FAMILY OF ORIGIN AS A FACTOR IN THE DEVELOPMENT OF BULIMIA: IMPLICATIONS FOR TREATMENT

BY

HEATHER D. FISHER-CORBETT

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Department of Educational Psychology
University of Manitoba
Winnipeg, Manitoba

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ABSTRACT

Bulimia is a distressing and disruptive disorder, increasingly prevalent in our society, and wielding a destructive impact on the lives and bodies of those so afflicted. It overwhelmingly affects women, and the onset of this disorder often coincides with a time prescribed by this culture as one marking the transition to adulthood. Questions arise as to how effectively the family environment has prepared women with bulimia to navigate this transition, so the purpose of this study was to examine the perceptions that women with this disorder have both of themselves and of their family of origin experience. Unstructured interviews were conducted with eight women suffering from bulimia, exploring the family of origin experience according to six broad themes: communication, affect, control, values, boundaries, and differentiation. The data collected was analyzed and synthesized across participants and themes, as well as correlated to information presented in the literature review, emphasizing family of origin theory and therapy. Results indicate these women believe an underlying low self-

esteem, sense of inadequacy, and dissatisfaction with appearance supports their disorder, characteristics developed in a non-nurturing, authoritarian, and conflictual environment. It is suggested that bulimia is an expression of lack of differentiation, and that family of origin therapy accentuating the process of differentiation be explored in a therapeutic trial. Bulimia is a challenge to both clinicians and researchers alike striving to better understand and treat this disorder. This study provides an informative look at the perspective that eight women have of their bulimia and their family, an additional step on this challenging journey.

Chapter 1

Introduction

Though bulimia as a symptom has been described in the literature throughout this century, as a syndrome it is of recent origin, having only been identified as a separate disorder from anorexia nervosa by the American Psychiatric Association in 1980. It is an eating disorder, (ie, disorders that feature gross disturbances in eating behavior), and is characterized by the following: recurrent episodes of binge eating, a feeling of lack of control over eating behavior during the binge, regular purging behavior in effort to prevent weight gain (either through self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, vigorous exercise, or some combination thereof), and a persistent overconcern with body shape and weight (American Psychiatric Association (APA), 1987). During a binge eating episode, food tends to be eaten rapidly and with little attention paid to taste and texture, often consisting of high caloric, easily ingested food that the individual is attempting to exclude from the diet. Up to 3500 calories or more may be consumed in a thirty minute period, with the

individual stopping only due to physical discomfort, social inter-ruption, induced vomiting, or sleep. Food becomes an obsession, and the binge-purge cycle becomes a ritual that consumes the individual's life. The bulimic episode invariably occurs in secret, often during times of stress or at the same unstructured or transitional time of day, such as during the evening after work. Frequency of bulimic episodes can vary from several a day to only the occasional loss of control. Between these episodes most afflicted individuals attempt to follow strict dietary regimes (Anderson, 1984; Casper & Eckert, 1980; Fairburn, Cooper, & Cooper, 1986; Jones, 1989; Mizes, 1985; Neuman & Halvorson, 1983; Thompson & Gans, 1985). As a result of this pattern, body weight fluctuates up and down, but usually by not more or less than 15% (Casper, 1983; Dippel & Becknal, 1987). The well-guarded secrecy of the binge-purge cycle plus the normal appearance of the individual with bulimia makes this disorder almost impossible to detect until the individuals themselves choose to disclose their symptoms.

Bulimia usually begins in late adolescence or early adult life (APA, 1987). The most frequent age of

onset cited in the literature is 18 years of age, a time when most young people are under a great deal of pressure to make major life decisions and transitions. The onset of the disorder has most often been associated with a voluntary period of dieting or during a traumatic life event, most typically a loss or separation, such as leaving home or rejection by a boyfriend (Gandour, 1984; Mizes, 1985). The voluntary dieting tended to begin in response to an underlying low self esteem, with these individuals often describing themselves as emotionally insecure, inadequate, and ineffective in their relationships with others. However, many young adults are plagued by a diminished sense of self and most embark on a life apart from their family, yet not all will develop bulimia.

Statement of the Problem

Given the age of onset of bulimia -- a time prescribed by our culture as the transition into adulthood and leaving home -- questions arise regarding how effectively the family environment has prepared the individual with bulimia to navigate this transition.

The purpose of this study is to examine family of origin variables that may have an impact on the development of this disorder, and subsequently, how these same variables might be addressed in treatment.

Delimitation of the Study

Bulimia has only been classified as a separate disorder since 1980. Therefore, this study reflects research limited to the past ten years. This is also a disorder that overwhelmingly afflicts women, and because of this, word choice often reflects feminine gender, and the study population is exclusively comprised of women. Lastly, though reference is made to family systems research in regard to family of origin, this is not to imply that this study reflects an exhaustive review of this variable.

Value of the Study

Due to the shame and secrecy associated with bulimia, it has been difficult to assess the actual incidence of the disorder, but it appears to be alarmingly prevalent. Studies of college populations have reported prevalence rates ranging from 8% to 19%

(Johnson & Berndt, 1983; Langway, 1981; Potts, 1984; Pyle, Halvorson, Neuman, & Mitchell, 1986). A study of family practice medicine revealed that 20% of female patients showed abnormal eating concerns and habits, and more than 10% fit the DSM III criteria for bulimia (Leichner, 1985). Estimates are that between one and three million women binge eat at least weekly (Johnson & Berndt, 1983), and less than half of women defined as bulimic seek treatment (Potts, 1984). Conflicting prevalence rates likely reflect a problem of definition, confusing the actual syndrome with more casual binge eaters, and recent studies indicate a rate of prevalence less than originally speculated (Halmi, 1987; Yager, 1988). However, it is still a disorder of some magnitude, and the high profile it has recently been receiving in both the popular and scientific literature will likely result in increased requests for treatment. Bulimia is also a disorder with serious medical complications. Affected individuals run the risk of developing throat and mouth ulcers, gastric and dental problems, hernias, ruptured esophagus and/or stomach, disruption of normal liver and kidney function, electrolyte imbalance (especially of potassium which can lead to cardiac abnormalities),

hematological, neurological, and endocrine abnormalities, menstrual irregularity and amenorrhea, and laxative dependency (Langway, 1981; Mayer, 1982; Mitchell, 1986; Mizes, 1985; Neuman & Halvorson, 1983; Schlesier-Stropp, 1984; Yager, 1988). Suicide risk is also a frequently cited factor. Therefore, a greater understanding of the syndrome itself as well as treatment hypotheses and guidelines for further research will be of interest to both researchers and clinicians. Though the literature on bulimia is expanding, research is in the elementary stages and has been described as rudimentary (Copeland, 1985), meager (Thompson & Gans, 1985), and reflecting gaps in knowledge and a paucity of supporting data (Emmett, 1985; Mizes, 1985). Further, very few studies have attempted to evaluate the family dynamics and environment of individuals with bulimia (Ordman & Kirschenbaum, 1986; Strober & Humphrey, 1987), and little remains known about the role of the family in the development of this disorder (Pole, Waller, Stewart, & Parkin-Feigenbaum 1988; Scalf-McIvor & Thompson, 1989). There are also questions as to how and when family factors and members should be involved in therapy (Vandereycken, 1987). The significance of

this study is in its attempt to shed further light on family of origin factors in the development of bulimia, and the implication these factors may have for effective treatment.

Definition of Terms

Binge eating, or binging, is defined as the rapid consumption of a large amount of food in a discrete period of time (APA, 1987). Family of origin is defined as the original nuclear family than an individual belongs to. Separation and individuation, used interchangeably, refers to the individual's development of autonomous functioning. Purging and bulimia have previously been defined, and several other select terms that appear in the text are defined in the glossary (Appendix A).

Body of the Study

The body of the study is presented in chapters two through five. In chapter two, a review of the literature is presented. Chapter three offers a discussion on the importance of family variables and family of origin theory and therapy. In chapter four,

the method of the study is described with particular emphasis on the interview, and Chapter five is a presentation of the data collected from the interviews. The final section of the study, presented in chapter six, summarizes the findings of this investigation and attempts to correlate these findings to the current literature. Implications and recommendations for treatment and further research of the bulimia syndrome provides the conclusion to this thesis.

Summary

Bulimia is a secretive and potentially disabling disorder of mounting prevalence, with serious medical and emotional consequences. This chapter described the background to the proposal for an examination of family of origin variables and the implication of these variables in the development and treatment of bulimia. The organization of the study as it unfolds is outlined.

Chapter 2

Review of the Literature

> If I deviated by one slice of bread from my diet, my day was shot. Then I'd have to eat a bag of cookies, two boxes of doughnuts, several candy bars, two bags of English muffins with jam, you name it. Afterward I'd vomit (Langway, 1981, p. 60).

This picture of the individual with bulimia has been painted quite consistently in the literature. Two realities are experienced -- compulsive eating and compulsive dieting. Sticking to a diet has come to be equated with being good, and even the smallest slip can trigger self-deprecation and another binge. Self-induced vomiting is the most common method of purging, with chemical agents representing the second most preferred method (Mizes, 1985). The quantity of laxatives consumed has been reported as high as one hundred or more tablets of the common preparations a day, with diuretics also ingested in quantities sufficient to markedly reduce potassium levels (Anderson, 1984). Through purging, the individual with

bulimia hopes to re-establish a sense of effectiveness, and thereby increase a felt sense of acceptability to both self and others. Very low food consumption and/or fasting will also follow a binge, usually setting up a repeat of the cycle. Though researchers are in agreement with these expressed characteristics of the syndrome, they differ in regard to etiology.

Etiology

The literature reflects a diversity of factors theorized to have a role in the development of bulimia. These factors can be grouped under the following general categories: biological, cognitive-behavioral, psychoanalytic-psychodynamic, sociocultural-feminist, and family factors.

i) Biological factors

The most prominent biological theory of etiology links bulimia to affective disorder (Agras & Kirkley, 1986; Fairburn, Cooper, & Cooper, 1986; Gwirtsman, Roy-Byrne, Yager, & Gerner, 1983; Hudson, Katz, et al, 1987; Hudson, Pope, Jonas, & Yurgelun-Todd, 1983; Hughes, Wells, & Cunningham, 1986; Pope & Hudson,

1985). The evidence highlighted to support this relationship includes: (1) the presence of depressive symptoms similar in type and severity in both bulimia and major affective disorder as well as the prevalence of depression among first-degree relatives, (2) reports that both disorders respond to the same class of medications, and (3) reported similar responses to specific biological tests. Family studies of the first-degree relatives of women with eating disorders have found a high prevalence of both depression (Gwirtsman et al, 1983; Hudson, Pope, et al, 1983), and alcohol abuse (Butterfield & Leclair, 1988; Hudson, Pope, et al, 1983). Studies with antidepressant medication have noted symptom improvement in both major affective disorder and bulimia. Several uncontrolled studies with antidepressants have shown a moderate to marked reduction in the frequency of binges as well as a marked decrease in depressive symptoms, obsession with body weight, and preoccupation with food (Pope &, 1985). A couple of placebo-controlled, double-blind studies with antidepressants revealed more mixed results, with one demonstrating moderate reduction in binge frequency and depressive symptoms (Pope, Hudson, Jonas, & Yurgelun-Todd, 1983), and the other

demonstrating marked improvement in depressive symptoms but no change in binge frequency (Pope & Hudson, 1985). Appetite suppressant drugs have also been targeted for study due to bulimia's association with increased appetite and carbohydrate craving (Freeman & Munro, 1988). Initial results have been positive, with the afflicted individual reducing both the binging and the overall caloric intake. Two other classes of drugs -- anticonvulsants and appetite stimulants -- have been subjected to controlled trials, but the initial promising results have not been replicated, and further studies have not appeared in recent years (Mitchell, 1988; Pope & Hudson, 1985). Biological tests likewise suggested a link between affective and eating disorders. The dexamethasone suppressant test (DST) is a laboratory test thought to be highly specific for depression and in the diagnosis of major affective disorder. Studies have shown 50% of patients with bulimia display abnormal DST (Fairburn et al, 1986), and 86% of these recovered normal levels following antidepressant treatment (Hughes et al, 1986). Both an abnormal thyrotropin response (TSH) and growth hormone response (GH) to thyrotropin-releasing hormone (TRH) have been seen in patients with major depression, and a

study by Gwirtsman et al (1983) demonstrated similar abnormal responses in patients with bulimia. However, other studies reflect these subjects with normal DST responses (Hudson, Katz, et al, 1987), suggesting that bulimia does not necessarily share these neuroendocrine abnormalities seen in major depression. A recently launched research project at Ottawa Civic Hospital in Ottawa, Ontario (Canadian Broadcasting Corporation, 1991) is testing the theory that there is a direct chemical link between diminished light levels and bulimia, similar to the proposed connection between reduced sunlight and depression (seasonal affective disorder). However, this research has yet to demonstrate results and remains controversial.

A second biological theory suggests a hypothalamus-triggered response to the stress of self-imposed dieting (Copeland, 1985; Potts, 1984). Women with bulimia often vascilate between binge eating and prolonged dieting and fasting, and it is hypothesized that starvation provokes hypothalamic changes. Binge eating, as well as many of the internal states described by these women have been documented in studies of experimental starvation (Copeland, 1985; Garner, Rockert, Olmsted, Johnson & Coscina, 1985). It

is further hypothesized that neuroendocrine changes may predispose a person to eating disorders, and that self-imposed starvation may itself lead to additional neuroendocrine changes, setting up a cycle supporting the disorder.

A third biological study is based on research with laboratory animals and is highly speculative at present (Fairburn et al, 1986). The research suggests that dietary manipulation can influence the entry of tryptophan into the brain, affecting its synthesis. The hypothesis is that changes in brain levels of tryptophan will influence the choice of food. Therefore, a carbohydrate-poor, protein-rich diet similar to the type consumed by extreme dieters may lead to diminished brain tryptophan synthesis and result in a strong urge to eat carbohydrate.

ii) Cognitive-behavioral factors

Underlying the cognitive-behavioral theories is the combination of an extreme desire to be thin and excessive dietary restraint. Supporting this theory are clinical findings that women with bulimia were often slightly overweight prior to the onset of the

disorder, and therefore, made a decision to diet (Agras & Kirkley, 1986; Gandour, 1984). This lead to the initial restriction of food intake, a real or perceived sense of deprivation, and inevitably, breakdown of the restraint followed by overeating. According to cognitive-behavioral theories, attitude toward shape and weight is central to the maintenance of this disorder. Typically, these women believe that success and failure will be determined largely by their appearance (Fairburn et al, 1986). They then employ rigid dietary rules that lead to avoidance of certain foods, particularly those believed to be fattening. Consuming even a small amount of forbidden food leads to feelings of failure, loss of control, and binge eating. Cognitive distortions, such as dichotomous thinking, overgeneralizing, personalizing, and perfectionistic and superstitious thinking appear common to women with bulimia (Agras & Kirkley, 1986; Fairburn et al, 1986; Johnson & Pure, 1986; Steere & Cooper, 1988). These cognitive errors are not only symptomatic of the disorder itself, but appear to be of primary importance in its maintenance. Even the slightest deviation from the extreme dietary rules becomes proof of worthlessness and failure and results

in the temporary abandonment of self-control. The fear of losing control is also cognitively distorted, and losing control with food can imply the frightening potential of losing control with any impulse (Browning, 1985; Hudson, Katz, et al, 1987).

Women with bulimia often describe negative feeling states prior to a binge (Mizes, 1985; White, Jr., 1985). For these individuals, binging has become the primary method of coping when confronted with feelings such as anxiety, depression, anger, boredom, loneliness, or fatigue. These women report more frequent binge eating during situations perceived as stressful (Cattanach & Rodin, 1988), and stress-induced overeating, as well as the sensation of hunger, can be learned in response to any arousal, not just food deprivation. Parallels have been drawn to chemical dependency, with binging, rather than drugs or alcohol, utilized in an attempt to anesthetize or alter the underlying feeling state and provide temporary relief from painful experience (Neuman & Halvorson, 1983). Both ultimately lead to guilt, further pain, and the continuation of the cycle.

Purging methods are also used as an alternative response for coping with negative affect and becomes

part of the cycle. A negative feeling state precipitates a binge, and as a result of the binge, the dysphoric mood is significantly reduced. Subsequent to this, negative affect and cognitions re-emerge, serving as a cue for purging. These again diminish following the purge, but additional ones resurface (such as self-disgust), eventually precipitating another binge. Purging may be more central to the reduction of anxiety than binging (Steere & Cooper, 1988). Though the binge reduces the negative affect, it results in extremely high anxiety and a morbid fear of becoming fat. Vomiting is immediately reinforcing in both its relief of anxiety and lessening of these fears.

Women with bulimia have been characterized as having a passive coping style and an inability to express their feelings, more often turning affect inward (Cattanach & Rodin, 1988; Hudson, Katz, et al, 1987). They may have difficulty mediating stress because they are unable to use their coping strategies effectively, and binging and purging becomes a maladaptive method of dealing with unrecognized feelings.

iii) Psychoanalytic-psychodynamic factors

The psychoanalytic-psychodynamic perspective has focused primarily on unconscious conflicts and fantasies. Conflicts about sexuality have been proposed, particularly pregnancy wishes (Boskind-White, 1985), and sex role conflicts, with emphasis on an over-identification with femininity (Neuman & Halvorson, 1983). Rizzuto (1985), noting that onset of bulimia often coincides with launching in late adolescence, proposed that due to early maternal deprivation the adolescent is ill-equipped to meet this challenge. Binging, then, represents the search for an orally-approving maternal object, while purging represents the urge to rid oneself of the monstrous child within who frantically demands so much. This angry monster was covered up in childhood by compliant, good behavior, covertly prescribed by the parents to gain their approval, yet at the same time, they neglected to attend to the fears, uncertainties, and concerns the child had about herself. Hungry for maternal love, the individual struggles with the conflict of wanting to satisfy the monster while at the

same time control it. Beattie (1988) proposes that women with bulimia often have some special tie to their mother, possibly as an only child or only daughter, or through being selected as a special confidante or caretaker. As girls must simultaneously individuate from and identify with a primary caretaker of the same sex, the early process of separation from an all-powerful pre-Oedipal mother is more difficult for girls than boys -- much more difficult again for girls with special status. According to Beattie, as food is the most concrete possible symbol of the maternal object, food intake can be a way of both demanding and rejecting nurturance. Binging and purging can be used to act out aspects of the ambivalent struggle with the actual and internalized mother. Woodman (1980), on the other hand, describes a dependant father-daughter relationship and an idealized father image, with the woman suffering with bulimia having learned to esteem the values of a male-oriented culture and losing to her unconscious her own feminine principle. The unconscious conflict that results is the rebellion of this lost femininity manifesting herself in somatic form as she attempts to find a place in the patriarchal culture and masculine world.

iv) Sociocultural-feminist factors

a) Sociocultural. The sociocultural perspective links the development of bulimia to the cultural pressures on women to diet and be thin, both symbols of beauty and success. Our culture glorifies youth, instilling in people a desire to stay young forever. Youth is viewed as a sign of beauty and sensuality, with the current cultural ideal closely resembling the immature body of a prepubescent girl (Garner, Rockert, et al, 1985). Health issues are willingly compromised for the highly-prized slim body. When cyclamates, an artificial sweetener, was banned by the Federal Drug Administration for being potentially carcinogenic, there was a great public outcry (Neuman & Halvorson, 1983), with people more ready to risk getting cancer than surrender their diet products. Even after deaths were widely publicized following the use of liquid protein diets, many dieters continued its unsupervised use. Of women who diet, the majority acknowledge doing so for cosmetic rather than health reasons (Schwartz, Thompson, & Johnson, 1985). It is estimated that over 20 million Americans are seriously dieting at any given

moment, spending more than ten billion dollars a year in the process (Neuman & Halvorson, 1983). There has been a proliferation of diet products, including diet articles in women's magazines, best-selling diet books, diet aids, appetite suppressants, health spas, weight clubs, calorie-reduced TV dinners, light beer and wine, and even dietary products for pets (Futrell & Collison, 1987; Garner, Rockert, et al, 1985). Names of diet foods have become part of our general vocabulary. Though society has also come to place greater emphasis on fitness, it has given women a different message than it gives men. For women, rather than emphasizing the attainment of cardiovascular fitness or other health benefits, the fitness message has emphasized the achievement of a sleek, curveless body shape (Garner, Rockert, et al, 1985). In today's society, concern about diet and exercise has shifted from a leisure time hobby to a national obsession.

This contemporary preoccupation with thinness appears to be restricted to Western nations not affected by food shortages. Eating disorders in general are almost exclusively of Western culture. There are no indications of anorexia nervosa or bulimia among the poor peoples of the Third World, and in these

nations, as well as in many parts of Eastern Europe, obesity is considered a status symbol (Nasser, 1988; Neuman & Halvorson, 1983; Stierlin & Weber, 1989). Only in the affluent Western societies are consumers called upon to exercise restraint and self-control in the face of abundant food supplies. Western society is exposed to contradictory requirements and expectations, which is crystal clear in the way food and body are presented and valued. The media is full of advertisements for high-caloric foods while also preaching the desirability of slimness, physical attractiveness, and fitness, further implying the need for self-control, dieting, and restriction (Nasser, 1988; Stierlin & Weber, 1989). Women, as the most important purchasers of food, must choose wisely for the good of their family's health and welfare, while also facing continual images of slimness and advice on how to eat sensibly, lose weight, and have a happy life (Orbach, 1978). The very appearance of a thin person becomes walking testimony to a life lived in moderation, void of self-indulgence, while the overweight person stirs up images of over-indulgence, selfishness, and lack of willpower (Boskind-White, 1985). Not only are we seeing socially-ascribed

virtues associated with slimness, there exists an unparalleled social stigma against obesity.

Subcultures that demand thinness for success, such as ballet dancers and models, report a greater than average risk for developing eating disorders. This lends further support for the social role in etiology (Garner & Garfinkel, 1980; Nasser, 1988). Ethnic variables are also important to consider. In Western nations, eating disorders have been rare among black and hispanic women (Hsu, 1989), and were more frequently associated with the middle to upper classes. However, the incidence is rising in both ethnic groups and lower socioeconomic classes as these people become more assimilated into American culture.

The cultural ideals of feminine beauty vary dramatically over time. A body can be in fashion one year and out of fashion the next, yet many women attempt to remold their bodies to fit the style currently in vogue (Katzman, Weiss, & Wolchik, 1986; Mazur, 1986). An overadaptation to these changes may explain the increased prevalence of eating disorders (Mazur, 1986). Over the last twenty years, there has been a shift toward a thinner ideal shape for women, which is reflected in the advertising, retailing, and

entertainment industries (Garner, Garfinkel, Schwartz, & Thompson, 1980; Mazur, 1986; Nasser, 1988). Since the 1970´s, Miss America Pageant contestants have become taller and thinner, as have Playboy centrefolds, who have also reflected a decrease in the size of bust and hips (Garner, Garfinkel, et al, 1980). Fashion trends of the mid to late 1960´s, such as the miniskirt, have emphasized and encouraged slender hips and thin legs (Mazur, 1986). Informal records that have been kept of the woman thought to be most beautiful by the 3500 yearly visitors to Madame Tussaud´s London Waxworks also reflect this trend. Since 1970, Elizabeth Taylor has fallen steadily from the top of the list at the same time that Twiggy has ascended. Twiggy first made the top five in 1974, and by 1976 she ranked number one (Schwartz, Thompson, & Johnson, 1985). A systematic examination of three popular women´s magazines from 1900 to 1983 revealed that preference for a more androgynous body type, characterized by a smaller bust and hips relative to waist measurement, emerged during the 1960´s and 70´s (Agras & Kirkley, 1986). During the same two decades, the number of articles about dieting and weight loss also steadily increased (Garner, Garfinkel, et al,

1980). It is important to note that during this same twenty year period, updated life insurance weight tables indicate the expected weight for women under thirty has actually increased at about the same rate that the average weight of Playboy centrefolds and Miss America Pageant contestants has decreased (Garner, Rockert, et al, 1985; Schwartz, Thompson, & Johnson, 1985). Therefore, the cultural pressures are even more significant when one considers that, on average, a heavier woman is encouraged to become thinner. There are other historical markers of disordered eating emerging when thinness became more fashionable. Silverstein, Peterson, & Perdue (1986) described newspaper articles that appeared in the 1920's about "stylish girls" starving themselves to attain the silhouette figures fashionable at that time. They also note a correlation between a thin standard of bodily attractiveness and periods in history when intelligence and professional competence of women are stressed. Both lend support to the sociocultural perspective that eating disorders have their roots in social influence rather than individual pathology.

The sociocultural shift in Western society from dependency to liberation has left women experiencing

internal conflict and insecurity. Women have long been socialized to be passive, fragile, romantic, sweet, and leery of competitiveness, yet the 1980's heralded in the expectation to achieve and perform, leaving women with the unrealistic pressure to pursue and excel at wifehood, motherhood, and career (Boskind-White & White, 1986; Garner & Garfinkel, 1980; Neuman & Halvorson, 1983; Selvini Palazzoli, 1978). Though roles for women and the means for attaining success are more varied, they are also more ambiguous, resulting in role strain (Brown, 1990; Katzman, Weiss, & Wolchik, 1986; Murphy, 1985; Neuman & Halvorson, 1983). Women are expected to compete in business and professions, while still devoting a great deal of time to family and their own personal appearance. Women growing up today in our culture are the first generation to be brought up by mothers on Weight Watchers, exposing them to a lean body preference since childhood (Neuman & Halvorson, 1983; Wooley & Kearney-Cooke, 1986). They are also the first generation expected to live a life different from their mother's; to instead live a life closer to their father's. Choosing either mother or father's role entails a cost. To embrace mother's role is to associate with the devalued role of nurturing

others to gain a longed for connectedness. Embracing father's role is to associate with achievement and self-control, freeing a woman up from traditional role demands but imposing isolation (Wooley & Kearney-Cooke, 1986). These sociocultural expectations result in an ongoing conflict between autonomy and success versus dependence and failure. Eating disorders become a metaphor of this conflict, with thinness and self-control symbolizing strength, and eating and body fat symbolizing failure (Wooley & Kearney-Cooke, 1986).

Our culture socializes women to have an intense concern for their body shape, and this basic message is exposed through all channels of social influence, including family, schools, business, and the media. Beauty, success, self-worth, and personal happiness become dependent on a thin shape. Studies have found that for women, slenderness is viewed as one of the most important aspects of physical attractiveness (Garner, Rockert, et al, 1985). Women continually report more dissatisfaction with their bodies than men. Boskind-White & White (1986) reported on a recent national survey conducted by Glamour magazine on women's attitudes regarding their bodies and food. Of the 33,000 women polled, 41% were moderately or

extremely unhappy with their bodies, and the majority (80%) felt they had to be slim to be attractive to men. A large number of the respondents used potentially dangerous substances for weight control, such as diet pills (50%), liquid formula diets (27%), diuretics (18%), and laxatives (18%). Fasting or starving had been tried by 45% of the respondents, and 15% had used self-induced vomiting. A survey conducted in 1985 through Psychology Today reported that 57% of women who fell within normal weight standards still considered themselves overweight (Schneller, 1989). Health & Welfare Canada conducted a survey in 1988 which revealed that 45% of Canadians over the age of twenty wanted to lose weight, and women in particular were most obsessed with weight loss (Wickens, 1989). According to this survey, 70% of the women interviewed whose weight was considered normal wanted to be slimmer, while 23% of the women surveyed who were considered underweight wanted to weigh even less. Almost no woman, it would appear, regardless of her size feels that she is thin enough. Sadder still, in another Canadian survey, over 80% of teenage girls have dieted by age 18, and 40% of nine year old girls have already dieted (Sheinin, R., 1990.). Amid such

confusing and conflicting cultural expectations, the pursuit of thinness emerges as one activity a young woman can engage in that consistently provides favorable social responses and over which she has some control, both which help to enhance self-esteem (Brown, 1990; Katzman, Weiss, & Wolchik, 1986; Johnson & Pure, 1986). Much of the literature on sociocultural influence stresses the theme that eating disorders could almost entirely be eliminated if society placed less emphasis on weight, diet, and thinness. Not only is the social impact important to etiology, but according to this view, might be the one factor that can explain the steady rise in the incidence of eating disorders.

b) Feminist. The feminist perspective, while similar to the sociocultural one, more directly underlines the social inequality of women. The fact that eating disorders are overwhelmingly a women's problem suggests that etiology has something to do with the experience of being female in our society. Femininity and being female has long been distorted and devalued in our male-dominated culture. Young women today face added stress strictly by being female. A patriarchal society such as ours not only stresses autonomy, aggression,

and achievement at the expense of intimacy and connection, but also expects women to continue to emulate the devalued feminine ideal (Bass, 1990). This devaluing of women has a long history in Western culture and is rooted in Judeo-Christian doctrine. Women have traditionally been seen as less rational and spiritual than men, and have been held responsible for tempting men into bodily and sexual evil. Women have long been blamed for men's "uncontrollable" sexual urges, and rape victims today are too often accused of provoking an attack, thereby forcing the victim into accepting responsibility for the rapist's violence (Sheinin, 1990). A society that so obviously devalues females leaves women and girls vulnerable to physical, sexual, and emotional abuse, and a connection is beginning to emerge between eating disorders and a history of such abuse. A study conducted in 1989 by the University of Michigan discovered that 75% of the women they interviewed with eating disorders had been sexually, physically, and emotionally abused as children (Bass, 1990).

Another recent study cited by Bass (1990) found that girls who buy into patriarchal society's idealized view of womanhood and repress their own needs are more

likely to develop eating disorders than girls who resist such cultural pressures. A women's capacity to reproduce and provide nourishment has locked her into the role of caring for and socializing children. To become a mother, a woman must have a man, so she learns to regard herself as a commodity and becomes expert at self-scrutinization, attempting to make herself into the image of womanhood presented by the media, fashion, and diet industries (Orbach, 1978). Bulimia then becomes a problem of how womanhood is socially constructed, a process in which physical appearance has historically played a central role. Throughout history the female form has been viewed as an object of pleasure for men (Orbach, 1985). Men place more importance on the physical attractiveness of women than women do on the physical attractiveness of men. Women's social opportunities are also more affected by their physical beauty than men, so women are under more pressure to conform to the ideal of beauty, and a sense of beauty or lack thereof becomes an important facet of a young woman's self concept (Hsu, 1989; Mazur, 1986). Women experience greater dysphoria, poorer self-image and body concept, and greater role confusion during adolescence (Hsu, 1989), all which in turn, contribute

to the risk of developing eating disorders, as these very factors intensify the pursuit of thinness. Though there are conflicting reports that a very small percentage of college-aged men binge, a study by Schneider & Agras (1987) found that a majority of these men were homosexual or bisexual. As sociocultural demands for thinness affect men and women differently, heterosexual men may be protected by this difference, whereas cultural pressures for thinness may be greater for homosexual men.

For women, a paradoxical relationship exists between food and feeding. The ability to nurture and feed others provides an important aspect to a woman's identity, yet women also come to realize and accept that food has an altogether different meaning for them. The same food a woman gives to others with love and caring is somehow dangerous to her (Orbach, 1985). The diet industry, with promises of love, male approval, and magical solutions to life's problems, has cashed in on women's self-consciousness, uncertainty, and anxiety.

Though women are presented with more opportunities than ever before, they continue to be exposed to the female stereotype, with expectations that they be both

maternal and womanly, caring and giving, and at the same time, sexually desirable (Cantelon, Leichner, & Harper, 1986; Stierlin & Weber, 1989; Timko, Striegel-Moore, Silberstein, & Rodin, 1987; VanStrien & Bergers, 1988). Women continue to be encouraged in a male-oriented society to adopt the traditionally female characteristics of dependency and lack of assertiveness. Though they are also expected to pursue a career, they lack experience in coping with criticism, confrontation, and rejection, yet are expected to compete with men in the business world (Boskind-White, 1985). They learn to say yes instead of no in an attempt to win acceptance and approval, to avoid hurting feelings, and to live up to an image. Women learn to take an accommodating approach to life and construct their self-image around the expectations of others, with fear of rejection becoming a critical motivating force (Gandour, 1984; Katzman, Weiss, & Wolchik, 1986). Lack of assertiveness and adaptive coping behavior can lead to noneffective responses in interpersonal situations. The centrality of food in the traditional woman's role may lead to a prevalence of excessive food intake as a coping mechanism. Women who have difficulty expressing emotions directly or

assertively may turn their attention to eating instead of focussing on what is eating them (Katzman et al, 1986; VanStrien & Bergers, 1988). Women often describe feeling caught up in a sense of inadequacy, fear of failure, and the risk of being disapproved of. The patriarchal pressure to be passive, conforming, and slim can set the stage for disordered eating as a symptom choice for women (Weinstein & Richman, 1984). Women with bulimia will respond to these pressures by expressing their anger and assertiveness through controlling their body appearance with binging and purging.

The traditional feminine stereotype of our patriarchal culture has taught women that anger, resentment, and hostility are not nice emotions and must be suppressed. Expressing anger is an assertive act, and assertion for women is difficult. There are few models of angry women to follow, so anger, as a legitimate emotion for women, has no cultural validation (Orbach, 1978). Women are condemned as castrating or domineering when they have attempted to assert their rights, so they learn from this that keeping quiet is safer than assertion, and they swallow their anger and other emotions through binge eating.

Women then blame themselves for not having asserted themselves, yet at the same time they feel guilty for having been selfish enough to even conceive of their own wants in the first place -- an act that implies depriving some other (Orbach, 1978). It is safer for women to use their mouths to feed themselves rather than to use them in a verbal expression of assertiveness.

From an early age, women are socialized to take care of others, learning that their own needs for emotional support and growth will be satisfied through this act of giving (Brown, 1990; Orbach, 1978). Women are expected to take care of their children, their husbands, and only then, themselves. They are barraged with contradictory messages which they use to measure their performance as caregivers, and in the confusion they come to mistrust their own impulses, not only in caring for their families but in learning to care for themselves (Orbach, 1978). The cost of giving to and nurturing others is not fully developing the self. Women often describe a sense that something is lacking, and may turn to eating in their search for love, comfort, warmth, and support. Food not only then becomes a form of giving to, but a means of

replenishing, oneself (Orbach, 1978). Schaef (1985) describes an inner space or void that she refers to as the cavern theory, relating this to being female and learning to look outside the self for validation and approval. Women are aware of their cavern and the need to shrink or fill it, which contributes to their developing eating disorders. According to Schaef, as women reclaim their identity and determine who they are from the inside, they will no longer experience the same hunger and their cavern will shrink and get smaller.

The feminist perspective also asserts that controlling the body has become a precarious substitute for real control in women's lives. Instead of attempting to gain control over the real issues, women attempt to control their weight, transforming their bodies instead of their problems (Brown, 1990). Self-loathing about body shape and eating habits can provide a less threatening issue to worry about than other possible problems (Orbach, 1978). The binge-purge cycle allows a woman to maintain the illusion of control for the outside world, but it has become a maladaptive outlet for ridding emotional tension, anger, and guilt (Brown, 1990). Having learned in a

masculine world to suppress their needs and withhold opinions, the control of both food and body may be the only way women feel they can truly express themselves. These suppressed feelings, however, will eventually become very powerful and frightening, with maintenance of control again becoming paramount. A paradox exists in attempting to maintain control through controlling the body, yet all the while feeling more out of control, an experience often described by women with bulimia (Brown, 1990). To truly feel in control is to feel one's own power in the world, and to feel confident about one's ability to direct their life and actions. The way in which women continue to be socialized more likely leaves them feeling inadequate, powerless, and vulnerable. Though on the surface, eating disorders appear to be a painful, self-destructive activity, feminism maintains that it is invariably an adaptive attempt to cope with sexist pressure in our contemporary patriarchal society (Orbach, 1978).

v) Family Factors

Proponents of a family systems perspective assert that family factors are influential in the creation and maintenance of bulimia. They concur that an eating disorder is a reflection or symptom of a deeper, more pervasive problem in the family's role structure, affective expression, relationship dynamic, and style of interacting (Humphrey, 1989). Minuchin, Rosman, & Baker (1978) observed families with children suffering from diabetes, asthma, and anorexia nervosa, subsequently formulating a model of psychosomatic families. They repeatedly observed a cluster of four characteristics that seemed to encourage somatization in families: enmeshment, overprotectiveness, rigidity, and lack of conflict resolution. A fifth characteristic to emerge in these families was the somatic child's involvement in parental conflict, (either through triangulation, detouring, or a parent-child coalition), and it was this factor that appeared key in supporting the symptom. The symptom, in turn, played an important role in maintaining family homeostasis. Minuchin and his colleagues observed that when significant family interactional patterns were

changed, significant changes occurred in the symptom as well. Selvini Palazzoli (1978) also studied anorexic families, finding such characteristics as cross-generational coalitions, marital conflict hidden behind a facade of unity, and family loyalty taking precedence over the development of individual autonomy. She also observed that patients would abandon their symptoms when families began to function in a new way. Hilde Bruch (1979), in her work with anorexia nervosa, noted several common features in the families of these individuals, including emphasis on polite behaviour and conformity, overconcern with image and achievement, a facade of a harmonious marriage, (often leaving the anorexic daughter feeling obliged to make up to the parents what was lacking in their relationship), and a general rule of nonexpression of feelings.

Thus, the role of the family in the development of anorexia nervosa has been investigated for some time, but it has only been in the past few years that the literature has begun to reflect attempts to delineate the dynamics of bulimic families. One of the consistent findings in studies that have evaluated bulimic family environment is that they are frequently disengaged, chaotic, and highly conflictual (Armstrong

& Roth, 1989; Johnson & Pure, 1986; Kog & Vandreycken, 1989; Stern, Dixon et al, 1989; Strober & Humphrey, 1987). They also appear to manifest indirect patterns of communication, have high achievement expectations, emphasize a traditional concept of femininity, give special meaning to food, eating, and appearance, place low emphasis on open expression of feelings, and are less supportive, orderly, and organized than nonbulimic families (Humphrey, 1989; Johnson & Flach, 1985; Johnson & Pure, 1986; Roberto, 1986; Schwartz, 1987; Sights & Richards, 1984). The communication of mutually exclusive and disqualifying messages have been noted (Johnson & Pure, 1986), supporting a belief that thoughts and feelings are not valued, and resulting in a difficulty in identifying and clearly articulating internal states, a characteristic shared by many women with bulimia. Wooley & Kearney-Cooke (1986) have noted marital discord and emotional distance between spouses in bulimic families. The result often is involvement of the afflicted daughter in the marital conflict (Lieberman, 1989), or of a parent becoming dependent on the daughter for emotional support and companionship. Ultimately, the parents are perceived as inaccessible and unavailable to meet the daughter's needs. Many of

these daughters have reported feeling responsible for holding together a family that at times appeared on the verge of falling apart. They express a sense of having experienced absent or insufficient parental care and empathy (Pole et al, 1988; Scalf-McIvor & Thompson, 1989; Steiger, VanderFeen, Goldstein, & Leichner, 1989; Strober & Humphrey, 1987).

Bulimic families also tend to show greater emotional instability and often display negative feelings openly, usually in abrupt outbursts that are almost as abruptly suppressed out of a sense of shame and guilt (Stierlin & Weber, 1989). Bulimic behavior has been described as a metaphor for family deficits and excesses. A woman with bulimia craves food just as she periodically craves and attempts to solicit nurturance and empathy. She then purges, just as the family abruptly expels aggression and frustration toward one another in an absence of structure, focus, or resolution (Strober & Humphrey, 1987).

Root, Fallon, & Friedrich (1986) have developed a framework for bulimic family typology, classifying these families as either perfect, overprotective, chaotic, or a combination thereof. The perfect family emphasizes appearance, loyalty, and achievement and

learns to smile even when in pain. The bulimia reflects an attempt to express and suppress feelings while maintaining the perfect veneer. The overprotective family is enmeshed and intrusive, with the good of the family and family loyalty taking precedence over individual desires and needs, leaving separateness difficult to achieve. Bulimic symptoms in this case function to establish boundaries and allow for passive rebellion. In the chaotic family, one learns not to talk, trust, or feel. Family members are unavailable to one another, inconsistent rules prevail, and victimization abounds. Bulimia serves to provide the individual with nurturance, also offering an outlet for pain and anger. As well, it recreates the powerlessness felt in the family, and expresses the family's unpredictability through being rigidly in control one minute and totally out of control the next.

Individuals with bulimia often display dysfunctional patterns of thinking and relating that can be traced to the family system in which the individual was raised (Roberto, 1986; Roth & Ross, 1988; Stierlin & Weber, 1989). Patterns of thinking are extreme and polarized, and basic assumptions become an internalized family code of behavior. These codes

and assumptions help organize the family and tend to be transmitted across generations (White, 1983). In bulimic families self-sacrifice, which often is the ultimate virtue, can result in a multigenerational failure to provide basic nurturance (Humphrey & Stern, 1988; Roberto, 1986). The daughter suffering with bulimia has inherited the legacy of mothering her mother, is left hungry emotionally, and binges to fill the feeling of deprivation and emptiness. This code of self-sacrifice also gets translated into self-worth being dependent on the love and approval of others (Neuman & Halvorson, 1983). A marked desire to keep impulses in control results, with hurtful, hostile, or offensive feelings and attitudes suppressed. Only a friendly, controlled outward appearance is presented, as these individuals further learn to deny, avoid, and displace dysphoric events to ensure approval and maintain family homeostasis (Johnson & Pure, 1986; Stierlin & Weber, 1989). The family emphasis on compliance contributes to an inability to assert oneself or deal with problems directly, which can result in the decision to binge and purge. This self-defeating behavior is ultimately tied to the roles, values, and beliefs that have crossed generations, and

when beliefs are rigid and implicit, the range of coping choices available to family members is severely restricted.

Several authors describe the existence of an idealized or false self (Browning, 1985; Friedrichs, 1988; Schwartz, 1987; Weinstein & Richman, 1984). This is a persona that is constructed and presented to the world to satisfy significant others. In order to assure themselves of love and nurturance, the individual with bulimia becomes what they believe their parents and others expect and need them to be. This leaves them forever in the position of receiving nourishment without being filled, as it is this false self that is nourished. Though there is a real risk of losing contact with the authentic self, it is difficult to let go of the false self without invoking the fear of abandonment. However, as the false self requires excellence in all areas of undertaking to maintain approval, the result is anxiety, fear, and self-deprecation, along with the need to channel further energy into hiding the real, unworthy self. It becomes risky to stay in touch with one´s own true feelings as their acknowledgement will further threaten the false self. These feelings are numbed through the bulimic

syndrome, leaving the individual at the mercy of the false self. Weinstein & Richman (1984) describe six themes that emerge in women with bulimia and relate to this false self. The first theme is an image of the real self being bad and ugly. The second is a strong need for approval, with the real self hidden in passivity and self-sacrifice out of fear of rejection. An inability to be a separate person is the third theme. These women become so successful at playing roles that they are unable to identify or acknowledge feelings, and will roleplay what they believe they are expected to feel. A fourth theme is the perceived high expectations on the part of parents. This translates into a goal to be a perfect daughter and peacemaker, attending to the needs and wishes of others in the family. This daughter excels at making others happy but cannot see herself as an independent entity. The fifth theme is the fear of rejection by men, with this woman remaining passive in relationships and becoming what the man in her life wants her to be. The sixth and final theme is a hidden desire to rebel, to lash out against the suffocating need to conform, with binging becoming a private rebellion.

As previously noted, a prominent factor in bulimia is the age of onset, an age where a transition to leaving home often begins, highlighting the significance of separation and individuation from the family of origin. The daughter has achieved her parents' approval through being good, compliant, and adapting to others' needs. She has come to feel responsible for her parents, so it is difficult to move toward independence without feeling guilty or fearful, not only of the loss of this relationship, but also of her own ability to survive (Friedrichs, 1988). She has become extremely skilled at responding to family problems, but at the same time finds herself increasingly awkward outside the home. Safety can be gained through dependence, which often means moving to a reliance on different powerful others. Unresolved separation issues will be displaced to and re-enacted in the context of the marital relationship, with the woman suffering from bulimia again submitting to the perceived needs of another -- her spouse (VandenBroucke & Vandereycken, 1988). Even when appearing independent on the outside, these women often are found to have strong emotional ties with their family of origin (Vandereycken, 1987). Prior to leaving home, attempts

at separating were often negatively connoted by the family. The developing separate self was largely ignored or criticized, except when it was enlisted to meet the parents' needs (Humphrey & Stern, 1988). For individuation to be embarked upon successfully, both the family system and the individual need to feel secure. Plagued with self-doubts, women with bulimia often lack the necessary coping skills to effectively deal with difficult life events (Lacey, Coker, & Birtchnell, 1986; VanBuren & Williamson, 1988). They report a weak sense of autonomy and self-sufficiency when apart from their family, and the resulting sense of ineffectiveness and insecurity can lead to difficulty separating and individuating (Ordman & Kirschenbaum, 1986).

Armstrong & Roth (1989) noted that individuals with bulimia not only have difficulty with separation, but also with attachment. Given this woman's experience of her family of origin as disorganized and conflict-ridden, and with parents unavailable to consistently meet her security needs, she learns to expect that others will be similarly unavailable when called upon for support. This, coupled with a basic sense of inadequacy and helplessness, results in an

anxious attachment to family in order to feel safe and secure. Binging, however, emerges as the most reliable and available method of self-nurturing and self-soothing. Feelings of ineffectiveness, difficulty identifying or articulating internal states, tension management problems, and nonassertive behavior and maturity fears all impede the individual's ability to successfully separate from her family of origin (Johnson & Flach, 1985).

Summary

A variety of theoretical factors have been proposed in the literature as important to the development of bulimia. The biological theories highlight a genetic, biochemical, and neuroendocrine influence, underlining a link to affective disorder. However, to conclude that the two have the same etiology is premature, as a co-occurence of a family history of depression and bulimia does not indicate a causal link. As well, the success with antidepressant therapy provides only indirect evidence at best, and new theories suggest that the drugs may act directly on the mechanisms that affect hunger and satiety,

specifically reducing the urge to binge, and thereby altering the negative mood associated with binge eating (Rossiter, Agras, Losch, & Telch, 1988). Most antidepressants also provide a subsidiary antianxiety action, leaving it possible that the improvements noted are due to these anxiety-reducing properties and have nothing to do with the amelioration of depression (Freeman & Munro, 1988; Levy, Dixon, & Stern, 1989; Mitchell, 1988). Reported abnormalities on biological tests have been inconsistent, with many individuals with bulimia responding comparably to normal controls, casting doubt on this as evidence of a similarity between bulimic and depressed patients (Hudson, Katz, et al, 1987). There is also growing evidence that in most individuals with bulimia any depression is a secondary phenomenon, and more likely related to the presence of abnormal eating.

Cognitive-behavioral theories suggest that bulimia is the combination of dysfunctional attitudes toward shape and weight and maladaptive coping strategies for mediating stress. They emphasize the importance of determining binge-purge behaviors as well as negative messages the individual indoctrinates herself with, in order to design a program that will bring about a

cognitive shift and behavioral change. Difficulties arise, however, when the afflicted individual is confronted with internal conflicts, environmental factors, and developmental events that may have lead to the original dieting in the first place, and which she had not been prepared for through a behavioral program. Still, normalizing chaotic eating can be an important first step to overcoming bulimia, as it can be very difficult to deal with underlying issues when feeling out of control. Further, the treatment strategies employing cognitive-behavioral methods have been showing some promise (Fairburn, 1988; Freeman, Sinclair, Turnball, & Annandale, 1985; Kirkley, Schneider, Agras, & Bachman, 1985; Mizes, 1985; Rossiter, Agras, Losch, & Telch, 1988).

The psychoanalytic-psychodynamic theories have emphasized fears, fantasies, and unconscious conflicts. They highlight on one hand a maternal deprivation and overidentification with femininity leading to a struggle with the internalized mother, and on the other hand a loss of the feminine due to attempts to identify with a male-dominated culture -- both outwardly expressed through bulimic symptomatology. Bruch (1986) has pointed out that the interpretations of traditional

psychotherapy represent for the woman with bulimia a painful reexperience of being told what she feels and thinks, and can interfere with the development of self-trust, autonomy, and self-directed identity. There is also a risk of reinforcing passivity through what could be perceived as blaming the victim.

Sociocultural theories underline society's glorification of thinness and dieting as instrumental in the development of bulimia. An entire industry has been born out of diet and fitness products, and the media continues to bombard us with the thin ideal. Women are suffering from role conflict and overload as they attempt to take on both the liberated and traditional roles. Feminist theories move this one step further as they underscore the social inequality of women in a patriarchal culture. They cite the importance instilled in women of physical attractiveness, the historical portrayal of women as objects of pleasure, and the centrality of her role as mother and nurturer as primary contributing factors to the selection of bulimia as a coping mechanism in a sexist world. While it is true that many women do experience a sense of powerlessness over their own destiny, and view their bodies as the one thing they do

have control over, only a small percentage of all women exposed to these cultural pressures develop bulimia. Questions then remain about what else might be contributing to the development of this disorder.

Family systems theories propose that bulimia is a reflection of family interactional patterns, and that changes in these patterns would result in changes in the symptom. Bulimia has variously been described as a metaphor of family process, and the family's style of relating, as well as the various roles it prescribes, has hampered the affected individual's ability to move toward independence. A question that arises is whether or not the disturbed family functioning might be a result of living with a family member struggling with this disorder, rather than family dysfunction being a preexisting condition. Much of the literature does tend to point, however, to entrenched styles of interaction that have even crossed generations. The bulimia, then, serves a purpose, and for a woman suffering from bulimia to gain this awareness allows her to begin to see herself in a more positive light and remove some of the self-imposed judgement levied against her behavior. She can then begin to examine what purpose the disorder is serving her now.

Chapter 3

The Importance of Family Factors

To emphasize family factors in the development of bulimia is to include, at least in part, all of the theoretical perspectives outlined in the previous chapter. The clustering of affective and eating disorders that has been noted in families may reflect a particular interactional style that sets the stage for choosing a passive, self-sacrificing symptom in an attempt to cope with stressful living and relating. Affective disorder, like bulimia, can be an indication of poor self-regulation of tension and negative mood states. The family belief system often reflects cognitive distortions that encourage maladaptive coping behaviours, both of which are further reinforced in relation to family and others. Thinking styles are translated into rules which families transmit, helping to enforce conformity and family loyalty. The psychodynamic search for an orally-approving maternal object or an idealized father has its roots in the early family environment, with both the child and the parents colluding to ensure good and compliant behavior, leaving the launching adolescent ill-equipped

to deal with stressful events and emotions. Finally, the family is the primary agent of socialization, and will convey to its members whatever society is offering in the way of values, expectations, models, and contradictions. Women continue to run the risk of being prepared for a life of inequality, a life of pleasing and nurturing others at the expense of herself. Therefore, a focus on family environment embraces an interdependence of factors contributing to the development of bulimia. Just as there are a variety of family interactional styles and experiences, individual effectiveness in making the transition to independent adulthood will also vary. This might then explain why only a portion of women develop bulimia rather than the masses -- pointing once again to the significance of family of origin.

Family of Origin Theory and Therapy

The development of a theory of family of origin has largely been attributed to Dr. Murray Bowen. In working with schizophrenic families in the 1950's, Bowen was struck by the family's interdependence and emotional intensity where feelings would overwhelm

thinking, and began to conceptualize the family as an emotional unit (Bowen, 1978; Kerr & Bowen, 1988). After directing his research away from schizophrenia to families with and without clinical problems, he discovered the same mechanisms at work in all families, though to a lesser degree and with less emotional impairment (Bowen, 1978; Nichols, 1984). The following is a review of the basic principles of Bowen's theory, which is comprised of six major interlocking concepts.

i) Differentiation of Self

Differentiation refers to both an independence of self from others and a psychological separation of intellect and emotion, and marks the cornerstone of Bowen's theory. The concept defines people on a continuum based on the degree of fusion between emotional and intellectual functioning. At the low extreme are those whose emotions and intellect are so fused that their lives are totally dominated by feelings, are relationship oriented, emotionally dependent on others, inflexible, and easily stressed into dysfunction. On the high extreme are individuals with greater distinction between emotion and intellect, more independent of the emotionality around them, more flexible and adaptable, cope better with life stresses,

are able to follow independent life goals, and have more orderly and successful lives (Bowen, 1978; Guerin, 1976). This purely theoretical scale represents a continuum of adaptive functioning and describes a variation that exists among individuals. People differ in the amount of emotional separation they achieve from their families of origin, which is influenced by the degree to which an individual's parents have achieved emotional separation from their own families, as well as the emotional character of the relationship between an individual and his or her parents (Kerr & Bowen, 1988).

ii) The Undifferentiated Family Ego Mass (Nuclear Family Emotional System)

This concept refers to an emotional oneness within the family, with lack of differentiation and a blurring of boundaries. There is an intense and clinging interdependence, in which individual identities get lost in the family togetherness. Family members become so dependent on one another that it is risky to define a distinct self (Guerin, 1976; Nichols, 1984). The mechanisms most often employed to deal with this fusion are emotional distance and symptom development, usually impairing a spouse or a child (Bowen, 1978).

iii) Family Projection Process

This is a process in which the undifferentiation impairs one or more children in the family. The child involved in the process is usually one emotionally special to the mother, who gets caught up in the parents' marital conflict and its cycle of distance and closeness. The child becomes anxiously attached to the parents, which further hampers the differentiation process (Kerr & Bowen, 1988; Nichols, 1984). This child may eventually develop symptoms, creating further parental concerns and solidifying a family pattern.

iv) Multigenerational Transmission Process

This concept suggests that the family projection process will continue, with trends in functioning developing over a number of generations. The process is anchored in the family emotional system, which includes emotions and feelings, as well as attitudes, values, and beliefs that are transmitted from one generation to the next. How emotional patterns are played out in one generation can have fairly predictable consequences for the next generation (Kerr & Bowen, 1988). As in the case with individual functioning, however, family units in the same multigenerational family will exist on a continuum

between the extremes of stable and unstable functioning.

v) Sibling Position

Bowen found theories on sibling position -- ie, the belief that specific, predictable personality characteristics are related to a child's position in the family -- applicable to his own theory. He noted that extreme deviations from this theory indicated some degree of family fusion and dysfunction, and pointed to the child who was the object of the projection process (Bowen, 1978).

vi) The Triangle

A triangle refers to the way any three people relate to each other, involve others in the emotional issues between them, and manage the intensity of emotional attachments. Formation of a triangle is the stabilizer in an emotional system (Bowen, 1978). A two person relationship has low tolerance for anxiety, and at a certain intensity, will predictably and automatically involve a vulnerable third person in the emotional issues. The level of anxiety will then become diluted as it shifts back and forth among the three interdependent relationships. Though the triangle provides stability, it is dysfunctional as it

prevents resolution of the issues and can eventually result in impairment and symptom formation. Minuchin (1974) and Haley (1976) also theorized about triangles, with Minuchin noting a rigid triad forming when parents used a child to deflect spousal conflicts, and Haley underscoring the triangles that result from cross-generational coalitions, adding that a symptomatic child is usually holding a problem marriage together.

The triangle helps to illustrate the interlocking nature of these six concepts. A child is caught up in the projection process by being triangled into parental conflict, and often will deviate from the characteristics typical of his or her sibling position. As a result, a normal process of differentiation of self is inhibited. Less well-differentiated persons are more subject to the emotional climate of the family system, (this undifferentiated family ego mass), and are, therefore, more likely to be triangled in. These children as adults often continue to mediate the relationship between their own parents, establishing interlocking triangles that cross generations and comprise one of the key ways that patterns of relating and functioning are transmitted in a family, the

multigenerational transmission process (Bowen, 1978; Nichols, 1984).

According to Bowen, the triangle also becomes the prime point of intervention in family of origin therapy. Resolving triangles leads to a greater differentiation of self, which is the overall goal of this therapy. Detriangulation occurs through learning to relate to others by responding, not reacting, and through developing person-to-person relationships (Bowen, 1978). In families, even a very minor stimuli will trigger an intense emotional reaction. If an individual can become aware of the part the self plays in this automatic emotional reactiveness, he or she can begin to respond in a new way and avoid participating in triangular moves. Increasing cognitive processes over emotional ones, choosing to respond rather than automatically reacting, understanding relationship dynamics and practicing through roleplay can all be facilitated through therapy. If successful, the well-established chain reaction is interrupted, and the family is forced to relate in a different, and usually more functional, way (Bowen, 1972). As differentiation increases, individuality is better developed, togetherness needs are less intense, and emotional

reactiveness is better modulated. If thinking and emotion can become less contingent on others, a greater capacity to be a separate individual is permitted. The more the members of a relationship system can be in contact with one another yet remain emotionally autonomous, the less likely someone in the system will experience impaired functioning and symptom development (Kerr & Bowen, 1988).

Bulimia as an Expression of Undifferentiation

Bulimic families have been described in the literature as chaotic, conflictual, disorganized, and emotionally unstable. The daughter who develops bulimia often acts as mediator between conflictual parents, which both reflects and further perpetuates a blurring of boundaries and an emotional interdependence. The family system thus described resembles Bowen's undifferentiated family ego mass, and the affected daughter the triangled object of the family projection process. The inability to separate emotion and intellect cited by Bowen as a hallmark of undifferentiation is suggested in bulimic families through the descriptions in the literature of their

characteristic patterns of thinking and relating, such as employing loyalty tugs to encourage self-sacrifice. Undifferentiation is also expressed through thinking and emotional functioning being contingent on others, which can lead to a reliance on the false self, a fairly common experience for women with bulimia.

As lack of differentiation hampers both the development of a separate identity and individuation from the family of origin, this might explain the development of symptoms and the impairment of functioning at a time when the individual is called upon to navigate the transition into independent adulthood. Bulimia itself can be conceptualized as the third leg of a triangle, pulled in to help reduce the anxiety and emotionality experienced in relating to significant others, yet preventing the resolution of the more salient issues. If bulimia, then, is an expression of lack of differentiation in and from the family of origin, a valid therapeutic choice in the treatment of this disorder may be family of origin therapy. Prior to embarking on a course of therapy, however, it becomes important to determine if the markers of undifferentiation are significant in the family of origin of individuals with bulimia. Chapter

four provides a description of the investigation embarked on to explore for these family of origin conditions.

Chapter 4

Method

Subjects

Subjects for this study were recruited via referral from mental health professionals in the south central region of Manitoba, (specifically psychiatrists, social workers, and community mental health workers). The study was restricted to adult women, 18 years of age and over, and inclusion required that subjects currently (or at the time of first seeking treatment) meet the diagnostic criteria for bulimia outlined in the DSM-III (R) (APA, 1987): recurrent episodes of binge eating, feeling of a lack of control over eating behavior during a binge, minimum average of two binge eating episodes a week (for at least six months), regular engagement in purging behavior to prevent weight gain, and persistent overconcern with body shape and weight. Though prior or active treatment for bulimic symptoms was not a requirement for inclusion in the study, all subjects have received some form of treatment for bulimia and/or

depression, six subjects continue to receive treatment, and all had access to a therapist for debriefing (if desired) following the interviews. Subjects successfully overcoming bulimic symptoms as a result of treatment were required to have experienced the full-blown bulimic syndrome as described in DSM III (R) within the past five years.

Instrument and Rationale

Each subject participated in an in-depth, unstructured interview. This form of qualitative research has been described by Lofland & Lofland (1984) as a guided conversation aiming to elicit details of the interviewee's experience of a particular topic or situation. Every individual (bulimic or otherwise) attaches meaning to their own experience, creating their own personal reality, which is subsequently applied toward their own and other's actions. Moon, Dillon, & Sprenkle (1990) describe qualitative research as an attempt to understand the meaning of events, actions, and interactions from the point of view of the participants involved. The qualitative researcher looks for universal principles by examining a small

number of cases intensively. If one of the purposes of qualitative research is to describe social reality and discover facts which will aid in the formulation of hypotheses, the in-depth interview of bulimic subjects provides an opportunity to discover the picture this individual carries of herself, as well as factors from her family of origin picture which may have contributed to the development of her bulimia. Cole (1976) has stated that social research tries to specify what social conditions influence the development of a particular psychological state or behavior. The in-depth, unstructured interview of the bulimic subject attempts to identify conditions in the family of origin that may have influenced the development of her present psychological makeup and bulimic behavior. Through the intensive examination of a small number of cases and an attempt to understand the meaning the individual with bulimia attributes to her family experience, her picture of self, and her symptom, it is possible that some universal conditions will emerge that have potential applicability to all individuals suffering from bulimia. Hypotheses can then be formulated, both in regard to the development and treatment of bulimia, including whether or not family of origin therapy could

have potential status in the treatment armamentum for bulimia. It is recognized however, that it is a tenuous assumption that information obtained in a small, deliberate sample can be generalized to those who have not been interviewed. It is further recognized that self-report data is subject to error as reality may be distorted, memory may be vague, and omissions or embellishments may occur in effort to please or impress the interviewer, plus there is the ever-present risk of researcher bias. Still, with the best interest and the successful treatment of the client with bulimia as its impetus, this qualitative study attempted to make "the familiar strange" (Moon et al, 1990), approaching the data collected without letting specific assumptions get in the way, and attempting to see events in a new way before interpreting what was seen. The aim of analyzing the data was to describe the social reality of the afflicted client in effort to formulate hypotheses regarding development and treatment of bulimia. The client's reality then, whether distorted or not, gives meaning to her experience, helping to define who she is as an individual and in her relationships with others. The goal of the analysis was not to support a

hypothesis but to generate details and discover theory. However, in collecting and analyzing data, details and incidents would emerge to either confirm or disconfirm assertions about the influence of family of origin on bulimia, and illuminate possible paths for treatment and further research.

Design

A restriction of six subjects minimum and ten subjects maximum, each fulfilling the diagnostic criteria for bulimia previously outlined, was established at the outset to allow for some variation in the bulimic picture to emerge without the study becoming too unwieldy. This in-depth interview was a one-time event for each subject and took approximately 90 to 120 minutes to complete. An interview guide was followed so that each subject received as similar an interview experience as possible, yet allowed for the detail and character of each subject's account in her own terms to emerge. The interview guide also provided focus for data collection and subsequent analysis, but flexibility was anticipated and questions would change at times during the course of the study. The guide

contained a list of topics to cover, plus specific reminders for the interviewer to probe for in an open-ended and exploratory fashion. It became a vehicle for engaging the subject in conversation, rather than a list of specific questions to be asked by the interviewer verbatim. The guide began with a facesheet to allow for the securing of factual data, (such as name, age, ethnicity, religion, education, occupation, date and place of interview, and so on). It also included a post-interview comment sheet (Lofland & Lofland, 1984) which allowed for the recording of insights and reflections, feelings during and about the interview experience, any difficulties experienced, emotional tone, etc. (A complete copy of the interview guide can be found in Appendix B).

The topics covered during the interview (and outlined in the guide) were based on the following four sources:

1. The Family Assessment Measure (FAM), (Skinner, Steinhauer, & Santa-Barbara, 1983). This is a self-report instrument designed to provide quantitative indices of family strengths and weaknesses. It is divided into scales devised to assess different aspects of family functioning. The FAM interpretation guide,

which highlights seven categories for family assessment on a continuum between functional (strengths) and dysfunctional (weaknesses), provides useful family system markers to probe for, helpful in this study given the focus on the subject's family of origin.

2. Beavers Interactional Scales: Family Competence and Family Style, (Beavers & Hampson, 1990). These scales are also designed to assess family competence vs. dysfunction, and again provide categories and specific markers to consider in assessing the subject's family. Together, the two constructs, (competence and style), produce a "conceptual map of family functioning" (p. 46) useful for locating family system characteristics associated with individual psychological and behavioral functioning (Beavers & Hampson, 1990).

3. Bowen theory. Bowen & Kerr (1988) propose a systematic process of evaluating a family based on Bowen's family systems theory, which asserts that families exist on a continuum based on their autonomy (or lack thereof) in emotional functioning. The theory also links clinical symptoms to the emotional system, with symptom development rooted in undifferentiated aspects of human functioning. The interlocking

concepts in Bowen theory provide parameters around which an investigation of the family of origin can follow.

4. Literature review. Several family factors common to the bulimic individual were illuminated as a result of the literature review. These also served as markers during the family of origin assessment.

The categories and components highlighted in the above four sources were incorporated to form the basic structure of the interview guide. The guide is grouped into six broad themes:

1. Communication. Of interest is whether or not communication was direct and clear, whether sharing of information was encouraged or discouraged, whether or not messages were openly received, and how members responded to passive, assertive, or aggressive behaviors.

2. Affect. Emphasis is on the range of emotions expressed, whether or not the expression of feelings was encouraged and attended to, how family members managed tension and conflict, and how the intensity of expressed affect impacted on the family system.

3. Control. The family's leadership style is of significance here, including its effectiveness, its

ability to adapt to change and explore alternatives, whether or not power struggles existed, and if so, were they overt or covert.

4. Values. Of note is whether or not the family rules were clear, consistent, and made sense; whether values declared were congruent with those displayed, what role food and dieting played in the family, and whether or not the social emphasis on achievement, appearance, and the feminine ideal were also conveyed in the family.

5. Boundaries. Of concern is whether or not the interpersonal and generational boundaries were distinct and well-established, what patterns existed if boundaries were not clear, were parents perceived as accessible or inaccessible, and to what degree did emotional reactivity exist in the family.

6. Differentiation. The ability to be a separate person and to function autonomously is considered here. Also of interest is the degree to which the family promoted autonomy, whether family loyalty was emphasized over individual identity, and whether or not self has been sacrificed for the sake of others.

The details elicited in the interview became the data to be analyzed. In examining the individual and her family of origin, these six broad themes allowed for the elucidation of the degree of passivity and conformity, emotional reactiveness, boundary deficiencies and/or violations, loyalty tugs, inconsistent rules or unpredictability, desire for approval, fear of rejection, feelings of insecurity and ineffectiveness, and difficulty setting limits. Each of these are also expressions of undifferentiated aspects of the family's functioning and all can lead to difficulties with successful individuation from the family of origin.

Procedure

Participants in the study were referred by their psychiatrist, social worker, or community mental health worker subsequent to permission having first been gained in a confidential discussion with their worker about the nature and purpose of the proposed study. (Each mental health professional sought out as a referral source had been verbally informed of the proposed study, its nature, purpose, and focus, and the

client criteria for the proposed interview.) Each referral was then sent an introductory letter (Appendix C) outlining again the purpose of the study and focus of the interview, probable length of time required, how she came to be selected, promise of confidentiality and anonymity, participant right to discontinue participation without penalty, and intent to follow with a phonecall arranging the date, time, and place of the interview. Once the interviews were arranged, the above was again reviewed at the beginning of the actual interview, with greater detail provided as necessary, and a re-emphasis on responses being treated in strictest confidence and participants remaining anonymous in any written report. Permission was then sought from each participant to record the interview, explaining the purpose of such a procedure and obtaining their signature on a release (Appendix D). Participants were unanimous in their consent to have the interview tape recorded. It was also clarified that there are no right or wrong answers -- the purpose of the interview being to gain the perspectives, opinions, and personal experiences of each individual participant. Each participant was also advised that if they desired, a summary of the results would be

forwarded to them at the completion of the study, and finally, a reminder was again given that they had a right to discontinue participation at any time during the interview without penalty.

Demographic information was obtained from each participant as indicated on the face sheet, and factual data in relation to the eating disorder was gathered, including age of onset, number of binge/purge episodes per week, body image perception, and methods of purging, to name a few (see Appendix B). This was followed by the construction of the participant's family genogram, (see sample, Figure 1), which became an ongoing exercise, with additional relevant family information appended as the interview progressed through the various themes. All participants found the visual impact of their family genogram quite interesting, and commented that it often served to trigger additional family factors and memories. The themes were covered in each interview in the order that they appear in the interview guide: communication, affect, control, values, boundaries, and differentiation. The guiding questions as outlined served only as reminders to the investigator of the areas to be explored. Questions ultimately asked,

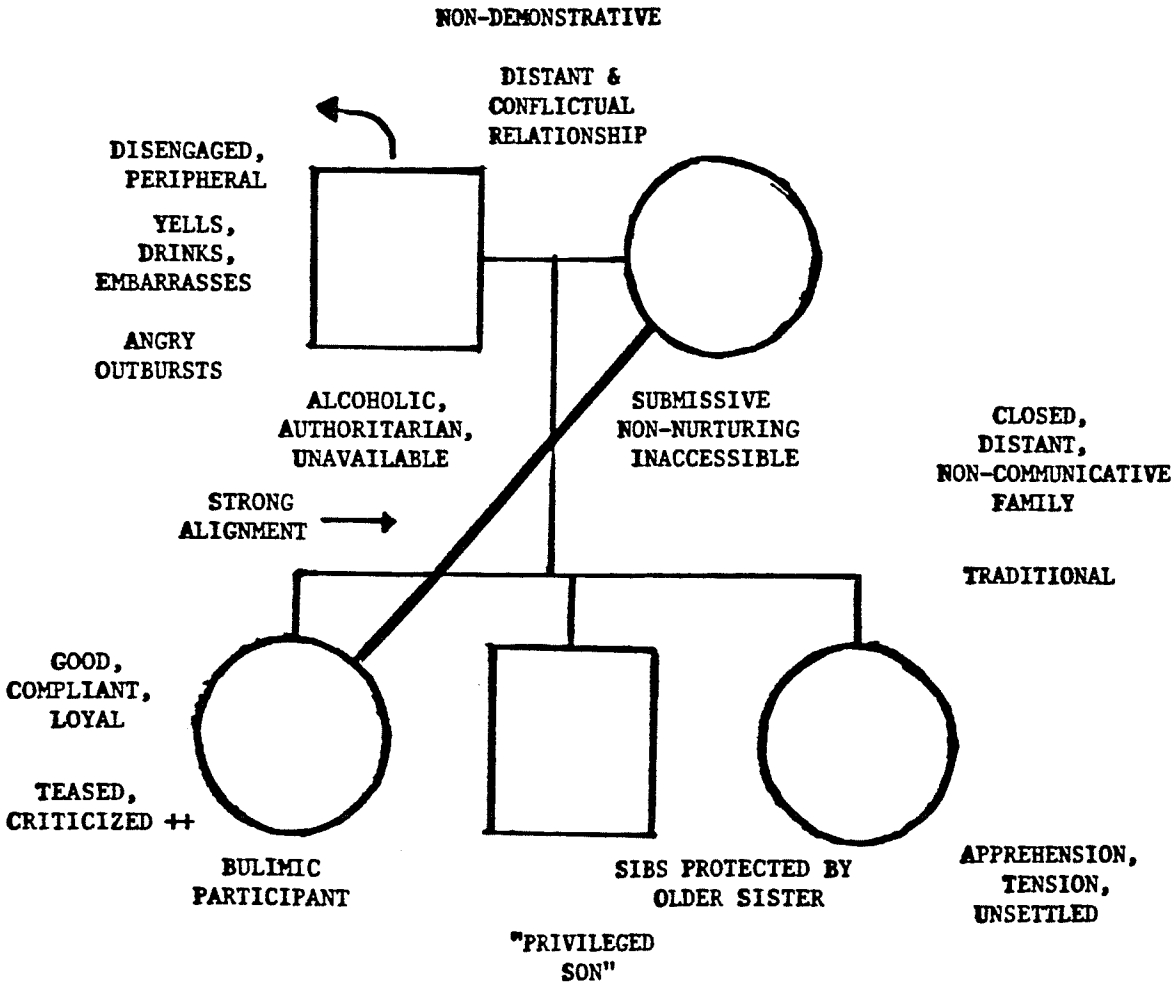

Figure 1: A Sample Genogram

though similar, were more simple and straight-forward, matched as much as possible to the participant's level of understanding, and always open-ended and exploratory in construction. Participant's answers would also form the basis of subsequent questions. Interviewer responses were aimed at facilitating an atmosphere of openness and trust, and reflecting acceptance of and sensitivity toward the participant's experience and perceptions. Each interview required at least 90 minutes to complete (with none requiring more than 120 minutes), which comfortably allowed the participant's to respond as extensively or as minimally as desired. There were no difficulties encountered during any of the interviews.

The interview time and location was selected in accordance with both participant convenience and the assurance of privacy. Locations varied from the interviewer's office to the participant's living room, and time of day also varied from morning to evening depending on the participant's schedule and availability. The initial telephone contact served to establish the beginning of rapport and relationship development, which carried over and was further established during the actual interview. Each of the

participants appeared relaxed throughout the interview, expressed appreciation for research interest in bulimia and their own particular struggle, and were eager to share their experience and "help in any way" in the search for an effective treatment for this disorder.

The post-interview comment sheet was completed immediately following or as soon as possible after the conclusion of each interview. This became the ongoing record of the investigator's subjective reactions, impressions, observations, and thoughts in relation to the interview process and to each participant. Following the completion of the scheduled interviews, each taped interview was transcribed in part in order to preserve the descriptive detail provided, but any identifying information was deleted. Participants were randomly assigned a letter code to protect anonymity, and all taped material was erased within six weeks of the appointed interview. The partial transcripts, along with the demographic information, factual data related to the bulimia experience, family genogram, and the post-interview comment sheet comprised the body of data analyzed. The following chapter offers a presentation of these findings.

Chapter 5

Presentation of the Interview Findings

Ten women were referred as potential candidates for the interview. Through telephone follow-up to arrange interview times and locations, nine women agreed to be interviewed and appointments were coordinated. Subsequent to this, one woman exercised her right to withdraw from the study, with the remaining eight women participating as pre-arranged. This chapter presents the data collected during the interviews, organized according to demographics, a summary of participants' family history and picture of self, the six interview themes, participants' own understanding of their disorder, and the interview process.

Demographics

The eight women interviewed ranged in age from 25 through 70, with a mean age of 43 years. Three of the women were raised in urban centres, with the remaining five raised in rural areas. Three ethnic backgrounds were represented -- English/British, German, and

Mennonite -- and all but one of the participants declared a religion. Level of education ranged from Grade 8 through doctoral training, with a Grade 12 education representing the mean. Seven of the eight participants were married and employed with the eighth -- the eldest -- both retired and a widow. There was a variation in sibling position, with two eldest children represented, two youngest, two second eldest, one second youngest, two only daughters, and one only child. Only two of the eight women declared a history free of abuse, with the remaining six describing emotional, physical, and/or sexual abuse in their history, either alone or in some combination.

Age of onset of the bulimia syndrome ranged from 16 through 33 years, with a mean age of 22.5 years. Three of the women declaring an age of onset of 24 years or over recalled struggling with binge eating, restrictive dieting, and an overconern with weight and appearance at an earlier age, (ie: late teens and early twenties), but did not perceive the disorder as full-blown until later in their history. However, factoring in these earlier ages results in a mean age of onset of 19.5 years. One of the eight women had also been diagnosed as suffering from anorexia nervosa prior to

her diagnosis of bulimia, experiencing a weight loss of over 25% of her body weight. It was during her hospitalization for treatment of anorexia nervosa that she "began to learn the bulimia game", eating to please her caregivers and purging to control her weight.

Duration of the disorder spans six to thirty-seven years, with a mean duration of 18.5 years. All of the women have been in treatment for bulimia and/or depression, with four of the women currently in individual therapy, one in group therapy, and the remaining three no longer in active therapy but continue to perceive themselves as connected to a therapist. Four of the eight women are receiving antidepressant medication, with one receiving the medication for depression, and the three remaining to specifically target the bulimia syndrome. Binge frequency ranged from one through 15 episodes per day, with a mean of 4.4 episodes. Methods of purging varied, with 63% of the women engaging in vomiting, 75% using laxatives, 50% using diuretics, 75% using appetite suppressants, 50% using liquid formula diets, 50% fasting, 63% engaging in daily and excessive exercise, and 88% following a severely restricted diet. Of the women who use vomiting as a method of purging,

daily episodes ranged from 1 to 10, with 3.5 episodes representing the mean. All of the women declare themselves as heavier than their ideal weight, all are afraid of becoming fat, and none of the women are satisfied with their body weight and shape. Table 1 depicts a comparison of demographics, and Figure 2 represents the composite participant in this study.

Participant Family History and Self Concept

The following summarizes the salient features of each of the participant's family of origin experience as well as the picture they carry of themselves.

(i) Participant 010: Family of Origin. The participant is the second eldest of four siblings and only daughter. Her father was an alcoholic, her mother described as "exercise obsessed", two of her brothers are now alcoholic, and the remaining brother a drug addict. At age six she was sexually molested on three occasions by someone outside the family, yet kept the secret having already learned to "keep things to herself". Mother and Father had a "distant relationship" with "not a lot of love between them." Mother was described as "a very beautiful woman that

Table 1: A Comparison of Demographics

Participant	010	020	030	040	050	060	070	080
AGE	49	25	48	41	35	37	70	39
MARITAL STATUS	M	M	M	M	M	M	W	M
ETHNIC BACKGROUND	German	Mennonite	British	English	English	English	Mennonite	English
SIBLING POSITION	2nd born, only daughter	Youngest	Eldest, only daughter	2nd eldest	Only child	Eldest	2nd youngest	Youngest
EDUCATION	Gr. 11	Community College	Doctorate	Gr. 12	Bachelor's Degree	Gr. 12	Gr. 8	Gr. 12
DECLARES A RELIGION	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
EMPLOYED?	Yes	Yes	Yes	Yes	Yes	Yes	Retired	Yes
HISTORY OF ABUSE?	Emotional, sexual	No	No	Physical, emotional	Emotional	Emotional	Emotional, sexual	Emotional, sexual
BULIMIA: AGE OF ONSET	20	19	16	27 (18)	19	24 (18)	33 (24)	22
DURATION	25 full-blown Varies last 4	6 yrs	22 full-blown Varies 5-10	14 yrs	16 yrs	13 yrs	37 yrs	17 yrs
PRESENTLY IN TREATMENT?	Yes	Yes	Support Group	Yes	No	No	Yes	No
MEDICATION?	Prozac	Desipramine, Clonazepam	Not at present	Sinequan, Trilafon, Lithium	Not at present	No	Prozac	Not at present
FREQUENCY OF BINGES	10-15/day	5-6/day	8/day	Continuous thru evening	2/day	1-2/day	1-2/day	2-4/day

Table 1: con'd

Participant	010	020	030	040	050	060	070	080
PURGE METHOD: VOMITING	10/day	5-6/day	8/day	No	No	No	1-2/day	2-4/day
LAXATIVES	Yes	Yes	No	No	Yes	Yes	Yes	Yes
DIURETICS	Yes	Yes	No	No	No	No	Yes	Yes
APPETITE SUPPRESSANTS	Yes	Yes	Yes	Yes	Yes	No	No	Yes
LIQUID DIETS	Yes	No	No	Yes	Yes	No	Occ'l	No
FASTING	Yes	Yes	No	No	Yes	No	Occ'l	No
EXERCISE	Daily & excessive	4-5 hr/day	Daily & excessive	Daily & excessive	Sporadic excessive	1 hour/day	Daily	Sporadic excessive
RESTRICTIVE DIETING	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
HEIGHT	5'6"	5'8"	5'3"	5'7"	5'3"	5'6"	5'5"	5'2"
PRESENT WEIGHT	145 lbs	123 lbs	125 lbs	161 lbs	112 lbs	132 lbs	145 lbs	130 lbs
IDEAL WEIGHT	125 lbs	115 lbs	115 lbs	135 lbs	105 lbs	125 lbs	130 lbs	115 lbs
SATISFIED W. WEIGHT/SHAPE	No	No	At times	No	No	No	No	No
FEAR OF BECOMING FAT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

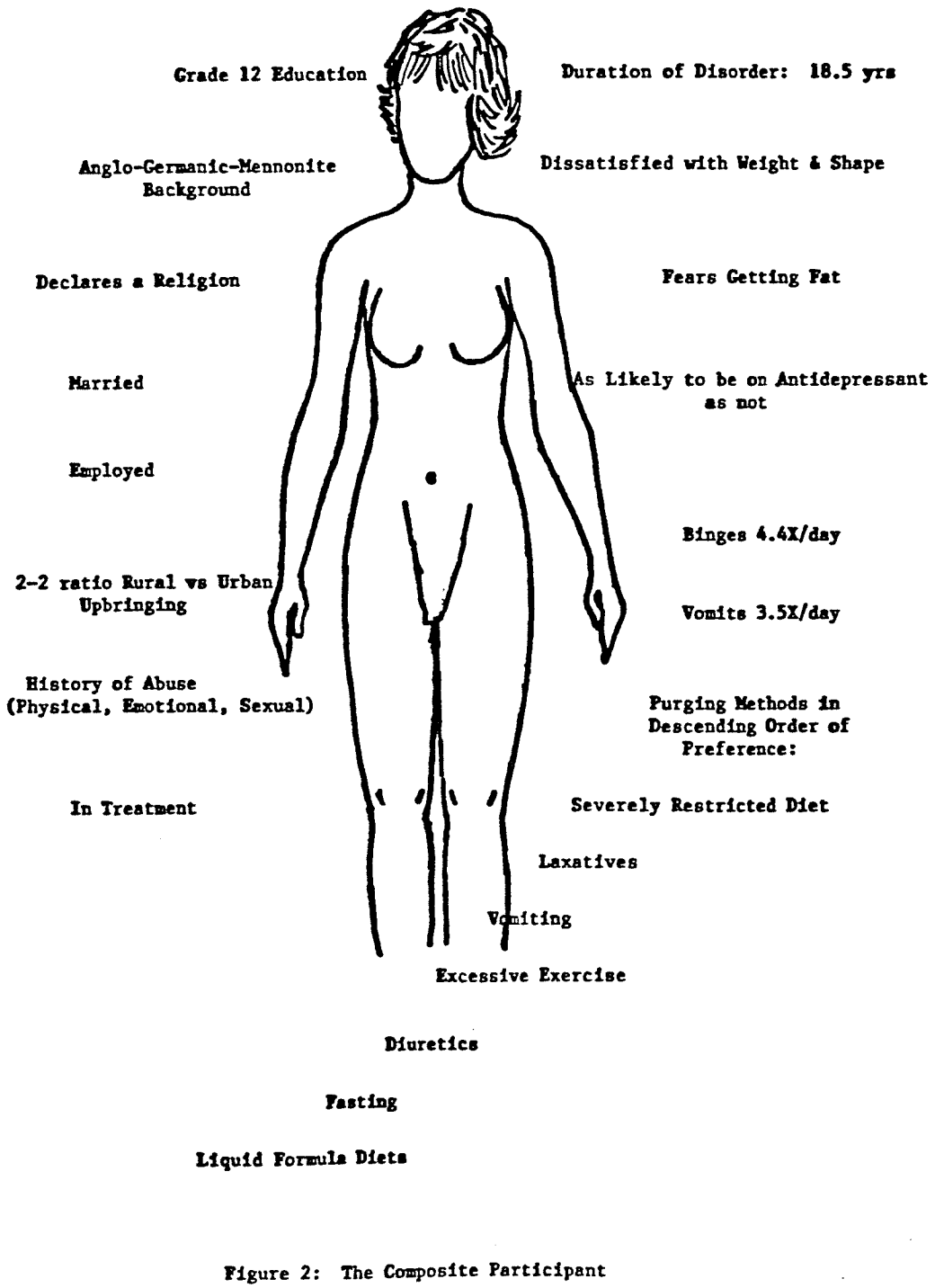

Figure 2: The Composite Participant

Father married for "an ornament". This participant was often concerned about her parents' marriage breaking down, particularly when her father was drinking. Mother and Father would often engage in loud arguments, yet Mother was

> .... totally dominated by Dad. She never learned to drive, never learned to write a cheque, didn't shop for groceries, and never had money of her own. All she did for years was knit ....

Father was described as "authoritative and controlling", whose "word was law." The children learned not to ask questions, not to express their feelings and opinions, and to keep their distance from Dad, especially when he had been drinking. As the only daughter, the participant was expected to do a lot of household tasks, meal preparation, and childcare duties, but "nothing was ever good enough by Mother's standards." There were no demonstrations of affection in the family, and the participant recalled

> .... I was never ever hugged by my parents. I don't think there was ever an occasion when

> my father even touched me. I couldn't get him to notice me no matter how hard I tried....

A lot of importance was placed on appearance and achievement in this family. The participant was always bigger than her brothers and physically developed at an early age, menstruating by age ten. The outcome for her was enduring a lot of verbal and emotional abuse by her family.

> My mother and brothers called me names and teased me about being big and fat. At my mother's insistence, our family doctor started me on diet pills when I was only ten years old, in the fifth grade.

She excelled academically and musically, and was considered a very good pianist and singer. When an opportunity arose to pursue her musical talents out of province, her father intervened, forbidding it,

> .... as it would be a waste of money. He figured girls didn't need an education

> anyway, and I was destined to marry and have kids....

She described herself as becoming "rebellious" in her teens, engaging in forbidden behaviors (such as drinking, smoking, and dating) behind her parents' backs. Her last year in school (grade 11) saw a falling of her grades, and she finally left home at age 16.

Self Concept. This participant recalled feeling "empty, unimportant, and unloved" while growing up. She remembers having no one to confide in and kept everything to herself.

> I though I wasn't good enough, that I didn't measure up. I tried to be the good little girl to get attention, but nothing ever seemed good enough....and where my mother was concerned, there was always something bad about everything.

She recalled being shy and not having a lot of girlfriends while growing up. At age 13, after a

particularly difficult period of feeling scapegoated by her peers, she attempted suicide.

Even as an adult, this participant often feels like an outsider. She continues to keep things to herself, commenting that she "is being eaten up inside." She described herself as

> .... too sensitive and a perfectionist. I feel like I've failed in many areas and I blame myself....carry a lot of guilt inside. I take things too seriously and I can't stand rejection. I want to be liked by everyone, and I live for other's approval....and just like my mother, I've allowed my husband to dominate me....

(ii) Participant 020: Family of Origin. This participant is the youngest of eight siblings, the eldest six being her half-siblings. She is her biological mother's youngest child and only daughter. Her father and two half-siblings have suffered from clinical depression, and the daughter of one of her half-sisters has been diagnosed with anorexia nervosa. Her father is described as "controlling and

authoritarian", and her mother as "silent and submissive." Father was prone to temper outbursts, and would "fly into a rage if disobeyed." Mother was "physically weak" and powerless with Father.

> She wasn't a strong woman....Dad overwhelmed her and didn't allow her an opinion....It was hard for her to take on his children. No one ever took her seriously.

The participant felt tugged to protect her mother.

> There was a bond between us, and Mom confided in me a lot....I was a model child, a good little girl, for Mom's sake....My goal in life was to not hurt my mother....I would do anything to make her hurts go away....I felt that I had to take care of her.

Though she felt close to her mother, her father and siblings did not display any outward signs of affection. The family learned to "tiptoe around Father" and do things "behind his back". Except in relation to her mother, she didn't feel a part of her family, and family members "never knew I was around".

> Everyone worked hard to avoid tension, except for my father. I learned to swallow my problems and not talk about them.

She recalls her father not wanting her to grow up, and not allowing her to be a teenager.

> Dad saw me as weak like my mother. He believed my faith wasn't strong enough, and that I needed direction....He had plans for me, and even told me who I should marry....Since we were a family mainly of girls, getting married and raising a family was what was stressed....it wasn't important if we got an education....I never even tried to do the things that teenagers do....I didn't ever want to do things behind my parents' back, as I was afraid I would hurt my mother.

She excelled in school, both academically and musically. Though achievement was not considered important in the family, the participant had her own desire to achieve from a deep sense of "never having been good at anything". Following high school, the

participant remained at home while many of her friends were getting married, leaving her feeling alone and lonely. It was at this time she began to diet restrictively.

> I was pleased with the measure of control I had over myself. It was the only thing I did have control over. My whole life had been mapped out before me....and the skinnier I got, the better I felt.

The eventual outcome was hospitalization and a diagnosis of anorexia nervosa. One of the requirements of her discharge contract was to live independent of her family, something she did not feel prepared to do. Along with her "new and private battle with bulimia", she entered a "rebellious period", culminating with "being disowned" by her father.

Self Concept. This participant recalled feeling lonely and unnoticed growing up, and had a sense of not being heard by her family. She felt her half-siblings resented her and the relationship she had with her mother. She described herself as quiet and shy, somewhat isolated and not very outgoing. She

believes herself to be easy-going, concerned about others, and works at turning her anger inward, or doing nothing with it at all.

> I´m like my mother. I´m quiet, and I don´t show any anger....I´m a compulsive worrier....often there´s an inner turmoil, but I present otherwise to the world.

She further describes herself as achievement-oriented and a perfectionist.

> I will persevere to do well and achieve, no matter what the cost. In fact, I guess you could say I´ve overdosed on it.

She recounts a pervasive guilt feeling in regard to her various relationships. Though as an adult, her independence and "having a place" is important, she describes still feeling controlled by her father, and fears confronting him.

iii) Participant 030: Family of Origin. This participant is the eldest of three siblings and the only daughter. She recalled herself and her brothers "learning to be passive" as the result of relating to

their domineering father. Though Father was the authority figure and the children knew not to cross him or go against him, she recalls having a lot of respect for him.

> In fact I think I had my father on a pedestal....he didn't show any affection, and for the most part he was unavailable because he was away so much, but I always knew he loved me.

Her mother and father had a distant and often conflictual relationship, arguing and yelling at one another. Mother was described as an angry and frustrated woman, unhappy in her role as housewife, and often a single parent with Father being away a lot of the time.

> Mother would scream when she was upset....I remember being upset myself and frightened by her anger....I would talk back at these times, maybe to distract her....but I was always obedient with my father.

Both achievement and appearance were emphasized in the family. Higher education was stressed, and a lot of attention was paid to body weight and shape.

> My mother was one of three daughters and a good figure was always important....Eating proper foods was also stressed, but I didn't like mealtime....Mother was often irritable at mealtime....she took her anger out in the kitchen....she was very disorganized and would throw things.

The participant recalled that after being alone so much, her mother would be irritable whenever Father was around, and Father, angered by her irritability, would sometimes drink. For the most part, the participant's father was emotionally unavailable to both his wife and his children. She recalls being called upon by her mother for emotional support and would often take on other aspects of her mother's role as a way of helping -- the result being that her own needs went unmet.

> I learned to be pleasing, giving, nice...I liked to wait on my Dad and my brothers....I learned to be quiet, and I didn't get

> angry....well, at least I didn't show my anger....with all the anger around me I learned not to be angry....I was really a good kid....I wanted to do well....

She excelled academically, and left home following high school to attend university.

> I couldn't wait to leave home....I wanted to do my own thing. I felt ready to leave, but I missed home much more than I had anticipated....A lot of time needed to be devoted to studying....but I wanted to socialize and I wanted people to like me....I maintained relationships too well....It was a difficult time.

Self Concept. This participant recalled being shy and lacking confidence while growing up, and would often withdraw socially. She sees herself as being passive and pleasing, groomed to help and serve others, to put others first. She is competitive and achievement-oriented, but not a perfectionist.

> ....instead, I´m disorganized and lack discipline, like my mother....

She believes she has a compulsive nature, and is too soft, too compassionate. She recognizes a tendency to stuff her anger and other emotions, and has to consciously work at dealing with her feelings.

iv) Participant 040: Family of Origin. This participant is the second eldest of five siblings. Her father was an extremely abusive man, and had been variously diagnosed as either manic-depressive or schizophrenic. He physically and emotionally abused both his wife and his children, and the participant recalled many frightening scenes where she witnessed her father beating her mother. Father was described as

> .... a very harsh and controlling man....his was the only opinion that counted....it was his way or no way....we were afraid of his anger and would walk on eggshells....well, we always knew the blowouts would happen, we just didn´t know when....

Her mother was a passive, dependent woman, who never stood up for herself. She was often blamed by Father as the reason for his outbursts. The participant's eldest sister left home "as soon as she could", resulting in the participant often taking on the household and childcare duties, and also feeling responsible for Mother and for holding the family together.

> I had this unspoken fear that my father would kill my mother....I often wished she would leave him, but I knew deep down that she wouldn't....I became her confidante, and would support her and console her....I would also move in and take some of the lickings to protect my younger sisters and brother....Dad really ran our lives. The funny thing is, for the longest time I thought all families were like this.

The participant learned to "mind my own business", and to keep her feelings and fears to herself. She learned to take a passive and accommodating approach in her relationships, and to please and take care of others, referring to herself as "old faithful". She

comments that to this day, she has a lot of difficult expressing her feelings, and in light of her father's abusiveness, she is extremely uncomfortable with anger in general, both her own and that of others. She was anxiously ambivalent about leaving home, tired of being "under Father's thumb", yet worried about leaving her mother. However, at age 18, when it was sanctioned by her father, she indeed left.

Self Concept. This participant recalls having a very poor self image and low self esteem while growing up.

> There were so many things I wasn't allowed to do, that I ended up feeling that I wasn't able or capable....Dad would also discourage us a lot....He was always criticizing me and putting me down....and of course the fact that he would hit me, left me feeling that there was something wrong with me.

She also learned about body weight and image.

> In my teens, when I started developing, (Dad) would tease me about my body and the meat I

> was putting on....I certainly learned that it was not good to be fat....

Since entering adulthood, along with her struggle with bulimia, this participant has been diagnosed with, and treated for, bipolar depressive disorder. She comments that it has taken a long time, but she is beginning to see that illness and "being sick" was one of the ways her family coped.

> Dad's abusiveness was always blamed on his being sick, especially by Mother....Mom, too, would often take to her bed with one complaint or another....and when things would get really hot at home, all of us would focus on some symptom....

v) Participant 050: Family of Origin. This participant is an only child. She clearly remembers feeling caught between her parents, who had a conflictual and "unhappy" marriage.

> I think I was very special to my mother, being her only child. Yet I also remember being a "Daddy's girl"....it seemed to me

> they would vie for my support, to side with one against the other....I often felt the need to protect either my mother or my father from the anger or barbs of the other....it was like I was responsible for holding their marriage together.

Mother was described as a very angry and frustrated woman, unsupported by her husband.

> They had a very traditional marriage. Mom looked after her daughter and her husband, all the meals and household duties, everything really....Father brought home a paycheck and did little else....They fought a lot, but what I remember most is my mother yelling....she yelled at both my father and me....she never really seemed happy....and I though I should be able to make her happy....

Her father was described as distant, whose anger was often veiled in humor.

> Father would often withdraw to another room to read....he seemed unapproachable at times ....He was also a critical man, but he

> conveyed his criticisms sarcastically, in a joke....He often made fun of me....my intelligence, my appearance, mimicking the way I talked....I learned I was supposed to laugh....after all, it was a joke....

The participant excelled academically, was well-behaved and obedient. She learned "not to make waves", to please others, and to keep things to herself. She believes the volatile atmosphere she grew up in explains the difficulty she experiences today in asserting herself, as well as her discomfort with anger. She also recalls mealtime being "a real fuss".

> Often mealtime was the only time we all sat down together....There would be so much yelling and arguing, I would find it hard to eat....then I'd get in trouble for not cleaning my plate....

Self Concept. This participant recalled being very shy growing up. Though she often achieved what she set out to do, she experienced a pervasive sense of not measuring up, of not being good enough.

> I was a very sensitive child....always concerned about what people thought....wanting them to like me....yet so afraid that they wouldn't I would often withdraw....I felt empty inside....ugly....a failure....yet on the outside I was an achiever, a perfectionist....I don't think anyone knew how awful I felt inside....

On one hand she recalls feeling unnoticed and unloved by her parents, and on the other hand she felt very important in their lives.

> There were so many of my needs that didn't get met, and yet I hardly ever expressed what it was I needed....I still have trouble with that to this day....I was always so quiet, so good....the attention I got was often through helping my parents....I think I got the strokes from meeting their needs....It was really hard for me to leave home as an adult.

vi) Participant 060: Family of Origin. This participant is the eldest of three siblings. Her father was an alcoholic, often absent and unavailable

to the family. Her parent's marriage was described as distant and conflictual.

> They fought a lot, and it seemed they were yelling at each other all the time....They were not close or affectionate with one another....I remember seeing the bruises on my mother's arms from my father grabbing her or shoving her....Dad was always flying off the handle....He was so drunk at times that he was incoherent....I remember often being afraid for my mother.

Their relationship was also described as traditional, with Father having the final word.

> We were all under Dad's thumb....we weren't allowed our own opinions....whatever Dad said, went, and Mom went along with it....He expected the house to be kept a certain way, the meals prepared a certain way....Mom wasn't allowed to see his paycheck, and to this day she has never written a cheque....she just learned to live with it.

As the eldest, the participant was "expected" to take on a lot of the household duties, but she also recalls willingly doing so as she wanted to help her mother.

> Mom had so much on her mind, so much to deal with....I would look for ways to lighten her load....often, after a confrontation with Dad, I would end up crying....Mom wasn't there to comfort me, as she needed to comfort herself....I guess I comforted her more than she comforted me....I wanted to be loyal to my mother and not let her down....I couldn't be loyal to my Dad because all he ever did was let me down.

The participant learned to "do my own thing" and to keep things to herself. She learned how to "deny my feelings" and function in a constant state of tension and apprehension.

> We were afraid to plan things because we knew the likely outcome....When we were brave enough to take part in events, Dad would show up drunk and embarrass the whole

> family....Mealtimes were also a dread because of Dad's drinking....He was always late and he was always drunk....and then he would always make us finish what was on our plate....always a production....

She left home at the age of nineteen.

> I was glad to leave....I wanted to put some distance between myself and my family....I felt mixed about how I would handle things....I was naive, but I knew I could survive.

Self Concept. This participant recalled having "no love or attention" growing up.

> I pretty much kept to myself....I especially didn't want to be a bother to my mother....I was a real "Miss Goodie Two Shoes"....When I did risk opening up, I felt minimized....I'd hear things like "it's nothing", "you worry too much", "don't be upset", "don't be a baby"....There was no warmth in the family....

She remembers receiving a lot of criticism from her father, and neither Mom or Dad recognized her accomplishments.

> Dad put me down a lot....and I really took it to heart....My brother got all his attention....he was the only son....Dad managed to make it to my brother's sporting events....and sober....but not to mine....or if he did, he was falling-down drunk or starting fights....I never got any praise from Mom, either....she was there, but only in body....I guess I felt I couldn't measure up no matter how hard I tried.... and I tried.

This participant also received specific messages about her body weight and shape.

> When I was going on eighteen, I guess you could say, I way pudgy....I got teased a lot, both at home and at school....they called me "beefy", "pregnant", "fat ass"....an uncle used to tease me about buying my clothes at a

> tent and awning store....I immediately dieted and lost fifteen pounds....

She states that she still keeps things to herself, and is afraid of getting close to people, because "you might get hurt". She has a desire to be "liked all the time", and often puts herself out to maintain relationships and make "other people happy". She describes herself as passive, "not a fighter", and tends to blame herself and feel responsible for things. She is aware of "a lot of anger inside", but doesn't handle it well, keeping it in and dealing with it quietly.

> I'm angry at my father for the man he is....I'm angry that I couldn't get close to my mother....I'm angry at my in-laws for smothering me and for demanding so much of my husband....I'm angry at my friends for being so busy....I'm angry at myself for my failures....but I'm afraid to deal with my anger....it will hurt others....and I don't want anyone to get caught in the middle....that's not a comfortable place to be.

vii) Participant 070: Family of Origin. This participant is the second youngest of eleven children. She recalled not really having a mother or a father.

> My father was a farmer and not around very much....My mother was in bed a lot....my memories of her are that she was always sick....I guess you could say I was raised by my second oldest sister....she was really bossy, and tried to rule the roost....

She remembers her parents' marriage as a distant and conflictual one, and recalls a lot of tension in the family.

> They fought and argued a lot....Mother learned to give Dad a lot of space....Dad had a bad temper, and the family was always squabbling and blaming one another. There was always yelling and screaming....I guess that's how we communicated....Sometimes Dad and my brothers would get into physical brawls....it could be quiet scary at times.

She also recalls not having much of a childhood.

> One way or another, we ended up protecting Mother....As I was growing up, I took on more and more household duties....had to prepare meals for the farmhands....and we were always taking care of Mother....Often I would be taken out of school to be with my sick mother....I usually missed the few functions around because I had to stay with Mother....You can bet Dad never did.

This participant was also sexually abused by two of her older brothers while growing up.

Her father was in control of the money and had the final say when decisions were made. At mealtime, Mother and the children would eat first, and then her father would come to the table. Mother was on a very strict diet because of her illness, with a lot of emphasis placed on what kinds of food should be eaten, and it was always important to eat everything on your plate. She states she learned "absolutely nothing" growing up, except to "be quiet" and "look after yourself".

> I received no real direction or instruction....Mother was always under the

> blankets....I didn't learn to cook or bake, even when I wanted to....I felt unprepared for marriage, and unprepared to be a wife....The message I always received from Mother was that marriage was a mistake....I didn't adequately learn any skills at home....The only thing I knew was not to have sex....Still, I wanted to get away, so I left home when I married at age 24....and immediately went from the frying pan into the fire.

Self Concept. This participant recalled feeling invisible at times while growing up. She longed for the love and approval of others, but that was not available.

> There was never any interest in who you were or what you were doing....No one paid attention to each other....There was never any encouragement....The only thing I recall was a lot of don'ts, or a lot of criticism and interference from my sister....There was never any signs of love....Even your birthday

> went by like any other day....I was no different than the hired help....

She describes herself as long having been an angry woman, but one that never coped with it well.

> As a kid growing up, I kept my anger to myself....I learned that anger could be frightening....I had no respect for my father, and he was an angry man....My husband was also an angry, controlling, and abusive man....I didn't know what to do with the anger I felt in my marriage....at times I would rant and rave....or I would eat....Finally, I had a nervous breakdown.

viii) Participant 080: Family of Origin. This participant is the youngest of eight siblings. Her father was an alcoholic, and her parents' marriage broke down when she was five years old, at which time her mother and the three youngest children moved to another locale. Prior to this split in the family, the participant had been sexually abused by her two oldest brothers. (In more recent years, she has learned that her two oldest sisters were sexually abused by her

father, and there were other incidents of sexual contact between siblings.) Her early recollections of Mother and Father together were that they would "fight and argue", and for the most part, that Father was unavailable. Between the ages of five and twelve, the participant was raised by her mother and maternal grandmother. She remembers her mother being "sick a lot", and her grandmother being "strict" and "somewhat unapproachable".

> I remember Mother in bed a lot....My grandmother was quite old, and didn't have a lot of energy, so I entertained myself....Grandma was easily angered, and I learned to step lightly around her....I would try very hard to be good, to do what I was told, to help out....I loved my mother very much....I remember cradling her head in my arm and brushing her hair....I think I took care of her more than she ever took care of me....I sometimes think she knew what my brothers did to me....Occasionally I'll wonder why she didn't protect me, but I

> quickly stuff that away....I would have done anything for my mother.

When the participant was twelve years old, her father was reunited to this family unit. He was suffering from cirrhosis of the liver, and so the participant ended up caring for both her mother and her father. A year later, at age thirteen, her mother died, and the following year, when she was fourteen, her father died. As her grandmother was now too old to look after her, she was sent to live with one of the brothers that had sexually abused her. The abuse resumed.

> At times it seemed like a joke....Why was this happening to me? I tried to tell some of my family, but no one believed me....I started to get a reputation as a trouble-maker.

As a teenager, this participant developed a "weight problem", which resulted in her being teased by family and friends. The combination of sexual and emotional abuse prompted her to "run away many times", and she would end up being "shuttled back and forth"

between various members of her family. Upon completion of high school, she struck out on her own, "looking for answers". She became "obsessed with diet and exercise" in her late teens, and has always harbored a fear of once again becoming "that fat adolescent". She has always found it difficult to express herself and get close to people. At age 22, she "jumped into a disastrous marriage" that only lasted a matter of days, and within a month she attempted suicide.

> ....I have a long history of running away from my problems....

Self Concept. This participant recalls having long struggled with "anxiety and depression", and has always had a "poor self image and low self esteem".

> Most of the time, I don't like myself....I often feel hopeless, trapped....like I don't have any power....like nothing I could do would make a difference....I guess I feel like I don't matter....What I say wasn't important because no one believed me, and when I cried I was called a baby....There are

> times when I still feel it was my fault....like I was too ugly, or too stupid, or too fat....I guess the bottom line is that no one cared enough to do anything about it....Maybe I am crazy....

The Interview Themes

The interview itself unfolded according to the six interview themes outlined in the guide. The following comprises a summary of the information gathered during the interviews according to these six themes. This information is also presented in a more abbreviated version in Table 2.

i) Communication

The majority of participants, (seven out of eight), described an indirect and closed style of communication in their families. Open discussions were not encouraged, there was a sense of having to read between the lines, and family members often kept their opinions to themselves. The one exception was participant 030, who described fairly open discussion with her mother, and recalled communication as being fairly direct. For the sake of comparison, several of

Table 2: The Interview Themes

Theme / Participant	COMMUNICATION	AFFECT	CONTROL	VALUES	BOUNDARIES	DIFFERENTIATION
010	Closed Indirect	Tense Conflict Non-nurturance	Authoritarian Rigid Predictable	Inconsistent Good front Compliance	Vary: Rigid & Blurred	Cutoff
020	Closed Indirect	Tense Outbursts Non-nurturance	Authoritarian Rigid Predictable	Inconsistent Passive Self-sacrifice	Vary: Rigid & Blurred	Enmeshed/ Cutoff
030	Fairly open with mother	Tense Conflict Non-nurturance	Authoritarian Inflexible Predictable	Inconsistent Passive Compliance	Vary: Rigid & Blurred	Ambivalent Tie
040	Closed Indirect	Unsettled Outbursts Non-nurturance	Authoritarian Rigid & Abusive Chaotic	Inconsistent Passive Self-sacrifice	Vary: Rigid & Blurred	Ambivalent Tie
050	Closed Indirect	Tense Conflict Non-nurturance	Authoritarian Power Struggles Predictable	Inconsistent Good front Self-sacrifice	Blurred	Enmeshed
060	Closed Indirect	Unsettled Outbursts Non-nurturance	Authoritarian Rigid Chaotic	Inconsistent Passive Compliance	Vary: Rigid & Blurred	Cutoff
070	Closed Indirect	Conflict Outbursts Non-nurturance	Authoritarian Inflexible Chaotic	Inconsistent Passive Self-sacrifice	Blurred	Ambivalent Tie
080	Closed Indirect	Tense Unexpressed Non-nurturance	Authoritarian Inflexible Chaotic	Inconsistent Good front Compliance	Blurred	Cutoff

the other participants also found it easier to talk to their mothers than their fathers, yet perceived their family communication style as closed. A common experience described was having learned not to speak up and not to express feelings, (an experience also shared by participant 030 in relation to her father), and each of the women interviewed believed she had learned a passive, accommodating approach in her family.

ii) Affect

The emotional tone in the families represented ranged from neutral to anxious and tense. None of the family atmospheres could be described as relaxed. The women were unanimous in their experience of lack of nurturance in regard to their emotional needs, and they all describe difficulty in articulating their feelings. Each of the families experienced open conflict, intense affect was displayed by at least one family member, and a passive compromise often brought conflict to resolution, though issues at times would remain unresolved.

iii) Control

The participants were again unanimous in their experience of a traditional family structure and division of labour, with an authoritarian leadership

style that included a dominant father and passive mother. In the case of participant 080, the parental dyad for a number of years was comprised of her mother and grandmother, with mother remaining passive and grandmother assuming the dominant position. Each of the participants viewed this authority figure as rigid and predictable, and even those described as chaotic were predictably so. Roles and allocations of tasks were viewed as rigidly clear and inflexible. Six of the participants described a family member trying to run their lives, and power struggles were portrayed in the majority of cases, with the participant often invited into the struggle.

iv) Values

Each of the participants experienced values declared that were not always consistent with those displayed in the family. They did perceive the values as fairly consistent with the larger society, and each recalls "appearances" and "putting up a good front" as quite important. Passivity, compliance, and a traditional concept of femininity were stressed in these families, and though achievement was not always directly stressed, it took on a degree of importance for each of these women. A black and white

presentation of right and wrong, with little to no latitude, was the unanimous experience, and rules were perceived as clearly laid out, though not always consistent, and not always making sense. Each of the women interviewed received some message about her weight, shape, food, or diet.

v) Boundaries

Each of the families represented displayed some form of boundary violation. Seven of the eight women were called upon to provide emotional support for one or both parents, and each of the women, in some maladaptive way, had been elevated to the status of parental child. There were cross-generational coalitions and/or triangulations in six of the families, and three of the women had been sexually abused as children. Rigid boundaries were also apparent, with each of the women perceiving one or both of their parents as inaccessible, and family members were described in general as "a bunch of individuals". Cutoffs also occurred in several of the families as a way of gaining and maintaining distance. At the same time, several participants described difficulties establishing privacy in the family, often feeling intruded upon. Illnesses and addictions appeared in

six of the families, three of the participants described feeling responsible for holding the family together, and seven of the participants felt responsible for their mothers. Though a tenseness and anxiety appeared to pervade these families, the majority experienced a blunting of emotions as opposed to emotional reactivity.

vi) Differentiation

All eight of the participants recounted an anxious concern about their family, albeit in varying degrees. Each of the women recalled receiving messages implying the importance of the family and remaining loyal to it. In spite of this, six of the participants reported a feeling of disconnectedness among family members. Seven of the eight women recalled being criticized, and their developing individuality discouraged or largely ignored. All eight of the women report self-doubt and feelings of insecurity, difficulties asserting themselves, feeling responsible for and concerned about what others' think, and placing a lot of importance on relationships and pleasing others. Six of the participants relate feeling awkward on the inside while portraying an independent and "together facade" to the rest of the world. Five of the women reported some

anxiety about leaving home and their ability to function independently, while an additional five remembered an intense desire to leave. Three of the women abruptly cut themselves off from their families at the time they left home, and a fourth woman experienced cutoff due to circumstances outside of her control.

Participant Understanding of Bulimia

Though there was some variation in the kinds of circumstances described by the participants as precipitating events, all but one of the women cited a specific experience that she associated with the onset of her bulimia. The participants were unanimous, however, in their belief than an underlying low self esteem and lack of confidence supported their disorder.

Participant 010: A weight problem as a child and the family's extreme emphasis on appearance, resulted in an imposed diet by the age of ten. After leaving home at age sixteen and cutting herself off from her family, this participant began to diet restrictively, citing the isolation, lack of confidence, and poor self image as contributing factors. She married at age

eighteen, ("a difficult experience as I wasn't ready"), and following the birth of her first child at age twenty, the bulimia syndrome exacerbated with vomiting added to the cycle.

Participant 020: Loneliness and a desire to "gain some control over my life" was the impetus for this woman's development of anorexia nervosa. Vomiting was something discovered while hospitalized, and the bulimia syndrome became established following her "being forced" to live independently, with the subsequent pressures this entailed both from the experience itself and from her family.

Participant 030: A "competitive and compulsive nature", family emphasis on appearance, and dissatisfaction with body shape lead to restrictive dieting at age sixteen. This was followed by a cycle of compulsive binge eating and further dieting. Following the stillbirth of her second child at age thirty-one, the bulimia was exacerbated, with vomiting a newly-added feature. This participant believed that the "repeated attempts to starve myself" are behind her disorder.

Participant 040: This participant recalls that when she left home at age eighteen, she suddenly became

"very self-conscious" and began to diet restrictively, setting up a cycle of sporadic binge eating and restrictive dieting. In a one week period at the age of twenty-seven, her father committed suicide and her second born child died two days after birth. The result of these stressors was an exacerbation of her bulimic symptoms.

Participant 050: This participant recalls a number of factors.

> I grew up feeling shy and lonely....I had low self-esteem....I was unhappy with the way I looked, everything about me....When I was eighteen I remember starting to think I should strike out on my own....I got mixed messages from my mother and father, but it was more of a society (pressure)....I knew, though, that I wasn't ready....I started to "pig-out", but would then get more disgusted with myself....I flip-flopped between starving myself and making a pig out of myself....

The full-blown syndrome was established for this participant by the age of nineteen.

Participant 060: A poor self image, low self-esteem, and being teased about her appearance lead to restrictive dieting at the age of eighteen. The participant was married at age twenty, and the binging and dieting that was earlier established continued. At the age of twenty-four, following the birth of her last child, the full-blown bulimia syndrome was in place. This participant, however, does not perceive an associated event with the development of her disorder, which she comments "only adds to my frustration".

Participant 070: This participant recalls starting to diet restrictively and exercise excessively following her marriage at age twenty-four. This was described as an attempt to please her husband, who "would have had me pencil-thin if he could". During her pregnancy at age thirty-three, and following the birth of this child, her first, the bulimia symptoms exacerbated. In the years that followed, the participant recalled "using food" as a way of coping with the anger she felt toward her husband.

Participant 080: A poor self image and a dissatisfaction with body shape supported a desire for this participant to diet restrictively, following her leaving home at age sixteen. She recalls wanting to

improve herself as she "faced the world and left my family behind". A compulsive cycle of binging and dieting was established, and at age twenty-two, following her marriage breakdown and suicide attempt, the bulimia symptoms exacerbated, with vomiting added at this time.

The Interview Process

Each of the interviews unfolded in an open and relaxed fashion. Those that took place in the investigator's office were less prone to interruptions or distractions, but for the most part, interruptions were virtually non-existent. The unstructured format allowed enough flexibility to capture the affective, non-verbal, and value-laden aspects of the participants' responses, as well as enough time to determine the personal significance and meaning these had for each participant. Throughout the interview, the participants shared of themselves spontaneously and with candor. The major challenge for the investigator was maintaining the role of reporter rather than counsellor. The accounts provided were often moving, and at times, both participant and investigator would

express a sense of feeling drained by the interview's conclusion. However, each one of the participants expressed satisfaction with the interview experience, and acknowledged a hope that one day, they and other women with bulimia, would be free of this struggle.

Summary

This chapter has presented the findings of this investigation under four topic headings. Following a presentation of demographics, the majority of the chapter focused on a description of the picture each participant carries of herself, as well as her experience in her family of origin. Information provided by the participants was also organized according to the six interview themes outlined in the interview guide, and each participant's understanding of the origin of her eating disorder was presented. The chapter concluded with an examination of the interview process.

Chapter 6

Synthesis of the Study

In this final chapter, the findings of this investigation are analyzed and synthesized, including a presentation of how they relate to the information documented in the literature review. A discussion of family of origin and bulimia, as well as treatment implications and recommendations for further research on bulimia are incorporated into this chapter.

The purpose of this study was to explore and describe the picture the bulimic woman carries of herself and of her family of origin, and how this might relate to the development of her disorder. The selection of the unstructured, in-depth interview as the medium with which to capture this picture, allowed for the emergence of a rich and detailed description based on the perspective of the eight women with bulimia who participated in this study.

Limitations of the Findings

It is recognized that there are several limitations of this study that may influence the

significance of the results. The eight women interviewed do not comprise a random sample, but rather, a select group who have undergone some form of treatment in varying degrees, likely impacting their perspective of self and their disorder. The selection of a qualitative research paradigm can be limited by factors such as difficulty with replication, subjectiveness of the design and researcher bias, plus information collected is dependent on the participant's memory and subject to interpretive reflection. Researcher bias may influence the design of the study guide, the choice of probing questions, and the overall tone of the interview through verbal or nonverbal response. Self-serving errors are always a risk, as this study (like many others before it) unfolded with some tentative assumptions in mind. The focus at the outset on family of origin indicates some degree of expectation as to its relationship to the development of bulimia, yet declaring these potential biases and remaining acutely aware of how they interfere with the interpretation of the subject's reality can enhance the reliability of research results. The aim of this study has in part been to provide a picture of the woman with bulimia and her family of origin, through both the in-

depth interview and the overview of the literature. The fact that there are similarities between the findings and the literature review supports the relevance this investigation has to information currently available about the bulimia syndrome.

The Portrait Illuminated

The picture that emerged in this study of the woman suffering from bulimia depicts a sensitive, caring, and giving woman, yet one riddled with perceived deficits and imperfections. She is passive, yielding, and dominated by others. She fears confrontation and rejection, and turns her anger and other emotions inward. The approval of others' is desired, she is concerned about what people think, and places a lot of importance on being liked. She fears failure and is often propelled by a perfectionist drive. She is soft, nice, well-behaved, obedient, pleasing, and very responsible. She lacks confidence, has low self-esteem, and is dissatisfied with the way she looks -- always afraid of becoming fat. There are many times when she has felt minimized, incapable, hopeless, invisible, guilty, unimportant, unnoticed,

unloved, lonely, less than, unencouraged, empty, ugly, and an outsider -- yet the image she portrays to the world belies her inner experience.

This woman grew up in a home with a dominant, authoritative father and a passive, submissive mother, organized around a fairly traditional division of labour and concept of femininity. Her parents' marriage was both distant and conflictual, and one or both parents was inaccessible, failing to adequately meet her emotional needs. Though she worked hard to be noticed, either through compliant, good behavior, or excelling academically, her budding individuality and achievements were minimized or largely ignored. Given the paucity of positive affirmation and demonstrations of affection, along with an atmosphere of conflict and tension, this woman learned not to ask questions, not to express her feelings, and to keep her distance. She at times felt responsible for holding the family together, and would search for ways to help look after her mother and/or her family. She has become accustomed to organizing her life around illness and/or addiction, and has been the recipient of emotional, physical, and/or sexual abuse.

The composite woman that emerged in this study may or may not have been overweight as an adolescent, yet for the most part was (and is) unhappy with her appearance. She feels out of control when binging, and compensates for her binge through restrictive dieting, laxative abuse, vomiting, excessive exercise, diuretics, liquid formula diets, and fasting. She can recall a specific incident that relates to her desire to diet and lose weight, and often a significant event occurred concomitant to the exacerbation of her bulimic symptoms. She is convinced that an underlying low self-esteem and sense of inadequacy helps support the disorder, and she is, or has been, involved in some form of treatment.

Relation to the Literature Review

The portrait that was illuminated through the interviews is fairly consistent with that which is presented in the literature. As much of this available information reflects different theories regarding the etiology of bulimia, the findings of this study as they relate to the literature is presented under the same general categories.

i) Biological factors

The emphasis of the biological theories has been on bulimia's relationship to clinical depression. Each of the women interviewed has experienced depressive symptoms, and each recalls feeling depressed both prior and subsequent to the onset of her disorder. Six of the eight women report depression and alcohol abuse among first-degree relatives, consistent with that reported by Butterfield and Leclair (1988), Gwirtsman et al (1983), and Hudson, Pope, et al (1983). Four of the eight women interviewed are currently receiving antidepressant medication, (either for their depressive or bulimic symptoms), and three of the remaining four have received antidepressants in the past. Only one of these women, (currently receiving Prozac), reports experiencing a moderate to marked reduction in the frequency of both binging and purging behavior. The remaining women, (one of whom is also receiving Prozac), described experiencing a moderate to marked decrease in depressive symptoms but little to no change in binge or purge frequency -- a description most closely paralleling the investigations by Pope and Hudson (1985).

The initial favourable results of studies that target the increased appetite and carbohydrate craving of bulimic subjects with appetite suppressants (Freeman and Munro, 1988), was not reflected in this study, as six of the eight women have used appetite suppressants without experiencing any break in their binge-purge cycle. There was some support for the biological hypothesis that self-imposed starvation may predispose a person to eating disorders (Copeland, 1985; Garner, Rockert, et al, 1985; Potts, 1984), as six of the eight women recalled experiencing compulsive and rapid eating following a severely restricted and self-imposed diet.

ii) Cognitive-behavioral factors

The emphasis the cognitive-behavioral theories place on a combination of a desire to be thin and excessive dietary restraint was supported in this study. Each of the women, unhappy with their appearance, made a decision to diet at or prior to the onset of their disorder. In accordance with studies by Agras and Kirkley (1986), Fairburn et al (1986), Johnson and Pure (1986), and Steere and Cooper (1988), cognitive distortions were very apparent in the eight women interviewed. Most predominant was their tendency toward dichotomous thinking, with very rigid and often

unrealistic standards in place for success vs. failure and right vs. wrong, allowing for very little flexibility or shades of grey in between. Similar to descriptions in the literature noted by Cattanach and Rodin (1988), Hudson, Katz, et al (1987), and Neuman and Halvorson (1983), these eight women reported difficulties expressing their feelings and coping with stress, and have come to use food to deal with anything perceived as stressful and uncomfortable. Purging has also become a maladaptive strategy that these women employ for dealing with anxiety and stress. Each of the participants reported their fear of becoming fat was initially reduced through purging, but due to the feelings of deprivation and/or self-disgust that followed, another binge was provoked.

iii) Psychoanalytic-psychodynamic factors

Some of the conflicts characterized in the psychoanalytic-psychodynamic theories were highlighted by the eight women interviewed. They were unanimous in describing a feeling of being caught between a pressure to assume the values of a male-oriented culture and to identify with the traditional concept of femininity that had been stressed in their families. In accordance with reports by Beattie (1988), each of the

women had a special tie to her mother, with four of the women being her only daughter or only child, and all eight feeling called upon as a special confidante or caretaker, which, according to Beattie, increases their difficulty with the process of individuation. While only two of the women described the idealized father image theorized as important by Woodman (1980), the majority of participants reported yearning for maternal and/or parental love and approval, and to this extent, their binging and purging could indeed represent a desire to both satisfy and control their need for nurturance.

iv) Sociocultural-feminist factors

The eight women that participated in this study acknowledged a desire to emulate our cultural symbol of beauty and success -- the thin, curveless body. They each have spent a great deal of money on diet aids and products, and, as previously noted with import in studies by Garner, Rockert, et al (1985), exercise has become for these women as well, an avenue for weight loss rather than cardiovascular health. All eight of the women have experienced the pressure of juggling careers, relationships, and families, and all have expected themselves to excel in their endeavors, look

good while doing so, and be liked and approved of by all whom they encounter. Each of these women described themselves as passive and caregivers, placing others' needs before their own, which, as theorized by Bass (1990) and Weinstein and Richman (1984), will more likely result in the development of eating disorders, than in those women who assert their needs and resist the patriarchal view of womanhood.

Women and girls are more likely to experience abuse in a society that devalues females. The fact that six of the eight women interviewed (or 75%) reported either physical, sexual, or emotional abuse in their history, provided an exact parallel to a study reported by Bass (1990), highlighting a connection between eating disorders and a history of abuse.

The patriarchal pressure to adopt a passive and accommodating approach to life, which each of the participants claim as their style of relating, has resulted in all eight of the women suppressing their anger and other emotions, or left struggling with feelings of guilt when they have not suppressed them. The desire for acceptance and approval has resulted in each of the participants becoming other-focused,

looking outside of herself for validation, and ultimately leaving herself at the mercy of others.

v) Family factors

The family dynamics as described by the eight participants in this study closely resembles the bulimic families portrayed in the few studies that have appeared in the current literature. The marital discord and emotional distance between spouses as described by Wooley and Kearney-Cooke (1986) was the unanimous experience of the women in this study, as was the tug to provide emotional support for one or both parents, noted in a study by Lieberman (1989). Several of the other authors cited in chapter two reported family environment characteristics that parallel the experience of the women in this study, including families that are disengaged, disorganized, chaotic, highly conflictual, less supportive, communicate indirectly, emphasize the importance of appearance, as well as a traditional concept of femininity and/or achievement, and parents that are perceived as inaccessible. Three of the women distinctly remembered feeling responsible for holding the family together, an experience reported in the literature, and six of the women recalled having mothered her mother. A tendency

for bulimic families to vacilate between abruptly displaying and abruptly suppressing their negative feelings and emotions, which was described in the literature by Stierlin and Weber (1989) and Strober and Humphrey (1987), was also the experience of seven of the eight women in this study. A rigid and dichotomous family belief system that emphasizes compliance and limits available choices, highlighted by several authors, was again the unanimous experience of the women in this investigation. The idealized or false self as described in the literature was acknowledged by each of the participants as something they too have constructed to present to the world. The six themes that underlie the false self set forth by Weinstein and Richman (1984), including a real self perceived as bad or ugly, a strong need for approval, an inability to articulate and assert feelings and needs, assuming the role of caregiver and peacemaker, remaining passive in relationships, and harbouring a desire to rebel against the need to conform, was echoed by each of the women in this study. The bulimic family framework developed by Root, Fallon, and Friedrich (1986) could plausibly be applied to the families described in this investigation, with four of the women divided evenly

between the perfect family classification and the overprotective family, and the remaining four most closely meeting the characteristics of the chaotic family. Finally, the transition to leaving home was noted with significance by each of the participants, either through a strong desire to get away, to escape, or through a felt sense of not being ready to leave. Several authors described self-doubts, insecurity, good and compliant behavior, adapting to others' needs with one's own needs largely unmet, and having experienced the developing separate self as either criticized or ignored, as resulting in difficulties with the achievement of successful individuation. Each of these descriptors is applicable to the participants in this study. VandenBroucke and Vandereycken (1988) note that unresolved separation issues will be displaced to subsequent relationships, such as with the spouse, and that strong emotional ties to the family of origin, whether positive or negative, will remain. Each of the eight women who participated in this study acknowledged an ongoing difficulty and awkwardness with relationships, a continued tendency to put the needs of her spouse before her own and remain passive in this relationship, and a sustained and often anxious

connection to her family or origin, whether or not she was in actual contact with her family.

In summary, the findings of this investigation generally support and are supported by the current literature on bulimia. These findings augment the literature review by delineating themes apparent in the family of origin of individuals with bulimia, and by providing evidence to support a growing belief that there is a connection between eating disorders and a history of abuse. Lastly, the investigation has both underscored and added descriptive information to that which is currently available.

Synthesis of the Theories

The theories of etiology presented in this thesis are talking about the same disorder but from different standpoints. In the case of the investigation outlined herein, each of the theories could be considered applicable. What does this suggest, then, in regard to the origin of bulimia? There are at least two possible explanations. The first is that the cause of bulimia is multifactorial. A young woman growing up in our society will have been inundated with the cultural

pressures to diet and be thin. The one that moves on to become bulimic may be predisposed to depression, given the high probability of a family history of affective disorder. Given that depression is at times described as a thought disorder, this young woman might very likely grow unhappier and more dissatisfied with herself, displaying some well-entrenched cognitive distortions and depressive symptoms. She may attempt to address her feelings of worthlessness by focusing on her appearance, which is culturally acceptable, and therefore make a decision to diet. Growing up in a culture that devalues women and in a family that has neglected her early emotional needs, this young woman becomes fearful and conflict-ridden, adopts a passive coping style, and anesthetizes any uncomfortable feelings through alternatively eating and focusing on her diet and weight. Her bulimia, then, results from a combination of factors, each having a role in its development.

The second explanation is that the different theories of etiology are symptomatic of one condition -- the same condition that underlies the development of bulimia. Our society has strongly subscribed to a medical model of health and illness. The emphasis on

bulimia's biological underpinnings reflects this model, and implies that the problem is located within the individual. The individual, then, is left to shoulder responsibility for this problem, while passively receiving treatment direction from the medical profession, the authority on illness and disease. This model is also indicative of our male-oriented culture, as it exemplifies what is valued most: power, achievement, professional competence, autonomy, a scientific focus, rational thought, and an emphasis on the individual and self-control. The obvious omission, however, is that we do not live in a vacuum. Studies that revealed a revolving-door syndrome in psychiatric institutions pointed to the futility of treating an individual removed from his or her context and then returning that individual to the same, unchanged environment. Still, the medical model reigns supreme in psychiatry and in every other specialty of the medical field, and typifies the ideals of a male-focused world. Carol Gilligan (1982), in her work on women's development, highlighted the difference between a male and female view of the world, where women see a world comprised of relationships and men a world that is disconnected and hierarchical. The medical model

and biological theories are perpetuated through this male view.

Cognitive-behavioral factors, like the biological ones, also point to the individual as owner of the problem, through incorrect thinking or behaving. Even though learning in the context of the environment is taken into consideration, the emphasis in both the cognitive-behavioral and biological perspectives remains on the diagnosis or description and amelioration of the depressive symptoms, maladaptive behaviors, and cognitive distortions. Not only does this provide a neat, rational, and scientific response to a problem, it maintains the hierarchy and power dynamics in the guise of self-control, without addressing what lies beneath a particular thought, feeling, or behavior. Women suffering with bulimia will likely continue to feel depressed, perceive themselves as hopeless and stuck, and focus on eating and dieting until they are empowered to use their voices to be heard, believe they have a cultural right to be heard, and feel like they truly belong.

The psychoanalytic-psychodynamic perspective arises out of interpretations based on male development and is conceptualized from a cultural male bias

(Gilligan 1982; Schaef, 1985), fitting as well into the medical model. The qualities deemed necessary for adulthood and emphasized in this perspective are those associated with masculinity, and, therefore, are considered undesirable as attributes for feminine personality. Psychoalytic interpretations often used in this orientation maintain a power imbalance with analyst as expert, plus reinforce passivity, interfere with autonomous development, and ignore social inequality. This again, is symptomatic of our male-oriented culture.

The family system's perspective has been criticized for its tendency to ignore gender biases, rather than recognizing that in a male-oriented society, gender is the basic category on which the world is organized (Hare-Mustin, 1986). The inability to see this larger social context is comparable to the revolving-door syndrome described earlier, as to alter the internal functioning of families without concern for the social, economic, and political context, is to conspire with society to keep the family unchanged. This, though, is the penchant of society, as the family meets its needs by shaping people for the various social roles. However, it is these very role

differences between the sexes which have been constructed by our patriarchal society, that keep women compliant, conforming, and oppressed. It is this societal condition -- one that focuses on male life as the norm and devalues women in the process -- that permeates the theories of etiology and ultimately underlies the development of bulimia.

Family of Origin and Bulimia: Discussion

It has been stated that the goal of a functional, healthy family is to promote the development of a well-differentiated and individuated identity in the offspring (Walsh, 1982), and that the capacity to function as a spouse and parent is largely a consequence of childhood relationships in the family of origin. How these relationships and attachments are defined, enacted, and resolved underlies Bowen's theory of family of origin. He characterizes two opposing forces within an individual and family -- those that bind persons in a family togetherness, and those that fight to break free toward individuality (Kerr & Bowen, 1988; Nichols, 1984). This desire to gain independence and define a separate identity is a natural one in our

culture, and has often been described as part of the developmental process of adolescence. Frequently there are differences and discomforts generated between the generations at this time, as a result of the emotional contact between them, and there is a degree of emotional connection for all persons developed in early life to their parents and families. There can also be a certain amount of unresolved emotional attachment that exists in families, and it is how this is dealt with that is of concern to Bowen. Before individuals can experience themselves as mature and separate beings, they must resolve this emotional attachment to their family, rather than just passively accept or reactively reject it. Bowen applied the term emotional cutoff to the act of gaining "separation" through this rejection, either through isolating, withdrawing emotionally, or running away from the family of origin, or denying its importance. He asserts that the maintenance of good, healthy emotional contact in families across the generations helps to defend against the surfacing of serious problems, both in individuals and in their relationships.

Reducing emotional cutoff from the past is one of the most important elements of Bowen's family of origin

therapy (Kerr & Bowen, 1988). How well individuals differentiate from their families of origin and how much emotional attachment remains, will impact on how they handle their ensuing emotional relationships. Mate choice, marital, and parent/child relationships can be based on the hope of meeting unfulfilled needs, and unresolved issues from the past can be played out in these current relationships. Emotional cutoff can exist in varying degrees, and physical distance does not equate emotional distance. Family members that live thousands of miles apart may be in better emotional contact than family members living in the same town or on the same street. Declaring oneself as independent and leaving home does not indicate differentiation and individuation either, as the emotional issues may remain unresolved. Running away from home can be as indicative of emotional dependency as never leaving home. Bowen, however, contends that it is possible to achieve higher levels of differentiation through therapy, and that an adult can go back to the family of origin, actually or figuratively, and successfully resolve the emotional attachments.

Anxiety, and the degree to which it is present and coped with in a family, is an important variable in the degree of differentiation achieved, according to Bowen. It is chronic anxiety, and the family tension that results from it, that determines level of differentiation, family dysfunction, and symptom formation. A fusing into emotional oneness, and the development of individual and family pathology, results when the family system is no longer able to effectively manage the chronic anxiety and tension. Boundaries become blurred, and individual identities are lost to the family togetherness, resulting in the undifferentiated family ego mass previously described. This lack of differentiation is handled through emotional distance between the spouses, overt marital conflict, physical or emotional dysfunction of a spouse, or projecting the problem onto a child (Nichols, 1984), which, in effect, triangles that child, and can result in later impairment. It is important to reiterate that these patterns can become entrenched and occur over several generations without the situation of chronic tension readily apparent. The emotional distancing, for example, that initially developed in an alcoholic family, may continue in

relationship patterns over several generations even though alcoholism is no longer creating a current conflict.

The markers of a lack of differentiation were visible in the families of origin of the eight participants in this study. The women unanimously described a tension and anxiety that tended to pervade their families, with some families struggling with an obvious and chronic conflict, and other families experiencing more of a chronic undercurrent. Marital conflict and emotional distance between the spouses was a factor for all eight of the participants, and six of the women experienced the physical or emotional dysfunction of a parent, either in the form of illness, alcoholism, or depression. There was a variety of sibling positions demonstrated in this study, yet the significance of this factor is not readily apparent, given the similarity of behaviors exhibited by these different women, regardless of their position in the family. However, this similarly could suggest a loss of the distinctive characteristics of sibling position, which coincides with Bowen's theory. Yet of greater importance, it appears, was their special status or relationship to a parent, either through being the only

child, only daughter, or one on whom befell, or was at times projected, some particular responsibility. This special child was also caught up in the parental and/or family anxiety. Though boundaries were at times blurred and individuality deposed by emphasis on family loyalty or through indifference, the intense and dependent clinging often described by Bowen during times of increased stress was not the majority experience in this study. Though there were instances of this, usually between the special daughter and a parent, (though, on rare occasion, reverberating through the entire family), the rule became a reaction of withdrawal, avoidance, lack of connection, and disengagement. However, this exemplifies the flipside of the coin that addresses lack of differentiation; that is, the emotional cutoff described earlier. Several of the participants went on to an even more abrupt cutoff, with the remaining women expressing difficulty or ambivalence about leaving. The environment for some kept them bound through an exaggerated sense of responsibility, and for others, repelled them to an abrupt cutoff. Yet in both cases, they remain emotionally entangled with their family. The transition to leaving home also coincided with the

development of bulimic symptoms, lending support to the hypothesis that the women had not been effectively prepared to navigate this transition.

The participants also exhibit markers of an undifferentiated self, including perceiving themselves as relationship-oriented, seeking approval and acceptance, dependent on others for a sense of self, conforming, lacking an autonomous identity, and feeling overwhelmed by, though unable to effectively deal with, dysphoric feelings. These women also demonstrated the discomfort with emotional connection and unresolved emotional attachment discussed earlier, acknowledging either difficulties leaving home or an anxiousness to cutoff from their family. Having failed to effectively differentiate and carve out an independent self, these women either accepted or opposed the tie with their family -- remaining quiet, withdrawn, and passively waiting, or becoming upset, rebellious and leaving. Though on the surface this appears to represent dependence versus independence, underneath the same lack of differentiation is reflected.

Once the transition to leaving home begins, whether complete or in process, these individuals become vulnerable to playing out all the difficulties

experienced in the family of origin in each new emotional relationship they become involved with. Having been unable to move their relationship with their parents to an adult, person-to-person stance, they risk reacting in subsequent relationships as they had to their parents. For these women, this has meant taking a passive stance and conforming to the wishes of others, avoiding confrontation, meeting the emotional needs of others at the expense of their own, responsibly taking care of the relationship, relating in as pleasing a way as possible, and keeping any negative emotions hidden. They run a further risk of reinforcing their feelings of inadequacy and low self-esteem, as their own needs continue to be unmet, and they once again perceive themselves as a failure in their relationships. The bulimia, therefore, is triangled in as a quiet and passive way of coping with the anxiety generated in their relationship experiences.

The family of origin is also the setting where the self-concept begins its development, and the foundations for adult coping, whether effective or ineffective, are formed. The women in this study clearly developed poor self images and coping skills

that are often ineffective and maladaptive. The family is also a primary agent of socialization, and as was the case for the participants in this study, often reflects the values of the larger culture. Women in these families were largely devalued, and assumptions were made about a future in the role of wife and mother. Male domination was the norm, and female family members responded in a passive, conforming, and submissive fashion, providing these women with their primary coping mechanism. The hierarchical structure of these families contributed to some of the dysfunctional relationship patterns displayed, as the power discrepancies, demands for obedience, conformity ,deprivation, and guilt invoked in a hierarchy can result in conflict, struggles for power, distance, and detachment. Those with less power learn to defer to those with more, very much like society in general, and any resentment, hostility, or other uncomfortable emotions stirred up are hidden, denied, or displaced. The women in this study invariably used eating metaphors when they described dealing with their emotions, including "eating my anger", "swallowing my problems", "stuffing my emotions", "my anger eats away at me", or "I´m being eaten up inside". Given the

centrality of food to a woman's role as wife and mother, as well as the lack of social approval and outlets for women's strong and negatively-connoted emotions, it is interesting that these emotions are addressed, both actually and metaphorically, through the use of food and eating, which is also a coping mechanism that is passive, ineffective, and maladaptive. Food, eating, mealtime, and dieting was also a noteworthy factor cited by each of the women in this study in regard to their family of origin.

Implications for Treatment

The biologically-based treatment strategies for bulimia have demonstrated mixed results, and in this study, antidepressants proved effective in reducing bulimic symptoms in only one of seven cases. Cognitive-behavioral methods of treatment have evidenced more promising results in the research, yet whether or not a shift in maladaptive thinking and behaving will prevent symptom formation in the future remains questionable. It is what underlies the symptom that must be targeted for treatment to be effective.

For the women that participated in this study, a pervasive sense of ineffectiveness and inadequacy lies beneath their bulimia, a factor supported as well in the literature. Their need for nurturing was neglected in their primary relationships, they were undervalued in their families, and later undervalued by the larger society. Dysfunctional family systems, where conflict and tension reigned, created fears and anxieties left largely unaddressed, and the developing young woman learned to be obedient, responsible, and invisible in order to survive. At times, a tug to protect, (either others or self), would result in her getting caught up in the conflict, yet this merely functioned to further solidify the emotional attachments to her family. The outcome of her experience was a desire to be approved of and cared for, leaving her overly friendly, conforming, and passive in her subsequent relationships to ensure the satisfaction of this desire. Yet her relationship to the larger society parallels in many ways that to her family. As a woman, she has less power in the world, leaving her feeling vulnerable and frightened at times, just as she was in her family. Having been socialized to be responsible and take care of, she works hard at achieving and ensuring others'

lives run more smoothly, both demanded by society. However, she often receives little credit or validation for her efforts, an experience again reminiscent of her family. She has been ineffectively prepared to cope with the world, and food, symbolic of a woman's role, becomes a readily available form of nurturance and comfort, filling the emptiness inside and keeping uncomfortable feelings at bay. Yet society also demands that her appearance be pleasing and attractive, and in order to satisfy both her need for nurturance and approval, food becomes both savior and enemy, and the compulsive cycle of eating and dieting is established.

Targeting the family of origin in therapy can offer opportunities to address the issues that underlie the bulimia. Facilitating an increased differentiation of self is the goal of Bowen's family of origin therapy (Bowen, 1978; Nichols, 1984). This would be accomplished through reopening the closed or cutoff family ties and attachments, and helping a person to detriangulate from their family system. Unlike many family therapy advocates, Bowen does not believe the entire family system need be present in therapy for change to occur. Rather, change initiated by one

individual can create a positive shift in the other family relationships. Further, changes in the individual's perception of these relationships, as well as how the self is perceived in relation to others, will also occur. These factors are significant given that many women with bulimia, including those that participated in this study, are often unable to easily access their family system, due to distance, deaths, or feeling unready to tackle such a task based on lack of safety or comfort. Techniques for change would include gaining an understanding of one's position in the family and in the triangles, and transforming the emotionally charged images of family members to allow this woman to see her family as people, and herself as a capable adult rather than an ineffective and powerless child. She would also be coached to more effectively handle emotionally charged situations in her family, through responding with thought rather than reacting with emotion, plus learn to block the attempts to pull her in to fix, mediate, and take care of her family. This would initially be accomplished through roleplay, followed by support and encouragement to develop person-to-person relationships with family members through increasing the frequency and intimacy

of emotional contact. Other techniques to effect these changes would include learning assertiveness skills, learning to declare oneself and take "I-position" stands (Bowen, 1978), and practicing cognitive-restructuring skills to help modify both the picture of self and of family. Throughout this therapeutic process, the focus would always remain on the family of origin and the resolution of the triangles and emotional attachments.

Bowen has stated that "the most needy people have achieved the least emotional separation from their families" (Kerr & Bowen, 1988, p. 109). The women suffering with bulimia portrayed in this study and in the literature experienced very little nurturance, and therefore display many unmet needs. Through working at more effectively separating from their family and carving out an independent self, these women will perceive themselves as more capable and effective, and gain the courage to translate these skills to their relationships outside the family. Perceiving themselves as successful in their interactions with family can encourage more effective interactions with others. These women can begin to declare themselves in all of their relationships, and work at finding ways to

get their own needs met, rather than depending on others. A common experience for the women in this study, as for those in the literature, is the difficulty expressing needs and emotions, complicated by a sense that there exists a deep-seated anger that can be frightening at times. An exploration of family of origin relationships can be the catalyst for releasing this anger in a safe, therapeutic environment. The process of blocking the old triangular moves and declaring oneself in one's family, can provide these women with a more effective strategy for coping with anger that can again be applied to other relationships and experiences.

One criticism that can be levied against Bowen's theory is that this also reflects our male-oriented world. The hallmarks of lack of differentiation, such as being relationship-oriented, highly emotional, dependent on others, and conforming, are the same characteristics traditionally described as feminine. The markers of a well-differentiated person, on the other hand, are the characteristics traditionally attributed to men, including the ability to be rational, logical, responsible for self, goal-directed, and able to express opinions. Women, who define the

world through its interrelationships, recognizing a responsibility for one another, and who are often intuitive and operate from a felt sense, are again devalued. Kerr (1984) asserts that Bowen's theory is not anti-relationship or anti-emotional, but rather, implies choice. Well-differentiated individuals are more free to choose emotional or intellectual interaction, rather than be chosen by it. They have more freedom to move back and forth between intimate emotional relationships and other non-relational activities, can better tolerate anxiety and other intense feelings, and are more free to enjoy deep emotions. Still, it is difficult to ignore the distinctions here that tend to parallel the value-laden discriminations set out in our larger society. Yet, if through the process of gaining greater differentiation women with bulimia could begin to value their gifts of intuitiveness and community, along with clearly defining their self and discerning their options, they could more freely move toward establishing gratifying relationships based on equality and the mutual satisfaction of needs.

The underlying social issue cannot be overlooked in a discussion of treatment. Given this society's

obsession with beauty and slimness on one hand, and food and consumption on the other, women will continue to be bombarded with a double message, and eating disorders will likely continue to proliferate. It does not seem unrealistic to suggest the execution of a consciousness-raising movement that would target the media and advertising agencies, calling attention to their part in this destructive process, and possibly boycotting the most offending products and companies. A mass reeducation process also needs to be embarked upon, both to enlighten people in regard to eating disorder symptoms and what underlies them, and to increase their awareness of the part they play in reinforcing the patriarchal structure in our society. We need to work collectively to reduce the sex role stereotypes and gender biases that pervade our culture, encourage passivity and dependency, and lock women into a devalued role.

Recommendations for Further Research

This investigation has corroborated the few studies to date that have appeared in the literature defining the family dynamics and interactional patterns

typical of bulimic families. Given that factors in the family of origin of women with bulimia appear to impact their developing a diminished sense of self, and further, that a form of family or origin therapy is available to enhance individuation from the family and increase differentiation of self, it is recommended that a trial of family of origin therapy be undertaken with a small group of consenting women experiencing the bulimic syndrome. It is important that such a study focus solely on family of origin and not on the symptomatic expression of bulimia, save to highlight the purpose the symptom is serving, so as not to confound the variables being addressed. A treatment comparison would also prove interesting to investigate, for example randomly assigning bulimic subjects to either a trial of family of origin therapy or cognitive-behavioral therapy, with a waiting list utilized as a control. Given that lack of assertiveness skills and an ineffective managing of uncomfortable emotions, particularly anger, have surfaced as factors common to women with bulimia, assertiveness training and anger management groups could be two additional alternatives for comparison

purposes to family of origin therapy, or to simply investigate the effectiveness of such an approach.

Since research on bulimia as a separate disorder from anorexia nervosa is only ten years old, and an interest in family dynamics has only begun to appear in the last four or five years, further research that explores and described these families as well as pursues Root, Fallon, and Friedrich's (1986) work on distinguishing bulimic families into subtypes, would be appropriate. It is recommended that the relationship between bulimia and a history of physical, emotional, and sexual abuse be further investigated, and it is encouraged that these factors routinely be explored for in women presenting for treatment of bulimia. As many of these women experience a deeply felt sense of shame, both in regard to past family experiences and to their current struggle with bulimia, an investigation of this variable, both alone and in conjunction with family of origin, is encouraged. For the women struggling with this disorder, a focus on treatment is highly recommended to increase the probability of relieving them from this private hell. Reports on outcome studies have been few and far between, and research is needed on all possible treatment approaches for

bulimia. Given the similar family of origin experience of the eight women highlighted in this study, a treatment incorporating family of origin therapy may be an important place to begin.

Concluding Remarks

Women with bulimia are fighting a formidable battle. It is a fight that consumes them, and carried out in secret, it is their's alone to bear. But their bulimic symptoms are really only half the battle. These women are prisoners of low self-worth and a negative self-image, a sentence inflicted by a non-nurturing family and a wider culture they were ill-prepared to cope with, and one that continues to devalue them. Given their passive and conforming style of relating and surviving, they are unable to effectively resolve their emotional attachments, or freely communicate their needs, wishes, and opinions. They swallow their resentments as they swallow their food, and get caught not only in a cycle of binging and purging, but in a cycle of self-blame, self-deprecation, and a further diminishing of self-esteem. To be free of their bulimia, these women must be

released from the family and cultural legacy that oppresses and disempowers them, leaving them to doubt their own effectiveness and to look to others to define their world.

To this extent, the family can be considered a microcosm of the larger culture. A dysfunctional society with a rigid hierarchy and displaying maladaptive thinking is bound to spawn families similarly comprised. For the woman struggling with bulimia to gain the freedom and courage to be who she is in relation to her family, allows a greater likelihood that she will feel her power in the world. Both the interviews and overview of the literature presented herein concur that the family of origin of women with bulimia is perceived as significant in the development of her disorder. It is hoped that this connection, along with the appearance of symptoms around the culturally-prescribed time of separating from the family, will form the basis for further research on the family of origin as a therapeutic strategy in the treatment of bulimia.

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APPENDIX A

Glossary

binging. The rapid consumption of a large amount of food in a short period of time.

boundary. An emotional barrier that protects and enhances the integrity of individuals and families. Rules defining who participates and how.

cross-generational coalition. An inappropriate alliance between a parent and a child, who side together against a third member of the family.

cutoff. The creation of distance, either emotional or physical, to reduce the discomfort and anxiety of being in emotional contact.

detouring. To bypass and therefore avoid the main problem through focusing on another issue.

differentiation. A psychological separation of intellect and emotion, and an independence of self from others.

disengaged. A psychological isolation that results from overly rigid boundaries.

eating disorder. A disorder that features gross disturbances in eating behavior.

enmeshment. A loss of autonomy due to the blurring of psychological boundaries.

family of origin. The original nuclear family that an individual belongs to.

genogram. A schematic diagram of the family system.

homeostasis. The comfortable, status-quo balance or equilibrium.

individuation. An individual's development of autonomous functioning.

parental child. A child allocated power to take care of younger siblings, and is adaptive in large or

single parent families when done deliberately, but maladaptive when results from unplanned abdication of parental responsibility.

purging. An attempt to prevent weight gain, through behaviors such as self-induced vomiting, laxative or diuretic use, strict dieting or fasting, or vigorous exercise.

separation. An individual's development of autonomous functioning.

triangulation. A detouring of conflict between two people by involving a third person, which stabilizes the relationship between the original pair.

APPENDIX B

INTERVIEW GUIDE

Interview Date: _____

Location: _____

Name: _____ Subject No.: _____

Address: _____

Date of Birth: _____ Age: _____

Ethnic Background: _____

Religion: _____

Marital Status: _____

Education: _____

Present Occupation: _____

History of Illness (Medical/Psychiatric), addictions (drug/alcohol/gambling), abuse (sexual/physical/emotional) _____

_____

Age of onset of eating disorder: _____

Any precipitating event? _____

No. of binge eating episodes/week _____

Amounts eaten _____ Over _____ hours?

Duration of eating disorder _____

Do you perceive yourself as having control over your eating during a binge? _____

Do you perceive yourself as too fat, too thin, okay?

_____

Are you satisfied with your body shape? _____

Are you afraid of becoming obese? _____

Present weight _____ What do you consider your ideal wt.? _____

Do you diet restrictively, avoid certain foods (esp. high carbohydrate or fat containing)? _____

_____

Have you ever fasted? _____ How often? _____

Engaged in self-induced vomiting? _____

How often? _____

Used laxatives? _____ Diuretics? _____

Appetite suppressants? _____ Liquid diets? _____

Purpose of exercise _____

Frequency? _____ Length of time _____

What are your typical feelings before a binge? _____

_____

Following a binge? _____

_____

Are there any situations or circumstances related to binge eating? _____

_____

Are you presently taking any prescription medication?

_____

Type, frequency, amount, reason for use _____

_____

Describe self: _____

_____

_____

Describe social life, social adjustment, relationships, and social skills: _____

_____

_____

_____

_____

Any other info. about your eating disorder you consider important? _____

_____

GENOGRAM

INTERVIEW THEMES

COMMUNICATION

(a) Degree of self-disclosure in family

- are thoughts, beliefs, attitudes, feelings shared?
- sharing encouraged, discouraged?

(b) Degree of clarity and directness

- sufficient information shared, mutual understanding, or assumptions, misunderstandings, distortions, masks?
- if confused, can clarification be sought? Indirect messages the norm?
- can differences be discussed openly and directly? Assertive vs. passive, accommodating approach?

(c) Receptiveness of receiver

- are family members open and available to messages sent?
- listen to what is said and pay attention to each other?
- how do family members respond to assertive/ aggressive behaviors?

AFFECT

(a) Range of expressed emotions

- expression of feelings encouraged/attended to? Nurturance and support provided? Appropriate, inappropriate?
- members pay attention to each other's feelings? Understand each other's upsets?
- able to clearly identify and articulate feelings?
- what was the general mood and emotional tone?

(b) Level of anxiety and tension management

- does stress precipitate crisis? Anxiety reverberate through system? Emotional reactivity apparent?
- intensity of expressed affect adequate, inhibited, intense?
- coping skills apparent for handling tension and anxiety?

(c) Conflict management

- ease with which differences of opinion resolved? Is functioning hampered by unresolved issues?
- active participation and negotiation or passive compromise? a lot of arguing or avoidance?
- responsibility taken for actions, or blaming, scapegoating, putdowns, or lying, secrets?
- is conflict overt or covert?

CONTROL

(a) Leadership style and effectiveness

- authoritarian vs egalitarian; dominant-submissive; rigid vs flexible; traditional vs laissez-faire?

- spontaneous, predictable, chaotic? Adaptable, able to adjust to life cycle demands? Alternatives explored and attempted?

- basic tasks met, roles understood and agreed upon? Family members know what is going on in family?

(b) Power struggles

- exist and overt, or covert? Shaming or nurturing attempts to control? Others invited into struggle?

- family members compete and fight with each other? Everyone has say in family plans and decisions?

- do some family members try to run other family member's lives?

VALUES

(a) Degree of consistency and congruency

- values declared congruent with those displayed?
- clear, consistent about what is right and wrong? Able to discuss? Latitude that allows for comfortable functioning?
- cognitive distortions?

(b) Clarity of rules

- explicit and implicit rules make sense, are consistent?
- easy or hard to tell what the rules are?
- rules of compliance, self-sacrifice, please, take care of others, etc? Others?

(c) Societal messages

- family values consistent, in conflict with larger society?
- family presents self as proper, socially appropriate and desirable?
- importance of achievement? Role of women? Traditional concept of femininity? Passivity and saying yes important?

(d) Role of food

- importance of food, dieting? Messages about weight, shape?

BOUNDARIES

(a) Clarity of interpersonal, generational boundaries

- well-established and distinct vs vague, fuzzy, or rigid
- invasiveness and intrusions, closeness-distancing patterns, coalitions, triangles, cutoffs
- parents perceived as accessible, inaccessible

(b) Degree of emotional dependence

- family members go own way or are proud of being close
- family members read each other's minds, talk for each other, think the same, etc.
- impairment of child or spouse? Daughter feels responsible to hold family together? Distance gained through illness, addiction, other?

DIFFERENTIATION

(a) Degree individual able to be a separate person

- autonomous functioning, assertiveness, spontaneity vs insecurity, self-doubt, feeling responsible for self and others, doubt own ability to survive (maturity fears)?

- relationship oriented, seek love and approval, self-esteem dependent on others, sacrifice self for sake of others?

- false or pseudo self presented to world; role-play what expected to be and feel; affected by what other's think?

(b) Level of emotionality

- feeling dominated, cognitions clouded by emotions, or distinguishes between emotion and intellect?

- preoccupied with keeping relationships in harmony; excel at making others' happy; appear independent, yet emotionally dependent on family and feel awkward away from home?

(c) Degree family promotes autonomy

- family loyalty over individual identity emphasized?

- developing individuality encouraged or critisized, ignored or fraught with mixed messages?

- family members do things together rather than with others; members discouraged from being special or different?

POST-INTERVIEW COMMENT SHEET

Time of day:

Emotional tone:

Feelings during/about the interview experience:

Insights and reflections:

Difficulties experienced:

Other:

APPENDIX C

The University of Manitoba
Faculty of Education
Department of Educational Psychology
Winnipeg, Manitoba

Dear _____,

I am currently completing the requirements for my Master's Degree in Educational Psychology from the University of Manitoba. As part of my thesis, I am conducting a study on the eating disorder bulimia, with primary emphasis on family of origin factors that may have an impact on the development of this disorder. I plan to interview six to ten women who have suffered with bulimia, focusing on the interviewee's concept of self, family, and relationships, as well as her experience with bulimia. With this in mind and with your permission, your doctor/therapist has forwarded your name to me as a potential participant. The interview will be a one-time event, lasting approximately 90 to 120 minutes, and arranged at our mutual convenience. All participants will remain anonymous and all responses will be treated in strictest confidence. Each participant has the right to discontinue participation in this study at any time without penalty. A summary of the results of the completed study will be available upon request for each of the participants.

In the coming weeks, I will contact you by telephone to arrange the interview time and location, (or if it is more convenient I may be contacted at home, , or at work, 325-4325). Thank you in advance for your willingness to participate in this project.

Sincerely,

_____

Heather Fisher-Corbett
Graduate Student

APPENDIX D

The University of Manitoba
Faculty of Education
Department of Educational Psychology
Winnipeg, Manitoba

Dear _____,

The interview you have agreed to is part of my Master's Thesis work on the topic of Family of Origin Factors and Bulimia. Your permission to tape-record this interview is required. All data recorded will remain anonymous and strictly confidential, will be reviewed solely by myself, and will be used only as the anecdotal component of my thesis, with anonymity maintained in the written report. Recorded material will be erased within six weeks of the interview. You have the right to discontinue participation at any time during this interview without penalty.

Your endorsement of this form indicates your agreement to the above. Thank you very much for your cooperation in this project.

Sincerely,

_____

Heather Fisher-Corbett
Graduate Student

I give my permission to the above.

Signed _____

Date _____