questions in an interview. My participation will consist also of carrying an electronic pager for the duration of 3 days. I will be asked to respond to the pager between 8:00 a.m to 10:00 p.m. I will be asked to respond to each page by filling out a self-report form. I understand that the contents will be used only for doctoral dissertation purposes and that my confidentiality will be respected.

I understand that since this activity deals with very personal information, it may induce emotional reactions which may, at times, be negative. I have received assurance from the researchers that every effort will be made to minimize these occurrences.

I am free to withdraw from the project at anytime, before or during an interview, refuse to participate, and refuse to answer questions without consequences.

I have received assurance from the researchers that the information I will share will remain strictly confidential. I, in turn, assure other participants that I will treat in the same confidential manner any information I may obtain in the context of this project. Parents of women under 18 will be sent an executive summary of the results where pseudo names will be used.

Any information requests or complaints about the ethical conduct of the project may be addressed to the Research Ethics Board (562-5800). If I have any questions, I may contact Professor Janice Leroux, Tel: (613) 562-5800 (ext.1787). There are two copies of the consent form, one of which I may keep.

Participant's signature

Date

Appendix E
Participant Consent Form

Researcher's signature

Date

I, _____, am interested in collaborating in the study _____
conducted by Professor Janice Leroux and Ph.D. student Maria Assunta Cuffaro of the Faculty of
Education of the University of Ottawa.

Optional: I wish to receive a summary of the findings of this study which will be available by
August 2000 (approximate date) at the following address:

_____.

Appendix F

Interview Guide

In every interview thank each woman for her participation in the study. I will explain that I am interested in how she experienced her ED and talk about what was associated to its development.

Interview One: Focussed Life History of Woman's Life Before the Eating Disorder

1. Thank you for taking part in the study. I would like us to talk about what has influenced the development of your ED? Could you talk of your experiences, emotions or memories about your life before the ED?

Questions for adolescents and adults

- (a) How would you describe your family?
- (b) How would the people closest to you describe you before the ED?
- (c) Tell me about the experiences and memories involving school, classmates and teachers before you had an ED?
- (d) How would you describe the role your peers had in your life before the ED?
- (e) Can you provide me with a description of the community you were part of before the development of the ED?

Question for adolescents only

- (f) How would you describe the role of play in your life before the ED?

Question for adults only

- (g) How important is/was work to you before your illness and why?

Interview Two: Details of Eating Disorder Experience

1. Thank you for taking the time to come to a second interview. I found that our first interview helped me to understand what your life was like before the ED. Today we will talk about the details of the experiences that were associated to your ED.

Questions for both adolescents and adults

- (a) Can you tell me of the first memories of your ED?
- (b) Can you tell me how you felt about yourself when you developed an ED?
- (c) How did you see, perceive and act towards the world when you developed an ED?
- (d) Tell me how you feel and think when you are not eating or bingeing and purging?
- (e) How do significant people in your life perceive you?
- (f) Describe for me in as much detail as possible what a routine day was/ is like for you after the onset of the ED.
- (g) If I asked you to write an autobiography about your ED, what would the titles of the chapters be?
- (h) How did you cope with the demands of daily living when you developed an ED?
- (i) How did you live your life after you developed an ED?
- (j) Can you tell me the priorities and goals you held after you developed the ED?

Appendix F
Interview Guide

Interview Three: Reflection on the Meaning of the Experience of the Eating Disorder.

3. Thank you for coming to the final interview. Based on what you have told me about your life before and after the onset of your ED, I would like in this interview to understand how you make sense of what your ED meant in your life.

- (a) What do you believe was associated/is associated to the development of your ED?
- (b) What role did/does the ED serve for you?
- (c) What were/are the critical experiences, memories you have that in your understanding were associated to the ED?
- (d) What would you identify as the coping strategies you use/used during your ED?
- (e) What is your role or responsibility in the development of the ED?
- (f) What role do you understand the world around you had in the development of your ED?

Appendix G
Experience Sampling Self-Report Form

Date: _____ Time Beeped: _____ am/pm Time Filled out _____ am/pm
 as you were beeped...

What were you thinking about? _____

Where were you? _____

What was the MAIN thing you were doing? _____

What other things were you doing? _____

WHY were you doing this particular activity?

☐ I had to ☐ I wanted to do it ☐ I had nothing else to do

	not at all	1	2	3	4	5	6	7	8	9
How well were you concentrating?	0	1	2	3	4	5	6	7	8	9
Was it hard to concentrate?	0	1	2	3	4	5	6	7	8	9
How self-conscious were you?	0	1	2	3	4	5	6	7	8	9
Did you feel good about yourself?	0	1	2	3	4	5	6	7	8	9
Were you in control of the situation?	0	1	2	3	4	5	6	7	8	9
Were you living up to your own expectations?	0	1	2	3	4	5	6	7	8	9
Were you living up to the expectations of others?	0	1	2	3	4	5	6	7	8	9

Describe your mood as you were beeped:

	very	quite	some	neither	some	quite	very	
alert	0	o	.	—	.	o	0	drowsy
happy	0	o	.	—	.	o	0	sad
irritable	0	o	.	—	.	o	0	cheerful
strong	0	o	.	—	.	o	0	weak
active	0	o	.	—	.	o	0	passive
lonely	0	o	.	—	.	o	0	sociable
ashamed	0	o	.	—	.	o	0	proud

Appendix G
Experience Sampling Self-Report Form

involved	0	o	.	—	.	o	0	detached
excited	0	o	.	—	.	o	0	bored
closed	0	o	.	—	.	o	0	open
clear	0	o	.	—	.	o	0	confused
tense	0	o	.	—	.	o	0	relaxed
competitive	0	o	.	—	.	o	0	cooperative

Did you feel any physical discomfort as you were beeped:

Overall pain or discomfort	none	slight	bothersome	severe
	0 1 2 3 4	5 6 7 8 9		

Please specify: _____

Whom were you with?

☐ alone ☐ friend (s) How many? _____
☐ mother ☐ female ☐ male

☐ father ☐ strangers
☐ sister(s) or brother(s) ☐ other _____

Indicate how you felt about your activity:

	<i>low</i>								<i>high</i>
Challenges of the activity	0	1	2	3	4	5	6	7	8 9
Your skills in the activity	0	1	2	3	4	5	6	7	8 9

	<i>not at all</i>								<i>very much</i>
Was this activity important to you?	0	1	2	3	4	5	6	7	8 9
Was this activity important to others?	0	1	2	3	4	5	6	7	8 9
Were you succeeding at what you were doing?	0	1	2	3	4	5	6	7	8 9
Do you wish you had been doing something else?	0	1	2	3	4	5	6	7	8 9
Were you satisfied with how you were doing?	0	1	2	3	4	5	6	7	8 9
How important was this activity in relation to your overall goals?	0	1	2	3	4	5	6	7	8 9

Appendix G
Experience Sampling Self-Report Form

If you had a choice...

Whom would you be with? _____
What would you be doing? _____

Since you were last beeped has anything happened or have you done anything which could have an effect on the way you feel?

Nasty cracks, comments, pictures.....

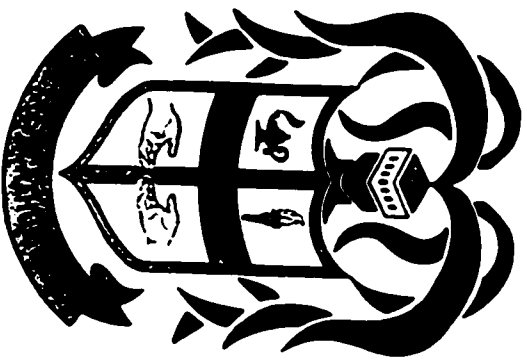
Modified from Csikszentmihalyi, M., & Larson, R. (1992).

Appendix H
Artifacts for Hazel's Case Study

Honour Certificate

This Certificate is presented to

in recognition of achieving an average of
eighty percent or higher.



ST. PETER CATHOLIC HIGH SCHOOL

Principal

Date



Carleton
UNIVERSITY

Enrichment Mini-Course Program
May 1999

This is to certify that

has participated in the
Enrichment Mini-Course

Emma Chisit And The Fourth Earl Of Sandwich

given at
Carleton University



1981 - 1999

Benoit Magnidy
Instructor

Robin Allardyce
Robin Allardyce, Director
Instructional Television

SIGNATURE OF SCHOOL OFFICIAL
SIGNATURE DE LA PERSONNE AUTORISÉE

* -DENOTES COURSE FINAL MARK FOR SCHOOL YEAR

DIES / PROGRAMME D'ETUDES		TEACHER / ENSEIGNANT (E)	COMMENTS / OBSERVATIONS	MEDN	MARKS/ NOTES	EARNED CREDITS OBTAINED
MUSIC REPERTOIRE		VIGNERON, G.	EXCELLENT WORK! SABS = 0	93	96	1.00
ENGLISH		LESLIE, E.	DEMONSTRATES EXCELLENT INSIGHT AND ORIGINAL IDEAS. SABS = 4	74	87	1.00
LIVING IN A CHANGING WORLD		O'CONNOR, J.	A VERY POSITIVE CONTRIBUTOR TO COURSE. A PLEASURE TO HAVE YOU IN CLASS. SABS = 2	78	94	1.00
FAMILIES IN CANADIAN SOCIETY		BEUTHIEN, G.	EXCELLENT WORK! SABS = 7	76	92	1.00
HEALTH & PERSONAL SERVICES TECH.		O'NEILL, J.	STUDENT IS HAVING EXCELLENT RESULTS IN PRACTICAL WORK. SABS = 9	85	90	1.00

FINAL AVERAGE 91.2

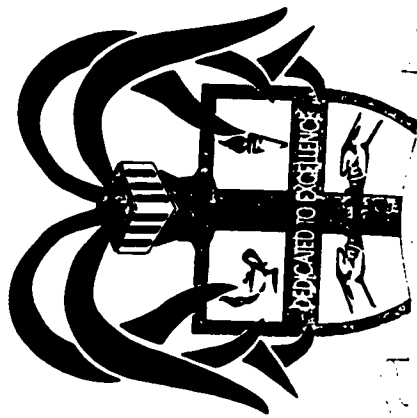
Daily Attendance		TOTAL	
ABSENCE	3	4	
DAYS	1.0	1.0	2.0
1/2 DAYS	0.0	0.0	0.0
LATE	0.0	0.0	0.0

FIRST DAY OF SCHOOL: SEPTEMBER 5, 2000

HAVE A GREAT SUMMER!

YOU HAVE EARNED 5.00
CREDITS OUT OF 5.00
ATTEMPTED

Honour Certificate



This Certificate is presented to

✓

in recognition of achieving an average of
eighty percent or higher.

OLJC

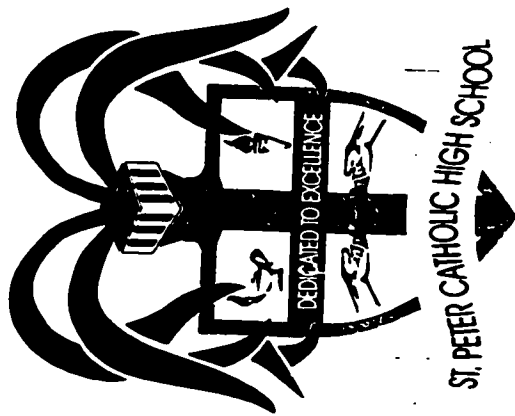
Bulbin

Principal

June 19, 1998

Date

Honour Certificate



This Certificate is presented to

in recognition of achieving an average of
eighty percent or higher.

ST. PETER CATHOLIC HIGH SCHOOL

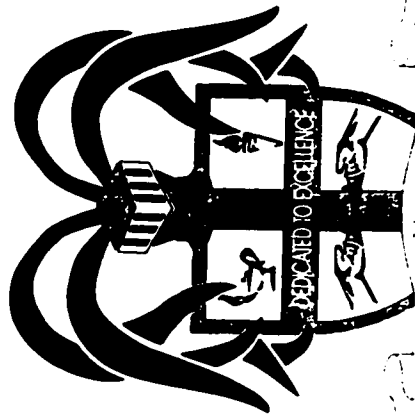
Blahm

Principal

June 19, 1997

Date

Honour Certificate



This Certificate is presented to

in recognition of achieving an average of
eighty percent or higher.

OLJC

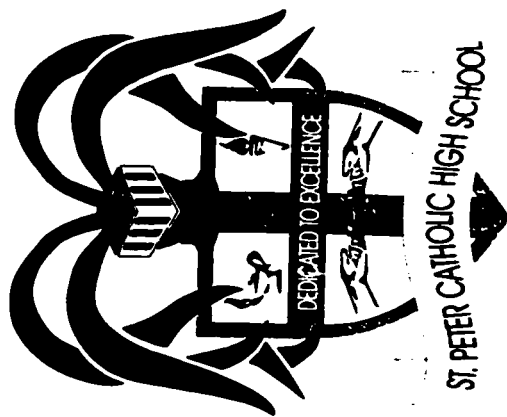
B. Wilson

Principal

June 19, 1998

Date

Honour Certificate



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In recognition of achieving an average of
eighty percent or higher.

ST. PETER CATHOLIC HIGH SCHOOL

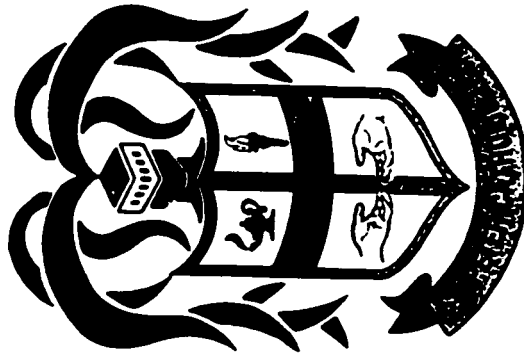
B. Khan

Principal

June 19, 1997

Date

Honour Certificate



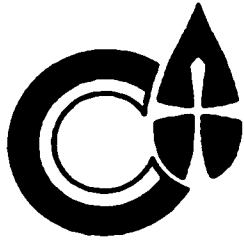
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in recognition of achieving an average of
eighty percent or higher.

ST. PETER CATHOLIC HIGH SCHOOL

Principal

Date



**Carleton Roman Catholic
School Board**

Certificate in Public Speaking School Finals

This certificate is to honour

**in recognition of outstanding performance in
public speaking.**

School

APRIL 7, 1995

Date

Principal

Teacher



ADVENTURES

IN ENGINEERING AND SCIENCE

Certificate of Participation



has successfully completed a forty hour introduction
to Engineering and Science

[Handwritten signature]

University of Ottawa

Instructors

Summer 1994

Director

Bravo! pour un discours remarquable à la finale ontarienne.
Félicitations de la part de l'Association
ontarienne des professeurs de langues vivantes
et de Canadian Parents for French.



Simone Oliver

Présidente de l'Association ontarienne des
professeurs de langues vivantes

Brenda T. Grand

Présidente de Canadian Parents
for French (Ontario)

Carleton Roman Catholic School Board

Cours d'Art Oratoire

Français Langue Seconde

Cycle 7^e et 8^e

HONNEUR ET MÉRITE

À —

Président(e) du Conseil

Jeanne Thériault



Directeur de l'Éducation

Philippe G. Boes

le 24 mars 1997

CONCOURS D'ART ORATOIRE

*Certificat de mérite
présenté à*

pour sa participation au
CONCOURS D'ART ORATOIRE

21

Marion Seignin
Signature

le 12 mars 1998
Date

Carleton Roman Catholic School Board

Cours d'Art Orale

Français Langue Seconde

Cycle 7^e et 8^e

HONNEUR ET MÉRITE

À —

Président(e) du Conseil

Jane Flynn-Jones



Directeur de l'Éducation

Philip A. Pardo

Le 6 mars 1996

ART ORATOIRE

*Certificat de mérite
présenté à*

*pour sa participation au
CONCOURS D'ART ORATOIRE
à l'école St. Peter Catholic High School*

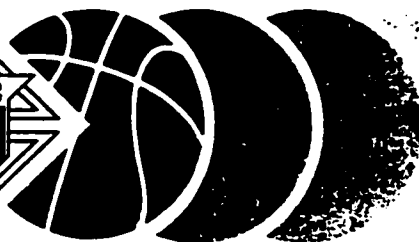
B. Walim

Signature

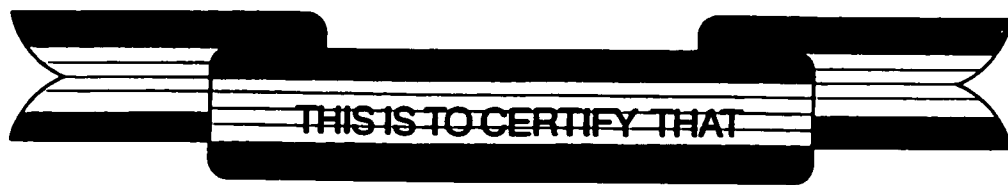
March 5 1997

Date

*Knights of
Columbus*



F R E E T H R O W C H A M P I O N S H I P



Has Participated In The

**KNIGHTS OF
COLUMBUS
FREE THROW
CHAMPIONSHIP**

SPONSORED BY Council 7873

DATE January 14, 1995

Divine Infant

GRAND KNIGHT





Girl Guides
of Canada
Guides
du Canada

11

was a Guide in the

Company. She was enrolled

November 10 1992

and left the Company

June 6 1995

She was

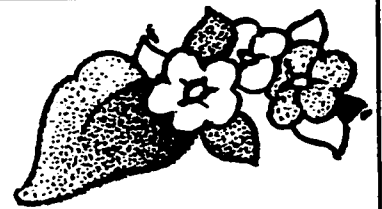
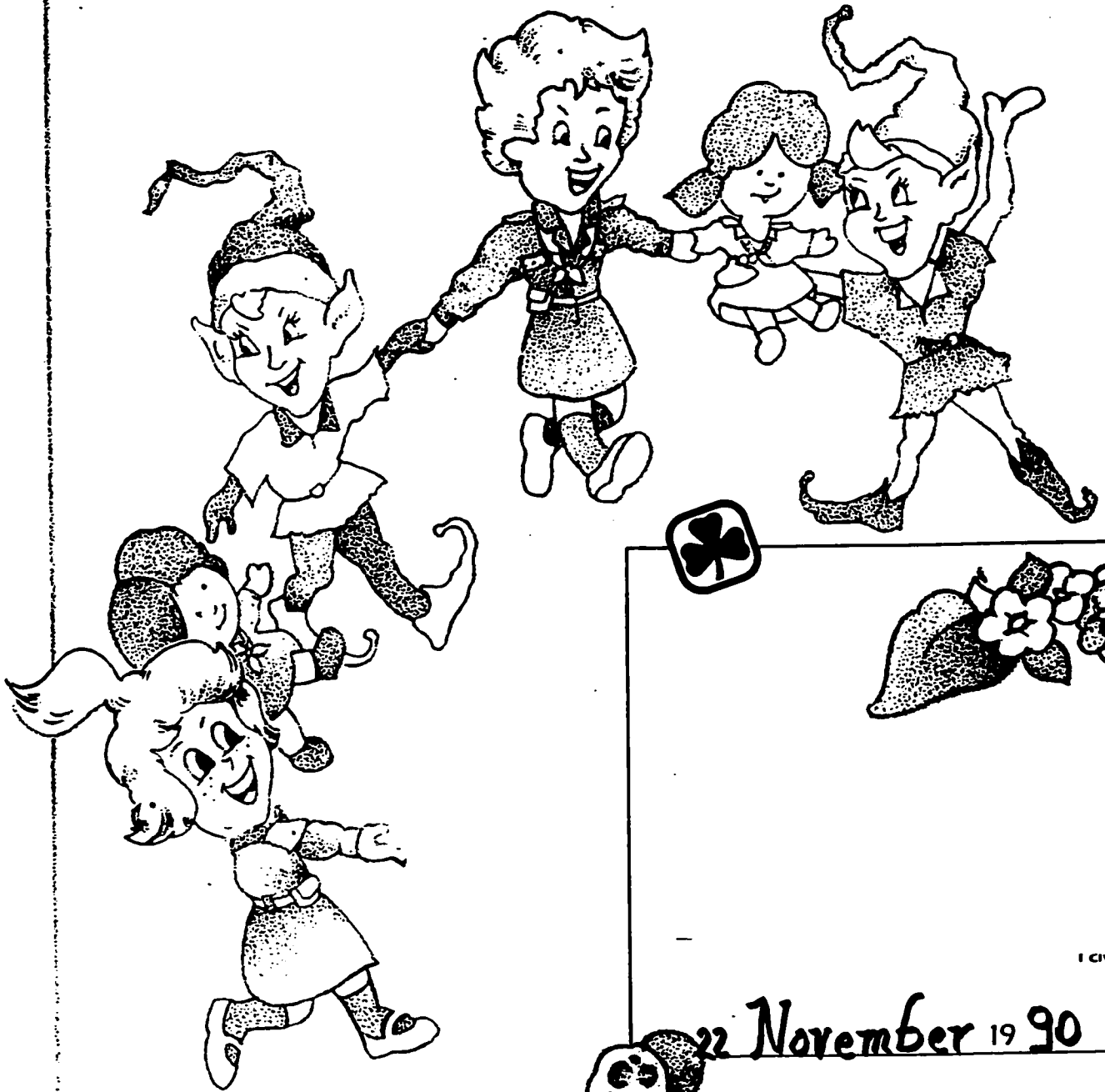
Patrol Leader

of the

Daffodil

Patrol. She has joined





ack

22 November 1990



Girl Guides
of Canada
Guides
du Canada





Girl Guides
of Canada
Guides
du Canada

Company. She was enrolled

November 10, 1992

and left the Company

June 6, 1995

She was

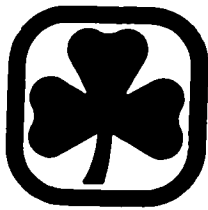
Patrol Leader

of the

Daffodil

Patrol. She has joined





Girl Guides
of Canada
Guides
du Canada



Religion in Life Certificate

Granted to

*who has completed
the requirements for the*

second

*Stage of the
Religion in Life Program*

Spiritual Leader

Girl Guide/Scout ✓

May 14, 94
Date

I Promise To Do My Best
To Do My Duty To God

Service des Incendies
Cumberland
Fire Department

*This is to certify that
Ce document certifie que*

*has satisfactorily completed
a completé satisfaisamment*

Fire Safety Badge

October 19, 1993
Date


Fire Chief
Chef

This certificate acknowledges that

has successfully completed the Buddy Program for
Summer Camps 1999 with the City of





Judith Tremblay

Program Coordinator



Seema Guram

Camp Coordinator

Insurance policy

The Certificate Holder is protected under an Excess General Liability policy, in the amount of One Million Dollars (\$1,000,000), for possible claims that may result from giving first aid. The policy bearing #1620139 is issued to the Certificate Holder for a period of 3 years.

The coverage is provided to the Certificate Holder as a condition of graduation.

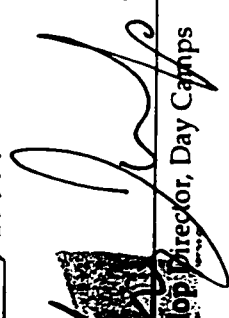
- Bodily injury and property damage
- Medical expenses
- The cost of defense

YOUTH ADVENTURE CAMP

NOTARY PUBLIC
This is to certify that

_____ has completed the 2 week YMCA-YWCA Youth Adventure Camp Program.

This day of July, 1997.



Leadership Counselor, YMCA-YWCA of /d'Onawa-Carleton is Director, Day Camps



The Terry Fox Run

For Cancer Research



This Certificate Certifies that

De

has participated in the Terry Run(s) for the year(s) indicated

January

Appendix I
Artifacts for Pat's Case Study

Journal Entries

Jan. 12, 2000

I sit here, at my desk, shoving another greasy cheese stick into my mouth. This is my third, although the three cheese sticks are the only things I have eaten today. I feel so fat. Yesterday I had a tiny bowl of pasta and that's all I had. Now I'm going to have dinner and shove more food down my throat. Being at school does not help. All the girls are so thin and all I see is fat on myself. I'm huge and I take up so much room and space in the world. Today I tried to purge myself. I went to the bathroom and rammed my finger down my throat. I gagged and my eyes watered, but I couldn't make myself bring up my food. I'm pathetic. I can't even do something as simple as that. My marks in biology dropped from an 84% to an 82% and English went from 92% to 88%. I'm screwed. I have to work double over time to get them higher before exams.

Jan. 13, 2000

I'm so pathetic. I gave in and ate today. I had a huge bowl of pasta (about 15gms of fat), an orange and a handful of chips. I looked at myself in the bath and I nearly died. I'm so huge! I wish I could eat, then purge, because starving and restricting is so hard. I've only really been starving myself severely since Monday and it's only Thursday. I need to weigh less, like around 82 lbs. I don't even know why. I never used to be like this, so concerned about my appearance & weight. What's wrong with me.

Journal Entries (continued)

mar. 1, 2000 (Hofewill meeting)

Today I learned what the word anguish finally meant. I saw it on someone else's face and I heard it in their voice. All the hurt and pain; trying so hard to be composed, fighting everything to keep it all from spilling out. It was so deep, so painful; it was all I could do to keep from crying out. To see this look on someone's face physically hurts. It creates a gut-wrenching feeling that rips out your heart, tears at your soul and steals your next breath, leaving you gasping for air. You breathe in deeply, harder; watching for the composer to come undone. We are all waiting for the silence to break. It never comes and you can't breathe. Why does this hurt so much? It's as if a knife stabs you in heart and leaves you to bleed as it's plunged deeper. Eventually you'll die. You look at the pain, fear and desperation on a face and you realize ~~you saw~~ you've seen that look before. As you gaze into a mirror, you discover that the face is your own. You feel this way - with all the hurt, pain, suffering, shame. You cannot move and the very core of your being is collapsing. It hurts too much. You're screaming with all of your might, but no one can hear you through the deafening silence. You're drowning in your own tears and there's no one to save you. You've lost control and there's no turning back. Today I experienced the word anguish for the first time. I finally understood what it meant.

Journal Entries (continued)

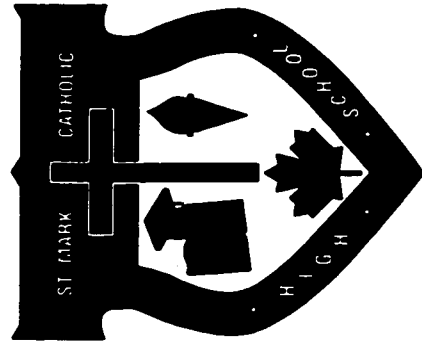
Mar. 2, 2000

I don't know what's wrong with me. I'm hungry ~ or at least I was hungry. Even though I can count on one hand what I've eaten today, I still feel so fat, bad, guilty I've eaten too much and what's even worse is that I've let myself give in. I used to be able to starve myself for a whole school day, but now I can't do it anymore. I've lost total control and I can't get it back. I wish I could binge and purge because then I could eat and maybe not feel so bad. I can't believe I'm saying this. I'm such a horrible, bad person. I don't seem to care about anything anymore I'm just so tired of it all.

June. 28, 2000

Reading over past journal entries is depressing. Sad thing is, it hasn't gotten any better. I'm not doing any better. I'm still trying to starve myself, but it's still not working. I'm so weak and pathetic. I can't do it. I'm so hungry all the time. I still wish I could purge. I've thought of it so often. School went so badly. My English exam ~~raped~~ me and I know I failed. I was so fried trying to write my religion exam afterwards, I know I still did poorly. With my other exams, I just didn't care anymore. I'm so tired. I've been taking medication to try and calm my anxiety. It's not working. I've also been reading so books on ED's to try and help myself, but I really don't care. I'm passed caring. Sometimes... I wonder... why I hate myself so much.

Honour Certificate



This Certificate is awarded to

in recognition of academic
achievement with honours

St. Mark Catholic High School
Manotick, Ontario

Principal

June 1998

Date

To Whom it may concern,

I hereby give Maria Cuffaro full consent to document any conversation, words thoughts, feelings, actions and any other necessary details in her study. I am fully aware of what has been already written, and I verify that every testimony was done in truth. I gave all my answers freely and willingly and was in no way influenced or forced to change my answers. Everything has been completed openly, honestly and professionally. I understand that my personal information will be withheld and I will remain anonymous for the sake of confidentiality. The documentation portrayed the nature of the topic and issues discussed accurately, purposely, and thoughtfully. Therefore, permission, verification and issues surrounding the study have been dealt with professionally.

I have read and understand all that has been documented and I comprehend all that had been asked of me. I give full verification and permission to Maria Cuffaro for the purpose of her study.

Sincerely,

A blacked-out redacted signature.

Appendix J
Artifacts for Sheila's Case Study

Poems Written by Sheila

We live in an imitation world. We make replicas of the real thing
We use each other to achieve our own goals
We step on people and hurt them
We call them friends yet they're only stepping stones
And worst of all we use the word love as just a
word and not a feeling. Love is real not imitation

Love is for dreamers
Love is for sharing
of time and moments
of heartbreak and victory

To pass the true test
To live through it all
To accomplish this
Is the hardest task
But to do this
Is all I ask!



MATHER PUBLICATIONS

August 26, 2000

Maria Cuffaro
27 Lipstan Avenue
Nepean, ON
K2E 5Z2

Dear Maria,

I'm so impressed by the work you've done on my arm of your study. You have embraced the very essence of what I hoped to communicate to you—with accuracy. Also, you were successful in not imputing your interpretation.

Maria, it was a great experience participating in your study. Meeting with you, carrying and responding to the beeper, and finally, reading your documentation caused me to be grateful for where I am in my life now. Heretofore, especially during my eating disorder, I would have never thought I could feel so happy, peaceful, and be myself—all the time.

I would like to close by conveying how grateful I am that you are committed to uncovering the complex causes of eating disorders. As you know, I believe an eating disorder is caused by an emotional disconnection—or not having ever formed a connection—with parental or guardian love. I hope this fact is soon a central component of the treatment process.

Congratulations on your great work, Maria!

Warmest wishes,

Sheila Mather
President

An Autobiographical Book Called

Leaving Food Behind

Author: Sheila Mather

*An inspiring personal story of recovery from
Bulimia, Starving and Overeating*



**Sheila Mather speaks at
radio and television
stations, schools,
libraries, hospitals,
eating disorder clinics
and bookstores
throughout North
America.**

**Please contact us to
have Sheila visit your
location.**

**\$17.99 Can**

(\$14.95 + 1.05 GST + 1.99 s&h)

\$15.94 US

(\$12.95 + 2.99 s&h)

\$21.85 US, all orders outside North
America[About the Author](#)[About The Book](#)[Table of Contents](#)[Speaking
Events](#)[Order Form](#)[Introduction](#)

To order *Leaving Food Behind*,
please go to the [order form](#) or call our Toll-free number:

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or send a cheque or money order including
your full name, full address and telephone number to:

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Nepean, ON, Canada, K2G 5Y9

Voice: 613-226-8252 * Fax: 613-225-3044

(please allow 1-2 weeks for delivery)

Site created by:

jazz@igs.net<http://www.leavingfoodbehind.com/>mathermh@civheris.ca

4/17/2000.

About The Book

... nobody knew. I would eat enough for four, go to the washroom after every meal, or starve for three days straight. For ten years, nobody knew I had a problem with food -- I fooled everybody. Nobody knew, not even me, that my eating disorder was never about food. I had been feeding myself love, safety, security and strength. I could conquer the world, be anybody, do anything when I was eating. When I felt I was losing control of my eating, I starved and immediately, I regained control. Then one bright sunny spring day, the sunlight shone down on me, exposing the person I had become. Student and employee by day -- binger, purger, exerciser and starver by night. I felt revolted but couldn't run. I could no longer binge, purge, starve or overeat -- my body was utterly exhausted. My emotions were painful well beyond my control. My recovery began. For the next four years, I experienced emotions I had held inside me, emotions that previously I had been too afraid to feel. Little by little, I was becoming the person I had been born to be. I felt happy, excited and alive. I felt a vibrant inspiration to participate in life. I wanted to live -- and I was -- living and feeling in this beautiful world. This book is about how I came out of hiding and back into life . . . leaving food behind.

"I couldn't put this book down. Only someone who had been through it herself could have reached me. I felt hope for the first time in a very long time."

Canada

--Ester S., Ottawa,

"Sheila's story was my first big step in overcoming bulimia. I learned to feel again. I no longer feel ashamed or alone."

Canada

--Carla I., Halifax,

"I learned that loving and valuing oneself is possible."

Canada

--Helen M., Ottawa,

Table of Contents

One	<i>My Eating Disorder</i>
Two	<i>Guilt</i>
Three	<i>Shame</i>
Four	<i>Fear</i>
Five	<i>My Escape</i>
Six	<i>My Head and Heart</i>
Seven	<i>How I learned My Thoughts</i>
Eight	<i>My Basic Messages</i>
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Ten	<i>I Was Guilty</i>
Eleven	<i>I felt Inferior</i>
Twelve	<i>I Searched for My Identity</i>
Thirteen	<i>I Isolated Myself</i>
Fourteen	<i>The Beginning of My Recovery</i>
Fifteen	<i>Anger</i>
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Seventeen	<i>My Warehouse of Emotions</i>
Eighteen	<i>My Experience with Grief</i>
Nineteen	<i>Stepping Out of My Symbolic World</i>
Twenty	<i>My Spirit World</i>
Twenty-one	<i>I Was Learning About Me</i>
Twenty-two	<i>I Developed a Boundary</i>
Twenty-three	<i>I Tried My Best</i>
Twenty-four	<i>Leaving Food Behind</i>

In *Leaving Food Behind*, Sheila Mather courageously shares her inspiring personal story of recovery from 10 years of bulimia, starving and overeating. Sheila's eating disorder began when she was 15 years of age. Societal pressure, the need to belong, the need to be loved, the need to be safe, the need to be perfect, the need to be slim -- all combined -- contributed to Sheila's need to binge, purge and starve. At age 25, her recovery began.

Leaving Food Behind is a gripping, heart-moving description of significant events in Sheila's life that caused her to reach for food, and then, recover. Sheila's fervent wish is that everyone who suffers from an eating disorder will be able to recover who

Speaking Events for Sheila Mather in February 2000

Date	Time	Location
Monday, February 7	10 a.m.	Regional Headquarters 111 Lisgar, Ottawa "Hopewell Launch"
Monday, February 7	6 p.m.	Chapters, Centrum Plaza 400 Earl Grey Drive, Kanata (exit Terry Fox Drive)
Tuesday, February 8	12 Noon	University of Ottawa Bookstore University Centre Building, Ottawa
Tuesday, February 8	7 p.m.	Real Estate Sales Office Woodward Avenue, Ottawa "Hopewell Open House"
Wednesday, February 9	6 p.m.	Chapters, Pinecrest Pinecrest Shopping Centre 2735 Iris Street, Ottawa
Wednesday, February 9	7:30 p.m.	Chapters, Rideau 47 Rideau Street, Ottawa
Thursday, February 10	7 p.m.	Chapters, City Park 2401 City Park Drive, Gloucester (exit Blair Road)
Tuesday, February 15	9 a.m.	Frederrick Banting Alternate High School 115 Terence Matthews Cres., Kanata

*All speaking events are in Ontario, Canada.

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About *Sheila Mather*

Sheila Mather, author of *Leaving Food Behind*, survived a 10-year struggle with anorexia, bulimia, and binge-eating. Her recovery began at age 25, and now at 33, her passion lies in supporting and guiding any victim of an eating disorder. The Canadian author does not promote any one recovery plan. Instead, by explaining her own experience, she encourages those with bulimia, anorexia or binge-eating to understand themselves.



Mather is the president of Mather Publications for Growth & Wellness, Inc., a publishing company that focuses on business and personal growth. Mather is a graduate of the Small Business Program at Algonquin College of Applied Arts & Technology in Nepean, Ontario, and also works as a consultant developing business plans for small businesses. Mather is currently working with a team of professionals and parents at Hopewell, The Eating Disorders Support Centre of Ottawa, Canada www.hopewell.on.ca

In support of her commitment to tell her message of recovery, she offers workshops based on *Leaving Food Behind*, in which she shares her prescription for a healthier lifestyle. This former model speaks directly with young girls, women and parents at high schools, colleges, universities, libraries, health facilities, and women's centers.

Although aerobics is her primary source of exercise, this multi-faceted author enjoys playing guitar, singing, sewing and reading. Mather also maintains her physical health through jogging, tennis, yoga, and healthy eating.

Mather's other professional affiliations include membership in Toastmasters, The Inspiring Speakers Bureau, and the Astrology Association.

Mather has been interviewed on such programs as: CHCH-TV News at noon, Hamilton, ON; KVUE-TV Morning Show, Austin, TX; Creative Health & Spirit Radio Show, Manhattan Beach, CA and published in *Personal Excellence Magazine*, Provo, UT.

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Marriage after Having Kids



by Lynn Scoresby

AFTER HAVING children, you may struggle to keep your own relationship alive. You must be determined to overcome the challenges that are introduced into intimacy from parenthood.

Causes of Decreased Intimacy

Many factors may contribute to the decrease in marital intimacy during parenthood. Life only becomes busier and involves more people.

- **Lack of time.** Taking care of a baby requires lots of time, including long days and interrupted nights. Parents begin to have less time with each other as the baby demands more time from them.

- **More responsibility.** Having a baby is an enormous responsibility. Parents have more duties and as a result, become tired more quickly. They often do not want to work on the parts of their relationship they once did—including intimacy.

- **Parents are not prepared.** Many parents enter into parenthood without enough information. They are not expecting such strenuous days requiring time and effort. They realize a baby is a huge responsibility, but have not gained knowledge of what to expect. They may not know how to work on the intimacy of their relationship with so much else going on.

What Doesn't Work

- **Impatience.** Both parents need to give and receive patience to and from one another as they adjust to the new child and the new circumstances.

- **Not communicating.** Simply put, one partner may not know what the other partner needs unless he or she communicates those needs tactfully. Even though you may think your partner should be able to figure out your needs, let him or her know.

- **Giving up.** Parents must work together to help satisfy each other's needs. Don't quit because the days become difficult. Work together—the strength you have as

a team will help you more than your strength as an individual.

- **Being selfish.** Parents cannot be selfish. They share all responsibility for the child. The child's needs must be met as necessary, and this sometimes requires parents sacrificing their own needs.

Helpful Hints and Solutions

You are not alone. Many couples need to work and improve their marital relationship after having children. Here are some helpful suggestions:

- **Spend time alone as a couple regularly.** Make private time a priority, and teach children to respect that time. Even brief moments together can make a huge difference.

- **Maintain friendships.** You cannot expect one person to meet all of your needs. Talking to and sharing time with friends with moderation can be beneficial.

- **Share life maintenance activities.** Sharing obligations increases the

opportunity for making decisions together and supporting each other. Washing the dishes or running errands can be fun to do together.

- **Make dates.** Setting aside time ensures that the dates will really happen. Set aside time with each other for going to dinner, making love, discussing concerns and other activities.

- **Appreciate each other.** Give compliments and be as specific as possible in giving your spouse the support he or she needs.

- **Balance the children's needs with your own.** Recognize that both children and parents have needs. Along with nurturing their children, parents must also learn to nurture themselves.

PE

Dr. Lynn Scoresby is the author of *Marriage Promise* published by Knowledge Gain and Resources and Information You Need to Raise Successful Children; www.familyADV.com.

ACTION: Arrange for someone to watch your children and go on a date with your spouse.



True Beauty



by Sheila Mather

TRUE BEAUTY comes from what you can't see—your heart.

How many times have you watched your favorite beautiful-looking star being interviewed and been disappointed that they were nothing like you thought? How many attractive people have you dated only to leave them?

Something was missing.

We're going to the heart of the matter to uncover your beautiful self. If you've been focused on externals, then an internal reconnection is about to happen. Shifting the focus back to your authentic self is easier than you think.

Here are daily steps to living from your heart. Get ready for your internal makeover.

1. **Look in the mirror straight into your eyes.** We look into other people's eyes all the time but how many times have you looked into your own? I mean really look and not while shaving or applying make-up. That's what I thought—not very often. Try it.



2. **Begin to ask "What do I want?"** Watch out for those "shoulds." When we should do something, it doesn't come from our heart but rather from what we believe others expect of us. Our heart, will tell us what we really desire. If you can't put what you're about to do with what you want in the same sentence, reconsider.

3. **Write in a journal.** List what you are grateful for, what you enjoyed, what you didn't, and how you can do it better next time. Write in your journal before bed, during your coffee break, or at lunch. It takes two minutes.

4. **Listen to your thoughts.** Is your head filled with thoughts that enhance and inspire your life? Thoughts

expend valuable energy. Like a bank balance, manage your thoughts to purchase the most worthy outcomes today.

5. **Honor what you feel.** Your sixth sense is telling you not to, but you do it anyway. The outcome—exactly as your gut feel predicted:

unsuccessful. Act on that initial gut signal and you'll be acting from your heart. Your heart is right—every time.

PE

Sheila Mather is author of *Leaving Food Behind* and president of Mather Publications for Growth & Wellness, Inc.; www.leavingfoodbehind.com.

ACTION: When faced with a difficult decision ask yourself if you would be doing it because you think you should or because you really want to.

Former Timmins resident brings hope

by JOELLE KOVACH
THE TIMMINS TIMES

In her thinnest days of modelling, Sheila Mather, who stands an elegant 5'9" weighed 113 pounds.

"And I wanted to be a five more pounds," she said. Former Timmins resident Mather, 31, is a survivor of bulimia, anorexia and overeating.

At age 25 she lead her own recovery without clinical or medical help.

While 8 million people suffer from eating disorders in Canada, the price of clinical treatments for these problems can cost up to \$30,000 a month.

But Mather insists the situation is not so bleak for the other 99 per cent of those with eating disorders, because, if she can recover on her own, anyone can.

In fact, she wrote the book on it.

In Timmins this week promoting her book, *Leaving Food Behind*, Mather, now a resident of Ottawa, explained that an eating disorder would better be called a spiritual disorder.

"An eating disorder is not about food at all," she said, sipping coffee in Aroma Café on Tuesday morning. "It's a broken spirit."

"I had completely disconnected my mind from my spirit."

Mather goes into great detail on the subject of this crippling disconnectedness in her book.

In fact, *Leaving Food Behind* distinguishes itself from self-help tomes on the market by describing her story and her recovery in an almost journalistic narrative.

Indeed, Mather bares all to her readers, allowing them into the complex reality of her self-loathing.

My body weight had become the symbol of my shame. I measured my shame by the number on my scale. I occupied my time with food and felt less shame when the

number was low, more shame when it was high," she writes. "However, I always felt shame."

After 10 years of bingeing, purging, starving herself and overeating, Mather decided to commit her life to recovery. Instead of checking into a clinic, she confined herself to safe spaces — such as her apartment — and surrounded herself only with positive, supportive people. "I couldn't be around negative energies," she said.

Starting from that point, Mather said she began sifting through her life experience, honestly grieving losses in her past that she had long buried. While she had long dismissed the impact of early childhood losses on adult life, she began to understand that having been separated from her twin in infancy — she was adopted by a separate family — was indeed a significant loss.

This shed light on her fear of abandonment. "I always thought, 'If this person abandons me, I will die.' Which was totally untrue," she said.

Further, she had a very supportive friend who helped her through this grief. "He just listened to how I was feeling."

In fact, Mather said that is the best thing anyone can do for a loved one suffering from an eating disorder.

Scolding a person for not eating enough will only compound the situation, she said.

"That person is filled with shame — any criticism just alienates."

"The main important thing I want to tell people is that they can recover — they absolutely can recover," she said.

Taking that first step toward recovery, she said, means no longer second-guessing emotions.

"Your feelings are 100 per cent right for your 100 per cent of the time."

More information about Mather's recovery, eating disorders and her book can be found at her website www.leavingfoodbehind.com.



Former Timmins resident Sheila Mather, a survivor of anorexia, bulimia and overeating, self-published a recovery book called *Leaving Food Behind*.

Poems Written by Sheila

**We live in an imitation world. We make replicas of the real thing
We use each other to achieve our own goals
We step on people and hurt them
We call them friends yet they're only stepping stones
And worst of all we use the word love as just a
word and not a feeling. Love is real not imitation**

**Love is for dreamers
Love is for sharing
of time and moments
of heartbreak and victory**

**To pass the true test
To live through it all
To accomplish this
Is the hardest task
But to do this
Is all I ask!**

Appendix K
Artifacts for Catherine's Case Study

Worldly Success

I am crying now my God
 My feet are cold
 my hands tremble
 as they hold this slender pen.

A world of sounds-
 the smell of fried fish
 and stale bananas
 from the place next door-
 life, thick and cloyed
 surrounds this tiny globe
 my room.

I cannot work tonight.
 One long endless trek
 down duty's narrow path
 has left me breathless,
 without life- an empty
 shell of self-accomplishment,
 a product of time spent,
 not shared-
 a life without desire,
 No lilt of chance,
 no careless whim
 mars the perfection
 of my days
 alone.

Who am I then?
 A well-rounded automaton-
 pride of assembly line
 production-
 the academic angel who
 manages on time
 each assignment to complete.

Where is the chorus
 of applause inside my heart?
 The joy of work well-done,
 a life truly lived?
 Have I come of age?

Appendix K
Artifacts for Catherine's Case Study

Prayer to an Unknown God
March 1970

If you are there
 when my knuckles strain
 thin and bare
 to seek the pain of iron fists,
 of sharpened nails dug into flesh,
 do not rest silent to my need.
 Relieve me of this hard-indifference-
 this cursed self-control-
 release my fettered soul
 and to this cell, my life,
 give meaning.
 In the stillness
 I am waiting
 for Your hand
 to break the agony
 of Your silence
 and let me know
 You understand.

Death in Life
December 1970

My world, this room, silent and bare.
 My life, this corpse, propped in a chair
 centers the void.

My soul down corridors of silent night
 gropes-raw
 the razor edge of light
 splits the dawn

I stir my step to stagnant pools
 half frozen at my feet.
 Desire to cross cools
 in living death-drowns
 in the stiff images of my dreams.

Catherine Joyce
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Waneva Books

Catherine Joyce

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Website: www.magma.ca/~joyce

For the last ten years I have dedicated myself to writing a series of novels set in the Gatineau Hills. This resume reflects related work I have done in and around this primary project.

EXPERIENCE

- 1999 Writing Workshops for Adults, two nights a week, Spring & Fall '99.
 Writing Workshop for Teens, *Chapters*, 1 year Gloucester Arts Board Grant.
 Writing group at The Children's Hospital of Eastern Ontario for
 Anorexic and Bulimic girls, 1-2 a week, April & September.
 Completed the final novel in my Waneva Series, *And Know The Place*.
 CBC TV profile in May, CHRO (Community TV) in April.
 Writers' Craft classes at Colonel By High School (IB program).
 Job Description Writing for the Federal Government
- 1998 Beginning the 4th novel of my Waneva Series, *And Know The Place*.
 Reworking the 3rd novel, *Fugue in Winter*, first written in 1992.
 Second edition of my 1st novel, *Locked Rooms*, published in May.
 Tutoring high school students: essays and creative writing.
 Teaching a series of writing workshops at *Chapters*.
 Manuscript evaluations for other writers.
- 1997 Publication of the 2nd novel in my Waneva Series, *The Unknown Shore*.
 Noon Hour Reading Series, Main Library, October.
 Tutoring high school students: essays and creative writing.
 Manuscript evaluations.
- 1995-96 Writing *The Unknown Shore*.
 Three courses in Drama (*Voice, Design, Canadian Theatre History*) at Ottawa U.
 Tutoring high school students: essays and creative writing.
 Mentoring individual writers exploring fiction.
 Teaching creative writing to adults four nights a week.
 Judge for Short Fiction Contest, Ottawa Valley Writers Guild.
- 1994 Reading from *The Unknown Shore, All In a Day*, November 8th.
 Publication of my 1st novel in the Waneva Series, *Locked Rooms*, May 1994.
 Teaching creative writing to adults, two nights a week.
- 1993 *Artist in the School* program at Chelsea Elementary: grades 4 to 6
 Re-writing *Locked Rooms*.
- 1992 National Library lecture on *The Inner Voice in Fiction*, September 30th.
 Writing the first draft of *Fugue in Winter*, 3rd novel in the Waneva Series.

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Writing english-language research profiles for the *Annual Report of The Social Sciences and Humanities Research Council (SSHRC)*.
Editing and proofreading marketing guides to various Japanese industries for the *Department of External Affairs*.

- 1991 Recipient of a one year *Explorations Grant* for fiction from the *Canada Council* to complete my 1st novel, *Locked Rooms*.
- 1990 Free-lance writer for *Naylor Communications Ltd*.
- 1988-89 Free-lance writer for *CanadExport*, Department of External Affairs.
Started 1st novel, *Locked Rooms*, in my Waneva Series.
- 1985-88 Full-time motherhood; teaching creative writing through *Learning Connections*; writer of promotional material for *Odyssey Theatre*; writer of advertising copy for *Maxad Agency*; studying art and design at the *Ottawa School of Art*.
- 1984-85 Prince Edward Island, November '94 to August '95: paid by CIDA as a teacher in International Education with the *Canadian Red Cross*: responsible for developing new teaching materials for the elementary, intermediate and senior public schools; lecturing on famine in Ethiopia; developing and touring PEI with a dramatic play on food aid.
- 1982-83 Writing fiction in Ottawa—short stories.
- 1981 Policy Analyst with the federal *Department of Energy, Mines and Resources*; writing the policy report, *An Energy Strategy for Northerners*.
- 1980-81 Toronto: free-lance writing—a column for the *Financial Times*, entitled *Women in Business*; teacher of creative writing at *Seneca College*, *Ryerson*, the *North Y*, *21 McGill Women's Club*; data analyst and editorial consultant for a quarterly report, *Political Alerts*, published by the stock brokerage, *F.H. Deacon Hodgson*.
- 1978-80 Toronto: policy analyst for the *Ministry of Intergovernmental Affairs*; speech-writing for the Minister and the Premier; briefing notes for the constitutional talks; representing Ontario at international meetings; one of a 3 person committee setting up the new *International Education Resources Agency*.
- 1974-77 Toronto: writer and researcher for *CBC TV*; research and development of ideas for current affairs documentaries such as *Quarterly Report*, *The Press and the Prime Minister*, *The Champions: Trudeau and Levesque*; research and writing drama-documentary scripts on Canadian heroes such as *Sir Wilfred Grenfell*; writing *Script & Film*, a monthly column for the magazine, *Books in Canada*, as well as regular book reviews; teacher of creative writing at *21 McGill* where I started a weekly Book Club for women members.

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- 1974 St. Anthony, Newfoundland: teacher in the hospital school of the *Grenfell Mission*; drama adjudicator for Northern Nfld. and Labrador in the *Centennial Provincial High School Drama Festival* in Grand Falls (April 1974).
- 1972-73 Aberdeen, Scotland: teacher, *The American School of Aberdeen*: grades 7-12, English and Journalism.

EDUCATION

- 1971-72 MA in English, York University, Toronto (Scholarship).
Tutor in the *Writing Workshop* at York.
- 1971 First class Honours BA in English, *Queen's University*, Kingston.
Student poetry editor for *Quarry*, the literary magazine.
Tutor for first and second year English students.
- 1968-70 General B.A. French, Spanish and Film, *Queen's University*.
Film researcher and writer for the *Film Department*.
Summer courses in *Fine Arts*.
- 1966-68 Qualifying and First Year at *Carleton University*.
Swimming instructor in French at *Camp Trois Saumons*, St. Jean Port-Joli, Quebec, summer '68; waitress, *Jaspar Park Lodge*, Alberta, summer '67.
- 1962-66 Ottawa: Glebe Collegiate, grades 9-12.
Counsellor in Training, *Camp Tawingo*, Huntsville, '66; camper, '63-'65.
Sailing instructor, *Gatineau River Yacht Club*, '66.
- 1955-62 Ottawa: Public School: Mutchmor, Devonshire, Connaught.

OTHER ACTIVITIES, CONFERENCES, COURSES

- 1976 *CBC Directors and Writers Course*, May-June, Toronto.
- 1978 *Breadloaf Writers Conference*, August, Vermont.
- 1978-80 *Inequity Players*, an informal amateur group dedicated to monthly presentations of dramatic readings of Canadian Plays.
- 1985-94 Member of *Ottawa Independent Writers (OIW)*
Seminar speaker at their annual writers' conference at Carleton U.
- 1995-99 Member of *Ottawa Valley Writers' Guild*.
- 1997-99 Member of *The Writers' Union of Canada*.

Medusa



a collection of writings
by women with eating disorders

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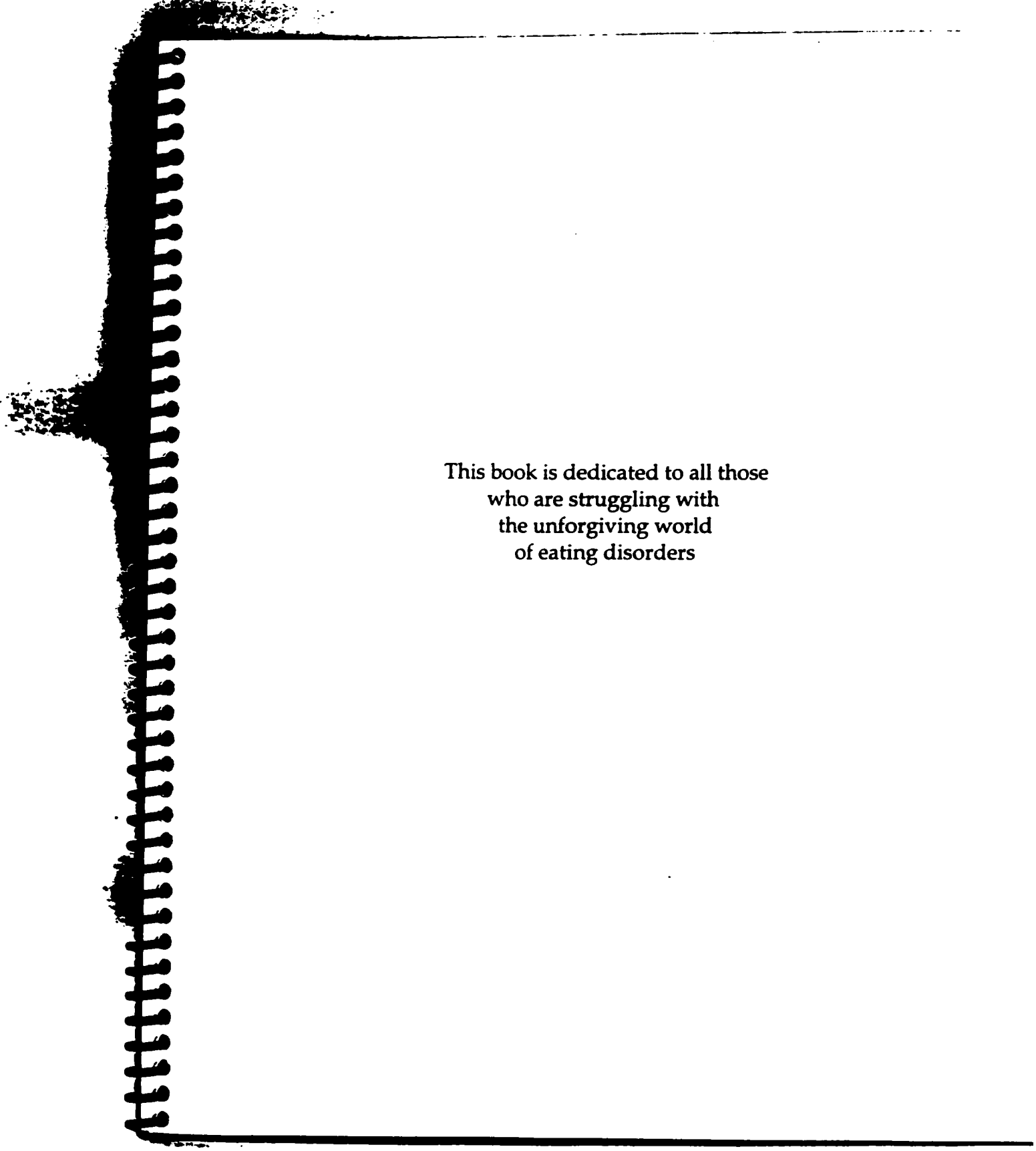
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This book is dedicated to all those
who are struggling with
the unforgiving world
of eating disorders

The Gloucester Arts Council

Project facilitator

Write Yourself Into Being is a community art project facilitated by the Gloucester Arts Council. Broadly defined, community art is a collaborative process between a professional practicing artist and a community. Community art provides a unique way for communities to express themselves—it is as much about the process as it is about the artistic product or outcome. The word “community” can mean many things—in this case the community is a group of people with a common problem: eating disorders. This group of women has come together through the creative art of writing—as part of the community art project, they have engaged in a collaborative artistic expression. Their innermost feelings have been put to paper and are included in this book.

We hope that you find their writings thought-provoking and that the women who took part gained strength and support from their peers and the creative process.



Hopewell

Eating Disorders Support Centre of Ottawa

Hopewell is a registered charitable organization offering individuals the hope, support and information they need to survive an eating disorder. We feel very fortunate to have been given the opportunity to work in partnership with the Gloucester Arts Council on a project that has given voice to a long silenced group of our community. It is our hope that in the future Hopewell will be able to offer more arts programs to help unlock the stranglehold that anorexia and bulimia have on people's lives.

The Partners Involved Introduce You to this Project

How It All Began ...

Catherine Joyce, author and guide

In the spring of 1999 I began teaching my writing process, *Write Yourself into Being*, with young anorexic and bulimic girls on the ward at the Children's Hospital of Eastern Ontario (CHEO). It was an informal experience inspired by Judith Ready, their occupational therapist, as a way of offering the girls another way of looking at their lives and their struggle with food. Within a few sessions, the results were inspiring.

With these positive results, I approached the Gloucester Arts Council in the autumn of 1999. Christine Tremblay was keen to sit down to explore with me how we could bring this process out into the community, to touch the lives of girls and women silently and secretly suffering from eating disorders. Joanne Curran of Hopewell kindly and enthusiastically joined us as our community partner, supporting our vision and efforts to bring writing as an expressive art experience to the eating disorder realm. Our *Write Yourself Into Being* project grew out of hours of discussion as together we shaped a proposal for a community art project.

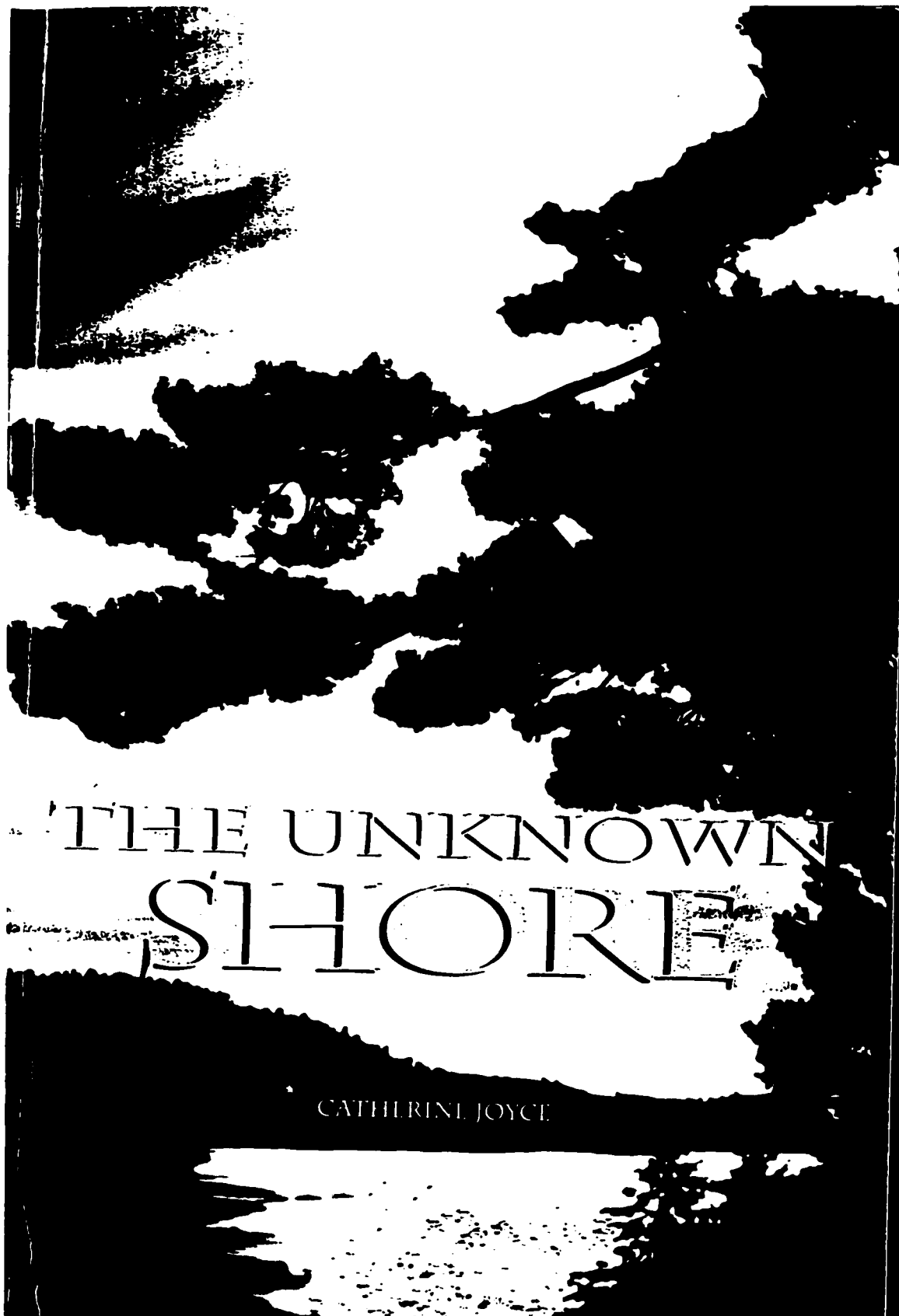
By the spring of 2000, our efforts bore fruit. Throughout April and May, three writing groups met once a week for two hours at a time. Heads bowed, hands moving quietly across the page, young girls and women came together to find their 'voices', to hear their hearts first whisper, then cry and finally thunder through their journals. After years of silently struggling with anorexia or bulimia, binge or over eating, they discovered that they could fight back with the pen. They could give 'voice' to the nightmare, to the grief and rage that possesses their bodies and haunts their souls. Stories, poems, meditations, letters, all came pouring out. Group discussions inspired more writing. Themes sparked further talk and deeper explorations. Reading archetypal myths identified life patterns, revealing hidden story lines that compel behaviour: to write about these unconscious patterns felt like the beginning of change.

LOCKED ROOMS



A novel by

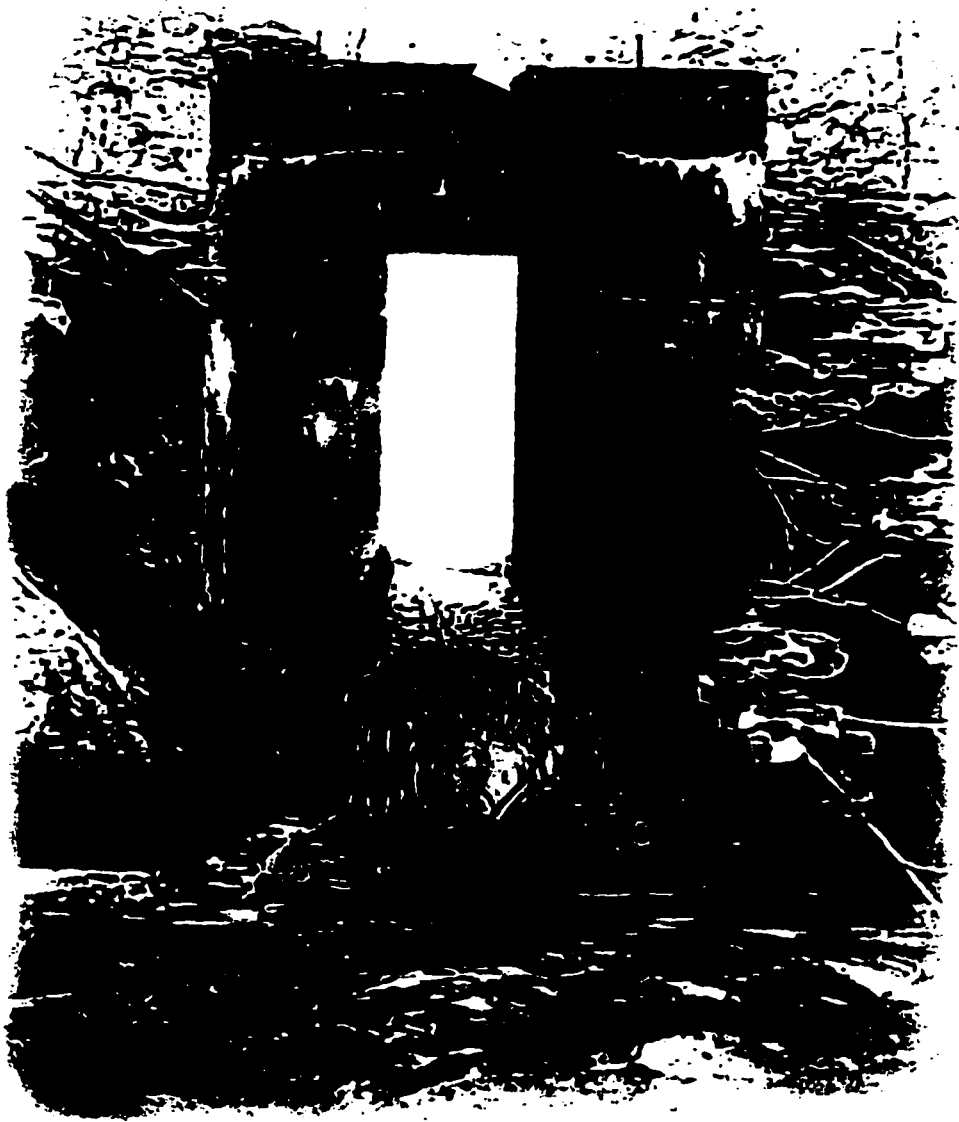
CATHERINE JOYCE



THE UNKNOWN SHORE

CATHRINE JOYCE

AND KNOW THE PLACE



A novel by

C A T H E R I N E J O Y C E

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December 3, 2000

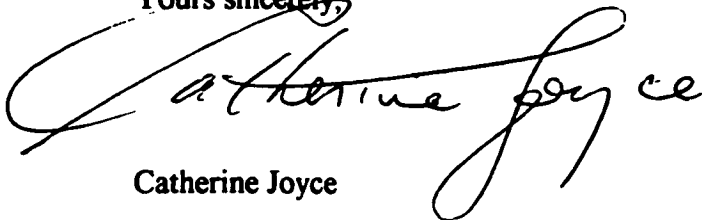
Dear Maria,

I have read the Findings in your thesis related to my material and everything is accurate and very well expressed. Thank you for doing such a thorough and insightful study.

Also, you have my permission to quote from my Waneva novels. Molly's words are very connected to our discussion and I feel they say things that I cannot always express any other way.

Thanks again for all your efforts. Good luck with your thesis.

Yours sincerely,

A handwritten signature in cursive script that reads "Catherine Joyce". The signature is written in black ink and is positioned below the typed name.

Catherine Joyce