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Family and cultural factors in the development of eating disorders : a study of feminine identity in twenty-four bulimic women.

Carolyn F. Hicks
University of Massachusetts Amherst

FAMILY AND CULTURAL FACTORS IN THE DEVELOPMENT OF EATING DISORDERS: A STUDY OF FEMININE IDENTITY IN TWENTY-FOUR BULIMIC WOMEN

A Dissertation Presented

By

CAROLYN F. HICKS

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Approved as to style and content by:

Dr. Grace Craig, Chairperson of Committee

Dr. John W. Wideman, Member

Dr. Alexandra G. Kaplan, Member

Mario D. Fantini, Dean
School of Education

DEDICATION

With love and appreciation

for my parents,

Paul Landis Hicks

and

Annette Boehms Hicks

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ABSTRACT

Family and Cultural Factors in the Development of Eating Disorders: A Study of Feminine Identity in Twenty-four Bulimic Women

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Carolyn Faye Hicks, B.A., Vanderbilt University

M.Ed. University of Massachusetts

Ed.D. University of Massachusetts

Directed by: Professor Grace Craig

In this study twenty-four bulimic women participated in a questionnaire and semi-structured interview designed to examine their perceptions of themselves, their eating problems, and their families. In accord with the literature in the field, the questionnaire and interview were structured and data analyzed to facilitate a comparison of bulimia and anorexia nervosa. The analysis suggests that eating patterns and family experiences of bulimics and anorexics differ in significant ways.

There was no one significant or common eating pattern for all subjects. However, all the women engaged in secretive eating binges which did not appear to be motivated by hunger. Unlike anorexics, all women were acutely aware of their eating problem and shared an obsessive

concern with food and body size. None were hyperactive.

Most striking was the significance of the late adolescent transition of leaving home. Unlike anorexics for whom entering adolescence is a central conflict, bulimics experience mildly troubled adolescence and more severe difficulty entering adult womenhood. However, for bulimics the problems of adolescence centered on their emerging sexuality and peer relations. These problems highlighted certain characteristics of their relationships with parents.

Subjects reported relationships with mothers to be overinvolved and conflict avoidant. Identification with mothers was problematic and conflictual for all women Subjects described their fathers as emotionally unavailable. Alcohol abuse was present in a significant minority of fathers.

During the transition from family of origin to living autonomously dysfunctional eating patterns intensified. It was suggested that conflicts between family culture and the larger culture played a significant role in the development of bulimia.

It was concluded that the entire field of eating disorders is in need of further conceptual clarification. Current classification schemes fail to discriminate amongst phenomena that may be discrete in origins and dynamics. A

comparison of the early dynamics of individuals suffering from a variety of eating disorders could provide some of the clarification needed.

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CHAPTER I

INTRODUCTION

Background and Significance of the Problem

In the past two decades there has been an increasing emphasis in our society on weight and dieting. Current estimates indicate that at any given moment twenty million people in this country are on a serious diet (Harvard Medical School Health Letter, 1980). Popular magazines and books which appeal to and are purchased by women are replete with articles on losing weight and controlling eating. Since 1960, magazine articles on dieting and weight control have doubled in volume (Boskind-Lodahl, 1977). Although it is difficult to estimate the number of quick weight loss diets that have emerged, it is apparent that losing weight is big business in this culture. An estimated 10 billion dollars is spent annually by Americans in pursuit of slenderness (Orbach, 1978). Over the past twenty years commercial weight loss groups such as Weight Watchers, Overeaters Anonymous, TOPS, and Diet Workshop, have shown impressive membership figures. Weight Watchers alone has seen a membership of more than eight million people since its founding in the early 1960s (Goldberg,

1977). Weight reduction clinics, camps and programs abound and while many individuals have lost weight through these programs, some research suggests as much as a 95% recidivism rate (Orbach, 1978).

The fact that preoccupation with fat and food is commonplace for many women and has become a national concern often obscures the reality that cyclical compulsive overeating and dieting is a serious and painful reality for the individuals involved. The media image and ideal figure held for most women is that of the professional model and is often achieved only through extreme measures. An obsession with slimness and anxiety over being slightly overweight has precipitated serious physical and emotional problems in some individuals (Bruch, 1973) and for many, what begins as an attempt at normal dieting results in eating dysfunction that is damaging both physically and psychologically (Boskind-Lodahl, 1976; Bruch, 1973). Medical evidence suggests that it is less hazardous to one's health to remain up to 15% overweight than to run the risk of damaging health through on and off again dieting (Wyden, 1965). In the extreme cases of those who develop the dramatic symptoms of anorexia nervosa or obsessional self-starvation, an estimated 9-17% die from starvation or suicide (Tamagna, 1975).

A popular notion of weight consciousness and dieting being primarily a women's issue is supported by

statistics which point in this direction. An estimated 50% of American women are overweight (Orbach, 1978). Ninety percent of those who suffer from the life-threatening problem of anorexia nervosa are women (Bruch, 1978; Palazzoli, 1978). Certain research indicates that women go on more diets than men and lose less per diet, that women tend to diet for appearance while men diet for health reasons, and that emotional eating, that is, eating when worried, stressed or to relieve loneliness occurs five times more frequently in women than in men (Wyden, 1965).

Overweight is a problem for women and seems to be particularly so in certain socio-economic classes. While obesity is seven times more prevalent in lower class women, it is only among upper and middle class women that obesity is correlated with psychological maladjustment, suggesting the psychological and social pressures surrounding body size and appearance are more severe in these classes (Moore, Stunkard & Strole, 1962). Moreover, it is predominantly in members of the upper middle and upper classes that anorexia nervosa occurs (Bruch, 1973; Crisp, Palmer & Kalucy, 1976).

Statement of the Problem

Since the end of the 19th century eating disorders have been the subject of extensive research in psychology and biology. This research has focused on two major eating

disorders or syndromes: anorexia nervosa (self-starvation) and obesity (excessive overweight). Contemporary researchers and clinicians have identified an eating disorder characterized by periods of excessive eating and extreme methods of weight loss. Lodahl (1976) labelled this syndrome "bulimarexia." Most recent writers in psychiatry have identified this syndrome as bulimia. Bulimarexia or bulimia is characterized by regular ingestion of large quantities of food (binging) followed by rigorous dieting or in extreme vomiting, fasting, laxative or amphetamine abuse (purging), and abnormally low self-esteem.

While anorexia nervosa and obesity have been the focus for extensive inquiry and speculation, research on bulimia is just beginning. Perhaps it is the visibly dramatic physiological and behavioral changes in anorexia (skeletal thinness, amenorrhea, refusal of food, hyperactivity, denial of thinness) and the high incidence of medical complications accompanying obesity which account for the concern and interest of practitioners, researchers and theoreticians. The bulimic, who rarely requires hospitalization for either medical or psychological reasons and who tends not to present this as an initial complaint in therapy, is less visible.

While bulimarexia was originally described as a syndrome in which "anorexia-like" behavior is exhibited, the criteria offered for both bulimarexia and bulimia

emphasize the "binge" rather than the starvation aspect of the cycle as the major source of distress and manifestation of the problem. Binging behavior, followed by repeated attempts at losing weight through continuous dieting or other measures of more or less extremity, characterizes the eating problems of some individuals described in the literature as compulsive overeaters (Orbach, 1978), thin-fat people, or reactive obesity (Bruch, 1973). Other descriptions and case examples which would provide insight into the problem of binging and purging are scattered throughout clinical literature under the categories of primary anorexia nervosa, true anorexia, atypical anorexia, dysorexia and secondary neurotic anorexia. As yet it is unclear whether the eating pattern of binging and purging should be considered an undereating disorder, an overeating disorder, or a separate classification.

In both psychoanalytic literature and more recent socio-cultural (feminist) perspectives, eating disorders are associated with an expression of conflicts concerning separation, autonomy and female identification. The fact that eating disorders are an overwhelmingly female problem suggests it has to do with being female in the culture and with the relationship of mothers and daughters which prepares the young woman for adult female identity. While previous studies on eating disorders acknowledge the importance of the mother-daughter relationship in the

etiology of anorexia nervosa and obesity, few studies have systematically examined the nature of the mother-daughter relationship for its relevance to the disorder of excessive eating and dieting. The original intent of this study was to identify the central features of the mother-daughter relationship in bulimics and to examine the ways in which this eating dysfunction might represent conflicts in the mother-daughter dyad. However, in preliminary interviews it became apparent that the entire family context of these women had to be taken into account.

Since bulimia is a recently defined syndrome, little documentation of the personal or family histories of these women is available. This study evolved from my clinical curiosity which found little satisfaction in the literature, and my concern over research and statistics which indicate an increasing rise in the prevalence of women suffering from bulimia (New York Times, 1981).

Purpose of the Study

The purpose of this study then was to describe the eating patterns, perceptions of self and family of origin in twenty-four bulimic women. All subjects were given a questionnaire and personal interview. An analysis of the data provided a profile of the eating behaviors, family dynamics and adolescent experiences of women suffering from bulimia and further supported distinctions between bulimia

and anorexia. This study suggested the importance of viewing bulimia in the context of transitions occurring in the individual, the family and the larger culture.

In addition to providing new information about the lives of bulimic women, this study suggests implications for future research.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

Eating disorders have become a serious and common problem for many women today. One of the most widely researched and dramatic of these is anorexia nervosa, a serious psychosomatic condition in which young women starve themselves to the point of emaciation and/or death. In the past few years, observations of women exhibiting another abusive food pattern of cyclical binging and purging have increased in number. While there is continuing debate concerning the classification of a syndrome of binging and purging, writers and researchers in the field have often related these symptoms and characteristics to those observed in anorexia nervosa. Because binging and purging has been most clearly linked with anorexia, this review will be grounded in the literature on anorexia.

The proliferation of literature on anorexia nervosa renders an inclusive review cumbersome and, it is questionable that its relevance to the binging-purging syndrome would increase. Thus, this is a selective review paying particular attention to those works which would increase

our understanding of binging and purging and its relation to anorexia. The chapter will be divided into three major sections. The first section will address classification and diagnosis and will provide an overview of anorexia, its history, definition and clinical manifestation, as background for understanding current confusions in the classification of binging and purging.

The second major section presents a review of theoretical formulations. This section contains contributions from behavioral, psychoanalytic, family systems and feminist perspectives on anorexia and binging and purging.

The final section of this chapter is concerned with the family contexts of anorexia and binging and purging and reviews the social characteristics, emotional tone, and interactional patterns of parents and siblings.

Classification

Historical overview. It is possible and likely that cases of anorexia nervosa existed from woman's earliest beginnings. Recorded history reveals however, that the disease was common in the Middle Ages amongst witches and women thought to be possessed by the devil (Palazolli, 1978). The earliest description of cases resembling what are now known as the conditions and characteristics of anorexia are credited to an English physician Richard Morton. In 1689 he described a case of "nervous atrophy" specifying the chief

characteristics of the disease as amenorrhea, lack of appetite, emaciation and hyperactivity, with a marked indifference to the condition on the part of the patient. Although Morton linked the disease with nervous worries and cares of the adolescent girl, it was not until reports published 100 years later that specific attempts were made to relate those nervous cares and worries to an etiology of the disease. In the works of Lasegue (1873) and Gull (1868) anorexia emerged as a clinical entity with a defined symptomatology not directly attributable to any biological cause. Their descriptions of the outward manifestations of the condition generally correspond to current observations. Lasegue described three phases of anorexia beginning in adolescent girls: reduced food intake and overactivity, followed by a state of "mental perversion" or intense preoccupation with the disorder and finally, emaciation and severe depression. Gull observed in his cases the symptoms of emaciation, amenorrhea, loss of appetite, slow pulse and respiration, absence of somatic pathology and hyperactivity. He is credited with first employing the term anorexia nervosa after abandoning an earlier diagnosis of "hysteria apepsia" on the grounds that the condition was not limited to females althoug it occurred primarily in women. Gull's distinction of the condition of anorexia from hysteria marked the beginning of a spate of writing concerned with nosological problems which

continue today.

By the turn of the 20th century, there was general agreement that anorexia was a mental disorder with psychopathological origins. Janet's 1903 analysis of "mental anorexia" in the case of Nadia describes the disease as an obsessive form of disgust with the body which represented a rejection of a feminine sexual role. While this interpretation became the foundation for psychoanalytic formulations which were to re-emerge in the 1930's, Moris Simmond's report of a case in which death by starvation was due to glandular malfunction and atrophy of the anterior lobe of the pituitary gland (1914) altered the trend begun by Janet and confused the issue considerably. This publication and the subsequent report of two similar cases captured the interest of doctors and medical researchers who were to focus solely on the physical manifestations of emaciation for the next thirty years.

Diagnoses of Simmond's disease (or endocrine disorder) were indiscriminately applied to cases of self-inflicted starvation and the term anorexia nervosa with its apparent links to psychopathological processes was virtually abandoned. By assuming pituitary malfunction, malnutrition was followed by treatments involving pituitary grafts or transplants. Sheehan (1939) is credited with clarifying the mistaken belief that emaciation in young women was due to the destruction of the pituitary by endocrine pathology.

By differentiating Simmonds disease from anorexia nervosa, a classical view of anorexia as a particular psychopathological entity was reinstated. Other reports followed which substantiated these findings (Richardson, 1937) and once again inquiry turned toward nosological questions, exploring and establishing the psychogenic origins of the disorder and effective treatments. This emphasis continues to the present.

Primary anorexia nervosa. The identification of anorexia nervosa as a unique clinical entity continues to be the subject of much debate and confusion in psychiatry. This debate focusses on the following issue: is anorexia a disorder in its own right, a specific and unique clinical entity with features which distinguish its occurrence from all other forms of psychogenic weight loss, or, does it represent a constellation of psychophysiological symptoms which could occur in any psychiatric illness. As Bemis (1978) states:

> The frequency with which appetite disturbances are observed in a variety of organic and psychiatric illnesses has occasioned a controversy about whether "anorexia nervosa" comprises a specific disease entity. (p. 593)

A similar question exists within the categories of eating disturbances and affects this study; specifically, is binging-purging a form or phase of anorexia nervosa or can it be differentiated from anorexia to represent a

distinct clinical population. It is important to note that there are many reasons for the confusion surrounding the classification of eating disorders, particularly anorexia. The fact that the condition is not a fixed one but rather involves various stages, the fact that the state of malnutrition effects psychological changes thus changing the clinical picture, and the fact that the disease itself has dramatic effects on those who come in contact with it could account for difficulties in uniform classification (Bruch, 1973).

Reports of externally induced starvation point out forcefully that many of the characteristics and "symptoms" of anorexia, e.g., bizarre eating habits, food preoccupation, depression, amenorrhea, lassitude and withdrawal, are not specific to the disorder of anorexia nervosa but occur under naturalistic or experimental conditions of starvation or semi-starvation (Bruch, 1973; Bemis, 1978). However, under conditions of induced starvation, victims will eat any available food. As Bemis (1978) points out in a review of etiological factors and as others who study the problem conclude (Bruch, 1973) the single most identifying characteristic of anorexia nervosa is an active and persistent pursuit of thinness.

Generally, anorexia nervosa is considered a syndrome characterized by a pursuit of thinness and motivated by a fear of becoming fat which masks and is related to underly-

ing disturbances. Bemis (1978) observed anorexia to be "a complex of physical, emotional, and behavioral changes occurring in individuals who starve themselves because of an aversion to food or weight gain" (p. 593).

Hilde Bruch, whose work on anorexia and other eating disorders spans forty years of observation and clinical experience, is credited with first identifying a triad of developmental disturbances which warrant considering anorexia a specific nosological entity. These three dysfunctional processes are (1) a disturbance in body image and body concept in which emaciation is defended as normal and is the only security against becoming fat (2) a disturbance in the perception and cognitive interpretation of body stimuli including hunger, fatigue, cold, absence of sexual feeling, (3) a paralyzing sense of ineffectiveness and lack of awareness of personal resources.

Palazolli (1978) essentially confirmed these as necessary characteristics for the diagnosis of anorexia nervosa but added that in her experience the anorexic is not truly convinced that her emaciation is normal but pretends that it is in order to allay fears of obesity. She further suggested that the inability to perceive and identify body stimuli, particularly hunger, is most characteristic of the advanced stages of anorexia. The patients in her research were constantly aware of hunger in the beginning phases of starvation, and overcame it through great

efforts of will. She concluded that primary anorexia nervosa represents a desperate need to grow thinner and not an absence of appetite. As such the diagnosis of anorexia nervosa represents a special clinical syndrome.

The relationship of primary anorexia to other clinical conditions. Considerable work has led to a definition of specific syndrome of primary anorexia nervosa and its distinction from other unspecific eating disorders. In the process of discovery and definition, anorexia was linked to a variety of clinical conditions including conversion hysteria, obsessive-compulsive neuroses, schizophrenia and depression. Sours (1980), Palazolli (1978) and Bruch (1973) all present excellent historical accounts of these attempts to understand anorexia and its relationship to other psychiatric disturbances. I refer the reader to these works for further clarification.

For the purposes of this discussion some current conceptualizations distinguishing anorexia from other psychiatric conditions in which food refusal is prominent will be summarized.

Hysteria. The anorexic's active denial of her condition distinguishes her from the hysteric who is often flamboyantly engaged in her illness and uses it to elicit concern from other people. The rejection of food has a symbolic significance and may follow a sexual trauma. This

form of non-eating may be considered a form of atypical or secondary neurotic anorexia (Bruch, 1973; Palazolli, 1978).

Obsessive-compulsive neurosis. Obsessive-compulsive traits have been observed with great frequency in individuals with anorexia nervosa leading some researchers to consider it essentially an obsessive-compulsive neurosis with a fixation of anorexia and vomiting (Palmer and Jones, 1939). The major difference here is one of felt discomfort by the client. Individuals with fixations and phobias of weight gain or swallowing show some concern over their behavior manifest in diffuse anxiety, tension and fears concerning the symptoms. This contrasts markedly with the denial of the anorexic non-eater.

Depression. The relationship of anorexia to depression is a complicated one. Depressive features may be present in individuals with anorexia but depression is not a basic aspect of the disorder in its acute state. One rarely sees a pleasurable pursuit of thinness or the characteristic hyperactivity in those clinically depressed (Palazolli, 1978). On the contrary, depressed clients usually complain of appetite loss and appear more restricted or inert in physical activity.

It is important to note however that many anorexics experience a depressive phase prior to the onset of anorexic symptoms. This period of depression appears as a reaction to developmental stresses and precedes the anorexic's

attempt to resolve her difficulties through the control of her body size. Furthermore in instances of chronic anorexia, a general apathy pervades which is difficult to distinguish from depression (Bruch, 1973). And finally, depression may emerge if a patient is involved in therapeutic endeavors which alter her patterns with food. Food and its control may be serving as a defense against a deeper or psychotic depression and/or suicide (Palazzoli, 1978).

Schizophrenia. The schizophrenic presents a more disturbed sense of reality than the anorexic and often shows an indifference toward emaciation. The disturbance usually reveals delusions about eating and fantasies of being poisoned. The pursuit of thinness as a pleasurable activity, hyperactivity and perfectionistic strivings characteristic of anorexia are missing in this group. As in hysteria, food refusal is often symbolic of other conflicts (Sours, 1974). In the more severe cases of anorexia, however, the distinction is blurred and has led some clinicians to postulate and examine a "schizophrenic core" in anorexia nervosa (Bruch, 1973; Palazolli, 1978).

Types of anorexia nervosa. The problems in definition and recognition led researchers to sub-divide or separate different types of anorexia nervosa. Attempts at differentiation have been made through contrasting differences in

psychological features, personality characteristics and eating patterns.

Differences based in psychological features. Bruch's (1973) delineation of "true" or primary anorexia and atypical anorexia is one commonly used distinction based in differences in psychological features. Bruch differentiates the atypical patient from the true anorexic by the "absence of the characteristic features of the primary syndrome, namely, pursuit of thinness in the struggle for an independent identity, delusional denial of thinness, preoccupation with food, hyperactivity and striving for perfection" (p. 238). She further suggests motivational and dynamic differences centering on the preoccupation with "control." In the primary anorexic there is an attempt to establish a sense of one's own identity through control and manipulation of the body; in the atypical anorexic, the preoccupation with control is an attempt at influencing others to permit dependent behavior and remain sick.

Bruch's grouping somewhat corresponds with Meyer's (1965) classification of primary anorexia and secondary neurotic anorexia. Meyer defines secondary neurotic anorexia as a transitory disturbance of appetite which occurs in response to an intolerable existential situation, such as humiliation or perceived failure. Unlike primary anorexia the reaction is not concerned with resolving psychological conflicts. It is a reaction directed at the

outside world rather than at the self.

While Bruch restricts the diagnosis of primary anorexia to the triad of disturbances previously mentioned and differentiates two types of anorexia, she does not establish any sub-groupings within the category of primary anorexia nervosa.

Differences based in personality characteristics. Others who study the problem have not employed the distinction between primary and atypical but rather have subdivided types of anorexics according to differences in personality characteristics. Dally (1969) divided anorexics into three categories: an "obsessional" group; an "hysterical" group and a group of mixed etiology. Here anorexia is a symptom that exists in different characterological types. Lesser, Ashenden, et al. (1960) also classified three types of anorexics--a histrionic group, a rigid and perfectionistic group and a third who were apathetic, withdrawn and schizoid. Warren (1968) failing to find schizoid tendencies in any of his subjects notes the prevalence of shyness and reserve in these women accompanied by obsessional traits. Halmi (1974) also found anxiety, shyness, and obsessive-compulsive traits in the majority of her anorexic subjects. Smart, Beaumont and George (1976) criticize these studies for the use of terms such as "obsessional" or "histrionic" which are not clearly defined and vary from author to author. They go on to say "some

authors have tended to concentrate on personality inadequacies and abnormalities in an attempt to 'explain' the cause of the disturbance rather than to describe patients in terms of traits recognized as important in the general population" (p. 59). In their study they made such a comparison and found that anorexics showed higher degrees of neuroticism, anxiety and were more introverted than the normal population. One problem in these studies is that during the course of anorexia, symptoms emerge which would unquestionably affect the results of personality tests and thus, objective measures may indicate only the dominant characteristic at one point in time. While preliminary and inconclusive, these studies do suggest the variety of self-presentations and qualities in individuals exhibiting anorexia nervosa. In summary, among the most frequently encountered neurotic traits were hysterical, obsessive-compulsive, depressive, autistic and hypochondrical symptoms.

Differences based in eating behavior. Beaumont, George, and Smart (1976) have suggested sub-dividing patients suffering from primary anorexia nervosa according to differences in their eating behavior and attitudes. They subdivided patients according to "dieters" and "vomiters and purgers." Their distinctions were based in the eating patterns, rather than psychological characteristics, thus differing from criteria used by Bruch or Palazolli which do

distinguish categories of anorexia through psychological features. Beaumont et al. suggest that anorexic "dieters" are highly neurotic and introverted exhibiting "moderately severe obsessional features and average intelligence" (p. 621). The "vomiter/purger" is seen as extroverted and as having more normal social interactions. A more detailed discussion of binger-purgers requires a fuller discussion of the characteristics of anorexia nervosa.

Signs and symptoms of anorexia nervosa. Despite the diversity of opinions about what anorexia is extensive research has provided generally consistent signs and symptoms of the condition. The descriptive characteristics employed in this study come primarily from the work of Bruch (1973).

Severe weight loss. Most researchers who study anorexia agree that the cardinal physical symptom of this syndrome is a substantial loss of weight due to a refusal or restriction of food intake. Bliss and Branch (1960) propose a criterion of twenty-five pound weight loss for the diagnosis of anorexia. This figure, often still used in medical practice, fails to differentiate between primary and secondary anorexia. More recent diagnostic criteria for anorexia include a weight loss of twenty-five percent or more of original body weight (Feighner, 1972; Bemis, 1978). Rigid adherence to this figure can be misleading

due to variability in heights, ages and pre-illness weight. Thus, severe weight loss is a necessary but not sufficient condition for the diagnosis of anorexia nervosa.

This weight loss may be achieved by severe restriction of food intake by dieting or abstention. Obsessional preoccupation with food, its caloric value and preparation is frequently observed in anorexics. Many anorexics are gourmets who take great interest in food and its preparation. Halmi (1977) notes that forty-eight percent of the anorexics in her study cooked excessively before the onset of self-starvation suggesting this behavior may be one of the best warning signs of anorexia.

Other disordered eating patterns ranging from severe limitation of intake to uncontrolled excessive eating without awareness of hunger or satiation have been observed. Binging on food may be followed by self-induced vomiting, laxative abuse, fasting or use of dieuretics (Bruch, 1973; Halmi, 1974; Feighner, 1972).

During the active phase of anorexia, most patients engage in increased physical activity in an effort to lose weight (Halmi, 1974). This phase of <u>hyperactivity</u> is motivated by the pursuit of thinness and a desire to control the body (Bruch, 1973) and may be manifest by excessive walking, jogging, calisthenics, dancing, etc. Research measuring the activity of normal and anorexic women has shown anorexics to be more active (Stunkard, 1972).

However, once the anorexic has lost up to fifty percent of her normal body weight, hyperactivity gives way to periods of anxiety, listlessness or apathy, conditions seen in victims of externally imposed starvation.

An interesting finding concerning hyperactivity is reported by Halmi (1979). In a study of the relationship of pre-treatment characteristics to weight gain in anorexia, Halmi and her colleagues found that greater overactivity prior to treatment was associated with greater weight gain during treatment thus suggesting a sub-group of "most active anorexics" which are not as ill.

Amenorrhea. The presence of amenorrhea is defined by the loss of menstrual periods for at least three months (Dally, 1969). Amenorrhea is a defining characteristic of anorexia nervosa and is often one of the earliest symptoms of the disorder. Some dispute exists over whether amenorrhea is a result of malnutrition or has a psychogenic origin. Cases have appeared in the literature indicating that menstruation can cease prior to weight reduction (Halmi, 1974; Kay & Leigh, 1954). Recent endocrinological studies have shown abnormalities in hormonal functioning to be reversable with weight gain (Frisch, 1977; Vaitukaitis, 1979) suggesting endocrinologic dysfunction is a secondary result of the anorexic syndrome; weight reduction below the critical amount necessary for menstruation stops the menstrual flow. One explanation might be that some

anorexics begin secretive starvation prior to puberty. Menstruation is delayed by inadequate nutrition thus giving the appearance that amenorrhea developed prior to weight reduction. In any case, amenorrhea, once though to substantiate theories centering on a rejection of feminity is now thought to be a result and not a cause of malnutrition (Boskind-Lodahl, 1977; Vaitukaitis, 1979).

Since amenorrhea is central for the diagnosis of anorexia, some researchers have excluded men from this category. Others do include men (Bruch, 1973; Palazzoli, 1978; Sours, 1980) and have found the endocrine disturbance is revealed in anorexic males as a loss of sexual interest or feeling.

Disturbances in the perception and cognition of bodily states. Anorexics show a disturbance in their ability to perceive and interpret bodily sensations including hunger or fatigue. They rarely recognize hunger as a sign of nutritional need and seem impervious to other physical conditions which may result from malnutrition such as pain, cold, or loss of menstrual functioning. As Bruch (1973) has stated:

> Such individuals do not recognize when they are hungry or satiated, nor do they differentiate need for food from other uncomfortable sensations and feelings. They need signals coming from the outside to know when to eat and how much; their own inner awareness has not been programmed correctly. (p. 51)

This disturbance in inner awareness will be discussed further under Theoretical Approaches. It should be kept in mind that Palazolli (1978) failed to find this inability to recognize hunger in her anorexic patients.

The extent of denial of thinness and appetite has been shown to correlate negatively with weight gain and is a useful pre-treatment indicator of outcome (Halmi, 1977).

Body image disturbance. As the anorexic loses weight, signs of her condition become apparent to all observers except the anorexic herself. Thinness is denied and emaciation is defended as normal. The anorexic patient will often insist that her body is plump or overweight in spite of a skeletal appearance.

A distortion in body image is consistently present in anorexic patients. Slade and Russell (1970) have shown that anorexics significantly and consistently overestimate their body size on a variety of measures. It is important to note that most adolescent girls are prone to distortions in body image (Casper, 1979) since the changing shape of the body prevents a stable body perception. However, while body image disturbance is not unique to anorexia nervosa (Garner, 1976; Casper, 1979) it has been found to be associated with aspects of the eating dysfunction (Pierloot and Houben, 1978; Garfinkle, et al., 1977). Casper (1979) found the overestimation of body size to be associated with greater denial of illness and less weight gain during

treatment indicating that "the degree of body image disturbance was related to the severity of the illness" (p. 65). This further suggests the psychological defense mechanism of denial serves to help the anorexic avoid anxiety and conflict aroused by sensations of hunger and awareness of her thin condition.

Paralyzing sense of ineffectiveness. Anorexics often experience an undifferentiated sense of helplessness (Bruch, 1973) which pervades all thought and action. Everything is experienced by the anorexic as something happening to her beyond her control. This psychological characteristic may be masked by negativism and a refusal to eat, but emerges as a profound difficulty in self-regulation. Bruch suggests that because the anorexic-to-be has been such a model child, complying with parental demands for her to act and be a certain way, she has developed very little sense of self or capacity for self-oriented decisions. At adolescence, the increased need for independence presents a conflict for the anorexic child, one which she attempts to resolve through controlling her food intake and becoming thin.

Binging-purging syndrome: anorexia or bulimia? In recent years, increased observations of cyclical binging and purging have led to suggestions of a syndrome related to anorexia yet different in important ways. In the pages that

follow these differences will be highlighted in a discussion of problems in classification, definition and diagnosis of binging-purging.

Classification of binging-purging. As yet there is no uniform agreement as to the classification of binging-purging. Traditionally, it has been viewed as a form or phase of primary anorexia nervosa. Bruch (1973) considered it a phase of anorexia which can occur at any point in the progression of the disorder. She observed that about one quarter of those diagnosed as primary anorexics regularly binged and purged and further suggested it appeared only in primary anorexia nervosa.

> The nutritional disorganization has two phases, absence or denial of desire for food and uncontrollable impulses to gorge onself, usually without awareness of hunger, and often followed by self-induced vomiting . . . This occurred in about 25% of the cases with primary anorexia nervosa. No patient in the atypical group reported such episodes of bulimia. (p. 253)

Palazolli (1978) considered binging-purging to be a final phase occurring only in the most advanced and chronic stages of primary anorexia. Crisp (1977) supported this notion, labelling binger-purgers as "severely ill anorectics" (p. 59).

These views of binging-purging as a severe form of primary anorexia conflict with recent observations and formulations. In ground breaking work, Boskind-Lodahl (1977) suggested evidence of a "mildly neurotic" syndrome less severe than primary anorexia. Lodahl offers the term

"bulimarexia" to describe the cycles of overeating and starvation evidenced in this pattern with food.

> The syndrome "bulimarexia" is exhibited by women who alternately binge on food and then purge themselves, by a combination of forced vomiting, fasting, laxative, or amphetamine abuse. It differs from classic anorexia nervosa in that binging is the major manifestation rather than starvation; however the women invariably do both. . . . Unlike the classic anorexics, bulimarexics are able to function within the confines of daily life, albeit with difficulty, rarely requiring hospitalization." (p. 84)

In her formulation of bulimarexia, Lodahl (1977) suggests this is a specific syndrome resembling anorexia which, if viewed on a continuum, falls midway between anorexia and normal weight control. She fails to address directly the diagnostic question of whether only those who are true anorexics engage in this behavior or whether the phenomena should warrant a separate classification.

Bruch's (1973) description of "Thin Fat People" shows remarkable resemblence to what Lodahl referred to as bulimarexia, although the classification of a binging-purging disorder was not mentioned. "Thin Fat People," according to Bruch, were once fat or thought themselves to be and have managed to reduce with much strain and tension. They appear interesting and attractice but function with great difficulty and at a level far below what their pctential abilities suggest. Since they never permit themselves to eat adequately they suffer from malnutrition and evidence its consequences in depression, irritability, and an

inability to follow education or professional goals. Often they maintain a "magical weight" at the price of constant vigilance and severe tension. She further notes that these women have a compulsion to be special and are preoccupied with self-improvement and improvement of the world.

Bruch suggests that the major difference between "Thin Fat People" and anorexics seems to be one of degree and kind. Here, the obsessive concern with weight and body size camouflages a deeply held self-doubt and identity confusion; in anorexia, there is a more severe misperception of reality.

Lodahl (1977) also sees the differences between bulimarexia and anorexia in terms of degree. She suggests:

> . . . the variables that seem to influence whether or not a girl becomes anorexic or bulimarexic can be summarized in the following manner:
> 1. The degree to which the adolescent girl is controlled by parents and acquiesces to parental demands for conformity.
> 2. The degree of her social isolation.
> 3. The degree to which she possesses certain social skills such as assertiveness, self-reliance and independence and ensuing self-esteem experiences.
> 4. The significance and importance she attributes to having a male companion and male rejection experiences. (p. 31)

Rich (1978) presents two cases of binge eating and self-induced vomiting and concludes that unless there is substantial loss of weight the diagnosis of anorexia should not be given. He fruther questions whether this behavior warrants psychiatric classification or whether it simply represents an extreme method of weight control.

Gawelek, in a 1979 doctoral dissertation, examined the eating patterns, psychosocial histories and affective styles of five binger-purgers. In this important study, she found evidence to suggest two unique types of binger-purgers: those who are primarily anorexic and began binging and purging during severe emaciation and those who began binging-purging after an average weight loss. She concludes: "Since the anorexic may engage in binging-purging when the wish to eat cannot be controlled, the two eating disturbances have been assumed to be the same" (p. 63).

The American Psychiatric Association's Task Force on Nomenclature and Statistics suggest a disorder of binge-eating and self-induced vomiting called "bulimia." Writers of The Diagnostic and Statistical Manual III of the American Psychiatric Association felt the absence of the characteristics of extreme denial and severe weight loss found in anorexia nervosa were sufficient to delineate criteria for a separate classification. Bulimia is defined by:

> episodic binge eating accompanied by an awareness that the eating pattern is abnormal, fear of not being able to stop voluntarily and depressed mood and self-deprecating thoughts following the eating binges . . . A binge is usually terminated by abdominal pain, sleep, social interruption or induced vomiting. Vomiting decreases the physical pain of abdominal distention allowing either continued eating or termination of the binge, and often reduces post binge anguish. (p. 69)

Defining characteristics of binging-purging. In definitions of bulimia and bulimarexia, the "binge"rather

than a failure to eat is underscored as a distinguishing feature and regular manifestation of the problem. "Binging" is defined here as the ingestion of larger than normal quantities of food at a single setting or eating continually for hours or days. Binge eating is often accompanied by feelings of a loss of control, an "ecstatic" high, or an inability to stop eating. Binging behavior may vary in intensity and degree. Reports of caloric intake range from 1,500 (average binge) to 55,000 (extended binges) (Brody, 1981). In some instances there is little preference expressed for type or kind of food (Boskind-Lodahl, 1977) while others report that binge food is frequently high in calories, sweet and of a texture which can be rapidly eaten (DSM III, 1977).

A binge is usually terminated in response to physical symptoms such as abdominal pain or sleepiness, social interruption or forced vomiting. When self-induced vomiting occurs, it may function to relieve the physical discomfort of overeating thus permitting continued eating or it may signal the end of the binge. Many binger-purgers report post binge feelings of shame and self-loating which motivate rigid dieting, fasting, laxative, dieuretic or amphetamine abuse.

Once a routine of gorging and purging is established it may become a time-consuming and focal aspect of the women's life, preventing her from more normal social

and work relations. The disordered pattern with food serves to reinforce feelings of loneliness, "freakishness" and depression which in turn become precipitants for further cycles of binging-purging.

Eating binges (and purging techniques) are often done with secrecy. In contrast to anorexics, most individuals with bulimia feel their behavior to be abnormal, and experience the binging as a source of distress and concern. "Unlike primary anorexia, the presenting symptom is usually the gorging behavior which commonly is disguised behind complaints of loneliness and depression. The shame and guilt associated with these behaviors often keeps the bulimarexic from revealing her maladaptive, consummatory pattern to friends, family and therapists" (Boskind-Lodahl, 1977, pp. 14-15).

Some variance exists in reports of the frequency with which bingers seek therapy as contrasted with anorexics. Binge eating has been cited as a frequent precipitant for seeking therapy in obese populations (Stunkard, 1976; Bruch, 1973). Stunkard (1976) who examined binging behavior in obesity, suggested that binge eating is more commonly associated with anorexia than with obesity and suggests as many as fifty percent of anorexics may eat in binges. His criteria for anorexia is not clearly stated. He does suggest that those who binge may have a better prognosis in treatment since binging as a source of distress offers

a symptom with precipitating events which can be examined and leads directly to exploration and treatment of major personal conflicts.

In contrast Palazolli (1978) reported differences in patients with different eating behaviors and found binger-purgers to show more signs of disorganized thinking than those who restrict food. She also reports these patients as having a poorer prognosis for treatment than those who stabilize their eating patterns. Bruch (1973) reported an inability to establish such differences through projective testing or clinically and stated "It may be accidental but patients with eating binges and vomiting seem to come more often for intensive psychotherapy and to persist in it" (Bruch, p. 268).

The amount of weight loss appears to be significantly different for anorexics and binger-purgers. While a severe weight loss is evidenced in anorexia and is necessary for the diagnosis of anorexia (Bemis, 1978), binger-purgers often appear within normal weight range or may show sizable weight fluctuations which are never so great as to be life-threatening.

> Bulimia is seldom incapacitating except in a few individuals who spend their entire day in binge eating and self-induced vomiting. Electrolyte imbalance and dehydration can occur in those below normal weight who vomit after binges. (DSM III, 1977, p. 70)

Unlike the anorexic, those who binge-purge rarely require

hospitalization for weight loss or emaciation (Boskind-Lodahl, 1977).

In addition to differences concerning weight loss, the eating patterns and activity levels appear to be different in the two groups. Gawelek (1979) reports that binger-purgers in her study were unable to maintain control over their desire to eat as contrasted with the rigorous dieting and self-denial evidenced in anorexia. The DSM III (1977) reports eating patterns of bulimics to be "binges [which] alternate with periods of normal eating, or with periods of normal eating and fasts. In extreme cases, however, there may be alternate binges and fasts with no periods of normal eating" (p. 70). Furthermore, anorexics engage in strenuous activity and exercise in their attempts to lose weight. The binger-purgers in Gawelek's study reported moderate exercise, not in the same proportion as the anorexic. No information or mention of activity levels are reported by Lodahl or the DSM III.

While the binging-purging cycle is the source of shame and self-loathing, becoming "fat" or gaining weight is often more frightening, particularly since the binger-purger is inordinately preoccupied with body size. Lodahl (1977) reported complaints of being too fat from all thirty-five subjects in her study even though outside observers (including the therapist) did not share this observation, suggesting a distorted body image in bulimarexics.

Gawelek's five binger-purgers also "assessed themselves to be overweight" (p. 164) even though they appeared within normal weight. The DSM III suggests, "Individuals [with bulimia] may manifest undue concern with body image and appearance, often related to sexual attractiveness, with a focus on how others will see and react to them" (p. 70). This is contrasted with steadfast denial of thinness in anorexia suggesting binger-purgers may have a less severe body image disturbance.

Although the presence of amenorrhea is a central feature of anorexia (Bruch, 1973; Feighner, 1972), amenorrhea is not included in diagnostic criteria for bulimia in the DSM III. Gawelek (1979) reported the binger-purgers in her study experienced amenorrhea specifying however that minimal binging-purging did not seem to effect menstruation. Of the thirty-five subjects in Lodahl's 1977 study, approximately one-half (18) reported normal menstrual cycles. Thirteen subjects reported irregular menstrual cycles and four reported amenorrhea. Many of the subjects with irregular menstrual cycles reported seeking medical treatment or the use of birth control pills in attempts to stabilize menstrual functioning.

Summary

Since binging and purging is a recently defined phenomena, research is scant. All attempts at classification pose problems. At this time there appears to be at leat three prevalent ways of looking at this particular eating problem:

(1) Form or phase of anorexia. This is the most prevalent approach in the literature. Here, binging-purging is considered a form of primary anorexia which can occur at any point in the illness (Bruch, 1973) or as a final phase of primary anorexia nervosa which represents chronicity (Palazolli, 1978).

(2) Syndrome related to anorexia in which "anorexic-like" behaviors are manifest. These approaches emphasize that anorexic symptomatology ranges from severe psychopathology (psychosis) to everyday societal and cultural manifestations (Sours, 1980). Boskind-Lodahl (1977) differentiates primary anorexia nervosa as a rare phenomenon and calls binging-purging, "bulimarexia." Bulimarexia appears as anorexic-like behavior in otherwise functional and mildly neurotic women.

(3) Bulimia. A syndrome of binge eating which is terminated through a variety of methods. Bulimia does not involve the severe weight loss or degree of denial apparent in anorexia nervosa and must be differentiated from the

diagnosis of anorexia nervosa. While it seems to early to choose between the various classificatory schemes, the writers of The Diagnostic and Statistical Manual III (1977) seem to offer the clearest behavioral indicators for defining this population in their definitions of bulimia.

Preliminary studies do suggest that binger-purgers appear to resemble anorexics in their obsessions about food, dieting and physical appearance. Binge eating, rather than starvation, appears to be a central component of the dysfunctional eating pattern. Emaciation, amenorrhea and gross body image disturbance appear to be less severe in binger-purgers than in anorexics. Hyperactivity, a characteristic of anorexics is not reported as a feature of binger-purgers.

Theoretical Approaches

Traditionally binging-purging has been viewed as a form or phase of primary anorexia nervosa. Recent contributions suggest important differences between habitual binger-purgers and primary anorexia nervosa and a newly defined classification of bulimia has been suggested. This presents major difficulties in a review of pertinent theory as much of this information is grounded in and derived from work with primary anorexia nervosa. At the same time to review only those studies which focus exclusively on the binging-purging phenomenon would be to omit from

consideration important theoretical possibilities for understanding bulimia. With this in mind, the following section will include an overview of major theoretical approaches to anorexia but the reader is cautioned in assuming too much about their applicability to bulimia. This is a newly recognized phenomenon and as such will require extensive examination before conclusions concerning its relation to anorexia nervosa or other eating problems can be ascertained.

Behavioral approaches. The behavioral approach to anorexia emphasizing operant conditioning emerged in the last decade. In keeping with the behaviorist tradition, behavioral researchers consider anorexia a learned behavior reinforced by environmental factors (Blinder, 1970) and thus focus on treatment design rather than etiology. Briefly, behavior therapy is aimed at changing the dysfunctional eating patterns without considering the meaning or function of this pattern in the anorexic's life. Little attention is given to underlying causes or internal dynamics. Desired behavior in the patient is reinforced positively. Since weight gain is the desired behavior in treatment of anorexia, positive reinforcements are contingent on pounds gained. Continued hospitalization may be used as a negative reinforcer for pounds lost.

Reports of behavioral treatment programs often

reveal promising results (Bachrach, Erwin, and Mohr, 1965) but frequently do not report follow-up information. In those behavioral studies which do present follow-up reports, long range results of behavioral treatment are mixed. Bhanji and Thompson (1974) presented a behavioral treatment approach with eleven anorexics. Ten patients gained weight sufficient for discharge but follow-up on seven of the patients was less promising, revealing overall adjustment ratings of "fair" and "poor" in six patients and "good" overall adjustment in one patient. A more successful result was obtained in an operant program reported by Halmi et al. (1975). These researchers treated eight anorexics in a hospital setting and instructed their parents to offer positive reinforcement for weight gain when the anorexics were discharged. Follow-up at seven months revealed half the patients to have maintained "good" overall adjustment, three had made "adequate" adjustment and one "fair."

Serious criticisms of behavioral programming and research have focussed on small sampling and inadequate follow-up studies, the absence of clear diagnostic criteria, inappropriate emphasis on rapid refeeding and weight gain, and the ethics of enforced treatment (Bemis, 1978). One of the most outspoken critics of behavioral therapy is Bruch (1974).

> Uniformly, my patients had experienced the program as brutal coercion by which they were reduced to utter helplessness; whatever self-confidence they might have achieved in individual therapy was nullified. (pp. 1421-22)

Since an important aspect of the anorexic's condition is her intense feeling of ineffectiveness and loss of autonomy, a behavioral method might serve to reinforce such feelings. If so, such treatment might have a damaging effect. Bruch further points out that since anorexics are often good achievers they will make the desired weight gain while in the hospital only to revert to dysfunctional eating patterns once they leave. The end result is weight gain without any correction of the underlying psychopathology, a result which can strengthen the anorexic's sense of helplessness.

It has been noted that one-quarter to one-third of patients who experience rapid weight gain during hospitalization experience bulimia or compulsive overeating after discharge (Theander, 1970).

Family systems perspective. A family systems perspective is grounded in the idea that human problems are interpersonal, involve several people and as such, wide systems of relationships rather than individual members should be observed and treated. Within this conceptual framework, anorexia nervosa is viewed as a symptom which has interpersonal significance for the whole family and is maintained

by dysfunctional interactional patterns in the family context. In turn, the symptom serves to maintain these family patterns in a protective way. Family systems therapists analyze these interactional processes and devise interventions which will restructure family communication and resolve the symptom.

In their extensive work on psychosomatic families, Minuchin, Rosman and Baker (1978) found the following characteristics in the transactions of families with an anorexic member: (1) enmeshment or diffuse interpersonal boundaries between family members, (2) diffusion of conflict, (3) overprotection, particularly of the anorexic, (4) rigidity and inflexibility in transactional patterns and (5) participation of the identified patient in detouring conflicts occurring between other family members. Minuchin and his colleagues claim an eighty-six percent recovery rate by their method of treatment. Since it is beyond the scope of this study to present the work of family systems theory and therapy in detail, I refer the interested reader to Minuchin, Rosman and Baker (1978) for further explication.

Problems arise when considering family treatment for binger-purgers. Since the binger-purger is often living away from her family of origin at the time of onset of symptoms (Boskind-Lodahl, 1977), involving the whole family in treatment may be difficult or impractical.

Psychoanalytic contributions. Psychoanalytic thinking about eating disorders can be characterized by two major trends. The first of these trends rests on Freud's (1918) assumption that impairment in the nutritional instinct was related to the individual's inability to master sexual excitation. This formulation gained prominence in the 1930's and continued to inform psychodynamic explorations for 40 years. A second trend in psychoanalytic inquiry began in the 1960's, is based in explorations of ego psychology, and postulates a disturbed early mother-infant relationship to account for anorexic behavior. While all the variations within psychoanalytic thinking are too numerous to include here, an overview of these two major trends will be presented.

Freudian analysis. Interpretations of eating dysfunction as representing sexuality conflicts can be found in numerous case examples over the past forty years. This trend in psychoanalytic inquiry has been summarized as a "symptomatic approach" (Bruch, 1973) in which the symptoms of anorexia including the eating disturbance represent symbolic expression of an internalized sexual conflict. Here anorexic and bulimic behavior are considered as expressive of unresolved Oedipal conflicts and a rejection of femininity. The fact that anorexia occurs at puberty and that it is associated with amenorrhea led these writers to interpret anorexia as a regression to an earlier stage of

development in which oral gratification is associated with sexual pleasure and reproduction. Starvation or fear of eating is interpreted as a fear of oral impregnation or penis fear (Waller, Kaufman and Deutsch, 1940) and bulimia represents the wish for a child through oral insemination or gratification of the sexual instinct through oral masturbation (Kaufman and Heiman, 1964).

Wulff (1945) writes that compulsive overeating is one aspect of a larger neurotic maladjustment which assumes that there is pre-genital fixation characterized by the person's

> . . . fight against her sexuality which through previous repression, has become greedy and insatiable. . . . Periods of depression, in which patients stuff themselves and feel themselves "fat" . . . "dirty" . . . or pregnant alternate with "good" periods in which they behave ascetically, feel slim and conduct themselves normally . . . (p. 241)

Waller, Kaufmann, and Deutsch (1940) specify psychological factors centering around pregnancy fantasies involving the gastro-intestinal tract.

> . . . The wish to be impregnated through the mouth which results at times in compulsive eating, and at other times, in guilt and consequent rejection of food, the constipation symbolizing the child in abdomen and the amenorrhea as a direct psychological repercussion of pregnancy fantasies. (p. 2)

While diminishing in popularity, these views still persist in some circles. Meyer (1971) defines a central goal of adolescence as "the acceptance of the role of the sexually and socially mature woman . . . when considering

why these young girls react with anorexia to their maturation problems, we have to bear in mind the relation between the sexual and food instincts" (p. 540).

The interpretation of eating disorders as representing unconscious sexual conflicts has been criticized recently by clinicians who failed to find evidence of oral impregnation fears in their patients (Kay and Leigh, 1954; Boskind-Lodahl, 1977; Palazolli, 1978). Oral pregnancy fears are often reported in the general population of adolescent girls and are not therefore sufficient to explain the pathnogenesis of anorexia.

Bruch's interpersonal theory. Bruch, failing to find in her own extensive clinical work cases exemplifying this preoccupation, also rejects the oral impregnation theory and represents a second trend in psychoanalytic theory. Essentially Bruch's theory of the genesis of eating disorders represents a shift from psychoanalytic libido theory to a developmental learning theory. Interactions between the infant and her environment become the foundation for later interpersonal relations.

Emphasizing the interpersonal climate of the child's development, Bruch stresses the anorexic's fear of maturity and a faulty mother/child relationship from the earliest beginnings. Her work recognizes the importance of connecting those issues and conflicts arising out of the oedipal conflict with the effects of pre-oedipal experience.

Foremost of these effects, Bruch postulates, is "faulty hunger awareness" or a basic disturbance in the way the sensation of hunger is experienced. This disturbance is seen to underly any disturbed eating pattern. Although the origins of faulty hunger awareness are unclear, it is assumed to begin in the earliest stages of symbiosis in the mother-child dyad. Maintaining that hunger awareness is learned rather than innate, she hypothesizes a relational experience between mother and infant which goes beyond a dichotomy of somatic and psychological development.

In an adequate mother-infant experience, the infant begins to recognize and differentiate her physiological needs if her cues are responded to appropriately, that is, by behavior which satisifes those needs. From this mutual process (the expression of needs and their satisfaction--hunger/food; cold/blanket; wet/change of diaper) the infant becomes aware of her bodily identity. Put in other terms, the development of a rudimentary ego is based in the differentiation of bodily states.

In this scheme, the infant is not totally passive but participates by giving off signals indicating need. If these signals are responded to appropriately both infant and mother are satisfied. Moreover, important learning is taking place as the infant becomes aware of her needs and begins to differentiate between them. This earliest learning is necessary for hunger awareness and other biological

needs to become differentiated and organized into recognizable patterns.

> Appropriate responses to clues coming from the infant, in the biological field as well as in the intellectual, social and emotional field, are necessary for the child to organize the significant building stones for the development of self-awareness and self-effectiveness. (p. 56)

When this process has been faulty as it is assumed to be in anorexia and bulimia, the individual will remain to some degree confused and alienated from the body as the primary source of experience. Before a child can give validity to her own bodily experiences and perceptions, they must first be legitimized by the person in authority (the mother). Instead of legitimizing the child's feelings or physical signals, it is assumed the mothers of anorexics impose their own. Rather than responding to the infant's cues, the mother names and superimposes another need on the child and initiates behavior to satisfy the superimposed need. It is important to note that this mislabeling probably occurs at many different levels during the life of the child and extends to emotional reactions and eventually to the child's role in the family as well (Palazolli, 1978). Under these circumstances, the individual may misperceive intrapsychic conflicts or those which are interpersonal in origin as related to the body, its appearance, size or function.

Consequently, the individual will proceed in

development but without a solid belief in her own feelings. She will not be able to discriminate and interpret certain bodily states.

> The patient's sense of not knowing how they feel and of not being in control of their sensations is a literal expression of faulty self-awareness. The core problems being their profound sense of ineffectiveness, their lack of awareness of their sensations, not feeling in control, or not even owning their own bodies. (Bruch, 1973, p. 57)

The confusion in self-body concept results in a lack of a sense of separateness or "diffuse ego boundaries" and as a result the individual feels helpless, ineffective and at the mercy of external forces.

The ability to recognize physical hunger sensations has been directly studied and research confirms this postulate for both obese and anorexics. In a study by Bruch and Coddington (1970) obese and anorexic patients were more inaccurate in recognizing whether or not or how much food had been received in an experiment where measured amounts of food were ingested. Measuring accuracy of identifying hunger contractions, Stunkard (1959) found that obese patients were less able than normal subjects to identify hunger contractions. Schacter (1968) concluded from similar research that bodily symptoms labelled as "hunger" differed for obese and normal subjects. Since both anorexics and obese have difficulty identifying physiological cues and express body image disturbance, it is assumed that an incorrect or faulty learning experience took place.

In anorexia, a triad of dysfunctional ego processes emerge from these early falsified learning experiences: a diffuse sense of body boundaries, faulty awareness and understanding of internal states and feelings, and a paralyzing sense of ineffectiveness. These disturbed processes manifest themselves in a severe body image disturbance, an inability to recognize hunger, fatigue, and cold, and a pervasive sense of ineffectiveness which often lies beneath a stance of stubborn defiance in the anorexic.

Bruch's emphasis on the early transactions of infant and environment locates the origins of anorexia in an interpersonal context. Her observations regarding faulty learning experiences in anorexia are compatible with an understanding of anorexia in object-relations terms.

Object-relations theory. An object relations perspective is most clearly explicated in the work of Mara Selvini-Palazolli and represents an important contribution within the second major trend in psychoanalytic thinking.

Briefly, object relations theory is one which argues that the child's social relational experience from earliest infancy is determining for psychological growth. A child takes into itself (internalizes) conflictual relationships as it experiences them. What is internalized from an on-going relationship becomes unconscious and persists more or less independently of the original relationsip. The earliest internalizations of self and other are

pre-verbal and experienced largely in a somatic manner. These internalizations of aspects of one's parents and of oneself in relation to the parent, while unconscious, remain as influencers of later behavior. Thus, the development of the personality is grounded in an individual's relationship to his body from the moment he perceives it as whole and separate from the mother's (Winicott, 1972).

In anorexia, this internal climate and later behavior of the anorexic is assumed to be as follows: the potential anorexic child is frustrated from having an early good body experience with the mother. (An early good body experience is defined as one in which the body in relationship with the mother is a source of predominantly pleasurable sensations.) Instead, early bodily experiences are frustrating, ritualized or controlled resulting in a psychopathological body experience (Palazolli, 1978) which becomes unconscious. The child who is yet unable to see herself as separate from the mother experiences her body as the source of bad sensations or as being inhabited by a bad object (p. 85).

This absence of self-differentiation goes unnoticed in latency. Unable to assert their own needs, the anorexic conforms to parental desires and ambitions for her and appears as a model child. The stresses and pressures of adolescent development, that is the second phase of separation-individuation (Blos, 1967) demand that she

establish peer relationships, separate from her mother and adjust to her emergent female sexuality. As this process ensues, the anorexic concretely identifies with the maternal object (Palazzoli, 1978).

At adolescence the daughter's body is becoming more like her mother's body which is remembered unconsciously as powerful and threatening. Because of the development of breasts and other feminine curves, the body is experienced as concretely as the maternal figure from which the anorexic is trying to separate. All the bad aspects of the earlier experience with the mother are projected by the anorexic on to her own body. Equating her body with the negative aspects of her mother, the anorexic then experiences her own body as threatening and powerful, as that aspect of the self that is too angry, or too sexual, too out of control. Put another way, the body seen as the source of needs which overpower the undernourished ego is objectified as a threatening force that must be held in check or destroyed.

For the anorexic, there is a split between the body and the self. As the body grows the object/"thing" grows and the individual must split off from the body in order to gain control. Food must be kept at a minimum if the body/"thing" is to be contained. The positive aspects of the mother are aligned with the anorexic's superego or non-physical self. The negative aspects are projected onto the body. The anorexic fears that giving nourishment to her

body is giving power to the negative part of herself which by becoming larger might overpower the good nonphysical self. Food intake is used to separate self from non-self and control is exercised by stopping eating. Thus, in object relation terms, the battle to control her body can be seen as the anorexic's attempt to control some aspect of her internalized relationship with her mother. This rejection of the body and all that it needs provides the anorexic a delicate ego balance. "The power motive frustrated in interpersonal relationships is shifted to the intrapersonal structure, that is to rigid control of the patient's body" (Palazolli, 1978, p. 94).

In summary an object relations perspective emphasizes the reactivation in adolescence of an overwhelming sense of helplessness and ineffectiveness of the ego ordinarily experienced during the oral phase of development when self-expression and basic need differentiations were frustrated in the mother-infant relationship.

Recent developmental contributions. Current psychoanaltic thought and interpretation is further informed by the work of developmental psychologists, most notably Margaret Mahler (1968, 1972).

Mahler sees establishing a relationship with the mother and subsequent separation and individuation from her as the most important tasks in the first three years of life. By separation is meant establishing a belief in the

possession of separate boundaries. By individuation is meant the development of personality and character traits that are one's own. This includes the establishment of gender identity.

Mahler subdivides the processes of separation-individuation into subphases. She designates these as (1) differentiation, (2) practicing, (3) rapprochement, (4) the child on the way to object constancy. The tasks of separation and individuation begin as the infant (approximately 6-8 months old) begins to move out of a fused or symbiotic state of oneness with the mother. Differentiation of or the realization of self as separate from the mother (approximately 6-10 months) markes the beginning of becoming more physically mobile and the development of an ego. An inadequate symbiotic phase will delay differentiation or precipitate premature attempts to assert autonomy. These attempts are impaired as the infant lacks a firm relational base with the mother from which to differentiate.

The period of differentiating self from other partially coincides with another process which Mahler labels "practicing." During this time (10-18 months) the infant increasingly experiences his own physical mobility and takes pleasure in this achievement, checking back with the mother for "emotional refueling." During the practicing sub-phase the mother is needed as a stable point, a home base from which he can explore the world and take pleasure

in his own functioning.

> Libidinal cathexis shifts substantially into the service of the rapidly growing autonomous ego and its functions, and the child seems to be intoxicated with his own faculties and with the greatness of his world. . . . The chief characteristic of this practicing period is the child's great narcissistic investment in his own functions, his own body, as well as in the objects and objectives of his expanding "reality". . . . he is often so absorbed in his own activities that for long periods of time he appears to be oblivious to the mother's presence. However, he returns periodically to the mother, seeming to need her physical proximity from time to time. (Maher, 1972, p. 490)

The third sub-phase, rapprochement, begins with "toddlerhood" or when the infant has mastered physical mobility and is less absorbed in his own autonomous functioning. During this sub-phase individuation proceeds rapidly. Self-representations and object representations are more clearly differentiated. The exhiliration of the "practicing" phase is replaced by acknowledgment of frustration, separation anxiety and the use of coping mechanisms to avoid separation. Seemingly contradictory behavior emerges; the child is increasingly independent and at the same time makes demands for his mother's constant participation.

The task of toddler and mother at this stage lies in the realization that they are separate individuals and that gestures of "pre-verbal empathy between mother and child, will no longer suffice to attain the child's goal of satisfaction, of well-being. Similarly, the mother can no

longer make the child subservient to her own predilections and wishes" (p. 494). It is this sometimes slow and painful recognition of separateness and vulnerability that Mahler labels the "rapprochement crisis."

> Three great anxieties of childhood meet at this developmental stage. (1) While the fear of object loss and abandonment is partly relieved, it is also greatly complicated by the internalization of parental demands that indicate beginning superego development. . . . we observe an intensified vulnerability. (2) Fear in terms of loss of the love of the object results in an extrasensitive reaction to approval and disapproval by the parent. (3) There is greater awareness of bodily feelings and pressures. . . . (p. 506)

Recent work by Kaplan (1979) locates the anorexic struggle in faulty separation-individuation. Grounding her work in Mahler's stages she suggests the symptoms and underlying dynamics of anorexia nervosa are prototypical of the vulnerabilities involved in the normal transition from practicing proper to rapprochement.

The anorexic's strivings for perfection and power might be considered as aspects of a manic-like state that defends against the grief and ambivalence that accompany rapprochement. Separateness, aloneness and vulnerability characterize the developmental passage of rapprochement. Anorexic features of low self-esteem and imperviousness to the needs of the body can be seen as prototypic of the earlier stage of practicing proper (Kaplan, 1979).

Psychodynamics of binging-purging. The psychodynamics of binging and purging have been presented by

various authors. Binging-purging has been associated with pre-genital development (Bliss and Branch, 1960) and with "a disturbed ego and psychosexual development beginning with the earliest mother-daughter relationship (Ehrensing and Weitzman, 1970, p. 201). Successful separation-individuation is impeded by inappropriate mothering in which the young child was well fed but received little validation for her true feelings. A fixation at the separation-individuation stage of development prevents the establishment of object constancy (Sours, 1980).

Seligman (1976) also attributes the binging-purging syndrome to inappropriate mothering. She sees the binging component as an effort to seek "the ever-nourishing maternal breast," while the purging component relieves guilt and shame over this loss of control and expression of "greed." Here, the dynamics of binging and purging are closely related to those assumed to exist in anorexia nervosa.

As with anorexia, the idea of concretization of the body as representing the maternal figure and subsequent rejection of the body has not gone unnoticed by theorists attempting to understand the dynamics of binging and purging. Guiora (1967) suggests that in the "dysorectic" one might conceptualize a lesion in the ego structure which shows up in proccupation with the body. The body, a concrete embodiment of the ego, is a constant source of concern and

anxiety for the binger-purger. Further he suggests that early rageful feelings towards the mother are re-awakened at the advent of puberty and block any identification with the mother. An exacerbation of earlier deficiencies in the ego occurs in the general picture at puberty when independent functioning is necessary. These psychodynamic explanations of the binging-purging syndrome emphasize and make a strong case for its relation to anorexia nervosa.

Psychodynamic treatment approaches. The most extensively employed psychological treatment approach to anorexia has been classical psychoanalysis or long-term "insight" oriented psychotherapy. The aim of this approach is resolution of the intrapsychic conflicts underlying anorexia through the use of interpretation. These approaches have been criticized for being costly and ineffectual in alterning anorexic behavior (Blinder, Freeman and Stunkard, 1970; Palazolli, 1978). Furthermore the effects of therapists' expectations are visible in many of these reports (Boskind-Lodahl, 1977) and conclusions in many of these studies are based on the analysis of a single patient, thus limiting the possibility for comparison.

Therapists working within the conceptual framework of ego psychology have suggested modifications of psychoanalytic theory (Ehrensing and Weitzman, 1970; Horner, 1979). They advocate another kind of intensive psychotherapy, one which provides a warm and nurturant

relationship to help patients correct their deficits in self-perception and autonomous functioning through recognition of their own capacities for self-initiated behavior.

A major proponent of this model is Bruch (1973) who has developed a therapeutic approach which involves "the constructive use of ignorance." She emphasizes that problems in living have been "camouflaged" by a misuse of the eating function and can be addressed differently as the patient becomes aware of her inner resources and own experiences. "The therapeutic goal is to make it possible for a patient to uncover his own abilities, his resources and inner capacities for thinking, judging, and feeling (pp. 338-39).

While Bruch has provided a summary of a long-term follow-up study of forty cases, it is difficult to assess the relationship of psychotherapy to the various outcomes. In summary, the efficacy of psychotherapy with anorexics is difficult to assess. Statistical measures based on weight gain alone are misleading and may not reflect information about the patient's psychological or social functioning. Additionally, the model does not lend itself to evaluation.

Feminist perspectives. In most of the theoretical approaches to anorexia, whether the focus is on the individual's behavior or the family as a dysfunctional unit, fundamental issues of female socialization have been rarely

mentioned. Bruch (1973) seems to point in this direction when she cautions against an oversubscription to the stereotyped image of women.

> Traditionally, the concept of a maternal woman is that of a plump and cheerful one. In our culture there is an overemphasis on the sexually attractive woman, who is conceived of as very slim, and a condemnation of the maternal type as being dowdy and even unfeminine. For some women this culturally induced dilemma between the two roles, motherhood and sexual attractiveness, may represent an insoluble problem. (p. 131)

Palazolli (1978) raises some questions concerning the possible relationship of an increasing prevalence of anorexia and the contradictory nature of women's roles, yet she does not specify these ambiguous demands nor their relation to the social inequality of women.

In contrast, current feminist research is beginning to examine social dimensions that have led women to choose eating dysfunction and views eating disorders as rooted in the social position of women in this culture. Lodahl (1976) views the symptom of bulimarexia as a "personal psychological reaction to supposedly healthy, sociocultural conditions" (p. 68). Here women are seen as especially susceptible to a preoccupation with thinness because they are brought up to conform to an image of womanhood that places significance on appearances--size and shape of body --and to regard the primary work of womanhood as those of wife and mother. Since these roles depend on the securing of a relationship with a man, a woman comes to view herself

as a sexual commodity, an object which must be attractive and pleasing in conventional ways in order to attain the status of wife. Rather than rejecting femininity, they "have devoted their lives to fulfilling the feminine role rather than the individual person" (p. 19) and, rather than developing a personal identity based in feelings of self-worth, they rely on others to validate these feelings and are preoccupied with pleasing others. Ego manifests itself in social symbols--beautiful body = male approval = self-validation.

Combining a socio-cultural and psychological orientation, Lodahl offers the following understanding of the binging-purging cycle. For the bulimarexic who possesses unrealistic ascetic control over her life, binging represents a release, an ecstatic high and rebellion against control. Giving herself over to the experience of binging activates feelings of guilt and shame. Pressures to be thin then intrude and purging begins in an attempt to ward off the consequences of eating too much. Since the bulimarexic is unduly preoccupied with male rejection which she equates with having a fat body, purging is an attempt to avoid the social consequences of being fat. Her explanation of the psychodynamics of binging and purging is compatible with an ego psychology point of view.

Orbach also sees compulsive eating disturbances as "adaptation to sexist pressure in contemporary society"

(1978, p. 14). She suggests a complex relationship between mothers and daughters as central to the problems of overeating and dieting. Since the role of mothering generally lacks social and economic validation in the culture, female socialization is an "ironic process, for women are prepared for this life of inequality by other women who themselves suffer its limitations--their mothers" (p. 26). She suggests that compulsive eating dysfunction is an expression of conflict and tension concerning women's roles and represents ambivalence in the mother-daughter relationship in areas of independence and female identification.

Both Boskind-Lodahl (1977) and Orbach (1978) advocate a group treatment approach which includes a recognition of the societal factors that lead women to eating disorders. The research provided by Boskind-Lodahl and Sirlin (1977) on their group method showed a promising rate of success. Here a combination of behavioral and gestalt therapy techniques were utilized to encourage women to be less dependent on others and more aware of their own capacities for self-initiated action. While follow-up studies need to be done to evaluate the effectiveness of this model over time, a group approach should not be overlooked when treating women with eating problems.

In summary, a variety of theoretical and treatment approaches to anorexia have emerged over the years. Despite their diversity, most of these approaches stress the

importance of familial influences in the development of anorexia and related eating disorders. Therefore, in order to more fully understand the conditions assumed to exist in anorexia and bulimia, a fuller examination of the characteristics of these families is required.

The Family Context

On first glance the families of origin of women suffering from bulimia are strikingly similar to families with an anorexic member. However, preliminary research suggests there are some important differences in these two families. In the section which follows these differences will be highlighted.

Social background. Initial impressions of anorexic families are that they are a normal, successful, nuclear unit. They are motivated toward achievement, success, physical fitness and social status. They are middle or upper class, often professional or executive families, with a lower than average divorce rate (Crisp, 1977; Halmi, 1977; Dally and Gomez, 1979). Parents are somewhat older than average, mid-thirties or older, when the anorexic to be is born (Bruch, 1977). These families are small (2.8 children) and often show a preponderance of female offspring (Bruch, 1978). Anorexia is not ethnically linked although it seems more common in families with a tradition of family

solidarity around food, eating and mealtimes (Sours, 1980).

Families of bingers-purgers have been observed to possess characteristics similar to those mentioned above (Gawelek, 1979; Sours, 1980) although some researchers mention variation in class background. Recent reports of the National Association of Anorexia Nervosa and Associated Disorders conclude that binging-purging occurs in all socio-economic classes.

Emotional tone and family style. The emotional tone of the anorexic family can be characterized as extremely controlled. Calmness, orderliness and obedience are highly valued. Open displays of affection are limited or nonexistent (Wold, 1973). There exists an aversion to anxiety, disorder and conflict. "The anorexic family is vigilant to distress, wants to damp painful anxiety and to obfuscate conflict; the child is sheltered even from herself" (Sours, 1980, p. 322).

While calmness is valued, underlying tensions exist between family members and continuous bickering over trivial matters suggests underlying aggression (Palazzoli, 1978). The absence of overtly strong feelings, particularly ones which would arouse anger is combined with a high degree of intellectuality and pseudorationality in family interactions (Bruch, 1973; Sours, 1980).

Family members rarely speak directly about their

own feelings. Bruch (1978) refers to this phenomenon as "a confusion of pronouns" because one never knows in whose name one is speaking" (p. 35). In this atmosphere, self-expression is neither valued nor encouraged. Disagreements might be discussed but real positions are rarely clarified and a general tone of politeness and rationality prevails.

Dinner time conversations exemplify these values and characteristics of the family. Polite and controlled on the surface, there is an atmosphere of irritability that permeates. Often mothers exert control over what is discussed and do so in a didactic manner (Sours, 1980).

Unlike normal families, families with an anorexic member are stable rather than happy (Bruch, 1973). The appearances of stability and normalcy masks dysfunctional communication patterns (Minuchin, 1979).

Inflexibility in negotiating the developmental passages of its members is described as a feature of anorexic families. Particularly with the child who is anorexic, normal age-appropriate developmental transitions meet with disapproval (Crisp, Harding and McGuinness, 1974). The daughter's attempts at independence, autonomy, self-awareness and bodily self care are felt as gestures disloyal to the parents.

Families of bingers-purgers have also been described as highly controlled. They are viewed as "ideal"

families but relationships are conflicted and strained (Gawelek, 1979).

Parental dyad. The facade of stability in parental dyads masks an emotionally immature and basically unstable relationship between parents (Bruch, 1973; Wold, 1973; Palazolli, 1978; Sours, 1980). It has been suggested that the parents of anorexics live in a loveless marriage and expect their children, particularly the anorexic, to compensate for their disappointments in their partner (Bruch, 1973). Minuchin (1978) suggests the daughter serves as a bridge between the parents serving to keep them together but at a safe distance. In the pre-anorexic stage the dependencies of childhood unite the parents. At adolescence she unites her parents in concern over her illness thus enabling them to avoid their feelings towards each other, their conflicts and disappointments in the marriage (Crisp, 1977).

Many writers suggest that parents have resorted to fixed power roles. Mothers pretend deference to the fathers but in reality exert primary control in the family. Contradictory results concerning the incidence of apparent dominance-submission behavior in parents are revaled in a recent clinical survey (Dally-Gomez, 1979). These researchers found only twenty to thirty percent incidence of fixed dominant-submissive behaviors in the parents.

Siblings. Little research has been done which directly studies the nature of the anorexic's sibling relationships. It has been suggested from clinical case material that because the anorexic is the "model" child who conforms to to parental expectations she is the object of resentments, jealousies and rivalrous feelings from her brothers and sisters. Sours (1980) suggests sibling relationships are intensively competitive especially when an older sibling is female. Often this competition is focused around losing weight and eating. During the active starvation phase the anorexic may become extremely critical of her brothers and sisters focusing her criticism on their eating behavior (Palazolli, 1978).

The pre-anorexics good behavior serves to isolate her and increases her enmeshment with her parents, their personal sufferings and disappointments (Bruch, 1978). In some families siblings may be able to stay out of the enmeshed interactions of the anorexic, her mother and father, and find satisfactions outside the family (Bruch, 1978). This further isolates her from the possible support of a sibling sub-system (Minuchin, 1979) and leaves her increasingly vulnerable to parental needs for her to act in special ways.

It is noticed that in families of binger-purgers there is often one or more child in addition to the binger-purger who shows overt psychopathology (Gawelek, 1979).

Mothers. Descriptions of mothers of anorexics are abundant and clear in the literature. A high achiever early in life, she is seen as a powerless and ineffectual woman who abandoned her career aim and other ambitions for marriage and motherhood. Having unrealized expectations for herself, she looks to her daughter to provide the satisfactions missing in her own life.

To the world these women appear to be devoted to the roles of mother and wife. If they work outside the home, it is for "fulfillment" rather than because their work is valued economically or considered necessary to the family (Taipale, Tuomi and Aukee, 1971). They are often quite social but lack meaningful friendships of their own. An anorexic daughter is often the mother's main confidant (Bruch, 1973).

Characteristically, these women provide amply for the basic needs of their children. They feed them well, send them to good schools, make sure they have private lessons and are culturally enriched (Sours, 1980). They foster ambition in their children and often expect special achievements, particularly from the anorexic-to-be (Bruch, 1973). They appear subservient to their husbands but in reality they dominate household matters with a joyless control (Palazolli, 1978).

It is reported that mothers often choose husbands who are successful providers but they resent their

husband's power and merely pretend to respect him. They hold their husbands in secret contempt and feel they are often "second class." Frustrated from a lack of a satisfying marriage or work life they turn to their daughters, particularly the anorexic to provide gratification (Taipale, Tuomi and Aukee, 1971). The mother-daughter relationship has been described as over-involved with a striking absence of clear boundaries (Ehrensing-Weitzman, 1970). One explanation for this is that mothers of anorexics are unable to separate from their own mothers and recreate their relationship with their mothers with the anorexic (Wold, 1973; Taipale, Tuomi and Aukee, 1971).

Mothers of anorexics are often described as evincing a silent disgust with the body and bodily functions (Palazolli, 1978). They are attentive and conscientious concerning the outward appearance of the bodies and health of their children, but are unable to provide an atmosphere of acceptance or understanding concerning the body and its development (Taipale, Tuomi and Aukee, 1971).

This absence of warmth and understanding from mother to daughter has been frequently mentioned in the literautre (Wold, 1973; Guiora, 1967; Ehrensing and Weitzman, 1970). Recent attempts to isolate the psychoneurotic traits of mothers reveal that they are often depressed (Cantwell, 1977). Dally (1979) in a sample of 120 anorexics reported that seventy-five percent of the mothers were

depressed showing lowered energy, depressive mood, helplessness, irritability and diminished sexual feelings. It is important in interpreting this data to remember that signs of depression may be appropriate for a mother whose daughter is starving herself. Pre-illness characteristics of the mothers are difficult to ascertain since the family presents such a strong image of normality. However, in another study of neurotic traits of parents there was little evidence to suggest depression in mothers at the beginning of the daughter's treatment (Crisp, Harding and McGuiness, 1974). As the daughter's weight improved, however, the mothers showed a significant increase in anxiety. These researchers speculate that the mother's anxiety is contained by the daughter's illness. As the daughter improves and begins a more normal phase of adolescent separation, the mother becomes anxious. Taipale, Tuomi and Aukee (1971) also note anxiety and depression in mothers as the anorexic responds positively to treatment. These studies are inconclusive but suggest that the mothers might be highly neurotic, their symptoms emerging at the time of the daughter's adolescent separation.

The descriptions of mothers of women suffering from bulimia appear for the most part similar to the descriptions offered for the anorexics' mothers. Some important distinctions are noted. The bulimic experiences more open conflict with her mother (Boskind-Lodahl and Sirlin, 1977;

Gawelek, 1979; Sours, 1980). Rather than exhibiting the "model-child" compliance of the anorexic, the bulimic rebels during her development, with considerable conflict emerging during adolescence. While anorexics are described as possessing unconscious hatred of their mothers (Bruch, 1973), bulimarexics are "painfully conscious of despising their mothers" (Boskind-Lodahl, 1978). No consistent explanation of the nature of this conflict is offered.

Gawelek (1979) in her case study of five binger-purgers, found the mothers were often actively involved in career pursuits outside the home. The daughters in her study expressed admiration for their mothers' accomplishments but felt their mother "lacked understanding and did not value them as individuals" (p. 154). This conflicts with impressions offered by Boskind-Lodahl (1977) who found mothers to be ineffectual non-achievers.

Like the mothers of anorexics, mothers of bulimics appeared uncomfortable in discussing sexual matters with their daughters and seemed sexually unresponsive in their marriages (Gawelek, 1979).

Fathers. In contrast to the prominence of references to an overbearing and controlling mother, fathers of anorexics receive brief characterizations, generally as passive or ineffectual men in the domains of child raising and family life (Sours, 1974, Bemis, 1978). They have been described

as successful career-oriented men who are "emotional absentees" from the home (Rowland, 1970; Bruch, 1973). It has been mentioned that although most fathers are successful in their work place some feel defeated and consider themselves to have made important sacrifices in their vocational desires (Bruch, 1978).

Bruch (1978) described them as persistent in their demands that their daughters be conventionally attractive and high academic achievers. Like their wives, they are described as conformists who expect similar behavior from their anorexic-to-be daughters. They value physical fitness and outer appearances and have high expectations for their daughters in these realms.

Also, like their wives, they are usually disappointed in their marriages (Palazolli, 1978) and expect from their daughters some special achievement which would compensate for their efforts in providing for the daughters' material needs. They use the perfection of the anorexic-to-be as confirmation of their success as a giving, bountiful parent (Bruch, 1978).

Some research has found alcoholism and infantile behavior in fathers of anorexics (Taipale, Tuomi and Aukee, 1971). Wold (1973) describes fathers as "rigidly compulsive persons with violent tempers" (p. 1396). Crisp (1977) suggests a high degree of obsessionality and problems with impulse control in fathers of binger-purgers. Dally (1979)

found evidence to suggest that depression is prominent in these men. Twenty-five percent of the fathers of 120 anorexics showed signs of depression both at the beginning of treatment and later, when the anorexic began to gain weight. The fact that weight gain in anorexic daughters was concommitant with the emergence of depression in the fathers supports a suggestion that the daughter's anorexia could serve to protect the father from his own feelings of depression (Crisp, Harding and McGuiness, 1974).

Fathers of women who binge and purge appear to be a more potent force in the daughters' lives. While the anorexic's father is viewed as distant or "second-best" in the family, the binger-purgers father may be the object of "hero-worship" (Boskind-Lodahl, 1976). He too is success oriented and places perfectionistic demands on his daughter with some regularity. Many of the daughters in Boskind-Lodahl's study consciously identified with their fathers but simultaneously felt excluded from the world which their fathers represent. They then pursue "a social acceptance which would enable them to act out their mother's role in relation to the father" (p. 348).

The five binger-purgers in Gawelek's 1979 study felt an "emotional affinity" (p. 155) with their fathers which belied both an attachment to and an identification with him. Childhood relationships with fathers are recalled as happy with closeness diminishing during puberty.

This real or perceived loss of or change in the relationship with fathers at adolescence is a consistent finding in the five women.

In this chapter a review of the literature on anorexia and a syndrome of binging and purging was presented. Differences and similarities between anorexics and bulimics were highlighted with special emphasis placed on those areas important in providing a description of bulimia. Chapter III will describe the method of this study.

CHAPTER III

THE METHOD

This study seeks to increase our understanding of the lives of women suffering from bulimia. A major goal of this study is to provide a descriptive profile of these women. Additional attention will also be given to characteristics which distinguish bulimia from anorexia nervosa.

During the formulation and preliminary investigation of this problem it became apparent that few accounts of the individual experiences of bulimic women existed. Similarities and differences in their perceptions of themselves, significant events and relationships in their lives, and their perception of their eating problem had not been adequately explored or documented. While the initial intent was to focus on the mother-daughter relationship it became clear that the entire family context, specifically the relationships of these women and their fathers and siblings, had to be taken into account. Based on the paucity of research in this area and the exploratory nature of this study, an interview format in which each subject could describe her experience was devised. Twenty-four women exhibiting the characteristics of bulimia responded to a questionnaire and in-depth interview.

Choice of Methodology

The decision to utilize a qualitative method of inquiry was based on research considerations. A qualitative method is considered a useful method for looking at newly identified problem areas where it is premature to offer definitive hypotheses (Lofland, 1971). Since qualitative analysis permits the researcher to preserve and convey the essence and richness of each subject's experience, it is particularly useful for pioneer studies which seek to identify significant factors for future research.

The qualitative method is concerned with descriptive detail and aims toward discovering the characteristics of social phenomena rather than the quantification of data or establishing causal links. This emphasis on detail and description has limitations as well as advantages. The advantage of a qualitative method lies in the researcher's ability to get "close" to the phenomenological experience of the "subject" thereby understanding the person in her world and on her own terms (Lofland, 1971). It is not concerned with proving causal links and as such the generalizability of findings is limited. However,

> While small numbers research cannot claim to provide statistical generalizations or "proof" of theory, it can by assuming that people are not entirely unique, generate theoretical generalizations and significant descriptions about complex processes and relationships. (Piotrkowski, 1978, p. 290)

Although there was a temptation to ask more limited

questions which would provide more quantifiable data, special care was exercised to ask questions which would elicit more complex processes. Thus, the results of the interviews here will be qualitative and descriptive. From this exploratory beginning it is hoped that future studies could be generated and directed toward more quantifiable data collection.

The Sample

Twenty four women were interviewed in the summer and fall of 1980. Twenty four respondents enabled the use of a detailed, semi-structured interview and provided a large enough sample to identify the prevalent similarities and differences among subjects.

The subjects range in age from twenty one to forty years of age; the average of the sample population is 28.25 years.

At the time of the interview all subjects were living in an academically oriented community. The women show some variation in educational status, although only five had not completed college degrees. Of those five, two are B.A. candidates and one is an aspiring writer. Four have Masters degrees and two are Ph.D. candidates. Educational status and occupations are listed in Table 1, and tend to confirm previous descriptions of binger-purgers as academic achievers (Gawelek, 1979).

TABLE 1

SUBJECTS' OCCUPATIONAL OR ACADEMIC STATUS

Subject	Current Occupational or Academic Status
1	Dance instructor
2	Ph.D. candidate
3	B.A. candidate
4	B.A./Administrative asst.
5	M.A./Psychotherapist
6	B.A./Full time mother
7	B.A./Horticulturist
8	B.A./Parelegal
9	B.A./Nurse
10	M.A./Counselor
11	B.A./Lab technician
12	B.A./Retailing
13	Ph.D. candidate
14	B.A./Social service worker
15	B.A. candidate/Waitress
16	M.A./Psychotherapist
17	B.A./Unemployed counselor
18	M.A./News photographer
19	B.A./Nurse
20	B.A./Biological technician
21	B.A./M.A.T./Secretary
22	B.A. candidate
23	2 yrs. college/Cook
24	H.S./Writer

Of the twenty four women, fifteen identified themselves as heterosexual, five as lesbians and four as bi-sexual. Three are married, three divorced, and one is separated. Twelve are single and living alone, five are single and living with a lover.

Subjects represented a range of geographic locations and ethnic backgrounds (see Table 2), although no black or third world women chose to participate in the study. Although the majority of subjects originate from middle class business or professional families, socio-economic class is also varied.

The subjects for this study were primarily self-referred. All were involved in some form of psychotherapeutic treatment at the time of the interview. Many had had multiple experiences of seeking help for their problem. While this presented some problems in the way each subject "framed" her problem and self-understanding, it was decided that using subjects who were in therapy had definite merits. They might be familiar with sharing in-depth information about themselves and their families and might more easily discuss their eating problems than would someone who had never talked about it before. Furthermore, it seemed likely that in the course of the interview process, painful issues and conflicts might emerge. The interviewer felt she would be constrained by the research task and unable to respond should such conflicts arise. Subjects who were in

TABLE 2

SUBJECTS' FAMILY DEMOGRAPHIC DATA

Subject	Current Age	Birth Order	Sex and Number of Siblings	Age of Parents at Subject's Birth	Geographic Location	Ethnic or Religious Background
1	40	4	3-F	M-29 F-31	New England	WASP
2	30	2	1-M	M-35 F-40	Northwest	WASP
3	21	1	1-M 1-F	M-26 F-29	Eastern Seaboard	WASP
4	30	1	3-M	M-24 F-28	Southwest	WASP
5	28	2	1-M 1-F	M-34 F-37	England	WASP
6	35	2	1-M (Deceased)	M-33 F-38	New England	Catholic
7	22	2	1-F	M-34 F-38	Midwest	WASP
8	23	1	1-M	M-27 F-34	New England	Jewish
9	29	2	1-F	M-21 F-27	Southeast	Catholic
10	40	2	1-F	M-38 F-40	New England	WASP
11	31	1	1-F	M-27 F-37	New England	Jewish
12	24	3	1-M 2-F	M-25 F-32	Midwest	Jewish
13	34	1	2-M	M-30 F-33	Midwest	WASP
14	24	2	1-F	M-29 F-28	New England	Jewish
15	24	1	1-M 1-F	M-26 F-28	New England	Catholic
16	29	2	2-M	M-30 F-35	Midwest	Jewish
17	24	4	2-M 1-F	M-39 F-41	New England	Jewish
18	32	3	3-M 1-F	M-25 F-29	New England	Catholic
19	28	1	1-F	M-35 F-39	New England	Catholic
20	24	5	1-M 2-F 1-M (Deceased)	M-36 F-42	New England	Catholic
21	31	2	1-M	M-34 F-34	New England	WASP
22	22	2	1-M	M-29 F-31	New England	Catholic
23	27	2	1-M	M-24 F-29	Northeast	WASP
24	26	1	3-M	M-23 F-23	New England	Catholic

therapy would have a place to deal with any distress the interview might have created for them.

While information based on therapeutic interaction offers the promise of obtaining richly varied information concerning the personality characteristics and affective style of the subject, I decided I did not want to introduce my research into the ongoing therapeutic relationship with my own clients. The women in this study were not coming to resolve their problems or obtain symptom relief. They spoke of desiring to be helpful to other women experiencing similar problems, to a researcher investigating their problem, and to themselves in that they could reflect on their lives in a less emotionally charged environment than is frequently the case in therapy. Since the goal was information sharing rather than behavioral or psychological change, anxiety and defensiveness were minimized.

Instruments

Data was derived from two sources: a written questionnaire and an oral interview. The written questionnaire provided information concerning ages, income levels and occupations of family members (Appendix A). Additionally, each informant was asked to be as detailed as possible concerning her eating patterns. These questions were derived from the descriptions offered in previous literature on bulimarexia (Boskind-Lodahl, 1977). All subjects fit these

descriptions and the criteria proposed in the Diagnostic and Statistical Manual III of the American Psychiatric Association for the diagnosis of bulimia.

Following the completion of the written questionnaire, subjects engaged in an interview. The interview format was selected to allow each subject to tell her own story. The object was to elicit from each woman what she considered to be the most significant aspects of her life and her perceptions of the social and familial influences on her development. I wanted to create an atmosphere in which each subject could "teach" me about herself. The intensive interview provides such a model of inquiry.

> Its object is not to elicit choices between alternative answers to preformed questions but, rather, to elicit from the interviewee what (s)he considers to be important questions relative to a given topic . . . (Lofland, 1971, p. 76)

The interviews in this study were structured by an interview guide (Appendix B). Topics chosen to guide the interview process came from the literature reviewed in Chapter II concerning anorexia nervosa and the binging-purging syndrome and from information acquired through an 8-hour pilot interview with a colleague suffering from bulimia. The literature on binging-purging and the pilot interview had suggested the following characteristics of bulimic women:

- A preoccupation with food and its control as a central and painful feature of daily life.

- Secretive episodes of binge eating as the major manifestation of the disturbed eating pattern.
- Awareness that the eating problem is abnormal accompanied by shame and self-depracating thoughts which inhibit open discussion of the problem.
- Weight fluctuations which are varied but never so great as to become life threatening.
- An inordinate preoccupation with physical appearances, concern about how others perceive them and an often distorted view of their own bodies.
- An absence of a trustworthy and reliable sense of self.
- A conflictual feminine identification with sexual issues problematic.
- Socially extroverted but unable to form stable and satisfying relationships.
- Feelings of worthlessness and an unusually low self-esteem.
- A family dynamic in which the parental dyad is strained and the daughter is involved in the marital struggle (Gawelek, 1979).
- An openly problematic mother-daughter relationship.
- A strongly bonded father-daughter relationship in childhood with changes in this relationship occurring at puberty (Boskind-Lodahl, 1977).
- Emotional problems in one or more siblings (Gawelek, 1979).

The interview was organized in two parts. The first part was designed to elicit information concerning subjects' family histories and perceptions of the interpersonal climate at home during childhood, adolescence and the present. In the second part of the interview, subjects were queried concerning their perceptions of themselves,

their mothers, and the mother-daughter relationship in areas of feminine identification, sexuality and achievements. Although the interviews were guided by predetermined categories, they were to a great extent open-ended, thereby providing the maximum flexibility for pursuing relevant information. The order of inquiry varied somewhat according to the specific concerns of the individual woman; however, each topic in the interview outline was covered with all subjects.

Procedures

To recruit subjects, a flyer (Appendix C) was sent to a local women's counseling service which offers groups for women with eating problems and a number of practicing therapists were advised of the project and the interview format. Forty women with various eating difficulties responded. Only those who experienced cyclical compulsive eating and dieting were asked to participate. In three instances, prospective subjects made appointments which they later cancelled and subsequently withdrew from the study.

Prospective subjects were told in the initial phone contact that I was conducting a study of women with cyclical and compulsive eating problems. Participation in the study would involve a questionnaire and interview entailing approximately three hours of their time. They were

informed that the research would involve talking about their eating problems and their perceptions of their lives growing up and currently and that confidentiality would be preserved. In lieu of reimbursement for their time, they were offered a copy of the transcript or tape of their interview. The majority of women who responded were in therapy. Respondents not involved in therapy were refused as subjects and asked if they wanted a referral.

On initial meeting subjects were informed of the two-part interview and given a consent form (Appendix D). They were assured of their right to discontinue the interview at any time. Subjects were asked to begin by filling out the written questionnaire and were told I would be in the adjoining room if they had questions or were confused by any part of the questionnaire. They were further reassured that if there were questions that they felt uncomfortable answering they could omit them or state they didn't want to disclose this information. Reassurance of confidentiality and the importance of letting me know if they felt something was troublesome in the questionnaire seemed to facilitate rapport between subject and interviewer. All subjects completed the entire interview process.

The interview was conducted in two separate sessions for all but five subjects. The first session consisted of filling out the questionnaire and an oral

interview concerning relationships with parents. The second interview session focused primarily on subjects' perceptions of themselves as women. For logistical reasons five subjects were interviewed at a single sitting. The protocols of these five subjects did not differ noticeably from those who had two sittings.

After completion of the questionnaire subjects were asked to come into the adjoining room for the oral interview. Subjects were informed at this point that time would be alloted at the end of the process for any comments or questions concerning the interview. Again they were reminded that they could terminate the interview at any point.

Digressions from the interview topics were treated as important information. In most instances subjects' initiations or "leads" were followed on the assumption that even though they had deviated from the topic at hand, useful information might emerge. If the material introduced in the digression seemed strikingly off the topic, an assumption was made that for whatever reasons this particular topic was difficult for the subject to discuss directly. In these instances, the researcher communicated a need to move on and that time would be allowed at the end to get back to what they had brought up. Flexibility in the design enabled the interviewer to re-introduce the same topic in a different way at a later point in the interview

when, perhaps, more trust had been established. During particularly emotionally charged responses, the interviewer attempted to communicate understanding, empathy and respect for the subjects' emotional reactions. Comments acknowledging the painful aspects of reviewing one's life were offered. Occasionally subjects would make inquiry of the researcher concerning her opinions of methods of help for their problem. Subjects were told there would be time following the interview to address these questions.

At the close of the interview subjects were asked if they had any reactions or feedback concerning the interview. Most stated they had found it useful to review their eating patterns and their life histories. A few requested transcripts of their interviews. The researcher expressed appreciation for their participation and informed them of the anticipated date of completion of the study. Some asked to be notified when the study was complete. A brief synopsis of the study will be sent to those who asked to be notified.

Review of the Data

All interviews were tape recorded. Interviews were transcribed by the secretary of a college counseling service who was experienced in the transcription of taped clinical material. Throughout the transcripts, points of significant affective expression were denoted in parenthe-

ses. Interruptions in the flow of communication were marked by a series of dots.

Each transcript was reviewed as soon as possible. Transcripts were numbered so that the information in each interview remained distinct. The information generated was organized according to the main topics of the questionnaire and interview guide. Notations were made of important themes which had not been initially included in the interview guide. After all interviews were completed, the material was examined a second time to ascertain whether the unanticipated themes mentioned above were present in other transcripts. For instance, the frequent mention of sibling relationships as an important concern of some women required a second look at all transcripts for information concerning siblings.

While reviewing the transcripts, characteristics common to all subjects were noted. Themes common to ten or more subjects were considered significant enough to include in the final reporting of data. The selection of ten or more responses kept the task of data analysis manageable.

Excerpts selected for presentation and illustration of particular themes were chosen on the basis of clarity of expression and representativeness of the sample's responses. Some women, because they had extensively examined their eating problem, its meaning for them and impact of certain relationships and events in their lives, were skilled at

articulating their feelings, thoughts and perceptions. In other instances, subjects were just beginning to think about their lives and issues surrounding food and eating, and while their responses were less elaborated, they did reveal a "freshness" of perspective. It is my impression as a clinician that all subjects were quite candid in their presentations.

To maintain confidentiality all names and other identifying characteristics such as locations have been changed or deleted.

The results of the questionnaires and interviews will be presented in Chapters IV, V, and VI. These chapters organize the information according to the following categories: Chapter IV--Eating Behavior; Chapter V--Family Dynamics and Identification with Family Members; Chapter VI--The Adolescent Experience. With the exception of the chapter on adolescent experience, they follow the general areas suggested in Chapter II and as such allow for a comparison with what has been suggested in literature about anorexia nervosa and the binging-purging syndrome. Adolescent experience is included because my clinical experience had alerted me to the potential importance of the late adolescent and young adult experience in binger-purgers. Thus, in this study, late adolescence was given a fuller examination than in previous discussions of this phenomenon. Throughout the presentation of this material

differences and similarities between binger-purgers and anorexics will be highlighted.

The wealth of information provided by each subject prohibits detailed individual case analyses. Instead, the material will be presented collectively and illustrated with quotations from transcripts when appropriate. It is hoped that by viewing this information collectively important characteristics or patterns will be revealed which will contribute to a greater differentiation of the binging-purging syndrome from anorexia nervosa and serve as the foundation for meaningful theoretical speculations.

C H A P T E R I V

EATING PATTERNS AND RELATED BEHAVIORS

This chapter describes the eating patterns and related behaviors of the twenty-four subjects in this study. Subjects' eating patterns, activity levels, menstrual functioning, body image and drug use are reported and compared with what is known to exist in anorexia nervosa and the binging-purging syndrome.

Eating Patterns

The eating patterns of all the women in this study fall within the diagnostic category of bulimia as proposed in the Diagnostic and Statistical Manual III of the American Psychiatric Association (see Table 3). At the time of the interview, none fit the criteria proposed for anorexia nervosa. However, five subjects appeared to have experienced acute anorexic episodes during adolescence as evidenced by rapid weight loss, extreme thinness and amenorrhea. Only one of these five was hospitalized for weight loss.

Preoccupation with food and dieting. Sixteen of twenty-four subjects considered themselves "preoccupied" with food. Four were "somewhat preoccupied" and four reported

TABLE 3

SUBJECTS AND THE DIAGNOSTIC CRITERIA FOR BULIMIA

	Subjects																						
Criteria for Bulimia*	1	2	3	4	5	6	7	8	9	10	11	12	13	14**	15**	16	17	18	19**	20**	21	22**	23	24
Current Age	40	30	21	30	28	35	22	23	29	40	31	24	34	24	24	29	24	32	28	24	31	22	27	26
Age of onset	26	child-hood	17	19	11	13	5-7	14	28	4	?	18	10	14	18	?	11-14	7	17	21	16	16	12	?
Recurrent episodes of binge eating	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
At least 3 of the following:																								
1. Consumption of high-caloric, easily ingested food	X	X	X	X	X	X	X	X	X		X	X	X		X		X	X	X				X	
2. Inconspicuous eating	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
3. Termination of eating by abdominal pain, sleep, social interruption, self induced vomiting	X	X	X	X		X	X		X	X	X			X	X	X	X	X	X	X	X	X	X	
4. Repeated attempts to lose weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
5. Frequent weight fluctuations greater than 10 lbs.		X	X	X	X	X	X	X	X	X	X	X	X		X		X	X	X	X	X		X	X
Awareness that eating pattern is abnormal and fear of not being able to stop	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Depressed mood and self deprecating thoughts following a binge	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Ruling out anorexia nervosa (307.10)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
1. Intense fear of becoming obese which does not diminish as weight loss progresses																								
2. Disturbance of body image (feels fat when emaciated)																								
3. Weight loss of 25% of original body weight																								
4. Refusal to maintain body weight																								
5. No known physical illness																								

*From the Diagnostic and Statistical Manual III of the American Psychiatric Association.

**Reported acute anorexic episode during adolescence.

no current preoccupations, although they had been in the past. The nature of this proccupation seemed to revolve around feelings of being out of control of food and their impulses to eat when not hungry. Subjects' obsessions with food as a condition of daily life is best revealed in the following quotations.

> Not a day goes by that I don't think about what I'm eating and what other people eat. I'm afraid of certain foods (don't want them in the house). I read articles on food or recipes even when I'm bored by them. (Subject #6)
>
> I have a thought that prioritizes all others, i.e., I must hurry home and eat whatever I remember was there before going on with whatever I was doing. (Subject #9)
>
> Until I started therapy I felt absolutely addicted to food--at the mercy of an uncontrollable force. (Subject #13)
>
> If I didn't eat, I thought about the fact that I wasn't eating and if I did [eat], I thought about vomiting. (Subject #14)
>
> I plan my life around my next meal. What to eat, when to eat . . . also places where there is a lot of food make me nervous. (Subject #15)
>
> I love to cook [pick at food]. During the day I'm always thinking about what I can eat and throw-up when I get home. (Subject #19)
>
> [Food] basically defines my feelings about myself. (Subject #23)
>
> [Food is] the major consideration in my life. Always wonder each day if I've gotten heavier. (Subject #16)

This obsessive preoccupation with food and body size resembles what has been reported previously in the literature on anorexia and binging-purging (see Chapter II).

An examination of the eating patterns of the women here further confirmed that binging is the central and consistent feature of their disturbed eating patterns, differentiating them from the anorexic who actively starves herself in an effort to lose weight.

Binging behavior. All subjects reported recurrent episodes of binge eating. Reports of frequency and duration vary from short occasional binges to daily binges of several hours at a time. (Table 4 contains a summary of each subject's eating pattern.) In addition to frequency of binging, other factors such as the age of onset of binging, what precedes and follows a binge, and current precipitants are detailed. I refer the reader to this chart for an overview of each subject's binging behavior.

The actual quantity of food consumed during a binge seemed to vary from subject to subject. For many of the twenty-four women, binging consisted of the ingestion of large quantities of food at a single setting. A bag of cookies, three to four peanut butter sandwiches, a loaf of bread and a pound of cheese, or several candy bars were not uncommon responses. Six subjects gave ambiguous responses such as "varied," "fluctuates," "lots," "don't really know because I'm spaced out," and one subject refused to respond.

Binges were frequently terminated in response to

TABLE 4

EATING PATTERNS

Subject	Age Binging Began	Precipating Factors	What Precedes a Binge Now	What Follows a Binge	Frequency of Binging
1	26	Loneliness, weight gain following pregnancy. Had dieted from age 17.	Lonely, bored, hating mundane responsibilities.	Vomiting. A certain relief.	2-3 x daily.
2	I cannot remember not binging	Don't remember.	Work tension. Boring, tedious activity. Home alone. Interpersonal conflict. Sexual drives.	Sleep, sick feeling. Guilt. Self-hate. Depression.	Daily short binges to monthly bings of 2-4 days.
3	17 (freshman in college)	Tensions involving being behind on school work	Anger, loneliness, sadness, or depression.	Guilt. Shame. Sometimes a restored perspective. Calm. Vomiting.	Once a week.
4	19	Value system disrupted. Living alone, away from family, longer moved away. Generally felt lost.	Exhaustion, feeling overwhelmed. Stressful social situation or being around a lot of people for a long period of time.	Physically feeling bad, uncomfortable. Depression.	Once a week.
5	10-11	Family tension and conflict.	Depression, sadness, disappointment. Loneliness, when can't get the contact I want. Relationship going badly.	Numbness, blanking out.	
6	12-13	Don't remember.	Feeling overwhelmed, frustrated, angry, agitated.	Dulled out, less agitated. Depressed and sleepy.	2-3 x monthly.
7	5-7	Overweight as a child. Peak 160 lbs. in 8th grade. Binging preceded dieting. Lost weight then vomiting to maintain it.	Tired, depressed, bored, or sometimes having to make a decision.	More depression. Guilt. Negative feelings towards self. Used to be vomiting.	2-3 x weekly.

TABLE 4 (continued)

Subject	Age Binging Began	Precipating Factors	What Precedes a Binge Now	What Follows a Binge	Frequency of Binging
8	14	Following a 6-7 lb. weight loss due to the flu. There was a party the upcoming weekend and I proudly fit into a smaller dress size. As I recovered from the flu, I began binging when mother wasn't around.	Boredom, restlessness, or hyperactivity. A rush of anxiety.	Calm, rest, or involvement in reading or handiwork.	3-4 x weekly.
9	28	Psychiatric hospitalization for suicide attempt.	Usually extremely happy or extremely depressed.	Depression. Displeasure with self. I'll eat until someone appears or until I feel physically uncomfortable doing so. I have vomited at times, then continued to eat.	3 x a week at least.
10	4	Gradual development of overeating patterns throughout life.	Stress, anxiety. Terrible physical tension.	Sleep. Minor distress over eating now--used to be major.	Couple of hours 2 x month.
11	Young--can't remember exactly.	Feelings of inadequacy.	Feelings of inadequacy, insecurity, frustration, depression and anger.	More anger at self. Self-punishment and self-reproach.	No set patterns of frequency.
12	18	Don't remember.	Depression, anxiety, worrying about something. Wanting to avoid thinking about or doing something.	Depression, guilt, disgust, self-hate.	Once a week.
	10		Need (of rest, touching, sex, loving, stimulation, etc.)	Self-hate and recrimination.	Major binge once a week. Binging on smaller amounts daily.
13	14	Forced vomiting came first. Binges were later, but don't remember when.	Feelings of frustration or depression concerning family or school. Trying.	Feeling afraid of weight gain. Feeling bloated. Used to be vomiting.	Varied. Many times in one day to several consecutive days of not binging.
14	18	End of relationship with my one and only long term relationship 5 years ago.	Empty feelings, loneliness, anger, sleepiness or fatique. Working hard with no fulfillment. Frustrations in relationships.	Guilt, sleep, frustration. Anger at self and then looking for some kind of diet program--Weight Watchers or Diet Center.	Once or twice a week

TABLE 4 (continued)

Subject	Age Binging Began	Preclpating Factors	What Precedes a Binge Now	What Follows a Binge	Frequency of Binging
16	Don't Remember	Don't remember when it began. Remember at age 18 thinking I was extremely heavy and hating myself for that.	Internal conflict or should vs. shouldn't. Feeling anxious or restless.	Hopelessness about ever maintaining control. Dissociate and become numb. Vomiting.	Twice weekly.
17	17-18	I wanted to avoid my feelings. I wanted to feel full inslde and eating dld that. Real binglng began in college when I began hidlng food and restaurant hoppIng. I was lonely, afraid of not maklng it.	Feeling sad and unable to get something done (schoolwork). Unable to reach out to others. Anger at myself.	Sadness. Maybe vomiting, nausea, withdrawal from the world. Desire to purify myself.	Used to be for days on end. Now not at all
18	7 or so	My father's anger. My not being perfect. Jealousy.	Anxiety, frustration, and nervousness.	Anger at myself. New plans that usually fall through. Vomiting.	2-3 times a week.
19	17	Had lost considerable weight in school without dleting. I had a job and a boyfrlend. That summer the guy left me and I was facing leaving home for the first time to go to school.	Nothlng I can single out. I pick at some food and then feel I've gone over my limit and then lose control.	Guilt feelings. Need to purge. Vomiting.	3-4 x daily on weekdays. 2-6 x on weekends.
20	21	Despair.	Ennui, nervousness, frustration, anxious about things.	Self-anger.	Twice daily.
21	16	Waiting for telephone call from boyfriend. Said to myself, "I'll eat cookies until he calls." He never did.	Feeling anxious. Overstimulated. Uneasy. Too high.	Guilt. Remorse. Self-hate. Concelling activities. Drinking alcohol, sleep. Vomiting.	Periodic episodes of several times a day for days on end.

TABLE 4

EATING PATTERNS

Subject	Age Binging Began	Precipating Factors	What Precedes a Binge Now	What Follows a Binge	Frequency of Binging
22	16	Family tensions.	Helpless, depression, frustration, anger, boredom, anxiety, feeling of defeat, worthlessness.	Remorse, self hatred, disgust. Vomiting.	4 x once every 2 weeks to 3-4 x daily when visiting family of origin.
23	12	Not knowing what I want or how to get it alone, useless.	Not knowing what I want or how to get it alone. Useless. Wanting to do something.	First vomiting, then a high feeling. Energy. I can do anything. I don't feel fat.	Varies. Once a month to 1-2 x weekly.
24	?	Do not remember.	Anxiety, nervousness, or depression.	Self-criticism, guilt, and depression.	Used to be frequent. Now once or twice every two weeks.

physical discomfort, depressed thoughts, sleep, social interruption, guilt over having eaten too much, negative feelings towards oneself, hopelessness and self-criticism.

While the frequency, duration and extent of eating binges are varied within the twenty-four subjects, the need for privacy and the secretive nature of their eating patterns are consistent. All subjects reported "inconspicuous" eating and all but three of the subjects emphasized the necessity of being alone when they binge. In the three who did not, two had food "buddies" with whom they binged and one seemed defiant of the anxiety associated with telling people about her binging behavior, although actual binging occurred in private for this women as well.

A majority of women reported that binging interfered with work and/or relationships. The most frequently cited cause was a preoccupation with getting time alone to eat. Other reasons for interference included effects of binging such as exhausion, depression, "feeling sick," lethargy, or emotional states such as "withdrawn and unable to make contact." It appears that for many of the women here binging first emerged in connection to perceived or real changes in a significant relationship (separation, loss, disappointment, feelings of rejection) or as a method of coping with conflictual feelings.

Subjects were varied in their descriptions of what

precedes current eating binges (see Table 4). Intense feelings of lonliness, sadness, depression, anger and frustration were frequently mentioned, as were states of fatigue, restlessness, anxiety or boredom. All but four subjects reported late afternoons and late evenings to be the most likely time for binging on food. Other times cited were "anytime connected to stress," or "when I have time to think about how I really feel."

It is significant that while these descriptions were varied, no subjects reported the sensation of hunger as a precipitant or motivator for binge eating. This suggests that physiological hunger is almost never the stimulus for binging.

Age of onset and precipitating factors. While the average age of subjects is 28.25 years, the mean point for the onset of binging behavior is 14.2 years. This mean point is calculated for 20 subjects; four subjects could not remember the actual age binging began although in two of the cases it was thought to be very early in life. The range of ages of onset is presented in Table 5.

Recollections of the precipitants for initial binging on food vary. Four subjects reported childhood eating binges in response to separations from parents, illness and father's anger. Five reported binging occurring in early to mid-adolescence in response to family tensions or

TABLE 5

AGE OF ONSET OF BINGING BEHAVIOR

Age of Onset	Number of Subjects
4 - 7 years	3
10 - 14 years	6
16 - 18 years	7
19 - 21 years	2
26 - 28 years	2

feelings of inadequacy. For nine of the subjects binging on food began in late adolescence or young adulthood (ages 16-21). Here, frequently cited precipitants involve social pressures, disappointments or rejections, conflicts about values, worries about self-sufficiency. Two subjects reported being in their late twenties when binging began. In one instance, binging began at age 26 following subject's weight gain during pregnancy and the sudden accidental death of her husband. In the other, binging began at age 28 following a hospitalization for suicidal gestures following the break-up of a relationship.

Purging behavior. Eighteen subjects reported extreme measures of purging following eating binges. The remaining six subjects reported dieting and/or fasting after binging. A summary of subjects' weight loss methods is offered in Table 6.

TABLE 6

SUBJECTS' METHODS OF WEIGHT LOSS

Subject	Controlled Dieting	Fasting	Forced Vomiting	Laxative/ Dieuretics	Diet Pills/ Amphetamines
1	X	X	X		
2	X	X			
3	X	X	X		
4	X	X	X		
5	X	X		X	
6	X	X			
7	X	X	X		
8	X				
9	X		X		X
10	X	X		X	
11	X	X		X	X
12	X	X			
13	X				
14	X		X		
15		X		X	
16	X	X	X		
17	X		X	X	X
18		X	X		
19		X	X	X	

TABLE 6 (continued)

Subject	Controlled Dieting	Fasting	Forced Vomiting	Laxative/ Dieure-tics	Diet Pills/ Ampheta-mines
20	X		X		
21			X		
22			X		
23		X	X		
24	X				

In fourteen subjects, forced vomiting was employed as a method to counteract the effects of binging and as a method of tension release.

> I used to diet a lot, then I switched to vomiting which allowed me to remain thin yet eat what I wanted. (Subject #7)

> I was overeating and gaining weight, very unhappy about the uncontrollable weight gain and eating. (Subject #22)

> I remember binging-dieting before I left home but no vomiting. Binging-vomiting came when I read about the Ancient Greeks and Romans and how some famous stars manage to keep their weight down by vomiting. (Subject #19)

Additionally, four subjects who did not vomit reported purging through the use of laxatives and dieuretics. In many of these subjects, fasting, controlled dieting and amphetamine use had preceded forced vomiting. Only one woman, Subject #14, described vomiting as preceding binging and occurring independently of prior efforts to diet or control weight.

In the eighteen women who engaged in extreme methods of purging, the average age of onset of a binging-purging pattern is 19.8 years. This suggests that binging-purging emerges in women who are facing the responsibilities of young adulthood. This information is consistent with what has been suggested in other research on binger-purgers (Gawelek, 1979).

Related Behaviors

Activity level. None of the subjects in this study reported hyperactivity. Levels of exercise, frequency, extent and duration varied. Six subjects described themselves as "inactive," reporting no regular exercise. The remaining eighteen described themselves as engaging in regular exercise and were equally divided between "moderately active" (two to four times weekly) and active (five to seven times weekly). None appeared excessive in their pursuits and many spoke of long periods of inactivity which coincided with an intensification of the binging-purging cycle. Even in those subjects who described periods of great activity, the actual activity levels did not seem uncommonly high. An example is Subject #16 who spoke of swimming 1/4 mile daily during her most active periods. Three subjects who described themselves as "inactive" spoke of daily routines involving high degrees of activity. Subject #23 doesn't own a car and walks approximately six to ten miles daily to get about town; Subject #1 is a part-time dance instructor and receives considerable exercise when she teachers; Subject #18 does not have an exercise program but her job requires that she move 80-100 lbs. of equipment several times daily. Thus, it appears that no subjects engaged in strenuous activity for the purpose of losing weight.

In several of the reports, Subject #17 being one example, a discrepancy emerged between subject's perception of her activity level and her description of the actual amount of exercise. One explanation for this discrepancy between perceived activity and real activity might be the inability to recognize or discriminate bodily states, and might parallel the inability to rely on hunger as a motivation for eating. Matters to do with the regulation of bodily needs appeared to be confusing to subjects.

Menstrual cycle. Table 7 contains information concerning the menstrual functioning of the twenty-four subjects. At the time of the interview, fourteen women reported reported regular menstrual cycles while ten indicate irregular menstrual cycles. Of these ten subjects, five had experienced periods of amenorrhea of up to one year in duration. One of the five was currently amenorrheic and one was taking hormones to stimulate menstruation. Both these subjects were engaging in frequent binging and purging. The remaining three subjects who reported past periods of amenorrhea had resumed menstruation during times when their eating problem was more under control. In all five women, the loss of menstrual functioning coincided with a rapid weight loss or low body weight suggesting that their eating behavior directly influenced their menstrual functioning. Thus, while it appears that none of the subjects

TABLE 7

MENSTRUAL CYCLE

Subject #	Age of Onset of Menstruation	Stability of Menstrual Cycle
1	Couldn't Recall	Regular
2	12	Irregular until age 23
3	16	Regular
4	13	Slightly irregular
5	11	Regular
6	13	Irregular 20-53 day cycles
7	13	Regular
8	12	Regular
9	12	Regular No problems
10	9	13-18: Menstrual period frequent and of long duration (6 months)
11	13½	Regular. Cramping. Periods lasting from 11-15 days.
12	13	Irregular
13	12	Regular
14	13	Irregular
15	13	Irregular. Amenorrhea at age 19 for 7 mos. Birth control pills to regulate period.
16	13	Regular

TABLE 7 (continued)

Subject #	Age of Onset of Menstruation	Stability of Menstrual Cycle
17		Regular
18	14	Regular Severe Cramping.
19	13	Irregular. Episodes of amenorrhea since age 17. Takes hormones to stimulate menstruation.
20	14	Irregular. Amenorrhea at age 20.
21	12	Amenorrheic
22	11	Regular. Amenorrhea following dieting at age 12.
23	10	Regular
24	12	Some irregularity Pain during ovulation

were classically amenorrheic, many had experienced periods of menstrual irregularity due to their eating pattern.

Body image. The majority of subjects (twenty) complained of being "too fat." Many complained of not seeing themselves as others see them, perhaps indicating some disturbance in their body image.

A large number of the subjects measured self-worth in terms of their body size. Thinness was often equated with being "good" and permitted them to be socially or sexually active. Feeling of being overweight was equated with being "bad" and in many instances subjects radically curtailed their social activity during these periods. Self-hate or feeling amorphous often coincided with small weight gains. As one subject described a ten pound weight gain:

> I've just become like a giant slug. I think of myself and I don't feel like doing anything. I'm not proud of my body. I never dress up. I just kind of wear the same pants over and over . . . and things like that. (Subject #19)

Drug or alcohol use. Most of the subjects in this study had some experience with drugs and/or alcohol. In some instances this was a source of conflict with parents during adolescence. In most cases however, other family members did not know about drug use.

Fears of becoming alcoholic were expressed by several subjects as the following quotation illustrates.

> I worry about being an alcoholic, but I have that same kind of tendency with food, you know what I mean? I use food like someone would use alcohol. And somehow that doesn't have that social connotation as being sick. You have to eat. You have to be able to control it. You don't have to drink. You can just quit. (Subject #15)

One subject considers herself alcoholic and described the relationship of alcohol to the abusive food pattern in this way:

> I started drinking after I had been involved with the binge vomiting symptom for several years. . . . I began drinking alone after I had thrown up. I would drink, like, after I had thrown up to sort of blot out, I think both psychologically and I think there may have been some physical kind of like, you know, craving. I guess that I just found that it made me feel better afterwards. . . . I think I might have become alcoholic anyway, but I'm not sure. I think that the alcoholism really kind of spun off that symptom. (Subject #21)

While there is evidence of experimentation with drugs or alcohol, it appears that the majority of these women turn to food and its control, and preoccupation with bodily size and shape to manage stress in their lives. Food is a more acceptable "substance" abuse.

> I think I try to control my alcohol intake very strictly because . . . I can be a real abuser. I think I could very easily be an alcoholic. I see tendencies in my--I'm very compulsive, a very compulsive drinker. I like to drink. I would do it every single day probably, if I could afford it. I don't know. I think I'm too wary of it to let it happen, at least at this point. I think, you know, that at any time it could go to the other extreme, I'm sure. In part I think my eating problems developed as opposed to maintaining the pot and the booze syndrome . . . It's more acceptable in my eyes. It really is (laughs). (Subject #22)

Summary

An examination of the subjects' eating patterns and related behaviors revealed several characteristics common to all or most of these women.

All subjects considered themselves preoccupied with food and experienced distress in relation to their eating pattern. Unlike anorexics who deny the existence of their eating problems, the women here were acutely aware of the problematic aspects of their eating behavior.

No one consistent eating pattern emerged for all subjects. However, all subjects engaged in eating binges which did not appear to be motivated by hunger. While the quantity, duration and frequency of eating binges were varied, almost all binging was secretive and occurred in isolation. For the majority of subjects, the initial onset of binging was mid-adolescence and was frequently related to changes in a significant relationship or personal feelings of inadequacy. A majority of subjects reported binging as most likely to occur at transitional times during a day when they were not occupied with the responsibilities of daily life.

Almost all subjects engaged in purging or rigorous dieting to counteract the effects of binge eating. No one method of purging was employed by all subjects. Hyperactivity as a method to achieve weight loss did not appear to

be characteristic of these women and differentiates them from anorexics who are excessively active in an effort to be thin.

A strong majority of the women reported difficulties in seeing themselves as others see them. Almost all subjects were inordinately preoccupied with their physical appearance and used their body size as a measure of self-worth. The presence of these qualities suggested a distorted body image.

An unanticipated finding in the sample was the frequency with which subjects likened their eating problem to alcohol abuse or feared becoming an alcoholic.

There were no apparent or obvious differences in the eating patterns and related behaviors reported by the five subjects who had experienced acute anorexic episodes during adolescence.

C H A P T E R V

FAMILY DYNAMICS AND IDENTIFICATION WITH FAMILY MEMBERS

This chapter presents the subjects' perceptions of their family contexts. The family background of each subject was explored in depth during the interview. For many of the women, this exploration appeared to be emotionally charged. Expressions of strong affect (tears, nervous laughter, long pauses and sighs) often accompanied descriptions of family life.

All subjects have on-going contact with their families of origin.

Sociocultural Background

Recognizing the importance of environmental factors, the sociocultural backgrounds of the subjects' families are reviewed here. On first glance the families appeared to be successful intact nuclear units. In most cases, both parents were present in the home. The average size of these families is 2.6 children. A majority of the sample (16 subjects) were second or later born children. The parents tended to be relatively old at the time of subject's birth, the average age of the mothers being 29.7

years and fathers being 33.5 years.

A wide variety of social backgrounds were represented in the sample (see Chapter III, Table 2). No one ethnic group emerged as prominent. Religious affiliations were varied as were the geographic locations from which the subjects originated. The majority came from business or professional families whose current economic status could be considered middle class. The following table summarizes the family income levels.

TABLE 8

FAMILY INCOME LEVEL

Estimated Annual Income of Parents	Number of Subjects
30,000 or above	10
15-30,000	5
10-15,000	2
10,000 or below	4
Don't know	3

Since the assessment of family income level was based on current earnings it may not accurately reflect economic circumstances during subjects' childhood and adolescence. Some subjects described upwardly mobile families who had meager beginnings. In these cases, parents were often concerned about financial matters. Other subjects described parents who were financially well established before they had children. Thus, it appears that this sample of

bulimics originate from different class backgrounds.

Most subjects felt their parents had provided for their basic material needs. Even in those instances where money was a source of concern, subjects did not recall going without food, clothing or shelter. However, an absence of emotional availability and empathy was foremost in subjects descriptions of their parents, suggesting an economy of emotional scarcity in many families.

Mothers

Perception of mothers. Subjects saw their mothers as women for whom family, its functioning and maintenance, was a main priority in life. For the most part mothers are described as models of self-sacrifice: dutiful wives who relinquished their career aims and personal ambitions for marriage, childbearing, and motherhood. For those who did work outside the home while their children were young, work was seen as either a diversion or a burden. In varying degrees, their daughters had little indication of any inherent satisfactions or pleasure taken in work either inside or outside the home.

> I can remember um, I can remember her telling . . . that getting married when she was 30 was kind of hard because she had developed her own life and she--I suppose she had to give up a lot of things, to be married and then to have kids. She had to give up her career. . . . (Subject #7)

> She was a nurse, and also she was a nursery school teacher. So she pretty much worked, you know, on and off . . . I mean quite a lot . . . during the time I was growing up. But it was always secondary, you know, to my father. And I think that was something she has resented . . . she had the ability and the energy to have a career . . . she sort of had one but it wasn't quite the same. I think the times when she WASN'T working and wasn't doing anything else, there was definitely MORE tension . . . she just got herself more frazzled in terms of worrying about what was going on in the family. (Subject # 5)

> After they were married she started having children right away, and after that she like, experienced some depression. . . . (Subject #9)

> She did not work when I was growing up. She wanted to teach. She wanted to write, too . . . she says that she wanted to have children and I believe that; I think also she wasn't--she really feels like she was shortchanged in that marriage, you know, that she probably would have liked to start working sooner and . . . just felt real limited by, in what she could do because there was no support from my father for her doing any of that. . . . (Subject #4)

Several mothers were active in community or school projects, working part time as volunteers or unpaid supportive labor to family businesses. For these women who did work outside the home but without pay, work was seen as "frivolous" or "superfluous," not contributing substantially to the support and maintenance of the family.

> . . . she's always very active and had lots of causes and things, but she certainly didn't have a real job (I don't mean to say "real" job, because certainly they were jobs but she wasn't paid from them). (Subject #3)

In five instances, where mothers worked outside the home for pay, there is indication that it was devalued, seen as a burden without any intrinsic satisfaction, and happened

secondarily to father's work and career.

I: How would you describe your mother's temperment?

S: Pitiful! Perfectly pitiful. Christian martyr, who believed absolute that the more that she was made to suffer here on earth would be the greater her rewards in heaven, and you, that's how--(laughs) she got her backward strokes, I guess.

I: What did she communicate to you about her work, how she felt about working?

S: Um--she was a teacher and was (sighs) the oldest of seven or eight kids, who raised them pretty much, cause their mother died. The only one of the family who broke away and went to school--I'm saying this cause there's a contradiction here someplace I haven't worked through--graduated from college, the only one in the family--this is in backwoods New England you have to realize. But--I realize there must have been something in her youth that motivated her. I know that in my head. The only thing she ever personally communicated to me, cause I had no sense of working or anything, was that she had to work. We were poor and she had to work--not that she had a career, or that she was a teacher or--and she was a very, very poor one--um--but simply that she had to work because we were poor.

I: Any pride in her work?

S: Such a thing did not exist. It was a burden, a labor.

Most of the subjects' mothers were predominantly housewives who had exclusive responsibility for the running of the household. Recently, housework has been the subject of sociological analyses. Many of these analyses characterize housework as a kind of "invisible work" (Oakley, 1974), that is, it is noticed only when it is not done. These analyses are especially suggestive because many of

the subjects feel themselves to be "invisible." Questions of visibility or invisibility are related to issues of power and it is reasonable to assume that people reduced to doing invisible work might have doubts about their own power and importance.

This issue is highlighted in many of the families where there was a prevailing tone of self-sacrifice. Remarks such as the following were present in several subjects' accounts.

> Thinking about yourself, doing things for yourself, was bad. You know, you should always be thinking of another person, you should totally forget about SELF, you know, what your wants and needs are. You should totally concentrate on another person's wants and needs, always--no ifs, ands, or buts about it. (Subject #7)

It is important to keep in mind that the theme of self-sacrifice in some of these families represented more than a family dynamic, that is, a cultural tradition as well.

> . . . it is a value system that--it's the stoic, the--that the only behavior which is admirable is to endure and to demonstrate that you can endure without complaint. . . . I did some research. My father is Swiss. His parents were immigrants of Switzerland; they came over, I think, when he was quite young. I did some research into family relationships in that culture, which said essentially that the man never did talk to a wife in that culture either. My mother is you know, New England Yankee stoic-- (Subject #10)

A tradition of self-sacrifice and self-denial can often result in self-deprecation. For example, a strong majority of subjects perceived their mothers to be bright women who downplayed or denied their intelligence and

compared themselves negatively to the father, and sometimes the children as well.

> . . . my mother would tell us, when we were children --I can remember from an early age, growing up--she would tell us that she was not very intelligent. She does not believe that she is very intelligent --in spite of the fact that she went to Smith College and got mostly A's. (Subject #21)

> . . . she definitely had always given everyone ELSE credit. She always did stuff, but she always gave other people credit. For a long time she seriously downgraded herself, especially her intelligence. It was very peculiar; she was just always saying that all her children were smarter than she was. You know--you're 13 and your mother's 38 and she's telling you that you're smarter than she is (laughs). It was a little bit ridiculous, and I tried to tell her that. (Subject #12)

It is no surprise then that these mothers are frequently remembered as victims of unequal power relationships in their marriages. They are described as deferring to their husbands and male "experts" in public and criticizing them to their daughters in private. While their subordinate position was a source of complaint and unhappiness, it was accepted as woman's fate. Some mothers conveyed an image of being powerless to change these circumstances. "That was just the way things were" was a frequent refrain.

> . . . She worked until she got married. She didn't get married until she was 27, so she had quite a few years of work, and then she got married and didn't work until I was in high school. And then she did, I think it was part time . . . so it was really, she couldn't work till the children were grown up, that's the way it was. . . . it was very clear to me that the reason she wasn't working was because DADDY didn't want her to. (Subject #6)

There is a suggestion here that perhaps more was involved in their mother's powerlessness than an unexamined acceptance of the roles of wife and mother as culturally defined. In some reports there was indication that the mothers were abused or neglected as children and that their marital relationships replicated some of the abusive dynamic in the mother's family of origin.

> . . . Daddy used to yell . . . my mother never--she used to concede to him, like she never used to yell back or anything like that. Instead--now she does, a little bit more so, more often than I can remember growing up. But I can remember a couple of times when I was younger . . . it's funny, I remember taking a bath, and my mother coming in and crying, and just saying, "When you grow up you'll know," you know. Meaning she had problems with my father about something, and she'd just be crying about it. And it used to bother me a lot, with her crying. . . . she would just concede to him, and then she would end up crying, you know, but never really--never really, she would just give in, cause he was the man, he was the boss, he was the breadwinner. . . . when she was growing up I know--she used to talk about her pa--I guess her father was a real bastard. He was just a--you know, like, he used to--abuse my grandmother, you know, physically abuse her and stuff like that. So my mother I think tended to be more like her mother and, you, just--that was the way things were. (Subject #19)

While subjects exhibited empathy and support for their mother's position, they also expressed feeling angry, resentful or let down by the example of openly catering to the father. Often they held their mothers in contempt, and, as in this example, went to great lengths to avoid a similar fate.

> And I think I felt that my mother, who is a very good woman, would bring this man orange juice in bed every day--and still does, after something like forty years of marriage--and I can remember being in my room and saying, "How could she do that for that rotten son of a bitch?" You know, he's just taken me out and he's whipped the shit out of me, and she's bringing this guy juice--and how can she be so--just do this for him? She did everything for him. My mother was just a perfect slave, as I would call her. You know, and I did not want to, and I fought any sort of domestic thing at all--any sort of training in this and that. I burned myself with an iron very early, so I never had to iron. I really did fight it. (Subject #18)

To make matters more complicated, some subjects recognized that their mothers participated in a dynamic which maintained an image of victimization and powerlessness but in fact led to being in control; that is, they managed to get their own way by exploiting their seemingly powerless condition. The following examples speak to this kind of interaction and are typical of the majority of descriptions of parental interactions in this study.

> . . . he'd [the father] kind of lose his temper very quickly and unpredictably over one never knew what. And he was never, you know, physically violent to anybody in the family, but he would do things like kick things and throw things and let everybody know that he was angry. And my mother would usually either kind of clear out when that happened or else she would become very kind of apologetic and obsequious in the face of his anger. And she would kind of like hover around him and try to make peace in a way that would kind of feed, I think, his enjoyment of, you know, kicking things or whatever. And um--I don't know, like--for a long time, as a child, because of that dynamic I always saw my father as being the "bad" one, I mean the explosive one, the person who kind of stirred things up and was mean to my always very controlled and, you know, sort of giving and martyr-like mother. And

it kind of took me a long time to figure out that she was very much a part of that dynamic. You know, that there was stuff that she did very passive-aggressively that really fed, you know, kind of his explosions. But I guess I was always, like, a little bit afraid of my father. There was--not because I thought he would hurt me, but there was a sense of his being very unpredictable and sort of volatile, and um, I never--I never quite understood what it was that made him angry. I always had a sense that he was never really angry at whatever it was that he was reacting to--it was always something else. . . . temperamentally, they were really opposites. My mother was real concerned with pleasing people--in her own way she's very controlling, she's very, like, passive aggressive. I mean, she actually gets her own way a great deal of the time, but it's never through openly stating her needs or asserting them; it's always through this very deviant kind of--or, you know, much more oblique kind of way of doing things. (Subject #21)

. . . with my father, she always on the surface seemed to be trying to build him up. You know, "Oh, don't ask me that math question--ask Daddy. I don't know how to do that." It was very obvious to me even as a child that she did know how to do it and that she was just trying to make poor old Daddy, whom she saw as a sad case, feel better. And I knew Daddy knew it, too. So it was--I guess it's not so subtle--not very subtle at all, but I think she thought it was. And, um there was a lot of that --until the tables kind of turned and then she would talk about how sad my--I mean, she got eventually to talking about my father more the way she felt about him when I was older. She saw him as rather pathetic. But when I was a child it was more keeping up this pretense of big, strong, smart Daddy. . . . I always saw my mother as the victim and my father as the tyrant, and I didn't realize how much a role she had played in negative things and how manipulative she was. (Subject #6)

Perception of self as like or different from mother. Self-sacrifice, unhappiness, and frustration prevailed in descriptions of mothers and seemed to become a central part of these women's images of womanhood. In 22 instances,

these images provide something daughters don't want to be like, rather than a positive image of female identification. Some explicitly cite fears of turning out like their mothers or negative feelings about the ways in which they are like their mothers.

> Um . . . I think . . . I will probably be very much like her. And it scares me. Because--there are good points to it. Like, she's really goal-oriented, and I think that's very good. And I want to have my own career, so . . . But I can see--I mean, on one hand I think I would be a good parent if I ever had kids. On the other hand, I can see where I might not be. I would just get too selfish about the whole deal and get freaked out by being tied down by them and everything, and just be lousy like she was. So I fear it when I feel my being like her . . . the only role model I really have is my mother. And, you know, maybe she has a successful life, but she's certainly made a mess of her family. And, you know, I'm a symptomatic child and so is my brother. He is a very bad stutterer, and that's kept him immobilized. He's 24, and he's still pretty immobilized by it. And I just--I guess I don't have a very optimistic outlook on things. I don't see that I can have a career and a family and make them work. It's got to be one or the other. And I don't know which to choose, cause I want both (laughs). (Subject #22)

> I didn't want to grow up to be neurotic and screaming and yelling and . . . I saw my mother as pretty unhappy, and I didn't want to grow up like that. But my--I think my general feeling was that she was just really uptight all the time, and I just didn't want that, I didn't want that for my life. And I certainly didn't want to get married. I mean, I did and I didn't, but--at that time, I did want to get married, but I didn't want to be married to someone like my father, you know, who was very--I wanted someone to be very verbal and affectionate with me. And, I don't know, basically I think I wanted to see more of the world than Mom had. (Subject #16)

> I don't want to get caught up in things that I think my mother has, you know. It often frightens me that I might, you know. And I hope that awareness prevents me from doing that . . . (Subject #9)

I: Do you see your life as like or different from your mothers?

S: I guess I have fears of ending up like my mother. In some ways I think that's good; in some ways that's bad. I feel like that in many ways she had a very good life, that she had a very good family life, a very supportive husband, that it was very FULL. And yet I don't feel like that she as a person developed all that much in that situation . . . that when I look at her now, that she really doesn't have enough self-confidence always to go out and do what she'd like to do. And I don't see myself as wanting to be that dependent on a relationship. (Subject #2)

I don't want to have as much self-hatred as she does. I think I'm already more aware of myself than she is, or ever was. I'd like to make the break with her cleaner and more healthy than it was between her and her mother. I think she's a wonderful, giving, loving, smart woman. And she's two different people to me, really she's that, and then she's this awful daemonic kind of figure. I think I've disliked her, or at least resented her ambivalence, her conflicting voices. (Subject #3)

Even in cases where subjects spoke of admiring and wanting to be like their mothers during childhood, the qualities admired were often later the source of complaint. For instance, in childhood Subject 21 saw her mother as a beautiful woman who was "perfectly giving." Later on she begins to view her mother as "passive-agressive and controlling."

What emerged then, in most subjects' descriptions of their mothers, was a sense of personal unhappiness and an inferior role. As subjects became older and observed the negative features of their mothers and their mothers' roles, there seemed to be a recognition that they were like this person who is unhappy and were likely as adults to

enter their mother's roles, replicating perhaps her powerlessness in relation to men, her unhappiness and dissatisfactions with her choices, her passive-aggressive stance in relation to conflict.

On the surface, these descriptions seemed to reflect a high degree of disidentification or a subjective sense of being different from their mothers. However, when we return to subjects' statements of disidentification we can speculate that they in varying degrees reflect not having worked through a separate identity from the mother but rather an intention and a desire to be different. With an acknowledgment that the potential for her is in her mother's example, considerable effort was directed toward trying not to be like her mother. It seems likely that this effort robbed these women of energy which could have been directed toward the development of themselves. The result was disidentification and the rejection of a possibility of following in her mother's footsteps.

> I don't recall ever knowing any woman that I admired. I think I hated . . . (laughs slightly) found most women disgusting. . . . I don't know whether I found my mother herself disgusting--probably her lack of self-respect. The fact of--it's hard for me to say it <u>real</u>. I can say it in analytical type terms now. (I: What . . . ?) Her constant saying that she was not worth anything, her clothes were so ragged, and her underwear (laughs painfully) was disgusting and nothing but holes, and her stockings, and she wouldn't buy anything for herself, because she--that was because she came last. And she treated herself and her own body as a contemptuous thing, and I did that also, and learned to do that. But I was even <u>more</u>

contemptuous of the fact that she did that, and that's the only model that she gave me! I had some kind of double awareness, I think, of that, even at eight, nine, and ten--of being ashamed of my mother, but even--but that terrible anger at her for being that way when I felt it was not at all necessary. (Subject #10)

I: Were there things about either of your parents that you admired or wanted to be like?

S: With my mother--(laughs) I really can't think of anything with her. More--when I think about her, it's more the things that grated horribly. (I: What were some of those things?) The way she was disorganized and hysterical, and in social situations would, you know, talk endlessly and not listen to people . . . and, those were the things I cited, "I do not want to be like that, I am NOT going to be like that." So with her it was more of a reaction. (Subject #5)

In many cases, identification with mothers was complicated still further by indications that the mother both expected her daughter to be like her and at the same time hoped her daughter would be different. In some instances this paradox emerged as a negative injunction: don't be like me, don't be different from me.

I: Did your mother give you any ideas of what she thought you should be when you grew up?

S: Some kind of professional. Not necessarily stating what. I had studied art when I was younger. My mother studied art. There's a big jealousy thing I'm just uncovering between my mother and me. . . . my mother was an artist when she was younger, and she encouraged me to be an artist . . . and I fantasize about becoming an artist, living my life as an artist, and it was really important to me, but it was like, that wasn't good enough for my mother. And I think it was, she couldn't be, so I shouldn't be allowed to be kind of a thing. You know, like, encouraging me and discouraging me all at the same time. (Subject #11)

The confusing and conflictual messages of "be like me" and "be different from me" put the daughters in a bind such that whatever way they developed they would be displeasing her. Becoming like their mothers might lead to a similar negative self-image or arouse competitive feelings in both. Choosing to be different from her could be construed to mean betraying her. This dynamic was particularly salient in several subjects' descriptions of body weight and dieting.

Weight, Dieting and the Mother-Daughter Relationship

In many cases, mixed messages and ambivalence concerning identification with mothers were revealed in descriptions of body weight and eating.

Fourteen of 24 women reported their mothers were overweight and/or preoccupied with their own physical appearance. In some, mothers showed weight fluctuations of 15 lbs. or more throughout subjects' growing up years. Dieting in some cases became a central feature of the mother-daughter relationship.

In eight instances, sisters were also described as having problems centering on weight control and were preoccupied with eating and body image when subjects were preadolescent. In two instances, sisters were diagnosed as anorexic.

> My mother's always had a weight problem . . . um, she's always dieting, or binging. (Subject #17)

> . . . my mother understood [my weight problem] more, because she had a weight problem. Nothing serious . . . I mean, like I know when she was heavier, like when she was my age now, maybe 20 or 30 pounds overweight. And then she had the same problem, kind of up and down, up and down, you know, like 20 or 30 pounds--thin, fat, thin, fat, you know . . . (Subject #7)

> [My mother was] overweight all of her life about 20-30 pounds . . . mostly what is called "plump." She lost weight for the first time in a major way about 15 years ago . . . has gained weight back at least twice and then lost again by dieting as a function of her self-esteem. (Subject #13)

> All my life she's [mother] been preoccupied with food and thin and fat. She has never been truly fat. Her weight fluctuates 10 pounds. She is a compulsive eater. (Subject #6)

> My mother was always dieting, then not dieting. No one in my family could be calssified as obese or even more than 15-20 pounds overwieght. (Subject #8)

A link between dieting, pressures to be slim within the family and identification with other females in the family emerged in many subjects' accounts.

> [My mother had the] Same weight problem. Although SHE didn't develop a weight problem until she got out of high school. She was terribly thin until she graduated from high school and then she slowly started putting it on, and then she would diet to take it off and then she'd put it on, take it off, put it on . . . and so it's the same, you know, diets then binge, syndrome. And uh . . . yeah. Pretty much eating was a . . . my Dad never had a weight problem, though. But he could, like, eat pretty much wat he wanted to, and he stayed thin. And so, it was, like, you know, my Dad could eat all these sweets and all this stuff, but my mother and sister and I would all go around trying to be strong, you know, and still all these goodies were

around the house for my Dad, so it was like temptation there . . . and it's okay for him to eat them, but you know, we had to stay away--the women in the house. (Subject #7)

. . . my sister did a lot of damage in terms of my eating behavior, I think, because she was--oh, a plump adolescent, and ridiculed a little bit by family and friends, and I was still at an age where I shouldn't even have begun to think about those things. I stopped eating potatoes. My sister when she was in college ate about 300 calories a day . . . she ate maybe half a yoghurt and two apples, and . . . I idolized her. And I didn't even understand why I was doing that, cause I was in sixth grade! (Subject #14)

. . . my weight was always a big thing [to mother]. I mean, I always got blasted about being overweight. "You'd look so much better . . . . my mother is obese. I wrote that down on the questionnaire, but that's also really important. I'm only beginning to understand why my mother is obese, too. My mother has a very low self-esteem, and, because she doesn't have any self-esteem it's hard for her to set an example to me or to my sister so that we can have self-esteem. I was always embarrassed by my mother when I was younger, that she was fat, and I didn't want people to come over to my house and visit and see my mother and make fun of her, or what not, as kids do . . . I don't know how much my mother weighs. I can guess from working in a hospital and seeing overweight women. My mother is 5'1" and I bet she weighs 200 pounds. . . . I can remember times when she was slim, attractive, and then put weight back on. And I can't remember how long now she's been overweight without having tried with any amount of success to diet for more than five or ten pounds. And it bothers me. I feel she has tremendous difficulty dealing with her obesity, her reasons for obesity, her relationship with her mother, her availability to communicate with my sister and me. (Subject #11)

With my mother, because I knew she was so intensely preoccupied with her body, I figured she must be about mine, although she wasn't very overt. What happened, as I started to overeat in high school and get heavy--and I got heavy like I am now, only I think that I carried it less well in high school, you know what I mean--I think I looked fatter then

> than I do now. But I never got obese. . . . what she did with that was, she just acted very sorry for me, and like, "Oh, dear, I don't want this on you," and really monitored my food intake, I mean, really was always saying, "Who ate all the peanut butter?" when she knew it was me, and these big glances--so I knew that she didn't like the way I was looking, if she felt so terrible that I was eating more. And I felt very helpless. I mean, I had this incredible compulsion. It was like, back then I thought of it as if, like, a spell was cast on me. It just seemed sometimes that I had to eat, I couldn't stand not to eat, and I didn't have any idea what was going on. I mean, it was completely a mystery. Even though I had seen my mother, somehow it didn't seem ordinary. It didn't seem, "Oh, I'm just doing what Mom does." Because I guess I hadn't felt that for all those years, and suddenly I did, and I didn't understand it at all. (Subject #6)

There is a suggestion that a preoccupation with body size and dieting was a basic aspect of their female socialization. One subject aptly labelled this an "apprenticeship in dieting."

> The first dieting was--the first formal diet I went on must have been around fifth or sixth grade. I think I was probably younger than what I said on the sheet, because it was my natural mother who was in a bowling league at the time--she was always dieting --and brought home for me a--like a mimeo sheet of a diet that she picked up at the bowling alley, that was in a pile of, you know, "Take ones," prescribed by some doctor. And she--she had me read the whole thing. And I was--maybe I was 12 then--and follow it. And she helped me through it, and--I guess I lost some weight on it. But it's such a vague memory now. I have the sense that it was almost like going through the motions and not really having absorbed any of the mentality that was supposed to go along with dieting yet. But getting the messages all along the way that, "This relates to you as a woman,"--to you as a potential wife and to you as--you know, all the things that mean attractiveness, that kind of stuff. I mean, I knew that

> that's why she was doing it, and I guess to a certain extent it was kind of fun to be on a mother-daughter diet. But it was again--it was almost like an apprenticeship, which was different from how it became later when I would do it on my own. (Subject #8)

Often within the context of the mother-daughter relationship dieting became a conflictual issue. Subjects' accounts of these conflicts were varied. For some, food intake and weight control became a question of who is in charge, often a source of concern to their mothers or the precipitant for family fights. Others experienced a competitive dynamic in which mothers overtly encouraged them to diet and at the same time were subtly discouraging of their efforts. In this situation which parallels the general process of identification, if the daughter succeeds at losing weight she runs the risk of "betraying" her mother by surpassing her; if she fails at losing weight she is not living up to her mother's hopes and expectations and is leaving herself open for criticism from her mother or other significant people in her life.

For example, Subject #4 felt that being like her mother meant being "fat" and having to deal with the consequences of that, specifically, her father's criticism and judgment. Being "thin" was considered a rejection or betrayal of her mother. Here, as for many other subjects, being "like" or being "different" from the mother posed a dilemma.

> There's also a lot of stuff with my mother around how, you know, just how I feel about my body and stuff, because she's--she's overweight, she's heavy, she's always had--since I was born--had a problem with it. A lot of my feelings about my weight and my body and my parents are also caught up in that whole thing of my mother and how my father saw her, because, like, for me, you know, both in terms of I'm sure some element of saying, "I don't want to be fat," this is a judgment of my mother in some kind of way, or a rejection of her, but also that--I mean, that whole battle between my parents, and my body, is like saying, "I can accept myself even being heavier," is, then I'm coming up against my father's judgments about being fat and sloppy and gross and not something that you should be, kind of thing. Plus a lot of I think connections to my mother around food . . . in terms of her using it in certain ways, you know, like using it for reward. (Subject #4)

Another example is Subject #6 who explicitly framed this problem in terms of competitive feelings in the mother-daughter relationship. Again, conflicting messages concerning body size and eating emerge. Here one can speculate that the daughter's remaining overweight could serve to protect the mother from her own conflicts in this area.

> I think she was very insecure about herself, sexually and just physically, and certainly had a lousy relationship with my father . . . she didn't particularly like being married to my father and hadn't almost from the beginning. My brother had left the nest and I was soon enough going to, and I think that a lot of energy went into competing with me in a very subterranean way, a very unconscious way. And the way that it really got going was this whole body thing, and really giving me mixed messages about, "Oh, dear, I don't want you to be fat--I feel so sorry for you. Let me help you"--by disapproving, basically, and acting incensed when you eat--not incensed, it was subtler than that--there was THAT and then there was, "Oh, I hope you don't fit in this," or "I hope I'm still small". . . . and that's STILL the

> way it is. I know on one level she really wants me to be happy and she really wants me to feel good about myself, and on the OTHER level it makes her feel worse about herself if I'm feeling good about myself. (Subject #6)

While for many women in this culture, shared concern with dieting and appearance is the basis for closeness and intimacy, for most of the women here the conflicts evoked by these shared interests did not result in greater intimacy or mutuality. Indeed, for these subjects, the shared interest in body size resulted in a closeness the nature of which prohibited mutuality and intimacy.

Closeness, Conflict Avoidance and Appearances in the Mother-Daughter Relationship

Closeness. Sixteen women described relationships with their mothers as being close in childhood and adolescence. Closeness here does not mean the same thing as intimacy and may well mean over-involvement. Intimacy includes closeness, openness in exchange, the ability to tolerate differences and manage conflict. The women's descriptions of feeling close are of over-involvement, inability to tolerate differences and an inability to manage conflict. Contained within these descriptions of closeness, however, was tremendous variation, complexity, and often relative or contradictory meanings. For example, Subject #22 who described herself as closer to her mother than any other family member said, "I've never been able to talk to her

really, at any point."

Feelings of closeness are not the same in different periods of childhood. For some, periods of childhood closeness with mothers are remembered as diminishing in adolescence. For others, closeness increased at the time of adolescence or as the daughter prepared to leave home. In several instances "closeness" in the mother-daughter relationship was remembered as occurring in relation to a third person. Subject #17 describes a period of increased closeness with her mother during adolescence in which subject and mother unified against the maternal grandmother who intermittently lived with the family.

For Subject #17 peer relationships were an area of conflict in the mother daughter relationship prior to the grandmother's arrival. When her grandmother became critical of the subject's friends, the mother allied with the subject.

S: My mother would take on the role--she'd get angry at my grandmother. You know, "Leave her alone," she'd say. . . . and I was very angry at my grandmother for butting into my business. And so my mother and I sort of came together at that point. And it's interesting that--I just realized this--that my--I guess when my grandmother died, my mother and I came--you know, at heads.

I: What kinds of things did you tend to fight about . . . ?

> S: My body. She--well, maybe we didn't fight about that, but that was one of my angers. . . . it was always, you know, "[_____] has such a pretty face." Everyone in the family: _____ has such a pretty face if only she'd lose a little bit of weight. (Subject #17)

In this case, problems in the mother-daughter relationship were temporarily obscured by uniting in anger against a third person.

Descriptions of such alliances in the mother-daughter relationship were frequent and often it was the father against which mother and daughter bonded. Many subjects reported being "sounding boards" for their mothers, particularly concerning their mothers' dissatisfactions and conflicts in her marriage.

> Well, my mother involved me in conflicts about my father, when she, you know, and she still does . . . talks to me about . . . complains about what is going on. . . . It's sort of like she used me as her main support. (Subject #5)

> I think they [parents] have lots of problems and I think I've always been in the middle. My mother would always tell me about it. (Subject #22)

> So I jumped in there with Mother--I'd sort of be her ally--and we stood up against him [father] together. (Subject #1)

> I went always with my mother. My father had a raging hatred for her. (Subject #10)

Although being mother's confidant gave the illusion of closeness it can be an indication of an overinvolved mother-daughter relationship in which individual boundaries are absent. Confiding in daughters or eliciting their support often served the function of circumventing or avoiding

conflict in the marital dyad.

Conflict avoidance. The notion of conflict avoidance in these families is supported in descriptions of mothers' attitudes towards anger. Fifteen women described their mothers as conflict avoidant.

> Nobody ever showed anger in the family. . . . that was something that came along with the high moral standing, is that, "You do not get angry." you know, and its like, you know, "Turn the other cheek." And that's the way I grew up, you know, it's BAD to be angry--you cannot FEEL anger, you cannot SHOW anger . . . you have to just take it all into yourself and, you know, that's IT. (Subject #7)

> . . . if you're angry at somebody, well don't tell them you're angry. Just go do something else until it subsides. . . . there was conflict there, but it was not openly expressed. My friends go home and tell me about growing up as kids and having arguments and so forth over the dinner table--and that would--that would be absolutely unheard of. You just didn't have those kind of conflicts. . . . openly expressed anger was something that was considered immature and childish and something you tried to transcend. (Subject #2)

In some instances open fighting or bickering is described as characteristic of the mother-daughter interactions. There is little sense of any exchange of different points of view which suggests that real conflict and its resolution were avoided.

> My mother would yell, but I would just yell back; I didn't take her anger seriously. It was just a game. It never got too loud. Anger was never expressed that much around my house. (Subject #12)

> We used to order them [clothes] out of a catalogue, so we would sit and fight over the catalogue was basically what it amounted to. It was a battle, cause I liked stuff that she didn't like. We used to fight about that--clothes. I used to roll up

> my skirt at the bus stop when mini-skirts were in style cause my mother wouldn't let me wear 'em that short. . . . Um--I used to think we had really different taste in clothes. But I don't think we really did, I think it was just something to fight about, you know--anything. (Subject #15)

In other instances where fighting was avoided the absence of a sense of resolution is apparent. Angry feelings or disagreements are to be avoided or "swallowed."

> . . . in my family we didn't deal with conflict, feelings, openly. Instead when things were really kind of upsetting what I learned to do was go off and eat. (Subject #5)

> You know, it's like when we talk about things it's clear in the beginning at least that I'm facing her with something that she might not agree with, some opinion that she maybe wouldn't hold for herself--but then what usually happens is that she'll sort of take it in and change her mind and that's okay. So we don't get to talk about it, there's not an exchange really. So it's like sort of--uhh, where did that go? And my fear is that what she does with that is take it in and it tears her up, but I never see that--that she struggles with herself in some way, or else just bury it, I don't know. I don't really know what she does with it. But there is no <u>exchange</u>. (Subject #4)

These perceptions suggest a strong tendency toward the suppression of real feelings and a denial of or aversion to open conflict in the mother-daughter relationship.

<u>Appearances</u>. The absence of overt conflict in these families contributed to a public image of harmonious relations. When asked to describe their families, ten subjects described their families as giving the appearance of happy normal families. The following quotations are offered as representative of this perception.

> Most people would be--my physician asked me a year ago--both my sister and I have been married twice--and he said--and he's dealt with our family for years and years and years--"I can't understand it," you know--he sees my mother and father with these--"You're such a fine family! A great family, a tight family, da-da-da-da." He has an appearance, an idea, of my family. I mean--to have this man know that my father was beating the living shit out of me would startle the hell out of him, you know. He wouldn't believe it. I mean, he just would be--he would be shocked. (Subject #18)

> I had a nice house, that was awful inside, but nobody was every invited in. (Subject #10)

> I grew up with the delusion that we were--besides my grandmother, we were a perfect family. Wasn't it obvious that my parents loved each other? They never argued, and for all appearances everything was fine. I thought we were just one big happy family, that there was no problem between my mother--and--it was a real shock when they started to argue. I was really blown away . . . then I started hearing all this historical stuff. It was very hard for me . . . The first time was when I was 15, and my father told me they were going to get a divorce. (Subject #16)

The emphasis on appearing to be a well-adjusted family seems to exist within the family as well as without and effects the level of exchange in relationships with parents, particularly in the mother-daughter relationship.

Several subjects felt that they had to present to their parents the image of a happy, well-adjusted, accomplished child.

> . . . it was essential that I was always happy. I always had to be happy. (laughs) Nothing could ever go wrong in my life, and if it did I was to forget it. (Subject #16)

> My mother has always been one that would kind of like judge something by its physical appearance. You have to be very conventional and look like everything's okay, you know, everything's fine--handle everything, be very strong. . . . (Subject #9)

Other accounts emphasize feeling "invisible" or overlooked within the family.

> I don't think I was ever seen at all, and, you know, probably what I carried around for the rest of my life is the sense that I'm invisible. (Subject #10)

> . . . it seems like there were always tons of people in my parents' lives. I should say my mother's life, since my father was kind of out of it. So I've always felt, you know, like in the back seat . . . there's always somebody else. (Subject #22)

> I had no place to go with a lot of very small child kinds of issues and for me that's kind of where the ground work was laid for a lot of this stuff [eating behavior]. When I became a teenager, I had this very similar experience, I had no place to go with my anger, no place to go with my, no place to . . . and I was having a lot of painful experiences. (Subject #13)

In some instances subject's felt their parents were overtly neglectful of them failing to notice apparently odd behavior. However, changes in body size, becoming either too thin or too fat, were noticed by parents.

> I think I was kind of obviously disturbed about some things. And I could--just my note-writing behavior to them seemed a bit odd to me when I look back at it. But they didn't really think anything of it either. And even . . . when I was starting to get very thin, that was not really too noticed either. I mean, I had to go to a real extreme level before they noticed it. (Subject #22)

> . . . my father--when I lost--again, a couple of years ago when I went on the fast and lost a lot of weight--that was the first time he ever really noticed . . . when I lost the weight, that was the

> first time he ever noticed me--He said, "What's the matter with you? You're getting skinny". . . . You know, it was the first time he ever really noticed me (laughs). (Subject #19)

> Both of them give me stuff about, um, my body. Every time I go home, I've either lost or gained weight . . . And, you know, I told them as best I could what had been going on for me--when I told him [father] that I used to make myself throw up, he said, "How could you be so stupid?" . . . he just couldn't understand the psychological stuff that was involved. (Subject #17)

Reports of feeling "misunderstood," "missed," not seen for who they really are often converge with subjects' descriptions of their parents as being emotionally unavailable.

It is important to note that many women spontaneously tried to account for their mothers' difficulties in being emotionally available. Although such explanations were not specifically sought, many subjects saw their mothers as having unresolved conflicts with their own families of origin and perhaps reinacting these conflicts with their daughters. In several instances, subjects described their mothers as having been neglected or abandoned as children. For example, Subject #18 accounts for her mother's difficulties in helping her daughter deal with menstruation:

> She was very uncomfortable about it. It was not anything that she was--her upbringing was extremely strict and extremely cloistered, and she was raised by her grandparents until she was five because my grandfather was in art school. And so she wasn't even brought up with her parents. And then she was shipped to boarding school. (Subject #18)

Another example is Subject #9 who explained her mother's unavailability and discomfort with her daughter:

> . . . she feels very uncomfortable around me. I remind her of her mother. My mother's an only child, and my mother has a lot of animosity towards her mother because my grandmother is a non-conformist, and she left my mother with relatives to kind of find herself way back when that was rather something that was kind of tabu. And when my grandmother came back to kind of claim my mother, and she got married again and that type of thing, my mother was like 12, and you know, she had already formed a lot of her opinions. And they just had a rather--well, not even a relationship. (Subject #9)

While the majority of women felt that both their parents were emotionally unavailable, their mothers' unavailability was perceived as having to do with the mother as a person, her development and conflicts within her own family of origin. Descriptions of fathers' unavailability appeared in a different context. In descriptions of their fathers, subjects seemed to perceive his unavailability as having to do with his work commitments and role as "the provider" rather than his personhood.

Fathers

Perceptions of fathers. There was evidence in many interviews that the father-daughter relationship was basically problematic and unsatisfactory. Although many explanations were given, in most cases these difficulties were understood in terms of fathers' unavailability. In nineteen accounts fathers appeared as removed from family life,

emotionally unavailable or unapproachable as nurturant figures. This absence was explained primarily in terms of work involvements, alcohol abuse, physical or psychological problems, and temperament.

Involvements in work. A majority of subjects described their fathers as men who were primarily involved in the world of work, their careers and the monetary support of the family. Many women here cite involvements in work as reasons why their fathers did not participate in family life or were unavailable.

> My father was really absent a lot. I mean, he--I saw him at breakfast time, and during my young childhood he worked very late. And then on weekend mornings he always slept very late. So I mean, he really was not that active a parent. (Subject #6)

> He was pretty distant; he wasn't really involved in the family very much. He didn't really want to be a father, I don't think. He was really into his work. He worked as a police officer, so he worked, you know, all hours--he was away from home a lot. (Subject #5)

> I just don't have very much of a sense of who my father was all through growing up, until I went away. I don't remember very much about being with him. Cause, you know, for the first few years as I was growing up, he was working seven days a week. And as soon as he got off work on Saturday, he'd be out on the golf course, and also there on Sunday. And then, you know, I would go out or he would fall asleep when he came home--so it was dinner time that I usually saw him. And I usually ate before they ate. (Subject #17)

> . . . my father was a traveling salesman so he wasn't always home. (Subject #11)

> He never really--he was away a lot when we were kids. He was a traveling salesman then, so we didn't really see him a great deal . . . he golfed every Saturday, we never saw him on Saturdays . . . did his expense account all day Sundays, and watched football while he was doing his expense account. (Subject #18)

> Dad was a truck driver. That was his life as best I can see. (Subject #20)

The tone that runs through many of the interviews suggests that a significant number of the women experienced their fathers' work involvement as a form of disloyalty to family life. The frequency with which fathers' emotional unavailability is blamed on their work commitments tells us something about the dynamics of many of these families. Fathers are seen as disloyal to the family because of work interests; work is seen as an excuse for non-parenting. For many mothers, marriage and parenting are seen as an excuse for not working.

Although it is common for fathers to be absent from family life because of work, other reasons appear here which might have served to give subjects a painful sense of their fathers as absent or unavailable. For a significant minority it was not just that fathers were distant in some traditional sense but were unavailable for what most people would consider a consistent parental relationship.

Alcohol use. There are eight accounts of alcohol abuse by fathers. In the following quotations, drinking is linked with fathers' unavailability and other disappointing qualities.

I: Did your father drink while you were growing up, too, or has that been more recent?

S: I think it's become more pronounced, but he WAS [drinking], in maybe more of a social way. I think it's become more pronounced or it's become more obvious, I'm not sure which. . . .

I: What feelings do you remember having towards him?

S: Mainly, I think, disappointment . . . and anger, I think, because he could never be counted on to do anything. You could never count on him to be there at a certain time, or come to a specific event, like a school thing or something. I mean, he would say that he would do it and then he wouldn't do it. So there were a lot of, like, disappointments. There was a lot of anxiety, I think, about him, you know, in terms of how he would behave or how he would be . . . and never knowing--you know, he would say one thing, but you never knew if he was going to follow through on that or not. So he was very, kind of, unreliable. (Subject #5)

. . . my father is just a kind of blob . . . he doesn't get easily upset . . . you know, if I talk to him, he doesn't really understand things. He'll go off onto another tangent. He doesn't seem to understand . . . I would have to say that they're [both parents are] very unobservant. They never seem to notice anything [about me]. I think it's always because they're--you know, they drink so much, their awareness is kind of down. (Subject #22)

I: How would you describe your father's temperament?

S: My father drinks a lot.

I: Has he always?

S: Well, as much as I can remember that he was home --yes. He drinks quite a bit . . . he tolerates his anger and his displeasure by drinking . . . It's--it's very difficult for me to describe the relationship with my father. I hardly know the man, really. I do remember, like having talks with him, you know. And he would, like, want to

> know how school was or something. But--everything was just so--just like I said, so perfunctory, you know. I wouldn't really let myself feel anything with him. (Subject #9)

Physical or psychological problems. Several women reported physical or psychological problems in fathers which served to intensify the experience of fathers as unapproachable. While the reports of these illnesses and problems varied in their intensity, most of these subjects felt cut off from a realtionship with their fathers. In each instance, father's unavailability was understood in terms of the illness or emotional problems. Thus while these women lacked a fully developed relationship with their fathers, their fathers were still a strong presence in their lives.

For instance, Subject #1 described her father as a distant figure who was hospitalized for psychiatric reasons when the subject was six. He is seen as a "maniac" whose rigid spiritualism and temper tantrums made him the object of family ridicule and concern. She goes on to say:

> I don't think I had a Dad--there's no question--there was just no father figure except a maniac that (sic) sort of--I love him, but to this day when I sit down with him I have to ask myself: "Is that a father?" and "What do I feel?" And emotionally I feel NOTHING. As much as I say I love him, I think I love a French poodle as much. If he died tomorrow I'd say, "Hell--_____ died." Because we never shared an emotional feeling of warmth, father-daughter, ever, and it would be pretty hard to feel anything for him. (Subject #1)

A similar account is found in Subject #10's description of her father's rigid and complicated eating habits. In this case, the father strictly held to a value system of ascetic denial which prevented contact between father and daughter.

> He was a natural food nut--he never ate anything except whole wheat breads and clear meats himself. He didn't even eat vegetables or fruits or grains. That's all he ate, and he slept on boards on the floor . . . he was a fanatic about this . . . it wasn't really religious with him, cause he--he's an atheist, if anything . . . My father always cooked his own food and ate it alone, and my mother would pick when she felt like it. Nobody wanted to sit down at the table with my father! . . . he [father] never spoke to me, in all the years that we lived together. I recall his addressing me, specifically, really well, maybe three times. I usually think it was two. I think once he said, directly, "Get out of my sight--you make me sick." And warned me several times in terms of, you know, that he would kill me if I ever--if I did not--if I was in his presence. And he didn't really speak to me, but he would make me sit in the room while he lectured on nutrition--of all things. . . . my father was a man in some ways way above his time. (Subject #10)

A third example is Subject #2 who felt a great attachment to her father in spite of his long working hours and extensive involvement in his career. In her case, father's unavailability was seen to be the result of a serious illness which occurred during subject's adolescence.

> . . . when I was 14, my grandmother and my father got cancer simultaneously. My grandmother was living, like, 600 miles away. And while my mother was gone taking care of grandmother, who was terminally ill, my FATHER got cancer and we almost lost him. So there was a whole block of time between the time I was 14 and 18 when my father was sort of--well, "he may be here today and he may be gone tomorrow," sort of thing. He had one serious operation. Then

> he came back, it took a year or two to bring him back to some sort of health, and then he had another recurrence, and he went through a whole series of cobalt radiation treatments and so forth. So that was another couple or three years--it was about when I was a sophomore or junior in college that he started looking good and started feeling like maybe he was going to make it through . . . then he had very good years from that time until he died two years ago. I guess it would tend to make it kind of an unusual adolescence situation because all the times, when I look back on it now, that one would go through normal trying to divide oneself off from the parents . . . I had a lot of guilt complexes over that because I felt like that if I did that then I might be causing my father's death or might be hurting the illness or something more . . . (Subject #2)

Temperament. In many accounts, the temperament of fathers was seen to be a contributing factor in the experience of father's unavailability (or an impaired father-daughter relationship). Fifteen subjects described their fathers as prone to outbursts of temper ranging from verbal trantrums to threats of, or actual incidents of, physical abuse. In some instances, the subjects explicitly stated being fearful of their fathers. In other cases there was indication that they were fearful or felt that they had to cater to their fathers or stay out of his way. Additionally, ten subjects described their fathers as childish or self-indulgent, often expressing resentment of fathers' privileged position in the family. The resentment these ten women expressed towards their fathers centered on viewing their fathers as spoiled and unable to control their tempers when their needs were not immediately met.

. . . I guess I was always, like, a little bit afraid of my father. There was--not because I thought he would hurt me, but there was a sense of his being very unpredictable and sort of volatile, and um, I never--I never quite understood what it was that made him angry. I always had a sense that he was never really angry at whatever it was that he was reacting to--it was always something else. But I could never, you know, really tell what it was. (Subject #21)

I remember my Dad did have a bad temper. I remember him like, maybe, two or three times in my whole life that I can remember him getting angry, but it was very, very traumatic, like he got really angry, and when he got angry he really lost his temper and he would, like--well, I can remember him getting angry at my sister if she did something really bad, like grabbing her and shaking her and slapping her or something, and that was . . . in our family, anything like that happening was like a VERY SERIOUS PROBLEM. It was like, oh, I'll never forget this--and I still HAVEN'T. It's still in my mind, these instances, just very clear. (Subject #7)

My Dad is both an easy-going person and a person who is stubborn and has a hot temper . . . my father's really stubborn at times, when he gets angry he just . . . he's not the kind of person that you want to spend time talking to, trying to convince him. Because, I mean, I know that ten minutes later he'll be willing to hear, but not at the outburst. And he was never frightening in his outbursts--to me, except maybe once or twice in my life. But my mother--um--I mean, I think we would just kind of come together knowing, "Well, just don't talk to him now." You know, or I would want something, and she'd say, "Well, wait until after he's had something to eat," you know . . . I mean, I think that--my father isn't a real powerful person in the house. So there's catering, but always I think ambivalent catering, because my mother always knows that she would--I mean she knows what's going on a whole lot more than he does . . . You know, she really was the powerful person, although she wanted to think he was. (Subject #17)

Within the sample, an interesting difference emerged in subjects' descriptions of their fathers' temperaments. Fourteen of eighteen purgers (those who force-vomit or use laxatives after binging) described fathers as emotionally unpredictable men who had volatile tempers and who might be prone to physically acting out their tempers. Of the four purgers whose fathers were not described as volatile, three had fathers who abused alcohol. This suggests, perhaps, an inability in these men to manage strong feelings and, in some cases, an attempt to deal with their feelings by alcohol use.

In the six bingers who do not purge, only one reported that her father was prone to emotional outbursts. Fathers of these women were more frequently described as conflict avoidant or as expressing their displeasure and anger by withdrawal and/or withholding of affection. In three of these women who had milder eating problems, descriptions of fathers were more generally positive. While "unavailability" was often a part of their descriptions, other characteristics were also frequently mentioned indicating a greater degree of closeness and respect in the father-daughter relationship.

It is reasonable to assume that a father's unavailability might have the effect of intensifying or increasing the daughter's involvement with her mother and the mother's involvement and reliance on her daughter. Fathers, who

could have been central in mitigating the unhealthy dependencies (symbiosis) of the mother-daughter relationship, instead often became distant objects of hostility, unifying mother and daughter in their criticism and anger.

Subjects vary in their descriptions of closeness with their fathers. Unlike the reports in Boskind-Lodahl's (1977) or Gawelek's (1979) studies, there appears to be little consistency in patterns of closeness in the father-daughter relationship. These earlier studies found deeply bonded relationships with fathers in childhood diminishing markedly at puberty and during adolescence. Only nine of twenty-four women here reported this pattern occurring in their relationships with their fathers. It is difficult to account for this discrepancy in findings.

Siblings

Sibling relationships emerged as a significant topic in the interviews. It is noteworthy that although subjects were not specifically queried about their sibling relationships, this information was often brought up spontaneously. Flexilibity in the interview design enabled the interviewer to pursue this topic.

Sibling relationships held considerable emotional importance in subjects' descriptions of family relationships in the past and presently. Intensely competitive sibling relationships were frequently mentioned, expecially

relationships with brothers. Additionally, many subjects reported their parents treated them differently than their brothers often emphasizing traditionally understood differences between boys and girls.

> I really feel like there were a lot of double messages about what I was supposed to be, who I was supposed to be and . . . adding this was a real intense competition with my older brother. . . . And, in my head, as long as my brother was getting pushed into all these careers and was supposed to excel, well, shit, I was going to do that but I was going to do it better, you know. So, I wasn't really sure how I was going to resolve that with getting married, but I knew somewhere that, damn it, if he was supposed to be a doctor, I had to do something better than that . . . And, I wasn't quite sure what that was. (Subject #16)

> [My brother] and I are not very close, and we didn't get along for a real long time, we had a lot of problems--my parents were throwing me in his face without my ever knowing it . . . he was coming at me from every direction and I didn't even know what was happening, which took me a long time to figure out. (Subject #15)

> I always felt an intense competition with my brother. He's two years ahead of me, and if he got an A or something--and his grades weren't quite as good as mine--it seemed like there was always a real big deal over his grades, you know. If he got an A, it was great. But it was just . . . expected of me, par for the course. He was always better. (Subject #22)

One outcome of this intense competition was that subjects felt envious of their brothers.

> My brother seemed to have things easier. There wasn't as much pressure on him to do this and that. And there were just so many things about being a woman that--just the--cleaning and my mother's, you know, trying to get us to understand what it meant to be a

> woman in her eyes, that I just was apalled by it--I was adamant. I think that threw me into being a tomboy. (Subject #18)

> When I was a kid, I envied boys because I felt like they had more freedom, and my brother was always more athletic and he always had more power over me because he could beat up on me and escape before I could retaliate. And it always seemed to me like he had less DUTIES than I did. He didn't have all the housework and stuff, that he wasn't supposed to be doing all these things, and if he didn't get the garbage carried out then there was no big reprimand. But it was insisted that I do the dishes--I felt like he had more freedom . . . if he wanted to do something he could just go ahead and do it, I had to get permission. (Subject #2)

In another instance, a subject described feeling guilty for having received special attention.

> I don't think that he had a lot of feelings of resentment about the fact that I got--it seemed like I got a lot of the good stuff. I got the fancy education, and . . . probably more attention. And, I don't think that he really resented that. He was always rather kind to me, and I think somewhat proud of my accomplishments. So there wasn't competition. But--I think I felt a good deal of guilt . . . it seemed to be harder for him. (Subject #21)

In two cases where envy and guilt were not strongly identified or acknowledged aspects of sibling relations, subjects described brothers who were the object of "hero" worship. Additionally, there were two reports of incestuous brother-sister relations beginning in early adolescence.

Subject #2 highlights another theme mentioned by several subjects, that is, the centrality of siblings' attention to appearances, their own and the subject's, and how that was used in sibling conflicts.

> My brother and I lived a relationship that was a love/hate thing--very close in age, competing for the same admiration, I having the upper hand because I was very academic and my father liked that. My brother was not a good student; my father was always mad at him because he wasn't a good student, and my father put all of these hopes and dreams for the scientist on me and hoped that [my brother] could get a career in athletics or something like that where he didn't have to use his mind. So, ummm, my brother was ALWAYS on me about being too heavy. It was something that I think he felt like he had over me because he always had a nice body and he never had a problem with weight. . . . he was always telling me "Well, so-and-so or such-and-such man said they would like you if you weren't fat--you have a real nice personality." (Subject #2)

For Subject #17 two older brothers are seen to be relentless in their criticism and attention to appearance and body size.

> My brothers have always said something, always said something about my weight--to this day, when I get on the phone with either of them, they say, "Well, how much do you weigh now? When I see them in person, the first thing that they do--and they want to make sure that I see them--is to look me up and down . . . you know, they check me up and down and then say, "well, you still don't look very good." I've never gotten anything positive from them. Even when I was thin . . . because I'd been on diet pills and was wired out--they were real excited that I had lost weight and I got good feedback but again, it was just because of my body. (Subject #17)

Attention to appearances also emerged in some subjects' descriptions of their older sisters. In these cases, sisters were not described as being critical of subjects' body size but instead were remembered as dieters who were preoccupied with their own slenderness.

A suggested outcome of conflictual sibling relationships is the isolation of the subject within the family context (Minuchin, 1978). As one woman in this study poignantly described:

> My brother's really close to my mother. . . . He's very quiet, he's got a charisma about him. He's a very attractive guy. . . . And, my sister is, she was like a Momma's girl all the time. She was always with my mother, she was kind of a sickly kid and so she was always home and she and my mother were always pretty close. She and my father are close too. You know, my father calls her all these little names and stuff. They--it was like, the four of them would have a great family, but then there was me. . . . It was like, when I wasn't there, everything was real good. When I was there, there was friction. (Subject #15)

It is also important to note that fifteen subjects reported having at least one sibling with symptoms ranging from emotional problems such as stuttering or hyperkinetic behavior to more severe psychiatric disturbances. In one instance, an older brother committed suicide. In two other cases, older sisters were hospitalized for anorexia. This suggests a family environment conducive to the development of psychopathology.

Occasionally, in interviews with particularly insightful subjects, dramatic illustrations of several familial themes emerged. Here, subject #6 describes an especially difficult time in her family which was intensified by her brother's leaving home. The themes of dissatisfaction and suppression of real feeling in the marital relationship, covert family tensions and daughter's weight

gain, involvement of the daughter as her mother's confidant and ally, a fear of father's temper, and father's emotional problems and alcohol abuse, all appear in the following quotation.

S: . . . when I went to high school, my brother went to college . . . I was suddenly the only child in a--my parents' marriage was getting increasingly unpleasant and overtly unpleasant at that time, so there was like a LOT of tension at home and a LOT of tension in high school . . . And that's when I really got going gaining weight.

I: Were you involved in the tension between your parents?

S: Well, there was real catch-22 to that. My mother--my father--my father ended up my senior year in high school having a manic-depressive breakdown. And he had been in a manic stage my junior and senior years, and then when I was in college, my first semester in college he went into a depression and went into the hospital and had a lot of shock treatments and then was put on lithium. . . . It was all confused by alcohol --he was drinking a lot. And I, who knew nothing about stuff like manic-depressive psychosis, just thought that he was being made crazy by alcohol. So that was an issue. I mean, my big thing was, you know, get Daddy to stop drinking and things will be better. My mother--what was going on with me and my mother was--one thing that was going on was--I mean, she was, like being more obvious in her distaste for him, in effect, in a number of ways. And he was trying to--itching for a fight. He was always trying--he was being very antagonistic. And what she did was she got completely passive, and he got more aggressive, and da-da-da-da. And it never got seldom got physically abusive. I never saw it get physically abusive. But verbally it was very, very abusive. And it was always the threat of real violence.

I: Did either of them talk to you about what was going on?

S: She did. We analyzed it a lot. Not just "we," it was, I was like her comrade. I don't think she talked to anyone else. (Subject #6)

Summary

The data from the twenty-four interviews suggested characteristics common to all or most subjects' families. For the most part, these descriptions appeared similar to what has been suggested in the literature on anorexia (see Chapter II). In the following summary, similarities and differences between these women's accounts and those found in the literature on anorexia will be highlighted.

Parental dyad. Almost all subjects described their parents having unsatisfying relationships marked by unresolved conflicts. Many subjects reported they had been involved in mediating conflict between their parents. Often the daughter described herself as aligned with the mother against the father or some other significant family member (usually a grandparent). In a significant minority parents were separated or divorced as these subjects' entered their late adolescent years which suggests these women might have played a central role in the stability of the family.

Mothers. The women described their mothers as self-sacrificing women who were dissatisfied in their roles of wife and mother. For those five mothers who worked outside the home, work was also seen as a burden rather than a

source of satisfaction.

The majority described their mothers as lacking in warmth and understanding. The subjects did not feel that their mothers valued them as individuals or could respond to their emotional needs. The highly strained relationship between these women and their mothers was characterized by overinvolvement and an absence of clear interpersonal boundaries. In instances where anger was openly expressed there was little sense of conflict resolution. This corresponds with what has been suggested in the literature on the mother-daughter relationship in anorexia. However, while conflict between mother and daughter was often avoided, these subjects did appear to be more openly angry at their mothers than is the case in descriptions of anorexia and confirmed earlier research findings on binger-purgers (Boskind-Lodahl, 1977).

Identification with mothers was strongly ambivalent for all subjects. Almost all felt their mothers gave confusing and conflictual messages about what they expected from their daughters. A paradoxical bind of "be like me" but "be different from me" was described by many subjects. This conflictual message often was reported in terms of body size and dieting, although some subjects described this dynamic in relation to their achievements as well.

Fathers. The subjects' fathers were often involved in work or activities outside the home. While "unavailability" was a prevalent theme in subjects' descriptions of their fathers, many indicated that their fathers were still a strong presence in their lives. The women were mixed in their descriptions of childhood closeness with their fathers. However, all felt they had never had a consistent father-daughter relationship. A majority expressed ambivalent feelings towards their fathers. Here, fathers are seen as unapproachable because of their erratic and unpredictable temperament. A significant minority described fathers who abused alcohol. Fathers appear to have a more central role in their daughter's lives than is described in literature on anorexics.

Family members with weight problems. Almost all women reported that one or more family members other than themselves had a history of weight problems. Dieting was a central concern in these mother-daughter relationships. Over half the subjects described their mothers as preoccupied with their own weight and dieting. In many of these cases, the mothers were overweight or prone to weight fluctuations of ten pounds or more.

Response to appearances. Subjects often felt evaluated on the basis of physical appearance, particularly by their fathers or brothers although not exclusively so.

Slenderness was highly valued in most of these families. Family members tended to notice and criticize subjects for their weight gains more than other behavior, contributing to the subject's feeling "invisible" in the family.

Siblings. Silbing relationships were highly competitive. An unanticipated finding was the importance of brothers in subjects' accounts of their sibling relationships. The relationships with brothers appeared more significant than has been suggested in the literature on anorexics where competitive relationships with sisters are frequently mentioned. A majority of subjects reported one or more siblings, in addition to themselves, who exhibited emotional problems.

C H A P T E R V I

THE ADOLESCENT EXPERIENCE

The tasks of normal adolescence have been described as (1) assuming responsible ownership of the body, (2) becoming emancipated, (3) defining values and commitments for oneself (Rothchild, 1979). The subjects of this study reported a diverse and wide range of adolescent experiences. For purposes of organization and clarity, the discussion of adolescent experience will address these three tasks in terms of the following issues: (1) emerging sexuality, (2) parental control and rebellion, (3) peer relationships and social activity and (4) late adolescence and leaving home. These categories are offered to aid the reader in understanding what seem to be critical differences between bulimics and anorexics.

Emerging Sexuality

The subjects' accounts of their sexual education are similar. Most remembered receiving information about menstruation and intercourse from educational booklets given to them by their mothers. They recalled being approached by their mothers rather than soliciting the information themselves. Words frequently used to describe this

experience are "clinical," "matter-of-fact," "uncomfortable," "technical" and "scientific." About one-half of the subjects perceived their mothers to be uncomfortable or very tense while imparting this information; in other instances, subjects described feeling embarassed for their mothers, perhaps sensing some unspoken difficulty on the mother's part.

> She talked to me. She got the books and all that, you know, these little pamphlety things, and we sat down, and she told me the facts of life . . . I don't think she was real comfortable with the terminology she was using. But she didn't seem embarrassed. I remember feeling embarrassed for her having to tell me this stuff . . . after it was all over and she said, "Do you understand everything?" And I said, "Yes," because I didn't want to have to listen to it all again. It was like, I already heard all I wanted to hear. . . . It was like, too shocking to admit, you know. I wasn't interested. (Subject #15)

> She always referred to it as "The Curse." I have many a memory of that: "Oh, I've got The Curse." But she was not personal in any of this. I mean, she--at a very young age she told me all about sexual intercourse. Very young. She got out her nursing books and showed me a picture of a penis and a picture of a vagina and told me about the seed and all this, and I went around telling all my friends and their mothers were mortified because, you know, they were so young. But it was very impersonal--it was very clinical and very--and I guess some God stuff too, like you know, "God makes a man and woman want to do--" But it wasn't like, "Let me tell you what it's like to be a woman because I'm a woman, too." And she, she very seldom was naked, I mean, bodies were always covered up at my house. (Subject #6)

While the overall tone of these exchanges is "matter-of-fact" these incidents were reported with striking detail and vivid recall suggesting that the experience of learning

about their bodies and sexuality was traumatic for most subjects.

> My mother told me about the facts of life, like period and babies and things like that. My sister is 2-1/2 years older, and my mother was going to tell my sister one day--and so she said--I remember her saying to me--she said, "Why don't you come listen to this so I won't have to repeat myself?" And I--I listened, you know, and my sister was--you know--I watched the look on my sister's face. I--I knew nothing that was happen--you know, what she was going to say. And she had these books, and she--it was all rather textbook like, what she was talking about, you know, and she would ask us if we had any questions. . . . I couldn't believe that it existed like that . . . she seemed rather comfortable. But she seemed rather like it was necessary, you know, and she wanted to get it over with, you know, and talk about it. I didn't really grasp it all mentally, thinking, "that's going to happen to my body." I remember the books, and I read them . . . And I couldn't believe it. Ironically, I got my period before my sister . . . I didn't tell them [sister or mother] for a while. I just wanted to keep it by myself. (Subject #9)

> Mother . . . approached me, saying she had a book. I can remember where I was sitting and all that stuff about--the kitchen table--in fact, it was a Tuesday night and she was saying she had this book that she got from my uncle, and you know, I'd be growing up and . . . and . . . she gave it to me . . . you know, like, I'd be having my period some day, and . . . I remember reading the book. I was real embarrassed, and I hated when she used to broach the subject . . . I don't know why . . . but she would be the one to . . . I've never really approached her . . . she would always be the one to approach me. . . . I can remember reading the book. It talked about the typical--the kinds of things like when you --obviously, fertilization and, you know, with the egg traveling down, you know, that really didn't--it didn't hit home. I never thought about it in terms of reality. (Subject #14)

> She talked about menstruation with a little book, but that was basically all of it. I can remember going into her room, and closing the door . . . it was like,

> a relief when it was over with you know. . . . There was a definite tension as far as discussing it. I was embarrassed, somewhat inhibited about asking my mother anything more than what she was willing to offer me. There's always been that kind of a barrier that way. (Subject #11)

In several instances, these informational sessions were not remembered as helpful to the subject in dealing with her own body or as "linked-up" with subjects actual experience of her body. Subject #16, for instance, recalled being told the "facts of life" at age nine or ten. Menstruation, however, came as a complete surprise at age thirteen and was equated with beginning to hate herself.

> . . . age 13, I start my period and I started to hate my body. I didn't know what had happened. No one had told me. I thought--I didn't even know what it was. I thought I was hemhorraging to death, I didn't know. And, I begged my mother not to tell anyone, I was so ashamed. And she called her best friend upon the phone right away and told her . . . from that point I remember feeling tremendous shame about my body, that I'm still carrying. (Subject #16)

Subject #21 describes another variation in which all parties appear to be comfortable with the discussion but essentially the same theme emerges, that is, the absence of a connection between how female bodies work and her own experience.

> . . . Both my parents sat me down when I was in fourth grade with a little book which we read together. I have a vivid memory of one sitting on each side of me. And I think that we were actually, like, all sitting on a bed, with one on each side--which was interesting. And we read the book, and it was all very kind of scientific. And I was invited to ask questions. But--I don't know, I don't remember

> them being--seeming to be real uncomfortable about doing that. And I don't remember feeling very uncomfortable about hearing it. But I don't--I also don't think that there was any real connection made between hearing about the facts of life and--somehow it didn't--it wasn't--communicated to me that that was going to be something that was going to affect me. . . . It was a very, very abstract, encapsulated little piece of information. And then we never talked about it again. (Subject #21)

Further, for some subjects information sharing about sexuality is seen as an isolating experience rather than one of increased closeness with peers or in the mother-daughter relationship.

> . . . she gave me a book called YOU AND YOUR BODY . . . spent about seven minutes--inadequate minutes --her being very nervous about it. And she was very worried, because everybody in the neighborhood had their menstrual periods, and I was fourteen, and she was so concerned that I'd been playing so much touch footabll and tackle football on the playground that I'd wrecked my body and I wasn't going to get my period. So I remember the day when I got it, she called--she embarrassed the hell out of me--she called EVERY single neighbor so that when I went out of the house I felt like I was wearing a, you know, red flag--"Hey, she's fourteen, she's finally got it! She's now a girl!" So it was humiliating. . . . she spent about ten minutes and gave me this book and told me to read it, and showed me the little "bricks," we used to call them, and said, "This is what you do." I thought, "Oh, God." (Subject #18)

> . . . I grew up in a neighborhood with thirteen boys and me. There were no other young girls on the block. . . . I didn't even think that, me a girl and them a boy--I don't ever remember thinking I was a girl until my--I remember my mother told me the facts of life. That was so bad. I'm out there playing basketball with three of the guys. My mother calls me and sits me down at the kitchen table. Everything happens at the kitchen table . . . And, she sits down and says, "Do you know how babies are born?" I go, "Sure. You kiss, the guy drops the seed in your stomach, and a baby grows and then it

> somehow pops out." And she got--I mean, and I can still feel my mother's awkwardness--and she got really technical, using "penis" and "vagina," and I didn't know what she was saying--and explained it to me, in like five minutes, and said, "okay." And then I had to go back out and play basketball with these--now I knew. . . . So then I was a girl, and then at that point I started feeling really awkward around, that I didn't--and then we were all starting to hit that age where they were starting to gang, and all the guys hate all the girls, so I was left for about three or four years having virtually no friends, that I didn't feel like I fit in any more with the guys . . . and I was getting too old. (Subject #16)

Generally it seems that sexual education for these women is not remembered as a time of warmth or shared experience between mother and daughter but rather one of discomfort, embarassment or humiliation. Sexual information was most often imparted at the mother's initiative and for some subjects too early, leaving the young woman with vague and perhaps alarming notions of how her body worked.

Three women in this study recalled neutral rather than unpleasant experiences in learning about intercourse and menstruation. Interestingly, these three women present the mildest eating problems with no evidence of forced vomiting or the extreme measures of weight control described by other subjects.

> Actually, I got the facts of life from a book which I read at church. My parents had probably given us explanations before that because I don't remember being surprised by any of that information. Neither of my parents ever sat down and ever gave me any information, but my mother did when I started my period, did show me how to use . . . a napkin and belt . . . and also collaborated with me when I think about it,

> in keeping the whole thing a big secret. I'm sure she told my father, but I'm sure that she also told him that he was to act as if he had no idea what was going on and consequently I had several years of complete privacy about it . . . there was never any discomfort about the whole time. (Subject #13)

> My first conversations about menstruation were with my natural mother, who had books waiting for me when I popped the questions. She sent me to my room to read, and when I was done reading she invited me to ask any questions that I had. And about six months after that I actually started to menstruate, so it was really good timing. This was about twelve. And then--then I . . . remember masturbating very early on, like about seven or eight. And feeling--I remember calling my mother while she was at work to tell her. . . . because I was so guilt-ridden . . . she encouraged me to calm down about it. You know, to not feel guilty or anything. And that was the jist of her response. She didn't say one way or the other whether she approved or disapproved, she just didn't want me to panic about it. But I never got the sense that it was wrong to do, at least in terms of her response to me. (Subject #8)

One can speculate that many women who do not have eating problems might have similar experiences regarding sexual education. It is interesting to note however that in the milder eating disorders, the process of exchange between mother and daughter is remembered as somewhat mutual, that is, sexual information came in response to curiosity rather than being imposed. Confidentiality between mother and daughter was respected. The difference here is that women with less severe eating problems felt in charge of information about their bodies and their experiences as sexual beings. This is noteworthy because it has been suggested that for women with eating disorders, a core difficulty in the early infant mother relationship is that

mothers, rather than responding to the needs of the infant, impose or mislabel needs of the infant and initiate responses to those imposed needs (Bruch, 1973; Palazolli, 1978). The above vignettes concerning sexual education suggest the possibility of this kind of mother-daughter experience throughout the life of the child.

Parental Control and Rebellion

Subjects exhibited great diversity in their descriptions of parental control and rebellion in adolescence. While the majority felt their adolescence was tightly controlled by parents, the subjects' ways of responding to that experience differed considerably. They ranged from compliant to mildly rebellious to delinquent in their self-portraits as teenagers. Additionally, for some, rebellion against strict rules and parental expectations began at home and was carried out in secret. For those who were compliant with parental wishes as teenagers, leaving home was painfully conflictual, marking the advent of rebellious acts (promiscuity, drug or alcohol use, failures to achieve) or periods of intense internal conflict and depression.

Descriptions of parents' responses to their daughters during adolescence also varied. Some were described as intrusive, controlling or dogmatic; others were seen as neglectful and unobservant. Common in a majority of

reports is an extremely conflictual adolescence with strained family relationships.

The nature of these conflicts and strained relations often focussed on parental worries and concerns about emerging sexuality. As one subject poignantly describes:

> We had conflicts about . . . specially my mother and I had conflicts about boy friends, and going--you know, staying out late--and she wanted to be really in control. And she insisted on interviewing any boys that I was going out with. I was so humiliated --ohgg! But, so, she was very uptight. Very uptight. I don't think she knew how to deal with my adolescence, you know, sexuality, everything. (Subject #15)

> I had a very rough high school experience in that I was a major delinquent, I suppose. I skipped school all the time, and I stole things . . . and got caught for a forty-nine cent cream rinse, and was at the police station, and just broke into a cottage with a bunch of wild girls, and destroyed the cottage--so I was not in favor, and did not become in favor with them [her parents] until I was married the second time. . . . My father was very strict . . . (Subject #18)

> Well, I can remember one time in high school when they found out I'd been smoking, and they didn't have, like the actual evidence that I had been but somebody had told them that I was. And they, like, took me into their bedroom and sat me down and gave me a good talking to. Which is another thing that is very VIVID in my mind, you know, I can remember that it was VERY, VERY serious, you know, that I had been smoking and it was really horrible. And I remember my mother saying to me, you know, and CRYING, saying, "I hope you don't become a woman of the world." And . . . I guess it's been very hard for me to LIVE with that. I mean in my mind I could still see her saying that, and crying, and like when I think about it now it still makes me feel--I don't know, very EMOTIONAL, like I want to start crying or I want to say, "Oh, mother, I won't" you know--"I'll be good!" (Subject #7)

> They [my parents] were very strict, and um, we had to be home by a certain time if we went out, they had to know where we were going, and all that jazz . . . and they had to know who we were going with. It would have meant, you know, not going anywhere . . . the little bit that we did go out. Or not being able to talk to, you know, the one or two friends that I did have, who were a source, in their own way, of salvation, you know. . . . I mean, I, um --there was a boy I was friends with in high school who would give me a ride home from school, but because he wasn't Jewish he had to drop me off two blocks away from my house. Hence, you know, maybe the neighbors would see and tell my parents. I mean, I didn't trust anybody. I never trusted anybody. (Subject #11)

As might be expected conflicts about food and weight gain were also an aspect of adolescent struggles at home. The nature of these conflicts seem to point out important differences between binger-purgers and anorexics. Typically, anorexics are high achievers who strive to meet the expectations of their parents. They are often described as extremely compliant except as regards food, dieting and losing weight. The women here frequently defied parental expectations and were engaged in open conflict with their parents. Many reported secretly binging and gaining weight rather than the self-starvation typical of anorexics. Although no conclusive distinctions or trends emerged within the sample it is noteworthy that most purgers described rebelling against parental expectations in ways other than food restriction, differentiating them from the descriptions of "model" behavior associated with anorexics.

Peer Relationships and Social Activity

An examination of peer relationships is not generally included in profiles of women with eating problems yet peers are often a critical source of support for the individuating adolescent. For many of the women in this study, friendships and participation in peer culture were the source of considerable conflict. For many, friendships did not seem to contain intrinsic rewards for the self but were rather a way of pleasing or rebelling against parents. In most cases, peer relationships, a potential source of support in the adolescent separation process, were thwarted. Some avoided socializing and making friends in adolescence. Others experienced friendships as frustrated by the demands of their families. Some pursued social relations despite family opposition and in these instances, friendships or dating frequently became a pathway for rebellion against parental control and expectations. Still others who pursued friendships expressed an intense need to achieve a social acceptance which would confirm that they had met certain familial expectations (that they be popular or have dates).

> I had no social life in high school. I really never dated and was a real kind of odd one in high school. . . . I wanted to be one of the top--and I just didn't make it at all, and I didn't make it on a lot of fronts, but what I did with that was, okay, well, I'll stay home and eat. I mean, that's what I virtually--I ate and I stayed home and ate. (Subject #16)

> [In adolescence] I really didn't have a choice on much, I mean, I could go out with who I wanted to go out with but basically I lied about who I was going out with, you know, where I'd say I was going out to do this or that. I really was not honest with my parents at all. I knew what their restrictions were, you know: "I don't like that friend. I don't like these people, I don't want you going here, I don't want you going there." So I never ever told them the truth. (Subject #18)

> I traveled in a very--I think probably a very conservative group. My friends were all very like me. And I also had lots of boyfriends when I was a junior and senior. Lots. And I think that pleased my parents, but made my mother delighted that I was so popular. . . . I was very free to choose . . . who my friends were, what I wanted to do with my future. Their concerns were always very important to me, so I'm sure I shaped my path largely in consultation with them. (Subject #3)

> . . . in general my peer group, the women that I ran around with in high school, was very much oriented towards getting married and having kids. And that was something that my parents really tried to tell me not to get involved in. Don't do that, you--wait until you get your degree, go out, do all . . . my mother particularly I think: even though she got married fairly late, she dropped all of her career goals in favor of helping my father finish his degree. And then after she got married she didn't pursue any of that again. (Subject #2)

> . . . I couldn't become involved in a lot of things, or they would discourage it because there'd be nobody there to go pick us up after school or to cart us around. . . . I really couldn't do too much of extracurricular kinds of things cause there would just be no way of getting back. Even though we lived--like, they just live up the road a little ways from _____ [name of school]. It was like that. (Subject #19)

The conflicting value systems of peer culture and family life present a dilemma for the individuating adolescent. In many of the accounts here, family religious or class values were experienced as isolating the young woman

from her peers.

> S: But, um growing up . . . well, I suppose in a way it was hard becuase they were very strict, and as a kid that can be hard, you know, if you can't be like all the other kids . . .
>
> I: There were things you weren't permitted to do that. . . .
>
> S: Oh, a lot of things. Even things like going to a movie or going to a dance, that you want to do to be accepted by your other classmates, when you can't do it, you know, and then it's hard to explain to them WHY you can't do it, you know: "My parents won't let me go." "Why?" "Because they think that dancing is wrong," you know. And when you don't even understand it yourself that well it's hard to explain to other kids. But it kind of maybe ostracized me, you know, from my peer group . . . it made me different, it made me separate . . . and that might have been part of what started me eating. (Subject #7)

One subject described the opposing value systems that she and her sister (who is anorexic) faced and the painful dilemma which resulted. While her sister lost weight during adolescence, this subject reported uncontrollable periods of binging and weight gain during her first year of college.

> . . . the only possible place of support, security, for us, was with our peers. . . . And the only value that--peer value--was in how sexy you looked . . . for both of us I think there were the three opposing value systems that we lived under. Which was one, from my mother and the Church, which was the only value in a woman was to be pure and chaste and solemn and sober. From the social, the rural town society that we lived in, the only value of a woman was to be strong, hard worker, a good child bearer--which is my mother's background--you know, the man who was pitied was the man with a weakly wife, a sickly wife. And the only value of a woman that we got from our peer system in school--in the 50's, 40's and 50's was

> how good we looked, you know. We only got attention if we would do it, from--but if we did it at home, we would get killed. You know, it was that--those three conflicting value systems that we lived in that created nothing except sheer insanity about our bodies, how we were to look, and their function . . . if that makes sense (laughs). It took me a long time to understand where there was sense in that. I was eventually able to isolate those value systems that we participated in . . . (Subject #10)

An interesting comparison of social activity in adolescence exists between those women who purge and those who do not. Eleven of eighteen binger-purgers were socially active teenagers. Social relationships were pursued despite the fact that they were a source of conflict both internally and with family members. In juxtaposition, all six of those women who had never purged were socially inactive teenagers. One possibility is that those who were socially active might be more vulnerable to social pressures to be thin and might consequently resort to more severe methods of weight loss to achieve slenderness and peer acceptance.

Whether socially active or inactive, it appears that for a majority of subjects the bridge from family to peer culture was shakey. These conflicts tended to become more pronounced as the young woman prepared for and eventually left her family of origin.

Late Adolescence and Leaving Home

Eating disorders appear to be related to conflicts involved in transitions; moving from dependence to independence, incompetence to greater competence, childhood to womanhood, family culture to larger culture. This section looks at the transition of late adolescence and leaving home. A majority of the women in this study reported difficulty in leaving home. These conflicts centered around assuming the responsibilities of young adulthood and relinquishing the ties and responsibilities of the family of origin. It appeared that the transition from family of origin to living autonomously was particularly problematic for the women in this study and deserves careful attention.

In subjects' descriptions of this transition, a conjunction of family patterns and eating patterns appeared. It seemed that in many instances, transition from the family of origin to living on one's own resulted in an intensification of destructive eating patterns. In fact, subjects' descriptions of leaving home were often punctuated by statements about their eating problems. Descriptions of both binging on food and dieting or purging were intertwined with descriptions of taking steps away from the family. In these accounts, subjects were not just talking about leaving home per se (although in many instances that was true) but they were also describing a variety of

transitions which involved beginning a new phase and acting autonomously. In their accounts, subjects saw themselves and their families as experiencing profound difficulties in making this developmental transition.

For many subjects leaving home precipitated feelings of loneliness, isolation and personal inadequacy. Dysfunctional eating patterns were reported as emerging or intensifying at this point in their lives. These subjects did not experience themselves as competent to manage the tasks of living independently.

> In college, my first year I did badly, having come from a high school and from a place where I just, you know, wasn't very academic at all, into college --it was really shocking for me, I didn't really even know how to study, and I didn't--you know, I didn't know what to do, and I felt very inadequate. And that is when I started putting on much more weight and binging. I wasn't starving at that point because I'd only starved through diet pills, always, and I didn't have any that year. (Subject #17)

> I was very alone, lonely, and falling into the same syndrome that I had been in before--in other words I couldn't get anything in on time, I was taking five courses, and it was just hell, especially the last week of school, and so I ended up gaining some more weight and losing it over the summer. That's been my pattern--gaining weight in times of stress and then losing it.
>
> . . . binging and purging [was] a way to . . . I was living alone at the time, and I was very alone . . . and very frustrated by that, and had lots of work, and of course brought more work home so that I would always have this barrier to going out and playing with friends, and feeling that my friends were ignoring me when I was probably ignoring them just as much . . . And no one knew. And I think my weight fluctuated a little bit, but not much. (Subject #3)

While subjects reported that overeating and in some instances binging had occurred at an earlier point in their lives, periods of rigorous dieting and severe methods of weight control were generally remembered as emerging in late adolescence or shortly after leaving the family of origin.

> The first time I remember having a real weight problem was, like, maybe, third grade . . . and I think I peaked out at about eighth grade . . . then when I got into high school, there's so much peer pressure that you had to be real thin, you know, that I starved myself all day long and then I'd go home and eat in the evening, pretty much eat whatever I wanted. And I managed to lose about fifty pounds, so I was pretty thin in high school. And then . . . also toward the end of my high school years, that's when I started the . . . the vomiting thing. And it got to be a real serious habit with me, like regularly, and it really scared me, and it really gave me a lot of bad feelings toward myself. (Subject #7)

In the case of Subject #5, binging is remembered as beginning at age ten when the family made a major geographical move. Periods of binging and starving emerged when her family moved again and she began living independently at age fifteen. This pattern with food intensified at later points of transition in her life in which similar feelings of separation and loss occurred.

> . . . Then I lived on my own. So I was about . . . I was about 15, 15-1/2. I mean, it was pretty disastrous (laughs) but . . . (I: In what way?) --Well, I--well, I . . . I got to be pretty isolated and I got to be pretty lonely. And I think it increased my feelings of being cut off from my family. And it sort of made me more withdrawn. . . . I think during that time I went through periods of, you know, eating a lot and then eating very little, kind of one or the

> other extreme. But I remember that as definitely being something that was pretty focal, connected with being on my own. Since then I've noticed that my eating patterns change a lot in terms of, like, any kind of loss that comes up, or separation, or anything like that, can trigger off a whole change in my eating behavior. . . . when my husband and I separated and I moved to the East Coast . . . and that was when my eating really got at its worst, where it became really uncontrollable. . . . another transition, less major, was finishing up at graduate school and then moving out here and beginning to work. And that again was another time of moving and another time when--my--my eating was much better because I had been working on it, and then again it got totally out of control, and then more recently, when I was going through a lot of conflict in a couple of relationships, and losing a relationship, um . . . I went through a period of change in my eating where I really--but rather than binging and eating a lot it was more the opposite, like, eating very little, and that again, it was associated with loss. (Subject #5)

While the disordered eating pattern was intensified in response to separation and loss, it is suggested here that the feelings of helplessness and desparation in response to loss arise from an absence of a trustworthy and reliable sense of self.

This finds further support in the case of Subject #1. Here, the progression of an eating disorder is related to her difficulties with separation and becoming autonomous. This woman has been binging and purging for fourteen years. Periods of rigid starvation and weight gain began when she left home to become a dancer.

> I was around sixteen and I was going to be a dancer if it killed me. And I did get a scholarship, one of two, and it was out of a lot of kids, and I did dance well. And I went into New York and I took five and six classes a day--and there were all these

> strange homosexuals, and nobody spoke English, and I was literally with THE COMPANY . . . I was overweight a little bit--not bad. But it was a dilemma and a half. . . . I mean, that kind of life is very--I mean, I consider it very abnormal. So I did that for a summer and almost died, and came out with hives from losing weight and from eating my oranges when I went in--determined to make it but it really just, it SHOT dance for me. . . . (Subject #1)

While she continued binging-purging intermittently this subject reports a painful loss which strengthened the dysfunctional eating pattern and alludes to a family dynamic of overinvolvement with her mother which could partially contribute to her vulnerability to separation and loss. It is reasonable to assume that the difficulties in separation in part have roots in an inability to fully separate from her family and become an independent person.

> I had just had the two babies [when my husband drowned]. THAT was the real trauma. That's when the bulimarexia set right in as a firm kind of thing. Because separation--because of my attachment, I'm sure--I mean, my mother and I really, I don't think two women could ever have been closer--you know, as allies and everything else. Maybe it was just overly so because Dad was just such a vacuum, that for me to have to lose _____[husband] and have TWO babies in diapers--four months and a year and four months--CLINGING to me, both in wet diapers constantly--oh! it was superstress. . . . I became very bulimarexic. . . . I was devastatingly lonely . . . that separation thing is a biggie with me. (Subject #1)

In two instances, leaving the familiar structure and values of family presented intense conflicts stressful enough in nature to precipitate "nervous breakdowns." In both instances obsessive preoccupations with eating or not eating can be seen as dysfunctional efforts to control

their lives.

> . . . my first year in college and--I won't consider it major, but I had a nervous breakdown that I--all my values got very jumbled--it was right during the hippie movement, and I wasn't part of it, but I was catching wind of it, and all my values got really nuts. And I'd just lost a relationship with a man that I was involved with and feeling depressed, and I got more depressed, and that was the beginning of a long stretch of depressions . . . um . . . and I just started laying in bed, and my grades were dropping, and then I started getting really anxious, and then they were putting me on drugs at the Health Center . . . after that first breakdown, and feeling like everything was very different and I didn't understand anything that was going on in the world or my life, that . . . I got obsessed--obsessed--with my body and my being thin, I had to be thin. And I see then--I mean, I really see a lot of this with control --that I felt SO out of control of my life . . . I didn't know what my values were, I didn't understand my sexuality, it just--everything--I didn't know if I wanted to go back to school--everything was so nuts. And all I could think about is, I wanted to be thin. Everything was thin. I had to, like, really--and that's when I started along the starvation, and a lot of the force-vomiting at that point, too. (Subject #16)

> I had a diagnosed nervous breakdown, or whatever you want to call it, after my first year of college . . . in which I left--I flipped out (laughs) totally. And that was very food-connected. That's--the moment in which I knew I had lost it--I began to have time gaps. I didn't know how I had gotten from one place to another or what I was doing there, and one of them--that was the year--I had never been fat before that time, and this was--what, nineteen or twenty [years old]. . . . I remember I was sitting in my room making a list of all the things I couldn't eat because I had begun to gain weight terribly. And while I was sitting in my room, say, listing these things that I can't, I then was at the snack bar ordering these things--with no time transition. I have no knowledge of the movement from one place to the other. And at that point I said, "There is something wrong with me." And I walked from the snack bar into the infirmary, and I said, "There is something wrong with me." And I think I sort of collapsed in some way, because I know that the nurses

> there took one look at me and got me into a bed.
>
> I went there because it sa--the brochure sounded like all my fantasies of what school should be, cause I'd spent my life in opposition to my father fanatiasizing educational systems. . . . I would, if I were being clinical, define what happened to me as culture shock, rather than a nervous breakdown. I went from a backwoods . . . strict Baptist culture, where I never heard anybody intimate that there wasn't a God (laughs)--or such a thing--and to, you know, a free-flying place. And it was marvellous. I had some--also a couple--I had a high before my breakdown . . . some very far out religious experiences . . . the oneness of the universe and stuff . . . so I moved from a dogmatic religion to experiencing something about my spirituality. . . . And you know, people talked about sex--I couldn't believe--my mind was utterly blown by the experience. And I began to engage in some of those things, very surreptitiously, and all the guilt and stuff, and within six months I'd lost it.

In contrast, leaving home was less traumatic for the subjects who had milder eating problems (bingers who did not purge). Entering college was described as a time of experimentation and increased competence. As Subject #8 described, "It was really through college that I started to formulate anything concrete that I could really do. . . . I made myself self-sufficient."

Subject #13 reported college was the time she set about acquiring skills she hadn't gotten as an adolescent, a period which began by establishing a boundary in her relationship with her mother.

> Early in my college career . . . I remember I was home for one or other of the vacations and we were in the kitchen and she said something about weight or weight loss, me and weight loss, I don't even know what she said, and I don't think she said, I don't think she ever really said, you have to lose

> weight, kind of thing . . . but, what I experienced was, turning and telling her absolutely flatly, in no uncertain words, terms, that she absolutely never to discuss this again with me, ever, I didn't want to hear anything about it ever again, absolutely. Period. End of subject. And she didn't mention anything to do with fat or food or anything for at least five years. For the first time I had some peace on the issues. It was mine now. That's what I was really saying. It was mine, and they could cease to be involved in it at all, and that was the end of it.
>
> In college . . . not only did I take control of my body, but I took control of my life . . . and so I started to get to know men, in what I now know was a slow careful searching process. (Subject #13)

For all the women in this study, including those with less severe eating problems, heterosexual relationships appeared difficult and the source of great strain. A majority of subjects reported feeling inadequate and confused by heterosexual relationships. Feelings of inadequacy or an absence of confidence in their own abilities were revealed in descriptions of relationships with men. Being "thin" meant receiving male attention; being "fat" served as justification for social withdrawal and a reason why relationships weren't going well. Often they connected their disordered eating with problems in heterosexual relationships. Especially significant were rejections and losses of important relationships.

> "There's something wrong with my body, and I've got to get thinner," really started when I went to college and started to, like, date around, and I wanted to, you know, look really sharp, and you know, I started starving at that point, losing a lot of weight. (Subject #16)

> I'd lost some weight when I started going out with a guy. And it was--it was just because I just didn't--you know, just didn't eat and stuff--but it wasn't--I didn't really miss food or anything. And people would take notice and say that I'd lost weight and I looked good. And that summer when, you know we broke up, right before I left home and stuff, that's when I put on a lot of weight, and I continued to do so in nursing school, and that's when the problems started to come in. (Subject #19)

> When I starved and ate, and starved and ate. I would stay home, you know, hoping he would call. Meanwhile I'm eating out the cupboards, and then I'd say, "I'll be damned if he'll make me eat. I'm not going to get fat over him." And then I'd starve myself for the next three days, and then he'd call or something . . . and then he'd do it to me all over again, and I'd have to go through the same bullshit all over--I just went--you know, it was like I was up and down--the mood swings were so--you know, one month I would be on Cloud Nine, the next month I was in the pits. And since then, that's the way it's been, I've lived a very up-and-down-y kind of--I don't live a very calm, even existence. The mood swings are really high and low, high and low. You know, and that's eating and not eating, and eating and not eating, you know, go with that kind of mood swing type thing. (Subject #15)

One subject explicitly described the misuse of weight gain in her sexual relationships.

> . . . I can use fat as an excuse to cover up all sorts of other anxieties that are naturally there in any sexual relationhip or in other relationships, and that my saying, "I'm fifteen pounds overweight," just gets rid of all this other stuff--and that's so true, because I feel like that's the problem, and that's NOT the problem; it's covering up the problem. (Subject #3)

For Subject #21, who grew up in a sheltered environment where sexual expression was considered taboo, the first experiences of living on her own were recalled as overwhelming. Heterosexual experiences appeared as

traumatic. Anxieties about what to do with the presence or absence of male attention emerge in her description. Her reported inability to disengage from a relationship she didn't want suggests a pervasive feeling of ineffectiveness and an inability to make self-oriented decisions and implement them.

> . . . in terms of my own crises . . . well, I think leaving home for the first time the summer before I went to college . . . I had this job working as a waitress . . . on this little island called _____. And I went out there to work as a waitress. And had to come back early . . . because I couldn't handle it. There was trouble . . . that was focussed around getting attention from men and not knowing what to do with it . . . hooking up with this boy who was attracted to me and then not knowing how to get rid of him. There was trouble with food then. I was kind of starving myself, and then gained a lot of weight at the end. My parents had to, like, come and pick me up and rescue me from this situation. (Subject #21)

She further describes an intensification of her eating problems when she was at college. An intersection of personal feelings of inadequacy, threats to family integrity, and binging and purging emerge in her report of the first two years of college.

> I was, you know, symptomatic at the time I was in college. That started my, like sophomore year in college . . . the summer after my freshman year. So it was after the first time that I'd really left home. It was--there were a couple of things that happened that year that were kind of heavy. It was . . . the advent of real sexual issues . . . I was seeing men during that year that I wanted to sleep with, to whom I was attracted and having sexual feelings towards for the first time. I got--I lost my virginity being raped, hitch-hiking . . . I think I blocked out a lot of feelings around that . . . what I did was, I immediately went out and

> saw a doctor to make sure that I wasn't pregnant or didn't have VD or something. I immediately got on the pill and proceeded to sleep with my boyfriend, and then eventually with some other men as well . . . And, I think just that being my first year away from home was a big thing, too. Just sort of a feeling about whether I was going to succeed or fail in college. My first semester in college I felt like I was doing pretty well and handling things pretty well. And then . . . second semester began to feel like things were real out of control. My eating went out of control. And then the summer after my freshman year, the other thing that was going on was that my mother was hospitalized for a very serious intestinal operation . . . she almost died . . . and I was home, taking care of my father, learning how--learned how to cook . . . and spent the whole summer kind of like cooking these big elaborate meals and being with my father, and like feeding him and taking care of him while my mother was in the hospital. And I felt extremely guilty that I had gained some weight and was gaining weight. My mother had lost a lot of weight in the hospital and always had been thin. (Subject #21)

Subjects' reports of late adolescence indicated that leaving home was an extremely conflictual time for them. Difficulties in coping with feelings of separation and loss, managing the clash of family values and those of the larger culture, and negotiating heterosexual relationships were frequently cited. While subjects described themselves as beset with personal difficulties in late adolescence, many also felt that their families were unable to adjust to their separation and leave-taking.

A significant minority reported that family "normalcy" began to crack during late adolescence. Seven subjects reported instances of parental separation and divorce, psychiatric disturbance or alcoholism in one or the

other parent. In two additional cases divorce was threatened at the time the subject left home and one or both parents relied on these subjects to be confidants in the marriage. These accounts suggest that subjects played an important role in family stability.

While subjects show considerable variation in their reports many gave the impression that they felt their families were unable to function adequately and several mentioned being fearful that the family would fall apart if they left home.

For instance, Subject #22 describes an intensification of marital disharmony in her parents' relationship when she left to go to college. Her mother's fears of divorce and loneliness appear in mother-daughter communications.

I: When you think back over your life are there any times of major transition or crisis in the family which come to mind?

S: I can't really see any . . . I mean, I just remember . . . um . . . maybe most of my life . . . just the standard joke around the house was, you know, my mother saying, "Do you think your father will divorce? Do you think your father will divorce me?" That kind of thing.

I: Why do you think she was afraid of that?

S: Probably cause she was--she was not being you know, the dutiful wife. I mean, she was off gallivanting on her own . . . and my father was not really involved in it too much . . . you know. And she was always saying, "Well, I guess we won't get divorced because neither of us will leave the house," ha, ha--you know, cause they

have a nice house. My father wouldn't leave, and certainly she wouldn't leave, so . . . I guess things were secure.

I: Were you ever worried that they might?

S: Um . . . I don't think so. I guess it was something I never really thought about too much. Cause it was always there--just always those jokes floating around. I never really thought about it too much. I think it started striking me more when I went away to school, because then my brother and I were both gone, and it was just my family. I mean, my parents just left to deal with each other and my grandparents. And I guess --I guess that was probably the crisis situation in their lives. That's the only one I can really think of . . . You know, they kind of had . . . my first year away from home was kind of hard on them. My mother would call me up all the time. "I miss you, and it's so lonely here in the house." You know, that kind of stuff. (Subject #22)

In the following passage she describes an intensification of her eating problem when she moved away from home to college. This passage suggests that for this subject dysfunctional eating patterns were a way of staying connected to her family through their concern for her and perhaps shifting the focus of her mother's concern from her own marriage to her daughter's illness.

I didn't start being really anorexic and totally crazy about it until . . . after high school. And I had started to work in a factory, and I guess I really hated it, and I wanted to quit. But they were against the idea of my quitting, so . . . I can see where I just . . . I wanted to control things better, so . . . and I got very depressed, anyway so I just lost my appetite and stopped eating. And I lost a lot of weight. And I just kept losing weight and everything, and I got really caught up in it . . . and went away to U. Mass, you know, and I was a freshman and everything . . . and I was out of

> solution, that if she was going to be venomous and terrible, then to have me be the mom. And then that didn't happen, and I subsequently moved out anyway. . . . The times I've left [home], even last spring, they really wanted me to have those experiences--so I haven't felt like I've been abandoning ship, except I had trouble making those breaks anyway . . . I was fearful that my younger sister was going to fall apart, as she had said--that she couldn't stand being the only child because my brother went away to school this fall. (Subject #3)

While this subject saw her family as overtly supportive of her leave-taking and independence there is indication that she saw herself as needed by them. Her sense of responsibility might have served to frustrate establishing her own life.

Summary

The subjects' descriptions of adolescence revealed several important themes. A summary of these major trends is provided here.

Sexuality. For most subjects, learning about their bodies and emerging sexuality was traumatic and confusing. Mothers were perceived as uncomfortable with sexual matters and lacking in warmth or understanding. The mothers appeared limited in their ability to be empathic to their daughter's needs and often imposed their own concerns.

An important contrast emerged in the descriptions of women with milder eating problems (those who diet following binging). These women indicated a more positive

> my head. And I went home for Thanksgiving, and, you know, I think I had lost maybe ten pounds more than when I left for school. And . . . I guess by that time I looked pretty bad . . . I was threatened with being removed from school . . . and I had an ultimatum, you know, "Put on at least ten pounds in two weeks, or we're definitely going to take you out of school and put you in the hospital." And, you know, I didn't want that to happen, so I started eating . . . And my mother would call me every day, and I'd have to check in to her. She was very worried about the whole thing. It--it really did shake my family up a lot. I guess it did what I wanted it to do. (Subject #22)

Another example is Subject #3. Here a sharp dichotomy emerges between subject's experience of her family before and after she left home. The appearance of a "happy" family disintegrated at the time of late adolescent separation.

> Life was blissful and carefree for me as a junior in high school. Less when I was a senior, but still pretty much the same. I was loved, and I just--everything was wonderful. The discovery that my mother was not perfect and was an alcoholic; that my brother was being rebellious; that my father couldn't solve everything; that I was having lots of academic troubles because I couldn't get my act together--all happened in one burst. Which was my sophomore year. That was one of the BLACKEST years of my whole life. There were obviously light moments in that and bleak moments in my junior and senior years in high school, but I would just say that those stand out as extremes. (Subject #3)

In a description of her mother's alcoholism and its effects on the family she says:

> . . . I guess for a while last year she thought I was going to replace her--Daddy was going to kick her out and I would have to be Mom--she didn't want that and Daddy didn't want that but that seemed like a viable

experience concerning sexual development and indicated they felt a greater degree of respect and mutuality in their mother-daughter relationships.

Conflicts with parents. These women's descriptions revealed more open conflict and rebellion during adolescence differentiating them from the model behavior associated with anorexics. While food and its control was a source of conflict in these women's family relationships, weight gains or becoming "fat" were more often the source of concern that weight loss.

Social relationships. Peer friendships and heterosexual relationships were a source of conflict in the family and appeared problematic for all subjects.

Late adolescence. Almost all reports indicated that leaving home was an extremely conflictual experience for subjects and their families. It appeared that these women did not experience themselves as competent in managing the tasks of living independently. Dysfunctional eating behavior often emerged or intensified in response to the transition of leaving home. While the majority described feeling divided in their loyalties to their parents and to themselves, the women with milder eating problems indicated less difficulty in negotiating this developmental transition.

C H A P T E R V I I

DISCUSSION, SUMMARY AND CONCLUSIONS

The intent of this study was to increase our understanding of the eating patterns and familial relationships of women suffering from a cyclical and compulsive eating pattern known as binging and purging. While this eating behavior has been most frequently associated with anorexia nervosa, new definitions of bulimia suggest that binging and purging may be a disorder in its own right. In this study, the eating patterns and life histories of self-referred bulimic women were examined to determine the similarities and differences in their perceptions of themselves, their eating problems and the significant events and relationships in their lives. Twenty-four bulimic women participated in a questionnaire and semi-structured interview lasting approximately two hours. The partially structured interview guide enabled the exploration of a range and variety of pertinent themes and topics. The data derived from these interviews was presented in Chapter IV, V, and VI. This information has resulted in a composite portrait of bulimic women and their families and is discussed in this chapter.

Eating Patterns

The writers of the DSM III deserve a note of thanks for having given credibility within psychiatric and medical circles to an often disguised and little recognized obsession which is affecting thousands of women today. The breadth of their indicators permits us to identify and give credence to a previously overlooked syndrome.

Unlike anorexia which reveals itself in the death-like appearance of young women starving themselves, bulimia is a hidden symptom on many levels. The abusive patterns with food often occur in secret. The symptom and its effects on the body are not immediately apparent. Binging and purging, most often considered a form or phase of anorexia (Bruch, 1973; Selvini-Palazolli, 1978) has not been widely recognized or addressed in psychiatric circles. Consequently, the specific behaviors and problems of bulimic women have often been neglected by medical and psychiatric professionals. Some have even viewed binging-purging as a dietary tool (Rich, 1978) and questioned the necessity of a separate classification for binging and purging.

While the women in this study all fit the criteria set forth by the DSM III for the diagnosis of bulimia, they also revealed tremendous variation in the intensity, duration and destructiveness of their eating patterns. All women in this study had a history of binging. For eighteen

of them, binging and purging was a frequent activity. For some, multiple bouts of binge eating and forced vomiting occurred within a short period of time, for others it occurred periodically. For still others, huge quantities of laxatives and dieruetics were used following bouts of binging in efforts to purge unwanted calories. For a minority of subjects, binges were followed by less severe efforts at weight control--appetite suppressants, fasting and rigid dieting. What all have in common is the experience of secretive compulsive eating and an obsession with the size of their bodies and their appetites. Although this preoccupation was a major focus of their lives, the variability of eating patterns raises the question of whether the diagnostic indicators for bulimia offered by the DSM III aren't so inclusive as to render a meaningful diagnosis within the category of eating disorders impossible.

Bulimia is confusing as a symptom. Because of the swings in eating behavior from overeating to food restriction, it would seem that depending on which part of the cycle is being viewed this symptom could masquerade as either anorexia or obesity. To add further confusion, the symptom may not be obvious. In many cases there is a carefully maintained balance which serves to keep the person within certain range of weight. What appears to differentiate this symptom from primary anorexia is that it is a cycle, a sequence, a process. In anorexia, a relentless

pursuit of thinness dominates all other behaviors (Bruch, 1973). In bulimia, it is the cycle of alternating eating patterns which appears to be the central feature.

Perceptions of Families

To a casual observer, the families of the subjects give an illusion of being symptom free. Although their symptom is quite dramatic the majority of women came from rather ordinary family backgrounds. These women represent a range of religious affiliations. No particular ethnic group emerged in the sample. They are predominantly middle class. Many parents were active in community affairs and viewed as happy and well-adjusted by the community at large. For the most part the families were intact with the fathers working outside the home and mothers assuming primary responsibility for children and household management.

Before looking more carefully at descriptions of these families a cautionary note is necessary. While these descriptions may be accurate the conclusion that parents are primarily responsible for the fate of their daughters is not. Approaches which emphasize the hostility of an ambivalent, overbearing and over-protective mother and the neglectful and passive qualities of fathers often result in blaming the parents rather than attempting to understand how they became this way. Further, the idea that parental personality types uniformly produce psychopathology is a

simplistic, erroneous and dangerous assumption. Multiple factors such as individual endowment, sociocultural influences on development, other family members and family interactional styles interact to produce a particular clinical syndrome or choice of symptom and nowhere is that more apparent than in the overdetermined etiology of eating disorders. "Just as there is no schizophrenogenic mother, likewise there is no anorexogenic mother" (Sours, 1980, p. 323).

In the interviews the women described their relationships with their mothers as especially meaningful. Over and over again mothers appeared as models of self-sacrifice who indicated little pleasure or satisfaction in their roles as wives and mothers. The daughters felt that their mothers depended upon them to provide satisfactions missing in their own lives. The mother-daughter relationsip appeared problematic and strained for all subjects. While for the most part they remembered their mothers as responding to basic security needs, subjects often felt their mothers were unable to see them for who they really were. The mothers seemed to take care of their daughters without communicating much warmth or passion. There was little respect for individual differences. Consequently, subjects felt their mothers to be unavailable as empathic and nurturant figures. As might be expected given their perception of mothers, identification with mothers was

problematic and ambivalent. The unavailability of mothers in combination with their seeming unhappiness as married women led many subjects to reject the option of being like their mothers. In many instances, substantial effort was directed toward not being like them. However, a paradox emerged in the relationship between mothers and daughters in terms of eating and weight. A large number of mothers were women who themselves had problems with weight control or obsessions with their bodies. The conflict between the implicit message about being like mother and the explicit message about being thin posed a paradox, the attempted solution to which might be revealed in a symptom that responded to both messages simultaneously, i.e., binging-purging.

It is commonly believed that fathers are important in helping children differentiate from their mothers (Abelin, 1971). For the most part, fathers did not appear to be a source of support or positive identification for their daughters. Indeed unavailability is almost as common a theme in subjects' descriptions of their fathers as of their mothers. Particularly noteworthy in subjects' descriptions of fathers is a frequency of violent outbursts of temper and alcohol use. It is interesting that a number of subjects related and likened their own problems with food to a potential for alcohol abuse. In fact many stated they feared becoming alcohol abusers. This might

suggest an unconscious identification with fathers. Further the style of purging and rigid control over the body is a violent physical act, a self-punitive act. Regular and excessive use of force-vomiting, laxatives or dieuretics suggest a style of violence against the self. This is perhaps related to a frequency with which women here reported violent outbursts in their fathers.

The problematic relationship with fathers may be related to difficulties in heterosexual relationships, a frequent concern for subjects. Experiences of relating with males within the family did not provide positive models for male-female interaction. Not only did subjects have problematic relationships with their fathers but also with brothers. Often this relationship was highly competitive. Nor did parents offer a satisfying model of heterosexual relationships. Subjects were often involved in their parents' conflicts with each other and with family members.

The Adolescent Experience

Adolescence emerged as a critical time in the lives of women suffering from bulimia. Relationships with parents became more overtly conflictual and much of subjects' behavior became oppositional. Although many had relationships outside the family there is indication that peer relations held little intrinsic rewards for these

women. Rather it seemed that through the nature of their peer involvements subjects maintained a tie with their parents, either through seeking approval or by rebelling. Nor is there any indication that developing a woman's body was a source of increased esteem or pleasure for most subjects. On the contrary reports indicated that the transition from childhood to womanhood meant "contracting," becoming less active, more passive and accomodating. The experience of menstruation, for instance, which could have increased bonding between daughter and mother and other young women was seen to be an isolating experience sometimes mixed with alarm about the developing body. There is little evidence that the conflicts and changes of adolescence were resolved in such a way as to facilitate the transition to young adulthood.

An important contrast exists between anorexia and bulimia in terms of adolescent experience. With the alarming symptoms of starvation and denial anorexia nervosa calls attention to itself. It is a visible and dramatic symptom which interrupts family life and the possibility of normal adolescent experiences. The symptoms of bulimia are not as dramatic or handicapping. While binging serves as a coping mechanism and may mildly interfere with some activities it is not severely debilitating.

Although there were differences in the adolescent experiences of bulimics and anorexics, their families did

not appear grossly dissimilar.

Speculations Concerning Early Development

While the material generated from the interviews did not provide direct information about the early development of these women it is interesting to speculate that the difficulties in later developmental transitions, e.g., leaving home, are perhaps grounded in unresolved conflicts originating in developmental transitions much earlier in life. While highly conjectural, I would like to suggest that these difficulties may be different for anorexics and bulimics.

In infancy and early childhood the mothering one serves as a bridge between external reality and the child's inner world. It is through her empathic response that a basic organization of bodily sensations, feeling, cognitions and perceptions are mediated with reality and eventually organized into a sense of self capable of engaging in the world. If development proceeds normally, a child internalizes a maternal figure which is reliable, coherent, and available to the self in times of need just as the actual mother was during previous times of need (Horner, 1980).

The experiences of bulimics during transitions suggests an inability to maintain a reliable sense of self and other. They are beset with loneliness, emptiness and fears

of abandonment. Few self-soothing mechanisms are available. Binging a central feature of the bulimic pattern seemed to be connected to a sense of longing for the presence of someone or some aspect of the self. Object constancy has not been achieved. Binging in these cases, might be interpreted as a hunger for the missing object who once provided a sense of comfort (Seligman, 1976).

Dieting or purging in this case might represent an effort at denial of the vulnerability associated with object loss and an attempt to ward off the shameful feelings associated with object need. These women live a "fiction of self-sufficiency" (Smolen, 1982). Bulimia then can be viewed as a process of self-deception, a process in which one's appetites and the satisfaction of appetites are felt but must be hidden. In the most concrete terms of one subject, "I could eat and remain thin."

The major feature of the anorexic pattern is self-denial. The anorexics' starvation to the point of emaciation, her hyperactivity, denial of her body and negativism suggests a similar conflict but one which might have origins in earlier phases of the separation-individuation process. This might be seen as a stronger defense since early experience with the mothering one has perhaps been a more conflictual and confusing experience. Mutual cuing necessary for individuation has not occurred. Attempts at autonomy have been discouraged. The anorexic must be

impervious to her own needs since the possibilities of return to the maternal object are intensely threatening. In this instance, the threatening aspects of her desire for the object must be denied. The bulimic acknowledges her need but attempts to obliterate it, often stuffing down the painful feeling with food. The anorexic must never acknowledge her need.

For both anorexics and bulimics, the stresses of later transitions can precipitate regression and an intensification of these tendencies in self-object pathology.

Hilde Bruch, a most noted expert on eating disorders, has stated: "Many have said that anorexics are expressing a fear of adulthood. They are actually afraid of becoming teenagers" (Bruch, 1978, p. 65). It appears that rather than fearing adolescence the women in this study had difficulty entering womanhood. While they had difficulty negotiating adolescence they found a way of coping with it, i.e., binging. They had a mildly troubled and problematic adolescence. For these women major difficulties emerged in coping with young womanhood and the late adolescent transition of leaving home.

Leaving Home

As Haley (1980) has stated, "in any organization, the time of greatest change occurs when someone is entering the organization or leaving it" (p. 31). All families

experience stress in the late adolescent transition of leaving home, however it seemed unusually stressful for these subjects and their families. More overt conflict appeared between parents at this point than previously. In six instances parents actually divorced around the time of the young woman's departure from home. In other instances, subjects recalled becoming involved in conflicts between the parents, or experienced heightened concern about the welfare of their siblings at home.

Subjects themselves experienced the transition from living with family of origin to living autonomously as problematic--a time of loneliness and isolation. Peer relationships were often unsatisfying or in conflict with family values. The reports suggested that the normal differentiation of adolescence, i.e., moving away from the family to establish peer relationships, was a threat to family stability and further suggested a faulty sense of autonomy and competence in the individual women. In two reports, these pressures were described as severe enough to precipitate nervous breakdowns after leaving home. This transitional phase is clearly troublesome for most adolescents but may have led many of these subjects to eat more compulsively and diet more rigorously in an effort to manage their stress. Although this eating pattern might have initially emerged as a solution to the problematic transition of leaving home it could later become the attempted

solution to any transitional stress. While a majority of subjects had reported that binging began earlier in adolescence, it was not until late adolescence or young womanhood that purging began. It seemed as if the symptom developed at the point at which family and larger culture intersected.

The Cultural Context

In bulimia, transitional stages appear problematic on individual, family, and cultural levels. Most studies on eating disorders have focussed on intrapsychic dynamics. In recent years some studies have encompassed family context and interactional patterns as well. Very few studies have focussed on the culture. These women's life stories very strongly suggest that the cultural context is greatly influential in the development of eating disorders. It is important to recognize that the field within which this problem develops is larger than the individual and the family. The concerns with issues of achievement and sexuality expressed by bulimics suggest a psychological phemenonon which is permeated by the social position of women.

The women in this study expressed uncertainty and concern about what it means to be a woman. They experienced conflicts about becoming desirable and expressive persons. Within their families they received conflicting and confusing messages about what was acceptable female

behavior and about their possibilities as women. On the one hand these families seemed to want their daughters to be attractive and were attentive to and emphasized good appearances. On the other hand, they appeared to be conventional in their approach to sexuality and seemed to fear their daughter's emerging sexuality and attractiveness. Additionally, these women were expected to be independent achievers able to place their own interests ahead of others; at the same time, for them to be good family members, they had to subordinate their own iniatives to the requisites of the family. This ambiguity in family expectations is further exacerbated by women's social position and cultural attitudes towards their sexuality and achievements.

Clearly, during the last fifteen years our culture has been involved in a major social transition concerning the meaning of sexuality, gender and sex roles. Issues that have to do with women's place and power in society are being re-examined. This social change has implications for identity. During times of transition the social base for identity is transformed. People do not quite know who they are. With the role of women changing the social base for gender identity becomes uncertain. This study suggests the stresses associated with a change in women's position in society may be one of the significant factors in the development of bulimia.

These social changes have implications for the family as well as the individual since both are subject to cultural norms. They too receive mixed messages concerning sex-roles and sexuality. If a social transition is taking place in which definitions of masculinity and feminity are changing then developmental transitions are leading people into ambiguously defined sex-roles and sexuality. The normal stress associated with transitions is amplified because of heightened uncertainty about role-expectations and relationships. Current cultural forces impinging on individuals and their families often require flexibility in roles and changes in traditional attitudes within the family. However, the families of these women seemed rigidly organized and unable to meet these changes with flexibility. For these families, transitions concerning the social position of women are occurring from within and without. From within is the transition from childhood to adulthood; from without is a transition in the larger culture. The individual adolescent girl is also facing transitions on many levels. When she leaves the family and enters the larger culture she experiences a clash between family norms and cultural norms. In some situations the conflict is overt. In other situations, a conflict within the family might be excaberated by the changes her leaving home requires. Or, perhaps she simply is underprepared by her family to deal with the ambiguity she encounters in the

larger culture concerning her possibilities as a woman. In any case these conflicts are especially difficult for both the individual and her family, especially so since there is little experience in resolving conflicts in these families.

Without doubt individual, family and cultural factors each play a central role in the evolution and development of bulimia. The symptom can be said to emerge at the intersection of transitions in the individual, the family and the culture. I would suggest that bulimia be considered a disorder of transition.

Suggestions for Future Research

The importance of the late adolescent transition in the development of the symptoms of bulimia suggests the need for more research on transitional phases within the family and the individual and the bearing these phases might have on eating disorders.

Extensive examination needs to be done on the family contexts of bulimic women. Structural assessments of the family may broaden our understanding of communication patterns and interactional styles present in these families.

The variation of eating patterns of the women in this study suggests the need for further refinement of diagnostic categories. Future research which could compare

anorexics, bulimics and obese women might contribute to greater differentiations within populations suffering from eating disorders.

Object relations theory and developmental diagnosis hold much promise in understanding the psychological processes involved in eating disorders. Studies which examine early object-relations in women exhibiting the symptoms of bulimia are needed.

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Personal Communication

Bonnie Smolen, January, 1982.

A P P E N D I X A

QUESTIONNAIRE

1. NAME: 2. AGE:

3. OCCUPATION/ACADEMIC STATUS:

4. YOUR ANNUAL INCOME: (circle) 0-5,000 5-10,000

   10-15,000 15-30,000 over 30,000

5. PRESENT LIVING SITUATION: (Alone/with whom)

6. RELATIONSHIPS: (circle) Single Married

   Living with Lover Separated Divorced

   Involved in serious relationship
   but not living together

7. CHILDREN: (number, ages, sex)

8. SEXUAL PREFERENCE: (circle) Bisexual Heterosexual

   Lesbian Undecided

9. ETHNIC/RELIGIOUS BACKGROUND:

10. FAMILY OF ORIGIN:
    How far in miles are you from your
    family of origin?

    How often do you see your family?

    MOTHER: AGE: OCCUPATION:

    If deceased, your age at death?
    Briefly describe your relationship with mother:

    FATHER: AGE: OCCUPATION:

    If deceased, your age at death:
    Briefly describe your relationship with father:

    SIBLINGS: (sex, age, occupation)

ANNUAL INCOME OF PARENTS: (circle) Below 10,000

10-15,000 15-30,000 over 30,000

11. Your order of birth:

12. Have either of your parents or other family members had problems with weight or eating? Please describe.

13. Please describe your current eating patterns:

14. Briefly describe your binge-ing behavior:

    a. How frequently do you binge?

    b. At what age did you start?

    c. How much do you eat when you binge?

    d. Does binge-ing interfere with your relationships? (if so, how?)

       With activities or work?

    e. Are there particular times of the day that you are more likely to binge?

    f. What precedes a binge? Typical events or feelings?

    g. What follows a binge?

15. What method(s) do you use to get rid of food and/or to lose weight? (circle)

    Fasting Forced vomiting Laxatives Dieuretics

    Controlled dieting Other

    Have these methods changed over time? (please explain)

16. What motivates you to diet or lose weight?

17. Do you consider yourself "preoccupied" with food? (Please explain)

18. What do you remember of the circumstances that contributed to your first binge?

19. Have you ever dieted prior to your first binge?

20. What is your present weight?

What is your ideal weight?

What is your typical weight fluctuation?

Do you think of yourself as too fat, too thin, just right?

21. When you look in the mirror are there parts of your body that are difficult to look at?

Do you think you see yourself as others see you?

22. What is the average amount of sleep that you get?

23. Do you engage in regular exercise?
What kind?
How often?

How would you describe your energy level? (circle)

Frequently fatigued average high energy

24. How old were you when your menstrual cycle began?

Do you have a regular menstrual cycle?

Have you experienced any problems in your menstrual cycle? If so, at what age(s) did these problems occur and what was the nature of the problem?

Please describe any medical treatment you had for these problems and the results of that treatment.

25. What do you think are the reasons why you binge?

26. Have the problems that are or were associated with eating been transferred to other aspects of your life? Please describe.

27. Does anyone know about your eating problem? If so, who?

Do you tell others about a weight gain or loss? Who?

How do you feel when you talk about your weight or eating patterns?

28. Have you ever sought help specifically for your eating problem? If so, please describe in detail along with an account of the results, particularly those aspects you remember as being least and most helpful to you. If not, are there any reasons that come to mind as to why not?

29. How would you describe your relationships with men and women both in the past and presently?

    Do you tend to get along better with men or women?

    Any recurrent problems that you've noticed in your relationships?

30. What are your present feelings about your body? Are they different now than in the past? How?

31. How do you feel about being a woman?

32. What are your dreams, expectations, plans for the future in terms of career, marriage, children?

A P P E N D I X B

INTENSIVE INTERVIEW GUIDE

Introduction

--purpose of the interview, signing consent form, emphasize confidentiality

--present interview format and anticipate subject's difficulty in sharing material.

Written questionnaire

Oral interview. Begin with themes established by final questions of written interview (e.g., future plans, dreams, goals). Ask subject what she wanted to do or be when she was younger, who she admired, did she want to be like parents, in what ways, in what ways different from parents. Did parents communicate definite ideas about what daughter should be or do--feelings about this.

--Relationship with parents:

Describe quality of relationship with parents, childhood, adolescence, currently
What was life like growing up? What kind of people are subject's mother, father (temperment, activities, interests, occupations, feelings or attitudes towards work)
How involved are they in her life now? (What do they talk about, extent of contact and frequency, advice giving--in what areas, her feelings about their involvement)

Extent of subject's autonomy during childhood, adolescence, currently. What was she free to choose, how did she make choices. Sources of conflict between self and parents in childhood, adolescence, currently. Assess importance of parent's opinions, approval or criticism at this point in her life.

Parental attention to appearances, childhood, adolescence, currently.

Major concerns or worries expressed by parents about subject--childhood, adolescence, now.

Parental dyad--how do parents get along with each other? How much do they involve the subject in their conflicts, past, presently? Does she feel parents are satisfied in their marriage, happy-unhappy--how does she know?

How close or distant does she feel to parents? Closer to one or the other, childhood, adolescence, currently? How does she account for changes in this area?

Major turning points--Are there times that stand out as ones of particular change (crises, marker events, turning points) in the family, in her own life . . . explore.

--View of her own life: (Feminine Identification, Sexuality, Achievements)

Make transition to questions having to do with subject's perception of herself through exploring how she sees self in relation to each of her parents. Is she like or different from her parents? What similarities, what differences (physical appearance, temperament, interests, intelligence)

Feelings about being female, childhood, adolescence, currently.

Person talked to about sex, parents reactions to body.

Assess and describe relationship with mother re: menstruation, sexual experiences, pregnancy, child-birth, mothering.

See life/self as like or different from mother's life --in the past, currently, future

History of significant relationships and extent of current sexual involvements.

Explore general identification and empathy with other women, relative like/dislike; intimacy, comfort with women vs. men. Women or men particularly admired.

Achievements, special interests, competencies. What does subject consider major accomplishments or areas of competency? Parental response to performance in schools (childhood, adolescence, currently, if applicable). Sense of what she thought she would do after high school, college? Sense of what mother/father thought she would do after high school, college? How important is work (career) in subject's life now? Conflicts in this area?

End oral interview with life overview: when think over entire life, what are times of particular change, sadness-happiness; growth-conflict, that come to mind.

Ask the subject if there is anything else she thinks I should know, and her reactions to the oral interview.

A P P E N D I X C

FLYER

ATTENTION: WOMEN WITH EATING PROBLEMS

I am a therapist and graduate student interested in the problems women encounter with compulsive overeating and dieting. As part of a study on the relationship of growing up female in this society and problems involving food, eating and body, I am presently conducting confidential interviews with women who have experienced cycles of compulsive or binge eating and would greatly appreciate your help.

The interviews will last from 1-2 hours and will be scheduled at a time convenient for you. The content of these interviews will be held in strictest confidence. I wish I could pay you for your time but I do not have the resources to do so at this time. However, as part of the study you will have access to material covered in your interview and to the results of this study which should be completed in the next few months. Hopefully, the interview will be of some use to you in reviewing certain aspects of your life, your thoughts, concerns and feelings about being a woman and the importance overeating and dieting has had in your life.

If you are interested in being interviewed or know someone else who might be, please call me at 586-6847 and leave your number, or call me at home, 586-1720.

Sincerely,

Carolyn Hicks
16 Center Street, #516 (office)
57 Huntington Rd, Hadley (home)

A P P E N D I X D

CONSENT FORM

I recognize that the following interview is a part of a research study on eating disorders being conducted by Carolyn Hicks for fulfillment of her doctoral dissertation requirements. The primary purpose of this interview session is to share my personal history and patterns surrounding food and eating. I am aware that this interview session will be tape recorded and that I have the right to listen to the tape on request any time within a two year period at which point the tape will be erased. The information obtained in the written and oral interview will become part of the research material of this study and I have given Ms. Hicks permission to use direct quotations from the interview at her discretion. The only persons listening to the tapes will be Ms. Hicks and a few professional colleagues helping her with the study. I understand that my identity will be kept strictly confidential and any identifying information such as locations or information of persons mentioned by me will be disguised or withheld in the writing of the dissertation or any reports produced from this study. I understand that I have permission to

terminate my participation in this study at any time.

I have read this consent form and voluntarily agree to be a part of this research study.

_____
Name

_____
Date