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EATING DISORDER NARRATIVES: PERSONAL EXPERIENCES OF ANOREXIA AND BULIMIA

by

VERONICA ASHLEY PRZYBYL

Under the Direction of Cassandra White

ABSTRACT

The following paper explores the ways in which we currently understand eating disorders, examining the current theory and literature as well as providing the stories of three women and one man with first-hand experience with eating disorders. Through the use of formal interviews, the paper focuses not only on the ways in which an eating disorder affects an individual's life but also on the ways in which an individual's life affects the manifestation of his or her eating disorder.

INDEX WORDS: Anorexia nervosa, Bulimia nervosa, Eating disorders, Medical anthropology

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by

VERONICA ASHLEY PRZYBYL

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2010

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Veronica Ashley Przybyl
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May 2010

ACKNOWLEDGEMENTS

I would like to thank my advisor, Dr. Cassandra White, for the time and energy she put forth from the beginning of this research to the end and my committee for their very helpful critique in the editing of this paper. My research participants, Chloe, Claudia, Piper, and John, also deserve much praise, as this study would not have been possible without them.

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1 INTRODUCTION

Anorexia nervosa and bulimia nervosa have become increasingly prevalent problems in the United States over the last two decades. According to the National Eating Disorders Association, as many as ten million females and one million males suffer from anorexia or bulimia and many more cases likely go unreported due to stigma attached to the illnesses (National Eating Disorders Association n.d.). Despite this, eating disorders research continues to receive inadequate funding (National Eating Disorders Association n.d.). Personally, I have known many people who have suffered from eating disorders and many more who have struggled with poor body image, unhealthy dieting practices, and general tendencies toward disordered eating. This, coupled with my interest in medical anthropology as a means to discover new ways to examine mental illnesses, led me to pursue eating disorders research.

Upon my decision to focus on eating disorders, I searched for an internship or an opportunity to volunteer at an eating disorders treatment facility. Due to the sensitive nature of these illnesses, this type of opportunity is difficult to come by. I eventually happened upon an internship opening for program evaluation at a non-profit organization in Atlanta. The organization focuses on raising awareness about eating disorders and making treatment options available to those in need. The organization was beginning a program to raise body awareness in elementary school children through the use of a children's storybook. The storybook focuses on the different rates at which children's bodies grow and develop and promotes healthy relationships with food. The organization had recently received a grant to implement this program in several elementary schools in the city of Atlanta and needed a program evaluator to assess its efficacy.

I inquired about the position and met with the organization's executive director. We spoke at length about the goals of the organization and the program and about my research. The director was very interested in my research and in becoming a participant. I saw an opportunity to not only educate myself about eating disorders and to help a worthy cause, but also to gain valuable contacts for my research and so took the position as program evaluator. The more I worked with the organization, the more I learned of the director's own battles with anorexia and the more this woman became a friend. As I became more involved, I was introduced to two other women with experiences with eating disorders and thus built a small group of contacts that were willing to participate in my research.

I grew to respect these women immensely, as they had taken their own experiences and used them to help others. I find that working with the organization is an extremely positive experience. The usual gossip that often occurs in all-female settings is absent. Rather, one finds these women not only have great mutual respect for one another, but also provide support as they continue to struggle with the consequences of their experiences. Furthermore, they are fully dedicated to the organization's mission and find it a worthy cause. I was later introduced to John, whose location prevented me from meeting him in person. Although I did not build as close a relationship with him as I did with the others, I have a great amount of respect for him as well. John has also used his experience with an eating disorder to help others by founding an organization for men with eating disorders.

During the course of my research, my participants became very important to me. As such, while I have included chapters on the existing eating disorders literature and the methods I used during the course of my research, a significant portion of my paper is dedicated to the telling of my participants' stories, beginning in childhood and continuing to the present. These stories are

presented in the participants' own words as much as possible, in order to provide them the agency they deserve. This is followed by an analysis of their stories and what they can contribute to our current understandings of eating disorders and their treatment, and an examination of the current theory on eating disorders. Traditionally, an examination of the theory is placed before the presentation of the data. I felt that it was important, however, to integrate the data with the theory. As such, an examination of the theory is offered after the presentation of the data, so as to reduce the distance between theory and example for the reader.

For the purposes of this paper, it is important to set out the working definitions of certain key terms used throughout the text. "Eating disorders" refers specifically to anorexia nervosa and bulimia nervosa, but not to the myriad other conditions that can be encompassed in the term, such as chronic overeating. "Anorexia nervosa" refers to the act of excessive restriction of food intake and "bulimia nervosa" refers to the act of purging one's food either via vomiting or the excessive use of laxatives. Excessive exercising can be seen in both anorexia and bulimia. It is also important to note that I worked solely with participants who were clinically diagnosed with either anorexia or bulimia at some point during the course of their illnesses. As such, the diagnostic criteria set forth in the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, are also important in identifying both anorexia and bulimia. While these criteria were useful in understanding the participants' disordered behaviors, they are also problematic. This will be discussed more fully later in the paper. Additionally, while anorexia and bulimia can be separate phenomena, there is also great potential for crossover between the two. This will be further explored in the paper as well.

It is also important to explain that, while anorexia and bulimia are considered disorders in the Western world, the Western biomedical system is a cultural construct just like any other

medical system. As such, what is normal versus what is considered a disorder is very much culturally defined. It is important to remember that, in the United States, a preoccupation with food control, diet, and exercise is normative.

In the interest of confidentiality, all names have been changed and certain details have been excluded in order to protect the identities of the participants. The name of the organization through which I met the participants is not given, nor are the names of any treatment facilities, medical practitioners, or friends and family of the participants. Location names have been generalized to state or city. Additionally, because eating disorders are so much more common in women and because the majority of the participants in my study are female, I have chosen to use feminine pronouns throughout the paper except when directly referencing the male participant.

2 LITERATURE REVIEW

The topic of eating disorders presents an interesting case because, as our knowledge of it has grown, it has become inherently interdisciplinary. Seemingly disparate disciplines have found common ground in researching eating disorders. Because eating disorders are so prevalent in the United States and now globally, much first hand research has been conducted on the topic. First hand studies are most common within psychology/psychiatry. Researchers from other disciplines tend to contribute more theory than first hand research. As anthropologists have become more interested in eating disorders research, however, they have begun to conduct first hand studies that highlight the importance of culturally and ethnically aware research and the need for more in-depth methods, such as interviews. Researchers in the field of feminist studies still tend to be more theoretically inclined.

Feminist Studies

It is rare that first hand research is conducted within the feminist studies field. Most of the literature is purely theoretical, attempting to situate eating disorders socially and politically. Some feminist researchers have taken the gender concept further and have begun to investigate gender-related issues in eating disorders in new and interesting ways. Moulding (2003), for example, argues that, because psychologists and psychiatrists understand that eating disorders have a gender component (since women are overwhelmingly more affected by them), they make gender assumptions that "structure explanations and associated interventions used for eating disorders" (58) and that, therefore, may directly affect women's experiences of eating disorders. To investigate this potential issue, Moulding (2003) conducted a series of semistructured

interviews about how eating disorders may be caused and explained with 31 health care workers involved in eating disorders therapy and prevention in three cities in Australia. These health care workers spanned several disciplines, and included psychiatrists, social workers, psychologists, community workers, counselors, nurses, general practitioners and dietitians, and health promotion workers.

In conducting these interviews, Moulding (2003) identified problems with the way in which health care workers construct identity. Most of the health care workers held a dualistic view of the relationship between the individual and society. They understood a person with a healthy, complete identity to be a sovereign individual who is socialized by the wider collective but who stands apart from it at the same time. In this view, individuals with eating disorders were seen as having disrupted identities that are incompletely formed and as using their eating disorders to help form a complete identity. Individuals with eating disorders are believed to be more subject to outside social forces and overly attached to others because of a lack of sense of self and a weak identity formation. Moulding (2003) states, "the eating-disordered individual is constructed as having an immature, incomplete identity that is fundamentally *over*-connected to other people, rather than autonomous and self-contained" (64). Health care workers believe autonomy to be the core aspect of selfhood, meaning that individuals with eating disorders are assumed deficient because they have failed to achieve this autonomous identity.

Moulding (2003), however, argues that these assumptions about identity are inherently gendered. According to her, the ideal identity is masculinized, meaning that women are subjected to contradictions, because women are expected to be both connected and responsive to others, while this connected-ness and responsiveness are said to make for a weak identity. In this way, a weak identity is feminized and a strong identity is masculinized. Because of this, health care

workers make assumptions about identity that are inherently gendered and are, therefore, damaging to the treatment of female patients with eating disorders. Moulding (2003) argues that using a feminist ideology in the treatment of female individuals with eating disorders will help both patients and practitioners to challenge dominant discourses and to more successfully treat these disorders.

While Moulding's (2003) research is a rare example of first-hand feminist research in eating disorders, it identifies a common strain in feminist thinking: that gender assumptions that seem second-nature to most people in Western culture are, in fact, not natural and need to be challenged and reconsidered before a more effective eating disorder treatment can be formulated.

Psychology/Psychiatry

Psychological/psychiatric approaches traditionally focus on finding a personality "type" in order to better identify and treat eating disorders patients. This has perhaps been done in order to fit eating disorders patients into more manageable psychological categories that have known treatments since eating disorders tend to defy categorization and are extremely difficult to treat and nearly impossible to cure. One could argue that a person is never really cured of an eating disorder, but is in a state of lifelong recovery. There are several examples of psychological research that has attempted to identify personality types within eating disorders patients.

For example, Vervaet et al. (2004) conducted a study to compare clinical and personality features in anorectic patients with a high and low drive for thinness. The anorectic patients with whom the researchers worked took several questionnaires, including the Eating Disorder Inventory in order to determine restricting behavior, bingeing/purging behavior, and high or low drive for thinness. The researchers found that patients with a low drive for thinness were more

likely to display restricting behavior than purging behavior and were associated with less eating-related pathology and less severe psychopathology. Vervaet et al. (2004) theorize that food restriction in patients with a low drive for thinness may be due to increased anxiety rather than fat phobia. While others (Ramacciotti et al. 2002) have suggested that treatment for patients with low drive for thinness "should be less cognitively based and less focused on cultural tyranny and fat" (Vervaet et al. 2003:378), Vervaet et al. (2003) suggest that cognitive strategies should be included to challenge the anxiety-food connection.

Similarly, Brewerton et al. (1993) conducted a study comparing anorectic and bulimic patients with healthy control individuals to determine levels of novelty seeking, harm avoidance, and reward dependence using a Tridimensional Personality Questionnaire. They found that all eating disorders patients scored higher than controls in harm avoidance, but only those with bulimia scored significantly higher in novelty seeking. Brewerton et al. (1993) compare these characteristics with patients with obsessive-compulsive disorder and note some similarities. This is a good example of the tendency within psychology to liken eating disorders (or components of them) to other disorders that have been effectively treated in order to understand ways in which eating disorders may be similarly treated.

Another study, conducted by Welch et al. (2009) shows that this type of research is still being conducted within the discipline of psychology. Welch et al. (2009) gave questionnaires to volunteers to assess the relationship between disordered eating and perfectionism. The researchers found that perfectionism acts as a mediator between body dissatisfaction and disordered eating behaviors and attitudes and as a moderator between body dissatisfaction and binge eating. It was not, however, possible for the researchers to conclude whether perfectionism was a consequence or a cause of disordered eating attitudes and behaviors. What is most

interesting about this study are the researchers' suggestions for future studies. Welch et al. (2009) note the need to employ a multi-method study that uses both surveys and interviews. They also note that the potential effect of ethnic and cultural background needs to be addressed.

The suggestions made by Welch et al. (2009) are indicative of some of the shortcomings in psychological research. While questionnaires can be useful, using them in conjunction with interviews and/or observation may provide a more complete picture. Anthropological research seems to fill this gap with its approach.

Anthropology

Like feminist researchers, anthropologists address cultural issues in their eating disorders research. Unlike feminists, however, they focus on gender in addition to several other cultural issues such as race and religion or morality (Giles Banks 1996). Anthropologists also tend to focus on individuals rather than populations and on larger portions of patients' lives that may or may not be directly related to their eating disorders. Anthropological methods vary greatly from the methods employed by psychological researchers and add depth to the existing knowledge of eating disorders.

Katzman et al. (2004) investigated the presence of anorexia nervosa in Curaçao in response to the growing number of cases of anorexia in non-Western contexts. They conducted interviews in addition to collecting questionnaires in an effort to fill the gap left by previous survey studies and case reports. They found that all of the women who took part in the study who suffered from anorexia were of mixed race; none were of the majority black population. These women were from high-education and high-income sectors and most had spent time overseas. The study also addressed some of the issues seen in the feminist and the psychological literature:

the women with anorexia reported higher levels of perfectionism and anxiety than the controls and they showed vulnerability to three factors that threatened identity formation. These three factors were their mixed race and the desire to fit in with the mostly white elite while distancing themselves from the black majority; their means for education and travel that made them feel caught between modern and traditional ideas of femininity; and their having lived overseas, which caused them to feel frustrated at the limitations of island life upon return. While addressing issues such as identity formation and personality characteristics that are addressed in the feminist and psychological literature, Katzman et al. (2004) also found that issues of race and class were equally important factors in these women's anorexia. The researchers suggest that this might speak for other developing countries in that it is perhaps possible that eating disorders are limited to specific subgroups for which specialized treatment and planning efforts may be needed.

Anderson-Fye (2004) conducted a longitudinal person-centered ethnography (in addition to the use of surveys and other quantitative methods) in San Andrés, Belize with adolescent girls in order to understand why this community, despite many risk factors associated with the development of eating disorders, has shown resistance to previously documented patterns. Anderson-Fye (2004) found that most of the difference could be summed up through ethnopsychology – "the local understanding and processing by which people make meaning and behavioral decisions" (576). She found that most girls were concerned with the shape of their bodies rather than the size of their bodies. Furthermore, the commonly employed concept of "Never Leave Yourself," which focuses on self-care and self-protection, helped young girls psychologically cope with most situations in their lives. While disordered eating behaviors and attitudes were rare in Anderson-Fye's (2004) study participants, she found that those who did

display these behaviors and attitudes often came from transnational families, where a member of the family either works in or travels often to the United States, and/or from families involved in the Western tourism business.

These findings are similar to those of Katzman et al. (2004), which may suggest that their assessment of subgroups requiring specialized treatment may be correct. It is also important to note that both of these studies imply that some sort of exposure to Western culture may be a factor in the development of eating disorders, but that issues of class are also at hand. This seems to support Lester's (2004) theory that Western cultural influences on eating disorders in non-Western contexts may, in fact, be more closely related to class issues and cultural change brought on by Westernization, but not by Western "culture" itself. Becker's (2004) study on the impact of television on young Fijian girls seems to support this theory as well. The young women, influenced by televised images of thinness, saw thinness as a way of gaining employment in their rapidly changing society.

Implications/Conclusions

One of the major gaps I see in the literature on eating disorders is a lack of studies that focus on the transition from strict dieting and exercise to anorexia nervosa and bulimia nervosa (O'Connor and Van Esterik 2008). I believe there are two main reasons for this. First, this transition is ambiguous and hard to pinpoint. Even eating disorders patients and survivors have a difficult time understanding when and how this transition takes place. It is for this very reason, however, that I think it is so important to further study this transition. It is one of the factors of eating disorders that is least understood and perhaps a better understanding will shed light on effective ways to prevent and treat eating disorders. The second reason why this factor is under-

studied, I believe, is because much of the research on eating disorders is focused on subjects that have already developed eating disorders and the ways in which these people can be helped, and understandably so. When so many individuals are already suffering from eating disorders, it seems more salient and imperative to help treat these individuals than to understand how their stories can help prevent others from meeting the same fate.

I believe that prevention may be even more difficult than treatment because eating disorders are highly individualized and a complete overhaul of Western cultural values relating to food and beauty will likely be required to decrease the prevalence of eating disorders. Given this, I find it interesting that so few studies challenge the diagnostic criteria used to identify anorexia and bulimia. In my opinion, once an individual meets the diagnostic criteria set forth in the Diagnostic and Statistical Manual of Mental Disorders, it is already too late. There must have been a point in time when unhealthy behaviors or feelings about food could have been recognized prior to a drastic loss in weight or the beginning of a purging habit. By better understanding the progression from unhealthy thoughts and behaviors relating to food to eating disorders, I believe it is possible that an individual can be identified as being at-risk for an eating disorder before she meets the diagnostic criteria.

That being said, I find anthropology to be uniquely well suited to the study of eating disorders because of its holistic nature and its highly individualized approach. Historical research (Garrett 1998, Vandereycken and van Deth 1994, Lester 1995) has shown that disordered eating is certainly not a new phenomenon, but that its manifestation has changed over time. In addition to this, current research shows that the manifestation of eating disorders can vary widely from person to person. As such, an individualized and holistic approach is necessary in the study of eating disorders. Because anthropological researchers focus on the individual and, often, the

individual's entire life, including seemingly irrelevant aspects, anthropological research can offer a clearer and more well-rounded picture of eating disorders. It is entirely possible that the seemingly irrelevant or trivial aspects of an individual's life that have previously been under-studied or ignored may hold the key to a better understanding of eating disorders.

Regardless of anthropology's unique fit to the study of eating disorders, I still believe that interdisciplinary cooperation is necessary. No single discipline or theory can fully explain or help to prevent or treat eating disorders. Additionally, while anthropological research is unique in its ability to gain both a breadth and a depth of understanding, it is not always practical considering issues of time and money. Anthropology is also relatively new to the research of eating disorders because eating disorders have historically been the realm of psychology and women's studies while anthropology has traditionally focused on the non-Western other. A continued effort to research eating disorders using interdisciplinary cooperation is perhaps the only way we can ever hope to fully understand, treat, and prevent these illnesses.

3 METHODS

Throughout the course of my research, I obtained life history narratives from sufferers of anorexia nervosa and/or bulimia nervosa. I conducted four interviews with participants over the age of 18. Three of the participants were female and one was male. My goal was to understand the personal experience of disordered eating and to gain some understanding of the progression of an eating disorder, from the point of view of the patient. For example, when does dieting turn to unhealthy dieting, when does unhealthy dieting become dangerous, and when does dangerous dieting turn to an eating disorder?

In general, I followed the model laid out by Kleinman (1988a) in his book, *The Illness Narratives*, in which he obtains life history narratives from patients with chronic illnesses in order to understand the disconnect between patient understanding of illness and the understanding of disease by health care professionals. He strongly advocates the use of oral histories because they allow the researcher to identify major life themes that may affect illness over time. Kleinman (1988a) also argues that these oral histories should be as broad and general as possible because even seemingly irrelevant life events and circumstances may affect an individual's experience of illness.

Sampling

Because my research depended largely on life history narrative interviews, my emphasis was placed on the quality of interviews rather than the quantity. O'Reilly (2005) argues that this emphasis is inherent in lengthy, complex oral histories. Since I was working with small numbers of people, I found that the snowball technique was useful in establishing my sample. Bernard

(2006) explains the snowball technique as useful for studying hard-to-find or hard-to-study populations. While my population was not difficult to find nor particularly difficult to study, I was lacking a specific and concrete field site. The snowball technique proved especially plausible for me because I had a few personal contacts I interviewed that, in turn, could recommend personal contacts of their own that were also interested in interviewing.

Some problems also exist with the snowball technique. For instance, it is true that, when using the snowball sampling technique, not every individual has the same probability of being named, meaning that the resulting sampling may not be representative of a large population in a large area (Bernard 2006). I was not particularly concerned with issues of representation, however, as my ability to be representative of a large population was severely hindered by my inability to continue my study for more than a few months. The benefit of focusing qualitatively on a few participants outweighed the risk of not being quantitatively representative of a large population. As such, my study's sample is relatively homogeneous, including middle to upper class Caucasian participants.

Life History Interviews

The basis of my research, the audio recorded life history interviews, covered topics such as childhood experiences, family dynamics, and the transition from strict dieting to disordered eating. These interviews were a blend of unstructured and semi-structured and they were formal. The interviews were arranged in order to maximize privacy and comfort and the questions were open-ended so that I could "understand the other person's world-view" (O'Reilly 205:120). One of the interviews, due to issues of location, could not be conducted in person and so was

conducted via e-mail. Although the process differed, the format for the e-mail interview remained the same.

Bernard (2006) argues that unstructured interviews, despite the lack of structure or an interview script, are still inherently formal and not deceptive, since there can be no doubt that the researcher and the interviewee are sitting down to conduct an interview and not to "chitchat" (211). He also writes that unstructured interviews are characterized by a minimum of control over the interviewee's responses and that they are the best method when the researcher wants to know about the lived experience of the interviewee. O'Reilly (2005) states that, in unstructured interviews, "the interviewer may have a guide or plan, or simply a topic to address, and the interviewee is given the opportunity to respond in a leisurely way" (116). Semi-structured interviews, on the other hand, leave room for informants to explore ideas, but also search for fixed responses to certain criteria.

Since there were certain criteria I wanted to address, such as specific childhood characteristics like religion, schooling, and socioeconomic status, but since I was also interested in the lived experience of the interviewees, I planned to use the three phase approach to narrative interviews as outlined by Flick (1998). The first phase begins with a generative question referring to the topic of study, which is intended to stimulate the interviewee's narrative. During this phase, the interviewee is allowed to completely finish his or her narrative without much interruption. This is followed by the second phase in which the researcher probes narrative fragments that were not well detailed. The third phase is the balancing phase in which the researcher asks theoretically aimed questions in order to understand the meaning of the story from the interviewee's perspective. This approach allows for an unstructured interview and then follows up with more structured interviews, making it possible to learn about the lived

experience of the interviewee while still obtaining information about specific criteria. I found, during the course of my research, that the three phases of the interviews were sometimes integrated as the participant told his or her story. I found that I was able to complete all three phases in one interview and that it was not always necessary for me to actively engage the second two phases, as the participant's narrative was essentially complete without much probing. I found that second and third interviews were not necessary with any of the participants, but that any additional questions I had could be sufficiently addressed either via e-mail or in person without requiring an interview format. I believe that one reason it was not necessary to actively engage in the third phase of the interview process is because all of the participants had been through some form of therapy and treatment, meaning that they were, in some way, trained to think about their lives in a theoretical way.

Life history interviews are slightly different from oral history interviews. Life history interviews are beneficial in ethnography because, according to O'Reilly (2005), the researcher must become very well acquainted with the interviewee over several visits and meetings. She also argues that life histories are especially well suited to ethnography because they emphasize meanings the interviewee places on his or her own life events. Oral histories, on the other hand, place less emphasis on a whole life and more emphasis on a topic or part of a life. Whiteford and Bennett (2005) also argue the benefits of oral history interviewing. They argue that oral histories have been used effectively to understand personal experiences of particular health conditions and to understand the interactions between the patient and health care professionals relating to those conditions, especially when they are stigmatized. According to Whiteford and Bennett (2005), by collecting oral histories from different people with varying points of view about a health problem, we can gain a better understanding about that health problem.

When I began my research, I intended to combine life history and oral history because I wanted to know about the interviewees' personal life experiences while emphasizing a particular topic in order to understand how one's life history affects the topic. I found, however, that life history and oral history integrated in a different way during my research. The participants' life histories were impossible to give without focusing on the topic because their illnesses were such an important part of their lives.

The interviews I conducted also allowed me to, as Handwerker (1998) describes, "track life experiences" (167). Tracking life experiences involves identifying significant events and circumstances in people's lives that shape the way they understand the world. Through these interviews, I was able to track life experiences across several interviewees' narratives to find commonalities that point to a shared understanding and meaning.

These interviews required rapport to be built between the participants and myself. While this rapport needs to be built in any ethnography, it is usually done so during the course of participant observation. While my study lacked a significant participant observation component, I was able to build rapport with most of my participants while interning at the organization for which the three women work. By the time I conducted my interviews, I had relationships with these three participants that allowed for comfortable interview experiences. The rapport I had built with these participants extended to my fourth contact because he has a working relationship with them.

Participant Observation

While interviews formed the basis of my research, I also had the opportunity to obtain information from my experience as an intern at a local non-profit organization that focuses on

raising eating disorders awareness. I worked as a program evaluator for a new elementary school program designed to raise body awareness. The internship, while not directly related to my study, provided me valuable background information and an arena in which I was not only able to gain contacts for interviews, but also to simply talk about ideas and theories in an eating disorder-aware environment.

Participant observation, according to deWalt and deWalt (1998), is a method in which the researcher/observer takes part in people's "daily activities, rituals, interactions, and events" (260) in order to learn the explicit and tacit aspects of those people's culture. It allows the researcher to collect data in an unstructured manner in naturalistic settings.

deMunck (1998) describes participant observation as a process involving three stages. The first, "stranger" stage is the one in which the researcher learns the rules and the language of the community while the community members become familiar with the researcher. In the second, "acquaintance" stage the researcher is accepted as part of the audience and she begins to learn how to be competent as a local. The third, "intimate" stage is one in which the researcher can act and respond automatically in the social setting.

O'Reilly (2005) discusses this contradiction, calling it an oxymoron, citing specifically the tension between participating and observing. She argues that this tension need not be resolved, as it is where participant observation draws its strength. The tension is often the point of participant observation because the researcher must "both empathise and sympathise, to balance destrangement and estrangement. Participating enables the strange to become familiar; observing enables the familiar to appear strange" (109). In other words, it is this tension that allows the researcher to describe both the emic and the etic perspective. During the course of my research, I found that this tension was ever-present because, as an intern working mostly outside

of the office, I was not fully integrated into the organization. Additionally, I have not personally suffered from an eating disorder so, while I was able to sympathize with my participants on many levels, they had experienced life events that I could never fully understand. This inability to fully understand these experiences, however, proved to be the strength of my research, as it spurred me to gain in-depth interviews from my participants so that I could understand their experiences to the greatest extent possible.

Participant observation has many advantages. deWalt and deWalt (1998) argue that it "enhances the quality of the data obtained during fieldwork" (264), "enhances the quality of the interpretation of data" (264), and "provides a sense of the self and the Other that isn't easily put into words" (264). deMunck (1998) states that participant observation allows the researcher to gain access to what he terms "backstage" culture or, what goes on behind the scenes. He also argues that it allows for a thick description of a society and that it provides a means and an opportunity to describe and report unscheduled behavior and events. Additionally, observation of informants, when done in conjunction with interviewing, allows the researcher to understand and explain the difference between what people say they do (the ideal) and what they actually do (the real), an important and hallmark aspect of ethnography. I found that, during the course of my internship at the organization for which my participants work, I was able to take part in everyday conversations. This provided valuable comparison material for the interviews I conducted. Chloe, for example, believes that she has fully recovered from her eating disorder and that it is no longer a significant part of her daily life. Both Claudia and Piper, on the other hand, feel that they may never fully recover and that their eating disorders are persistent parts of their lives. I witnessed several conversations between the three women that confirmed these statements.

While all three women often talk about food, dieting, and weight, Chloe displayed a more blasé attitude toward these topics than did Claudia and Piper.

Participant observation also has many disadvantages and limitations. For example, O'Reilly (2005) notes that the researcher cannot always participate as much as she would hope, like in doctor/patient interactions for instance. The researcher is also sometimes called upon to participate in ways that may not be anticipated, producing potentially awkward situations. O'Reilly (2005) also argues that sometimes participation is not useful and it is simply easier and more comfortable for everyone for the researcher to be seen in a purely researcher role, although this is true only in some contexts. In my research, my role as intern was limited, meaning that I did not have the opportunity to spend large amounts of time at the organization for which I was working. Most of my work was carried out in my own home and I made only short trips to the organization's office to pick up materials. As such, my glimpses into everyday situations in the lives of these women were limited, thus limiting the role of participant observation in my research.

deWalt and deWalt (1998) note an ethical issue with participant observation, namely that it is less clear to informants that the data gathered during participant observation will be used in the research than with other forms of data collection such as interviews. In order to account for this, the researcher must keep names of people and places hidden, even in field notes, and must be sure that she obtains informed consent and is upfront and explicit about her goals. deWalt and deWalt (1998) also note the possibility of unintentional ethnographer bias; the researcher's experience in the field and personal background may skew her description of events. In order to balance the description, the researcher must account for this potential bias and be reflexive in her writing. I have refrained from disclosing both the real names of my participants and the names of

the organizations for which they work. I have also generalized location names, meaning that they will not be more specific than a city name. Additionally, I acknowledge the potential for bias in my presentation of the data, as I have developed a close working relationship with most of the participants and feel an immense amount of respect for all of them. As such, in presenting the stories of my participants, I make every effort to maintain their own voices by including direct quotations.

Ethics

The types of interviews that I conducted had the potential to create ethical dilemmas that were possibly deeply personal to the subjects with whom I worked. The topic at hand was sensitive and had the potential to cause emotional distress. I employed many strategies to address these issues. First, I focused on participants that are either recovered or recovering. Ideally, the interview process was a therapeutic exercise for my participants as they were able to look back on their lives and their illnesses and see how far they have progressed (Shohet 2007). The participants felt strongly that talking about their experiences is a helpful exercise in the recovery process.

It was also important to make clear to my participants that confidentiality was of the utmost importance and that they would not be identified in my writing. I allowed the participants to choose pseudonyms for me to use in writing and I was very careful to protect their identities. Additionally, in order to ensure maximum comfort for my participants during the interview process, I allowed the participants to choose the locations for the interviews (the male participant was given the option to interview over the phone or via e-mail). It was important to be in an environment in which the participant felt safe in order to both obtain useful data and to ensure

the participant did not feel intimidated or vulnerable. The three female participants with whom I conducted in-person interviews chose to have their interviews take place in the offices of the organization for which they work. As such, when conducting an interview with one participant, the other two participants were sometimes present. The participants felt comfortable with this arrangement since they are all familiar with one another's experiences. This allowed me to hear a participant's narrative, but also, in some cases, to hear the other participants comment on the narrative.

I also made clear to the participants that the interview could be stopped at any time if he or she felt uncomfortable. During the course of the interviews, I did not encounter any issues regarding the comfort of the participants. Ultimately, the most I could do was to ensure confidentiality and to make the participant feel that he or she was in control of the interview process. These tactics proved to be successful. I also believe that, because I focused on participants who were either in a state of recovery for fully recovered, the process of talking about their illnesses was not a novel situation, meaning that they were prepared for any emotional turmoil that could have occurred during the interview process.

4 CHLOE

I first met Chloe when I was looking for a way to get involved in the treatment and prevention of eating disorders. Chloe is a woman in her thirties who previously worked for an organization active in eating disorders awareness and prevention. I inquired about an opportunity to become involved in a program to promote healthy body awareness in elementary school children. Upon meeting, Chloe told me of her own struggle with anorexia nervosa and how her experience inspired her to help others with similar experiences. Chloe was very open and candid about her experiences and was immediately interested in participating in my research. As we worked together, I learned that Chloe is very much of the opinion that raising awareness of eating disorders and promoting positive body awareness can go a long way in the prevention of eating disorders. She has reflected on her own experience and has had time to theorize about why and how her eating disorder began and progressed.

Chloe was born and raised in Atlanta, Georgia. She grew up in what she describes as a "strong Christian home" with her father, her mother, and her older sister.[1] Her family was Southern Baptist, attended church twice a week and she and her sister were not allowed to participate in certain common childhood activities, such as trick-or-treating on Halloween. She describes the household as strict, with an emphasis on Christian morals and values. For example, when she was in sixth grade, Chloe signed a pact stating that she would not engage in premarital sex. Chloe recognizes that this strict upbringing had long-term effects on her life. For instance, she describes herself as a "sensitive child," who saw things in black and white, without shades of gray in between. As such, Chloe was a child who did not often need to be punished, as she would

[1] All quotes included in this chapter are from an interview with the author, February 18, 2010. In quotes with words emphasized, emphasis is the participant's.

punish herself when she felt she had done something wrong. This punishment often took the form of feelings of guilt. Chloe, however, does not feel that it was her parents who made her feel this way. She credits her parents with trying to teach her right from wrong, but believes that her own personality caused her to follow these ideals in a radical way. It is possible that Chloe internalized her parents' teachings to such a degree that they became the norm for her, which makes it difficult to distinguish between a pursuit of perfection to please herself and a pursuit of perfection to please her parents.

As Chloe began to emotionally mature and as her body began to develop and undergo the usual changes one experiences during puberty, she began to feel uncomfortable with her body and experienced feelings of guilt for becoming a young woman. This, in addition to what Chloe calls her "preconceived notions about the opposite sex," meaning her belief that men want nothing more than sex, contributed to a desire to halt the changes in her body. Chloe recalls a boy from her childhood who picked on her, often telling her that she was stupid or ugly. She remembers him as an example of her tendency to internalize the things people would say to her and credits this facet of her personality, combined with her beliefs about the opposite sex and her discomfort with her changing body, with providing her with a low sense of self-worth as she headed into high school. This low sense of self-worth was, as Chloe recalls, particularly striking when it came to her interactions with males. She did not date in high school, never had a boyfriend, and avoided situations in which this interaction was necessary, such as school dances. Chloe feels that "boys were never interested in [her]," but that this was so because when they would approach her, she would "put up a wall" in order to avoid talking to them, which made her uncomfortable. Because Chloe would avoid talking to boys in high school, she did not garner the attention that other girls were receiving, which further contributed to her low self-esteem. This

created a never-ending cycle in which Chloe's low self-esteem prevented her from interacting with the opposite sex, which, in turn, worsened her low self-esteem.

Additionally, Chloe's best friend in high school was a year older than her and so graduated a year before she did. The summer after her friend graduated, Chloe attended a Christian youth camp, which was a positive experience for her, but which also spurred her to set unrealistic goals for herself. She came back from camp with the goal of being what she calls the "perfect Christian," which became her new focus for her last year of high school. The loss of her best friend, who had moved on to college, and her new goal caused Chloe to distance herself from her classmates. She began to spend much more time by herself. Chloe feels that, in her attempt to avoid situations in which she could not be a "perfect Christian," she denied herself an outlet for her negative feelings.

It was at this point that Chloe first decided that she wanted to diet and exercise in order to both enhance her physical fitness and to feel better about herself emotionally. Initially, Chloe's success with dieting helped her improve her mental state and her feeling of self-worth. Given Chloe's family history and dynamic, however, this seemingly healthy dieting practice soon became unhealthy. Chloe's mother was always very thin and Chloe characterizes her mother's relationship with food as disordered. Additionally, Chloe's father suffered from anxiety and depression and his mother suffered from an eating disorder and ultimately committed suicide, although Chloe's family did not learn about the eating disorder until many years later. Given this information, Chloe describes herself as a "prime candidate" for an eating disorder because of her anxiety, genetics, low self-esteem, and her tendency toward "Christian perfectionism." In fact, Chloe expressed surprise that her anorexia did not present itself sooner in her life.

Additionally, Chloe's sister experienced a struggle with her parents to maintain what they viewed as an acceptable weight. This struggle created an unhealthy dynamic in which Chloe's parents would encourage her sister to lose weight by offering her money and gifts when she succeeded. As such, Chloe's mother and sister were both dieting constantly, which made eating meals with them uncomfortable for Chloe. Chloe remembers feeling "unladylike" when eating with her mother and sister.

When Chloe began to diet, she was initially successful, but the dynamic that had been created in her family caused dieting to become "very competitive" between her and her mother. Chloe recalls that her mother could not exercise as often as Chloe and so would eat less. Chloe, not wanting to be "shown up" by her mother would then eat even less. Thus, an unhealthy, competitive dynamic was created between Chloe and her mother.

To worsen the situation, Chloe's body responded very quickly to her dieting. This, coupled with the competitive atmosphere at home, caused Chloe to progress very quickly into anorexia. She began dieting in the fall of her senior year of high school and was anorexic by graduation. She remembers losing around sixty pounds in only three or four months. Worse, however, than the physical consequences, Chloe was not aware of the "chemical component" of her unhealthy behavior. She describes this chemical consequence as preventing her from thinking clearly, which spurred her to make increasingly bad decisions, furthering her unhealthy behavior.

After graduation, Chloe's friends and classmates began to recognize that Chloe had a problem. Likewise, Chloe understood that recording her consumed calories and being "obsessive" about food and exercise was "not normal" but she and her family were unaware of eating disorders and did not understand Chloe's behavior. All Chloe knew of eating disorders

was that anorexics did not eat and that bulimics purged after eating. Chloe did not engage in either of those behaviors. According to her, she "exercised excessively…took diuretics, and…ate only lettuce, *but [she] ate*." Knowing, however, that her problem was food-related, Chloe and her parents decided that Chloe should visit a nutritionist, who placed her in an outpatient program for girls with eating disorders. Chloe attended a group dinner with other girls with eating disorders. Chloe, however, felt that the other girls were "crazy" and that she did not deserve to be grouped with people like them. She decided not to participate in the group, but was told that she would need to raise her weight to a healthy minimum before she could attend college.

Raising her weight to a minimum was particularly important, as Chloe had already begun to experience dangerous physical side effects of her anorexia. She had shrunk one-half of an inch in height and her red and white blood cell counts were drastically outside the normal ranges. Chloe remarks that she "looked like a cancer patient." Chloe's mother's insistence that Chloe gain weight before leaving home for college exacerbated the negative relationship between Chloe and her mother. Chloe's mother was a nurse and argued that Chloe needed to be healthy. Chloe, however, felt that her mother needed to reflect on her own disordered eating. When met with this idea, Chloe feels that her mother adopted the "attitude of 'You're the sick one. You're the one with problems. Figure it out…don't blame this on me'…which made [Chloe] even more angry." This highlights one of the more drastic emotional changes Chloe experienced as her eating disorder progressed. Chloe, who feels that she was never an angry person prior to her eating disorder, grew angrier and angrier as her eating disorder progressed. She attributes this to an excess of emotions that were never expressed. She believes that she dealt with her emotions through diet and exercise, but that the excess came out in the form of anger. As her eating

disorder progressed, Chloe increasingly experienced an excess of emotions, causing her to become an angry person.

In order to gain some independence and to leave her stressful home life, Chloe gained enough weight so her parents would allow her to leave for college. She immediately lost the weight, however, as soon as she was out of her parents' home. Upon arriving at college, Chloe joined a sorority and made many new friends. She also found that, since she had lost so much weight, she had "lost a lot of [her] womanness," and thus felt more comfortable around men "because [she] knew they couldn't want [her] for sex." In addition to her new female friends, Chloe found herself with male friends as well, an experience she had never had before. Chloe characterizes her life during this time in the following way: "Life was good, or at least I thought. Except for the fact that, you know, I was sleeping like two hours a day and weighed nothing and my hair was falling out…and I was gradually losing my mind." Chloe's happiness with her newfound independence and way of life clouded her judgment and it was not until her mental instability affected her daily life that she understood anything was wrong. Chloe recalls, "It had gotten to the point where I couldn't…complete a sentence. I couldn't read…I couldn't do anything. What I was going to eat for the day and when I was going to exercise *consumed* me."

Chloe attempted to better herself on her own, but was unable to do so, leading to more feelings of self-hatred. Chloe eventually decided that she should withdraw from her classes and go back home in order to get better, but she did not feel comfortable talking with her parents about it. She called an old friend from church camp to come pick her up at school, a decision Chloe feels "is very telling about the state of [her] relationship with [her] parents." Upon returning home, Chloe visited her family doctor who seemed to think that Chloe was not suffering from an eating disorder. At the insistence of Chloe's friend who had picked her up

from school, Chloe's parents took her to a psychiatrist. The psychiatrist referred her to a treatment center for women with psychological issues. Chloe's parents took her to see the treatment center, at which point she was, in her words, "locked in" to the facility to begin her first one-month treatment.

Chloe spent her first month in treatment educating herself about her condition, as she had never truly learned about anorexia nervosa previously. Feeling armed with her new education, Chloe was optimistic about her release from the treatment facility. She discovered quickly, however, that she had not been "taught the tools" to deal with the family problems that were still very much alive at home. Furthermore, Chloe was still underweight and envious of her friends back at school who were enjoying their college experiences.

Chloe characterizes anorexia as an addiction. She believes that the longer one struggles from an eating disorder, the more difficult it is to become healthy and the more long-term damage it causes. She also believes that an eating disorder relapse, like a drug addiction relapse, is often worse than the original problem. The long-term nature of Chloe's eating disorder and the troubles Chloe faced at home upon her release from the treatment facility caused her to relapse. She was sent back to the treatment facility where she was hospitalized and tube-fed for a period of time. After her second month in treatment, Chloe was re-inspired to get healthy and felt that she was mentally ready to recover. Her body had been malnourished for so long, however, that she found it very difficult. Additionally, Chloe felt that her eating disorder "had become who [she] was" and that being anorexic had "become [her] identity." Despite her struggles, Chloe was able to attend a local community college part-time and obtain employment at a restaurant. After about six months, however, Chloe found that she simply "couldn't get it together."

It was at this time that Chloe found a therapist with whom she was truly comfortable. This therapist still treats her even today. Chloe and her parents also began family counseling and Chloe noticed a determination in her mother to change her own disordered behaviors in order to help her daughter. Her mother's determination inspired and encouraged Chloe. Chloe would spend one more month in the treatment center – a month that Chloe felt was unnecessary. This last stint in treatment convinced Chloe that she did not want to spend the rest of her life in and out of treatment facilities. Chloe wanted to be independent – she wanted to return to school, move out of her parents' house, and stop being hospitalized – but her "disease was keeping [her]…in a childlike state," unable to take care of herself without the help of her parents and doctors. At the same time, Chloe's older sister was diagnosed with cancer and needed emergency surgery to have a large part of her colon removed. Chloe felt guilty because, while she was making herself sick, her sister had not chosen to become ill. Chloe's sister became healthy again and Chloe became determined to overcome her anorexia.

Chloe was soon able to return to college full-time and to move out of her parents' home. This time, Chloe feels she was more able to experience college in the ordinary way, but she still struggled against her anorexic tendencies. Her obsession did not, however, continue to affect her daily life and Chloe was finally able to focus on school and her social life. Chloe experienced a true breakthrough in her recovery from anorexia when she studied abroad in Italy. She found that being removed from her comfort zone, where she was faced with entirely new people and where she was forced to relinquish control (due to the language barrier), allowed her to gain perspective on her illness. Additionally, Chloe received positive attention from men, despite her weight being the highest it had been since the onset of her illness. This allowed Chloe to understand that

women are perceived differently in different cultures and that a large part of her illness was due to her upbringing in the United States. She finally felt that "all of the pieces fit together."

Chloe now feels that she has been in recovery since her return from Italy, upon which she believes that she finally began "blooming." She began a relationship with her first boyfriend and explored her first sexual relationship with him. She believes that she began experiencing at the age of 22 what others experienced at the age of 16. Even today Chloe feels she is "a little behind the curve in terms of [her] age group." Her friends are now married and having children while Chloe is still discovering what her peers did years earlier. Chloe summarizes these feelings with the following:

> In essence, I think…when you have an eating disorder, you kind of pause everything. Or you think you're pausing everything, but everything else is going on. What you're pausing is…*your* development and *your* life.

A few years later, Chloe's older sister was re-diagnosed with cancer, a battle that she ultimately lost. Chloe feels, however, that her own experience with anorexia allowed her and her parents to adequately cope with their loss and believes that her illness occurred for that very reason. Chloe's experience also encouraged her to reach out to young girls experiencing similar emotions to the ones Chloe had as a teenager. Ultimately, she became involved in the prevention and awareness of eating disorders in the non-profit sector and is now working to help market an eating disorders treatment facility whose treatment methods are in agreement with her own ideas about eating disorders treatment.

5 CLAUDIA

I met Claudia when she took over Chloe's old position. (After I worked with Chloe for a few months, she was offered a position working as the marketing director for an eating disorders treatment center.) My interview with her was much more difficult. She was not as open and candid as Chloe. I believe this is for two reasons. First, Claudia's childhood was traumatic and much darker than Chloe's, as will be described below. Second, Claudia is very much still in recovery from her eating disorder and has not had the same amount of time to reflect as Chloe has. For these reasons, gaining knowledge of Claudia's experience required me to pay attention not only to what she said, but also to what she did not say. Understanding Claudia's story required much more analysis on my part and I believe this is because, on some level, Claudia herself does not fully understand her story.

Claudia is in her forties and was born in South Carolina. She is an only child, as was her mother. Claudia's father committed suicide when she was only three years old, after which she and her mother went to live with her maternal grandparents for two years. Claudia describes her grandparents' home as the only "stable, two-parent" household she ever had.[2] During Claudia's childhood, her mother had a string of bad boyfriends, some of whom were abusive, often committing acts of violence against her mother in her presence. Claudia was often forced to take care of her mother, intervening between her and her boyfriends and calling the police or an ambulance when necessary. Furthermore, Claudia has lapses in her memory around the time she was eight years old. After working with a therapist, Claudia believes that these gaps in her memory are a result of possible sexual abuse by one of her mother's boyfriends. As such,

[2] All quotes included in this chapter are from an interview with the author, February 18, 2010. In quotes with words emphasized, emphasis is the participant's.

Claudia describes herself as having "issues with men" and did not feel comfortable with any sort of physical contact from men until much later in life.

When Claudia was six years old, she began taking ballet lessons. She continued to dance until the age of 20 and was even admitted to college on a ballet scholarship. As a competitive dancer, Claudia experienced immense pressure to maintain a ballerina's physique. Claudia always had a physique that fell into the healthy range as dictated by the Western biomedical system, but felt that ballet demanded a much thinner body. Claudia began to experiment with different diets, but found that nothing she tried helped her become thinner. At the age of 15, Claudia began purging after every meal; tried unhealthy diets, sometimes subsisting solely on baby food or candy bars, or simply eating nothing at all (even for seven days at a time); and sometimes took up to twenty water pills per day. Though Claudia was likely to purge, however, she never binged. She recalls that, at this time in her life, she felt guilty just thinking about food, as if she would gain weight simply by thinking about it. Claudia describes herself at this time as "always striving to be perfect" and never feeling thin enough. Claudia cannot remember how she transitioned from dieting to purging. She believes that, after trying several dieting techniques, she simply decided that it would be easiest to expel the food she ate and that purging was the only way she knew how to "get rid of it." Claudia also expresses the possibility that she may have read about bulimia or seen it on television. This is entirely possible since Claudia's bulimia began around the time that eating disorders began to garner more attention from the media.

The most interesting part about Claudia's struggle with bulimia is her inner conflict about whether it was emotionally motivated, or motivated solely by her ballet. This is interesting because it is possible that it was a combination of both, with the expectations of ballet being one of the triggers of her unhealthy behaviors. Claudia expresses both sides of her story, but

consciously believes that her ballet was the main contributing factor. She describes her insecurities caused by being around other dancers who seemed more able to maintain the proper ballet body and firmly believes that her issues with her weight are what caused her to begin dieting. She even once asked her mother if she could have a breast reduction because she wanted to look more like the typical professional ballet dancer. Claudia does not remember her family ever having attitudes about food and weight that would have caused her to begin purging, and so firmly blames ballet. She recalls "begging" her mother to allow her to quit ballet in order to relieve this pressure to be perfect, but believes that her mother would not allow her to stop dancing due to her own dream of being a ballet dancer. This is also why Claudia believes that her mother ignored Claudia's bulimia, despite explicit knowledge of her purging. This emphasis on her mother highlights the other side of Claudia's story. As much as Claudia solely blames ballet for her bulimia, she spent as much time during her interview, if not more, describing the ways in which her emotional issues impacted her unhealthy behavior. As further evidence that Claudia's bulimia was emotionally motivated, Claudia quit ballet at the age of 20 – an event she describes as liberating – but she did not quit purging.

Claudia mentioned that she believes that her bulimia started because of her issues with abandonment. She felt abandoned by her mother's lack of parenting and says, "I was abandoned by my father" when he committed suicide. Claudia also suffered from depression and mentions stress as a trigger for her "urge to purge." What seems most likely and what Claudia has described, is that her eating disorder evolved as she got older. It became less about being thin and more about her emotions. She says that as she got older, she "simply could not stand the full feeling" and that she thinks the "fullness just triggered…[her] emotional fullness." Claudia remembers that when her grandmother died, she felt especially tempted to purge because of the

stress of the situation. This dichotomy between emotional issues and weight issues continues today for Claudia. She says that advertising and images of women in the media often trigger feelings of low self-esteem, leading her to worry about her weight. On the other hand, Claudia says that she is most tempted to purge now when she is "really angry and [she does not] express her feelings" and that expressing her feelings helps her feel less full.

Though Claudia's eating disorder continued into her thirties, she was never hospitalized. She believes this is because she never lost enough weight to be considered unhealthy, she was always able to function properly on a daily basis, and because she was able to hide her bulimia from others, even her first husband. Claudia married her first husband when she was 29 and she was able to hide her bulimia from him even though, in her words, she "purged all the time." Even the side effects of Claudia's bulimia were easy to hide. The blood vessels under her eyes would burst, resulting in small red dots, but she was able to cover those up with makeup. And her fatigue and headaches could often be ignored or attributed to other causes. The purging itself proved easy to camouflage because Claudia was able to make herself vomit without using her fingers and, as she argues, it was much less violent than what one would experience with the flu, so she was able to slip away after meals to purge without anyone asking questions.

Claudia did not seek help for her bulimia until after her divorce from her first husband, after two years of marriage. The divorce caused Claudia to reflect on her life and she felt that something must be wrong with her. Claudia was also concerned about the physical effects of her bulimia. She had heard that purging could cause seizures and she was worried that she had done permanent damage to the enamel on her teeth. Determined to be healthy both mentally and physically, Claudia sought a therapist and began attending both individual and group therapy once a week. She continued this cycle for two years. The individual and group therapy

complemented each other and Claudia feels that the group therapy was a vital component to her recovery. Group sessions included people dealing with various kinds of addiction, from eating disorders to gambling to drugs. It was during group therapy that Claudia realized that her eating disorder was an addiction and that others were dealing with many of the same emotions and feelings as she was, but that they manifested themselves in different ways.

Claudia firmly believes that an eating disorder is an addiction that one lives with forever. She says, "You heal, but yet it's something that's always there…it could always pop up in moments of stress." She characterizes her recovery as a constant struggle. Claudia still purges today, but she does it "very rarely." She has learned coping mechanisms to avoid purging, such as talking about her feelings as they present themselves and practicing positive self-talk that focuses on the things she likes about herself. Claudia has attempted to return to ballet, but has found that even non-competitive adult classes place too much stress on her. Ballet is a trigger for her bulimia to which she can never return. Claudia never formed a healthy relationship with her mother. She was eventually able to confront her about her childhood and the consequences it has had for her adult life, but Claudia feels that her grandmother was more of a mother to her. In fact, Claudia credits her grandparents with providing positive role models in her life, allowing her to see "that there was a possibility of normalcy." She strongly believes that the stable life her grandparents had prevented her from ending up like her mother.

Today, Claudia has remarried and is a stepmother to three young girls, one in high school and two (twins) in elementary school. She focuses her efforts on encouraging positive self-esteem in the girls. Claudia tries to protect her stepdaughters from negative self-talk and is careful not to instill negative ideas about food. This places her at odds with the girls' mother, who Claudia does not believe understands the negative impact this type of behavior can have

because she has never had an eating disorder or known someone who has. According to Claudia, the girls' mother often talks negatively about her own body and eating habits in front of the children and tells them that certain foods should not be eaten because they are fattening and can have negative impacts on the girls' bodies. Claudia finds this type of behavior "infuriating," but understands that she cannot intervene. She simply avoids these behaviors in front of the children and does her best to educate them about healthy eating behaviors and the vast differences between peoples' bodies. Claudia places blame on the media and firmly believes that images of women in advertising and other media contribute to the development of eating disorders in young girls. She has spent ample time explaining to her stepdaughters that, not only are women's bodies vastly different from one another, but that the media presents a myth and cannot be relied upon to show what a woman really looks like. She is now working for a non-profit organization, helping to raise awareness about eating disorders.

6 PIPER

I first met Piper a few weeks after I began working with Chloe. She too had suffered from an eating disorder, had recovered, and wished to use her experience to help others. Piper, who is in her thirties, was born and raised in the suburbs of Atlanta, Georgia. She lived the first seven years of her life with her parents and her older brother.

Piper's parents placed a high premium on public image. Her father was an important and active member of the community and her parents felt that Piper's appearance had a direct effect on his public image. Piper remembers her parents calling her fat even though she believes she was a "skinny kid," and her father always emphasized the importance of being pretty and popular.[3] As such, Piper believes her mother suffered from an eating disorder and recalls her standing in front of the mirror telling herself, "You're a dog." Piper's brother, on the other hand, was perfect in his little sister's eyes. Piper admits that she always wanted to be perfect, like her older brother, and that her eating disorder began, in part, to gain attention from her parents. Piper grew up feeling like "the scapegoat of the family, the screw up" and struggled with depression and self-harm in addition to her eating disorder.

When Piper was seven years old, her parents divorced, her father moved out, and she stayed to live with her mother. Piper's father was not often physically present; she viewed him as a financial source. Piper describes her mother as "not the most loving mother and most attentive mother," so Piper was left at an early age without much parental support. Her mother eventually returned to school to get a law degree, where she met a man and married him. Piper feels this man was the complete opposite of her father and was a "horrible person."

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[3] All quotes included in this chapter are from an interview with the author, February 19, 2010. In quotes with words emphasized, emphasis is the participant's.

Piper began attending a summer camp every year at the age of seven. At the age of 13, she had a camp counselor who she idolized. This camp counselor ate only lettuce and mustard every day (a zero-calorie meal) and Piper wanted to be like her and to imitate what she did. One night, Piper and her roommates snuck into the camp's kitchen and stole junk food. The girls binged on the food and then decided to make themselves throw up for fun, to see if they could do it. Piper noticed that, while other girls struggled to purge, "it just came *way* too easily for [her]" and it felt "like second nature." At this point, Piper understood that this could potentially be a problem, but she was young and did not "latch onto it."

When she returned home from camp, however, Piper began to experiment with restricting her food. She vividly remembers her mom making her stand over the sink while she shoved broccoli in Piper's mouth because she was refusing to eat. This continued and worsened for the next few years. By the time Piper was 16, she had truly begun her eating disorder. She did not purge at this point, but was severely restricting her food intake. Her relationship with her parents worsened until, as she puts it, her "parents just didn't like [her] and [she] wasn't getting along with anybody." Piper's parents sent her to boarding school where she could be better supervised. She was forced to be weighed by the school nurse every day. While at boarding school, Piper continued to restrict her food intake and also began exercising excessively. She could often be found running laps around the school's track late into the night. By the time Piper returned home from her first year at boarding school, she had pushed her body to its limits. She purged ten to 15 times per day, without binging and was still restricting and over-exercising.

When Piper returned home from boarding school, she decided to move in with her father. She and her mother were at odds and her stepfather had a tendency to make sexual remarks to Piper, which made her feel "dirty." This dynamic made Piper extremely unhappy, worsening her

eating disorder, so she decided to live with her father. Piper experienced a complete lack of structure when living with her father, in part because he was often away from home and in part because he was apathetic. This meant that Piper was free to continue her eating disorder without comment or interruption. One night, however, Piper had gotten up to purge in the middle of the night and threw up blood and "something that had to be part of [her] stomach…[she did not] know what it was, but it *freaked [her] out*…[she] thought [she] was dying." Piper was so scared that she woke up her father to tell him what had happened. Her parents took her to the doctor the next day.

When Piper visited her doctor, she was told that she needed to be hospitalized because she was at risk for a heart attack. Her potassium levels were very low and she was passing out "all the time." She was referred to a local eating disorders treatment facility, which allowed her to be treated as an intensive outpatient because she did not need to be put on a feeding tube. Piper feels that she was not ready to receive help when she went into treatment the first time. She remembers her first day, during which she was asked to put butter in her green beans at meal time. She refused to include the butter in her meal and so was given an option: she could either drink Ensure, which she describes as "every anorexic's nightmare," or she could eat the butter plain. Piper did not want to drink Ensure, so she was forced to eat the butter. This made her feel angry and humiliated. This first day set the tone for the rest of Piper's experience at the treatment facility. She found the atmosphere to be extremely competitive. Patients often wondered why the same rules did not apply to everyone, for example, why the types and amounts of required foods were not the same for everyone. Piper disliked this treatment experience and, as such, would not recommend the treatment center to others. Her experience did have some effect on her nonetheless. After this first time in treatment, Piper stopped purging for the most part and relied

mainly on restricting. This pattern, an emphasis on restricting and less emphasis on purging, continued throughout her eating disorder.

Rather than sending Piper back to boarding school, her parents re-enrolled her in the local high school. Piper's best friend, also suffering from an eating disorder, attended the same school and the girls tended to feed off of each other, encouraging their eating disorders further. As part of the girls' treatment and to attempt to change this unhealthy dynamic, a nutritionist arrived at the school every day to take Piper and her friend to eat lunch, a ritual Piper remembers being "pretty embarrassing."

Piper finished high school and attended college. She feels that she kept her eating disorder under control her freshman year, even gaining what she terms "the freshman 30," but struggled from depression and anxiety, specifically social anxiety. Her sophomore year, Piper panicked at how much weight she had gained previously and so intensified her eating disorder again. Piper's junior year saw another improvement in her eating disorder, only to be shattered the following two years. Piper "got really thin" and says this "was a pretty low point." Two events happened to worsen Piper's condition. First, Piper had been date raped in high school and this happened again in college. After she was raped, Piper's self-esteem was at an all-time low. Second, some months later, Piper got pregnant and had an abortion (unrelated to the rape). This further lowered her self-esteem. Piper describes herself in the following way: "I've never had self-esteem. I have really bad self-esteem. Really low self-confidence. I've never felt pretty. I've never felt good enough." In times of stress, when Piper felt a lack of self-esteem, she could always rely on her eating disorder. She says, "My eating disorder has always…been that one thing that I can just go back to if I'm feeling really bad…or something traumatic happens. I can

just lean on that and it's…been my best friend and it's something that I can control." By the time Piper finished college, she was relying heavily on her eating disorder.

Piper graduated from college and moved back to Atlanta, where she secured her first job. She says that she "totally butchered it" because she had to go into treatment almost immediately after being employed. She was first sent back to the local treatment facility she had been referred to in high school and then was sent to Arizona for an intensive inpatient stay. At the treatment facility in Arizona, Piper struggled with whether or not she really wanted to overcome her eating disorder. On the one hand, she wanted to get better because she did not want to destroy her career and her life. On the other hand, she feared abandoning her illness that had been her "best friend" and was still frightened of the prospect of gaining weight. Piper feels this internal conflict prevented her from taking full advantage of the center and wishes that she had "given in" more to the available treatments. Piper believes that it is important for one to feel ready to receive treatment for an eating disorder. She feels that this feeling of readiness comes when an individual has truly hit "rock bottom," when she is no longer able to function on a daily basis and when she is actively not participating in her life. Even a feeling of readiness, however, must compete with the "scary feeling" one gets when she is confronted with the idea of no longer having an eating disorder, something that has given the individual "happiness and contentment" for such a long time. Piper feels that the idea of treatment causes panic at the thought of losing a part of oneself. It also causes the individual to wonder whether the people in her life will still care about her well-being when she no longer suffers from an eating disorder.

The center in Arizona offered "alternative" treatments, including acupuncture, herbal treatments, all-organic meals, biofeedback (monitoring of automatic bodily functions in order to train oneself to voluntarily control them), and reiki (during which a therapist attempts to channel

energy into a patient's body through touch). While in treatment, Piper worked through many of her issues, including her rape and her abortion, as well as her family issues. She feels that the employees at the center "really work at getting to the root of why you have an eating disorder. We all know it's not about the food. It's control. It's about…the mental aspect of it. The food is…the vehicle for…what you're trying to get out or what you're trying to keep in."

Ultimately, Piper was able to get well enough to live independently and to function on a daily basis, something that she was once incapable of doing. In high school, for example, Piper could not maintain good grades and became a "hermit" because she avoided social situations in which she would have to eat. After college, when she first became employed, her eating disorder and her depression prevented her from attending work on a constant basis. Piper feels that anxiety, depression, and eating disorders tend to go hand-in-hand. She says that depression and an eating disorder feed off of one another, worsening both. For example, Piper would feel depressed because of her body issues, which would spur her to further lose weight. She also felt depressed because having an eating disorder would make her feel like a failure, creating a vicious cycle. She describes this period of time in this way: "I was *so obsessed*. I could not think of anything else, but what I was going to eat, when I was going to eat it, how I was going to eat it…when I ate it, what was it going to do to my body." During this time, she lost many of her friends and destroyed her relationship with her family.

Currently, Piper has a better relationship with her mother. She says that she and her mother are "best friends" and that her mother is much more loving now than she was when Piper was a child. Piper feels that her mother still struggles with her own eating disorder, which makes eating meals together difficult, but the two have been able to maintain a healthy, happy relationship. Piper also has a healthy relationship with her brother. Piper's brother is very good

to her and makes it a point to tell her often that he is proud of her. Piper makes an effort to no longer compare herself to her brother. Unfortunately, Piper still does not have a good relationship with her father. She still seeks his approval and feels that he is not proud of her. He still makes negative comments about Piper's weight and her eating habits and Piper feels that he only tells her she is beautiful when she has lost a significant amount of weight. While Piper of course loves her father, she feels that their relationship is mostly based on his financial support of her.

Piper still struggles very much with her eating disorder, but has learned to avoid unhealthy behaviors. For the time being, Piper relies on some coping mechanisms she learned during the course of her treatment to get her through the rough patches. She knows now that if she purges even once, it will send her back down a dangerous path, one that she does not want to revisit. Rather than giving in to the urge to purge, Piper tries to make the feeling nothing more than a fleeting moment. She does this by immediately engaging in a distracting activity, such as calling a friend, reading a book, or cleaning her home. Before treatment, Piper would obsess about this urge, but now she finds it easier to keep her mind off of it.

Despite this ability, Piper still finds herself obsessing over her body. She says,

> I would love to be able to not obsess or think about these things. I would love that. I have no life. That's all I think about…Like right now I'm having a conversation…with you right now…and I'm nervous that you're looking at me, thinking 'she's really unattractive.' And I know it sounds stupid, but…that's what I'm thinking when I'm having a conversation with someone. It's annoying…and it takes up a lot of energy. And I don't like it because I want to be able to have a conversation with someone.

When Piper was speaking about this in her interview, Claudia contributed to the conversation with something that she and Piper had previously discussed. They wonder if they will still have these anxieties when they are much older, if they will be sitting around as old women wondering

if people think they are fat or unattractive. This provided an interesting contrast to Chloe, who feels that she is completely recovered and says that she does not concern herself with these issues.

When asked what she believes contributes most to the development of eating disorders in young women, Piper responded by saying, "I think your parents play a *huge* part," which is indicative of Piper's experience with her own parents. She also believes that an individual's socioeconomic background is significant, as a large portion of women with eating disorders are middle to upper class and white. Piper also names one's peer group as a contributing factor and believes that seemingly small negative comments in childhood can stay with an individual for life. Additionally, Piper believes that genetics also play a significant role, causing a predisposition in an individual, and that individual personality, namely, how one handles criticism, is also important. She feels that representations of women in the media play only a small part in the development of eating disorders in young girls.

Piper still struggles with maintaining her health. She says, "I guess I never really…tried to do it the healthy way" and that she simply "dove in head first" to her eating disorder. This makes it difficult now for Piper to find a healthy balance because she never understood it in the first place. She finds that if she begins to diet and exercise, she always takes it to an extreme. On the other hand, when she does not diet and exercise, she feels that she also takes that to an extreme. She says, "Now when I'm trying to do it the healthy way, I find that I'll either become too obsessive or not obsessive enough." Piper also feels angry that she needs to exercise to maintain a healthy weight because she believes that she has "messed up [her] metabolism so much" that losing and maintaining weight is very difficult. She is angry that her poor choices in

her youth have caused long-term effects and that they were self-inflicted, rather than imposed by an outside force.

While Piper clearly still struggles with many of her body issues, she has learned healthier behaviors to cope with them and she actively participates in the raising of eating disorders awareness through her employment. Piper is not fully recovered and believes that this may not be entirely possible. She describes herself today in the following way:

> I still struggle a *whole* lot with body dysmorphia, I struggle a whole lot with self-esteem, I struggle a whole lot with not liking myself. I do a lot of negative self-talk…I still don't really like myself very much…I don't make myself throw up. I definitely want to, a lot, but…I'm proud of myself…that I have learned enough coping skills that…I'll do something to…keep myself from doing that.

Piper still experiments with her food intake, sometimes watching what she eats, sometimes slipping and eating too much. She often obsesses over what she eats, sometimes for days at a time, unable to think of anything else. She wonders if people can tell when she has eaten too much or if they think she is fat. Piper believes that an eating disorder stays with a person forever. She feels that even when one is able to conquer their binging, purging, or restricting, one still has a small voice in the back of her head that prods at the person's insecurities. Perhaps given some time, Piper will be able to quiet the voice in her head.

7 JOHN

I was introduced to John by Claudia, who was kind enough to pass information about my research along to him. Claudia and John had come into contact because John founded and runs an organization for men with eating disorders. John had asked Claudia to include his organization's information on her organization's website. John does not live in Atlanta and, as such, I was only able to communicate with him mostly via e-mail. I was therefore unable to obtain as in-depth an interview with John as I was able to with Chloe, Claudia, and Piper, but I feel that it is important to include a male perspective on eating disorders and John's responses highlight some important issues facing men with eating disorders.

John grew up in a town outside of Buffalo, New York in a middle class family. His family was the most important thing in his life. He is the oldest of a family of five children, with four boys and one girl. John had very close relationships with all of his family members, particularly with his mother, who filled the role of caregiver in the family. His father, on the other hand, was more distant. John felt it easy to talk to his mother, but had difficulty feeling comfortable talking with his father. John's family perceived him as the "responsible, older son who worked hard at school work despite difficulties posed by [his] visual disability" (John is legally blind).[4]

John's eating disorder began when he was 18 and a senior in high school. He credits the anxiety caused by his school work and a crisis of sexual orientation with contributing to the development of his eating disorder. He began by limiting what he ate at lunch at school every day. His eating disorder worsened while in college, where he severely restricted what he ate and began eating only when he was alone. He ate very slowly while he worked. Eventually, he felt

[4] All quotes included in this chapter are from a personal communication (e-mail) with the author, March 4, 2010. In quotes with words emphasized, emphasis is the participant's.

uncomfortable eating any foods with sugar, which he calls his "unsafe food." John feels that his eating disorder had little to do with wanting to be thin and more to do with coping with stress and conflict. He did not count calories, did not compulsively exercise, and he was not obsessed with weighing himself. Eventually, "[his] thinness would become [his] identity, and as such would be hard to give up." Now that John is "out about being gay," he feels that his eating disorder is precipitated by traditional sexual moral values and the lack of a life partner.

John first realized that he should seek treatment when he graduated from college. Currently, he has been "in and out of therapy several times [and] once in residential treatment." He feels that therapy has "only been minimally helpful" and that it "seems to have been more explorative than practical." He was motivated to seek treatment due to his mother's concern for him and his previous, unsuccessful "desperate attempt[s] to get 'unstuck' from the illness. Today, John does not feel like he has recovered, but that he is "just 'holding [his] own,' which means [he] is not as restrictive with [his] eating, but still [has] hang-ups with eating sugar and feel[s] uncomfortable eating socially."

John feels that his experience of an eating disorder is very different from the usual case. First, he is not female. Second, as he makes clear more than once in his responses, he is not an athlete. John obviously feels that the majority of male cases of eating disorder occur in athletes. He established his organization "to offer support to males with eating disorders, to make the public more aware that males get disorders too, and to be a resource of information on the topic." He says that his "passion to start the non-profit came from [his] need to give meaning to [his] own regrettable personal 30 year experience with anorexia by helping others and to meet the need for greater support and resources for males who are an under represented and mostly untreated population with eating disorders."

8 ANALYSIS

The four stories presented here are vastly different. Chloe and John suffered from anorexia, Claudia from bulimia, and Piper from a combination of the two. Furthermore, each participant struggled especially with a particular part of his or her eating disorder. Chloe's experience is characterized by her fear of becoming a woman and her fight to maintain her Christian values. Claudia's experience is much more focused on traumatic childhood events. Piper was fighting to garner the attention of her parents and to live up to their standards. John struggled with a sexual orientation crisis and his clash with traditional moral values regarding sex. Despite these major thematic differences, however, there are some striking similarities in the stories.

One theme that appears in the stories of Chloe, Claudia, and Piper is perfectionism. Each of these participants describes a drive to be perfect. This drive, however, manifests for very different reasons for each woman. For Chloe, her drive to be perfect is very much a reflection of her Christian values. She strived to be a "perfect Christian," which put her at odds with the changes her body experienced during puberty. Her anorexia provided a way to prevent these changes from happening, allowing her to avoid becoming a woman. This, in turn, allowed her to avoid attention from men and the sexual connotations that come along with it. Preventing these changes helped Chloe maintain her Christian perfectionism. Claudia, on the other hand, struggled to maintain the perfect ballet dancer's body. Her bulimia helped her do this and she even went so far as to yearn for a breast reduction in order to achieve this perfectionism. Piper felt that her appearance needed to be perfect in order to gain acceptance from her parents. Because her behavior was imperfect and at odds with her parent's standards, her restricting and

purging could at least ensure that her physical image reflected the unfair standards her parents had set in place.

Additionally, a striking difference can be seen in the ways in which Chloe and Piper dealt with their family's reactions to their eating disorders. Piper displayed the reaction to her family dynamic of which many theorists have taken note. She admits that she began her eating disorder partly because she hoped to gain attention from her parents. It is possible, and even likely, that, because Piper's family was somewhat disbanded after her parents' divorce, that her eating disorder was an attempt to bring her family together again. Many girls who come from similar family situations develop eating disorders because their illnesses provide a point around which a family can rally. Chloe, however, found that her family rallying around her eating disorder produced feelings of guilt. When her sister fell ill, Chloe no longer wanted to be the center of attention. She felt guilty that, while her sister, who had not asked to become ill, was fighting for her life, she was deliberately making herself sick. It is also possible that Chloe was vying for attention on a subconscious level, but that she no longer wanted or needed it when her family had another reason to come together. So while Piper's family's reaction to her illness was a motivating factor to continue her illness, Chloe's family's reaction was a motivating factor to recover from her illness.

Furthermore, it is interesting that each of the women's bodies responded very differently to the illness. Chloe's anorexia produced an almost immediate response in her body, one that was very difficult to reverse. Piper also experienced a drastic change in her body, but experienced less difficulty in reversing the effects. Claudia, on the other hand, found it very difficult to produce a change in her body and practiced purging mostly to maintain her weight, as she could not easily lose it. It is important in eating disorders research to address differences such as these.

These bodily responses may be fundamental in the evolution of an individual's eating disorder. For example, it is possible that Claudia's inability to produce the desired physical effects shaped the path her eating disorder followed, namely, her focus on purging rather than binging or restricting. Claudia herself says that she turned to purging because no amount of restricting produced the effects she wanted and purging was easier than starving herself.

These different physical responses also highlight an important point to keep in mind when attempting to understand eating disorders – each individual's experience is intensely personal. No two people will have identical experiences. As such, I believe that it is extremely important that those who treat eating disorders make an effort to promote cooperation between the different disciplines that produce eating disorders theory. For instance, Chloe brings to light issues that abound in feminist theory when she discusses feeling "unladylike" when eating with her mother and sister. Claudia's experience, on the other hand, falls into the realm of traditional psychological theory because it involves childhood trauma and potential sexual abuse (although her reactions to these experiences could be culturally shaped as well). Piper's story highlights ideas present in family dynamics theory, involving issues of divorce, the remarrying of parents, and multiple children households. John's experience points out the need to focus on gender in eating disorders theory in a way that moves beyond feminist research that discusses the effects of a beauty-obsessed patriarchal society on young women. Each of the participant's stories involves aspects of the theory of several disciplines. In order to effectively treat an eating disorder, it is important that practitioners take a collaborative approach and treat patients holistically.

Moreover, these stories highlight issues with the definition and diagnosis of eating disorders. Chloe's experience with her family practitioner, who insisted she was simply thin and enjoyed exercise, is unacceptable. At the time, Chloe was dangerously underweight and was

unable to live a normal life because of her eating disorder. It is unfortunate that cases of eating disorders go undiagnosed because of a cultural acceptance of extreme thinness in the United States and it points to the need to raise awareness about eating disorders and their dangers. Claudia's and Piper's experiences show how important it is to update the definitions of eating disorders because they do not fall into the neat categories set forth by the diagnostic criteria. As it is, the current definition of anorexia nervosa according to the American Psychiatric Association is as follows:

> 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 gaining weight or becoming fat, even though underweight.
> C. 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 postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.) [American Psychiatric Association 2010]

The diagnostic criteria for bulimia nervosa is as follows:

> 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 behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

> C. The binge eating and inappropriate compensatory behaviors 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. [American Psychiatric Association 2010]

These definitions are problematic for several reasons. First, the definition for anorexia nervosa refers to body weight that is less than "that expected," but does not address the fact that an expected weight for "age and height" is culturally determined and that it is socially acceptable for women to be proportionately thinner than men. Additionally, the definition for anorexia also refers to amenorrhea is postmenarcheal females. Amenorrhea is relatively common in serious athletes and may or may not be experienced simultaneously with disordered eating behaviors. These types of issues must be addressed when identifying anorexic patients. One of the main diagnostic criteria for bulimia nervosa is the presence of "recurrent episodes of binge eating." This is problematic because many bulimics do not binge eat. Both Claudia and Piper, for instance, purged often but rarely or never binged. Furthermore, the definition for bulimia nervosa mentions binging as "eating…an amount of food that is definitely larger than most people would eat," but it does not define what most people would eat. This leaves significant room for interpretation, which can make diagnosis difficult. These definitions also do not address the potential for crossover between the two. For example, the use of laxatives, or over-exercising may be seen in both anorexia and bulimia.

These problems in identifying and diagnosing anorexia and bulimia can have serious consequences for those suffering from eating disorders. For example, Claudia was never underweight and was never hospitalized, but was clearly suffering from bulimia. She was not medically diagnosed until she made a personal decision to seek treatment. Likewise, John only sought treatment at the insistence of his mother. As a male, it is likely that he faced a medical

bias that favors the diagnosis of eating disorders in girls and women because they are less common in boys and men. Piper, as a young girl, experimented with purging and restricting. These types of behaviors need to be recognized and dealt with before a dramatic drop in body weight occurs.

The experiences of Chloe, Claudia, Piper, and John speak volumes on eating disorders in general. For example, all four agree that treatment will not be effective and that a person cannot recover from an eating disorder until he or she decides that he or she wants to. Chloe, Piper, and John described similar feelings about their eating disorders, Chloe seeing hers as her identity, Piper calling hers her "best friend," and John seeing his thinness as his identity. Until an individual suffering from anorexia or bulimia is willing to shed his or her identity or abandon his or her best friend, treatment will not likely help him or her recover. Chloe, Claudia, and Piper also agree that an eating disorder is very much like an addiction, but their ideas differ on whether one can truly recover. Chloe feels that she is completely recovered and no longer needs to think about her eating disorder. Claudia and Piper feel, however, that an eating disorder is an addiction from which one never truly recovers. They are, to this day, in a process of recovery and still struggle to avoid disordered eating and behaviors. John also does not feel as if he is fully recovered and feels that therapy is only minimally effective. Chloe's experience is interesting in that her parents entered family counseling with her. Perhaps this treatment approach made Chloe better able to fully recover. Maybe, with time, Claudia, Piper, and John will also feel that they have truly fully recovered from their eating disorders.

One point Chloe, Claudia, and Piper felt it was important to talk about is the state of advertising and the media in the United States. Chloe, Claudia, and Piper all feel strongly that the media greatly contributes to the prevalence of eating disorders among young girls. Chloe got a

first-hand look at how different life could be without this media pressure when she studied abroad in Italy and it allowed her to have a breakthrough in her recovery. While a message of positive body image and health in the media would require a complete cultural overhaul in the United States, it is an important and worthy goal toward which we can all begin to work. Chloe, Claudia, and Piper have all already begun their missions to erase these harmful messages.

John's experience is, at first glance, difficult to understand alongside Chloe's, Claudia's, and Piper's experiences. Upon further investigation, however, John's story contains many of the same themes. For example, John's eating disorder began in part because of a crisis of sexual orientation. This is similar to Chloe's fear of her burgeoning sexuality, which she avoided and controlled with her eating disorder. Furthermore, John feels his eating disorder was perpetuated later in his life, once he was comfortable proclaiming his sexual orientation, by the pressure to adhere to traditional heterosexual values, which could also be described as traditional masculine values. This is similar to the pressure Chloe and Piper felt to adhere to traditional feminine values. Chloe expresses this when she discusses her inability to feel "ladylike" when eating with her mother and sister and Piper expresses this when she discusses her need to please her father and to maintain an appropriate feminine image. Interestingly, like Chloe, Claudia, and Piper, John has also begun his own crusade to raise awareness of eating disorders, although his is specifically targeted toward men with eating disorders. Perhaps using one's experience to help others is an important part of the recovery process, as it is something all of the participants share.

9 THEORY

Once considered purely psychological syndromes, anorexia nervosa and bulimia nervosa have shown themselves to be wrapped up in a psycho-cultural package, confounding our ability to prevent, diagnose, and treat them. The major theoretical perspectives that have informed my research are feminist studies, family studies, psychology/psychiatry, public health, and anthropology. It is important to note, however, that it is difficult to separate conceptual and theoretical frameworks when discussing eating disorders because the study of these disorders lends itself to interdisciplinary cooperation. Often, it is the methods used that separate psychological, public health, familial, anthropological, and feminist research. Even given the differing methodological approaches, however, there is still quite a bit of overlap. Feminist research can be integrated with psychology and anthropology, the realm of psychological anthropology is growing, and the idea of investigating eating disorders through a cultural lens has permeated all of these disciplines. It is perhaps more useful to think of the study of eating disorders as one field in which many disciplines operate. It is also crucial to note that within each of the many general theoretical approaches to the study of eating disorders, there are many smaller, more specific theoretical discussions occurring. For the purposes of this discussion, however, I find that it is more important to focus on the more generalized theoretical veins than on the individual theorists that may in fact add much to the investigation of eating disorders, but that do not provide as useful a framework with which to understand my research.

Furthermore, it is important to distinguish between the various aspects of eating disorder research. These traditionally include diagnosis, treatment, and recovery. Generally speaking, the eating disorders literature can be divided among the investigation of eating disorders prior to

diagnosis, during treatment, and after recovery. Personally, I was less interested in how an eating disorder affects an individual's life (post-recovery) than in how an individual's life affects and/or causes her eating disorder. As such, the theoretical perspectives that informed my research focus on the identification, prevention, and treatment of eating disorders (the reasons for their existence and what can be done about it).

Culture in Eating Disorder Research

In the discussion of theory, it is important to highlight a major theoretical shift that has taken place in the last thirty years: from understanding eating disorders as purely psychological syndromes to understanding eating disorders as culture-bound syndromes. After this shift occurred, it was believed that anorexia nervosa and bulimia nervosa were culture-bound syndromes because of the lack of confirmed cases outside of the Western world (and Japan, which is considered an exception because of its highly industrialized society and ready grasp of Western ideals). This notion seemed to be confirmed when cases began to pop up in non-Western areas of the world after globalization had imposed "Westernization" on these regions. In fact, the spread of eating disorders to non-Western contexts is a relatively recent phenomenon; anorexia nervosa was seen only in the Western world as late as the 1980s (Kleinman 1988). As the cultural component in the study of eating disorders has grown, anthropologists have become more involved in the investigation of them.

The permeation of culture into eating disorders research has taken a different form in each discipline. Medical and psychological researchers have acknowledged the importance of culture in understanding eating disorders, but they have generally done so only insofar as to mark eating disorders as culture-bound syndromes. They have not yet begun to investigate, on a large

scale, the ways in which an individual's culture influences the particular manifestation and/or presentation of her eating disorder or the ways in which sufferers of eating disorders construct their own culture.

Feminist Studies

Feminist theory includes other areas of study such as media studies and political studies in its literature on eating disorders. Most of the feminist literature on eating disorders has focused on patriarchal social and political structures and the impositions these structures have placed on women. This includes not only beliefs about Western culture's patriarchal attributes, but also criticisms of media and advertising.

Wolf (1994), for example, points out that the patriarchal structure in the United States has dictated the ideal feminine body based on the level of freedom that has been granted to women. She argues that the beauty ideal of thinness did not become fashionable until the 1920s, when women were granted the right to vote and were given rights equal to those of men. To support her argument, she notes that, during the 1950s, a plumper body was more fashionable, but women were confined to the domestic sphere during this era and the thin ideal came back into fashion once women broke free of this sphere. According to Wolf (1994), as women have been given more liberties, they have been forced to separate their minds from their bodies. This is because the liberties women have been given have been given only to their minds, and as women's minds have been given more freedom, their bodies have become more restricted, so that as women have been granted the ability to enter the university or to advance their careers (for example), they have been held to beauty ideals that are difficult to attain for some and entirely unattainable for many. Chloe supports this argument when she discusses the concept of

ladylike eating, which suggests that, despite Chloe's freedom to attend college and enter a career of her choosing, her body is bound by cultural norms that dictate not only what food she can eat, but also the way in which she is expected to eat it. Wolf (1994) also argues that if eating disorders were as prevalent in young men as they are in young women, more notice would be taken and there would be more concern with finding effective treatments. This idea is particularly interesting because there is a distinct lack of attention to male eating disorders and there is most certainly a stigma attached to them. This stigma exists because eating disorders are considered a female problem. John's discussion of his experience also points out that male eating disorders are common in athletes where it is likely that they are unnoticed or ignored because they potentially enhance athletic performance. Considering the attention that female eating disorders have gained in recent years, it seems logical that, if male eating disorders were more common outside of athletic circumstances, they would cause much more panic. Whether this attention would aide in the discovery of more effective treatments for eating disorders, however, is unknown.

Perlick and Silverstein (1994) highlight another common theoretical approach in the feminist literature – issues in identifying with the mother figure. They identify two scenarios that lead to ambivalence about one's gender and, therefore, potentially to eating disorders. The first is one in which a young girl has a mother who is nontraditional (who does not operate within the traditional female gender roles of wife and mother or who operates within these roles but in a nontraditional manner). According to Perlick and Silverstein (1994), the girl with an eating disorder identifies with her nontraditional mother but fears the backlash and the lack of respect she has observed directed toward her mother because of her choice to be nontraditional. On the other hand, a young girl may have a traditional mother with whom she cannot identify. Both of

these scenarios, Perlick and Silverstein (1994) argue, cause the girl to feel ambivalent about her gender and this ambivalence leads to the development of an eating disorder. Piper expresses an inability to relate to her mother when discussing her experiences. She states that she and her mother were unable to get along and that this is part of the reason she was eventually sent to a boarding school. Piper's mother seems to be very traditional. For example, while Piper was growing up her mother emphasized the importance of portraying an image that would further her father's popularity and influence in their community. Piper expresses resentment toward her parents' insistence that her image is a reflection of them. It is possible that Piper's resentment of her mother's traditional values contributed to the development of her eating disorder. Her relationship with her mother certainly played an important role in her life and was one of the main themes of her narrative.

Susan Bordo is one of the preeminent feminist writers to have theorized eating disorders. She has criticized classic authors such as Hilde Bruch for their lack of concern for gender in the face of an overwhelmingly female illness. Bordo (1993) argues that anorexia nervosa is, in fact, a form of social protest and that the demedicalization of it is a necessary component in fully understanding it. She does not mean to say that anorexia has no biological or medical component, simply that one must understand the often contradictory social and cultural roles that women are expected to play if one is to understand and treat anorexia. Bordo's (1993) argument states that, by focusing less on biology and medicine and more on gender and culture, we can gain a more complete and more accurate picture of eating disorders. She notes in particular the ways in which health practitioners and researchers position the anorectic as a helpless and desperate individual. It is this attitude that Bordo (1993) is arguing against. She is attempting to return some agency to the anorectic individual and argues that individuals with eating disorders

have a deep and embodied understanding "of what culture demands might be the *source* of the anorectic's…suffering" (65). While this argument is in fact feminist, it is also highly political, situating the anorectic as an individual with agency and power, despite clinical attempts to position her as weak and helpless. Chloe, Claudia, and Piper reclaim this agency when they argue that an individual with an eating disorder will not recover or find treatment successful until he or she is ready to recover. In positioning the patient as the only individual capable of beginning the recovery process, the participants give back to the patient the agency that some health practitioners and researchers take away.

Family Studies

Researchers in family studies argue that analyzing medical conditions such as eating disorders from a purely individual perspective can be extremely misleading. They believe that the family of a patient must also be analyzed in order to truly understand a medical condition. Kog and Vandereycken (1989) provide a good review of prevailing theories of eating disorder families (families in which at least one member suffers from an eating disorder). They group family theories of eating disorders into three categories: the linear causal role of certain family members, the pathogenic role of particular parent-child interactions, and family systems theory.

The linear-causal role of certain family members may take several forms. Referring to the mother, the bond between mother and baby is seen as physiologically and psychologically important because the mother is the baby's first source of food. The mother may contribute to causality by projecting her own desires onto the child. This type of causality is evident in Claudia's story, as Claudia's mother pushed Claudia to continue ballet despite it being a bulimic trigger because of her own past desire to pursue ballet. Additionally, three types of fathers are

identified in eating disorder families: emotionally distant; weak, submissive, and passive; and dominant. Generally, parents in eating disorder families are said to emphasize achievement, success, conformity, traditional concepts of femininity, and appearance. They are said to be domineering, demanding, and controlling. Strong sibling rivalries have also been noted in eating disorder families. This family description applies very strongly to Piper's family. Piper's father is emotionally distant and her parents worked very hard to control Piper's behavior and appearance because they emphasized conformity, appearance, and success. Additionally, Piper felt a strong rivalry with her brother because he was better able to live up to their parents' expectations.

Theory regarding pathogenic parent-child interactions stresses a specific type of parent-child interaction, isolated from other family interactions. These interactions include developmental learning processes and Oedipal conflicts. During the developmental learning process, the anorexic child is given advantages and privileges, but self-expression is discouraged and reliance on one's own inner resources is undeveloped. This is descriptive of Piper's childhood, in which she was given the advantages of financial resources and superior education, but she was never expected to financially support herself. She is still dependent on her father for financial support. Oedipal conflicts result in the anorexic child's fear of biological and emotional maturity. Chloe expressed a fear of biological and emotional maturity that directly contributed to the development of her eating disorder. This fear of maturity, interestingly, was a result of a religious emphasis on abstinence until marriage. Chloe even took part in a ritual in which she was given a ring symbolizing purity in exchange for promising her father that she would remain chaste until marriage.

Family systems theory describes the family as a system that must be maintained. When the system becomes dysfunctional, the anorexic girl sacrifices herself in order to maintain homeostasis within the family. In other words, the family must "pull together" in the face of the anorexic patient's illness and, thus, the family system enters homeostasis once again. Piper's eating disorder certainly served this function. Piper's parents divorced when she was very young and her eating disorder forced her family to pull together to make decisions about Piper's health. Before her eating disorder developed, Piper engaged in deviant behavior to achieve this same effect.

Psychology/Psychiatry

As previously stated, psychologists and psychiatrists have acknowledged the need to include culture in eating disorders research. They have for the most part, however, limited this inclusion to labeling eating disorders culture-bound syndromes, specific to Western or Westernized contexts. As such, the culture concept is minimized in much psychological literature.

For example, Russell and Treasure (1989) argue that, while culture certainly plays a role in anorexia and bulimia, it does not amount to a fundamental cause. Rather, sociocultural forces "play an important part in molding the form of anorexia nervosa and its psychological content" (19). They also note that, while culture is important, biology is equally important and the interaction of culture and biology "is crucial in explaining why only some individuals succumb to anorexia nervosa in spite of pervasive adverse sociocultural influences" (19). According to Russell and Treasure (1989), the most important biological factors are weight homeostasis and genetic makeup. Weight homeostasis refers to the body's ability to maintain a weight appropriate

for the age and sex of an individual (which is interesting because an appropriate weight is largely culturally determined) and the tendency of the body to return to this weight after weight gain or loss. Russell and Treasure (1989) argue that this mechanism is disturbed in eating disorder patients so that their bodies are no longer able to maintain an appropriate weight. Piper expresses frustration at the disturbance of this mechanism, as she believes that her previous eating disorder makes it difficult for her to maintain an appropriate weight now because of its effects on her metabolism. Furthermore, the genetic makeup of an individual may predispose her to an eating disorder. In fact, this weakness in weight homeostasis may be due to genetic makeup. Russell and Treasure (1989) additionally note that genes may also dictate a particular personality type, a predisposition to psychiatric illness, or a disturbance of body image that could make an individual vulnerable to eating disorders. In her interview, Chloe expressed her belief that her personality type predisposed her to an eating disorder because she was sensitive to criticism and tended to internalize it and because she sought to please others by striving to maintain a Christian perfectionism. Additionally, her family history involving eating disorders may have genetically predisposed her to her illness. Keel and Klump (2003) also highlight the role of genetic makeup in individuals with eating disorders and argue that genes may actually be more important than sociocultural factors.

Another common theme in the psychological literature on eating disorders is set forth by Palmer (1993) and Simpson (2002), both of whom argue that a preoccupation with weight or thinness should not necessarily be a criterion for eating disorders. Simpson (2002) argues that anorexia nervosa can exist without the fat phobia that is typical of Western culture and that a culturally biased view of anorexia nervosa as a fear of fatness can be damaging to patients with anorexia because it obscures health care professionals' understanding of a patient's reasons for

self-starvation, which may hinder their recovery. Palmer (1993) suggests that health care professionals substitute the criterion of eating restraint in which the subject is overinvested for the criterion of weight concern. This, Palmer (1993) argues, will have advantages for both the clinical classification of eating disorders and for the research of eating disorders because it will widen the range of possible social influences.

Bruch's (1973) landmark work, *Eating Disorders*, sets forth another common theme in the psychological literature: that young women develop anorexia because they fear the development of the body brought on by puberty. It is believed that in some cases young girls fear the onset of puberty, not only biologically, but emotionally as well. The onset of menstruation, and its bleeding and "new and disturbing sexual impulses" (Bruch 1973:277), marks a loss of control in a young girl's life, a life that probably did not give her much control to begin with. Bruch (1973) argues that the "frantic preoccupation with weight is an attempt to counteract this fear of losing control; rigid dieting is the dimension through which they try to accomplish this" (277). As previously discussed, Chloe expressed a fear of sexual maturation and found that her eating disorder allowed her to delay the onset of this maturation both biologically and emotionally.

Public Health

The theoretical approach of public health and nutrition combines cultural, medical, and political approaches. Proponents of this theory argue that the public messages of nutritional public health create "a culture of disordered relations to food and fat" (Austin 1999:245) by ignoring how culture is central in people's attitudes toward eating, food, and fat. Austin (1999) states that by ignoring the cultural complexity surrounding food, bodies, and diet, public health

"gives scientific credibility to our society's obsession with dieting and loathing of fat" (246). This, according to Austin (1999), also fosters the belief that a fat body represents a deviant body. This "scientific credibility" is apparent in Chloe's narrative when she discusses her family practitioner, who believed that Chloe was simply thin and enjoyed exercise when, in reality, she was dangerously underweight and unable to conduct everyday activities. This gross disregard of Chloe's health by her doctor supports the idea that the cultural climate in the United States, which stresses thinness, has been given scientific credibility. Additionally, Piper's description of her parents highlights the belief that a fat body represents a deviant body. According to Piper, her parents believed that her "fat body" would indicate that they had failed as parents.

These arguments are inherently wrapped up in culture and politics for several reasons. First, the very existence of a nutritional public health that must warn against overindulgence is a sign of the abundance of the Western world. Abundance is not an option for the majority of the population outside of the Western world and, interestingly, even for many within its boundaries. Second, the idea that institutional and governing bodies are somehow responsible for the prevention of overindulgence in individual bodies is very much a product of the current political climate in the United States.

Anthropology

Historically, anthropologists have always recognized that food is an important aspect in any culture and that the practices surrounding the serving and eating of food can have far-reaching cultural consequences. The theoretical literature on this topic, and the ways in which these food-related cultural attributes intersect with culture-specific notions of beauty and body, is vast. The theoretical literature on the specific intersection of beauty ideals and food practices that

leads to eating disorders is less, but is growing and actually has a great deal to offer to the investigation of eating disorders. Generally, the theoretical anthropological literature tends to focus on appropriate ways to engage culture in eating disorders research (since it has been firmly established that culture is an important component of eating disorders) and to call for a holistic and interdisciplinary approach to researching eating disorders in order to obtain the kinds of information anthropologists deem important to eating disorders research.

Anthropologists also work to problematize the assumption that the spread of Western cultural ideas to other areas of the world contributes to the rise of eating disorders in non-Western contexts. Lester (2004), for example, argues that, while the assumption that the rise in eating disorders in non-Western areas of the world is associated with globalization may in fact be correct, it is incorrect to assume that this tells us anything useful about the relationship between culture and psychiatric distress. Rather, Lester (2004) argues, this connection really tells us something about class and the processes of social referencing, especially since, in many parts of the world, the process of replicating Western culture is a marker of class. Ultimately, Lester (2004) notes, the "culture" that researchers in other disciplines utilize is problematic because it is assumed to be "a single, homogeneous set of understandings or beliefs that is relatively unproblematically passed on from generation to generation" (609) and geographically bounded. Lee (2004) agrees with Lester's (2004) arguments and goes one step further to suggest that the only way to reconcile this misuse of "culture" is to employ research methods "that can tap culture in a thicker way, such as qualitative techniques, and ethnography in particular" (617).

Fabrega (1995) also calls for an overhaul of the methods used in eating disorders research both in order to better assess the cultural components of eating disorders and to capture the interdisciplinary nature of the research of eating disorders. According to Fabrega (1995),

researchers need to combine attention to structural factors (politics, economics, medicine and psychiatry), experiential expressions, and biological features by using a variety of methods from several disciplines. Fabrega's (1995) attention to all aspects of eating disorders is unique to anthropology. Most researchers in other disciplines focus on one or a few factors that either cause eating disorders or are related to them and do not attempt to utilize methods from several disciplines.

Similarly, Gordon (2004) calls for what he terms "clinical ethnography," which he describes as "the attempt to situate clinical cases within a cultural framework, one that is based on *both* the specialized expertise of the clinician and the broad-based grasp of cultural issues that characterizes the ethnographer" (604). This clinical ethnography, Gordon (2004) argues, is important in articulating exactly how cultural factors actually intersect with individual factors to produce eating disorders, an articulation that is missing in both the Western clinical literature and the literature produced in non-Western contexts. Gordon's (2004) arguments are similar to Lester's (2004) in that he recognizes that what is being called "culture" in the eating disorders field is misleading and that other factors may be at play. A clearer picture of the interaction between cultural and individual factors should help in articulating just what about "culture" is really at work.

Spiro (2001) argues that claims for culture as cause in any psychopathology can only be assessed when they are grounded in a theory with three specific attributes: one that specifies the cultural variables that are apparently causal, one that explains why and how they are causal, and one that explains the processes or mechanisms by which these cultural variables produce their psychological effects. Furthermore, Spiro (2001) discusses the difference between cultural causes and social causes of mental illness. He argues that cultural causes are ideational while

social causes are experiential. This discussion highlights what Lester (2004) and others argue – that, while Western cultural exposure may be related to eating disorders, it is really an individual's experiences of the (perhaps changing) social factors brought on by exposure to Western culture that may result in an eating disorder.

Pike and Borovoy (2004), in their review of the rise of eating disorders in Japan, note something similar to other anthropological theorists – that it is important to explain exactly what cultural factors are at work when studying eating disorders. Pike and Borovoy (2004) recognize that values and expectations regarding gender roles, relationships, self-determination, and beauty ideals are all important cultural factors and that these risk factors "appear to be shared across cultures" (524), meaning that what people may recognize as Western cultural factors may in fact really be a product of the society in question. For example, the cultural factors noted by Pike and Borovoy (2004) became salient in Japan during a time of rapid urbanization and modernization. Perhaps cultural *change* is really at work and the fact that Western cultural ideals tend to be synonymous with modernization is obscuring what is really happening. In other words, it may be possible that the manifestation of eating disorders is related to rapid social changes, regardless of Western influence. It may simply be that this rapid social change is seen *because* of Western influence. This would also account for the prevalence of eating disorders within sectors of Western cultures that are not white and middle to upper class and that may not feel connected to Western culture despite being within its geographic boundaries.

Generally speaking, the anthropological literature on eating disorders serves to problematize the concept of culture. This is important because the use of the culture concept by other disciplines must be analyzed, especially since anthropologists have been working out just

what exactly "culture" is for the last several decades while other disciplines have not necessarily been doing so.

Analysis of the Theory

The general theory on eating disorders is lacking in many areas. First, eating disorders theory does not generally deal with gender issues in a way that addresses the fact that men also have eating disorders. It also does not address the differences between people who develop eating disorders for emotional reasons and people who develop eating disorders for athletic reasons. While these issues are discussed in more peripheral literature on eating disorders, the majority of eating disorders literature focuses on traditional cases: those occurring in adolescent Caucasian girls in the United States from upper to middle class families that are a result of emotional and/or psychological issues.

Despite these gaps in the theory, after conducting my research on eating disorders, I agree that culture is an important factor in the development of eating disorders in young people. While I believe that other factors, such as a genetic predisposition, are at work, I believe it takes a specific cultural climate for an eating disorder to manifest in an individual. I found that my participants' experiences cemented this idea. Piper discussed issues of class and race while Chloe's experience in Italy showed her the cultural component of her eating disorder. Claudia highlights the importance of the media, as she sees its contribution to the body image issues of her young stepdaughters. Culture, however, cannot be considered as a single unit. The methods I used to collect the data (in the form of illness narratives) allowed me to gain a holistic picture of the way in which one experiences an eating disorder. This holistic picture suggests that it is not

just a single variable, such as athletics, family, genetics, or American body ideals, that is at work, but that these factors work together to cause an eating disorder and cannot be separated.

It seems clear that a certain set of cultural values greatly contributes to the prevalence of eating disorders. More than this cultural influence, however, I believe that the idea of cultural *change*, as set forth by Pike and Borovoy (2004), is important in understanding eating disorders. I believe, in fact, that it is a climate of change and/or instability (a state of constant change), whether cultural, emotional, biological, or any combination thereof, and an individual's inability to deal with that change or instability, that causes eating disorders to manifest or precipitates their continuation. Margaret Mead wrote at great length of the effects these types of changes can have on an individual, especially an adolescent, in her book, *Coming of Age in Samoa* (1939). In comparing the United States and Samoa, Mead (1939) argued that the rapidly changing social environment in the United States regarding attitudes about sex and sexuality, gender roles, and technology, among other things, served to create an insurmountable generation gap that contributed to adolescent angst and a troublesome shift to adulthood. She found that, in Samoa, where these rapid changes were not occurring, adolescence was a relatively angst-free time in the lives of her participants. While Mead's (1939) work is highly controversial, it adequately illustrates the way in which change and instability can have a powerful impact on an individual. An eating disorder is simply one way in which this inner turmoil can manifest.

There are several examples of change and instability that coincide with the development of the participants' eating disorders and with periods of intensification of them in the data. For instance, Chloe experienced drastic physical, hormonal, and emotional changes as she began puberty. These changes contributed to the formation of Chloe's eating disorder, which she began as a way to prevent these changes from taking place and which she continued when she found

that she was successful. Chloe's eating disorder also began after her best friend graduated from high school a year ahead of her and after she attended a church camp that provided her with a new outlook on life. The combination of all of these changes created an unstable social environment that potentially interacted with Chloe's possible genetic predisposition. Furthermore, Chloe experienced an intensification of her eating disorder when her life once again changed rapidly: when she graduated from high school and attended college, finding herself in new social situations.

Interestingly, one of the most intense times of change in Chloe's life, her trip to Italy, was a positive experience. Chloe's trip to Italy presents an interesting case because she credits it with allowing her to finally see and understand the cultural component of her eating disorder and to what extent her illness was a result of her upbringing in the United States. This is interesting because attitudes toward women and beauty ideals in Italy are similar to those in the United States. I believe that it is likely that Chloe's trip to Italy, rather than allowing her to compare and contrast media influences or attitudes toward women in Italy and the United States, simply placed Chloe outside of her comfort zone and that, because Chloe was placed in an entirely novel situation and was able to enjoy herself without experiencing the pressure she normally felt in these types of contexts, Chloe found a new confidence to deal with life and all of the change an instability that goes along with it. Chloe confirmed this later in her interview when she argued that her experiences with her eating disorder allowed her to better cope with her sister's death. This trip to Italy occurred after Chloe had sought treatment and found a therapist with whom she enjoyed working. With this kind of help, Chloe was finally able to use the element of change to her advantage and to aid in her recovery.

Claudia, on the other hand, rather than experiencing distinct periods of change in her life, lived a life of constant change, or instability, as a child. Claudia's mother had several boyfriends throughout Claudia's childhood, none of which were able to provide her with a stable, two-parent home. Claudia feels that the only time she was able to experience this type of household was when she lived with her grandparents as a very young child. As such, when Claudia's grandmother died, another period of great change in Claudia's life, she felt especially tempted to purge, further showing that the stress of change and instability in Claudia's life triggered her disordered behaviors. Interestingly, another important event in Claudia's life, her divorce from her first husband, caused her to seek treatment so that she could learn to better cope with these periods of change and instability.

Piper's experience of her eating disorder can also be characterized in this way. Her parents' divorce and her mother's remarrying caused Piper to experience a lack of structure and emotional support in her young life. This instability caused Piper to seek attention, which she did via her eating disorder. Furthermore, Piper's moving in with her father after her return from boarding school again placed her in an environment lacking structure and emotional support and, as such, Piper experienced a worsening of her disorder. Piper again experienced a worsening of her eating disorder when she underwent a period of extreme emotional instability in college after being raped and, later, getting pregnant and having an abortion. Again, Piper experienced a period of change after she graduated from college and began a career. It was this period of change, with which Piper was ultimately unable to cope, that spurred her to seek treatment for her eating disorder.

John's experience of his eating disorder follows a similar pattern. His eating disorder began after a crisis of sexual orientation in high school, an event sure to cause great emotional

and hormonal change and instability. College again presented itself in John's story as a trigger for disordered behavior, as John experienced a worsening of his anorexia during this time, while he was dealing with newfound pressure and social situations. Later in life and currently, John finds that the instability of not having a life partner maintains his eating disorder.

All four of the participants' stories show patterns of change and instability that directly coincide with either the beginning of their eating disorders or periods of intensification of them. It seems clear that an inability to cope with this change and instability in a healthy manner is a major contributing factor in the development and continuation of an eating disorder. This would explain why eating disorders become more prevalent in non-Western societies that are subject to Westernization. It is likely, as argued by Lester (2004) and Pike and Borovoy (2004), that, rather than Western cultural ideas wreaking havoc on young women's bodies and sense of self, it is cultural change and ambivalence in dealing with this change that causes these women to develop eating disorders and disordered attitudes toward food and fat.

Furthermore, adolescence and these periods of change and instability act as liminal phases in an individual's life. Turner (1969) describes a liminal phase as one in which an individual is in between two life phases, being neither in one or the other. Adolescence, for example, is the phase between childhood and adulthood. What is interesting about liminal phases, according to Turner (1969), is that they provide individuals with a sense of communitas. Communitas can be described as the spirit of community among individuals, stemming from feelings of solidarity and togetherness. Communitas is often present among individuals who go through liminal phases together. What is interesting about the experiences of Chloe, Claudia, Piper, and John is that each of them seems to have gone through liminal phases without the support of communitas, resulting in solitary experiences of liminality. This solitary liminality

took place within a context of external control in which the participants had no power. For Chloe, this external control took the form of pubertal changes. For Claudia, it was her mother's unstable lifestyle. Piper experienced this external control in the form of her parents and their high standards for her behavior and her body. For John, the emotional turmoil caused by his sexual orientation crisis, as well as his position in his family as the responsible older son, served to exert control over him. In this climate of external control, the participants' eating disorders were their ways of struggling to find control and agency. Because the participants were experiencing periods of liminality without communitas, however, they had no support system and therefore found themselves with feelings of guilt and shame in a context of secrecy.

My research has shown me that it is important to not only understand all of the factors that contribute to the development of an eating disorder in an individual, but also the mechanisms by which these factors contribute to the illness. I have found that anthropological research and its holistic methods are well suited to understanding eating disorders and to problematizing the use of the culture concept in other disciplines. My research has also shown me that it is extremely important to understand individuals suffering eating disorders as whole units that are greater than the sum of their parts, rather than examining individual factors that may or may not contribute to their eating disorders. I have found that it is impossible to separate these parts when researching eating disorders and that the interaction between and integration of these factors is just as important as the existence of the factors themselves.

10 CONCLUSION

Throughout the course of my research, it has become clear to me that, regardless of the reasons behind the development of eating disorders in young people, the current cultural climate in the United States that stresses thinness is damaging to young people. Addressing this climate, however, would require a cultural overhaul that is unlikely to occur. This cultural climate has, however, recently gained some negative attention, as evidenced by the backlash in the fashion industry that has called attention to the use of underweight models in advertising campaigns and runway shows. In recent months, the fashion industry has begun to address this problem and several fashion magazines have released issues featuring plus-size models. Interestingly, however, "plus-size" typically refers to a model that wears about a size eight (in women's clothing), whereas plus-size clothing refers to sizes 18 and above. These efforts are praise-worthy, but skeptics point out that plus-size models are still smaller than the average American woman and are wary of the persistence of these efforts once the negative attention directed at underweight models dies down. Furthermore, underweight models seem to be facing discrimination because of their size. Some have even been prevented from participating in runway shows because they are underweight. This type of size discrimination is no better than the discrimination against larger models. On the other hand, models are aware that, in order to work in the fashion industry, they are required to manipulate their bodies. How is it different to ask them to gain weight than to ask them to lose it?

Interestingly, a recent study conducted by researchers at Arizona State University suggests that looking at plus-size models can be as damaging, if not more damaging, to women's self-esteem as looking at very thin models (Freeman 2010). In the study, women's self-esteem

was measured by self-reporting by the participants before and after viewing images featuring certain kinds of models. The researchers found that women with lower body mass indexes experienced a boost in self-esteem when viewing all models because they identified with the thin models and saw themselves as different from the plus-size models, while women with higher body mass indexes experienced a drop in self-esteem when looking at all models because they saw themselves as different from the thin models and identified with the overweight models (Freeman 2010). Women with normal body mass indexes experienced the most shifts in self-esteem because they were able to identify with both moderately thin models, creating high self-esteem, and larger models, creating low self-esteem (Freeman 2010). Studies such as this one show that changing images of women in the media will not solve the self-esteem problems created by such images.

Additionally, beauty ideals that favor overweight women can be just as damaging to a population's health and emotional well being. For example, in the African country of Mauritania, obesity is a sign of wealth (Associated Press 2007). As such, men prefer to marry large women and girls are sometimes force-fed (Associated Press 2007). These practices lead to weight-related illnesses such as diabetes and heart disease. It also causes the same kinds of discrimination we see in the thin-obsessed United States. What is important is highlighting the way in which one's weight is important to one's health, emphasizing that a healthy weight is different for each individual and that a healthy weight *range* exists for each individual (one that will prevent the development of weight-related health complications), as opposed to a particular weight one should strive to maintain. Russell and Treasure (1989) touch on this when they discuss the idea of weight homeostasis, which refers to the body's ability to maintain a weight appropriate for the age and sex of an individual and the tendency of the body to return to this weight after weight

gain or loss. This idea of weight homeostasis is problematic because it medicalizes what is cultural. While the idea of weight homeostasis is biological, the concept of an appropriate weight for the age and sex of an individual is culturally determined.

The increased medicalization of issues of weight can have adverse effects on society, as discussed in the public health literature on eating disorders. This medicalization provides justification and scientific credibility for the encouragement of a preoccupation with diet and exercise. It is also points to the political climate in the United States today, a climate in which the government has become responsible for the health of its citizens. One must wonder whether it is truly the responsibility of the government to monitor the health of individuals or if individuals should be responsible for their own health. This also raises issues of the anorexic and/or bulimic body. In recent years, the Internet saw a growing popularity of "pro-ana" (pro-anorexia) and "pro-mia" (pro-bulimia) websites aimed at providing community space for individuals with eating disorders who believe that anorexia and bulimia are valid lifestyle choices. When the general public learned of this trend, however, a call to have these websites shut down was heard. Almost all of these sites have since been disbanded and new ones have been prevented from forming. This raises issues as to whether size tolerance should extend to individuals with eating disorders.

Ferreday (2003) argues that these pro-ana and pro-mia communities formed because the Western biomedical system seeks to erase the anorexic/bulimic body by "curing" an individual. In other words, an ideal world is one in which people with anorexia and bulimia do not exist. The removal of this agency, Ferreday (2003) argues, is the motivation for people with anorexia and bulimia to make themselves more visible. While I personally believe in practicing tolerance of all shapes and sizes, I also believe that individuals suffering from anorexia and bulimia are not

only physically harming themselves, but are also suffering psychologically and emotionally. It is possible to help these individuals while allowing them to maintain their agency. I believe that the key to this is in the methods used by health practitioners and researchers, who must strive to ensure that their practices are holistic in nature and acceptable to the patient. Anthropology's holistic approach can be particularly useful in the investigation of eating disorders and other issues of mental health. Gordon's (2004) recommendation of instituting a clinical ethnography process in which researchers and health practitioners should "situate clinical cases within a cultural framework" is one that should be seriously considered (604).

According to Gordon's recommendations, each eating disorder case should be examined from both a clinical and a cultural perspective. Doing so will shed light on "how cultural factors actually intersect with individual ones to produce eating disorders" (604). Because anthropologists seek to document the broader picture and to focus on individuals, its methods are well suited to the study of eating disorders. Furthermore, of the disciplines involved in the research of eating disorders, anthropology does the most work to thoroughly examine and problematize the concept of culture, which is just as important as including culture in eating disorders research. Assuming that culture is homogeneous and unproblematically passed down from generation to generation can be as damaging as assuming that eating disorders do not have a cultural component. Because anthropologists have been examining culture for so long, their perspective is especially useful in finally determining the cultural component of eating disorders. By its nature, anthropology seeks to understand a problem from all sides. In the case of eating disorders, an anthropologist hopes to learn not only about the biological and psychological components of the illness, but also the family dynamics; racial, religious, and economic upbringing; and the social life of the patient. In other words, anthropology and its methods

inherently promote the cooperation and collaboration of the many disciplines that examine eating disorders. I firmly believe that each discipline has something important and useful to offer to the study of eating disorders and that each contributes greatly to our understanding of them. Furthermore, as broad a scope as possible is necessary because each eating disorder experience is vastly different from the next. The critique I offer of other disciplines' involved in the research of eating disorders, aside from that of their use of the culture concept, is a critique of their methods. In order to better understand eating disorders, the disciplines need not only to collaborate but also to broaden the scope of their methods, using the more holistic approach that is characteristic of anthropology.

Working to remove eating disorders from the cultural landscape is extremely difficult. Teaching pre-adolescent children about body awareness, healthy attitudes toward food, healthy eating behaviors, and the problems with body size discrimination is certainly worthwhile and laudable, but I believe that it will take a generation of parents with healthy attitudes to reverse the behaviors that lead to eating disorders. In a society where extreme behaviors related to diet and exercise are normative, it is important that we reach the people who teach children about food and the body. While I think it is important to work with parents regarding these issues, we must remember that, because strenuous diet and exercise are believed to be healthy behaviors in our society, it will be extremely difficult to reverse attitudes and beliefs regarding food and the body.

As such, I think it is also important to reconsider public health messages in the United States. These messages are partially responsible for unhealthy attitudes toward food and the body because, as Austin (1999) argues, they serve to legitimize them. Rather than warning against overindulgence in food and fat, I think it is more useful to encourage individuals to be in tune

with their bodies. By promoting body awareness, public health messages can assist people in understanding that every individual's health needs, pertaining specifically to how much food and exercise one needs to maintain health, are different and that it is more important to find what works for oneself, rather than to adhere to an arbitrary standard.

This notion of an "arbitrary standard" raises another important issue. It is so easy to forget, in the science-supported Western biomedical system, that many of our beliefs are culturally produced and contextualized. We must always keep this in mind so that we remember that our "standards" are flexible, not only over time, but also on an individual basis.

Most importantly, we must realize that, in our efforts to erase eating disorders, we are also removing agency from individuals with eating disorders. It is important that, as we work to cure eating disorders, we also ensure that our measures restore agency to those individuals whose lives have been affected by them. I attempted to return agency to the participants in my research and I feel that I accomplished this by allowing them to tell their stories from beginning to end without interruption or imposition and by presenting their stories in their own words. I hope that I have done them justice.

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