



1986

Religiosity, Rituals and Patterns in Anorexic and Bulimic Families

Patricia A. Lavallee
Loyola University Chicago

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RELIGIOSITY, RITUALS AND PATTERNS

IN ANOREXIC AND BULIMIC FAMILIES

by

Patricia A. Lavallee

A Dissertation Submitted to the Faculty of the Graduate School
of Loyola University of Chicago in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

September 1986

ACKNOWLEDGEMENTS

The author wishes to thank Dr. Marilyn Susman, Director, Dr. Steven Miller, and Dr. Manuel Silverman, members of the Dissertation Committee, for their help and encouragement throughout the project. The author also remembers with gratitude the co-operation and openness of the women who participated in the study. Finally, this dissertation would not have been completed without the unfailing support, encouragement, and editorial feedback of Dr. Michael Rosenzweig.

VITA

The author, Patricia A. Lavalley, was born August 8, 1945 in Leominster, Massachusetts. She graduated from Annhurst College with a B.A. in Sociology in 1968. Her Master's Degree in Guidance and Counseling was obtained from Northeastern Illinois University in 1981. At present, she is in the doctoral program in Counseling Psychology and Higher Education at Loyola University of Chicago.

Her professional experience includes clinical practice, teaching, counseling, and consultation. At present, she is involved in counseling, consultation, and supervision of the therapeutic staff at the Albany Park Community Center in Chicago and has a limited private practice. Further plans include a private practice specializing in doing individual and group work with anorexic women.

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CHAPTER I
INTRODUCTION

In the last generation, anorexia nervosa has received recognition as a psychophysiological illness intruding itself more and more into contemporary consciousness. Anorexia nervosa is a distinct illness characterized by a relentless pursuit of excessive thinness. It is found primarily in young women living in highly developed societies such as the United States. Those afflicted struggle against feeling enslaved, exploited and unable to live a life of their own. They would rather starve than continue a life of accommodation to the expectations of their families. In this blind search for a sense of identity and selfhood (control over their own lives), the typical reaction of the anorexic person is to reject or resist any outreach from parents or from the world at large.

There has been no consensus among researchers on the etiology of anorexia nervosa. Currently, six main theories, organized along different conceptual lines, attempt to explain it (Hsu, 1983). The six theories are: the social-cultural theory, which emphasizes environmental factors such as society's emphasis on the desirability of thinness (Garner and Garfinkle, 1980); the family pathology theory, which examines parental attitudes, values and patterns contributing

to anorexia in family members (Minuchin et al., 1978); the individual psychodynamic theory, which examines attitudes about the self that have their origin in early life (Sours, 1974); the developmental psychobiological theory, which addresses anorexia nervosa as a disorder of weight, pivoting around specific maturational changes occurring at the time of puberty, both biological and psychological, and in which starvation represents a phobic avoidance of the responsibilities associated with adolescent/adult development (Crisp, 1977); the primary hypothalamic dysfunction theory, which examines biological factors, particularly the role of the hypothalamus, to account for anorexic weight loss (Russell, 1965); and finally, the theory that anorexia may be an atypical affective disorder occurring in an adolescent female at a time in her life when body image issues are important (Cantwell et al., 1977).

This paper will focus on two of the major theories listed above, the family pathology theory and the individual psychodynamic interpretation. These theories focus directly upon early environmental factors leading to the development of anorexia nervosa. The family systems models of Bowen and Minuchin will be utilized as part of the examination of the family pathology theory. The individual psychodynamic interpretation will be used in an exploratory search for deficits in ego development as causative factors contributing to anorexia in women. The major thrust of the present study

will be to provide clarification about the etiology of this syndrome. An effort will be made to explore the following effects in the development of anorexic symptomatology: family rituals, patterns of interpersonal interaction in the family, and the interpretations of religiosity by anorexics within the family structure. Special attention will be given to those patterns which reflect rigidity and authoritarianism. In families where interactional patterns reflect such rigidity and authoritarianism, it is likely that their religious belief system would have them see God in a rigid and authoritarian framework. It is therefore hypothesized that in families where religiosity is an operational dynamic, religiosity would reinforce one's tendency to become anorexic.

Minuchin et al. (1978) have suggested that the manner in which religion is perceived and interpreted in the family may make family interpersonal dynamics more rigid. It is a widely held view that if children see authority as punitive, they will grow up more inclined to be externally controlled, (eg., act out of a fear of punishment or experience guilt feelings). A person's perception of parental authority can be easily transmitted to a person's perception of God as an authority figure. This study seeks to explore the possible connection between the expression of religiosity in the home and the development of anorexia in women, as well as to explore other familial rituals and patterns that might have

some bearing on the development of anorexia nervosa in women.

Anorexia nervosa is an extremely complex illness. Its origin appears to derive from the child's passive participation in life, absorbing from the world without actively integrating anything from the environment, failing to build a strong sense of self. The relationship of anorexics to their parents appears superficially to be congenial; actually, it is too close, without necessary separation, individuation and differentiation. Murray Bowen (1980), in his systems approach to family therapy, reinforces this concept with his theory that when a child grows up too enmeshed in the "ego mass" of the family system, independence and differentiation cannot take place. Additional factors which are formative influences in the development of anorexia in young women include: the existence of a family environment in which there is subtle estrangement between parents with little true affirmation of the child; an environment in which people function superficially with minimal authentic communication. The religious influence in the home is often inflexible and rigid.

There is disagreement as to the relative influence of the mother versus the father in contributing to the development of anorexia in young women. Crisp (1979) speaks of the mothers as unable to provide the necessary warmth and security because they themselves are neurotic. He describes

the fathers as soft, inactive in the family and unable to take a stand against their wives. In contrast, Garfinkle and Garner (1982) profile the father as typically obsessive-compulsive, oftentimes rigid and controlling. Groen and Feldman-Toledano (1966) report that anorexic children suffer from severe love deprivation. Their parents live in loveless marriages that do not satisfy either of them, and they demand exemplary academic performance and correct behavior from their children.

The following areas of disturbed psychological functioning seem to be characteristic of anorexics: 1) severe weight loss, 2) a disturbance of body image and body concept, 3) hyperactivity and denial of fatigue, 4) a paralyzing sense of ineffectiveness, and 5) a family life in which self-expression was neither encouraged nor reinforced, where expectations were extremely high and sometimes rigidly expressed (Bruch, 1973). Prognosis for recovery without therapeutic intervention is at best poor; with intervention, the success rate is reported at 10 - 15% (Garfinkle and Garner, 1982).

Recent research suggests a distinct difference between the restricting anorexic (one who fasts to the point of emaciation) and the bulimic anorexic (one who follows a pattern of gorging and purging to reach the same end). Garfinkle et al. (1980) found that bulimics showed unique

characteristics as a group; they had a history of weighing more and were more commonly pre-morbidly obese. They displayed a variety of impulsive behaviors, including the use of alcohol and street drugs, stealing, self-mutilation, and suicidal inclinations.

STATEMENT OF THE PROBLEM

The present investigation will focus on exploring the possibility that certain patterns and rituals in the home during the child's formative years might have some bearing on the development of anorexic symptoms in young women. It is assumed that parental interaction with the growing child modifies and influences subsequent development in the child. In families where parental attitudes are rigid, authoritarian, with unquestioning obedience to doctrine expected, it is anticipated that these attitudes are linked to the development of anorexia. Religiosity, where present, will be examined with special emphasis on whether religious expression reflects an internal or external locus of control.

Because the study is exploratory in nature, a structured open-ended questionnaire given in an interview setting to each respondent by the researcher will be the instrument used to generate data leading to the formation of hypotheses. Questions selected were based on relevant issues focused on in the literature as well as through consultation with

professionals working with anorexic women. The list of questions used constitutes a relevant and plausible representation of the major psychological issues faced by anorexic women.

DEFINITION OF TERMS

RESTRICTING ANOREXIA NERVOSA is a condition of severe emaciation brought about by voluntary food refusal, in which the main issue is a struggle for control, for a sense of identity, competence and effectiveness. BULIMIA NERVOSA is a condition similar to the above except that the members of this group follow a gorging/purging syndrome, relying heavily on vomiting and laxative use to control their weights.

LIMITATIONS

The study will be limited to a purposive sample of ten women, five of whom are defined clinically as restricting anorexics and five defined clinically as bulimics. These subjects are currently undergoing or have undergone outpatient psychotherapeutic treatment. The study will be limited to women since that gender comprises an overwhelming majority of the identified anorexic population. Participants will be selected from the Chicago area in response to a radio announcement requesting volunteers for the study.

METHODOLOGY

The sample mentioned above is restricted to a private practice/outpatient population in which women are being treated for or have been treated for anorexia-related symptoms. This group is being selected rather than a more severely disturbed hospitalized group in an attempt to gather information consistent with a prevention/early intervention model. It is felt that an examination of early causative factors will provide clarification of the etiology of the syndrome to both clinicians and families of anorexics.

It is characteristic of those suffering from anorexia that they have problems with self-esteem, that they feel vulnerable and are easily threatened by what they perceive as intrusions from the "outside". Control issues have been identified and documented as part of the anorexic syndrome. Outpatient anorexics who agree to be part of the study will be more candid and more willing to be self-disclosing in their responses because of their exposure to psychotherapy.

The researcher will administer an open-ended questionnaire to each respondent and each session will be audio tape recorded. The recordings will then be transcribed verbatim for purposes of data analysis question by question via the constant comparative method. If someone refuses to be taped, then that person will not be used in the study and replaced by someone who is willing to participate.

Summary

Anorexia nervosa has been described as an illness concerning itself with issues of control. The present study seeks to explore the possible effects of patterns, rituals, and religiosity in the family in the development of anorexic symptomatology, especially where those patterns reflect rigidity and authoritarianism. A further question to be explored is whether rigidity has a greater influence in the development of restricting anorexia or bulimia in women.

Chapter II will review the literature on anorexia nervosa, systematically addressing explanations of its etiology in terms of the family systems approach and individual psychodynamic theory. Chapter II will also address the literature suggesting distinctions between restricting anorexia and bulimia. Religiosity will also be examined as a possible factor in the development of anorexia and bulimia.

Chapter III will address the methodology to be employed in this study. In addition, there will be a discussion of the instrumentation and research design. Chapter IV will analyze the data, question by question, by using the constant comparative method, which is a qualitative approach to data analysis. Chapter V will contain conclusions of this study which will be based on the data analysis. Further, it will address the strengths and limitations of the study, and

implications for future research. Finally, Chapter V will indicate those conclusions and implications for treatment that are based on and limited to data derived from the study.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

Eating disorders are not merely physiological. Whether the symptom is obesity or emaciation, the behavior is an attempt to solve or camouflage problems of living that appear to be otherwise unsolvable. Food is endowed with complex values, elaborate ideologies, religious beliefs, and prestige systems (Bruch, 1973). Anorexia nervosa remains a puzzling disorder. Controversy surrounds theories of its cause, its prevalence and its treatment. Currently, there are six major theories organized along different conceptual lines that try to explain it (Hsu, 1983). While the theories are not mutually exclusive, they range from solely biological explanations to solely psychological interpretations (See Chapter I), and offer no definitive explanations as to what really causes people to become anorexic. In addition, there has been confusion about whether anorexia nervosa exists as a distinct disorder or whether there are diagnostic subtypes.

There is disagreement among researchers as to what constitutes a true anorexic personality type. Swartz (1985) states that the syndrome cannot be understood apart from its specific cultural or subcultural context. Most authorities agree that restricting anorexia is characterized by a willful

desire to be thin and by a loss of at least 15 to 25% of ideal body weight unrelated to other psychopathology or illness (Yager, 1982). However, diversity beyond this is great (Russell, 1977; Anderson, 1977). Some cases of anorexia nervosa begin as early as nine or ten years of age, others do not become apparent until the 20's or 30's or even later, sometimes after the patient has borne children. Some patients develop marked hyperactivity and others do not. A certain number develop binge eating, self-induced vomiting and/or laxative abuse whereas others do not. There is no uniformity of personality, so that obsessive, hysterical and other patterns are seen. People differ with respect to ego development, psycho-sexual development, peer and heterosexual relationships and experience, social competence, academic and social striving and a host of other areas (Yager, 1982). Coping mechanisms range from extreme conformity to parental expectations to rebelliousness against prescribed family rules (Kalucy et al., 1977). Personality styles and stress response patterns vary in both individuals and families. Some utilize denial and isolation as defense mechanisms, others deal with their problem in an obsessive fashion, constantly doubting and/or blaming themselves for not being perfect, others take a more adaptive approach and try to understand and cognitively change what they can (Lazarus et al., 1969).

This paper will address the following theoretical areas

of research concerning anorexia nervosa. The first theory examined will be the family/systems theory. This will be followed by the individual psychodynamic theory. The distinctions between restricting anorexia and bulimia will be examined. Finally, religiosity will be looked at as a factor in the development of anorexia and bulimia.

The Family/Systems Theory

Beginning with the nineteenth century, early investigators have emphasized family pathology in anorexia nervosa (Charcot, 1889; Gull, 1874; Laseque, 1873). Laseque (1873) described the noticeable family enmeshment and urged clinicians not to overlook the family pathology. He observed that the parents of anorexics he treated reverted to two methods of interaction with their daughters, "entreaties and menaces", and that the anorexic became the sole preoccupation and topic of conversation in the family. Consistently, the earlier research, conducted by physicians, has addressed familial predisposing factors such as estrangement between parents or a need within the family system to focus interfamilial stress on the child, making it the family's "identified problem".

More recently, Crisp (1979) has identified a number of investigators who report the existence of long-standing patient-parent relationships that range from hostile to

dependent as leading to the genesis of the illness. Minuchin et al. (1978), postulated the predominance of environmental factors as determinants of behavior. They placed the locus of the illness in the family and alluded to the possibility of a religious presence as having an effect on personality development in the anorexic population. Minuchin and his co-workers advocated an open systems model for psychosomatic illness including anorexia nervosa. This system examined parts of the system such as extrafamilial stress, family organization and functioning, and any physiological factors impacting on the symptomatic child.

These authors have emphasized almost exclusively the family system's pathology and stated that "When significant family interaction patterns are changed, significant changes in the symptoms of the psychsomatic illness also occur" (Minuchin et al. 1978, p. 21). They further hypothesized that: 1) certain family characteristics were related to the development and maintenance of psychosomatic symptoms in children; 2) the family's identified characteristics were enmeshment, overprotectiveness, rigidity and lack of conflict resolution. Meanwhile, the child was used to maintain stability and to avoid open conflict, and thus was often caught (triangulated) in the parents' covert conflict. The illness enabled the parents to submerge their conflicts in protecting or blaming the sick child, who was then defined as the sole family problem. Bruch (1973) maintained the same

position and referred to patterns of disturbed family interaction as being very subtle, below the surface. She stated that parents are often quick to point out that they cannot understand the direction the child has taken (in becoming anorexic) since the child, up to that point, had always been so "happy, docile, submissive, received good grades, never gave anyone any trouble...". Viewed from the outside, the impression is that the family unit is functional, even close.

In a study measuring marital satisfaction in the parents of anorexics, Kalucy et al. (1977), reported that 34% of fathers and 19% of mothers explicitly threatened parental separation before the onset of the child's illness. In some cases, the focus on the child as "identified problem" relieved some of the pressures reflected in the marital discord of the parents. In another study dealing with parental compatibility, Crisp et al. (1980) reported marked parental discord and dissatisfaction with their mate in more than 50% of the cases they studied.

According to Bruch, (1979) the interaction of anorexics with their families generally results in failure to achieve a sense of independence. Because of unclear boundaries between parents and children, parents are unable to give their daughters what is necessary to help them grow up with good feelings about themselves (i.e. affirmation, confidence, and

feelings of self-worth). The arrested emotional development of the parents create an environment in which affirmation, positive regard, and the instilling of confidence are not present. The problem is compounded by the tremendous demands placed on the child to do things perfectly, and to always be socially acceptable. Parents try to resolve their own shortcomings by vicariously experiencing the success of the children, therefore, they put tremendous pressure on them to succeed. Consequently, the anorexic child is not given the opportunity to develop the ego strength necessary to differentiate herself from her parents in a healthy way.

Researchers have found that parental behavior, particularly that of the mother, is an important antecedent of locus of control orientation. Several studies have reported that adolescent females who perceive their mothers as providing low structure and little protectiveness, score higher in internal control on internal-external measures than do females who perceive their mothers as exerting high structure (Levensen, 1973; Scheck, 1978). Levensen (1973) suggests that warm, accepting families raise their daughters to believe that they should be dependent and that a more rejecting home environment encourages independence.

The parents of an anorexic face ambiguity, uncertainty and few guidelines regarding how to deal with her problems.

Given the ambiguity about the causes of the syndrome, parental coping mechanisms generally consist of guilt and/or denial. Projection of guilt is virtually inescapable (Yager, 1982). Consequently, it is anticipated that familiar rituals and/or coping mechanisms will surface as family members try desperately to attain or maintain a semblance of homeostasis.

A high prevalence of personality and psychophysiological disturbance has been reported in the parents of anorexics, but diversity in diagnostic criteria and the absence of comparison groups presents limitations in adequately assessing the significance of many observations. Halmi et al. (1977) described the occurrence of gastrointestinal disorders in first-degree relatives of 44 patients: peptic ulcer (16%), gastritis (32%), irritable colon (23%). Dally (1969) reported peptic ulcer in 11% of parents of anorexics. Kalucy et al. (1977) reported that 30% of their patients' mothers suffered migraine. The nature of these symptoms reflects unhealthy coping mechanisms and suggests that externalized controls are present in the family environment where parents model personal ineffectiveness in coping with life.

Yager suggests that differences in sample selection, diagnostic criteria, socioeconomic status, etc. make it difficult to compare different studies of patients that have been reported in the literature. He poses the following

questions about the role of the family in the pathogenesis of anorexia:

1) What characterizes the family that invites anorexia as opposed to other modes of breakdown? Incomplete, suggestive responses are available to this question.

2) How much of what has been described as typical family patterns represent stress reactions in the wake of the impact of anorexia rather than pre-existing and enduring family patterns? Several studies have attempted to deal with this problem, but the issue remains confused.

3) Can we distinguish necessary pre-conditions in the family from those that are simply permissive but non-essential in promoting the appearance of anorexia nervosa in the vulnerable person. He asks as a corollary, "What is the incidence in the general population of various family patterns that have been described in relation to anorexia (e.g., food faddisms, parental overcontrol, enmeshment, etc.)? Here, there is as yet, nothing firm in the literature.

4) Finally, what family factors are conducive to maintaining the syndrome and influencing prognosis?

To date, some preliminary answers have been put forth (Yager, 1982:46).

This paper next addresses the individual psychodynamic theory as it relates to the development of symptomatology in anorexia nervosa.

Individual Psychodynamic Theory

In 1931, Brown observed that anorexia nervosa was a pathological manifestation of the detachment of the adolescent from parental authority. Bruch (1962, 1970, 1973, 1977) has repeatedly stated that anorexia nervosa was a struggle for a self-respecting identity. That this struggle took the form of willful starvation suggested serious defects in psychological development. Central to such defects was the failure of parents to regard the child as an individual in her own right; in effect, they failed to transmit a sense of competence and self-value in the child. The youngster was instead treated as something to complement the parents' needs. In short, the child was made to feel that she was the property of the parent (Hsu, 1983). The illness thus represents an effort to escape from this role and to establish control.

Palazzoli (1974) and Boskind-Lodahl (1976) have stated that because of their disturbed perception of bodily sensation and a paralyzing sense of ineffectiveness, anorexics misinterpret their biological functioning and

social role, and come to interpret thinness and starvation as an expression of their uniqueness and self-control in an exaggerated way. In 1976, Boskind-Lodahl described anorexia nervosa as a rejection of femininity stemming from an intense hatred of one's mother. She also suggested that there exists a distinct difference between the true restricting anorexic and the bulimic, with the restricter rejecting femininity and the bulimic overidentifying with femininity. A pilot study of women by Boskind-Lodahl and White (1978), discovered that all 12 subjects, restricters and bulimics alike, manifested a distorted body image. In further research with both groups, Boskind-Lodahl disagreed with her previous hypothesis, suggesting that women who restrict their food intake do so as a rejection of femininity. Instead, Boskind-Lodahl and White (1978) indicated that the women are trying desperately to fit themselves into a stereotyped feminine role by their relentless pursuit of thinness.

Sugarman (1979) suggests the possibility that anorexia nervosa is in reality a schizophrenic phenomenon, since the anorexic has a tendency to maintain a stable personality organization and only regresses under particular sorts of stress. He states that the anorexic has the ability to retain distorted images of herself while otherwise maintaining adequate reality testing. This is conceptualized in terms of the poorly integrated self and object representations of the infantile personality and subsequent

potential for distortion of body images.

There is general agreement that feelings of ineffectiveness are a central dimension of the anorexic personality (Bruch, 1977; Crisp, 1977; Selvini, 1974; Sours, 1969). Individual case histories and clinical intuition are not satisfactory bases for establishing theories. Several authors have commented on the lack of research in this area and have stressed the need for objective personality measurement (Kay, Shapira & Brundan, 1967; Smart, Beaumont & George, 1976). Garner, Garfinkle & Moldofsky (1976) refer specifically to the need for an adequate measure of the ineffectiveness dimension. An earlier study by Garner, Garfinkle, Stancer and Moldofsky (1976), which found a positive correlation between body image disturbance and external locus of control suggests that the internal-external construct may be related to feelings of ineffectiveness in anorexia nervosa.

A major concern of the anorexic is for approval. In a study by Branch & Eurman (1980), a questionnaire completed by family and friends of anorexics indicated that the patients met with more approval than disapproval. These results indicate our society's preoccupation with thinness. In a society where thinness is looked at with admiration, the subconscious and conscious quest for thinness on the part of the anorexic can be interpreted as striving to become someone

special, fitting a much desired societal model.

Research Related to the Distinction Between Restricting
Anorexia Nervosa and Bulimia

During the last 20 years bulimia emerged as an additional eating disorder from within the studies on the eating disorders of obesity and restricting anorexia nervosa, (Garfinkle & Garner, 1982; Russell, 1979; Wilson, 1978). The characteristic which differentiated this new disorder was binge eating. This was found to occur among all weight groups from the obese to the restricter (Rau & Green, 1975; Wermuth, Davis, Hollister & Stunkard, 1977). Interest in bulimia developed from anorexia research because a number of investigators found bulimic characteristics in many of their anorexic patients (Ben-Tovim, Marilov & Crisp, 1979; Garfinkle, Moldofsky & Garner, 1980; Hsu, 1980; Pyle, Mitchell & Eckert, 1981; Russell, 1979).

Although all anorexics severely restrict food intake in their pursuit of thinness, two distinct groups were now recognized. Categorization depended upon the method of food intake restriction (Schlesier-Stropp, 1984). Individuals who exerted extreme control and ingested minimal amounts of food were categorized as either the "fasting group" (Casper et al. 1980), "abstainers" (Ben-Tovim et al. 1979), "the restricting group" (Garfinkle et al. 1980), or "dieters" (Beaumont et al. 1976). In contrast, some individuals ate enormous amounts of

food followed by self-induced vomiting or the excessive use of laxatives. This type of anorexic was referred to as the "bulimic group" (Casper et al. 1980; Garfinkle et al. 1980), "vomiters" (Ben-Tovim et al. 1979) or "vomiters and purgers" (Beaumont et al. 1976).

Controversy developed over whether restricting anorexia and bulimia were separate syndromes or extreme ends of the same disorder. Guiora (1967) coined the term "dysorexia" for the syndrome which suggested that it was the same disorder but comprising both anorexic and bulimic behavior. Russell (1979) clearly identified bulimic patients during his research but stated that it was premature to think of the disorder as a distinct syndrome. Instead he used "bulimic nervosa" to describe binge eating and purging behaviors.

Differing opinions among researchers regarding definitions and categorizations of bulimia and anorexia were resolved when bulimia was classified as a separate eating disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, American Psychiatric Association, 1980). According to the DSM-III, p. 69, the diagnostic criteria for anorexia nervosa are:

A) an intense fear of becoming obese which does not diminish as weight loss progresses, B) disturbance of body image, e.g., claiming to 'feel fat' even when emaciated, C) weight loss of at least 25% of original

body weight, and D) refusal to maintain body weight over a minimal normal weight for age and height.

Bulimia, on the other hand, is described by the DSM-III, p. 71, as follows:

A) recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours), B) at least three of the following; 1) consumption of high caloric, easily ingested food during a binge, 2) inconspicuous eating during a binge, 3) termination of such eating episodes by abdominal pain, sleep, social interruption or self-induced vomiting, 4) repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or frequent use of cathartics or diuretics, 5) frequent weight fluctuations of greater than ten pounds due to alternating binges and fasts), C) awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily, D) depressed mood and self-deprecating thoughts following eating binges, and E) the bulimic episodes are not due to anorexia or any known physical disorder.

Russell (1979) was one of the first investigators to research differences between anorexic and bulimic patients. According to his findings, the anorexic patients exhibited

self-induced severe weight loss, persistent amenorrhea, and intense fear of losing control over eating and becoming fat. Unlike the anorexic group, the bulimic patients were only slightly underweight, or even normal or overweight, a characteristic identified by other researchers as well (Fairburn, 1981; Linden, 1980).

Bruch, (1979) reports the abstinence of restricting anorexics as based on a fear that if they do start eating, they will not be able to stop, and therefore, they attempt to stay away from food altogether. She further associates hyperactivity with restricting anorexics, in which exaggerated exercise may take on many forms. Sometimes an existing interest in athletics becomes intensified. Others engage in activities that seem to be aimless, such as walking for miles, chinning and bending exercises, refusing to sit down, or literally running around in circles.

A bulimic's day revolves around food and eating. Bulimics consistently report that their minds are filled almost constantly with thoughts of food, eating and vomiting. Further, their concentration on everyday activities is impaired (Fairburn, 1980; Fairburn & Cooper, 1982; Herzog, 1982).

Dally (1969) describes the bulimic group as often possessing an interest in cooking, sometimes gourmet cooking. Russell's study (1979) points to the bulimic group as having

depressive symptoms severe enough to lead to suicide. The anxiety experienced finds its expression in the binge/purge syndrome. A binge episode typically lasts from one to two hours but can last an entire day (Pyle et al. 1981). Generally, sugary or starchy foods are devoured, with one patient reporting a caloric intake of 15,000 to 20,000 calories during a single binge (Russell, 1979). Johnson (1981) reports that the bingeing, per se, is not a gratifying experience, but rather is associated with feelings of disgust, helplessness, guilt and panic. The purge, on the other hand, is viewed as a source of relief for most victims.

According to findings reported in the literature, the bulimic is typically a white woman in her mid 20's. She probably began overeating at about 18 and began purging, usually by vomiting, a year later. It is common for her family history to include a high incidence of obesity and/or alcoholism (Garfinkle & Garner, 1982). A study conducted by Johnson & Flach (1985) found that the high disorganization of the families of bulimic subjects was associated with the severity of symptoms. According to the same study, it appeared that bulimic family milieus could be characterized not only as enmeshed but also as disengaged, with high conflict and a low emphasis on self-expression -- particularly expression of conflicting issues. A high achievement orientation prevailed against a backdrop of low emphasis on intellectual and social activities. Among the

restricters, the literature seems to indicate a greater family emphasis on intellectual development and excellence.

Both the bulimic group and the restricting group seem to have lost a sense of a realistic body image and perceive themselves as overweight. Although mood swings are common in both groups, bulimic individuals have been found to experience high levels of depression and anxiety (Schlesier-Stropp, 1984). Intense feelings of guilt, shame and self-contempt are characteristic of both restricters and bulimics.

An examination of clinical differences within the anorexic population suggests that the externality hypothesis (a tendency toward external control) may not be generalizable to all patients. The behavior of the abstaining/restricting anorexic as compared with that of the bulimic seems to focus on a different interpretation of control. Whereas the dieter demonstrates considerable self-discipline and denial, the bulimic is often described as fluctuating between an intense sense of self-control and loss of control (Garfinkle, Brown & Darby, 1981). Whether or not external control is characteristic of the entire anorexic population or tends to be confined to a specific clinical subgroup (bulimics) is a question to be addressed in the present study.

Religiosity As a Factor
in the Development of Anorexia and Bulimia

Feelings of guilt, denial of sexuality, lack of control over oneself, are reinforced by exposure to an environment where rigidly held views of right and wrong, repressive interpretations of sexuality and blind obedience to someone or something outside of the self act to devalue the person. Mosher (1961) maintains that religious training affects how one perceives oneself, that a "good" person's reward is being happy, free from guilt, and that if a person perceives herself as a "bad" person, she also sees herself as deserving of punishment. It is generally accepted that one's image of God, the ultimate authority figure, is not unlike one's image of authority represented in one's own parents. The demands from parents for external perfection coupled with a lack of affirmation and validation of the child's sense of self-worth contribute to religious guilt feelings leading to self-destructive behavior in the child.

The literature contains no documented evidence of family dependency needs being met through religious expression or ritual. However, there is general agreement that feelings of ineffectiveness in family members are tied into the family's typical coping patterns. Further, that if externally-focused religiosity (form vs. content) is a prescribed family value, it will only serve to reinforce external control both in the family as a whole and in the anorexic member.

Levin (1979) proposes an explanation of religious behavior in terms of an attachment/detachment theory, where the young child's attachment to the mother finds its expression in the development of religious attitudes. Another study, conducted by Sturgeon & Hamley (1979) on religiosity and anxiety, divided Christians into intrinsic and extrinsic orientations according to Allport's Religious Orientation Scale. The study found that intrinsic Christians have less anxiety and greater internal locus of control and that those labeled as extrinsic Christians (those relating more to the form rather than the content of religion) tended to be externally controlled.

Kalucy, Crisp & Harding (1977) found that a religious attitude often exists which plays a part in the development of the following characteristics. First, there is an unusual incidence of phobic avoidance and obsessive-compulsive character traits. Second, one finds an unusual vulnerability to seemingly ordinary life events and a tendency to be unusually interdependent.

Larsen (1979) investigated the frequency, range and pattern of religious experience as related to self-actualization. His finding was that frequency, range and pattern are dimensional aspects of religious experience that are differentially related to self-actualization. The young adult woman with anorexic/bulimic symptoms has not reached a

high degree of self-actualization. The frequency, range and pattern of her religious experience contribute to an understanding of the development of her anorexic symptoms.

Summary

The present study is an attempt to examine anorexia nervosa, to become familiar with its symptoms, and to critically study the background and environment out of which it develops. Noting the restricting anorexic through the literature, one tends to find a different type of person than the young woman manifesting bulimic symptoms. Since the literature places great emphasis on family environment in the development of anorexia nervosa, this research project is designed to focus on the discovery of whether or not certain rigid rituals in the family, especially of a religious nature, could have some effect on the development of anorexia and bulimia in young women.

Chapter I introduced the present study. The research was designed to explore the possible effects of patterns, rituals, and religiosity in the family in the development of anorexia symptomatology.

Chapter III will address the methodology employed including a discussion of the instrumentation and research design. Chapter IV will analyze the data, question by

question, by using the constant comparative method, a qualitative approach to data analysis. Chapter V will state conclusions based on the data analysis, address the strengths and limitations of the study, and implications for future research.

CHAPTER III

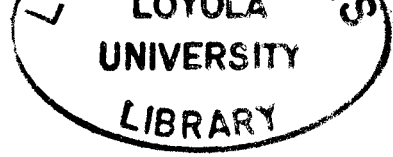
METHODOLOGY

Nature of the Study

The present research investigated early environmental factors, rigidity, familial patterns of interaction, and the interpretation of religiosity by family members. The case study analysis approach was used to study the above factors as they pertained to anorexic and bulimic women. The qualitative focus provided a framework within which respondents were able to express themselves in their own terms. The literature on anorexia nervosa is highly speculative. The methodological approach utilized here attempts to provide a more precise delineation of family patterns which has been limited by the lack of meaningfully valid quantitative techniques for measurement (Yager, 1982).

Qualitative inquiry was judged to be the most suitable for the following reasons. First, much of the literature using quantitative methods relating to the causative factors in the development of anorexia is unclear and contradictory (Kay, Shapira & Brundan, 1967; Smart, Beaumont & George, 1976; Garner, Garfinkle & Moldofsky, 1978 -- for further references, see Chapter II of this study).

Secondly, a qualitative approach was preferred in order



to utilize Glaser's (1967) concept of grounded theory. Glaser maintains that an effective approach in gathering useful data is to address the study with no predetermined hypotheses or theories, but rather, to allow theory to emerge as the data is collected and analyzed. Used within the structure of the constant comparative method throughout the research process, the theory is open to modification as new insights emerge. Consequently, the existing model is constantly open to change. Given the complexity of the anorectic syndrome, this approach was viewed as a highly viable option for recognizing patterns within the family system that might be amenable to treatment, before the syndrome became more destructive to the victimized individual. It was also felt that identifying possible factors, not yet acknowledged as having etiological significance, could lead to further challenge and testing in other settings and with other subjects to support the generalizability of the findings.

The issues of validity and reliability in this study were addressed through the utilization of the concept of triangulation (Denzin, 1978). Implied in this technique is the use of two or more strategies to investigate problems and interpret findings. Triangulation refers to the combination of methodologies in the study of the same phenomena. Denzin (1978) has identified four basic types of triangulation: (1) data triangulation, the use of a variety of data sources in a study; (2) investigator triangulation, the use of several

different researchers or evaluators; (3) theory triangulation, the use of multiple perspectives to interpret a single set of data, and (4) methodological triangulation, the use of multiple methods to study a single problem. He explains that the logic of triangulation is based on the premise that no single method ever adequately solves the problem of rival causal factors and that each observational research method reveals different aspects of empirical reality.

The present study used data triangulation and theory triangulation in keeping with Patton's (1980) holistic-inductive paradigm. This strategy includes; (1) qualitative data, (2) a holistic-inductive design of natural inquiry, and (3) content or case analysis.

In this study, overlapping concepts in the questionnaire was one way triangulation was employed. Another application of triangulation was through references made to the literature and to other theories. While triangulation has problems in terms of a logic-of-choice (Miller, 1982) its strength in this study was seen in helping to correct for the qualitative counterpart of a Type II error and in contributing to the issues of validity and reliability. Validity and reliability will be further addressed in the discussion of the questionnaire.

Sample

The total sample consisted of ten anorexic women, five restricters and five bulimics between the ages of 15 and 35. The study was limited to women, since the literature indicates that women represent an overwhelming percentage of the identified anorexic population (Bruch, 1973; Garfinkle and Garner, 1982).

The women in the sample were volunteers solicited through an announcement on a Chicago radio station. The announcement specified that potential subjects be currently in therapy or had undergone outpatient psychotherapeutic treatment for anorexia-related symptoms. This specification was in keeping with a prevention/early intervention model. Because much of what has been studied has been carried out with a severely disturbed or hospitalized anorexic population, it has been difficult to determine cause from consequence. Also, because control issues have been identified and documented as part of the anorexic syndrome, it was felt that those outpatient anorexics who agreed to be part of the study would be more candid and willing to be self-disclosing in their responses. This indeed was found to be the case with all subjects interviewed.

Qualitative research is primarily concerned with "thick description" (Geertz, 1973). This means that the researcher's primary interest is not in generalization

(external validity), but rather in an in-depth examination of the "way of life" of a given group. Although the sample was "self-selective" and therefore presented a potentially biasing factor, it was felt that since the subjects were volunteers, that status would induce them to reveal more details about their personal lives.

This point-of-view (thick description) is a distinguishing characteristic of the qualitative approach. The emphasis is on obtaining reliable information based on the respondents' thorough understanding of the questions (Weber, 1949; Winch, 1958). This approach also focuses on the dual-role of the investigator: (1) as a participant or observer of the "life" of a selected group, and (2) as an "interpreter" of the meanings displayed by the group. Thus, while the qualitative researcher acknowledges the quantitative researcher's approach as one way of studying social issues, his/her particular view is different but not necessarily contradictory. That is, the qualitative researcher posits an alternative methodological approach for the study of social phenomena, which is primarily concerned with an "inductive" view of peoples' behavior, rather than an "imposition" of predetermined assumptions, constructs and methods.

Instrumentation

The instrumentation for this study was limited to an open-ended questionnaire (see Appendix A). The advantage in using such a questionnaire is that it might reveal information not made available through other more specific types of instrumentation. Prior to actual use, the questionnaire was shown to three experts working with anorexics. The experts consisted of one psychologist and one social worker associated with an eating disorder clinic in the Chicago area, and one psychologist specializing in eating disorders at a Chicago university counseling center. Their responses to the questionnaire indicated that the questions seemed relevant and pertinent to the anorexic populations they were dealing with, but that pursuing religiosity as an operant dynamic might be "grasping at straws". The study was pilot tested to verify that the questions were relevant and valid for use with this population. Those who served as preliminary subjects were five women identified as anorexics, two from the private practice of the researcher, and three in treatment with other therapists who agreed to field test the questionnaire. Their responses and comments to the questionnaire resulted in revisions which added to the clarity of what was being asked and sharpened the instrument in terms of face validity (Kerlinger, 1973).

Patton (1980) states that the purpose of open-ended

interviewing is to access the perspective of the person being interviewed. He further describes the open-ended interview as a set of questions carefully worded and arranged with the intention of taking each respondent through the same sequence, asking each respondent the same questions with essentially the same words. Although flexibility in probing is limited, this format is preferred when it is important to minimize variation in the questions posed to interviewees. This reduces the possibility of bias when having different interviews for different people, including the problem of obtaining more comprehensive data from certain persons while getting less systematic information from others. Considering the nature and focus of this study, it seemed appropriate that the standardized open-ended interview be used as the primary tool in the data gathering process. By standardizing the open-ended interview, the writer was able to obtain data that was systematic and thorough for each respondent.

It should be mentioned that a major limitation of this manner of interviewing is that it constrains the flexibility in relating the interview to particular individuals. It also limits the naturalness of responses to questions and answers (Denzin, 1978; Patton, 1980).

The Questionnaire

Validity in qualitative research refers to the degree to

which research findings are interpreted correctly. Kirk and Miller (1986) address the concept of validity by dividing it into apparent (face) validity, instrumental, and theoretical (construct) validity. Face validity was established in the pilot testing of the questionnaire through open-ended interviews with preliminary subjects in order to ascertain that the questions were clearly understood and relevant.

Kirk and Miller (1986) state that instrumental validity can be said to exist if it can be shown that observations match those generated by an alternative procedure that is itself accepted as valid. Quantitative studies researched, (Minuchin et al., 1978), (Garfinkle and Garner, 1982) indicate parallel problem areas of anorexic women as those discussed in this study. Some examples of this are: difficulty in expressing appropriate anger, tendencies towards external control, and unresolved guilt-related issues.

Theoretical or construct validity has minimal application to this study since there is no unified theory concerning the etiology of anorexia nervosa, and most previous research is contradictory in its findings.

Reliability, like validity, is meaningful only with reference to some theory. Kirk and Miller (1986) distinguish several sub-types of reliability; quixotic reliability, diachronic reliability, and synchronic reliability. Quixotic

reliability refers to the circumstances in which a single method of observation continually yields an unvarying measurement. Responses to the questionnaire generated consistent themes as existing in the lives of the respondents: anger, control issues, and feelings of guilt. This seems to give credibility to the consistency of findings.

Diachronic reliability refers to the stability of an observation through time. Again, the literature on anorexia reports a heavy quantitative bias, but findings, both in reported literature and in the present study, give indications of recurrent themes in the anorexic personality.

Synchronic reliability refers to the stability of an observation within the same time period. The present research utilized this type of reliability in that all the data was gathered within a period of two weeks.

The data gathering instrument in the present study consisted of two sections: a) a demographic part designed to elicit background information to be examined for any patterns related to the emergence of anorexic symptoms, and b) a set of 13 open-ended questions designed to provide data in the following cluster areas: religiosity, a parental profile, parental values and attitudes, family rituals and patterns, and current self-concept of the anorexic woman. The demographics had been suggested in the literature as having

possible significance in the development of anorexia and were included in this study as an auxiliary component.

Webster's 9th New Collegiate Dictionary (1984) defines religiosity as: a) a personal set or institutionalized system of religious attitudes, beliefs and practices; and b) scrupulous conformity. The present study posed the question of whether or not the interpretation and expression of religiosity in the home is relevant to the development of anorexia and bulimia in women. The manner in which religion is perceived and interpreted in the family may have an effect on family dynamics, on how children view authority and learn to direct their own lives or be controlled by someone or something outside of themselves (eg., fear of punishment or generalized guilt feelings). It was anticipated that if a respondent described herself as religious or having grown up with an organized religion, the nature of her religiosity reflects patterns established in the parent-child relationship. The religiosity factor might be a reinforcer in the person's perceiving herself as out of control, especially if her views of religion followed the pattern of scrupulous conformity (concern with externals rather than intrinsic worth).

Bruch (1973), Garner & Garfinkle (1982) and others have noted the importance of early environmental influences in the development of anorexia. Some of the questions in the open-

ended questionnaire were designed to explore the nature of certain rituals and patterns in the family (such as what went on at a typical family meal) and to see how those patterns and rituals might related to how the anorexic views herself and her world in the present. The list of questions used constituted a relevant and plausible representation of issues faced by anorexic women -- no parallels for such an interview format had been previously presented in the literature.

Each session with a respondent lasted approximately 1 1/2 hours. Written permission was sought and audio tape recordings made of all sessions. Following the interviews, verbatim transcripts were written up for purposes of analysis. All of the interviews were conducted by the researcher of the present study and concerted efforts were made to assume as neutral a position as possible so as not to affect the validity and reliability of responses. It was recognized that since each question sets up a frame of reference for succeeding questions, it was important to expose each subject to as constant a stimulus as possible.

At the end of the interview, subjects were asked if they would be interested in feedback on the study. All agreed and arrangements were made to send each respondent a written synopsis of the research data.

Method of Qualitative Analysis

The Constant Comparative Method

This method of analysis, formulated by Glaser & Strauss (1967), stresses the importance of theory building and utilizes the grounded theory concept as a vehicle for drawing certain interpretations from the data. Theory is systematically built through explicit coding and analytic procedures.

Bogdan & Biklin (1982: 70) recount the steps in the constant comparative method as follows:

- 1) Begin collecting data.
- 2) Look for key issues, recurrent events, or activities in the data that become categories of focus.
- 3) Collect data that provide many incidents of the categories of focus with an eye to seeing the diversity of the dimensions under the categories.
- 4) Write about the categories being explored, attempting to describe and account for all that the data reveals while continually searching for new incidents.
- 5) Engage in sampling, coding and writing as the analysis focuses on the core categories.

As Glaser notes, although one can conceive of the constant comparative method as a series of steps. What has just been described may go on simultaneously, and the

analysis keeps doubling back to more data analysis and more coding.

The major strength of this method is that it is viewed as an important way of controlling the scope of data collecting. A weakness of the constant comparative method, which could be generalized to qualitative research per se, is that of being able to convey the credibility of any findings or theory derived. However, in an attempt to address these concerns, the present study utilized a rigorous codifying procedure, searched for negative cases (those which do not fit the hypothetical model), and considered alternative hypotheses as means for ensuring more substance and credibility.

In the actual analysis of the data, the researcher went through each set of interview responses looking for themes (Bogdan and Biklen, 1982: 173). If a particular dynamic was recognized in one individual, it was coded and all other responses examined for the existence of or a variation on the same theme.

The choice of coding strategies in qualitative research may be broadly described as either "inductive" or "deductive" (Miles and Huberman, 1985). A deductive coding scheme is basically an a priori decision to create either a simple or complex coding format based on concepts deemed important by the researcher and deriving from either personal experience

with the subjects under study, concepts drawn from the literature, or both. While the deductive framework is subject to revision as data are collected and analyzed, the formulation of the code beforehand imposes some constraints on the researcher.

An inductive coding strategy, on the other hand, allows the researcher to enter the setting with certain "sensitizing" concepts, but allows the relevant concepts for coding to emerge for analysis and revision. Since the constant comparative method is an inductive code-generating procedure, it was this strategy that was utilized in identifying and interpreting various themes.

The researcher was also alert to any negative cases which might not fit the existing model; however, none were apparent. It should be noted that negative cases are often central in qualitative research. Negative cases (or instances) are data which are counter to or in opposition to an emergent theme. While negative cases are directly relevant to the qualitative technique of Analytic Induction (Robinson, 1951), they were considered in the present study as a possible supplementary form of analysis. The fact that no negative cases were discovered lends additional credence to the general validity of the coding approach used in the study.

Responses to all interviews were computerized so that all responses to question 1, for example, were grouped together for comparison purposes. Following the guidelines for the constant comparison method, key issues and recurring events became the categories of focus and interpretations were thus derived from the words of the respondents themselves.

Summary

The present study was conducted utilizing a case study approach on a sample of ten anorexic women; five restricters and five bulimics. Subjects were limited to those in outpatient treatment in keeping with a prevention/early intervention model. Instrumentation consisted of an open-ended questionnaire. Data analysis focused on the constant comparative method, a qualitative approach to research which systematically attempts to build theory through explicit coding and analytic procedures. The following chapter will systematically address analysis of the data on a question by question basis. Through coding, any emerging patterns will be examined for comparison with previous findings in the literature and for generalizability within the subject group.

CHAPTER IV

DATA ANALYSIS

This study examined the following factors as possible etiological influences in the development of anorexia nervosa and bulimia: rituals in the family, religiosity, nature and quality of parental emotional support, unrealistic parental expectations, use of guilt as a behavioral determinant, locus of control, statements about self concept, and personal achievement aspirations. White (1983) suggests that the anorexic person grows up with a rigid belief system in which any behavior reflecting disloyalty to the family is considered to be an act of betrayal. While responses early in the interviews gave evidence of strong family loyalty in terms of withholding information which might discredit the family, confidence seemed to grow with the progression of the interviews and subjects became more self-disclosing and candid in their responses. Data gathered in this study indicated familial patterns of rigidity, the subjects' deep feelings of personal inadequacy, and lack of interpersonal intimacy between parent and child concurrent with enmeshment within the family system. An intense need for positive parental approval and a view of God as a strong protective force also were found to be present.

Individual Question Analysis

The following systematic analysis of data derived from the interviews is examined on a question by question basis. Question 1, "What was it like for you growing up in your family?", generated the following kinds of information: enmeshment in the family system (60%), a mother who could rarely be satisfied with her daughter's behavior (50%), the child's feeling responsible for family harmony or disharmony (70%), the child's needing to conform to perceived parental expectations (80%). Phrases like "I had to be the good little daughter", "I was held responsible for my mother's happiness", and "I was the problem child" all focus on the daughter's having to fit a role she felt her parents, particularly her mother, expected of her in order for her to meet with approval. Yager (1982) explains that it is typical for the parents of an anorexic to ignore the daughter's fragile self image and feeling of ineffectiveness and that the daughter then tries to fill her inner void with parental approval in place of autonomy.

The ambiance of the family environment ranged from "crowded but fun" to "tense and lonely". The "crowded but fun" statement was contradicted later in the interview with the subject's admission that she desperately wanted more individualized attention from her parents. The literature indicates that personality styles and stress response

patterns vary in both individuals and families. Some are predominantly minimizers, isolates, or deniers, others are excessively hypervigilant and ruminative worriers (Lazarus et al., 1974). Respondents in this study reflect the above statement as they reported how they felt present to and with their families. An interesting observation was the almost universal lack of strong sibling bonding. In 30% of the cases, the father's presence was not experienced on a daily basis due to either alcoholism or a job that required traveling.

Question 2, asked, "How would you have wanted your experience of growing up in your family to be different?" All of the subjects would have wanted more individualized attention from their parents. A typical response was: "I would have wanted to be closer to my family and to have done things together". Another theme brought out by this question was the subjects' uncomfortableness with their birth order. Oldest children and middle children seemed to fare the worst. One respondent stated, "(being the oldest) made me feel more responsible for my sisters when my mother got depressed..." Another respondent, a middle child of five, expressed that she felt forgotten, that even in the present she fades into the background at family gatherings, convinced that her parents won't find her "special" or worthy of their attention. An emphasis on values external to the family was also found to be a problem area. "My mother was very

materialistic...she'd worry about what people would think (in terms of dress)". In one case, religion was directly addressed: "I would have wanted a home where Christianity was lived day to day and not just on Sundays." One interpretation of this question's responses is that the families were structured, but in a way that was unfulfilling to their daughters and that extrinsic worth was given a great deal more credence than internal validation (form vs. content). Bruch (1979) has suggested that anorexics have serious deficits in self-initiated behaviors and that in part, these are related to a neglect of appropriate external responses to the child's internal states.

Question 3: "What rituals were part of your upbringing?" revealed that in 90% of the cases, subjects found mealtimes to be unpleasant experiences. Potentially destructive patterns were described that reflected parental issues of avoidance. For example, one person described dinnertime in these words: "I remember that at dinner Mom never sat down and ate with us...she'd nibble and stand at the sink with a chicken leg". Another subject talked about how, as a teenager, the family would sit around the table every night and watch Mr. Rogers and Sesame Street because the mother was a nursery school teacher and used the mealtime to get ideas for her teaching.

Food took on symbolic meaning for many of these

anorexics. "I recall that being good meant always cleaning your plate"; "My mother would try to soothe us with food...I'd get mixed messages...my mother would feed me with milkshakes and give me Preludin (a diet pill) at the same time." In many cases, food was directly put on the plates of the subjects rather than letting them serve themselves. In later years (in particular the teen years) the subjects used refusing to eat as a form of rebellion. It is assumed that adolescence is a natural time for a child to rebel, to make moves toward greater independence. Hsu (1983) has suggested that the emerging adolescent threatens already rigid and experience-denying parents. The parents become more threatened and focus to an even greater extent on the child as the problem, rather than deal with their own psychopathology. Consequently, adolescence is a time when symptoms of anorexia begin to appear for many persons so inclined. This was borne out in 80% of the cases in this study.

Birthdays and religious holidays like Christmas or the Jewish Sabbath brought up memories of huge amounts of food being put out. It might be hypothesized that the ritualized behaviors brought out by these occasions did not positively encourage development of the self. Eating was frequently associated with unpleasantness and loss of control; therefore, by regulating food intake either by restriction or by bingeing, the subjects could make themselves feel more in

command of their lives.

Question 4, "Tell me about your father and what was important to him when you were growing up", generated the following profile: a man who was hard-working (80%), a man who kept to himself (60%), a person who either favored the subject or was overtly lacking in empathy toward his daughter. Twenty per cent of the subjects interviewed reported feeling closer to their Dads. Three of the subjects' fathers were alcoholics. In a study, Halmi and Loney (1973) report well-documented alcoholism in 13% of fathers and 2% in mothers.

Levels of academic and business achievements broke down as follows: 10% unemployed, 20% with an MBA, one with a Ph.D. in nuclear engineering, four were owners of their own businesses (tool and die company, sales, machine shop, TV repair shop), and one social worker/ professor. What appears evident is that these men were, for the most part, high achievers, that many were self-made and worked hard to provide a good living for their families. Two of the fathers of the respondents are now deceased, one from cirrhosis of the liver and one from a heart attack precipitated by stress.

In describing their fathers, the respondents used words like "taskmaster", "morally rigid", "unable to express feelings", "depressed", and "bottled up most of the time". One subject described her father as always having been

overweight and that he had a tremendous rage toward his own mother.

Disciplining, in most cases, seems to have been left to the mothers. However, in one case, the father seemed physically abusive to the daughter (he would like to pull her hair until she would scream).

It seemed important to the anorexic daughter to have her father's respect. Verbalizations such as, "A lot of the things I was doing in my life were to please him" and "He wanted respect...he's very strict on respecting your elders" reflect this attitude. Two of the fathers pushed their daughters to excel in sports, but gave the message that they could not be satisfied with their daughter's level of achievement. One subject summed it up this way. "I could never be good enough for Dad. That could be for anything. He always wanted more. Three or four years ago I was in a racquetball competition. I played as hard as I could and I won. I was so ecstatic. His (father's) response was, 'You could have done better. You screwed up on your backhand'. I was hurt and furious. It was always, if I got B's, why not A's."

The question, "Tell me about your mother and what was important to her when you were growing up", revealed an interesting fact. Fifty per cent of the mothers suffered from debilitating diseases: alcoholism, migraine headaches,

colitis, agoraphobia, and multiple sclerosis. In a study on bipolar illness preceded by anorexia nervosa, Hsu et al. (1984) found that familial affective disorders can predispose female adolescents to develop anorexia nervosa. The same study's findings also showed more depression and substance abuse disorders in first and second generation relatives of anorexics. In another study, Cantwell et al. (1977) reported that 33% of parents had a diagnosis of primary affective disorder.

Sixty per cent of the mothers did not work outside of the home. The remaining four were: nursery school principal, registered nurse, transcriber in a hospital, and commercial artist. Forty per cent of the respondents described their mothers as very religious and involved directly in Church or Synagogue activities. Four other respondents saw their mothers as extremely focused on the family, with their main objective in life based on domestic activities and child rearing. Those working outside of the home made more of an issue out of the importance of externals and conformity to social pressures. Two subjects described their mothers as "too close". Two other subjects said that work was first in their mothers' hierarchy of importance and that these same mothers exhibited high expectations for their daughters and acted with a lot of rigidity. Seventy per cent saw their mothers as concerned with food, either by giving love through food or by telling their daughters to watch

their caloric intakes constantly. Three mothers used food as a reward or punishment. Five daughters saw their mothers deal with food and eating abnormally. One subject recalled her mother becoming very much overweight, sitting in a dark room watching TV with a half gallon of ice cream fairly regularly. Another subject's mother would never sit down with the family for meals.

The relationship between the parents seems to reflect what the literature has noted in terms of lack of real intimacy, inability to directly communicate feelings, inability to work together as a team. A subtle and sometimes not so subtle sense of anger on the part of the wives toward their husbands was a theme indirectly expressed by most subjects. One subject refers to her mother's being agoraphobic and having to see a psychiatrist. She says, "My Dad used to tell her that she should get over it herself. He was no help."

Another suggestion of the mothers' frustration and anger seems to have some connection with placing their daughters in double-bind situations. For instance, they often wanted their daughters to confide in them but when the daughter actually did, the mothers appeared not to be listening.

The interviews also suggest the mothers as being really good at instilling guilt in their children just for being

children. In one instance, the subject was asked what she felt contributed to her mother's migraine headaches. Her response was, "I always assumed it was us (the children)." She also stated, "My mother always used to say that if she had had a choice, she would not have had so many children." Another subject, in talking about her father's not being around, relates a conversation with her mother in which she asked her where her father was going. The mother's response was, "He's got to go out someplace because he just can't stand being around you kids." The subject then added, "I guess we were too noisy, but he was out a lot."

Question 6, "Describe the kind of attention you received from your parents when you were growing up", gave indications in 50% of the subjects of their mothers as strong disciplinarians. In general, the subjects were more in touch with having received negative attention than positive attention. Phrases like, "I could never measure up" and "I had to conform" were typical responses. Positive attention usually took the form of parents' presence at their child's piano recitals (30%) or at sporting competitions in which the daughters participated. Two subjects expressed that they could not recall having gotten any attention at all, either positive or negative. In 60% of the cases, the fathers were not present in any significant way to the subjects, although they (the subjects) in 70% of the cases express how important it was for them to feel their fathers' approval.

Attention was often viewed as a reward for being "good", that is, conforming to perceived parental expectations. This took the form of high academic achievement or of being "responsible" for taking care of younger siblings. In three cases, it took the form of the child's having to mirror the mother's values and/or personality. One subject expresses it as follows: "My mother protected me, guided and directed me, but it was an enveloping kind of closeness. I felt tied to her, unable to break away and be me."

Three people mentioned that the kind of attention they received had something to do with the laying on of guilt. "I felt overprotected but felt too guilty to say anything, like I was supposed to play that role or something to please them." This will be addressed more fully in question 10, but it seems evident that the guilt was somehow associated with not being perfect.

One subject recalled experiencing positive attention from her father. She describes her relationship with him as follows: "I was the apple of his eye. ...He would take me to the corner store to get candy and comic books."

In none of the cases studied did the parents present a united front. Rather, as the literature suggests, they appear to have existed in superficial or loveless marriages, with their own hurts and unmet needs standing in the way of their being able to be there for their daughters in a healthy

way.

Question 7, "How did people in your family deal with anger when you were growing up?", concerned itself both with how the parents dealt with anger between themselves, and how they expressed anger to their daughters. Seventy per cent of the cases revealed familial patterns of avoidance in dealing with anger. This might take the form of the parents giving each other the silent treatment, of the fathers walking out of the house, or of one or both parents using the defenses of denial or repression. Sixty per cent of the subjects reported that they were somehow made to feel guilty if they felt angry. One subject expresses herself thus: "Anger scared me. I would turn it in on myself. I was afraid of its rearing its ugly head. Good little girls didn't get angry. Everybody likes good little girls...It was important for me to be liked by everybody." Another subject states: "If I got angry, I would feel that I had done something wrong...that there was something wrong with me." This is supported in the literature. Yager (1982) says that typically the family communicates along narrow lines and rigidly denies or minimizes that anyone is angry toward anyone else. Parental concerns and stresses are channeled and deflected toward the children so that the mothers become excessively involved with them.

Sixty per cent of the bulimic group literally swallowed

their anger. One bulimic recounts, "I ate for comfort. I swallowed my anger. I'd binge then take diet pills...I'd get up at night and eat huge amounts of food."

Physical punishment was exerted in 50% of the cases, some of it of an abusive nature. One subject states, "Mom would yell, pinch, hit...degrade." Another describes getting the strap regularly. Another recounts, "Dad had a thing about hitting us in the head. He had a really bad temper. He'd love to pull my hair out. I got to the point that I'd cringe and not let him. Sometimes I'd get grounded and have to write lines: 'I will do what I'm told to do when I am told to do it 500 or 1000 times'."

In general, the fathers were described as much more repressed or uncomfortable in their expression of anger. The typical pattern was for them to keep things bottled up until they would violently explode. One might hypothesize that the effect on the child would be one of fear, that to be angry meant to be out of control and so one had to avoid being overtly angry at all costs.

The next three questions had to do with perception of God, with locus of control, and with internalization of guilt. Question 8 read: What is your perception of God, and is having a belief in a Supreme Being very important to you? Adjectives used to describe God were: a blaming God, a monitor or controller, a parent, an overseer, a powerful

force with a lot of energy, a forgiving God, an unjust God, and a loving God (2). Three subjects have given over control of their lives to God by joining organizations whose basic philosophies incorporate dependence upon a Supreme Being (e. g. Overeaters Anonymous or Alcoholics Anonymous). In one subject's words, "God is everything to me. To be in touch with him is everything. I'm a 'program person'... by turning myself over to the will of God I can have a happy life. Before I was out of touch with God's plan and I was a really sick person." Another states, "I see God as some power bigger than me who puts some order in life. I don't have control over much of anything...I look to a higher power for guidance. My God is a God of justice...and love."

There were significant references made to God as a parent, either directly or indirectly. One restricter relates: I feel God controls my doing things or stops me from doing other things...like a parent, you know, you worry about how a parent is going to react to something you do..."

* Of those interviewed, 70% were exposed to some formalized religious training, either Catholic, Jewish or Protestant. In the present, all have rejected the religion of their childhoods for either no religion, a change to a more Fundamentalist-oriented kind of religion, or giving themselves over to "program". Those raised Catholic seemed to have the strongest anger and resentment toward their religion, associating it with the instillation of guilt

feelings related to either their femininity or their right to be human and make mistakes. One states, "I was raised Catholic, but now I'm Methodist. I resented Catholics and a lot of their beliefs. They live in their own dream fantasy world. I don't want to be with a bunch of mopes." Another (Catholic/bulimic) states, "I feel hostile toward the whole thing (religion). I think the Catholic Church had some really screwy ideas 15 years ago and still does...like sex was bad. I'm really bitter about the way they treat women, like they're second class citizens...I guess I do believe there is a God but he's not a fair one. Maybe I'll change my mind in 10 years. I'm just really angry right now."

Sixty per cent of the subjects reported that having a belief in a Supreme Being was of some importance to them and forty per cent felt it was very important. This same forty per cent reflects those who have consciously given over control of their lives to a force greater than themselves through ritualized or institutionalized programs of behavior modification.

Question 9 asked, "Do you feel that you control your own life or do you feel that something or someone outside of yourself controls you?". Seventy per cent said that they controlled their own lives, but three of the seven went on to say that they controlled their own lives by giving their wills up to God. To illustrate, one subject stated, "I have

a choice every day. I can look for God's will for me or I can live negatively. I start the day by offering myself up to God. I ask Him to take away my being an overeater, my being a drug addict, and my being an alcoholic." This philosophy gives evidence of the locus of control being outside of the self, of the subject's having substituted one kind of authority for another.

One subject felt she controlled her own life by adopting an anorexic/bulimic lifestyle. She spoke of being able to eat anything she wanted because of the subsequent mechanisms she employed to regulate her weight. Three people admitted that their being bulimic was the one area in which they did not feel in control over their own lives. In all cases, the bulimic episodes were triggered by pressures from the external world, like having to meet a job deadline, or by the subject's getting down on herself for not meeting some kind of self-imposed standards. These standards reflect expectations laid upon them as a child. In one bulimic's words, "Sometimes I let my alter-self take over and give up all feeling of responsibility. I was raised with the life script that my mother needed me to remain a little girl...it's still a pressure on me to stand on my own and make my own decisions."

The control factor also manifested itself by interfering in several of the subjects' ability to engage in meaningfully

intimate relationships with members of the opposite sex. One restricter expresses, "To say 'I love you' is hard for me because it makes me feel that I'm giving in and someone will drop me." Another states, "I married a controlling man. I was afraid of him. I had to lie to him about my bulimia..."(The subject was divorced after two years). Yet another describes a problem in her marriage where she feels sexually restricted. In her words, "He (her husband) wants me to act out more freely but I can't. I used to think that if I looked skinny enough, he'd leave me alone."

To sum up, two expressed ambivalence about who controlled them, two admitted to no sense of personal control, two felt controlled by their families, one by her husband, and three felt that they were most controlled by God.

The focus on question 10 was on gathering information about the internalized guilt feelings of the respondents. They were asked, "What kinds of things make you feel guilty?" Seventy per cent of the responses indicated guilt feelings associated with either parental disapproval, not living up to a parental expectation of being the "good little girl", or of the subjects having negative thoughts about their parents. Not working hard enough was mentioned in 60% of the cases, although their words gave concurrent evidence that they were workaholics. One expressed a lot of guilt about rebelling against the (Catholic) Church. Three mentioned feeling

guilty about engaging in the self-destructive behaviors associated with anorexia and bulimia.

A particular theme identified was doing something against the mother's wishes, either expressed or unexpressed. For example, "I'd feel guilty if I did something I felt she didn't want me to do", or "I feel guilty going over to my mother's house. She tries to make me feel that I need her, that I can't take care of myself." Another felt guilty about accepting money from her mother, "She gave me \$400 for my birthday. It indebts me to her and I know it, but still I accepted it." The same person further expresses herself about her lack of separation from her mother in the following tragic account, "I reacted to my father's death by going up to 238 pounds. I checked myself into 4 or 5 hospitals because I couldn't control my eating. I didn't get any help or recognition, so I went back to my mother's house. My plan was to eat myself into oblivion, then kill myself. I stayed in the house without ever going out for nine months." (Fortunately this patient found the strength to leave the house by turning to something else for strength, God and Overeaters' Anonymous).

Question 11 dealt with the subjects' views of their appearance and how they wanted people to perceive them. The question asked, "Is how you look important to you" and "How do you want people to view you?". While predictable, most

wanted to be thinner, all said that how they looked was very important to them. Interestingly, the subjects did not want to be seen as physically attractive in the conventional sense. Rather, they used words like "(I want to be viewed as) 'together', 'neat appearance', 'not sexy, casual', 'healthy and vigorous', 'clean and neat', 'younger', and 'businesslike'." None of the subjects liked the way they look. Some expressed fear about looking too physically attractive; as one expressed it, "I'm still afraid of my sexual responsibilities." Another expressed the same theme in a slightly different way, "If a man compliments me on my appearance, I feel embarrassed, I feel like throwing a rotten tomato at him..." One restricter described her feelings about her appearance by saying that no matter how thin she is it is never enough. She added that this has gotten her into a lot of trouble in relationships. In her words, "I'm a mess in relationships." From this data it seems plausible to suggest that the anorexic person, whether restricter or bulimic, wants to be perceived as perfect, but the nature of the perfection does not reflect her femininity. In fact, specific measures are taken to downplay femininity. Perhaps one could conclude that to admit to one's femininity is to admit identification with one's mother, and it seems clear that for most anorexics, the mother-child relationship was a destructive and painful one that left scars. It would seem to be in the subject's best interest to separate and want

her own identity instead of feeling overly enmeshed or too close to her mother.

The twelfth question asked, "Do you like the person you have become and what kinds of things are important to you?". Since all of the subjects either had been or were currently in therapy, most made reference to the positive effect therapy had had for them and that gradually and painfully their lives were being turned around. They mentioned things like, "I like myself better now", "I've separated more from my parents", "I'm learning how to accept myself for who I am and not for who people want me to be". Several in the bulimic group addressed the realization that they see themselves as always having a weakness toward bulimia much as an alcoholic is always an alcoholic, but that they are finding more constructive ways of dealing with their anger and learned helplessness. While some have turned to religion to help them cope, it seems to be the supportive and accepting environment they find that encourages them. This researcher questions how giving control over to God and His will can help the person feel more internally controlled, but perhaps for some it is a step in a process.

The last question sought data on what these women felt they could be proud of or what they felt a sense of accomplishment about. The question stated, "What is there about you that you feel proud of or that you feel you have

accomplished?". Of all the questions asked, their answers to this one were the shortest. Fifty per cent were proud of having broken away from their parents in the sense of having become more independent. Eighty per cent felt they had accomplished something significant by getting advanced degrees and by having attained good jobs. Being highly motivated and having an inner drive to succeed at something approved of by society seems to have been a strong dynamic in getting these women to where they are today. An occupational breakdown would show the following: secretary, accountant, day school principal, audiologist, nurse, medical technologist, credit manager in an office, investment banker, homemaker, and social worker.

While attempts were made to critically examine any differences between the restricting group and the bulimic group, the data did not indicate any significant differences between the two groups, either in environmental factors they were exposed to as a child or in the nature of the relationship they had with their parent(s). The bulimic group mentioned exercising and working out as a daily activity more than the restricting group and also mentioned patterns of alcohol abuse whereas the restricters did not.

All respondents were raised in intact families. One family divorced when the subject was a teenager. This finding supports the literature (Garfinkle and Garner, 1982)

which suggests the importance of the family presenting to the outside a semblance of harmony and perfection. In actuality, an examination of the cases showed that the families did not reflect that. In one case, the daughter begged her family to get counseling help when she was a teenager. After several months, the father agreed. In the first session his words were, "We are here because R. has a problem. The family has no other problems." This seemed particularly ironic since the man made his living as a social worker.

Placement among siblings was varied among respondents. Three respondents had twins in their family (one was a twin herself), one was the middle of 5, two the younger of 2, two the oldest of 3, one the middle of 3, one the 4th oldest of 9, and one the 5th oldest of 7.

Summary

In general, the data gathered in this study tends to confirm the findings of previous research which show that there are a multiplicity of factors involved in the etiology and development of anorexia nervosa in women. Rituals and patterns in the families of the subjects studied indicated the following: minimal positive interaction between family members at mealtimes, food being used as a mechanism of control, that the father was absent from meals, either physically or emotionally, that food was always

associated with formalized religious celebrations such as Christmas or Passover, and that grace was a ritual engaged in before meals.

In examining the association of religiosity and locus of control, the following factors were found to exist: that all of the subjects gave up their religion of origin, that for those who adopted an alternative religion, the form chosen was more highly controlling, parental, and protective of them. What seems to have occurred is a transfer of control from parents to God or to an organization in which the existence of God is part of the fundamental framework, such as A.A. or O.A. Authority still served as an external control, even though the majority of subjects stated that they felt in control of their own lives.

With regard to the nature and type of family support experienced, the subjects indicated high levels of dissatisfaction within the family system. Parents could not openly communicate about problems, there were frequent incidences of alcoholism and psychosomatic illnesses in the parents, and typically, the anorexic child tended to be scapegoated or made the identified problem for the family's dysfunction.

The parents created unrealistic expectations for their daughters. Often, the daughters were put into double bind situations by being expected to excel, yet were rarely

granted sufficient recognition for their achievements. Most of the subjects reported a feeling of guilt concerning an inability to live up to parental expectations. Subjects also indicated experiencing guilt concerning behaviors contrary to parental wishes.

In all cases, the anorexic perceived her physical appearance primarily in an asexual dimension, covering such areas as neatness, healthiness, cleanliness, maintaining youth, and presenting a businesslike persona. Achievement was very important to these women, in fact, most could be described as overachievers. This was accomplished by the attainment of advanced degrees or upper echelon employment.

What seems clearly evident is that exposure to a family environment in which subtle estrangement between parents exists concurrent with little true affirmation of the daughter, where patterns of rigidity and enmeshment are present, it is likely to have a strong effect in producing an anorexic child, especially if the family is upward-mobile and the parents manifest areas of pathology reflecting self-doubt, repression of anger, and a tendency to internalize guilt feelings while not specifically acknowledging problem areas or a willingness to deal with problems.

CHAPTER V

Conclusions

This study was an attempt to examine the psychophysiological syndrome known as anorexia nervosa, to become familiar with its symptoms, and to critically study the background and environment out of which it develops. Since the literature places great emphasis on family environmental factors in the development of anorexia nervosa, this research project was designed to focus on whether or not certain rigid rituals in the family, especially of a religious nature, could produce some etiological clarification.

This chapter addresses the following areas: strengths and limitations of the study, an examination of religiosity as a relevant factor in the development of anorexia nervosa, the extent to which the findings of this study are consistent with or discordant with other research findings, and implications for future research.

Strengths and Limitations of the Study

The following items can be considered as the more important areas of this study:

- 1) the use of a prevention/early intervention model employing subjects already in treatment for anorexia-related

symptoms narrowed the identified population down to those more likely to talk uninhibitedly about themselves.

2) Use of the open-ended questionnaire gave subjects the freedom to expand on their responses and provided the interviewer with data that might otherwise have been missed or overlooked. Subtleties regarding authority, control, and expression of a structured religiosity are examples of personality factors that became apparent in the interviews.

3) The ethnic and religious diversity of the subjects contributed to the potential generalizability of findings. Jewish, Catholic and Protestant women were represented; the ethnic breakdown consisted of women of Irish, Italian, Jewish, Scotch, English and Swedish ancestry.

4) The rapport that developed between the interviewer and the respondents gave the subjects the security and confidence to be more fully self-disclosing and to express themselves in their own terms. This could not have been achieved in a written questionnaire or in a pencil and paper test.

5) Use of the face-to-face interview technique disclosed discrepancies between stated self perceptions, which are usually socially acceptable, and actual self perceptions. Non-verbal cues such as voice tenseness, nervous laughter, gestures, and body language strengthened

the ability of the interviewer to interpret what was being communicated.

6) A lack of pre-existing hypotheses facilitated the emergence of significant themes related to the problem under study.

7) The use of the constant comparative method of data analysis provided flexibility and permitted change and modification where appropriate in terms of data analysis.

The limitations of the study can be described as follows: 1) the small sample size; 2) the fact that all subjects were from the same geographical area (Chicago and its environs), which might have limited representation of certain attitudes and values of women raised in other parts of the country or in other parts of the world; and 3) the fact that no males were represented.

Religiosity as an Influence in the Development of Anorexia

The subjects in the study described God as a parent, more specifically, a controlling parent. Parallel to this was the subjects' descriptions of their parents as out of reach, unempathic, yet expecting a great deal from their daughters. Consequently, religion could be said to function as a reinforcer in developing a personality profile that reflects poor self esteem. Religion was also found to be

associated with the instillation of guilt feelings. Fear of offending God inhibited the subjects from doing things in their own best interest. Certain behaviors such as expression of their sexuality were interpreted in terms of how the Church sanctioned or prohibited them.

Of importance to this study is the fact that even though all respondents had left their childhood religions, those who adopted a new religion did it in the direction of a more formalized, structured and controlling belief system. Consistently, God was portrayed as a controller, a protector, and a judge.

Eating was a highly significant part of the religious rituals of the Jewish Sabbath, Christmas, etc., and were times when it was traditional for huge amounts of food to be consumed. Because of the association of food and religious ritual, one might conclude that, symbolically, food became a reinforcer of a previously established view of God as an external controller.

Comparison of Findings with Other Research

Previous research (Levensen, 1973; Scheck, 1978) has found that parental behavior, particularly that of the mother, is an important antecedent of a locus of control orientation. The findings in the present study were consistent with this position. Many of the mothers (50%)

were described as having psychosomatic problems of their own, which suggests an inability to cope with life in an integrated or healthy way. Their daughters identified with these role models reflecting a lack of internalized control. In addition, frustration and anger over unresolved marital conflicts seemed to be displaced onto the daughters by their mothers.

The need for the subjects to focus on external approval was also confirmed. Branch and Eurman (1980) found that in a questionnaire administered to families and friends of anorexic patients they were working with, the subjects met more with their approval than their disapproval, suggesting a need to conform in order to gain acceptance. In the present study, subjects described themselves as working hard to live up to what they felt their families and friends expected of them. Variations on the phrase, "...but I could never be good enough to suit them..." convey the anger and frustration experienced by the young women desperately trying to belong.

It might be hypothesized that the need to belong accounted, at least in part, for some individuals to identify with highly structured religions and/or with highly structured organizations such as Alcoholics Anonymous and/or Overeaters Anonymous.

As far back as 1873, Lasegue described the striking

family enmeshment and urged clinicians not to overlook the family pathology. More recently, Minuchin et al. (1978) and Yager (1982) reiterate this position. Results of the present study indicate that in all of the cases, the respondents continue to struggle to maintain a healthy psychological independence from their families. Being in therapeutic treatment, creating physical distance from the family of origin, and finding other support groups, are typical ways in which these women are handling their problems. The price that they continue to pay is a tremendous sense of guilt in the process of becoming differentiated.

As stated in Chapter IV, the data gathered in this study tends to confirm the findings of previous research. The findings show that there exists a multiplicity of factors involved in the etiology of anorexia nervosa.

Previous research has also suggested that there are noted differences between the restricting anorexic and the bulimic (Fairburn, 1981; Linden, 1980) in terms of attitude about self and manifested behaviors. The present research, however, found no differences between restricters and bulimics in terms of their present perceptions of themselves and their interactions with their environment. Guilt feelings, control issues, and interpretations of religiosity were equally represented in the two groups. It may be suggested that the lack of discrepancy between the

restricters and the bulimics can, in part, be accounted for by the fact that all of the subjects in this study had undergone psychological treatment, and that this may have minimized the polarity between the two groups. It can therefore be hypothesized that subjects with pathologies of greater intensity might reveal discrepancies between the two groups, as previously reported in the literature.

Implications for Future Research

The present study indicates the appropriateness of qualitative research in gathering data on a traditionally difficult population. The implications are that there needs to be more emphasis placed on qualitative inquiry rather than an exclusive focus on research that is largely quantitative.

However, additional extensions of the qualitative research paradigm for this population are needed. For example, it would have been desirable to have included a male anorexic sample to further clarify the etiology of the syndrome. In addition, it is recommended that possible follow-up studies be conducted which attempt to follow an anorexic/bulimic population over a period of time. Finally, cross cultural comparisons would test out the effect of religiosity as a factor in the development of anorexia and bulimia.

Conclusions and Implications for Treatment

It is clear from the present study that the etiology of anorexia nervosa is both complex and multidimensional. Combinations of factors such as the nature of the parental relationship, how control is defined and understood, and how the person is allowed to express herself and her feelings, all play a part in the development of the anorexic personality. What is clearly lacking in the anorexic woman's early development is a healthy family environment. Cohesion and bonding are non-existent. Instead, family enmeshment and unrealistic expectations only confuse and frustrate the child, making her turn inward upon herself and prevent her from trusting either herself or anyone else.

What seems indicated for those therapists treating anorexics is the need to provide an environment of total acceptance and trust early in the therapeutic relationship. The absence of a trusting relationship in her early development has played a major part in the anorexic's inability to emerge as a healthy and independent woman.

This study also reinforces the position that there be a strong insight-focused component to treatment in addition to the building of a strong therapeutic alliance. Self understanding must be a crucial goal in the treatment plan since the anorexic is struggling against a distorted perception of herself.

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APPENDIX

INTERVIEW SCHEDULE

Background Information:

- a) Restrictor _____ Bulimic _____
- b) Age Range: 15-25 _____ 26-35 _____
- c) Religious Affiliation: Catholic _____ Jewish _____ Protestant _____
Other _____ None _____
- d) Family Structure: Intact Family _____ Single Parent Family _____ Other _____
- e) Birth Order: Only Child _____ Rank Order _____

OPEN-ENDED QUESTIONNAIRE

1. What was it like for you growing up in your family?
2. How would you have wanted your experience of growing up in your family to be different?
3. What rituals were part of your upbringing?
4. Tell me about your father and what was important to him when you were growing up.
5. Tell me about your mother and what was important to her when you were growing up.
6. Describe the kind of attention you received from your parents when you were growing up.
7. How did your family deal with anger when you were growing up?
8. What is your perception of God? Is having a belief in a Supreme Being very important to you? If so, how?
9. Do you feel that you control your own life or do you feel that someone or something outside of yourself controls you?
10. What kinds of things make you feel guilty?
11. Is how you look important to you? Is how you present yourself to others important to you? How do you want people to view you?

12. Do you like the person you have become? Tell me about that person; for example, what kinds of things are important to you?
13. What is there about you that you feel proud of or that you feel you have accomplished?

APPROVAL SHEET

The dissertation submitted by Patricia Lavallee has been read and approved by the following committee:

Dr. Marilyn Susman, Director
Assistant Professor, Counseling Psychology and Higher Education, Loyola

Dr. Manuel Silverman
Professor, Counseling Psychology and Higher Education, Loyola

Dr. Steven Miller
Professor, Foundations, Loyola

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

10/1/86
Date


Director's Signature