Testing Guidano's Model of Psychopathology in Eating-Disordered Individuals: A Multiple Case Study

THESIS

Submitted in fulfilment of the

requirements for the Degree of

MASTER OF SOCIAL SCIENCE (PSYCHOLOGY)

of Rhodes University

by

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December 1997

Abstract

This thesis sets out to critically examine Guidano's model of psychopathology in eating-disordered individuals. The literature review highlights the diverse etiological approaches that have been taken in understanding eating disorders. Guidano's model is presented as an alternative to traditional approaches. It is a developmental, unitary model of psychopathology, conceptualised within a systems/process-oriented approach to organised complexity. Within a qualitative framework, case study methodology is utilised to test the viability and limitations of Guidano's model. Four in-depth case histories are presented which offer appropriate material for the testing of the model. The data is analysed using the reading guide method and presented in terms of the four features of Guidano's model: (1) dysfunctional patterns of attachment; (2) sense of self; (3) major themes on systemic coherence; (4) common coping strategies. The findings of the research support Guidano's model of psychopathology in eating-disordered individuals. The findings are: (1) attachment styles are ambiguous, intrusive, and enmeshed; participants experience a disappointment in the preferential attachment relationship; (2) that participants' sense of self is blurred and wavering; (3) the major theme on systemic coherence is the oscillation between seeking and avoiding intimacy; (4) common coping strategies are: the seeking of supportive intimacy with minimal self-exposure; withdrawal into the self; perfectionism; the development of an eating disorder; continuous thoughts about food, eating, and weight which prevents participants from becoming aware of the real issues confronting them. An evaluation of Guidano's model in terms of its specific contribution to knowledge and research on the role of father in child and adolescent psychopathology, as well as how father effects evidence in eating disorders, demonstrates the model's value as an explanatory tool and raises implications for future treatment, theory, and research practices of eating-disordered individuals.

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ACKNOWLEDGEMENTS

Many thanks are due to those who supported and guided me to the completion of this research. Professor David Edwards, the first supervisor of the research, was integral in the conceptualising stages of the research. Dr Kevin Kelly, who assumed the supervisory role in Professor Edwards' absence, for his contribution in providing a method suited to the research. Professor Chris Stones, who in Dr Kelly's absence, oversaw administrative and examination requirements.

Dr Jacki Watts has gently and patiently urged me back to the language of words and I am learning to speak again. Jacki, your relentless and fierce, yet gentle, pursuit to show me the world of living and loving, in this instance, precludes words. Over the years you have become an essential part of my life and development. Although this work is inextricably linked to my own experiences and hunger for greater understanding, it has simultaneously been borne out of our work together. Always, thank you.

Jacki, Steve, Maria, and Angela, the participants of this research, my deepest thanks. The sharing of your experiences with me surpassed all of my (preconceived) expectations that you would be typically evasive and uncommunicative. Not only did you provide me with intimate and at times, painful material borne out of your struggles, you have at the same time, facilitated my own and others understanding of eating disorders. I wish you all well on your continued journeys.

To my family and friends, who have at times put up with a nightmarish daughter, granddaughter, sister, cousin, and friend, many, many thanks. 'Mickey Brown' Michael and Noula, for being there at every turn of computer and personal disaster, my gratitude is immeasurable. Special mention to Savva, Tania, and Philippo for doing everything imaginable to ease me during all the times of transition, and for all the countless wonderful meals, thank you. Philippo, angel sent from heaven, I hope one day to tell you how you have changed my life. I dedicate this work to you.

Winnicott (1975) once said, "research is perhaps always to some extent an attempt on the part of an analyst to carry the work of his own analysis further than the point to which his own analyst could get him" (p. 201). This research has been a way for me to break my own silence. But, of course, it has been more than that. It has been a steady source of inspiration, tears, despair, and joy for many years. It has taught me that it is possible to take something which once hurt me so deeply and turn it around. It is teaching me how to let go.

The financial assistance of the Centre for Science Development (HSRC, South Africa) towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at are those of the author and are not necessarily to be attributed to the Centre for Science Development.

Preface

Ithaca

When you set out on the voyage to Ithaca,
pray that your journey may be long,
full of adventures, full of knowledge.
Of the Laestrygones and the Cyclopes
and of furious Poseidon, do not be afraid,
for such on your journey you shall never meet
if your thought remain lofty, if a select
emotion imbue your spirit and your body.
The Laestrygones and the Cyclopes
and furious Poseidon you will never meet
unless you drag them with you in your soul,
unless your soul raises them up before you.

Pray that your journey may be long,
that many may those summer mornings be
when with what pleasure, what untold delight
you enter harbours you've not seen before;
that you stop at Phoenician market places
to procure the goodly merchandise,
mother of pearl and coral, amber and ebony,
and voluptuous perfume of every kind,
as lavish an amount of voluptuous perfumes as you can;
that you venture on to many Egyptian cities
to learn and yet again to learn from the sages.

But you must always keep Ithaca in mind.
The arrival there is your predestination.
Yet do not by any means hasten your voyage.
Let it best endure for many years,
until grown old at length you anchor at your island
rich with all you have acquired on the way.
You never hoped that Ithaca would give you riches.

Ithaca has given you the lovely voyage.
Without her you would not have ventured on the way.
She has nothing more to give you now.

Poor though you may find her, Ithaca has not deceived you.
Now that you have become so wise, so full of experience,
you will have understood the meaning of an Ithaca.

(Constantine Cavafis 1863 - 1933)

INTRODUCTION

Foetus

What story you cannot tell,
silent life
floating wan and breathless,
(perfect porcelain form)
fragile germ of life
torn from the womb -
flame extinguished and
entombed for eternity in
murky sepia amnion.
What tears for you,
Hapless and hopeless -
what eulogies?
As you hide from the world
in your cold clinical jar,
weeping for lost humanity -
face covered for the
shame.

Do not rebuke me
though I gag in revulsion,
little one, stooped
with the guilt of a
savage soulless species.
Torment me not,
bottled abomination -
cynical tribute to the fabled miracles
of modern medicine -
rude mockery
of life.
For gather'd round
they, raucous ravens, laugh and mocking
sneer
"vinegar boy!"
What hopes,
what light denied to you, homonculus?
For never will you know the sun,
mirrored mosaic,
golden on sea,
or smiling,
run with the wind.

The poem was written by an 18-year-old school boy as part of a combined English and Biology lesson. The class was shown human foetuses at various stages of intrauterine development and asked to write a poem describing their thoughts. This poem was submitted by Steve, a male anorexic. For those familiar with eating-disordered literature, the poem could easily be viewed as reflecting an anorexic's self- and other-description. Similarly, glaring commonalities and differences would be observed were this poem to be read alternately through a 'bulimic, obese, or compulsive-eating lens'.

Would some biographical data of Steve influence the reader's perception? Were the reader to be told that this boy comes from a dysfunctional family, where father was an alcoholic, diabetic, depressed, and who in the end committed suicide by gassing himself in the family car, influence our perception of this individual, or our interpretation of the poem? What if the writer of the poem was called Maria and she was a compulsive eater? Could not the "murky sepia amnion" be referring to the layer of fat Maria has wrapped around herself? In her reports to the researcher, she clearly states that at the same time that fat protects her from others, it also extinguishes and wipes out the real Maria, leaving her wondering about who she is. What if the writer was named Jacki or Angela, both bulimic individuals? Speaking with the researcher, both these individuals repeatedly refer to bottling their emotions. Both regard their emotional lives as dangerous and as something to be suppressed and denied at all costs. Both individuals make it inordinately clear that the primary function of their bulimic behaviour is to allow for the expression of their emotions and for the relaxation of their self-image as people who are emotionally controlled. Is it then far-fetched for a researcher to interpret the purging of emotions into a toilet bowl as an indication that emotional life is abhorred by these individuals?

A dilemma exists in understanding and interpreting this poem similar to the dilemma facing those who attempt an holistic understanding of eating disorders. It emphasises that eating disorders are a multifaceted phenomenon where selective focusing on one level of analysis will render any treatment modality and/or research study, seriously limited. It highlights that poetry (and any form of self-expression, even the adoption of an eating disorder), both expresses and belies a multiplicity of meaning.

The inadequacies of both traditional and contemporary etiological perspectives on eating disorders are revealed by the division both between and within theoretical domains, where proponents are locked into vociferous arguments about who the protagonists are and which perspective must be followed. The multifaceted and complex nature of eating disorders is evident in the wide range of etiological approaches that have been adopted to understanding them. There has been little resolution of the

divisions between biomedical, sociocultural, and psychological perspectives in the understanding of eating disorders.

1.2 Summary of contents

In **chapter two** various etiological theories of eating disorders are presented. The biomedical perspective focuses on patterns and processes which emerge as a direct result of starvation and over-consumption in eating-disordered individuals, as well as physiologically-based etiological theories. Sociocultural perspectives are based are two essential postulates: That eating disorders are one of the most prevalent psychopathologies of the modern day and, that there exists a cultural preoccupation with thinness. Several factors are identified for the increased incidence of eating disorders, as well as for changing cultural trends. Feminist contributions variously identify the juxtaposition of women and work as the constant theme of the twentieth century. They alternately attribute eating disorders to patriarchal society, mother-child interactions, and the contradictory role of women in modern society. Psychoanalytic contributions offer a traditional perspective to eating disorders and their observations of the early infant-mother relationship (especially the feeding situation), offer rich data for the understanding of the child's subsequent personality development and behaviours. Research on the role of father in the development of child and adolescent psychopathology is presented, an area previously neglected in theory and research. Most notably, it is shown that father effects (through father's psychopathology, behaviour, or characteristics) are comparable to mother effects in their contribution to the development of psychopathology in their children. Recent psychological perspectives posit a relationship between childhood sexual abuse and the later development of an eating disorder in their exegesis of (possible) etiological factors.

In spite of a multiplicity of perspectives and theories of psychopathology, no model exists which adequately explains the link between attachment behaviour and its impact on the later development of personality and the formation of psychopathological symptoms or disorders. In contrast, Vittorio Guidano presents an integrated model of psychopathology. It is a developmental, unitary model of psychopathology developed within the perspective of a systems/process-oriented approach to organised complexity. Within this perspective, Guidano's model is presented, which explains a diversity of eating disorders by positing certain common invariant features.

In **chapter three** the aims and rationale of the research are presented. The case study method is chosen as the preferred strategy in achieving the study's aims. Methodological considerations

pertinent to the research are presented, with a critical evaluation of the case study method and the way in which data was collected and subsequently analysed. Questionnaires and guidelines used for the interviews and other data collecting questionnaires are presented in appendices two and three.

In **chapter four** a summary of the thematic analysis performed across four cases is presented in terms of the four central features of Guidano's model. This chapter presents the findings of the research. Individual case descriptions for each of the four features this research was designed to test, are presented in appendix one.

In **chapter five** the findings of the research are discussed in terms of the extent to which they support Guidano's model. Other literature is simultaneously used to collaborate, or further elaborate on the findings of the research. Criticisms of Guidano's model and the shortcomings of the research are discussed. In general, the findings of this research support Guidano's model of psychopathology in eating-disordered individuals. The implications for psychology in general and in the eating disorders field specifically, are discussed in terms of the model's contribution to research on the role of father in the development of eating disorders. A short presentation of the aims and findings of the research is presented as a conclusion.

The shortened term 'anorexia' is used when referring to 'anorexia nervosa'. The pronoun 'she' is used throughout the presentation when referring to anorexic/bulimic/obese individuals and compulsive eaters due to the preponderance of females struggling with eating disorders.

CHAPTER TWO: REVIEW OF LITERATURE

The review of the eating disorder literature will be divided into several parts: (1) biomedical perspective; (2) sociocultural perspective; (3) psychological perspective; (4) a thorough presentation of Guidano's model. Research data and theoretical models within particular approaches will also be presented. Literature on specific eating disorders (obesity, compulsive eating, anorexia, and bulimia) will be explored within each approach. The body as the site of symptomatology will also be a focus throughout the presentation, with explanations being offered as to why the body becomes the site of symptomatology, as opposed to other sites or symptomatology.

2.1 Biomedical perspective

Pertinent biomedical elements which deserve consideration in the understanding of eating disorders include: clinical presentation and physiological complications; nutritional issues; the critical pituitary and neuroendocrine factors; and the benefits of a psychopharmacological therapeutic approach. The first part of this presentation will focus on the physiological changes which occur as a result of eating disorders. The second half of this section will focus on physiologically-based etiological theories to eating disorders.

2.1.1 Physiological consequences of eating disorders

Anorexic behaviour and the resultant weight loss are usually grossly visible to others, whereas the bulimic's apparent semblance of external physical normality may disguise other physical changes (Cooper & Fairburn, 1983; Dana & Lawrence, 1988; Dwyer, 1985). Diverse physiological changes may result as a consequence of the individual or combined effects of starvation, laxative and diuretic abuse, and/or vomiting and binging (Berkow & Fletcher, 1987).

2.1.1.1 Endocrine manifestations

The endocrine system is changed by both anorexia and starvation. Hormonal levels alter proportionally to the degree of weight loss (Dally & Gomez, 1979; Spack, 1985). Amenorrhea is a primary classificatory symptom of anorexia, with 80% of individuals developing it (Berkow & Fletcher, 1987). This has led to anorexia being regarded "as a primary hypothalamic disorder"

(Spack, 1985, p. 6), although stress alone may account for amenorrhea (Bemis, 1978). The relationship between emotional factors and menstruation is well established in a variety of contexts and lends strong support to the psychogenesis of menstrual disturbance in anorexia (Bemis, 1978), bulimia (Cooper & Fairburn, 1983), and obesity (Berkow & Fletcher, 1987).

> The evidence of menstrual disturbance in female concentration-camp prisoners, usually cited to support the relationship between food deprivation and amenorrhea, can also be used to refute this hypothesis. While amenorrhea was observed in 54% of the 800 women interned in one prison camp, 60% of these cases were manifested in the first month of imprisonment, and 94% resumed regular functioning prior to release, despite adverse physical conditions (Bass cited in Bemis, 1978, p. 608).

Amenorrhea results because of reduced oestrogen levels (Berkow & Fletcher, 1987). Consequently, (in women) the ovaries shrink, the endometrium becomes fibrous, and vaginal mucosa degenerates (Selvini-Palazzoli, 1985). The clinical implications of a reduced oestrogen state increase the risk of osteoporosis (Copeland, 1985). Andersen, Wirth, and Strahima (1982) and Wesselius and Anderson (1982), document that weight-related diminished libido and decreased testosterone levels occur in both sexes (cited in Spack, 1985). The reproductive function of women with bulimia may be altered even after they return to what is considered ideal weight. It has been found that more than half of such women (at ideal weight) experience reproductive disorder - no menstrual bleeding or irregular periods ("Weighting Game," 1994). Reproductive disorder results because of low levels of luteinizing hormone, the hormone that controls the cyclical secretion of progesterone and oestrogen. Even bulimics with regular menstrual bleeding have been shown to have deficiencies in circulating hormone levels. The return to normal reproductive function is linked most closely to what women weighed before they resorted to extreme weight control measures ("Weighting Game," 1994). Thus, the lower their current weight as a percentage of the past body weight, the lower their levels of luteinizing hormone. Kaye (cited in "Weighting Game," 1994) reports that what distinguishes bulimic women with and without reproductive disorder, is that bulimic women at ideal weight appear to be **under-weight** in relation to their own lifetime high body weight. Additionally, it is posited these women are still eating restrictively, hence causing some form of malnutrition. Thus, hormonal normality does not depend exclusively on regaining weight but also on normalising eating patterns ("Weighting Game," 1994).

Thyroid function tests often reveal gross abnormalities in anorexics and bulimics who are at a normal weight (Berkow & Fletcher, 1987). In bulimics, thyroid hormone levels are generally normal, although some studies report a blunted thyrotropin-stimulating hormone response to thyrotropin

releasing hormone; the same response reported in individuals with major depression. This neuroendocrine feature links bulimia and affective illness (Copeland, 1985). In anorexic patients, a high level of cortisol production is noted, a feature shared with endogenous depression (Copeland, 1985; Dally & Gomez, 1979). However, not all anorexic patients may be classified as depressed (Levy & Dixon, 1984). These findings render the affective theory of eating disorders (see pp. 15-17) seriously limited. Mecklenburg, Loriaux, Thompson, Andersen, and Lipsett (1974 cited in Bemis, 1978) indicate that growth and cortisol hormones are typically in the higher than normal range in anorexics; a finding common with individuals starved for other reasons.

2.1.1.2 Fluid, electrolyte, and gastrointestinal complications

Early on in starvation states, endocrine changes result in diuresis, with dramatic changes in fluid balances. The fluid-regulating organ (kidney) eventually adjusts to the starvation state by preserving sodium and potassium. Further danger ensues if starvation continues, as edema may result due to extensive sodium retention (Dwyer, 1985). Fluid and electrolyte complications are documented in obese, anorexic, and bulimic individuals (Berkow & Fletcher, 1987). In the case of diuretic and laxative abuse, Wigley (1960) and more recently, Berkow and Fletcher (1987), report on chronic potassium deficiency and decreased urine-concentrating ability. In the case of vomiting, potassium is lost via the gastrointestinal tract and via increased urinary loss (Berkow & Fletcher, 1987). Gastrointestinal disorders such as diarrhoea or self-induced vomiting further deplete the body of potassium, to the point where it may become life-threatening (Dwyer, 1985). Russell (1981) reports a case where the powers of the Mental Health Act (compulsory admission) were invoked in a patient whose repeated vomiting had led to dangerous potassium depletion.

When a dangerously low serum potassium concentration exists, an individual is at mortal risk, as amongst other muscles affected, the heart muscle is at most risk, with cardiac arrhythmias or asystole resulting (Berkow & Fletcher, 1987). Spack (1985) reports that this is the most probable cause of death in eating-disordered individuals who vomit. Jennings and Klidjian (1974) report acute gastric dilation and rupture in anorexia and bulimia. Saul (1984) describes "one unfortunate bulimic whose stomach contained eight litres of undigested food and fluid at the time of surgery. The patient ultimately succumbed to gastric infarction and perforation" (cited in Spack, 1985, p. 11). Healy (1984) reports two other complications of self-induced vomiting, upper gastrointestinal tract haemorrhage and malrotation of the bowel. Gall bladder disease and gout have been linked to obesity (Wardle, 1995). Constipation is noted in anorexics and bulimics due to dehydration, lowered

metabolic rate, delayed gastric emptying, hypokalemia, and altered composition of food (Selvini-Palazzoli, 1985). Malnutrition and starvation both affect glucose metabolism, often resulting in hypoglycaemia (Selvini-Palazzoli, 1985). Many anorexic, bulimic (Hillard, 1983; Powers, 1983; Roland & Bhanji, 1982 cited in Spack, 1985) and obese individuals (Wardle, 1995) suffer from diabetes mellitus. Other biochemical changes include low serum carotene levels in bulimics, and high cholesterol levels in anorexics (Bhanji & Mattingly, 1981) and obese individuals (Wardle, 1995).

2.1.1.3 Cardiovascular, haematologic, and immunologic complications

When 30-50% of body protein is depleted, respiratory functions are often impaired, predisposing individuals to pneumonia and respiratory infections (Berkow & Fletcher, 1987). In extreme emaciation cases, the heart muscle may begin to waste, leading to cardiac abnormalities (Dwyer, 1985). Berkow and Fletcher (1987) note that bradycardia, hypotension, and a decreased heart rate during exercise, are the expected cardiovascular complications of anorexia. Obesity is a clear risk factor for cardiovascular disease and hypertension (Wardle, 1995). In anorexics, cold extremities are the result of diminished peripheral circulation (Bemis, 1978). Lampert and Lau (1976) and Mant and Faragher (1972) document anemias in anorexia nervosa (cited in Spack, 1985). Although anorexics have a propensity to certain viral infections due to a compromised immune system, they are surprisingly free from recurrent or infectious diseases (Berkow & Fletcher, 1987). Spack (1985) proposes this anomaly is due to anorexic individuals' relatively stable intake of protein, as opposed to other starved individuals high intake of carbohydrate and fat.

2.1.1.4 Psychologic, neurologic, and ophthalmologic complications

Effective psychological treatment is precluded by the severe starvation state of anorexic patients (Russell, 1981). In Keys, Brozek, Henshel, Mickelson, and Taylor's classic World War II study (1950 cited in Copeland, 1985), volunteers were kept on a diet of 1660 calories a day for a period of 24 weeks (semi-starvation), and participants were aware that the period of food deprivation was finite. Nevertheless, behavioural patterns similar to those displayed by anorexics were exhibited. Bemis (1978), Berkow and Fletcher (1987), Dally and Gomez (1979), Dwyer (1985), Selvini-Palazzoli (1985), and Spack (1985) list the emotional changes which occur as a direct result of emaciation and prolonged starvation: sleep disturbances, mood lability, depression, decreased mental concentration, obsessional behaviour, preoccupation with food (talking and daydreaming about it, collecting recipes, reading cookbooks), indecisiveness, and hyperactivity. Hsu (1980) and Schwartz

and Thompson (1981) note that these starvation-related symptoms explain the high incidents of suicide in anorexic individuals (cited in Dwyer, 1985). Dally and Gomez (1979) and Russell (1981) report that the morbidity rate in anorexia is mainly due to suicide.

Sein, Searson, Nicol, and Hall (1981) document reversible cerebral and cerebellar atrophy in anorexics. Ophthalmologic complications in anorexics are reported. Archer (1981) reported 'cataracta cachectica' in three anorexics, a condition previously found in individuals who had been starved, had chronic anaemia, or suffered chronic diarrhoea. Anorexic and bulimic individuals who vomit display severe dental complications from the chronic exposure of gastric acid from repeated vomiting (Berkow & Fletcher, 1987). Regurgitated acid leads to oesophageal irritation, a persistent sore throat, infected or irritated salivary glands, often resulting in a chipmunk-like appearance (Berkow & Fletcher, 1987), hiatus hernia (Dwyer, 1985), and damaged vocal chords (Dana & Lawrence, 1988).

2.1.2 Biochemical etiological theories

2.1.2.1 Central nervous system neurotransmitters

Central nervous system neurotransmitters implicated in the control of appetite and weight are norepinephrine, opioids, and serotonin (Copeland, 1985). Some hypotheses which explain the manifestation of anorexia and other eating disorders are that: (1) a neurochemical change predisposes an individual to anorexia or bulimia; (2) self-imposed starvation or frequent dieting may itself lead to neuroendocrine changes which foster other behaviours, such as binge eating ("Breaking," 1995).

Marrazzi (cited in "Breaking," 1995) proposes that bulimics and anorexics may be biologically predisposed to an addiction cycle that is set into motion by chronic dieting i.e., in response to self-starvation, the brain releases opioids which cause a "high". Marrazzi believes that opioids create a drive to correct starvation, as well as may cause an adaptation to starvation. Thus, bulimics become addicted to the opioid-induced drive to eat, and anorexics become addicted to the opioid-induced adaptation to starvation. Using naltrexone, a drug used in the treatment of heroin addiction, Marrazzi has found that starvation, binging, and purging are reduced enough in bulimic and anorexic women to convince them not to diet. And, she proposes, it is when dieting stops that the tide of opioids is stemmed, allowing the brain to take in new information and thus for effective treatment to take place.

2.1.2.2 Dieting as a trigger for anorexia, bulimia, and obesity

When the etiology and pathogenesis of eating disorders is discussed, a frequent question which arises is whether dieting to lose weight is a **cause** (Hill, Weaver, & Blundell, 1990; Wooley & Wooley, 1985), or merely a **manifestation** of an eating disorder (Dally & Gomez, 1979). Dieting normally precedes the onset of an eating disorder (Polivy & Herman, 1985 cited in Hill *et al.*, 1990) and it is thus regarded as an important risk factor for the development of an eating disorder. "At 15 years old, the relative risk of dieters becoming cases is eight times that of non-dieters" (Hill, Oliver, & Rogers, 1992, p. 96). Research suggests that to regard dieting as a cause of eating disorders is far too simplistic. "However, the mind sets, attitudes, and behaviours associated with dieting may predispose individuals to develop these disorders" (Copeland, 1985, p. 29). (See also sociocultural perspective on cultural preoccupation with thinness and dieting).

A number of antecedent events have been linked to anorexia and bulimia. Garner and Bemis (1982), and Slade (1982) examined the functional relationships among antecedent events and positive and negative reinforcers in the development and maintenance of anorexia and bulimia. Slade (1982) noted that most research focused on antecedent events, (events which determine the initial behaviour), and neglected to take into account the role of consequences, (events which determine the maintenance and exacerbation of the behaviour, which include the role of reinforcement, especially cognitive or self-administered reinforcement). The anorexic's stereotypical behaviour, (dieting, exercising, purging), may be understood within the avoidance paradigm i.e., that a behaviour increases following negative reinforcement or the removal of an aversive stimulus, which in this case, is fatness. According to this view, dieting is the mechanism by which the aversive stimulus is avoided or removed (Garner & Bemis, 1985). Garner and Bemis (1982) found that aversive stimuli are functional in that the threat they hold over the anorexic actually assists her in the difficult task of oral self-restraint, in spite of insatiable hunger. In other words, instead of avoiding the aversive stimulus, the anorexic is seen as not wanting to be relieved of her anxiety surrounding food and weight, as it is these very experiences which assist her in keeping constant vigilance and thus control over herself. Garner and Bemis (1985) state that anorexic symptoms are maintained by both positive and negative reinforcement. Weight loss is thus not only a way to avoid fatness, it provides a sense of gratification in its own right. Utilising existing literature and clinical research, Slade (1982) formulated a functional model of anorexia and bulimia. He states that given certain setting conditions, specific psychosocial stimuli trigger initial dieting and weight loss. And, if once dieting behaviour has commenced it leads to feelings of success and being in control, it is reinforced both positively, (by the resultant feelings of

satisfaction/success) and negatively, (through fear of weight gain and avoidance of other problems). Because of the nature of the setting conditions, the resultant reinforcements from dieting are sufficiently powerful to ensure that the behaviour is intensified, with the result that more stringent dieting follows and consequently, increased reinforcement of both a positive and negative kind.

> Thus the model suggests that it is the consequences of dieting for the individual (in the form of both positive and negative feedback loops) which rapidly lead to a shift in behaviour from initial, normal benign dieting to a state of drastic and pathological curtailment of food intake....The factor responsible for converting normal, limited-target dieting...into the downward spiral into anorexia nervosa [and bulimia] is the potent positive reinforcer of "feelings of success", "feelings of being-in control", and "feelings of self-satisfaction"....It is suggested that this positive reinforcement is context dependent, in the sense that it is not simply a consequence of dieting **per se** but rather of perceived success in the context of perceived failure in all other areas of functioning (Slade, 1982, pp. 169, 174, 176).

Garner and Bemis (1982) and Slade's (1982) contributions offer an explanation about the causal role of dieting in the development of eating disorders. They are able to illustrate that it is not dieting **per se** which causes an eating disorder but rather, that in contexts where individuals are predisposed towards self- and bodily-control, that **successful** dieting is powerfully reinforced by its **consequences.** It is then these consequences which rapidly lead into the world of eating disorders.

> [The] picture of the dieter as an unhealthy individual, obsessed by her body weight and the caloric content of foods, engaging in episodes of self-starvation and overeating, has been reinforced by the comparisons made with certain eating disorders....Dieting is viewed...as a precondition to anorexia nervosa...and to bulimia...and the breakdown of dietary restraint has been proposed as a laboratory model of binge eating (Hill, Rogers, & Blundell, 1989, p. 166).

Studies exist which implicate dieting with the development of various eating disorders. It has been found that restrictive diets often precede the onset of binges in bulimic (Johnson, 1982 cited in Dwyer, 1985; Welbourne & Purgold, 1984) and obese individuals (Dally & Gomez, 1979; Friedman & Brownell, 1995). Herman and Polivy (1975) have shown that most obese people show habitual dietary restraint. Whereas successful restraint can be a positive feature, it has also been linked with abnormal eating patterns, such as binging and emotional eating in obese individuals (Friedman & Brownell, 1995; Hibscher & Herman, 1977; Wardle, 1988 cited in Wardle, 1995). In fact, Wardle (1995, p. 111) states that, "binge eating may also be a consequence of steps taken to control obesity (e.g. dietary restriction)". Marcus and Wing (1987) report that binge eating is presented as a problem by as many as half the obese individuals who seek treatment (cited in Wardle, 1995). Marrazzi ("Breaking," 1995) and Wooley and Wooley (1985) believe dieting is addictive. Although binge eating appears to be a psychiatric symptom, Russell (1979 cited in Yong, Checkley, & Russell, 1983)

proposes that it is likely a hypothalamic response triggered by the stress of self-imposed dieting or suboptimal body weight. Thus, "bulimia in anorexia nervosa may be viewed as a 'breaking through' of uncontrolled appetite" (Copeland, 1985, p. 52). Hill *et al.* (1989) demonstrated that dietary restraint is functional, predicting break of dietary restraint and overeating in 12- to 14-year-old girls in the same ways as noted in adults. Thus, in a paradoxical way, dieting predisposes individuals to periods of overconsumption given particular conditions. The disinhibitors of dietary restraint vary between individuals and include psychological stress (Russell, 1979 cited in Yong *et al.*, 1983), the consumption of, or the belief that high calorie food has been consumed, exposure to highly palatable food stimuli without eating, anxiety, and alcohol (Hill *et al.*, 1989). In a study on dieting concerns of 10 year-old-girls and their mothers, Hill *et al.* (1990) found that highly restrained daughters and their mothers are more likely to break their dietary restraint and to eat following negative mood states (being upset, bored), than the low restrained girls and their mothers.

Charnock (1989a) questions the validity of claims that dieting is causally implicated in the onset of bulimic episodes. She states that in spite of the intuitive appeal of the construct of dietary restraint and the boundary model - a model based on the premise that "disinhibition of dietary restraint is the inevitable consequence of the dieter's adherence to diets based on strict, limited daily quotas" (Polivy & Herman, 1985 cited in Charnock, 1989a, pp. 329-330) - methodological and conceptual problems abound in the study of dietary restraint and overeating. She identifies the nature and measurement of dietary restraint and the phenomenon of disinhibition and counter-regulation as areas which require standardised measures, clarity of terminology and further research. In this regard, she states that conclusions about the causal role of dietary restraint in the development of bulimic episodes are premature and too general to account for the development and maintenance of disordered eating (Charnock, 1989a). Polivy and Herman (1989) respond to Charnock's (1989a) criticism of the restraint literature and the phenomenon of counter-regulation. They point out that much of Charnock's criticism of existing measures of restraint is based on her erroneous comparison of restraint scales which are designed to measure different things (and not the same, as Charnock supposes). Additionally, Polivy and Herman point out how, throughout her paper, Charnock confuses the concepts of disinhibition and counter-regulation, which results in a faulty understanding of counter-regulation. Charnock (1989b) responds to Polivy and Herman (1989), acknowledging their contribution in the area of dietary restraint and its relationship to abnormal eating patterns. However, she returns to the salient point of her article: That further research is required as, "it has yet to be determined whether restraint theory and the boundary model for the regulation of eating will prove useful for explaining the development of abnormal eating behaviour" (Charnock, 1989b, p. 345).

Recently, Williamson, Barker, Bertman, and Gleaves (1995) examined the factor structure of eating disorder measures in nonclinical subjects. The primary constructs which these assessment methods are designed to measure, (dietary restraint, body image, and body dissatisfaction), were identified and confirmed in nonclinical subjects, an area previously neglected in research, which has made it difficult to compare results across nonclinical and clinical subjects. The study's merit lies in the definition of control groups and guidelines for the selection of measures to be used in studies of anorexia and bulimia.

Copeland (1985) and Dally and Gomez (1979) hypothesise that neuroendocrine differences between anorexic and bulimic individuals establish their predisposition to binging and that the consequences of starvation are manifested in disorders of appetite regulation. Drawing on Keys' (1950) famous study in experimental starvation, Copeland (1985) notes that, after the 24 week period of semi-starvation where refeeding was at first limited and then unlimited, participants of the experiment remained preoccupied with food and that many men began binging during the time when food was unrestricted. These findings (two citations below) parallel bulimic behaviour of anorexics, as well as normal-weight bulimics. Most significantly, these findings lend credence to the theory that starvation or dieting may trigger the development of an eating disorder.

> The men frequently found it difficult to stop eating. No. 21 "stuffs himself until he is bursting at the seams, to the point of being nearly sick," and still he felt hungry; No. 120 reported that he had to discipline himself to keep from eating so much as to become ill; No. 1 ate until he was uncomfortably full; and subject No. 30 had so little control over the mechanics of "piling it in" that he simply had to stay away from food, because he could not find a point of satiation even when he was "full to the gills" (Keys *et al.*, 1950 cited in Copeland, 1985, p. 52).

Garner, Rockert, Olmsted, Johnson, and Coscina (1985) quote the extreme behaviours, mood swings, and stress some subjects developed during the period of semi-starvation in Keys' study.

> He exhibited a compulsive attraction to refuse and a strong...desire to root in garbage cans [for food to eat]....He repeatedly went through the cycle of eating tremendous quantities of food, becoming sick, and then starting all over again...[and] became emotionally disturbed enough to seek admission voluntarily to the psychiatric ward....[Another subject went on a] spree of shoplifting....He developed a violent emotional outburst with flight of ideas, weeping, talk of suicide and threats of violence. Because of the alarming nature of his symptoms, he was released from the experiment....Another man chopped off three fingers of one hand in response to stress....[One subject] experienced...periods in which his spirits were definitely high....These elated periods alternated with times in which he suffered "a deep dark depression". [He] felt...he had reached the end of his rope [and] expressed...fear that he was going crazy...[and] losing his inhibitions (p. 526).

Other studies which implicate dieting as a trigger for the development of eating disorders are documented: (1) Garner, Garfinkel, Schwartz, and Thompson (1980) report that certain individuals are predisposed to developing eating disorders because the nature of their work exalts thinness (hence dieting), such as models and ballet dancers. Crago, Yates, Beutler, and Arizmendi (1985), and Druss and Silverman (1979) have shown an elevated presence of eating problems among dancers, professional models, athletes, and women who attend a health club at least once a week (cited in O'Mahony & Hollwey, 1995). Others have also documented this phenomenon (Buckroyd, 1989; Crisp, Palmer, & Kalucy, 1976; Levenkron, 1982; Marano, 1994). Powers has found that eating disorders are more common among elite athletes, especially figure skaters and gymnasts, and that it is occurring more in tennis players and swimmers (cited in "Elite Athletes," 1996); (2) The easy access to, and abuse of prescription and over-the-counter drugs for weight loss contribute to the development of eating disorders (Copeland, 1985); (3) Feicht, Johnson, Martin, Sparks, and Wagner (1978), Garner and Garfinkel (1978), and Smith (1980), conducted studies which hypothesised a link between mass media and social pressure to engage in vigorous competitive sport, and the development of eating disorders. They found that individuals "often practised so religiously that they go beyond enjoyment to the very limits of endurance, and...increasing...studies have found anorexia-nervosa-like symptoms among those who do so" (cited in Dwyer, 1985, p. 30). The above studies lend supporting evidence to the model which views dieting as a trigger for anorexia and bulimia.

2.1.3 Evidence for physiologically-based theories of eating disorders

2.1.3.1 Biological treatments of eating disorders

The need for an effective therapy which is able to show positive results in a controlled study provides the impetus for the pharmacological treatment of eating disorders. However, conclusive studies are lacking (Pope & Hudson, 1985). The first drugs subjected to controlled trials were cyroheptadine (Periactin) for anorexia and phenytoin (Dilantin) for bulimia. Both produced vague results. Periactin is an appetite stimulant. Although anorexia is not a disorder of a lack of appetite, Crisp and Bhat (1982 cited in Pope & Hudson, 1985) postulated that if appetite was stimulated, it may result in an improvement of the disorder. In a controlled study of 10 anorexics, all participants treated with the drug gained significant amounts of weight as opposed to those who received placebo pills. Studies by Goldberg, Halmi, Eckert, Casper, and Davis (1979), and Vigersky & Loriaux (1977 cited in Pope & Hudson, 1985) failed to demonstrate the effectiveness of cyroheptadine. The usefulness of this drug remains tenuous and subject to further clinical trials, especially because 50% of anorexics display bulimic behaviour and a drug which stimulates appetite may exacerbate the urge to binge

(Berkow & Fletcher, 1987). Dilantin is an anti-convulsant drug. The rationale for its use in treating bulimia is based on the hypothesis that binges may represent a form of seizure disorder and thus may be a compulsive automatic response, as seen in epilepsy. Initial studies provided excellent results but further research could not verify the presence of abnormal electroencephalograms and the response with this drug (Pope & Hudson, 1985). Yong *et al.* (1983) investigated the use of an anorectic drug (methylamphetamine) in one male and seven female bulimic patients. In every patient who received methylamphetamine, reduced self-ratings of hunger and amount of food eaten were found. Additionally, the symptom of bulimia (rapid and excessive eating followed by purgation or self-induced vomiting) was only observed in four subjects after receiving placebo but in none after receiving methylamphetamine. It was concluded that: hunger and food intake of bulimic patients can be modified by drugs; the symptom of bulimia may be amenable to drug treatment; further research is required to explore how methylamphetamine suppresses bulimia (Yong *et al.*, 1983).

2.1.3.2 The major affective disorder theory

A popular biological theory of eating disorders proposes that anorexia (Levy & Dixon, 1984) and bulimia (Hudson, Pope, Jonas, & Yurgelun-Todd, 1983) are closely related to major affective disorder. Major affective disorder is recognised as a biological illness with a hereditary component and demonstrable biochemical anomalies (Berkow & Fletcher, 1987). Pope and Hudson (1985) and others, have documented five lines of evidence linking eating disorders with major affective disorder: (1) **Anorexic and bulimic individuals often report symptoms of major and manic depression.** In the past it was postulated that these symptoms may result from the eating disorder itself. However, Hudson (1983 cited in Pope & Hudson, 1985) and Levy and Dixon (1984) found that half of their eating-disordered patients developed major depression a year prior to the onset of the eating disorder. (2) **In follow-up studies when an eating disorder was in remission, anorexics have been found to still display depressive symptoms.** Cantwell, Sturtzenberger, Burroughs, Salkin, and Green (1977 cited in Levy & Dixon, 1984) found a significant incidence of major depression in anorexia patients at follow-up even though anorexic symptoms were absent. (3) **Family studies report a high frequency of family history of major depression and/or bipolar disorder in the first-degree relatives of anorexics and bulimics.** Hudson *et al.* (1983) investigated the relationship of anorexia and bulimia to other psychiatric disorders, particularly affective disorders. The 420 first-degree relatives of patients with anorexia, bulimia, or both disorders were assessed. "Most striking was the high prevalence of major affective disorder in the relatives of all three subgroups of eating disorder probands: 70 of the relatives had bipolar disorder or major depression. Alcohol use disorders were

second in prevalence to affective disorders and accounted for 44 cases among the first degree relatives" (p. 134). (4) **Laboratory studies** - the dexamethasone suppression test (Carroll, Feinberg, & Greden, 1981) and the thyrotropin-releasing hormone stimulation test (Kirkegaard, 1981) - **reveal positive results in patients with major affective disorder and bulimia,** lending support to the theory that bulimia may be linked to major affective disorder (cited in Pope & Hudson, 1985). (5) **Anorexics and bulimics respond to the same medications used in treating major affective disorder** (Pope & Hudson, 1985). These findings (points 1-5) lend support to the view that eating disorders may be related to affective disorders.

Given the internally consistent findings linking eating disorders with major affective illness, (Hudson *et al.*, 1983) it is surprising that few controlled studies exist. Most studies use antidepressant drugs for their appetite stimulating properties rather than for their antidepressant properties. Hence, they are administered in dosages well below the range required for an antidepressant effect (Pope & Hudson, 1985). Two antidepressant drugs, trazodone (Desyrel) and tranylcypromine (Parnate), have offered potentially useful results in anorexia. In three out of six patients previously resistant to all other treatment, a 15-40% weight increase in eight weeks was reported, as well as a marked reduction in anorexics' fears of eating and phobia about weight gain (Pope & Hudson, 1985). However, these results were obtained from uncontrolled studies and so their validity is questionable. Other factors which were not controlled or accounted for in these studies could have been responsible for the reduction in the anorexics' food and weight phobia, such as positive therapeutic changes (Pope & Hudson, 1985). Gross, Ebert, Faden, Goldberg, Nee, and Kaye (1981 cited in Hudson *et al.*, 1983) conducted a double-blind controlled study of lithium carbonate in anorexia and found statistically significant differences between anorexics on lithium and those on placebo. Not only did the latter group gain more weight than those on placebo, they also improved on other measures of eating behaviour. Results of the study had to consider that it was not clear whether the improvements observed were due to the antidepressant action of the drugs or simply due to weight gain, which is a well documented side effect of these drugs (Hudson *et al.*, 1983). Coppen, Harwood, and Wood (1984) carried out the dexamethasone suppression test (DST) on 143 patients with a major depressive disorder who were classified into those with a history of weight loss and those without weight loss. It was found that weight loss can occur independently of abnormal DST results in depressive patients who are being treated with lithium. The use of lithium in anorexia thus requires further study.

The treatment of bulimia with antidepressant medication was originally derived from the view that bulimia is a form of affective disorder. Rich (1978 cited in Pope & Hudson, 1985) first described

the successful treatment of bulimia with antidepressants. He treated a bulimic woman with phenelzine. Her binge eating disappeared while on this drug, reappeared when the drug was withdrawn, and again remitted when phenelzine was readministered. Rossiter, Agras, Losch, and Telch (1988) compared the dietary restraint of bulimic subjects treated with cognitive-behavioural therapy or pharmacological treatment. One of the goals of cognitive behavioural treatment is aimed at helping bulimics normalise their eating patterns, while at the same time challenging their dysfunctional beliefs about body weight, shape, caloric intake, and dietary restraint. Antidepressant medication acts directly on serotonergic mechanisms which affect hunger and satiety, thus reducing the urges to eat and binge (Agras & McCann, 1987 cited in Rossiter *et al.*, 1988). Rossiter *et al.* (1988) hypothesised that only cognitive-behavioural treatment would result in non-purged calories, whereas both treatments would result in a reduction of purged calories. Twenty bulimic subjects were treated with cognitive-behavioural therapy or imipramine and their results compared before and after treatment. Findings showed that both groups reduced their purged calories equally and significantly, indicating that both treatments are effective in the short term. However, maintenance of treatment benefit was found to be better in the cognitive-behavioural group than in those treated with imipramine. It is suggested that one of the reasons for better outcome in the latter group is that patients receiving cognitive-behavioural treatment are taught skills which help them normalise their eating patterns and dietary restraint, which in turn, decreases the probability of binge eating. Overall results showed that cognitive-behavioural treatment lessens dietary restraint, whereas imipramine treatment does not (Rossiter *et al.*, 1988). Leitenberg, Rosen, Wolf, Vara, Detzer, and Srebnik (1994) conducted a comparison of cognitive-behaviour therapy, desipramine alone (antidepressant medication), and cognitive-behaviour treatment alone, in the treatment of bulimic patients. They found that cognitive-behaviour treatment alone is more effective than desipramine alone, and that the combination of the two was no more effective than cognitive-behaviour therapy alone. These findings were consistent with those reported by Mitchell, Pyle, Eckert, Hatsukami, Pomeroy, and Zimmerman (1990 cited in Leitenberg *et al.*, 1994) in their comparison of cognitive-behaviour therapy and imipramine. A growing body of evidence citing positive results in bulimia using antidepressants has highlighted the usefulness of a pharmacological approach to bulimia, as well as the need for carefully controlled studies (Jonas, Hudson, & Pope, 1983; Mendels, 1983; Pope & Hudson, 1982; Walsh, Stewart, & Wright, 1982 cited in Pope & Hudson, 1985). In spite of the strong case for the effectiveness of antidepressants in bulimics, questions about long term efficacy and the tendency for relapse over time, require further study. It is suggested that combining treatments (such as cognitive-behavioural and pharmacological treatments) is a promising approach (Rossiter *et al.*, 1988) but one which requires further research (Leitenberg *et al.*, 1994).

2.1.3.3 Conclusion of biochemical etiological theories

The biomedical model has limitations, revealing it not to address certain fundamental issues: (1) there exists the old chicken-and-egg problem which in this instance, centres around which comes first, starvation or endocrine changes? depression or the eating disorder itself? A common biological characteristic of anorexics that is clearly an **etiological cause** and not a **consequence** of starvation has yet to be identified (neither in other eating-disordered individuals); (2) although certain biochemical anomalies are documented in female eating-disordered individuals, the model fails to explain why young women are mostly affected by these disturbances and not men; (3) a biochemical perspective does not address the social characteristics of the eating-disordered population. Eating disorders (anorexia in particular), are not universal diseases. They are usually found in developed countries among affluent, educated, white middle and upper classes (Morgan, Purgold, & Welbourne, 1983; Selvini-Palazzoli, 1985). A biomedical perspective that isolates the etiological agent exclusively within the body does not acknowledge these social facts (Brumberg, 1988).

2.2 Sociocultural perspective

This review will be divided into three interrelated psychosociological parts: (1) introduction to sociocultural perspective; (2) studies indicating increased cultural preoccupation with food and slimness; (3) studies indicating increased incidence of eating disorders; (4) the role of body image disturbance and body dissatisfaction in eating disorders; (5) feminist psychoanalytic theories on the etiology of eating disorders.

2.2.1 Introduction

> If we exclude the social world in our attempts to solve the difficulties of individuals, however deep we may delve into the psyche in the pursuit of causes and explanations, we shall never find them. Rather, I believe we must pluck our understandings from external **and** internal experience (Lawrence, 1988, p. 26).

Sociocultural explanations of eating disorders are based on the premise that pathological eating behaviour is engendered and maintained by a powerful cultural imperative that demands that beauty, (especially women's beauty), is chiefly determined by slimness. Sociocultural theories provide answers to questions of why eating disorders have assumed such prevalence in the present day, why women are especially predisposed to these disorders, and why the body is the site of symptomatology.

In a detailed review of eating behaviour through the ages, Brumberg (1988) demonstrates that it is a historical fact

> That women use appetite as a form of expression more often than men...and that there have been moments in time, other than our own, when large numbers of women and girls refused to eat regularly or practised extraordinary forms of appetite control (p. 2).

Similar observations are made by others (Buckroyd, 1989; Dally & Gomez, 1979; Selvini-Palazzoli, 1985; Welbourne & Purgold, 1984). Although symptomatic continuities exist through history which suggest anorexia is an age old malady, Brumberg (1988) makes an important point; the presence of a behaviour across time or cultures does not necessarily imply the same etiology. Using case study methodology (reviewing cases of women fasters through the ages), Brumberg displays that there are changing interpretations of food-refusing behaviour, as well as divergent reasons for female control of appetite. "Even as basic a human instinct as appetite is transformed by cultural and social systems and given new meaning in different historical epochs" (1988, p. 3). Brumberg (1988) states that not only is disease a 'cultural artifact' but that disordered eating existed long before there was a cultural preoccupation with dieting, thin female bodies, and body image imperatives; a point noted by Dally & Gomez (1979) and Buckroyd (1989). Focusing on the sociocultural contexts of the epochs where women have refused food, as well as on what their experiences were at the time, Brumberg allows for a broad spectrum of meaning to unfold without attempting to prove that a consistent psychological experience existed throughout history. The question guiding her research is the following: "Why is it that women and girls in certain cultural systems and historical epochs become susceptible to particular forms of exaggerated behaviour centering on food?" (Brumberg, 1988, p. 4). Her answers are that not only has the meaning of food and eating changed over time but that fundamental historical changes have transformed society; a point noted by Carter and McGoldrick (1989).

Brumberg (1988) identifies the transition from 'sainthood to patienthood' as the central feature which transformed society. Drawing on cases from the sixteenth through the nineteenth centuries, she demonstrates how society evolved from a religious world view to a scientific-medical view in explanations of human behaviour. By the 1800's, a rapid decline of religious faith coupled with a rise in scientific authority, "transformed refusal of food from a religious act into a pathological state" (Brumberg, 1988, p. 5). Various authors also note the changed historical meanings of food and eating (Buckroyd, 1989; Dally & Gomez, 1979; Lawrence, 1988; Selvini-Palazzoli, 1985; Welbourne & Purgold, 1984). In an excellent appraisal of cultural variables (as well as age, class, gender, ethnic origins and world view), Brumberg (1988) offers a concise historical account of how and why the

symptomatology of eating disorders changed in response to different social and cultural environments and how new symptoms mirror contemporary society. She indicates how different explanations of a disease can exist at the same time. She does not subscribe to any one etiological agent as causation and is adamant that, "culture is the critical variable that explains why and how anorexia nervosa became the characteristic psychopathology of the female adolescent of our day" (p. 7). The notion that a symptom or behaviour can be gender-specific is not a new one, e.g., Freud's hysterical patients were largely women; depression is far more prevalent in women than in men; alcohol abuse and violence are predominantly male symptomatology (Buckroyd, 1989; Phares & Compas, 1992).

Brumberg (1988) explains how sociocultural changes influencing women's attitudes to food and eating have changed over the eons. A random example chosen by the writer will suffice. Saint Catherine of Siena (1347-1380) was one of numerous women saints who "ate only a handful of herbs each day and occasionally shoved twigs down her throat to bring up any other food that she was forced to eat" (Brumberg, 1988, p. 41). Fasting and eating little during the medieval period was a fundamental aspect to the model of female holiness and medieval spirituality and it is noted that few men saints ever fasted. These fasters were numerous in the thirteenth to the fifteenth centuries where food rituals were central to the Christian faith. The existence of women fasters does not imply that anorexia can be dated back to the twelfth century, in spite of some writer's insistence that it can. Bell (cited in Brumberg, 1988) argues that Catherine of Siena and other medieval women fasters engaged in the same anorexic behaviour as that of the modern anorexic woman. Such an argument is inherently flawed, as it assumes that the psychology of women is fixed over time and that past and present are the same (Brumberg, 1988). Society (Kruger, 1984) and women's psychology (Dana & Lawrence, 1988) have undergone a rapid period of change. In light of this perspective, to liken Saint Catherine's refusal of food with Karen Carpenter's, is to succumb to narrow-minded argument. Fundamental sociocultural changes are ignored because Saint Catherine's refusal of food (as other fasters') was coupled with an explanation, that of religious asceticism. Karen Carpenter's refusal to eat and consequent death in 1983 from cardiac complications as a result of prolonged anorexia, had nothing to do with religious calling. Carpenter's death was a manifestation of a thoroughly different social and cultural order. Carpenter did not cite reasons of faith for not eating. Brumberg cogently argues about the inappropriateness of understanding and interpreting the past through a modern day lens: "In order to understand fully the long tradition of female food refusal, one must do more than merely 'lay on' psychological constructs drawn from modern life or search out look-alike symptoms" (1988, p. 43).

Central to sociocultural theories about eating disorders of the modern day, is that society plays an integral role in shaping the form of psychopathology and that symptoms and behaviour are manifestations of a particular cultural system (Brumberg, 1988). Psychological disorders mirror prevalent moral and cultural patterns through time (Kruger, 1984; Wooley & Wooley, 1985). Throughout history, a woman's size and shape has been associated with gender and class identity (Brumberg, 1988; Selvini-Palazzoli, 1985; Welbourne & Purgold, 1984). "Obesity is strongly determined by social class, with lower class women showing greater proclivity than their upper-class counterparts. In contrast, anorexia nervosa has been shown to have a marked preponderance for adolescent females of upper social class" (Garner *et al.,* 1980, p. 490). Disease is a fashionable accessory. In Victorian times, it was fashionable for women to be sickly. "In the closing decades of the nineteenth century amongst the middle and upper classes in England and America...a morbid aesthetic developed, in which sickness was seen as a source of female beauty, and beauty - in the high fashion sense - was in fact a source of sickness" (Lawrence, 1988, p. 36). During times of war it was fashionable for women to be fat, as this indicated wealth (Brumberg, 1988; Lawrence, 1988). In the 1990's, it is fashionable to look emaciated and waif-like.

> Anorexia nervosa has to be seen as a 'stylistic' breakdown resulting from cultural pressure, since it amounts to a pathological exaggeration of society's message to women. That message has been with us as a pervasive problem for more than a decade and a half, and the incidence of anorexia has escalated during the last five years (Levenkron, 1982, p. 4).

To understand the power of contemporary society's preoccupation with slimness, one needs to first assess whether this is the case. **If** eating disorders are considered one of the most prevalent psychopathologies of the modern day, a researcher needs to demonstrate that eating disorders are a modern disease and secondly, that there exists epidemiological evidence for its increased occurrence.

2.2.2 Cultural preoccupation with food and slimness

> Eating disorders are first and foremost a cultural phenomenon, that like hysteria, results from an impossible conflict between cultural demands and biological drives. And, like hysteria, eating disorders appear to be part of a breakdown in the transition from sexual and social maturity to adulthood among well-educated young women, who are most sensitised to and responsive to cultural expectations. If the social changes accounting for the rise of hysteria are now complete, those accounting for the rise of eating disorders are at their peak (Wooley & Wooley, 1985, p. 391).

Hilde Bruch was one of the first clinicians to notice a changing trend in contemporary society by stating that during the latter half of the twentieth century, society had become increasingly

preoccupied with food and eating. "One might speak of an epidemic illness, only there is no contagious agent; the spread must be attributed to psychosociological factors....I am inclined to relate it to the enormous emphasis that fashion places on slimness (Bruch, 1978 cited in Schwartz, Thompson, & Johnson, 1985b, p. 96). The relentless pursuit of thinness is said to have replaced society's previous engrossment with sex and sexual matters (Schwartz *et al.*, 1985b). In Freud's Vienna of the nineteenth century, hysteria was the common symptom of distress; a rare phenomenon in the modern day except in Asian societies which are still largely sexually repressed (Buckroyd, 1989). The sexual revolution (of the 1960's) in the Western world has now made sexual gratification almost obligatory, but the association between food and sexuality has not disappeared, merely taken on a new form; that "a women's sexual acceptability depends on being slim" (Lawrence, 1988, p. 33). Fursland (1992) discusses how food and sex are interrelated and how from the beginning of time women have had their eating and sexual behaviour charged with the same moralistic attitude; that appetite needs to be controlled. Chernin (1993, pp. 23-24) describes her ambivalence, which many women feel, about satisfying their needs and appetite.

> My hunger filled me with despair. It would always return, no matter how often I resolved to control it....I had these same feelings about masturbating when I was a little girl. Then too it seemed to me that a powerful force would rise up from my body and overcome my moral scruples and all my resistance. I would give in to it with a sense of voluptuous release, followed by a terrible shame. Today I begin to see that there is a parallel here. A woman obsessed with losing weight is also caught up in a terrible struggle against her sensual natures....She is attempting to govern, control, limit and sometimes even destroy her appetite. But her body and her hunger are, like sexual appetite, the expression of what is natural in herself; it is a futile, heartbreaking and dismal struggle to be so violently pitted against them.

Throughout history a woman's acceptability has, to a large extent, depended on her ability to subdue and deny her body (Brumberg, 1988; Chernin, 1993; Lawrence, 1992; Wooley & Wooley, 1985). Historically, asceticism was perceived as "freeing the soul out of the prison of the body" (Lawrence, 1988, p. 34) and yet, this has been the (almost) exclusive domain of women. It is women's bodies and not men's that have been traditionally viewed as dirty, impure and dangerous. Because women's bodies are essentially uncontrollable, they have been viewed with fear and intonations of evil and temptation, not as natural or miraculous. Social mythology (with its beliefs on menstruation), illustrates how primitive societies tended to view women as inherently immoral (Fursland, 1992; Welbourne & Purgold, 1984). Lawrence (1992), Brumberg (1988), and Selvini-Palazzoli (1985) chart another social attitude displayed towards women and eating prevalent throughout history and part of the modern day too; that eating is an unladylike and unfeminine activity. Lawrence quotes Huxley's (1958) novel Chrome Yellow which depicts how society is impressed by women who hardly eat (see citation on next page).

> "Pray, don't talk to me of eating", said Emmeline, drooping like a sensitive plant. "We find it so unspiritual, my sisters and I. One can't think of one's soul when one is eating!"....For his part, he thought them wonderful, wonderful, especially Georgiana. Georgiana was the most ethereal of all; of the three, she ate the least, swooned most often, talked most of death and was the palest. At any moment it seemed she might lose her precarious hold on this material world and become all spirit (1988, p. 35).

Evidence exists of a social attitude in contemporary society that men are allowed to eat more than women. In a survey conducted by LaPorte (cited in "Binging," 1996) of 400 American college students, more than half felt that eating three doughnuts constituted a binge - **if the person feasting on them was a woman**. However, men had to eat six doughnuts before the same number of students labelled it a binge. Most striking was the fact that **women** respondents were particularly likely to show this sexist bias, indicating that it is not only men but (mostly) women who hold sexist attitudes towards eating.

Up until the mid-1970's, there was a paucity of studies documenting changing cultural trends (Buckroyd, 1989). Wallechinsky, Wallace, and Wallace (1977 cited in Schwartz *et al.*, 1985b), produced a systematic (although nonscientific) study which reflected the changing cultural trend from small-waisted, wide-hipped women to slim, thin-hipped women. Of the thousands who visit Madame Tussaud's London Wax Museum annually, visitors were asked to note whom they thought is the most beautiful woman in the world. The results over the years clearly reveal a shift in cultural trends. "Since 1970 Elizabeth Taylor has fallen steadily from the top of the list and Twiggy, surely an idealised anorexic, has ascended. Twiggy first made the top five in 1974. By 1976 she ranked number one" (Schwartz *et al.*, 1985b, p. 97). Sadly, Elizabeth Taylor (Buckroyd, 1989), along with other modern day exemplars of beauty (by virtue of their fame and excessive wealth), like Christina Onassis (Wright, 1992), have also not escaped the cultural imperative for thinness. Both struggled with weight lost and rapidly regained. Onassis' untimely death at the age of 37 of a heart attack, is linked to her obsessive struggle with weight and her addiction to dieting pills (Wright, 1992). Dana and Lawrence (1988) comment on another modern day exemplar of beauty, Marilyn Monroe, indicating the present day's predilection to thinness and that not only do men but women, define the female standard.

> When we [women] see 1950's movies of...Marilyn Monroe, an acclaimed beauty of her time, what we can now become uncomfortably aware of is a woman who is, by our present standards, overweight....Certainly Monroe has the body of a mature woman, with breasts, hips and a roundness which is distinctively feminine. It seems that our present preferences are for women who are not quite so unequivocally female (p. 34).

Garner *et al.* (1980) looked for evidence that cultural norms did in fact reflect a change in a tendency toward thinness. They studied exemplars of ideal feminine beauty: winners of the Miss America Beauty Pageant and Playboy Magazine Playmate centrefolds from 1959 through 1978. Focus was on changes and contrasts of cultural prototypes through the 20 year period. Women selected as exemplars of feminine beauty for each consecutive year were thinner for each year as compared to the norms for corresponding population means. Actual weight also declined over the 20 year period, revealing that thinness was increasingly exalted. Crucial to this study is the fact that up until 1970, winners of the pageant were the **same** weight as other contestants; after 1970, the winner's weight was always significantly **less** than the average weight of contestants. Thus, not only have ideal shapes for women changed but there is an increased preference for thinness. In this regard, Garner *et al.* (1980) comment that, "it is ironic that the current symbols of 'sexual attractiveness' may be gravitating toward a weight which is in biological opposition to normal reproductive activity" (p. 490). In the same study, Garner *et al.* sought parallel evidence for an increased cultural preoccupation with dieting and slimness. Six major women's magazines were reviewed for the same 20 year period for the number of articles covering dieting and weight loss. A systematic increase was found; the mean number of articles for the second decade was almost double that of the first decade. Recent research shows that what cultural dictates deem as suitable (ideal) weight for women may be in direct opposition to what the body regards as normal. In a study of bulimic women who had returned to ideal weight, more than half of them experienced reproductive disorder. It was found that these women were in fact underweight when compared to their highest lifetime body weight ("Weighting Game," 1994). This confirms the trend which Garner *et al.* (1980) predicted almost fifteen years before. More recently, Garner and Kearney-Cooke (1996) substantiate that the cultural trend towards (increasing) thinness is still present in 1996. In the most recent attempt to verify that personal and cultural preferences are for thinner bodies, and that this trend has continued and changed (increasing preference for even thinner bodies) over the last 30 years, Garner (1997) conducted a national survey on body image in conjunction with Psychology Today. Statistical analyses conducted on the first 4 000 responses confirmed previous studies (Garner *et al.*, 1980). However, the largely female respondents (86% women, 14% men) shows a much wider gender split than in previous surveys and speaks clearly of the stake women have in this topic. Garner's (1997) survey provides empirical evidence for anecdotal claims that there is indeed cultural preoccupation with thinness.

Elite female athletes (top gymnasts, swimmers, figure skaters, tennis players) are powerful role models by virtue of the fact that they are the quickest, strongest, and most flexible women in the world. As such, it would be expected that they are also the fittest and healthiest. Sadly, eating

disorders are common among these women as a result of their belief, (like ordinary women), that more fit equals less fat (Powers cited in "Elite Athletes," 1996). Recognition of this erroneous belief is evident by the steps taken by the American Gymnastics Federation to begin a hotline nationwide that young athletes can call if a parent or coach is pressuring them to lose more weight than is healthy; additionally, coaches will receive training on how to detect and prevent eating disorders in their athletes. Another positive step which is seen as a counter-balance to society's preoccupation with slimness, (and the idea that thinness equals fitness), is that American athletes competing in the 1996 Olympic Games will have higher body fat levels than their predecessors. And as Powers states, "if we can get role models like athletes to be normal size and shape, then we might have a chance of getting our kids to be normal, too" (cited in "Elite Athletes," 1996, p. 17). Fashion models are the number one idols of young women today (Marano, 1994). By examining what contemporary Western society attributes to and projects onto models, the attitudes and ideals of our society become evident. Research shows that

> Encounters with models' images on television and on the printed page have a virtually inescapable impact; in defiance of all reason and often biology as well, most women spend a great deal of time, money, and energy trying to look like them - and their successes no less than their failures wound deeply (Marano, 1994, p. 52).

In a first ever account, two psychotherapists, Diller and Muir-Sukenick, (both ex-models) provide an inside view of modeling, and try to understand why it is that so many of the women who seem to have it all tend to end up with so little (Marano, 1994). Based on their own past personal experiences as successful models and their subsequent studies and interviews with models, their contribution is unprecedented in this field. Diller and Muir-Sukenick identify common themes and two major trajectories which models take. There are successful models who did modeling well and then leave modeling to do something else with their life and are very satisfied with this. And there are those who are successful models but once the acclaim is over, end up on drugs and alcohol or with an eating disorder. Common to models who did not make it, is a particular personal history. These models came from a background that did not support a solid sense of self and where they were defined in terms of their appearance. These girls' mothers are "often more focused on the reflected glory of their child's immediate success than on her long-term future" (Diller cited in Marano, 1994, p. 54). The commonality between family characteristics of models and eating-disordered individuals, is striking. Diller's descriptions of models' families could easily be describing the patterns identified in eating-disordered individuals' families (see family studies pp. 73-80). Diller states that for a child to develop a strong sense of self, a parent needs to be emotionally in tune, responsive, and available to the child. However, in their studies they have found

> Unsupportive, inappropriate parent-child interactions to be unusually common in the background of models who do not do well after modeling. When we explored their family history, there was frequently a relationship between the child and the mother that was not emotionally supportive....There's a real lack of affirmation on the part of the parent to acknowledge the child as separate and worthy....Such a child can only feel good about herself if she's pleasing that parent. The parent may applaud the child, but the message is 'aren't you wonderful, aren't we wonderful, aren't I wonderful' (Diller cited in Marano, 1994, p. 54).

Diller and Muir-Sukenick state that a model whose parents have not nourished her self-esteem, is narcissistically vulnerable and thus will look to the outside world for approval and for the experience of mirroring or affirmation. Ironically, such a model can feel less and less self-worth if all her worth is dependent on how beautiful or how desirable she is in the eyes of others. Diller and Muir-Sukenick's concept of **narcissistic injury to the viewer** is a serious comment about society's portrayal of a specific image of women (increasingly gaunt and young) and the extent to which these images of models can penetrate a viewer's sense of self. The images of models presented to us are photographs which are carefully prepared and selected, and even more carefully retouched. They are not the truth and yet, we are encouraged (by editors, photographers, advertisers) to regard these photographs as representations of the truth. It is human nature to negotiate the world by identifying with and comparing ourselves to others, and viewers are encouraged to identify with models (by casting them in real-life settings).

> Although the viewer is unknowingly seeing a false person (a person who is the fabrication of the magazine, stylist, or photographer), she nevertheless makes a self-comparison. She winds up feeling inadequate - in other words, narcissistically wounded. The inadequacy women feel in looking at unreal images feeds the desire to constantly improve their looks.... Women keep looking at these images with the expectation that they will reveal how to look better. They think there's an answer in the next image, or the one after that, but with each look they're just repeating the narcissistic injury (Muir-Sukenick cited in Marano, 1994, p. 57).

Diller and Muir-Sukenick's contribution provides an important insight into how and why the pursuit (and portrayal) of a particular image of women affects both the model and the viewer, and that not only is the idolisation of models very telling of us (women) but also of our society, where thinness and the image of beauty are increasingly seen as inseparable and exalted.

Hill and his co-researchers (1990) investigated the dietary concerns of 10-year-old girls and their mothers. Their study addressed the empirical question of whether 10-year-old girls are concerned with dieting and whether dieting similarities exist between young girls and their mothers. They found a strong family link between mothers and their 10-year-old daughters in their motivation to diet. The significance of this association lies in Hill *et al. 's* (1990) identification of highly restrained 10-year-

olds, in the risk represented by early dieting for later eating problems, and in the description of family features which characterise anorexic and bulimic families. They state that

> The forces which encourage adolescent girls and adult women to pursue thinness pervade our environment and the process of socialisation into Western culture...Not only is thinness portrayed as the media ideal, but it is socially demanded. It is therefore likely that parents act as an important vehicle for these concerns, and that their attitudes to weight and dieting are conveyed to and accepted by their children from an early age...There is good evidence from both young children and late adolescents that they acquire and retain the food preferences of their parents (Hill *et al.*, 1990, p. 346).

In a more recent study documenting the rise of dieting in childhood and adolescence, Hill *et al.* (1992) compared 84 nine-year-old girls and 86 14-year-old girls for dieting motivation and attitudes towards body image. Girls from both age groups were identified as high and low restraint groups and their scores compared. Results confirmed high levels of dieting motivation in both groups.

> The highly restrained girls expressed low body esteem and body discontent with their body build, weight and certain regions of their body. Furthermore, their "ideal" body shape was significantly slimmer than their perception of their current body shape, and slimmer even than that of the non-dieters....What is most revealing is the number of girls who were highly restrained but who were **not** overweight. Nearly 40 per cent of the highly restrained 14-year-olds and 50 per cent of the nine-year-olds were within normal weight limits (+-10 per cent). In addition, one of the highly restrained 14-year-olds and two of the nine-year olds were **under**weight (Hill *et al.*, 1992, p. 102).

Most significantly, results of this study showed that the highly restrained girls' choice of their ideal figure and that deemed attractive to boys were both slimmer than that chosen by unrestrained girls; and it was **perceived** rather than **actual** weight which was best correlated with weight and body satisfaction. Hill and his colleagues question why, in the absence of weight motivation (actual body weight), so many of these children are both dissatisfied with their bodies as well as motivated to diet. They explain this as coming from the fact that

> Children are "eating in the adult world" in two senses. Children are exposed to adult beliefs, values, prejudices and stereotypes more so now than at any time this century....They live, eat and feel in the adult world, rather than in the haven of childhood. But there is more than this. Children actually consume these beliefs, values and prejudices and adopt them as their own...The importance to adults of physical appearance, body shape, dress sense and personal attractiveness is a message which is available to and readily accepted by pre-adolescent children. It follows that adult stereotypes of thinness and obesity...have been embraced by children...[It has been concluded that] children acquire an active dislike of the obese body build by six to nine years of age. In addition by the age of seven...they have acquired adult cultural perceptions of attractiveness (Hill *et al.*, 1992, p. 103).

In a study to determine why self-starvation and dieting is the "not-so-proud domain of white women" ("White Weight," 1994, p. 9), cultural standards of beauty are identified as the critical variable. Nichter and Parker (cited in "White Weight," 1994) asked black and white adolescents to describe their version of the ideal girl, and two vastly different images were reported. The white girls had a very fixed image of what beauty is - "a pert portrait of Barbie, 5'7, between 100 and 110 pounds, with blue eyes and long flowing hair" (p. 9) - and because the girls did not match up to this image, they reported feeling very dissatisfied and frustrated with themselves. The black girls' description of the ideal girl had nothing to do with physical characteristics - it was of "a girl who has a personal sense of style...who knows where she's going, has a nice personality, gets along well with other people, and has a good head on her shoulders" (p. 9). When the black girls were pushed to name physical characteristics that black men value, they included large thighs, fuller hips, and a small waist. Ninety percent of the white girls stated they were **dissatisfied** with their weight, whereas 70% of the black girls were **satisfied.** For the white girls, weight was found to be all-too critical to their self-concept. Nichter states, "as they see it, if you have the perfect body, you get the perfect boy and then you'll have the life they see in the magazines" (p. 9). Black girls were found to be not concerned enough about their weight and thus were more likely to have hypertension as adults. Both sets of responses raise serious concerns about current standards of beauty and their effects on adolescents' developing body- and self-image.

Studies such as Garner's (1997), Garner *et al.* 's (1980), and Hill *et al.* 's (1990; 1992) which clearly document an increased preference for slimness and the rising incidence of dieting in children and adolescents, gives strong support to the assertion that there is indeed a cultural preoccupation with thinness. "The other side of society's approval of abstinence and thinness is its revulsion for obesity and excessive eating" (Schwartz *et al.*, 1985b, pp. 97-98). Lawrence (1988) notes that research indicates that thin children show a preference for images of children represented as thin as opposed to fat, and that children prefer physical closeness with thin people. Prejudicial attitudes towards fat people are not gender specific in early childhood but in adolescence they are clearly focused on adolescent girls' bodies (Lawrence, 1988). Research shows clearly that obese people are viewed less favourably and are less liked than people of normal weight (Friedman & Brownell, 1995). Lawrence (1988) posits that just as minority racial groups are discriminated against, so are fat people. She states that fat people have become the "emotional dumping ground" of modern society and that, "we collectively project on to fatness bad qualities which do not belong to it at all, but to ourselves. Then all we have to do is to avoid being fat, and we are safe from the very worst of ourselves" (p. 39). Staffieri (cited in Friedman & Brownell, 1995, p. 5) found that when compared to normal-weight

individuals, obese individuals have been described as "lazy", "stupid", "cheat", and "ugly". Because obese people live in a culture that condemns their physical appearance and more importantly, blames them for their condition, negative attitudes about obese people are often translated into discrimination and prejudice against obese individuals (Friedman & Brownell, 1995). Sobal (1991 cited in Wardle, 1995) found that in many Western cultures obese people are thought of as unattractive and lacking in willpower. Allon (1982 cited in Wardle, 1995) has documented that there is discrimination against obese people in medical, educational and occupational settings. Gortmaker, Must, Perrin, Sobol, and Dietz (1993 cited in Friedman & Brownell, 1995) have found that individuals who were overweight as adolescents are less likely to be married, to have lower household incomes, and to have higher rates of household poverty later in life, than individuals who were normal weight as adolescents. Wooley and Wooley (1979) summarised existing literature on the stigma and hatred displayed towards obesity in childhood.

> Studies document the hatred of obese children by other children and by adults. The impact this hatred has on the...child is probably irreversible. It is not only the obese child who suffers from this hatred; anti-fat attitudes learned in childhood no doubt become the basis for self-hatred among those who become overweight at later ages, and a source of anxiety and self-doubt for anyone fearful of becoming overweight (cited in Schwartz *et al.*, 1985b, p. 98).

Selvini-Palazzoli (1985) notes the contradictory roles of modern women, stating that sociocultural conflicts women face are contributing factors in the development of eating disorders.

> Young girls are subjected to...specific pressures: the fashionable need to appear slim and sophisticated, the widespread publicity of dietetic aids, the constant discussion, at home or among friends, of calories and weight, and above all the social ridicule in which women of Rubensian proportions are held. Modern fashion rejects the fat girl, who is destined to remain a lonely spinster (pp. 35-36).

Wooley and Wooley (1985) not only confirmed that modern society is intolerant of fatness, they also verified that this social dynamic affects women more than men. "Beginning with adolescence, females are more affected than males by this prejudicial climate" (p. 98). Stunkard (1955) notes that obese men are not exposed to the social ridicule and rejection with which obese women are (cited in Selvini-Palazzoli, 1985). Teasing about physical appearance is a provocative new area of research, where teasing is considered a risk factor for the development of psychopathology in obese individuals (Friedman & Brownell, 1995). Studies show that high levels of teasing are associated with negative effects e.g., body image dissatisfaction (Thompson & Psaltis, 1988), and negative self-concept (Cash, Winstead, & Janda, 1986) in obese individuals and that women are affected more than men (cited in Friedman & Brownell, 1995). This is a crucial difference and one which any etiological theory needs

to be comprehensive enough to account for; the disproportionate number of women with eating disorders as opposed to men.

Literature on male eating-disordered patients is sparse and only with the recent surge of biomedical knowledge is it accepted that both sexes can and do develop eating disorders. However, because of the rarity of anorexia in males (and that the few published reports which exist comprise mainly case histories and descriptions of small samples), it is difficult to conduct a thorough comparison with a female population (Burns & Crisp, 1984). Disagreement exists about the incidence and prognosis of anorexia nervosa in males. The proportion of cases is rated from one in 20 (Buckroyd, 1989) to about one in 10 (Dally & Gomez, 1979; Welbourne & Purgold, 1984). Because diagnosis is predicated on the presence of amenorrhea, starving males are often perceived to be developing schizophrenia. Most clinicians accept that anorexia and other eating disorders can occur in males but that most males who develop anorexia display more pathological symptoms than women, and that their prognosis is poorer (Brumberg, 1988; Dally & Gomez, 1979). Burns and Crisp (1984) conducted an outcome study of anorexia in 27 males who were followed up 2-20 years after presentation. Several areas were identified as indicators of outcome in male anorexics: (1) in terms of weight, good outcome was associated with good psychological and social functioning, while poor outcome was associated with greater weight loss during illness, previous treatment, late onset of illness, and longer duration of the illness; (2) in terms of psychosexual development, poor outcome was associated with an absence of premorbid sexual fantasy and activity (masturbation and flirting), while good prognosis was associated with regular premorbid masturbation and the existence of a clear heterosexual precipitant; (3) in terms of the quality of the parent-child relationship, a poor relationship with mother or father during childhood was predictive of a poor outcome. Overall, they found outcome predictors and prognosis in males to compare very closely with a similar group of female anorexics (Burns & Crisp, 1984). Rosenvinge and Mouland (1990) conducted a retrospective study on the outcome and prognosis of anorexia in 41 subjects, of which two were male. They confirmed previous findings (Halmi, Goldberg, Casper, Eckert, & Davis, 1979; Morgan *et al.*, 1983) that length of illness, poor motivation for treatment, and poor familial and social relations are associated with poor outcome in both male and female anorexics. Endocrinological theories which claim ovarian dysfunction as the essential cause of anorexia are thus inherently thwarted (Brumberg, 1988). This is because not only do males develop anorexia, but its occurrence in pre- and post-menopausal women is well documented (Copeland, 1985). Kellett, Trimble, and Thorley's (1976) case report of a 54-year-old woman represents the first published description of anorexia with onset after menopause.

Several authors offer possible reasons for the low incidence of male anorexia: (1) In modern Western society, it is women, rather than men, who relentlessly pursue thinness (Crisp *et al.*, 1976; Dally & Gomez, 1979). Two studies note the female adolescent's desire to be thin, as opposed to a lack of this desire in male adolescents: Nylander's Scandinavian study (1971 cited in Crisp *et al.*, 1976) of 18-year-old boys and girls reveals this discrepancy: 50% of girls perceived themselves as too fat, whereas only 7% of boys experienced themselves this way; in another study of 1000 American High School adolescents, the same results were reported: 50% of girls thought they were too fat and were obsessed with dieting, as opposed to the boys who were on average more reality-oriented in evaluating their size (Dally & Gomez, 1979). Maine (1993) reports that dieting has almost become a rite of passage for girls, as by the age of 13, 80% of girls have attempted to lose weight compared to only 10% of boys. (2) Another reason posited for the preponderance of female eating disorders, is that during puberty a girl's body changes noticeably and in a way which cannot escape awareness (Crisp *et al.*, 1976). Growing breasts and widening hips ensue with menarche, the very centres around which women's fear of fat lies (Hill *et al.*, 1992). For adolescent boys, hips do not widen, only chests do, and this is usually welcomed as a sign of burgeoning masculinity. When males express a fat phobia, it is centred around their whole body, as opposed to women who centre on particular parts (Dally & Gomez, 1979; Fursland, 1992). (3) The psychoanalytical concept which explains the fear of fatness with pregnancy or oral pregnancy fantasies does not apply to males. Additionally, few anorexics reveal such fantasies (Bemis, 1978; Dally & Gomez, 1979). (4) Over the past century, a progressively younger onset of menarche has been noted. Crisp *et al.* (1976) posit that early puberty contributes to the development of eating disorders and that the difference between boys' and girls' ages at onset of puberty predisposes girls to eating disorders, as girls are usually two years ahead of boys in this regard. Graber, Brooks-Gunn, Paikoff, and Warren (1994) conducted a longitudinal study in 116 adolescent girls (drawn from a normal population) over an 8-year period from young adolescence to young adulthood. The aim of the study was to examine attitudes and patterns of eating behaviour, to identify factors associated with maladaptive behaviour, and to identify protective factors associated with healthy behaviours. Girls were grouped on the basis of their eating attitudes and behaviour over time, making it possible to identify correlates of group membership and the short- and long-term outcomes of these trajectories. Long-term outcomes of adolescent trajectories were assessed at the young adulthood assessment. "The chronic and the low-risk groups were differentiated by their age at menarche, with girls in the chronic group having the earliest age of menarche and girls in the low-risk group having the latest age of menarche" (Graber *et al.*, 1994, p. 828). The most significant finding of Graber *et al.* 's (1994) study was the confirmation that the development of disordered eating follows different trajectories during the adolescent decade. It was thus possible to identify

psychological and physical characteristics of girls who would have long-term eating problems, as well as other adjustment disturbances. It was found that girls on the chronic-risk trajectory had **earlier** ages at menarche. "These findings suggest that early maturation is a risk factor for not simply an episodic eating problem but also chronic problems" (Graber *et al.*, 1994, p. 830).

> Earlier maturational timing may represent the interplay between psychological development and social pressures in that early-maturing girls have had less time to develop coping strategies for dealing with the physical changes of puberty (e.g., weight gain) and experience those changes before other girls and boys, leading to a different social context for their development (Graber *et al.*, 1994, p. 831).

(5) The role of the mother is often implicated as a contributing factor in the development of eating disorders. Children usually identify with the same-sex parent. It is thus presumed easier for a boy to separate himself from his mother than it is for a girl (Dally & Gomez, 1979). The role of the father has been largely neglected in family studies (Maine, 1993; Phares & Compas, 1992; Roberts, 1996). (6) Eating disorders are emotional disorders occurring where needs and feelings are inhibited. Girls and women are more likely to inhibit their aggressive feelings than are boys and men, who tend to act out their feelings. Boys are also more likely to act out their sexual feelings (masturbation) than are girls. In fact, there exists a universal taboo on female sexuality outside marriage in Western societies, which includes pre- and extra-marital sex, lesbianism and masturbation (Fursland, 1992). (7) It is hypothesised that the incidence of male eating-disordered individuals could be more common than appears. Few people would perceive a male to be anorexic if he lost weight, whereas there is a tendency to more readily identify anorexia with females (Dally & Gomez, 1979).

Idiographic features of the male anorexic or eating-disordered person are similar to those of women patients. All the secondary signs of starvation are noted. However, Crisp and Toms (1972 cited in Dally & Gomez, 1979) report on 13, and Dally and Gomez (1979) on 12, male anorexics and their families respectively, and record an unusually high incidence of affected relatives.

> Two patients each had a sister with anorexia nervosa and one had an affected brother...the adoptive father of one of the patients...himself had chronic anorexia. Of our 12 patients, one had a younger sister who later developed anorexia...and one patient's mother had severe anorexia, lasting some years, in her late teens and early twenties (p. 149).

These observations indicate that greater attention needs to be paid to identifying etiological factors in the pathogenesis of eating disorders in men, as this will help to account for differences and similarities between the male and female eating-disordered population.

2.2.3 Increased incidence of eating disorders: A modern phenomenon

At no other time in history has there been the abundance and variety of food to choose from as in the present (Buckroyd, 1989). Not only are we confused by the hundreds of bright packages marketing the same product, we are at the same time a society obsessed with the healthy. The multimedia bellow messages of warning about carcinogens and vitamins, what to eat and what to avoid. It is almost as if we are a people in need of nutritional education in spite of the fact that as a society, we have no precedent in history for our knowledge of the human body and nutrition. Food industries survive by strategies employed to get more people to buy more food (Lawrence, 1988). In 1990 alone, Americans spent a staggering 33 billion dollars on weight loss products and classes, almost double the amount spent in 1980 (Maine, 1993). Modern society is dulled by mixed messages: Buy more, eat more. Eat less! At the same time, we are horrified by film footage of entire nations starving and dying in their thousands, as the world is suddenly unable to feed its population (Lawrence, 1988). "It is, then, only in the last thirty years or so that our society has been glutted with food as it is now, and that consequently pressure to eat has become as enormous as they are" (Buckroyd, 1989, p. 32). "Dieting is currently a national obsession" (Hill *et al.*, 1992, p. 95). Studies reveal that dieting is a normative behaviour amongst adolescent girls (Hill *et al.*, 1990). Hill *et al.* (1992) investigated dieting motivation and attitudes to body shape and weight amongst nine-year-old and 14-year-old girls and found that dieting was becoming more frequent in younger age groups. They concluded that the appearance of these behaviours and attitudes to body weight and shape by the age of nine, or earlier, "may result in a marked increase in future clinical eating problems and disorders" (p. 95). Dana and Lawrence (1988), and Buckroyd (1989) document how patterns of eating in Western society have changed in the last 50 years and illustrate how food and eating convey various messages in contemporary society, messages different to those in the past.

> It could only be in a society in which food was so immensely important that eating disorders would make sense...if you are anorexic in a society in which many people are underfed then you are not so remarkable, but to starve in a society of overfed people is something very different. This is equally true of obesity. In a society where food is in short supply, then to be fat is a signal of the power to choose to eat when that power is not general. It therefore conveys wealth or status in that society. Where we all have the opportunity to overeat, the fact that only some take it gives that gesture emotional meaning and significance. If, even more strangely, people eat and then get rid of the food, so that it cannot nourish them, they make an even more violent statement (Buckroyd, 1989, p. 33).

Lawrence (1988) states that women are the exclusive targets of the food propaganda machine. In spite of the sexual revolution which saw women's status and roles changing, women remain charged

with the role of feeding their families and ensuring their physical well-being (Dana & Lawrence, 1992; Eichenbaum & Orbach, 1982). The elevation of cooking and housewifery from once being a simple part of life is now described and taught as a scientific activity (Ehrenreich & English cited in Lawrence, 1988). Baby and child feeding is still considered a fundamentally feminine activity, as is demonstrated in that most literature refers to 'mother' on this subject (Roberts, 1996). Additionally, the successful modern woman is portrayed by the media as nearly always slim (Lawrence, 1992; Marano, 1994) and seldom are fat women used in advertisements (Lawrence, 1988; McCarthy, 1990).

Evidence that there is in fact an increase in anorexia and related eating disorders could be due to various factors: (1) Better reporting and record-keeping (Schwartz *et al.*, 1985b). Not only are there better records, but the early 1980's heralded a culture of coming "out of the closet" (Brumberg, 1988, p. 14). Molested children, homosexuals, alcohol and drug abusers, adopted people, and eating-disordered individuals who had mostly suffered alone and in silence, came forward and made their struggles public. Famous actresses and singers revealed their eating disorders, like Jane Fonda who revealed her bulimic behaviour in 1983 and Karen Carpenter, a famous singer, her anorexia (Buckroyd, 1989). Books and films have also popularised eating disorders (Levenkron, 1982). Other famous people upheld as exemplars of beauty, include Princess Diana, the Princess of Wales, who on international television (BBC, Panorama, November, 1995) spoke about the pain of being a bulimic. Public disclosures have "had the effect of imprinting bulimia and anorexia on the national consciousness" (Brumberg, 1988, p. 18). (2) Since World War Two and the baby boom, the number of adolescents has increased (Brumberg, 1988; Levenkron, 1982). (3) Increased interest in eating disorders by both professionals and the public (Dana & Lawrence, 1988; Schwartz *et al.*, 1985b). (4) Confusion between numbers in referrals and actual numbers of eating-disordered persons (Schwartz *et al.*, 1985b), as well as the lack of standardised diagnostic procedures (Brumberg, 1988). (5) It may be that a diagnosis is made which is fashionable, leading to an over-diagnosis of eating disorders (Brumberg, 1988). (6) Media attention to eating disorders may also account for the statistical increase of patients. Not only are eating disorders 'in' diseases but the copycat phenomenon which Bruch referred to as 'me too' is estimated to account for 30% of current cases. Bruch states that "the illness used to be the accomplishment of an isolated girl who felt she had found her own way to salvation. Now it is more a group reaction" (cited in Brumberg, 1988, p. 14).

Dana and Lawrence (1988) note that eating disorders exist predominantly in societies where there is an abundance of food and where thinness is prized. Levenkron (1982) makes a similar point (see citation on next page).

> That young women (and young men) are compelled to starve themselves amid plenty holds a morbid fascination for many of us. That we have become, as a society, so arrogant about our ability to feed ourselves that we have made the "ideal" feminine appearance suggestive of the very brink of starvation fascinates me. Anorexia nervosa, once extremely rare and closeted by its victim, is now exposed and possibly epidemic (p. xvi).

Clinical impressions and empirical studies support the notion that eating disorders are increasing. Schwartz *et al.* (1985b) report on a clinical psychiatrist's remark to his medical and psychiatric students in the 1950's that they were unlikely to encounter more than a few cases of anorexia in their lifetime. In the 1980's, the same psychiatrist notes that now it is almost the norm to find five or six cases at the same time in his hospital. Similar anecdotal observations are noted elsewhere; the University of Wisconsin admitted one anorexic case a year in the 1960's; in 1982, over 70 cases were admitted (Brumberg, 1988). However, proving a **real** rather than **apparent** increase, is not easy.

Leading authorities in the field of eating disorders agree that the increase is real (Garner, 1997; Wooley & Wooley, 1985). Bruch (1985) highlights that it is a common problem in high schools and universities. Theander (1970 cited in Crisp *et al.,* 1976) conducted a retrospective study covering 30 years and found significant results. The average incidence for the entire period was 2.4 cases per one million population. What is significant is that for the period 1951-1961 the annual incidence was 4.5 cases, almost double the average rate, indicating increased incidence. Kendell, Hall, Hailey, and Babigian (1973 cited in Schwartz *et al.,* 1985b) investigated three locales and found increased incidence. Crisp *et al.* (1976) investigated target populations (girls' schools) and found one case of anorexia per 200 girls in public schools, and one case per 100 girls in private schools. Most significantly, their results were in accordance with Nylander's findings that one in every 150 Scandinavian women is affected (1971 cited in Crisp *et al.,* 1976). Crisp *et al.* concluded that, "our overall impressions, like that of others, is one of increasing incidence and prevalence of the disorder" (1976, p. 553). Lacey (1979) estimated that 7% of adolescent girls in England suffered with anorexia (cited in Schwartz *et al.,* 1985b). Utilising Crisp and Nylander's figures, Schwartz *et al.* (1985b) posit that between one and 450-750 women are afflicted with anorexia or severe anorexic symptoms.

Epidemiological surveys indicate that the prevalence of obesity is both high and rising in developed countries (Wardle, 1995). Gregory, Foster, Tyler, and Wiseman (1990) document that in the United Kingdom, the proportion of obese adult men increased from 6% in 1980 to 8% in 1987, while figures for adult women increased from 8 to 12% (cited in Wardle, 1995). Millar and Stephens (1987) document higher obesity rates in North America, with figures of 12% for men and 15% for women in 1987 (cited in Wardle, 1995). Gortmaker, Dietz, Sobol, and Wehler (1987) document increasing

childhood obesity in the United States (cited in Wardle, 1995). In the United States, approximately 27% of adult women and 24% of adult men are obese (Kuczmarski, 1992 cited in Friedman & Brownell, 1995).

Another useful index for the increased prevalence of eating disorders is found in the growth of eating disorder literature (Welbourne & Purgold, 1984; Wooley & Wooley, 1985). The International Journal of Eating Disorders was founded in 1981 to document and stimulate research in eating disorders (Brumberg, 1988). The need to establish a separate journal focusing exclusively on eating disorders suggests that the problem is indeed a large one. Schwartz *et al.* (1985b) report that until 1950, there were approximately 250 individual case reports described in the literature on anorexia. In 1985, more than 5000 individual case studies had been reported, ranging in sample size from 20-350 anorexics. Graber *et al.* (1994) report that over 800 articles were published on the correlates (biological, psychological, social) of eating disorders and subclinical disrupted eating patterns **alone** in two years (1992-1993).

Brumberg (1988) reports that popular women's magazines speak of epidemics, proclaiming that there are between one hundred thousand and one million anorexic Americans, excluding other eating-disordered people. Their prognosis that between five and fifteen percent of anorexics die, has given this pathology the highest rate of fatalities amongst the psychiatric population (Levenkron, 1982). Rosenvinge and Mouland (1990) report a 10% mortality rate in their retrospective study of 41 anorexic subjects with a mean duration of 14.4 years after treatment. Latest research puts the death rate for anorexics at 11% (Halmi cited in "Breaking," 1995). Another index for increased incidence of eating disorders lies in the upsurge of specialised hospitals and clinics (Brumberg, 1988; Emmett, 1985) which deal exclusively with eating disorders, a phenomenon of the 1980-1990 years. In the 1970's, anorexics were placed in general hospitals in paediatric or adolescent units (Russell, 1981). Today there exist specialised and organised treatment centres (Brumberg, 1988). The multitude of theories and treatment modalities over the last two decades supports the idea that eating disorders are increasing. Evidence that eating disorders have increased in the modern day is massive. However, with almost no epidemiological data for past occurrence, it is difficult to make comparisons about present day prevalence. It is, however, accepted that anorexia and related eating-disordered patterns, (bulimia, obesity, compulsive eating), are increasing (Dana & Lawrence, 1988; Levenkron, 1982; Schwartz *et al.*, 1985b). Brumberg (1988) states, "the incidence of the disorder is higher today than at any other time since the discovery of the disease over a century ago" (p. 14).

2.2.4 The relation of social and cultural norms to the role of body image disturbance and body dissatisfaction in eating disorders

The pioneering observations on body image in the eating disorders were made by Hilde Bruch in the early sixties (Slade, 1994). Based on her observation that emaciated anorexics insist that they are actually fat, Bruch concluded that body image distortion (BID) was a central diagnostic feature of anorexia; a disturbance of "delusional proportions" and as such, implying that it was something fixed and thus resistant to modification. In an attempt to test Bruch's thesis that eating-disordered individuals do possess a distorted body image, Slade and Brodie (1994) analysed all previous studies which had measured the accuracy of body size estimation in the eating disorders and concluded

> (a) That individuals suffering from an eating disorder, whether anorexia or bulimia nervosa, do tend to overestimate their physical size (bodily widths); (b) that randomly selected female controls, and psychiatric groups, also overestimate their physical size, albeit to a lesser extent; and that (c) the tendency to overestimate physical size is neither unique to individuals suffering from an eating disorder, nor is it diagnostic (cited in Slade, 1994, p. 498).

In the same review, Slade and Brodie (1994 cited in Slade, 1994) outline five sets of recent observations which have led them to a reconceptualisation on the nature of BID in eating-disordered individuals. Slade (1994) lists these observations (based on studies) and the conclusions which were derived from them in the following way: (1) **Attitudinal bias versus perceptual inaccuracy** - differences in body image judgement between female anorexic and control subjects were found to be attitudinal and not perceptual in nature. (2) **Cognitive versus affective instructions** - results of studies which compared two verbal instructions on body image accuracy judgements, cognitive instruction (subjects asked to make judgements according to how they **think** they look) and affective instruction (subjects asked to make judgements according to how they **feel** they look), have been consistent. Eating disorder subjects always displayed significantly greater overestimation of body size in response to the affective instructions (compared to cognitive instructions), whereas controls were not affected by either of the instructions. (3) **Variability in accuracy judgements** - accuracy of body size estimation was analysed in four groups (normal, anorexic, bulimic, obese women). Bulimics were found to be either accurate estimators or biased toward viewing themselves as fat. However, both the obese and anorexic groups had sizeable percentages in all three categories of accuracy (accurate- under- and over-estimation). Variability within these two groups is understood in light of these individuals' history of repeated weight change. (4) **Effects of mirror confrontation on body size estimation** - size estimation accuracy judgements were measured before and after a period of self mirror gazing in four groups of women (normal control group, emotional control group, anorexic,

and bulimic groups). The former two groups were unaffected by the manipulation; both eating disorder groups showed a reduction in body size estimation after the mirror confrontation. (5) **Evidence that anorexics exhibit fluctuating body size judgements** - using the video method, body size judgements in anorexics were found to change over time. On the basis of these observations, Slade and Brodie (1994 cited in Slade, 1994) offer a conclusion different from Bruch's about BID in eating disorders:

> That individuals with eating disorders do NOT have a fixed, implacable distorted body image in the manner implied in Bruch's writings; rather, they have an UNCERTAIN, UNSTABLE and WEAK body image; such that, when confronted by enthusiastic researchers and clinicians, they err on the side of caution and overestimate their body size (p. 499).

Slade and Brodie (1994) questioned "what important factors then lead eating disorder S's, on average, to overestimate their body dimensions on size estimation tasks?" (cited in Slade, 1994, p. 499). They suggest that the most likely explanation for this bias is to be found in sociocultural theories. Sociocultural theories propose that the predominant ideal among women in Western societies is towards a "thin body cult" (McCarthy, 1990) and away from obesity and higher body weight (Sobal & Stunkard, 1989 cited in Slade, 1994). Sociocultural theories also suggest that the media reflect and reinforce this desire for thinness. Hamilton and Waller (1993) and Waller, Hamilton, and Shaw (1992) have demonstrated that eating-disordered individuals showed a significant increase in their overestimation of body size after exposure to magazine pictures of thin female models, whereas female controls were unaffected by the pictures (cited in Slade, 1994).

> Thus, social and cultural norms may have a specific and powerful effect on those individuals who go on to develop an eating disorder. We...propose the following mechanism for such an hypothetical effect: "That the cultural ideal in developed societies conveys the message that females should be thin; and that young women, particularly those with a WEAK body image, respond to this message by judging themselves to be fat and consequently exhibit a marked tendency towards overestimation of body size or BID" (Slade & Brodie, 1994 cited in Slade, 1994, p. 499).

Within Slade's (1994) model, body image is conceived as a "loose mental representation of the body" (p. 500) which is influenced by at least seven factors: (1) history of sensory input (kinaesthetic, visual and tactile) to body experience is viewed as shaping the mental representation of the body; (2) history of weight fluctuation/change has the effect of loosening body image; (3) cultural and social norms have been shown to account for the prevalence of eating disorders in women in Western societies; (4) individual attitudes to weight and shape have shown that girls are much more concerned with dieting and conforming to the thin body ideal dictate than boys of the same age; (5) cognitive and

affective variables have been shown to influence the estimation of body size; (6) individual psychopathology (such as anorexia and bulimia) clearly influences body image and is itself influenced by many of the above variables; (7) biological factors (menstruation, metabolic rate) have also been shown to influence body image.

Bruch's thesis that body image disturbance is a pathognomic feature of anorexia has led to a plethora of research endeavouring to quantify eating-disordered individuals' perceptions of their bodies in an attempt to provide empirical evidence for their assumption (Bowden, Touyz, Rodriguez, Hensley, & Beumont, 1989). Results from many of these studies have been inconsistent and it is posited that different measures of body size estimation and different experimental conditions have contributed to the variability of research findings (Bowden *et al.,* 1989). The estimation of one's own body size is one of the most commonly used operationalisations of body image (Probst, Vandereycken, Van Coppenolle, & Pieters, 1995). Bowden *et al.* (1989) compared the results of three techniques for estimating body size and found that results from different measures are not comparable. Bowden *et al.* (1989) compared anorexic and bulimic patients (experimental group) with normal control subjects who had no history of an eating disorder. Participants were required to make size judgements on the way they felt they looked (affective response) and of the way they knew they looked (cognitive response). Within the control group, there was very little difference between estimates of how subjects knew they looked and how they felt they looked. However, within the experimental group, subjects felt larger and thought that they were much bigger than they actually were. A significant difference within this group was that bulimic individuals consistently showed that they felt larger than their actual size. Bruch's assertion that BID is a causal factor in the development of anorexia was partially supported by the finding that anorexic subjects did overestimate their body size to a greater extent than the control group. However, her assertion that BID is pathognomic of anorexia is seriously challenged by three critical points based on the findings of this research: (1) all bulimic subjects in the study overestimated their body size which is evidence that BID evidences in an eating-disordered population other than anorexics; (2) normal-weight control subjects also overestimated their body size; (3) not all anorexic subjects gave cognitive overestimations, which suggests that perceptual distortion of body size is not a central feature in the diagnosis of anorexia. A significant difference was found between the experimental and control group on the affective instruction. "The body image distortion appears to be most significantly manifested in the affective rather than the perceptual domain" (Bowden *et al.,* 1989, p. 200). The finding that BID is more marked when assessed affectively suggests that a relationship exists between BID and psychological factors such as negative self-concept. In this study, body satisfaction was related to other self-report measures (such as low

self-esteem) which supports the theory that "low self-esteem and body dissatisfaction may play a role in misperception of size in eating disorders" (Bowden *et al.*, 1989, p. 200). The finding that some normal-weight controls also overestimated their size can thus be due to the fact that these individuals measure their self-worth in the same way as anorexic and bulimic individuals. The finding that not all anorexic and bulimic individuals overestimated their size can be due to the fact that, "not all eating-disordered subjects can translate their feelings of dissatisfaction into an estimate of their body size" (Bowden *et al.*, 1989, p. 200). The results of Bowden *et al.* 's study challenge and de-emphasise the widely held view that BID is a necessary prerequisite for the diagnosis of anorexia. Huon and Brown (1986) compared bulimics' estimates of body size with those of non-patient women and anorexics and found that bulimics' consistently felt fatter than the other groups (cited in Huon & Brown, 1989). Huon and Brown (1989) devised two measures to assess bulimics' dissatisfaction with their body (beyond their preoccupation with its weight). They compared 67 bulimic women with 67 non-patient women for overall body dissatisfaction as well as for dissatisfaction with specific body parts. Results indicated that bulimics' showed a greater overall dislike for their bodies as well as disliked more than 50% of its specified parts. The assumption that all bulimic individuals' concerns about their body are directly related to their weight (Cooper & Taylor, 1987; Cooper & Fairburn, 1987 cited in Huon & Brown, 1989) is challenged by the findings of this research to be an over-simplification. Instead, Huon and Brown (1989) state that, "it is unlikely that our subjects' dissatisfaction was simply concerned with the fatness of their body, since they also disliked their shoulders, hands, neck, face and feet" (p. 284).

Research has shown that dissatisfaction with one's body is a motivating factor for dieting (Williamson *et al.*, 1995). Gleaves and Eberenz (1995) conducted a study to validate a multidimensional model of the psychopathology of bulimia where it was proposed that body dissatisfaction represents a distinct dimension of the disorder, separate from restrictive behaviours. Results of the study confirmed the importance of body dissatisfaction as a separate and major psychopathological dimension of bulimia. Two significant correlations among the latent dimensions of the model tested were found: body dissatisfaction correlated significantly with restricting behaviours and with affective disturbance. However, both correlations were negative. Regarding restricting behaviours, this result was unexpected (a positive correlation was expected) because it is hypothesised that dieting causes binging (Polivy & Herman, 1989). Gleaves and Eberenz' data suggest "that current levels of dieting are not **maintaining** factors for bulimia" which is consistent with the position that "disordered eating results from a history of dieting rather than a current state of dietary or cognitive restraint" (1995, p. 188). The meaning of the negative correlation with affective disturbance is less clear. It may be that

affective symptoms of disturbance are sequelae of bulimic symptomatology (Garner, Olmsted, Davis, Rockert, Goldbloom, & Eagle, 1990 cited in Gleaves & Eberenz, 1995), or that bulimia may be secondary to a primary body image disturbance (Rosen, 1992; Thompson, 1992 cited in Gleaves & Eberenz, 1995). Findings validate a multidimensional model of bulimia and highlight the significance of body dissatisfaction as an underlying dimension of the disorder. The implication of this finding is that "it would be essential to treat the body image disturbance before permanent changes in eating behaviour could occur" (Gleaves & Eberenz, 1995, p. 188).

Probst *et al.* (1995) have devised a new method for studying eating-disordered individuals' body size estimation, the video distortion method on a life-size screen. They tested this method in female anorexic, bulimic and normal women, and found that it yielded very high reliability scores. Using a video camera and projector, the subjects' full frontal image with correct proportions appears on a life-size screen. The subject is then asked to turn a button which narrows or widens the image on the screen. Subjects are asked to adjust their image in response to three instructions (cognitive response - what subject thinks she looks like; affective response - what subject feels she looks like; and optative response - what subject wants to look like). Subjects are also asked to estimate the size of a neutral object on the screen (a circle) so that the existence of a perception disorder may be ruled out; this is referred to as the control response. Results of the three groups on the different tasks were compared and yielded data in support of Bowden *et al.* 's (1989), Huon and Brown's (1986), and Slade's (1994) findings. There were no significant differences between groups for the control task and cognitive task. However, significant differences were noted between groups for the affective and optative tasks.

> Bulimics differed significantly from anorectic patients and controls on the optative and affective response. Bulimic patients gave evidence of a tendency to overestimate their real body width, and desired a rather slim body. Their higher affective response means that they 'felt' their body as being thicker than did anorectic patients and controls. For anorectics and controls there was no difference between their affective responses, or between their cognitive responses....Results for the affective image indicate that bulimic patients feel themselves markedly 'thicker' than they are in reality...For the controls there is no difference between feeling and thinking how wide their body is. Some anorectics feel themselves as being too thin, others too thick, and still others seem to experience their body widths as they are in reality. Hence, we should refute the often made statement that anorectic patients overestimate their body image (Probst *et al.*, 1995, pp. 987, 989).

In many Western cultures obesity is a stigmatised condition, particularly among women who "are seen as falling short of prevailing beauty ideas as well as being personally responsible for their unattractiveness" (Wardle, 1995, p. 113). Body image distortion has been observed in obese

individuals (Friedman & Brownell, 1995; Slade, 1994). As in anorexic individuals who have a history of repeated weight change, obese individuals with a history of substantial weight and bodily change have been shown to display distorted and inaccurate body perception judgements (Collins, Beumont, Touyz, Krass, Thompson, & Philips, 1987 cited in Slade, 1994; Friedman & Brownell, 1995; Gardner & Morrell, 1991 cited in Slade, 1994; Wardle, 1995). Overall, research of body dissatisfaction and BID suggests that these phenomena are neither diagnostic, nor unique to particular eating disorders, (nor to the eating-disordered population in general). In fact, findings indicate that on average, bulimic individuals have a much more severely distorted body image, as well as display the most dissatisfaction with their bodies, than both anorexic and obese individuals. Slade's (1994) model of body image is an excellent contribution towards the development of a comprehensive theory of culture. Not only does his conceptualisation indicate the interface between the cultural and the personal, the model is also able to explain why not all women living under the same cultural conditions have eating disorders.

2.2.5 Feminist psychoanalytic theories on the etiology of eating disorders

The feminist psychoanalytic approach developed as a reaction to the anti-Freud bias in the early stages of the Women's Movement (Eichenbaum & Orbach, 1982). Central to feminist psychology is the tenet that women are oppressed, that traditional psychology is gender biased in favour of men, and that individual psyches embody a collection of patriarchal social relations (Eichenbaum & Orbach, 1982; Orbach, 1985a). Orbach (1985a) elaborates on two aspects. The first aspect is that throughout history, the female body has been an object of pleasure for men. What is considered fashionable and desirable over time by different cultures changes, and women are expected to adapt their form and shape to cultural norms so that they may be regarded acceptable and successful (Brumberg, 1988). The imperative to appear in a certain way, however much one suffers, is poignantly described by Mitchell in her novel Gone with the Wind.

> "Put down that tray and come lace me tighter", said Scarlett irritably. "And I'll try to eat a little afterwards. If I ate now I couldn't lace tight enough"...."Hole onter sumpin' and suck in yo' breaf", Mammy commanded. Scarlett obeyed, bracing herself and catching firm hold of one of the bedposts. Mammy pulled and jerked vigorously and, as the tiny circumference of whalebone girdled waist grew smaller, a proud, fond look came into her eyes...."Now you come eat, honey, but doan eat too fas'. No use havin' it come right back up agin". Scarlett obediently sat down before the tray, wondering if she would be able to get any food into her stomach and still have room to breathe (cited in Buckroyd, 1989, p. 54).

Other writers describe the cultural imperative for thin women (Boskind-White, 1985; Chernin, 1993;

Lawrence, 1988; Pennycook, 1992; Selby, 1992; Selvini-Palazzoli, 1985; Wooley & Wooley, 1985). Fursland puts this cogently: "Men act and women appear. Men look at women. Women watch themselves being looked at. This determines not only most relations between men and women but also the relation of women to themselves" (1992, p. 16). The second aspect Orbach elaborates on, is that a woman's identity and well-being is derived largely from assessments she and others make of her ability to nurture and feed others (Eichenbaum & Orbach, 1982; Orbach, 1985a,b). These social relations, (women's relationship with their bodies and the meaning of food and eating), are arenas of ambiguity, mixed messages, and conflict for most women (Eichenbaum & Orbach, 1982). Regarding the imperative to adapt to cultural norms, Orbach states that women have no choice but to separate themselves from their bodies. "Women tend to live outside their bodies, judging them, evaluating them, looking at themselves to see whether they can mirror the received images of femininity" (1985a, p. 131).

> In...1966, a 17-year old 5'6" 97-pound nymphet from England, Lesley Hornby Armstrong, nicknamed Twiggy, burst upon the American fashion scene and draped her emaciated 31" -22" -32" skeleton over the pages of Seventeen and Vogue. Created in part by slick opportunistic promotion, Twiggy became an overnight sensation. Thousands of young American women began to pattern their clothes, makeup, hairstyle...body after her (Boskind-White, 1985, p. 115).

Although preoccupation with the body is a publicly sanctioned activity, the anguish which so many women experience to their bodies remains a private domain (Boskind-White, 1985). Orbach (1985a) states that regarding their role as nurturers and feeders of others, women encounter further conflict. Whether a woman assumes the role of nurturer and the responsibility of ensuring the health of others or not, a woman is still ridden with guilt about whether she is doing a good job or not, and if she has chosen not to identify herself with this role, she is still left with guilt and/or a sense of loss of an aspect of herself. Orbach identifies another arena of conflict and that is, that a simultaneous awareness exists within women that feeding others and feeding themseves is not the same. The same food she prepares for others is considered dangerous for her own consumption.

> They must restrain their desires for the cakes they bake for others and satisfy themselves with a water-packed tuna salad with all the trimmings. Diet, deprive, deny is the message women receive. Even more sinister, they must pretend that cottage cheese and melon is as pleasurable as a grilled cheese sandwich (Orbach, 1985a, p. 131).

The ambiguous and contradictory role of the modern woman is well documented (Chernin, 1993; Lawrence, 1988; Maine, 1993; Pennycook, 1992; Selvini-Palazzoli, 1985). Feminist contributions provide answers to two questions which biomedical and many other theories of eating disorders fail

to do. In examining women's roles within contemporary society, they account for two distinguishing features in the etiology of eating disorders: (1) why eating disorders preponderate in women, and (2) why the body is the site of symptomatology.

"To men a man is but a mind. Who cares what face he carries? Or what form he wears? But woman's body **is** the woman" (Bierce cited in Wooley & Wooley, 1985, p. 391). In light of the social relations and cultural imperatives which govern contemporary society, it is not a strange phenomenon that so many women become eating-disordered. Feminists posit that an eating disorder is an individual's response, a solution to a crisis or intolerable social position (Chernin, 1993; Cooper, 1992; Dana, 1992; Dana & Lawrence, 1992; Epstein, 1992; Lawrence, 1988; Orbach, 1985a; Selby, 1992). Eating-disordered individuals view their behaviour as a solution, at best, their only solution. The enormous secrecy eating-disordered individuals display about their eating behaviour, verifies that the traditional notion of these people as manipulative or wilful, is incorrect. "It is rather, the woman's attempt to have something for herself, something she can feel good about and hold onto" (Orbach, 1985a, p. 132). Most women, especially those whose solution is not visible to others, will only seek treatment after years of private anguish. This raises another point which feminist psychology debates: Why does a woman seek to find control? and control over what? The answer is provided by historical and contemporary reflections on social relations: That most women feel that from birth onwards, their lives have been shaped by others (Orbach, 1985a).

> The anorexic has responded to the desires of others and tried to fit herself to their projections. She is not able to live this way anymore. She'll "do her own thing" at any cost. She turns to her body which becomes the arena for struggle. Treating it as an enemy, she wrestles with it, trying to dominate it by denying its needs. She puts all of her energy into trying to conquer her body, control it, and have it submit to her will. She will be active in relation to it. Paradoxically, and tragically, in this struggle with her body, she perpetuates the very denial of self that she is fighting against. But in the process she gains a measure of self-respect and peace for she has shown herself and the world that she can be more in charge of her own life than anyone else (Orbach, 1985a, p. 133).

Bulimia, obesity, and compulsive eating, are noted to perform the same function; the desperate desire to assert self-control (Dana, 1992; Dana & Lawrence, 1992; Epstein, 1992; Selby, 1992). Orbach (cited in Buckroyd, 1989) identifies two purposes in the behaviour of the compulsive eater: (1) power and the defiance of the impotent image of women by society, primarily by the mass media, and (2) anger. Women are traditionally depicted as emotionally feeble, choosing to cry rather than express their anger. Epstein (1992) postulates that compulsive eating and fat are masks for unexpressed anger, anger which is 'delegitimised' for women. On compulsive eaters, Dana (1992, p. 56) states that, "as she is cut off from the part of herself that knows what she wants or needs or desires, she

experiences a lack of something, which she desperately tries to satisfy by reaching out for food". On bulimia, Dana states:

> The bulimic woman usually sees herself as having two sides or aspects. One is competent and successful in the world, organised and "good". Underneath this, she experiences herself as messy, bad, unacceptable - the part of her which is encapsulated in her bulimia...the hidden part is a terrible secret she must not reveal to others. This is represented by the pattern of eating and vomiting. This pattern of eating is a reflection of deeper feelings of having an internal part that is "messy, unacceptable and bad" (1992, p. 56).

The eating-disordered individual's body is viewed as symbolically linked to her emotional needs (Bloom, 1992; Buckroyd, 1989; Carlson, 1990; Chernin, 1993; Dana & Lawrence, 1992). Put simply, control over the body is an attempt to control emotional neediness, "that dreaded cost of femininity" (Orbach, 1985a, p. 133). Differences between individuals are viewed as variations on this theme. Anorexics and bulimics are noted for their rigorous exercise rituals (attempts to deflect from their emotional life), as it is these very conflicts and needs which they experience as intolerable and as attacks on the self. Compulsive eaters and obese individuals are noted for their low level of motoric activity (Orbach, 1985a). The need to control emotional life is a distinguishing feature of women's psychology (Boskind-White, 1985; Buckroyd, 1989; Carlson, 1990; Chernin, 1993; Dana, 1992; Dana & Lawrence, 1992; Epstein, 1992; Selby, 1992; Wooley & Wooley, 1985). Chernin (1993) perceives women's control over their emotional lives as an adaptation to the culture we live in and that because we are a culture bent on separating and dividing itself, it should come as no surprise that we are separated from our bodies too; preoccupation with the body and eating disorders thus need to be viewed in this light.

> Culture is seriously divided within itself, splitting itself off from nature, dividing the mind from the body, dividing thought from feeling, dividing one race against another, dividing the supposed nature of women from the supposed nature of man. As part of this self-division we have come to believe that only those things that concern the soul and the spirit, the mind and its creations, are worthy of serious regard. And yet, when we probe beneath the surface of our obsession with weight, we will find a woman obsessed with her body is also obsessed with the limitations of her emotional life. Through her concern with her body she is expressing a serious concern about the state of her soul (Chernin, 1993, pp. 2-3).

The mother-daughter relationship is identified as the transmitter of certain attitudes pertinent to little girls and women: (1) little girls absorb very intensely their mother's message that their lives must be shaped to meet the needs of others (Carlson, 1990); (2) the developing woman must not only attend to other's needs, she also has to learn to negotiate her own needs in an environment which precludes female expression and autonomy. In essence, little girls grow up understanding the dangers and

impossibility of living a life for one's self (Orbach, 1985a). Authors have written extensively on the mother-daughter relationship (Carlson, 1990; Chernin, 1993; Dana, 1992; Dana & Lawrence, 1992; Friday, 1988; Maine, 1993; Selvini-Palazzoli, 1985). Central to women's psychology is the shielding from view their own dependency needs and converting them into caring for others (Boskind-White, 1985; Buckroyd, 1989; Rizzuto, 1985; Selby, 1992; Wooley & Wooley, 1985). Orbach (1985a) cites a case example:

> Roberta, tells me of knowing she always had to wake up with a smile. It was imperative that she fulfil her parents' projections. Any expression of pain was illegitimate and terrifying to the family. Roberta was denied the right to develop a capacity to deal with distress, conflict, or even ordinary unhappiness. Uncomfortable feelings were to be hidden. They were felt to be obscene, vulgar and overwhelming. They must not be exposed. In denying herself food and...developing an ever increasing series of daily tasks to be accomplished, Roberta is attempting to suppress her needy side, assuaging the guilt that these aspects of self engender while policing her emotional life. As she brutally denies herself, she is reassured and temporarily soothed by her success at keeping her inner experience from view (p. 134).

Feminist writings have turned traditional thinking on eating disorders upside down. Feminists suggest that perhaps women do **not** want to be thin and that compulsive eating and obesity is in some way intentional and that fat is serving some purpose; that it is a way of protesting against the objectifying of women's bodies and their abuse; and a protest against the powerless roles relegated to women in society (Buckroyd, 1989; Eichenbaum & Orbach, 1982; Epstein, 1992; Selby, 1992). Feminists embroiled in understanding and treating eating-disordered individuals purport that an individual needs to be made conscious of the messages their eating disorders are giving, and that women need to be taught a new way of treating themselves. "She must learn again to speak/starting with I/starting with We/starting as an infant does/with her own true hunger/and pleasure/and rage" (Piercy cited in Chernin, 1993, p. 45).

Swartz (1985) states that because eating disorders preponderate in women, feminist models of understanding seem particularly suited. She identifies Boskind-Lodahl and Orbach's contributions as two of the more popular and well known feminist theories and suggests that there are fundamental theoretical and methodological flaws inherent in their views. In spite of some differences in their theories, (Orbach believes anorexia and related eating disorders involve sexual role conflict, whereas Boskind-Lodahl does not), both writers agree that anorexia is a triumph of culture over nature. Swartz (1985) identifies this assumption as the most fundamental of the Orbach/Boskind-Lodahl hypothesis and the distinction between concepts of nature and culture as the most problematic. It is suggested that one of the implications of Orbach and Boskind-Lodahl's hypothesis is that it, to some extent, normalises anorexic behaviour and that this approach may be seen as legitimating symptoms.

> Orbach and Boskind-Lodahl's agreement....attaches [them] to what Ingleby (1981) has called the 'normalising' approach of the Laingian movement. This approach is typified by an attempt to make mental disorder understandable within a context, and to establish in what way madness can be seen to be a normal response to an abnormal situation (Swartz, 1985, p. 431).

Swartz (1985) states that even if one argues that socially accepted "normality" and "illness" are on a continuum, a central question remains: "Why do these people and not others become 'ill'?" (p. 432). Given the fact that both Orbach and Boskind-Lodahl reinforce the view that symptoms are psychologically natural, (by constantly emphasising the connection between their patients and themselves), a kind of camaradie is created between theorists and patients which goes a long way in destigmatising mental illness. This "in itself naturalises...what can be a life-threatening condition by breaking down barriers around the condition and putting it in a 'reasonable' context" (Swartz, 1985, p. 432). Given the fact that they try to destigmatise eating disorders and the fact that their work is presented in a conversational style which is aimed at attracting a large market, Swartz states that it is not unreasonable to infer that their approach may actually **contribute** to the view that anorexia (or related symptoms) is a **desirable** way for women to express their distress. Swartz (1985) presents three reasons in support of her statement: (1) That if it is the case that anorexia is simply an expression of obvious social contradictions, then Orbach and Boskind-Lodahl's work may be viewed as an implicit call for individuals to express their recognition of these contradictions. "One of the ways this can be done is through the development of anorectic behaviour. It is certainly the case that the anorectic image is very powerful and could easily serve as a strong platform from which some women could express discontent and anger" (p. 432). (2) It is documented that some women who enter treatment for other reasons (depression, personality problems) develop anorexic symptoms partly as a result of the influences (of anorexic patients) in that environment. One of the reasons posited for this is the amount of attention programmes for anorexics offer, as opposed to other programmes. It is thus possible that in other contexts, other rewards could encourage anorexic symptoms. (3) Many women (some overweight, some not) express the wish to be "just a little bit more anorectic" (p. 432) and that if points (1) and (2) are the case, then it becomes quite possible that anorexic symptoms may be acceptable means to express already existing difficulties.

In highlighting both the inadequacies and usefulness of Orbach and Boskind-Lodahl's theory, Swartz returns to some basic questions. "What are the requirements of a feminist theory of anorexia nervosa?" which she broadens into, "what are the requirements for a feminist theory of anything?" which she broadens still further into, "what are the requirements for a theory that attempts to locate any condition within a social context?" (1985, pp. 433-434). In examining how medical anthropologists have defined culture-bound syndromes, she identifies three criteria which feminist

analyses of eating disorders must incorporate:

> That we need to understand the culture in order to understand the disorder, and that we need to establish how the disorder reflects meanings and norms of the culture.... [Additionally] it is not sufficient for feminist writers to reinterpret anorectic behaviour as a response to oppression without indicating how this behaviour in fact **maintains** that oppression (Swartz, 1985, pp. 434-435).

In other words, feminist theory needs to address the development of a theory of culture which is able to indicate the interface between the personal and the social. However, in the absence of a well articulated theory of culture, (which would explain why living under the same social conditions only some women develop eating disorders whereas others do not), Swartz remarks that it is premature to conclude that thin is indeed a feminist issue. Instead, she concludes by stating

> That the real challenge for feminists is not to establish a sense of support for anorectics (which is useful) or to legitimise anorectic symptoms (which is not) but to indicate what role the feminist stand has in the understanding of the structures underlying **all** psychological distress (1985, p. 436).

2.3 Psychological perspective

Psychological etiological models of eating disorders can be subsumed into three broad categories: (1) psychoanalytic theories; (2) family systems theory; (3) social psychology. These frameworks offer diverse and often conflicting perspectives. Social psychological theories have been discussed under the sociocultural perspective; family systems theory is used by Guidano as an adjunct to his model of human development and psychopathology, and is addressed simultaneously in section 2.5.

2.3.1 Psychoanalytic theories

Psychoanalysis offers three divergent frameworks for the understanding of eating disorders: (1) drive-conflict theory; (2) object relations theory; and (3) self-psychology.

2.3.1.1 Drive-conflict theory

The earliest theories of eating disorders developed within the Freudian context. Freud's final model of the mind (1923/1961 cited in Goodsitt, 1985) was made up of three structures (id, ego, superego). Pathological symptoms were viewed as a result of conflict between these structures. Such a model

is predicated on the existence of well developed structures so that there may be a predilection for conflict between them. The first etiological theories about anorexia nervosa were of the drive-conflict model. Psychoanalysts explained the physical and psychological symptoms of anorexia in terms of oral ambivalence and it was proposed that anorexia was a defence against sexual fantasies of oral impregnation (Freud, 1958; Szyrynski, 1973; Waller, Kaufman, & Deutsch, 1940;1964 cited in Bemis, 1978). Grimshaw (1959), Margolis and Jernberg (1960), Masserman (1941), and Tustin (1958), postulated the existence of ambivalent oral impregnation fantasies or oral sadistic fantasies. Berlin, Boatman, Scheimo, and Szurek (1951), and Masserman (1941) believed that self-starvation was a defence against ambivalent cannibalistic and oral sadistic fantasies. Masserman (1941) presents a case of anorexia nervosa and neurotic vomiting in a 35-year-old woman who had presented herself for psychoanalysis. Using psychoanalytic concepts, Masserman (1941) traced his patient's long history of food refusal and psychogenic vomiting to oral ambivalence and cannibalistic guilt.

> That this mechanism was operative in my patient was indicated by her prolonged refusal of food and frequent vomiting during the several months of depression after the death of her father. It is significant, however, that mere anorexia was apparently insufficient to expiate the guilt attached to her previous aggressive incorporative fantasies towards the lost father, so that vomiting as a symbolic restitution was also economically necessary (p. 237).

Goodsitt (1985) and Geist (1985) indicate that such conflicts are confined to drive impulses and fantasy and that consequent symptom formation would be of the sexual and/or social inhibition type. Anorexic symptomatology of body image distortion, repudiation of emaciation, and the alienation from inner feelings and physical perceptions, cannot be explained sufficiently by such a conceptualisation (Goodsitt, 1985). The profound disturbances noted in the mental structures of anorexics are thus limited by a drive-conflict model. Bemis (1978) states that classic psychoanalytic interpretations of anorexia may be criticised on three levels: (1) theory formulation - conclusions are based on the analysis of a single patient without the opportunity for comparison and control; (2) methodology - significant evidence of oral impregnation fears have not been found in larger patient samples; it has also been noted that similar fantasies are reported by many adolescent girls; (3) therapeutic efficacy - "psychoanalytic therapy has proven singularly ineffectual in altering anorexic behaviour" (Bemis, 1978, p. 600).

2.3.1.2 Object relations theory

Object relations theorists attempt to ameliorate deficiencies of the drive-conflict theories by utilising various developmental theories. Mahler's theory of human development documents the stages of

object relations. She posits that an infant moves from a stage of infantile autism to symbiosis, and then to separation-individuation (Mahler, Pine, & Bergman, 1975). Goodsitt (1985) notes how Selvini-Palazzoli utilises Mahlerian concepts in conjunction with drive-conflict theory in her explanation of anorexia. Selvini-Palazzoli's thesis (1985) is that the anorexic displays unresolved conflicts of the oral-incorporative stage which thwarts separation-individuation. She views eating-disordered behaviour as the result of distortions in the images of body, self, and other. She states that the anorexic fantasises an oral incorporation of a maternal, bad, and overcontrolling object, (the maternal introject), which is then equated with the anorexic's body. In this way, the anorexic experiences the identity of her body **as** her mother. The adolescent's self-starvation is thus viewed as an attempt to halt the feminisation of her body and thus to minimise the ambivalent and confused identification with the mother (Selvini-Palazzoli, 1985).

Goodsitt (1985) outlines the limitations implicit in such conceptualisations. He notes that in spite of its theoretical sense, in reality, few such cases have been described. Dally and Gomez (1979), Geist (1985), and Bruch (1985) also note the lack of such clinical descriptions. Goodsitt (1985) states that anorexics seldom confuse their bodies with their mothers. Instead, anorexia is viewed as an attempt to halt feminisation of the body and an attempt to minimalise identification with mother. The oral fantasy theory is thus viewed as limited and without basis. Multiple ways exist which anorexics employ in perceiving their bodies. It has been noted that many eating-disordered individuals see their bodies as "the battleground of the separation-individuation war" (Goodsitt, 1985, p. 58), where who owns the body is a contentious issue. However, to dogmatically state that the anorexic perceives her body as a bad maternal introject through an oral incorporative fantasy, is both narrow-minded and superficial. Goodsitt states that anorexics perceive their body

> To be the last vestiges of their infantile, archaic grandiosity. Grandiose individuals need to be the centre of all things around which the world revolves, to feel they are in control of everything, and to experience themselves as perfect. They focus all of these needs on their bodies. Now their bodies must be perfect and unchanging, and they must be in total and absolute control of them. The changes of puberty in a child, then, threaten this grandiosity and thereby threaten the adolescent's fragile psychic equilibrium. None of this has anything to do with oral incorporative fantasies (1985, p. 58).

Masterson (1978 cited in Goodsitt, 1985) adds Mahlerian concepts to the libido theory of the drive-conflict model. His theory rests on the premise that anorexia is a result of thwarted separation-individuation attempts and that distorted self and object representations are the cause of this disorder. Masterson proposes that various introjects are responsible for the simultaneous existence of two opposing self-representations: "There is a hostile, rejecting, withdrawing, maternal introject in

response to the anorexic's attempt at separation. There is a supportive, rewarding, maternal introject in response to the anorexic's regressive, clinging behaviour....Two...self representations...are inadequate, bad, guilty, and empty, and passive, compliant, and good" (cited in Goodsitt, 1985, p. 59). A striking limitation of Masterson's theory is the frequent use of object relations language which tends to confuse, rather than simplify his explanation (Goodsitt, 1985). Sours (1980 cited in Goodsitt, 1985) stresses ego and self deficits and posits a failure to develop self and other object constancy. In spite of the deficits he proposes to exist in anorexic individuals, his theoretical treatment of them is no different than his treatment of neurotic individuals who do **not** display structural deficits (Goodsitt, 1985). Levenkron (1982; 1985) on the other hand, gives theoretical and practical recognition to identified self and ego deficits, visible in his development of a nurturant-authoritative therapy with eating-disordered individuals.

Sugarman and Jaffe (1987) are object relations theorists who have worked extensively with bulimic individuals. An ego deficit is proposed to be the predisposing factor in individuals who develop bulimia. The central tenet of their thesis about bulimics is that they lack the ego function of object constancy. Sugarman and Jaffe (1987) trace the development of psychological separateness and highlight four stages in which the separation-individuation process may be arrested. Self-and object representations change according to developmental stages. (The more that self and object are able to at the same time differentiate and integrate, so psychological boundaries separating self from object are able to develop). Inability to form adequate self-other psychological boundaries are thus viewed as the foundation for psychopathology. Sugarman and Jaffe state:

> Severe psychopathology may be understood as a failure to develop or to maintain self-and object representations. Clinical experience with such patients easily demonstrates that such individuals have poorly differentiated and integrated representations of themselves....The failure of individuals with severe psychopathology to internalise key regulatory functions at the appropriate developmental stages leaves such patients continually dependent on others to provide such regulation...they remain psychologically unseparated from caretakers (1987, p. 424).

Bulimic symptomatology is viewed as an inappropriate attempt toward internalising regulatory functions which should have been internalised when individuals were much younger. A developmental trauma is posited to occur in the transition from the differentiation to the practising subphase. Trauma could be attributed to various causes (family problems, violation of transactional boundaries, parental under- or over-involvement). Consequently, inhibition of the normal path for autonomy and other independent activities characteristic of the practising subphase occur.

The bulimic-prone individual thus suppresses her natural tendencies towards growth and independence (Sugarman & Jaffe, 1987).

> The caretaker's inability to tolerate or promote her child's separateness prevents the child from developing a firm boundary between self and object representations. Such a developmental arrest leaves the child fixated at a level of sensory-motor self and object representation (Blatt cited in Sugarman & Jaffe, 1987, p. 437).

This fixation is reflected in the bulimic's inability to evoke a representation of the mother in her absence and instead experiences the separation from mother as a tantamount loss. Consequently, "through the use of her body, the bulimic attempts to maintain a sense of psychological separateness and individuation....Gorging and vomiting become actions that promote self/other differentiation" (Sugarman & Kurash, 1982 cited in Sugarman & Jaffe, 1987, p. 441).

> When separated from the symbiotic mother, they are unable automatically to evoke a mental representation of the mother and become soothed. Since eating is a sensorimotor activity associated with the childhood feeding experience with the mother, binging becomes a means of evoking the sensorimotor object representation of the symbiosis (Goodsitt, 1985, p. 61).

Clinical manifestations of a tenuous self/other boundary are described by Sugarman and Jaffe (1987) and Geist (1985). Sugarman and Jaffe (1987) identify ego deficits pertinent to bulimics: (1) a distorted sense of reality - while engaged in a binge/purge cycle, bulimics often report feeling detached from others and this feeling of detachment is temporarily enjoyed as it allows them to feel (temporarily) separate and superior from others (because at that moment their own experience is far more important than anyone else's). Time is often distorted, as the bulimic's frantic behaviour makes the present all-important and for that time, past and future are removed; (2) sense of judgement - is often distorted, revealed by the life-threatening behaviours these individuals engage in; (3) difficulties in regulating sexual and angry feelings - displayed by passive-aggressive behaviour; (4) body ego distortion.

Because most object relationists focus on deviant self-and object representations, early structuralisation processes and conflict, explications are limited by the inability to address or account for structural deficits (Goodsitt, 1985). Sugarman and Jaffe's (1987) contribution is a step in addressing these limitations and a step toward expanding existing models (which have mostly focused on anorexia), to include bulimia. As an explanatory model though, it lacks the explicitness and clarity required for a comprehensive understanding of human development and pathology. No conceptual framework is offered explaining processes such as cognition and memory.

2.3.1.3 Self psychology theories

Goodsitt (1985) asserts that the difficulties anorexics experience in relation to their bodies rests on the fact that the body has not been integrated into a self-organisation. The core of the self is noted to be a body-self and the nucleus of the self, bodily sensations (Goodsitt, 1985). Freud (1923/1961) stated, "the ego is first and foremost a bodily ego" (cited in Goodsitt, 1985, p. 59). Kohut (1981) points out that when the cohesive self becomes unstable, bodily symptoms result. Geist (1985) and Goodsitt (1985) state that when cohesion and integrity of the self is threatened, the anorexic experiences the threat directly as a loss over body control. To obstruct further feared disintegration the anorexic "hypercathects, stimulates, and obsessively focuses on the body....The anorexic's constant activity and exercise are her attempts to feel herself within her body. They are attempts at feeling whole and cohesive" (Goodsitt, 1985, p. 59). To prevent psychic decompensation, the self psychologist posits that certain internal mental functions and structures need to exist, predicated on the ability to tolerate separation (Goodsitt, 1985; Mahler *et al.*, 1975). It is postulated that within the anorexic-prone individual's psyche, certain deficits exist in the self, primarily regulatory functions (Geist, 1985). "If the internalisation process goes awry, the individual cannot separate successfully, because he or she cannot provide for his or her own sense of well-being, security, soothing, vitalisation, cohesion, tension regulation, and self-esteem regulation" (Goodsitt, 1985, p. 61).

Acclaimed psychoanalysts in the psychology of the self provide the conceptual ground on which self psychology theories are based. Their observations of infant behaviour and mother-child interactions provide the developmental input of these theories. Kohut's (1981) psychoanalytic study of the child highlights the importance of 'mirroring' and confirming a child's sense of grandiosity, as well as allowing for the idealisation of parental 'selfobjects' if a child is to develop normal self and object relations. Winnicott (1988; 1990) notes that an inadequate or disrupted 'holding environment' leads to inadequate self/other boundaries and representations. If the internalisation process is aborted by a lack of appropriate 'selfobject' responsiveness, a disorder of the self may result. Anorexia is viewed as a disorder of the self, as without an external 'selfobject', "the individual is likely to feel helpless, ineffective, overwhelmed, unworthy, unreal, incomplete, or empty" (Goodsitt, 1985, p. 62). Bruch (1985), Geist (1985), and Guidano and Liotti (1983), describe anorexics in a similar way. Goodsitt (1985) and Geist (1985) note that the reason anorexics feel intruded upon and exploited is because of the lack of self-regulatory functions, making them overreliant on external selfobjects. Consequently, the anorexic feels out of control, ineffective and personally inadequate, which she deflects from self-awareness through constant overactivity and rigorous exercise.

> She finds in being...anorexic...some contrived meaning to her existence. By focusing on food and weight, by turning off her need of others and turning inward to herself, by filling up her life with rituals that help her feel a sense of predictability and control, she narrows down her world to something she feels she can manage. She attempts to negate her reliance on the needed selfobjects that she unconsciously perceives have failed her. By devoting herself to the care, feeding, and well-being of others, she becomes a selfobject for them and thereby attempts to negate her own selfobject needs. By starving herself, she feels strengthened and temporarily superior to others. This is the antidote to her feelings of weakness and inadequacy related to her true need of selfobjects (Goodsitt, 1985, p. 62).

('Selfobject' is merely Kohut's term for the same concept used interchangeably and referred to as 'transitional object' by Winnicott (1953; 1988), and 'symbiotic object' by Mahler (1975). A selfobject is "cognitively perceived as external to the self, but is experienced as a part of the self" (Goodsitt, 1985, p. 61). Treatment modalities of self psychology are informed by the structural deficits of eating-disordered individuals, and seek to fill and heal them (Levenkron, 1982; 1985). In essence, self psychologists view the therapeutic process as assisting in the psychological birth of their patients, which up to that point, has been thwarted.

2.3.2 The early feeding experience

Many theorists have utilised and attempted to integrate the early feeding experience within their etiological theories to eating disorders. A range of theoretical diversity exists: (1) drive-conflict models such as Selvini-Palazzoli's (1985) concentrate on one aspect, how cues for comfort are misinterpreted for hunger signals by mother, hence the physical-psychological mechanism for hunger is distorted or retarded; (2) feminist psychoanalytic theorists such as Eichenbaum and Orbach (1982), Chernin (1993), and Lawrence (1988; 1992) posit that sociocultural values influence the early feeding relationship of little girls as opposed to little boys and that the relationship between food and femininity cannot be overstated. Common to these theories is that selective attention is focused on the power of mother (caregiver) to influence the psychologies of their infants. "Current child-rearing arrangements, in which women mother...ensure that the power of the mother is deeply embedded in our psychologies" (Orbach, 1985b).

Expanding on psychoanalytic writings of infantile emotional development, Winnicott (1953) pursues the theme of transitional objects and transitional phenomena. He highlights the powerful influence of mother in the infant's journey from purely subjective reality to objective reality. In tracing an infant's steps from using objects that are not part of the infant's body, (but not yet recognised as belonging to external reality either), the transitional object, (or the first not-me possession, which may

or may not be the mother), is identified as central to this process.

> There is no possibility whatever for an infant to proceed from the pleasure-principle to the reality principle or towards and beyond primary identification...unless there is a good enough mother....The good enough mother....starts off with an almost complete adaptation to her infant's needs, and as time proceeds she adapts less and less completely, gradually, according to the infant's growing ability to deal with her failure....**If all goes well** the infant can actually come to gain from the experience of frustration, since incomplete adaptation to need makes objects real, that is to say hated as well as loved...exact adaptation resembles magic and the object that behaves perfectly becomes no better than an hallucination. Nevertheless **at the start** adaptation needs to be almost exact, and unless this is so it is not possible for the infant to begin to develop a capacity to experience a relationship to external reality, or even to form a conception of external reality....The mother, at the beginning, by almost 100 percent adaptation affords the infant the opportunity for the **illusion** that her breast is part of the infant. It is, as it were, under magical control....Omnipotence is nearly a fact of experience. The mother's eventual task is gradually to disillusion the infant, but she has no hope of success unless at first she has been able to give sufficient opportunity for illusion (pp. 94-95).

Winnicott (1991) provides poignant descriptions of the baby feeding experience and the powerful influence of the mother. Mother is the closest to baby, especially during infancy when mother's body provides nourishment, comfort, and a secure 'holding environment'. Using Fairburn and Guntrip's thesis (1952; 1969 cited in Orbach, 1985b) that the capacity to individuate rests on the gratification of early dependency needs, Orbach expands her view on the power of the mother by stating that, "in the process of psychological birth of the human infant, from utter dependence to separation-individuation, the mother's psychology is 'taken in' by the developing person and forms the very core of his or her personality" (p. 88). Klein (1987), Mahler *et al.* (1975), and Spitz (1965), have written on the mediating role mother plays in organising baby's experience (mother mediates the stimuli which flow continuously between baby and the world). Utilising Spitz's work on the oral cavity, Rizzuto (1985) highlights the developmental significance of eating. Spitz (1955) proposes that the feeding situation and its gestalt form the beginnings of perception and are the origin of the self.

> What appears to me significant...is that the **inside** of the mouth, **the oral cavity,** fulfils the conditions...for the perceptive purposes both of the inside and of the outside. It is simultaneously an interoceptor and exteroceptor. It is here that all perception will begin....The site of the origin of perception and of psychological experience has far-reaching consequences....It is here that the task of distinguishing between inside and outside has its inception...and will lead in an unbroken development to the separation of the self from the non-self, of the self from the objects, and, in the course of this road, to what is accepted and what is rejected (Spitz, 1955, pp. 220, 222).

In a case described by Kreisler, Fain, and Soule (1974 cited in Rizzuto, 1985) the importance of the mothering-face gestalt is highlighted. A six and a half month old infant, Christopher H. developed acute vomiting and required hospitalisation. There it was observed that he induced his own vomiting

by putting his fingers into his mouth or by a direct effort to vomit. His hands were restricted and with the help of antiemetics he regained his health. Questioning of the mother revealed that the child had been perfectly normal up until the mother developed a cold. Not wanting her child to catch a cold, the mother wore a facial mask for eight days whenever she went close to Christopher to feed him. Fain explained Christopher's behaviour in the following way: The mother's mask had transformed her into a stranger, "with the end result that the infant confuses the good mother with the strange masked mother and experiences simultaneously the wish for closeness and the need to escape the frightening mother" (cited in Rizzuto, 1985, p. 201). Because of Christopher's age and the yet unformed ability to distinguish between food and mother, he must have had a need to escape from seeing the stranger's face. Spitz (1965) states that at three months old the prototype for projection is vomiting and regurgitation. Freud (1925) commented on this very feature: "The original pleasure-ego wants to introject everything into himself that is good and to eject from itself everything that is bad. What is bad, what is alien to the ego and what is external...are identical" (cited in Rizzuto, 1985, p. 201). Anna Freud (1946) talks about the significance of food in the mother-child relationship:

> The image of food and the mother-image remain merged into one until the child is weaned from the breast....Though food and mother become separated from the conscious mind of all children from the second year onwards, the identity between the two images remains so far as the child's unconscious is concerned....The child's conflicting behaviour towards food does not originate from a loss of appetite...but from conflicting emotions towards the mother which are transferred onto the food which is a symbol for her (Freud, 1946, pp. 125-126).

Contemporary writers have also documented this phenomenon (Bloom-Feshbach & Bloom-Feshbach, 1987; Buckroyd, 1989). Rizzuto (1985) uses the concept of monsters to illustrate Freud's statement that children "eject from themselves everything that is bad" (p. 207). She demonstrates that if the parents of a child are selectively responsive and complementary of compliance and achievements and disregard or do not accept negative feelings, that a child will be unable to integrate and accept their own badness. They will develop "a compelling need not to be seen, psychologically, and in real life" (Rizzuto, 1985, p. 207). Winnicott (1988) has written extensively on the child's need for 'mirroring' and the development of a 'false self'. Geist (1985) is more specific on the theme of mirroring:

> The anorexic patient is not lacking in good enough mothering; she experiences a distortion of a very specific aspect of mothering - empathic mirroring. Such mirroring produces inner fragmentation and distorts her emerging self in a manner analogous to the child who gazes into a fun house mirror and receives a contorted misrepresentation of her own image (p. 274).

Because the child's perception of the mother's face is so essential and utilised for the formation of

a sense of self, and because from the beginning of life these experiences relate to feeding, it is proposed that the perception of the maternal face and the simultaneous "coenesthetic gastrointestinal state of satisfaction, fullness, and satiation or their opposites" are necessarily integrated and thus may not be divorced from each other (Rizzuto, 1985, p. 207). Winnicott (1971/1988) states that when 'good enough' mothering is absent/inadequate

> The child is left with a profound wish for oral mothering, which is dissociated from the disapproving maternal representation but linked with the sensation provided by food....I propose that the need to eat is the dissociated search for the orally approving maternal object, and the need to vomit, the urge to rid oneself of the monstrous creature who demands so much so frantically. The risk is that if the monster is not expelled, it may take over the total person (Rizzuto, 1985, pp. 209-210).

2.3.3 Early experience and adult psychopathology

> And the first step, as you know, is always what matters most, particularly when we are dealing with those who are young and tender. That is the time when they are taking shape and when any impressions we choose to make leaves a permanent mark (Plato cited in Clarke & Clarke, 1976, p. 4).

Psychoanalytic theory literature supports the notion that early experiences are fundamental in shaping one's later emotional development. Although supporting evidence exists, it may not be regarded as an all-encompassing empirical fact about human nature. Wachs and Gruen (1982) provide an excellent appraisal of the primacy of early experiences, and provide summaries of hundreds of studies on this topic which reveal the tentativeness of such dogmatic statements. Clarke and Clarke (1976; 1979 cited in Wachs & Gruen, 1982) concluded that the relevance of early experience cannot be denied but that early experience is not to be regarded as the sole template of all future development. Clarke and Clarke (1976) suggest that there is nothing more special about the early years than future years in the shaping of one's emotional well-being.

> Early influences will fade unless supported by later experiences, and later experiences can have as dramatic effects upon development as early experiences: there is certainly no implication that infancy and early childhood are unimportant, only that their long-term role by itself is very limited (Clarke & Clarke, 1979 cited in Wachs & Gruen, 1982, p. 3).

Wachs and Gruen (1982) state that it is wrong to assume that the effects of early and later experiences are equivalent. They stress that early experiences (from infancy to five years of age), "have a greater **probability** of having a more dramatic and longer lasting impact upon the organism than later experiences" (p. 4). This is because a critical period for central nervous system (CNS) development

exists, pinpointed as the first five years of life. Because CNS development depends on experience during the first five years of life, it is empirically true to assert that the early years are of more significance than the later years in shaping one's emotional development (Wachs & Gruen, 1982). Guidano and Liotti (1983) and Guidano (1987), note how patterns and processes of human knowledge are physically based, as especially during the first five years of life, the CNS and neural activity is developing simultaneously with emotional-cognitive processes. Rutter (1986) conducted a review of literature pertaining to maternal deprivation and found that early environmental deprivation (including maternal deprivation), probably has a much greater effect than a similar impairment and loss experienced later in life. Rutter's findings confirmed the validity of previous research (1976) which had documented the psychological effects of parent-child separation on children. John Bowlby's attachment theory (1991 a,b,c) has led to an array of contemporary theorists who utilise his framework for the understanding of childhood, adolescent, and adult psychopathology (Bloom-Feshbach & Bloom Feshbach, 1987; Guidano, 1987; Holmes, 1993; Klein, 1987; Parkes, Stevenson-Hinde, & Marris, 1993).

> Modern thinking reflects a tendency toward integration of...factors. It is generally recognised that the characteristics of each particular person have a basis in his or her genetic biological endowment, but that early life experiences are essential for the differentiation and organisation of the innate potential (Bruch, 1985, p. 7).

On the basis of existing evidence and theory, the researcher accepts that all developmental periods are important but that in terms of their impact on later affective states, the early period of life (up to five years old), is regarded as the most crucial.

2.3.4 The role of father in child and adolescent psychopathology

Interest in fatherhood is a distinctively twentieth century phenomenon, and more specifically, one characterising the 1990's (Roberts, 1996). Up until the Industrial Revolution of the 1700's, when most fathers worked in and around the home, and where fathers were more involved in child rearing, Western culture regarded them as the ones most responsible for how their children turned out (Roberts, 1996). However, industrialisation ushered in the "feminisation of the domestic sphere and the marginalisation of father's involvement with their children" and by the mid-1800's, "child-rearing manuals were geared towards mothers, and this trend continued for the most part until the mid-1970's" (Phares cited in Roberts, 1996, p. 50). At the turn of the twentieth century, both science and society viewed the psychology of parenting as the psychology of motherhood. The classical psychological viewpoint at the time reiterated this sentiment. By the 1950's, researchers began to re-

examine the 'mother-centric' view and the phenomenon of 'mother-blaming (i.e., blaming mothers for all the behavioural and emotional problems of their children) in light of little supporting evidence that there did exist a unique maternal instinct, and science began to recognise that there was some paternal impact on early childhood (Roberts, 1996). However, it was not until the feminist movement in the 1970's that researchers began to systematically study how and why maternal and paternal parenting strategies differed, and to examine what these differences meant for children. Lamb's article (1975 cited in Phares & Compas, 1992) entitled "Fathers: Forgotten contributors to child development" was one of the first studies on the role of fathers in normal child development. Lamb argued that there was an urgent need for researchers and theorists to pay attention to the role of fathers in the socialisation of children. His work provided the impetus for further research on the role of fathers in child development. However, although substantial advances have been made in this area, most of this research has focused on normative developmental processes, such as social development and attachment (Phares & Compas, 1992; Roberts, 1996).

The identification of factors associated with increased risk for emotional and behavioural maladjustment in children and adolescents is an integral part of developmental psychopathology (Phares & Compas, 1992). However, paternal psychopathology and the characteristics of father have largely been neglected in the analysis of child and adolescent psychopathology, where the pervasive tendency has been to focus on and blame mothers for causes of maladjustment or dysfunctional developmental pathways in their children (Caplan, 1986; 1989 cited in Maine, 1993; Caplan & Hall-McCorquodale, 1985 cited in Phares & Compas, 1992). In a review of nine clinical publications from 1970, 1976, and 1982, Caplan and Hall-McCorquodale (1985) found that "72 different kinds of child psychopathology were attributed to mothers, whereas none were attributed to fathers" (cited in Phares & Compas, 1992, p. 387). In an attempt to assess whether fathers are included in studies of developmental psychopathology, Phares and Compas (1992) reviewed eight clinical and developmental journals from January 1984 through January 1991 for the inclusion of mothers and fathers in clinical child and adolescent research. They also conducted a computer-based literature review to identify any other articles that investigated paternal characteristics. Of the 577 articles identified, 48% of the studies involved mothers only, whereas only 1% of studies included fathers only. These results indicated that there has been no improvement in the inclusion of fathers since Caplan and Hall-McCorquodale's (1985) review and that mothers continue to be used more than fathers in clinical child and adolescent research. Such a striking difference in numbers would not be expected unless some type of bias was operating in the research process (Phares & Compas, 1992).

Because the nature of the target population sampled is an important methodological issue in developmental psychopathology, Phares and Compas organised the review of their literature in terms of target populations: clinically referred or diagnosed children and characteristics of their fathers; clinically referred or diagnosed fathers and characteristics of their children; and nonreferred children and fathers and characteristics of both. (The researcher acknowledges the use of Phares and Compas' format in presenting their findings. However, points made and studies cited will be those directly relevant to the aims of this study).

The first research methodology, investigating paternal characteristics of clinically referred or diagnosed children, revealed that many characteristics of fathers have been investigated in relation to a wide range of childhood disorders. Studies of depression, suicidal behaviour and eating disorders will be presented. Overall, studies which directly investigated the fathers of depressed children reveal that there does not appear to be a strong link between childhood depression and paternal factors. Instead, there is a stronger association between maternal factors and childhood depression (Cole & Rehm, 1986; Jensen, Bloedau, Degroot, Ussery, & Davis, 1990; Kaslow, Rehm, Pollack, & Siegel, 1988; Puig-Antich, Lukens, Davies, Goetz, Brennan-Quattrock, & Todak, 1985a,b cited in Phares & Compas, 1992). In studies which investigated the fathers of suicidal children and adolescents, the fathers of suicidal children appeared to be more distressed, (with regard to increased depression and decreased enjoyment of time spent in the family and in the marriage), than fathers of normal control children (McKenry, Tishler, & Kelley, 1982 cited in Phares & Compas, 1992). It was also found that fathers of suicidal children are more physically abusive toward their children and spouse than fathers of nonsuicidal, psychiatrically disturbed children (Myers, Burke, & McCauley, 1985 cited in Phares & Compas, 1992).

Although eating-disordered and non-eating-disordered families are usually found to differ in perceptions or observations of family interactions (Waller, Slade, & Calam, 1990), there are also examples where no differences were found (Garfinkel, Garner, Rose, Darby, Brandes, O'Hanlon, & Walsh, 1983; Leon, Lucas, Colligan, Ferdinande, & Kamp, 1985 cited in Phares & Compas, 1992). Humphrey (1986 cited in Phares & Compas, 1992) found that bulimic adolescents perceived greater deficits in parental nurturance than anorexic, bulimic-anorexic, and nonclinical adolescents. Additionally, these findings were most consistent for the bulimic daughter-father relationship. In another study of observed family interactions, Humphrey (1989) found that

> Both fathers and mothers of anorexics gave a double message of nurturance and affection combined with neglect of their daughter's needs. Fathers and mothers of bulimics were

> hostilely enmeshed with their daughter and appeared to undermine their daughter's attempts at separation and self-assertion. In contrast, the fathers and mothers of nonreferred adolescents showed higher levels of helping, protecting, trusting, approaching, and enjoying one another. Although these different patterns were found for both fathers and mothers in the three groups, fathers showed less unique differences across the groups than mothers (cited in Compas & Phares, 1992, p. 394).

Phares and Compas (1992) suggest that overall, it appears that the investigation of perceptions of maternal and paternal relationships may be helpful in elucidating different patterns of involvement of fathers and mothers of adolescents with and without eating disorders, as well as may be helpful in discriminating subtypes of eating disorders. Taken together, **studies of fathers of clinically diagnosed children show increased levels of psychopathology** than fathers of children that have not been diagnosed or referred for psychological treatment.

Within the second research methodology, studies of children whose fathers have been diagnosed or referred for clinical treatment, it was found that the psychological and behavioural adjustment of children has been investigated in studies of fathers with a wide variety of diagnoses. Studies of depression, alcoholism and substance abuse, physical illness, and child sexual and physical abuse will be presented. Substantial research indicates that the children of alcoholic fathers (or fathers who abuse alcohol) have been consistently found to be at increased risk for a wide range of behavioural and emotional problems. Seven studies reviewed showed that children of alcoholic fathers are more disturbed than children of control fathers (Benson & Heller, 1987; Berkowitz & Perkins, 1988; Callan & Jackson, 1986; Goodwin, 1986; Helzer, 1987; Manning, Balson, & Xenakis, 1986; West & Prinz, 1987 cited in Phares & Compas, 1992), whereas findings have been unclear when comparing the effects of maternal alcoholism and paternal alcoholism (El-Guebaly, Offord, Sullivan, & Lynch, 1978; Levenson, Oyama, & Meek, 1987; Steinhausen, Gobel, & Nestler, 1984; Werner, 1986 cited in Phares & Compas, 1992).

Parental depression and its relation to child maladjustment is one of the most extensively researched forms of psychopathology, although most of this research has investigated the impact on children's functioning of depression in mothers. Phares and Compas (1992) note that in several reviews of children of depressed parents, no mention is made of depression in fathers (e.g., Beardslee, 1986; Beardslee, Bemporad, Keller, & Klerman, 1983; Cytryn, McKnew, Zahn-Waxler, & Gershon, 1986; Orvaschel, Weissman, & Kidd, 1980; Weintraub, Winters, & Neale, 1986). However, recent findings indicate that "failure to consider paternal depression represents an important omission" (Phares & Compas, 1992, p. 396). In eight out of 11 studies investigating the functioning of children

of depressed fathers, these children were found to be at increased risk for psychological and behavioural maladjustment when compared with control children (Atkinson & Rickel, 1984; Beardslee, Schultz, & Selman, 1987; Billings & Moos, 1983; 1985; El-Guebaly *et al.*, 1978; Jacob & Leonard, 1986; D.N. Klein, Clark, Dansky, & Margolis, 1988; Orvaschel, Walsh-Allis, & Ye, 1988 cited in Phares & Compas, 1992).

Literature on fathers identified as perpetrators of abuse against their children has mostly concentrated on sexual abuse, whereas studies of physical and emotional abuse have almost exclusively involved mothers (Wolfe, 1985 cited in Phares & Compas, 1992). In studies of childhood sexual abuse (CSA) where the relationship of the perpetrator and the child was examined, it was found that "there was evidence of greater psychological trauma in victims from experiences involving fathers or father figures compared with all other types of perpetrators" (Brown & Finkelhor, 1986 cited in Phares & Compas, 1992, p. 398). More recent studies underscore the adverse outcomes associated with CSA, as well as the increased risk for children to receive a psychiatric diagnosis when abuse is perpetrated by the father or father figure (Sirles, Smith, & Kusama, 1989 cited in Phares & Compas, 1992). Studies of children physically abused by mothers or fathers show that these children are more disturbed than controls (Garbarino, Sebes, & Schellenbach, 1984; Rogeness, Amrung, Macedo, Harris, & Fisher, 1986 cited in Phares & Compas, 1992). However, the effects of physical abuse by father are equivocal, as most literature is based almost entirely on samples of mothers only, or on parental samples where paternal factors are not discussed separate from maternal factors (Wolfe, 1985 cited in Phares & Compas, 1992). The role of CSA in eating disorders is presented more thoroughly in section 2.3.5.

The presence of paternal physical illness and the possible impact it may have on the psychological adjustment of their children, has largely been ignored in the literature. In fact, only one study was identified which specifically examined the psychological functioning of children whose father was physically ill (Rickard, 1988 cited in Phares & Compas, 1992). There is a need for more research on the possible impact of paternal physical illness on children, as well as the mechanisms by which paternal illness might effect children (Phares & Compas, 1992). In summary, **children whose fathers have been psychiatrically diagnosed or referred for psychological treatment are at increased risk for a variety of different types of psychopathology,** as compared to children whose fathers have not been diagnosed or referred (Phares & Compas, 1992).

The third research methodology, studies of nonreferred samples of children and fathers, examines

indicators of maladjustment and psychopathology in cases where neither father nor the child have been diagnosed or referred. Most of these studies examine the degree of association between a list of psychological symptoms in the father and a comparable measure for the child. These include: alcohol and substance abuse, delinquency, nonspecific behaviour problems, depression, paternal stressful events, and paternal unemployment. The findings of these studies are consistent with studies of referred or diagnosed children and studies of referred or diagnosed fathers, which indicate that there is a significant correlation between paternal factors and child and adolescent maladjustment. Studies on the acute and stressful experiences associated with paternal unemployment and economic loss indicate significant effects on children. However, these effects have been found to be indirect rather than direct in that, "paternal economic loss leads to greater negativity and pessimism in the father, which in turn leads to deterioration in the father-child relationship, which results in children's sociemotional problems, somatic symptoms, and reduced personal expectations and aspirations" (McLoyd, 1989 cited in Phares & Compas, 1992, p. 402). McLoyd (1989) has identified several moderating variables that affect the relationship between paternal unemployment and child maladjustment, including the child's temperament, gender, relationship with mother, the degree of contact with the father, and the child's attractiveness as rated by the father (cited in Phares & Compas, 1992).

From their review, Phares and Compas (1992) state that it is clear "that fathers play a significant and substantial role in the occurrence of psychopathology in their children" and on the basis of their findings conclude that, "paternal behaviours, personality characteristics, and psychopathology are significant sources of risk for child and adolescent psychopathology (p. 403). However, psychopathology in children and adolescents is the result of a wide variety of factors, of which paternal characteristics are but one (Phares & Compas, 1992). Although researchers may identify a sample of diagnosed/referred children, the etiological factors that may have contributed to these children's psychopathology may be quite diverse. For example, in some cases of diagnosed or referred children, the father may be implicated in the onset and maintenance of maladjustment in some children but not in others; in cases where the father is diagnosed or referred (characterised by some level of psychopathology), the majority of these children may be at risk for maladjustment. It is thus important to note that paternal psychopathology may represent a sufficient condition for the development of psychopathology or maladjustment in children but that it is also not a necessary condition for child or adolescent psychopathology (Phares & Compas, 1992). The conceptual and methodological issues raised by Phares and Compas' review and the implications for further research in this area, are discussed in conjunction with the evaluation of Guidano's model and its application in this research (see discussion, pp. 193-200)

2.3.5 The role of childhood sexual abuse in eating disorders

Recent studies have indicated the possible relationship between childhood sexual abuse (CSA) and the subsequent development of an eating disorder. Studies of women with eating disorders suggest that sexual abuse may play some part in the establishment of an eating disorder (Andrews, Valentine, & Valentine, 1995; Kern & Hastings, 1995; Maine, 1993; Palmer, Oppenheimer, Dignon, Chaloner, & Howells, 1990; Williams, Wagner, & Calam, 1992). Studies of women sexually abused as children often include clinical case histories of eating disorders, where the individual is understood to have developed an eating disorder as a response to, or as a consequence of CSA (e.g., **CSA and bulimia** - Bass & Davis, 1992; Blume, 1993; Follette & Pistorello, 1995; Maine, 1993; **CSA and obesity** - Bass & Davis, 1992; Blume, 1993; Felitti, 1991 cited in Whitfield, 1995; Sanford, 1991; **CSA and anorexia** - Bass & Davis, 1992; Blume, 1993; Kritsberg, 1993; Maine, 1993; Pennacchia, 1994; **CSA and compulsive eating** - Bass & Davis, 1992; Blume, 1993; Fredrickson, 1992; Kritsberg, 1993).

Williams *et al.* (1992) investigated eating attitudes in survivors of sexual abuse to see to what extent these women have difficulties with eating beyond that which would be expected among the general population. All participants had reported an unwanted sexual experience with a close male relative between the ages of three and 16 years. It was found that women who have experienced intrafamilial sexual abuse are more likely to experience problems with eating, than women who have not been abused. In fact, "of the 21 subjects, eight (38 per cent) reported that they had at some point suffered from an eating disorder, and 10 (48 per cent) scored above the clinical cutoff of 30 on EAT - Eating Attitudes Test. Furthermore, higher numbers of unwanted [sexual] experiences of all kinds were associated with higher EAT scores" (Williams *et al.*, 1992, p. 205). Calam and Slade (1987) proposed that anorexic symptomatology might be associated with intrafamilial abuse, "as self-starvation might act to punish the abusing parent, and might be functional in preventing further abuse" (cited in Williams *et al.*, 1992, p. 203). Palmer *et al.* (1990) tested this hypothesis on 158 women with eating disorders but failed to find evidence to support it. However, Calam and Slade (1990) did find some support for the hypothesis (cited in Williams *et al.*, 1992). Coons (1989), Felitti (1991; 1993), Gleaves and Eberenz (1993), Goldfarb (1987), Hall (1989), and Schechter (1987) have found that eating-disordered individuals have a higher frequency of abuse history than the general population (cited in Whitfield, 1995). In this regard, Whitfield (1995) has shown that eating disorders are one of the high risk disorders associated with CSA.

Poole, Lindsay, Memon, and Bull (1995) conducted a survey of American and British (doctoral-level) psychotherapists' opinions, practices, and experiences regarding clients' memories of childhood sexual abuse (CSA), and found the samples were highly similar on the vast majority of measures. One measure required clinicians to list the five problems/concerns that their adult female clients reported most frequently during the past two years. Eating disorders ranked seventh on a list (of 29) of most common presenting complaints mentioned by 5% or more of the respondents (Poole *et al.*, 1995). In order to assess the psychotherapists' opinions concerning the role of CSA in contributing to their clients' problems, the clinicians were asked to list the indicators that lead them to suspect CSA. The total sample listed 85 different indicators and of these, 22 indicators were mentioned by at least 5% of the clinicians. Eating disorders were the seventh most commonly perceived indicator of CSA in psychotherapists' opinions. Two interesting aspects from these data emerged: (1) that a wide range of complaints are taken as indicators of CSA and, (2) that when compared, most of the listed presenting problems were also listed as indicators of CSA. "Confidence in the reliability of such indicators is in sharp contrast to clinical research, which indicates that CSA accounts for a relatively small portion of the variance in adulthood symptoms and that there is as yet no well-defined post-CSA syndrome" (Poole *et al.*, 1995, p. 435). It is hypothesised that the 'representativeness heuristic' (tendency to associate A with B on the basis of the perceived similarity between A and B), may lead some psychotherapists to either exaggerate the relationship between presenting problem and CSA, or to explore the possibility of CSA as an explanation for the presenting problem "before considering other etiological factors that have a higher base rate of occurrence" (p. 435). Although Poole *et al.* 's study did not explore the relationship between CSA and eating disorders specifically, their results highlight that there is, even if an as yet unclear link, between eating disorder symptomatology and (possible) CSA. This is evidenced by the high rate of concurrency in psychotherapists' opinions, judgements, and perceptions that eating disorders are regarded as one of the top 10 indicators of CSA. The findings of this survey indicate an urgent need for further research aimed at improving clinicians' ability to discriminate between clients who were sexually abused as children and those whose psychological problems have other etiologies (Poole *et al.*, 1995).

Andrews *et al.* (1995) examined the relationship between CSA and two psychiatric disorders (depression and eating disorders) in two generations of women (mothers and daughters). It was hypothesised that age would be a moderating variable on diagnosis in that following CSA, depression would be more common in the mothers and eating disorders more common in the daughters. Results confirmed that depression was more common in the mothers and bulimia more common in the daughters. Most significantly, results showed a close association between CSA and bulimia in the

daughters (nine daughters were identified as bulimic and of these, seven [33 percent] with CSA had bulimia). The association between CSA and depression in mothers was not as strong as the latter association. Andrews *et al.* (1995, p. 48) attribute this difference to "different ways in which psychopathology may be manifested at different ages, despite a common etiology". Because evidence for the existence of a link between CSA and eating disorders is not unequivocal, and because conceptual and methodological problems abound in the study of CSA (e.g., **false memory syndrome,** Loftus & Briere, 1994; Neimark, 1996; Terr, 1994; Whitfield, 1995; **inconsistent definitions of CSA across studies,** Kern & Hastings, 1995; Palmer *et al.*, 1990; Poole *et al.*, 1995; Williams *et al.*, 1992), little more can be stated with confidence than to suggest that in some cases, CSA may play a part in causing later clinical eating disorders. "Such a suggestion is plausible and the effects of these experiences [childhood sexual contact] upon self-esteem and sexual confidence may well be the mediating variable" (Palmer *et al.*, 1990, p. 702). As Slade (1982) states, such effects may act as 'setting conditions' which predispose individuals to later disorder; the same point is made by Andrews *et al.* (1995) and Classen and Yalom (1995). Overall, research suggests that clinicians treating eating-disordered individuals should be alert to the possibility of CSA in their patients, particularly in cases of bulimic symptomatology.

2.4 Introduction to Guidano's model of psychopathology

The severity and increased incidence of eating disorders is noted. Most research studies and treatment models address only one level of analysis: biomedical, cognitive, behavioural, social, psychological. Considerable research is still needed to test these models that are emerging, but because these models are not well operationalised, they are not easily accessible for systematic testing. In sharp contrast, Guidano (1987) presents an integrated model of psychopathology which **is** operationalised **and** testable. The model is purely **structural** and **explanatory.** It is a developmental, unitary model of psychopathology carried out within the perspective of a systems/process-oriented approach to organised complexity. The need for a comprehensive and **scientific** model of psychopathology and psychotherapy provides the impetus for the development of Guidano's model. Guidano is dissatisfied with traditional psychology's dispositional and descriptive accounts of dysfunctional behaviour, whose main aim is to reduce complex and variable emotional disorders into appropriate terms and labels. Additionally, his theory is a reaction to the traditional paradigm and its shortcomings that: (1) much of the psychotherapeutic field remains ambiguous and scientifically questionable; (2) there has yet to be developed an integrated model which **explains** how early development has formative effects on personality development and the emergence of psychopathology. Guidano is critical of contemporary

psychology's view of man and reality. To believe that the human mind is merely a passive receptor to the outside world, he states, is too simplistic. He believes that the development of a comprehensive model of psychopathology needs to view man as an active respondent to the environment.

> To consider living organisms in terms of complexity means to emphasise from the very start their self-determination and self-organisation, as well as the openness and plasticity of their evolutionary and developmental pathways...such an approach is not a new theory or discipline...rather a way of seeing things - a paradigm or reference frame in which available observational and experimental data can be reconsidered in a more holistic and dynamic perspective (Guidano, 1987, p. x).

Methodologically, therefore, this perspective implies a systems/process-oriented approach. This approach addresses the multiplicity of levels of analysis within a complex unit, as well as the relations between them which underlie its wholeness. The attainment of an explanatory level is a fundamental problem of contemporary psychology. On this point, Weimer (1982) cogently states:

> Mature sciences are explanatory rather than descriptive. Explanation consists in rendering intelligible how and why the phenomena within a domain exhibit the properties that, descriptively, they do possess. Science explains by conjecturing theories...that tell why things must be as they are observed to be. Psychologists, in contrast, have limited their accounts to dispositional analysis of the psychological domain. Dispositional analysis is at the best descriptive and cannot be considered explanatory. It is thus incumbent upon psychology to develop the sort of explanatory theory that the mature sciences possess - theories that will derive surface-structure appearances lawfully from an abstract, deep-structural realm that is causally productive of those appearances (cited in Guidano, 1987, p. xi).

Guidano's model is thus an attempt to address the challenge for a developmental and unitary model of psychopathology. A brief description of the basic principles underlying the systems model will be presented in two parts, as it is within this perspective that Guidano developed his theory of psychopathology: (1) theoretical principles underlying Guidano's model, and (2) Guidano's model of human development.

2.4.1 Theoretical principles underlying Guidano's model

During the 1970's, an evolutionary, holistic, and process-oriented perspective to living systems directed focus to concepts of 'hierarchical organisation', 'temporal becoming', and 'dynamic equilibrium'. One of the basic epistemological assumptions relevant to a systems approach is that the human knowing system is conceptualised as "a self-referent, organised complexity whose distinctive hallmark is its self-organising ability" (Atlan, 1981; Jantsch, 1980; Jantsch & Waddington, 1976;

Laszlo, 1972; 1983; Nicolis & Prigogine, 1977; Prigogine, 1980; Varela, 1979; Weimer, 1982; 1983 cited in Guidano, 1987, p. 3). The autonomy of a self-organised system is predicated on two aspects: (1) because self-identity is not only received from an objective external reality but is actively constructed by the subject, an individual produces his own identity by ordering ongoing experience; (2) pressure for change is exerted as a consequence of assimilating experience. This pressure is always subordinate to the maintenance of identity. Self-identity thus remains an invariant of self-organisation. Varela (1979) and Zeleny (1981) state that, "though one experiences changes in his/her 'parts' throughout the lifespan, the individual **as a whole** maintains his/her perceived identity over time" (cited in Guidano, 1987, p. 4). Such a conceptual viewpoint seeks to understand the interrelatedness of each part of the system.

Within the field of psychology, evolutionary epistemology has made little impact. This is because an empiricist-behaviouristic perspective still prevails, which focuses on descriptions between individual and environment and little concern with the origin of knowledge (Guidano, 1987). Weimer (1982), Piaget (1971), and Popper (1972), argue for an evolutionary perspective in psychology, as knowledge is viewed as both a biological and psychological process (cited in Guidano, 1987). Within a systems perspective, knowledge is seen to assume different levels of organised complexity according to evolutionary levels. The evolution of autonomous, self-organising units is matched by a parallel structuring of hierarchical systems (Pattee, 1973 cited in Guidano, 1987). An organisation is made up of interrelated subsystems or levels, which hierarchically arranged ensure the maintenance of its individuality. Hierarchical organisations indicate evolutionary adaptation and the way in which a hierarchical system distributes control, further ensures survival. The more a system displays 'decentralised' control (a defining feature of hierarchical systems), the more likely it and its subsystems will adapt to changes (Sameroff, 1982 cited in Guidano, 1987).

The distinguishing feature of a self-organising system is not so much the homeostatic preservation of itself but rather, the maintenance of the **coherence** of one's ordering processes. The term 'systemic coherence' is utilised by Guidano for its clarity as a more suitable term in light of systems approach methodology. However, the concept 'homeostasis' may be used interchangeably. A systems approach researcher has to accept this feature as inherent to any organised system and instead of trying to identify one opponent polarity as the true one, to focus on the **patterns** between polarities in order that a hypothesis may be formulated regarding the kind of internal coherence a particular system exhibits (Pattee, 1982; Varela, 1976; 1984 cited in Guidano, 1987). Systems theory accepts a human being is both a knowing and a historical system. A lifespan developmental perspective is

thus incorporated as a necessary and imperative adjunct for understanding systems. "This is because the **systemic coherence** of any self-organising unit can be understood only by taking into consideration the system's starting boundary conditions and its subsequent **developmental pathway**" (Guidano, 1987, p. 13).

A motor-evolutionary epistemology perspective views the acquisition of any knowledge as an active process involving self and world. "We do not first think and then act, since cognitive processes are themselves actions...to know an object means to accommodate and assimilate it into one's ongoing level of expectations, which, in the final analysis, essentially means to act upon it" (Guidano, 1987, p. 15). A motor theory perspective thus rejects that mental functioning results from classical and operant conditioning. This perspective views tacit and explicit aspects of knowing as two closely related levels of cognitive processes. Tacit processes are viewed as the higher hierarchical level through which conscious experience is ordered by beliefs, theories and problem-solving strategies. Others have called these cognitive structures 'schemata' (Bartlett, 1932), or 'mental sets' (Pribram, 1960 cited in Guidano, 1987). Kuhn (1970), Lakatos (1974), Polanyi (1966), and Weimer (1973), have developed unitary frameworks for the understanding of conscious and unconscious thought processes (cited in Guidano, 1987).

Tacit processing is the first level of knowing in the course of human development. The evolutionary nature of cognitive processes is described in Piaget's theory of cognitive development. There exists the immediate and global apprehension of self and other characteristic of infancy and preschool years. The highest cognitive structural level is reached during adolescence, (Piagetian formal operations), where abstract thought is achieved. It is during the formal operations stage that tacit and explicit knowledge processes undergo reorganisation, as the "prelogical and emotional apprehensions of the self elaborated thus far can be structured into a conscious self-image capable of directing the programming of one's life" (Guidano, 1987, p. 23). Within the systems perspective, adulthood is not considered an end point of explicating individual tacit processes. Instead, "each individual lifespan is an open-ended, generative process, in which no special state of maturity...is ever reached" (Guidano, 1987, p. 24). Within an evolutionary perspective, emotions are viewed as probably the first organised knowing system which orders and assimilates the environment. Cognitive abilities are seen to represent the last evolutionary products (Eibl-Eibesfeldt, 1972; Plutchik, 1980; Zajonc, 1980 cited in Guidano, 1987). Leventhal's (1979; 1980) concept of 'emotional schemata' is viewed as an attempt to develop an integrative model of emotional experience linking various emotional components (imagery, memory and perception, cited in Guidano, 1987). The concept of 'emotional schemata'

is able to explain how inborn and acquired patterns of emotional reactions are differentiated and integrated.

How does a perspective on organised complexity view the self? Guidano (1987) views selfhood as a dialectical, interactive process. The epistemological philosophy of Guidano's theoretical framework is the tenet that, "any self-knowledge has its foundation in the presence of, and interaction with others" (Guidano, 1987, p. 29) and that identity is formed through the progressive differentiation of self and nonself. The fundamental childhood psychological task of accomplishing progressively more differentiated and integrated representations of self and other is well documented, although theoretical diversity exists (Bloom-Feshbach & Bloom-Feshbach, 1987; Freud, 1969; Klein, 1987; Kohut, 1981; Mahler *et al.*, 1975; Mitchell, 1986; Moberly, 1985; Sidoli, 1989; Spitz, 1965; Winnicott, 1988; 1991). Research on primates gives increased support to the notion that prior exposure and interaction with others is a prerequisite for self-recognition (Gallup, 1970; 1977; Hayes & Nissen, 1971; Linden, 1971 cited in Guidano, 1987). Further, that self-recognition is a product of a dynamic interplay between opponent processes: (1) others provide the template that allows for the scaffolding of a unitary self-perception; (2) similarly, a unitary self-perception is predicated "through an active demarcation from the perceived other" (Guidano, 1987, p. 30). Therefore, from the beginning of an individual's life, two simultaneous but different flows of stimuli are integrated by the human knowing system, self-perception and perception of the world.

> The elaboration of knowledge appears to be a **unitary** process that occurs through a dynamic interplay of two polarities, the self and the world, that can be metaphorically equated to the two sides of a coin: a subject's self-knowledge always involves his or her conception of reality, and conversely, every conception of reality is directly connected to the subject's view of self (Guidano, 1987, p. 30).

Utilising a systems/process approach to understanding and explicating the human condition in its totality, Guidano integrates the developmental dynamics of **selfhood processes** with **attachment processes** and in this way explains how the unitary interplay between these processes may result in specific dysfunctional patterns of behaviour. Psychoanalytic literature has long assumed the complementarity and interplay of these processes (Bowlby, 1991a,b,c; Greenspan & Pollock, 1989; Holmes, 1993; Kohut, 1981; Parkes, Stevenson-Hinde, & Marris, 1993; Rutter, 1986; Sidoli, 1989; Winnicott, 1988; 1990; 1991). Within a systems approach, the development of attachment relationships is seen as crucial for identity development. A primary and exclusive bond with one or two attachment figures is seen as a developmental imperative (Bowlby, 1991a). The uniqueness of the attachment relationship offers a means whereby otherwise chaotic information about the self can

be organised into a coherent whole.

> During early development, when cognition is more or less closely bound to the existing situation, children can abstract their own sense of personal uniqueness from the very experience of being involved in a unique relationship, i.e., building a unique relationship with a significant other represents an important way (perhaps not only during maturational stages) one may obtain a sense of uniqueness and oneness (Guidano, 1987, pp. 32-33).

Guidano uses Bowlby's attachment theory (1973) as an integrating paradigm of human development. Others have noted the benefits implicit to such an approach (Holmes, 1993; Johnson & Marano, 1994; Parkes *et al.*, 1993). Guidano is thus able to integrate existing observational data with his own model of human development and to present a comprehensive view of the predominant factors contributing to the development of self-knowledge. How can identification processes be viewed within the continuous interplay between self and others? Guidano proposes that at any developmental point, a child's ongoing sense of self is the product of two opposite tendencies, the 'outward and the inward'. During infancy the self is undifferentiated, in a world just as incomprehensible as itself (Mahler *et al.*, 1975). The capacity to recognise information pertinent to oneself is predicated on the capacity to perceive one's "similarity between one's ongoing self-perception and the perception of a significant other (identification processes)...a general 'outward tendency'" (Guidano, 1987, p. 33). The opposite 'inward tendency' functions to elaborate a genuine sense of self.

> [It is] the ability to transform the perceived similarity to an attachment figure into a stable personal attribute (identity processes). In other words, children imitate the roles and attitudes of their attachment figures, but, in the process, make them their own, creating a single, subjectively coherent personal identity" (Guidano, 1987, p. 33).

Identification processes differ according to the developmental period. In infancy the reciprocal relationship between child and caregiver has a pervading influence "on the structuring of fundamental emotions" and consequently, on the first stable patterns of self-perception (Guidano, 1987, pp. 33-34). It is through the caregiver's constant behaviours, attitudes, and motivations that an infant begins to transform subjective emotional experiences into 'emotional schemata' (Guidano, 1987). In preschool and early childhood, the still limited cognitive abilities of children means that they require the mediating of emotional aspects within the ongoing significant attachment relationship. Through this ongoing process the child develops both emotional differentiation and a sense of self as separate. The logical/deductive abilities of adolescence allows for a shift from identification processes toward internalising more abstract life values, usually taken on from the significant attachment figure. In adulthood, new kinds of attachment emerge, (intimate love relationships), so that the process of self-

knowledge may continue (Ainsworth, 1993). Selfhood is conceptualised by Guidano as a spiralling, open-ended process continuing throughout the individual lifespan. Bowlby's attachment theory is expanded on by others (Holmes, 1993; Liotti, 1993; Parkes *et al.*, 1993) as a conceptual framework for understanding attachment across the life cycle.

2.4.2 Guidano's model of human development

> Man is a machine by birth but a self by experience....The special character of the self lies in its experience not of nature but of others. A man enters the lives of other men more directly than he can enter nature, because he recognises his own thoughts and feelings in them; he learns to make theirs his own, and to find in himself a deeper self that has the features of all humanity...knowledge of nature teaches him to act, and makes him master of the creation. The knowledge of self does not teach him to act but to be; it steeps him in the human predicament and predicament of life; it makes him one with all the creatures (Bronowski, 1971 cited in Guidano, 1987, p. 36).

The nature of the caregiving relationship of early life and the resultant pattern of attachment (the parent-child relationship) is identified as the foundation underlying both, "(1) the development of identity and attitude toward oneself, and (2) the development of interpersonal behaviour and attitude toward reality" (Guidano, 1987, p. 41). The unitary interplay of attachment and selfhood processes has enjoyed recognition in the eating disorder literature (Buckroyd, 1989; Chernin, 1993; Geist, 1985; Goodsitt, 1985; Guidano & Liotti, 1983; Lawrence, 1992; Levenkron, 1985; Rizzuto, 1985; Selvini-Palazzoli, 1985; Spitz, 1965; Sugarman & Jaffe, 1987; Winnicott, 1991).

Using existing developmental models (Erikson and Piaget) Guidano notes the various tasks and features inherent to each developmental level. Guidano's model integrates attachment processes, developing self-knowledge, emotional differentiation, and family and cultural variables which influence the developmental process. Guidano (1987) proposes that the development of an individual's **personal cognitive organisation** (P.C.Orgs.) is influenced by the parent-child attachment pattern. "Personal cognitive organisation...refers to the specific organisation of knowing processes that gradually emerges in the course of individual development" (Guidano, 1987, p. 91). Thus, although we live in a shared social reality, each individual will construct his/her own unique view from within. Dysfunctional attachment patterns give rise to unstable P.C.Orgs. which in turn form the basis of psychopathology. (The researcher will follow the framework as presented by Guidano, 1987 in his explication of eating disorders).

2.5 Guidano's model of psychopathology in eating-disordered individuals

2.5.1 Introduction

In spite of variability of surface features in eating-disordered individuals (anorexia, bulimia, obesity, compulsive eating), invariant aspects are identified in the cognitive organisation of dysfunctional eating patterns (Guidano & Liotti, 1983; Guidano, 1987). The common feature within the eating-disordered organisation pattern, is that individuals seek to change their body image through dysfunctional eating behaviour (Guidano, 1987). These patterns emerge as a response to a perceived disequilibrium between two opponent emotional polarities: (1) the absolute need for significant others' approval, and (2) the fear of intrusion and disconfirmation by significant others (Guidano, 1987). Others also describe this pattern (Bruch, 1985; Minuchin, Rosman, & Baker, 1978; Selvini-Palazzoli, 1985; Strober & Yager, 1985).

2.5.2 Invariant aspects of dysfunctional patterns of attachment

Guidano (1987) proposes that **two invariant aspects of dysfunctional patterns of attachment** combine and produce a specific discrepant experience in the child's emerging sense of self: (1) an ambiguous, disguised, undefined attachment style which predicates a self-perception only through an **enmeshed relationship with an attachment figure,** causing personal meaning to be centred on a blurred sense of personal ineffectiveness. Thus, personal identity organises itself around deep boundaries oscillating between the absolute need to be approved of by significant others, and the fear of being disconfirmed or intruded upon by them; (2) during childhood or adolescence, the individual experiences a **disappointment with the same attachment figure.**

2.5.2.1 Enmeshed patterns of attachment

> An image came to her, that she was like a sparrow in a golden cage, too plain and simple for the luxuries of her home, but also deprived of the freedom of doing what she truly wanted to do. Until then she had spoken only about the superior features of her background; now she began to speak about the ordeal, the restrictions and obligations of growing up in a wealthy home (Bruch cited in Buckroyd, 1989, p. 78).

The family environment of most eating disorder-prone individuals can be typically characterised by ambiguous, disguised, and contradictory communication (Bruch, 1985; Dym, 1985; Goodsitt, 1985; Guidano, 1987; Guidano & Liotti, 1983; Minuchin *et al.*, 1978; Strober & Yager, 1985). Formal aspects of child-rearing (social appearances and academic life) are exalted by the parents (Selvini-

Palazzoli, 1985). Parents aim to create an image of themselves as a very happily married couple, which they achieve by denying the expression of emotions or opinions which would tarnish their image. These parents thus have a strong tendency to deny and conceal personal difficulties (Guidano, 1987; Guidano & Liotti, 1983). "Anxiety lurks unacknowledged because these families are not good at exploring their feelings. They do not let themselves see what is there; they certainly do not talk openly about what disturbs them" (Welbourne & Purgold, 1984, p. 29).

> Anorexic families as a rule short-circuit feelings by taking actions that cover over and cover up inner experience....Anorexic families do not, as a rule, know how to encourage the exploration and sharing of inner experience. When anxiety or depression occur, it is ignored, minimised, or smothered (Goodsitt, 1985, p. 66).

Parents of eating disorder-prone individuals project an image of themselves as people entirely dedicated to ensuring the good upbringing and welfare of their children. This parenting attitude belies the fact that their behaviour is aimed more at confirming the image of themselves as good parents, rather than attending to the real emotional needs of their children (Guidano, 1987). "Child care appears to be excellent: everything is provided for, materially, psychologically, and culturally. However, little attention is paid to the child's expression of needs, wants, and feelings" (Bruch, 1985, p. 12). Selvini-Palazzoli (1985) notes this contradiction in parenting behaviour: "Mothers...though usually extremely concerned with the child (and often overprotective) derive no pleasure from nursing, and control prevails over tenderness and emotional warmth" (cited in Guidano, 1987, p. 156). Others have documented this parental feature (Buckroyd, 1989; Rizzuto, 1985; Sargent, Liebman, & Silver, 1985; Welbourne & Purgold, 1984). Strict behaviour control and abnormal emotional links within families are strongly related to eating disorders (Waller, Slade, & Calam, 1990).

Because of the lack of recognition, inconsistency, and/or disappointments, children develop a self-image where their lovableness and worth is vague and questionable (Guidano & Liotti, 1983; Slade, 1982; Strober & Yager, 1985). Drawing on acclaimed family theorists, Minuchin, Rosman, and Baker (1978), Guidano highlights one of the most specific invariant aspects found in family interactions of eating disorder-prone individuals, enmeshment:

> Enmeshment refers to an extreme form of proximity and intensity in family interactions. It has implications at all levels: family, subsystem, and individual. In a highly enmeshed, overinvolved family, changes within one family member or in the relationship between two members reverberate throughout the system....On an individual level, interpersonal differentiation is poor....In enmeshed families the individual gets lost in the system. The boundaries that define individual autonomy are so weak that functioning in individually

> differentiated ways is radically handicapped....Excessive togetherness and sharing brings about a lack of privacy. Family members intrude on each others' thoughts and feelings...these problems of enmeshment are reflected in the family members' poorly differentiated perceptions of each other and, usually, of themselves (Minuchin *et al.*, 1978, p. 30).

Minuchin *et al.* (1978) observed psychosomatic families over an extended period of time and documented five characteristics of family functioning: enmeshment; overprotectiveness; rigidity; lack of conflict resolution; and child involvement in parental conflict. These characteristics are visible in the various subsystems of the family (family, subsystem, and individual levels), and are elaborated on in relation to the findings of this research in the discussion. The consequences for a child living in an enmeshed family environment are enormous. Not only do children develop "a deep and pervasive feeling of unreliability concerning their ability to recognise and decode their own inner states" but, "only within an ongoing emotional relationship with an attachment figure can they infer what is 'permissible' to feel and think" (Guidano, 1987, p. 157). Geist (1985) makes the same point. Similarly, Bruch (1973) states that "encouragement or reinforcement of self expression has been deficient, and thus reliance on their own resources, ideas, or autonomous decisions had remained undeveloped...depriving the child of a sense of authentic individuality" (cited in Guidano & Liotti, 1983, p. 286).

2.5.2.2 Perceived disappointment within the preferential attachment relationship

The second invariant feature of eating disorder-prone individuals which Guidano posits, is that their developmental pathway is characterised by a more or less intense disappointment in the preferential attachment figure. The disappointment is noted to occur at some point between the end of childhood and the adolescent phase (Guidano & Liotti, 1983; Guidano, 1987). Others note the occurrence of a disappointment in the developmental histories of their patients (Dally & Gomez, 1979; Lacey, 1985; Maine, 1993; Welbourne & Purgold, 1984).

Guidano and Liotti (1983) report that within the developmental histories of their anorexic patients, they "almost always found experiences of disappointment in the emotional relationship with their fathers in adolescence or preadolescence (and infrequently during childhood)" (p. 287). No descriptions of disappointment in the mother were obtained but subsequent research has provided proof of disappointment in mother, although this is not common (Guidano, 1987). Dally and Gomez (1979) and Wold (cited in Dally & Gomez, 1979) also note the involvement of father with the eating-disordered child. In order to understand the impact of change within father-child relationships, one needs to consider the significance of an initial good relationship with father within an enmeshed

family. It is noted that in most eating disorder-prone individuals, the little girl forms her closest relationship with father, as opposed to other family members. One of the many myths which exist within the family, (and which the young girl shares), is that the father is a strong and meaningful figure whom she loves very much.

> But later something happens (usually, but not always, earlier for obese than for anorexic patients), and the daughter's image of her father changes. Most of the time, she discovers some 'weakness' of his, either because he is going through a period of depression or economic difficulty or because the mother more or less covertly manages the relationship with her daughter so as to make her realise her father's 'weakness' (Guidano & Liotti, 1983, p. 288).

It can also occur that the 'relativisation' in the image of the father results because of positive events. For example, an 11-year-old girl who came from a poor and uneducated background was awarded a scholarship for further study. She returned home after a year and suddenly realised how uncultured and obtuse her peasant father was (Guidano & Liotti, 1983). Other reasons for a disappointment in the relationship with father originate in their relationship e.g., a father may need to be away from home because of work and the child comes to understand this as father's work being more important than she or her mother is. In such a case, father's absence is usually a way of denying the existence of marital discord, as parents pretend that they are happy when they are together. In another example, a girl may suddenly realise that her father loves the image of himself as a father of a little girl more than he loves her as a person. Bruch (1973) comments on this point in the following case:

> There were also walks with father on Sunday mornings...she was dressed up for this, but always in clothes that she felt were not comfortable, with emphasis on looking nice for father. To him the whole thing was very important: "here I am, a father, taking his daughter for a walk," and he wanted to be proud of her (cited in Guidano & Liotti, 1983, p. 288).

Bruch (1973) notes another peculiarity of fathers of anorexics which predispose anorexics to disappointment: "The father, despite social and financial successes which were often considerable, felt in some sense 'second best'" (cited in Guidano & Liotti, 1983, p. 288). The father's self-image of confidence and importance can thus belie a profound sense of insecurity which may suddenly be revealed and expose him as weak and/or disappointing in his daughter's eyes. Guidano and Liotti (1983) note a high frequency of neurotic reactions (mostly depression) of fathers of eating-disordered individuals during their (the adolescents') adolescence. Another peculiarity which Bruch (1973) comments on and which Guidano and Liotti (1983) provide corroborative evidence for, is the very low percentage of broken homes in the developmental histories of eating-disordered patients, especially of anorexics. Very few fathers explicitly leave their families, even if they are dissatisfied

with their marriages. If there is more than one daughter within the family, the one most likely to develop an eating disorder is father's favourite, as the least favoured one will have developed different emotional schemata (Guidano & Liotti, 1983). The primacy attributed to the father-child relationship is predicated on the significance Guidano and Liotti (1983) attach to cognitive development at this time. They identify two reasons central to this postulate:

> Firstly, the patient has emotional schemata regarding an affectional bond representing safety in the middle of confused, contradictory and deceptive early interpersonal relationships. These emotional schemata will later lead her in search of highly intensive love relationships, conceived of as "safety" or as the sole desirable relationship. This encourages easily aroused enthusiasms and with equal ease lead to disappointments in flirtatious relationships during adolescence and youth. Secondly, having experienced a very painful disappointment, the patient will be afraid that it may happen again, and therefore from then on she will "test" her partners before getting totally involved in the relationship (p. 290).

Maine (1993) offers a contrasting viewpoint to traditional eating disorder literature which thus far has mostly concentrated on the mother-child relationship and sought to make mothers responsible for their children's pathologies. Maine (1993) brings the father back into the family and society and her phrase 'father hunger' is used to refer to the natural longing and need children feel for the presence of their fathers, which if absent or left unfulfilled may lead to the development of a variety of problems. In this regard, Maine (1993) examines sociocultural and multigenerational factors which "have resulted in fathers becoming not only physically, but emotionally disconnected from their families, and how this distance affects the development of sexuality, body-image, self-esteem, and identity in adolescent daughters" (p. ix). In contrast to other sociocultural, feminist and psychological theories which tend to blame men and patriarchy for women's disorders, Maine (1993) avoids 'father bashing' by providing developmentally-based psychological explanations for the differences which exist between men and women and which cause many men difficulties with expressing their feelings and developing nurturing skills. Others report that the disappointment is usually with father in anorexia (Goodsitt, 1985) and bulimia and obesity (Wooley & Wooley, 1985). Specific invariant aspects of characteristic family styles of interaction and attachment patterns have been noted elsewhere in the eating disorder literature, providing evidence in support of Guidano's model (Bemis, 1978; Clark, Parr, & Castelli, 1989; Dana, 1992; Waller, Calam, & Slade, 1989; Wenar, 1990).

The McMaster Model of Family Functioning (Epstein, Bishop, & Levin, 1978 cited in Waller *et al.*, 1989) is an assessment device developed to measure perceived interactions that differentiate normal from clinical families. It considers six dimensions: (1) communication - the clarity of information given; (2) problem solving - the family's style of resolving problems; (3) roles - differentiation of

tasks; (4) affective involvement - concern for each other; (5) affective responsiveness - experience of emotion; and (6) behaviour control - clarity of rules within the family (Waller *et al.*, 1989). The Family Assessment Device (FAD - Epstein, Bishop, & Levin, 1983 cited in Waller *et al.*, 1989) measures these six dimensions along with a global measure of family functioning. Waller *et al.* (1989) used the FAD to see whether it distinguished the families of women with eating disorders from comparison families, and whether it differentiated specific eating disorders. The FAD was completed by 41 eating-disordered women, (12 anorexic, 21 with bulimia nervosa and eight with bulimia simplex ie., bulimia with no history of anorexia), and 27 comparison women (women with no history of psychological disorders). In general, the eating-disordered women rated their family interaction as less healthy than the comparison group. However, although the anorexia- and bulimia-nervosa groups showed similar perceived family pathologies, it was found that, "bulimics with no history of anorexia showed a pattern of family interaction that was more severely 'unhealthy' than that of the other clinical groups" (Waller *et al.*, 1989, p. 285).

> The anorexia nervosa group rated their family functioning as unhealthy in affective involvement and behaviour control. The bulimia nervosa families were rated as poor on problem solving, behaviour control and affective involvement...The bulimia simplex sufferers rated their family interaction as poorer than the comparison women's on all scales except behaviour control (Waller *et al.*, 1989, p. 285).

Anorexia nervosa and bulimia nervosa were found to have similar family styles and thus foci for therapy (individual or family) in these cases are affective involvement, behaviour control, and (in bulimia nervosa) problem solving. The bulimia simplex group was typified by more unhealthy family interaction than the other clinical groups and foci for treatment in these cases are role differentiation, affective involvement and problem solving (Waller *et al.*, 1989). Although it was found that women with eating disorders rated their family interaction as unhealthy, Waller *et al.* (1989) caution that "this rating may reflect a cognitive misinterpretation of the relationships, rather than a simple reality" (p. 286). Research which investigates the validity of individual family member's descriptions of family functioning is presented in more detail in the methodology chapter (p. 113). It has been found that the eating-disordered individuals' perceptions of family interaction are the most accurate and reliable sources of information within the family (Waller *et al.*, 1990).

Kern and Hastings (1995) reviewed the results of 10 published studies which examined the relationship between bulimia and retrospective self-reports of family functioning obtained via the Family Environment Scale (FES - Moos & Moos, 1984 cited in Kern & Hastings, 1995). They found that these studies' results "support the conclusion that bulimics' reported childhood families were

typically characterised by lower cohesion, expressiveness, independence, and recreational ability, as well as higher conflict, than families of normal eaters" (Kern & Hastings, 1995, p. 500). When the etiological significance of family environment is being investigated, factors that might be associated with both bulimia and family environment need to be ruled out, (e.g., depression, childhood sexual abuse), as it has been noted that the type of family disturbance reported by bulimic families parallels the characteristics of generally distressed families (Moos & Moos, 1984 cited in Kern & Hastings, 1995). Kern and Hastings (1995) examined whether the abnormalities of bulimics' family functioning are specific to bulimia, or whether they may be due to covariation with another problem, childhood sexual abuse, which is also associated with abnormal family functioning. Seven hundred eighty-six undergraduate women were recruited and completed three measures which assessed family environment, bulimia, and CSA. Findings were consistent with previous studies that have compared family environments of normal eaters and bulimics, as well as abused and non-abused individuals.

> Bulimics reported significantly less cohesion, more conflicts, less independence, stronger achievement orientation, and greater control in their families than did individuals with normal eating patterns....Results were also consistent with previous research that has compared the family environments of CSA victims and non-abused individuals. CSA victims' family environments were characterised by significantly less cohesion, less expressiveness, greater conflict, less independence, less activity, and greater control than the family environments of individuals who did not report CSA (Kern & Hastings, 1995, p. 504).

When subjects' CSA and bulimic status were analysed concurrently, most of the previously obtained differences between normal eaters and bulimics failed to emerge, suggesting that abnormal family environment appears to be more closely associated with CSA than with bulimia. However, one difference between the families of bulimic and normal eaters remained when CSA and bulimic status were analysed concurrently, which was reflected on the Achievement Orientation Subscale. "Bulimics' families appeared to place an abnormal emphasis on the importance of social, monetary, academic, work, and overall life achievement" (Kern & Hastings, 1995, p. 505). Kern and Hasting's finding duplicated the results of the only other study to investigate the uniqueness of bulimics' family environment (Blouin, Zuro, & Blouin, 1990 cited in Kern & Hastings, 1995). These results suggest that high familial achievement is a risk factor for bulimia, along with sociocultural, contextual, and biological factors (Kern & Hastings, 1995). The significance of identifying family environments unique to specific disorders strengthens the etiological viewpoint that family environments are related to the development of disorders. Although Kern and Hastings do not provide definitive causal conclusions about how bulimia and high achievement orientation are related, they do provide an insight into this relationship. "It can be hypothesised that bulimics perceive weight control to be of major importance in the attainment of family approval and/or success" (1995, p. 505). The

relationship between these variables is a point which Guidano (1987) and other authors have made (see section 2.5.6). Other family studies are discussed in depth in the discussion.

2.5.3 Sense of self

2.5.3.1 Identity development

> Human experience of identity has two elements: a sense of belonging and a sense of being separate. The laboratory in which these ingredients are mixed and dispersed is the family, the matrix of identity (Minuchin, 1974 cited in Guidano, 1987, p. 160).

Central to the eating disorder-prone child's existing cognitive organisation is the interference by parents in the differentiation between self and others. A healthy psychological familial style should allow children to achieve both differentiation and emotional identification with parents.

> While clearly perceiving the affective state of a significant attachment figure is a necessary condition for recognising the same feeling within the self (outward tendency), the acquisition of a definite sense of one's self requires at the same time a turning away from the source of identification (inward tendency) (Guidano, 1987, p. 160).

Slade (1982) states that the adolescent conflict most striking in anorexic girls is that of "'dependence/independence' (the autonomy) issue)" (p. 169). Goodsitt (1985) states that family involvement is intimately tied to issues of separation-individuation and that "anorexia develops within a family of arrested symbiosis and separation-individuation" (p. 74). Sugarman and Jaffe (1987) make the same point about bulimic individuals. Mahler *et al.* (1975) elucidate how impeded separation-individuation from parents leaves children with annihilation anxiety, fragmentation during separation, and psychic disruption. Guidano (1987) states that enmeshed patterns of attachment, which prevent children from developing feelings of their own, severely hamper a child's sense of being separate. This has the effect of producing "during infancy and preschool years a precarious, loose demarcation between their emerging sense of self and the internal representations of parents" (Guidano, 1987, p. 161). What exactly does Guidano mean when he speaks of a blurred and wavering sense of self? He notes that it is a peculiarity of eating-disordered individuals to display a confusion of self-boundaries between what is me and what is other. Some examples can clarify this concept: (1) Most anorexic and bulimic individuals expect failure, however the failure remains undetermined; neither personal responsibility nor a precise external event is used as justification for this expected failure. In contrast, obese individuals are more likely to blame themselves for an expected or perceived failure (Guidano & Liotti, 1983). (2) The way in which eating-disordered

individuals constantly shift their causal attributions from the self to the outside world and back to the self again, also points to imprecision and blurred self-boundaries (Guidano & Liotti, 1983).

> Talking with patients with eating disorders...we get the distinct impression of a sort of confusion or vagueness of the boundaries between the self and the world (if not of an 'evanescent' self), which is sometimes explicitly recognised...as by the anorectic patient who stated that "her mind was in the mind of other people" (Guidano & Liotti, 1983, p. 283).

(3) In the same way that failure is expected in an undetermined way, these individuals are unable to integrate successes with their self-image, and as Guidano and Liotti (1983) note, "these patients showed a sort of 'emptiness' in personal identity, as though there were nothing definite 'inside' them to which they could attribute successes and failures" (p. 283). (4) Another feature indicating a blurred and wavering sense of self, are the difficulties which anorexic and other eating-disordered people experience with communication (Bruch cited in Guidano & Liotti, 1983). (5) Bruch's descriptions of these individuals' scarce or contradictory use of abstract concepts, which are rarely or incorrectly applied to others or the self, are another indication of a blurred and wavering sense of self. Guidano and Liotti (1983) quote Bruch (1978) on this feature:

> Patients keep on demanding **concrete** and continuous proofs, for example, of their partners' affection; they place much importance on their looks as a means of interpersonal attraction and at the same time say they want to be loved "for what they are" and not because of their looks; and they claim they are not satisfied with themselves, apparently referring to relatively abstract aspects commonly known as "character" or "personality," and then the only definite reason they can give for their dissatisfaction is the physical aspect - "too fat" (p. 285).

Because scenes of nonrecognition and disconfirmation of any autonomous expression of thoughts and feelings are repeated from the earliest time, the resulting product is "the selective differentiation of opponent sets of prototypical emotional schemata as the bases underlying the structuring of a blurred sense of self" (Guidano, 1987, p. 161). This results in the child's self-boundaries

> Continuously and loosely wavering between being 'externally bound' in order to achieve a definite sense of self (in which the reduced sense of individuality is experienced as a feeling of personal ineffectiveness) and trying to be 'internally bound' in defining his/her sense of self (in which the resulting higher sense of individuality is matched by a feeling of emptiness and self-unreliability) (Guidano, 1987, p. 161).

As these 'prototypical schemata' become progressively formalised and ordered into 'nuclear scenes' at the end of preschool years, children are in more of a position to control challenging feelings of personal ineffectiveness and emptiness by seeking intermediate positions (Guidano, 1987). The

pervasive feelings of personal ineffectiveness and self-unreliability are noted by several authors and expanded on in section 2.5.6.

> A steady and dynamic equilibrium is generally achieved by selecting the preferred figure of attachment as the essential 'criterion image' for properly decoding one's inner states, while at the same time, trying to display self-sufficient, controlled attitudes in order to recover a sense of differentiation from the figure itself (Guidano, 1987, p. 161).

Tantamount to this, is that the child remains focused on the parent at a time when he/she should have learnt to decode his/her inner states. The steady and dynamic equilibrium which Guidano (1987) refers to is maintained by specific patterns of decentralised control: (1) selective exclusion of sensory inflow which is capable of activating "direct and defined expressions of one's emotions" (p. 161) reduces the possibilities of incoming challenging disconfirmations; (2) the child constructs a self-image on the perceived expectations of the preferred parent and thus, can be more or less successful in ensuring the necessary confirmations required for the maintenance of a sense of self. The pleasing perfection noted as common to so many eating-disordered individuals can be understood in light of these considerations (Guidano & Liotti, 1983; Slade, 1982).

2.5.3.2 The adolescent resolution

Adolescence is matched by a parallel emergence of higher cognitive abilities. This functions to create a disequilibrium, as the decentering from the world brings with it a relativisation of the absolute image of the parent; the image on which a stable sense of self is predicated. The childhood strategy of deriving a stable sense of self from a preferred figure is now challenged by a distressing discovery that one can be intensely disappointed within this relationship (Guidano, 1987). Thus, feelings of personal ineffectiveness and/or emptiness (as well as feelings of self-unreliability) emerge, where self-worth and self-esteem are vague and questionable. In such a situation, individuals' resolution to the crisis remains centred around receiving confirmations from significant others, as this is still the essential way they can attain a stable and satisfactory self-identity. For these individuals, the only possible adolescent resolution, is "to seek a supportive intimacy and, at the same time, to minimise the effects of disconfirmations and disappointments, whether perceived as the outcome of a deceiving reality or of one's incompetence and unlovableness" (Guidano, 1987, p. 162).

Guidano (1987) describes how causal attribution varies according to the way the perceived disappointment is understood. It is noted that an attribution made from a "blurred and wavering sense of self always remains within rather ample margins of indefiniteness and oscillation" (p. 163).

Guidano (1987) states that the making of an external rather than internal attribution depends on whether the appraisal of the disappointment is actively "'discovered' (i.e., experienced as volitionally imposing one's view upon reality) as opposed to passively 'accepted' (i.e., experienced as adapting oneself to an overwhelming distressing event)" (p. 163). The developmental variables which may influence the quality of the appraisal are presented in the discussion. The internal-external attribution Guidano refers to is the same term as the internal-external locus of control which is used in studies to define the ineffectiveness construct further. These are presented on pp. 89-95.

2.5.3.3 The attitude toward oneself and reality

The eating disorder resolution offers the means whereby a steady and dynamic equilibrium between two opponent emotional polarities is achieved. That is, between the dire need for significant others' approval and the fear of being disappointed within these relationships (Guidano, 1987). The 'recursive oscillation' between these two opponent polarities allows the individual to perceive "a sense of self as reliable and worthy" (because of the perception that they can manipulate others in their favour), as well as allows the individual to experience herself as separate and distinct from others, (because of the perception that they can control others' deceitfulness and intrusiveness) (Guidano, 1987, p. 164).

Guidano (1987) proposes that this dynamic equilibrium results from a specific attitude toward oneself and reality. The most prominent characteristic of the attitude toward oneself is the individuals' propensity for uncertain attribution of causality to their feelings (that which occurs is because of some unspecified emotional state). Guidano (1987) believes that it is this feature which underlies the perfectionism and self-deception so common in eating- disordered persons. How is this feature to be understood in the development of an eating disorder? Because of the lack of confidence in self-perception (due to enmeshed patterns of attachment), individuals characteristically display an overreliance on external frames of reference. Thus, if one's sense of self is drawn from other's evaluations, perfectionism becomes the logical answer. A cycle of inflationary self-evaluation ensues as individuals are constantly setting themselves higher goals (Mahoney, 1974 cited in Guidano, 1987). Such an attitude predisposes one to the very disappointments which one is seeking to avoid. Consequently, perfectionistic attitudes are protected from challenging disturbances by the simultaneous structuring of a self-deceiving attitude (Guidano, 1987). The self-deceiving attitude not only allowing individuals to avoid confrontations which could turn into disappointments, it also functions to exclude the feelings of personal ineffectiveness and emptiness from one's identity. "It is the uncertain

attribution of causality to feelings that makes eating disorder-prone individuals able to prevent themselves from becoming aware of what they actually do know" (Guidano, 1987, p. 165). Slade (1982) views the anorexic's preoccupation with food, weight, and body size as a form of avoidance behaviour which allows her to avoid direct confrontation with the aversive stimuli (interpersonal problems, adolescent conflicts, failure experiences) which formed the motivation for the anorexic/ bulimic behaviour in the first place. Once feelings of personal ineffectiveness and emptiness are activated by challenging confrontations (which are both unpredictable and inevitable), the eating disorder-prone individual will make sense of these feelings by believing that she has an unacceptable body image (Guidano, 1987).

The eating-disorder-prone individual's attitude to reality highlights the uncertainties and contradictions with which these individuals experience the primacy of the interpersonal realm (Guidano, 1987). On one level, to attain an acceptable sense of self depends on establishing an intimate, reciprocal relationship with an attachment figure. On another level, the disclosure and commitment such a relationship demands is experienced as too threatening, as criticisms and/or disappointments would make personal identity even more vague and blurred. It is noted that the eating disorder-prone individual's vulnerability to negative criticism far exceeds the sensitivity to criticism found in other clinical disorders (Slade, 1982). Eating-disordered individuals develop relational strategies which offer tentative solutions to such interpersonal dilemmas; the aim is to obtain from the other/partner "the greatest possible guarantee of supportive intimacy, while avoiding as much as possible any clear commitment and self-exposure in the relationship" (Guidano, 1987, p. 166). Paradoxically, affectional styles which are ambiguous, undefined, and constantly test partners, predispose these individuals to the very criticisms and disappointments they seek to avoid (Guidano, 1987).

Guidano and Liotti (1983) further operationalise the concept of the self. Within therapeutic relationships shared with eating-disordered individuals, they note that if a therapist listens attentively to patients' reports of their inner representations, a therapist can gather information about causal theories, irrational beliefs, and basic assumptions. Thus, the type of attitude patients maintain toward themselves and reality, as well as the way they define (and debase) their self-identity and esteem, becomes clearer. Attention can be paid to the way an individual conjugates five verbs:

> To be, must, can, to need, and to be worth. The manner in which these verbal forms - or their synonyms - follow the pronoun "I" leads to a reconstruction of the patient's self-identity and self-esteem; the manner in which they follow other pronouns ("you," "he," "they") leads to a reconstruction of the patient's attitude toward reality (p. 139).

Eating disorder literature suggests a lack of intimacy in married patients with anorexia and bulimia (Van den Broucke, Vandereycken, & Vertommen, 1995). Van den Broucke *et al.* (1995) state that although one of the impressions created in the literature is that married eating-disordered individuals and their partners often report dissatisfaction with their relationships, the marital relationships of eating-disordered individuals have received little empirical research. These researchers state that failure to achieve or maintain intimacy in the relationship with one's partner can influence one's well-being (physical, emotional, psychological). In explaining the negative effects of a failure to achieve intimacy, Van den Broucke *et al.* (1995) state that

> The emergence of symptoms may be regarded as an avoidance reaction to situations that are perceived as threatening the patient's identity (e.g. the partner's attempts to achieve more intimacy) or alternatively, the existence of the relationship itself (e.g. overt conflicts that arise as a result of the low level of intimacy) (p. 68).

Marital intimacy is defined by these researchers as including six structural dimensions: three on the relational level (cognitive, affective, and instrumental interdependence); two on the individual level (openness and authenticity); and one on the situational level (exclusiveness). Twenty-one eating-disordered patients (ED) and their partners (9 bulimic and 12 anorexic women of which 17 were married and the remaining four cohabitating with their partners), were compared with two control groups: a 'marital distress' (MD) group (21 couples who had applied for marital therapy and where the presence of marital distress was verified by standardised measures), and a 'non-distressed' (ND) group (21 couples who were checked for the absence of psychological and marital distress). A self-report intimacy questionnaire (Marital Intimacy Questionnaire or MIQ) based on the multidimensional definition of intimacy was constructed and used to investigate the degree of marital intimacy in eating-disordered patients and their spouses/partners. Results confirmed the clinical impression that an intimacy deficiency, (particularly a lack of openness), characterises eating-disordered couples' marriages. It was also demonstrated that ED couples' overall level of intimacy is lower than that of ND couples, although higher than that of MD couples. It was also substantiated that the low level of intimacy in ED couples cannot be reduced to the effect of their marital distress, as when compared to the two control groups, the ED group differed significantly on account of their lower level of openness and higher level of intimacy problems. The "lack of open communication in accounting for these couple's low level of intimacy is consistent with the more general findings regarding the relationship between intimacy and self-disclosure....The lack of openness in ED patients' marriages may indeed be considered as a serious relational deficiency, which may represent an important obstacle to growth and enhancement of their marital intimacy" (Van den Broucke *et al.*, 1995, p. 75). Van den Broucke *et al.* stress that caution is due when interpreting the results of this study, as the

observed intimacy deficiency of ED patients' marriages does not imply that the eating disorder is caused by this deficiency. Instead, they state that

> The relationship between these marital problems and the occurrence and/or development of an eating disorder must probably be conceived of as a circular one, with the marital relationship both being influenced by the presence of the disorder, and in turn influencing the further course of the disorder (Van den Broucke *et al.*, 1995, pp. 75-76).

O'Mahony and Hollwey (1995) examined the relationship between eating disorders and problems in interpersonal functioning among several groups of women. The multidimensional nature of both interpersonal functioning and eating disorders makes it unlikely that there is a simple causal relationship between the two. For example, in one causal direction, it is noted that eating problems can cause psychological problems, such as social withdrawal and loss of sexual interest (Keys *et al.*, 1950 cited in Garner *et al.*, 1985). In another causal direction, interpersonal problems may predispose individuals to eating problems and at risk for developing eating disorders. For example, individuals who are interpersonally insecure may engage in attempts to achieve a thin beauty ideal so that they may be more attractive to others (O'Mahony & Hollwey, 1995). In addition to a possible causal role, interpersonal problems may be seen as maintaining or perpetuating eating problems. Alternately, these authors state that, "insofar as eating problems directly cause social difficulties, such a process could become self-perpetuating, whereby eating problems cause interpersonal difficulty that exacerbates the eating problems, and so on" (p. 346). O'Mahony and Hollwey (1995) state that the literature is not clear as to the exact nature of the causal relationship between interpersonal difficulties and eating problems and that it could very well be the case that both problems may be due to another variable (e.g., emotional disturbance). These researchers studied this relationship among three groups of women who showed eating symptomatology of varying degrees and severity: (1) 31 anorexic women; (2) 105 women who had a hobby or occupation in which physical appearance/condition was important (dancers, athletes, professional models, and women who attended a health club at least once a week). This group was referred to as the 'concerned' group; (3) 96 women recruited from the general public who were non-sports oriented (students, nurses, lawyers, physicians, teachers, business women, and secretaries). The women were assessed using standardised measures for eating symptomatology, interpersonal functioning, and psychological well-being or maladjustment. Results showed that there were eating-related problems in all groups. The anorexic group showed both the most eating problems and the greatest degree of interpersonal problems and distress (anorexics also showed significantly more psychological maladjustment). However, both the normal groups reported a substantial amount of eating problems.

> For example, 23% of the anorexic, 16% of the concerned, and 16% of the general public groups admitted to binging once a week or more; 48, 45, and 33% of the three groups reported being preoccupied with the desire to be thinner; and 68, 47, and 33% of the three groups had intrusive thoughts of food and weight (O'Mahony & Hollwey, 1995, p. 348).

There was little difference between the normal groups regarding interpersonal problems and adjustment. The research was able to demonstrate that a substantial and significant relationship exists between eating symptomatology and interpersonal functioning in all groups. However, when general neuroticism was partialled out, the association only remained in the anorexic group. It was concluded that interpersonal problems are unlikely to cause eating disorders in individuals with no specific behavioural or personality predisposition to such difficulties. At the same time

> Once eating problems have developed beyond a certain degree, a relationship between these problems and interpersonal difficulty emerges that is independent of general maladjustment and that becomes stronger as the eating problems become more severe...A number of mechanisms may underlie this association....but the present findings argue against a strong primary role for interpersonal difficulty in the genesis of eating problems (O'Mahony & Hollwey, 1995, p. 350).

2.5.4 Systemic coherence

Guidano (1987) notes the thwarted attempt for individuality in light of the primacy attributed to the interpersonal realm by eating disorder-prone individuals. He also recognises that with the emergence of logical/deductive thinking (and its disappointments), there is a relativisation in the role attributed to the interpersonal domain: "The search for supportive relationships turns into a more complex attitude, aimed at obtaining a confirmation of one's felt identity while, at the same time, preserving the gradually emerging sense of one's individuality" (p. 166). The dynamic equilibrium achieved in adolescence has its own contradictions and discrepancies. In the eating disorders attitude, it is the propensity to produce events which are understood in terms of disappointments and disconfirmations (Guidano, 1987). Slade (1982) notes that clinical research among anorexic individuals reveals that, "such patients tend to see events and their own achievements in black and white terms such that anything less than idealised, perfect success/attainment represents failure or lack of success" (p. 171). Were disequilibria (with the resultant distressing feelings), able to be assimilated and integrated by individuals, a much more stable and reliable self-perception would ensue.

> The pattern of organisational closure underlying the systemic coherence of an eating disorder P.C.Org...is the fact that one's inner life becomes progressively ordered into personal experience only if matched with the recursive oscillation between the need for others' approval and the fear of being intruded upon or disconfirmed by others (Guidano, 1987, p. 167).

'Experience-assimilating' procedures differ between eating-disordered individuals. In the anorexic case, Guidano (1987) posits that the **active** struggle these individuals display over their perceived personal ineffectiveness, leads to the development of "more complex and abstract self-sufficient attitudes" (p. 167). In contrast, the obese pattern is marked by its **passiveness** toward distressing feelings activated by a disappointment. This passive attitude is what often leads to the parallel structuring of bodily and emotional patterns which "provide more defined and controllable forms to one's perceived personal ineffectiveness" (p. 168).

2.5.5 The dynamics of cognitive dysfunction

The eating disorder-prone individual's search for individuation is noted to encounter a disequilibrium; a disequilibrium which is the result of distressing feelings being activated (Guidano, 1987). However, these individuals' inability to integrate and assimilate these feelings leads them to alternate modes of explaining and controlling their feelings: "**Individuals are led to explain and control them through modifications of their body image produced by alterations of the eating behaviour**" (Guidano, 1987, p. 168). Guidano (1987) documents the life events which are most likely to activate a disequilibrium and Lacey (1985) lists a similar series of life events for bulimic individuals (see discussion pp. 158-159).

> A disequilibriated eating disorder P.C.Org. is characterised by an interplay among simultaneous and competing processes. On the one hand, the emergence of critical feelings that challenge one's ongoing felt identity increases a blurred sense of self. On the other hand, there is the attempt to exclude such feelings from one's felt identity (or at least to control them) by attributing them to circumscribed parts of the self (Guidano, 1987, p. 169).

Guidano (1987) outlines the interplay between tacit and explicit processes. At the conscious level, the individuals' pervasive feeling of ineffectiveness is embodied in the unbearable representation of themselves as having an unacceptable body image, usually viewed as a figure too fat. In the anorexic's case, the unbearable image of the self is fought against through a rigid controlling of biological impulses, and the high level of motor activity in these individuals is noted, despite their often worn-out physical appearance.

> The anorexic attempt to maintain a consistent positive self-image is carried out by opposing the challenging sense of ineffectiveness with a sense of personal power derived from the continuous confirming experience of being able to dominate even the deepest and most embedded impulses (Guidano, 1987, p. 170).

Within the obese pattern, at the conscious level individuals think themselves unable to control their impulses (to overeat, binge, and vomit). Because of these individuals' propensity for making internal causal attributions, efforts to keep the self-image as unchanged as possible

> Centre on accepting one's perceived negativity, but restricting it solely to external appearance. The diversionary role played by this passivity and lack of control is, indeed, clearly highlighted by what could be rightly considered a catchword of obese people: "What other people reject is not really me; they reject my fat body" (Guidano, 1987, p. 170).

At the tacit level, the awakening of distressing feelings is accompanied by changes in motor setting and autonomic activation. However, because eating disorder-prone individuals lack "adequate cognitive mediation" (Guidano, 1987, p. 170), these feelings tend to be immediately acted upon by corresponding changes in eating and motoric behaviour. Guidano (1987) notes the diversities found between different eating disorders. Anorexia is noted as "an acute disequilibrium of the adolescent/youth phase" (pp. 170-171) and thus, is seen as a disorder with a tendency toward readjustment. In contrast, obesity, (especially when its onset is in adulthood), is viewed less optimally. This is because of the tendency "to structure itself in a rather stable self-deceiving attitude aimed at coping with both one's perceived negativity and others' deceitfulness and intrusiveness" (p. 171). In essence, this means that the more an individual believes that his/her failure could consist of not being loved and approved of, the more the person can come to feel that it is an unacceptable body image which protects him/her from the disappointments and rejections which he/she fears so much. Because of the centrality accorded to feelings of ineffectiveness in Guidano's model, as well as in the eating disorder literature, the last section examines this concept more closely.

2.5.6 The concept of ineffectiveness in eating disorders

Bemis (1978), Garner and Bemis (1982; 1985), Hood, Moore and Garner (1982), and Slade (1982), identify feelings of ineffectiveness as a central component of the anorexic and bulimic personality. Anorexia and bulimia are thus viewed as maladaptive defences against these feelings.

> Relentless dieting is maintained by potent **cognitive self-reinforcement** from the sense of mastery, self-control, and competence derived from successful dieting. For the anorexic, hunger is no longer simply an aversive stimulus. It acquires a new meaning, because it is associated with a higher-order accomplishment. The anorexic's extraordinary attempts to control her appetite provide a long-coveted sense of mastery within the context of lifelong feelings of incompetence. Weight control or weight loss becomes the preeminent barometer of achievement and a reliable referent for self-evaluation (Garner & Bemis, 1985, pp. 109-110). [See also Slade, 1982, section 2.1.2.2, pp. 10-11]

That weight loss or control becomes the means whereby the eating-disordered individual measures her sense of worth and esteem, is revealed in the importance which she attaches to weight loss. Various authors (Bruch 1973 cited in Guidano & Liotti, 1983; Garner & Bemis, 1982; 1985; Hood *et al.*, 1982; Slade, 1982) have emphasised that the reason weight loss has such a profound impact, is because it occurs within the context of feelings of inadequacy and ineffectiveness in most other areas of functioning. Others have noted that their patients describe their weight status as an "accomplishment", and themselves as "proud" (Bruch, 1985), "powerful" (Boskind-White, 1985), "successful" (Kern & Hastings, 1995), and "in control" (Lawrence, 1988; 1992). Selvini-Palazzoli (1985) observes that, for the anorexic

> Every victory over the flesh is a sign of greater control over one's biological impulses....Emaciation becomes the symptomatic expression of the search for security and power (and therefore a defence against insecurity, inadequacy and impotence).... Emaciation [is seen] as the magic key to a greater **power** (pp. 72, 74).

Although sense of ineffectiveness is identified as one of the three central components of psychological dysfunction in anorexia, Hood *et al.* (1982) noted that this dimension had received little empirical research, and that there was a lack of an adequate measure of the ineffectiveness dimension. Garner, Garfinkel, Stancer, and Moldofsky (1976 cited in Hood *et al.*, 1982) had previously correlated body-image disturbance and external locus of control, which suggested that the internal-external (I-E) construct may be related to feelings of ineffectiveness. Gilmor (1978 cited in Hood *et al.*, 1982) found that an important antecedent of locus of control orientation is parental behaviour, particularly mother's behaviour. Levensen and Scheck (1973; 1978 cited in Hood *et al.*, 1982) reported that adolescent girls who perceived their mothers as providing little protectiveness and low control scored more internally on the I-E measures, than girls who perceived their mothers as exerting high control. Levensen (1973 cited in Hood *et al.*, 1982) suggests that early independence expectancies, less intrusiveness, and suggestive rather than directive interaction, are maternal attitudes which directly influence later internality in their daughters. Hood *et al.* (1982) noted that these findings were in direct contrast to those which describe anorexics' mothers and which suggest that external I-E orientation is a characteristic of anorexic patients. In examining clinical differences within the anorexic population, Hood *et al.* (1982) suggest that the externality hypothesis may not be applicable to all patients. They identify two groups, dieters (who bring about weight loss through exercise and food abstention) and bulimics (who control their weight through vomiting and purging) and state that

> The importance of this distinction...centres on issues of control. Whereas the dieter demonstrates considerable self-discipline and denial, the bulimic is often described as

> fluctuating between an intense sense of self-control and loss of control....It seems reasonable to conclude that the bulimic continues to experience feelings of ineffectiveness and that the restricter has been successful in her search for self-control (p. 4).

Using Reid and Ware's (1974) multidimensional Internal-External Locus of Control Scale (I-E scale) Hood *et al.* (1982) compared scores of female anorexia patients to norms. Both samples were divided into two groups matched for age and educational status (high school and university students). The I-E scale is a forced-choice questionnaire where the subject is given a choice between internal and external interpretations of various events. The I-E scale yields three factors in addition to the total score: (1) fatalism factor (measures the degree to which the subject perceives luck or fate as controlling life events); (2) social system control (measures perceived personal versus sociopolitical control over environment); and (3) self-control (indicates how much control the subject feels over her desires, impulses, and emotions). Although results of the study indicated that external I-E is not a global characteristic of anorexic patients, it was found that within the patient group

> Over twice as many externals as internals induced vomiting on a frequent basis...and bulimia and laxative abuse were about 20% higher in the external group...Marked denial of weight loss, which is associated clinically with lack of insight, was more characteristic of internal subjects....External subjects were found to use alcohol on a frequent or regular basis significantly more often that internal subjects....Internal subjects were described as excellent or above average students more often than externals....The within-patient comparison yielded...findings clearly related to differences in eating behaviour....Severe depression [was] associated with...binge-eating...and bulimia...confirmed by the symptomatic scores obtained by externals.....Externals demonstrated a more disturbed perception of ideal body size.... Compared to internals, external subjects suffer from greater weight fluctuation, loss of control, and feelings of guilt....External anorexics were less stable and more guilt-prone, self-reproaching, and careless of social rules. They followed their own urges and were tense, frustrated, and overwrought in comparison to internals...Results suggest that internally controlled anorexics, although slightly neurotic, represent a healthier group of patients. Indeed, the vomiting and purging pattern that was found to be most characteristic of external subjects has been associated with poor prognosis (Hood *et al.*, 1982, pp. 6-7, 9, 11- 12).

Although externality was not found to be a global characteristic of anorexic patients, Hood *et al.* (1982) were able to demonstrate the usefulness of externality as useful prognostic index of other measures of psychopathology. Several investigators have administered different versions of the Locus of Control Scale to anorexic, bulimic, and obese individuals in an attempt to define the ineffectiveness construct further. Garner and Bemis (1985) attempted to operationalise the ineffectiveness construct further by developing an Ineffectiveness subscale to the Eating Disorder Inventory (Garner, Olmsted, & Polivy, 1983 cited in Garner & Bemis, 1985). Results of their study showed that anorexic and bulimic individuals score significantly higher on the Ineffectiveness subscale than normal female-college students.

One of the major problems with weight reduction in obese individuals is relapse and weight gain after the termination of a weight programme (Nir & Neumann, 1995). Various personality characteristics have been identified which attempt to explain success in long-term weight reduction goals. Nir and Neumann (1991) found that high self-esteem subjects were more successful in losing weight than low self-esteem subjects.

> Persons with high levels of self-esteem tend to be more autonomous and to display a basic trust in themselves and in others. They are more optimistic and possess the ability to adapt more readily to new situations. Failure does not worry them...therefore, occasional setbacks do not lead them to feelings of either helplessness or worthlessness....They respect themselves and consider themselves people of worth and are not psychologically preoccupied with others' evaluation of them....Low self-esteem subjects dislike themselves and, thus, doubt the accuracy and/or efficacy of their beliefs and behaviours. They are characterised by a lack of confidence in their own attitudes and/or behaviours. Hence, their attitudes and behaviours are more apt to be affected by social and psychological variables....[This] characteristic, "plasticity," refers to susceptibility to external and, in particular, social forms of influences....Low self-esteem tends to be correlated with feelings of worthlessness and inferiority...as well as a low capacity for social adjustment and a low level of adaptation to life changes or demands (Nir & Neumann, 1995, p. 483).

Internal-external locus of control is linked to weight reduction in the literature (Nir & Neumann, 1995). Locus of control refers to the extent to which an individual believes she/he has control over her/his life. Belief in internal locus of control leads to the perception that reward is the result of one's own self-control. On the other hand, the perception that reward is the result of luck, fate or chance, or that it is under the control of powerful others, is attributed to external locus of control (Nir & Neumann, 1995). Nir and Neumann (1995) conducted a study which explored the relationship among self-esteem and I-E locus of control as predictors of long-term weight loss maintenance. Out of 116 obese women who participated in a 10-week weight reduction programme, a follow-up study (covering 15 to 47 months) of 66 women was conducted. Subjects were divided into two "internal" and "external" groups and into three self-esteem groups. At follow-up it was found, (1) the higher the self-esteem score, the lower the average weight regain (ie., the longer the period of maintaining weight), and (2) the higher the locus of control (ie., the more internal) the smaller the weight regain. The differences between high and low self-esteem groups and between internal and external groups, are explained in terms of differences in their ability to adapt to reformative self-control. It is suggested that a central aspect of reformative self-control behaviour is that an individual take full responsibility for their own actions. Results of the study showed that low self-esteem subjects and external subjects utilised mainly redressive self-control behaviour as their psychological preoccupation with themselves, (due to the lack of self-confidence and doubts about themselves), prevented them from experiencing and learning reformative self-control behaviour (Nir & Neumann, 1995). It was

concluded that self-esteem and locus of control play a crucial role in the management, attainment, and maintenance of weight loss. It is recommended that weight reduction programmes be designed with specific reference to personality constructs of participants.

Williams, Chamove, and Millar (1990) note that standardised investigations of perceived control and assertiveness in eating-disordered individuals are limited, even though anecdotal literature indicates that eating disorder patients feel controlled by external forces (familial and sociocultural) and are unable to assert themselves against these controls. They note how unassertiveness can take the form of submissiveness or hostility and that hostility may be either inwardly or outwardly directed. "One consequence of unassertive behaviour is self-directed hostility which the literature suggests as a likely characteristic of anorexia and bulimia" (Williams *et al.*, 1990, p. 328). Because perceived control, assertiveness, and hostility have been noted in psychological disorders associated with eating disorders (such as depression, anxiety, and obesity), and because both anorexia and bulimia have two components (psychological factors and dieting behaviour), Williams *et al.* (1990) conducted a study which compared (1) eating disorder patients (anorexic and bulimic females), (2) psychiatric control patients, (3) non-patient/non-dieting controls and (4) dieting females on five standardised measures of (1) eating disorder, (2) assertiveness, (3) locus of control, (4) hostility and (5) family environment (in terms of the encouragement of independence and control). Williams *et al.* (1990) correlated the results of all 184 subjects and showed that greater eating disorder symptomatology is associated with (1) a low degree of self-assertion, (2) high levels of self-directed hostility, (3) a perception of being controlled by external forces, and (4) a perception of the family as less encouraging of independence and more controlling. When the results of the four groups were compared, the eating disorder group showed (1) the greatest locus of external control and (2) the most self-directed hostility, but (3) the least assertiveness and (4) the least family encouragement of independence. The question was asked, "why, if they perceive this 'external' control do such patients not attempt to assert personal control?" (Williams *et al.*, 1990, p. 333). It was found that eating disorder subjects were significantly less assertive (and thus more submissive and ineffective), as despite perceiving external control, they did not possess the behavioural repertoire to counteract it. The idea that eating disorder subjects have feelings of being controlled and are unassertive because they come from controlling family backgrounds was also tested. These women did not report their families to be more controlling, rather they felt their families to be less encouraging of independence. "This suggests that family interactions in this group are more subtle than overt control, and the familial dominance" and 'control' described by Bruch (1985), Geist (1985), Goodsitt (1985), Guidano and Liotti (1983), Guidano (1987), Minuchin *et al.*, (1978), Selvini-Palazzoli (1985), and Slade (1982), "may be a

consequence of a failure to promote autonomy rather than an attempt to suppress it (Williams *et al.*, 1990, p. 333). Results of this study provide empirical data and confirmation of anecdotal claims which describe eating disorder patients as being "non-assertive and deferential" (Schwartz, Barratt, & Saba, 1985a) and as suffering from a "paralysing sense of ineffectiveness" (Bruch, 1985).

Ghiz and Chrisler (1995) note that no studies have specifically examined the relationship of assertiveness, depression, and obsessive thoughts of food on compulsive eaters. One might expect that compulsive eaters lack assertiveness because they eat in response to emotional states (Dunn & Ondercin, 1981), and that compulsive eaters are at risk for depression because of dissatisfaction with their bodies, the belief that appearance is very important, and through the effects of dieting (McCarthy, 1990). Ghiz and Chrisler (1995) conducted a study which attempted to demonstrate the interrelatedness of these characteristics and that these are either causes or consequences of compulsive eating. Fifty-three women who defined themselves as compulsive or binge eaters were prescreened to exclude those with probable diagnoses of anorexia or bulimia. Participants were asked to fill out six questionnaires: (1) The Three Factor Eating Questionnaire (measures dietary restraint, disinhibition, and hunger), (2) The Beck Depression Inventory (measures the severity of depression), (3) The Compulsive Eating Scale (measures states of emotion as they relate to eating), (4) The Eating Obsessive-Compulsive Questionnaire (measures the degree of obsessive-compulsive tendencies toward eating), (5) The Personal Assertion Analysis (measures aggressive, passive, and assertive behaviour), and (6) The Personal Inventory (asks about dieting history, binges, attitudes toward the self, and collects information about family history of compulsive eating and drug, alcohol, and sexual abuse). Results showed that (1) obsessive thoughts of food and compulsive eating were related to depression, (2) participants had a low ability to assert themselves but were not seriously lacking in assertiveness, and (3) that obsessive thoughts and disinhibition were predictors of compulsive eating but that depression, assertiveness, restraint and hunger were not. Although findings were similar to those of Greenberg (1986 cited in Ghiz & Chrisler, 1995) who reported that mild depression and assertiveness level did not predict compulsive eating, Ghiz and Chrisler's finding that "compulsive eating is associated with mild depression and a moderate level of assertiveness is somewhat surprising because one might expect compulsive eaters to be more obsessed, more depressed, and less assertive than was true of these participants" (1995, p. 496). It was hypothesised that this may have been due to the fact that subjects were recruited from weight loss programmes and that depressed people were less likely to join such programmes than those who feel more in control of their lives. Additionally, the cycle of compulsive eating is to binge and then to diet. "Compulsive eaters on the upswing of dieting", as these participants were, "are less likely to be depressed" (Ghiz & Chrisler, 1995, p. 496).

> As expected, disinhibition and obsessive thoughts of food are good predictors of compulsive eating. It was surprising, however, that restraint and depression were not. Disinhibition and restraint can be thought of as opposites; therefore, restraint should be negatively related to compulsive eating and low levels should predict binges. The fact that depression did not predict compulsive eating was probably due to the mild level of depression reported by the women in this sample. Hunger was not expected to be a predicting factor because it has much less to do with compulsive eating than do other variables, e.g., emotional state. Nor did assertiveness level predict compulsive eating. This may be because assertiveness is characterised on questionnaires as an interpersonal behaviour. Perhaps how assertive one is with others has little to do with feeling in control of oneself (Ghiz & Chrisler, 1995, p. 497).

It was concluded that women who were not enroled in weight reduction programmes would have provided a much clearer picture of the typical compulsive eater. Although this research is clearly an attempt to understand the dynamics of compulsive eating, (an area which has largely been neglected in theory and research), it remains on an exploratory level, as no attempt is made to explain or discuss how, if at all, the proposed interrelatedness of obsessive thoughts of food, depression, and levels of assertiveness are causes or consequences of compulsive eating. It is evident that compulsive eating is a complex issue and that explanatory theories are still in their infancy.

2.5.7 Conclusion

The most important features of Guidano's model for eating-disordered individuals have been presented. The presentation is limited to those aspects of the model which this research is designed to test. It is noted that not only does Guidano (1987) present a model explaining three other psychopathologies but that Guidano and Liotti (1983) have developed a structural model of psychotherapy based on the findings of their research.

CHAPTER THREE: METHODOLOGY

3.1 Aims and rationale

The aim of this research is to investigate the validity of Guidano's formulations about eating-disordered persons. Guidano's use of a multiple case study in the development of his theory remains implicit, as his cases are not formally described, nor are his assertions tested against new cases. There are no in-depth descriptions of individual cases, nor does he show how his theory is derived from these. The goal of this research is, therefore, to explicitly test his model against new cases using a rigorous and systematic multiple case study methodology.

3.2 Historical and contemporary issues of case study methodology

Historically, the case study method is presumed "to antedate the rise of philosophy, history, and natural observation in classical times" (Bromley, 1986, p. 10). In the 1920's and 1930's, case study research was a widely used method of inquiry for the development of knowledge in the human and social sciences, especially in the fields of medicine, sociology, anthropology and psychology (Bromley, 1986). After the Second World War, and with the advent of quantitative methodologies (statistical analysis, psychometrics, questionnaire methods, survey and experimental design), there was a simultaneous departure from the use of the case study method as a research tool, except in anthropological studies (Bromley, 1986; Edwards, 1990; 1993; Mair, 1980). The ideological tenets of a positivist research methodology in teaching and research institutions changed. Models which established validity and causal links between variables replaced models which sought an understanding of content. Statistical and mathematical inferences thus became the basis for explaining and predicting human behaviour (Edwards, 1993). Case study methodology was rejected as "'prescientific' and incapable of yielding valid conclusions about the causes of outcome" (Bolgar, 1965; Kazdin, 1981 cited in Edwards, 1993, p. 1).

Paradoxically, some of the most influential theories about personality and psychotherapy, (such as those described by Sigmund Freud and Carl Jung in Fordham, 1987), are based on the in-depth examination of individual cases. Scrupulous examination and documentation of individual cases formed the basis of their theories and in effect, launched a century of subsequent teaching and training of psychology scholars. Their attention to individual cases

allowed them to develop personality theories of such ingenuity and clarity, that their contributions to psychological theory development are still relevant and drawn upon by their successors. Their contributions also heralded a new era, where psychology was advanced the status and recognition of a scientific profession.

Differences between approaches which emphasise "individual differences among unique individuals" (idiographic approach) and those that emphasise "universal processes characteristic of people in general" (nomothetic approach) (Allport, 1937 cited in Silverstein, 1988, p. 425) reveal a contemporary clash over a contentious issue dating back to Aristotelian philosophy (Kazdin, 1992). This refers to the "philosophical tension between the particular and universal facets of substance" (Silverstein, 1988, p. 425). The philosophical question of "how an individual's uniqueness may be incorporated into a general understanding of how to define him or her" (p. 425) requires a careful solution for the integration of the two approaches. Drawing on Aristotelian philosophy, Silverstein (1988) offers such a potential resolution.

> Idiographers...insist that because each personality is truly unique it must be studied primarily in terms of the individual only and his or her personal history...and that individual differences in personality will yield only superficially to being studied by any set of formula-driven methods....Those who advocate the nomothetic approach rely on the operations of personality inventories and dimensional concepts grounded in functional relations. Idiographers require as cornerstones the procedures of case studies, biographies, and concepts of the "self" drawn from natural language categories and humanistic traditions (Silverstein, 1988, p. 425).

Discussing the implications for psychology which the resolution of the nomothetic and idiographic tension has, Silverstein is emphatic in his opinion that, "psychologists may draw from this contention an interesting lesson in the value of the biographical case study for the beginning of an understanding of both the uniqueness and general laws regarding human nature" (1988, p. 429). Silverstein describes how all humans are products of their 'developmental functional histories' (DFH) and that each DFH has a uniqueness encapsulated within the general factors that will inevitably influence its development. Quoting Calvino, Silverstein offers an almost poetic metaphor for the understanding of this paradoxical concept:

> Mr Palomar, the title character experienced the sword of light from the setting sun on the sea and noticed that this sword is imposed equally on the eyes of each swimmer: there is no avoiding it. He wondered, "is what we have in common precisely what is given to each of us as something exclusively his?" (Calvino, 1985 cited in Silverstein, 1988, pp. 429-430).

Edwards (1990; 1993b) notes that most relevant and useful theory and research suited for clinical applications is the result of naturalistic, idiographic approaches which have been derived from practitioners working with individuals and not by researchers' elaborate statistical analyses (where no felt sense of what the individual is actually like, is revealed). He quotes Strupp (1981) on this issue: "There can be no doubt that most of what the field has learned about psychotherapy since Breuer treated famous patient Anna O. a century ago has come from astute and creative clinical observation" (cited in Edwards, 1990, p. 3).

Following convinced proponents of the case study method (Barlow, 1981; Greenberg & Rice, 1988; Polkinghorne, 1985; Safran & Stake, 1978; Strupp, 1981 cited in Edwards, 1993b), an argument may be made for the case study method as a scientific research tool for the advancement of understanding, pursuit of knowledge, and theory development. The study of individual cases as the essential prerequisite for the development of general theoretical principles is identified as the framework within which other research initiatives may be accommodated (Edwards, 1993b). As Stake (1978) puts it, "the aim of the practical arts is to get things done" and this aim is fulfilled by the case study method (cited in Edwards, 1993b, p. 2). Research which is time-consuming and rediscovers what is already known, is pointless. The case study method is not limited by content or context. Instead, it lies on a continuum which ranges from being able to describe new phenomena, explore familiar phenomena in-depth, develop theory, as well as test already existing theory (Edwards, 1990; 1993b). Because of its wide applicability in the research process, its value as a research tool is enhanced. The fact that it is able to offer a research design compatible with a wide range of phenomena, adds to its value.

Psychotherapy researchers have an advantage over other researchers in that the unique and creative psychotherapeutic relationship offers a field ripe with fruits, yielding data for the continual development and refinement of personality, cognitive and behaviour theories. The 'practitioner-as-scientist' model of psychotherapy is based on three fundamental aspects: (1) the psychotherapist has special access to quality research data; (2) the professional context of psychotherapy is a structured research setting; (3) psychotherapy is an exercise in applied science (Edwards, 1990). It is within the fairly recent appearance of a psychotherapy-as-research model that there has been a resurgence in the popularity and acceptance of the case study as an essential means of developing knowledge (Edwards, 1990).

Maslow (1973 cited in Edwards, 1993, pp. 2-3) identifies two processes in the development of knowledge: (1) "pioneering, scouting, originating", and (2) "validating, checking, verifying". The scientist-practitioner split in clinical psychology (Edwards, 1990) is mirrored in researchers' selective bias for either of the two processes mentioned above. Recent literature on the case study method (Bromley, 1986; Edwards, 1990) argue for its use as an umbrella-method, a method which can unite and heal the split caused by the fiercely defended and divided proponents of various research methodologies.

Giorgi (1975) and Kruger (1988b) have been at the forefront of championing the dual importance of "the context of discovery and the context of verification" in phenomenological qualitative research (Edwards, 1993b, p. 3), as opposed to emphasising the context of verification at the expense of discovery. The Duquesne phenomenological method and psychotherapy process research are contemporary qualitative methodologies where researchers usually study a single phenomenon across a number of cases in a single study (multiple case study methodology) (Edwards, 1993b). Studies using the Duquesne phenomenological method such as Brooke's study on guilt (1985), Fischer and Wertz' analyses of being criminally victimised (1979), Dapkus' thematic analysis of time (1985), and studies within psychotherapy process research, all make use of case material to develop and refine theories. They also use case material to establish the reliability and validity of conceptualisations and conclusions (Edwards, 1990). This method is not limited to descriptive analyses and can be employed to test theories too. Mahrer (1988) argues that hypothesis-testing psychotherapy research is an unproductive, traditional approach to confirming or disconfirming theories of psychotherapy and that discovery-oriented psychotherapy research is a better-suited alternative to hypothesis-testing.

> No theory can be proven true by empirical data. And, just as it is impossible to prove a theory, so also is it impossible to prove one false....I know of no established theory of psychotherapy that declared bankruptcy because of research that failed to confirm, disconfirmed, or falsified its theoretical propositions and...assumptions; nor is there a logical necessity for this to occur. Theories of psychotherapy wax and wane because of considerations that have virtually nothing to do with the testing of hypotheses bearing on their theoretical propositions. It is simply a sad fact that in soft psychology theories arise and decline, come and go, more as a function of baffled boredom than anything else....The careers of theories of psychotherapy are under no logical necessity of being seriously affected by the results of hypothesis-testing research (Mahrer, 1988, p. 694).

Mahrer (1988) launches a fierce attack on the fruitlessness which hypothesis-testing research

has on developing a cumulative body of psychotherapeutic knowledge because it neither confirms nor disconfirms theoretical propositions and yet, he notes that it is still one of the most widely used forms of research.

> Intensive study of the single case (either controlled or uncontrolled, with or without measurements) is a valuable **source of hypotheses**...discovery of hypotheses is a legitimate and essential scientific activity. But idiographic study has little place in the confirmatory aspect of scientific activity, which looks for laws applying to individuals generally (Kiesler cited in Mahrer, 1988, p. 697).

Mahrer (1988) offers an alternative approach to psychotherapy research and urges researchers to adopt the rationale, aims, and methods of discovery-oriented psychotherapy research. Two aims and purposes different from hypothesis-testing research are identified: (1) an in-depth, discovery-oriented focus on therapeutic phenomena, and (2) attempts are made to uncover the relations among psychotherapeutic conditions, operations and consequences (Mahrer, 1988). The aim and rationale of discovery-oriented studies is to learn more, not to find out what one already knows or expects. "The aim is to take a closer look in order to discover what may be there to be discovered" (Mahrer, 1988, p. 698). Mahrer (1988) describes a proposed research method and offers helpful guidelines to the researcher for making sense of the data. In this way he offers the means whereby a researcher may examine the data to find a discovery-oriented answer to his/her research question. He proposes that:

> The field of psychotherapy will benefit more from discovery-oriented than from hypothesis-testing research, and that rigorous and productive discovery-oriented research will unseat hypothesis-testing as the scientific means of inquiry in the field of psychotherapy research (Mahrer, 1988, p. 701).

This is because findings from the latter approach are able to build scientific theory in the psychotherapeutic field, engender advances throughout the field of psychotherapeutic practice, as well as integrate theory, research and practice in the field of psychotherapy (Mahrer, 1988). Much of the research work Mahrer (1988) describes involves the intensive study of a group of individual cases in order to fulfil research aims (to develop, refine, and test theoretical frameworks and propositions) (Edwards, 1993b). As Edwards conceptualises it, "it can...be viewed through the lens of multiple case study methodology" (1993, p. 8). The subsequent section of this chapter will revolve around two aspects: (1) a critical evaluation of the case study method as a scientific tool of inquiry, and (2) an argument will be made as to why the case study method was chosen for its suitability to this project.

3.3 Case study research method

Advocates of the case study method argue that the advancement of knowledge in any discipline results from rigorous application of appropriate investigative techniques suitable to the subject matter and research question (Bromley, 1986; Edwards, 1993b). Proponents of case study methodology regard the approach as fundamental in building the cumulative body of knowledge in the social sciences and particularly, in psychology. Kazdin (1992, p. 152) states, "the case study has played a more central role in clinical psychology than in other areas of psychology". Bromley (1986, p. ix) asserts that, "the individual case study, or situation analysis is the bedrock of scientific investigation". Equally emphatically, Edwards (1990, p. 1) states that, "the fundamental method by which knowledge is advanced in the development and testing of interventions in cognitive therapy has been the systematic analysis of individual cases". Kaplan (1964 cited in Simon, 1969, p. 53) quotes Freud as saying that, "the true beginning of scientific activity consists in describing phenomena and (only) then in proceeding to group, classify and correlate them". Along the same lines, Bromley argues that "the case study method is a basic form of scientific inquiry that underpins effective professional practice especially in relation to human problems" (1986, p. 41). What Freud, Bromley, Edwards, and Kazdin are saying, is that any form of scientific inquiry must begin with description and that the case study method not only proposes that this should be the case, but that the case study method is in fact just that; a means whereby a detailed account of a naturally-occurring event, phenomenon or individual may be made, using detailed description as the underlying method towards achieving this aim (Bromley, 1986; Zeisel, 1984). A case study design is used when intensive knowledge about one complex object is sought. The fundamental essence of all case studies is thus a desire to understand an individual, object, event, or phenomenon as a whole (Zeisel, 1984). The traditional bifurcation between the case study and empirical research (Kazdin, 1992) and the ideological clash between the idiographic and nomothetic approaches (Silverstein, 1988), has divided the discipline along fundamentally different lines regarding practice and research.

> The practice of psychology often is characterised as the focus on the individual subject, usually in the form of case studies, where scientific rigour is sacrificed. In contrast, research in clinical psychology usually is characterised as rigorous experimentation in laboratory or applied settings, typically with groups of subjects (Kazdin, 1992, p. 153).

This split is based on the methodological discrepancies of the two approaches for evaluating variables that contribute to behaviour (Kazdin, 1992). See citation on next page.

> The case study usually consists of uncontrolled observations of the individual client in situations where concrete and immediate concerns of that person must be given high priority. Experimentation usually consists of carefully controlled evaluations of groups of individuals in which the research question is accorded high priority. This bifurcation is unnecessary because methods of evaluation are available to study the individual case experimentally and to accord high priority to the clinical concerns of the individual (Kazdin, 1992, p. 153).

The lack of controlled conditions, objective measures of functioning, and scientific rigour, has limited the use of the case as a research tool (Kazdin, 1992). However, the naturalistic and uncontrolled conditions of the case have also made it "a unique source of information that complements and contributes to experimental research" (Kazdin, 1992, pp. 153-154). Kazdin (1992) offers a six point summary of the value of the case study: (1) the case study has served as a source of ideas and hypotheses about human development and behaviour; (2) case studies have frequently served as the source for developing therapy techniques; (3) case studies allow for the study of rare phenomena; (4) the case study is valuable in providing a counter-instance for notions that are considered universally applicable; (5) case studies have persuasive and motivational value; (6) cases are usually selected systematically to illustrate a particular point. Not only do case studies serve the function of developing specific therapeutic techniques and hypotheses about clinical disorders, they also function to stimulate further research by others who want to test and critically evaluate previously made assertions.

Edwards (1993b) demarcates how the research process can be broken down into six steps, within each of which, the case study may play a role. These demarcations are not mutually exclusive, as several of these may be included in a single case study. In the first step, **descriptive work,** the aim is to document one or more instances of a particular phenomenon to arrive at a thorough description. There exists **exploratory-descriptive work,** which focuses on a relatively unknown phenomenon, and **focused-descriptive work,** where an already described phenomenon is described more fully. The Duquesne (in Giorgi, 1975; Kruger, 1988a,b) and Mahrer (1988) approaches are both examples of methodologies developed to suit this work. In the second step, **theoretical-heuristic work,** the goal is to build theory. A dialogue between descriptive data obtained and a theoretical framework allows for more clarity and rigour to be extended to a particular theory. In the third step, **grounded theory building,** theory is built up based on an accumulative case-law (Bromley, 1986). Theoretical propositions derived from one case (or more) are tested against new cases in order to support a theory or to call for its modification. Central to this process is the notion that every case counts and a case that does not conform to a particular proposition is not disregarded but included within

resultant discussions. A fourth interrelated step, **hermeneutic work,** takes grounded theory building a step further in that, "complex theoretical frameworks from existing literature are appropriated as a means of deepening our understanding of a case for which there is not a readily applicable case law (Edwards, 1993b, p. 14). In the fifth and sixth steps, **theory testing casework,** empirical tests are made of generalisations and predictions that exist in a well-developed case law. A suitable case(s) is chosen to test selected theoretical propositions. This study can only take place once theory is well developed and operationalised (Edwards, 1990). Careful attention needs to be paid to the selection of a suitable case, as if the case fails to support a particular theory, the researcher needs to be in a convincing position to be able to argue why the case failed to support it. Theory testing work can take the form of **testing hypotheses about psychological structure,** where a series of theoretical propositions are tested against a series of case studies to either verify or disconfirm theory (such as Brooke's, 1985 study on guilt) or **hypotheses about relationships between events.** The outcome of psychotherapy is one category where relationships between types of event may be studied (such as Mahrer's work on the relationships between conditions, operations and events in psychotherapy which influence the consequences and outcome of the psychotherapeutic process, 1988).

The notion of validity and reliability in case study research is accorded lengthy discussion and debate by Edwards (1993b) and Kazdin (1992). In elucidating the methodological threats which could undermine the suitability and acceptability of the case study as a scientific tool of inquiry, it is argued that if researchers were attentive to these issues, the case study method is no more or less valuable as a research tool than any other qualitative or quantitative methodology. In fact, Edwards (1993b) states that the methodological threats facing case study researchers are the same threats each researcher needs to keep in mind, regardless of the research design.

Edwards (1993b) divides the research process into three steps: (1) data collection; (2) data reduction; (3) data interpretation. Within each of these steps, Edwards identifies the essential issues of validity facing researchers. In the first step, **data collection,** the issue is whether the raw data collected is genuine and free from selection bias, and whether the case studied is a genuine, prototypical example of the behaviour, characteristic or phenomenon being investigated. In the second step, **data reduction,** the usually large and cumbersome raw data is organised into a coherent whole. Methodological issues concerning validity in this step centre around how the material is organised and whether it remains faithful to the raw data. For example, selective presentation of data which omits serious discrepancies is not useful nor

accurate. In the **data interpretation** step, where new theory is developed or aspects of it tested, it is essential that the researcher is able to offer a logical link between the data and theory and to indicate how conclusions have been arrived at (Edwards, 1993b).

The concept of external validity refers to whether conclusions from a research setting may be generalised to real situations (Edwards, 1993b). In this regard, case studies usually have a higher external validity than controlled laboratory experiments, as they occur in naturally-occurring settings and are not experimentally manipulated. However, experiments, simulations or contrived events are a type of case study too, in the broadest sense of the word (Bromley, 1986). Criticisms of the case study approach are not unfounded. A lack of scientific rigour will yield any research invalid and the case study is no exception. Freud and Jungs' pioneering and ingenious development of psychoanalytic and analytic theory respectively, resulted from scrupulous attention to individual cases (Bolgar, 1965 cited in Edwards, 1993). However, Strupp (1981 cited in Edwards, 1993b, pp. 20-21), indicates how this method was abused within the psychoanalytic movement and describes how it led to

> Total commitment to a single theoretical and technical model; enshrinement of theoretical formulations as dogma; imperviousness to research progress in neighbouring fields; rigid indoctrination of trainees; failure to inspire students to become critical and independent thinkers; failure to teach students abiding respect for empirical data and rival hypotheses; insufficient attention to clinical realities.

A case study which is unable to fulfil the call for validity and reliability is one which makes unsubstantiated claims, does not have a systematic way of ordering data, is speculative and makes overgeneralisations, and ends up being of no value to the scientific world. As Edwards puts it, "rigour has been lost and methodological errors have been committed" (1993b, p. 21).

3.4 Multiple case study methodology

The goal of case study methodology is to describe and systematise knowledge about a particular phenomenon into a coherent and accumulative case-law (Bromley, 1986; Edwards, 1993). When there is in existence a well-developed theoretical framework derived from a series of cases, it is possible to conduct rigorous case studies on cases which are selected to provide a crucial test of particular theoretical propositions. This is the situation in respect of Guidano's theory. It is sufficiently elaborated and operationalised to be rigorously tested against new cases.

Guidano (1987) proposes that the development of an individual's personal cognitive organisations (P.C.Orgs.) is influenced by the parent-child attachment pattern. Dysfunctional attachment patterns give rise to unstable P.C.Orgs. which in turn form the basis of psychopathology. He identifies four specific cognitive organisations each related to a different dysfunctional pattern of attachment, and each giving rise to a different psychopathology. (See Table 1). Guidano claims that his theory is based on case material from 270 cases treated by him and his supervisees. Methodologically, therefore, his theory was developed out of an empirical multiple case study approach, and the claim that four types of psychopathology (depression, agoraphobia, eating disorders, obsessive-compulsive behaviour) correspond to four types of P.C.Orgs. is based on the data from these cases. However, Guidano's lack of transparency (the lack of in-depth descriptions of individual cases), and the fact that he does not show how his theory is derived from these cases, is a fundamental abandonment of one of the central tenets of multiple case study methodology, which insists that a researcher is able to make explicit the conclusions derived from one's raw data if one is testing or developing theory (Edwards, 1993b).

Table 1: Major features of selected P.C.Orgs. in a clinical sample (N=270)

Feature	**Depression (N=50)**	**Agoraphobia (N=130)**	**Eating disorders (N=60)**	**Obsessive-compulsive pattern (N=30)**
Dysfunctional patterns of attachment	Loss/separation; patterns of 'affectionless control'	Overprotective indirect interference with exploratory behaviour	Ambiguous, intrusive enmeshment	Ambivalent double-bind attachment
Sense of self	Negative self with emphasis on self-reliance	Controlling agent	Blurred and wavering	Antithetical opposite
Major themes on systemic coherence	Oscillations between helplessness and anger	Oscillations between seeking and avoiding pain	Oscillations between seeking and avoiding intimacy	All-or-none oscillations between certainty and uncertainty
Common coping strategies	Compulsive self-reliance	Control of self and significant others	Seeking supportive intimacy that demands minimal self-exposure	Seeking certainty through systematic doubt

(Guidano, 1987, p. 122)

The aim of this research is to test Guidano's formulations concerning eating-disordered individuals against new cases. Edwards (1993b) states that only a single case is needed to settle a theoretical point, citing a famous example from mechanics to illustrate this: Aristotle proposed that the heavier an object, the faster it will fall. Galileo on the other hand, proposed that the object's weight was irrelevant to the rate of fall. In 1650, with the discovery of the air pump, a vacuum could be created and it was established that Galileo was in fact correct, as was indicated by the single experiment where a coin and a feather were dropped simultaneously (Eckstein, 1975 cited in Edwards, 1993b).

However, in terms of this research, a multiple case study approach was applied as it best fulfilled the aims of the study. Not only was it the selected approach used by Guidano to arrive at his theoretical formulations but in terms of testing his theory, at least one individual from each eating disorder category which he discusses was needed if the theory was to be tested comprehensively. Notwithstanding the criticisms waged against the case study method, its value as a scientific tool of inquiry was seen to far outweigh possible methodological errors, which could be attended to before and during the research process. A multiple case study approach, within a qualitative framework, was thus the chosen methodology used for this research endeavour as the researcher perceived it to be the most suitable in fulfilling the goals and aims of the project.

3.5 Selection of participants

3.5.1 Criteria for selecting participants

The criteria for selecting participants who were suitable for the research, were those who: (1) **met the criteria for eating disorders** as defined by Guidano (that participants fell into one of the many categories of eating disorders: anorexia; bulimia; obesity; compulsive eating), and that the diagnosis is predicated on a psychiatric or psychological assessment for eating disorders as set out in the DSM III (Diagnostic and Statistical Manual of Mental Disorders); (2) were **willing to be extensively interviewed** in-depth over a period of time; (3) were **articulate enough** to provide experiential accounts in relation to the phenomena being researched; (4) were willing to **allow their experiences to be documented** and made public for others interested in furthering their own or scientific knowledge (adapted from Stones, 1988). Four participants were selected who met the criteria for eating disorders and who were willing to be

extensively interviewed in-depth. Of these, one was male and the rest female. Age, gender, race, nationality and marital status were not controlled as the model tested is not limited to a particular population.

Note: In remaining true to Guidano's model, the researcher emulated his use of the loosely used broad terms 'eating disorders' and 'eating-disordered individuals'. The conceptual and methodological implications of blurring diagnostic categories are discussed in depth on various levels in evaluating the validity of this study. (See discussion pp. 184, 185, 189, 199).

Table 2: Identifying and demographic data of participants

Identifying and demographic information	**Jacki**	**Steve**	**Maria**	**Angela**
Eating disorder	Bulimia	Anorexia	Compulsive eating	Bulimia
Age at onset	15	12	12	12
Eating disorder symptomatology	No anorexia, history of laxative and diuretic abuse, dieting pills	Premorbid obesity (56 kgs at age 11), no history of bulimia	No anorexia or bulimia, history of laxative abuse	No anorexia, history of laxative abuse
Present age	25	18	26	18
Sex	Female	Male	Female	Female
Race	White	White	White	White
Marital status	Married	Single	Married	Single
Origin of nationality	Father English Mother Dutch	Father German - Afrikaans Mother Greek	Both parents Greek	Both parents South African
Primary role	Teacher	Scholar	Teacher	Bank clerk
Highest level of education	Four year university degree	Second last year of high school	Four year university degree	Completed high school
Religion	Methodist	Catholic	Greek Orthodox	Catholic

Table 3: Detailed weight and dieting history of participants

	Jacki	Steve	Maria	Angela
Current weight	74 kgs	37 kgs	84 kgs	54 kgs
Current height	1.76m	1.58m	1.60m	1.63m
Desired weight	70 kgs	Unsure, but agrees with doctors to be at least 42 kgs	60 kgs	52 kgs
Highest adult weight since age 18	85 kgs at age 24	42 kgs at age 18	84 kgs at age 26	59 kgs at age 19
Lowest adult weight since age 18	67 kgs at age 18	29 kgs at age 20	59 kgs at age 21	53 kgs at age 19
Highest weight between ages 12-18	74 kgs at age 18	50 kgs at age 14	63 kgs at age 18	56 kgs at age 17
Lowest weight between ages 12-18	66 kgs at age 18	34 kgs at age 12	50 kgs at age 12	43 kgs at age 13
At your current weight how do you feel?	Moderately overweight	Somewhat thin	Extremely overweight	Moderately overweight
At what age did you begin to restrict food intake due to concern over body size?	Age 14	Age 11	Age 12	Age 13
Previous hospitalisations	No	Yes, 8 times for anorexia	No	No

Case one: Jacki is a 25-year-old married teacher who during adolescence (age 15), developed bulimia. She is the eldest child in a family of three children and spent her childhood and adolescent years living with her parents and siblings. She has been bulimic for ten years.

Case two: Steve is an 18-year-old scholar who during late childhood (age 12), developed anorexia nervosa. He is the eldest child in a family of three children and spent his early years living with his parents and siblings. Since his father's suicide when he was 15, he has been living with his mother and siblings. He has been anorexic for seven years.

Case three: Maria is a 26-year-old married teacher who from the age of 12, began binging and is now a compulsive eater. She is the younger sister of two girls and spent her childhood and adolescent years living with her parents and sister. Her binging behaviour has continued for 14 years.

Case four: Angela is an 18-year-old high school graduate who during late childhood (age 12), developed bulimia. She is the eldest child in a family of three children and spent her childhood years living with them and her parents. Thereafter, she spent her high school years at boarding school, visiting her family on weekends and vacations. She was bulimic for seven years.

3.5.2 Selection procedure

Two participants who were known to the researcher were approached and asked if they would like to participate in the research. Another participant who wanted to share her experiences approached the researcher upon hearing about the research. The fourth participant made contact with the researcher after hearing about the research project from the leader of the eating disorders group which she attended. Once contact had been made with each individual, the requirements of the research were discussed with them. It was stressed that not only would the process be time-consuming but that it would also involve a commitment to honest, in-depth discussion of relationships with others, and that this could prove to be painful at times. The researcher made an initial assessment of the support systems available to each individual, where in the case of certain interview material surfacing which was painful or upsetting to participants (needing resolution or supportive intimacy), individuals would be able to seek out the support of someone close to them and not be left struggling alone with issues reawakened in the course of the interview process.

Because the nature of the interviews was such that it demanded openness and sharing of often painful memories on the participants' part, the need to ensure that individuals were in a supportive environment was constantly reassessed, especially when the contents of a particular interview session were obviously upsetting for individuals. At no time was an interview brought to closure without ensuring the safety and well-being of participants. This was achieved by either the researcher talking-through with participants the feelings which had been reactivated during an interview session, or by asking participants whom they could approach to discuss a particular issue. In three cases, the female participants expressed that they would talk to their husbands or boyfriend. In the male case, the support system included talking to a parent or to a psychiatrist.

A verbal contract was made with all individuals regarding their privacy. Participants were assured that their identities would be preserved and that their experiences would be treated with

confidentiality. It was also necessary to ascertain from individuals their willingness to share their experiences with others, as the findings of the research would be disseminated amongst the research community and made available for public perusal. Participants made a commitment to being reliable and honest co-researchers in the research endeavour, as well as made themselves available for the time-consuming and lengthy process of data collection. A verbal contract was made for ten sessions of an hour each, once a week, which was subject to change depending on the rate with which interviews progressed.

3.6 Data collection

A case history of each participant was compiled. This was based on a series of interviews with each participant. The first interview was largely open-ended with loosely phrased questions. As the interviews progressed, they became increasingly structured and directive in accordance with the goals of the research. Material from each interview predetermined the context and narrowed the focus of each subsequent interview. In addition, where it was deemed productive and useful, interviews were conducted with family members of participants. Other sources of collateral information were also used (interviews with psychiatrists and other helping professionals). Participants were also given the **Diagnostic Survey for Eating Disorders** to fill out (see appendix 2). This was more as a means of ensuring that biographical data was correct and available should the researcher require material at a later stage which had not been covered during the course of the interviews.

3.6.1 Interviewer-interviewee relationship

Initial interviews were more structured, with the aim of gaining biographical data relevant to each participant. Because these questions were of a relatively non-threatening nature, it also facilitated the development of a relationship between researcher and participant. Both participants (interviewer and interviewee), could develop a feel for each other and ultimately make a decision as to whether they wanted to continue working with each other. For the researcher, this time enabled her to decide whether the individual would be a useful participant or not, based on whether they were verbally fluent and able to communicate their experiences with relative ease to the researcher.

As Edwards (1993a) suggests, a relationship of trust needs to be developed with the participant.

The skills of a counsellor or therapist may be used as a model for the researcher (for example, creating conditions which will facilitate the ease with which individuals reveal their thoughts and feelings). In this regard, an empathic, non-judgemental stance on the interviewer's part, genuine interest and presence to what the person is revealing, and contracting for the individual's privacy, are all ways in which a trusting relationship may be developed (Edwards, 1993a). Casement (1990) was consulted by the researcher for further knowledge on the patient-client relationship and for skills used by the counsellor to strengthen their alliance (rules and interview space; 'reflective viewpoint'; freedom of expression).

3.6.2 The interview

The number of interviews conducted varied between individual participants. Some participants were immediately relaxed and willing to share intimate material; others were more cautious, hence the difference in pace with which interviews progressed to more intimate levels. On average, 12 interviews each an hour long, were conducted on a weekly basis with each participant. All interviews were tape recorded and transcribed.

Interviews are one of the most common methods of gathering data in the social sciences and especially, in psychology (Haralambos, 1983). Formal, biographical data was elicited with the use of structured questions (Haralambos, 1983) or as Edwards (1993a) phrases it, 'directive questioning'. These were questions related to events around birth, family of origin, school and medical history. As the interviews progressed, the interviews became semi-structured and more directive. The result was that the interviews became more like an informal conversation, rather than a rigid question-answer session (Haralambos, 1983). Although the interviewer had preset questions to cover during a particular session, the participant was allowed the freedom to develop answers in whatever way he/she chose. At the same time, the interviewer was allowed to probe answers that were ambiguous so as to better understand the responses (Haralambos, 1983). Edwards (1993a) offers explicit examples of three forms of directive intervention during the interview, of which the first two were followed by the researcher.

When a participant responded to a question with implicit emotions embedded in what they had said, the researcher would **reflect** back to them in an explicit way, those emotions, inviting them to explore their feelings further. For example, "...it sounds like you were very lonely at the time...". The second type of directive intervention followed by the researcher was

designed to get participants to **focus** on a particular topic which was of particular relevance to the research. For example, "...you said that...could you tell me a bit more about that...". Thirdly, when participants are going on at length about events irrelevant to the topic, or to the overall research aims, they are interrupted and brought back to the initial topic by the interviewer saying, "could we go back to...". However, the researcher found this form of intervention quite difficult, as she often felt the participant may be offended or feel she was not interested in their stories were she to intrude. So more often than not, she allowed for their long stories without interfering, believing that the maintenance of the relationship far outweighed the time a participant spent on irrelevancies or a possible rupture in their relationship if she were to interrupt.

A lot of attention was placed on the developmental histories of participants, especially (1) infancy, preschool years, childhood, and (2) adolescence and early youth, as the model of psychopathology tested in this research is a developmental model of pathology (Guidano & Liotti, 1983; Guidano, 1987). These authors state that, "the way in which people recollect their early experiences and the meaning they attribute to them constitute a gold mine for the cognitive therapist" (Guidano & Liotti, 1983, p. 135). Although it is accepted that accounts may be misinformed, biased or blurred, it is also accepted that one's present conception of reality or cognitive representation of a set of problems, usually stems from a "fundamental source of stress during childhood, around which grow the multiform interpretations of reality and the ways of dealing with it" (Guidano & Liotti, 1983, p. 136). Guidano and Liotti (1983) note that attention to childhood and adolescent periods in conducting historical research will yield data about problems and partial solutions to those problems. They note how this type of data is usually easily recollected after a "direct probe of the patient's memory" and that the researcher needs to be satisfied with "hints and cues rather than expecting to obtain full accounts" (Guidano & Liotti, p. 137). In this research, participants expressed delight at being questioned on this level, as all individuals conveyed that no one had previously regarded these periods in their lives as significant enough to warrant detailed discussion. Further, because the focus of the research was not on eating disorders as such, something which all participants found difficult to discuss and quite threatening (even painful at times), participants were relaxed during interviews and expressed this at various times to the interviewer. That the researcher was interested in details of their lives besides their eating disorder, functioned to keep participants curious and interested in the interview process.

Waller, Slade, and Calam (1990) investigated which family member's account of family functioning has the greatest clinical validity. In the case of eating disorders, the most useful measure of concurrent validity is the existence of a diagnosable eating disorder. They compared anorexic and bulimic womens' perceptions with their parents' perceptions of family functioning, to see whose perceptions are best at predicting the existence of eating disorders. Thirty comparison families and 48 clinical families (daughter suffering from a diagnosable eating disorder) participated in the study. Parents and their daughters were asked to complete, separately from each other, the Family Assessment Device (FAD). Results supported previous findings (Waller *et al.*, 1989) that eating-disordered women perceived their families as less healthy than the comparison group on all levels. Significant differences were found in the patterns of individual family members' perceptions of their interaction, as well as in the abilities of those perceptions to differentiate comparison and clinical families.

> The daughters' ratings...differentiated the clinical groups from the comparison groups on all six scales....Mothers...of anorectic and bulimic women rated their families as less 'healthy' than comparison women did on only two scales...The fathers' ratings...failed to differentiate the clinical and comparison groups on any scales (Waller *et al.*, 1990, p. 548).

It was found that the daughters' ratings of family functioning had the greatest concurrent validity (predicting their eating disorders) and that the parents' ratings were less useful and less valid. In fact, "fathers' ratings had virtually no predictive power, suggesting that they did not share their daughters' perceptions of the family interaction as problematic....Mothers were fairly accurate, but their rate of false positives was higher than that of their daughters" (Waller *et al.*, 1990, p. 549). The relevance of these findings is that the clinician or researcher "who wishes to understand how perceived family interaction is related to eating disorders should attend to the anorectic or bulimic sufferer's experiences of her family. Her parents' perceptions will be less immediately relevant. However, it may be necessary to make parents aware of their daughter's experience" (Waller *et al.*, 1990, p. 549). Thus, although information provided from a single source is subject to misinformation or personal biases, the case histories compiled based on participants' accounts of their experiences and descriptions of their families, were regarded as reliable and valid assessments of their situations. An account of the preset questions asked of the participants is included in appendix 3. It must be noted that questions were tailored to meet each participant's unique experiences. In other words, the circumstances and experiences of individuals differed, and thus certain material was included for some that was excluded for others. For example, in the anorexic case, the topic

of death and its impact on that individual required deeper focus and thus an extra interview was devoted to exploring this issue. For others, it may have been an issue of psychopathology within the family, or how moving home so frequently affected the development of friendships. Not included in these interview sheets is the focusing and directive questions which were as a result of participants' responses during the interview. They thus need to be examined as indications of particular topics and issues raised within an interview session and not as **how** interviews progressed, nor the rate at which they progressed.

The **Rhodes University Psychology Clinic Intake Assessment Interview** was especially useful for the compiling of a developmental history. Other parts of the assessment interview were expanded on in the assembling of a comprehensive case history. Freeman, Pretzer, Flemming, and Simon (1990) was also consulted for this exercise, as they discuss topics to be covered during an initial evaluation. Freeman *et al.* (1990) in conjunction with the Rhodes Clinic Assessment Interview, were used as a basic structure for the interview process, as these were considered to be useful and thorough guides for an exhaustive case history.

Topics that were covered included: (1) **presenting problem** which included the nature of problem(s), course and participants' understanding of problem, previous and current attempts at dealing with problem; (2) **current life situation** such as living and work situation, interests and activities, use of leisure time, family relationships, level of satisfaction with current life; (3) **developmental history** included: **family history** - description of parents, relationships with parents and siblings, and major events during childhood; **school and/or occupational history** - the level of achievement, satisfaction, enjoyment, interests, career choices and problems experienced; **social history** - included peer relationships in childhood, adolescence, and adulthood, sexual relationships, sexual identity and preferences, dating, serious relationships and marriage, including description of partners and any relationship problems; (4) **traumatic experiences** such as disruptions of family relationships, medical, psychological, or substance abuse within the family, and physical and/or sexual abuse; (5) **medical history** included current health, time since last check-up, current medications, allergies to medications, previous medical problems, substance abuse, family history of medical problems, psychological problems, and/or substance abuse; (6) **psychiatric history** included previous and current therapy or counselling, (when? with whom? why? what was helpful/unhelpful? were/are there any problems with therapy?) previous occurrences of current problems, their course and outcome, goals of therapy; (7) **mental status** which included appearance, attitude, behaviour, mood and affect,

speech and thought, perception, intellectual and cognitive functioning (Freeman *et al.*, 1990).

3.7 Data analysis

The method of analysis used in this study is a method of textual interpretation first described by Mishler (1986 cited in Packer & Addison, 1989). It was developed for "extricating from a text those features of a text which clarify the meaning of a text in terms of particular questions" (Kelly & Van Vlaenderen, 1994, p. 14). It is a hermeneutic or interpretive approach to psychological studies and an alternative approach to the more traditional methods that have been used in past research studies. One such study is presented by Brown, Tappan, Gilligan, Miller, and Argyris (1989) where an interpretive method was developed as a guide to reading interview narratives on moral conflict and choice. Another study employing the reading guide method, that of Kelly and Van Vlaenderen (1994), adapted Brown *et al.* 's (1989) reading guide method for their study on the dynamics of participation in a community health project. Within the Brown *et al.* study, the theoretical and methodological foundations of the reading guide method are discussed.

3.7.1 Theoretical and methodological foundations

Drawing on Mishler's work on narrative interviews, Brown *et al.* (1989) clarify numerous issues crucial to the reading guide method. In their work on real-life moral conflict and choice, Mishler's work on interview narratives allowed these researchers to see clearly the narrative structure within their own data, and to realise that what individuals most frequently respond with is a narrative, in other words, a story. Mishler (1986) comments that:

> Telling stories is far from unusual in everyday conversation and it is apparently no more unusual for interviewees to respond to questions with narratives if they are given some room to speak....In general, researchers in the mainstream tradition either have not recognised the pervasiveness of stories because...the standard survey interview "suppresses" them, or have treated stories as a problem because they are difficult to code and quantify. We are more likely to find stories reported in studies using relatively unstructured interviews where respondents are invited to speak in their own voices, allowed to control the introduction and flow of topics, and encouraged to extend their responses. Nonetheless respondents may also tell stories in response to direct, specific questions if they are not interrupted by interviewers trying to keep them to the "point" (cited in Brown *et al.*, 1989, p. 143).

A second point which Mishler's (1986) work helped clarify for these researchers, is the critical

role that context exerts in the interpretation of any interview narrative. Meaning is always "contextually grounded - inherently and irremediably" (Mishler 1986 cited in Brown *et al.*, 1989, p. 143). In order to understand a respondent's answer to a question (including the narrative which he or she provides), it is essential that the researcher have some understanding of the context out of which interviewer and interviewee have come, as well as some understanding of the actual interview encounter. (The relationship between the two individuals, as well as the actual setting in which the interview is taking place) (Brown *et al.*, 1989).

The work of Paul Ricoeur (1979 cited in Kruger, 1988b) and Wilhelm Dilthey (1900/1976 cited in Brown *et al.*, 1989) are drawn upon as sources clarifying the interpretive/hermeneutic nature of the reading guide Brown *et al.* developed. The hermeneutic circle described by Dilthey (cited in Kruger, 1988b), points out that things (human phenomena, interview narratives), are understood in a circular, paradoxical way; in terms of both the whole and its parts. Dilthey is quoted on this circular concept:

> Here we encounter the general difficulty of all interpretation. The whole of a work must be understood from individual words and their combination but full understanding of an individual part presupposes understanding of the whole....[Thus] the whole must be understood in terms of its individual parts, individual parts in terms of the whole.... Such a comparative procedure allows one to understand every individual work, indeed, every individual sentence, more profoundly than we did before. So understanding of the whole, and of the parts, are interdependent (cited in Brown *et al.*, 1989, p. 144).

The reading guide method described by Brown *et al.* (1989) is one way of systematically operationalising the hermeneutic circle described above. The method involves "building an interpretation of a whole interview narrative out of its constituent parts" (Brown *et al.*, 1989, p. 144).

3.7.2 Development and application of a reading guide for individual interviews

The purpose of developing the reading guide method was to develop a method of textual interpretation; a way of reading and interpreting texts or interview narratives for those engaged in social scientific research. The development of a reading guide begins with the generation of questions through which the raw data (interview text) is to be read (Kelly & Van Vlaenderen, 1994). Initial application of the reading guide provides a classificatory role as well as order to the interview material, which is still largely scattered and disorganised. At this

point, the researcher was faced with a mass of raw data consisting of repetitious material, similar themes in different places of the data base, and material which was not relevant to the goals of the research, which all needed to be organised into a manageable form. Edwards (1993a) discusses the same issues confronting a researcher with a massive data base and offers advice on how to construct a succinct rendering of the material.

In this study, the major theoretical features of Guidano's model of psychopathology in eating-disordered persons are tested on new cases in a multiple case study. The four essential features of Guidano's model which this research intended to test, had already been identified and were sufficiently well-operationalised. The major themes around which Guidano's model evolves, are: (1) dysfunctional patterns of attachment; (2) sense of self; (3) major themes on systemic coherence; (4) common coping strategies. A reading guide was developed out of the four essential theoretical features of the model. The four reading guide questions which were then applied to all interviews were:

(1) What patterns of attachment are evident in this person's life?
(2) How does this person experience him/herself, and the world?
(3) In what way is systemic coherence achieved or, what experience-assimilating procedures are evident?
(4) What are the common coping strategies used by this person?

The interpreter (reader/researcher) read the interviews a total of five times each. The first time was to enable the researcher to get a feel of the material and to become familiar with it as a whole. The text was then read a total of four different times for each case. Each reading served to identify a different aspect of the narrative. Each case was read for each question. A different coloured pen was used to underline contextual material relevant to each question. At times, the same material was relevant to more than one question. Multiple readings were necessary because each reading approached the narrative from a different standpoint (Brown *et al.*, 1989). In other words, the same text is approached several times, each time using a different interpretive lens. "To extend the metaphor, each lens brings into focus different aspects of the narrative. To switch metaphors, each reading amplifies different voices" (Brown *et al.*, 1989, p. 149). The reading guide was thus the interpretive procedure used in ordering the material, as well as for answering the questions which this study was designed to do.

Applying the reading guide for each question, in all cases, proved a lengthy exercise. After the text was read for each question, those parts of the text underlined in a particular coloured

pen were coalesced. Enough text was retained in each case so that each unit of text was self-explanatory, as well as to ensure that the original character of the text was preserved for use as examples in the discussion that would follow. A summary was written for each question, in each case, where material was organised and synchronised. At this point, the aim was not to search for categories, so the process of homogenisation or bias towards uniformity, where atypical elements are eliminated or excluded, was avoided (Kelly & Van Vlaenderen, 1994). Because the aim of the study was to test particular theoretical propositions, examples of invalidation would have still proved useful in that they would call for a modification of Guidano's theory. The researcher was careful to include all aspects of the data base in summarising individual results. The individual summarised descriptions for each question are available in appendix 1.

3.7.3 Development and application of a reading guide for describing the four essential features of Guidano's model

The next step in data reduction was to read across all four summaries for each question and to write a general account of the results obtained. The reading guide questions informing this reading were:

1. What are the similarities between cases?
2. What are the differences between cases?

In light of the aims of the study, citing differences found between cases was as important as noting the commonalities. The results of this level of analysis are presented as the results in the next chapter. These results will also form an important part of the discussion section, where results will be discussed in terms of a theoretical framework, as well as to what extent the results support Guidano's (1987) model or call for its modification.

CHAPTER FOUR: RESULTS

4.1 Description of patterns of attachment across cases

4.1.1 Family environment

Participants' families are characterised as very close and family-oriented, where individuals conform to a family ideal, often at the expense of their separate identities. Ties with extended family and friends are maintained and in all cases there exist strong and clear boundaries separating families from the outside world. This is contradicted by the simultaneous presence of weak and permeable boundaries within families. In this regard, all participants experience their parents' overprotective behaviour towards them as uncomfortable and intrusive, rather than as supportive or caring. A high degree of enmeshment is visible in all families i.e., one or both parents show little or no regard for the boundaries separating them from their children and instead, view their children as their creations, extensions of themselves, and thus, as reflections of their worthiness and success to the outside world.

Formal aspects of child-rearing are exalted in all families, as parents regard these aspects to be indications of their social status as well as of their success as parents. Thus, emphasis is laid on academic success early on in participants' lives, and in all cases it is emphasised that failure will not be tolerated. There exists an emphasis on physical appearance but in varying degrees: (1) in the compulsive eating case, as well as one bulimic case, individuals are criticised within the family for their physical appearance and are constantly told to lose weight; (2) in the anorexic case, all family members were either obese or overweight at one point. Although Steve was not teased for being overweight at home, he was aware of what was socially acceptable, and with his mother's focus on her weight and beginning a diet with him, the way was paved for him to develop an acute interest in his physical self; (3) in the second bulimic case, there is little interest within the family on body consciousness, although each family member has some degree of consciousness which is reflected in their exercise programmes and healthy eating lifestyle. In all families, protocol and what one projects to the outside world is emphasised, even if it is at one's expense. Rules exist which are law, for example, being forced to starve before a dance to ensure a flat stomach for appearance sake.

Four common communicative patterns are identified in the family environments of participants: (1) self-expression is seldom recognised or allowed. In all cases, attempts at self-expression, i.e., autonomous thoughts and feelings different from those of the parents, are met with disapproval,

negation, rejection, or criticism by one or both parents; (2) an ambiguous style of communication exists between family members. On the one hand, parents insist on their children's openness and the sharing of problems. On the other hand, parents are repressive and intolerant of their children's individual thoughts and feelings; (3) in another contradictory style of communication, participants report a hidden style of communication. Parents display knowledge of their children's difficulties/ lives but at the same time things are covered over and ignored (seldom mentioned), leaving participants uncertain as to what their parents do in fact know. This lack of explicitness within the family is reported by all participants, who experience a continuous sense of uncertainty about who their parents and other family members are, and what is going on in their lives; (4) the parents' tendency to conceal their own difficulties from their children is found in all but the compulsive eating case. Marital, financial and emotional problems are concealed from participants, although all participants are acutely aware that something is wrong with or between their parents at the time.

In all families, conflict is not resolved between members as the source of the conflict is seldom allowed to surface. In all cases, participants are involved where conflict is between parents. In all except the compulsive eating case, parent-child coalition is the strategy adopted, with participants intervening and taking one parent's side against the other. In Maria's case, triangulation is the strategy adopted, where mother actively asks Maria to intervene or mediate on her behalf during times of conflict with her husband. Different conflict-avoidance patterns emerge (strategies dealing with conflict situations) between the individual cases where conflict is between participants and one or both parents: (1) in the anorexic case, when conflict was between Steve and his father, Steve's mother would intervene on his behalf and become engaged in an argument with her husband. Typical conflict situations centre on superficial issues and seldom on the source of the conflict; (2) in both bulimic cases, the parent not directly involved in the conflict intervenes and takes the side of the other parent (detouring). Typical conflict scenarios end up by blaming the participants, who are then forced to apologise to the parent in question; this is usually followed by punishment metered out by the offended parent; (3) in the compulsive eating case, one parent's withdrawal and silence is regarded as support of the other parent (detouring). With Maria always being outnumbered by her parents, she silently withdraws. Typically though, the existence of conflict is denied within the family. Another characteristic found within these families is the rigid attitude of parents toward their children and their reluctance or resistance to change. This rigidity is mirrored in an inability to accept the differing levels of their children's maturity (even when they reached adulthood), as well as in their continuous efforts to control them, often still treating them as young children.

4.1.2 Attachment with mother

Participants' mothers are characterised as undemonstrative and controlling. In all except the anorexic case, she is critical and openly rejecting of participants. In all cases, an attachment exists with mother which is characterised by distance and withdrawal. All participants express uncertainty regarding their mothers' ability to contain or tolerate their emotional expressions, either because she is perceived to be emotionally fragile, or because of her critical and rejecting attitude. Thus, during times when individuals need understanding and support from someone, they withdraw into themselves, never approaching their mothers for comfort. For all participants, the uncertainty surrounding their mothers' response to them has functioned to keep them withdrawn from her and to keep communication with her on a superficial level, where participants are careful not to reveal their inner lives to her.

In all cases, mother is perceived as someone not to be trusted to support them in times of conflict with the other parent, as she always sides with her husband at these times. In the anorexic case (in the absence of father), mother is still not trusted as she is seen to take the side of helping professionals against her son. Further, because she controls Steve's food intake, she is regarded with suspicion by him, where he feels she may try to trick him by dishing out more for him than is needed. Although mother is experienced as controlling and intrusive, she is simultaneously perceived by participants as someone lacking strength. And, in spite of her often loud emotional outbursts, mother is perceived to be under the control of father and also subject to his rules. It is only in the anorexic case that there exists an exceptionally enmeshed relationship with mother. In the other cases, the physical and emotional distance maintained away from mother has ensured quite clear self-boundaries between them. In Steve's case, the arrested level of their relationship is maintained by his physical and emotional needs (to the point where Steve believes that he cannot survive without his mother). Because his mother does not encourage separation from her and because of her own inability to separate herself from her son, the dysfunctional attachment with each other continues.

4.1.3 Attachment with father

For all participants, a preferential attachment exists with father. In two cases (the anorexic and bulimic case, Jacki), the attachment is negative, marked by conflict and an inability to communicate with each other. It is noted that although Steve's most intense emotional relationship in his immediate home environment was his father (in spite of the enmeshed relationship with his mother), that up until

her death, his grandmother was his preferential attachment figure. Up until a certain point in their development, participants' perception and image of their fathers is that he was superhuman, someone who could do no wrong, someone who always knew the right answers, and someone who was perfect. In all participants' reports of father, he is either described as a god, or as a good force with lots of power. In Steve's case, there is an idealised image of his grandmother and evidence of the simultaneous presence of unintegrated idealised images of his father. (Unintegrated because at this time Steve is unable to combine the two contrasting images of his father as someone who was both good and bad).

Participants developed a preferential attachment with father in childhood because he was the parent who provided physical contact and who showed the most interest in them (even if negative). This is true in Steve's case too, as in the absence of his grandmother (who did not live with the family), it was his father's attention and interest which he sought and not his mother's. Thus it is with father that all participants share the most intense emotional attachment.

Participants' perceptions of their fathers reveal common features: Apart from being extremely overprotective of their children, strict and moralistic, they are perfectionists and seldom if ever, do they express their inner lives to members of their family (apart from rage and anger). Participants are thus not able to know what is going on in their fathers' lives, nor how they are feeling. Participants' perceptions of their fathers reveal two other common features: (1) they do not tolerate or recognise autonomous self-expression in their children, especially anger, and (2) they make it clear that they will not tolerate failure (academic) in their children. Because these two behaviours are reinforced and made clear by fathers, all participants soon came to the realisation that one way of hoping to maintain their relationships with their fathers, was to conceal their emotional lives from him and to work hard and achieve at school. Achievement is always met with approval and recognition, except in the anorexic case, where inconsistency is a defining feature of father's behaviour. However, the need to gain even occasional recognition from his father, functioned to make Steve a perfectionist in whatever task he performed.

All participants express a need for gaining their fathers' approval and share a fear of his rage if they were to disappoint him. In this regard, all individuals have developed a perfectionistic attitude in the hope of avoiding their fathers' criticisms were they to fail. Additionally, participants have developed a certain image of themselves which they project to their fathers (where they are self-sufficient and controlled), and which they feel bound to uphold. Individuals do not approach their father in times

of need, as they fear (1) his criticism and possible rejection, and (2) that he would be unable to integrate their needy behaviour with the self-image they project to him (self-sufficient and controlled), hence he would be angry and disappointed in them.

4.1.4 Perceived disappointment within the preferential attachment relationship

In the developmental history of all participants, there is evidence of a gross emotional disappointment within the preferential attachment relationship. For all individuals a disappointment occurred in the relationship with father, although in Steve's case, a distinction is made between preferential attachment relationship (grandmother) and most intense emotional relationship (father). There is variance in both the developmental age of the participants at the time of the disappointment, as well as the nature of the disappointment. In all cases (except one bulimic case), the disappointment occurred in late childhood or preadolescence: (1) in the bulimic and compulsive eating case, the disappointment came when they were both 10-years-old; (2) in the anorexic case, when he was 11- and again when he was 15-years-old; (3) in the second bulimic case, when she was 15-years-old.

The nature of the disappointment was as a result of the relativisation of the image of father in all but the anorexic case. Individuals were suddenly faced with an image of father that no longer fitted the image they previously had of him. In essence, it was the idealisation contained in their father image which was suddenly tested by reality. In the anorexic case, the disappointment was as a result of death, first of his grandmother and then of his father by suicide. In all cases, the importance of fathers' opinions and his attitude towards participants is still evident in all of their lives, except in the anorexic case where father is dead. In this case, brother has replaced father and efforts are focused on pleasing him in the hope of gaining his approval.

4.1.5 Patterns of attachment with others

Within participants' attachment behaviour towards others, there is a glaring commonality: Individuals recoil from revealing themselves to others, rather choosing to keep certain parts of themselves hidden (usually their emotional lives and those issues which cause them the most pain and difficulty). However, they initiate and maintain friendships with others, describing themselves as extremely loyal partners. Within these relationships, participants seek approval, support and reassurance but with the least bit of self-exposure. All the above attachment patterns are mirrored in the anorexic case, even though the relationships maintained are few and bound to the immediate home environment (there is

little indication of attachment behaviour with others besides those with helping professionals). In all cases except the anorexic case, the first intimate relationship individuals experienced is either with their present husbands or boyfriend. These relationships are characterised by limited amounts of self-exposure at first, matched by ever-increasing self-revelations as individuals began to trust their partners and the relationship matured.

Note - The reader is asked to refer to appendix 1.1 for individual case descriptions of patterns of attachment.

4.2 Description of sense of self across cases

4.2.1 Identity development

The developmental history of participants is characterised by patterns of attachment which preclude self-expression and autonomous behaviour. Enmeshed attachment patterns and continual criticisms from parents have prevented these individuals from developing feelings of their own. Because of the emotional unavailability of mother, all individuals formed a preferential attachment with father (with the exception of the anorexic case where a preferential attachment was formed with grandmother outside the home and with father inside the home). Father is the main attachment figure, as he is the one who provided physical and emotional contact (even if negative contact, as in the anorexic and bulimic case), as well as displayed a preferential attachment to these individuals, preferring to spend time with them, rather than with other members of the family. In the two cases where attachment is identified as negative, a preferential attachment is posited, as in both cases participants are the ones father is inclined to focus on and with whom father reveals a preference for in interactive situations.

During childhood, within the perceptions of all individuals, there was an idealisation of father (and grandmother) as revealed in images of them as god, good force, the boss, "he saved my life". Father was someone who could do no wrong and who would always make things alright. Father was thus the role model and criterion image for all individuals and the person from whom participants derived a sense of self- and felt-identity. This is also the case in Steve's situation even though the image of his father is of an either/or kind. (Present descriptions of father who is now dead, reveal an idealisation, as well as evidence that he is Steve's role model and criterion image). Because of the importance accorded to father in the development of a self-concept, all individuals soon learnt that one way of maintaining their attachment to him was by pleasing him academically, as this was usually

met with approval, and by keeping their emotional lives concealed from him, as emotional expression was seldom tolerated by these fathers.

Because the home environments of these individuals precluded emotional expression and did not recognise autonomous behaviours, the boundaries of the self were continuously fluctuating between being externally and internally bound for all individuals. (That is, alternating between deriving a sense of self from others and from one's self). This characteristic is common to the self-boundaries identified in all participants' self-structures: Self-boundaries vacillate between being externally bound (by the fathers' continuous appraisals and judgements), and internally bound (by displaying a self-sufficient, controlled attitude over emotional life). It is only within the compulsive eating case that external boundaries are bound by both parents and not only by father. The fathers' controlling, critical, overprotective and intrusive attitude (and in the compulsive eating case, the mother's critical attitude), is experienced by participants as a feeling of personal powerlessness (impotence) and ineffectiveness in asserting control over their fathers and over their own lives. All participants structured a self-image on the basis of perceived expectations of parents/grandparent, which later came to include the perceived expectations of others and the world in general. This self-image (based on the perceived expectations of others), allows participants to experience themselves as competent and personally effective (because of the ability to reduce feelings of personal ineffectiveness and/or emptiness), and as separate individuals (because of the perceived ability to manipulate others).

In all cases, the fathers' overt attack on their children's emotional lives, (and in the compulsive eating case, the mother's attack), denigrating, vilifying, dismissing and rejecting it, led individuals to the conclusion that their emotional lives were responsible for their shortcomings and hence all of them resolved to keep this part of themselves hidden from others (primarily their parents). This was achieved either by separating themselves from their emotional lives, or consciously choosing to suppress it. Instead, participants focused their attention and energies on pleasing their fathers (and grandmother), where only perfection was perceived as satisfactory and anything other than that, a failure. In this regard, for all participants, their pleasing attitude is revealed within the academic and sports' spheres. It is only within the anorexic and one bulimic case that this also included an attempt to please grandmother by attaining a goal weight whilst on diet (anorexic case), and attempts to please father by trying to lose weight (bulimic case). In all cases, a sense of self (self-worth, self-esteem, self-confidence) for these individuals was dependent on and derived from the recognition they received from father (and grandmother), where as long as they were able to maintain their performance and achieve, allowed them to feel special and approved of by him/her.

4.2.2 Child resolution or adolescent resolution

During the development of a self-concept, participants are confronted with an emotional disappointment within their preferential attachment relationship. This occurred earlier for some and later for others. In all but one bulimic case, the disappointment came when individuals were 10- or 11-years-old. As noted in the section on attachment patterns, the developmental age of participants as well as the nature of the disappointment is varied: (1) within the developmental history of one bulimic case and the compulsive eating case, the disappointment occurred when both participants were 10-years-old. In both cases, the disappointment was as a result of the relativisation of the image of father, where father was suddenly seen to be something other than what was previously believed; (2) in the anorexic case, the participant was 11-years-old at the time of his first disappointment, which was his grandmother's death. Following this, he was emotionally disappointed again when he was 15, this time by his father's death; (3) in the second bulimic case, the disappointment was as a result of the relativisation of the image of father, which occurred when the participant was 15-years-old.

Following the disappointment in the preferential attachment figure, participants came to include their fathers' (and in the compulsive eating case, mother's) criticisms and rejections as indications of their unlovableness, worthlessness and incompetence. This was matched with a two-pronged resolve: (1) individuals would work even harder to gain their fathers' approval, and (2) that their inner lives should be kept to themselves. In all cases, there was a marked withdrawal from fathers externally (and mother in the compulsive eating case) and yet, all participants remained internally preoccupied with trying to please him (and in the compulsive eating case, with trying to please father only).

The parallel structuring of a self-image on the perceived expectation of parents is revealed in all cases: (1) in the compulsive eating case, Maria took on the role of joker and actress in the family, where she pretended she was happy and hid her feelings of inadequacy; (2) in one bulimic case, Angela reports that during the time after her disappointment, she simultaneously became inexplicably angry with the world and adopted a tomboy, butch posture, where she could play roughly and take on the image of being tough and unaffected by others; (3) in the second bulimic case, Jacki took on a self-controlled, unaffected posture, where she portrayed herself as someone cold and without emotion; (4) in the anorexic case, Steve has taken on a sick role/image, where the stringent control of his weight is perceived by him to be controlling of others (because of his belief that he is able to manipulate others through it).

4.2.3 Attitude to self

After the emotional disappointment suffered by all participants, feelings of betrayal (in the attachment figure), as well as feelings of personal ineffectiveness (in controlling reality or the relationship with father) and/or feelings of emptiness (at the loss), surfaced. This led all individuals to make two decisions: (1) to never trust others again, and (2) that their inner life/feelings were responsible for their pain and present predicament; hence the resolve to never accord it any importance in their lives. However, for all participants, the inability to differentiate and integrate their feelings only fuelled their need for increased levels of perfection and the need to assert control over their emotional lives. Faced with distressing feelings (see above) and unable to integrate them, another commonality is found amongst participants: Individuals turned their attention and energy on changing their body shape, as in all cases, it was suddenly perceived to be the source of their feelings of worthlessness and incompetence, (as well as the reason for others' criticisms of them). In all cases, the body was perceived to be unacceptable because it was too fat and/or unattractive. Thus, participants believed that if they could change it and make it thin (and hence attractive), they would immediately become more acceptable to others and to themselves.

With the exception of one bulimic case and the compulsive eating case, where weight was an issue for participants, it is noted that in the remaining two cases weight was a minimal issue in the sudden focusing on the body. With the exclusive focusing on the body and altered eating patterns, participants succeeded in gaining relief from distressing feelings, either by the stringent control over food intake, vomiting, or binge eating. For all individuals, the development of an eating disorder provided a feeling of self-control as well as a means of digesting (assimilating) their emotional lives: (1) for the anorexic, the feeling of control which came from eating less and less gave Steve the feeling that he was at least in control of one aspect of his life; (2) for the bulimic individuals, the act of vomiting was a means of coping with distressing feelings, as well as seen as a weapon against others (by virtue of its secrecy); (3) in the compulsive eating case, the feeling of fullness which came with a binge allowed Maria to feel that the enormous emptiness she experienced, was being filled.

Only within the anorexic case is the eating disorder used and held onto as a means of self-identity. This is repeatedly revealed by Steve to be the main reason for his resistance in shedding anorexia. For Steve, anorexia provides an identity, as well as a way of ensuring he does not physically mature into an adult. In the other cases, the eating disorder is something which individuals want to be rid of, resenting the label/classification, seeing it as an indication of weakness, rather than as a strength.

4.2.4 Attitude toward reality

Participants' sense of self is derived from and dependent on others' appraisals. Parental approval (especially fathers' approval/recognition), is of utmost importance to the well-being of participants. In the anorexic case, in the absence of father, a younger brother has assumed this role. Not only is parental approval accorded primacy in these individuals' self-concept but so is recognition and approval from the outside world. Others' recognition and approval of them is crucial to participants' sense of worth, self-esteem, and self-confidence. In all cases except the anorexic case, there exists a common pattern within heterosexual relationships: Before the present serious relationships participants are engaged in, participants would either initiate or terminate relationships to prove to themselves that they were either good enough (attractive enough) to others, or whether they in fact were too fat and unattractive. Within all these relationships, there was minimal self-exposure, as participants feared rejection and/or criticism were they to reveal themselves. Within their present relationships, either with husbands or with a boyfriend, participants constantly seek reassurance that they are alright and when this need is neglected because partners assume it is something understood between them, participants become sensitive and either cause a fight, or withdraw into themselves. In the anorexic case there is no interest in hetero/homosexual relationships.

Relationships with friends or colleagues mirror the need for gaining others' approval. In the anorexic case, there exist no relationships with others besides those in the immediate environment and it is within these relationships that the need for admiration and approval is found. Because of the great need participants have for others' recognition (coupled with a fear of rejection, disapproval, and disappointment), their relationships are characterised by a lack of emotional intimacy. This is because participants believe that were they to reveal themselves to others, even to friends, they would be rejected. Further, because participants feel bound in upholding a certain image of themselves as self-sufficient and unaffected by emotion, they believe that suddenly revealing themselves otherwise to others, would disappoint them. In the same light, within the larger realm of society, participants attach great meaning to what others think or say about them and are extremely sensitive to criticism. Their behaviour is motivated by the need to gain others' approval and recognition, and when they do not receive it or are criticised, they are likely to perceive themselves as failures. When participants are afforded compliments (for appearance, for an achievement), they are not likely to believe them and are unable to integrate these with the image they have of themselves as failures. Instead, they see its bearer as having an ulterior motive for giving it. There is a constant expectation of failure but participants are unable to offer either specific personal/or others' attributes as causal explanations.

Similarly, there is an inability to attribute personal successes to concrete traits of the self.

Although all participants are careful when approaching the world, they are all engaged in numerous relationships with others, except in the anorexic case. The attitude toward reality which is revealed in the anorexic case is extreme compared to the rest. In the anorexic case, the perception of reality is that it is disappointing and to be avoided. This attitude is influenced by both the asocial behaviour displayed, as well as the emotional disappointments following the death of both main attachment figures. This has resulted in Steve's belief that it is pointless getting to know others or getting close to them because he is sure that they would die and abandon him. He also believes that others would not like him if they knew him and this, coupled with his disinterest in others, has resulted in the paucity of attachments he has with others.

Another area in which it becomes clear that participants' sense of self is blurred and wavering is found in the attitudes toward self and reality. In all cases, a wavering sense of self is revealed by the constant vacillation between making external and internal attributions when faced with criticism or challenges to the self. Participants constantly waver between blaming themselves for their predicament and in the same breath, making others' responsible. This pattern is also found in individuals' accounts of what they perceive to be important to them. On the one hand, participants speak of inner beauty and being loved and accepted for who they are. On the other hand, they are quick to link their feeling of unacceptability to their body image. Within participants' self-concepts, there is a profound sense of uncertainty and an inability to know (or verbalise) who they are. In another example of a blurred and wavering sense of self found only in the anorexic case, there is evidence of an inability to differentiate personal reality from a shared one. For example, Steve will accept what others tell him about himself as the truth, instead of perceiving these as only opinions and using them to arrive at his own conclusions. In fact, he is unable to talk about himself without using descriptions of himself which others have offered him beforehand.

It can thus be said that participants' sense of self is extricated from, as well as dependent on, others' evaluations of them. Further, it can be said that the sense self is revealed to be blurred and wavering. (Clarity in defining themselves is absent, and this imprecision is revealed by the frequency with which participants alternate in their self-perceptions).

Note - The reader is asked to refer to appendix 1.2 for individual case descriptions of sense of self.

4.3 Description of major themes on systemic coherence across cases

The way in which participants experience themselves and the world reveals an interrupted sense of self. In all cases, individuals displayed at first, an extensive reliance on the preferred figure of attachment (criterion image) to derive a sense of felt-identity, which later came to incorporate others as indispensable means of establishing a sense of identity/self. The primacy attributed to the interpersonal realm is revealed in participants' attitude to themselves and to reality. Their attitudes are both influenced by the outside world, as well as dependent on it. The primary aim guiding their behaviour is the need for others' approval and recognition, matched by the simultaneous need to avoid others' intrusions and disappointments. Within the attitude to themselves and to reality, a clearer understanding of this concept (which is the major theme on systemic coherence), is arrived at.

It is noted that in all cases, there is an extensive reliance on external frames of reference for a felt-identity. In terms of attitude to self, perfectionism is the common strategy chosen by all participants in attempts to secure others' approval and attempts to avoid disapproval, criticism, or disappointment by them. In terms of the attitude to reality, again, the interpersonal realm is at the forefront in terms of influencing and determining participants' attitudes. All participants engage in behaviours aimed at securing others' approval, admiration and recognition, while at the same time avoiding situations of intimacy which would reveal them and hence, lay them open to criticism. All participants, fearing intrusion by others (because of the weak and diffuse boundaries between individual family members in their homes), characterise themselves as intensely private people, who are extremely sensitive to criticism. In this regard, the only difference found between cases is within the anorexic case as compared to the rest. Steve is the only participant who will respond to criticism with criticism of the other, whereas the other participants are more likely not to respond at all.

In all cases, following the emotional disappointment in the preferential attachment figure, participants resolved to work even harder to attain that figure's approval/love, as well as resolved to conceal their inner lives from others. This was as a result of the belief that not only was emotional life the cause of their pain and unhappiness but also because in all cases, there was a certain image which individuals had of themselves which they felt bound to uphold. Were they to go beyond it and reveal their inner selves, they believe they would be met with criticism, rejection and disappointment.

Systemic coherence is maintained through the balance achieved between two opposing emotional polarities which are experienced simultaneously: (1) seeking approval and fearing disapproval, and

(2) seeking and avoiding intimacy. In all four cases, seeking and avoiding intimacy is revealed to be the major theme on systemic coherence. However, in the anorexic case, the need for intimacy is not as pronounced as in the other cases. This difference is accounted for by the difference found within Steve's attitude to reality. In his view, reality is deceitful and disappointing, hence not to be trusted and something to be avoided. In all the other cases, participants approach reality/the world with caution but nevertheless, approach it. Steve's asocial behaviour precludes most situations of intimacy.

In terms of experience-assimilating procedures, when confronted with a negative reality or major challenges to the self, the following attributive styles are noted: (1) in both the bulimic cases, an internal attribution is the most likely way individuals make sense of their experiences, finding some inherent fault with themselves as the causal explanation; (2) in the compulsive eating case, as well as the anorexic case, there is a wavering between external and internal attributions; an external attribution is made (where others are blamed), closely followed by an internal one, where participants' own incompetency and ineffectiveness is perceived to be the source of the negative reality they have been confronted with.

Certain bodily and emotional patterns are noted as developing alongside participants' personal cognitive organisations, with differences between cases: (1) in the bulimic eating disorder pattern, as well as the compulsive eating case, individuals respond to distressing feelings with a passive attitude; that there is nothing they can do to change reality. They view themselves as out of control (cannot stop themselves from vomiting or binging), as well as perceive reality as being out of their control. It is through vomiting, or in the latter case, binge eating, that individuals attempt to assert some control over their emotional lives; (2) one difference noted between the bulimic cases and the compulsive eating case, is that both bulimic individuals are to some degree quite active in their struggle, engaging in exercise to deal with distressing or uncomfortable feelings. In contrast, the motor activity of the compulsive eater is extremely low; (3) in the anorexic eating disorder pattern, Steve strives to control his sense of personal ineffectiveness and incompetence through a very active struggle. His anorexic posture allows him to experience himself in control of at least one aspect of himself, his weight. This in turn allows him to feel that he is actively doing something about the way he feels.

In summary, the major theme on systemic coherence in the personal cognitive organisations of participants is the seeking of, and avoidance of intimacy. This is revealed by the patterns and processes engaged in to ensure organisational equilibrium between two opposing emotional polarities

of, (1) the need for others' approval and recognition with the simultaneous need to avoid intrusion and disappointment by others, and (2) a need for, and an avoidance of intimacy (cited in all cases). It can be said that the above behaviours are the major strategies which participants engage in to ensure a dynamic and steady internal equilibrium. It is through these lenses that participants interpret and assimilate their personal experiences.

Note - The reader is asked to refer to appendix 1.3 for individual case descriptions of major themes on systemic coherence.

4.4 Description of common coping strategies across cases

The earliest coping strategy exhibited by all participants except in the compulsive eating case, is a withdrawal into the self. Because autonomous self-expression was neither confirmed, nor recognised in their homes, individuals learnt that one way of attempting to maintain their relationships with the preferential figure of attachment, was by adopting a silent, withdrawn posture. In the compulsive eating case, Maria's earliest coping strategy was seeking the security, support and reassurance of her father, her main attachment figure. However, she simultaneously adopted a withdrawn posture towards her mother, her worst critic, and the one who disconfirmed and rejected her self-expressions.

In all cases, following the emotional disappointment in the main attachment figure, participants resolved: (1) not to trust others again, and (2) blamed their emotional lives for their resultant feelings of pain and betrayal (as emotions were seen to be the cause of their difficulties), and resolved to keep their emotional lives under control. It was also during this time that all participants decided to work even harder to gain (primarily) their fathers' and others' approval. Perfectionism is noted in all cases as the strategy chosen to achieve the aim of gaining others' approval, while at the same time attempting to avoid criticism and disappointment by them. As noted in the section on systemic coherence, not only is the above strategy evident in the personal cognitive organisations of participants as one of the ways an internal equilibrium is maintained, but so is the seeking of, and avoidance of intimacy. Here is revealed another major coping strategy.

In all cases, participants seek supportive intimacy which demands minimal self-exposure. Within their relationships to others, there is a need to gain reassurance, support, recognition, and approval, while at the same time, maintaining a safe distance from them. It is only in the anorexic case that there exists an almost total avoidance of intimacy by virtue of Steve's asocial behaviour. He thus has no

relationships with others besides those in his immediate environment (his family and his psychiatrist). Within these relationships is mirrored the above coping strategy too; wanting their support and approval but avoiding self-exposure as much as possible. In all cases, it is reported that the need to maintain a certain image of themselves to others (one which they believe others expect of them), prevents participants from revealing their inner lives. Were they not to do this, they are all of the opinion that they would be criticised, rejected and disappointed. Although this is not revealed to be the entire reason for minimal self-exposure in Steve's case (his reason being that he expects to be disappointed in others and to be abandoned because they would die), the same coping strategy is nevertheless revealed; seeking supportive intimacy with minimal self-exposure.

Following the emotional disappointments in their preferential attachment figure, (the one from whom individuals derived their sense of identity), criticisms and rejections came to be incorporated into their self-concept and were regarded to be indications of their worthlessness and unlovableness. In all cases, participants were unable to make sense of their resultant feelings of disappointment and betrayal, as well as the feelings of emptiness and personal ineffectiveness which followed their disappointments. It is here that a disequilibrium in systemic coherence occurred for all participants. The inability to integrate and make sense of their feelings led all participants to an alternate (yet common) mode of explaining and controlling these feelings. In all cases, participants turned their attention and energies to their body shape, seeing it as the cause of all their difficulties and resolving to change it through the controlling of their food intake. The body was viewed as too fat and/or unattractive and was followed by different decisions as to how to change it: (1) in the anorexic case it was through stringent control of food intake; (2) in the bulimic cases it was through the elimination of food by vomiting; (3) in the compulsive eating case it was through dieting followed by binge eating, starving, binging.

Through the development of an eating disorder, all participants have found a way of dealing with their emotional lives: (1) in the anorexic case, Steve's rigid control over his food intake provides him with a feeling of control and self-sufficiency over his emotional life; (2) in the bulimic cases, the act of vomiting allows for the expression of emotion, as well as provides a place where participants can relax their need to be in continuous control of themselves; (3) in the compulsive eating case, Maria is able to temporarily fill the great emptiness she feels inside by eating, as well as find comfort in food when faced with distressing feelings. In all cases, obsessive and continuous thinking and focusing on weight, food and eating, prevents participants from becoming aware of the true nature of their problems or situations.

Another common coping strategy revealed in all but the compulsive eating case, is self-destructive behaviour. These behaviours have not been life-threatening and again, are a means of emotional expression. These include: (1) piercing one's own ears as a rebellion against father; (2) eating soap and attempting to asphyxiate oneself with blankets as a way of removing oneself from a situation; (3) hitting and hurting genital organs as a way of removing one's sexual identity; and (4) cutting hands with broken glass when feeling neglected. Other coping strategies found amongst participants but not common to all cases include: (1) blaming others for their present predicament, except in the bulimic cases; (2) compliance to avoid conflict is noted in all but the anorexic case; (3) almost complete denial of emotional life as well as the existence of an eating disorder, is noted in one bulimic case; (4) exercise to cope with feelings of being fat, or with the feeling of being full after a meal. All participants except the compulsive eater engage in various forms of exercise to feel better about themselves.

In summary, coping strategies common to all participants are: (1) withdrawal into the self; (2) perfectionism; (3) seeking supportive intimacy that demands minimal self-exposure; (4) denial and suppression of emotional life; (5) the development of an eating disorder; (6) continuous thoughts about food and eating which prevents participants from becoming aware of the real issues confronting them.

Note - The reader is asked to refer to appendix 1.4 for individual case reports on coping strategies.

CHAPTER FIVE : DISCUSSION

The discussion will revolve around four parts: (1) a dialogue between Guidano's model of psycho-pathology in eating-disordered individuals, literature cited in the review, and the findings of the research; (2) an elaboration of methodological considerations, examining the shortcomings of the method employed and implications for further research; (3) an evaluation of Guidano's model in terms of its specific contribution to research on the role of fathers in child and adolescent psychopathology; (4) a short summary of what was done in the study and the findings as a conclusion to the study.

5.1 Relating the findings to a theoretical context

Guidano's model for eating-disordered individuals is based on four essential themes: dysfunctional patterns of attachment; sense of self; major themes on systemic coherence; common coping strategies. Findings are presented within this framework in the results section. The discussion of the results will be presented as follows: Pertinent features within each section of Guidano's model will be stated, followed with the generalised findings of the thematic analysis performed. Selected interview material from one case is presented as illustrative of particular concepts. Because four in-depth case studies were conducted, an example from each of the cases for each of the four features of the model, will prove too lengthy. The reader is asked to refer to appendix 1 for individual case examples elaborating the features of the model. Findings will be discussed as a dialogue with cited literature, citing explanations and possible reasons for differences and commonalities.

Examples cited from interview material are indented. The letter 'R' refers to researcher. The letters 'J' (in discussion), and 'S', 'M', and 'A' (in appendix) refer to Jacki (bulimic), Steve (anorexic), Maria (compulsive eater), and Angela (bulimic), respectively. Within participants' narratives emphasis is indicated with italics.

5.1.1 Dysfunctional patterns of attachment

Guidano (1987) posits two invariant aspects in the developmental pathway of eating disorder-prone individuals: an enmeshed relationship with an attachment figure which is ambiguous, disguised, and undefined; a disappointment occurs during childhood or adolescence with the same attachment figure.

5.1.1.1 First invariant feature of dysfunctional patterns of attachment

As Guidano (1987) states, findings of this research indicate **enmeshment** is prevalent in all families, especially between participants and the main attachment figure. Drawing on Minuchin *et al. 's* (1978) conceptualisation and operationalisation of this concept, the researcher could expand her understanding of enmeshment when applied to participants' narratives, as Guidano (1987) only provides an elaboration of one feature, enmeshment. Minuchin *et al.* (1978) first coined the term enmeshment and identified five features typical of enmeshed families: enmeshment; overprotectiveness; rigidity; lack of conflict resolution; child's involvement in parental conflict.

First feature of enmeshment: Enmeshment

Minuchin *et al.* (1978) state that enmeshment on the family level is visible in a variety of ways: dialogues between members are quickly extended to include other members; a conflict between two members can easily lead to shifting alliances between members; direct communication between family members is rare - often, a message between two members is relayed by one of them to the third party. On the subsystem level, in enmeshed families boundaries between members are diffuse, weak, and easily crossed. It is for this reason that subsystem functioning is often poor. Where boundaries are crossed, the following examples may be found: parental roles are assumed by children; children act inappropriately toward siblings or their parents; children join one parent against the other. As Minuchin *et al.* (1978) note, in participants' families, weak and permeable boundaries exist between members. Boundaries are crossed, as evidenced by children assuming parental roles and functions and vice versa; or children joining one parent against the other (see also child involvement in parental conflict). Enmeshment, as outlined by Guidano and Liotti (1983), Guidano (1987), Minuchin *et al.* (1978), and Selvini-Palazzoli (1985), includes the finding that participants' families are characterised as extremely close traditional families, with emphasis on doing things together to maintain a family ideal of togetherness (even when this is not the case and is at the expense of separate identities). For example, in Jacki's family, father decides that all members are too fat and must go on diet, regardless of the lack of individuals' agreement or consent. Various authors state that eating disorders manifest conflicts of separation-individuation or dependence-independence issues (Goodsitt, 1985; Slade, 1982; Sugarman & Jaffe, 1987; Waller *et al.*, 1990).

> **J:** The one year my father went on a huge diet where all we ate was cold slaw....He made my sister go on diet and...he was like so militant in it....
> **R:** Did he force you to eat it as well?

J: Ya, but I didn't really care because I was quite happy about it for a change.
R: What was his reason?
J: We were going on this mass diet. We were all just too fat and overweight and did no exercise.
R: The whole family?
J: Ya, me included and I'd like already lost weight at that stage.

In terms of relations with the outside world, the findings of the research are in accordance with Guidano (1987) and Minuchin *et al. 's* (1978) observations. Families maintain ties with friends and family, yet strong, very clear boundaries separate the family from them and the outside world. What goes on in the family is regarded as private and only for the family to know.

J: There's no love lost between my mom and her sister....It's not very close family bonds there at all. My father has disowned his sister....My father didn't have much time for his father...so there's not much love lost there, not very close family ties....There isn't much discussion between families in our house. There's not much love going on there....I've got second cousins in South Africa but my parents stick very much to themselves. They not social people you know. They might visit each other once a month but not like strong kinship ties at all.
R: And in terms of friends, do your parents have friends?
J: They do, but a small circle. They so much to themselves. They never go out on week nights....They always at home for us. I think their whole lives have been for their children. I mean, I don't know what's going to happen now when my brother goes off to university. I think my mother will crack.
R: So they've spent their whole lives designed and centred around their children?
J: Ya, I mean when we go home for a weekend, it's just the family. It's always been family. I mean we eat breakfast together, lunch together, supper together. *That* is how family oriented we are.

As Guidano (1987) and Selvini-Palazzoli (1985) report, within participants' families, parental emphasis is on formal aspects of child-rearing, where education, social appearance, and protocol are exalted and regarded as indicators of the parents' social status and success as parents. Academic success is stressed early on in individuals' lives and it is made unequivocally clear that academic failure will not be tolerated. Kern and Hastings (1995) have shown that bulimics' families are unique in the abnormal emphasis they place on the importance of academic, work, social, monetary, and overall life achievement, and that high familial achievement is considered a risk factor for bulimia. As Guidano describes, participants' parents project an image of themselves as people completely dedicated to the well-being of their children, which is aimed more at wanting to confirm the image of themselves as good parents, rather than attending to the real emotional needs of their children.

J: I was a perfectionist. Now I look back and I see...I used to take great pains and stuff, especially around exam time...I used to get stressed out and that.
R: About doing well?

J: Ya, I mean I couldn't fail and I had to please my father, and he was always going on about varsity and that he's done so much for me.

Sociocultural forces encourage and demand the pursuit of thinness as the media and social ideal in Western culture, and parents are an important vehicle for these concerns. It has been shown that parents' attitudes to weight and dieting, the importance to parents of physical appearance, dress sense, personal attractiveness, and body shape, as well as parents' food preferences, are conveyed to and accepted by their children from an early age (Hill *et al.*, 1990; 1992). Findings are in accordance with Guidano's (1987) observation that these families have a tendency to focus on physical appearance and attributes. Attention to physical appearance and body shape and size is evident in various degrees in all cases and ranges from constant criticisms that they are too fat, to families' preoccupation with dieting, to healthy eating styles and rigorous exercise programmes.

R: When you've spoken about food and your bulimia you've spoken a lot about your father and his criticism of you, of the way you looked, the way you dressed, that he teased you. Did he used to tell you that you are fat?
J: *Yes*! I remember he used to say, "look at the size of your arse, look how it wobbles".... When I met my husband I didn't have him screaming at me or telling me I looked fat or I must put a petticoat on or I look like I've been playing with a paintbox and got slapped on with make-up.
R: Is that what your father used to tell you?
J: Ya, "oh, you've been playing with the paintbox" or, "why are your eyes so black, take off that mess" you know, or "your arse is getting so fat, look at that arse of yours". It got to the stage where I couldn't even go out the house, like now still, I don't go to the cafe any more because I'm so scared people are going to look at me. I've just got so self-conscious about it....It's like he always used to scrutinise me you know. Like the way I used to dress, he used to say, "I don't like that" or, "that looks nice" or, "you actually look pretty today" or, "you're *not* going out with those pants on, take them off now!"....I think Joe [husband] was actually a turning point in my life. Because there I could seek comfort and I was never demised or screamed at or told me my make-up looked shit or I looked like a shit or I was a shit-head or whatever, like my father did.

Second feature of enmeshment: Overprotectiveness

Overprotectiveness is indicated by the inordinately high concern family members display towards each others' well-being, and the family is hypersensitive to signals of distress (Minuchin *et al.*, 1978). Parental overprotectiveness arrests children's independent and explorative behaviour (Sugarman & Jaffe, 1987). Effective boundaries between family members are absent and yet, boundaries that separate the family from the outside world, are too restrictive (Sargent *et al.*, 1985). There is hardly any recognition of personal autonomy, rather of a collective, 'family identity' (Selvini-Palazzoli, 1985). Greater eating disorder symptomatology is associated with less familial encouragement of

independence (Williams *et al.*, 1990). There is a lack of privacy and family members intrude on each others' thoughts and feelings. Family members have poorly differentiated self-images and poorly differentiated images of other family members (Minuchin *et al.*, 1978). As Minuchin *et al.* (1978) state, findings of the research reveal that in all cases, the strong and clear boundaries separating the family from the outside world are contradicted by the simultaneous presence of weak and diffuse boundaries between individual family members. Parents' overprotective behaviour toward participants is experienced as intrusive, rather than as supporting or caring. Either one or both parents disregard the boundaries separating them from their children, and there is little or no regard for privacy evident in all families. In Jacki's case, a stark degree of overprotectiveness is observed.

> **J:** Like now, having to move to Jo'burg. I mean they both put their foot down. I'm 25, Joe is 27, and they've both refused to let me move out and live by myself. I *have* to stay here. They still dictating to me...I was going to move out and go board with a friend...and they said, "no ways". I've got to stay here where I am.
> **R:** So even though you married they still dictate to you as if you are their little girl?
> **J:** Ya, they won't take my husband's word or anything for it. They always of the opinion that they actually know better. They've lived their life before and they know what life's about and they will do the right thing for me....
> **R:** How would you describe your parents' marriage?
> **J:** Very stable. I come from a very stable, very close family.
> **R:** And by close, meaning?
> **J:** Very loving, very supportive.
> **R:** Of you or of each other?
> **J:** I would say of each other and for their children. I mean they've always looked out for the best needs of their children and that. I mean we've never ever actually had to want for anything...although I've not really agreed with it most of the time. I mean, I've always rebelled against everything....But as parents, they are exceptionally overprotective over us children. Any drama in our lives and they always right there on the spot kind of thing.

Third feature of enmeshment: Rigidity

Rigid families are immersed in maintaining the status quo. When change and growth is indicated, these families have great difficulty in accepting the need for, and implementing change (Selvini-Palazzoli, 1985). For example, an adolescent child may demand more autonomy to go out. The rigid family insists on maintaining previous rules, particularly around issues of autonomy, where negotiations are seldom allowed to surface (Minuchin *et al.*, 1978). Waller *et al.* (1990) have shown that strict behaviour control and abnormal emotional links are strongly related to eating disorders. As Minuchin *et al.* (1978) demonstrate, findings reveal that a rigid attitude and reluctance or resistance to embrace change is displayed toward participants by their parents. Parents are unable to accept their children's different levels of maturity, even when development necessitates changes in attitude and behaviour. This is revealed in parents' constant attempts to control and exert influence

over participants, still treating them as though they are young children and unable to make their own informed decisions.

> **R:** How would you describe your father and your relationship to him?
> **J:** Then? Then it was fine, it was much better but then I think it actually got worse.
> **R:** At round about the age of 12?
> **J:** Ya, but even before that because I was a very early developer....I started wearing a bra when I was 10. And I developed like with pubic hairs and I think it was also quite difficult for him....I started adolescence early and I started getting stroppy....I was a very stroppy child and indifferent, and I started getting sulky and he didn't like that....You see, I physically changed. I also started developing my own opinions. I don't think he liked that. He wanted a child and then I didn't like wearing the dresses he would buy me. I wanted to wear grown-up dresses and he wouldn't let me....I actually had very bad adolescent years. My years of adolescence were terrible....I think there must've been some decision because the relationship actually got worse between my father and I....From the age of like 13 going on 14 I discovered boys and make-up...and he used to absolutely hit the roof if he caught me with make-up or mascara or eye liner. He wouldn't allow me, or to have boyfriends. He used to get very angry about it....He used to make me unstable....I was so frightened and intimidated by him and he would just go off the deep end screaming at me, accusing me of smoking, taking drugs at school, when I wasn't even doing that....Having such overprotective parents I was always too scared to do anything wrong or out of line....He had a total misconception of me....He didn't trust me so then I did start being naughty and coming home late at night....He wanted to suppress me trying out new things. He wanted me to be a child for as long as possible....
> **R:** Where do you see the cut-off point where you didn't think of yourself as a child any more?
> **J:** Childhood, I would say 23. Really, I think that until I left varsity and moved out of home. When I took a stand, I think I realised then I was an adult, at the age of 23...because I was *always* subject under his rule. I was always petrified to do anything and now I've learnt to stand on my own two feet. I always was a child....It was basically like that until the time I actually stood up on my own two feet said, "*that's it*, I'm going now, I'm leaving home".

Fourth feature of enmeshment: Lack of conflict resolution

Lack of conflict resolution is typical of pathologically enmeshed family patterns and in combination with the rigidity and overprotectiveness which characterises their transactions, it makes these families' thresholds for conflict very low (Minuchin *et al.*, 1978). Because conflict is not resolved, (either by being rigid, avoiding discussion, changing the subject, or denying that there is indeed conflict), conflicts constantly reappear, only to be avoided again. The idiosyncratic nature of individual families accounts for the diversity in ways families avoid conflict. For example, if one spouse is an **'avoider'** he/she may detour confrontation when it is brought up by the other spouse; or one spouse may leave the discussion or house when the other raises a problem. In other families, the existence of problems is denied, so there is no need for discussion; or one member of the family constantly interrupts or changes the subject, not allowing for the conflict to surface (Minuchin *et al.*, 1978). The findings of the research attest to the lack of conflict resolution between family members, as

conflict is seldom allowed to surface in its original form and the source of the conflict is not the focus assumed during arguments. Instead, it is deflected to irrelevant topics. Alternately, mother and father assume the role of 'avoider', where faced with confrontation by the other spouse, the confrontation is detoured. Some patterns of conflict avoidance identified between cases are: (1) where conflict is between participant and parent, the other parent intervenes on the participant's behalf and becomes embroiled in argument with the spouse; (2) detouring - the parent not directly involved in an argument will intervene and take the partner's side; or participants are not allowed to give their opinions and arguments are usually monologues of father's/mother's vociferous and exaggerated accusations; (3) conflict is avoided and repressed to protect mother from becoming upset, or father will leave the house during arguments; (4) one partner's silence is perceived by participants as assuming a united front with the other spouse. In Jacki's case, father engages in detouring. "**R:** Were meal times a place where arguments happened? **J:** Ya, I would storm off or my father couldn't bare to sit at the same table as me and he would storm off....He'd say 'I can't eat at this table, I'm not hungry' and just like storm off".

Fifth feature of enmeshment: Child involvement in parental conflict

The child's involvement in parental conflict is another defining characteristic of enmeshed families, further indicating that boundaries separating individual members are weak and thus easily crossed. Minuchin *et al.* (1978) identify three conflict avoidance patterns characteristic of families who do not resolve conflict: (1) **triangulation** - parents are split in conflict and openly press the child to take sides. The difference between triangulation and parent-child coalition is that in triangulation, the child is put in such a position that to express him/herself, it is inevitable that he/she takes sides; (2) **parent-child coalition** - the parents are clearly split in conflict and the child is recruited to ally him/herself with one spouse; (3) **detouring** - in this pattern, parents are openly united with each other and deny the existence of conflicts between them by adopting a posture of protecting or blaming the sick child. Different patterns emerge as attempts at conflict resolution between individual cases, typical of Minuchin *et al. 's* typography. Common to all cases is that participants become involved in conflict between parents, and there are times when conflict between parents is dulled by selective focusing and/or blaming participants. By making participants the focus (protective detouring), parents can deny the existence of any problems between them. Findings reveal that parent-child coalition and triangulation are the most common strategies in these families. The following example (next page) illustrates parent-child coalition in Jacki's family.

J: When they've had arguments I've tried to intervene and say, "look you know, mommy is right in saying this that and the rest", and my father would just say, "shut up and just get out of it, you not being spoken to, get to your bedroom *now!*".
R: Would you find yourself taking sides?
J: Yes, I always took my mother's side.
R: Always?
J: *Always*, always my mother.

Patterns of communication typical of enmeshed families

As Guidano (1987) and others (Bruch, 1985; Dym, 1985; Goodsitt, 1985; Guidano & Liotti, 1983; Minuchin *et al.*, 1978; Strober & Yager, 1985) document, findings of the research support the notion that most eating disorder-prone families are characterised by ambiguous, contradictory and disguised communication styles. The researcher identified four common patterns of communication in the family environments of participants.

First pattern of communication: Autonomous self-expression discouraged

The autonomous behaviour of self-expression is either not tolerated or not allowed. Participants' attempts at self-expression are alternately met with repression, disapproval, disinterest, overt rejection, or criticism. This specific parental feature, of paying little or no attention to the child's expression of needs, wants, and feelings is well documented (Bruch, 1985; Buckroyd, 1989; Goodsitt, 1985; Rizzuto, 1985; Sargent *et al.*, 1985; Selvini- Palazzoli, 1985; Welbourne & Purgold, 1984).

R: What would you say was/is the typical way you argue with your father?
J: His way was right and that was it.
R: What he said was right and you never spoke?
J: No. He would just drag it out. He'd blow it out of all proportion and just bring up everything and throw it in my face, everything....It was always about how worthless I was as a person. And that I wasn't like my sister who was such a happy child and always smiling and such a pretty child, or like my brother who was just perfect.
R: Am I right in assuming that when you argued the argument would be about your worth, but you wouldn't say anything or would you?
J: No, what's the point of arguing? He had established points about me, I was like talking against a brick wall so I just shut up.

Second pattern of communication: Ambiguous and contradictory

Ambiguous, contradictory styles of communication exist between family members. Parents insist on children's openness and sharing and at the same time, display intolerance and denial of their

children's thoughts and feelings. Similar observations are made by Bruch (1985), Goodsitt (1985), and Selvini-Palazzoli (1985).

> **J:** My father would say you know, "I just don't like the way you being saying things" or, "the way you speak to your mother" or, "you don't talk enough, why are you so quiet, what is going on?" but he would never talk to me, we'd never talk. We would have outbursts of rage. My father and I could never sit down and talk.
> **R:** Would you also have an outburst of rage?
> **J:** I would just keep quiet and I would switch off and he knew it. I taught myself to switch off and he used to get so angry and he'd just let rip....He used to say that I've been nothing more than a fuck-up....It used to be stages. I mean he wouldn't even look at me. I'd walk in the house and he wouldn't acknowledge my presence, we didn't greet each other. And the worst was when I came in contact with him and I had to eat meals at the table. I just couldn't handle it. I just couldn't cope with it. I just could never be like good enough you know.... I never knew when my father was going to start on me. I couldn't be in the same room with him. I was too scared to eat at the table in case he started on me again. I actually felt *tiny*. I felt like this tiny insignificant person in his eyes....I was this insignificant person because I didn't have a right to *say* anything. I didn't have a right to *do* anything.

Notice the contradictory style of communication. On the one hand, father rejects and is intolerant of Jacki's self-expressions (above example) and on the other hand (example below), he attempts to convince her that she is acceptable to him and wants Jacki to share her difficulties with him.

> **J:** My sister was like my father, saying you know, "you look so fat and look at those boobs" and I had such a complex about those boobs too.
> **R:** So your father would tease you about your weight?
> **J:** Yes, *always*, but I think he realised when I was in standard nine, and vomiting and that, he tried to say you know you're not fat, it's your build even if you did exercise. He actually did try for a while but by that stage I was too far gone in my habit. I don't know, I don't think I actually trusted him. I actually lost trust, which is a horrible thing to say....Like the one time I'd just broken up with this guy and I remember...I just cried. I was actually hysterical. And my parents actually were so gentle. My father...said to me, "look, if there's anything you want to talk about just come and talk to me" but by that stage I was too scared to, I was too petrified. I felt so intimidated and threatened by him that I couldn't. I think it was too late. And still now it's too late.

Third pattern of communication: Disguised communication

"These families are not good at exploring their feelings. They do not let themselves see what is there; they certainly do not talk openly about what disturbs them" (Welbourne & Purgold, 1984, p. 29). Others document this parental feature (Buckroyd, 1989; Goodsitt, 1985; Rizzuto, 1985; Sargent *et al.*, 1985) which supports the finding reported by participants that a hidden/concealed type of communication characterises these families. Parents display knowledge of their children's problems (in fleeting comments or arguments) yet at the same time, things are ignored and concealed. Thus,

a profound sense of uncertainty is experienced by participants as to what their parents do in fact know about them.

> **J:** I was sexually molested when I was five or six....My parents discussed it that afternoon and it was never discussed again....It was never brought up again....I always blamed myself...but now I realise, my God, what does a child of five know?....At school I thought if my friends ever had to know they wouldn't want to be friends with me.
> **R:** Do you think your parents (interrupts)
> **J:** We *never* discussed it Helen, it was closed. *Never ever* spoken about again.
> **R:** Have you ever wanted to speak about it with them?
> **J:** No, because even when I took an overdose of dieting pills and fell, I mean my parents have never discussed my leg issue again, *never, ever, ever.* It's been a closed book....Things just don't get discussed in my family.
> **R:** So if there's a crisis they will handle it and it's closed?
> **J:** Ya, end of subject.
> **R:** What was the leg issue?
> **J:** I got horribly drunk....I woke up with glass sticking out my leg...blood everywhere. Only the following morning did my mother take me for stitches. I had fainted three times already and my mother tried to get me to eat, that was the fourth day I hadn't eaten and I was still vomiting. Well, they lied to the doctor about what actually happened. I mean the doctor must've known something was up because he could see the wound wasn't fresh....My father never spoke to me for three weeks....I think he's made two references since then about my leg, that I must have plastic surgery to hide it. That's all that's been spoken about it.
> **R:** So everything must be hidden in your house, hey?
> **J:** Oh ya, we never talk about it, it's hidden and I've got to deal with it.
> **R:** It sounds like that's always been the case.
> **J:** For years afterwards I actually didn't wear shorts at home, I always wore long skirts. Now I couldn't care....It happened you know, it wasn't a nice thing but I've got to keep going....They just brush it underneath the carpet. I don't know, I couldn't handle it. I never want to bring my children up like that though...in the same environment I've been brought up in where everything is hidden.
> **R:** Ya, it's hidden but at the same time it's not let go of either....Everything is pushed under the carpet but it's never pushed and left, it's always hanging there.
> **J:** Ya, if my father has a fit he'll throw it in my face again next time we have an argument, he keeps it in store. It's ammunition against me or that's the way I see it...to break me down again....
> **R:** So you don't think they ever knew you were bulimic?
> **J:** Maybe they *did* know! With my bloody family they might've known but they hid it. They probably kept quiet about it like they keep quiet about everything else.

Participants also report a continuous sense of uncertainty regarding their parent's ability to deal with their (children's) emotional lives, who their parents and other family members really are, and what is going on in their lives.

> **J:** I have the relationship with my husband that I didn't have with my parents kind of thing.... With Joe I can share things. If I'm upset about something I can tell him. If I'm angry about something, I can vent it. I couldn't do that at home because I mean, I don't think my parents would know how to deal with it....
> **R:** How did your father respond to you when you were upset, angry or depressed?
> **J:** You see, I would never show him my upsetness or anger. I used to bottle it. And they

used to get so angry with me because I wouldn't tell them what was upsetting me. I used to just fight it back, always. My mom and dad would always be home at lunchtime for me and they could see it straight away...they would know, parents are parents....So he used to end up getting angry with me because I wouldn't tell him why I was angry, why I was upset.
R: Why wouldn't you?
J: I don't know. I honestly don't know. I just couldn't because I don't know how they would take it I suppose.

The subject sample in this research is too small to make inferences about the percentage of eating disorder subjects with a history of sexual abuse. It is, however, significant that even in the small sample, one out of four participants (Jacki) reports an incident of sexual abuse to the researcher. The exact relation between child sexual abuse and the subsequent development of an eating disorder is still unclear, although many authors draw some link (Bass & Davis, 1992; Blume, 1993; Follette & Pistorello, 1995; Fredrickson, 1992; Kritsberg, 1993; Pennacchia, 1994; Sanford, 1991). Recent research suggests that clinicians should be alert to the possibility of CSA in eating-disordered patients (Maine, 1993; Palmer *et al.*, 1990; Whitfield, 1995; Williams *et al.*, 1992), and especially in individuals who display bulimic symptomatology (Andrews *et al.*, 1995; Kern & Hastings, 1995; Poole *et al.*, 1995).

Fourth pattern of communication: Concealment, indirect communication

As Guidano (1987), and Guidano and Liotti (1983) observe, findings reveal that parents exhibit a tendency to conceal their personal difficulties from their children (marital, financial, emotional), although participants are acutely aware that something is wrong with one or both parents at the time. Only in the compulsive-eating case is there a tendency to directly involve children in parental difficulties (and this is always as a result of mother's insistence and never father's), where Maria is asked to relay messages from her mother and sister to her father. Minuchin *et al.* (1978) view the lack of direct communication between family members as indicative of weak, diffuse boundaries between members, characteristic of enmeshed attachment styles.

R: Do you know anything about your mom's pregnancy with you?
J: Ugh, you know my mother never talks like that....I'd love to know but she never talks about it. The way I see it from what I've heard, although now I hear stories from my husband that my father used to steal to support us. *I* never knew that. To get money, he would steal, sell or pawn it, to get money to feed us. So I don't know, I'm sure my mother had a very unstable pregnancy. Look, I was a shotgun baby, she was in a foreign land, she didn't know the currency, she couldn't even speak English properly....
R: Why did you say your husband says? meaning he and your father talk?
J: Ya, have obviously been chatting. And my father's never told me. I think there's lot of things that have happened that I didn't even know about, that's been kept quiet from me....My mom's also very neurotic like I am so I think it must have been quite a neurotic pregnancy.

> She said that I was born a week late but three months premature. We never even discussed that I was a shotgun baby. They won't even talk about it....My mother was three months pregnant with me before she got married. But that's never been discussed. It's always been kept very taboo in the family....It's their 25th wedding anniversary now and I've just had my 25th birthday, but nothing was said, nothing was questioned. It was just kept quiet. They seem to do that.

Studies that have compared the family environment and functioning of bulimic and anorexic individuals with comparison families reveal that families of eating-disordered individuals are more clinically unhealthy (on a wide variety of measures rating family interactions), than non-eating-disordered families (Humphrey, 1986; 1989 cited in Phares & Compas, 1992; Kern & Hastings, 1995; Waller *et al.*, 1989; Williams *et al.*, 1990). Enmeshment as conceptualised by Guidano (1987) and Minuchin *et al.* (1978) in anorexic families has received recognition by other writers (Bruch, 1985; Buckroyd, 1989; Goodsitt, 1985; Guidano & Liotti, 1983; Lawrence, 1992; Orbach, 1985b; Sargent *et al.*, 1985; Selvini-Palazzoli, 1985; Welbourne & Purgold, 1984). Studies of families of bulimics have found enmeshment to be as prevalent in these families as in anorexic families (Schwartz *et al.*, 1985a). However, the family environment and interaction patterns in bulimic families are characterised as more severely unhealthy (Waller *et al.*, 1989), more hostilely enmeshed (Humphrey, 1986; 1989 cited in Phares & Compas, 1992), and to display an abnormal emphasis on high familial achievement (Kern & Hastings, 1995), than in anorexic families. Studies of families of anorexic and bulimic individuals (see above) and families of obese individuals (Wooley & Wooley, 1985) support Guidano's model (1987) and the findings of this research that enmeshment is a defining characteristic of families of eating-disordered individuals. Little documentation of the family environment of compulsive eaters was found, although Epstein (1992), Lawrence (1992), Selby (1992), and Rust (1992) note the presence of enmeshment in these families too. The findings of this research attest to the presence of enmeshment in the family of the compulsive eater. No significant differences in the degree or types of enmeshment between the compulsive eating case and the other cases are observed.

In accordance with Guidano and Liotti's (1983) appraisal of the nature of the relationships between eating disorder-prone individuals and their parents (as well as their characterisation of parents), this research lends supporting evidence. As Guidano and Liotti (1983) document, striking qualitative differences are found in the attachment behaviour and relationships of participants with mothers and fathers. In all cases, the relationship with mother is described as having developed consistently and uniformly over time, a relationship perceived as neither overly positive or negative. This is a stark contrast to the relationship shared with father in all cases, where relationships are "generally marked by a gap, a 'disappointment' or a loss" (Guidano & Liotti, 1983, p. 288). The following separate

analyses of attachment with mother and father also make clearer how enmeshment evidences in maternal and paternal relationships.

Attachment with mother

As Selvini-Palazzoli (1985) notes, mothers of participants are characterised as undemonstrative and controlling and in most cases, (except the anorexic case), she is critical and openly rejecting of the eating-disordered individual. Others characterise the mother-daughter relationship in the same way, citing both psychological and sociocultural reasons as motivation (Carlson, 1991; Chernin, 1993; Dana, 1992; Dana & Lawrence, 1992; Friday, 1988; Orbach, 1985b). Developmental histories of participants reveal an attachment style of withdrawal and distance from mother. All individuals express profound uncertainty regarding their mothers' ability to contain or withstand their emotional lives, either because she is perceived to be emotionally fragile, or because of her distant and/or critical and openly rejecting attitude.

> **J:** I can't wait to have children.
> **R:** How will you treat them?
> **J:** I suppose in the same way that I see my dogs. I'm very overprotective but at the same time I let them go. I will *never* be like the way my father brought me up....I don't want to repeat the pattern of...like drilling into a child that he's worthless, that he's hopeless, that he's nothing but rubbish. I will *never* do that....And I will show my children that I love them. I will kiss and cuddle my children. I will encourage them to love me back....I want an explicit relationship with my children....I wouldn't be as closed off as my mother....She's very aloof and very stoical. I know she loves me...but I wish she'd give me a hug or a kiss....It's always got to come from me and I can't do it....You see, it's the way I've been brought up and I just can't do it....My mom's side of the family is very hard, very strong....It's not kissy-kissy, huggy-huggy like my dad's family. They not like that. They don't show emotion....My mom just gets on with it. That's life. She's also very hard, exceptionally hard.
> **R:** In terms of where death's involved or all difficult things?
> **J:** Ya, everything....When my grandmother died...my mother took it quite well. She just broke down once when she watched Steel Magnolias because it was related to the same issues as cancer....Now that my grandfather's decided he wants to die, to go ahead with euthanasia, she's coping all right, she's not even prepared to go and see him....He decided a couple of nights ago he wanted to die and I mean I had my mother on the phone hysterical....I was in tears the rest of the night....When I phoned that Sunday inquiring how she's feeling...she wouldn't even talk about it. She's absolutely dead. She shuts herself off and that's it.

Participants' mothers are not approached (and never have been) when individuals need support or understanding, as the uncertainty regarding mothers' response keeps individuals withdrawn away from her. All participants describe communication with mother as superficial, and great care is taken not to reveal their inner lives to her. In the following example, Jacki's report of her relationship with

her mother reveals withdrawal, uncertainty regarding her mother's responses, and a lack of intimacy.

> **J:** I would say my mom and I have a fantastic relationship....We can talk about everything you know....
> **R:** Has it always been like this, that you've been close to her? I mean do you tell her things about you?
> **J:** No, I'm not like that. I can't you know. I will say, "I've come out and got eczema" but I find it very difficult, I don't know....Sometimes I phone and I cry but I won't *exactly* tell her what it's about. I don't think I've ever cried on her shoulder or cried in her arms, never. Because I don't know how she would handle it.
> **R:** You don't know how she would handle it?
> **J:** No, my sister will cry on her shoulder and kiss and hug her, but I can't do that....In the holidays...she actually put her hand on my arm...and I actually took my arm away because I'm not used to her doing that to me. You know, we go shopping together, it's the best thing but we not...ugh....You know what else, my mother has never told me that she loves me, not *once* did I hear those words. She's so stoical and hard, she's never *once* told me she loves me, not even when I was small. My dad hasn't said that to me either but actually he's always been affectionate you know, and he'll say things like, "who's daddy's big girl" or, "come to daddy, tell me who you love" so he's always been softer you know, more loving, but my mother is so distant, removed you know....
> **R:** You said earlier that you think your mom was proud to have you as a daughter.
> **J:** Ya, I think she is. I mean she also had some tough times. I don't think she was happy when I started all this vomiting and having to go to doctors. I mean she always thought I was a mental case....Now I think it's got better.
> **R:** So she knew about the vomiting?
> **J:** No, she had her suspicions you know....I think only when I kind of told her about it, then I got sent to the doctor, but she thought it was all pre-menstrual stuff. I didn't really tell her the full truth.

Participants experience mother as someone not to be trusted or relied upon for support during times of conflict with father, as she usually unites with father during these times. In Steve's case (where father is absent), mother is still regarded with suspicion and as someone not to be trusted, as she is perceived to side with helping professionals against her son. In Jacki's case, mother is not trusted because she is perceived to always side with father against Jacki.

> I get on well with my parents now that I'm out the house. Living at home with them as a teenager was terrible...the worst, and even being 22 and living at home....My father kicked me out three times in the ten months I was at home then....We just couldn't see eye to eye on anything and maybe it's like that in other families too....My mother is very much dominated by my father and would always run to him and tell him what was going on.

The physical and emotional distance participants institute from mother (except in the anorexic case), has allowed for a level of cognitive-emotional separation between them. In the anorexic case, an exceptionally enmeshed attachment relationship exists between mother and son. In this case, mother's inability to separate herself from her son and her lack of encouragement of independent behaviour, (in conjunction with Steve's physical and emotional demands on her), maintains the dysfunctional

attachment they share; a feature which Minuchin *et al.* (1978) identify as actively supporting the maintenance of sickness.

The features of the mother-child relationship described above are variously explained by psychoanalytic, feminist, and sociocultural writings. Psychoanalytic explanations tend to focus on and blame mother for the development of psychopathology in their children by virtue of the importance attached to the early mother-child relationship. This relationship is regarded as germinal in the development of later psychopathology (Bloom-Feshbach & Bloom-Feshbach, 1987; Bowlby, 1991a,b,c; Geist, 1985; Goodsitt, 1985; Levenkron, 1982; 1985; Mahler *et al.*, 1975; Rutter, 1986; Selvini-Palazzoli, 1985; Sugarman & Jaffe, 1987; Winnicott, 1988; 1990). These theories go some way in offering an understanding of why an initial good relationship with mother/caregiver is crucial in the later development and formation of personality. Feminist psychoanalytic writings (Bloom, 1992; Boskind-White, 1985; Chernin, 1993; Cooper, 1992; Dana, 1992; Dana & Lawrence, 1988; 1992; Eichenbaum & Orbach, 1982; Epstein, 1992; Fursland, 1992; Orbach, 1985a; Pennycook, 1992; Rust, 1992; Selby, 1992) are useful in that their contributions offer insight into psychological and social factors influencing women (and mothers) and consequently, how mothers transmit these attitudes to their children (Brumberg, 1988; Buckroyd, 1989; Carlson, 1990; Friday, 1988; Rizzuto, 1985; Selvini-Palazzoli, 1985). The focus on men and patriarchal society contributes to knowledge of the role of men (fathers) in the case of eating-disordered individuals (Maine, 1993). However, these theories are unable to account for the non eating-disordered population if it is assumed that the conditions they posit as existing, exist simultaneously for all people living in the same society (Brumberg, 1988; Swartz, 1985).

Sociocultural contributions relate the alarming increase in eating disorders over the last thirty years to the intense cultural and social pressures on women to conform to a thin body ideal (Bruch, 1985; Brumberg, 1988; Buckroyd, 1989; Crisp *et al.*, 1976; Dally & Gomez, 1979; Dana & Lawrence, 1988; Garner *et al.*, 1980; Garner, 1997; Lawrence, 1988; 1992; Levenkron, 1982; McCarthy, 1990; Selvini-Palazzoli, 1985; Schwartz *et al.*, 1985a,b; Welbourne & Purgold, 1984). Contemporary society's body image ideal (that views thinness as an ideal of feminine attractiveness) is unprecedented in history, both in the degree of thinness and the extent that this view is promulgated (Garner *et al.*, 1980; Garner & Kearney-Cooke, 1996; Garner, 1997; Marano, 1994; O'Mahoney & Hollwey, 1995; Schwartz *et al.*, 1985b). The powerful cultural imperative for thinness and the need to appear in a certain way reinforces dieting behaviour. Hill *et al.* (1990; 1992) have shown that dieting to lose weight and fear of fatness are common amongst adolescent girls and adult women and increasingly

so in young children (girls as young as nine). Research shows that the risk of developing an eating disorder is eight times higher in 15-year-old girls who diet than in non-dieting 15-year-old girls (Hill *et al.,* 1992). A large literature attests that dieting is viewed as a trigger for eating disorders (Copeland, 1985; Dally & Gomez, 1979; Friedman & Brownell, 1995; Garner & Bemis, 1982; 1985; Herman & Polivy, 1975; Hill *et al.,* 1989; 1990; 1992; Polivy & Herman, 1989; Slade, 1982; Wardle, 1995; Welbourne & Purgold, 1984; Wooley & Wooley, 1985). Dieting is strongly related to body image dissatisfaction (Gleaves & Eberenz, 1995; Williamson *et al.,* 1995) and eating disorders are one of the manifestations of a negative body image (Bowden *et al.,* 1989; Friedman & Brownell, 1995; Huon & Brown, 1989; Probst *et al.,* 1995; Slade, 1994; Wardle, 1995). Research shows that both body dissatisfaction and dieting are the almost exclusive domain of women and that the cultural imperative for thinness affects women more than men, which explains why eating disorders preponderate in women ("Binging," 1996; Crisp *et al.,* 1976; Dally & Gomez, 1979; Garner, 1997; Graber *et al.,* 1994; Hill *et al.,* 1992; Maine, 1993; Selvini-Palazzoli; 1985; Wooley & Wooley, 1985). Documentation of social and cultural forces which influence women allows for an expanded understanding of the interface between the social and the familial, and more specifically, of the interface between culture and mother-daughter relationships. However, in the absence of a well-articulated theory of culture (Swartz, 1985), and because most of these theories do not integrate psychological and biomedical perspectives with sociocultural and feminist perspectives, it seriously undercuts their explanatory power (Brumberg, 1988). Slade's model (1994) is one of the first which proposes the mechanism through which sociocultural forces impact on individuals who have a weak body image. The model is able to account for differences between individuals living under the same social conditions but who do not develop eating disorders and is thus an important contribution to the development of a comprehensive theory of culture.

Attachment with father

Guidano (1987) posits that within enmeshed families, the eating disorder-prone individual will develop a particularly enmeshed relationship with one attachment figure, usually but not always, with father. A primary and exclusive bond with one or two attachment figures is seen as a developmental imperative. Bowlby (1991a,b,c) provides evidence which indicates that children find it difficult to form secure attachments with more than one person. This is because "attachment figures tend to be arranged in hierarchical order with the principal figure at the top" (Bowlby, 1973 cited in Guidano, 1987, p. 32). The findings of the research indicate that within the developmental histories of participants, a preferential and/or intense emotional attachment exists with father. In the anorexic

(Steve) and one bulimic case (Jacki), the attachment is negative (conflict, inability to communicate with each other), even though it is the most intense emotional relationship. It is noted that Steve's preferential attachment figure was his grandmother but that within the immediate home environment, an intense emotional attachment existed with his father (up until his death, and now replaced by his mother).

A preferential attachment with father developed during childhood because he was the parent who provided physical contact, who showed the most interest in them (even if negative), and/or who actively showed a marked preference for spending time with participants, rather than with mother or siblings. It is documented that a child will form an attachment with someone regardless of the negativity of the attachment (rejection, punishment, physical, sexual, or emotional abuse), because a relationship, some contact, is preferred to having nothing at all (Guidano & Liotti, 1983; Sanford, 1991). It is easy to understand a child's motivation for attempting to maintain and hold onto such relationships, as there is usually a complete emotional and physical dependence on these figures for survival (Guidano & Liotti, 1983; Rutter, 1986). In Jacki's case, a preferential attachment developed with her father as he was the one who provided physical affection and who showed the most interest in her.

> I think I loved my childhood because I was a child. I was never forced to grow up....I think it was a happy childhood....I've got no recollection of being close to any one of my parents. But my father always put us on his knee or had a recliner where we would cuddle with him. I can still remember things like that. My father's far more loving, he's still into cuddles and kisses. My mother, there's just *no* emotion there. If someone dies that's fine, you just get on with life kind of thing.

As Guidano (1987) reports, up until a certain time in their development, participants' perceptions of their fathers reveal idealised images of him, and someone who is experienced as perfect. In Steve's case, idealised images of grandmother prevail and there is evidence of unintegrated idealised images of father, (characteristic of childhood), alternately revealed with more realistic appraisals. During the course of her interviews with the researcher, the intense fear Jacki has of her father and the idealised image of him as the holder of absolute truths, is revealed best by her own words.

> **R:** How would you finish this sentence or story: When I was a child my father meant...
> **J:** In so many ways he was God because he knew everything. Ya, he was like *the boss*....He just put the fear of God into me, like it got to a stage when I was a teenager where he used to threaten me by saying, "I know you saying things out of the house. I know people....I work in many people's houses, and I hear these things about you". So I was actually petrified to say anything out of the house. I was so scared....Even when I used to come visit you he'd say, "oh, you going to speak to your friend the psychologist and tell her what a horrible father

> you've got". I could say he almost victimised me, and I was too scared to even talk about anything in case whoever I spoke to used it against me and told my father. He always found out.

Bruch (cited in Guidano, 1987) was one of the first researchers to document the father-child relationship and the impact of father on the eating disorder-prone individual. Traditional psychological thinking focuses on mother-child interactions, where more often than not, the mother is blamed for any psychopathology the child may later develop (Bowlby, 1991a; Rutter, 1986; Selvini-Palazzoli, 1985). In spite of a strong tendency to include mothers but not fathers in studies of developmental psychopathology, evidence for the role of father in child and adolescent psychopathology has accumulated. Phares and Compas (1992) reviewed studies between 1984 and 1991 and found that 48% included only mothers, whereas only 1% included fathers. Although 26% of these studies analysed data separately for mothers and fathers, and 25% of the studies included both mothers and fathers but did not analyse them separately, Phares and Compas (1992, p. 403) state that, "the bias toward studying mothers and therefore implicitly blaming mothers for problems in their children has continued unabated". Guidano (1987), Maine (1993), Phares and Compas (1992), and Roberts (1996) endeavour to bring the father back into the family by examining his role, function, and factors influencing his psychological make-up. From their review of studies, Phares and Compas (1992) conclude that not only do fathers play a significant and substantial role in the occurrence of psychopathology in their children, but that paternal psychopathology, personality characteristics, and behaviours are significant sources of risk for child and adolescent psychopathology. Studies of paternal characteristics of clinically referred or diagnosed children and adolescents show significantly higher levels of psychopathology in these fathers, than fathers of children who have not been diagnosed or referred for treatment (Phares & Compas, 1992). For example, Humphrey (1986; 1989 cited in Phares & Compas, 1992) found that bulimic adolescents perceive greater deficits in parental nurturance than anorexic and nonclinical adolescents, and that this finding is most consistent for the father-bulimic daughter relationship. Additionally, family studies of anorexic, bulimic, and non-clinical individuals evidence that not only do both mothers and fathers share a particular style of parenting, but that fathers' patterns show less unique differences across the groups than mothers (Humphrey, 1986; 1989 cited in Phares & Compas, 1992). The investigation of perceptions of paternal and maternal relationships elucidate the different patterns of involvement of fathers and mothers of eating-disordered and non-eating-disordered adolescents (Phares & Compas, 1992), as well as discriminate subtypes of eating disorders. Waller *et al.* (1989) have shown that perceived interactions are a useful and predictive measure in distinguishing normal from clinical families, (both anorexic and bulimic groups showed similar perceived family pathologies and rated their families as

less healthy than the comparison group), as well as in distinguishing subtypes of eating disorders, (the bulimic groups' ratings showed a more severely unhealthy pattern of family interaction than that of the other groups). It has also been shown that significant differences exist in the patterns of individual members' perception of their interaction, as well as in the abilities of those perceptions to differentiate normal from clinical families. In Waller *et al.* 's (1990) study which compared anorexic and bulimic daughters' and their parents' perceptions of family interaction with a nonclinical comparison group, the daughters' ratings differentiated normal from clinical families on all six scales, the mothers of anorexic and bulimic daughters rated their families as less healthy on only two scales, whereas fathers' ratings failed to distinguish normal from clinical families on any scales. "Fathers' ratings had virtually no predictive power, suggesting that they did not share their daughters' perceptions of the family interaction as problematic" (Waller *et al.*, 1990, p. 549). These data suggest that fathers may play a (substantial) role in the development, maintenance, and/or exacerbation of psychopathology in children.

In studies of diagnosed or referred fathers and their children, it has been found that these children are at increased risk for the development of psychopathology. Studies of depression, alcohol and substance abuse, physical illness, unemployment, and child physical and sexual abuse in fathers show clearly that children of these fathers are at increased risk for behavioural and psychological problems (Phares & Compas, 1992). Depression and physical abuse of children have been studied more often in mothers than in fathers, and alcohol and substance abuse, physical illness, unemployment, and child sexual abuse have been studied more often in fathers than in mothers (due to the preponderance of these disorders in male and female populations respectively). However, recent research which compares paternal and maternal factors in child and adolescent psychopathology reveal no differences between children of depressed, alcoholic, physically ill, or physically and sexually abusive mothers and fathers; in all cases though, these children are more disturbed when compared to children of controls (Phares & Compas, 1992).

The high rate of psychopathology and psychosomatic illnesses in the parents and first degree relatives of participants in this research is noted. Steve's father and Angela's mother have a major affective disorder, (Steve's father was clinically depressed and committed suicide, and Angela's mother diagnosed as a manic-depressive), and both had made two suicide attempts; Jacki's paternal grandmother and aunt were committed to mental hospitals (but Jacki does not know more about this); Maria's maternal uncle suffers from mental illness which she thinks is schizophrenia, but she is unsure because the family have always tried to hide the existence of mental illness within the family.

Hudson *et al.* (1983) report high rates of affective disorders and alcoholism in first degree relatives of eating-disordered individuals. Steve's father and all three Angela's mother's siblings are alcoholic; Jacki's father abuses alcohol and Maria's maternal uncle is alcoholic. Crisp and Toms (1972 cited in Dally & Gomez, 1979) show high rates of eating disorders among parents and first degree relatives of male eating-disordered individuals. Steve's father was obese and his mother and sister have both suffered from obesity. Eating disorder symptomatology is evident in the first degree relatives of all female participants too. Jacki's sister is obese and her mother's weight has continuously cycled over the years from very overweight to normal; Maria's mother is significantly overweight and she is obsessed with her weight, her father is significantly overweight, and Maria's sister has at times been seriously underweight. Psychosomatic illnesses in the first degree relatives of participants are also noted: Steve's father and maternal grandmother were diabetic, and Jacki's father suffers from stress-related eczema and psoriasis.

The identification of factors which are associated with increased risk for child and adolescent psychopathology provide important insights into the etiology and pathogenesis of psychological disorders. The identification of paternal factors in studies of diagnosed or referred children and their fathers, studies of diagnosed or referred fathers and their children, and studies of nonreferred and nondiagnosed fathers and their children, highlights the crucial (but thus far largely neglected) role of fathers in child and adolescent psychopathology. Most notably, these effects are comparable to the risks associated with maternal factors. When more than one (paternal) factor is present, the risk for increased child psychopathology is greater. In Steve's case, his anorexia is better understood if examined in the context of paternal factors which influenced the father-son relationship. His father was an alcoholic (which exacerbated his emotional and verbal abuse); he suffered from major depression and committed suicide; he was a physically ill man (he was diabetic, had coronary problems and underwent a triple bypass operation), as well as unemployed (and facing financial ruin). All these factors have been shown to affect parent-child relationships and more specifically, the psychological well-being of children (Phares & Compas, 1992). Guidano's developmental model (1987) explains how and why these and other factors combine and exert their influence in eating-disordered individuals.

This research identified common features in the characterisation and demeanour of participants' fathers: (1) they are overprotective of participants; (2) strict and moralistic attitudes prevail; (3) they are rigid and reluctant to make changes; (4) they are perfectionists; (5) seldom if ever, do they make their inner lives known to members of the family (apart from expressing anger). Consequently,

individuals report continuous uncertainty regarding knowing what is going on in their fathers' lives and what he may be feeling. Two additional features are identified in fathers: (1) fathers do not tolerate or recognise autonomous self-expression in their children, especially anger; (2) fathers make it inordinately clear that failure of any sort (especially academic), will not be tolerated.

As Guidano posits (1987), it is revealed that the early and constant reinforcement of certain behaviours by fathers (academic achievement met with approval and recognition; and autonomous thoughts and feelings alternately met with rage, intolerance, negation, and anger), led individuals to a common realisation: that the hope of maintaining the relationship with father rested on their ability to excel academically and to conceal their emotional lives from him. In all except the anorexic case, fathers consistently praised individuals for academic achievements. In Steve's case, father's occasional praise and approval functioned to keep Steve attempting to please him (in the hope of receiving his recognition).

According to Guidano's model (1987), an enmeshed relationship with an attachment figure precludes the development of a separate sense of self. This attachment style means that a child's self-perception is underpinned only through the ongoing enmeshed relationship with that attachment figure. Thus, personal identity is organised around deep, oscillating boundaries between the absolute need for significant others' approval, and a fear of being disconfirmed or intruded upon by them. Findings of this research support Guidano's assertions, as all participants (still) express a dire need for their father's/grandmother's approval, and share a fear of his/her rage and/or rejection were they to disappoint him/her. Perfectionism is evident in the performance of tasks by all participants in the hope of avoiding fathers' criticisms, which supports Guidano's model on this feature too.

> **R:** Did you find yourself doing things to gain your father's approval?
> **J:** Ya, I used to work even harder at school or even do better or try my best. I used to do things that he wouldn't find fault with.
> **R:** What type of things got you a favourable response?
> **J:** If I got good school marks, but it wasn't necessarily a bad thing that he wanted us to get a good schooling. He wanted the best for us. Maybe that's why I did so well at senior school. The better I did the *more* he approved.
> **R:** So did you succeed in gaining his approval?
> **J:** I think he is proud of me but the fact that I decided to do teaching is still, ugh, a bad mark against my name. He was against the fact that I did that....He would rather I did a commerce degree. I mean I was capable of that, I had the marks and the intelligence.
> **R:** So you don't feel you've been successful in gaining his approval?
> **J:** No...the last fight we had before I moved out of home was that...I decided to become a teacher, it's my own fault I lost my job and so I must sort myself out....It wasn't *my* fault I lost my teaching post....Sometimes I think maybe I should have done a commerce degree. I would've actually been better off in the long run. But I wanted to do something for *myself* for a change. He was always telling me what to do and how to do it and I was always trying

to please him. I think by...age 17, 18, I was actually quite rebellious....
R: Was it or is it still important for you to feel that your parents approve of you and your accomplishments?
J: Ya, it's *very* important in my life....My father can't tolerate failures. And I've always got to like prove my best, even in what I'm doing now, it's got to be good.
R: And do you succeed in that or how do you feel? Do you often get his approval?
J: Ugh...we don't talk about teaching at all....
R: Would you say you were constantly trying (interrupts)
J: I was trying to bring myself up to my brother's and sister's standards. I was always being constantly compared to the other two....They were always the better ones and I was always like the black sheep of the family, and I always had to prove myself you know. I was always the black sheep and the deceitful one in the family.

As Guidano (1987) states, in order for individuals' hope to maintain their relationship with father, there is a need to conceal certain aspects of the self from him (and mother), carried out by the selective exclusion of parts of the self perceived to be unacceptable to others. Findings support the existence of this dynamic. Participants project an image of self-sufficiency and control in the presence of their fathers, an image which they feel bound to uphold. Thus, during times of need, no individual approaches father for help or assistance, as, (1) they fear his possible criticism and rejection, and (2) because of the self-sufficient, controlled image they project to him, individuals share the opinion that father would be unable to integrate their needy behaviour with this self-image, and hence would be disappointed in them. In the next example, Jacki's image of self-sufficiency and control in the presence of her father, is revealed.

J: I have no self-confidence, no nothing. Same when I wanted to have this breast reduction, he said I'll never go through with it, it will do nothing for me, I must just lose weight. I mean if I lost weight and did some exercise and wasn't so bloody bone idle and lazy, I would have small boobs....And I would never be able to go through with it because I just couldn't handle pain, I had no threshold for pain....And you know what else he used to go on at me about now that I remember, is that I always put out this hard, quiet exterior on the outside, but *inside* I just used to crumble, that I just couldn't cope with life, I just used to be stressed out, that I was just hopeless on the inside. I used to have this like insolent look on my face but *inside* I was just falling apart and weak.
R: Was he right, or is he right?
J: I *am* very soft. But he actually made it worse. I mean he gave me no confidence at all. And then he used to argue why haven't I got any confidence, I must speak up....I think that's why I got so freaked out. I didn't get anywhere with him....I just could *never* win his approval. I just never got anywhere....I tried so hard but I just never got there and then something else would come up....I started going to church...and then I was suddenly one of his happy clappy charismatics. So I just gave up going to church because that didn't win their approval either.

5.1.1.2 Second invariant feature of dysfunctional patterns of attachment

The second invariant feature Guidano postulates in the developmental pathway of eating

disorder-prone people, is that a more or less intense **disappointment occurs with the main attachment figure** (1987), and that this is usually with father (Guidano & Liotti, 1983). Guidano and Liotti (1983) report that within the developmental histories of their anorexic patients, they "almost always found experiences of **disappointment in the emotional relationship with their fathers** in adolescence or preadolescence (and infrequently during childhood)" (p. 287). Within the developmental histories of their obese patients, traces of a disappointment or an almost complete loss of the relationship with father are noted, which occurred at a younger age (childhood). The relativisation phenomenon, where the image of the father changes for the worse, was noted in both their anorexic and obese patients; a significant number of male obese patients also exhibited this phenomenon. No descriptions of disappointment in the mother were obtained (Guidano & Liotti, 1983), but subsequent research has provided proof of disappointment in mother, although this is not common (Guidano, 1987). Dally and Gomez (1979, p. 79) note that, "fathers are often involved as deeply, through their relationship with their wives" with the eating-disordered child. Wold (cited in Dally & Gomez, 1979, p. 81) examined the role of fathers in three cases of anorexia and found, "all three fathers to be rigid compulsive men with violent tempers, who worshipped their own mothers and projected this attitude, which precluded open hostile expression, onto their daughters". Others also note the existence of a disappointment in the developmental histories of eating-disordered individuals (Lacey, 1985; Selvini-Palazzoli, 1985; Welbourne & Purgold, 1984). Others identify a disappointment specifically in the relationship with father (Bruch, 1985; Bruch cited in Guidano & Liotti, 1983; Maine, 1993). More specifically, Goodsitt (1985), and Wold (cited in Dally & Gomez, 1979), identify disappointment with father in anorexic cases, and Wooley and Wooley (1985) report on disappointment in father in cases of bulimia and obesity.

This research corroborates Guidano's (1987) and others' findings, as within the developmental history of all participants, there is evidence of a gross emotional disappointment within the preferential attachment relationship. For all individuals except Steve, the disappointment was in the relationship with father. In Steve's case, the disappointment occurred within the preferential attachment to his grandmother. However, a second emotional disappointment, of the same nature (sudden death), occurred in the relationship with his father. In all cases except in one bulimic case, the disappointment is located in the developmental period of late childhood or preadolescence (10- or 11-years-old). In the bulimic case, the participant was 15-years-old; Steve's same age at the time of his second disappointment. Findings give credence to Guidano's (1987) postulate that the disappointment occurs sometime during late childhood and adolescence and infrequently during childhood. For Jacki, the disappointment resulted from the single occasion where she went beyond her usual withdrawn state

and quietness when her father lectured her and instead, confronted him. Her own words exemplify the nature of the disappointment and the relativisation of the image she had of him up until then.

> **R:** You just said you thought of him as God, as the boss, when did this change for you?
> **J:** I was in standard eight....I was sitting in his chair at home and he came in and I said to him, "you know, you think you know everything, you always dictate to me, and you *don't* know everything and you *not* so big and bright". He got so angry and he gave me a hiding that night....
> **R:** What made you sit there and realise this because it sounds like up until then you did believe that he knew everything?
> **J:** I don't know. Maybe it's just going through adolescence but I just couldn't take it any more. And after that incident I just shut up even more. I just did my own thing...because I just could *not* be good enough for him you know....My marks just weren't good enough. My friends just weren't good enough. If he didn't approve of my friends I wasn't allowed to be friends with them. I just thought, "*oh stuff it*". I wanted to go to a party and he wouldn't let me....
> **R:** It sounds like...that night you looked at him and told him exactly what you thought.
> **J:** I've never *ever* done that again though, *never*. It was the first and the last time. I just learnt to shut up and say, "yes, no"....I don't know where I got the courage from because I normally would never have done that. It was just an isolated outburst....I just let rip and I don't think he could actually handle it coming from his own daughter you know.

The nature of the disappointment is varied, as evidenced by several authors. Guidano (1987) states that life events likely to precipitate a disappointment can be subsumed into two main groups: (1) **Changes in an interpersonal relationship that the subject perceives as extremely meaningful.** Events within this category include: the sudden discovery or revelation about an attachment figure which forces a reassessment of that person and the nature of the relationship; in a relationship where the partner demands more commitment and self-exposure, it is experienced as too threatening and challenging; a true crisis within a long-lasting intimate relationship occurs, where an individual feels it is impossible to leave the other but at the same time cannot accept being deserted by him/her. (2) **Developmental changes or new environmental demands that produce a confrontation with a new situation that the subject perceives as an unbearable challenge to his/her established sense of self-competence.** Adolescence has been identified as a crucial time in the eating disorders developmental pathway (Guidano, 1987). It has long been documented that anorexia and related eating disorders are a typical adolescent syndrome (Bruch, 1985; Dally & Gomez, 1979; Dym, 1985; Strober & Yager, 1985). The types of disappointments and disconfirmations which can elicit a disequilibrium often go unnoticed by others as they are typical comments in frequent situations, like teasing comments about being fat by peers (Bruch, 1978 cited in Guidano, 1987; Selvini-Palazzoli, 1985). **Other circumstances that can easily be perceived as 'testing benches' for one's established sense of self-confidence:** highly valued measures of success in one's social environment (such as high school examinations), can challenge one's sense of competence; changes in work or family relations

which demand more responsibility. From the events Guidano (1987) outlines as the ones most likely to precipitate a disappointment, the findings of this research consistently fall into two groups: (1) relativisation in the image of the main attachment figure; (2) developmental or environmental changes producing new situations which an individual feels unable to deal with. Lacey (1985) lists a similar series of life-events which, together with enmeshed patterns of attachment and a blurred sense of self, cause bulimia. (Two or three factors precipitate the disorder).

> 1. Sexual conflicts, particularly those surrounding the beginning or termination of a major relationship, or a profound uncertainty of a sexual nature within an ongoing or significant relationship. 2. A change in occupation and/or geographical location, such that the patient feels rootless and unsure. 3. "Loss" involving bereavement, estrangement, or separation from a significant family member or close friend (p. 434).

Lacey's (1985) list of life events seen as likely to precipitate bulimia is applicable to both bulimic cases in this research. Both participants' experiences may be subsumed under the category of "loss involving bereavement, estrangement, or separation from a significant family member or close friend" (p. 434).

With different developmental levels come different cognitive abilities (Guidano, 1987; Strober & Yager, 1985). The cognitive level most pertinent in understanding the nature and dynamics of the disappointment, is the emergence of abstract thought. During this developmental period, children's views and perceptions of their parents undergo a transformation. Whereas in childhood and pre-school years parents are considered the holders of absolute truths and values, during adolescence, (with the progressive emergence of abstract, formal thought), parents come to be seen in a different light, (as ordinary people, with problems and difficulties of their own). This change in perception about parents is referred to as **'adolescent relativism'** (Guidano, 1987). What are the implications of adolescent relativism for an eating disorder-prone individual? Guidano (1987) states that because eating disorder-prone individuals' sense of self is incumbent on adhering to the expectations of a parent who is perceived as an absolute model, that a reappraisal or relativisation of that model, can only be experienced as a disappointment; a disappointment so intense that it threatens one's established sense of self. Dally and Gomez (1979) and Lacey (1985) note how adolescents are especially sensitive to disappointments and that what may not appear to be a big deal to adults, is often experienced as overwhelming by an adolescent (especially when new roles or responsibilities are demanded, caused by death, divorce, or marriage of a sibling). Similarly, Welbourne and Purgold (1984, p. 39) describe the impact of events such as the loss of a friend or frequent school and home changes: "This kind of blow is more damaging to an adolescent who is just beginning to

discover his or her true identity than to an adult who already knows himself fairly well, because the loss happens at the time of maximum growth, change and uncertainty".

Selvini-Palazzoli (1985) documents two cases where individuals referred to her for treatment had developed anorexia following the death of a parent. Fourteen percent of Dally's (1979) patients who developed anorexia before the age of 15, had a parent die within a two year period prior to onset of anorexia. The death of a parent and (usually) mother's prolonged bereavement is identified as an important predisposing factor in cases where children later develop psychopathological symptoms/ disorders (Dally & Gomez, 1979). The impact of death or suicide of a parent is seen to predispose children to the development of psychopathological symptoms (Bowlby, 1991c; Parkes *et al.*, 1993). In Steve's case, anorexia followed both the death of his grandmother and the death of his father. Findings substantiate Dally's (1979) argument that in Steve's case, not only is mother but the entire family, locked into a prolonged bereavement over both grandmother's and father's deaths. Individual family members alternate between anger and hate towards father because of his perceived abandonment of them; grief and guilt over perhaps not having appreciated the depth of father's depression; and ruminations over what could have been had grandmother not visited the family when she did (and died).

Findings also substantiate Dally and Gomez' (1979), Lacey's (1985), and Welbourne and Purgold's (1984), observation that instability caused by frequent moves of home and town, are events which are given much more significance by children and teenagers than is often presumed. Ties with friends (at home and at school), are suddenly lost and these events are understood as a massive disappointment by these authors. In this research, Steve and Angela's families moved town and home a total of 15 times by the time participants reached high school (five times in the first case and 10 in the latter). Although Steve reports that the frequent moves did not affect him because he did not establish ties with anyone, and Angela states that it made her more independent, it is the researcher's opinion that both participants underplay the impact of these events on them. It cannot be said with surety that things would have turned out differently had both Steve and Angela lived in the same town and home all their lives. However, had they had the experience of constancy and the chance to develop intimate, long-lasting attachments to place, people, and things (instead of separation, loss and inconsistency), the profound expectation and scaffolding of experience in terms of loss and rejection in their personal cognitive organisations, (coupled with their home environments which are rigid and usually do not do well coping and adapting to change), may not have been so great. A similar point about separation and loss is made by Bloom-Feshbach and Bloom-Feshbach (1987).

Findings reveal that in all except the anorexic case, the nature of the disappointment resulted from a relativisation in the image of father. The idealised image of father was suddenly challenged by more realistic appraisals of him, leaving participants profoundly disappointed and consequently, causing a change in the relationship with father thereafter. In Steve's case, the disappointment was as a result of the death of his grandmother; an event which was to be cruelly replayed and compounded four years later by his father's suicide. Steve was thus exposed to a double trauma in the loss of his grandmother (his main attachment figure) and his father (the person with whom he shared an intense emotional relationship). At present Steve's perceptions of his father alternate between idealising and more realistic images.

Guidano (1987) states that within the eating disorder-prone individual's developmental pathway, the beginning of the separation process from parents is inevitably experienced as a disappointment. He notes that this disappointment is usually always found in the adolescent reorganisation of eating-disordered individuals, which explains why eating disorders are almost always developed at this stage. Guidano's (1987) observation that eating disorders are a typical adolescent phenomenon following adolescent reorganisation (after the disappointment) is supported by the findings of this research, as well as by others who have documented and explained the preponderance of eating disorders amongst the adolescent population (Bruch, 1985; Brumberg, 1988; Crisp *et al.*, 1976; Dally & Gomez, 1979; Strober & Yager, 1985; Welbourne & Purgold, 1984). Developmental demands that come with adolescence (increased physical-cognitive-emotional maturity) imply a relativisation of parental images which up until then are idealised. This developmental task (with its inherent and unavoidable disappointments), is essential for the ability of an individual to make realistic appraisals of others and consequently, to be able to take steps for ever-increasing emotional and cognitive separation from parents (Sugarman & Jaffe, 1987). To experience this disappointment as an event so intense that it threatens one's very sense of self, explains why there is such a high prevalence of eating disorders amongst adolescents. Dally and Gomez (1979) and Welbourne and Purgold (1984) explain the preponderance of eating disorders among adolescents as a result of the greater importance adolescents attach to relationships than adults. A sudden change or loss of relationships during adolescence leaves individuals extremely vulnerable, as this is a time where there is uncertainty about who and what one is. Cultural forces which encourage thinness have been linked to the rise of dieting and increased risk for the development of eating disorders in children and adolescents (Hill *et al.*, 1990; 1992). The findings of this research support Guidano's and other's findings about eating disorders being a common adolescent disorder. The age at which participants developed full-blown eating disorders ranged from age 11-15 (pre-adolescence and adolescence). Graber *et al.* (1994) have shown that

girls with earlier ages at menarche are at greater risk for chronic eating problems. Jacki and Maria were 11- and Angela 12-years-old at onset of menarche. Over this century, a progressively younger onset of menarche has been noted (Crisp *et al.*, 1976) which accounts for the relatively younger age participants developed eating disorders in this study.

Findings of this research support Guidano's (1987), and Bruch's (1973 cited in Garner & Garfinkel, 1985) observation that the attachment behaviour and communication style of eating-disordered individuals with others is typically evasive (where self-exposure is indicated), and that a typical false self (Winnicott, 1988), is projected to others (where an image of self-sufficiency and emotional control is displayed). A commonality between cases in attachment behaviour towards others is revealed; individuals recoil from self-exposure (especially of their emotional lives). Relations are initiated and maintained with others and reassurance, support and approval are important aspects sought within these relationships. In all cases except the anorexic case, the first and most intimate relationship experienced by individuals has been with their present partners. A period of excessive testing of partners and their trustworthiness characterises the beginnings of these relationships, where individuals expect to be betrayed, hurt, and disappointed. In Steve's case, the same attachment style is revealed in the few attachments he has. However, no relationships besides those in his immediate home environment and with helping professionals exist.

5.1.2 Sense of self

Dysfunctional patterns of attachment (enmeshment) are seen to underlie the structuring of a blurred and wavering sense of self in eating disorder-prone individuals (Guidano, 1987). Parents' constant precluding and redefining of their children's feelings, results in children developing "a deep and pervasive feeling of unreliability concerning their ability to decode their own inner states" and, "only within an ongoing emotional relationship with an attachment figure can they infer what is 'permissible' to think and feel" (Guidano, 1987, p. 157). Problems of enmeshment are reflected in family members' poorly differentiated perceptions of themselves and other family members. The implications for a child living in an enmeshed family are enormous. Within an environment where direct expression of thoughts and feelings is precluded by parents constantly redefining or ignoring children's opinions or emotions, (through lack of recognition, inconsistency, and/or disappointments), children develop a self-image where their sense of lovableness and self-worth is vague; and children do not develop clear self-boundaries between their emerging sense of self and the internal representations of their parents (Geist, 1985; Goodsitt, 1985; Guidano & Liotti, 1983; Guidano, 1987;

Klein, 1987; Kohut, 1981; Winnicott, 1991). The link between attachment processes and selfhood is a well-documented phenomenon in psychology, although diversity exists (Bowlby, 1991a,b,c; Greenspan & Pollock; Holmes, 1993; Kohut, 1981; Mahler *et al.*, 1975; Parkes *et al.*, 1993; Rutter, 1986; Sidoli, 1989; Winnicott, 1988; 1990; 1991). The dysfunctional attachment styles of eating disorder-prone families are seen to preclude satisfactory separation-individuation and a sense of selfhood (Bruch, 1985; Buckroyd, 1989; Chernin, 1993; Clark *et al.*, 1988; Dally & Gomez, 1979; Dym, 1985; Garner & Garfinkel, 1985; Geist, 1985; Guidano & Liotti, 1983; Lawrence, 1992; Levenkron, 1985; Minuchin *et al.*, 1978; Rizzuto, 1985; Selvini-Palazzoli, 1985; Spitz, 1965; Sugarman & Jaffe, 1987; Welbourne & Purgold, 1984; Williams *et al.*, 1990; Winnicott, 1991).

Several indices reveal a blurred and wavering sense of self in the self-structures of participants. This is related in individuals' self- and other-descriptions, as well as in their attitudes toward self and reality. The 18 indices the researcher lists (1-18) are findings of this research and compiled by her. They are regarded as defining criteria of a blurred and wavering sense of self by Guidano, although not explicitly listed in this way by him. Instead they are described in a scattered way in the 1983, 1987 editions of his work. Only item (9) is not mentioned as characteristic of a blurred and wavering sense of self in Guidano's work. However, the taking on of a 'sick' identity as a means of defining oneself, is regarded by the researcher as another indication of the existence of a blurred and wavering sense of self. All 18 indices presented provide evidence in support of Guidano's (1987) model.

5.1.2.1 Indices revealing a blurred and wavering sense of self

(1) As Guidano (1987) states, within participants' developmental histories, enmeshed patterns of attachment preclude the cognitive-emotional separation characteristic of adolescence and higher levels of maturity (in various degrees). At a time when separation from parents is indicated, **participants remain focused on the preferential attachment relationship/figure as a means whereby a self- and felt-identity may be extricated.** (The preferred figure is thus the criterion image). The critical role of fathers in the development of a self-identity is indicated by the inordinately high regard participants attach to their father's opinions, attitudes, and appraisals of them. Individuals' self-esteem, confidence, worth, and lovableness are inextricably bound and derived from (and thus subject to), fathers'/grandmother's evaluations of them. Both examples on the next page accentuate the extent to which Jacki's self- and felt-identity is inextricably bound to her father's appraisals of her.

R: Do you think he was proud to have you as a daughter?
J: Ugh, I think he went through his phases you know. In some stage I think he resented me, having this daughter. I mean I was nothing but a failure in his eyes, had done nothing right, had been nothing but a problem since the day I was born....
R: Is there anything you know for a fact that he liked or disliked about you?
J: Ugh, I don't know what he likes, I don't know. But disliking, he disliked the fact that I was an absolute failure and this problem and always causing problems.
R: But were you a failure?
J: Ugh, when compared to my brother and sister I was. I mean I didn't do the degree *he* wanted. I never used to wear the clothes *he* liked. I always used to wear make-up and when I started smoking he freaked out about that....I used to get very upset about it, I still do but I've learnt to shut it off though.

R: Did you feel you weren't acceptable at the weight you were at?
J: Yes! I thought I was disgustingly obese. My father always used to say "oh God, here comes blubber thighs" or "blubber boobs" or "thunder thighs", always something derogatory. But then I think my mother actually had a chat to him and said "look you know, she's going through a difficult age, just keep quiet". And then he actually tried. Like one time he made me put on a bikini to take a photograph of me to say "look, you not bad, you a big person, you've got to learn to accept it". But I think I was so far gone then, I'd lost all my self-esteem or any like respect for myself, that it just bounced right off me.

(2) Findings are in accordance with Guidano's (1987) appraisal that because all participants share the knowledge that their **fathers' demeanour toward them was/is dependent on pleasing them** (through academic achievement and by displaying control over their emotional lives), a perfectionist posture is adopted as the preferred strategy in achieving this aim. In Jacki's case, the desperate need to please her father is revealed in the next example.

J: My father was constantly chipping at me. I think that's why I got so freaked out. I just couldn't care....I gave up caring. I mean sometimes I think "my God, why haven't I got Aids now?" I mean I just went off the deep end, I just did my own thing. But I didn't get anywhere with him.
R: And you wanted to?
J: Ya, and I just could *never* win his approval. I just never got anywhere. I mean like I tried so hard but I just never got there....
R: How did he respond to you when you were happy or proud?
J: He used to be like nice if I good a good school report....He would praise me and be chuffed and we'd go out for supper. I was very involved with guides and I got the top award in the country, he was very chuffed....He was very proud of my achievements and that I got a degree....I was the first one in our family to get a university degree....It was a very proud moment for him. He was happy....
R: It sounds like he could be proud of you when you achieved.
J: Ya, when I achieved. He always used to compare me to my brother and sister, that I always used to be very quiet and under-handed and deceitful...but they would just come out and say they had a bad day or a good day and I wouldn't. I was always quiet and silent and that me the sneaky one in the family....
R: And was it the same when you were depressed or anxious?
J: Ya, I couldn't share it with them because they were like distant to me. They weren't close....My brother and sister are very close to them but I'm not. I don't know why I perhaps had to distance myself from them.

(3) As Guidano (1987) states, constant **vacillation of self-boundaries** which are alternately externally and internally bound, are noted in all cases, giving credence to the observation that self-structures are weak and diffuse in these individuals. In other words, participants alternate between deriving a sense of self from others, (especially from main attachment figure), and from one's self. This is revealed in Jacki's case where she vacillates between the self-knowledge that she is a good teacher (which makes her feel good), and the knowledge that her father disapproves of her choice of career, (which leaves her feeling disapproved of and willing to give up teaching in an effort to please him).

R: Do you feel that you are a person with special talents or abilities that others haven't recognised?
J: I think I've got a special talent for teaching.
R: And that other people don't know about it, or do they know about it?
J: No, ya, they do know about it. My headmaster actually saw I taught well. I've got this special talent of teaching with my voice that not many teachers have....I was actually quite shocked when he told me.
R: Do you feel or know that you've got this special talent?
J: Ya, because teaching is something I know I'm happy with....
R: And yet didn't you say in a previous interview that you don't know if you will ever go back to teaching?
J: I did, but on Thursday when I was helping with this project, it brought it all out of me. It's still *there*, it's still so *strong*. I thought I'd probably lost it, I'll never go back.
R: It sounds like you trying to kill that bloody teaching side of you.
J: Maybe I am....I actually would like to teach again.
R: Does anything stop you?
J: Sometimes I wish I'd never done teaching because my father actually like shat out about it in the first place.
R: So even though you happy with it and you chose something that you wanted to do, something that you know you good at, you still want to abandon it and do something else?
J: Ya, well I thought maybe I'll do some credits and get a commerce degree....He wanted me to do a commerce degree. Because now I'm thinking back and I'm thinking maybe I should never have done teaching in the first place. Maybe I should have just listened to him and done commerce.
R: Do you think things would be different if you had?
J: Oh yes. I'd have listened to him. If I hadn't done my own thing I'm sure things would have been different....
R: Did you find yourself doing things to gain your father's approval?
J: Ya, I used to work even harder at school or even do better or try my best. I used to do things that he wouldn't find fault with....I was always trying to *please* him.
R: What type of things got you a favourable response?
J: If I got good school marks, but it wasn't necessarily a bad thing he wanted us to get a good schooling. He wanted the best for us. Maybe that's why I did so well at senior school. The better I did the more he approved.
R: So did you succeed in gaining his approval?
J: I think he is proud of me but the fact that I decided to do teaching is still, ugh, a bad mark against my name. He was against the fact that I did that. He paid for my degree but he would have rather I listened to him and done a commerce degree. I mean I was capable of that, I had the marks and the intelligence....Sometimes I think maybe I should have just done a commerce degree. I would've actually been better off in the long run. But I wanted to do something for myself for a change.

(4) The fathers' (and in the compulsive eating case, mother's) denigrating, rejecting, and vilifying of individuals' emotional lives, set in motion the parallel **structuring of a self image on the basis of the perceived expectations of the selected parent**; a point made by Guidano (1987) which the findings of this research support. Findings show that this is an image which projects self-sufficient and controlled attitudes to the world and an image which all participants feel bound to uphold. In all cases participants (still) express a fear of rejection and criticism were they to reveal their true selves to father/mother.

> **J:** A month ago I got drunk....It was unintentional but I should never have drunk starting my periods because it affects my sugar levels. I actually can't even tell my parents that. I can't even make it a joke. I'm too scared to. *I'm 25 years old*!
> **R:** Do you think they should know about it?
> **J:** No, well it's a thing of life, like when I pranged my husband's car, I've never told them. I'm too scared to tell them. I made Joe swear never to tell my parents....
> **R:** Because?
> **J:** I'm too scared. I'm scared of being screamed at and shouted at. I'm so scared they going to judge me on it....I can't handle it. I can't handle them shouting at me any more. I don't like it any more....I just get so upset. I get so upset and I will *not* show them how upset I am. It just breaks me up inside.
> **R:** Especially when you not able to show it, because that makes it a hundred times worse.
> **J:** Ya, I can't show it. I'm suppressing it. Something I found was that I was so happy vomiting. It's like my way of retaliating back and showing them you know, fighting back all the time.

(5) Within participants' self-perceptions, an **uncertain attribution of causality to feelings** has led them to conclude that emotions cause and hence are responsible for, their difficulties and shortcomings. This is matched by a resolve to suppress emotional life both from one's self and from others. Guidano (1987) states that an uncertain attribution of causality to feelings is a defining feature of eating-disordered individuals' self-structures. This feature is revealed in the following example where Jacki describes her need to suppress her emotional life.

> **R:** Would you say you tend to be more emotional or more a cool-headed kind of person?
> **J:** I try to come across as cool-headed, that's what I *try* to do with myself.
> **R:** Why is that?
> **J:** Because I think it's more in line with me being a perfectionist, me being more logical, meticulous.
> **R:** Have you always been like that?
> **J:** No, I would say from the age of 14 I started becoming like that. Showing that I was cool-headed, I didn't get upset, I didn't get flustered, but essentially, I *am* an emotional person. But I give this very cool exterior or well, I *think* I portray that cool exterior on the outside.
> **R:** It's like what you said your father would often say to you.
> **J:** Ya, that I was strong on the outside and on the inside I was just cracking, crumbling. It's like what I'm doing now with Joe going. I've been acting so cool but on the inside I'm like....

R: But do you see feeling or being emotional as always crumbling or freaking out?
J: Ya, because I'm not *coping* with the situation. I'm not in *control* of it. I'm failing.
R: So any feeling is not coping?
J: Ya, I've got to curb it. I've got to be in control all the time of how I feel.
R: So would you say that's across all feelings? Sadness, anger?
J: Ya, both.
R: And if you happy, do you curb that?
J: No, look it's got much better now. I mean before I used to show no emotion, I always tried to be as cold as possible, and maybe that was adolescence.

Because of participants' uncertain attribution of causality to feelings (Guidano, 1987), individuals are on the one hand, able to experience a sense of self as reliable and worthy because of the perceived ability to manipulate others. On the other hand, participants are able to experience a sense of separateness from others because of the perceived ability to control them (see also '7' for emotional function of eating disorder). Sugarman and Jaffe (1987) describe how vomiting is an action that promotes self/other differentiation. In the narrative below, Jacki's uncertain attribution of causality to feelings (hence the purging behaviour) allows her to experience a sense of separateness from others, especially from her father.

J: I can see myself hanging over the toilet. I know exactly what fingers to use, how much water to drink and if I've eaten whatever, I know exactly how long it will take before the food comes up. Oh, I knew it off by heart towards the end. And I used to feel very much in control. I'd eaten all this food yet I would put on no weight. I would still look good and my parents wouldn't be any the wiser.
R: And while you sticking your fingers down your throat?
J: I feel *wonderful*. I feel *absolutely fantastic*. I've got such a good thing going. I've got the best of both worlds.
R: So were there thoughts going through your head?
J: Oh yes, like I'd eaten all this food, but they could never say I was putting on weight because I wasn't. I was like getting rid of the food. I mean I'd be fighting with my father, he'd be forcing the stuff down and trying to control my life, yet he *wasn't*, because he had nothing to control me with. I mean I refused to eat his food and one way or the other I would get rid of it.

(6) Following the emotional disappointment in the preferential attachment figure, participants are overwhelmed with the distressing feelings this incites in them. The inability to decode and integrate these feelings is noted in all cases. Faced with distressing feelings of worthlessness and incompetence (after the disappointment), participants turn their **attention and energies to altering their body shape,** as this is suddenly perceived to be the **source** of their feelings (of incompetence, ineffectiveness, emptiness), as well as the source of others' criticisms of them. The body is experienced as either too fat and/or unattractive in all cases. Guidano (1987) lists three reasons why the body becomes the focus: (1) changes in bodily states are still the most reliable forms of self-perception available to these individuals; (2) the characteristic family habit of emphasising social and

body appearance makes it tantamount in self-evaluation. Being fat or overweight thus becomes the predominant way of "representing to oneself a possible personal failure" (p. 165). It is also noted that anorexic individuals strive against this image of failure by over-controlling biological impulses, whereas obese individuals "tend to give up the struggle, since they do not feel up to the task" (p. 165); (3) sociocultural preoccupation with thinness is implicated as another predisposing factor. In Jacki's case, shortly after the disappointment in her father, she centred on her body and began to engage in purging activities in an attempt to rid herself of the feelings she felt pervaded with.

> **J:** It started when I was 15....I decided well this is a good idea to lose weight but I had no concept of bulimia or anorexia in my narrow little world....
> **R:** So at that stage you weren't happy with (interrupts)
> **J:** No, I wasn't happy. I mean the "in" thing was to be thin and wear your girdle on your hips and I could never do that because I had such big boobs, this tiny little waist and these big hips, so I started vomiting then....I started taking dieting pills and then I started puking on top of that, and it was wonderful.
> **R:** So you were losing weight and this is what you wanted?
> **J:** Ya, but then at the same time I was also having these fights with my father, like I wasn't allowed to go out. And then I realised, *I'm losing weight*! I'm not eating *his* food! I'm getting the *better* of him! I'm now in *control* of myself! So it was wonderful. I had this perfect solution. I mean I had everything there in my hand and all I had to do was put my finger down my throat.

Slade (1982) and Garner and Bemis (1985) have also reported that for eating-disordered individuals, the sense of mastery attached to weight loss or weight control gains significance (and becomes the most reliable self-referent) because it occurs in the context of a life-long sense of failure and incompetence. Other authors describe and explain eating-disordered individuals' feelings of ineffectiveness and/or emptiness and self-unreliability in the same way (Bemis, 1978; Bruch, 1985; Bruch, 1973 cited in Guidano & Liotti, 1983; Boskind-White, 1985; Hood *et al.*, 1982; Kern & Hastings, 1995; Lawrence, 1988; 1992; Selvini-Palazzoli, 1985; Schwartz *et al.*, 1985a), adding support to Guidano's model.

(7) Feelings of personal ineffectiveness and incompetence in asserting control over one's life and reality (because of extensive reliance on external frames of reference and enmeshed patterns of attachment), are relieved by focusing on the body and changing eating patterns. In all cases, **the development of an eating disorder** provides a means of self-control at a time when individuals experience themselves and reality as essentially uncontrollable. In Jacki's case, vomiting is a means of coping with distressing feelings (emotional life), as well as a weapon against others by virtue of its secrecy. See example on next page.

J: I think by puking up my food I used to think I was hurting my father because he was losing all this money he was like trying to put down my throat kind of thing. And at the same time I was actually *winning* there because I was losing weight.
R: So you were two up on him?
J: Oh yes, I was beating him at his own game.
R: So while you were vomiting you used to consciously think, "I'm getting you back?"
J: At first I tried it to lose weight and then I realised I was actually onto a good thing here because he was like trying to put all this stuff down me but I was rejecting it, I didn't want it. *He could take his money and stuff it*!
R: In other words what he was saying?
J: Ya, what he was saying. In the same way, I didn't want anything to do with him. Whatever he said or whatever he gave me, *I didn't want his stuff*! I was getting rid of it....I didn't want it.
R: So the real food and the metaphorical food? anything that came from him?
J: I didn't want, I rejected.
R: And did you feel good?
J: Oh, I felt wonderful. I felt actually in *control*. I felt *powerful*. Absolutely powerful. I think that's why, okay, I'm out of his house now, but I think now when I get sick I'm in control again. For me it's a power symbol.
R: Vomiting?
J: Ya.
R: And control over what?
J: Myself. Because it was also one way of curbing my emotions....When I was vomiting I used to detach myself from everything....I wouldn't have any feelings. I'd just be neutral, absolutely neutral.
R: But what were the feelings you said you would detach yourself from?
J: If I was upset or hurt or I was angry with my father, or I was so hurt over things he'd said, by puking up I was like detaching myself from them, they weren't a part of me....
R: Is it still mostly to do with your father or is it more generalised to when you feeling upset?
J: Well, it's so seldom now that I get sick, but if I feel like I'm losing control, then I vomit. I know that when I'm with people who I feel threatened by, like my best friend or my mother, I can't eat.
R: Because?
J: I don't know, maybe because she's so much tinier compared to me....I find if I'm threatened then I get sick....I know it sounds pathetic but that's my way of dealing with it....
R: Do you ever see the vomiting as something you do to hurt yourself?
J: Ugh, I don't know because sometimes I see vomiting as I'm actually punishing myself by saying like, "shut up, don't say anything, just keep quiet, just don't show anything"....
R: So you do recognise that it's bad for you, that you hurting yourself but it's (interrupts)
J: *Power* for me and *control*.
R: And getting back at others? Hurting others?
J: Ya, and control....I *never* see it as an attack against my mother. It's an attack against my father.

The lack of an adequate measure of the ineffectiveness dimension has made it difficult to provide empirical evidence in support of clinical observations (Hood *et al.,* 1982) and led to endeavours to evidence it. The internal-external (I-E) locus of control construct has been linked to feelings of ineffectiveness and used in studies of anorexic, bulimic, and obese individuals, and compulsive eaters. Hood *et al.* (1982) applied the I-E construct in two groups of anorexic patients, (dieters and restricters - those who lose weight through dieting and exercising, and bulimics - those who lose

weight through purging and vomiting), and compared scores with norms. Although results indicated that external I-E is not a global characteristic of anorexic patients, it was found that within the patient sample, externality was strongly associated with bulimia, as well as to the greater symptomatology found in this group. The more severe behavioural and emotional symptoms in the externals are attributed to the bulimic continuing to experience feelings of ineffectiveness, whereas the restricters are seen to be successful in the search for self-control.

Nir and Neumann (1995) explored the relationship between I-E locus of control and self-esteem as predictors of long-term weight loss maintenance in obese women. Findings revealed that the higher the self-esteem scores, the lower the average weight regain, and the higher the locus of control, (more internal), the smaller the weight regain. Both self-esteem and locus of control were found to play a crucial role in management, attainment, and maintenance of weight loss. Williams *et al.* (1990) compared eating-disordered patients (anorexic and bulimic females), psychiatric control patients, non-patient/non-dieting controls, and dieting females on five measures: eating disorder, assertiveness, locus of control, hostility, family control and family encouragement of independence and autonomy. Greater eating disorder symptomatology was associated with a low degree of self-assertion, high levels of self-directed hostility, the perception of being controlled by external forces, and a perception of the family as more controlling and less encouraging of independence. When the results of the four groups were compared, the eating-disordered group showed the greatest locus of external control and the most self-directed hostility, but the least assertiveness and the least family encouragement of independence. Ghiz and Chrisler (1995) examined the relationship of assertiveness, depression, and obsessive thoughts of food on compulsive eaters in an attempt to demonstrate the interrelatedness of these characteristics and that these are either causes, or consequences of compulsive eating. Although participants showed a low ability to assert themselves, depression, assertiveness, and restraint and hunger were not found to be predictive of compulsive eating. These results were surprising as it was expected that compulsive eaters would be more depressed, more obsessed, and less assertive than was true of participants. Criteria used for the selection of participants were identified as the reason for the unexpected results. These data (above four studies) provide empirical evidence of anecdotal claims which describe eating-disordered patients as suffering from feelings of ineffectiveness.

(8) The constant **shifting of attributive style from self to the outside world,** indicates confusion, vagueness, and weak and diffuse boundaries between self and world/other. As Guidano (1987) states, although there is variance between participants, it remains within the margins of an uncertain attributive style in all cases. He explains that the appraisal of the disappointment will determine the

making of an internal or external attribution, depending on whether the disappointment is actively discovered i.e., experienced as volitionally imposing one's view on reality, or passively accepted i.e., experienced as adapting oneself to an overwhelming distressing event. Guidano (1987) identifies three factors which will influence the appraisal of the disappointment, hence the attributive style: (1) **intensity of the discrepant event**. If a challenging situation overwhelms the coping abilities of a child, it can only be experienced as "passively suffered" (p. 163); (2) **intensity being the same, the subject's age** is an important factor. During adolescence, abstract cognitive abilities allow for a more active appraisal as compared to those in childhood. Guidano and Liotti (1983) note that disappointments usually occur earlier in obese cases than in anorexic cases; (3) intensity and age being the same, **the presence or absence of available alternative identification figures** is a significant factor. The possibility of replacing a beloved figure with an alternative identification figure can have a positive outcome. This is because the disappointment in the beloved figure can then come to represent "an active cognitive emotional separation from him/her" (Guidano, 1987, p. 164).

Not only are differences in attributive style explained in terms of these three factors but Guidano (1987) states that if the disappointment occurs during childhood, (when cognitive abilities for more active appraisals are absent), then individuals are more likely to experience themselves as passive and to make an internal attribution. In the case of an **external causal attribution**, individuals' perception of others is that they are deceitful and intrusive. Individuals strive against the deceitful reality by displaying self-sufficient, controlled attitudes, and it is these attitudes which function to keep their feelings of personal ineffectiveness and emptiness within an acceptable range. According to Guidano, this type of attributional style, can, during a disequilibrium, give rise to the typical anorexic disorders. In the case of an **internal causal attribution**, individuals restrict the "distressing effect of expected disappointments and disconfirmations" (Guidano, 1987, p. 163) by attributing them to specific, concrete, traits of the self, instead of to the feelings of ineffectiveness and/or emptiness with which he/she feels pervaded. This type of attributional style (which is more passive, bodily and motorically), can, during a disequilibrium, give rise to bulimic disorders and obesity. Findings of this research support the observation that the disappointment occurs earlier in obese cases than in anorexic cases. (The compulsive eater is considerably overweight and thus is assumed in the obese category).

The I-E locus of control construct is similar to Guidano's concept of I-E causal attribution. Various applications have been made of the I-E locus of control construct where it is generally defined as the extent to which an individual feels, perceives, and/or believes him or herself as in control of

personal/external circumstances, or controlled by them. Locus of control will thus influence and determine attributive style. Overall, studies have shown that external locus of control is associated with greater eating disorder symptomatology (Hood *et al.*, 1982; Ghiz & Chrisler, 1995; Nir & Neumann, 1995; Williams *et al.*, 1990).

(9) Only in the anorexic case is the **eating disorder used and held onto as a means of self-identity**, whereas in the other cases, being labelled as eating-disordered is abhorred and something participants are eager to shed and not be associated with. (See appendix 1 pp. 243-244, 283 for illustrative case material).

(10) As Guidano (1987) states, a blurred and wavering sense of self is further revealed by the **primacy attributed the interpersonal realm** by all participants. Sense of self (worth, confidence, lovableness, esteem), is derived from and dependent on others' (perceived) appraisals. Continuous self-assessments are made about the ability to please others and appear acceptable. Parental approval and recognition is still crucial to participants' self-concept and well-being. In Steve's case (in the absence of father), brother is the person from whom Steve seeks approval and recognition. In the following two examples, the primacy Jacki attributes the interpersonal realm, as well the extent to which Jacki's sense of self is incumbent on others' appraisals, is revealed.

> **R:** How would you describe yourself as a person?
> **J:** Serious....I have very high standards and I can't tolerate failure in anything...in myself as well as compared to anyone else....I'm very neurotic.
> **R:** What do you mean when you say neurotic?
> **J:** I mean very stressed out all the time. I'm always thinking, "do I look all right, have I said the right thing, have I done the work right?" I'm always like seeing that I've done everything right....I would say that I'm a perfectionist, I'm terrible like that because I can't even go to sleep at night if my house is dirty...I just don't relax and if my house is dirty, I just freak out, I can't handle it. I don't think I cope very well under pressure.
> **R:** What happens?
> **J:** I break down.

> **R:** You said you tried to help yourself to get over the bulimia. Could you tell me what you've tried?....
> **J:** I've learnt to say to myself, "look, you look fine, stop being silly about yourself. You've got this bad misconception in your mind when you look at yourself in the mirror. Yes, you *are* attractive because look how many boyfriends you've had". Reassuring myself the entire time. I've got to constantly reassure myself....Once, I made myself go to the beach and lie there in a bikini. I made myself *walk on the beach*! And people's mouths didn't hang open and I realised it was a lot of mind over matter and that I was far too self-conscious....Like last night I kept telling myself, "you look fine". I was bursting for the toilet and I wouldn't go. I had to keep saying to myself, "you look fine, your friends have commented, your husband says you look nice, just get up and go to the bloody toilet and *hold your shoulders back!*" I always used to hang on the floor in case people were looking at me so they couldn't see my face. But I'm 25 and I'm *still* doing that to myself.

(11) A striking significance is attached to **others' approval and recognition of participants.** Individuals' sense of worth, esteem and self-confidence are inextricably bound to the way others/external reality are perceived and experienced. Similarly, **criticisms are experienced as attacks on the self.** Consequently, much of individuals' time, behaviour and attitudes is aimed at obtaining sought after approval and avoiding criticism. It is noted that eating disorder-prone individuals' vulnerability to criticism far exceeds the sensitivity to criticism found in other clinical disorders (Guidano, 1987; Slade, 1982). In all except the anorexic case, (where homo/heterosexual relations are absent, as are friendships), a common pattern of initiating and terminating relationships to prove one's worth or attractiveness is noted in their social histories, as in the next example where Jacki describes the pattern her relationships with men assumed.

> I used to go through guys faster than I could change my underwear kind of thing and I don't know, maybe I was just testing to see how good I was, you know, if I was *actually* attractive, did guys *actually* find me nice or was I *actually* that dirty?

(12) Within present relationships with boyfriends or husbands, in spite of individuals' ability to tolerate higher levels of intimacy and trust, all participants reveal **a need for constant reassurance** that they are alright from their partners, and in Jacki's case, she still expects to be told what to wear and not to wear, as was the case when she was living at home (see example below). In the absence of overt recognition and/or confirmation from partners, participants become sensitive and either cause a fight, or withdraw into themselves.

> **J:** Still now, I expect my husband to tell me....I used to get so frustrated with Joe when we started living together because he never used to tell me how I looked! *Never*! And that's actually when I accused him of having an affair but I said to him, "you know, you *never* tell me how I look, or what I wear if I look nice, if I need a petticoat". I said, "my father *always* used to criticise the way I looked".
> **R:** So you were expecting him to criticise you too?
> **J:** Ya, of course. He said he does say and then he made the comment, "oh, that was a nice supper". I said, "that's *not* what I want. I need you to tell me *how* I am. I like your hair or I don't like your hair, or why don't you do this to your hair, things like that". I constantly need reassurance. And this has been going on for months. I finally blew up about it. I'd suppressed it for more than five months and then eventually I got it out of my system. That's what I'm like. I said to him, "well honestly, tell me when last did you give me a compliment?" He couldn't even remember and now he's starting to.
> **R:** Why do you think he's like that?
> **J:** Because as he says, "I love you the way you are. I like you without make-up on, I like you with make-up on. You've always dressed well, I've never had to say yuk!" But at the same time I *still* need that reassurance.
> **R:** Why's that?
> **J:** I'm so *used* to it. It's so *part* of me....Even when I buy clothes, but I think Joe does put his foot down there because he's very particular about what I wear and that. And I actually enjoy that.

(13) The need for others' recognition, coupled with a fear of rejection and criticism, has led all participants to the conclusion that their **inner lives must be kept hidden** from others (as emotional intimacy is perceived to cause rejection and/or punishment). In all except the anorexic case, (where no friendships are maintained), relationships with friends and colleagues reveal the simultaneous need for affirmation and fear of emotional intimacy. This is exacerbated by participants' belief that they are bound to uphold an image of themselves which others are used to (self-sufficient and controlled) and were they to give this up, they expect to be rejected. In the anorexic case, primacy attributed the interpersonal realm is the same as in other cases but limited to his home environment and to helping professionals engaged in treating him. The dynamic of keeping one's inner life concealed from others is clearly revealed in Jacki's reports to the researcher.

> **R:** How do you get along with other people?
> **J:** Sometimes I meet a person and I just click, I'll chat and joke and all the rest. People think I'm such a set-up person, that I just have my act together. People see me as being very organised, cracked up. I don't actually show what's happening on the *inside* kind of thing....It's like now, I'm stressed out about moving, I want to leave this town but for me it's a very frightening thought. And I can't show my husband that I'm upset because he's going to worry. So I mean I'm suppressing it, suppressing it, and every now and then it tries to come out and...like I had tears twice this morning and I just hide it all the time.
> **R:** So even from him you feel you must hide?
> **J:** I must hide it.
> **R:** Kind of be alright for him?
> **J:** Ya, I *have* to be alright. I mean my parents keep telling me I must smile and I'm so sick and tired of it because I've been smiling since bloody September and it's getting to the stage now where I just want to have a good crying session.

(14) Guidano (1987) notes that in the eating disorders attitude, there is a propensity to produce events which are understood in terms of disconfirmations and disappointments. Similarly, Slade (1982) reports that among anorexic individuals, the tendency is to see their achievements and events in black and white terms, so that anything less than perfect success represents failure or lack of success. Participants' **constant expectation of failure** is another indice revealing a blurred and wavering sense of self. In all cases, subsequent questioning of the expected failure elicited confused responses; individuals oscillate between assuming personal responsibility and pointing to imprecise external events. It is noted that within the compulsive eating case, Maria is more likely to offer personal attributes (than to blame an external event) in the likelihood of expected failure. Guidano (1987) explains this phenomenon to the disappointment occurring in childhood in cases of obesity (he does not elaborate on compulsive eaters). However, the findings of the research support Guidano's model in Maria's case.

(15) As Guidano and Liotti (1983) observe, participants display an **inability to accept and integrate success, praise and compliments** with their tattered self-images. There is also an inability to attribute successes or compliments to a specific, concrete trait of the self. Participants are suspicious of others' praise and compliments, viewing them as having ulterior motives for offering them, as evidenced in Jacki's case in the example below.

> **R:** How do you feel when someone praises you for something you've done?
> **J:** Actually embarrassed, very embarrassed. I always end up blushing.
> **R:** Is the feeling only embarrassment?
> **J:** No, I'm actually chuffed you know....I mean I'm proud of myself.
> **R:** Do you believe them?
> **J:** Ya, no, I do....I feel chuffed, I've done something nice.
> **R:** And if someone praises you and says you really looking nice, or that's a nice outfit?
> **J:** Ya, I can take that but then on the other hand I think *do* they mean it or are they just being nice? I'm always asking questions back which is so wrong. I can't just take a compliment as a compliment. I've always got to like investigate it, even when someone praises me.

(16) As Bruch (cited in Guidano & Liotti, 1983) observes, the manner in which participants use and apply **abstract concepts** to themselves and others, indicates another level where a blurred and wavering sense of self is revealed. When used, abstract concepts are usually applied incorrectly by participants. For example, all participants express the need and desire to be approved of and loved for who they are and not for their looks. When asked what is important to them in a relationship in this regard, individuals vacillate between identifying abstract concepts (love, sensitivity, trust) with physical traits. In terms of what is important in friendships, individuals again speak of abstract concepts and yet, a lot of time and emphasis is spent in a preoccupation with interpersonal attractiveness. Similarly, all participants express dissatisfaction with who and what they are, (creating the impression that they are referring to abstract concepts of personality or character), but when pressed for an elaboration, they are usually only able to point to physical attributes as the reason, either too fat and/or ugly.

(17) All participants reveal a profound **uncertainty about who they are**. Questions seeking concrete self-appraisals are met with confusion and uncertainty. In the anorexic case, a gross blurring of self-boundaries is noted, which is exceptionally pronounced (see appendix 1.2.2 pp. 248-249 for examples). In the next example, the uncertainty Jacki experiences about who she is, is revealed.

> **R:** Are you uncertain about such things as what kind of person you are, what your long term goals or career plans are?
> **J:** I *am* uncertain about who I am because I don't know exactly *how* I am. I mean I see myself but I'm not actually sure *how* other people see me. In terms of career, I am worried about that because I don't know if I want to go into teaching or into commerce. I don't

know. I'm very indecisive about that. But I know I want to be successful. That's my goal point, I want success.....I really think I actually should have gone to see a therapist.
R: Do you think it's too late to go now?
J: Well, I find that just by talking to you now, and...bringing things up that I've kept suppressed or like hidden for so many years, is actually helping me now. It makes you see more. I mean I never even knew actually what kind of person I was. *Now, now* it's coming out.

(18) The manner in which participants conjugate the **verbs "to be, must, can, to need, and to be worth"** in the first and third person, reveals the attitude to self and other respectively (Guidano & Liotti, 1983, p. 139). These descriptions give credence to the observation that the self in these individuals is indeed blurred and wavering.

5.1.3 Systemic coherence

Guidano (1987) postulates that the main theme on systemic coherence found in eating disordered-individuals, is the pattern of oscillating between seeking and avoiding intimacy. Additionally, the manner in which individuals have experienced the disappointment and the causal attribution made, will determine bodily and emotional patterns, with differences noted between eating disorders. Findings of this research are in accordance with Guidano's model. The primacy attributed to the interpersonal realm as a means of establishing a sense of self- and felt-identity is revealed in the attitudes participants have toward themselves and reality. In order for a stable self-perception to be maintained, there is a constant need for approval and recognition from others, as well as a simultaneous need to avoid others' criticisms, intrusions, and disappointments (as these are the very things which challenge one's established sense of self and which intimate situations would predispose them to). It is a paradoxical dilemma indeed. On the one hand, to attain an acceptable sense of self depends on establishing an intimate reciprocal relationship with an attachment figure/other. On the other hand, the disclosure and commitment such relationships demand, are experienced as too threatening, as criticisms and disappointments make personal identity even more vague and blurred. The solution is thus to develop a relational strategy aimed at obtaining the greatest amount of supportive intimacy, while avoiding self-exposure in the relationship. Ironically, relational styles which are ambiguous, undefined, and constantly test partners, create the very situations of criticism and disappointments which they are designed to avoid. Perfectionism is one of the strategies participants have adopted in attempts to secure their aims. Two other strategies are common in participants' behaviours and attitudes: (1) following the emotional disappointment in the preferred attachment figure, there is a resolve to work even harder to secure that figure's love and approval. In Steve's case, the resolve to work harder also functions to keep him protected from the feelings of

loss his grandmother's death incites in him; (2) in all cases, individuals blame their feelings for their pain and/or difficulties and resolve not to reveal their inner lives to any one again.

The major theme underlying the systemic coherence of participants is revealed by a common pattern in their personal cognitive organisations: **vacillation between the seeking of, and avoidance of intimacy**. Attitudes participants have toward reality and themselves are influenced and determined by the primacy attributed the interpersonal realm. The fear of criticism, rejection and disappointment, thus lays the paradoxical ground within which all individuals are engaged (in attempts to maintain systemic coherence). Seeking and avoiding intimacy is revealed in participants' attitudes toward themselves and reality. In the following example, the primacy which Jacki attributes the interpersonal realm, is revealed.

> You see, I'm fighting this constant battle all the time. I mean I'm age 25 now and I'm *still* saying to myself, "for God's sake Jacki, you never going to have a size eight hips. Just *accept* it". And some days I can cope. I feel wonderful about myself. I can cope with my body image. And then some days I feel repulsed by myself. It's like I'm forever saying to my husband, "feel my stomach. Is my stomach flat? How's my stomach?" My poor husband, I must drive him round the bend and up the bloody wall....Yesterday I was having my examination in the mirror and my stomach actually *has* got flat. And I wish Joe was here so I could say, "Joe, please feel my stomach now". You see, I have to have this constant reassurance. And another thing, my mother always said to me I was fishing for compliments. It's *not* as though I'm fishing for compliments. I just need the reassurance that I'm okay.

The only difference noted between cases in this regard, is that only in the anorexic case is criticism met with criticism of the other. The need for intimacy is not as pronounced in Steve's case as in the other cases. Steve's attitude toward reality is that it is both deceiving and disappointing and coupled with his asocial behaviour, he is mistrusting of others and hence seldom approaches them. In the next example, Jacki experiences criticism of her work as an attack on her self.

> **J:** I don't take well to criticism. If my lecturers criticised me at varsity, I used to freak out. I used to get so worked up because I thought," well I'd failed, that was it, I was hopeless". And the next lesson I would do twice the amount of work to make sure I wasn't criticised again.
> **R:** And if you were?
> **J:** I couldn't take it. It was devastating. I feel like I've failed, that I'm not capable of doing it....I take it personally....I take it as a reflection of myself. That I am not capable.
> **R:** How does that leave you feeling?
> **J:** I feel shit. I feel like I'm the dregs of the floor.

Van den Broucke *et al.* (1995) investigated marital intimacy in married (or cohabitating) patients with anorexia or bulimia and compared them with two control groups (a marital distress group and a non-

distressed group), to see to what extent intimacy deficiencies characterise eating-disordered couples' relationships. Results showed that the low level of intimacy in eating-disordered couples could not be reduced to the effects of marital distress, as when compared to the two control groups, they differed significantly, with both lower levels of openness and higher levels of intimacy problems. These findings confirm the clinical impression that a lack of openness characterises eating-disordered couples' marriages. Similarly, O'Mahoney and Hollwey (1995) examined the relationship between eating disorders and interpersonal functioning among anorexic women, women who had a hobby or occupation where physical condition was important, and women who were non-sports oriented, to see to what extent interpersonal functioning is implicated in eating disorders. Although it was found that a relationship exists between eating disorder symptomatology and interpersonal functioning in all groups, when general neuroticism was partialled out, the association only remained in the anorexic group. Results confirmed that the anorexic group showed the most eating problems and the greatest degree of interpersonal problems. However, in both studies, neither the observed intimacy deficiency of eating-disordered patients' marriages, nor the interpersonal problems of anorexics implies a simple causal relationship, i.e., that the eating disorder is caused by these problems. Instead, both Van den Broucke *et al.* (1995) and O'Mahoney and Hollwey (1995) suggest that the relationship between intimacy/interpersonal problems and eating disorders is better conceived if thought of as a circular one, i.e., with the marital/interpersonal relationship being influenced by the eating disorder and in turn influencing the course of the disorder. These data add supporting evidence to Guidano's observation that a particular relational style is characteristic of eating-disordered individuals.

Differences in experience-assimilating procedures are evident in the attributive styles between participants and as Guidano (1987) states, an attribution made from a "blurred and wavering sense of self always remains within ample margins of indefiniteness and oscillation" (p. 163). Parallel structuring of bodily and emotional patterns alongside personal cognitive organisations are noted, with differences between cases: (1) in the bulimic eating disorder pattern, as well as the compulsive eating pattern, there is a passive attitude toward the self and reality. Individuals believe themselves as essentially out of control of both themselves and reality (cannot stop themselves binging or vomiting). Through their disordered eating behaviour, participants attempt to exert control over their emotional lives; one difference noted between the two groups is the marked passive attitude of the compulsive eater as opposed to the bulimic cases, where in the latter cases both individuals engage in exercise as an adjunct to dealing with distressing feelings. The compulsive eater's motor activity is very low, (which Guidano attributes to the individual having given up); (2) in the anorexic case, feelings of incompetence and personal ineffectiveness are controlled through Steve's active struggle to control

his food intake. His anorexic posture allows him to feel he is in control of at least one aspect of himself (his weight). Although emaciation and starvation preclude his ability to exercise for lengthy periods, he plans and executes short walks, calculated with precision to burn up calories he has consumed.

5.1.4 Common coping strategies

Guidano (1987) states that the precarious nature of the sense of self in eating disorder-prone individuals (derived from and reliant on others for self-identity) lays the foundation for the formation of personal cognitive organisations which are predisposed to the slightest disequilibrium if challenged. Because life is essentially made up of disequilibria and because these individuals are unable to assimilate and integrate inner states, their only alternative for explaining and controlling feelings is to turn to the earliest form of self-perception they know, the body. Thus, when a disequilibrium is encountered, "individuals are led to explain and control them (feelings) through modifications of their body image produced by alterations of the eating behaviour" (Guidano, 1987, p. 168). Guidano identifies the common coping strategy in eating-disordered individuals as the **seeking of supportive intimacy that demands minimal self-exposure**. Within his discussion and explanation of coping strategies, he alludes to other coping strategies but these are not made explicit as strategies. Although he comments on the same coping strategies identified by the researcher as common to all eating-disordered individuals, he contradicts himself by only stating the above-mentioned strategy in his discussion of this feature of the model. Similarly, observations stated in earlier work (Guidano & Liotti, 1983) are not updated, included, or rationalised in later work (Guidano, 1987). It is not understood why Guidano only explicitly identifies the above-mentioned coping strategy. A possible hypothesis for this, is that considering the larger sample from which Guidano derived his assumptions, this coping strategy may very well have been the only one common to all individuals. Considering that the findings of this research are based on four case studies, a much larger sample may well render fewer commonalities.

(1) As Guidano and Liotti (1983) observe, developmental histories of all participants reveal **withdrawal into the self** as the earliest coping strategy. All individuals (except the compulsive eater), learnt that one way of attempting to maintain their attachment to the preferred figure, was to conceal their emotional lives from them, as these were not tolerated (see example on next page). Only in Maria's case, was father (main attachment figure) sought for his security and support up till the disappointment and mother was avoided from early on in her life.

J: I get on better with my parents now, but I also think being married makes a difference....I mean I could never speak to my father before....I was petrified of him, I was so intimidated by him. I could never trust him, even from an early age my parents always battled to get me to talk and that. If I had a bad day at school, even at primary school, I wouldn't say anything. And they would find out weeks later when I finally just cracked and released all the tension....When my father used to get cross and he used to shout, I couldn't handle that. I think I learnt to withdraw and just keep quiet....
R: As you grew older, did the way you that you think of you father change at all?
J: Ya, I closed myself even *more* off from him, and I wouldn't talk to him....I was too *scared* to ask him anything, I was too *petrified*.

(2) As Guidano (1987) states, findings of the research reveal that following the emotional disappointment in the preferred attachment figure, all participants resolved, (1) not to trust others again e.g., "**J:** That's the last time I actually decided to trust anybody", and (2) participants blamed their emotional lives for the resultant feelings incited by the disappointment, and hence all individuals resolved to keep their **emotional lives under control** (not revealing it to others) e.g., "**J:** After that incident I just shut up even more....I couldn't help myself. I used to go out of control....I used to get so depressed. I couldn't control my emotions. I wouldn't talk to anybody. I wanted to be left alone. And I'd just cry hysterically because my father could not communicate with me". A simultaneous decision was made to work even harder to gain (primarily) fathers' and others' approval/ love. **Perfectionism** is noted in all cases as a coping strategy, which Guidano (1987) explains is a logical answer if one's sense of self is drawn from others' evaluations.

(3) Guidano (1987) identifies **seeking supportive intimacy with minimal self-exposure** as the common coping strategy. Findings of this research reveal that all participants share this coping strategy. Relationships with others are characterised by the desperate need for reassurance, support, approval, and recognition, while at the same time maintaining a safe distance from others. Steve's asocial behaviour and attitude toward reality preclude most intimate situations. However, the same pattern of seeking support and approval with minimal self-exposure is noted within the few relationships he maintains with others. In the next example, Jacki seeks her husband's support and at the same time, she keeps part of her life concealed from him.

R: Does your husband know about the vomiting?
J: Ya, Joe knows about it but he thinks it's over, but it's not you know because I'm still doing it every now and then. But I've learnt to lie so well about it he never suspects now.
R: Because I'm worried that painful things may come up, like I may ask you questions about painful issues or relationships and I'm concerned that you have some support.
J: Oh no, Joe's there. I can talk to him....Joe's my support. He knows when I go home I can't handle it. I just puke and get sick all the time....
R: Has your problem with food or weight ever caused you any problems in your relationship with Joe?

J: Yes, it has. It's caused arguments, he doesn't understand *why* and so now I've stopped telling him and he's grown more understanding about it.
R: And the part about you don't tell him any more?
J: No, I keep quiet about it now because I don't want to upset him any more. We had a big argument about it and he couldn't understand why I had to do it, so now I just keep quiet about it, now it's *my* problem and I don't want him interfering....
R: You said earlier that his knowing about the problem has helped you curb your self-destructive behaviour. Does his being aware of the problem make it easier or more difficult for you?
J: I'm glad he's aware I've got a problem and so he understands why I act funny sometimes but on the other hand, it does bug me because I'm so scared he's going to catch me one day doing it....I feel guilty about hiding it but at the same time it's *my* problem....I don't want to give him extra burdens....
R: What do you imagine would happen to you if you didn't vomit?
J: I'd probably be a better person for it....I wouldn't have this *guilt*...of destroying my body any more...the guilt of lying to people and being deceitful behind their backs....The guilt of betraying my husband who thinks he knows....I found from last night's chat I was actually quite upset last night because things that I've blocked out have come out again....
R: What are you going to do with what's happened now, that you've started to think and feel about things?
J: I don't know. I mean, is it really worth it? My parents and I have a good understanding now....I don't want to bring it all up again. I've just kept it quiet. I've just backed down....
R: What do you think will happen if you did bring things up now?
J: I don't know. I think there'll probably be a big blow up again. I don't even want to go through it because I don't want to go through the hurt I went through then. Like I've learnt to find my comfort in Joe, and with Joe I can talk to. Joe will never betray me or anything like that. I think that's what makes our relationship so strong as well.

All participants explain the need for minimal self-exposure in light of their belief that they are **bound to adhere to a certain image** they perceive others to have of them (self-sufficient, controlled, happy). Were they to reveal anything but this image, they believe they would be rejected, criticised, and disappointed, (as well as disappoint others). This is starkly revealed in the following example where Jacki speaks about how she experiences her emotional life and why it has to be suppressed.

J: I don't think I cope very well under pressure.
R: What happens?
J: I break down. Like what's happening now with my husband going away. I mean I'm keeping up a brave front...you know, strong on the outside but inside I'm just cracking, crumbling....I've been acting so cool but on the inside I'm like dying....
R: So even from him you feel you must (interrupts)
J: I *can't* show Joe that I'm upset because he's going to worry about me. So I mean I'm suppressing it, suppressing it, and every now and then it wants to come out....I had tears twice this morning and I just hide it all the time. I *must* hide it....I *have* to be all right....But it's getting to the stage now where I just want to let it out.
R: But do you see feeling or being emotional as always crumbling or freaking out?
J: Ya, because I'm not *coping* with the situation. I'm not in *control* of it, I'm failing.
R: So any feeling is not coping?
J: Ya, I've *got* to curb it, I've got to be in control all the time of how I feel.
R: And if you happy? do you curb that too?
J: No, look, it's got much better. Before I used to show no emotion, I always tried to be as cold as possible and maybe that was adolescence. But it has improved.

R: With Joe would you say?
J: Ya, definitely with Joe. I've got the relationship with Joe that I didn't have with my parents kind of thing.

(4) As Guidano (1987) states, confronted with distressing feelings (after the disappointment) and unable to integrate and assimilate them, a disequilibrium occurred in all cases. All participants turned their **attention and energies to changing their body shape**, and this became the way of explaining and controlling their feelings. The body was perceived to be the source of all their difficulties and pain and thus became the focus of what needed to be changed. The body was either viewed as too fat and/or unattractive. Different decisions followed the resolve to change the body: in the anorexic case, it was through the control of food intake; in the compulsive eating case, it was alternately through dieting, binging, and starving; in the bulimic cases, it was through vomiting.

R: People often have theories to explain the cause of their difficulties. How would you explain your bulimia?
J: You see, it started off I think as a weight loss thing. Then it developed, I mean my father and I started getting on bad vibes...ugh, then I realised it was a power-control thing....I started putting two and two together and the more I talk about it the more I can see it. It was my way of attacking my father for being horrible to me.
R: And that even though you married now, there still times when you want to attack him?
J: When I'm in *his* house, then I still go funny....
R: So your theory explaining it is first it was a weight thing (interrupts)
J: Then it developed....It's the only way I can see it. I never see it as an attack against my mother. It's an attack against my father.
R: Did you feel unacceptable at the weight you were at?
J: Ya, I thought I was disgustingly obese. My father always used to say, "oh God, here comes blubber thighs" or "blubber boobs" or "thunder thighs", always something derogatory.

(5) As Guidano (1983; 1987), Buckroyd, (1989), Emmett (1985), Garner and Garfinkel (1985), Lawrence (1992), Levenkron (1982), Selvini-Palazzoli (1985), Sugarman and Jaffe (1987), and Welbourne and Purgold (1984) note, the **emotional function of the eating disorder** is evident in all cases. In Jacki's case, vomiting is a means of emotional expression, as well as allows for a relaxation of her image of self-control.

J: You know, the bulimia *has* got something to do with my family, because last weekend when I was at home, for the first time *ever*, I never wanted to get sick once and it was because my folks weren't there and I didn't feel I wanted to make myself puke....
R: Would you like not to vomit any more?
J: Ya, I think I would because you know, it's a hell of a thing to be a bulimic, it is. On the other hand, I think it's still my way of coping sometimes. It's my way of handling a situation. I mean I'd *hate* to think if I didn't vomit, what else would I do to myself?....Even at varsity, vomiting was just my way of coping. When I felt threatened or intimidated, I'd just vomit....It wasn't so bad after I met my husband. I was involved in a serious relationship, so it was fine. It got worse again when I finished my final year and my parents

made me move back home. Then it started all over again, and it got bad again. Then on my own initiative, I left home, was jobless, and I think *that* was one of the most important steps I've made for myself.
R: And the bulimia got better?
J: It *did* get better. I was out of that environment which worsened it. In order for it to get better I had to get out of the home environment. I've just remembered what happened the other night when I vomited. I've just realised it's because I went out....I didn't bring up the entire meal. I just had to satisfy myself by bringing up a little bit. And I felt I could *cope* again....It wasn't a big meal I'd eaten either but I just had to be in control....I just had a bad day, I just felt threatened and I don't know what it is but when I eat out in public *I just can't cope*. *That* I cannot cope with yet. And I can tell you I've only just discovered that for myself right this minute.

(6) Another behavioural feature Guidano (1987) and Slade (1982) identify, which this research corroborates, is that common to all cases is the **obsessive thinking about food, eating, and weight**, which functions to prevent individuals from becoming aware of either what they already know and/or the true nature of their difficulties or situations.

(7) Self-destructive behaviours are noted in all but the compulsive eating case, and are engaged in as a means of self-expression. These include: piercing one's own ears as a rebellion against father (Jacki); eating soap and attempting to asphyxiate oneself with blankets as a means of removing oneself from a situation (Steve); hitting and hurting one's genital organs as a way of removing one's sexual identity (Steve); cutting hands with broken glass when feeling neglected (Angela). (See appendix 1.4 for individual case examples).

(8) Apart from self-destructive behaviour, other coping strategies found amongst participants but not common to all cases include: **explicitly blaming others** for their present predicament, except in the bulimic cases; **compliance** to avoid conflict is evident in all but the anorexic case; **denial and blocking of emotional life** (and in one bulimic case the existence of an eating disorder), is noted in all cases; **exercise** to cope with feelings of being fat or too full after a meal is found in all but the compulsive eating case.

5.2 Methodological considerations

5.2.1 Criticisms of Guidano's model

(1) There is a lack of transparency in terms of how theoretical propositions and findings are arrived at. Guidano (1987) states that his model is developed out of research with 270 individuals, 60 of

which are eating-disordered. However, there is little case material provided to support his findings. Subsequently, the researcher had to rediscover what had already been discovered. In this regard, the implicit nature of Guidano's work had to be made explicit. Not only is there a glaring absence of illustrative material but there is selective focusing on certain concepts. For example, Guidano states that enmeshed attachment styles are identified in the developmental histories of eating-disordered individuals. However, he only elaborates on one aspect of this multifaceted concept, enmeshment. The researcher had to consult authors Guidano cites for an elaboration and consequent operationalisation of concepts. Although it is assumed that Guidano must have done this for the purpose of his research, he does not make explicit the specific criteria he used in order to identify the four essential features of his model. Instead, the model remains on an explanatory level which is consequential (statements build onto each other). For example, he states enmeshed patterns of attachment predispose individuals to develop a blurred and wavering sense of self and he explains how. He assumes a shared understanding of enmeshment exists (which it does), but there should be clear indicators of behaviours and how many need to be present (for each of the four features) in order for an enmeshed attachment style to be indicated, especially because this is an explanatory model.

(2) Guidano identifies invariant aspects common to all eating disorders in spite of variability in surface features. Assuming this position, he provides an explanatory model which can be utilised across a wide spectrum of eating disorders; thus it is a model which proposes to encompass and explain individual differences. His thesis is that the developmental age, nature of the disappointment, and availability of alternative significant figures in the developmental pathway of eating disorder-prone individuals, determines causal attributive style and accounts for differences between cases. However, Guidano is not specific enough about how differences between eating disorders may be understood or explained. His explication remains on a generalised level, primarily focusing on anorexia with some explanation of bulimia and a few sentences about obesity. No mention is made of compulsive eating apart from an introductory statement that it is also accounted for in the model. This is a serious shortcoming of an explanatory model which proposes to be general enough to account for the variability of eating disorders, while at the same time, accounting for differences.

(3) The lack of conceptual clarity in defining discrete categories of eating disorders is a serious shortcoming of the model. Guidano does not provide specific defining criteria for differential diagnoses (of eating disorders) besides stating at the onset of his presentation that the model is equally applicable to different eating disorder symptomatology (anorexia, bulimia, obesity, compulsive

eating). Although it is understood why he adopts this position of generality, the lack of diagnostic criteria for the patient sample out of which he claims to have developed his thesis, and the model's allegiance to the loosely-used broad term 'eating disorders', leads to a blurring of discrete categories of eating disorders (and consequently, in presenting and interpreting findings). Not only does this contribute to confusion about which eating disorder population the model is referring to, it makes it difficult for other researchers to use Guidano's general findings across other studies of eating disorders which do use strict diagnostic criteria in defining research samples.

(4) The role of grandparents and other attachment figures is not explored within Guidano's model; a feature shared with most traditional models of eating disorders which seem to overlook the sometimes primary role grandparents play in the lives of their grandchildren (as revealed in the findings of this research). Not only are grandparents important figures in traditional, close families, exerting overt and covert influence on individual family members (and hence family functioning), but the incorporation of their role in eating-disordered families could provide further insight to relational strategies of a multigenerational nature. Seeing that this model is formulated within a systems approach to organised complexity, it is surprising that this particular system has not been accounted for, as it is acknowledged that an organisation (family, individual) is made up of interrelated systems/parts.

(5) Similarly, the role of siblings in the families of eating-disordered individuals is not given much consideration by Guidano. Dally and Gomez (1979) note the high incidence of similar or different eating disorders in the close relatives of eating-disordered individuals. Findings in this study lend support to the observation that a high incidence of eating disorders exist within the immediate families of participants, especially among siblings. In the anorexic case, father was obese and mother and **younger sister have at times been obese** and at present are considerably overweight. In one bulimic case (Jacki), **sister is obese** and mother see-saws from being overweight to a normal weight. In the compulsive eating case, **sister has at times been below average weight,** father is comfortably overweight, and mother has been on diet ever since Maria can remember. Mother in this case is preoccupied with food, weight, and dieting; she binges and alternately starves herself. Guidano's model of psychopathology attributes differences found between siblings living in the same environment to the differences in perception which individuals have of themselves and of significant figures. For instance, the eating disorder-prone individual is noted to share a preferential attachment with one parent, usually father, and within the family it is common knowledge that this individual is father's favourite. A sibling who is aware of the preference certain family members have for each

other, would early on in life develop a different personal cognitive organisation, where experiences are assimilated and integrated differently. Although able to offer a structural explanation of differences, Guidano's account of differences in symptomatology between family members does not acknowledge nor explain the high incidence of similar pathologies found within these families. Neither does the model acknowledge the high incidence of affective disorders known to exist within these families, especially of the parents. In this research, Steve's father was diagnosed as depressive and Angela's mother as manic-depressive. Research shows that children/adolescents of mothers/fathers that are depressed are at increased risk for the development of psychopathology and/or maladaptive behaviours (Phares & Compas, 1992). Research also evidences the link between affective disorders and eating disorders (Hudson *et al.*, 1983). An explicit account of developmental pathways which determine different P.C.Orgs. (within eating-disordered families) would better explain the presence or absence of similar or different symptomatology between family members.

(6) Guidano's model fails to take into account the high incidence of psychosomatic illnesses prevalent in eating-disordered families. Although a large part of the model is drawn from the work of Minuchin *et al.* (1978), who view anorexia as one of related disorders, Guidano fails to integrate his own findings with Minuchin *et al. 's* observation that diabetes, alcoholism, and anorexia are related and characteristic of psychosomatic families. The findings of this research reveal the simultaneous existence of other psychosomatic illnesses in the families of participants. For example, in the anorexic family, father was an alcoholic and a diabetic, and maternal grandmother an insulin-dependant diabetic; in Angela's family, all three mother's siblings are alcoholics; in Maria's family, uncle is alcoholic; in one bulimic case (Jacki), father abuses alcohol and suffers from stress-related eczema and psoriasis, both medical conditions with a significant degree of psychological influence. Two participants suffer from eczema too, Jacki and Maria, which is exacerbated by stress. The reader is left to assume (perhaps incorrectly), that even though anorexia is one of related illnesses characteristic of psychosomatic families, that the invariant features Guidano identifies in anorexic families are in fact, unique to eating disorders.

(7) Although Guidano's model allows for the integration of expertise from different perspectives to eating disorders, he does not offer any examples of how biomedical knowledge of eating disorders can (and does) assist the individual and his/her environment. Research shows that individuals that are no longer emaciated and nutritionally starved do not have the same attitudes toward themselves and others, as when they are (Bemis, 1978; Berkow & Fletcher, 1987; Copeland, 1985; Dally & Gomez, 1979; Dwyer, 1985; Garner *et al.*, 1985; Russell, 1981; Selvini-Palazzoli, 1985; Spack,

1985). The biochemical treatment of anorexic and bulimic individuals with antidepressants is documented as a beneficial adjunct to an holistic treatment of these individuals (Pope & Hudson, 1985). Antidepressants have been shown to reduce anorexics' fear about eating and gaining weight (Hudson *et al.*, 1983; Pope & Hudson, 1985), and to significantly reduce binge and purging behaviour in bulimics (Leitenberg *et al.*, 1994; Rossiter *et al.*, 1988).

(8) Guidano offers no description or an explanation of differences between male and female eating-disordered individuals, except for a remark that within his research, disappointment is found in the relationship with father in all obese males. Instead, the model focuses on invariant features which Guidano proposes are common to all individuals. Differences are known to exist between males and females in terms of body image, weight-preoccupation, and sexuality. Various studies have found that in general, women have a much more distorted body image, are more preoccupied with their weight and size, and engage in dieting behaviour more often, than men. These studies are supported by epidemiological data which reveal both the high (and increasing) incidence and preponderance of eating disorders amongst women, as well as the cultural preoccupation with thinness, which again, is mostly aimed at women (see pp. 149-150 for list of studies). Although findings of this research are in accordance with Guidano's model of anorexia, the lack of recognition of the severity of symptoms known to exist in male anorexics (Brumberg, 1988; Dally & Gomez, 1979), leaves this a loose-end in the model needing to be tied up. The findings of this research suggest that any etiological model of eating disorders needs to acknowledge and explain the role that gender may play in differences between male and female eating-disordered individuals, (as this may account for differences in symptomatology, as well as why eating disorders preponderate in women).

(9) The part of the model discussing coping strategies is in sharp contrast to the well-organised and clearly presented other features of the model. This part is more a summary of the entire model, rather than dedicated to documenting and explicating coping strategies. The findings of this research indicate that the coping strategies of withdrawal, compliance, self-destructive behaviours, blaming others, denial of illness and blocking of emotional life, exercise, and obsessive thinking of food and weight, need to be considered more carefully in future research and theory practice.

(10) Overreliance on systems theory language, especially in presenting the epistemological and theoretical foundations of his work, is cumbersome and unwieldy. Guidano's allegiance to systems theory language often makes it difficult to translate the meaning of a particular concept across other ways the same concept is used in other psychological perspectives (to refer to the same process).

Explanatory models that assess the same phenomena need to be accessible to both professional and layman alike, so that their utility to future theory, research, and treatment can contribute to shared knowledge in a clear and systematic way.

(11) Guidano's work was originally written in Italian and translated into English. The translation is presented in a manner which is difficult to understand at the first few readings and often incomprehensible. It seems to have been translated directly from Italian with the use of dictionaries, and with its long and clumsy sentences and extremely formal style, it makes for difficult reading. A random sentence from Guidano's book explaining systemic coherence and change is given as an example. "A P.C.Org. appears as a complex system whose generativeness and productiveness are on the one hand, based on the interplay between organisational closure and structural openness, and on the other, are expressed through a dynamic, progressive equilibrium, that, according to the orthogenetic principle, moves toward more integrated levels of structural order and complexity" (Guidano, 1987, p. 94).

(12) The sociocultural context within which Guidano conducted his research, is not made known. Although he informs the reader of his work at the University of Rome in Italy, besides stating the age and gender of his patients, he does not make it known whether all or most of his patients are Italian or of similar origin (European). Knowledge of ethnic origin is vital for a theory which explains eating disorders, as a model which is based on attachment patterns and communication styles needs to be able to account for these factors (by taking into consideration the norms and ethics of different cultural groups). Within this research, two of the four participants have one parent (anorexic case), or both parents (compulsive eating case) that are Greek; one bulimic individual's parents (Jacki's) are from different countries on the European continent; Angela's parents (second bulimic case) are of South African origin. Selvini-Palazzoli (1985) is Italian and has written extensively on eating-disordered families. She identifies eating disorders as most prevalent in: populations of emigrants (especially those from agricultural villages who have moved to cities and where parents' lack of education is compensated by emphasising education in their children); traditional societies where there is difficulty in adapting to cultural and social changes; and in women conflicted between the traditional role of housekeeper and businesswomen. In contrast to Guidano, Selvini-Palazzoli acknowledges that her research is derived from observations of Italian families, where characteristic family styles of interaction and communication are identified, and which may be regarded as a prototype of eating-disordered families.

5.2.2 Shortcomings of method employed

(1) The research was conducted to test the validity of a model of psychopathology. Four individual case studies were conducted and comprehensive case histories compiled. These are based on individuals' subjective reports. Although findings corroborate Guidano's, it is noted that, although for example enmeshment is evident in all cases (as revealed by the various indices identified), it may not be regarded as proof of objective reality, and that another family member may well perceive the situation differently. Although it has been shown that eating-disordered individuals' perceptions are the most reliable in the family (Waller *et al.*, 1990) ideally, a situation where the entire family can be observed in a natural setting, in interactive situations, would lend further credibility to the findings.

(2) In remaining true to Guidano's model, the researcher accepted and emulated Guidano's conceptualisation and use of the generic term 'eating disorders'. Adherence to this perspective, which focuses on what is general and invariant, raises serious questions about the conceptual (and methodological) basis of this research and thus, the validity of its findings. Within this research, the lack of distinction between different eating disorders is evident both theoretically and methodologically - literature reviewed is not presented separately for different eating disorders; similarly, findings of the research and their interpretation are not discussed separately for each eating disorder - and in retrospect, is viewed as a serious shortcoming of this research.

(3) Although multiple case study methodology was used to fulfil the aims of this research, several methodological shortcomings are noted. Compiling a comprehensive case history for each participant provided the means whereby the model could be tested. However, the data base was large and cumbersome and a lot of the material obtained was not directly applicable to the study's aims and thus was discarded. A lot of time was thus unnecessarily spent conducting interviews, transcribing recorded tapes, and analysing data. However, the (often sensitive) nature of the material sought for the purposes of the research, did not, according to the researcher, lend itself to direct questioning and focusing. In fact, it was found that the semi-structured format of interviews (where the interviewer could probe for further details, and where participants had the opportunity to use the interview space quite freely), put both interviewer and interviewee at ease, and with interviews assuming a conversation-like style and tone, the anecdotes and stories participants related, provided some of the most valuable material. A clearer definition of research questions at the onset, to guide the collection of data required, would have significantly reduced the time and effort spent (by the researcher and participants) in gathering and analysing data that was not useful to fulfilling the study's aims.

(4) The eating disorders model tested is one of four parts of Guidano's model of psychopathology. A rigorous test of a model implies that each part of the model is tested systematically. Ideally, the model should have been tested in its entirety in order to assess the theoretical assumptions and findings posited for each of the four psychopathologies Guidano explains. In this way, the findings of each of the four pathologies could be compared for similarities and differences, which would provide a crucial test not only of the eating disorders part, but of the validity of Guidano's model of psychopathology in general. The inclusion of a control group (non-eating-disordered sample) as a comparison to the eating disorders sample used, as well as representative samples for the three other psychopathologies Guidano explains, would have clearly identified the specific and nonspecific characteristics of eating-disordered individuals. This in turn would have lead to empirical data which could validate claims that patterns and processes identified as common to eating-disordered individuals and their families, are in indeed not shared by other population samples, i.e., neither in other psychiatric disorders, nor non-psychiatric, non-emotionally disturbed populations.

(5) Only four individuals were selected as case studies in this research, of which three were female and one male. Two bulimic individuals (female), one compulsive eater (female), and one anorexic (male), provide the data base from which findings are derived. As noted in the discussion of coping strategies, a greater and more homogeneous sample may have provided more precise and refined results. A larger sample would also provide data for comparisons to be made of (the possible influences) age, gender, and cross-cultural differences between the various eating disorders.

(6) Although only one test is enough to support or call for the modification of theoretical propositions, in the case of a model being tested, at least one representative example of each category listed is essential. In this research, a clear-cut obese individual was not consulted. Instead, the compulsive eater (who is considerably overweight), was subsumed within the obese category in terms of interpreting results. Although the nature of the model allows for its application across different eating disorders, the blurring of diagnostic categories, is questionable. The omission in this study of an obese individual who is diagnosed according to medical criteria for obesity (and who is not bulimic, does not binge, nor eats compulsively), implies that this part of the eating disorders model was not systematically tested.

5.2.3 Implications for further research

(1) Guidano's model of eating-disordered individuals is not isolated. It is conceptualised within a

model of psychopathology which, although it is still limited to explaining the four most common psychopathologies found in Guidano's practice, (depression, agoraphobia, obsessive-compulsive disorder, eating disorders), is able to be expanded and refined one day to incorporate and explain all psychopathologies.

(2) Guidano states that the model is not limited by age, gender, social class, or marital status to a specific population and is applicable to any individual afflicted with an eating disorder. In South Africa, the large diversity of ethnic groups, as well as the political dispensation up until May 1994, precluded the conducting of empirical studies which were truly representative of the South African (eating-disordered) population. A conceptual model such as Guidano's, which is easily operationalised and not limited to a particular sex or racial group, could easily be implemented for a large-scale study of eating-disordered individuals across the South African population.

(3) Guidano's model focuses on and explains specific invariant features and patterns and processes which characterise the eating-disordered population. Specific implications of the model's utility are identified for individuals who present themselves for treatment: **(1)** the model highlights the need for compiling a comprehensive developmental history of patients; **(2)** because of the specificity of Guidano's claims, those engaged in the treatment of eating-disordered individuals are sensitised to, and given a hint about patterns and processes known to exist; **(3)** specific knowledge can function to focus and thus shorten the treatment process, rendering it more cost-effective; shortened treatment could provide an increase in professional manpower which is limited by the relatively long duration of treatment at this time; **(4)** utilising the findings of their research, Guidano and Liotti (1983), have developed a structural approach to psychotherapy which integrates both the theoretical and methodological frameworks out of which their work evolved. The therapist-client relationship and specific issues which may surface during treatment, (as well as ways of identifying these and ways of resolving them), are presented. Thus, a treatment strategy has already been developed which is readily applicable. It is based on Guidano's model of psychopathology for the four most common pathologies found in his research. Future research initiatives can focus on designing a test of Guidano's model of psychotherapy in eating-disordered individuals, which would further validate the model's claims about eating disorders.

(4) The findings of the research lend supporting evidence to Guidano's model and because others have made similar observations, there exists a large case law of corroborative evidence. Research and teaching institutions should consider including the model's teaching in their curricula, allowing

students and researchers to make their own informed decisions about its utility and applicability in the South African context.

(5) Guidano's model offers hope to a psychology long-divided by fiercely defended proponents both within and between different theoretical domains. Although not explicitly stated by Guidano, the model may be viewed through the integrative lens which a resolution of the idiographic and nomothetic approaches offers. The age old idiographic/nomothetic (Silverstein, 1988) philosophical questions which still divide psychology today and which remain contentious issues, cut through research, treatment, and theoretical practices. A model such as Guidano's which is able to integrate and contain the conflict between the two approaches, should be viewed as an achievement within the area of eating disorders. The model is able to at the same time, identify invariant features across variable symptomatology (different eating disorders), while acknowledging individual differences. Such a model can go far in healing the splits which epistemological philosophies adhering to either approach cause in research, treatment, and theoretical practices.

In no area of psychology is there as much squabbling and disagreement as when the pathogenesis and etiology of psychopathological disorders are the issue. Almost a century after psychology's inception as a discipline, there has as yet to be developed an adequate explanatory model of psychopathology. Instead, most theoretical models remain on a dispositional and descriptive level. There is disagreement between and within behavioural, cognitive, sociocultural, biomedical, psychoanalytic, and feminist perspectives about etiological cause and explanations (Emmett, 1985). The conceptual paradigm within which Guidano's model is formulated, allows for the integration and utilisation of all perspectives. Eating disorders are a glaring example of the disagreements about psychopathogenesis which characterise both traditional and contemporary psychological perspectives. The need for an integrative paradigm of psychopathology which is both descriptive and explanatory, is thus pronounced in the area of eating disorders, especially because these disorders are regarded as one of the most common and severe psychopathologies characteristic of the modern day. The adoption of, and working with, Guidano's model may provide a starting point for the healing of differences and the beginnings of a united psychology.

Guidano's model is a reaction to the inadequacies of traditional psychology to effectively identify, treat, and explain clinical disorders. Not only does Guidano make a courageous departure from traditional perspectives, he does so in a gracious and reconciliatory manner. At no point does he engage in theory bashing as other theories sometimes do. Contentious issues are appropriated from

an accommodating position and dogmatic statements are avoided. Existing studies are given credence and where possible, they are utilised and incorporated into his model. His careful selection of theories and research practices which provide integrative paradigms to vast and diverse areas of human development (e.g., Bowlby's attachment theory; Piaget and Erikson's cognitive theories; Mahler *et al. 's* work on selfhood processes; Minuchin *et al. 's* study of psychosomatic families), allow for the integration of existing knowledge and expertise. A perusal of the plethora of existing eating disorder literature evidences that it is scattered, disorganised, and repetitive (rediscovering and restating, from different methodological and theoretical perspectives, that which is already known). The gaps which have always existed remain. Glaringly, the absence of an integrated eating disorders paradigm. Guidano's model offers the means whereby systematic organisation within this field of psychology may begin, perhaps setting the precedent for others to follow.

5.3 Evaluation of Guidano's model in terms of its specific contribution to research on the role of fathers in child and adolescent psychopathology, and implications for further research

From Phares and Compas' (1992) review of paternal characteristics in child and adolescent psychopathology, a strong agenda for future research in developmental psychopathology is intimated. Although it is clear that fathers do make a significant and substantial contribution to the occurrence of psychopathology in their children, the exact mechanisms for how these effects are exerted, remain unclear (Phares & Compas, 1992). It is thus incumbent on researchers not only to increase evidence regarding the role of fathers and child psychopathology, but that there is a need for significant changes regarding the types of evidence that are gathered. Because Guidano's model is developmentally-based and focuses on how parental characteristics and relational patterns lay the ground for the development of particular personal cognitive organisations, (which form the foundation for the development of psychopathology in children and adolescents), Phares and Compas' suggestions for further research may be used as evaluating criteria for Guidano's model. Phares and Compas (1992) identify six broad issues as areas which developmental research needs to address. These will be listed as (1-6) followed by an evaluation of the extent to which Guidano's model addresses these issues, the extent to which the applicability of the model in this research met these requirements, and implications for further research in this field.

(1) Separate analyses of paternal and maternal factors - it is essential that data collected be directly and uniquely attributable to paternal characteristics. It is only by separating data pertaining

to mothers and fathers that it can be discerned when and under what circumstances maternal and paternal factors have similar or different effects on child psychopathology (Phares & Compas, 1992). Guidano's model clearly maps parental characteristics and behaviours which can be analysed separately for mothers and fathers. Guidano's particular focus on father's contribution to the development of eating disorders allows for the conceptualisation of separate analyses of maternal and paternal effects. The model is thus not only valuable because it does not focus exclusively on mother, but it sets a precedent (for future research) for the gathering of the types of data that are required in this field of psychology, and which models such as his can generate. The findings of this research are presented and analysed separately for mothers and fathers of participants. The identification of common paternal characteristics, attachment patterns, and the significance of the disappointment experience in the developmental histories of participants, highlights both the importance of father in the developmental pathway of eating disorders, as well as the need to include fathers in future research which attempts to identify etiological factors in the pathogenesis of eating disorders.

(2) Identification of variables that may moderate paternal effects - paternal factors are more likely to affect child psychopathology through interactions with other variables that act as moderators of these associations, e.g., the gender and developmental level of the child may be of greater consequence for some types of problems than for others (Phares & Compas, 1992). However, most studies of eating disorders do not investigate gender differences due to the preponderance of these disorders in adolescent girls as compared with boys. The developmental level of children needs to be taken into account as the effects of paternal characteristics and/or psychopathology may exert different effects on the child or adolescent depending on the developmental period in which the disruption takes place. However, Phares and Compas note that children's developmental level has not been systematically analysed. Nonshared environmental factors also need to be considered as they may play a role in determining which children within a family may be adversely affected by paternal characteristics. It cannot be assumed that all children within a family will experience, perceive, and respond to father in the same way. The implication is that researchers need to study all children within a family, rather than to select one child for study. Additionally, nonshared factors within the family may relate to other moderating factors, such as child gender. Siegel (1987 cited in Phares & Compas, 1992) found that fathers treat boys and girls more differently than do mothers, which may explain why paternal factors may contribute significantly to different experiences within the family for boys and girls; and that these effects may be magnified in families where father displays dysfunctional patterns of parenting. Guidano's model provides a systematic analysis of the developmental level of children in terms of how characteristic family attachment- and relational -

patterns, particularly the preferential attachment relationship with father, exert different effects on the child or adolescent depending on the developmental period in which the disappointment takes place. Additionally, Guidano identifies the intensity of the disappointment and the presence or absence of alternative identification figures as variables which act as moderating factors in association with developmental level. The identification of variables (in the context of the developmental period) which influence and contribute to how the disappointment (in father) is perceived and experienced, explains both how and why nonshared environmental factors may determine which child within a family is most affected by father and in what way; as well as explains differences in eating disorder symptomatology. Although Guidano acknowledges that the child's gender is another moderating variable on parental characteristics/behaviours and their effects on children, the model focuses on those aspects of paternal/maternal characteristics and their effects on children/adolescents which are invariant (thus allowing the model to account for both the male and female eating-disordered population). However, he does accord lengthy description and explanation to the particular relationship which forms between fathers and their daughters, and posits this as one of the reasons for the prevalence of eating disorders among girls as opposed to boys. Results of this study confirm that both the intensity of the disappointment, the subject's age at the time of the disappointment in the main attachment figure, and the absence of alternative identification figures, are variables which moderate the effects of the disappointment in the father (and in one case, also of disappointment in grandmother). In all cases, the finding that fathers are causally implicated through the effects of the disappointment on participants, implies that future research needs to acknowledge the role of father, and aim to clarify further both the interplay between variables and nonshared environmental factors that mediate the effects of the disappointment in father.

(3) Mechanisms through which paternal factors exert their influence - it is essential that researchers are able to ascertain how paternal characteristics exert their effects, e.g., potential mechanisms of transmission of father effects could include genetic effects; dyadic interactions between father and child, including modeling and social learning processes; patterns of disrupted or dysfunctional family interactions; parenting practices and behaviours, including teaching and providing a guiding and nurturing environment (Phares & Compas, 1992). Guidano's model identifies enmeshed patterns of attachment as the mechanism through which parental (maternal or paternal) factors exert their influence. Findings of this research reveal a common dysfunctional pattern of attachment in the developmental history of participants. It further emerges that a particularly enmeshed and ambiguous relationship exists with father, the main/preferential attachment figure. Enmeshment is revealed as underlying participants' development of a blurred and wavering sense of

self, as enmeshment precludes the development of a separate sense of self- and felt-identity. Because participants' personal identity is dependent on the relationship with father, when the disappointment occurs in father (as well as grandmother), participants' sense of self is threatened, (as the characteristic way of deriving a sense of self- and felt-identity from the main attachment figure is suddenly challenged). And, because of the thus far extensive reliance on this figure for what participants are allowed to think and feel, in its absence (through relativisation of that image, or death of the figure), participants are unable to integrate or assimilate the consequent feelings aroused in them by the disappointment. Consequently, all participants turn their attention and focus on the body, seeing it as the source of all their unhappiness and feelings of loss, worthlessness, ineffectiveness, and emptiness, (after the disappointment), and engage in efforts to control it through the adoption of various disordered eating patterns. Guidano's model and the findings of this research explain how paternal factors exert their influence through enmeshed attachment styles. The identification of particular attachment patterns which appear to characterise father-child interactions not only adds to knowledge of how paternal factors exert their influence, but implies that future research needs to continually test and refine this theoretical proposition in eating-disordered individuals, as if it can be reliably validated and cross-validated, (across different eating disorders and in studies which control variables which may mediate or moderate paternal effects), it could lead to the identification of a clear etiological cause in eating disorders.

(4) Maternal and paternal protective factors - research with fathers has so far concentrated on identifying variables that are associated with increased risk for child and adolescent psychopathology. It is, however, equally important to identify aspects of the father-child relationship and those paternal characteristics that could protect children from psychopathology (Phares & Compas, 1992). This approach would thus require the investigation of maternal characteristics that could protect children from paternal psychopathology and paternal characteristics that could protect children from maternal psychopathology. Guidano provides a description of paternal and maternal characteristics and attachment styles which are causally implicated in the development of eating disorders. Although Guidano does not discuss paternal psychopathology per se, his explication of dysfunctional attachment styles and characterisation of fathers, is confirmed by the findings of this research. In the anorexic case, Steve's father's psychopathology is understood to have increased Steve's risk to develop anorexia. In the absence of other participants' fathers' psychopathology, the risk posed to Steve by his father's psychopathology may be one of the variables which would explain why Steve, a male, (and thus an exception), is anorexic. Although Guidano's model focuses on factors causally implicated in the development of eating disorders, (and which findings of this research corroborate),

he also documents developmental theories which provide information on normative attachment and parenting strategies, and thus what protective factors potentially exist. Further research could focus on identifying protective factors within the eating disorders group as compared to other psychiatric disorders and a control group. This would provide knowledge on protective factors specific to eating disorders. The inclusion of non-affected siblings in studies of eating-disordered individuals and their families, could provide vital information about what protective factors exist within the family, as it is posited that the presence or absence of these factors (and individuals' perception of them) determines which individual will be adversely affected by maternal/paternal psychopathology.

(5) Explicit acknowledgement of conceptual models to guide future research - research which aims to understand the factors which may moderate paternal effects and the mechanisms through which paternal effects are exerted, "has to be guided by clearly defined and conceptually sound models of parent-child relationships and family functioning. Without the conceptual clarity offered by sound theoretical models, investigations of paternal contributions to child and adolescent psychopathology are likely to offer little more than a hodgepodge of complex statistical findings" (Phares & Compas, 1992, p. 406). A specified model will not only guide the selection of measures but also the interpretation of results. Careful attention thus needs to be given to the conceptual basis of research. Guidano's model is based on the well-conceptualised theoretical and epistemological assumptions of a systems/process-oriented approach to organised complexity. It is a developmental, unitary model of psychopathology that is structural and explanatory. Guidano's use of other well-conceptualised theories, (such as Bowlby's attachment and Mahler's developmental theory, Erikson's social development theory, Piaget's learning and cognitive theory, and Minuchin's thesis on family functioning), provides further conceptual explicitness to defining the dynamics of parent-child relationships, as well as the mechanisms through which paternal/maternal effects are exerted. This research tests Guidano's model of psychopathology in eating-disordered individuals. The conceptual basis of Guidano's model thus informs and guides the interpretation of results. In this way the contribution of fathers to the development of eating disorders, is made clear. Although findings of this research identify fathers' contribution as common to all participants, (thus contributing to evidence of paternal effects), the model is equally applicable to mothers. The implication is that future research using the model in a larger sample could provide comparative data for mothers and fathers, where essential differences may emerge which could allow for the identification of factors specific to fathers and/or mothers.

(6) Methodological problems - four methodological issues are identified as requiring attention in

research examining paternal factors in child psychopathology. The first issue is **the use of different measurements and different informants to assess child and adolescent psychopathology,** e.g., the use of fathers for information on their children's functioning, as well as sources of information on their own functioning, may be measures both subject to error and bias (Phares & Compas, 1992). In this research, participants are the source of information for both their own and their fathers' functioning. Although research shows that eating-disordered individuals' perceptions of family functioning are the most accurate and reliable within the family, and fathers' perceptions the least accurate (Waller *et al.*, 1990), these subjects' own psychopathology and/or cognitive distortions (the eating disorder itself) may be variables which distort their appraisal of both their own and their fathers' functioning. In future studies, the inclusion of fathers' and objective observers' (non-family members') assessments, (together with eating-disordered individuals' reports), would provide a useful measure in counter-balancing possible errors and biases which can arise from using a single source, as well as yield comparative data (from different assessors) which can be used across different studies.

The second issue is **the use of different assessment methods and different criteria in identifying paternal psychopathology** - there needs to be a standardisation of measures and criteria used in the diagnosis of paternal psychopathology, e.g., some studies rely solely on information from fathers, others are based on information from mother's reports on their husband's functioning (Phares & Compas, 1992). A serious shortcoming of Guidano's model is the implicit nature of his methodology; although his identification of enmeshment may be regarded as one defining set of criteria characterising father-child relationships, he does not explicitly state the assessment methods or criteria he used in identifying this feature. The findings of this research are presented and interpreted in terms of various authors' conceptualisation and operationalisation of enmeshment, which are regarded as defining criteria of this attachment pattern. Future research of families of eating-disordered individuals which assesses and compares these families' degree of enmeshment with families of non-eating-disordered individuals, psychiatrically diagnosed and non-psychiatrically diagnosed individuals' families, would render definitive the criteria for enmeshment in families of eating-disordered individuals. At the same time, methods of assessment should be explicit and the measures used, applied equally across studies.

The third issue is **the need for longitudinal as opposed to cross-sectional research designs** - most research in this area has been retrospective and cross-sectional and thus remains on the level of describing the relationship between father and child characteristics, instead of being able to provide information on predictive relations between these variables, or on providing explanations for the

relationships that have been found (Phares & Compas, 1992). Future research thus needs to provide prospective longitudinal data so that the direction of influence may be clarified, e.g., father to child or child to father (Phares & Compas, 1992). Guidano's model is a valuable conceptual model for further research because it is both predictive and explanatory of the relationship between father and child characteristics, as evidenced by the findings of this research. Additionally, the model shows the direction of influence as father to child. The model may thus be used to provide much needed prospective longitudinal data in the eating disorders field, as well as to better clarify the influence of the child on father's behaviour (as it may perpetuate or maintain father's behaviour).

The fourth methodological issue identified by Phares and Compas (1992) is **the representativeness of samples of children and fathers** - researchers need to be attuned to possible subtle biases in children, fathers, and families who consent to participate in research versus those who decline participation. Additionally, careful selection criteria for children and fathers can facilitate comparisons of children with different disorders and fathers with different disorders who are matched on other variables; in this way, the specific and nonspecific effects associated with different forms of psychopathology may be determined (Phares & Compas, 1992). The fundamental tenet of Guidano's model is the identification of invariant features characterising eating-disordered individuals and their families. However, the loosely-used term 'eating disorders' is the broad criterion used for the selection of his patient sample from which he develops his theory; he does not provide specific diagnostic criteria for each of the eating disorders he describes. In remaining true to the model being tested, this research emulated Guidano's loose definition of eating disorders, choosing to focus on similarities rather than on differences between eating disorder symptomatology. This is a serious conceptual shortcoming of Guidano's model and this research, and can be viewed as undermining the methodological integrity of both. This is because the initial lack of defining criteria for the selection of participants does not allow for preciseness when presenting and interpreting results. In retrospect, it is acknowledged that had the researcher presented and analysed findings in terms of the different eating disorders which exist, the sometimes subtle differences (in terms of degree) or exceptions found between cases, could have been accounted for by differences in symptomatology known to exist in the different eating disorders. The model and this research's findings do, however, make a valuable contribution to knowledge of invariant aspects in eating disorders based on the perspective of resisting traditional psychology's dispositional and descriptive accounts of dysfunctional behaviour, (where complex emotional disorders are reduced to terms and labels). Further research which is informed by the philosophical principles of Guidano's model, and is at the same time able to address clearly methodological issues of selection criteria (for fathers and children), may provide useful empirical

data. In this regard, clear selection criteria will allow for the systematic comparison of eating-disordered children or adolescents with children or adolescents with different disorders, as well as for comparisons of fathers' psychopathology and/or behaviours i.e., dysfunctional patterns of attachment, with fathers with different disorders and/or behaviours i.e., other patterns of attachment. In this way, the specific and nonspecific effects of fathers unique to eating disorders, may be identified.

5.3.1 Summary of the model's specific contribution to theory and research on the role of fathers

The value of Guidano's model is demonstrated in terms of its specific contribution to knowledge and research on the role of fathers in child and adolescent psychopathology. The model is able to generate the types of data that are needed to expand and refine existing developmental theories, (that describe children's normal and pathological developmental pathways mostly in terms of mother effects), to include the mechanisms through which paternal effects exert their influence on children. Guidano's model for eating disorders is an example of how the model's application provides an exegesis of psychopathology in a specific population. The value of the model lies in the fact that, as a conceptual tool, the model is able to at the same time, **explain the development of psychopathology,** (in terms of dysfunctional patterns of attachment), **include fathers in developmental studies and theories,** (thus acknowledging the significant contribution that fathers make to the occurrence of psychopathology in their children), as well as able to **indicate how father effects evidence in child and adolescent psychopathology,** (in this case, how father effects evidence in eating disorders). It can thus be said, that Guidano's model makes a useful contribution to developmental psychology and raises implications for future treatment, theory, and research initiatives of eating-disordered individuals.

5.4 Summary of the aims and findings of the study as a conclusion to the research

The aim in conducting this research was to test the validity of Guidano's model of psychopathology in eating-disordered individuals. Adopting a qualitative paradigm, the case study method as advocated by Edwards (1990; 1993a,b), Kazdin (1992), and Bromley (1985), (and other proponents of this method), was employed. Four in-depth case studies were conducted on three eating disorders (anorexia, bulimia, compulsive eating). An analysis of the findings in terms of the four central features of Guidano's model rendered the following results: **(1)** dysfunctional patterns of attachment - ambiguous, intrusive enmeshment - are identified in the families of participants; **(2)** participants have

a blurred and wavering sense of self; **(3)** the major theme on systemic coherence is the oscillation between seeking and avoiding intimacy; **(4)** common coping strategies are: seeking supportive intimacy that demands minimal self-exposure; withdrawal into the self; perfectionism; the development of an eating disorder; continuous thoughts about food, eating and weight. All four features of Guidano's model are supported by the findings of this research. The only significant difference are the additional coping strategies identified by the researcher as common to all cases. Although five coping strategies are identified by the researcher as common in all cases, Guidano only mentions the seeking of supportive intimacy with minimal self-exposure as the most common coping strategy. It is not understood why Guidano does not acknowledge other coping strategies in the part of the model discussing this feature, as additional coping strategies identified by the researcher are mentioned elsewhere by him. A possible hypothesis explaining this may be that a larger sample than the one used in this research would render more specific results on this feature, as more participants may reduce the commonalities between them.

The findings of this study fulfil the aims of conducting the research. The results of this research support Guidano's model of psychopathology in eating-disordered individuals. The implications for psychology in general and for those embroiled in understanding and treating eating-disordered individuals, have been discussed specifically in terms of the contribution which the inclusion of fathers in theory and research makes to developmental models explaining psychopathology. Guidano's model of eating disorders is an example of how the inclusion of fathers in developmental models of psychopathology can be applied to render explanations of relationships which exist (between father and child) but which have previously been neglected or not adequately incorporated in theories which attempt to explain eating disorders.

As revealed in the literature review, most etiological theories only touch the tip of the slippery iceberg of eating disorders. Guidano assumed a different position. He stood up and looked at the iceberg from the top, isolated gaps and weak spots, found a firm footstead, and systematically embraced the great mountain.

APPENDIX ONE

1.1 INDIVIDUAL CASE REPORTS OF PATTERNS OF ATTACHMENT

1.1.1 Case one - Jacki: Patterns of attachment

Jacki is a 25-year-old married teacher who during adolescence (age 15), developed bulimia. She is the eldest child in a family of three children and spent her childhood and adolescent years living with her parents and siblings.

1.1.1.1 Family environment

The family is characterised as very close and extremely family-oriented, where family life and togetherness is exalted at the expense of individualism. The family is quite an isolated unit, keeping very much to themselves, with very little interaction with extended family and the outside world. The parents' energy is spent focusing on their children and providing for them. Both parents display a total dedication to the upbringing of their children and their lives are designed with the children at the centre. However, parents' intentions are clearly more toward achieving and maintaining an image of themselves as good parents (of a good social standing), rather than addressing Jacki's emotional needs or any other real issues which would challenge this image. They are extremely overprotective of Jacki but their presence is experienced by Jacki as overwhelming and intrusive with no regard for privacy, rather than as caring and supportive.

The emphasis within the family on openness and sharing is contradicted by the simultaneous presence of an opposing style of communication: that of the parents' continuous attempts to conceal their own and Jacki's difficulties, despite the fact that she is singled out as the problem child and black sheep of the family. Thus, not only are certain issues pertaining to their own personal lives non-discussable but they relate to Jacki in the same way. The pervading sense one gets from this relational strategy is that the idealism of establishing and maintaining a close happy family unit as defined by the parents is primary, and any expression of thought, feeling, and behaviour which is contrary to this, is neither tolerated nor allowed. Conflict between individual family members is not resolved as it is seldom allowed to surface, especially from Jacki's side. When conflict is between parents, Jacki always intervenes on her mother's behalf (parent-child coalition) which only functions to infuriate her father.

The contradictory and ambiguous home environment is supported by a hidden style of communication. Parents display knowledge of Jacki's life and problems but at the same time things are covered over and Jacki is left with a pervading sense of uncertainty regarding their knowledge of her and her life. Because of this she never knows where she stands with them. Jacki experiences this hiddenness and lack of explicitness as a continuous source of uncertainty with regard to what is going on in the family, what type of people her parents really are, and a concern about what else she does not know about them and the family. There is little regard for personal opinion or any expression of autonomy despite differing levels of maturity (adolescence, early adulthood). This characteristic, rigid way of relating to Jacki as if she were a child (with no ability to think or direct her own life) continues till today, despite the fact that she is a 25-year-old married, adult woman. Within this contradictory, negating and distorted communicative context, Jacki developed her main attachments, laying down a pattern of subsequent attachment behaviour. A reconstruction of Jacki's developmental history reveals the patterns of attachment in her life.

1.1.1.2 Attachment with mother

Jacki's developmental history is characterised by an attachment to an undemonstrative mother who is described as hard and stoical and unable to express emotion (affection), the experience of which has left Jacki with the sense that she is distant and unapproachable with regard to sharing her intimate thoughts and feelings with her. Communication with her mother has remained on a superficial level, as anything that would go beyond that to a deeper level of intimacy is experienced by Jacki as threatening and frightening. This is because Jacki has a profound sense of uncertainty surrounding her mother's ability to tolerate any expression of emotion or personal thoughts. Jacki withdrew into herself during times when she desperately needed contact and understanding because she was always clouded with the fear surrounding the uncertainty of her mother's reaction were she to approach her on intimate matters. This fear was compounded by the fact that her mother would join with her father against her during times of conflict and thus was not someone whom she could trust and rely on to support her.

Her relationship with her mother is described as neither positive nor negative. Although by nature it contains inherent conflicts (where both individuals experience mutual disappointments), there is no indication that it has been marked by radical changes; it has developed and maintained its uniformity over time. Although Jacki reports that she is not close to either of her parents, there are clear indications that there are attachments to both parents but of different emotional intensity.

1.1.1.3 Attachment with father

The importance Jacki attaches to her father's opinions reveals that although their relationship is largely negative (frequent quarrels, inability to communicate, power struggles, and an intense fear of him), he is her main attachment figure. Thus, it is with her father that she shares the most intense emotional attachment, be it negative. Up until the time Jacki began to physically mature (age 10) and before she started to develop her own opinions, their relationship was good and her descriptions of childhood are ones of happy memories with him, as he was the one person who provided physical contact and openly expressed his affection for her.

Growing dissension between them was to mark her entrance into adolescence. This was because he (Mr E) was unable to accept the physical and consequent emotional cognitive changes in her. Many turbulent and highly conflictual years ensued, where his attitude towards Jacki was one of continuous criticism and overt rejection. Their level of communication was limited to his temper outbursts and lecturing her, with constant threats of disowning her and malicious comments about her worthiness and success as a person. His criticisms of her were experienced as attacks on her and this fear of him magnified as she was unable to know beforehand when he would attack her. A pattern of need and fear was established: Jacki desperately sought his approval and feared his rage and criticism in case she disappointed him.

Mr E would not tolerate any expression of individuality from Jacki or display any regard for her changing needs as a teenager. Instead, he continued to treat her as a child and to suppress her natural drive towards independence. He would repeatedly tell her who she was, what to do, what to say, how to feel, what to wear, who to associate with, and how to live her life. The message was that she belonged to him and that she had no right to a life of her own beyond that which he allowed and prescribed.

Mr E is described as a very strict, moralistic perfectionist, who is rigid in his opinions and lifestyle. His approval (and love) is conditional and he makes it known that he will not tolerate failure of any sort. Because of this, Jacki's attachment to him is fraught with an intense fear of him, especially of disappointing him. His presence is experienced as overwhelmingly threatening and this fear of him magnified during her adolescent years, leaving her with the felt sense and belief that he is unapproachable, dangerous, and never to be trusted.

The attachment she shares with him is characterised by an intense preoccupation to please him and fulfil his expectations of her. Because of his critical and rejecting attitude towards her, Jacki learnt that academic achievement (perfectionism) was the only way of maintaining her relationship with her father, as this was the only clear area in which he displayed any approval of her; approval which she desperately sought and needed from him but which she seldom felt she had won. Within this context, she also learnt that any expression of individuality (choice of clothes, friends, preferred weight and any expression which began with the prefix "I think, I feel") was not acceptable and would not be tolerated by him. Thus she learnt that not only was perfectionism and achievement the way she hoped to maintain an attachment with him but that one's inner life and problems must be kept to one's self.

Because of Jacki's attachment to a controlling, rejecting and repressive father, in who's presence she felt powerless and insubstantial (and whom she experienced as robbing her of her life and selfhood), her only recourse was to do battle with him secretly. A powerful scenario of a struggle for control over him dominates her adolescent years. Within this context, her silent posture, withdrawal, and living a "secret life" (being bulimic) were the only means where she felt she could assert her independence and feel her separateness from him.

The attachment to her father is fraught with ambiguities and contradictions: on the one hand, he would strip her of any right to speak her own mind and on the other hand, he would be angered by her silence and withdrawal from him and demand that she be open with him; a common conflict situation between them. There is a mutual mistrust of each other's motivations, as revealed by his accusations that she was doing things which she was not and her mistrust of his intentions for her. In this regard, another example of the contradictory communication style is evident. On the one hand, he would tease her about her weight, scrutinise her way of dress and make it known that he disapproved of her appearance. On the other hand, he engaged in efforts to convince her that she was acceptable.

Although her father is identified as the most significant figure in her life, there is no sense of a clear type of attachment. Instead, it is an attachment rife with contradiction, ambiguity and mistrust. Her feelings toward him are ambivalent, where she is torn between loving and hating him. In the same way, his attitude is one of wanting to protect and guide her under the guise of loving her, and then rejecting and threatening her. Although her father is identified as the most significant figure in her life, with Jacki's efforts and energy consumed with a desire to fulfil what she perceived were his expectations of her, her efforts were never to be rewarded.

During late childhood, the quality and intensity of their interactions progressively became more negative, their interactions resembling a battle ground of wills. It is within this relationship that Jacki experienced the most disruption, as their relationship changed for the worst when she began to physically mature, as Jacki perceived him as bent on treating her as his little child.

1.1.1.4 Perceived disappointment within the preferential attachment relationship

In Jacki's case, the disappointment is a consequence of the relativisation of the image of her father, her main attachment figure. The disappointment resulted from the single occasion where she went beyond her usual withdrawn state and quietness when her father lectured her and instead, confronted him; something which she had never done before and which has remained an isolated incident. On the occasion, she was 15 and he had refused to let her attend a school party. Her own words exemplify the nature of the disappointment and the relativisation of the image she had of him up until then.

> I was sitting in his chair at home and he came in and I said to him, "you know, you always know everything, you always dictate to me and you **don't** know everything and you not so big and bright"....Maybe it's just going through adolescence but I just couldn't take it any more. And after that incident I just shut up even more. Oh God, I used to pierce my own ears at that stage, anything, because I just could not be good enough for him you know....I just thought, oh stuff it. I wanted to go to a party and he wouldn't let me.

1.1.1.5 Patterns of attachment with others

Subsequent attachments to peers and her husband reveal the same pattern: a desperate need to be explicitly approved of and the expectation that she will be criticised and rejected if she reveals her inner world, thoughts and problems to them. The need to keep intimate parts of herself hidden, is a defining feature of her attachment behaviour.

1.1.2 Case two - Steve: Patterns of attachment

Steve is an 18-year-old scholar who during late childhood (12-years-old), developed anorexia nervosa. He is the eldest child in a family of three children and spent his early years living with his parents and siblings. Since his father's suicide when he was 15, he has been living with his mother and siblings.

1.1.2.1 Family environment

Mrs F married her husband against her family's wishes and under pressure that time was passing her by. From the beginning, the marriage was unstable, made turbulent by Mr F's drinking and ill-health. (He was an alcoholic, suffered from diabetes, and had a triple bypass coronary operation during the time they were married). Because of Mr F's job, the family was uprooted and moved to different towns on numerous occasions early on in the marriage. Mr F suffered from diabetes and depression, aggravated by alcoholism, and after he lost his job he sank further into depression and completely withdrew from the family. Seeing no way out for himself, he committed suicide by gassing himself in his car. Mrs F is still unemployed and relies on community support to sustain the family.

> **R:** Did you find anything particularly helpful after your dad died or since then?
> **S:** There's quite a bit of financial support from friends and family....My father didn't get on well with his family at all. Towards the end he never used to phone them. He used to tell everyone that his sisters hated him. I don't know how true that was. Possibly he felt ashamed....But my mom's side of the family is very supportive, they help us quite a lot.
> **R:** Help in what way?
> **S:** Financial. They send us food, vegetables, money.

The pervading sense one gets as a first impression while visiting this family, is that it is grossly dysfunctional. The family is characterised as perversely close and there is almost no interaction with the outside world, besides with those who directly support them (example above). Sharp boundaries keep others out, but a lack of boundaries characterises the family from within, as revealed in Steve's frequent use of "we" (example below).

> **S:** Normally when we go to a party I find a quiet spot on my own and eat. I won't sit in the thick of things anyway. Because people tend to sometimes get too involved with me and they tend to comment and that, which we try to avoid....
> **R:** Are you finding that our work together is causing you to think about things?
> **S:** Yes, but it helps. It's nice to have someone to talk to. We don't really have people who I can talk to. The family's got very few people who I can discuss things with.

Within the family there is a high degree of enmeshment and overprotectiveness. Mrs F's energy is spent focusing entirely on her children, especially Steve's illness. This almost exclusive focus precludes any real interaction or closeness on an intimate level. Her efforts are experienced by Steve more as intrusive and threatening, rather than as caring and supportive. The lack of regard for privacy, and the way in which boundaries separating individual family members are transgressed, is evident in the next example.

R: In the time that I've spent with you and your family I've noticed that your life is discussed quite openly amongst friends and teachers and those who are actively helping you (interrupts)
S: And you want to know whether that bothers me? *No*! It doesn't. I've got quite used to it....I don't like sometimes being the centre of attention but it's something I've got used to. I don't like it if everyone's always talking about me. This sounds funny because anorexia is basically an egotistical disease, you focus a lot of attention on yourself, and it's involved with emotional blackmail, but sometimes I get tired of people just going on about me all the time. You know, I can't sort of close my eyes without someone saying "he's dead" or something like that....I often feel that my mom, especially when she speaks Greek over the phone, that she's saying things secretly about me, like things to do with my weight. Generally to do with things that I prefer other people to not get themselves concerned with. They always asking things about me and I feel they always talking behind my back about things.

The emphasis within the family on openness and sharing is contradicted by a surprising lack of communication between family members and their attempts to conceal their difficulties from each other. This is evident between husband and wife, son and father, son and mother, and between siblings. This is supported by reports of individual members' sense that they do not know who the other members of the family are, and an inability to know what others feel about important issues.

R: Do you think that your brother understands your anorexia or any other difficulties you have?
S: No, I'd venture to hazard a guess that he feels perhaps helpless about it, that he can't understand it. He doesn't know what to do about it so he tends to withdraw from situations like that, and perhaps he feels he can't really talk to me about it because he doesn't. Maybe he feels that he doesn't know enough about it.

Conflict is not resolved between family members as arguments are not focused. Instead, they centre on irrelevancies and childish viewpoints (there is no compromise, from adult and child alike). Steve always intervenes on his mother's behalf to protect her from his father's rage when she and her husband are engaged in conflict (parent-child coalition). In the following example, the lack of conflict resolution between Mr and Mrs F is clear.

R: How did family therapy go?
S: It went fairly well. I'd say my father not being very open, being resistant, he didn't always say what he could've said. And sometimes he just refused to talk.
R: When you knew that he could've contributed?
S: I didn't know if he could contribute. But it used to sometimes end up with him and my mom having an argument there....Sometimes even petty things like the meaning of the word "pedantic". He would tell her not to be pedantic and my mother would then go and define the word pedantic and say that she wasn't being pedantic, so they'd end up arguing about something petty like that.

It is difficult to discuss the patterns of attachment in Steve's life, as at first glance they appear to be absent. Steve is asocial and the attachments he has formed are rudimentary and quite primitive.

1.1.2.2 Attachment with grandmother

Steve's developmental history is characterised by a paucity of attachments. The only positive attachment he formed early on in life which held the promise of growth, mutual affection, and recognition of him as an individual, was with his maternal grandmother. She is characterised as a strong woman, full of energy and concern for others, and the only one with whom Steve formed a deep bond of love. Up until Steve was 11-years-old, he describes his childhood as magical and idyllic. It was a time where his life centred around his visits to his grandmother and her visits to him, where he would be embraced with love and understanding. She was his key to a better world, and knowing he would soon see her, functioned to keep his spirit alive. In times of absence he held onto the memories of time they had spent together and he lived for the moment when they would be reunited. It is only with her that Steve was able to develop a relationship matching that of a parent-child. He could approach her unquestionably on any issue and know that she would meet him with acceptance and understanding; and he could initiate exploratory behaviour away from her, knowing that she was at home waiting for him. His descriptions of his grandmother are however, idealised, and typical of childhood cognitive abilities (grandmother is perfect, a saviour, infallible). It is the researcher's opinion that had she lived longer, the chances are that with time, their relationship would have matured (to include a realistic image of grandmother), resembling a relationship between two adults.

> **R:** What are your immediate thoughts if you think back to your childhood?
> **S:** I would say that I would *love* to go back to those times when my grandmother was still alive. I'd come here for the holidays. Holidays were a magical time, coming here to visit my grandmother....
> **R:** It sounds like you spent a lot of time with her.
> **S:** Yes, very much so. She used to take me down to the rocks....I loved exploring....This was the most wonderful place in the world then because it meant I was going to see my grandmother....It just isn't the same without her....
> **R:** Would you single her out as the most significant person?
> **S:** Yes, very much so. *Very, very* much. Yes I would.

1.1.2.3 Perceived disappointment within the preferential attachment relationship

Unfortunately, his grandmother died after a sudden illness when Steve was 11-years-old. Her death devastated Steve, and his feelings of loss and sorrow (combined with this massive disappointment), proved to be overwhelming for him. The year after his grandmother died Steve was admitted to hospital and diagnosed with anorexia. To this day, he is unable to think fondly of his grandmother without being overwhelmed by the feelings of loss and emptiness this induces in him, indicating that

he has been unable to accept her death and move on to a place where he can safely remember her and be filled with joy at the special times they spent together. His grandmother's death has functioned to lay the ground for his subsequent withdrawal from others, not allowing himself to become emotionally involved, or to form intimate attachments with others, hence he is disappointed by them. This is revealed in his belief that if he were to get too close to someone, they would surely die and leave him on his own. In the next example, Steve describes the events which led up to his first anorexic episode.

> **S:** I lost the weight I wanted to lose and we went off on holiday.
> **R:** So you were feeling good about yourself then?
> **S:** Yes, although something had happened in August, my grandmother died. That was quite a blow. I was very fond of her. She was a wonderful person....She was dead. Her lung collapsed....It came as quite a shock. I woke up quite early...before I'd even heard...and I knew something was wrong, that something had happened....As soon as I heard I started bawling incessantly. I just couldn't stop. It was instant, without any build up or welling up of feeling sad, just explosive.

1.1.2.4 Attachment with mother

Steve's developmental history is characterised by an attachment to an overprotective mother who is described as soft, patient and long-suffering. She is a passive woman who has not been able to take control of her life and who not only perceives herself as a victim, but who also lives out this role of helplessness. It is an attachment which has remained on an arrested level. Their relationship has not developed out of the primitive level of childhood, where increasing levels of separation and independence are initiated and celebrated. Instead, it is characterised by an overt level of dependency, both physically and emotionally. A high degree of enmeshment and overprotectiveness is visible within this attachment. Mrs F is unable to respond to Steve apart from her involvement in treating and discussing his symptoms. Because his anorexia is made the focus of the dysfunction within the family, interaction remains on this level: monitoring and controlling his food intake, repeated visits to health professionals who are seen as having the cure, and attempts to placate, rather than deal with his emotional life.

Although Steve reports he was never close to anyone besides his grandmother, he admits that he is close to his mother because he is dependent on her. He states that his biggest fear is that his mother will die, and that without her, he would die too. Such is the degree of enmeshment between them, that survival is predicated only in her presence. She looks after and maintains control over his physical life, telling him when to wash, what to wear, and when and how much to eat. Like a mother

with an infant, she gets up sometimes twice a night to change her son, who frequently still wets his bed. In spite of his expressed dependency on her (and fear of what will happen to him if she were to die), he resents her attempts to control him and to know about all aspects of his life, and this resentment finds indirect expression through the childish arguments they have. Most importantly, Mrs F's behaviour functions to maintain Steve's anorexic posture. He holds onto his anorexia as a way of remaining special and unique (a male anorexic is unique in his view), as without it he believes he will be ignored and not cared for.

> **R:** How does it feel having mom control your food intake?
> **S:** Frightening. She actually thought I was joking...when I told her I am actually frightened of you because of what the potential you have to do when you dish up huge amounts and that because I find you have power over me.
> **R:** So it's quite terrifying for you at the moment.
> **S:** Not terrifying like I'm scared out of my mind, but I think she has power over me....What if my mom dishes up a huge amount? How do I know my mom's not secretly frying the food more than she says she does?
> **R:** What would you think if I told you I think to have mom dish up for you means that you trust her implicitly with such a sacred part of yourself.
> **S:** I'd say I do. I am unfortunately quite naive, my trusting of people. But I feel that although they might not be able to do it perfectly either, they more competent than I am. I tend to believe that other people are more competent than I am.

Mrs F's sense of responsibility and feelings of guilt about her input in causing and maintaining Steve's anorexia, is an area in which Mrs F is unable to separate herself from her son and his illness, and thus is unable to obtain the distance she needs away from him in order to take remedial steps. The lack of boundaries as to where she begins and ends indicates the high degree of enmeshment between them. In the following narrative, the enmeshed relationship between mother and son becomes clearer, both by Steve's desire to influence his mother and the extent to which mother's opinions influence Steve.

> **R:** What do you think of your mother's appearance?
> **S:** Well the fact that she's fat affects me. I feel concerned about it. I wish my mom wasn't so fat, but there's nothing I can do. I'd love it if she could go on diet but then again she's a hopeless failure going on diet.
> **R:** Do you try to encourage her?
> **S:** I used to, and perhaps sometimes I still hint at that, but I think it's time that I stopped doing that because it's none of my business. She doesn't seem capable of actually managing to carry through a diet anyway.
> **R:** Is it important for you that's she's thin?
> **S:** Good question. I suppose I would feel that she's actually managed to do something and accomplish something major in her life, but it seems that most of her life she's been fat. And she could really make a change. I don't know, it might give her a bit of an ego boost as well because she's got a very poor self-image. I don't really see any point in her learning to drive in the end because, firstly, it's rather expensive to go to driving school. Secondly, cars are expensive, even second-hand ones. Thirdly, she's tried so many times and seems to end up

not doing it.
R: It sounds like you get your hopes up, and that you have quite often so that now you don't believe she's going to get it right.
S: Yes, I'd say so, I don't. She doesn't believe that I'll get out of anorexia either.
R: What do you think about that?
S: Well, I sometimes also entertain that feeling, that I'm never going to get out of it again.

There also exists an ambiguous and contradictory style of communication between them. On the one hand, there exists a closeness with each other where even each other's bowel movements are discussed, as are thoughts and feelings about seemingly superficial issues. On the other hand, there exists a gap of vital information, that of intimacy. Both Mrs F and Steve express to the researcher that they do not know what the other is actually thinking or feeling.

R: Could you describe your mother and your relationship through the eyes of the child that you were?
S: Well, I suppose I was biased in a way because I sometimes wouldn't mind doing things for my mom, maybe I'd find her more reasonable or thought she was more reasonable, but then again, because I had better relations with her I didn't mind doing things for her that much. She could communicate better with me.
R: So you could understand each other most of the time?
S: I should hope so.
R: From what you've said it sounds like you and your father were almost on different planets.
S: Yes.
R: And your mom? more on the same planet?
S: A little bit closer, at least a satellite sort of situation....
R: Do you think mom's proud to have you as a son?
S: I'd say that she probably finds me a bit of a handful at the moment....I'm being quite a strain on her with my problems.
R: Does she tell you that?
S: Dr Fern has said she's going through a lot of difficulty, or, because of me.
R: Do you talk to your mom about it? It seems like you're very open with your mom.
S: No, generally not....
R: Is there anything you know for a fact your mother likes or dislikes about you?
S: *No*! *No*! I don't ask her that sort of question.

Because Steve's perception of his mother is of someone who has suffered a great deal and of someone who is viewed as helpless when confronted with his illness (and specifically with his emotional life), he feels guilty and responsible for her pain. Because of his uncertainty about his mother's ability to cope with anything but his symptoms, he remains withdrawn from her and their interaction remains on this level.

R: If you can think back to the earliest time you can remember yourself, what is the first feeling or sense you have about your mother?
S: Long-suffering I suppose. Patient, but her character is more long-suffering....With my father we argued around food. He would get angry with me because he couldn't understand the situation. With my mom, it's more a feeling of helplessness that it generates in her

because she wouldn't know what to do in a situation....
R: So you didn't ask for help?
S: *No*, I was forced into treatment. Definitely! Very definitely. By Dr Fern and I suppose my mom. Well, my mom didn't really know what to do. She was frantic.
R: How did your family respond to the fact that you were seeing professionals to help you with your difficulties?
S: My father I don't think liked it very much. I don't know what my brother and sister think about it. And I think my mom's very grateful that I do have somebody that I can go to. Because my mom feels inadequate. She feels that she doesn't really know how to deal with me because I have a problem....
R: So what would happen if your mom and Dr Fern stopped helping you, say by controlling your food intake?
S: I'd die. Quite simple. Because my weight would just continue to go down.

1.1.2.5 Attachment with father

Mr F, an alcoholic who suffered from clinical depression, was a withdrawn man who seldom revealed himself emotionally to others. "**S:** My father never really expressed his feelings very openly and very well. He'd blow up sometimes but it was difficult to ever know what he was thinking or feeling".

Mr F's predominant form of self-expression was loud outbursts, where he was verbally and emotionally abusive to others, primarily to his son Steve. Although Steve reports that he was never close to his father, he is the family member with whom he shared the most intense overt emotional attachment (although negative). Note: Steve's main attachment figure was his grandmother. He expresses a clear preference for his mother as opposed to his father, always siding with her against his father. At the same time, he makes it clear that he never felt close to anyone besides his grandmother and that the closeness he experiences with his mother now, is because of his dependency on her. However, his most intense emotional attachment was with his father. Although their relationship was marked by conflict, the inability to communicate with each other, and an intense fear of him, there are indications that up to a point, Steve believed that he could influence and improve their relationship (indicating that Steve had an emotional investment in wanting to maintain, as well as improve their relationship). This is revealed by Steve's attempts to help his father learn to live a healthier lifestyle following a triple bypass operation. However, Mr F was unable to accept or even to tolerate Steve's suggestions and would respond to his suggestions in a critical and rejecting way, mocking his efforts instead of appreciating them.

S: My father suffered from anginas and I thought he was going to die....It was his own fault because he didn't look after his body, he abused his body a lot. He was fat, he used to eat too much, drink too much, smoke. He didn't care about himself or his body. I used to try

and tell him to be careful but he didn't like it when I did that. He *hated* it when I tried to interfere with him....He didn't care that he was abusing his body. He didn't like his body....
R: Did you worry a lot about him?
S: Yes, I got quite concerned about him. I always used to try get him to change his ways, not to eat too much, to stop drinking and smoking. He never listened to me. I guess I was trying to save him from himself....
R: What did you think of the fact that your father was so fat?
S: I didn't like it of course. I tried to talk him into going on diet several times. He never did anything close to that. He used to say if he really wanted to lose weight, he could lose it in his own way, he didn't need my help....I was always critical of how much he ate which used to lead to friction between the two of us....
R: Were you ever scared that you would become as fat as him?
S: I may have been. That may have been one of the reasons I went on diet. I can't remember all my reasons for going on diet. But I was scared of having a heart attack, having anginas and gout, everything like him.

Although Steve is unable to account for his father's behaviour, it is clear that his father's inconsistency with him laid the ground for his subsequent withdrawal away from him. His father's alcoholism and depression made him vulnerable to extreme mood swings, temper outbursts, and violent reactions, where he would threaten his wife and children. Steve would intervene at these times to protect his mother from any perceived threat (parent-child coalition), and so would find himself bearing the brunt of his father's rage. In an alternate relational strategy, Mrs F would intervene to protect her son from her husband - a pattern of conflict resolution (parent-child coalition) within the family which only functioned to promote conflict between spouses and between parent and child. As noted, conflict is not resolved between members in this family.

Because Steve always felt that there was a fundamental misunderstanding between them, he was not able to approach his father during times when he desperately needed understanding and affection. Instead, he would provoke his father into an argument, perhaps his only alternative to silence and no interaction with him at all. Steve's perception of his father was that he was unapproachable and closed off to him. A belief that was reinforced by Mr F's inability to respond to Steve's emotional life. During the times when Steve did venture to share his feelings with him, he was met with dismissal and rejection (Mr F swore at him and called him demeaning names).

S: I was taking my scouts exam and I had to go to someone's house. He told me to get out of the car and go and knock on the door and ask if it was the right house. And being shy as I am, I was very nervous to just go up to a strange house and just knock and ask. I pleaded with him if he wouldn't please go, and I asked again, and then he started swearing at me, using abusive language, he got more and more angry....I felt terrible. He called me a drip, he was swearing at me. He drove home quite fast in an absolute temper. When we got home he told my mother all these horrible things about me and I...I was in absolute tears. My mom calmed me down, she phoned the people and they came and fetched me.
R: So you were left there because you were too shy or too scared to go in on your own?

S: Yes, he didn't help. He didn't ask me anything. He wanted me to go by myself....I was only eight or nine years old.
R: Is that how things were mostly between the two of you?
S: Yes, when he was in a temper, hitting me....One time I was sitting on the chair and he *actually* punched me to the head with a fist. He hit me reeling into a cupboard. I actually saw stars. I was stunned, emotionally and physically. My ears were ringing from the pain, I couldn't believe that my father had actually punched me....I used to get scared and that just made him more angry.

The only area in which Mr F was able to relate to Steve in a positive and nurturing way was when Steve achieved academically. However, this too was subject to inconsistency, as Mr F's demeanour depended on what mood he was in. This, however, functioned to make Steve believe that he had to be a perfect achiever, if only to find the occasional recognition and approval he longed for from his father.

R: How did your father respond to you when you were happy or proud?
S: What was I happy about? If I was happy for example because somebody gave me a sweet at school, that would be of no consequence to him. But if it was something like let's say I got a prize at prize-giving, he'd be proud of me.
R: So when you were proud he could be proud too?
S: No, not always, you see, there again it depends....
R: How would you imagine your father describing you as a child?
S: Depends what I've just done. If I'd just had a fight with him...he'd call me a little brat, a drip, that sort of thing. The same sort of thing that happened with that scouts thing. I got into trouble with that. He might speak more favourably of me if we had just come from a prize- giving and I'd got a prize for something. You see, it depends on what the circumstances were.

Mr F was unable to tolerate any view of reality besides the one which he had, and the rigidity with which he approached life became another area where he and Steve disagreed. Their level of communication never went beyond petty arguments and as these became the focus of conflict, the more intimate issues which were the underlying source of these conflicts (such as resentment, disappointment, anger, love and hate), seldom surfaced.

R: Can you think of an example that would be typical of the way your father argued with you?
S: Difference of opinion. He would stick rigidly to what he thought and I would stick rigidly to what I thought and we both wouldn't move.
R: So there was never any compromise?
S: No.
R: Was there anything in particular you argued about?
S: About things that were fair or unfair. Sometimes he thought things were fair and I thought just weren't. Like having to go get something that's closer to him than it was for me. Or around food. He would be angry with me because he couldn't understand the situation.

Their relationship never changed, only to worsen when Mr F was on a drinking binge. It remained on an authoritarian level and Steve was never treated differently, despite his different levels of maturity. For his father, he remained a child that had to be disciplined and punished, never a son with whom he could share his deepest thoughts and desires. His attitude toward Steve was always one of criticism and rejection, and matched with hostile behaviour, his presence was experienced as threatening and dangerous, and not to be trusted. In the following example, Mr F's intolerance of Steve's emotional life is revealed, as is the inconsistency and ambiguity which characterised their relationship.

> **S:** We were all involved in a car accident....In the hospital I remember them trying to give me an injection...for shock. I was *definitely* feeling a lot of pain. I was definitely in a lot of pain and my father told me...to stop making a noise.
> **R:** And you wanted to make a big noise?
> **S:** Yes, I was hurt and I wanted to make a big noise about it....
> **R:** Would you say that the way your father told you what you should and shouldn't feel was characteristic of your relationship?
> **S:** Sometimes there was a bit of ambivalence with him because there were times when we'd be ourselves, and he'd take me to the shops with him and we'd look at toys together. There were times like the fishing expeditions which would always start out okay but always got worse later, the end of them was always a disaster. Or when we were in the car together coming to visit my gran, we'd have competitions to see who could count the most windmills, who would see the dam first, who would see my gran's house first....
> **R:** How did your father respond to you when you were upset?
> **S:** He often told me to stop my whining, or as he used to call it, my "neering".
> **R:** If you had to describe your father and your relationship through the eyes of the child that you were, what are your immediate thoughts?
> **S:** I suppose I feel afraid of him because I couldn't *understand* him, I couldn't communicate very well with him. There was some misunderstanding between us as well, we never really managed to get on each other's level....For example, let's say we were sitting in the lounge and he'd ask me to fetch something that was closer to him than it was to me, then I'd have to get up and do it. I would disagree with that because I'd feel that he's been lazy. That would cause friction and we'd clash.

1.1.2.6 Second emotional disappointment

Although Steve reports that he was never close to his father, the impact of Mr F's behaviour and attitude on Steve, (as well as Steve's preoccupation with, and constant attempts to please him as opposed to his mother), indicate that an intense emotional attachment existed between them. Although it appears that they could not stand to be with each other, at the same time, they could not stand not being with each other (even if their interactions were largely negative and conflictual). The fact that Steve now states that he hates him for the pain he caused him and the family, it belies the fact that Steve did make some attempt to approach his father when Mr F became severely depressed and spent the last six months of his life sitting alone and withdrawn in the home's lounge. His efforts were

rejected by Mr F and Steve never approached him again. When his father committed suicide and was found by Steve and his younger brother dead in his car, Steve was profoundly disappointed, again. Although he is unable to correlate his emotional life with this gross emotional disappointment, it was within a year that he again was hospitalised with a second bout of anorexia, one which he has been unable to overcome. And, he remains angry with his father for abandoning the family, leaving them in financial and emotional ruin.

It is noted that in spite of most of Steve's descriptions of his father being largely negative (that he hates him), he at the same time maintains an image of his father as someone essentially good. However, this idealised image of his father is one which Steve has been unable to integrate with the negative or bad aspects of him. This is revealed in his accounts to the researcher (first example) where he states that his father was not prepared to be part of his treatment and on hearing himself say this, apologises profusely and retracts his statement. In the second example where Steve is talking about the time prior to his first hospitalisation for anorexia, he describes his father's intolerant and angry attitude toward him for not eating and how in a fit of rage his father bundled him into the car and took him to hospital. In the next breath, Steve takes back the hurt and anger he felt towards his father for his insensitive manner toward him by saying, "my father saved my life. I owe my life to my father. If it was not for his quick action, I would be dead now".

R: How did family therapy go?
S: All I know is that my father didn't approve of this idea, he didn't like going to psychiatrists. He would drop me off there sometimes when he did finally get to know about therapy, but refused to come inside. He didn't want to get involved. He didn't want to be perhaps part of the solution. *No*! *No*! *No*! I'm sorry. I'll retract that statement. My father wasn't like that. *No*! *No*! Umm, he didn't like going to psychiatrists and being questioned and brought out about what might have been sensitive issues to him.

R: How would you finish this sentence: when I think back to my childhood it was?
S: Idyllic. Everything seemed to have a silver lining, to unfortunately use a cliche, everything seemed rosy....
R: We spoke about your father and you said that up until the age of about 11, they were wonderful, idyllic years even though there were bad times too....Was your relationship with him any different after or during the time you became anorexic?
S: I don't remember much about my father.
R: Do you wish that you did?
S: I don't *want* to remember anything about him or some of the things he did to me....
R: Did he notice that you were losing weight?
S: It was very gradual, very subtle....When I was on diet my goal was to lose weight.
R: But somewhere you must've gone beyond that goal, eating less, missing meals?
S: *My father saved my life*! My mother says she wishes she had noticed then....
R: You say that your father saved your life quite often, could you tell me a bit more about that?
S: I was in a situation where I was trying to decide. I was sitting at the table wasting time for the others because I couldn't decide what piece of chicken to take...and I was playing

around with chicken pieces, trying to decide which piece to take....I would decide which piece I wanted but I couldn't decide which thigh, which was an inconvenience for the rest of the family, picking and picking....He got me right in time. I was sitting there for hours. I was still trying to decide what to have for supper when he took me to the hospital. It was late at night so he couldn't exactly decide to drive all the way to the main hospital....
R: What did he take you to the hospital for?
S: He didn't say to me "I'm taking you to the hospital". He dragged me off. He was very angry, that sort of thing, that I was irritating him.

1.1.2.7 Patterns of attachment with others

Within this overprotective and disappointing environment, Steve has withdrawn to an almost autistic state and not formed other attachments. Steve's attitude toward himself and others is starkly clear in the following narrative.

R: Do you have friends at school?
S: There are people that I know, I wouldn't say that I have any proper, or I don't know if I have what might be classified as friends in the same sense that my brother has people that he might be able to call friends. I don't have the same relationships with others that he has. I just know people....
R: You moved towns a lot when you were young. Did it affect your relationships with others at all?
S: No, relationships with who? I didn't really develop ties with anyone so it didn't affect me....
R: Do you have any friends at the moment?
S: I don't have any. I know people by sight, I might even know their names. I know them and they know me sort of thing. We don't have in-depth conversations.
R: So do you feel others know you quite well?
S: Not very well, it's very superficial....
R: Would you like others to get to know you intimately?
S: I feel it would take too much time. I have a lot of going over and over to try and get them to understand. I don't understand myself properly all that well either so I would battle to try and explain it to them. It would be difficult for them to relate to me because they haven't got the same experiences as me....I can't think of any common issues that we might share....Occasionally they might say hello to me, I'll say hello, sort of mind our own business.
R: Aren't you interested in getting close to others, finding out about them?
S: No, it wouldn't interest me. I'm not really the type who likes finding out about people and what they do....
R: Don't you miss sharing things about yourself with others?
S: I don't know, they wouldn't be able to understand me even if they wanted to, and what can they do for me? Personal is all anorexia-related, depression-related and you can't really expect others to relate to that and besides, it's just putting an extra burden on them....I've never been much of a socialiser. I've never been particularly interested in people....I don't go round trying to find out about people's lives and that. I tend to be an egotist in that I talk more about myself than what other people do. I'm always referring to me, either "poor me", or, "look at all the problems I have", that sort of thing. I don't tend to have much consideration for other people....I'd say it's always been the case that I've never been particularly interested in what's going on with people. Haven't really ever been very much in touch with that.

R: Do you miss it at all?
S: Well, if it's something I've never really had, I wouldn't know what it's like to be missing it.

Except for his relationship with his brother (which has remained on a primitive level, Steve alternating between loving and hating him, imitating his every move in order to be like him), Steve has no friends and no interest in forming relationships with others. He believes that no one would want to get to know him and that if they did, would not like him. He has a desperate need to be approved of by others, primarily his mother and brother, but is unable to integrate their complements with the self-image he has of himself being a failure.

R: Does your brother do well at school?
S: He does very well, he's very bright....I get envious of him and I try to do as well as he does....There was a phase when I was trying to imitate everything he did which used to drive him crazy...although I think, I *hope*, that's stopped now.
R: The imitating bit?
S: Yes.
R: So you'd much rather be yourself?
S: I realise that it's more considerate to him, not to do that when it irritates him.
R: But would you still like to be like him?
S: Yes, but I know now that I can never be him.
R: Would you like to be him?
S: Often I wish so, yes, then I wouldn't have my anorexia for one....
R: You said earlier that he's the perfect role model.
S: He's *not* perfect! *Nobody's* perfect, but he's near to perfectness....He's bright, he's clever, he's polite. He knows how to speak to people. He doesn't say the wrong things. He says the right thing at the right time.
R: Don't you think you could learn from him?
S: If I hang around him for a while he gets irritated with me....In the holidays I was copying everything he was doing....If he was playing the piano I'd sit and drum my fingers trying to get the same amount of exercise that he's getting. Or if he was running around, I'd also try to run up and down the passages, which angered him tremendously....I also wish that I could eat the same amount he eats without getting seriously fat. I can feel intensely loyal towards my brother when people ask me how he is and what I think of him. I always say that he's very bright and that he's just about the perfect role model, that I'd love to be like him.
R: Would you say that you tend to be more emotional or more a cool-headed kind of person?
S: Definitely more emotional. My brother's the cool-headed one....I'd be getting all worked up and tense and tearful and my brother would be getting ahead and dealing with the problem, instead of getting all emotional about it.

1.1.3 Case three - Maria: Patterns of attachment

Maria is a 26-year-old married teacher who from the age of 12 began binging and is now a compulsive eater. She is the younger sister of two girls and spent her childhood and adolescent years living with her parents.

1.1.3.1 Family environment

The family is characterised as a close-knit traditional family, with emphasis on maintaining cultural and traditional values. They enjoy spending time and doing things together and they maintain strong ties with extended family and friends, a lot of time spent socialising with them. The parents, having emigrated to South Africa from Europe, have felt the need to prove to others that they have worked hard and done well for themselves. Because other peoples' opinions of them were afforded such importance, and because the parents were eager to portray themselves as being of a high social class and upbringing, (as well as parents totally dedicated to the well-being of their children), two areas were exalted by them: (1) physical appearance and protocol, and (2) intelligence. These are the markers which the H's use as indicators whereby they measure their success, social standing, and acceptability to the world.

> I don't know why Greek mothers are like this. Always *manners* and *appearance*. Appearance with *big* letters. My mother's very appearance conscious, to a terrible degree. Her daughters just had to be the best. They had to be the prettiest, they had to be the best dressed, they had to go to the best schools, they *had to be the best*! They had to have the best figures.

Although it was Mrs H who placed extreme pressure on her daughters, and especially on Maria to conform to what she perceived to be the ideal daughter, (perfect weight, immaculately dressed, always adhering to protocol, even at the expense of one's self), Mr H was perceived by Maria to agree with his wife, as his mostly silent posture on these issues indicated that he was on her side. There exist many contradictions and ambiguities within the family's communication style. On the one hand, a spirit of freedom and openness is purported, with emphasis on sharing and on the other hand, certain ways of being are not tolerated (being fat or stupid). Intimacy is invited and yet, is met with dismissal and negation. There is indirect communication between family members and children become involved in conflict between parents. Either Maria intervenes on her own in the case of conflict between parents (parent-child coalition), or Mrs H asks Maria to mediate on her behalf with Mr H (triangulation).

Maria has always longed for her parents' approval and acceptance but equally feared their rage if she disappointed them. Thus, a pattern of withdrawal developed where Maria would withdraw from intimate situations (especially with Mrs H), as the issues she was struggling with were the very ones which she felt would reveal her to be inadequate. Maria thus learnt to conceal her true feelings. Further, Mrs H's attempts at controlling some of the most intimate parts of her daughter's self (weight and intelligence) under the guise of care and concern, are experienced by Maria as grossly

intrusive on her freedom. She believes it to be obsessive control on her mother's part, rather than supportive or caring. The parents' rigidity and inability to assimilate change is revealed in their present attitude to Maria. Both parents continue to treat Maria as a child. In Maria's own words, being married has changed nothing, except that her husband is included in the family's way of life.

1.1.3.2 Attachment with mother

Maria's developmental history is characterised by an attachment to a controlling mother who is described as obsessive, austere, and distant. Because of her mother's continuous criticisms of her, blatant disapproval of her appearance and intellect, and her constant striving to mould her into the perfect daughter (someone Mrs H believes is exactly like herself), Maria always experienced profound rejection, and consequently withdrew from her. For example, "**M:** My mother used to always want me to go on diet, ever since I was three years old. **R:** Were you overweight? **M:** No, I just didn't have my sister's body....She just couldn't handle seeing me like I was because I was not the ideal little girl that she wanted".

Communication with her mother remains on a superficial level, as it is Maria's experience that deeper levels of intimacy are pointless. This is because of Maria's sense that her mother has never understood her or her pain. This feeling is exacerbated by Maria's belief that her inner life was never considered serious enough for her mother's attention. Instead, it was always her sister's emotional life which took precedence. This belief is validated by her mother's comments that Maria is not able to love, hence her pain, thoughts, and feelings are not as real as her sister's.

> **M:** My mother was always very involved in my sister's affairs, and very domineering. She always made me feel that my sister's affairs are much more important than mine....My sister's crises always took over, so I shut up....When I broke up with George, before we were married, my mother came into the room and said "it's all your fault" and I said "why?" My mother believes that I'm not able to give love, to give affection, because I didn't do that at home. I used to only give it to my dad and I also never used to open up. So she believed I'd lost George because I was cold with him....I remember crying and saying "*no*, *no*, don't tell me this. *Can't you see how I am*? Is *that* why you telling me this?"
> **R:** ....Why do you think the difference in response to you sister, even to the same situation?
> **M:** My mother felt my sister loved more. She told me this again a few weeks ago. She says to me, "you cannot compare your sister's devastation after the break-up with her boyfriend, to your's and George's". I said, "why? I went out with George, but you just didn't realise". She said "no, I know it's not like that. Your sister was *genuinely* devastated". My feelings were just not considered, never taken seriously....
> **R:** So how did your mother respond to you when you were upset or depressed?
> **M:** She would ask me but I wouldn't be able to answer her so I'd cut her off. I was aware that she was aware but I couldn't talk to her. She always approached me in a very austere and non-comforting way, so that immediately put me off.

During times when Maria or her mother attempt to bridge the distance between them and talk about intimate things, the result is always mutual disappointment. Maria remains unheard and her mother leaves the discussion believing her daughter is uncommunicative and not responsive to her. This is because Mrs H is unable to tolerate any perceived criticism of her behaviour from her daughter.

> There's a side to me that my mother can't understand. I also know *what* to talk to her about. Other things I keep to myself. So we can go to a certain point but no further....If I start talking about me she can't handle it....She tells me I always try and find something wrong with the way she brought me up. She gets all upset and sulky and leaves the room. Or she walks away and says "I can't communicate with you, and *this* is the thanks I get for all that I've done for you".

Within this relationship Maria has never felt accepted for who she is; neither physically, emotionally, nor intellectually. The only times her mother has expressed approval of her, is when the rest of the world has approved first. Thus, only in the arena of public life where Maria reveals her talents and is acknowledged for them by the community, is she able to find some of the approval she longs for from her mother. But, because of her mother's continuous criticism of her and her exclusive focus on her weak spots, Maria is left with the profound sense that she will never be good enough in her mother's eyes.

> **M:** As I said, I felt that my problems never counted. And I also felt that I was never good enough for her. She always had something to say, whether it's my work, my weight, my hair, my face, something. When she didn't approve of something she would definitely say it. She would even find things that weren't necessary to pick on, like my weight. If I was three kilo's overweight, it would be a huge big thing for her. She'd harp on these things more than she would the good things....She *never* accepted me the way I was.
> **R:** Do you think your mother was proud to have you as a daughter?
> **M:** I think from a certain age, about sixteen onwards, I had proved myself to be the way she wanted me to be. She was proud of me then. She's very image conscious and she loved showing off to people. Up until I was 16 she never appreciated anything....But after a while she saw that the whole Greek community knew me and when she saw that people were coming up to her and saying "congratulations for your daughter" *then* she started opening her eyes and thinking "well, I do have something important here". Once other people approved of me she was happy, she approved of me. So from age 16 onwards I'd say she was proud of me.

Maria's earliest memories of her mother elucidate their subsequent relationship. Her mother put Maria on diet when she was merely three-years-old, not because she was obese but because she did not look the way Mrs H wanted her to look. From that tender age, she told Maria what she was allowed to eat and when, how to walk, how to talk, and even, to pinch her nose in so that it would get narrower. This pattern of control and intrusive attachment which began during Maria's formative years continues to the present, in spite of the fact that she is a married woman and no longer lives at home. The only period in which there was a difference is between the ages of ten to sixteen.

Maria reports that it was a period when her mother did not concern herself with her and instead, spent all of her time with her older daughter.

1.1.3.3 Attachment with father

Maria's main attachment figure is her father. It is with him that she shares the most intense emotional attachment, one which she still has. Her descriptions of childhood are of happy, almost magical times which she shared with her father, the parent who spent time playing, teaching, and having fun with her. The image she had of him was that he was 'God', something which she believed for many years. For Maria, he was the creator of all good things, the one who brought home food and gifts, the one who was soft, warm and gentle, the one who loved and accepted her unconditionally, although he also had a temper and did get angry at times. He was always the one Maria approached for comfort and security and the one from whom Maria derived a sense of security. He showered her with affection which knew no bounds and it was only with him that she was able to reciprocate with physical and emotional affection. Maria's perception and experience of her father is clearly revealed in the following narrative.

> **R:** Was there anyone you were particularly close to when you were young?
> **M:** I would *definitely* single my father out. I was in awe of my father. I thought he was God....I actually believed he was God because one day I asked my mother "who is God?" and she said to me, "well, God is this spirit that gives us so many things. He gives us the water that we drink, the food that we eat, he brings things home, and he's big and strong". And I thought, "well, that fits my dad perfectly, so he *must* be God".
> **R:** So you can remember thinking that?
> **M:** *Absolutely*! And he contributed to that feeling because he also gave me a lot of support. A *lot* of security. He was always big and strong and playful....I used to spend a lot of time with my dad....I think I've always been more in awe of my father....I believed that he was God completely. He *never* made me doubt it....He didn't only bring material goods to the house, he also gave so much. He was a very secure presence in the house. I was very attached to him....He really was very important to me. Still now, *very* important, *very*.

However, Maria draws a sharp and clear distinction within her childhood: the first six years were the best years of her life.

> I had a very happy childhood. I just loved being in my little world of flowers, games, rain, music, and my father. That's up until I was six years old. There's a very clear distinction. We emigrated and I was taken out of this wonderful world of mine.

Maria reports that the following four years were filled with sadness and pain. These years were during the time the family emigrated to Greece and suddenly things were different. Her father's

frequent business trips back to South Africa were times of intense loss and sorrow for Maria, who would hold his photograph for hours and sit in his cupboard each night so that she could smell him, be with him, and feel his warm and secure presence.

> **M:** During those four years my father used to leave for months at a time. He used to come and go for business to South Africa. And I used to be devastated. I used to get so devastated that I used to sleep with his photograph next to me, I used to go into his cupboard to smell his clothes....It was unbearable....I used to think, "God is gone. He's gone. The house is empty". I wasn't close to my mother, my father was just everything....It was such a loss....It was so lonely, so empty....I wanted to be close to him. I used to climb into the cupboard and physically sit there....I used to take his clothes and put them against my face so that I could smell him. That was wonderful. It was like he was there. Especially a leather jacket he used to have. When I used to touch it, it felt like he was there, his body was there. I used to think "I'm with dad" and I felt better. It felt good in there. It was very traumatic when he'd go away.

1.1.3.4 Perceived disappointment within the preferential attachment relationship

In Maria's case, the disappointment is a consequence of her relativisation of the image of her father, her main attachment figure. Maria's time in Greece was marked by frequent long separations from her father and when she was seven, she began to experience problems at school, primarily with Maths. This became a point of contention and a source of immense pain for Maria. Both her parents began to question her intelligence and Maria came to believe that she was stupid and inferior to others. Suddenly, her father was seen to side with her mother (the ultra-conformist and perfectionist), who demanded she do better. It is within this area that Maria experienced intense disappointment with her father. He was no longer the loving 'God' she perceived him to be. He would become angry with her and give her hidings for not performing well. This was something which Maria could not integrate with the image she had of him and to this day, she is unable to understand her father's behaviour towards her at that time.

> I started developing big blocks in my head. I just couldn't do maths....So here I was, Maths had become such a problem that I used to go home and my parents used to try to tutor me. And my father used to try tutor me and he used to get so angry with me, that he used to *hit* me? (disbelieving tone). I used to get a hiding....He actually used to hit me. "Why don't you understand what I'm saying to you?" Pow! you know. Then I *really* couldn't understand what he was talking to me about....I was so depressed. What makes me wonder is that my parents didn't pick up these things. I mean I tell them today and they just can't understand, they themselves wonder. My father feels very guilty. He can't talk about that time with me. He can't even think about the fact that he used to hit me when I couldn't do maths....I think my mother convinced him that my school work wasn't good enough. I think if he had to really think on his own he wouldn't have minded so much. The funny thing is, he reacted more violently to it than my mother did. It was totally incomprehensible to me that he hit me for not understanding maths. I mean this was my *father*.

(It is interesting to note that during the four years spent in Greece, where Maria was confronted with a different image of her father, she became even closer to him and desperate for the security he offered her). See next example.

> **M:** It was so lonely, so empty. I felt as if I'd poured my heart out, I had no more to cry...just very devastated. Feeling, ugh, just, life is so hard, my dad's gone and it's hard....I missed his powerful and securing presence. He just gave me a lot of support although I just found it weird that he would hit when I couldn't do maths. And at the same time I adored him. And our relationship changed.
> **R:** When?
> **M:** *That* time, I became so emotionally attached to him. I was *so* close to him. During the time we were in Greece my relationship changed with my father. Before I was very close to him anyway, but *after* those huge trips and after the four years in Greece, I became even *more* close to him. I missed him so much that something happened to me. I just clung to him. And I'm like this with him up until now. From that time onwards I became *desperate* for my dad, absolutely desperate for him and our relationship is like that today.

The importance Maria attaches to her father's opinions of her and her need to do things which will gain his approval, are almost of a desperate nature. Thus, in spite of the openness and interdependence which characterises their relationship, and that Maria reports she always felt accepted by her father, it is also true that there are two levels of intimacy which are closed off between them. These are the areas which have caused and cause Maria the most emotional pain (her weight and her questionable intelligence), and yet the ones which she cannot share with anyone, not even her father. This is because she believes her father has a certain positive image of her and in sharing this part of her life with him, he would be saddened, disappointed, and unable to integrate this with the image she projects to him.

1.1.3.5 Attachment with others

In spite of the ambiguous home environment (freedom versus control) Maria has been able to initiate and maintain numerous friendships throughout her life. However, in spite of the openness which characterises her relationships with others, she is unable to be whole. She admits there is a part of herself which she keeps hidden, a secret, even from her best friends. This is the area concerning her appearance and weight. Maria reports that she has never been able to discuss this intimate part of herself with others, as she fears and believes that this would reveal her as someone inconsistent with the image she perceives others to have of her. (The image she believes they have of her as someone strong and together would be shattered and replaced with problematic and weak). It is only with her husband that Maria has been able to be both intimate and passionate, as well as needy and dependant (the emotions she hid while living at home). Although she often treats her husband as the one

responsible for her and her happiness, she has been able to see this as a behaviour originating out of the controlling relationship with her mother. It is Maria's hope and aim to transcend the critical attachment she has with her mother and in this way, find the freedom she longs for.

1.1.4 Case four - Angela: Patterns of attachment

Angela is an 18-year-old high school graduate who during late childhood (age 12), developed bulimia. She is the eldest child in a family of three children and spent her formative years living with them and her parents. Thereafter, she spent her high school years at boarding school, visiting her family on weekends and vacations.

1.1.4.1 Family environment

The family is characterised as strict and puritanical, with emphasis on maintaining tradition and family life. They are a close family, spending a lot of time together. However, this is more as a result of a rigid belief that demands they spend time together as a family, rather than a spontaneous event. Although there are good ties with extended family and friends, the family like to remain private and their affairs are considered their own. However, within the family, boundaries separating individual members are not as clear as the ones keeping the outside world out. In this regard, the parents are extremely overprotective (especially Mr G), and the well-being of his children is primary. Although his intentions are sincere, a pattern of communication and relational strategies exists which precludes their well-being. The ideal of presenting a happy, well-balanced family to the world, one which abides to strict morals and good behaviour, is exalted at the expense of his children. This is an image which is also exalted within the family, not allowing for a true appraisal of individual members and their functioning. Emphasis is laid on good education and academic achievement and a climate of perceived failure is not tolerated. Mr G has assumed many of his wife's roles (because of her absences and emotional instability) and thus is the one who controls the running of the household, both materially and emotionally.

During times of conflict Mr G would always side with his wife, afraid that she would turn on him if he was seen as unsupportive of her. Mr G also felt the need to protect his wife and so would dismiss Angela's feelings, regardless of the situation. He would excuse his wife's tantrums and irrational behaviour by virtue of the fact that she was ill and would tell Angela not to react to her because she (Mrs G) was fragile. Both Mr and Mrs G would force her to apologise to the parent in

question, regardless of the nature of the situation. This relational style was not only contradictory and oppressive, but also led Angela to the conclusion that she had to become everything but her real self.

> **A:** When my mother would scream at me, go berserk, I would *never* say a word. My father would explain it away by saying, "your mother doesn't mean it. She's just upset and you mustn't say anything. We mustn't upset her any more, we don't want her to go off the deep end"....
> **R:** How did that leave you feeling?
> **A:** *Furious*! I used to get *so* upset sometimes. I used to have to go to my room and when she used to say, "come and apologise" I was still *so* cross. Eventually it would be over and fine but each time all of that built up, built up....It would bug me and I wouldn't say *anything*. I became so angry with everyone else, so flipping angry but I would *never* go back to them, *never* with my parents. I kept it in, kept it in, kept it in.

1.1.4.2 Attachment with mother

Angela's developmental history is characterised by an attachment to a clinically depressed mother who is described as inconsistent, jealous and emotionally fragile. Mrs G is a manic-depressive, suffering from severe mood swings (feelings of joy versus depression and suicidal thinking) and was hospitalised on several occasions during Angela's formative years. Although Mrs G never worked and stayed at home to look after her children, Angela reports that she was distant and hardly there, never a presence.

> My mom was always there, except for certain intervals when she had a nervous breakdown. She was there but she was...ugh, my father was very much the dominant one. My mother was so quiet, she was always in the background. She just did what she had to do and that was it. We'd get our meals, our baths, our love and attention...umm, I remember her presence but not in an overwhelming way. My father worked, so he wasn't there all the time, but he was more dominant, a more present factor....Maybe that's why I'm maybe more toward my father because from a young age my mother would go away or leave and my father was there. He was always someone I could depend on. He would never go away without a reason and if he did go away, there was an explanation, "next week I'll be away for three days and then I'll see you". My mother was just gone. We'd visit her in the hospital....She'd either be totally out of it or so emotional. She would smother us, give us huge kisses and I'd just stand there. I just remember her being either very emotional or very angry around us children.

Mrs G's withdrawn state is in keen contrast to the times when she has emotional outbursts and blames her children for her predicament, setting up a pattern of gross emotional inconsistency within their relationship. See example on next page.

R: How would you describe your mother?
A: Kind of in the background, patient, sweet, kind, understanding, she'll always go for the underdog. She's quite shy. She's quite outgoing with some people. That's on the one hand. On the *other* hand, if she's tense, she gets bitchy. It's like she's a different person. It's everything opposite to what she usually is like. She's jealous, she becomes suspicious.

Because Angela's perception of her mother is that she is emotionally fragile, their level of communication has never developed beyond superficial matters to include emotional intimacy. Angela has never been able to share her inner life with her mother because of her profound sense that she is both distant, as well as unable to tolerate others' expressions, predominantly her daughter's. During times when Angela or her mother went beyond their usual communicative territory, Mrs G would complain that she was misunderstood and not appreciated by Angela, or the rest of the family. This served to reinforce the idea for Angela that it was pointless to even try to share things with her mother, as her mother was unable to extricate herself from what was being discussed and unable to listen to what she was being told. Thus, even during times when Angela desperately needed contact and understanding from her mother, she would remain withdrawn and silent, never revealing her true needs, instead pretending that all was well with her.

R: How would your mother describe you as a person?
A: I think the way she would see me and the way most people would see me, is like someone who's totally self-confident, is very much in total control of her life. You know, that I'm joking, nothing gets me down....Really, it's all a front....What my mother can't understand is that a lot of the feelings she has about herself, I have about *myself*, but I hide them. I won't act depressed if I'm down. I act so jovial, life's great, nothing gets me down....My father's like that too. I've got a lot of insecurities that I maybe just hide better than anyone else.
R: Would you agree with how she would describe you?
A: *No*, *no*. That's just an easy way of letting someone think that. I'm very much the opposite....When we do talk, it's not ever about me. *Never*! Not at all. It's *never* about me, and I mean if there's something really bugging me, I might mention it but nothing about actual feelings, you know, sort of deep feelings. No, they were never brought up. I never got into it and my mother didn't pry either.

Mrs G would dump her feelings on Angela, serving to enrage her but Angela would nonetheless withdraw further and never respond or express her anger or protest at her mother. This is a pattern of conflict avoidance which is actively supported and maintained by Mr G. See example below.

I do remember not being able to verbalise what I was feeling. Not being able to say it and I also always had this thing about not speaking back to my parents, especially to my mother....She went through a stage where she would shit on me and then a few hours later she would be fine....And every time she had like outbursts I would never say anything. *Never*! I'm speaking about the whole of high school, the whole of least year....Only now, in the last month did I realise this was actually bugging me because I'm always just taking it. The reason is, I always had this thing that I mustn't respond because she doesn't mean it. I mean there'd be outbursts about small little things and sometimes more serious things like, "I

> do everything around here, you don't help or do anything!" These sporadic outbursts and I wouldn't say a word each time....She would just go off the deep end and my father would always take her part. I mean he's obviously supporting her and I mean, hell, if he took the kid's part that would have been flipping hell to play for him. Like my mom would go to my dad and my dad would just say, "go and apologise to your mother". It used to *always* be like that and I used to have to just, ugh, I *had* to do it.

Mrs G's depression functions to maintain the distance between her and her daughter. Angela's fear that she will somehow be contaminated or develop her mother's intolerable symptoms if they got too close, was and remains an unbearable thought for her. It is something which she abhors and consequently, she made the conscious decision early on in her life never to allow herself to become like her. This was a decision which resulted in the denial of her inner life and intolerance of it, never giving it any credibility and instead, choosing to suppress it. It is only in the last year that Angela has slowly learnt to tolerate her own perceived negative feelings (depression, pain, disappointment, anger) and realise that feeling them will not necessarily make her a reincarnation of her mother.

> **R:** Am I picking up that you think being bulimic is quite a shameful thing?
> **A:** I *did* think that. But now that I've accepted it because it just didn't exist as a problem for me for five years, now I think, *that's* ridiculous. Why cope with certain things by vomiting? The reasoning behind it though, the practicality of it, is that it brought out in the open that my mother's always been depressed. I've always been *totally* petrified of being like that....And when the psychiatrist told me that some people who have bulimia also have bad depression, I thought, "oh my God. Here it comes. What I've been trying to avoid all my bloody life is the bloody depression and now here it comes"....A lot of the things they say about bulimia, the depression part, I am very scared of. I just don't want to end up like my mother.

1.1.4.3 Attachment with father

Angela's main attachment figure is her father, a man characterised as dominant, strict and overprotective. Because of Mrs G's emotional inaccessibility, Angela preferred the company of her father, who from an early age showed a preferential attachment with his eldest daughter. Although disappointed that she was not the son he longed for, he nevertheless spent lots of time playing with her (although the usual boys' games) and took her with him whenever the opportunity was afforded to him. Up until the age of 10, Angela's memories of childhood are of a happy, playful time with her father as the centre of the world. In her eyes, he was like a 'God', perfect in every way, someone who could do no wrong, someone who knew the answers to everything, and someone very important by virtue of his business suits and demeanour. In her own words, "he was just this big, good force, he took up all the space". See example on next page.

A: I used to think he was a really important guy. I used to see him in the mornings, sometimes if he'd come home for lunch, and in the evenings, and it was a major thrill to see him....I always thought he was someone important....My father was always very much a part of our games....We'd go for walks, we'd go for a bike ride. He was always initiating something. We'd play cricket on the beach, netball, anything. He was, and still now, is very much involved in things we can do together. I was always more toward my father....I went through a stage very much for my father and I thought I wasn't really showing it but when I thought about it afterwards, I *was* actually very much for him....He was someone big...a feeling of security. I remember it being so exciting when he was coming home. Just some large force, a good force, that was coming home. Very alive, full of fun, teasing us, tickling us....You feel his presence in a major way....
R: How would you finish this sentence: when I was a child my father meant?
A: I could say *everything* to me, the world to me. A very dominant force, very much so.

Because he was the one from whom Angela derived a sense of security and worth, as well as contact and affection, from an early age she realised that pleasing him and being what she perceived he wanted her to be, was the way of maintaining their relationship. He repeatedly made it clear that he would not tolerate failure of any sort, and because of the importance Angela attached to her father's opinions and her fear of enraging and disappointing him if she did not perform well, she developed a perfectionistic attitude, working hard and excelling in both academic and sport's spheres.

1.1.4.4 Perceived disappointment within the preferential attachment relationship

In spite of their preferential attachment to each other, after the age of 10, Angela reports that their relationship changed. Angela would no longer approach him when she needed to be understood and comforted. This was during a time when her uncle and grandfather had died and her father was preoccupied with handling their estates and resettling their families. Suddenly Angela felt that her problems were insignificant to demand Mr G's attention and his sudden distance from her, reinforced her belief that she was no longer as important to him as she had thought. Further, seeing her father upset and distraught and no longer strong and happy, was an image of him she was not used to and she had trouble integrating this with the old image she had of him. This disappointment with her father and realisation that he was not who she thought he was, functioned to change their relationship to its present status.

R: How did your father respond to you when you were upset?
S: I don't know, that's quite weird. Why I'm maybe hesitating is that I'm just thinking about that bad year of mine, when he actually wasn't as much of a force then as he usually was. I'm not sure if maybe that year my mom had a breakdown somewhere along the line, so I think he actually had more important things to worry about. My grandfather died and then my uncle, so obviously the funeral arrangements fell on him....The arrangement of all their financial affairs fell on him....So I think a little kid being difficult in that specific year was anything but important then. I'd always been an independent little kid, but my biggest change

was during that year, I became more independent, totally. Before that, I would always run to daddy if I was upset about anything and he would always say, "don't worry, it will be alright" and that usually made it alright....
R: And if you were angry?
S: My dad didn't tolerate any kid that had a tantrum or was angry. I'd either get a good talking to or a hiding.
R: What did you do with your angry feelings or any feeling then, like when you were upset?
S: I don't know. I *know* I actually must've suppressed them....
R: So you see a clear difference in your relationship from that year?
S: Ya, definitely. I think he actually had a lot on his mind that year too and so I'd imagine I would have gone to him more in that year. I would have approached him more than he would have approached me.
R: And after that, say years later?
S: You see after that I knew more. At that stage I became quite good at hiding my feelings. I knew that if I wanted to verbalise a problem it's up to me to do it, but I had this ability where I could carry on quite easily, seem as though the world is great when I was actually quite upset. Also, the following year, my school work improved, I started doing well at sport, I had friends at school, and I think as a family we were all happier, so I think if there was ever anything bothering me, I would also then say, "well, it can't be serious" and I'd also pretend to be happy. So I mean my father would seldom expect me to have something wrong....
R: Why do you think the change in how you thought of him?
A: It seemed like a more type of a mature look at him. You know, that he wasn't completely infallible, that he wasn't *quite* as brilliant as I thought he was....
R: Did you think he was infallible before?
A: It just seemed that he was basically perfect in every way. At his work he was getting better positions all the time, so I couldn't fault him there at all. You know why it seemed so perfect, because my friends would say that their fathers weren't really interested in their lives, whereas my father was very into knowing what was happening, wanting to know and meet our friends, have to meet their parents and see if they were okay. Always very involved with what was happening in our lives....
R: Do you sometimes love or greatly admire someone at one time and then hate or feel terribly disappointed in them at another time?
A: No, I think I've only ever felt that way about my father. You know, where I suddenly realised my stupid little girl's way of looking at him is, umm, you know, he's *not* perfect, he *is* just human, and that's just the way it is. I guess looking at him more realistically.

Her inner life became her own private world, no longer shared with her father. Angela withdrew from him and would pretend that she was happy even when she was not. Their relationship came to centre more and more around her achievements at school and now, her career. Even when Angela developed bulimia and was unhappy at boarding school, she was never able to let her father know. Her need to keep things hidden from him is compounded by the fact that she believes her father would not understand her problems, as well as not be able to incorporate them into the image of herself which she has worked so hard to portray to him (of someone together, with no worry in the world). She believes that he would be so disappointed and shocked to learn of her difficulties, that not only would it change his perception of her (probably reject her) but it would also be something which she is unable of even imagining doing (because the thought of disappointing him is both outrageous and deeply frightening to her). See examples on next page.

R: You said you started to hide your feelings. Could you tell me a bit more?
A: I don't know. Sometimes the things I say I only realise for the first time. During that year I think I'd say is when it started, where I didn't volunteer as much information about myself to my parents. I was very conscious of it.
R: About what type of things?
A: It might not even be anything important. I think just things like if you feeling down and depressed or something's bugging you, I wasn't easily volunteering that type of information.
R: Would you say they noticed or didn't have a clue?
A: *No, no*, I hid it pretty well. I just seemed totally happy and my dad was happy. I imagine the times that I *did* get upset it didn't seem important to worry anyone.
R: And when you were happy?
A: My father would be happy for me. Especially with sport or school work, he was always very encouraging with things like that which made you want to do it again or improve it because my mother was always, "well done, that's good" but my *dad* was like really enthusiastic about it....I also knew, or I think I knew that my mother wouldn't really mind if I didn't do that well but it would *really* bug my father....My father might not be alright with it, he would expect more you know.
R: Did you ever find yourself doing things to gain his approval?
A: All the time. I think any achievement, *anything* I did, it was directed at him, especially from mid-primary school because then you can see, "this makes him happy, this doesn't".

A: I had no reason to ever hide my feelings. I don't know what I was hiding from. My family life was open, my parents were open with each other...there was never any problem in that way. We weren't taught to hide our feelings but I always felt I had to....
R: Do you think your eating disorder has affected your relationship with your father?
A: I know that he couldn't understand it. It was *totally* foreign to him. Especially because we were like pretty close and it's something we've never been able to talk about....You could see it was a problem for him....
R: Why do you think that being so close to him you couldn't talk to him about it? Would you have liked to?
A: I don't know. No, I wouldn't. I mean he thought I was about as perfect as anyone can be. We were *very* close, and maybe he wondered why I couldn't speak to him about it, not even mention it for years....The only time I felt he *really* disapproved was when I first told, when it was so-called out in the open the second time round. He couldn't understand it and I knew he had difficulty speaking about it. I think he was very disappointed in me....He didn't understand it, he didn't know why, it didn't make any sense to him....
R: Why do you think it was so difficult?
A: I don't know. If not because of the image I had of *myself* but the image my father had of me. He just couldn't believe it. And I felt like such a failure too because even though my self-image wasn't very high, I always hid that, and then it all came out you know....
R: Something like you couldn't reconcile bulimia with the image you had of yourself?
A: Exactly. It was like putting a name to something I'd done for years. It was more the reasoning behind it that I couldn't believe. That *I, me*, who is usually quite a practical thinker, would go into something *so* ridiculous, *so* stupid, *so* unreasonable. It just didn't make sense to me and I don't think to my father either. I felt like I'd failed....Even with my mom, my sister. I would say they wouldn't be able to believe it of me, not at all. My mom also couldn't associate it with me.

Mr G's behaviour around his wife is perceived by Angela as betraying and unjust, as he would always side with his wife during times of conflict with Angela. He felt the need to protect his wife and so would actively dismiss Angela's feelings. He would excuse his wife's outbursts by virtue of the fact that she was ill and would tell Angela not to react to her because she (Mrs G) was fragile; a

communicative style which is both negating and dismissive. Mr G's rigid and critical attitude as to how things are meant to be, precludes any appreciation of Angela's different levels of maturity and although she is now an adult, he continues to be overprotective, as is revealed in his attitude towards whom Angela dates. "**A:** My father will always think of me as his little girl, treat me as a little girl". Although Angela is no longer living at home, her father continues to be a very important figure in her life. His opinions of her are still afforded major consideration and thus continue to exert a major influence in her life, where she is still desperate for his approval and recognition.

> **R:** Was or is it still important that your father approves of you?
> **A:** *Always*, and in a way I imagine it will always be. Although recently, I'm inclined to see that I can make my own decisions and be happy. Now I sometimes do certain things, go out of my way to actually shock him, both of them, umm, so his approval is important but not nearly as important as it was.
> **R:** Why do you think the change?
> **A:** I just think I've actually caught a wake up and also, it's about the only way I can actually go about starting to live my own life completely independently, so I think that I have to almost like have them disapprove of me. I've got to prove that I can manage, *I am* capable of looking after myself and *then* I can look for their approval again. I mean, I've practically been a perfect daughter. There's nothing they can point to or any reason for them to think I'm irresponsible, incapable, whatever. I *always* did what I was told and what I was expected to do.

1.1.4.5 Patterns of attachment with others

Angela's developmental and subsequent social history reflects an ability to initiate and form relationships with others. Although the family relocated 10 times and Angela changed school four times, she was able to surpass initial feelings of shyness and always had friends. During her adolescent years she began dating and could get on easily with the opposite sex. However, with both her boy and girl friends, Angela was seldom able to share intimate parts of her life, or tell them when she was troubled. Instead, she always felt forced to pretend that she was happy and seldom would go as far as "mentioning" that she was upset (but never elaborating). This was because Angela had a desperate need to feel approval from others and feared they would reject her if she were revealed to them, e.g., "**A:** I always had friends but I would never say I got very close to anyone". In the last year, with the support of both group therapy and her boyfriend, Angela has been able to take slow (although carefully thought out) steps to reveal herself, and she has been pleasantly surprised with the response she has received; acceptance and not rejection.

1.2 INDIVIDUAL CASE REPORTS OF SENSE OF SELF

1.2.1 Case one - Jacki: Sense of self

1.2.1.1 Identity development

Jacki's developmental history is characterised by ambiguous, intrusive patterns of attachment within a home environment where relational styles are critical, rejecting, and ambiguous. Within this milieu, Jacki formed a preferential attachment with her father, as he was the one from whom she received the most emotional contact and physical affection. From a young age, Jacki perceived him as someone big and powerful, like 'God', who always knew the answers and what was right, and hence he became her role model and the criterion image from where she derived a sense of self. She soon learnt that the way of maintaining this attachment was to please him academically and never to reveal her inner life to him. This was because the only area in which she received recognition and approval was when she performed well and because she knew that emotional expression and individuality were not tolerated.

Because her home environment precluded any autonomous self-expression and assertion of, and/or recognition of her individuality, Jacki's self boundaries continuously and loosely wavered between being externally bound (by her father's continual appraisals of her), and internally bound (by displaying a self-sufficient controlled attitude over her inner life). Because of her father's intrusive and critical attitude, Jacki experienced herself as powerless and ineffective in exerting any influence and control over her life, or over her father. Her father would not only criticise and reject her but would also tell her that behind the cool, hard exterior she projected to him (where she pretended she was unaffected), he knew that inside she was a weak person who was crumbling and unable to cope with anything. Jacki would thus withdraw and never express her anger or disappointments to him, believing that this would reveal that she was an emotional casualty. She soon developed the pervading sense and firm belief that her inner life was responsible for her shortcomings and so mounted an internal war against it, suppressing her emotions and separating herself from them. Instead, she focused her attention almost entirely on pleasing her father, where only perfection was perceived as satisfactory by her and anything other than that, a failure.

Adolescent resolution.../...

1.2.1.2 Adolescent resolution

With the onset of the physical and emotional maturation of adolescence, Jacki found it increasingly difficult to maintain her relationship with her father because he was unable to accept that she was no longer a child and had ideas of her own. However, her sense of self (self-worth, self-esteem, self-confidence), was still exclusively derived from her father's perception and evaluation of her. She thus continued to try and please him by dressing the way he wanted, exercising and going on diets to change her body shape (which was also scrutinised and criticised by him), and working hard and doing well at school. Jacki thus structured a self-image on the perceived expectations of her parents (especially her father), where she portrayed herself as self-sufficient and controlled. At a time when Jacki should have begun the process of emotional and cognitive separation from him, she was still beset with becoming who she perceived he wanted her to be, although she was never quite sure of this because of his inconsistency toward her.

When she was 15-years-old, Jacki was to discover that the image she had of her father was distorted and that he was not the man she thought he was. He was suddenly seen for the cruel, rejecting man he was, who was not perfect, and who did not know the answers to everything. This was something Jacki actively discovered but which left her struggling with who she was and how to be. She realised that it was pointless trying to please him, and pointless trying to express her needs and desires to him. In essence, she gave up on him and from then on believed that his criticisms and rejections were indications of her incompetence, unlovableness, and lack of worth. Externally, she withdrew from her father (but remained preoccupied with him internally) and found the support and (limited) intimacy which she longed for, from her friends. But, because she was careful never to reveal intimate parts of her life to them (incase they also rejected her), she was always left feeling profoundly alone and deficient.

1.2.1.3 Attitude to self

Jacki's resultant feelings of personal ineffectiveness within her relationship to her father, as well as her feelings of betrayal after her disappointment in him, led her to make certain decisions: (1) that she would never trust anyone again, and (2) that her inner life was the cause of all her pain and suffering, hence her resolve never to afford it importance and always to keep it under control. Because Jacki blamed her emotional life (feelings) for the way she felt and because of her inability to differentiate and express her feelings (even to herself), her only recourse was to strive for

increasing levels of perfection, as well as to continue believing that she was responsible for others' (notably her father's) attitude toward her.

In this regard, Jacki began to focus all her attention and energy on changing her body shape, as this was seen to be the source of her feelings of worthlessness, as well as her father's rejection of her. She came to believe that if she were thin and beautiful she would be both more acceptable to herself and to others. It was then that Jacki discovered that there was one area where she could secretly assert control over herself as well as over her father: that of self-induced vomiting. Vomiting became a vehicle for expressing her anger at her father (by vomiting his food and what she felt he was forcing down her throat, both literally and metaphorically), as well as a means of controlling her emotions, as during the vomiting she would become detached from herself and from her situation. Jacki considers vomiting as both a weapon (which she uses against her father), as well as a symbol of power (where she is able to feel powerful within the bounds of her secret).

1.2.1.4 Attitude toward reality

Jacki's sense of self is derived from and dependant on others' evaluations of her. Although she is now married and not living at home, she still finds it hard to believe that her husband accepts her the way she is. Within this relationship, her previous patterns of attachment are re-enacted. Although she has slowly been able to learn that she can trust him with intimacy, she still does not tell him important things relating to her, instead keeping them secret, and during times when she feels insecure or threatened in their relationship, she resorts to vomiting as her way of expressing her anger or disappointment. She constantly seeks his reassurance that she looks alright and when he fails to give her this because he feels it is something understood between them, Jacki becomes angry and a fight ensues. Further, Jacki is only able to feel secure in his presence, as he provides her with the support she so desperately needs.

Up until the time she married, Jacki engaged in numerous heterosexual relationships, where her aim was to prove that she was attractive to men and not as bad, dirty, or worthless as she felt herself to be. These relationships were short-lived, as once her partners had expressed sufficient interest in her, she would end the relationship. And, in spite of the fact that they did express interest in her and told her they found her attractive, she disregarded their complements and saw them as having ulterior motives (wanting to have sex with her). Within the larger realm of society, Jacki attaches great importance to what others think and say about her, always seeking their approval and trying to please

them in an attempt to assure herself of her worth. When she is criticised or fails to get the recognition she needs, she regresses to the little girl and teenager she was with her father, who felt worthless, inadequate, and unlovable. With her friends she is able to maintain strong relations but is still not able to share parts of herself with them. In this regard, Jacki is able to derive some stimulation and a feeling of support from them but because of her need to remain hidden, these relationships remain mostly superficial and often result in mutual disappointments, as the deep level of intimacy needed to sustain them is missing (thus her feelings of emptiness).

The primary way Jacki makes sense of criticisms or challenges to the self, is by making an internal attribution; that is, finding some fault within herself. At the same time, there is uncertainty regarding her emotional life. She is unable to know what comes from within and what comes from the outside world. Further to this, Jacki is unable to differentiate her physical self from her self-concept. Thus her belief that it is what is "inside" that counts to others, is contradicted by her continual self-assessments on the basis of physical appearance. In other words, she is unable to offer any other explanation as to why others would not like her besides in saying she is too fat.

At present her sense of self is almost always derived from an assessment of having fulfilled her father's (primarily), her husband's, and the rest of the world's expectations of her. In spite of the fact that she has been able to exert a physical separation from her father, she is still preoccupied with her internal father, who is her worst critic. Because of this continuing preoccupation with her father, as well as her attempts to control her inner life, she is grossly unfamiliar with it and thus regards it as an evil to be avoided. She is thus unable to know herself, who she is, and what she would like to be, beyond her father's appraisal of her.

1.2.2 Case two - Steve: Sense of self

1.2.2.1 Identity development

Steve's developmental history is characterised by ambiguous, intrusive, overprotective patterns of attachment, within a home environment which is critical and dismissive of him. He formed a preferential attachment with his maternal grandmother, as she was the only one who accepted and treated him as an individual, and who showered him with love and affection. However, their interaction was limited to holidays and occasional weekend visits which Steve lived for. She was regarded as his saviour and Steve's descriptions of his childhood are that it was an idyllic time spent

with his grandmother.

However, within his immediate home environment and in the absence of his grandmother, Steve formed an intense emotional attachment to his father (although negative), and a highly enmeshed relationship with his mother (the intensity of which increased subsequent to his grandmother's death and his development of anorexia). Although his father's behaviour towards him was critical, dismissive, and inconsistent, Steve learnt that one way of pleasing him and maintaining their relationship was by achieving at school. Further, he knew that emotional expression and individuality were met with indifference or rage; hence he hid his inner life from his father and kept his opinions to himself as much as he could. Within this environment, Steve's sense of self is blurred, with his self-boundaries constantly fluctuating between being externally bound (by his father's continuous judgements) and internally bound (by controlling his emotional life). Steve's need to control his emotional life is evident in the following example.

> **S:** At the clinic one of the ladies had a pained look on her face and I went round and sort of put my hand on her shoulder....
> **R:** Do you feel good when you are able to do something like that?
> **S:** I did have a good feeling inside me yes, although I try to suppress it.
> **R:** It sounds like you try to kill almost any good feelings you might have about yourself.
> **S:** Yes, I do....to stop myself from becoming too vain, too proud of myself.
> **R:** Do you think that could happen?
> **S:** Yes, I often have thoughts about being marvellously brilliant and very well behaved, which is what I call my egotistical thoughts.
> **R:** What will be different from now if you were brilliant?
> **S:** I feel I'll be more in *control* of my emotions....I'll be someone to be admired and looked up to, somebody who could be taken notice of.

His father's inconsistency (coupled with his critical and rejecting attitude), left Steve feeling powerless and ineffective in exerting any control over his own life, or over his father's intrusiveness. During times when Steve did go beyond his usual communicative style and expressed his emotions to his father, he would be met with rage and disapproval and called demeaning names because of his display of emotions. Steve learnt that not only was revealing one's self threatening, but that one's inner life was shameful and the cause of trouble, and that in any case, it must be kept to himself. (Note - Steve's self-image is based on the perceived expectations of his parents/grandmother. It is based on perfectionism and emotional withdrawal which is supported by his asocial behaviour). With the belief that he was unacceptable and worthless, Steve withdrew from his father and instead, focused his attention on his studies and achieving the highest marks, where only perfection was acceptable to him and anything less than that, was a failure. In the next example, Steve's knowledge that his father's demeanour toward him depended on his ability to achieve, as well as on his ability to conceal his

inner life from his father, is revealed.

> **R:** Did anything in particular get a favourable response from your father?
> **S:** Well, it seemed that when I did well at school he seemed to be proud of me, but I wouldn't say that dragged me to do better and better. My mom thinks that might've been the case, but I don't perceive it as such.
> **R:** And with mom, did you do things to please her and gain her approval?
> **S:** Well, obviously apart from just behaving myself, I mean your parents *are* going to approve of you more if you behave. But say for Mother's day, I might make her breakfast in bed, but I wouldn't say that I ever went and killed any monsters for her kind of thing.
> **R:** Was it important that your father approved of your accomplishments or of you?
> **S:** I think *anybody* likes to have their feelings approved of, so I'd probably say yes....I can remember one thing very clearly. My father came after a prize-giving and helped me get tucked into bed, and he gave me some of his lemonade and a few blocks of chocolate. I enjoyed that very much....I was really chuffed. He was really proud of me.
> **R:** And you knew he was proud of you?
> **S:** *Yes*! I could see from the way he was behaving....
> **R:** Do you think that your father was proud to have you as a son?
> **S:** It depends what frame of mind he was in. If he was feeling angry with me in particular, then he might not be.
> **R:** Did he tell you so?
> **S:** No, you see he wouldn't because he found it difficult to express his feelings, he didn't express his feelings very well....I could pick it up sometimes.
> **R:** Is there anything in particular that you know for a fact that he liked or disliked about you?
> **S:** Well, I think he'd be pretty sure to dislike me when I was crying or moaning or complaining about something. And then again, he might be pleased with me when I'd done well at school.
> **R:** So it was mostly when you were emotional, and when I say emotional I mean any emotion, that you felt he disliked you or disapproved?
> **S:** Probably so, yes.

Feeling self-conscious and too fat (age 10-11), Steve began a diet with his mother. He found it easy to keep to its restrictions and was pleased with himself for losing weight. His grandmother's recognition of this pleased him even further, as he felt he was making her proud of him, and he resolved to keep to it until he had reached an acceptable weight.

> **S:** I weighed 56 kilograms at the age of 11 so I was feeling obese....I started to feel very self-conscious....I didn't want to go to the beach any more. I just felt all exposed and fat, so I went on a diet and everything went along well. I started the diet in June and lost weight and when my grandmother saw me in August, that was the month she died, she saw and she was very, well, I'd say she was impressed and she congratulated me and all that.
> **R:** Did the family encourage you and your mom while you were on diet?
> **S:** I don't really remember, except for my gran. When she came down and saw how much weight I'd lost, she was *very* complementary about it and I felt proud pleasing her.

Notice how the primacy attributed to father as criterion image and role model is revealed in this case, where Steve is unconsciously modelling himself after his father. Steve perceives his father as not being a good adult role model which he can imitate. The fact that Steve believes that he too would

not make a "good" adult, indicates the identification with his father.

S: I want to opt out until the danger's passed.
R: Danger? One thing being exams?
S: Yes, and growing up. I'm scared of the responsibilities. I don't think I can handle the responsibilities of growing up. I feel that I've been so incompetent in the past that I won't be able to handle all the extra....Like being liable for one's own actions. Looking after oneself, not having parents to guide and support any more.
R: Do you think that if you had to grow up that you couldn't look toward your mother and other adults for guidance?
S: I feel I'd be expected to be more self-supportive, support myself, not rely on others to do everything for me because that is after all what children do....
R: So you don't see maturity as something that happens gradually?
S: I'd say physical maturity is more of a defined period, during adolescence. But like so many things, I mean there are some adults who don't behave the way adults are expected to behave. Sort of in the way a "mature" adult would, because there are certain standards one needs to abide.
R: It seems you have some idea of what an adult is, how an adult should behave.
S: I'm not actually sure how you should behave to be considered an adult, which is why I'm having trouble passing into that stage myself....
R: You've often spoken about your father's suicide. Do you have any particular thoughts about his death?
S: I suppose my first thought is it's a pity. He sort of wasted his life and again, we come back to the idea of being a better adult. If he had behaved more responsibly, that wouldn't have happened to him. He wouldn't have lost his job in the first place.

1.2.2.2 Child resolution

Nothing could have prepared Steve for the horrible disappointment which was to follow. His grandmother died after a short illness, leaving Steve devastated, empty, and longing to be with her. His feelings of loss and depression were perceived by Steve to leave him out of control and this feeling, (compounded by his inability to change reality and be back in time with his grandmother), found a focus in his body weight, which he desperately wanted to control. However, this too felt to be out of his control, as his intention was not to lose weight but to find a way of ensuring that he did not gain the weight he had already lost. Unsure of what was alright to eat and without the previous structure of his diet, Steve ate less and less and within a few months was hospitalised with anorexia; an incident which Steve understood as his father saving his life. (He reports that had his father not taken him to hospital when he did, he would probably have died because of his low blood pressure). After he left the hospital his relationship with his father deteriorated, as his erratic eating behaviour caused further conflict between them and was further aggravated by his father's drinking binges and his own inability to cope with his life. Steve continued to want to please him by becoming a perfectionist in what he did (his work and weight) and by trying to help his father overcome his unhealthy lifestyle (as he had just had a triple bypass coronary operation). However, this was only

met with disapproval and rejection, which Steve interpreted as an indication of his worthlessness and unlovableness.

> S: Things are very different around meal times now. Not like when my *father* was alive. He used to tell us that we supposed to shut up, which I didn't like very much....We weren't allowed to talk at the table. And when he was alive during my first bout of anorexia he used to go on about how long I used to take with trying to dish up and eat....I'd say now there's less of a sort of air of tension around than when he was around. There always used to be friction between he and I.
> R: How did you feel when he rejected your advice?
> S: I felt rejected that he thought my input wasn't any good, that he didn't care about his life at all.

1.2.2.3 Attitude to self

Steve's feelings of emptiness after his grandmother's death and the massive feelings of disappointment this incited in him (buffeted by the unsupportive and critical attitude of his father), reinforced the development of his belief that others could not be trusted and that his inner life needed to be controlled. In turn, his inner life became chaotic, as maintaining a silent, withdrawn posture towards his family left him with masses of unresolved feelings which he could neither understand, nor differentiate from each other. He strove for increasing levels of academic perfection and committed himself to controlling his body shape through the stringent control of his food intake. In the next example, it is revealed that anorexia became Steve's preferred way of dealing with, (amongst other things), his grandmother's death.

> R: On many occasions you've spoken of anorexia as your way of coping (interrupts)
> S: It's something that I'm so used to that I don't know what life's like without it.
> R: And as you've said before, there's a real fear that without it you would have nothing. That fear comes out quite strongly in the line of your poem, "as you hide from the world in your cold clinical jar".
> S: Yes, covering up his face and everything, so that nobody can see him, he can remain anonymous.
> R: It's also a statement that captures the sense you have about growing up, that you believe anorexia is one way of saying, "I don't want to be big. I don't want the responsibilities that go with adulthood". What are your thoughts?
> S: Well, the stuff about not wanting to grow up isn't my own idea, it's what I've been told and what sometimes seems to make sense to me. It's not my *own* idea.
> R: So you don't really agree with it?
> S: I'm not saying I *don't* agree with it. I'm just saying it's not my idea but I can see that it has some valid points. *I don't* want to grow up! I wish I could go back to when I was much younger.
> R: Because then?
> S: Well, to when everything was pretty much idyllic for me. When my grandmother was still alive.

In the next example, Steve speaks about his feelings of incompetency and ineffectiveness. In the second example it becomes clear how Steve links the controlling of his weight with the belief that it equals control over his emotional life.

> **R:** Have you ever tried to help yourself with your difficulties? What have you tried, and were you successful?
> **S:** I tried to take control of my life more and feed myself properly and *no*! I wasn't at all successful.
> **R:** Would you say that happens often?
> **S:** Yes, I feel generally that I'm incompetent. That I'm unable to deal with these big responsibilities.
>
> **R:** Do you think that you are fat?
> **S:** Sometimes I feel very fat if my clothing's tight. And sometimes when I'm gaining weight very rapidly, I'll start feeling fat as well.
> **R:** What does being fat or overweight mean to you?
> **S:** Losing control of myself. Of going back to how I was originally. I just don't like the idea very much....
> **R:** What specifically frightens you about being fat?
> **S:** Being more liable to have some sort of heart disease, arteries being blocked up. I just don't like the idea of being fat. I think people making fun of me as well. I feel self-conscious when I'm heavier.

His body shape became the single way Steve made sense of his difficulties and he became engrossed in trying to achieve an acceptable body image. His body image was not differentiated from his sense of self and instead, became the perceived source of his failure, incompetence, unlovableness, and unworthiness. In essence, it was the means with which he understood his rejection by his father, as well as his unacceptability to himself and the world.

This way of being continued for three years until Steve was 15 and he was to be grossly emotionally disappointed again. This time, with his father's suicide. Overcome with feelings of loss and disappointment again, and overwhelmed with conflicting emotions about his father (loving and hating him at the same time), Steve's sense of self encountered a rupture which caused him to regress to primitive states of being, bordering on pre-psychotic thinking at times and regressing to a child-like state. He desperately tried to contain himself by focusing entirely on his food intake but was soon to be hospitalised because of a dangerously low weight and low blood pressure. Feeling totally out of control (over his emotional life as well as his physical self), his mother had to assume many of his responsibilities. This has left Steve feeling both incompetent in looking after himself, as well as angered by his mother's intrusiveness and control over him.

He reports that he would like to remain a child, as he believes he will be unable to cope with the responsibilities which come with increased levels of maturity and adulthood. He cannot speak about

himself without contempt and despair at his perceived failure, in spite of his high intelligence and almost perfect academic record. Steve has assumed the image of a eunuch, where he can remain asexual and deny both his sexuality and the possibility of intimate relationships with the opposite/same sex. In this regard, his penis is regarded as a bother to him (the part of his body he hates the most), and which he has often attempted to hurt and destroy (by regularly hitting it against the bath and once pouring acetone over it), in the hope of being rid of it (see p. 284 for illustrative material).

S: I was 14 when I first found out about sex and I was totally horrified....It *still* horrifies me! I find it disgusting. Animal-like, demeaning process.
R: You don't associate it with pleasure or creation?
S: *No*! I see it as something purely animal.
R: So would you consider that all people are conceived in that way? Is that what you think of creation?
S: I just wish it could be done in some other way.
R: Do you have any ideas?
S: I don't know how to make babies any other way but I thought maybe we could assemble them from pre-packaged parts in a factory sort of situation.
R: Which would eliminate a relationship (interrupts)
S: All the unpleasant things, what I imagine, the puffing and panting. I don't even want to think about it....
R: So when you were told where you came from (interrupts)
S: I was horrified and I sort of resolved from then on I was definitely not going to get married. I've never been particularly interested in the opposite sex anyway.
R: So you've had no relationship with a girl?
S: *No*! Not at all.
R: And you don't want to ever have one?
S: *No*!
R: Because?
S: I don't want to get married and I don't want to reproduce.
R: Because you don't want to have sex?
S: *Yes*!
R: Would you say that's the main reason?
S: *Yes! Yes!*

At present, Steve is unable to perceive himself as an individual without anorexia. It has become both an entrenched way of life, as well as a means of identity. Without it, Steve believes he would have nothing, be a "no-one" and that the only thing which keeps him feeling special and taken care of, is the fact that not only is he anorexic but a male anorexic, which in his view, is indeed a rarity.

R: Do you feel that you are a person with special talents or abilities that haven't been recognised?
S: *Definitely* not. I'd like to be. I'd *like* to be something special which is maybe why I pale this anorexia, because it's something that makes somebody sit up and take notice.
R: Do you find that people sit up and take notice of you?
S: Well, they tend to see me and it's *only* because I'm anorexic. If I didn't have it then they wouldn't look at me or come and talk to me. Maybe that's also why I have to keep it, the anorexia that is, or else I'd have nothing. I don't have anything else....

R: Do you think being anorexic has affected your ability to form relationships with others?
S: I don't know. I don't have two separate existences, one anorexic and one not. It's one of those conditions that sticks like a plaster....I use my anorexia in an egocentric way...it's attracting attention to myself by being fragile, by falling asleep in class for the umpteenth time and by being taken to sick bay for the umpteenth time....
R: How does it feel knowing that you are in a very unique category because being a male anorexic immediately casts you into a special group of people.
S: I feel very egotistic about it. Very self-centred about it.
R: Can you tell me a bit more?
S: Well I'm attracting quite a deal of attention to myself just by being so unusual. And by being, well everyone else says I'm thin. So I'm attracting a lot of attention to myself....
R: How would you finish this sentence: because I am a male anorexic...
S: I'm a rarity. Although, with the recent goings on in the world of anorexia, not so much any more....Life would be very different without anorexia. I don't know. Maybe I'm too scared to let go of something I know and take on something else.

He craves admiration and approval from others, especially from his younger brother and mother. His brother has now become the most significant person in his life, someone whom he regards as almost perfect and someone whom he both idolises, envies, and hates (because of his ability to do things easily), and he aspires to being like him. Because Steve experiences himself as incompetent and ineffective in controlling his life, he has found in his brother a model which he would like to imitate and through that, find recognition. In this regard, Steve has been through periods of imitative behaviour where he would follow his brother and copy his every move, all in an attempt to learn to be like him (indicating his regressive behaviour to a child-like state).

R: Do you think that being anorexic has contributed in any way to your feelings of wanting to die?
S: If I wasn't anorexic I think I wouldn't have so many problems with growing up. I think part of my anorexia, as I've been led towards thinking, is because of my fear of growing up.
R: You've been led towards thinking? So you don't agree?
S: No, in discussions I do agree with it. It sort of seems to make sense to me....
R: So you don't think you'd have thoughts of wanting to opt out if (interrupts)
S: If I wasn't anorexic. Because of the problems, the underlying feelings with anorexia of inferiority, low self-esteem, lack of self-confidence, fear of growing up, that crops up again, and a bit of jealousy as well for my brother, that I'm not as good as I perceive him to be, although he's not perfect I've come to realise....
R: Do you want to tell me a bit about your brother?
S: I'd probably say I've had what might be described as a love-hate relationship. I idolise him and at the same time I'm jealous of him and resent him for the things that he seems to be able to do that I can't do, for the fact that he's much more active than I am, that he doesn't take as much time to learn something, that he can write quickly and neatly at the same time, that he can write as quickly as he can because I can't write as quickly as he does and it stands him in good stead in the exams....He knows when things are polite and when they aren't polite. He's bright, he does well at maths and he's able to get on with others. He knows the right things to say, he's eloquent.
R: Are you comparing yourself to him when you say that?
S: I *do* have a problem with that, yes, that I do tend to compare him with myself and that makes me feel very inadequate because I don't feel I have any of those things.
R: Do you think very often about achieving great things, such as being very successful,

powerful, brilliant?
S: *Oh yes*! I do. I often sit and daydream about myself being something marvellous or fantastic....Being like Albert Einstein or doing something really famous and doing something wonderful for humanity, with approval from my brother or my mom, so *everybody* would be proud of me...being able to provide and buy things for my family....
R: How are you affected by what other people think of you?
S: Sometimes if they were to think things about me that I sort of don't really care about or couldn't care a hoot about, it doesn't affect me. But sometimes, if it's like my brother, I mind very much what he thinks about me. I always try to win his approval and I'd like to know that he approves of me or thinks something I've done is worthwhile.
R: What type of things would you do to gain his approval?
S: Write a good book review that he might be able to read and find that there were some good points in it or write a poem that he thought was good....
R: What happens if you don't get a positive response or don't get the approval that you wanted?
S: If I get a cool reception, if he just says, "oh, it's okay, it's alright" then I feel dissatisfied. I feel he's not really interested in me. Let down, disappointed in myself, that sort of thing.

Since his father's death, Steve has wavered between life and death, his low weight a constant threat to his well-being. He is unable to attribute his feelings or thoughts as the outcome of situations, constantly vacillating between making external attributions and blaming himself. In this regard, although he is able to see that each time anorexia has followed a death of a significant person in his life, he is unable to correlate the significance of those disappointments as being of any relevance to him.

S: I was teased by others and called names occasionally, but I remember also feeling intensely self-conscious, especially as I got older. I didn't want to go to the beach. I didn't want to put a swimming costume on and I felt perhaps that I was fat.
R: When did you first start to feel self-conscious?
S: I suppose age nine, 10, early 11. I can't pinpoint it but I wouldn't say younger than nine.
R: So up until age nine, what do you remember of your childhood?
S: Idyllic. Everything was idyllic, spending time at my gran's house.

Notice how anorexia followed the death of grandmother.

After my gran died I seemed to be eating less and less. If my mom brought home fudge or biscuits I wouldn't want to eat proper food. I'd skip my food so I could eat half a piece of fudge....Eventually I was hospitalised with anorexia. This is also when the depression started to affect me.

And how anorexia followed the death of father.

Towards the end of that year my weight started dipping. I started feeling self-conscious again. Somebody told me at one stage earlier that year that I should be careful not to eat too much otherwise I'd get fat. I started feeling that I was just eating impulsively and not actually worrying about the amount of food I was having, whether I was taking too much in proportion

> to my degree of activity. And my weight started to drop again....With the loss of weight came a great deal of depression. The following year started out a very tough year for me. Firstly, well anyway, my father had killed himself sometime then, and that was quite a big shock for me, *not* that I cared much about him because I *didn't* love him. My gran's death came as *more* of a shock to me.

However, Steve is unable to connect external events with the impact they make upon him, which reveals an uncertain attribution style.

> S: I was very close to my gran, her death shook me quite a lot. It seems funny that on both cases anorexia followed after a death in the family. I'm not saying there's any connection, just that it's an interesting coincidence....The first time was after my grandmother's death and the second time came several months after my dad committed suicide....There might be no interconnection whatsoever, there might be something more subtle....
> **R:** You said that soon after you finished the diet something happened.
> S: Yes, the year after my diet, the year after my grandmother died, I eventually became anorexic....
> **R:** Yesterday you told me that after each death, anorexia followed (interrupts)
> S: Yes, but I don't necessarily see any connection between the two.

1.2.2.4 Attitude toward reality

Steve's sense of self has always been, and still is, derived from the assessments he makes of having fulfilled others' expectations of him; his grandmother's and his father's when they were alive and now his mother's and his brother's. In the following narrative, notice how Steve's sense of self is inextricably bound to his mother's opinions/appraisals of him and the impact they make on Steve.

> **R:** Would you say that your mom is compassionate to your struggle, that is, to your concerns around food?
> S: Yes, I do think she cares quite a bit. I feel sometimes she has despair about me and she worries about me a great deal. I sometimes think I'm never going to get better because she gave me the impression again yesterday and she said, "it doesn't even look as if you trying at all". And whenever she goes at me like that I pick on her driving.
> **R:** How does it leave you feeling? Do you fight with her or do you agree?
> S: It makes me feel, "ugh, I don't want to fight with you. I'm going to have to dig up the driving thing because you using something against me and I'm going to have to use something against you now to make it fair". I know both ends are unfair, picking on one's weaknesses.
> **R:** So you feel she's picking on a weakness?
> S: Yes.
> **R:** And the fact that she doesn't believe in you?
> S: She doesn't believe in herself either.
> **R:** Do you believe in her?
> S: No, the driving's become a family joke almost. And in case you going to ask this question, I often sometimes think well, I'm never going to get out of anorexia.

His experience of the world has been limited by: (1) his asocial behaviour (he is rude and critical of others and has never formed any attachments or relationships besides those with family members), and, (2) the two massive emotional disappointments of his grandmother's and father's deaths. In this regard, his social behaviour is determined by his belief that the world/others are disappointing and never to be trusted, and that there is no point in becoming close to anyone because they will surely die and leave him, or reject him.

> **S:** It isn't easy speaking about one's inner feelings, the *deeper* ones. The one's that are so entrenched, sort of sitting in their little trenches, not wanting to get out....I find it difficult that anybody could care about me or be concerned about me because I don't like myself very much. I know that if I had to deal with somebody like me I would have left them long ago, given up on them.
> **R:** Well, maybe you can get some hope that some people aren't going to leave you.
> **S:** I find that difficult to understand.
> **R:** And that maybe the only person who's left you is you. Do you know what I mean? That in some strange way it's *you* who's not wanting you.
> **S:** I don't like me, yes.

He is also of the opinion that no one would understand him, (as he does not understand himself) and that others have no interest in getting to know him besides in treating his anorexia. At the same time, this is buffeted by his own claim that he is disinterested in people and has no desire to make friends or form intimate relationships with either men or women. On the one hand, he desperately needs to feel approved of and acceptable to others, their recognition of him giving him a temporary feeling of self-worth, self-confidence, and self-esteem. Yet, in spite of their compliments to him, whether about his academic performance or his physical attributes, he is unable to integrate their praise with the image he has of himself as a failure. On the other hand, a lack of recognition and any criticism of him, is immediately experienced as disapproval and a further indication of his worthlessness.

Steve's overall attitude toward reality is that it is deceiving and disappointing. In this regard, he mistrusts his mother and his psychiatrist (who have assumed control over his physical self by feeding him), as he believes they are going to trick him and make him fat. Further, he believes that his cure lies outside himself and that it is up to those helping him to make him better. On an emotional level, Steve is unable to share intimate parts of himself with his psychiatrist, and as with his mother, their relationship remains on a superficial level, centred around monitoring and controlling his symptoms. Steve is afraid to tell his doctor certain things which he believes would have serious repercussions for him (e.g., he would be restricted or hospitalised). On an interpersonal level, because of Steve's blurred sense of self, with few boundaries separating him from others, he is likely to assume what others tell him (primarily his psychiatrist) about himself as the truth, instead of playing with the ideas

presented to him as possibilities and arriving at his own opinions. The following example reveals this feature clearly and thus is presented at length.

R: Do you think you are any different because of the anorexia?
S: I'm still tied to my mom's apron strings.
R: In other words, because of anorexia you are closer to your mother?
S: Yes.
R: Can you define what you mean when you say you're tied to your mom's apron strings?
S: She has to do things for me. She'd tell me what to eat and how much.
R: But most mothers do that with their children, when you a child you depend on your mother for a lot of things still.
S: I'm tied to my mother's apron strings.
R: You say that with conviction.
S: I *do* depend on my mother too much. I'd think you'd understand what I mean by that.
R: I don't really, because I know I depend on people for different things and I'm not sure what it is you depend on your mother for that makes you say you depend on her too much.
S: I think I'm being so perfectly clear that I can't see now how to explain it.
R: I think we all depend on someone to a certain extent for certain things.
S: I don't know. It's things like I don't know how much is okay to eat. I need her to tell me.
R: Okay, so it's around food....
S: Can we get on with something else? This is starting to irritate me because I'm convinced that *my* view is right and you are convinced that *your* view is right.
R: And what is your view?
S: Would you like me to get a dictionary for you and define what being tied to apron strings means?
R: I'm asking you what your understanding is because I know for a fact that it was your psychiatrist who told you those very words because I was present when he did....He told you in exactly the words that you are using now, that you are still tied to your mom's apron strings. I'm just wondering whether you agree with him and if so, on what grounds, and what you think he meant by it.
S: You're confusing me now because I don't *know* what to think. Any 18-year-old who still goes round to their mother and asks them whether they've got enough food in their plate, whether they can do this or that, you know, boys my age don't do that sort of thing. I'm abnormal in that sense.
R: So you can see it in terms of being particularly dependent on your mom around food because of anorexia?
S: *No*, because Dr Fern has used that term. He said that I'm still tied to my mom's apron strings, and that means just *that*.
R: I'm not convinced that you are totally dependent on your mother for everything.
S: Dr Fern convinces me because he says it's logical. He tells me to be logical. He tells me to say what I don't want to say.
R: He's getting you to say what you don't want to say? He tells you what you're feeling even if you are not?
S: He *does* tell me what I'm feeling. You're making him sound quite corrupt now.
R: What I'm trying to say is (interrupts)
S: You also telling me what I feel now.
R: Am I?
S: Yes.
R: I just think that what you're saying is important because Dr Fern is telling you things and you just believing them because he's your psychiatrist.
S: That's right, he's my psychiatrist and he makes sense.
R: Does it all make sense to you?
S: *You, you* telling me they don't make sense?

R: Okay, you tell me that I don't make sense. All I'm trying to do is make you see that you don't have to believe everything you are told about yourself without questioning it.
S: I'm talking about food.
R: Okay, we can agree that on that level you do depend on your mother to tell you what to eat, how much, when.
S: That's what I said.
R: But I also think there are some areas where you are self-sufficient which show us that you're not completely dependent on your mother....There are people in psychiatric hospitals who don't know when to go to the toilet and who need to be reminded to go.
S: I didn't mean that I didn't know when I had to go to the toilet....To me, being tied to someone's apron strings doesn't mean complete and utter dependence in everything....I can take myself to the toilet, but on an *emotional* level, I'm tied to my mom's apron strings.
R: In what way?
S: I think it's something so perfectly simple. It's just something that is. You seem to not understand because I'm confused because I can't see *why* you don't know what I mean.
R: I think we each have an understanding of concepts which is personal, which means what something means to me isn't necessarily how you would make sense of it....I don't think there's one shared understanding of concepts that's right and it's okay to agree to differ.
S: Well, I apply it differently and *I am* right....I'm really getting quite irritated with you, I think we're off the point.

In the next example, the profound uncertainty Steve experiences about who he is, is revealed.

S: I won't say I was trying to lose weight deliberately. I don't think that I was trying to kill myself deliberately despite what Dr Fern might say that I make a conscious decision.
R: Is that what he tells you about it?
S: He says that *I* decide still....He seems to think that I'm doing it out of sheer vindictiveness and maliciousness.
R: So you will not eat for some vindictive reason towards someone else or toward yourself?
S: Dr Fern says I want to hurt my family, that I want to cause them misery.
R: But isn't it your life?
S: Of course it is.
R: Do you tell Dr Fern that it's your life, or do you believe him?
S: Don't keep questioning him! You are making me all confused....
R: Are you uncertain about what kind of person you are?
S: I'd say yes, as in when you asked me how I'd describe myself. I sometimes find it difficult to actually sit and quantify that and say, "I'm this and this". I find it particularly difficult to actually speak about how I perceive myself because I'm not sure.
R: Are you uncertain about your long-term goals or career plans?
S: *Definitely*! I haven't got a clue what I'm going to be.

At this point, Steve has joined an eating disorders programme as an in-patient, where he is expected to remain for the next six months. He is left with the profound sense that he has no idea who he is (besides an anorexic) and thus is lost as to what direction he would like to follow in terms of a career.

1.2.3 Case three - Maria: Sense of self

1.2.3.1 Identity development

A reconstruction of Maria's developmental history reveals intrusive, ambiguous, and controlling patterns of attachment. Although an atmosphere of freedom and expression is advocated within the family, at the same time, there exists oppression, controlling, and rejection. Maria's preferred figure of attachment was her father, as he was the one she was closest to and the one from whom she derived emotional and physical contact. He not only spent a lot of time with her, he also displayed a preferential attachment for her. From a young age Maria believed that her father was 'God', the one who provided the family with material and emotional gifts, the one who was the strongest and most powerful, and it was only within his presence that Maria felt secure and in his absence, felt empty and lost.

At the same time, her mother's obsessive nature in wanting to mould Maria into the perfect daughter by controlling her weight, appearance, and intelligence, functioned to strengthen Maria's preferential attachment to her father, the only one she believed accepted and loved her for who she was. Because she believed her father was God, (that he was perfect as well as infallible), Maria wanted only to please him and keep him happy, thus making him the criterion image and role model for her self-development. Up until the age of six, Maria did not question her father's acceptance of her and because she believed so strongly in this she did not pay much attention to her mother's critical attitude towards her (which had begun when Maria was three-years-old). However, after the age of six when the family emigrated to Europe, with her father frequently away on business trips and her mother becoming increasingly restrictive and critical of her, Maria's self-boundaries became weaker, alternating between being externally bound (by her mother's evaluations of her, and her father's when he was present), and internally bound (by becoming increasingly self-sufficient and independent). Because of her mother's intrusive and critical attitude, where she assumed control over Maria's life, Maria experienced herself as impotent, powerless, and incompetent in exerting any influence over herself or her mother, as her feelings were always disregarded. In the following narrative, (see next page), Maria describes her mother's obsessive need to mould her children into what she (mother) perceived was acceptable. At the same time, the significance mother attached to how the world would perceive her family, is made clear.

> If there was a big dance coming up on a Saturday night, my mother's last meal would be on Friday lunch time. *And* the worst thing was that she used to force my sister and I to starve too, so that our stomach's don't stick out....We'd have to starve ourselves to death so that we'd go to the ball and our stomach's wouldn't stick out. And we weren't allowed to drink water either because water makes you bloated and full.

Her mother would not only criticise and overtly reject Maria's appearance and body shape, she would also negate and dismiss Maria's emotional life as irrelevant and less important than her sister's. Maria thus withdrew from her and consciously made an effort to keep her inner life secret from her mother. Further, her mother would constantly tell her that she (Maria) was not capable of loving, hence her feelings and thoughts were not as real as her sister's or her's (mother's). This functioned to keep Maria believing that her father was the only one who understood her (and thus kept Maria preoccupied with wanting to preserve the relationship between herself and her father).

> **M:** I never disagreed with my dad, I tried to avoid arguments because I hated bad vibes between my dad and me, so it never used to happen.
> **R:** Whereas with mom?
> **M:** We used to have it often, fight a lot. I feel that I constantly used to fight for myself, for my identity, for who I was.
> **R:** What would be an example of what you've just said?
> **M:** I used to try and fight and tell them that I *do* love them, try and fight and tell them for example after I broke up with George, that I *did* love him. Fighting, fighting, fighting, to let them know that I loved this man. It's not because of *me*....Fighting to prove my innocence and the truth. It never used to work though. They never used to get convinced of it. And when I say, "they", it's my mom and my sister. It's never my father.

1.2.3.2 Child resolution

Maria remained totally focused on her father and with pleasing him (age six to ten). However, soon after she started school Maria began to experience problems, especially with maths. It was then that she was to discover that her father was not all-accepting of her and that he became angry and disappointed with her inability to perform at school. Suddenly, 'God', her 'God', would scream at her and give her hidings when she could not understand his tutoring and this was something that Maria was not able to integrate with the image she had of her father as a warm, kind, secure presence.

Most importantly, her parents began to question her intellectual ability and tell her that she was stupid. And, her once perfect father, was seen to side with his wife against her and to display a personal weakness in allowing himself to be swayed by his wife. Maria started to believe she was stupid and the resultant feelings of inferiority, lack of confidence, and low self-esteem became part

of her self-concept. The disappointment in her father was something that Maria did not actively discover, instead was imposed on her (because of her developmental age), and overwhelmed by her feelings of worthlessness, stupidity, and disappointment, she resolved to work even harder to prove herself to him. From this time onwards, Maria began to include her mother's criticisms of her appearance and intelligence as further indications of her incompetence and unworthiness.

> Here was this daughter. I started feeling stupid and my family started feeling I was stupid too. My parents started doubting my intelligence. I keep on hearing this word in my head, "kouti" which means stupid....I started becoming very complexed about myself....My report would come and my parents would say, "what's *wrong* with this child? What are we going to do with her?"....I became very depressed. I used to think, "*why* can't I do it? *Why* can't I be like the other kids? *Why* can't I be like them?" I was always compared to my sister. "*Why* was this one so good and this one was not. What did we do *wrong* with this kid?"....I started believing that I was stupid. I started believing that there was something wrong with me.

During the four years spent in Greece, although horribly disappointed in her father, Maria became even closer to him, desperate to be with him and clinging to him all the time. It was almost as if she both knew and did not know about her disappointment in him, as on one level it appears she chose to overlook it and instead, become totally dependent on him for her emotional security.

1.2.3.3 Attitude to self

When Maria was 10-years-old the family returned to South Africa and soon after that, Maria began to experience problems at school again. Her feelings of disappointment in her father and her mother's blatant rejection of her, led her to two decisions: (1) that she would work very hard to prove herself to her father (and **only** her father, as it was his opinion which mattered), and (2) that she would remain distant from her mother and not reveal her inner life to her, as it was only ever met with dismissal. She also began to wonder whether their rejection was as a result of her questionable inner life, (maybe she actually did not know how to love) and so she resolved to keep herself distant from them. The lack of confidence in herself functioned to keep her preoccupied with her father and with achieving the image she perceived him to want of her. Although their relationship continued to be warm and open, Maria began to hide the parts of herself which she believed would reveal her to be inconsistent with the image she projected to him; that she was not as clever as he wanted her to be, that she felt inferior and unacceptable because of her body image, and most importantly, that expressing her feelings would make her appear less strong and "together". Her solution was thus to strive for perfection and to hide those parts of herself which she perceived to be unacceptable.

> **M:** When I have a family of my own I want to be with my children a lot of the time, like my parents were with us. Knowing every single phase of my parents, and they knowing every single phase of mine.
> **R:** Did that ever bug or irritate you, knowing everything so intimately about each other?
> **M:** As I said earlier, I was always closed up about important things, so they never knew me intimately.

At the age of 12, Maria turned her attention and energy towards changing her body shape, as this was suddenly seen as the source of her feelings of inferiority, as well as her mother's rejection of her. She came to believe that if she could be thin she would not only rid herself of her painful feelings (of being stupid and inferior) but would also manage to attain the acceptance and approval she longed for from her mother, as well as maintain her relationship with her father.

> We came back to South Africa....not long past before I started having problems at school again. I started feeling stupid and inferior. And I also just could not fit in with this mould of the skinny South African child....*That's* when I started feeling fat. I could see the children around me were much thinner....And *that's* when the binges started....I was never comfortable with my body and I was constantly trying to diet.

Thus began the cycle of starving-binging-dieting-starving...a vicious cycle which continues to the present. Her diets are short-lived as Maria gives up, believing she is a failure. Her lack of dieting success (she seldom loses weight, and ends up gaining weight after a diet) is attributed directly to herself, someone who she perceives is weak, has a problem, lacks self-control, is inefficient, and unreliable. Being fat and thus unacceptable has become the central focus and means by which Maria makes sense of her self and her difficulties.

1.2.3.4 Attitude toward reality

From childhood but more intensely since adolescence, Maria's sense of self and well-being was derived from the assessments others made of her and the extent to which she perceived herself to have fulfilled their expectations. Up until the time Maria was married, she engaged in numerous heterosexual relationships where a common pattern emerged: the relationship was going well but in Maria's view was not maturing as she wanted it to (no physical demonstration from her partners towards her). Almost always, the relationship was terminated by her partners and Maria made sense of its completion by believing that it was because she was not attractive enough and too fat. Hence she would resolve to diet to make herself more attractive and appealing to men, only to find that the same pattern would repeat itself. See narrative on next page as an example of this feature.

> Peter was the first serious boyfriend I ever communicated with. I could see that he appreciated me for me...and that gave me confidence. But it also destroyed me because when I used to feel something's happening, something would happen to show me he's *not* interested in me....He just never made a physical move on me. First I thought it was because he wasn't ready....Then I would express my interest in him and *still* he wouldn't make a move. He wouldn't respond to me and I started losing confidence in myself. Losing confidence in the way I look, my sexuality. I believed that I'm fat and that's why he didn't like me...he broke me down completely. I felt terrible about myself. He didn't want me and I used to wonder, "but *why*?" I believed there was something wrong with me, with my brain, with my body, with everything.

After she met and married her husband, Maria's attachment behaviour slowly came to include intimacy, where she was able to share her most intimate thoughts and feelings with her husband and feel completely accepted. Soon afterwards they moved to an isolated town because of her husband's job and there Maria was separated from all her family and friends. For the first time, she was left to deal with the emptiness she had always felt inside but which magnified greatly at this time. She began to eat compulsively (as food gave her a temporary feeling of fullness), binging whenever the opportunity afforded itself and soon gained a large amount of weight. Her feelings of unacceptability and inferiority resurfaced, affecting her relationship with her husband on both a sexual and emotional level. Maria began to hide from him, no longer taking the initiative during sex and feeling that she was repulsive and unattractive to him, even though he reassured her that this was not the case. Most importantly, Maria needed to tell him each time she had binged as his "forgiveness" allowed her to feel normal and not crazy. In fact, Maria made him responsible for her weight and her happiness by believing that it was his disinterest and not controlling her which left her so out of control; a common conflict situation between them which has only recently begun to change, as Maria realises that she is the only one who is responsible for her well-being and hence, the only one who can exert control over herself. Because of her husband's own difficulties with emotional intimacy, Maria's need for constant reassurance is often neglected and she becomes withdrawn and turns to food for comfort.

The importance Maria attaches to others' opinions of her is of such a great nature that it can be said that she either 'lives or dies' at their mercy. Her life centres around whether she feels others approve of her, and more often than not, she feels disapproved of because of her weight and appearance. Although by nature she is open-minded and comfortable to discuss any issue with her friends, that which causes her the most pain and suffering (her weight and feeling stupid), she is unable to share with them. This is because of her belief that she has a certain image of herself which she presents to them which she feels obligated to uphold (that of being a strong, together person), and thus if she were to reveal her true nature (as someone who struggles with her weight and body image, feelings of inferiority and worthlessness), she would be both disappointing them and revealing a self which

would be unacceptable and rejected (the same belief she holds with her father). From a position of minimal self-revelation, she engages in efforts to secure their recognition and approval, and it is through their (and the world's) recognition of her efforts, that she derives a sense of self-worth, confidence, and esteem.

> Standard nine was my best year at school. I became a prefect...and my parents were proud of me...I was their star. I always had problems with school marks but I satisfied them in other ways, like I made them proud. So they used to say, "this child doesn't study" but on the other hand they would be very proud of me and tell everybody about me. And *that* made me feel good.

At present, Maria's sense of self is almost exclusively derived from the outside. The two most significant people who's opinions she regards as crucial for her well-being, are her father's and her husband's. And, in spite of her academic and community achievements, she constantly seeks their reassurance and admiration and still feels the need to prove herself to them. Maria's need to feel accepted by her mother continues to exert a major influence on her life, although they now live apart. In this regard, much of Maria's present behaviour is a reaction to their past (and present) relationship. Maria blames her mother for her eating disorder as she believes it was her mother's obsessive nature in controlling her daughter which has resulted in her (Maria's) present obsession with food. A lot of unresolved anger towards her mother finds expression in her binges; and her present perceived lack of control over herself is fuelled by her feelings of always having failed in her mother's eyes and never having reached a point where she was acceptable to her. She thus abandons herself at the first hint of feeling she has failed.

Maria's self-boundaries are blurred and constantly fluctuate between being internally and externally bound. In the case of being internally bound, she experiences herself as ineffective (in asserting control over herself or her situations) and is overwhelmed by feelings of emptiness (which she attempts to fill with food). And in the case of her self-boundaries being externally bound, she experiences herself as inferior, unacceptable, and always, too fat. The following example reveals this point.

> **R:** How do you think other people would describe you as a person?
> **M:** I think they'd find me funny, quite animated. I enjoy acting things out and being quite an extrovert....They'd find me fun to be with, loving, but there would be something about me which they wouldn't quite....They would see me so together, I make out to be so together and extroverted and talk about things, but then again, I have a weight problem which is indicative of something else. So I think they would say all these things but part of them would not be sure what is going on in my head.
> **R:** So they would describe you as loving, as an extrovert but also as someone that is

overweight?
M: Someone that is overweight and *that* is indicative of some secret thing. Some other side of me.
R: A good side?
M: No, something bad. Another side of me which is negative. They would say for example, "she's a fantastic person, so much fun to be with, but overweight. *Why*?"
R: Which means what?
M: Something's going on, or why does she eat so much? She's not all she makes out to be....
R: So you get on better with people that aren't tuned in to outer appearance?
M: Ya, absolutely. I actually would like to look out for people that aren't because I feel they going to judge me less, because of my outward appearance.

Maria's wavering sense of self is further revealed by her uncertain attribution of causality (or the shifting of responsibilities from the self to the outside world), which constantly fluctuates between external (blaming her mother, husband, or society for her present predicament), and internal attributions (blaming herself for her predicaments). Further to this, Maria reports that she wants to be loved for who she is and not because she is either fat or thin. However, in her accounts about why she is dissatisfied with herself, it is only the physical aspect which is mentioned, that she is too fat.

R: Do you think societal pressure to be thin has contributed in any way to your problems?
M: *Absolutely*! You feel it every time you walk out of your door. You feel it every time you walk in a shopping centre. Every time you try clothes on at a shop and they don't look nice on you, that's society's pressure. If clothes don't look nice on you, you cannot go out with those because people will just not accept you with these clothes. Your legs aren't as thin as they should be to wear those clothes. Going out to a party, to relatives, that's society's pressure on you. They look at you up and down and tell you you've put on weight, they comment on what you're wearing. Society's pressure by paging through Cosmo or Vogue magazine and every single page has a stunning, perfect woman. You're obviously going to compare yourself to that woman all the time. So by the time you turn the back page over, you are ready to go and shoot yourself.
R: Is that how you feel?
M: Yes! I also want to be like them but I'm not. And *this* is the ideal woman. This is the woman that the world presents to itself. The woman that the world loves and you are not like that. So, therefore, you're not lovable, you're not successful, you're not how you supposed to be....
R: Would you say you've been conditioned to think that way?
M: Yes, in my family by my mother....I myself don't think of myself as good enough unless I look like that woman in Vogue magazine which a male wants to look at.
R: So even though the two most important men in your life, your father and your husband have accepted you as you are, it's still not good enough?
M: No, because the world doesn't accept me the way I am. Because I don't conform to the Western world's standards. And *that* matters the most. And I find that very sexist.
R: How does this leave you feeling?
M: I wish I could just revolutionise myself and just say to myself, "this is how I am. I'm a fat person and I want to go swimming". I should be able to put a swimming costume on and go swimming and not get looks from people like, "oh, that fat person should not be swimming...should not be eating, should not be running. Should not live and exist! Must just die, just disappear from the world".

R: Are you right?
M: I am right. That's how the world is and it makes me very angry.
R: If you could say something to the entire world, what would it be?
M: I'd say, "yes, I'm fat. You do not accept me the way I am but my fat does not stop me from giving you my talents and who I am. Being fat does not stop me from talking on the radio. Being fat does not stop me from being your friend. In fact, it makes me a better friend. And I'm going to live and exist the way you do". I don't see why I'm not allowed....You see little children looking upon a fat woman and having less respect for her. Why? Why? Why are fat children teased at school?
R: ....What do you think of thin people?
M: I find them very lucky. They can do many things that I can't do, physically and mentally.
R: What type of things physically?
M: They can put on a costume and go to the sea and swim...I am not going to do that. They can put their shorts on and go jogging. I am not going to do that because I get embarrassed. Mentally, it gives them confidence and they present themselves in a certain way.
R: Would you say all the thin people you know are confident?
M: No.
R: So what do you think about that theory then?
M: I don't think they are all confident but on the other hand, I say to myself fat people are far from being confident. I don't see many fat people being confident, whereas I see many thin people being confident....Being fat makes me look unacceptable and ugly and alienated from the world. It causes so many problems in my life.
R: How would you describe yourself as a person?
M: ....I think I give a lot of love and care, and I enjoy caring for people very much. I'm weak in that I'm overweight. I find that as a weakness.
R: You're weak because you're overweight?
M: Yes, and I don't have confidence in myself and who I am. I'm not very assertive. I don't believe in me as a person.

Maria experiences uncertainty about who she is. Similarly, although sure about what she does not want to be, she is at an impasse as to what she wants to do in terms of a career. Although she has a university degree in teaching, she only did this to pacify her parents but is not happy with teaching, as she is open and vulnerable to public criticism, and it is criticism which devalues her and leaves her feeling devastated and not good enough. An example follows below.

R: Are you uncertain about such things as what kind of person you are?
M: Yes, sometimes I feel I'm a contradiction and I show one side and then I feel another or I have conflicting emotions in me. So I'll say, "I hate this but I also love this". And I think, "but *who* am I? *Surely* I should have an opinion"....In terms of a career, I don't know what I'm supposed to do in my life. I have a very strong feeling that I'm supposed to do something, that I am made for something but I haven't found it yet. And that confuses and upsets me. It's one of the most tormenting things in my life. The fact that I have not found what I'm meant to do.

1.2.4 Case four - sense of self.../...

1.2.4 Case four- Angela: Sense of self

1.2.4.1 Identity development

Angela's developmental history is characterised by enmeshed, overprotective, and inconsistent patterns of attachment. Within this environment, she formed a preferential attachment with her father, as he was the one who was always accessible for physical and emotional affection. He not only spent the most time playing and teaching her, he also displayed a preferential attachment with her. From a young age, Angela perceived him to be big and powerful, a "good force" who was perfect in every way, and who she believed was a very important person. He became her role model and the criterion image from where she derived a sense of self. After she started school, Angela realised that the way of maintaining her attachment to her father was to please him by doing well at school, as he made it clear that he would not tolerate failure, and to be selective about her emotional expressions, as he did not tolerate any expression of anger. In essence, she constructed a self-image based on what she perceived her father wanted her to be.

> **R:** Was it important for you to do well at school?
> **A:** Ya, my father would be very upset if I didn't.
> **R:** Would *you* be upset?
> **A:** Ya, but I always thought my father would be very upset....I just had to be perfect....I was always very much for my father. I would always say to my friends, "oh my God, my dad's going to shit himself, these marks are terrible".

Within this strict, overprotective, and punishing home environment, where self-expression had to be controlled and individuality repressed, Angela's self-boundaries were constantly fluctuating between being externally bound (by her father's evaluations of her), and internally bound (by maintaining a controlled attitude over her emotional life). Angela developed the profound sense that her emotions only caused her trouble and because they were incompatible with the image she portrayed to herself and to others, (as someone unaffected by emotions and always happy), she would suppress and disregard her emotional life. This was further compounded by her belief that she would become as emotionally unstable as her mother was if she were to incorporate her inner life with her self-image. Instead, she focused her attention and energies on pleasing her father by achieving at school and on the sports field, where only perfection was acceptable. Her sense of self (self-esteem, self-worth, self-confidence) were dependent on and derived from the recognition she received from her father and as long as she maintained her performance, she felt special and approved of by him. See example on next page.

R: Is there anything you know for a fact that your father liked/s or disliked/s about you?
A: I'd say he liked my determined spirit, my attitude and outlook on life, although as I said yesterday, it wasn't *really* what I was feeling. I'm not sure exactly because I've got this facade. Like I never used to be upset, never unhappy. You know, say I was really feeling down and someone said, "gosh, what's wrong?" I'd think, "well, I'm not any different to the way I felt yesterday, it's just that yesterday I put on more of an act". I'm trying to change that now but I still catch myself saying to myself, "just make *sure* you don't revert back to if you aren't feeling great just acting great". And also, I felt that it was too much of a hassle going through the whole thing of telling someone. My father kind of encouraged it and I acted it out because I knew it made him happy.

1.2.4.2 Child resolution

When Angela was ten-years-old, her grandfather and uncle both passed away and her father assumed the responsibilities of administering their estates and relocating their families. At the same time, her mother had an emotional breakdown and was hospitalised. It was at this point that Angela was to be horribly disappointed and to discover that the image she held of her father was distorted. Because of his preoccupation with family matters, Angela was suddenly faced with not being as important or special as she thought she was to him, as he no longer approached her or spent much time with her. More than that, she suddenly saw her father distraught and unhappy, not the strong, happy man she was accustomed to (the good, strong force that she had believed could make everything alright, was suddenly revealed to be fallible and imperfect). During this time, Angela reports that she became inexplicably angry with the world and her family. She became hard and rough, living out the role of tomboy to the fullest. (Here is revealed the structuring of a self-image based on self-sufficiency and control which Angela has only begun to shed in the last year).

A: I used to be very sort of withdrawn as a child...I was very shy. I don't know what it was and I don't know if I was already thinking that this is just not the way to be, but I went through a drastic change where I was full of life. I didn't shut up for any one, my mother had a hell of a time with me....It was a really bad year for me....I would say I was unhappy then....I was a real little bitch. I was a real tomboy. I would play with the guys and I would beat them up. I don't know. I was really angry and I don't know if I was angry at myself for being so meek and mild before....I don't know why the change. I went through a *hell* of rebellious stage. I wanted to drop needlework and take woodwork....I think I was like rebelling against my own sex....I was rough, always pushing guys around, utterly bitchy to females....At high school I was called "butch". But I brought that on myself, I'd say "I'm so butch" and carry on about it, live it out to the "t".
R: Meaning what, that you're tough?
A: Ya, "don't give me bullshit". Also, it was the way I actually portray myself. I wasn't into anything feminine and even if I liked something that was remotely feminine, I would act as though I didn't. I'd always been a tomboy so I had to keep it up.

And, for the first time, Angela's academic performance was affected, almost failing her standard three

year. Angela felt that she was no longer the most important person in her father's life and this was aggravated by the conflict which her anger and perceived laziness was causing between them. After this time, she changed schools and assumed a different demeanour. Externally she withdrew from her father (no longer approaching him except for superficial matters), and internally, she resolved never to reveal her true self and to control her inner life at all costs. Further, she would work even harder to prove herself to her father, as his opinion of her was crucial to her well-being and his perceived criticisms and imagined rage at being disappointed by her, were experienced as devastating and as indications of her worthlessness and imperfection. During times of conflict with her mother, her father's dismissal of her feelings (together with excusing his wife's behaviour and forcing Angela to apologise to Mrs. G regardless of the situation), functioned to strengthen Angela's belief that her emotional life was not only the cause of problems but that it was something that had to be disregarded, suppressed, and never afforded any importance, not even by herself.

1.2.4.3 Attitude to self

Angela's feelings of betrayal after her emotional disappointment in her father, together with her mother's inconsistency towards her, led her to make two decisions: (1) that she would never trust others again, and (2) that her inner life was the source of her feelings of incompetence and worthlessness. However, because of the marked way in which Angela separated herself from her emotional life, she was unable to correlate her feelings as the outcome of a particular situation (uncertain attribution of causality), and her own inability to verbalise her feelings (even to herself), led her to rely even more on her father's appraisal of her. Her aim in life was to please him with ever-increasing levels of perfection, as this was the way she derived a sense of worth and confidence.

> I never expressed how I felt...and then I would snap at someone else or just be totally frustrated and in the end almost forget *why* I was feeling like that in the *first* place. Then I would feel even worse because there was no reason for why I was feeling frustrated or depressed or whatever it was. I always would withdraw, and never confront anything, especially with my family.
>
> In high school, I was always in the top ten at school but then I started to enjoy my sport more. Sitting down and slogging at work didn't seem that important and I remember when I had that thought I actually became scared. I thought, "oh my God. Now there's *no* ways you can do well if you don't work" and I always just directed it that I was scared my father would be cross and upset with me. For my father, sport and anything else didn't really matter, it was *school work*. That's how he saw how you were doing, from what your marks were like....If my marks went down, that's when I used to feel the disapproval came out. I used to feel guilty and terrible because I knew I could have worked harder....I just knew it would make him happy if I did well, and he did it for my own good type of thing. And if I didn't do well according to him, then he'd be cross and upset with me.

At the age of 12, Angela was sent away from home to a boarding school where she was confronted with intense feelings of loss and emptiness at having being separated from her family, especially from her father. It was then that Angela began to focus on her body and want to control its shape and size; a focus which was actively encouraged by the other girls at the hostel, who were all engaged in similar efforts.

> **R:** People often have theories to explain the cause of their difficulties. How would you account for your bulimia?
> **A:** I don't know. It really baffles me. But what I think it could be is that I was feeling slightly rejected by being sent off to hostel. I don't remember ever consciously thinking that then but you know, being sent away from home. I became worried or rather more conscious of my weight than before. Having so many girls around you can't avoid that....But it still bugs me that I don't quite know why the hell it started. It was the year I started hostel. I don't remember why, I don't know if maybe I don't want to remember....I don't know....It must've been initially wanting attention. I don't know from whom but I'd been sent away to hostel. But I was never upset about it. Then I must've told my parents that I keep on getting sick but not exactly why. They were very worried and wanted to take me out of hostel. But then I told them it had stopped, and I don't know if they were eager to just believe it but that's where it stayed and I carried on vomiting more in earnest after that.

Although Angela is unable to account for her sudden bulimic behaviour (as she reports her weight was a minimal factor at the time), she nevertheless found herself engaged with and obsessed with ridding herself of whatever she ate by vomiting. Because of her wilful self-control and her perceived need to fulfil others' expectations of her (by maintaining a certain image of always being self-sufficient and happy), Angela was able to extricate herself from any connection with her emotional life. In fact, although she maintained her bulimic behaviour for five years, at the same time, she was able to disregard it and pretend that it did not exist. In her own words, it was a separate part of her, not part of the image she had of herself as always being able to cope and hence, she never regarded bulimia as a problem. It was to remain this way until Angela realised that it was no longer something in her control and that in fact, it was controlling her.

> **R:** Were you more open about the fact that you were bulimic with your friends?
> **A:** You see, I didn't even think about it....I'd heard of bulimia in standard nine, and I thought it sounds quite similar to what's actually happening to me but of course it *wasn't*, you know....
> **R:** Do you have any thoughts about why you don't have much recollection of something that begun and for years increasingly came to invade or become more part of your life?
> **A:** I never thought it was part of my life. I had it under control and on the other hand, there wasn't anything to control. It was so under control according to me that it was almost not there. It's just something that happened and I never questioned it.
> **R:** So it was something separate from you?
> **A:** Ya, very much so, ya....It's one of the vaguest parts of my life. I'd love to re-live it, in an instant type of thing so that I can remember what I was thinking. I'd like to know *why* I did it. I never thought I'd be able to blot something out of my life so well.

R: Like you say, re-live it, experience it for the first time.
A: Ya, like with things that bother me. If something bothered me or really upset me, anything, it was just pushed to the back of mind and I'd ignore it. I managed to just push everything to the side and not think about it. And every now and then when I'd get depressed, I'd imagine that it was because of this weight thing, then I'd push that back too. So I never really knew why I was depressed. I'd always think, "but why am I feeling like this?"
R: So being bulimic didn't affect your relationships at all?
A: Not at all. It was like a different part of me. Like a separate part that carried on while I carried on.

It was, however, revealed that vomiting had become a place for Angela where she felt she could be "out of control", as she did not have to maintain her rigid, self-sufficient, controlled attitude during the purge. It became the space where she could give expression to her emotional life (by vomiting) and the place where she felt all-powerful because of her secret. Vomiting became the way she dealt with feelings of being threatened and upset and primarily, with feelings of rage and anger.

During this time, with the increased cognitive abilities characteristic of adolescence (age 14-15), Angela came to see even more clearly that her parents (and primarily her father), were not perfect, did make mistakes, and were, after all, only human. However, because of their intolerance of personal opinion and autonomous self-expression, Angela withdrew completely from her father. Their relationship becoming superficial and lacking its earlier intimacy, and Angela never went beyond her silent stance to verbalise her feelings to him. This is something which she believed she had no idea of doing and something which she still struggles with (knowing how she feels and verbalising it). For the rest of her school career she remained preoccupied with pleasing her father and gained some support from her friends, although these relationships were characterised by minimal self-exposure.

A: My dad is still very important to me now....I can see that I always used to be more inclined toward my father because it seemed we were so alike....So he still means ugh, it's just that now....
R: Is he still the world to you?
A: No, no.
R: Why do you think?
A: Firstly, he can't make everything better. I can't do things to make him happy....I would say that when I started going out with other guys, my dad took it badly because they started taking the place of his affections. It's just not as important to me. I'm also facing a few more home truths about him. You know, he's human, he has his downfalls....
R: When did he start to become more human for you?
A: When I went to high school but more so now. I started to see him not through such rose-coloured or tinted spectacles any more.

Attitude toward reality.../...

1.2.4.4 Attitude toward reality

Angela's sense of self is almost exclusively derived from the assessments she makes of having fulfilled others' expectations of her, primarily her father's. In this regard, she still needs his reassurance and approval of what she does (in her career and with whom she chooses to date), his admiration being crucial to her sense of worth, self-esteem and self-confidence. Up until the time Angela became involved in the serious relationship with her present boyfriend, her relationships with men shared a common pattern: when things were going well, Angela would withdraw and end the relationship, as she believed that she would always get hurt by others if she got too close to them. When there were disappointments and criticisms from them, they were always attributed to her appearance and her unacceptability. In the same vein, when she was complemented by others, she did not believe them and instead, perceived them to have ulterior motives for being nice to her. It is only with her present boyfriend that Angela has started to feel acceptable and worthy as a person (which she attributes to his persistence with her) and for the first time, she is beginning to learn to express the intimate parts of her life with someone without being afraid of rejection and intolerance. Still, she went through an extended period of time testing her boyfriend with small pieces of information about herself, each time convinced that he would leave her, only to find that it strengthened their relationship. See example below.

> I said to Tony (boyfriend), "I've got something terrible, disgusting and totally repulsive to tell you". I carried on for about twenty minutes. I explained it (bulimia) to him and he sort of looked at me and said, "yes". I said, "*well?*" and he said, "what?" He said he thought I was going to tell him something *really* terrible. And I said, "well, this *is* terrible. It's *terrible, terrible*!" His initial reaction was very important for me. I thought he wouldn't want to know me afterwards but he didn't leave me.

Throughout her high school years, Angela depended on her friends for support, always having friends around her. However, because she believed they had a certain image of her which she had to maintain (as someone always happy and together), she felt unable to approach them when she was upset or when she felt helpless to stop her vomiting, as this would have been inconsistent with the image she knew they had of her. Instead, she continued to pretend that all was well with her and to feel bound to play out the role of someone she was not. Because she feared disappointing them and possibly being rejected, (yet at the same time needing their support), she maintained many friendships where she was intensely loyal to others but where her own contributions and self-revelations were minimal; something which continues to the present. An example follows on the next page.

> **A:** I always had friends, that was terribly important....At hostel I got to know many people but not on a personal level, It was on a general level, they were acquaintances although we were all living in such close circumstances. I was actually quite petrified that say my friends went away for a weekend and I had to stay there alone, that I would probably not survive the weekend. I was very dependent on them but not in a bad way....At one stage we were all very dependent on each other. We did everything together, we went away together, we survived around each other....With friends, I always had someone to build me up, like a support you know....
> **R:** Did the bulimia ever cause you any problems with friendships or with your boyfriends?
> **A:** No, because no one knew about it. I would mention it to some people but they didn't really know. I'd make it sound like a tummy bug or something. I was very weary of their reaction....The first person I really told it to in detail was my present boyfriend and well, I told him and his expression didn't change, *nothing* changed! I thought maybe he didn't quite understand so I elaborated, *still* no change....I expected that nothing would carry on the same after that. That he *had* to see me as someone who had a bad problem now and not want to have anything to do with me.

At present, with the help of individual and group therapy, as well as her boyfriend's support and acceptance of her, Angela finds herself at a point of transition; replacing what she was with how she is to become. Although with little understanding about why she developed bulimia, she has been clear (no purging) for a few months now and her attitude towards herself and to reality is changing. She is less likely to attribute criticism to some inherent defect within herself but still wavers between making external and internal attributions for her difficulties, still unsure about who Angela is and what belongs to others. Her need to have her father's approval still continues to influence her but not to the extent that it did in the past. She is more inclined to verbalise her thoughts and emotions with her boyfriend but is still struggling to overcome the fear surrounding her inability to express herself to her father and mother. She believes she is made to do something but is unable to know what. Her indecisiveness and confusion about what type of person she is and what she would be good at, leaves her unsure about what career path to follow, revealing a blurred sense of self.

> **R:** Are you uncertain about such things as what kind of person you are?
> **A:** Not really (laughs). That's ambiguous isn't it? I guess I am. With some things I can say, "I'm this and this" but with other things not. Also, I wouldn't really be able to say them, verbalise them.

Further, Angela's inability to define herself outside her physical self (the body is still used to explain or understand intrapsychical processes), indicates a blurred sense of self. Angela believes that it is inner beauty which counts in the end and yet, in further discussions with her, it is revealed that others' dislike of her is understood to be as a result of her physical appearance. In other words, abstract concepts like inner beauty and personality are readily identifiable by her and yet, given a physical basis. She is thus unable to go beyond a physical explanation to account for abstract concepts. For instance, to identify what it is about her personality or inner beauty which would cause

others to dislike her. She is unable to integrate successes and compliments with her self-image and constantly expects failure (although unable to pinpoint why).

> **R:** How would you describe yourself as a person?
> **A:** I've actually been debating with myself lately, trying to get more positive....I think of myself as, or I'd *like* to think of myself as good-humoured, understanding, I'm not very positive....I've got low self-esteem but someone who doesn't know me very well would be quite surprised at that statement because of the way I come across. I've been trying to have a more positive self-image, thinking along the lines of, "you know you're not fat, you just slightly overweight....I'm not brilliant in any way but I'm a perfectionist. I don't like failing and if I think beforehand that I won't be able to do the thing properly, I'll more than likely not go for it. But then by not going for it I feel I've failed anyway....
> **R:** What were you referring to when you said low self-esteem?
> **A:** I know if someone had to look at me they won't die of shock kind of thing and have to go into hiding. My looks are very average, which I can do nothing about but I just wish I was more body-conscious. I remember as a kid always, when you start putting on puppy fat, thinking, "when I'm older, I'll go on diet". That thought stayed with me forever and I used to think, "God, what's your problem? Why are you never dieting? Why aren't you doing something?"
> **R:** So you would describe yourself very much in terms of body, weight, appearance.
> **A:** Ya, I don't like doing that but I can seldom find something that, umm, I can't verbalise anything that I wouldn't think positive about myself. Not even verbalise it, I have trouble *thinking* it, so I can't verbalise it.

1.3 INDIVIDUAL CASE REPORTS OF MAJOR THEMES ON SYSTEMIC COHERENCE

1.3.1 Case one - Jacki: Major themes on systemic coherence

Jacki's sense of self is derived from and dependent on other's evaluations of her. Because autonomous self-expression of thoughts and feelings was neither recognised, nor confirmed in Jacki's home, Jacki relied on her father's appraisals of her for a sense of self (her criterion image) and this extensive reliance on him and others for her sense of well-being continues to the present. The locus for her self-identity (esteem, confidence, worth) thus lies outside herself, in the outside world and is not derived from within.

The extensive reliance on external frames of reference is further mirrored by Jacki's attitude toward herself and reality. These attitudes are dominated by the centrality accorded the interpersonal realm, as well as dependent on it. In other words, in both scenarios, her attitude is dependent on the response which she receives from others, (whether her efforts have succeeded in securing the approval and recognition she longs for, or not). At the same time, the simultaneous presence of the opposing

and conflicting need to keep her self-directed identity clear of any intrusion or disappointment by others, is a key feature of her behaviour. Because she fears disconfirmation and criticism by others (especially from her father), she has not only developed a perfectionistic attitude, but she also avoids situations of intimacy where she would be revealed and thus open to criticism and rejection. (Achieved by the structuring of a self-image based on the perceived expectations of her parents, especially father, as someone who is self-sufficient and controlled).

This circularity is a contradiction in itself, yet is the major theme on systemic coherence evident in Jacki's case, providing the rules for assimilating experience. Following her adolescent resolution not to trust any one again (after her disappointment in her father), and to make sure she kept her inner life under control, Jacki focused almost exclusively on the interpersonal realm, (as opposed to a reliance on herself) and with achieving a confirmation of her identity from it, while at the same time being careful not to ever reveal too much of herself to others. In other words, seeking and avoiding intimacy. A glaring example of this is found in her behaviour with men. In her account to the researcher of heterosexual relations before she was married, Jacki would initiate and form relationships with men and when she felt they were sufficiently interested in her, she would terminate the relationship, as she had proved her point that she was attractive enough to them and not as ugly and worthless as she felt.

Other examples of her seeking and avoiding intimacy include her behaviour with friends and colleagues. She would seek out friends, maintaining friendships and always being very loyal to others and yet, could not share intimate parts of her life with them out of fear that they may inform her parents, or that they would be critical and rejecting of her. The same pattern exists between Jacki and her mother, sister, brother and husband. In this way, Jacki can experience a quasi-supportive environment without being truly intimate. In other words, by avoiding intimacy.

Jacki's rules for assimilating experience or how her inner world becomes meaningful (systemic coherence), is revealed in her personal cognitive organisation (P.C.Org.). Her inner life becomes ordered into personal experience if it is matched by the circular vacillation between the need for others' approval or confirmation and the fear of being imposed on or disappointed by others. It is in this way that she is able to achieve a steady and dynamic equilibrium between these two opposing needs. Because of the intrusive and rejecting home environment where Jacki grew up, where autonomous behaviour was punished and met with rejection, she has an intense need to safeguard her individuality. Hence, her attitude is one of obtaining, at the same time a confirmation and recognition

of her selfhood from others, as well as protecting it from infringement and impingement.

Faced with challenging information or criticism, the predominant way Jacki makes sense of it, is by making an internal attribution. In other words, she ascribes blame to herself and resolves to change that part of herself which she sees as the source of the problem or criticism. For example, following conflict with her father she resolves to diet to look pretty for him, or to work even harder to gain his approval and love. In another example, Jacki's choice of career after she finished high school was to become a teacher, something her father was against. Since then, although with concrete proof that she is a gifted and talented teacher (knowing that teaching gives her pleasure and happiness), she still wonders whether she should study for an accounting degree. Asked why she would want to do that, she replies that maybe she will finally succeed in gaining her father's approval. When they are locked in an argument where he tells her what a failure she is in his eyes, she immediately makes sense of it by believing that it is because she did not study what would have pleased him.

Jacki's rules for assimilating experience/systemic coherence (how her inner world becomes meaningful) have led her to develop bodily and emotional patterns which allow her to feel partly in control of herself and life. Through her bulimic behaviour she experiences herself as powerful and in control over herself, as well as her emotional life, as during a purge she is able to dissociate from her external situation, as well as from herself. Although her predominant attitude to distressing feelings is a passive one, she also engages in exercise rituals which allow her to feel better about herself.

1.3.2 Case two - Steve: Major themes on systemic coherence

Steve's sense of self has always been and still is, derived from the assessments he makes of having fulfilled others' expectations of him. At first his grandmother and father's, and now his mother's and brother's. Because emotional expression was met with rage or indifference in his home, Steve first relied on his grandmother and then on his father for his felt-identity (his criterion image). Since his father's and grandmother's deaths, he has relied on his brother's appraisals of him for his sense of self and on a lesser extent, on those in his immediate environment: his teachers, his psychiatrist, and his mother. His sense of self thus depends on how he interprets others as perceiving him.

Steve's extensive reliance on external frames of reference as a way of defining himself is evident in both his attitude to himself and to reality. His attitude toward himself is derived from certain

measures of success he holds as markers and against which he interprets his success or failure: these are his academic success and his weight. It is these markers and how well he believes he has achieved, which will influence his attitude toward himself. Academic success is measured not only by how well he has done, but by the award of prestigious prizes and recognition given to him by his teachers. However, in spite of his excellent academic record and being the recipient of many awards, his feeling of success is short-lived. Although he has done well according to external standards, his own ever-increasing need for perfection and inflationary high standards he expects of himself, set him up for disappointment each time. This leaves him feeling that he is a failure and that his efforts are not good enough. His attitude toward himself is thus heavily influenced by the recognition he gains from others and he especially seeks his brother's approval. At one point, Steve wanted to be so much like his brother (to win his approval), that he would imitate his brother's every move in the hope of becoming like him.

> **S:** I did very well in June and if I'd done well again in these exams, I would have been in line to get a prize, but now I lose *everything*.
> **R:** But you know that you've done well, even if you won't be writing exams now.
> **S:** No, I had set myself such a good base and now all that hard work has gone down the drain because I won't be getting my prize....
> **R:** How does it feel being awarded a prize?
> **S:** I could just about have fanfares when I imagine standing there in my imagination. To be seen standing there and I'd be known as *the best*, and everyone would be impressed with me.
> **R:** Is that very important for you, that others are impressed?
> **S:** *Very* important, it makes me feel good.

Steve's attitude toward reality is that it is deceiving and disappointing and never to be trusted. Although he craves others' admiration and approval, he at the same time, engages in asocial behaviour which in essence, almost ensures that others stay away from him and hence, seldom express their admiration for his efforts. His view of reality as deceiving and disappointing has been greatly influenced by his grandmother's and father's deaths and he now believes it is useless getting close to others or getting to know them, as they would surely die. Thus, by not initiating or forming any close relationships with others he feels he is avoiding the disappointment which he is sure will follow.

With the few people he does have a relationship with (his mother, brother, and psychiatrist), he seeks their approval and fears their disapproval or criticism of him. In order to avoid their disconfirmations as much as possible, he performs all his tasks in a perfectionistic way. When he is criticised, he responds with criticism. In the same light, he seeks and avoids intimacy with these people. He expresses that he often feels the need to talk to someone but seldom does because he fears the repercussions of what he would say. For example, he will keep certain information from his

psychiatrist in case he uses it against him (hospitalise him if he were eating less and less). With his brother, he longs to talk and discuss certain issues but when he is approached by his brother for a talk, he shuts him out and does not talk to him, saying he is busy. Both examples below reveal the pattern of seeking and avoiding intimacy.

R: Are you able to tell Dr Fern everything that you want to? or do you find that you're quite selective with him? Say for example, are there some things you would tell him and some things that you won't? or do you feel safe telling him what you feel, what you think, what you want, what you don't want, what you wish?
S: Some of the time I forget important things that I want to say to him. But there are probably times when I do mention some things and not others.
R: Is there a reason for not mentioning some things?
S: Perhaps the feeling of trying to keep myself safe by not revealing something to him.
R: Because if you revealed it then?
S: I might feel that I'd get into trouble or he'd try to stop me from doing something to myself....
R: Do you feel close to him? Could you imagine not seeing him for a while or is he somebody very important in your life now?
S: I think he has played an important role in my life. You know, he's somebody to talk to even though I sometimes have this love-hate relationship with him. I don't sometimes like what he's doing to me, like force-feeding me....
R: Do you ever wish that your mom and everybody else would just leave you alone?
S: Yes. Sometimes I wish that some people would leave me alone and other people will come.
R: Like?
S: Well, I prefer to have you in my company for example, than my aunt because she doesn't understand me. You seem to understand me, I can talk to you. With her, she doesn't understand the problem. She thinks anorexia is just with eating and that if you just ate and didn't complain, things would be fine....
R: Do your classmates know about your difficulties?
S: I think so. They seem to know from the way they sometimes react to me, but I don't think they actually understand it. I don't think anybody understands it perfectly, otherwise they would have cured it by now....
R: Would you like to talk to them, share your difficulties?
S: I find there's no point really in telling them because how do I make them understand something that I don't understand properly myself?
R: ....Do you find it helpful to talk to others when you are feeling upset?
S: I do. I find that it does bring certain or a great deal of relief to just empty my feelings with somebody. The problem is sometimes finding somebody who I can speak to....I'd say my classmates just expect everything to come easy for me. They just expect me to perform well. You see, they don't really know me at all, they're just interested in my marks and how well I do. I don't think they're interested in getting to know me. They're just interested in my marks.

S: By being so thin I'm attracting attention to myself.
R: Do you like it?
S: Not really. And it's wrong as well to try and attract so much attention to one's self. Because I mean I'm not the most important thing in the world that everybody must come and look at me.
R: But aren't you the most important thing in your life?
S: Am I?

R: Aren't you? For you, in your life?
S: Yes, that's why I'm being selfish and egotistical about it. I'm only concerned with myself. I'm trying to attract attention to myself, subconsciously.
R: And consciously?
S: Consciously I prefer to be ignored.

Seeking and avoiding intimacy is thus the major theme on systemic coherence evident in Steve's case, coupled with the need for others' approval and fear of their intrusiveness and that they will undoubtedly, disappoint him.

Following his preadolescent resolution never to get close to any one again and to control his emotional life (following the massive disappointment by his grandmother's death), Steve focused on his academic work and his weight as the means whereby he could gain confirmation of himself as worthy and competent. At the same time that his focus was on others for a confirmation of his identity, he also continued to avoid any social situation where he could have been revealed to someone and hence, be open to disconfirmation or disappointment. In other words, one of the rules for assimilating his experience is seeking and avoiding intimacy. An example of how he avoids intimacy is found in his thoughts about heterosexual relationships. Steve reports that he is disgusted and repulsed by the thought of sex and because of this, he would never get involved with any one. He regards himself as a eunuch, someone with no sexual preference or desire. In fact, so far will he go to ensure that he has no sexuality, that he engages in destructive behaviours to be rid of his penis (the organ he associates with intimacy). This is done in an attempt to avoid any type of intimacy with a woman. Yet at the same time, he speaks of longing to have someone to share his experiences with, who would understand him and who would help him overcome some of the loneliness he experiences at present.

Steve's rules for assimilating experience (systemic coherence) are revealed in his personal cognitive organisation. His inner life becomes ordered in terms of two things: (1) he moves between the need for gaining others' approval and recognition, and (2) simultaneously fears their intrusion, as well as the disappointments they will bring.

Because Steve's home environment was inconsistent, critical, and rejecting (especially up to his father's death), autonomous self-expression was punished or met with indifference. Because of the enmeshed relationship he shares with his mother (and which continues till today), Steve has an intense need for privacy, as well as a need to impose a self-directed identity. It is a salient paradox indeed, as the person from whom he is wanting to separate, is the person he depends on the most and without

whom he believes he believes he would die (and the person from whom he needs approval and recognition). Because of the inability to separate from his mother, he is still reliant on her for basic things, like telling him when and how much to eat.

Faced with challenging information or criticism the most likely way Steve will make sense of it, is by making an external attribution (blaming reality/others), but will soon follow this with an internal attribution (finding some fault with himself. See example below). This is followed by feelings of depression and lack of self-worth as Steve does not believe he can change himself, "once a failure, always a failure". In another example, in reply to his own assertion that he does not want to grow up, his rationale is that he did not have very good role models of responsible adult behaviour that he could imitate (citing his father's loss of a job because of fraud and then his suicide, as his example. This also indicates that Steve's criterion image was his father). Steve first blames reality but shortly afterwards changes his mind and says that it is his own feelings of incompetency which guide his belief that he would not be a responsible adult, hence he does not want to grow up.

> **S:** I tend to put people down, especially in criticising them. I'll sit and complain about people and criticise them and criticise my mother, and yet I've got so many faults myself and I'll be overcritical....I could turn it inside as well though and say I'm probably also critical of myself. I don't like myself very much....
> **R:** What about when someone criticises you?
> **S:** Then I can get very worked up because I can't take criticism at all. I tend to go to pieces.
> **R:** What type of things have you been criticised about?
> **S:** About my eating habits. Also what I'll do when someone criticises me, I'll criticise them back even if my criticism was about petty things, I'll tend to have a go at them....Often it's not to hear what they have to say, and so not to take the criticism properly. Whether it's constructive or not, I tend to get worked up....I lose my temper or I start criticising them back.
> **R:** When you get worked up, what is it that you're feeling?
> **S:** Anger, and sometimes, "oh well, I'm useless anyway" or, "I *am* inadequate, you probably right".
> **R:** But it still makes you mad?
> **S:** Yes, because I'm inadequate I feel cross with myself because I'm not good enough.
> **R:** So are you mad with them or with yourself?
> **S:** With them and myself.

Steve's rules for assimilating experience (systemic coherence) have led to the simultaneous development of bodily and emotional patterns which allow him to feel in control of himself. His anorexic posture allows him to experience himself in control of at least one aspect of his life (his weight) and hence, able to feel he is actively doing something about his feelings of incompetency and ineffectiveness. He engages in carefully thought out exercises which add to his feeling that he is actively doing something when faced with distressing feelings, like feeling full after a meal. See next

example.

> **R:** You said you exercised more than once a day to control your weight. Is that right?
> **S:** I suppose it's more to make me feel secure than anything else. Because my brother runs around a lot I feel that I'm at least getting something. It's got token value.
> **R:** How do you mean token value?
> **S:** It doesn't really have much value as exercise. It's basically just to make me feel better....
> **R:** And say you can't do the morning exercise session?
> **S:** It's okay because I walk around at school. Going from class to class, carrying my suitcase around, upstairs and downstairs.

1.3.4 Case three - Maria: Major themes on systemic coherence

Maria's sense of self is reliant on and derived from the outside world and the extent to which she perceives others approve of her or not. Because her home environment was ambiguous, intrusive and controlling, Maria instinctively turned toward her father (her main attachment figure) for comfort and security and depended on his appraisals of her for a sense of self. Her mother's intrusive and critical attitude toward her further encouraged Maria to turn her attention toward others in an attempt to derive a sense of felt-identity.

> **R:** Did you ever find yourself doing things to gain your father and mother's approval when you were young? And now?
> **M:** It was my father's approval. I would go out of my way to read certain books or poems, stuff that I could sit down and to talk to him about. I would go out of my way to look for certain things to go and tell him. Even now, if anyone asked me why I'm doing this community work, I'd say it's for my dad.
> **R:** Was or is dad's approval important to you?
> **M:** Very important, still now.

The centrality accorded the interpersonal realm is revealed in Maria's attitude toward herself and reality. The way she experiences and feels about herself, is determined by the extent to which she perceives others (primarily her father, mother, husband, and friends), approve of her or not. This is the primary way which Maria uses in making sense of her inner world. In other words, whether she has been successful in securing others' approval and recognition of herself. This need to feel approved of and admired is continuously revealed in her accounts to the researcher about what motivates her to act in certain ways.

> When I used to do badly at school, my mother used to come down on me like a ton of bricks. At the end of every year I used to say to her, "next year you'll see. I'm going to do well next year, for *dad*, and for him *only*. Not for you, for dad *only*".

R: How are you affected by what other people think of you?
M: *Extremely* affected. I might change my whole life, I'm talking about physical....I'm *very* affected by what they think of me.
R: So it's what others would think of you physically that affects you. The other part, that they'd describe you as fun, loving, extroverted, doesn't affect you, it's okay?
M: It does affect me because I repeat it. I repeat the fun, loving attitude. I enjoy doing it because I know people respond to it. The more they respond and admire it, the more I enjoy doing it. A lot of the time I feel I have to keep it up. They expect things from me. But the physical side affects me more. The way they see me in a negative light affects me *more* than in a positive light.

M: I think my talents are being recognised only now.
R: By whom?
M: By my parents. I think most of the time when I say, "they" I mean my parents.
R: So do other people matter, whether they approve or not?
M: They do but not as much as my parents matter. I feel my parents have to approve of what I'm doing....
R: Do you think they're proud of you now?
M: Oh yes, very proud....I'm out there on show and for my mother, that is the ultimate....My mother's in her element because I am on show....I'm on show, the daughter she didn't really believe in.
R: How does that leave you feeling?
M: It doesn't make me feel good, because *why* didn't they believe in me then? They *should've* seen my talents then. Now all of a sudden that I'm on show and the world approves, they approve.

At the same time that she is preoccupied with attaining others' approval, she is engaged in the conflicting behaviour (and need) of imposing her individuality on the world and keeping it clear of others' intrusions (her mother's), as well as engaged in attempts to avoid being disappointed by others. Regarding her attempts to avoid intrusions and disappointments by others, she executes her tasks with perfection in order to avoid criticisms and does not expose herself intimately to those people whom she fears will be disappointed in her and consequently, disappoint her.

The experience-assimilating procedures evident in Maria's case are starkly clear: she needs others' approval for her very sense of self but fears their intrusiveness and being disappointed by them. She thus seeks approval and fears disapproval; seeks and avoids intimacy. Alternatively, it can be said that systemic coherence (the basic strategy for maintaining an internal equilibrium) is mirrored in the personal cognitive organisation revealed above. Maria's fear of rejection were she to be anything but what others expect her to be, is poignantly revealed in the example below.

R: Do you think others would understand your problem with food?
M: It depends who the others are. Lots wouldn't understand and wouldn't approve of it. They wouldn't accept the fact that I'm okay even though I have this problem. I'm talking about my mom specifically, and my friends. My friends would understand more about it than my mom for example, but I avoid talking about it with my friends.
R: Because?

M: I just don't. I talk about anything and everything on earth but *that*....I can speak about very intimate things with people. Everything in my life I can speak about except food and my feeling of stupidity. Everything else.
R: What comes in your way? What is the fantasy of what would happen?
M: Disapproval. Everyone looking down on me.
R: So if things remain unspoken there might just be a chance that they don't know?
M: Ya, and they think to themselves, "well, even though you're overweight, you're still together". (Laughs). I'm just saying what I'm *hoping* they might think. Like, "you a nice overweight person. You don't have the problems of other overweight people". In the meantime....
R: In the meantime you do?
M: *Of course* I do! I just hide it very well. I make a conscious decision when I go out into the world to act proud of who I am. This is a fairly recent thing. I actually brainwash my brain to believe that.

It was during childhood, after her emotional disappointment in her father, that Maria resolved to work exceptionally hard to win her father's approval (and only **his** approval), and vowed to remain distant from her mother and never to reveal her inner life to her. It was during this time that she began to ever-increasingly focus on the interpersonal realm and with achieving a confirmation of her selfhood from it, while at the same time, being careful not to reveal those parts of herself to others which she believed would bring her criticism and rejection. For example, always having been an extrovert, loud and vivacious, she was known amongst her friends as someone who could easily talk about any issue. However, in her accounts to the researcher, she speaks of the fear of being revealed to them as someone weak and inadequate if she were to be truly intimate with them and speak about her difficulties and pain. Because she believes others have a certain image of her as together and strong (something which she works hard at maintaining), her revelations that she struggles with feelings of worthlessness, inferiority, and stupidity, would come as a huge disappointment to others. They would then view her in that way and that in turn, would cause Maria to feel unbearably disappointed. See example below. (The pattern of seeking and avoiding intimacy is replayed in her relationship with her husband).

R: Does your eating or weight problem ever cause you any difficulties in your relationships with friends?
M: *Big* problems. I hide things from them. I don't talk to them about my weight or my feeling of stupidity. There's a part of me which I don't talk about. And I feel that really strains the relationship for them.
R: What comes in your way of talking to them? Would you like to be telling them?
M: Ya, because I feel I need their help. But I feel I'm letting them down in a lot of ways. I've got this great big weakness in me and here I am this strong individual with my friends. I glue the people together and I feel I can't, I *can't* let them know I have this problem.
R: Because?
M: They're going to see me differently and *I'm* going to feel different.
R: What's going to be different?
M: That I'm *not* as strong as they thought I was. That I'm *not* the Maria they thought I was.

That I'm *not* the such-together person they thought I was.
R: So you come across as quite together with your friends?
M: Ya, they kind of know my problems and my insecurities and my fears but I think they see my strong points overriding all those things. And I feel I'm going to let them down in a lot of ways.
R: Has it always been this way?
M: Recently much more. Now I want to look good for them. Before I see them I'm in a complete tizz as to what they going to think of me....I want my sister to know but I don't want to have to tell her.
R: This seems to be coming up with everyone, you desperately want them to know about you but you want them to do the work of finding out.
M: I just have this fear of telling people. I can't tell them easily. It's a problem. I can't tell them. I feel I need to hide.
R: Because? If they had to know, then?
M: They'd think less of me. They'd think I'm weak. They'd think I have a weakness and a flaw in my character. You know, it's such a weakness too.

Faced with information or criticism which challenges her very sense of self, Maria oscillates between making internal and external attributions. Usually an external attribution first, closely followed by an internal attribution. Her attributive style is usually the following: faced with her mother's criticism that she is overweight and must do something about it, Maria will first blame her mother for her predicament (were it not for her mother's obsessive and critical attitude, she would not be fat in the first place). She then centres on herself, finding some fault within herself which she sees as responsible: that she is out of control, or that she is inadequate and a failure, hence is unable to control her food intake. In an alternative example, the predominant way she made sense of failed relationships with men before she was married was as follows: first she would explain the failure of the relationship to develop to a more physical level on her partner's unreadiness or unwillingness. For a while this is how Maria would make sense of a failed relationship. Shortly afterwards, she would replace this logic with the belief that there was something inherently wrong with her, hence men's disinterest in her physically, and this was usually because she was unattractive and too fat. In fact, after adolescence, her explanations usually centred on the latter logic (because she was too fat) and seldom included an external cause. Following disappointments, like the end of a relationship, or a sharp criticism from her mother, Maria always resolves to change that part of herself which she sees to be the source of her pain, her body shape.

M: When I used to have a traumatised relationship with a boy at school or at varsity and he used to break up with me, because that's what usually happened, I always used to think it was because of my weight. And when I had that traumatising year in matric with Peter, I thought, "he's not making a move because I'm overweight". I really and truly attributed all of my problems to that. When I wasn't asked to dance at a social or wedding, it was because I'm overweight....Even when I started going out with George. I went on a diet and I had lost a lot of weight and I looked lovely.
R: What motivated you to go on diet then?

> M: George told me when he first met me, "you must just lose five kilo's and you'll be fine". And I thought, "oh shit. Weight is coming between us. Me and another person, *again*!" So I decided this is not on and I went on diet again.

The way in which Maria makes sense of the world/her experiences has led her to develop complementary bodily and emotional patterns. Her passive attitude when confronted with a negative reality and distressing feelings of incompetence, emptiness and disappointment, is revealed by the fact that Maria always feels incapable of doing something to exclude these distressing feelings, or of changing reality. Instead, she will turn to food for comfort. This passive attitude is also revealed by the extremely low motoric activity displayed.

1.3.4 Case four - Angela: Major themes on systemic coherence

Angela's sense of self is almost exclusively derived from her assessments of whether she has fulfilled others' expectations of her, primarily her father's, as well as whether she has actively maintained the image of herself that she wants to project to others. Because autonomous self-expression was neither recognised nor confirmed in Angela's home, she relied on her father, the person she was closest to (and her criterion image) for a sense of felt-identity. This extensive reliance on her father and others for a sense of self continues to the present, although to a lesser degree.

Within both her attitude toward herself and to reality, her extensive reliance on the interpersonal realm for a sense of self is evident. Her attitude toward herself is dependent on whether she has succeeded in attaining her father's approval and recognition. In this regard, she developed a perfectionistic attitude regarding her academic work and sport, always wanting to please her father. At the same time, she feared his rage and the imagined disapproval of what would follow were she not to perform as well as he expected. A major theme on systemic coherence is revealed here: Angela made sense of her experiences in terms of how successful she was in securing her father's approval.

At the same time that Angela sought her father's approval and recognition, she feared being disapproved of. Further to this, because autonomous self-expression was not tolerated in her home, Angela learnt that one way of maintaining her relationship with her father was to conceal her emotional life from him and always to appear happy. Her need to keep her identity safe from others' intrusiveness and from being disappointed by them, is revealed in her strategy of keeping a safe distance from others (never revealing her true feelings or thoughts), as well as executing tasks with

perfection, and in this way hoping to avoid criticism. See example below.

> **A:** I'm not the type of person that a whole lot of people would really know, sort of a selected few would know me as I really am. Maybe one or two people would describe me as I *really* am, like my boyfriend....I have this image so the things that people see are not necessarily everything. It's just that they don't see everything. What they would see might be true, but there's just more to it. I used to be very open, trust everyone, until I got to hostel. Then I didn't trust anybody....Tony is the first person that I've ever been close to, who I've allowed to get close to the real me....He gives me so much support which I didn't have before.
> **R:** So is it easier or more difficult for you now to be yourself?
> **A:** It's more of a burden on me, and a burden on him too, especially my emotional state, I hardly ever speak about it. It worries me, wondering what's going to happen if I did....I'm a bit better with it now. Say I'm feeling depressed or worried that I'm going to start vomiting again, I don't quite say it in too many words, I'll say, "don't leave the food here, I'll eat it".
> **R:** Do you or did you ever vomit secretly and not want him to know?
> **A:** Oh yes, I *always* did it secretly and I didn't feel anything....It's what I'd been doing and I wasn't suddenly going to stop for someone....I felt feathers.

Systemic coherence or the experience-assimilating procedures revealed whereby Angela maintains an internal equilibrium, are reflected above in her personal cognitive organisation. She needs her father's/others' approval and fears his/their disapproval and criticism. She also seeks intimacy on a superficial level and avoids true intimacy.

Following the emotional disappointment in her father during pre-adolescence, where he was suddenly revealed not to be the man she thought he was, Angela resolved: (1) not to trust others again (to avoid being disappointed by them), and (2) not to allow her inner life any credibility (as she perceived this to be the source of all her problems). She came to rely even more on her father's appraisals of her for a sense of self and matched this with ever-increasing levels of perfection in an attempt to please him. At the same time, her behaviour toward her friends was influenced by her need to gain their approval, as well as their support. Seeking and avoiding intimacy was the primary way Angela used to achieve her aims. For example, Angela reports that her well-being at school depended on having friends, as they were supportive of each other, as well as dependent on each other. At the same time, Angela never went beyond superficial intimacy with them to share her true thoughts and feelings. This was because she believed they had a certain image of her (as someone happy and together) which she felt she was bound to uphold. She believed that were she to reveal her true nature to them, they would be critical and rejecting of her and hence, disappoint her.

> **A:** Emotionally, I'd say I'm generally happy. I don't like being depressed and down, but I find that I get more depressed and down than I like to admit. As I said before, I used to act happy all the time. Nothing was wrong with me, life was just a breeze and I had absolutely no problems. But I did have problems and felt depressed and down and under pressure.

R: In other words, all the usual feelings.
A: Exactly, normal feelings but just not admitting to them or letting myself feel them. So if I did feel depressed for a few days I'd think, "what's the matter with you? Just snap out of it. This isn't you" but in a way it was.
R: What would have happened if you had been the way you felt?
A: Everyone would have commented on it. It would have been, "what's wrong? you're never like this".
R: And then?
A: That's just the whole thing. It wouldn't have been that bad. I mean once when I really wasn't fine and I kept saying I was, it was because I also didn't want to go through the whole thing of insisting that I was fine when I wasn't. You see, I wasn't fine because I wasn't what they thought of being me. I just thought, "it's just bloody easier in the end acting as though there never was a problem".

Another example which reveals the personal cognitive organisation of seeking and avoiding intimacy, is found in Angela's accounts of her heterosexual relationships. Angela would initiate and maintain relationships with men her age. However, because she believed that she would always be hurt in the relationship, after some time had passed and she would begin to feel close or intimate with her partner, she would begin to act "bitchy" and uncooperative, wanting him to end the relationship, which is what would inevitably happen.

A: A lot of my friends had their first major love relationships at school and I saw how they were hurt and I thought, "well, every relationship inevitably breaks up and you get hurt". And that's how I went into anything. That's why any relationship I went into, when the person was getting too close to me I became a total bitch to live with, and most of the times I would make them break up with me, *I* wouldn't do it. It wasn't necessarily that I didn't trust men because I had no reason not to, but living through each of my friend's break-ups, I thought, "ugh, life's not that great". It was the usual things that you learn but I just took them more seriously and then I became much more closed. My feelings especially were all the more so *only* mine. I definitely wasn't nowhere near as trusting as I used to be....
R: And you learnt that it's better or easier to keep closed up?
A: It's easier and you don't get hurt. I've only realised now with my boyfriend, that to actually have a proper relationship, whether it's with a guy or with friends, you actually have to make yourself so totally vulnerable to be able to experience the full relationship in every way. I was like this right up until last year and it used to frustrate Tony immensely. He had to work on me all the time. At first I thought, "*don't* think I'm stupid. I'm *not* going to believe all this shit" but he just carried on with me....I just think if you let more out about yourself, the more you going to bug other people.
R: Like what type of things?
A: I'd imagine feelings mostly. Anger, ya, most emotions in general....Sadness, happiness, but I think mostly negative emotions.
R: What are negative emotions?
A: Sadness, anger, embarrassment, humiliation, things like that. Usually you can share happiness with most people but not bad moods or depression and things like that. I always think my negative feelings are going to create a negative impression of me.

Faced with a negative reality or criticism, Angela makes an internal attribution. For example, if she was at a party and was not asked to dance, her immediate way of making sense of this, was to find

fault within herself (that she was too fat or too ugly). However, at present, Angela is likely to waver between making an internal and external attribution, having begun to test her view of reality within the safe confines of her relationship to her boyfriend.

The way in which Angela makes sense of her experiences is matched with certain bodily and emotional patterns. Through her bulimic behaviour, she is able to experience herself as powerful and in control over her emotional life, (as during a purge she is separated from herself and her surroundings). Although her attitude toward challenging feelings is mostly a passive one, Angela engages in a vigorous exercise program which gives her the sense that she is actively doing something about the way she feels.

1.4 INDIVIDUAL CASE REPORTS OF COPING STRATEGIES

1.4.1 Case one - Jacki: Coping strategies

From a young age, Jacki's preferred coping strategy was to withdraw into herself. Because she knew that her father would not tolerate any autonomous emotional expression from her (and because she feared his rage if she did dare do so), she learnt that a silent posture was the safest option. Because Jacki was uncertain about how her mother would respond to her if she went beyond her usual superficial talk with her (and included more intimate details of herself), she maintained a silent posture with her too. If Jacki was upset by something at school or at home, she would not talk to any one about it, even when pressured to do so by her parents who could see that she was upset. This in itself served to cause more conflict between Jacki and her parents and reinforced Jacki's resolve to keep quiet.

With the advent of adolescence and consequent physical and emotional maturation, came years of intense conflict between Jacki and her father. It was during her adolescent years that Jacki was confronted with the intense disappointment and relativisation of the image of her father. He was suddenly seen for who he was and no longer the holder of absolute truths. It was during this time that Jacki resolved never to trust others again and to ensure that her emotional life was kept under control. It was also during this time that Jacki came to believe that her father's criticisms and rejections of her, were indications of her incompetency, unlovableness, and worthlessness. Her feelings of personal ineffectiveness magnified after the disappointment in her father, coupled with the belief that her inner life was responsible for her unhappiness. Because Jacki lacked the ability to

differentiate and integrate her emotional life (because it had never been mirrored back to her), and because she blamed her inner life for the way she felt (ineffective and incompetent), she began to focus all of her attention on changing her body shape, as this was suddenly seen to be the source of her unhappiness: a body that was too fat. She discovered that she could induce vomiting after she had eaten and it is within this arena that another major coping strategy is revealed.

According to Jacki's accounts, vomiting was a two-pronged weapon: not only was it a means of ensuring she did not gain weight, it was also a means of fighting her father. In this regard, it was a powerful weapon because she was ridding herself of what he had forced her to eat (both literally and metaphorically), and it was a weapon by virtue of it being a secret (it was something which only she knew about and which belonged exclusively to her). Vomiting was not only a weapon which allowed her to feel powerful, it also allowed her to feel temporarily in control over herself, as during the vomiting she became detached from her external situation, as well as from herself. In this way she felt she was controlling her emotional life. Vomiting soon became the major way of coping with negative and threatening situations. Although Jacki now reports to engage in sporadic bulimic episodes, she nonetheless vomits when she feels threatened. This occurs when she returns home for a visit, or as a way of attacking her husband when she is angry with him.

Another common coping strategy which is evident throughout her life until now, is the need to remain emotionally hidden. From a young age, Jacki would surround herself with many friends but would never totally reveal herself to them out of fear that her parents may find out, or that her friends would reject her. In this way she received supportive intimacy. This strategy continued throughout her adolescence and university career and is now a distinguishing feature of her relationship with her husband and present friends. In this regard, Jacki has been able to be intimate with her husband on levels never previously experienced. However, there are times when she seeks his support and reassurance but is unable to share with him the issues troubling her. Instead, she believes she needs to hide certain things from him which she thinks would upset and worry him. Although the dynamic is the same with regard to her friendships, her reasoning is slightly different; her need for approval and recognition surpasses her need to be intimate in the latter case.

Other coping strategies she has engaged in in the past, besides withdrawal and vomiting, include: (1) piercing her own ears to express her anger at her father; (2) compliance (agreeing in order to avoid conflict); (3) a continual need to control her feelings and emotional world. Jacki is afraid of her emotions, associating any negative emotion with hysteria or breakdown and hence, regards emotions

as something to be avoided. She reports that she is able to switch off her feelings but is unable to say how she does this, besides saying that it is something which happens automatically.

1.4.2 Case two - Steve: Coping strategies

From a young age, Steve was a loner, preferring to be on his own rather than with friends. His asocial behaviour was matched by a withdrawal into himself, and these appear to be his earliest coping strategies: withdrawal and isolation. Although his relationship with his father was characterised by its element of conflict (usually caused by Steve's back-chat), Steve was well aware that any autonomous expression of emotion by himself, would be met with rage and disconfirmation by his father, or with total indifference. He learnt to withdraw from his father and mother and never to reveal his true feelings to them. It was only on the occasions when his father was violent and fighting with his mother that Steve would intervene, asking his father to stop (which only caused further conflict between them). Thus Steve's early years are characterised by the coping strategy of withdrawal and isolation, never revealing to his parents if he was upset, angry, or sad. It was only with his maternal grandmother that he was able to be himself and be met with confirmation and love.

> **R:** Did you have close friends at school when you were young?
> **S:** I wouldn't say ever, never, no. I wouldn't say so....
> **R:** So do you tend to be a loner, rather than somebody who likes to be with people?
> **S:** Ya, a loner. I don't have a huge following, people that I go around with. And from an early age I found that I couldn't really keep up with the others so I tended to do things by myself....I used to sit and read because I couldn't play games like catch with everybody else because I couldn't catch anybody. I wasn't able to throw stones as far as the other children. I was no good at playing hide and seek because I didn't agree that it was the "proper" way of playing the game. And I didn't like some of their games anyway.

During pre-adolescence, when Steve was 11, his grandmother suddenly died (an intense emotional disappointment), leaving him grief-stricken and overwhelmed with emotion (disequilibrium occurred). Feeling that he had no control over reality and himself, Steve focused all of his energies on controlling his body weight and was soon hospitalised with anorexia. Controlling his body weight became and remains another common coping strategy for Steve. Through the stringent control of his food intake, Steve was attempting to impose some control over his chaotic inner life. He felt ineffective in changing reality (and restoring his grandmother back to life) and ineffective in controlling his feelings. As things continued to worsen in his home, with his father drinking more, out of a job, and depressed, so did conflict increase between father and son. Steve continued to seek his father's approval and confirmation by adopting a perfectionistic attitude to his school work and

to his weight (perfectionism being another common coping strategy). However, his efforts were subject to his father's inconsistency and drunken stupors and any effort Steve made to help his father back to health, was met with rejection and disapproval. This was interpreted by Steve to be indicative of his worthlessness and unlovableness.

Steve's feelings of emptiness after his grandmother's death (coupled with the critical and unsupportive attitude of his father), as well as his silent posture within his home, left Steve overwhelmed with emotions which he could neither differentiate, nor integrate at the time (disequilibrium occurred). Steve turned his attention to his body and came to believe that it was his fat body which was the cause of all his unhappiness. This is how Steve coped with the loss of his grandmother and the turmoil at home.

> **S:** I'd lost the weight I wanted to and we went off on holiday in December.
> **R:** So you were feeling good about yourself?
> **S:** Yes, although something happened in August, my grandmother died. That was quite a blow, I was very fond of her. She was a wonderful person....Then I started worrying that I was perhaps eating too much. I started worrying about being impulsive with eating. I didn't really know what to eat or how much to eat or how large my portions should be now that I was off the diet because I didn't have a guiding system to work by....So I ended up eating less and less and eventually was hospitalised.

Three years later he was to be faced with another gross emotional disappointment: the death of his father by suicide. Again, overwhelmed with feelings of personal ineffectiveness and loss/emptiness and unable to integrate these emotions (as he lacks the cognitive ability to do so), Steve returned to the only form of coping he knew, a way of being already firmly entrenched in his psyche: controlling his food intake in the hope of controlling his body shape. Again, he was hospitalised with anorexia after some time and since then, has had brief periods of remission followed with hospitalisations and tube-feeding.

> My father killed himself in January...that year proved to be the toughest year for me at school....I started out not too badly in the first term. I did well for myself, alright, marks were inflated because they were just tests....But I seem to think I was getting along. My weight remained at a pretty low level all the time. Dr Fern then decided to hospitalise me so he could monitor my weight....After I was discharged I went back to school and tried to catch up and fit back into school. I'd find that when I tried to do some extra revision I was struggling and I wasn't able to learn everything and remember everything. I started feeling more and more miserable at school until one day I just walked out of the classroom. I couldn't take it any more. I was calmed down, sedated. They phoned Dr Fern and that day I was admitted to the clinic....I stayed there until it was arranged for me to go to a specialist treatment centre....It had sort of just reached that stage and I couldn't go on any more.

Although it is clear that anorexia is a common coping strategy that becomes more pronounced when Steve is under stress (academic or emotional), in other accounts to the researcher, he has also made it clear that he holds onto anorexia as: (1) a form of identity; (2) as a means of making sure he is taken care of; (3) as a way of attracting attention to himself; (4) as a way of avoiding growing up, one of his greatest fears. He reports that he has suffered from anorexia for so many years, that it is the only way he knows how to cope and would be completely lost were he to give it up. Further, because he believes that he is incompetent, he is of the opinion that he would not be able to cope with the responsibilities of being an adult. He thus holds onto anorexia as a way of remaining a child and having others look after him. The following examples reveal that anorexia has many functions for Steve.

R: What do you think that you hold onto your anorexia because it keeps you unique and different?
S: *It does*! I'd say probably *that* is perhaps the reason. I'd also say that to me it's a coping mechanism and it's the only coping mechanism that I know or I know of. So I don't really know, if I abandoned anorexia what or how else I'd cope. I've had it for such a long time that I don't know anything different. I don't know if I'd be able to cope if I finally let go of it.
R: To cope with?
S: With *life*! Whenever I'm in trouble I sort of bring out my anorexia more and end up being put in hospital, to temporarily escape....Anorexia is the only sort of life philosophy that I have. It's become second nature to me.
R: So it makes sense then that you'd feel quite lost without it.
S: Yes, I wouldn't have a crutch to lean on.

R: How would you finish this sentence: because I am anorexic?
S: I'm incapable of growing up, of assuming more responsibility, of becoming an adult. Because I'll stay physically small, okay, my genes say that I'm going to be physically small anyway, but I've stunted my growth a bit.
R: Do you want to stay small?
S: I don't really mind my size that much. I'd say I want to stay young. I have what I call a Peter-Pan syndrome. I'm scared of growing up, becoming older, because I'm scared of dying of course.
R: Do you think that dying is the only thing that comes with growing up?
S: *And*, and you have to take on more responsibilities. It frightens me as well.

R: In reply to the question how much does a one kilogram weight gain affect your feelings about yourself, you said very much. Could you tell me a bit more about how it affects you?
S: I feel like I'm going out of control. Like I'm getting fat I suppose.
R: You also said a loss of one kilogram affects the way you feel about yourself. In what way does it affect you?
S: "Oh, well done". Pat on the back.
R: Do you think that your weight is something that you can control? Is it something that you want to desperately control?
S: Yes. Something that I feel is that it's a part of my life that I can control, so why not.
R: Is there any other part of your life that you think you could control or that you do control?
S: No, I don't feel there is. I mean I have to go to school. I'm forced to write exams. I can't really control that, although I suppose I can control it with my weight sometimes, whether I'm at school or not because I might be in hospital.

R: Are you happy about the fact that you were born male or would you prefer to have been female?
S: The whole question of sex is very uncomfortable for me. I don't like having this great big obscene floppy penis but at the same time I feel glad I'm not a woman because then I'd have these horrible breasts and I'd always be in danger of being raped. I only discovered about human reproduction when I was 14.
R: You told me, and that it was horrifying for you.
S: And it *still* is horrifying. I find it disgusting....
R: So you're not really happy being male but you also wouldn't be happy being a female.
S: Yes.
R: Can you think of another alternative?
S: I suppose I could be a eunuch. It's part of a thing I believe, umm, being asexual. In the case of a male for example, it might be a castrati....I believe that with anorexia or so I've been told, it's also a thing of not wanting to grow up, not wanting to develop. They sometimes feel that one can control one's physical development a bit, or at least to inhibit it, although that doesn't seem to be too much of the case with me.
R: Do you agree with that? Would you like to stop your sexual development?
S: Yes, I would like to stop it but I haven't been too successful.
R: So would you say you are sexually developed?
S: I suppose so but I would prefer not to be. There again, I mean anorexics would prefer to stay children for the rest of their lives. It's part of the problem.
R: And when you say you're sexually developed, what are you referring to?
S: Well, voice breaking, hair under the arms, more bodily hair altogether, great big horrible penis.
R: So you're not proud of your penis?
S: No, *I hate it*! It's the part of my body I hate the most. I regularly bash it in the bath with soap or whatever I happen to have my hands on. Bash it and try to hurt it and that sort of thing. Once I even poured acetone all over it.
R: Didn't it hurt you?
S: It hurt like anything.
R: What did you want to do to it?
S: Destroy it.
R: Cut it off?
S: I don't think I could stand the pain. I would need to be heavily anaethetised.
R: And if somebody cut it off for you?
S: If it can be done medically, thanks.
R: So you really see your penis as a problem?
S: I hate it, *yes*!
R: Why?
S: I associate it with reproduction. Before I knew about reproduction I hadn't minded it. I just saw it as an excretory thing. I didn't have a clue what my scrotum was there for.

S: Well, if so many other anorexics have been cured, why don't they do it with me then?
R: Don't you think it could be what you've said before, that you don't want to give it up?
S: Well, it's something I'm very used to. It's something I don't know what life would be like without it. Or it's been such a long time since I was normal that I don't remember what it was like.
R: Would you be prepared to learn?
S: It's a big risk for me.

Other common coping strategies besides withdrawal, perfectionism, and anorexia, include: (1) engaging in suicidal thinking and non-threatening ways of killing himself (eating soap, asphyxiating himself with a blanket). However, Steve reports that at those times, he is not serious about dying,

he only wants to "opt out" for a while.

R: You told me that you would rather kill yourself than go back to school and that you often have suicidal thoughts.
S: I often feel like that, yes. I wouldn't say I often have suicidal thoughts. It's when I feel particularly low, then I start wishing that I could just opt out for a while until things get better. Just sort of go into suspended animation for a while....All I've really done in the line of trying to kill myself I suppose wasn't particularly effective. I tried to swallow soap once, I just got a sore throat. I tried to suffocate myself but I found myself feeling too uncomfortable and hot and rather short of air which I couldn't stand. So I'm not the most successful suicide candidate.
R: So things have seemed quite hopeless for you at times?
S: Oh yes, quite often. When I'm sitting waiting for an exam or when I'm sitting through the nights struggling with learning. I just really haven't felt like going on any more....One thing I'd like to mention though, is that when I've thought of killing myself, I've only thought of it as a temporary thing, sort of if only I could sort of just die until the exams are over and then come back. So maybe I don't really want to kill myself....I just want to be in suspended animation or something like that.
R: So it's not that you really want to be dead, you'd just rather not be around under specific circumstances.
S: Yes, maybe in that sense that's why I haven't managed to kill myself because I don't really want to....
R: Can you remember how you felt during times when you've wanted to opt out?
S: Scared, quite sad. Feelings of fear brought on by what's approaching. I sort of felt that I wish I could opt out as a result of that fear, fear of exams say, that sort of thing....Well, I've come to realise more through talking to you, that I don't think I actually want to die. I just want to opt out until the danger's passed.
R: Danger? One thing being exams?
S: Yes, and growing up. I'm scared of the responsibilities. I don't think I can handle responsibilities of growing up. I feel that I've been so incompetent in the past that I won't be able to handle all the extra.
R: What type of responsibilities do you think it will involve?
S: Well, being liable for one's own actions. Looking after oneself, not having parents to guide and support any more.
R: Do you think that if you had to grow up that you couldn't look toward your mother and other adults for guidance?
S: I feel I'd be expected to be more self-supportive, support myself, not rely on others to do everything for me because that is after all what children do.

(2) He is abrupt and curt towards others, often replying with sarcasm and criticism to others' enquiries about his well-being. In this way, he ensures that others are never able to get close to him and he is protected against disconfirmation, rejection, and disappointment.

R: How do you think other people would describe you as a person?
S: My first reaction to that question would be that you have to ask other people. All I can say is how I would treat me, is I wouldn't treat me in a very nice way....I would not like me very much. I would tend to shun myself and reject myself....I don't think I'm very likeable, antisocial, sort of loner type....
R: Do you think that the usual way that you react to things or behave with people has caused you any problems?
S: Well, it's got me into trouble. Being criticised or shouted at for example because of the

way I interact with my mom or I get off badly with others because I don't know how to sort of speak to people properly.
R: You don't know how to speak to people properly?
S: I don't know the correct sort of thing to say, what is protocol or what is the polite thing or the done thing.
R: Do you think there's a correct (interrupts)
S: Yes, a polite way. You know, polite things to talk about it, normal things to talk about, whereas I would tend to talk about food or the way I feel because I'm anorexic. I don't know how to conduct a conversation.

(3) He focuses on food which takes up much of his thought processes and this keeps him from becoming aware of, or dealing with other more important issues facing him. Notice in the next two examples that in both instances, where Steve is talking about his grandmother and father, how his thinking splits off and centres on food.

R: How was it after your gran passed away? Do you remember or is it like a fog for you?
S: No, I do remember arrangements being made, how we were on our way to East London for the funeral, arriving at a relative's house. I remember having the most marvellous type of ice cream. It was four different colours and each colour was a different fruit flavour, the most gorgeous stuff. I remember how much I enjoyed that.

S: Fortunately there were some good times with my father but I remember more the bad times....
R: Do you tend to hold onto the bad things?
S: Well, I decide or I take guesses about how I'm going to get through the next meal or I keep busy by guessing what flavour my next build-up is going to be.
R: So a lot of your time and thoughts are taken up by thinking about food?
S: Yes. I talk about food all the time....I'm obsessed with food....
R: What does food represent to you? What are your immediate thoughts and feelings?
S: I groan with despair because I think of having to dish up and the trouble I have to go to where that's concerned. I worry that I might take too much because sometimes I'll dish up too much and then I'll take some off and I put a bit more on and then I'll take some off. It goes on and on like that and I never seem to get finished....
R: Earlier you said you are obsessed with food.
S: I think most anorexics have a sort of unhealthy view towards food, an unhealthy preoccupation with food.
R: Is that what you mean by obsession, that you're preoccupied with it?
S: Yes, I think, dream, talk about food. I talk about food often, especially at the table. Or I'll go on about what I saw at the shop today, say how much I'd like to try that one day. I find it difficult to stop talking about food.

(4) He seeks approval and recognition from others (his sense of well-being dependent on it), yet will offer as little information about himself to others as he can. In other words, he seeks intimacy from others (in terms of the support and help they can offer him) but he is careful to avoid self-exposure. This is visible in his relationship to his psychiatrist, mother, and brother. Although he wants others' help and support, he is distrusting of others and expects to be disappointed by them (so he avoids intimate contact). This results in ensuring his safety from others but leaves him alone and without

friends.

R: You said that you were more trusting of others when you were younger.
S: Perhaps, I don't know. I was younger then as well. Now it's more difficult for me because the disease has become engrained. I've become more hardened to life....I don't really think I trust the doctors. They say they not going to let me get fat but they might just keep saying for example when I feel that I'm fat that, "no, it's just you with your distorted irrational views that think you're fat. You actually not fat yet" and they might sort of try to trick me....I feel I'm going to carry on putting on weight and they won't do anything to stop it. I just don't trust them....It's all very well for them to say, "oh, we won't let you get fat" but if I say I'm fat they say, "no, it's just your clouded vision, you're not actually fat" so I mean, who do you believe?
R: How do you feel about the fact that others have taken control of a very intimate part of your life, in terms of dishing up your food, monitoring your food intake?
S: And trust and all of that? I think there was a similar question a while back when you said I must trust my mom a great deal. I feel with people like my mom I can trust her quite a bit. If it was someone like my aunt, I wouldn't trust her at all. I'd feel she'd be very heavy-handed, she'd dish up huge quantities because she didn't understand my problem. I feel more safe with people who have a more intimate knowledge of my problem.
R: Like with Dr Fern?
S: Yes, well I don't know. It's difficult for me to trust fat people. Because I feel they don't know how much to have either....
R: Don't you feel at all robbed of a part of yourself because monitoring your weight and food has become an issue for others to discuss and plan?
S: Not consciously.
R: Not? Do you want this part of you back?
S: I don't feel it's been taken from me really. I haven't really shown it to anyone, the inside part....
R: Do others notice when you're feeling upset or sad?
S: No. Unless I openly express myself I don't think they pick it up. When I express myself I actually go around looking very sorry for myself and miserable so that someone will ask me, and then I might come up with my story.
R: So do you feel understood or not?
S: Not really in the end. I feel I don't really understand myself very well, otherwise I feel I'd be able to handle things better.

1.4.3 Case three - Maria: Coping strategies

From a young age, Maria's preferred coping strategy was to seek the support and comfort of her father, the person she felt safest with, as well as wholly approved of and recognised. At the same time, she learnt to withdraw into herself when confronted by her mother, as her mother was dismissive and negating of any emotion or opinion which Maria expressed. Maria assumed the role of the clown in the family and in her acting out and imitating others, she was able to express some of her inner tensions.

Soon after Maria began school, she encountered problems with Maths, which slowly came to include all of her academic work. It was during this time that Maria was to be grossly emotionally

disappointed in her father, as she encountered a side of him which she could not integrate into the image she had of him as a kind, supportive and all-accepting man. His rage and intolerance toward her when she did not achieve well (coupled with both her parents' attitude toward her as someone stupid), led her to resolve that she would work exceptionally hard to gain her father's approval (perfectionism). Secondly, because of her mother's dismissive nature regarding Maria's emotional life, she resolved to keep distant from her mother and never to reveal her inner life to her (withdrawal). It was during this time, from the age of 10 onwards, that Maria came to incorporate her mother's criticisms of her into her self-concept and would be left believing that her criticisms were indications of her self-worth and competency.

With the greatest challenge to her sense of self coming with the disappointment in her father (and having to deal with the stress of being separated from him because of his business trips, as well as her mother's critical nature), and the resultant feelings of emptiness and personal ineffectiveness this incited in her, a disequilibrium occurred. Unable to make sense of or integrate these feelings, Maria turned her attention to her body shape and blamed her imperfect body for her pain and unhappiness. This was the time that Maria began binging-dieting-binging and from that time onwards, increasingly gained weight.

Here is revealed one of Maria's most common coping strategies: to deal with unpleasant feelings like depression, boredom, emptiness, and frustration, she seeks comfort in food, often eating large quantities in a short period of time (binging). During the time that she is binging, Maria is able to temporarily forget the issue which is troubling her and concentrate entirely on getting the food into her mouth. When she is angry, she eats. When she is depressed and sad, she eats. Even when she is happy, she eats. In essence, eating has become the metaphor whereby she attempts to digest her emotional life. Unable to assimilate her experiences, she denies them through the act of swallowing food.

> R: How would you define your eating disorder?
> M: I'm very attached to food. Emotionally, I'm very attached to it. It comforts me, it helps me, it depresses me. It does all those things to me and it's like a another live person in my life....I have a love-hate relationship with food. I love it because I love the taste of it, I love the look of it, I love it as a companion in my life, it's comforting. It's like your bed, you go to sleep and it's such a comforting feeling to be amongst the sheets and the bed is just so comforting. The bed keeps you up, it supports you, it keeps you going. That's how food is for me. It's great comfort and great support. It's like you're consuming something comforting, something warm, a live entity. I just love eating. On the other hand, I can't stand it for what it does to me. It makes me fat and it makes me very dependent on it. Not only to survive and to live, because I don't eat food to survive. That's what makes me so angry. That it shouldn't be such a pleasurable sensation and such a support in my life because

I abuse it. And I hate it for that. I *hate* it as well as love it.
R: Is this how your relationship has always been to food?
M: No, it started when I was twelve, when the binges started....I link and associate my eating problem with my lack of confidence and with the feeling of stupidity....It goes with that feeling of weakness, of stupidity, of inferiority, and the more inferior I feel, the more I eat, the more inferior I feel....Other superficial reasons are boredom, frustration, loneliness, and depression....The depression got worse when I got back together with George and I had all these hassles about being accepted by his family. I went wild binging then. I was just not accepted and that hit the wrong button.
R: Or maybe the right button....
M: Ya, I keep judging things and my criterion is the way I look.
R: What is the boredom, frustration and loneliness?
M: I'm not stimulated by what I'm doing. If I'm not stimulated by my life, if I'm not active, if I'm not in charge, if I'm not creative, that's boredom. Frustration when I don't know what I'm doing, when I don't know where I'm going, when I don't know what I'm supposed to do in my life, when nothing stimulates me. Loneliness when I don't have friends around me, that is a big part. Because they've disappeared out of my life in the last three years and *that* has devastated me more than anything, it really has.
R: Which goes back to the emptiness we discussed before, the gap.
M: Ya, there's a big gap there. I feel that's when I eat a lot.

The cycle of binge eating and starving gained its momentum soon after Maria was married. Having moved to a small town because of her husband's job, Maria found herself truly alone for the first time in her life and there, her feelings of emptiness magnified. She had been separated from her family and friends, the very people she depended on for her sense of felt-identity. To erase her feelings of emptiness, Maria began to eat more and more but because the relief she obtained only lasted for as long as a binge lasted, she would eat again after a short while.

R: Do you often feel bored or empty inside?
M: Very often. It's a kind of empty frustration. It's like there's an emptiness there and a frustration at the door.
R: Frustration because?
M: Because of the emptiness. Why do I feel empty inside? I feel frustrated that I'm empty inside. I might be doing something that stimulates me and as soon as I finish, I'll feel part of me is empty....
R: Is it all-pervasive or more specific to certain situations?
M: All-pervasive, generally....It got worse when all my friends emigrated. The emptiness grew then....It especially grew when I got married and we moved to a small town. Then I was all empty....
R: So your account for the emptiness is that you not getting something you need from the outside?
M: I don't think it's only from the outside. That contributes but it's also from the inside....
R: Can you describe the emptiness?
M: It's like a vacant hole, an actual hole....It sits in my stomach....And it's alive.
R: What would fill the gap apart from the fact that people close to you lessen it?
M: Finding what I want to be and do in my life....
R: Do you ever remember feeling empty when you were younger?
M: Yes, I felt empty when I was at school in Greece....
R: So you can connect the way you feel now to the way you felt when you were ten?
M: Ya, except then there was much more angst and fear about what they were going to do

to me because of my bad school marks. Now I know what type of person I am whereas then I thought I wasn't good at anything.
R: Say for instance you're feeling empty (she started to smile). Why do you smile?
M: I'm smiling because I think of the first thing that comes to my mind. I go to the fridge. I do. It's a very good feeling to open the fridge.
R: What do you do there?
M: I take out things that I want to eat and I just eat them.
R: Does it make the empty feeling better?
M: For a very small moment. Because after it's gone down properly and the enjoyment of eating is over and it's already in my stomach, then I'm feeling like a stuffed pig. Ugh, then the emptiness has grown.
R: The emptiness is worse after you've eaten?
M: Yes, because I realise I'm doing it because I'm feeling empty and I'm feeling guilty for everything that I've put into my stomach. It makes the emptiness grow....It's like the way the food goes down as well, the food falls down into this hole, into this emptiness....
R: You said food fills the emptiness for that moment. Is that what you did when you were in Greece too? Go to the fridge?
M: No, I was very healthy in my eating then. I never had a problem.
R: So when I asked you how do you fill this emptiness and you said the fridge, when did that start?
M: It started before the feeling started.
R: Why are you smiling?
M: Because I've just realised that the binging started long before the emptiness started. And that's a bit of a contradiction there.
R: A contradiction?
M: It's a contradiction in that I said when I feel empty I go to the fridge, and I said the emptiness started *after* I was married and we moved. But the binging, the eating, the going to the fridge, that started *long* before then, when I was at primary school, around 12, 13.

Another common coping strategy evident from Maria's accounts of herself, is the need for supportive intimacy with minimal self-exposure. This pattern is revealed in the most significant relationships she has with others. To the present day (although married), she still seeks out her father's support and security when in a crisis. However, she reports that although she is very close to him, she is unable to let him know what the true nature of her upsetness or depression is about. In fact, the two areas in Maria's life which provide the most discomfort and pain for her, (her weight and her intelligence), are the very areas which she is unable to share with her father, her greatest supporter and source of security. This is because of her great need for his approval and acceptance which she believes will be questioned if she were to reveal to him her true nature. Not only would he be disappointed in her, but she believes she would not be able to deal with her own feelings of having disappointed him, (as well as the disappointment she will be left with were he to withdraw his love and admiration).

The need for supportive intimacy from others with the least self-exposure as possible, is also mirrored in her relationship with her husband and friends. Although with her husband she has been able to be the most intimate she has ever been, there are times that she seeks his support and reassurance that

she is alright, without wanting to tell him what she is feeling. Instead, she will play games, asking him to guess and in this way, reveal tiny bits of herself at a time.

> **M:** I want my husband to know everything. I want him to share every single bit of me because I need him to....But it's not easy for me to tell him. I'll say, "I'm depressed" and he'll say, "about what?" and then I'll say, "you know". Then he'll start with all these other problems and eventually get there. He usually starts with superficial things and then he goes deeper and deeper...It's difficult for me to start talking. It's difficult to tell him I think I have a problem. He has to draw a lot out of me at first...
> **R:** Could you imagine ever taking the lead?
> **M:** Yes, and I do but I prefer not to do it because I want *him* to do it. It's like a test, which is horrible. I'm testing him. I want *him* to take the interest, I want *him* to go deeper. I don't want to have to dig deeper on my own every single time. I want *him* to do the digging for once. I don't want to have to put everything on a plate for him and say, "here it is". I want *him* to do some work for once.

With her friends she is extroverted and can discuss most issues, as long as she is not revealed. Once again, although she seeks their support, approval, reassurance, and encouragement, she is unable to ever share the true source of her pain and struggles. Again, this is because she believes she would be disappointing them, (as they have an image of her as someone together, which could not integrate the negative feelings she has about herself), as well as the fact that if she were to be revealed in this manner, she would be rejected, criticised, and disapproved of by them.

Other coping strategies besides withdrawal, comfort eating and seeking supportive intimacy, include: (1) blaming others for her predicament and making them responsible for her life. (She will blame her mother's critical-obsessive attitude about her appearance for her present weight problems; she will make her husband responsible for her failure to diet because of his disinterest. See first example below; alternately, she will blame society and it's focus on thinness. See second example below).

> I ask him (husband), please help me. I've asked him to be my policeman but it doesn't help. To tell me this is all you're allowed to eat and that's it. We always ended up fighting and now he refuses to do it....I'm realising there's a part of me which wants him to take control. Lately I see I'm the only one that can control this....Or I ask him to motivate me, that I need the motivation from him, I've even blamed him at times for my diet not going well. That is definitely passing on responsibility to him.

> You know what I was going to say when you asked me what I would say to the world if I could? The first thing I was going to say was, "*I'm fat and I'm proud of it*. And I'm hanging on *too*, so actually *stick it*. Really, it's *your* problem". That's why I think I'm hanging on to it, to get back at certain people in my life and at society in general. But the longing to be thin and feminine and beautiful *overrides* my resentful, rebellious streaks. It does, because I wouldn't have wanted to be thin but I *long* to be thin. Thin, and feminine.

Other coping strategies include: (2) denial - her loud and outgoing nature allows her to pretend that she is alright, even when she is not; (3) perfectionism - she sets incredibly high standards for herself, especially in her work situation. In this way Maria attempts to minimise criticism and rejection.

1.4.4 Case four - Angela: Coping strategies

Although Angela reports that she would approach her father for support and security during her early years, this is contradicted by the simultaneous report that she seldom (if ever) verbalised her feelings to her parents. In fact, the earliest coping strategy revealed in Angela's accounts, is withdrawal into herself. Her silent posture was the predominant way she dealt with any major upset or perceived negative emotion (sadness, anger). Angela knew that her father would not tolerate any expression of anger from her and this soon came to include any emotion besides happiness. Further to this, her mother's emotional instability and perceived fragility, forced Angela into a position of silent withdrawal in order not to upset her mother.

> **R:** How was it growing up with your mom, someone who was constantly changing toward you?
> **A:** I couldn't quite understand it....It just didn't make sense to me. It used to be so frustrating because you don't know what to think. And like I said before, I never used to say anything, so I just kept it all in, and then when I'd think, "I'm *not* taking this any more", she would be all nice and sweet, so I'd be left thinking, "huh? Did I miss out on something here? I'm really being too harsh on her". It just left me totally confused...I was so frustrated by not saying anything, especially because the concept of depression didn't make any sense to me....I wasn't saying anything and I was just left with a bitter pill to swallow each time, and then she'd be different again and I'd be left thinking, "my God, *now* you're being nice?" Like, how's your *timing* woman! But I shut up because she was all fragile. And also because you never speak back to your parents, unless you want a hiding.

After the emotional disappointment in her father (pre-adolescence), who was suddenly revealed to her as a fallible human being, rather than as someone perfect, she resolved not to trust others again (to avoid disappointment), and to keep her inner life concealed from others and from herself (as it was seen to be the cause of her pain). For years afterwards, she took on the role of a tomboy, acting rough and hard, in this way keeping others away from her. At that time, she had also resolved to work even harder to please her father and developed a perfectionistic attitude. She also became less intimate with her father, no longer approaching him, except to talk about superficial matters.

After the disappointment in her father, Angela blamed her inner life for her feelings of incompetence and unworthiness. At the age of 12 she was sent away from home to boarding school and it was there that she was suddenly confronted with intense feelings of emptiness and loss (at having being

separated from her father). Unable to make sense of the way she felt, or to integrate her feelings, a disequilibrium occurred and Angela's usual way of maintaining an internal equilibrium was suddenly ineffective in the face of these distressing feelings. It was during this time that Angela began to focus her attention on changing her body shape, (although she admits that weight was a minimal factor) and suddenly found herself engaging in bulimic behaviour. She became obsessed with ridding herself of anything she had eaten by vomiting and it is within her bulimic behaviour that another major coping strategy is revealed.

Vomiting became her vehicle of expression. When she was under academic or emotional stress, she would vomit. Because of her extreme self-control (she never revealed her emotions to others) and because of her need to maintain this image of self-sufficiency to others, she had found a sacred place in vomiting. She reports that not only was it a place of expressing her emotions, it was more importantly, a place where she could be **out** of control. Further, vomiting was a secret and because it was something she owned that no one knew about, it gave her an enormous sense of power over others. Vomiting offered many things to Angela. She reports that when she was feeling rejected or neglected she would bring out her bulimia more. In this regard, another coping strategy is revealed, namely seeking supportive intimacy with minimal self-exposure. She would, for example, tell others (friends, mother) that she was vomiting inexplicably but would never reveal the true nature of the problem. In this way, she was successful in gaining support from others (through their concern) but without having revealed herself. In her reports to the researcher, the function of vomiting is starkly clear.

> **A:** Vomiting was a silent way of voicing my emotions to myself. It was quite nice to be out of control for a while. It was like everywhere else I was, not quite perfect but controlled, and this, the vomiting, was totally uncontrolled. It was totally *not me*. It was just not the way I would've, could've, or should've dealt with something. And to have carried on with it for so long, there was also the challenge of stopping it, of wondering about that, and eventually realising, "God, this is actually out of hand. I can't stop it". That's where the frightened part came into it.
> **R:** So it was a place where you could be out of control but (interrupts)
> **A:** But also disliking being out of control.
> **R:** But up to a point you had the illusion that you were still in control?
> **A:** Yes, and it was also the biggest secret you can ever have. It's like this huge thing and nobody knows about it....
> **R:** Could we just stay with vomiting as a way of controlling emotions. Do you see that as the opposite of not controlling them but letting them be in a sense? Or was vomiting a way of not letting your emotions get to you in a sense?
> **A:** It was putting emotions into a different place. It wasn't controlling emotions, it was letting them out in a different way.
> **R:** Was that quite a powerful position to be in?
> **A:** I think it *was*. The feeling of power put me in a powerful position. You see, it's quite ambiguous. It was a place where I could be out of control and that felt powerful. But it

wasn't only where I could be out of control because I *was* out of control. I *had* no control....
R: How would you describe your relationship to food?
A: Warped. If I was upset I would eat....I loved and I hated food. That's why I was eating and bringing it up....Sometimes I'd eat a lot and didn't care because I knew I would bring it up afterwards....Other times, I could be upset and that would cause me to vomit or cause me to eat more and then vomit. Sometimes I would just vomit. I never had to have a reason to vomit. I could be in quite a good mood and vomit....
R: Do you have any strong feelings about food? One person I interviewed said food was a comfort for her.
A: I think I also thought that, because most times that I was upset or had a strong emotion, it was food that I would turn to, so it was comforting. At the same time, also liking and disliking it at the same time, you know, the love-hate thing.

Vomiting also offered support to another coping strategy: that of disregarding her emotional life and separating herself from it. Not only did vomiting provide a place where Angela was dissociated from herself and her surroundings, her treatment of the bulimia itself, (as something that was not part of who she was), reinforced another way of coping, denial. She denied her emotional life in the same way that she denied the fact that bulimia was in fact part of her life. The fact that her mother was emotionally unstable, suffering from manic-depression, further reinforced Angela's belief that emotions were disruptive and to be avoided. The coping strategy of seeking supportive intimacy with minimal self-exposure has already been mentioned, but demands more detail. Angela explains how she needed the support and reassurance of her friends and how at the same time, she never revealed herself to them in an intimate way. This was because she not only feared their rejection and criticism but also because she had an image of herself which she projected to others which she felt bound to uphold. In this regard, after her disappointment in her father, she would approach him for support but again, never revealed her real needs or pain. This strategy is mirrored in her relationships with boyfriends too, where she needed their reassurance and approval but would not share intimate details of her life with them.

A: My relationships only lasted about two months. As soon as I started getting emotionally involved I'd make them end it. But most of the times I never got involved....With Tony, I'm more myself. I tell him things....The last time he was away, I would write to him every day. Sometimes I would write, "I'm missing you terribly" and then I'd say, "oh gosh, I'm really going on here, you must be getting totally sick of hearing how much I love you". When he got back he said, "you know, the only part of your letters that really pissed me off was when you had to explain everything, like when you say you missed me and then end off by saying that you don't really think I need to be hearing that or that you shouldn't be saying these things". You know, I *always* do that. I *always* try and cover myself up incase he thinks something, or incase I'm wrong....
R: Do you see a future with Tony and you together?
A: Yes, I do. I don't see this as ending. It's actually quite a major thing for me to think like this because I usually thought of a relationship in terms of when it was going to end. That's how I would go into relationships and that's how it was ended too. I just knew it was going to happen. And this time, I'm far more involved than I've ever been in my whole life, in every single way.

Other coping strategies besides withdrawal, perfectionism, bulimia, denial of emotional life, and seeking supportive intimacy with minimal self-exposure include: (1) compliance - especially at home to avoid conflict; (2) self-destructive behaviour - cutting her hands with broken glass when feeling neglected (second example below); (3) minimalising - she minimalises her feelings and in this way succeeds in dismissing them; (4) continuous thinking about food, eating, and vomiting - allow her to remain unaware of the real issues she is facing and hence, to avoid them (first example below).

> I don't know if the bulimia ever got worse, I just became more aware of it....I'd probably not even noticed the things that had happened and were happening around me. I used to think, "I don't have a problem, I'm in control". I remember sometimes I would get so disgusted with myself. I would wake up thinking what I'm going to have for breakfast, or go to sleep thinking what I was going to have for breakfast, or thinking I mustn't eat breakfast, or I mustn't eat tomorrow.
>
> **R:** Have you ever deliberately tried to hurt yourself?
> **A:** Yes, I have. This is the first time I've ever admitted this....I was feeling very emotional....I just cut my hand but not enough to do any permanent damage. It was with a bottle and I was actually quite preoccupied with it. I was intrigued by what was happening....There was a lot of blood but when I was asked what happened I just gave some bullshit story about something....
> **R:** Can you remember how you were feeling around the time?
> **A:** I think I wanted attention. I wanted my boyfriend's attention. I wasn't getting the attention I wanted and it really mattered to me. I wanted some type of attention, no matter what it was.
> **R:** Did you feel desperate?
> **A:** I *did*, and what actually made me feel more desperate was that I wanted attention. *Why* did I want the attention? *Why* was it so important?
> **R:** ....It sounds like you were furious for needing someone.
> **A:** Ya, for needing attention, reassurance. But now I've admitted that I need those things. I *know* I need them. I enjoy hearing those type of things although I have difficulty asking for it....Just to go back though, I actually despise people who look for attention. Actually, with others it's okay.
> **R:** But with yourself it sounds like it isn't okay, that you don't take very kindly to yourself for having needs.
> **A:** No, I don't. I remember once admitting to myself that I needed reassurance, that I needed caring and that I needed to know I was important in someone's life. It was such a revelation to me when I admitted this for the first time in my life, to a boy when I was in matric. I said it once and never again. It was too much for me to comprehend that I actually need to be told things. I need that you know, it's important to hear things. I can't just assume some things I hear once every ten months. But the attention part, I just couldn't accept that I actually needed to be told things, that I needed to be told I was important. With things like that you should just *know* them, you *should* be able to deal with them yourself.
> **R:** Is that how it's always been for you? That you haven't been told things, like you're worthwhile or special?
> **A:** Ya, that's exactly how it's been. I think *that's* why I always think of myself as not very worthwhile.

APPENDIX TWO

2.1 DIAGNOSTIC SURVEY FOR EATING DISORDERS (D.S.E.D.)

(Adapted from Johnson, 1985)

INSTRUCTIONS: This questionnaire covers several eating problems that may or may not apply to you. You may find it difficult to answer some questions if your eating pattern is irregular or has changed recently. Please read each question carefully and choose the answer that **best** describes your situation **most of the time.** Also, please feel free to write remarks if this will clarify your answer. Thank you.

Name
Date
Permanent Address
Permanent Telephone

Identifying and demographic information

Sex

Male ____
Female ____

Date of birth: _____

Age: _____

Race (check one)

White ____
Black ____
Other (specify) ____

Your present religious affiliation (check one)

Protestant	_____	Jewish	_____
Catholic	_____	Greek Orthodox	_____
Dutch Reformed	_____	Anglican	_____
Baptist	_____	Other: (specify)	_____

Marital status (check one)

Presently in first marriage	____
Divorced and presently remarried	____
Divorced or separated and not presently remarried	____
Widowed and presently remarried	____
Widowed and not presently remarried	____
Never married	____

What is your present primary role? (check one)

Wage earner	____
Housewife	____
Student	____
Scholar	____
Other (specify)	____

Highest occupational level attained

	Check one for each person			
	Self	Father	Mother	Spouse
Higher executive, proprietor of large concern, major professional	____	____	____	____
Business manager of large concern, proprietor of medium sized business, lesser professional	____	____	____	____
Administrative personnel, owner of small independent business, minor professional, owner of large firm	____	____	____	____
Clerical or sales worker, technician, owner of little business, owner of medium sized firm	____	____	____	____
Skilled manual employee, owner of small business	____	____	____	____
Machine operator, semiskilled employee, tenant farmer who owns little equipment	____	____	____	____
Unskilled employee, sharcropper	____	____	____	____
Does not apply	____	____	____	____

(Never worked in paid employment)	____	____	____	____
Does not apply (no spouse)	____	____	____	____
Information not available	____	____	____	____

Current living arrangement (Check one)

With parents or relatives	____
Dorm or shared apartment with friend	____
Conjugal (intimate relationship with one other person, including spouse, boyfriend, etc.)	____
Alone	____

Highest level of education

	Check one for each person			
	Self	Father	Mother	Spouse
Completed post-graduate training	____	____	____	____
Some post-graduate training	____	____	____	____
Completed university degree, received four year academic degree	____	____	____	____
Completed high school; may have attended or completed trade school, or other non-academic training requiring high school completion	____	____	____	____
Attended high school	____	____	____	____
Completed primary school (std 5)	____	____	____	____
Attended primary school	____	____	____	____
No schooling	____	____	____	____
Does not apply (no spouse)	____	____	____	____
Information not available (Specify why)	____	____	____	____

Please describe your current occupation: _____

_____

_____

Weight history

Current weight: _____ kgs. _____ lbs.
Current height: _____ inches
Desired weight: _____ kgs. _____ lbs.

Adult Years

Highest adult weight since age 18: _____ kgs. at age _____

Lowest adult weight since age 18: _____ kgs. at age _____

How long did you remain at your lowest adult weight?

days _____ months _____ years _____

Adolescent Years

Highest weight between ages 12-18: _____ kgs. at age _____

Lowest weight between ages 12-18: _____ kgs. at age _____

Childhood

How did you perceive your weight as a child between the ages 6-12 years old?

Extremely thin _____
Somewhat thin _____
Normal weight _____
Somewhat overweight _____
Extremely overweight _____

As a child were you teased about your weight?

Yes about being underweight _____
Yes about being overweight _____

To what extent were you teased?

Extremely _____
Very much _____
Moderately _____
Slightly _____
Not at All _____

At your current weight do you feel that you are (tick one)

Extremely thin _____
Somewhat thin _____
Normal weight _____
Moderately overweight _____
Extremely overweight _____

Are you involved in an occupation that requires you to maintain a certain weight?

Yes _____ No _____

Please explain: _____
_____
_____

How much does a two-pound/one kilogram weight **gain** affect your feelings about yourself?

Extremely _____
Very much _____
Moderately _____
Slightly _____
Not at all _____

How much does a two-pound/one kilogram weight **loss** affect your feelings about yourself?

Extremely _____
Very much _____
Moderately _____
Slightly _____
Not at all _____

Has there ever been a time when your feelings about yourself or your social life have changed substantially as a result of losing weight?

Yes _____ No _____

Please explain: _____
_____
_____

How dissatisfied are you with the way your body is proportioned?

Extremely dissatisfied _____
Very dissatisfied _____
Moderately dissatisfied _____
Slightly dissatisfied _____
Not at all dissatisfied _____

Please indicate on the scales below how you feel about the different areas of your body.

1 - Strongly positive
2 - Moderately positive
3 - Neutral
4 - Moderately negative
5 - Strongly negative

Face _____
Arms _____
Shoulders _____
Breasts _____
Stomach _____
Buttocks _____
Thighs _____

How fat do you feel?

Extremely fat _____
Very fat _____
Fat _____
Somewhat fat _____
Not at all fat _____

How often do you weigh or measure your body size?

More than daily _____
Daily _____
More than weekly _____
Weekly _____
Monthly _____
Less than monthly _____

Dieting behaviour

Have you ever been on a diet?

Yes _____ No _____

At what age did you begin to restrict your food intake due to concern over your body size?

_____years old

In your first year of dieting how many times did you start a diet?

_____number of times

Over the last year how often have you begun a diet?

_____number of times

Please rank from 1-9 your preferred way of dieting (1 = most preferred way, 9 = least preferred)

Skip meals	_____	Reduce portions	_____
Completely fast	_____	Go on fad diets	_____
Restrict carbohydrates	_____	Reduce calories	_____
Restrict sweets	_____	Other (specify)	_____
Restrict fats	_____		

If you have ever been encouraged to diet, please rank from 1-10 the people that encouraged you to diet the most (1 = most encouraged, 10 = least encouraged)

Boyfriends	_____	Sister	_____
Girlfriends	_____	Employer	_____
Mother	_____	Teacher/coach	_____
Father	_____	Other relative	_____
Brother	_____	Other (please specify)	_____

Binge eating behaviour

Have you ever had an episode of eating a large amount of food in a short space of time (an eating binge)?

Yes _____ No _____

Please mark on the scales below, how characteristic the following symptoms are of your binge eating

I consume a large amount of food during a binge
Never _____Rarely _____Sometimes _____Often _____Always _____

I eat very rapidly
Never _____Rarely _____Sometimes _____Often _____Always _____

I feel out of control when I eat
Never _____Rarely _____Sometimes _____Often _____Always _____

I feel miserable or annoyed after I eat
Never _____Rarely _____Sometimes _____Often _____Always _____

I get uncontrollable urges to eat and eat until I feel physically ill
Never _____Rarely _____Sometimes _____Often _____Always _____

I binge eat in private
Never _____Rarely _____Sometimes _____Often _____Always _____

How long does a binge usually last?

Less than an hour _____
1-2 hours _____
More than 2 hours _____

Please rank 1-9 the times of day that you are most likely to binge (1 = most likely, 9 = least likely)

6am - 10am	_____		
8am -10am	_____	6pm - 8pm	_____
10am - 12pm	_____	8pm - 10pm	_____
12pm - 2pm	_____	10pm - 12am	_____
4pm - 6pm	_____	After midnight	_____

Please rank from 1-6 the place you are most likely to binge
(1 = most likely, 6 = least likely)

Home	_____
Work	_____
Restaurant	_____
Car	_____
Party	_____
Other: please specify	_____

Please rank from 1-4 how likely you are to binge eat in the presence of the following people
(1 = most likely, 4 = least likely)

Parents	_____
Alone	_____
Spouse/significant other	_____
Children	_____

How old were you when you began binge eating?

_____years old

How long have you had a problem with binge eating?

_____days _____months _____years

Within the last month, what has been your average number of binge episodes per week?

_____binges

What is the longest period you have had without binge eating since the onset of the problem?

_____days _____months _____years

What were the circumstances that helped you to **not** binge eat for that period of time (if more than one event is applicable please rank order the importance of the event with 1 = most important)

Began dieting	_____
Started exercising	_____
Sought professional help	_____
Began romantic relationship	_____
Left romantic relationship	_____
Developed illness	_____
Left home	_____
Divorce	_____
Marriage	_____
Pregnancy	_____
Work	_____
Vacation	_____
Other: please specify	_____

Using the scale below, please select the number which indicates the intensity of each of the following feelings **before** a binge

1 = Extremely intense
2 = Very intense
3 = Moderately intense
4 = Slightly intense
5 = Not at all intense

Calm	_____	Bored	_____
Empty	_____	Frustrated	_____
Confused	_____	Panicked	_____
Excited	_____	Relieved	_____
Angry	_____	Guilty	_____
Spaced out	_____	Depressed	_____
Inadequate	_____	Nervous	_____
Disgusted	_____	Other: please specify	_____
Lonely	_____		

Using the scale below, please select the number which indicates the intensity of each of the following feelings **after** a binge

1 = Extremely intense
2 = Very intense
3 = Moderately intense
4 = Slightly intense
5 = Not at all intense

Calm	_____	Bored	_____
Empty	_____	Frustrated	_____
Confused	_____	Panicked	_____
Excited	_____	Relieved	_____
Angry	_____	Guilty	_____
Spaced out	_____	Depressed	_____
Inadequate	_____	Nervous	_____
Disgusted	_____	Other: please specify	_____
Lonely	_____		

Have you noticed a relationship between the frequency of your binge eating and your menstrual cycle?

Yes _____ No _____

If yes, please indicate when during your cycle you feel more vulnerable to binge eating

During menstruation _____
11-14 days prior to menstruation _____
7-10 days prior to menstruation _____
3-6 days prior to menstruation _____
1-2 days prior to menstruation _____
After menstruation _____

How uncomfortable are you with your binge eating behaviour?

1 = Extremely uncomfortable _____
2 = Very uncomfortable _____
3 = Uncomfortable _____
4 = Somewhat uncomfortable _____
5 = Not at all uncomfortable _____

How willing would you be to gain 10 pounds in exchange for not binge eating any more?

1 = Extremely willing _____
2 = Very willing _____
3 = Willing _____
4 = Somewhat willing _____
5 = Not at all willing _____

Purging Behaviour

Have you ever vomited or spit out food after eating in order to get rid of the food eaten?

Yes _____ No _____

How old were you when you induced vomiting for the first time?

_____years old

How long have you been using self-induced vomiting?

_____days _____months _____years

Have you ever used laxatives to control your weight or "get rid of food"?

Yes _____ No _____

How old were you when you first took laxatives for weight control?

_____years old

How long have you been using laxatives for weight control?

_____days _____months _____years

How often are you now able to eat a "normal" meal without binge eating and without vomiting?

Never	_____	Several meals a week	_____
Less than one meal a week	_____	One meal a day	_____
About one meal a week	_____	More than one meal a day	_____

How soon after eating do you induce vomiting?

0-15 minutes	_____
16-30 minutes	_____
31-45 minutes	_____
46-60 minutes	_____
One hour or longer	_____

Which of the behaviours, binge eating or vomiting after meals came first?

Binge eating came first	_____
They both occurred at the same time	_____
Neither came first. I only have binge eating episodes	_____
Neither came first. I only have vomiting episodes	_____
Vomiting came first	_____
Neither came first, I have never had binge eating or vomiting	_____

During the entire **last month,** what is the average frequency that you have engaged in the following behaviours? (Check one for each behaviour)

1 = Never
2 = Once a month or less
3 = Several times a month
4 = Once a week
5 = Several times a week
6 = Once a day
7 = More than once a day

Binge eating	_____
Vomiting	_____
Laxative use	_____
Use of diet pills	_____
Use of water pills	_____
Use of enemas	_____
Exercise to control weight	_____
Fasting (skipping meals for entire day)	_____

Using the scale below, please select the number which indicates the intensity of each of the feelings state **before** a purge.

1 = Extremely intense
2 = Very intense
3 = Intense
4 = Slightly intense
5 = Not at all intense

Calm	_____	Bored	_____
Empty	_____	Frustrated	_____
Confused	_____	Panicked	_____
Excited	_____	Relieved	_____
Angry	_____	Guilty	_____
Spaced out	_____	Depressed	_____
Inadequate	_____	Nervous	_____
Disgusted	_____	Other: please specify	_____
Lonely	_____		

Using the scale below, please select the number which indicates the intensity of each of the following feelings state **after** a purge.

1 = Extremely intense
2 = Very intense
3 = Intense
4 = Slightly intense
5 = Not at all intense

Calm	_____	Bored	_____
Empty	_____	Frustrated	_____
Confused	_____	Panicked	_____
Excited	_____	Relieved	_____
Angry	_____	Guilty	_____
Spaced out	_____	Depressed	_____
Inadequate	_____	Nervous	_____
Disgusted	_____	Other: please specify	_____
Lonely	_____		

Exercise

How many minutes a day do you currently exercise (including going on walks, riding bicycles, etc.)?

_____minutes

Have you ever competed in any of the following physical activities? (Check as many as are applicable)

Distance running _____
Weight lifting _____
Dancing _____
Gymnastics _____
Wrestling _____
Tennis _____
Swimming _____
Other: please specify _____

Other Behaviour

Do you feel you have ever had an alcohol or drug abuse problem? (Circle one)

1 = Extreme _____
2 = Very much _____
3 = Moderate _____
4 = Slight _____
5 = Not at all _____

When did the drug or alcohol abuse problem start in relationship to the eating problem?

I never had a drug or alcohol problem _____
Before the eating problem began _____
After the eating problem began _____
At the same time the eating problem began _____

Please indicate how frequently you have used the following substances since the onset of your eating problem.

1 = Daily
2 = Weekly
3 = Monthly
4 = Less than monthly

	Amount	Frequency
Alcohol (specify type)		
	_____	_____
Amphetamines (Uppers)	_____	_____
Barbiturates (Downers)	_____	_____
Hallucinogens (LSD)	_____	_____
Appetite suppressants	_____	_____
Laxatives	_____	_____
Dagga	_____	_____
Tranquillisers	_____	_____
Cocaine	_____	_____

Cigarettes none _____ 0-half pack/day _____ 1 pack/day_____
More than 1 pack/day_____

Have you ever made a suicide attempt?

Describe:

_____

_____

Have you ever tried to physically hurt yourself (i.e. cut yourself, hit yourself with intent to hurt yourself, burn yourself with cigarettes)?

Yes _____ No _____

Describe:

_____

_____

Since the onset of your eating problem, have you been involved in stealing?

Yes _____ No _____

If yes, please describe types of items stolen:

_____

_____

_____

Sexual history

Have you ever engaged in sexual intercourse?

Yes _____ No _____

If your answer is yes, at what age did you first engage in sexual intercourse?

Age _____

Have you ever engaged in masturbation?

Yes _____ No _____

If your answer is yes, at what age did you first engage in masturbation?

Age _____

Please indicate on the scale below your interest in sex **before the onset** of your eating problem:

1 = No interest _____
2 = Somewhat interested _____
3 = Interested _____
4 = Very interested _____
5 = Extremely interested _____

Please indicate on the scale below whether there has been a change in your sexual interest **since the onset** of your eating problem:

1 = Much less interested _____
2 = Somewhat less interested _____
3 = Equally interested _____
4 = Somewhat more interested _____
5 = Much more interested _____

Please check your sexual preference:

Exclusively heterosexual _____
Primarily heterosexual, some homosexual _____
Bisexual _____
Primary homosexual, some heterosexual _____
Exclusively homosexual _____
Asexual (no sexual preference) _____
Autosexual (prefer masturbation to sexual relations with others) _____

Marriage and pregnancy (Check as many as applicable)

Was married before onset of the eating disorder _____
Was married after onset of the eating disorder _____
Was pregnant before onset of the eating disorder _____
Was pregnant after the onset of the eating disorder _____
Have one or more children _____

How satisfied are you with the quality of your sexual activity?

1 = Extremely satisfied _____
2 = Very satisfied _____
3 = Satisfied _____
4 = Somewhat satisfied _____
5 = Not at all satisfied _____

Menstrual history

Age at onset of menses (if you have never had your period please mark 0)

_____years

Since the onset of your eating problems, how many times have you stopped menstruating for three months or more (which were unrelated to pregnancy)

_____number of times

Since the onset of your eating problems, what is the total number of months that you have not menstruated (months unrelated to pregnancy)

_____months

Before the onset of your eating problems, what was the total number of months that you did not menstruate (months unrelated to pregnancy)

_____months

Approximate regularity of cycles **before** onset of eating difficulties (Check one)

Fairly regular (same number of days + 3)	_____
Somewhat irregular (variation 4-10 days)	_____
Very irregular (variation greater than 10 days)	_____
Never menstruated	_____

How many times in the past have you had episodes of loss of menstrual periods lasting 3 months or more associated with significant weight loss when you were not binge eating or pregnant?

_____number of times

Medical and psychiatric history

Have you ever had serious medical difficulties?

Yes _____ No _____

Please explain:

_____
_____
_____

Please indicate any prior hospitalisation for eating or emotional problems.

	Most Recent	2nd Prior	3rd Prior	4th Prior
Date admitted	_____	_____	_____	_____
Date discharged	_____	_____	_____	_____
Duration	_____	_____	_____	_____
Age	_____	_____	_____	_____
Primary reason for admission*	_____	_____	_____	_____

*Use number code: 1 = bulimia; 2 = anorexia nervosa; 3 = chemical dependency; 4 = depression; 5 = psychiatric other than depression; 6 = other (please specify):

_____
_____
_____
_____

Prior outpatient treatment for eating or emotional problems (i.e. a logically continuous series of treatments)

	Most Recent	2nd Prior	3rd Prior	4th Prior
Date begun	_____	_____	_____	_____
Date last visit of series	_____	_____	_____	_____
Duration(weeks)	_____	_____	_____	_____
Age	_____	_____	_____	_____
Primary reason for treatment*	_____	_____	_____	_____

*Use number code: 1 = bulimia; 2 = anorexia nervosa; 3 = chemical dependency; 4 = depression; 5 = psychiatric disorder other than depression; 6 = other (please specify

_____
_____
_____
_____

Are you currently on any medication?

Yes _____ No _____

Please identify: _____
_____
_____

What physical symptoms have you had since the onset of your eating problems? (If more than one response is applicable please rank order your answers with 1 = most troublesome, 7 = least troublesome)

Sore throat _____
Seizures _____
Feeling "bloated" _____
Stomach pains _____
Sores or calluses on fingers due to induction of vomiting _____
Dental problems _____
Other: please specify _____

_____

_____

Have you ever taken psychiatric medication?

Yes _____ No _____

Please identify_____

_____

_____

Please indicate, using the scale below, how frequently you experience the following symptoms:

1 = Never
2 = Rarely
3 = Sometimes
4 = Often
5 = Always

Depression _____
Anxiety _____
Difficulty getting up in the morning _____
Crying episodes _____
Irritability _____
Fatigue _____
Difficulty falling asleep _____

Life adjustment

Using the scale below, please indicate the quality of your relationship with each of the following:

1 = Terrible
2 = Poor
3 = Fair
4 = Good
5 = Excellent

Mother	_____
Father	_____
Husband/other	_____
Brother	_____
Sister	_____
Male friends	_____
Female friends	_____
Children	_____

Using the scale below, please indicate how much your eating problems interfere with the following:

1 = Never
2 = Rarely
3 = Sometimes
4 = Often
5 = Always

Work	_____
Daily activities (other than work)	_____
Thoughts	_____
Feelings about myself	_____
Personal relationships	_____

Family History

Have any of your first degree relatives had any of these problems?
(First degree relatives include children, brothers, sisters, parents).

Table 4: Family medical and psychiatric history

	Number of persons	Relationship to you (e.g., sister)	Require out-patient treatment (If yes, tick)	Require hospitalisation (If yes, tick)
Ulcers				
Diabetes				
Asthma				
Depression				
Manic-Depressive				
Schizophrenia				
Paranoid Thinking				
Hallucinations				
Obesity				
Alcohol				
Drug Abuse				
Severe Anxiety				
Phobias				
Bulimia				
Anorexia Nervosa				
Suicide Attempts				
Other				

Have you always lived in the same house?

Yes _____ No _____

If no, please record the places you have lived beginning from the time you were born to the present

Year	Place of birth	Duration of stay	Reason for moving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Did moving house/city/town affect you in any way?

Yes _____ No _____

Please describe: _____
_____
_____
_____
_____

List the schools you attended and the year and length of attendance:

Year	School	Standard	Length of stay
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Did changing schools affect you in any particular way? (e.g. difficulties with different school systems, difficulty making new friends etc.)

Please describe: _____
_____
_____
_____

APPENDIX THREE

3.1 COMPILING A CASE HISTORY

3.1.1 Identifying data, background information, and family history

1. Is there anything you want to ask or discuss with me about our meetings?

2. Do you understand what my role will be? (explain researcher's role).

3. Discuss length, duration of interviews, commitment, even though at times it may be painful to remember or talk about certain issues, permission to publish material providing participant's identity is protected.

4. Find out support system. If anything comes up which upsets him/her, does he/she have anyone with whom he/she can talk?

5. Why did you volunteer as a participant for this research?

6. What do you imagine is going to happen between us, if anything?

7. Do you think you will gain anything out of this research endeavour?

8. Perhaps we can start with you telling me who you are (age, place of birth, family background) which will help me to contextualise where you come from and assist me in getting to know who you are as a person.

9. What is your current living and working situation? Could you describe where you work, when did you start working there?

10. Do you have any brothers or sisters....who are they and when were they born....how do you get along with them....have there been any miscarriages, stillbirths or deaths in the family?

11. Could you tell me a bit about your family/parents: age....biological/adoptive.... educational/technical level....employment....living where....married when....still married....how would you describe their relationship....would you say it's a happy marriage....has it always been this way....if not, when did you notice a change in the way they got on with each other....had anything happened that you know about to cause this?

12. Could you tell me a bit about your parents' family background....where they come from....who their families are....in other words, who your extended family is....your aunts, uncles, cousins....are the families close, spend time together, go away together ....are there any major problems or differences between the families, disputes or feuds?

13. Grandparents....did you know them....are they still alive....how old are they or how old were they when they died....what was the cause of death....how would you describe them as people....are you particularly close to any one of them....what are your relationships like with them?

14. Who are you living with at the moment....are you married or involved in any relationship....are you happy with this arrangement....any problems?

15. Did you attend a nursery school....from what age....were there any problems that you know of?

16. At what age did you begin school....what school did you attend....did you change schools....when or at what standards....problems....when did you leave school....have you studied further?

3.1.2 Developmental history

1. Do you know about your mother's pregnancy with you....were there any medical or health problems....were you a full-term birth....was it a normal delivery/problems.... were you a planned baby, wanted or not....did they want a little girl/boy....were you breast or bottle-fed?

2. Were you a healthy baby? Do you know when you first walked, spoke, were toilet trained?

3. Parents often tell the same story to others about their children, either bragging or laughing about how cute or how naughty their children are, or how clever etc. Do they ever remind you of how you were when you were a child/baby, or have a favourite story about you?

4. Did you ever have nightmares or bad dreams when you were a child, sleepwalk, have tantrums, wet your bed after you were toilet trained, any particular food fads or foods you would not eat?

5. Did you have any major illnesses or operations when you were a child....suffer from convulsions....any other medical disorder?

6. Were you ever sexually or physically abused?

7. Do you remember your childhood....what is the earliest memory you have of yourself ....is this the earliest memory you have of yourself?

8. Did you have any particular fears as a child, for example of particular objects, situations or people?

9. Did you have close friends at school?

10. How did you do academically at school?

11. Were you ever in any serious trouble at school, for example with police or any other authority?

12. Were there adults other than your parents who played a significant role in your life as a child?

13. How did your father/mother respond to you when you were upset, angry, depressed, anxious about something?

14. How did he/she respond when you were happy or proud?

15. Did you find yourself doing things to gain his/her approval....what type of things got you a favourable response....did you succeed in gaining his/her approval?

16. Was it important for you to feel that he/she approved of you and your accomplishments....and now?

17. Do you think that he/she was proud to have you as a son/daughter....is there anything in particular that you know for a fact he/she likes/dislikes about you....how do you know this....did he/she tell you, or is it something that you gathered from the way he/she acted toward you?

18. Is there anything you did as a child that he/she particularly liked and encouraged, complimented you for?

19. How did your parents discipline you when you misbehaved?

20. Did your parents ever argue....what about....what did you do when they argued....were their arguments ever about you?

21. Can you remember any particular argument they had, or one which they had frequently and how it ended, or how arguments would typically end between your parents?

22. Did you ever intervene in an argument between your parents?

23. If you were involved in an argument with your father/mother, what would typically happen? Can you think of an example which would be typical of the way he/she argued/argues with you....was there anything in particular that you often argued about, or ended up fighting about?

Before I ask you the next set of questions, at what age do you see the cut-off point of your childhood, the age where you did not think of yourself as a child any more?

24. If you had to think back, how would you imagine your father/mother describing you as a child....would you agree with them....how would you imagine him/her describing you after the age of...? Do you think his/her perception of you changed at all from the time you were a child to when you got older, say from age 11 onwards....why do you think....how would they describe you now?

25. If you had to think back to the earliest time you can remember yourself, what is the immediate sense, feeling, thought, or visual image that comes to mind when you think of who your father/mother was that would best describe him/her? In other words, if you had to describe your father/mother and your relationship through the eyes of the child that you were, what are your immediate thoughts?

26. As you got older, did the way you thought of him/your mom and the kind of person he/she was, change at all? If yes, can you remember a time or a specific incident after which things were never the same again? For instance, did you ever see him/her do anything or say anything to you or someone else that suddenly made you aware that he was in any way different to how you thought him/her to be, perhaps underestimating the person he/she was or something else that left you wondering about who he/she was.

27. How would you finish this sentence: when I was a child, my father/mother meant...

28. How would you finish this sentence: when I think back to my childhood it was...

3.1.3 Social history

1. At what age did you begin dating?

2. Have you ever had any serious (long-term, exclusive) relationships?

3. Can you describe the most significant ones?

4. Is there a common pattern in these relationships?

5. How did they begin and why did they end?

6. How would you describe past sexual relationships, especially the first?

7. Are you dating anyone at present? If married, enquire about spouse.

8. What do you like about him/her?

9. Describe areas of compatibility in relationship.

10. Describe areas of incompatibility in relationship.

11. How did you meet your mate/spouse?

12. Have your relationships changed as a result of your current difficulties?

13. How are you getting along with people?

14. Are you finding your work/studies satisfying?

15. Has your performance been affected by your current difficulties?

Questions for Steve and Angela (frequently moved home)

1. Moving home is something that you are very familiar with. What did you think of being moved around so much?

2. Was there anything that caused you difficulty e.g., did you find it difficult to adjust to different schools or different ways of teaching?

3. Did changing schools and home cause difficulties in your relationships? In other words, can you relate the fact that you changed schools and homes so often to any particular problem you had, say in making new friends, or was this never an issue?

4. How do you think your family copes with changes because moving has been a part of all your experiences? And generally, when there is a need for change, does the family adapt quite easily to these new demands, e.g., when children get older, their needs change, they want to do and try things that demand a change in attitude and a lot of accommodating from parents, if not the whole family. How did your family respond to these changes?

For non-anorexic cases

1. Do you think others could ever understand your eating disorder?

2. Does your eating and weight problem ever cause you any problems or difficulties in your relations with friends? Has this always been the case?

3. Did it cause you any problems at school, e.g., with your school work?

4. What do you think others think of you? Could they ever understand your difficulties?

5. Do you know of any other people who share the same difficulties around food as you have? What do you think of them?

6. Did your friends know about your vomiting/eating binges? Did you want them to know or ever include anyone else when you binged or vomited?

7. Were you aware of anyone else at school and later at university and in your work-place who had similar difficulties as you were experiencing? Do you have any thoughts about this?

8. Being overweight in a highly body image conscious society, where despite inner ideals and personal values being exalted and an aspiration, the fact is, that outer appearance is still very highly emphasised, for example the Vogue model look. Do you have any thoughts or comments about this? Has societal pressure in any way contributed to your problem?

9. What are your thoughts if I told you we are living in a highly oppressive male-dominated society, where despite talk of equal rights and opportunities for women, in South Africa especially, we are still pawns to conforming to what society and especially, to how men want us to be, and that the media feed this male ideal, further forcing women into oppression by conforming to some ideal look?

10. How does this leave you feeling?

11. What do you think of the possibility that perhaps you hold onto your weight as a weapon to fight the oppressive nature of our patriarchal, male-dominated society and even, as a way to fight your mother, who as a woman has betrayed 'women' and sided with the oppressors (because she accepts and perpetuates their ideals)?

12. What are your thoughts if I told you that I thought that the position you have assumed (as a bulimic, compulsive eater) was a powerful position to be in? Would you agree that you are in a powerful position?

13. How would you finish this sentence: because I am fat or overweight/bulimic...

14. How would you finish this sentence: because I am a fat woman...

For anorexic case

1. How do you get along with the other boys and teachers at school?

2. Do your classmates know about your difficulties? Do you tell them? What do you think they think of you?

3. You were 11 when you first became anorexic, is that right? which means throughout your high school career you have suffered from anorexia. Do you think that being anorexic has affected your relationships at school?

4. Are you aware of anyone else at school who has similar difficulties to you, or anyone else who had or has anorexia? What are your thoughts about them?

5. If someone had to approach you, say a boy at school, to tell you that he was anorexic or who wanted to be as thin as you are, how would you feel? Would you encourage him to go on diet, or would you talk to him about your own difficulties and advise him on the basis of your own experiences?

6. Being an anorexic male is highly unusual because anorexia is a typically female syndrome. Do you have any thoughts about this?

7. How does it feel knowing that you are in a very unique category because being an anorexic male immediately casts you into a special group of people.

8. What are your thoughts if I told you I thought it was a powerful position to be in? Would you agree that you are in a powerful position?

9. What do you think that you perhaps hold onto your anorexia because it keeps you unique and different?

10. How would you finish this sentence: because I am anorexic...

11. How would you finish this sentence: because I am a male anorexic...

3.1.4 Personality

I am going to ask you some questions about the kind of person that you are, how you generally feel or behave.

1. How could you describe yourself as a person?

2. How do you think other people would describe you as a person?

3. How do you get along with other people?

4. Do you think that the usual way that you react to things or behave with people has caused your problems? (in what way?)

5. What kind of things do you do that other people might find annoying?

6. Would you say you tend to be more emotional or more a cool-headed kind of person? For instance, what would be a typical crisis situation for you and how would you handle it?

7. Do you tend to be a loner or somebody who likes to be with people?

8. How are you affected by what other people think of you?

9. Do you do things impulsively or unpredictably, or do you tend to plan things carefully in advance?

10. Do you sometimes love or greatly admire someone at one time and then hate or feel terribly disappointed by them at another time?

11. Do you sometimes have to take advantage of, or use other people to get what you want?

12. Have you often done things impulsively that could have got you into trouble like spending too much money, gambling, sex, drinking too much or taking drugs, reckless driving or eating binges?

13. Do you often have temper outbursts or get so angry that you lose control?

14. Have you ever tried to hurt or kill yourself or threatened to do so? How many times?

15. Have you ever deliberately tried to hurt yourself?

16. Are you uncertain about such things as....what kind of person you are....what your long term goals or career plans are....what kind of friends or lovers you want.... whether you are sexually attracted to men or women....who you feel loyal to, or what is important to you?

17. Do you often feel bored or empty inside?

18. How do you feel when someone praises you for something that you have done?

19. What about when someone criticises you?

20. Do you feel that you are a person with special talents or abilities that others have not recognised?

21. Do you think very often about achieving great things, such as being very successful, powerful, brilliant, attractive, or greatly loved?

22. Is it important to you that people pay attention to you or admire you in some way?

23. Do people often fail to give you the consideration you deserve?

24. Would you say that the problems that you face are so unique that few people could ever understand them?

25. How does it affect you if someone you know well is upset or hurting?

26. Are you often envious of other people?

3.1.5 Suicidal screening (Steve only)

At the end of our first interview, you told me that you would rather kill yourself than go back to school and that you often have suicidal thoughts. You spoke a bit about how you feel during those times and you told me that you have tried to kill yourself before. You also told me that you have written a poem or some prose about your suicidal feelings which I said we could look at more in-depth in a future interview. Would you like to talk about this for a while today? How would you like to approach it? Would you like me to read your poem first, or for you to tell me a bit about the poem? Alternatively, I could ask you some questions which could help you to start talking about your experiences.

1. Have things ever seemed to be hopeless?

2. Is this a new feeling or something that you have felt in the past....can you remember when you first started feeling hopeless and what the circumstances were around that.... did anything happen that caused you to feel that there was no hope that things could ever get better?

3. Have you ever thought that you'd prefer to be dead....when....how frequently would you say this thought crosses your mind?

4. Have you ever thought of killing yourself?

5. Have you ever made direct plans to kill yourself?

6. Do you have thoughts of killing yourself but would not carry them out? What stops you?

7. Have you ever tried to kill yourself....when....what were the circumstances surrounding the attempt....can you remember how you felt at the time, say just before, during, and after?

8. When someone would rather die than carry on living, it is usually because they feel trapped in a situation which is unbearable, or which they perceive to be too painful or frightening to bare or contemplate. Would you agree with this and can you identify with it in terms of your experiences and current situation?

9. What would be different if you had to die....would anything change....would you have achieved anything?

10. Have you ever thought about how your family would feel or react if you died or if you killed yourself? What do you imagine would happen if this happened?

11. Have you ever been afraid that because you are so thin, you could die?

12. When you have feelings about wanting to die, what do you do with them? For instance, do you find they generally get more and more, or do you try to ignore them?

13. On a number of occasions, you have mentioned your father's suicide. You told me that your father committed suicide two years ago, is that right? Would you mind looking at this for a while, or is it too painful?

14. Do you have any particular thoughts about his death?

15. Did he give any indication that he was planning to kill himself?

16. Had he threatened suicide before, or made any other attempts on his life?

17. Was his mood or general behaviour any different from the way it usually was the day that he killed himself, or in the few days before he died....was he any different toward you or with the rest of the family on the particular day that he died, or the day before?

18. What are your thoughts about why he killed himself....do you have any idea/thoughts about why he would choose such a drastic action?

19. Do you feel in any way responsible for his death, blame yourself....do you think that you contributed in any way to the way he was feeling and thinking that caused him to want to die?

20. Can you remember the last encounter you had with your father before he died? Was his behaviour unusual in any way?

21. Since your father died, have your thoughts about wanting to die increased, or had you thought of killing yourself before?

22. If there was one thing that you could have asked him before he died, what would it be ....and now?

23. On a previous occasion you have told me that at least your father managed to get it right, that is, to kill himself. What did you mean by this?

24. The death or loss of someone close to you, or someone who is very important to you, is one of the most painful human experiences but which is unavoidably a reality for all people at some stage in their lives. How did you cope with your father's death, or how do you cope with it now? It may be easier for you to answer this if you gave some thought to how you usually get through things, for example, if you are extremely upset about something, what do you do to make yourself feel better?

25. Did you find yourself doing things or thinking particular thoughts in the time after he died? Do you find it helpful if, for example, you keep yourself busy, or by thinking certain thoughts?

26. Do you find it helpful to talk things through with a friend or someone close to you when you are e.g., upset?

27. How did your family (mother, brother, sister) cope with your father's death?

28. Do you have any thoughts about what happens after death?

29. Would you say that your anorexia has in any way contributed to your feelings of wanting to die? In other words, do you think you would still have thoughts of dying and wanting to be dead if you were not anorexic?

3.1.6 Precipitants, course, and participant's understanding of the problem

1. Today I want to focus on the course which the anorexia/bulimia/compulsive eating has taken. In other words, your understanding of how things evolved through time. Most people find it helpful to talk of their experiences in a narrative form. For example, starting at a particular place in their life and proceeding with what happened next. For example, in your case....or for e.g., you started our first interview telling me that you were fat as a child, that you became increasingly self-conscious and that when you were 11 you joined Weighless. Could you take it up from there so that I can gain some insight into how the anorexia developed? You can include anything which you may think would be relevant in helping me to get to know your 'story'.

Or, in the absence of any information.../...

Maybe you can take some time to think about it, perhaps think of the time just before you became bulimic/compulsive eater and tell me what was happening in your life then, where you were, how you felt about yourself. Often, there is a particular event that marks the beginning, or which one sees as the event which finally culminated with the beginning of an irreversible cycle of events. Could you take it up from there so that I can gain some insight into how the bulimia/compulsive eating developed? You can include anything which you think may be relevant in helping me to get to know your 'story'.

Could you at the same time tell me when there was a move to a different town, as well as any illnesses or major family, or personal crisis. This will help me to situate your experiences into a context of time and place. I also need to know if you were receiving any help for your difficulties, when, with whom, for how long, whether it helped or not, if so what did and what did not. What we can do for simplicity's sake is talk about this separately.

2. What would you say are the main difficulties you are experiencing right now in your life?

3. People often have theories to explain the cause of their difficulties. How would you explain your anorexia/bulimia/compulsive eating?

4. You are seeing a number of professional people to help you with your difficulties. Who are they and do you think they are of any help?

5. When did you first seek help....what was the reason for this....who did you first approach....what was helpful or unhelpful....were there any problems with the treatment you were receiving? It may again be helpful to start from the first time you sought help.

6. Did you ask for help or were you forced into treatment?

7. How did your family respond to the fact that you were seeing professionals to help you with your difficulties....what do you think they think of you now? If they don't know that you are in treatment, how do you imagine they would react....is this what keeps you from telling them....would you like to tell them?

8. Have you ever tried to help yourself with your difficulties....what have you tried and were you successful....what would happen if you did not receive help for your difficulties?

9. In terms of your therapy/counselling sessions with Dr .... is it important for you to know that what you tell him/her stays between you, or have you found that he/she tells others?

10. Are you able to tell him/her everything you want to, or do you find you are quite selective with him/her for some reason....or is he/she someone safe with whom you feel you could reveal all of you, what you think, what you feel, what you want and what you don't want, what you wish?

11. What do you think of him/her....do you feel close to him/her? For example, could you imagine not seeing him/her or is he/she someone very important in your life?

12. Is there anything you particularly like or dislike about him/her?

13. Is there anything that he/she does for you that you particularly like or want him/her to be doing, or that you find helpful?

14. What do you think of him/her and the way he/she is treating you....are you aware of any treatment strategies he/she follows....do you feel he/she understands you and your difficulties?

15. What do you think he/she thinks of you? Does this fit with how you are?

16. If you had to give him/her some advice on what you thought would help, what would you say to him/her?

17. If you had to for a moment put yourself in his/her shoes, how would you describe you, your patient? In terms of the difficulties that you are experiencing, what would you for instance, say to your patient and what would your theory be about this patient.... what would your opinion be about what will happen to this patient....will he/she get better?

18. If in therapy or counselling: what do you hope to gain from this therapy? In other words, what are your goals?

For anorexic case

1. In the time that I've spent with you and your family, I've noticed that your life is discussed openly amongst friends, teachers, and those who are actively helping you. What do you think of this....do you for instance mind that people talk about you and your difficulties, your life, and sometimes in a way which is talking past you, as if you are not there, even when you are present? I've noticed that you either leave the room or occupy yourself doing something else. Would you agree that this is the case, and what does it feel like, what do you think about it because at least when I've been around, you have been the topic of conversation?

Group therapy questions for Angela

1. You've told me that you have group therapy every two weeks. Could you tell me a bit about the group, what happens there for instance.

2. Are you able to talk fully about your experiences and feel safe to do so with the others?

3. Do you experience any difficulties in the group, or is it quite easy for you to participate ....do you find it helpful....what specifically has helped you....is there anything you don't like or would like to change in the group?

4. Do you have any thoughts about the other group members? Are you quite close to them, can you identify with them?

5. Have you ever consulted any one else for help, for example have you ever been in psychotherapy? Is there any reason for this?

3.1.7 Medical history and current medical condition

Today I want to look at your medical history and current medical condition, as well as your family's health more in-depth.

1. When was your last medical check-up?
   What were the results?

2. Are you currently in treatment for any medical condition?
   Are you taking any medication at present?
   Do you have any medication or food allergies?

3. Are you satisfied with the treatment you have received so far? If not, what has been helpful or unhelpful?

4. Have you ever had surgery, minor illnesses or a serious accident resulting in injury? If so, when? Were there any lasting consequences, for example, chronic pain, weakness, hearing or visual defects, memory loss?

5. Does anyone in your family have any serious medical condition....are they in treatment.... what kind....hospitalisations necessary....when did this first begin.... does/did it affect you in any way....how has the family coped with this?

6. Have there been any psychiatric illnesses in your family....who....when....how has it affected you and how do you deal with it....how does the family deal with it?

7. Has heavy drinking or drinking caused you problems in your life or to anyone close to you? How much do you drink?

8. Have you ever used dope, speed, or any other drugs to make yourself feel good? Have you needed to increase your intake to maintain the effect? Quantities, frequency, duration.

9. Are you aware of anyone in your family or someone close to you who has a drug problem?

For female cases

10. In one of our previous interviews, you mentioned that you had started menstruating at the age of....is this right? Could you tell me about your first period....did you know what it was....who had told you....were you scared, happy, any strong feelings about it?

11. Have you ever had any problems related to your menstrual cycle....when did these begin....have you ever consulted a doctor or gynaecologist about it....what was the outcome?

12. Since the onset of your eating problems, how many times have you stopped menstruating for three months or more which were unrelated to pregnancy?

13. Before the onset of your eating problems, what was the total number of months that you did not menstruate, unrelated to pregnancy?

14. How regular were your menstrual cycles before the onset of your eating problems?

15. How many times in the past have you had episodes of loss of menstrual periods lasting three months or more associated with significant weight loss when you were not binge eating or pregnant?

16. Have you noticed a relationship between the frequency of your binge eating/vomiting and your menstrual cycle....is there for instance a certain time of the month which you feel more vulnerable to binge eating/vomiting?

17. Have you ever been pregnant?

18. Do you want to fall pregnant....are there any problems with this....does your husband/ boyfriend want a family?

19. Do you have any worries or concerns about this (pregnancy).....have you consulted a doctor about this....what were the results....how does this make you feel?

20. Do you feel any pressure from your husband/boyfriend, your family or his, and from society in general to bare children?

21. What will happen if you cannot fall pregnant....is it very important to you that you bare children....how many children would you like....how would you treat them....would you do anything differently from the way your parents brought you up....is there anything that your parents gave you that you would also like to give your children?

3.1.8 Symptomatology

I am going to ask you some questions about how you generally feel, your mood and any symptoms you may suffer from.

Mood and feelings

1. How do you feel in yourself?

2. What is your mood, how would you describe your mood?

3. How does the future look? In other words, what do you think of your future?

4. I am going to call out a number of different feelings and ask you to say which are applicable to you and how you feel.

Anger	Guilty	Unhappy
Annoyed	Happy	Bored
Sad	Conflicted	Restless
Depressed	Regretful	Lonely
Anxious	Hopeless	Contented
Fearful	Hopeful	Excited
Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense
Envy	Jealous	

5. Have there been other times in your life when you have experienced any of the above-mentioned feelings?
Establish onset, duration, frequency.

6. Have others noticed these?

7. What are your five main fears?

8. Have there been times in your life when you were unusually excited, irritable, or restless?

9. Have others noticed such times?

10. Have you been feeling anxious, nervous or tense?
Establish onset, duration, frequency.

11. Could you describe any other physical symptoms you have been experiencing, such as skin problems, blackouts, visual disturbances, hearing problems, sexual disturbances. When did this begin....how long does it last for....how often does it happen?

Sleep patterns

1. How do you sleep at night?

2. Have you noticed any changes in your sleep patterns at any other times in your life?

3. Do you have any recurrent dreams or nightmares?
Please describe them.

Obsessive-compulsive symptoms

1. Have you ever been bothered by certain thoughts that keep running through your mind so that you could not get rid of them no matter how hard you tried, such as silly, unwanted or scary thoughts or ideas that kept popping into your head against your will? Please describe them.

2. Have you ever felt forced to repeat a certain act over and over again, even though it did not make any sense to you or others....did this happen even though you sometimes knew it was silly and tried to stop yourself from doing it? Please describe.

Psychosis

1. Sometimes when people are upset, they have strange experiences. During this time, in other words, when you have been upset, have you had any unusual or strange ideas or experiences?

2. Do you seem to hear noises or voices when there is no one about and nothing to explain it, or that other people could not see or hear?

3. Have you felt that someone has been giving you a hard time, or trying to hurt you?

4. What about accusing you of things?

5. Have you felt (did you feel) that people were talking about you or taking special notice of you?

6. Have you ever felt any one touching you, like odd sensations on your body that makes you feel someone is touching you, or that anyone is around you, perhaps following you?

7. Have you **ever** had any of these experiences?

3.1.9 The meaning of food and eating

Today I want to ask you some questions about how you generally think and feel about food and eating, as well as how your family thinks and feels about food.

1. How would you describe your relationship to food?

2. Has this always been the case or has this changed in any way from how it used to be in the past? If so, when did your relationship toward food change....what are your thoughts about why this happened.

3. What do you think about food and eating? In other words, what does food and the eating of it mean to you?

4. How do you think others would describe your relationship to food....are they right in the ideas they have about you because often, there exists the layman's belief that anorexics hate food/that bulimics are greedy/that obese or compulsive eaters are selfish and insatiable?

5. How would you describe your family's relationship around food....is food a very important part of the family's life?

6. Are you a health conscious family? In other words, is there an emphasis on eating the right foods, maintaining a healthy diet?

7. How would you describe your family's behaviour around food....would you say that a great deal of importance is attached to eating the correct foods, i.e., are you a health conscious family, one which cares much about appearance and gaining weight?

8. What happens around meal times in your home? For instance, do you all eat together.... where....do you eat at the same times everyday....have you always followed this procedure or ritual in the family....are you happy with this arrangement....what is the procedure for dishing up in the family....who heads the table....do each of you dish up for yourselves, or does one person have that responsibility....has this always been the case?

9. What is the atmosphere like around the table for you? Is it say a time where the family takes a long time over the meal, talking and discussing the day's events, what the plans are for the next day, like a social occasion where you take a long time to eat, and where battles and disputes are fought, or is it reserved for eating only....has this always been the case....are things any different now that you are married/not living at home?

10. Before your difficulties with food began, was a meal time with the family something that you looked forward to....did you all eat together then?

11. Did anything ever bother you or make you uncomfortable at the table then....and after you were married, left home?

12. What does food represent to you? In other words, when you think of the word food, what are your immediate thoughts and feelings....does the word conjure up any visual images?

13. When you see other people eating and enjoying their food, does it bother you in any way....what goes through your mind when you see other people eat?

14. Does anyone else have an eating disorder in your family....is anyone else in the family over- or underweight....what do you think of the way your mother/father looks....does the fact that they are overweight repulse you in any way....would you like him/her to be any different from the way he/she is....would you say he/she eats a lot....what do you think of him/her when he/she is eating?

15. Were you ever scared that you would become as fat as him/her, or end up looking like him/her....did you ever want to look like him/her....how would you describe his/her physical appearance?

16. When you see a really fat person, what do you think or feel about them....and when you happen to be in their presence while they are eating?

17. What would you imagine goes through these fat peoples' minds if it so happens that you are in their presence and they see you eating....is there anything that you would be dying to say to them but don't?

18. Do you have any thoughts about thin people....and when they eat....is it more okay for them to eat than fat people?

19. Do you think that you are fat? What does being fat or overweight mean to you?

20. Is becoming fat something that you are afraid of....what specifically frightens you about that....so if for a moment you imagined yourself as fat, how physically big would you be....how would that make you feel....how much weight in kilograms would you have to have gained to be as big as this?

21. When you've described yourself as a child you've described yourself as .... Did you feel fat then....was this the primary reason that motivated you to diet?

22. In our talks, you have often told me that you are obsessed with food. What do you mean by obsession....do you think, dream, talk about food....do you think you do this too much....does it, for example, get in your way of doing other things?

23. When would you say that you first became obsessed with food and has this obsession gained in momentum....what are your thoughts about why this happened?

24. What was a typical day's eating regime before you developed an eating disorder....what would be a typical day's meals now, for instance, what did you eat the whole day yesterday?

25. Could you describe the way you feel, what your mood is, any thoughts that go through your mind when a meal time is approaching....has this always been the case....when did you notice that you started to think and feel in this way?

26. Do you get anxious at all before a meal....what do you do then....and after a meal.... what do you do then?

27. When you see the food on the table waiting to be dished up, how do you feel....and how do you feel during a meal, during the process of eating?

28. How do you feel after a meal....are you satisfied, still hungry....does it make you uncomfortable in any way?

29. Is it important for you to know a long time beforehand what it is that you will be eating?

30. Did you used to vomit at all before the eating disorder....what would have been a typical binge then....did you eat between meals then....did you mind eating in front of others then, or did you sneak into the kitchen secretly, not wanting anyone to see you....would you say that your eating behaviour was a problem then....what specifically would you say was a cause for concern?

31. Do you ever have eating binges now, where you consume a large amount of food in a short space of time? On the questionnaire you said that ... Were you referring to a time in the past or to the present....when did you last have an eating binge?

32. How would you describe your mood, how you feel before a vomit/binge....do you know when you are about to vomit/binge....how....and during the vomit/binge....are you aware of having any particular thoughts or feelings while you are eating....do you eat quickly ....are you ever afraid that someone will see you....where do you most frequently vomit/ binge and at what times of the day?

33. How do you feel having the food inside you? Does it, for instance, make you feel uncomfortable in any way....do you do anything to make yourself feel better....how do you feel after a vomit/binge?

34. How often do you vomit/binge? Has this always been the case?

35. Could you describe to me what you eat when you have a binge?

36. How long does a vomit/binge last?

37. Do you have any theory about why you vomit/binge....would you like not to vomit/binge any more....what would help....do you think you will ever be able to stop vomiting/ binging....what do you imagine would happen if you did not vomit/binge?

38. Do you do any exercise....what and how frequently....do you exercise at all to control your weight?

39. Do you have any food preferences....are there any foods that scare you so that you keep away from them....what are you scared would happen if you did eat them?

40. Do you have lists of good and bad foods that you will eat and some that you won't?

41. Are there any foods that you miss eating....what would happen if you let yourself eat what you wanted?

42. Once before, you told me that you are jealous of the fact that others can eat whatever they want. Why can't you also eat what you want....does something stop you?

43. Do you ever wake up after you've been asleep to eat, or at other times besides meal times....is it because you are hungry?

44. Do you ever get hungry....what do you do when you have a hunger pang and it's not yet time for a meal?

45. Are you hungry when you sit down for a meal? If not, are you able to say so, or do others take a firm stand with you and make you eat anyway....are you forced to eat at every meal time....has this always been the case....does this ever cause fights?

46. Do you ever wish that your mother and everybody else would just leave you alone to do your own thing....what do you imagine would happen, if anything?

47. How fat do you feel now? Was there a time before when you felt the same way?

48. Do you see fat as synonymous with a certain weight?

49. How much does a one kilogram weight gain affect your feelings about yourself? Could you tell me a bit about this and how it makes you feel?

50. How much does a one kilogram weight loss affect your feelings about yourself? Describe.

51. Would you say that your mom is compassionate to your struggle, that is, to your concerns around food?

52. Do you feel that she watches you to make sure you eat....how does this leave you feeling?

53. How does it feel having mom control your food intake?

54. Do you think that your weight is something that you can control....is it something that you want to desperately control....why?

55. How do you feel about the fact that others, principally your mother/psychiatrist/dietician have taken control of a very intimate part of your life in terms of watching what you eat, monitoring your weight....do you feel at all robbed of a part of yourself because it's become an issue for others to discuss and plan....do you want this part of you back?

56. What would happen if their attempts at controlling and monitoring your eating behaviour and weight were to stop?

57. Do you have an ideal weight which you think you will look good at....does your mother/ psychiatrist/dietician have one for you....do you agree with it?

58. Do you think that you look good now....have you ever thought that you looked okay at some weight?

59. Is it important for you to be thin....do you think you look good thin, or are more acceptable to yourself and others, than if you weighed an average weight for someone of your build and age?

60. When you look at yourself in the mirror, what do you see....do you like what you see?

61. How do you picture yourself in thirty years time?

62. Would you consider yourself to be healthy?

63. Would you consider yourself attractive to the opposite sex....how do you think they would describe you if they were asked to give their opinion on your body....would their descriptions be any different to how the same sex would describe you....would you like women/men to be attracted to you?

64. How would you respond if someone told you that they loved you and your body....have you ever felt that someone has loved your body....do you love your body....do you think you will ever love it?

65. Do you take great pride in your appearance, the way you look? Do you for instance take a lot of time dressing yourself to make sure you look good to create a favourable impression with others?

66. Do people ever compliment you about your looks....has anyone ever told you, for instance, that you have beautiful eyes/hair....what do you think then....do you agree?

67. How do you think your mother/father would describe your looks?

68. How do you imagine others would describe your outward appearance?

69. How do you feel owning the body that you are in?

70. Are you comfortable in your body....what would you change about yourself if you were given three wishes that would come true....would that change your life in any way?

71. Is there anything that you like about your body and would never change, that you could not live without, or which you consider an asset?

72. Has there ever been a time when your feelings about yourself or your social life changed as a result of losing weight?

73. Do you feel that you are in control of your body and its functions....for instance, do you believe that its size is under your control?

74. How dissatisfied are you with the way your body is proportioned....which part of it is not the way you would like it to be?

75. On the questionnaire, you said that you are dissatisfied with the way your body is proportioned. Which part of your body is not the proportion that you would like it to be?

76. How do you feel about the different areas of your body?
Face, arms, shoulders, breasts, stomach, buttocks, thighs?

77. Are you happy about the fact that you were born male/female, or would you prefer to be a female/male....are there any benefits or difficulties that you have because you are a man/woman?

78. Could you imagine yourself at a party one evening. First imagine yourself as fat at this party. Describe to me the surroundings, the people you are with, the clothes you are wearing, what you are doing and how you feel. What are the benefits of being fat at this party....is there anything that frightens you at this party?

79. Now imagine yourself as thin at this party. Describe your surroundings, the clothes you are wearing, what you are doing and how you feel. Is there anything frightening, or that scares you about being thin at this party....would things be any different on both occasions if you were/weren't anorexic/bulimic or a compulsive eater?

For anorexic case

1. You've told me that since you left the clinic, your mom has been dishing up meals for you. Has she always dished up your food....if not always, have you dished up for yourself at certain times....what happened that has led to the present circumstances....has this happened before, or is this something that happens often....do you have any thoughts about this, like do you want her to be dishing up for you.....does it help you in some way....if so, in what way....do you approve of the procedure or would you like to change it in some way....how?

2. Could you imagine dishing up for yourself....what comes in your way that causes you to believe that you need her to be doing this for you....do you think anything would happen if you dished up for yourself, say hypothetically your mom did not take on this responsibility for you?

For non-bulimic cases

1. Have you ever purposely vomited your food....do you ever feel like getting sick after you eat....what stops you then from vomiting your food....and spitting food out instead of swallowing it?

2. What do you think of people who eat and then vomit the food out....could you ever do that?

For non-anorexic cases

1. Do you have any thoughts about anorexics, people who wilfully deny themselves food?

3.1.9 The meaning of food and eating continued (except for anorexic case)

I'd like to stay with your experiences around food, eating and weight, and look more closely at what role it plays in your life, how if at all, it affects your relationships now, especially with your husband/boyfriend, your friends, and with the world in general.

1. **(For compulsive eater)** In a previous interview you said that it was always the case that when a relationship ended/wasn't going well, you figured that it was because you had a

weight problem. During that interview, you also said that on numerous occasions, your husband/boyfriend has expressed the wish that you were thin and that you could also look like one of the girls on his calendar. Do you have any thoughts about this....is this something that he tells you often....how does it make you feel, or how did it leave you feeling when he would say, "if only you lost a bit of weight, you would also look like these girls?"

1. Has your problem with food or your weight ever caused any problems in your relationship with your husband/boyfriend?

2. Are there any problems now in your relationship with your husband/boyfriend that are directly related to your eating and/or weight problem?

3. Does husband/boyfriend know that you have an eating disorder....did you tell him, or how did he find out....what do you think he thinks of this....how did you feel telling him, and when did you....does his being aware of the problem make it easier or more difficult for you?

4. Would you say that he understands your problem....how would he explain the difficulties that you have....would you agree with him?

5. Does he ever give you any advice on what to do about it, or offer to help you....do you want him to be involved in what I would call your 'struggle' with food and weight....do you ever ask him to help you....what do you ask him to do and is it of any help....do you find it easy to talk openly with him about your difficulties and about your eating disorder?

6. Do you ever secretly binge/vomit and not want him to know....how does this make you feel?

7. If you have had an eating binge/vomit would you like him to know....do you ever have guilt feelings about this....what do you do to make yourself feel better?

8. Are you comfortable eating in front of him....what do you think he thinks of you when you eat in front of him?

9. How would you describe his relationship to food?

10. How do you imagine he would describe your looks, your appearance....would you agree with him....has this always been the case, or do you think his perception of you is in any way different to how it used to be....how would you account for this change?

11. Has he ever seen you naked....what do you think he thinks of your body....do you feel that he loves it....would he love you any more if you were say thinner, or looked any different to how you look now?

12. How do you feel when you are naked in front of him....do you ever want to hide away or cover up?

13. When you've spoken about food and your weight, you've spoken a lot about your father/ mother and his/her blatant disapproval of the way you look and his/her constant striving

to want you to look better. You hardly mention your father/mother at these times. Is there any reason for this?

14. Has your eating disorder affected your relationship with your father/mother in any way ....if so, in what way....has this always been the case....if not, when would you say this started and why do you think?

15. What do you think your father/mother thinks of your weight?

16. Has there ever been a time when you felt he/she disapproved of you, where you wanted to look good for him/her?

17. Are you able to talk to him/her about your problem....is he/she aware of it?

18. How do you imagine he/she would understand it if you told him/her, or how do you think he/she understands it....is he/she right....do you agree with him/her?

3.1.10 Termination interview

1. Today is our last interview together. We have covered a great deal of your life experiences and at times you have shared, what I imagine, are very painful parts of your life with me. How has it been for you?

2. In the course of my obtaining a life history from you, we have discussed your childhood, your school and social history, medical and psychiatric treatment which you have received, the meaning of food and weight, your relationships with your grandmother, father, mother, brother and sister, and with the world in general. We have talked about your thoughts and feelings about anorexia/bulimia/compulsive eating, looked at its course, as well as possible causes for its development. Is there anything that you have thought of that you feel is relevant to who you are as a person that would help me in compiling your story but which I have overlooked in asking you?

3. You have on many occasions spoken of anorexia/bulimia/compulsive eating as your way of coping and that should you let go of it, there is either a real fear that you would have nothing left and/or what you would replace it with. Do you have any other thoughts about this, possibilities?

4. When I have asked you what you think would help, or what your theory is about why you are anorexic/bulimic/compulsive eater, you have replied that .... You've spoken of it as a coping mechanism, as a way of.... What do you think if I told you that you are right, and that the key to your freedom is in inside you and that with me, you have often picked it up and offered it to me as an explanation but that you just as quickly abandon it as non-applicable?

5. Do you feel you have gained anything from our meetings, perhaps learned anything, or do you feel that you have lost something by having shared so much of yourself with me?

6. Express thanks.

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