SOCIAL ORGANIZATION OF EATING DISORDERS:
Two Women's Stories of Resisting Oppression

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ABSTRACT

This thesis explores two women's experiences of developing, living with, and overcoming an 'eating disorder'. This research questions the 'self-evident' nature of 'eating disorders' as diseases, narrowly defined by medical and psychiatric language and technology. What I argue from analyzing the women's stories is that the seemingly 'crazy' behaviour of individuals with 'eating disorders', and the often inconsistent, ineffective and damaging treatment which individuals often endure when seeking 'help', occurs not by chance or accident, but as an effect of how 'help', and concomitantly, resistance to that 'help' is organized. 'Help' is more of the same kind of oppression that occurs in the daily lives of girls and women--objectification, domination, silencing, and expectations to conform to authority. Their resistance to oppression, while seemingly adhering to feminine conformity (through thinness, hunger, compliancy, self-sacrifice), is a force that keeps them caught in 'eating disorder' behaviour. Yet, paradoxically, their resistance to oppression and conformity is also the source of strength that eventually helps them move beyond the destruction.

I constructed the women's stories from taped interviews and notes constituting their accounts with seeking 'help' for anorexia nervosa or bulimia nervosa using a social organization of knowledge paradigm. While these women's stories are not universal, they are not idiosyncratic. The stories they told, particularly of medical and psychiatric 'help', in which I was most interested, illuminated general features of so-called 'helping' relationships. The women's interactions with family, peers and medical or psychiatric practitioners provide an entry point for analysis of social relations *implicit* in their narratives. I work to understand the women's stories from their standpoint, making *explicit* that which organizes and directs their care, concerns and abuses. This analysis goes beyond personal characteristics, family dynamics, practitioner incompetencies and inadequate knowledge to explicating how experiences are organized by relations of gender, age, status, and medical and psychiatric practices.

What comes into view in my feminist analysis is the disconnection and oppression in relationships with caregivers, and how power is used to effectively silence, dominate and objectify these women. I show connections between their 'imprisonment' in anorexia nervosa or bulimia nervosa and the 'help' they received, which is organized in such a way that it appears to exacerbate the distress and prolongs the 'eating disorder'. There is a benefit to seeing how societal perspectives and professional practices take shape from notions of femininity, desire and resistance, and how these ideas and practices socially organize the lives of girls and women with 'eating disorders', particularly when seeking treatment.

Girls and women with 'eating disorders' resist oppressive relationships and social pressures and norms through their bodies. Bodily changes caused the women in this study to experience physiological, emotional, intellectual and relational troubles during adolescence and adulthood, which located these individuals under the care of doctors and psychiatrists. The treatment they received further objectified, silenced and dominated them, so they resisted this oppression even harder. While this was understood by professionals as failure to comply with 'expert' advice, and further evidence of mental illness, these women were trying to make their own sense of what was happening to them, and transformed that resistance into a way out of their misery. They eventually left traditional treatment behind. These women did, however, retain tremendous strength throughout their troubles, strength which was hidden for a time by oppressive treatment, yet strength which resurfaced to help them recover and become stronger individuals. People caring for girls and women with 'eating disorders' must see this resistance differently, not as misbehaving or craziness or depression, but as strength. Working with this strength is the challenge of all affected by 'eating disorders'.

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ACKNOWLEDGMENTS

Writing about eating disorders, particularly the impact of treatment, from a feminist perspective is a risky business. My early nursing education was in the biomedical tradition, and I practiced clinical nursing in places endorsing ways of working similar to those examined within these pages. Now, in bringing a different perspective to the vast picture of women's oppression exemplified here through eating disorders, I risk offending those concerned, who like myself, are trying to understand these ongoing phenomena: professionals who dominate the eating disorders landscape, families of individuals who remain baffled by their family member who has an eating disorder, and perhaps, most vulnerable and important of all, girls and women central to the debate. However, issues I struggled with in clinical practice could no longer be pushed aside, just as I felt the struggles of women with eating disorders needed to be understood from where they stand.

I would like to thank the two women whose lives are represented, in part, in this thesis. Their courage, strength and perseverance is a lesson for us all. The members of the eating disorders association I volunteer for has been a training ground for some of this material, and supported this project throughout. While doing this work, many other people told me stories about themselves or someone they cared about who had experienced an eating disorder, and these vignettes helped me gain further insight and understanding. Thank you! We need to keep talking about anorexia and bulimia to demystify the aura of intrigue that surrounds these damaging and deadly phenomena.

For those who can be named in print, many thanks go to Marie Campbell, my thesis supervisor who, following the work of Dorothy Smith and other feminist writers, has helped me see with a new awareness. My committee members, Mary Ellen Purkis, Laurene Sheilds, and Michael Prince have lent their knowledge, support, insightful criticisms, and enthusiasm.

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INTRODUCTION TO THE RESEARCH

Anorexia nervosa and bulimia nervosa are crippling phenomena that affect a significant proportion of the population. Reported cases are between 90 to 95% female. Garfinkel and Goldbloom (1988) report that:

> In North America. . .serious anorexia nervosa (AN) [occurs] in about 1% of adolescent and young adult women, and clinically significant bulimia nervosa (BN) [is] seen in 2-3% of the overall female population. . . .cases unresponsive to therapy are associated with significant mortality--between 5% and 20% of such patients die. . . [and] chronic forms. . .develop in approximately 25% of patients.

Today anorexia nervosa is characterized in the American Psychiatric Association (1987) literature for diagnosing mental illness, *Diagnostic and Statistical Manual of Mental Disorders*, 3rd Edition Revised (abbreviated as DSM IIIR) as follows: a refusal to achieve or maintain a minimal normal weight body for age and height (15% below what is expected) due to severe restriction of nourishment or excessive activity; a fear of becoming fat even when underweight; a distortion in body image by claiming to feel fat when emaciated; and absent menstrual cycles for at least three months. While physicians have been documenting and (supposedly) treating anorexia nervosa since the late 1600's, it exists today much as it did then--evoking feelings of awe and bewilderment in bystanders, frustration and ineffectiveness in doctors, (leading to extremely controlling regimes as therapy), fear and helplessness in parents and siblings, and, not uncommonly, resulting in the death of sufferers.

Bulimia nervosa is characterized as: a persistent overconcern for body shape and weight often described as self-loathing; regular episodes (two binges a week for at least three months) of eating large amounts of food in a short period of time; feeling out of control with binge eating behaviour; and purging in some form such as vomiting, use of medicines to rid the body of food, excessive exercise, strict dieting or fasting (American Psychiatric Association, 1987). Bulimia nervosa is a more recent phenomenon than anorexia nervosa, however its frequency exceeds anorexia nervosa by as much as ten times. The [B.C.] Provincial Task Force eating disorder Report estimates "that 1% of school girls have anorexia nervosa . . .and 10% are bulimic" (McCreary Centre Society, 1989, p. 4).

I prefer to think of anorexia nervosa and bulimia nervosa as phenomena or socially constructed illnesses, and not as diseases with discrete biochemical, intrapsychic or familial causes. Doing the research for this thesis has confirmed a view I have come to hold: 'eating disorders' are responses to social pressures. I have seen in this work the same kinds of oppressions and disconnected relationships characterizing the lives of girls and women diagnosed as 'eating disordered'. This thesis explores two women's experiences of developing, living with, and overcoming these phenomena. What I argue from analyzing the women's stories is that the seemingly 'crazy' behaviour of individuals with 'eating disorders', and the often inconsistent, ineffective and damaging treatment which individuals often endure when seeking help, occurs not by chance or accident, but as an effect of how 'help', and concomitantly, resistance to that 'help' is socially organized. 'Help' appears to be more of the same kind of oppression that occurs in the daily lives of girls and women. They are objectified, dominated and silenced, and expected to conform to authority. Girls' and women's resistance to oppression, while seemingly adhering to feminine conformity (thinness, hunger, compliance, self-sacrifice), is a force that keeps them caught in 'eating disorder' behaviour. Yet, paradoxically, their resistance to oppression and conformity is also the source of strength that eventually helps them move beyond this destruction. As a nurse working in the eating disorder field for a dozen years, I have been dissatisfied with the way 'eating disorders' have been explained as physiological, intrapsychic or familial problems. My research sets 'eating disorders' in a social context, focusing particularly on the impact of helping encounters in the lives and illness trajectories of two women. While I am not universalizing the experiences of these two women, I use their stories to help explicate the social context of anorexia nervosa and bulimia nervosa as they enacted them. While these women's stories are not universal, they also are not idiosyncratic. The stories they told, particularly of medical and psychiatric 'help', in which I was most interested, illuminated general features of so-called 'helping' relations.

Chapter One describes the research problematic, expressed as paradoxes and puzzling issues and concerns which I experienced in my work and in my association with the everyday world of girls and women with 'eating disorders'. I have worked as a nurse clinician with adolescents with 'eating disorders' and with other professionals in other disciplines in this field. I have been involved in developing innovative programs for individuals with 'eating disorders'. And, I currently volunteer for an association supporting women who have 'eating disorders' and their families, while advocating for services and educating the public about 'eating disorders'. I bring considerable knowledge to this research, an asset in reflexive work. However, I was uncomfortable with many scientifically accepted ways of understanding what happened to girls and women with 'eating disorders'. I needed to go beyond what medical/psychiatric discourse could tell me, as there seemed to be a poor fit between scientific explanations and my knowledge of girls' and women's experience.

Chapter Two, the literature review and conceptual framework section of this thesis, helps me think about girls' and women's troubles. Apparently, anorexia nervosa and bulimia nervosa, frequently characterized as 'madness' or 'craziness', are girls' and women's expressions of resistance to social pressures and conflicts. Also, girls' and women's resistance to treatment may not necessarily be detrimental to their health. Feminist literature has opened up this discussion to show how the health care system is part of the oppression women experience. My conceptual framework focuses analytic attention on how this happens, that is, the social relations of 'eating disorders' and the part played by medical and psychiatric 'helpers'.

In Chapter Three a non-positivist research paradigm and a feminist perspective help me explore the experiences of women with anorexia nervosa and bulimia nervosa from where the women stand. From Dorothy Smith's (1990) method of inquiry we know that women and others in subordinate positions are able tellers of their own stories, however, their experience does not allow these people the capacity to understand how their lives are organized. Much of what accounts for our experience happens elsewhere. That is what makes the notion of social relations as described by Smith (1987) important, theoretically, to my study. Social relations means a complex set of abstracted, impersonal, and promoted-as-universal practices, and the discourse--talk, text and symbols--that surrounds the practices, found in ways of working in institutions such as governments, professions, schools, etc., and which create actualities in people's lives. Smith (1987) states that social relations provide "a procedure for analyzing local work practices--the locus of the experience of the subject--as articulated to and determined by the generalized and generalizing relations of economy and ruling apparatus" (p. 167). Social relations behind the experiences are for the most part invisible. I undertake an analysis which explicates, or makes visible, the organizing features of these women's experiences.

When I inquired into the experiences of Teresa and Diana, I brought my own knowledge as a worker in health to investigate not only what they told me, but to explore the gaps and silences in these women's lives. I asked questions about what happened to the participants, and received many responses which were out of order with pieces missing. I constructed a chronology of events based on what they told me and returned that construction of their stories to the participants for comments and changes. My knowledge of the health care system and of eating disorder treatment helped me locate missing pieces in the women's stories. Using my conceptual framework with its focus on 'social relations', I look for and find material connections based in the real life experiences of these women. Through this process I make sense of what happened to these women, seeing what were the social relations that organized their lives. This is a very reflexive process which allows me to understand how these same social relations are operating in my own life. This is how a social organization of knowledge inquiry proceeds.

Chapter Four presents the data--narratives constructed reflexively from in-depth interviews with two women, Teresa and Diana (whose names have been changed to protect their identity). They talked about experiences important to them taking place from before they developed physical and psychological symptoms of an 'eating disorder' in their mid to late adolescent years, until their present day life as recovered adults. While these stories are quite different from each other, my experience as a nurse tells me they are not atypical accounts, and constitute what becomes an unanticipated and unwelcome 'sentence' or 'imprisonment' in 'eating disorders'.

Chapter Five provides an analysis of the experiences of Teresa and Diana using the social organization of knowledge paradigm. I use their talk as an entry point into exploring the social relations organizing their lives, making sense of the seemingly disconnected or 'crazy' events and behaviours. The available 'help', for a variety of reasons, is often oppressive and engenders resistance in the women, exacerbating their problems and prolonging their 'internment' in anorexia nervosa or bulimia nervosa. Both narratives described in this research show the women's resistance to this oppression leads them eventually to give up professional treatment and use their resistance for recovery from their eating disorder. My analysis helps to piece together experiences, not as objective truth, but in a way that makes sense for these women, and for others who may be interested in anorexia nervosa and bulimia nervosa. What I explicate in this thesis is how Teresa's and Diana's own experiences are socially organized. What they knew at the time of the interviews was the basis of my research. Now the account contains more pieces of what was previously missing, especially about medical interventions. The research 'repairs' some of the disconnections in the women's stories.

When 'eating disorders' are explored as social phenomena, as I have done in explicating these two women's stories, a number of conclusions can be drawn. When I explore what Teresa and Diana experienced with medical and psychiatric personnel, I see, as readers may also see, distinctively gendered occurrences. For instance, girls and women are dominated by demands that they should meet or exceed certain expectations of perfection and femininity--treatment requires compliance with these and other images. These professional ideologies shape the interventions, and the women themselves are objectified, dominated and silenced in these so-called 'helping' encounters. Adding more domination to an already oppressive situation does not work. What becomes apparent in the two women's stories is that they got better when they disengaged from dominating treatment, or, conversely, became involved in supportive treatment. This suggests that directions for treatment for anorexia nervosa and bulimia nervosa must allow girls and women to pursue an image and a story of themselves coherent with who they really are.

CHAPTER ONE
RESEARCH PROBLEMATIC

For twelve years I have worked in the eating disorders field as a professional nurse and as a volunteer, and I have experienced a number of paradoxes or puzzles related to anorexia nervosa and bulimia nervosa, while trying to find solutions to the relentless pursuit of thinness. Girls and women are told there are unlimited opportunities for females in our society, however, society also supports the notion that females 'au naturel' are never good enough. Therefore, some girls and women go to extreme lengths to change what they look like, diverting most of their energy into an assault on the body. Hence, the body becomes the focus or location of a struggle for females as they try to make sense of conflicting messages and social pressures to be a certain way. Society's attitudes about womanly bodies reveal much about how girls and women are viewed in society. Women feel compelled to take up only a tiny space in the world. Girls and women learn to disbelieve in themselves, even when they are talented, bright and beautiful.

Weight preoccupation activities such as extreme dieting, excessive exercising, and 'eating disorders' are happening now in epidemic proportions. Medicine and psychiatry claim eating disorders as psychiatric diseases, however, in the communities I have been involved with, I notice that many physicians try to avoid these cases. When treatment is sought, families of individuals with anorexia nervosa or bulimia nervosa often appeared helpless and exasperated, and the individuals themselves resistant to help. Many adolescent girls and adult women I have known complained about the treatment they received for their 'eating disorder'. 'Help' is often punitive or inadequate in the experience of girls and women--something to be avoided. Practitioners seem to understand resistance to their ideas as pathology, instead of a possible way out of the dilemmas patients experience. I have wondered if girls and women could be encouraged to recover their lost voices and their lost confidence, they could tell us their story in a way that makes sense to them, and aid us 'helpers' in figuring out better therapeutic approaches.

In Vancouver, I worked with adolescents and their families in a professional role as a nurse clinician/counsellor in an outpatient youth service. I was part of a team of health care providers (doctor, nurse, social worker, dietitian, psychologist, occupational therapist) which developed a treatment program from the ground up. We saw the program struggle for survival along with our clients. I sometimes felt that I had a part in prolonging the clients' difficulties by operating under the medical and institutional model of short, weekly, individual appointments designed, it seemed to me, primarily to meet professionals' needs and to monitor cases. The etiology of eating disorders in the clinic was largely based on beliefs in individual deficiencies and negative family environments.

Inpatient treatment was often a revolving door, with many patients readmitted for relapses in weight loss. It seemed like breaking the spirit of the patient was the *modus operandi* in the reward and punishment system (under the guise of behaviour modification) of making changes (i.e., gaining weight). This spirit breaking was replicated in interactions with parents, whereby 'parentectomies' (forced separations between the parents and child under the guise of recuperation time) were common occurrences in the early phase of treatment. Societal structures and women's oppression were rarely addressed in therapy, and remained unchallenged and perpetuated in the doctor's control through 'doctor's orders' of patient activities. Compliance was the focus, particularly for the nursing staff who had twenty-four hour exposure to these patients. These girls and women were resisting social pressures to conform, and demands for more conformity by hospital staff often escalated stress and anxiety in the patient and the staff. The staff were often unable to be 'real' with the patients. A tension between the nursing staff, many of them young women sorting out their own body image concerns, and the patients, who had achieved thinness, par excellence, was created by the power of thinness. The staff's own weight concerns about body changes due to maturity, pregnancy or illness were not discussed. These situations, which could have been used to better access meaning in other contexts of power, nurturing, and femininity in relationships, were rarely explored as they arose in professional/patient relationships.

There were many difficulties we encountered in trying to respond to patients' needs. I saw that our attempts at responsive care were not welcomed by some of the hospital administration. The outpatients' needs did not fit very well with the hospital's expectation that outpatient visits would be limited to a few times a year for monitoring purposes designed to keep patients with chronic-type illnesses out of hospital, or that more acute problems would be resolved in short term treatment schedules of six to eight visits. The outpatients we cared for often needed weekly and sometimes twice weekly visits. Inpatients had lengthy stays, and sometimes recurring admissions within the same year. People with 'eating disorders' need much time and energy to recover. This is a problem for hospital administrators who are concerned about bed utilization, and push for shorter and shorter patient stays for all medical problems.

While innovative ways of working with adolescents were not entertained by the hospital that employed me, the physician I worked with was interested in alternatives to inpatient care. Under the auspices of a non-profit society, and in collaboration with this physician, I coordinated the first summer camp, anywhere, as an alternative to hospitalization for adolescents with anorexia nervosa and obesity. We had a sense that getting people together to experience and build relationships with others who could understand their situation, in a more youth-friendly setting, could benefit these young people and the staff working with them. We hoped that insight and understanding would be increased for all involved, that interest and support, particularly from government funding sources, would be developed for innovative alternatives for the treatment of adolescents with 'eating disorders', and that the hospital ward and clinic staff would get a break from an ever increasing load of younger, more severe cases.

As it happened, this innovative program met some of the hospitals own needs. During the summer, wards would be closed due to staff shortages or renovations, or wards might be staffed by casuals for holiday relief. These circumstances made for significant interruptions in the maintenance and success of behavioral programs. During the first summer camp the ward was to be renovated causing bed closures and creating less opportunities for patients to receive care. This may have prompted the Ministry of Health to fund the camp program, although they were always looking at ways to reduce the use of acute care beds. Whatever the reasons, subsequent summers have continued to be funded based on the success of the first experience, and it is still in operation as of this writing.

Although possible, patient-responsive care is unwieldy and not easily administrable given bureaucratic constraints. The health care system is set up to treat diseases, and treatment for anorexia nervosa and bulimia nervosa is configured accordingly. There seems to be a lack of understanding about the seriousness of the trajectories of these phenomena, both from the health care system and society in general. In many instances, these individuals' actions are characterized as 'attention getting' or 'misbehaving', and, therefore, not really in need of an acute care bed. The clients and their families often wonder at the quality of care, and fear for the continuity of treatment when initiatives are consistently blocked, increases in staff are seldom sanctioned despite a growing caseload, and the threat of the program's closure is frequent. Patients and families need more effective ways of treating 'eating disorders' than medicine or psychiatry can offer.

I am currently volunteering with a local non-profit organization concerned about 'eating disorders' whose mandate is advocacy, education, support, referral information, and research. In this group I associate with adult women and men who are all in some way affected by 'eating disorders' (sufferers, parents, grandparents, professionals, friends). I have experienced the power of collective consciousness, the power of women taking opportunities to be public about their struggles and their recovery, and the power of women peers and parents of individuals with an 'eating disorder' helping each other--that is, the power of connected relationships.

I learned from my volunteer work that the attitudes that girls and women have towards their bodies cannot be accounted for by individual personal or psychological problems. The girls and young women I have known seem noticeably bright individuals, garnering awards and measures of excellence in traditional circles (education, sports, music, etc.). However, they experience an uneasiness about their success, as if they didn't deserve it--as if their efforts were not unusual or difficult (paradox). They seem to be passive recipients of attention, or the nurturer of others, precluding them from feeling entitled to receive love, care and affection, yet remarkably strong in other ways (another paradox). These paradoxes and the many other puzzles surrounding the lives of girls and women with 'eating disorders' suggest that there is much that professionals do not understand about the anorexia nervosa and bulimia nervosa. My own puzzlement has motivated me to look more closely at the experiences of two women to see what can be learned that would benefit how I and others work with this problem.

CHAPTER TWO
LITERATURE REVIEW & CONCEPTUAL FRAMEWORK

The literature reviewed for this research discusses the ways in which girls and women with 'eating disorders' and their troubles are conceptualized. The powerlessness many girls and women feel breeds resistance to their subordinated and silenced positions. 'Eating disorders' are understood in this study as forms of resistance. Resistance which surfaces in response to oppressive medical and psychiatric treatment, in turn, is often characterized as 'madness' or 'craziness'.

Feminist literature has informed this work in content and process. Females are understood in relationship to their bodies, trying to achieve 'ideal' appearances to overcome a sense of powerlessness by 'doing' femininity and dieting. Not only has feminist writing helped situate the occurrence of 'eating disorders' and its treatments within a social organization of knowledge, feminist thinking has provided guidance for conducting this research process in a way that presents the materiality of girls' and women's everyday lives from where they stand.

'EATING DISORDERS' AS MEDICAL DISEASES

Trajectory of Illness

A course of illness for anorexia nervosa and bulimia nervosa, or "characteristic phases [of each phenomena], with symptoms to match, and [which] often only skilled intervention will reverse, halt or at least slow down the progress of the disease" are either not known or not discussed in many situations girls and women find themselves in when they seek help for an 'eating disorder'. (Strauss, Fagerhaugh, Suczek & Wiener, 1985, p. 8). One of many possible courses of an 'eating disorder' may be well under way by the time treatment is sought, or by the time the patient is taken seriously. Many health care professionals, not only the general public, are unable to detect the early symptoms of an 'eating disorder'.

An illness trajectory, more complex than a course of illness is the "physiological unfolding of a patient's disease. . .the total *organization of work* done over that course [of illness], plus the *impact* on those involved with that work [including professionals, patients and kin] and its organization" (Strauss, Fagerhaugh, Suczek & Wiener, 1985, p. 8; emphasis in the original). The trajectory of illness following a medical/psychiatric focus for anorexia nervosa or bulimia nervosa, often involves contacts with multiple professionals over the course of several years, as we will see in the narratives of the women in this study. Weight loss may happen over a few weeks to many months accompanied by physiological and psychological compromises or crises which, depending on the path taken and the support received, can result in several outcomes: seeking professional or informal help, making a personal effort towards recovery, suffering chronic disability, or succumbing to death. Whether one seeks help or makes a personal commitment to get better, the road to recovery is long and hard, and often fraught with relapses. The difficulties surrounding that journey are always a shock to patients and their families, and is not well understood by practitioners unacquainted with the possible trajectories for 'eating disorders'. All want a quick fix. Alternatives to a medically or psychiatrically organized trajectory are usually left unexplored by professionals, except for predicting disaster in the event that recommendations are not followed.

Strauss et al. (1985) note two striking features of health work which can affect an illness trajectory. One consists of "the unexpected and often difficult to control *contingencies* stemming not only from the illness itself, but from a host of work and organizational sources" as well as the social context of the lives of patients, family and professionals (p. 9; emphasis in the original). The second and crucial feature is that it is 'people work'.

> The product being worked on, over, or through is not inert, unless comatose or temporarily nonsentient. Two things follow: (1) the patient can react and so affect the work; (2) the patient can participate in the work itself, that is, be a worker. (p. 9)

Here the notion of resistance to professional help surfaces as an important kind of 'work' that girls and women with 'eating disorders' engage in--resistance that may arise in relation to the perceived etiology of 'eating disorders' as deficient individuals or families, and treatment which is coercive and engenders silence. Resistance to 'expert' advice is infuriating to most health professionals, and usually invites a more dominating approach to get patients to comply, or a threat of withdrawal of services. Resistance is a contingency 'difficult to control', which may situate the patient as 'mad' or 'crazy' from a medical/psychiatric perspective. I will return to the notion of resistance as it applies to 'eating disorders' following the discussion on medical and psychiatric treatment.

Miedema & Stoppard (1993) say that women are diagnosed with mental illnesses more often than men, characterized as *mad* more often, and hospitalized in psychiatric institutions more often. Ussher (1991) points out that men are characterized as *bad*, more "likely to manifest their discontent as deviancy or criminals. Whilst women are positioned within the psychiatric discourse, men are positioned within the criminal discours. . . .[and] regulated differently" (p. 10). In Western capitalist society, conformity of behaviour is expected. When someone does not conform, they may become part of the psychiatric (or legal, or both) discourse, treatable by drugs, therapy, and/or institutionalization, and follow a trajectory which often includes multiple helping encounters and repeat hospitalizations in order to press the patient to conform.

What Medicine and Psychiatry Offer as Treatment

Femininity and pathology became firmly linked in Victorian scientific and literary discourses. Ussher (1991) comments on a shift from madness to mental illness, a shift which affected many women. This could occur from non-conformity to roles as wife and mother--no longer from religious piety nor demonic possession--and came under the scrutiny and control of the nascent medical profession. It was no longer the *mind* which was at fault, but the *brain* (Ussher, 1991, p. 67). Mental or emotional troubles were transformed into physiological ones, treatable by medical technologies, such as clitoredectomies or severe confinement. 'Medical men' were the only profession with the right to provide diagnoses and cures for physiological maladies. "The general belief underlying the doctors' practice, as well as their public pronouncements, was that women were, by nature, weak, dependent and diseased. So to talk of 'mad' came to mean to talk of 'woman' " (Ussher, 1991, p. 69). This stigma follows women and their relationship to the medical profession today, according to many feminists (Chesler , 1972; Ehrenreich & English, 1979; Ussher, 1991).

Chesler (1972) says that "psychotherapy can. . .be viewed as a form of social and political control that offers those who can pay for it temporary relief, the illusion of freedom, and a self-indulgent form of self-knowledge" (p. 107). Keeping women subordinated in their oppressive and inferior positioned roles is the 'cure' in this type of ideology--getting women to accept wifely and mothering jobs as the ultimate roles for women. "Beliefs about the family, and the institution of motherhood as set forth as a sacred calling, do not fit with what is actually going on in families, with women's experience, or with women's devalued and subordinate role" (Penfold & Walker, p. 114). What may happen to individuals who succumb to the oppression of womanly roles or who protest too loudly to expected roles is to be labelled mentally ill. There are many accounts written about and by women who were institutionalized because their husbands or families could not make them 'fit' the role of wife and mother. Among the more widely read accounts are *The Bell Jar* by Sylvia Plath, *The Yellow Wallpaper* by Charlotte Perkins Gilman, and *Zelda* [Fitzgerald]*: A Biography* by Nancy Milford[1].

In society, women's contributions are often devalued, and roles for women are narrow, defined in relation to men, in unpaid work as wife and mother in the home, or in subordinate service or manufacturing jobs as cheap labour (Szekely, 1988). Being the parent at home with young children, the caretaker of elderly family members, or the person who works outside the home *and* manages a family is demanding, exhausting and not necessarily rewarding work. Women's 'labour' at home can carry on 24 hours a day, often unpaid, and with little relief. These experiences shape a woman's identity and her psyche.

Smith (1990) has studied the way such a set of experiences provides for a woman's own understanding of herself. Smith's (1990) account of a young women 'becoming mentally ill' shows how behaviours and events were assembled, processed, and tested in order to be matched against institutional and informal paradigms which provided criteria for designating someone as mentally ill. Events were transformed into facts. Concern over weight and shape is a common (and almost mandatory) preoccupation with girls and women of most ages today as they compare themselves to movie stars, models and mannequins. However, when these activities compound themselves with other troublesome behaviours around food, eating and exercise, a psychiatric diagnosis is in the offing.

When anorexia nervosa or bulimia nervosa are described as diseases, the etiology of 'eating disorders' render invisible the sociocultural contexts of girls' and women's oppression. When anorexia or bulimia are characterized as diseases and the girls and women as 'sick', then the medical approach is to seek solutions within individuals. This leads to work in search of an ultimate cause

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[1] See *The Bell Jar* by Sylvia Plath (1963), London: Faber and Faber; "The Yellow Wallpaper" by Charlotte Gilman Perkins (1892), *New England Journal, 5* (Jan.) p. 647-59; and *Zelda: A Biography* by Nancy Milton (1970), New York: Harper and Row.

(e.g. biochemical abnormality, personality defect or arrested development), and removes any possibility that influences on the situation emanate from anywhere but the affected person or their immediate family (Szekely, 1988). Medical researchers conduct studies supporting individual or family origins as the 'cause' of ‘eating disorders’: biochemical disturbances (Goldbloom & Kennedy, 1988), poor impulse control (Halmi, 1983), mother-daughter (seldom, it appears, father-daughter) conflicts (Boskind-Lodahl, 1976), enmeshed families (Minuchin, Rosman, & Baker, 1978) or role conflicts (Dunn & Ondercin, 1981).

Medicine prefers to think of health problems (and hence solutions) as unicausal, and embedded in the individual or possibly the family. Within the medical/psychiatric discourse, it appears that girls and women with ‘eating disorders’ are now thought of as more 'curable' than 'incurable' despite high death rates and an inability to fully understand the etiology. This may have something to do with the influence of the pharmaceutical industry. While food remains the medicine of choice for anorexia nervosa--as antipsychotics, antidepressants and appetite stimulants remain without utility--Goldbloom (1993) links neurotransmitter disturbances and depression to bulimia, supporting the use of medication in that instance. Fluoxetine (Prozac), an antidepressant, is now licensed in Canada for the treatment of bulimia nervosa. However, it is prescribed at three to four times its standard antidepressant dose to provide "evidence of clinically significant change in dysfunctional attitudes" (Goldbloom, 1993, p. 1). The rate at which psychotropic drugs are prescribed to women, more than twice (67-72%) as frequently as for men, “raises questions concerning the dangers of taking certain mental health problems to physicians” (Mowbray, Lanir and Hulce, 1983, p. 143; Penfold & Walker, 1983). For vague or emotional complaints, more commonly voiced by women and more frustrating to treat for doctors, a diagnosis is often dispensed with in favour of a ‘therapeutic trial’ of some mood altering drug. The results to the trial indicate the diagnosis. For instance, an improved outlook in a sad woman means drug treatment corrected an endogenous depression. Other factors affecting improvement are not necessarily considered, and the woman may well end up taking the medication for many month or years. In this way the industry creates a need for a product by defining the conditions for its use (Penfold & Walker, 1983).

This scenario mimics the larger picture occurring across the country in dominant/subordinate relationships, whether in the home or the workplace. Women turn to drugs to deal with their difficulty in traditional roles, their feeling a lack of 'rights' to express their dissatisfaction, and their lack of an escape route when obligations are overburdening. Moreover, prescription medication may be the only socially approved method for women of coping with their powerlessness, even as it erodes the need for society to develop strategies of human relatedness (Lexchin, 1984). Because drugs are based on so-called scientific evidence, supposedly objective and neutral, the use of drugs can be scientifically justified as being for the patient's own good.

Drug companies spend enormous amounts of money to keep sales high. The programming of doctors towards the use of drugs in their practice begins in medical schools. Drug companies have infiltrated the production of educational materials, as well as providing gifts, such as medical instruments, for students (Lexchin, 1984). The dependency of medical education on the pharmaceutical industry calls into question the integrity of the medical profession to remain 'objective' about drug prescribing (Lexchin, 1984). 'Educational' materials in the form of pamphlets, literature, and videos are followed by offers of free drug samples or other enticing products which are delivered to doctors offices routinely and without solicitation by the doctor. The art of 'wining and dining' potential promoters of their products is alive and well as "lunches, dinners, and small intimate all-expense-paid meetings" are often financed by drug companies (Penfold & Walker, 1983, p. 194).

In sophisticated marketing campaigns, emotional distress has evolved into universal symptoms treatable by medication. Indeed, in the 1960's and 1970's "advertising agencies, not research scientists, were discovering such new diseases as 'environmental depression' and 'behavioural drift'", requiring, of course, drug therapy (Lexchin, 1984, p. 134). Everyday problems of living have been included under medicine's wing, and myths about getting through life with little suffering, maintaining eternal youth and enduring constant happiness are promulgated in drug advertising (Penfold & Walker, 1983). The root causes of some diseases seem to be "social, political and economic factors associated with modern industrial society" (Lexchin, 1984, p. 208). The axiom central to capitalist economies is that individuals are the authors of their own destinies, therefore, problems in the medical field and elsewhere have been 'individualized', and 'the victim is blamed'. This fits well with the 'specific etiology of disease model' fostered by scientific medicine over the past century. If each 'dis-ease' can be attributed to a single causative micro-organism or a diseased body part, then discrete and isolable problems can be incorporated into the organization of capitalist economies like other commodities on the market (Ussher, 1991). Pope and Hudson (1988) feel a simple cause will be found for bulimia in the years to come and state that:

> Psychological, sociocultural, and other environmental factors. . . will of course influence the expression of this putative abnormality, as they do in every illness in medicine. Such factors are worthy subjects of study, but they should not unduly distract us from the search for a common abnormality which the principle of parsimony leads us to suspect. (p. 163)

The preceding passage exemplifies what Szekely (1988) has characterized as medicine's views, concealing the sociopolitical and economic roots of women's subordination in everyday society and disconnection in everyday relationships. "The social in the clinical literature is reduced to merely a factor" that further affects a weak personality (Szekely, 1988, p. 18-9). Medicine seems unprepared to realize that organizing oneself around dieting, and being organized by the drive for thinness are very powerful responses to levels of distress women feel.

Anorexia nervosa and bulimia nervosa are, at present, often understood as a problem of physiology and/or psychology originating within a troubled individual. Sociocultural factors are envisioned as part of the picture, but as distant and hard to influence ‘factors’. The current multidisciplinary treatment model, based on a multifactoral etiology, advocates a two track approach--renourishment to address the impact of biological changes due to starvation, then attention to the psychological context of the disorder including developmental, personality and familial factors (Garner, 1988).

Psychoanalysis in the tradition of Freud, a favoured technology in professional mental health treatment, represents a major technical advance informing psychiatric and medical practices today. Feminists have been very critical of Freudian psychoanalysis which predicates itself on long-term treatment, and the notion that regular individual visits to a psychotherapist can "cure ethical and political problems" faced by individuals, particularly women (Chesler, 1972, p. 107). Freud opened up a whole new field of expertise by associating pathological states with early childhood development, by developing a discipline associated with the interpretation of a levelled consciousness, and by starting a whole new way of doing business one-to-one in the privacy of the practitioner’s consulting rooms (Penfold & Walker, 1983). Collective efforts involving other girls and/or women to help one understand oneself find no place here. ‘Expert’ knowledge is what matters, and emotionally distraught persons are discouraged from using friendships to find acceptance and security (Chesler, 1972). Instead girls and women are offered a paid relationship with a therapist who is perceived as superior, whose role is detached, and who controls what patients say through subtle rewards or penalties.

Following Freud, theories of the development of girls and boys--their human nature, personality and behaviour--became more than descriptions of theoretical constructs, but “normative, prescriptive ideologies that purported to define normality in all areas of thought and actions” (Penfold & Walker, 1983, p. 24). Freud developed “technologies for examining experiences in relation to an ideology that legitimates and enhances conformity” in how one should feel, portray oneself and act (Penfold & Walker, 1983, p. 24). Freud’s work on the psychosexual development of both sexes was based on the experience of male subjects, culminating in the Oedipus complex. Karen Horney, a contemporary psychoanalyst to Freud who first opposed his ideas on female psychology, believed Freud’s concept of inevitable instincts controlling behaviour created only roadblocks, and did not provide avenues for change. She developed a cultural theory of human development and saw the origins of neurosis as a combination of a disturbance of human relations during childhood accompanied by intrapsychic conflict (Weskott, 1986). Devaluing or uncaring relationships in childhood and adolescence promoted fear and hostility. Neurotic expressions, for example, fixation, regression, and transference (and she included the unnatural Oedipal conflict) were efforts at striving for safety in relationships. Moreover, Freud’s work with female subjects, cited in Irigaray (1985), was altered to protect the phallocentric order when he, ‘distressingly’, found the following:

> Almost all of my women patients told me that they had been seduced by their father. I was driven to recognize in the end that these reports were untrue and so came to understand that hysterical symptoms are derived from phantasies and not from real occurrences. (p. 37)

What Freud was distressed about was not, perhaps, the similarity of the reports of incest, but the lack of acceptance of this finding amongst his colleagues schooled in the same dominant and unanalyzed supremacy of current theoretical formulations. Thus, the father of psychoanalysis seduced the public into thinking a new theory about subconscious desires was responsible for girl’s ‘difficult development', and gave no credence to women's stories of childhood sexual assault. For girls at puberty their 'difficult development' into femininity from a 'masculine sexuality' was expressed as penis envy or castration anxiety, leading to sexual repression and failure to develop successfully into womanhood (Gilligan, 1982). Penis envy was the fatalistic and deemed inevitable theoretical concept in Freud's instinct theory which ultimately explained all female behaviour. Weskott (1986) understands penis envy as a theoretical concept which serves to maintain several conditions for women: they resign themselves to behaviours they cannot change; they repress their anger; and they suffer a trivialization of their rage. Weskott (1986) states a resignation to the status quo, or the release of hostile or destructive impulses were justified by this theory, while paralyzing the search for specific sociocultural conditions of distress. The female character was, according to Freud, already "a static thing [constitutionally incapable of contributing to civilization] ordained by Nature and the unalterable laws of her anatomy. Inferior, vice-ridden, half-savage. . . by virtue of her deformed, castrated physiology" (Millett, 1970, p. 198). Freud created an "apolitical, ahistorical view which discounts or renders invisible political realities of our society" (Penfold & Walker, 1983, p. 76). Society was spared the realities of girls' and women's existence when Freud was pressured to change his findings. That blindness still exists in many types of treatment or therapy today--a refusal to acknowledge the oppression women live under. White (1991) is critical of the increase of interpreting social and emotional problems within a medical and psychiatric framework. White (1991) states "medical management has replaced moral management as a way of containing women's suffering, with respect to inequality, without confronting its causes" (p. 69). To me, it is not so much that medicine has replaced religion, law or family as moral managers, but that medicine is integrally involved in moral instruction as a technology for promoting health, aided and buffered by objective scientific knowledge, while claiming their neutrality in matters of social control.

Gender differences, a passion with many therapists, are fetishized "by flattening, normalizing and making 'scientific' those aspects of 'personal' experience that are ideologically constructed and born of inequality" (Fine, 1992, p. 9). Women are usually defined in relation to men, who are considered the norm. Feminist politics and scholarship of "women alone--defined without men--always embody social danger" (Fine, 1992, p. 9). Whether by choice or by circumstance--nun, prostitute, widow, single mother--a women alone creates social anxieties, signals danger, and inherits degradation. Research on women alone is deemed inadequate without a comparison group of men, whereas a study of men without women is data on human behavior (Fine, 1992). An emphasis on gender differences legitimates essentialist thinking and supports dualistic beliefs about femininity and masculinity, amongst other things such as race, ethnicity, and sexuality (Fine, 1992).

Garner (1988), a psychologist in the field of 'eating disorders', states an important cultural issue is the pressure on women to diet to be thin. Remedies to combat the prevailing 'thin is better' attitude are stated as 'sensitivities' (especially for male therapists) that must be adopted in considering pressures on girls and women, and resolving the therapists' (especially female therapists') own unrealistic attitudes about weight and shape (Garner, 1988). Garner's comments suggest that males don't have as much sensitivity as females, and think more realistically about their bodies. This promotes an essentialist view of human nature which would have us understand women as more 'naturally' emotional and caring, and more irrational about body concerns. Garner (1988) does acknowledge the scarcity of therapeutic suggestions for addressing sociocultural issues, and in doing so, he deflects away from the importance of looking at 'eating disorders' as products of socially constructed realities for many girls and women. The notion of therapists needing to develop sensitivity or resolution to issues may be more psychological technologies which further remove an individual from their own experiential caring and understanding of another human being. Emphasizing individualistic psychological technologies displaces a debate regarding the impact of patriarchal practices on women's lives, and avoids acknowledgment of the limitations of traditional theories of psychological development, based on male models of maturity, for explaining what is happening to girls and women in the 1990's (Lackstrom, 1993). Garner seems unable or unwilling to examine more closely the social context within which the incidence of 'eating disorders' has escalated.

Traditional therapy, in maintaining the status quo, tries to adjust the individual to fit societal roles, while ignoring issues of power, conflict and control. Ussher (1991) depicts therapy as tyranny. Ussher (1991) and many other feminists view therapy as based on patriarchal principles in a culture that supports misogyny (Chesler, 1972; Ehrenreich & English, 1979; Penfold & Walker, 1985). Misery and oppression are transformed into illness during therapy, and attention is directed at the self, obscuring factors outside their own 'madness'. Women's lives and pain are rewritten within a framework that conceals its control of women and encourages conformity (Ussher, 1991). As you will see in the encounters in this thesis, helping professionals coerced women into accepting their distressing situations. Ussher (1991) states that when women are pathologized as individuals they are effectively neutralized as threats to the dominant order. Past life events become an anthology of pathology that gets rewritten to fit psychiatric diagnoses. Feelings get compartmentalized, integrated into therapeutic 'normality', and then dismissed. Helping professions are firmly entrenched in medicalized models which reproduce definitions of normality that are not gender-neutral, but based on male prototypes (Ussher, 1991).

Szekely (1988) believes that the medical language used to describe 'eating disorders', so ingrained in our culture, is devaluing and pathologizing to women. Terms such as 'thought disordered', 'particularly oversensitive', 'distorted cognition', and 'developmentally delayed' are used to describe women and decontextualize an individual from her actual situation. The language obscures the sociocultural roots of oppression and exploitation of women, looking instead for an individual (genetic and victim blaming) cause (Szekely, 1988). Brown (1993) notes that the criteria for establishing a diagnosis for anorexia and bulimia have become more inclusive of candidates for psychiatric labeling over time, suggesting that the diagnoses are socially defined. The weight loss requirement for anorexia was reduced from 25% to 15% loss of body weight in the DSM IIIR. New labels appeared under the category "Eating Disorder Not Otherwise Specified", including normal weight persons fearing weight gain who vomit in the absence of binge eating, persons meeting all the criteria for anorexia nervosa except the cessation of menses, and persons meeting all the criteria for bulimia nervosa except for the frequency of binge eating episodes (American Psychiatric Association, 1987). Diagnostic labelling is becoming more all encompassing.

Western ideology, which upholds individualism as desirable, receives support from medicine's assumption that the problem and the cure for these phenomena lies within the individual, and not in institutional practices or social attitudes and relations (Szekely, 1988; Wolf, 1990). The idea that society is good and just is maintained, and physicians are attributed only humanitarian roles, dislocating them as part of agencies of social control (Penfold & Walker, 1983). Given this view, there is no reason to examine the meaningful structural relationships surrounding women's lives--social organization and the distribution of power does not figure in the medical prescription. Continuing to look at 'eating disorders' divorced from their social context, means we may be overlooking interventions that might be more effective than drugs and hospitalizations.

'EATING DISORDERS' AS RESISTANCE

Powerlessness and Resistance

Medical/psychiatric theory, and hence practice, is only one instance of the kind of ideological control that dominant groups (mostly males) have over women subordinates. But women do resist that control, sometimes overtly, sometimes covertly. Much has been written about the destructive effects on women of being in a group that is oppressed (Ehrenreich & English, 1979; Mueller, 1988; Roberts, 1983). Roberts (1983) notes that those who are oppressed try to internalize the values of the dominant group, but suffer self-hatred and low self-esteem while becoming marginalized or not fully fitting anywhere.

In a research study about being young women in the 1990's, Fine and Macpherson (1992) interviewed the same four adolescent girls on several occasions over dinner. This group tried on several "ways of being women [in their conversations] struggling through power, gender, culture and class." (Fine & Macpherson, 1992, p. 201). The researchers and the young women evolved a collaborative and critical form of conversation, a form of feminist methodology, as they struggled between discourses in feminism and adolescence. This method moved the participants from "pain to passion to politics, prying open the ideologies of individualism, privacy and loyalty" (Fine & Macpherson, 1992, p. 201). The interpretations of discourses on adolescence, femininity and feminism by these young women, found femininity incompatible with adolescence. Fine and Macpherson (1992) conclude that:

> Adolescence for these four young women was about the adventures of males and the constraints on females, so their version of feminism unselfconsciously rejected femininity and embraced the benign version of masculinity that allowed them to be 'one of the guys'. They fantasized the safe place of adolescence to be among guys who overlook their (female) gender out of respect for their (unfeminine) independence, intelligence, and integrity. For them, femininity meant the taming of adolescent passions, outrage, and intelligence. Feminism was a flight from "other

> girls" as unworthy and untrustworthy. Their version of feminism was about equal access to being men. (p. 176)

Rejecting their femininity was a way to resist all they deplored about the typical stereotypes of being female (subordinate, dependent, silly, and self-sacrificing), and their sense of powerlessness with those feelings. Feminism for these young women was not about celebrating their strengths nor creating a new way of expressing their femininity, they somehow knew it would not matter. Gaining corporate or professional success--the only kind that seems to matter in our society--does not embody feminine traits. What is needed for male-defined success was a respect for rule-based actions, including arguing about the rules, an independent and aggressive orientation to relationships, and a competitive nature (Gilligan, 1982). Women in the work force learn that qualifications do not necessarily guarantee advancement and autonomy, but “one’s sex often determines career success” (Mowbray, Lanir & Hulce, 1984, p. 14). That the "traditions and practices of 'femininity', as commonly understood, may be hazardous to the economic, social, educational and sexual development of young women" had not escaped the notice of the four young women Fine and Macpherson (1992) interviewed (p. 59). These girls were busy trying to divorce themselves from their childhood--denouncing their feminine peers as worthy only of contempt--fearing they’d see a reflection of themselves--and looking to masculinity as the way out of their discomfort. This is analogous to a process girls and adolescents with anorexia nervosa and bulimia nervosa experience as they enter adulthood--according to Steiner-Adair (1991), they hate being girls and they hate their bodies. Their negative feelings create outward submissiveness while inside they are seething with anger and in constant conflict. ‘Eating disorders’ may be silent rebellions against expected norms and oppressive practices within patriarchal society, even if those, whose bodies are the battlegrounds, are not able to articulate their actions in words (Brown & Jasper, 1993; Hall, 1993). Violence gets inflicted on the self, perhaps as an attempt to stay connected to oneself and others. Girls and women with ‘eating disorders’ desire an authentic existence, however, they are at odds with themselves and the consciousness they have internalized. A learned fear of aggression and of change maintains the status quo (Roberts, 1983).

A paradox arises for females with ‘eating disorders’. In response to perceptions of powerlessness in relationships, decisions to stop eating are very serious and potent forms of resistance. At the same time, not eating decreases the physical, intellectual and emotional power to change one’s circumstances. Women with anorexia nervosa and bulimia nervosa resist with their very lives and use the body as a means of speaking about their pain (Brown, 1993). Fine (1992) states that the patriarchal system works perfectly because women are "the repository of social secrets and made to feel responsible for social problems. To speak has been to betray [the] self" (p. 21). Feeling stripped of a means of making sense of their place in the world, starvation can be a very mobilizing force with which possibilities for changes in relationships become available, albeit a deadly possibility.

In my experience working with adolescence and young women with ‘eating disorders’, not eating creates reinforcing (yet temporary) internal changes. Crisp (1980) describes these changes as: a euphoria or a ‘spaced out’ feeling; hormonal and chemical bodily adjustments to keep going; powerful feelings about successful ‘dieting’ efforts when others cannot restrain themselves; and doing 'some thing' that is uncontrollable by anyone else. This euphoria appears as a sense of empowerment that initially reinforces the dieting or reducing 'labour', but is short lived when that 'work' somehow becomes another form of domination. Women become dependent on the temporary euphoria of a ‘light’ feeling body, while experiencing fear and isolation. Restricting one's intake also mobilizes external forces--family members and friends go scurrying to find help, and care is taken in any interaction with the individual, (like 'walking on eggs'), often with abandonment of normal rules of interacting. In the face of these changes accrued to 'eating disorders', these phenomena can be seen as desperate attempts for connection and relatedness with the self and others, even as they deny wanting relationships which, in the past, have consistently disappointed them.

Most individuals with eating disorders chase an ideal that can never be actualized. Szekely (1988, p. 14) feels these individuals get focused on striving for individual happiness with little recognition of "the world outside patriarchially defined women's roles". Controlling the body and their appearance is perceived and experienced as their only notion of independence. The 'thing' they try to be independent of remains invisible. The well-being of women with anorexia nervosa or bulimia nervosa is greatly threatened by their activities or 'labour' in pursuing thinness. Even when women achieve a measure of thinness, there is no joy, just 'work' in keeping the pounds off (Tisdale, 1993). It becomes a joyless existence that takes over a woman's life, and, in too many cases, ends it.

While individual practitioners may be well meaning and concerned for their patients, the structure of the medical/psychiatric institution within the larger system of power "mitigates against the attempts of individual practitioners trying to ensure that their practice is therapeutic" (Penfold & Walker, 1983, p. v). In the psychiatric sphere non-response or resistance to treatment is seen as recalcitrant behaviour, and in many cases, a further symptom of illness, perhaps even labelled as madness (Penfold & Walker, 1983). If 'eating disorders' are understood as rebellion to dominating relationships and gender biased norms, or attempts at finding connections that feel like 'home', how can traditional medical and psychiatric practices help girls and women?

Deconstructing/Reconstructing Women's Madness

Ussher (1991) states that neither mental health practitioners nor radical dissenters have done a good job at deconstructing madness, or reconstructing the oppressive experiences of women as harbingers of the conflicts and distress which can lead to diagnoses of mental illness. She goes on to say that:

> Madness cannot be understood either in the isolation of the consulting room, the deconstructed literary texts or through the subjective reports of an individual woman. Madness is more than a hormonal imbalance, a set of negative cognitions, a reaction to a difficult social situation, or the reflection of underlying unconscious conflict. Madness is more than a label. It is more than a protest. It is more than a representation of women's secondary status within a phallocentric discourse, a reaction to misogyny and patriarchal oppression. To understand madness we must look further and wider than the individual--to the whole discourse which regulates 'woman'. Yet we must also look beyond the category of 'woman' to the reality of the pain and desperation which is a part of this experience for the individual in distress. (Ussher, 1991. p. 289)

This study looks further and wider to understand the contexts of girls' and women's lives when they have anorexia nervosa and bulimia nervosa--how they are socially organized--while making clear the real despair they experience. In the treatment of 'eating disorders', madness in its many forms and definitions is present. In my experience, girls and young women with anorexia nervosa and bulimia nervosa are often very 'mad' or angry. These feelings get directed inwards as they are unable to express them openly (Garner and Garfinkel, 1985). Females are strongly discouraged from and punished for expressing any aggressive behaviour--displeasure, criticism, anger and rebellion--although in men, these behaviours are thought of as constructive and helpful. Femininity prohibits the possibility of contradiction or anger, and expression of aggressive behaviour calls one's sexual identity and mental health into question (Mowbray, Lanir & Hulce, 1984). This sets up the young person in a relationship of conflict with oneself, and fear and submissiveness towards others. To think of unleashing even one emotion in the range of feelings that have become pent up over time is often perceived as overwhelming, and tantamount to opening the flood gates of emotion from which one could never survive undamaged.

With the many symptoms that girls and women with ‘eating disorders’ experience, and, with their unusual patterns of behaviour around food and exercise, they are thought by onlookers to be, and often think of themselves, as mad in the sense of ‘crazy’. Their families are extremely distressed, themselves angry, at having their life interrupted by a member with an ‘eating disorder’, and want a quick fix to the problem. It is easy to see how families look to ‘expert’ medical help for guidance in these matters. The medical model offers quick fixes in the form of drugs and institutionalization, and it legitimizes parents concerns that ‘eating disorders’ are diseases needing medical treatment. Medical treatment absolves parents of many of their usual parenting functions, and often means parents don’t have to face to any great extent their own involvement in this. Failure in treatment looks to different drugs or different therapists--in essence, more of the same technologies. The location of the problem, however, has been firmly established within the individual affected, thus work on the problem is situated there.

Professionals working with these women experience a great deal of ‘tearing their hair out’ anger at the resistance of their patients--girls and women who have been pushed into a certain way of being. Yet women with ‘eating disorders’ are subject to ‘expertise’ from therapists that they find hard to accept. Women have been very limited, corresponding to their limited roles in society, when it comes to the production of "ideas, images and themes--the symbolic modes that are the general currency of thought" in our society (Smith, 1987, p. 19). Men, particularly male specialists, produce the ideology of our culture and control the public and the private access of any production of knowledge by women. "As history describes the doings of men, as fine art is the art created by men, as literature is writing produced by men, and as classical music is that composed by men, so the science, the news, the art, the literature, the music of today is produced by men" (Ussher, 1991, p. 279). Women are largely excluded from the power bases of knowledge creation (Smith, 1987). In psychiatry, and especially in the eating disorders discourse, men dominate ideas about how the phenomena are believed to develop in women, and how to produce the technologies that are reported to help.

Medical and psychiatric services have been mandated the care of individuals with 'eating disorders', and those professions present themselves as independent from bias, influence and political motive, because they are thought to be based on objective, scientific 'truths'. Thus, 'mentally healthy' becomes conformity to a certain set of beliefs postulated by medicine and psychiatry in the name of health, directed by these scientific 'truths'. Norms of development and behaviour, which mirror the qualities and beliefs of the dominant class, exclude everyone who does not match the prescribed human--that is, male--prototype. In the classic Broverman study (1970), the sex-role stereotypes of the male and female mental health psychologists, psychiatrists, and social workers involved, paralleled the stereotypes prevalent in society in general (Broverman, et al, 1970). Clinicians were asked to describe mentally healthy men, women and adults. Characteristics for a healthy male were very close to those described for adults. Healthy women were seen to differ from healthy men, and hence from healthy adults, by being:

> More submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, having their feelings more easily hurt, being more emotional, more concerned about their appearance, less objective, and disliking math and science. (Broverman et al., 1970, p. 4-5)

Professionals may "perpetuate these stereotypes under the guise of 'expert' opinion which can in turn exert a powerful influence on individual settings as well as in medical education and health policy arenas" (Mowbray, Lanir, &

Hulce, 1984, p. 132). Psychiatric and medical expertise informs a wide range of fields from legal and social policy, to education, sexuality and parenting (Penfold & Walker, 1983). Penfold and Walker (1983) say:

> It has been suggested, by men themselves [and women] that much of what is presented as the 'psychology of women' is merely patriarchal rhetoric and represents the desires and disappointments of men. It is also significant that only in recent feminist criticism has it become apparent that the 'psychology of women' correlates closely with the 'characteristics of oppression', a connection entirely overlooked in traditional psychiatric approaches. (Penfold & Walker, 1983, p. iii)

I am particularly interested in the ideology and practices shaping the health care system, its workers, and those it serves in relation to women's mental health, especially related to 'eating disorders'.

FEMININITY AND THE SEARCH FOR THE 'IDEAL'

Femininity, far from being a straight forward expression of the life of girls and women, must be seen as socially constructed. Powerful forces shape 'ideal' images of females, and girls and women take up the work of creating themselves as a reflection of that 'ideal'. Many feminists argue that girls and women are socialized into learning behaviours that define femininity and 'woman', and these become expected and normalized, thus taken as biologically 'natural' (Gilligan, 1982; Mowbray, Lanir & Hulce, 1984; Penfold & Walker, 1983). The ideas, actions and ways of being that are sanctioned as appropriate for women have enormous influence on what is considered healthy or unhealthy. Stereotypical feminine characteristics of passivity, dependence, self-sacrifice and non-aggressiveness are fostered by the use of mind numbing drugs. Women's escalating use of psychotropic medications reinforces the view that women are 'sick', particularly mentally unstable, instead of focusing on changes to patriarchal social structures, or modes of social organization which present the feminine as devalued, deviant and deficient, and antithetical to notions of citizenship, humanity, reason, culture and civilization (Coole, 1993).

"Femininity is. . .a textual discourse vested in women's magazines and television, advertisements, the appearance of cosmetics counters, fashion displays. . . . These are constituents of the social relations they organize" (Smith, 1990, p. 163). The discourse on femininity also includes discussions women have in relation to how they are portrayed, and reshaping oneself to look like a model in a magazine. This discourse and the search for the 'ideal' is intimately tied to a commercial process which creates structures to bring the buyer back to the store again and again to purchase more goods. Advertising is a specialized process of production which mediates and structures a market for organizing industry (Smith, 1990). Mass media in the diet, fitness and fashion industries coordinate multiple local sites (e.g. newspapers, magazines, TV and check out counters), where desire is translated into demand for products. Advertising mediates the image-desire-shopping circuit in capitalist economies, and these circuits need new markets to maintain viability.

Individualism, essential in a capitalist political-economic system, professes that through hard work and determination we can have it all (Szekely, 1988). However, if we are not successful, there is an assumption that the fault lies within--one is not smart nor energetic nor attractive enough. Improving and perfecting the body is seen as a path to success in personal and professional environments. By conforming to and/or actively accomplishing a prescription for femininity in their bodily practices and in their relationships with others, women deny their own unique and diverse expression of femininity (Szekely, 1988). Women participate in ideological offensives against themselves when attempting to achieve the 'ideal'--an elusive, possibly unattainable, and probably unhealthy goal. The 'work' of improving and perfecting the body, glamorized by growth industries in fitness, youthfulness and health-making, can be costly, time-consuming and exhausting, while promoting isolation and alienation from the self and others (Szekely, 1988).

The Body

Learning is a bodily function (Szekely, 1988). While all humans use their bodies to communicate identities to others, women are identified as bodies in our society (Szekely and DeFazio, 1993). Greenspan (1983) states, "woman in contemporary patriarchal society is fundamentally identified with her body. Her body is her power" (p. 164). Therefore, for many women, the body is a means for achieving success. The body may also become an object of 'labour' or a place of imprisonment.

Initial judgments are often made from how people look. Men are identified more with their brains, invisible to the eye, while women, more than men, are judged by their looks. Socially unacceptable characteristics--lazy, dirty, ugly, uncontrolled, stupid--are attributed to persons with overweight body sizes. 'Obesity' is constituted as an abnormal and unhealthy medical entity despite medical studies showing contrary evidence (MacInnis, 1993; Orbach, 1993). To be deemed worthy or unworthy based on body size is particularly troublesome for women, because there are few avenues sanctioned for validating women.

The medical community continues to validate the cultural stereotype of thinness for women. It remains an "active agent of fat oppression" by perpetuating myths that fat people are unhealthy and abnormal, by promoting dangerous 'treatment' strategies used to 'fight fat', and by being part of a patriarchal system that devalues (fat) women and turns them into profit making patients (MacInnes, 1993, p. 73). Women's lives are endangered through many kinds of interventions geared to reducing body fat--medications with serious side effects, intestinal bypass or stomach stapling surgery, and dieting 'prescriptions' (MacInnis, 1993). "Dieting, long thought to be the primary treatment for obesity, may be the primary cause of it" due to physiological changes which alter a person's setpoint[2] to a higher range after reduced intakes (MacInnes, 1993, p. 72). Furthermore, binge eating[3], a diagnostic criteria for bulimia nervosa, may well be precipitated by starvation diets. Fears associated with binge eating often prompt purging, excessive exercising or a return to restrictive eating. While there is this medicalized notion of dieting as a biological precursor to the development of an 'eating disorder', I am more interested in dieting as a well-practiced, socially organized prerequisite for developing 'femininity' taken up by well over half the females of adolescent and young adult age in North America (Health and Welfare Canada, 1988). The focus on the body and the sequelae from dieting seem more complex than medicine is prepared to address.

Pursuing thinness is a difficult 'job' which transforms girls' and women's bodies into a commodity in need of perfection (Szekely, 1988). Thinness, per se, is not what is sought after. Can it be that the real stakes are much larger and more far reaching? The pursuit of thinness through the body becomes a vehicle for striving for one's very existence (Brown, 1993: Steiner-Adair, 1991). The "personal is political [in that puberty or passage into womanhood], motherhood, childrearing and marriage are not simply life cycle events, but institutions that carry particular sociocultural legacies for women" (Lackstrom, 1993, p. 308). Robinson (1991) states that our culture "denies the reality of poverty, sexism, racism and sexual abuse" while glorifying violence, and [having] no voice, language and process to prepare adolescents, particularly adolescent girls, for the future" (p. 246). Under the guise of protection of young people, we hold on to unhealthy conventions of femininity, and fail to prepare girls about their health and the wide range of normalcy of the physical changes in their bodies. By giving

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[2] Setpoint refers to an apparent physiologically programmed weight range that is specific to each individual, and which transcends one's aesthetic preferences for body weight and shape.

[3] Binge eating often occurs after periods of low caloric intake, for example, following the repetitive dieting episodes in bulimia, or during the refeeding period following prolonged starvation in a state of anorexia nervosa.

the message that topics related to the body are taboo, such as nudity, contraception, and sexual exploration with the self or with others both in and outside of marriage, we are teaching young women to deny, misunderstand and ignore their bodies as objects unworthy of relationship. Therefore, girls mature physically "without understanding the significance of their development" (Robinson, 1991, p. 246).

Adolescents are, however, very aware that their bodies are public sites--commented on and monitored by family, friends and professionals. Because of their gender, young women are especially "subject to external surveillance and responsible for internal body management. . . .Culture and class determine how--that is, the norms of body and the codes of surveillance, management, threat, assault and resistance available to them" (Fine, 1992, p. 185-6). For boys, the childhood years mean more pressure to conform to appropriate behaviour and sex role expectations. However, beginning in adolescence, girls surpass boys in stress and mental health problems because they must abandon their male-defined values, goals and activities (like achievement), suffer pressure to adopt feminine roles, and become more aware that males receive a favoured status in society (Gilligan, 1991; Mowbray, Lanir and Hulce, 1984). The body may well seem like the only management tool available to some young women for sorting out confusing messages about conforming (to norms) and resisting (the status quo). Or because the body of a young women is perceived as a public site by herself and others this may seem like the site with which to raise a resistive stance.

Adolescence is the breeding ground for the onset of 'eating disorders' with anorexia typically occurring earlier in adolescence than that of bulimia (National Eating Disorder Information Centre, 1988). The female body is a "site of domination subjected to commodification, objectification, and alienation", therefore control over the body (and possibly the development of an 'eating disorder') may become the tool to attempt to break out of forms "of subjugation--in the hope of positioning oneself in less oppressive relationships" (Szekely, 1988, p. 18).

Femininity Structures Desire

A body is going to seem imperfect held up to ideal textual images, particularly when comparing oneself to photographically enhanced pictures in magazines--no blemishes, shiny hair, proportionate body. This creates a gap between actual and desired body/appearance. "Discontent with the body is not just a happening of culture, it arises in the relation between text and she [as subject] who finds in texts images reflecting upon the imperfections of her body [as object]" (Smith, 1990, p. 185). The text illuminates a gap or deficit (e.g. big hips); she reads a remedy (14 day diet and exercise regime) and has a solution; she enters the discursive organization of desire; and has an objective instead of a deficit. In the context of femininity discourse, a distinctive and alienating relation to the self arises--a body to be transformed, a work project. "Participating in the discourse of femininity is also a practical relation of a woman to herself as object" (Smith, 1990, p.187). Women with anorexia and bulimia seem locked into eradicating the non-eradicable imperfections of the body illuminated by text.

Smith (1990) describes three levels organizing the subject in the social relations of femininity. In the first level, females and males meet in the sanctioned and normative organization of the heterosexual social milieu. The subject-in-discourse, the feminine girl or woman, enters this sociality as the object of heterosexual desire, even though she may not choose to be desirable. A common theme amongst some authors, particularly in reference to anorexia nervosa, is the attempt to retreat from the process of maturation, to remain childlike (Crisp, 1980).

"The appearance of the body as object is a practice learned in childhood" (Smith, 1990, p. 195). Many girls or women clearly remember a comment by a family member or a boyfriend about some part of the body that needed attention. This was perceived as a trigger which launched them into dieting and the pursuit of thinness. As an object of another's desire and manipulation, action and intention are not seen as part of the potential of women at this level. Women are seen as a malleable body--an object in relation to another's desire. One could suppose, this may also be an attempt to refrain from entering the realm of desirableness and femininity 'work', and remain in a more genuine and satisfying relationship with the self.

The second level of relations in the discourse on femininity according to Smith (1990), behind producing themselves as objects of male desire, is an invisible subject-in-discourse who is active in creating the proper appearances to be thought of as attractive. Being attractive is intimately tied up in the pursuit of thinness. Thinness is a prerequisite for success in many relationships--inclusion in a peer group, to be chosen as a date, a life-long partner, or an employee (Szekely, 1988). Thinness is equated with health, youth, beauty, sexuality, attractiveness and femininity. Dieting and losing weight is advertised as effortless if you have 'what it takes' to follow a prescribed plan. Agency, particularly sexual or aggressive, is denied women at the first level, is antithetical to the notion of femininity as passive and demure, and is displaced by messages borne in the body and the appearance that awaits reading by males. At the second level is a subject who is fully agent in organizing the 'looking good' appearance necessary to be a member of a heterosexual world. The invisible *work* of girls and women with 'eating disorders' operates largely at this second level of active agent, however, many individuals with 'eating disorders' organize an emaciated and repulsive appearance, shunning sexual desire in themselves and from others. For girls and women with anorexia or bulimia nervosa, this agency may well take the form of resistance to traditional notions of conforming to femininity and its practices. This work is filled with despair, shame, secrecy and isolation.

Smith's (1990) third level of desire and identity is organized in the active relationship women have with the market through available commodities. Friendships and group identities are structured by how one looks. Shopping, talking, planning, evaluating, and showing off clothes, cosmetics and images are important pastimes and 'work' for girls and women. Capitalism perpetuates and "rewards only the relentless pursuit of self interest" (Adamson, Briskin & McPhail, 1988, p. 101). Magazines educate readers in the doctrines of femininity and train them in the production of appearance. Magazines are like trade magazines which shape the work of the feminine girl or women. Women have learned that their social value is equated with appearance, and the "only way [women] can legitimately access power is by achieving and maintaining the socially constructed ideal of beauty" (Ciliska & Rice, 1989, p. 14). "Managing desire through the discourse of femininity implicates women as active participants in its discursive relations" (Smith, 1990, p. 203). However, while girls and women *produce* an appearance and *manage* their desire to be like the ideal in the text, they represent themselves as other than themselves. This alienation of the subject, as a representation of a textual image, produces conflict within and amongst individuals--a disconnection. Smith (1990) thinks this objectification of women's bodies--viewed and treated as others on the outside of themselves would see them (*perfectly* feminine)--can only encourage a mind/body split in women's thinking about themselves.

Dieting - The Solution to Self-Improvement

Dieting is a central motif in the lives of many females of all ages accompanied by the notion that the personality creates the body. Size is envisioned as voluntary or within control of the individual (Tisdale, 1993). Eating, when dieting, is like cheating. Food becomes corrupt. The misery of dieting fosters the belief that the person is bad, reduced to only a body (Tisdale, 1993). Half of North American women are dieting at any given time, 70% are weight preoccupied and 80% dislike their bodies (National eating disorders Information Centre, 1988). Seventy percent of all Canadian adult women wanted to lose weight according to a Health and Welfare Canada (1988) study, while 36% of women believed they were overweight when they were normal weight. This same study estimates that 61% of adolescents and young adult women are dieting at any given time, just to look good. Eight and nine year old girls of normal weight restrict their intake for fear of becoming fat. "The fact that young girls, but not young boys, have such precocious concerns about attractiveness is compelling evidence for the power of sex-role socialization and the potency of the diet message" (Brumberg, 1989, p. 253).

The multi-billion dollar diet industry, a remarkable entrepreneurial legend in its short history, is predicated on failure and deception (Ciliska, 1993). It is believed that 95% of diets fail to achieve long term weight loss and many dieters exceed their pre-dieting weight, perhaps by altering to a higher position their set-point or internal control system which indicates how much fat the body should carry (MacInnis, 1993). Fewer calories are needed than before dieting to maintain one's body weight at a raised set-point. Not only do dieters who stop their diets end up weighing more than when they started, their body composition changes to less muscle mass and more fat (Ciliska, 1993). Thus, a cycle of dieting, weight loss, then weight increase begins. Ciliska (1993) notes that the diet industry is self-generating and ever expanding as dieters typically regain weight after stopping their diets, feeling compelled to try to lose weight again by the next fashionable diet, or weight loss clinic, or exercise machine, or herbal remedy that hits the media.

Once significant time and energy gets deposited into dieting as the way to attain an 'ideal' body, and hopefully an ideal existence, it becomes a way of life that seems very difficult to turn around unassisted (Kennedy, 1988). Many hours are spent calculating calories, studying diets, comparing body shapes, and planning when and when not to eat. That this pursuit becomes a consuming passion and an identity reinforced in oneself and by others, makes it difficult to interrupt. Once the pattern of restricting one's intake, exercising excessively and/or purging is initiated--what some would call 'madness'--'imprisonment' in the reclamation of self emerges which can last for many years. This 'internment' is exemplified as a consuming 'sentence' of 'labour' pursuing thinness at the site of the body. This involves much investment of self, energy, and time, and requires goals, planning, interventions, evaluations and forgoing other life pursuits to achieve thinness. It may end in death. This 'labour' has been labelled by the professions of medicine and psychiatry as an 'eating disorder'--anorexia nervosa or bulimia nervosa--and consequently comes under their jurisdiction for treatment.

The terrible 'costs' of this 'labour'--physical, mental, and emotional health, friendship, money--seem to be blindly ignored, possibly even accepted. The supposed ease of willfully changing one's shape, and hopefully one's future, is reinforced by most women's magazines, fashion establishments and diet centers, and conceals the money to be made in keeping these illusions alive. Weight 'reduction' symbolizes the small spaces that women feel permitted to fill in our society (Tisdale, 1993), and the work of 'doing femininity', according to these cultural sanctions, may take some girls and young women down the troubled road to an 'eating disorder'.

Wolf (1990), herself a sufferer of anorexia nervosa in her adolescent years, characterized herself as a "wind-up obedience toy" (p. 202). While Wolf's account of her story is organized to say particular things about herself and her 'dis-ease' during her adolescence, it is an account reflecting similar occurrences to those of Teresa and Diana in this study--disconnection with herself, and subordinate and diminished relationships with others in her environment and with her world. Wolf (1990) states: "There were many starving girls in my junior high school, and every one was a teacher's paragon. We were allowed to come and go, racking up gold stars, as our hair fell out in fistfuls and the pads flattened behind the sockets of our eyes" (p. 202). She states that an alien voice took over hers, changing it to monotone, devoid of any expression. Her teachers saw nothing wrong with this, and in fact, showed approval of the change. Wolf (1990) remembers her dreams "were none of the adolescent visions that boys have, or free and healthy girls; no fantasies of sex or escape, rebellion or future success. All the space I had for dreaming was taken up by food" (p. 202). She felt anorexia nervosa was the only way to keep the dignity she felt in her body as a child, but would lose as a woman. Wolf (1990) did not want to have choices in her future confined to inconsequential things, while major choices were made for her based on her womanly shape. She states:

> The larger world never gives girls the message that their bodies are valuable simply because they are inside them. Until our culture tells young girls that they are welcome in any shape--that women are valuable to it with or without the excuse of 'beauty'--girls will continue to starve. (Wolf, 1990, p. 205)

Wolf thinks that 'eating disorders' exact political damage on women by a "social order that considers [women's] destruction insignificant because of what we are--less" (Wolf, 1990, p. 208).

EXAMINING THE SOCIAL RELATIONS OF 'EATING DISORDERS'

The context of girls' and women's lives is social and relational. Their power to control their own lives evolves in and is constrained by a social context, arising not just out of family or peer relations, but in relations extending into the wider social fabric. As suggested by Szekely (1988), Wolf (1990), and others, to understand 'eating disorders', we need to look beyond the intrapyschic and interpersonal lives of girls and women to see how society organizes their 'choices'. I maintain that while attention to the body through dieting may have initially seemed like a personal decision for individuals, there are many subtle and obvious societal pressures that influenced that process, and the progression to an 'eating disorder' from dieting practices is unanticipated in the individuals suffering these phenomena.

Feminist scholars, researchers and therapists are interested in girls' and women's lives and how they are organized. Feminist theory offers some conceptual tools for understanding the lives of girls and women. Smith (1990) sees social life organized by ruling apparatuses, that is "those institutions of administration, management and professional authority, and of intellectual and cultural discourses, which organize, regulate, lead and direct, contemporary capitalist societies" (Smith, 1990, p. 2). Ruling, as Smith describes it, depends upon practices of objectifying knowledge which individuals participate in often unknowingly, and which organize their lives.

Social relations means a complex set of abstracted, impersonal, and promoted-as-universal practices, and the discourse--talk, text and symbols--that surrounds the practices, found in ways of working in institutions such as governments, professions, schools, etc., and which create actualities in people's lives. Smith (1987) states that social relations provide "a procedure for analyzing local work practices--the locus of the experience of the subject--as articulated to and determined by the generalized and generalizing relations of economy and ruling apparatus" (p. 167). Social relations are not conceptual, theoretical or abstract things, but real and investigatible. They are, however, for the most part invisible, not available in people's experiences, even when they structure those experiences. For instance, women's experiences of health care need to be explored with the objective of seeing how professional relations organize women's responses.

The ideology of professions and institutions in healthcare is postulated as neutral--outside the domain of the state--and unrelated to and not representative of those in dominant power positions. Medicine, including psychiatry, "does not fully acknowledge the nature of these social relations", presenting itself as grounded in objective truths based on unbiased scientific experimentation (Penfold & Walker, 1983, p. iv). Ideology, according to Penfold and Walker, is a:

> Socially produced construction of ideas and explanations; a set of procedures and practices which both accounts for and organizes the social system. In the process, ideology provides an explanation that obscures actuality by providing an alternative view which legitimates the position of those who create it. Thus, if women's reactions to oppression can be explained in terms of individual pathology, or a function of feminine psychology, the objective facts of oppression are obscured and need not be changed. (1983, p. vi)

Feminist Theory and 'Eating Disorders'

Feminist theory, which informs feminist research and therapy practices, is dedicated to uncovering imbalances of power in situations of oppression and inequality, but the many perspectives and considerations which encompass feminist thinking are not without controversy amongst feminists themselves. The debate amongst feminist practitioners and scholars addresses, amongst other issues, how to identify and express the voices of girls and women in research and in treatment (Brown & Jasper, 1993; Harding, 1987; Penfold & Walker, 1984; Szekely, 1988).

Women are beginning to create words that express their experiences and to give voice to their lives. Feminists are recognizing a diversity in women's experiences, and understanding that gender has never exclusively shaped women's lives. "Women's interpretations, values, interests, and actions can differ dramatically according to sexual orientation, class, race, ethnicity, education, age, and national origin", and greatly influence their everyday experiences (Hall & Stevens, 1991). I would add that health influences the above stated factors and plays a part in determining one's experience.

Girl's and women's mental health is affected by many factors that health care practitioners do not address to any significant degree. Mowbray, Lanir and

Hulce (1984) discuss four factors centering on cultural relationships which influence female mental health: women's socialization, their status in society, discrimination against girls and women, and biases supporting inequality. A feminist analysis helps in understanding how and why girls and women engage in the relentless pursuit of thinness, risking their lives and enduring suffering to attain a thin and often unrealistic ideal, by giving voice to girl's and women's stories, thereby connecting the social context of girl's and women's existence to what happens to them in their daily lives. A social organization of knowledge inquiry looks at the social context of girl's and women's experiences and shows how these experiences do not happen accidentally, and may be replicated beyond their individual contexts through social relations.

While feminist theory holds promise for understanding girls' and women's experiences in the pursuit of honest and supportive relationships, albeit through achieving thinness, Szekely and DeFazio (1993) note some contradictions. Feminist theory on the body, adolescent female development, and 'eating disorders' are not well defined, yet feminists have made many claims about the development of 'eating disorders'. Living comfortably in the body is a continuously present issue for many women and men. Therapists working with weight preoccupied women should address their own weight and body size as issues relevant to a therapeutic relationship. Women are encouraged to celebrate the body size they are meant to be, however, there is a recognition that a fat woman must live through the pain of never being thin and "liberate herself from the tyranny of slenderness and from patriarchy" (Szekely & DeFazio, 1993, p. 367). Thus, fat persons are never allowed to live fully in their bodies with their own authentic experiences, but work to construct a life of resignation and peace in their largeness. 'Proper diet(ing) and exercise' are endorsed for 'health reasons' by feminist magazines, with the belief that fatness and fitness cannot go together. These messages imply that the preferred body shape is thin, possibly encouraging a mind/body conflict.

With these concerns in mind, feminist theory is valued in this study because it strives to put women as the 'subject' of knowledge about themselves, not just make them the 'object' of study. They are affirmed as expert knowers about their own experiences. Feminists are challenging the many messages women receive and internalize about their bodies, lending insight into why women view dieting as a private 'choice', forgetting that they grew up in a society where thinness is viewed as better. This internalization of dieting as a 'choice' belies the powerful forces at work in our individualistic society which views thin as the only figure acceptable for women. When dieting is viewed as a 'choice', behaviours are justified which abuse mind/body harmony by violently trying to fit bodies into molds to which they cannot conform. Fine (1992), a feminist psychologist and researcher, encourages us to examine the social construction of quiescence of the female voice, while the body is screaming.

Feminist Research

Feminists researchers, have created a space where they can speak authoritatively about injustices faced by girls and women. Thus, they also have a responsibility to shape their research activities through an activist stance. This must be a critical and open stance, lest feminists "collude in reproducing social silences through social sciences" (Fine, 1992, p. 206). Social activism is presumed to be the context in which feminists conduct their work because "deep and sustained power asymmetries [are believed to] construct our conceptions and relations of gender, race, class, disability, and sexuality" (Fine, 1990, p. viii).

White (1991) outlines some basic tenets in feminist research: (a) all investigation is value laden and context bound, (b) the unit of analysis is often larger than the individual, (c) women are affirmed positively as knowers, (d) experiences are explored and valued, (e) collaborative working relationships are developed with the research participants, and (f) research findings promote social, rather than individually based, change--particularly strategies to mitigate gender inequities (p. 79). While feminist research uses the same basic data gathering techniques as traditional social sciences such as examining trends or records, interviewing or listening to participants, and direct observation, the intentions are quite different. Studying girls and women from their own understanding of themselves in their relationships, their experiences and their world reflects participants' concerns in all their diversity, and tries to find answers for these individuals, not some profession, industry or government. This understanding occurs in and is organized by relatedness. Social relations are a way to understand how girls' and women's lives are organized. This research investigates how the relations of gender, age, status, health, and medical/psychiatric ideologies and practices situate 'eating disorders' in the realm of mental health.

The medical/psychiatric perspective offers the dominant, ideological view of 'eating disorders', largely seen as a problem in the psyche or family of an individual. An analysis that makes more sense to me includes how girls and women and their problems are constructed in our society. Feminist scholars are pointing out that the way in which women's problems are conceptualized in society builds in the perspectives and biases of the observer, in taken-for-granted ways, creating barriers to understanding (Smith, 1974). Concepts such as 'anorexia' or 'bulimia', used to name these phenomena, place boundaries on what we are able to know about these phenomena, and how to organize their treatment. These labels conceal the very relationships and practices that produce them (Szekely, 1998). Therefore, it is imperative to study the practices and interactions of women who struggle with thinness from their perspective and in the context of treatment--what these women actually did and what was done to them which built into unanticipated 'imprisonment' in 'eating disorders'. Feminist ways of working make sense to me--a collaborative environment, valuing women and their stories, working for social change.

Smith (1990) has developed a method of exploring everyday life from the standpoint of actual subjects. Other feminists besides Smith have been trying to reverse what they see as objectifying tendencies in science which obscure the subjectivity of those whose lives are studied (Harding, 1987). Using Smith's "method of experience", or speaking about one's life, situates the teller as the subject of knowing (Smith, 1990, p. 5). Feminists have used this 'method' extensively and examples can be found in the work done by Campbell (1988) with nurses, by Ng (1988) with immigrant women, and by Mueller (1988) with women in developing countries. But knowing experientially has limits, and to gain new understandings of experience, Smith's method advocates research that "explicates" it, and shows its social determinants. The relationship of discourse to everyday experiences are investigatable. Smith (1990) states:

> Textually mediated discourse [talking, reading, and writing] is a distinctive feature of contemporary society existing as socially organized communicative and interpretive practices intersecting with and structuring people's everyday worlds and contributing thereby to the organization of the social relations of the economy and of the political process. (p. 163)

Some of the textually based forms for maintaining power discussed in this work are: professional 'talk' based on medical/psychiatric discourse taking the form of placating, lecturing or dominating treatment encounters; the writing of prescription medication for social ills; drug company advertising which portrays women as inferior and subordinate in order to sell products; standardized assessment forms used to assess and program protocols used to correct mental health problems while remaining unresponsive to the patients needs, and which foster acceptance of feminine roles instead of new ways of looking at socially determined problems; and medical training and continuing education which supports stereotypical views of women while offering little understanding of health concerns arising out of the everyday ‘labour’ of women.

The practices of talking, reading and writing text--whereby the talker, reader, and writer is organized by the text to 'do knowing'--invite the reader into the objectified knowledges of the relations of ruling (Smith, 1990). This is not always perceived as coercive, but rather a way to facilitate more connectedness. For example, women's talk and reading organizes leaner meals, shopping excursions and the fight against body fat. Almost every newspaper and popular magazine has advertisements for weight loss clinics and/or fitness centers--promoting weight loss through training--containing written testimonies of ‘satisfied’ customers. What is not written or talked about is that 95% of diets fail to create *sustained* weight loss, reproducing ‘failure’ as an individualized fault, and of those who regain weight, most gain more weight than they lost (MacInnis, 1993).

Women's magazines and television programming organize people all over the world into trying the same diets, desiring the same (thin) body, buying the same clothes, and using the same makeup, while at the same time fueling capitalist production and profits through demand for diet products, clothes, makeup, etc. Without the advertising for cosmetics, perfumes, cigarettes and clothes which portrays only thin, young, well-dressed and well-positioned women and men, many magazines and television stations would be bankrupt. Clever advertisements make extraordinary claims using scientific-like language and allusions to scientific proof to sell their products. However, women’s health is put at risk through some of these commercial ventures. It is difficult to avoid exposure to advertisements and products aimed at girls’ and women’s dissatisfaction with their bodies, and it is easy to see how girls’ and women's attempts to alter their bodies are not out of place, nor ‘crazy’, in a world that upholds, rewards and demands thinness as the ideal body shape for women, and is seen as their key to happiness, success, health and relationships. Anorexia nervosa and bulimia nervosa appear to be socially organized phenomena greatly influenced by capitalist values and defined ways of being for women. I am interested in how women's socially organized lives are further organized by the help they find when their image-making is beyond a minor preoccupation, and in fact, takes over their lives as an 'eating disorder'. Smith's (1990) method of inquiry offers a way of uncovering the perspectives of the participants and linking their experiences vis-à-vis social relations.

RESEARCH QUESTION

What intrigues me is the ‘help’ girls and women with anorexia nervosa or bulimia nervosa receive in the context of professional health care treatment, and their resistance to that ‘help’. For the women in this study, the ‘help’ was like punishment rooted in oppressive practices and relationships which devalued them and disconnected them from themselves, their families and the world. This interest is reflected in the following research questions:

> **How is the relation between girls and women with anorexia nervosa or bulimia nervosa and professional ‘help’ socially organized such that the individuals seeking help have to resist it?**
>
> **What can the experiences of two women now recovered or recovering from anorexia nervosa or bulimia nervosa tell us about the conflicts and contradictions girls and women face when seeking help?**

CHAPTER THREE
METHODOLOGICAL APPROACH

INTERPRETIVE RESEARCH/FEMINIST PERSPECTIVE

Interpretive research which aims at investigating the social organization of knowledge has some special features that distinguish it from positivist research. It challenges how, why and by whom knowledge is created, and it uncovers power inequalities. This type of research helps us grasp the world of the participants from where they stand (in this case women with 'eating disorders'). These participants are not in the mainstream of power and are prone to being positioned as objects, or existing as only subjects in discourse. According to Smith (1987):

> Taking the standpoint of women. . .cannot be equated with perspective or worldview. It does not universalize a particular experience. It is rather a method that, at the outset of inquiry, creates a space for an absent subject, and an absent experience that is to be filled with the presence and spoken experience of actual women speaking of and in the actualities of their everyday worlds. (p. 107)

Interpretive research takes as a starting point that reality has multiple interpretations and cannot be expressed as a universal truth or law. Traditional positivist research goes to great lengths to ensure objectivity (i.e. neutrality and freedom from researchers' values) in the research process, whereas interpretive researchers hold the belief that objectivity is neither desirable nor possible. George Smith (1990) states: "Objective knowledge is no longer 'the truth'" (p. 433). He sees objective truths, inextricably incorporating the standpoint of men, used as ways to control society. He argues that researchers must shift from striving for objectivity to working reflexively, where the researcher is part of the world that is being investigated, and the researcher's knowledge is an asset, not a liability in the research process.

Fine (1992) states that “feminist inquiry must enter that space that articulates the personal and the political to understand how women position themselves and are positioned to "experience and critique the social as a personal moment" (p. 25). Fine (1992) feels, in fact, that the “mystified space yawning between ‘objectivity’ and ‘politics’ is exposed as an illusion, justifying and laminating existing forms of social privilege in the name of objectivity” (p. viii). That mystified space, treated as real or self-evident, is the very ‘reality’ which I am challenging in this work. For example, many individuals with ‘eating disorders’ are characterized as depressed or misbehaving. Thus, following the cause and effect medical/psychiatric model, supposedly sound scientific technologies for depression (mainly psychotropic drugs) and misbehaving (behaviour modification) are used. Both technologies are forms of annihilation of the self--a political act. In my estimation, girls and women are not necessarily depressed nor just acting, their distress comes from another, perhaps as yet, unnamed and disconnected space in the experience of girls and women, which we don’t really understand to any degree. While the medical view has taken precedence, I view anorexia nervosa and bulimia nervosa as social phenomena--a political strategy for enacting resistance.

Jackson (1991) states that "the social world has no existence independent of the activities and understandings of social actors, including the understanding and activities of researchers. The validity of the research is said to depend on making this fundamental unity central to the investigation" (p. 1). The view that Jackson (1991) espouses is that people’s understanding of how the world works is embedded in their behaviour and is socially organized.

Knowledge (including research and writing), social and historical contexts or relationships and linkages amongst that which is studied (present and past) play a role in constructing reality and ongoing activities, and hence are investigatable (Smith, 1992). The careful examination and telling of specific moments in individuals' lives informs us about the embeddedness of the social relations organizing and organized by those moments. I will show how specific moments in the lives of girls and women with 'eating disorders', in this case some of the events in their development and in their encounters with health practitioners, are connected to a larger scheme of relations that affect the course of their 'internment' in it, a scheme which they themselves help to create. That which organized these women's lives remained largely invisible at the time it was happening. I undertake an analysis which explicates or makes visible the organizing features of these women's experiences. I did not know in advance all that I would discover or learn, but tried to understand experiences from the standpoint of women who have experienced an 'eating disorder' (Smith, 1987).

I used my own knowledge as a worker in health to investigate not only what Teresa and Diana told me about their experiences, but to explore the gaps and silences in these women's lives. My knowledge of the health care system and of 'eating disorder' treatment helped me locate missing pieces in the women's stories. Real things happened to these women that were not due to biochemical, intrapsychic or family problems, but rather to how medical interventions were organized and affected their lives. The notion of social relations as discussed in my conceptual framework allows connections to be made between these women's experiences and what organized their material lives.

RIGOR IN QUALITATIVE RESEARCH

In qualitative and feminist research, a number of criterion are important for maintaining rigor or adequacy "that reflect the whole process of inquiry, relative to the purposes of the study" (Hall & Stevens, 1991. 20). Because qualitative research refers to many widely divergent research methods, it is impossible to devise a single set of criteria applicable to all methods (Sandelowski, 1986). The criteria used by this author in this study, analyzing the experiences of women with eating disorders, will be discussed.

To Sandelowski (1986), achieving **auditability**, "the decision trail" or "the progression of events in the study", and understanding the researcher's logic is an important criterion (p. 34). In this study, I explain how I became interested in this topic through my previous professional and volunteer work. At various times I discuss my 'location' or standpoint emphasizing feminist and non-positivist perspectives. The specific purpose of this study is outlined--explicating the connections between the 'help' women participants received for anorexia nervosa and bulimia nervosa, and their resistance to that 'help' as socially organized phenomena. How participants were selected, and how and where data were collected is described. I use Smith's (1992) social organization of knowledge paradigm to analyze the data, paying particular attention to social relations. **Credibility** and **fittingness or coherence** are sought in constructing faithful accounts of the participants' narratives so that insiders are able to recognize themselves in the interpretations, and outsiders can make sense of and endorse the research (Hall & Stevens, 1991; Sandelowski, 1986). However, inconsistency in the narratives highlights the diversity of women's experiences and does not invalidate their perceptions, rather, it offers an opportunity to explore various dimensions of oppression (Hall & Stevens, 1991, p. 24). The participants validated their re-collected stories and revisions were made accordingly. As the participants read their stories, it stimulated more re-collection of information and tightened the sequence of events. I questioned the design of the research and the interpretation of the data, and sought the perspectives of my colleagues and my thesis supervisor. The thesis exemplifies the power, usefulness and healing of women's stories.

Reflexivity, or accounting for the researcher's own knowledge creation and interpretation practices, is embedded in the social relations of which the researcher and the participants are a part (Szekely, 1988). Smith (1987) states that "the aim [of feminist sociological inquiry] is to explicate the actual social processes and practices organizing people's everyday experience from a standpoint in the everyday world" (p. 151). My knowledge of women, 'eating disorders' and medical practices informs my understanding of the standpoint of women, located, as Smith states in "bodily sites--local, actual, particular" (Smith, 1992, p. 92). The **complexity** of women's reality and **relevance** of findings to women's interests are demonstrated by situating the analysis in the everyday lives of the participants (Hall & Stevens, 1991).

Collaboration with participants (and other researchers) reinforces the **relationality** of knowledge construction (Hall & Stevens, 1991). Support and challenge are offered when discussing a line of thinking with others, providing opportunities for critical reflection and incorporation of new information. The researcher's role is one of **engagement** in, not detachment from the research process and the participants, as it is the experiences of participants that the researcher tries to understand as situated in everyday actualities and relationships (Smith, 1992).

Exploring the context is paramount, as it allows us to make social relations visible. **Naming** experiences in the participants' language allows their voices to be heard. Direct quotes are used in the re-collected accounts of the participants and the analysis. Naming experiences and problems from participants' perspectives helps us get beyond and behind what we have been socialized to believe exists--it removes the silence and the secrets that women are expected to harbour about their relationships and their worries. There is power in naming and creating gendered knowledge of women's experiences, particularly when women recognize something of themselves in the accounts, which may stimulate a retelling of their own story (Hall & Stevens, 1991). Fine (1992) encourages feminist researchers to position themselves as participatory activists because "their work seeks to unearth, disrupt, and transform existing institutional arrangements. . . .These writers position themselves as political and interrogating, fully explicit about their original positions and where their research has taken them" (p. 211-212). As stated earlier, I have been working with individuals with anorexia nervosa and bulimia nervosa for a dozen years. In the research, I call on my own knowledge in this field to make sense of 'eating disorders' as socially organized phenomena.

Participants

This study involves women as participants, as females (90-95%) are primarily affected by anorexia nervosa or bulimia nervosa. For this study, I sought participants who had been diagnosed by health professionals with anorexia nervosa or bulimia nervosa and had been actively striving for an end to their pursuit of thinness for two years. My experience tells me that most individuals have been suffering for approximately a year or more prior to seeking treatment. Therefore, the participants would have been coping with an 'eating disorder' for at least three years, and would have had some experience with professional help. As such, they are 'experts' in 'doing' anorexia nervosa or bulimia nervosa. The participants reflect the trajectory of a struggle which began in adolescence, a most typical occurrence. The participants were in early to mid adulthood at the time of this study, one with an eighteen year history and the other with a six year history of coping with these phenomena.

A non-probability sample was used to select participants as the assumption was made that not all women are equally knowledgeable about the subject and not all are willing to share information. Purposive sampling was used as I interviewed women who were knowledgeable about 'eating disorders' and receptive to discussing their situations (Morse, 1986). I found my informants through my network in the 'eating disorders' self-help movement. Through my participation at meetings and advocacy events, people became familiar with my ideas about 'eating disorders' and my thesis project. When I asked individuals to volunteer for the study, they did so with enthusiasm. I interviewed two participants, one who was diagnosed with anorexia nervosa and one who was diagnosed with bulimia nervosa. While their stories are quite different, they are not atypical. I did decline the offer of others who were interested in telling their stories because of the depth and breadth of the data contained in these varied eating disorder narratives.

Data Collection: Interviews With Teresa and Diana

In my contact with Teresa, the interview process took place over three sessions totaling about six hours. With Diana, three interviews took place over about five hours. I met with these women individually in their own homes. I tape recorded all but one of the conversations, at which time I took notes of the comments made.

In the initial session with each participant we talked about her struggle with an 'eating disorder'--what she did, thought and felt, and her interactions with others especially related to seeking help for anorexia nervosa or bulimia nervosa, or striving for freedom from her symptoms. We focused on what the participant thought was important. Between interviews I wrote up the data in chronological order, that is, sequencing events in the order they occurred, rather than the order they may have described them to me. In the narratives and the analysis I refer to numbered encounters with professionals (signaled in brackets with a number [#] sign). This is a way to identify what the participants experienced in which encounters. In discussions with my supervisor, I tried to make sense of what I could say about their experiences and the care they received--seeing similarities and differences. I tried to understand what they thought impacted on the development of their 'eating disorder', particularly their relationships, and what was helpful or not helpful in their encounters with health care providers. Because the encounters took place over several years, subsequent sessions found us talking more in-depth about time lines, specific incidents and clarifying understandings about what happened. I found by three sessions that the women agreed on my re-collection of their stories as we had discussed them during the interviews, and I had a clearer idea of the context of their relationships and encounters, and their perspectives on these events.

Data Re-Collection: Women's Stories

From taped interviews and notes I reconstructed Teresa's and Diana's stories (presented in chapter four) to show the sequence of events that constituted their involvement with anorexia nervosa or bulimia nervosa. I have recorded the relationships in their growing up years as they talked about them, and what they found significant in each of the encounters with helpers or helping programs. The stories about these relationships and encounters are used as entry points for analysis of the social relations which organized the women's lives. The participants have had an opportunity to read the chronological write-ups of their stories for accuracy and to make comments. These women concur with my organization of the historical material, and it has provided some clarity to what happened during their active struggle with an eating disorder. The clear and memorable incidents, when pieced together, helped them recount the times when they went about their life in great distress and desperation. I use direct quotes from our interviews (noted by double quotation marks) from time to time, otherwise the work is my retelling of their stories. This is what constitutes the data which I analyze.

'DOING' ANALYSIS

I use my own expert knowledge from my experience as a nurse clinician working with adolescents and adults with eating disorders to uncover how the actualities of their lives did work. These women's talk became entry points to understanding the way they were organized in and by the social relations of age, gender, health, status, and medical/psychiatric practice. My goal was to investigate how the social relations of girls and women with eating disorders were present in their everyday lives, how the social relations were accessible through their talk, and in fact, how these relations organized their talk and their actions, as well as our discussions together.

In doing this type of analysis Teresa and Diana were active subjects in their own narratives, and in the social relations. However, just how social relations work in everyday life is not always (or often) clear to them or to us. How our lives are organized, outside of our own intentions, usually remains invisible. Smith (1987) states that:

> The relations among multiple everyday worlds and the accomplishment of those relations within them create a dynamic organization that, in the context of contemporary capitalism, continually feeds change through to our local experience. In the research context this means that so far as their everyday worlds are concerned, *we rely on what women tell us*, what people tell us, about what they do and what happens. *But we cannot rely upon them for an understanding of the relations that shape and determine the everyday* [my emphasis]. (p. 110)

What I analyze in this data is the way the everyday experiences of Teresa and Diana are connected to and by the social relations of age, gender, status, health, and medical/psychiatric ideologies and practices which "frame, organize and determine [their] everyday practices and cares" (Smith, 1987. p. 204). The actual relations are *implicit* in their narratives, and my goal is to understand their talk/stories from a standpoint of women, making *explicit* that which organizes and directs their care, concerns and abuses. Everyday experiences provide entry points into the social relations that are organized as femininity, appearance, dieting, power, resistance, and madness, and become central to understanding women's struggles with 'eating disorders'. Through an interpretive research process and feminist analysis, I 'make sense' of the informants' talk by explicating their experiences situated in these social relations. I write an account which shows how the connections between their relationships with others and the help they received exacerbated and prolonged their trajectories in ill-health.

The way Teresa and Diana are configured in their interactions with professionals creates a discourse driven 'sentencing' for them in addition to their work at pursuing an education, sustaining a job, and establishing a home and relationships. I want to focus on Teresa's and Diana's 'labour' of overcoming their 'eating disorder', and explicate how they were objectified, dominated and silenced. It is no accident that objectification, domination and silencing happen the way they do. These women received training in objectification and silencing in their growing years, so they were already skilled in relating to others in positions of authority be they parents, teachers, or boyfriends.

The encounters Teresa and Diana had with professionals illustrate their situations as young, single, distressed girls and women with problems not well attended to by the health care system. In these narratives I identify how the health care system supports the way professionals work at the expense of the wellness of patients. I also demonstrate how gender is a key issue in what happens to Teresa and Diana, but it is not readily visible in the historical telling of their experiences. However, gender is integral to the seemingly neutral, impersonal, and universal ways that girls and women, particularly those with 'mental illnesses', are conceptualized and acted upon, so that the conceptions and actions appear genderless (Smith, 1987).

Class relations and gender-based treatment regimes are perpetuated by the domination/subordination relationship of helper/patient. Other ruling regimes, such as social assistance and education are mentioned in the narratives and dovetail into the health care system. They all maintain the aura of neutral, impersonal, and universal forms of doing business. The social relations at work serve to disempower the help-seeker, while offering no guarantee of appropriate service. From my analysis of these women's narratives I will argue that their ill-health is exacerbated and prolonged by their oppressive encounters with helping professionals. Resistance to oppressive treatment plays major part in the trajectory of illness, but it also moves the participants beyond their disconnected relationships with families, professionals and institutions into recovery. I will explore the possible necessity for these women to enter into ruling regimes for treatment from time to time, before finding an alternate path that works for them.

CHAPTER FOUR - TWO WOMEN'S STORIES

"The individual moment. . .has its hidden structures, unique in combination yet always culturally and historically shaped" (Okely, 1991, p. 10).

TERESA - "A PURE THING, LIKE A SNOWFLAKE"

Teresa is the oldest of five children (the family pattern is two girls, a boy, two girls). Her mother worked as a pharmacist and her father was a math professor. They lived in an upper middle class neighbourhood in Edmonton, Alberta, and the parents had their "eye on upper class living." She always felt she had to be the model child for her siblings. As a teenager Teresa "was a high achiever academically. I was room rep, so I went to all the [high school student] council meetings. I was on the gymnastics team. I wasn't in with the in-crowd, but I was involved. I didn't do drugs, didn't have sex, I didn't have a boyfriend. I was sort of a 'pure' thing, like a snowflake type of thing." She describes herself as 'shy' and found out just how shy when her family moved to another city in her grade nine year. She remembers moving away from the friends she had grown up with and "going for days without uttering a word to anybody and nobody talking to me." They moved back to her old neighbourhood for grade ten and "moved back to sort of old friends and patterns."

Teresa received mixed messages from her dad. On the one hand he would say "it doesn't matter what you do just as long as you are happy". At other times his needs were met at the expense of the children. When she was three or four years old her dad took Teresa into his bedroom and showed her a picture of a ballerina. He asked her if she wanted to grow up and be like the person in the picture. She remembers being very adept at responding the way others expected her to answer, so responded with a 'yes' to her dad's question. For a number of years Teresa took ballet and hated it. "For a long time I tried to be that dancer", but at fifteen or so Teresa dropped dance for gymnastics because "I wasn't built like a willow." Teresa remembers feeling rejection and anger from her dad as she was developing into a young women. "It was hard for him to show affection 'cause it was all wrapped up in sexual overtones." She often wondered if she had been sexually abused by her father as was her sister, but Teresa has no memories of that. She did feel he "didn't have clean ideas about" her and recalls an incident as an adult where he kissed her inappropriately and grabbed the clothes she was wearing. However, she feels her father knew she would "cry wolf", that she'd say something, unlike her sister and mother who closed down in such circumstances. The mother was aware of the abuse going on between her husband and daughter and said nothing; the abused daughter would drink in her room and come to the dinner table drunk. Nobody would say anything about her drinking.

Teresa felt her mother either maintained tight control or gave complete freedom; there seemed to be no in-between. Teresa felt her mother was "always busy doing stuff" and was quite unskilled in "attending to the emotional needs of her children. It was something she just couldn't do." Later on in life, especially with the addition of grandchildren to the family, Teresa and her siblings had to teach the mother to give hugs.

There was little in the way of celebration in the family. Teresa remembers opening her birthday presents during her teen years, which her mother had left on the table before leaving for work, with nobody around to help her celebrate. There was no party or cake later in the day. Teresa feels there was a pattern of "learned responses" to any good things that might happen which she and her siblings acquired from her dad. Her dad was the youngest of twelve and his mother's favourite--the one who held promise for the family--so he would get things, then feel guilty for this favouritism and be unable to enjoy what he received.

Teresa recently experienced an episode, that she calls "restricting", which caught her off guard. This followed several positive events in her life around work and personal growth, such as being asked to co-lead a keynote address at a conference with a physician respected for his knowledge of eating disorders. A friend remarked that she thought Teresa had lost weight when Teresa herself had been feeling heavy. Without conscious realization, she just found herself, much to her surprise, in the act of restricting her intake, being 'busy' with many things. Indeed, she had lost several pounds unknowingly. Teresa does remember clearly the guilt she experienced when these good things were happening. She states: "I had this secret [work related] that was so great, that I thought others would be jealous, and question me on it, and think awful things about me because this good stuff came to me. I could feel it happening. The restricting was unconscious, but. . .the guilt was really obvious and open." She would apologize for everything to her friends when talking to them and could not enjoy what she was doing, even though she was glad to be taking new projects on. As well, Teresa's sister was applying for a high profile job she wanted, and upon completing the interview "she put herself on a fast", making a joke to Teresa saying: "I hope this isn't the beginning of an eating disorder." Teresa tried to reinforce the sister's deservedness for job advancement, and feels her sister's restricting came from similar fears about others' reactions to her good news.

Teresa remembers when she was on her own, she had a sense of rebellion against the very structured family life with which she had grown up. Her rebellion took many forms. She went to parties, did drugs, and drank alcohol. She became an exotic dancer and used her training from her unhappy years in ballet. She did not want to "engage in the corporate world, the capitalist, the sort of buy/sell system" that her parents aspired to, so she lived in shared accommodation "scrounging everything she could." Teresa banked her money (at times she was making good money when working two jobs) because she “didn’t feel entitled to [spend] it.” She could not buy herself nice things nor often what she needed. She kept exacting diaries of everything she spent, something her mother had always done. Teresa held judgment over her own actions and felt she would be “better in a moral sense, closer to God. . .more independent” and self-reliant if she did not indulge her desires. It was difficult for Teresa to “use the word mine. Ownership was out of the question. Maybe part of it was deservedness. . . .I was trying to share with everybody, so the highest good is not to own things.” So she walked instead of taking the bus or having a car; she thought she should make her clothes instead of buying ready made things; and she ate low cost food--all the while recording every penny, for example, twelve cents for an apple. She does not think she recorded the food she binged on because at those times “I was too crazy.” However, she did keep ordered calorie counts “in my normal life.”

In her family, children were to be seen and not heard, and expected to respect their elders because they were adults in positions of authority. Teresa remembers a conversation at the dinner table one day when she was in grade twelve when she challenged her father on this issue. She said she would not respect someone just because they held an important position, but “a person has to gain respect by what they do.” In her estimation, her dad took this remark very personally. A few months later he made a unilateral decision to tell her, by letter, that she was not going to be returning to the family home when she came back from attending summer school in Banff . The letter stated that her father was shocked that Teresa felt that he had to live up to her expectations and gain her respect.

Her parent's marriage was unhappy. One day her dad turned to her mother at the dinner table (when Teresa was 17 years old) and said: "Well I guess it's time we got a divorce." She remembers that the family was all sitting there in silence. She suspects it was the first time the mother had heard about his plans, and it certainly was the first time the children were aware. The parents separated unofficially in the spring of Teresa's grade twelve year when dad went on a sabbatical to Quebec. Teresa "felt abandoned by him when he went away." The official separation was in August of that year. They divorced a year later.

"Borderline Sort of a Restrictive, Exercising Type of eating disorder"

Teresa recites an 18 year history of anorexia and bulimia nervosa--three years restricting her intake and exercising excessively (anorexia nervosa type activities), then fifteen years of binge eating and purging with a continuation of her hyperactivity. "I first had an almost anorexic experience summer of '71, when I was seventeen, and I was at [a fine arts program] for the summer on a French scholarship." Although Teresa did not know what was happening to herself, she states: "I lost weight, and I got very judgmental about the people around me, how they were eating, and I isolated myself." She consumed little herself and exercised a great deal. She described herself as in an "anorexic mode." This was her first experience with these types of behaviours.

During the summer when her father wrote to Teresa "kicking me out of the house, by a long distance sort of way", her mother, who was always stoic, positive and busy, tried to "rescue" Teresa when she heard that her daughter wasn't going to be living at home upon her return. The mother drove Teresa around town looking for a rooming house where she could stay. In the meantime the father had moved to a separate room in the house, then officially moved out of the family home by the time Teresa returned to go to university. She returned home in a thinner state.

Teresa experienced secondary amenorrhea[4] for nine months. Thinking back, she sees that she "had a borderline sort of a restrictive, exercising type of

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[4] Secondary amenorrhea means menstrual cycles stop once they are established, and pregnancy is not indicated. Primary amenorrhea is the failure of menses to commence when normally anticipated for the age and development of an individual, usually in the late childhood years or during adolescence. Amenorrhea may occur in situations where considerable weight is lost or

eating disorder." She expressed concern about her 'lost periods' to her mother. Teresa did not know why her periods had stopped, nor that the cessation of menses may have been linked to her low weight and poor nutritional state. The mother knew birth control pills would make the periods reappear, and suggested Teresa see a doctor friend who put her on the pill to regenerate her menses (encounter #1). In actuality, Teresa's interaction with her mother was her first encounter with a health professional even though she was seeking help from her mother as such, not as a health professional. Therefore, I will begin the encounters with the first doctor caring for Teresa.

The doctor Teresa saw on her mother's recommendation did not seem at all concerned as to why her periods had stopped. He did not do a physical exam, but proceeded to accuse her of poor moral standards for wanting contraceptives. "He was awful. He called me all sorts of names 'cause he thought I was sleeping around. He was older. He was from another culture and didn't understand. He was so cruel." Following this appointment Teresa was in tears in her mother's office, which was in the same building as the doctor's office. Demonstrating her emotions was unusual behaviour for Teresa because in her family people were not supposed to cry.

Three years later, in 1974, she remembers her first binge eating and purging episode following a breakup with a boyfriend of three years. He had gone to Australia and she dated somebody else, "he came back, we split up and that was it. I started binging and purging." She was feeling guilty about her decision to be with someone other than the boyfriend she was supposed to be committed to, and fearful about her future. Her university degree was a three year accelerated program. In her final year, Teresa began to question her direction

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severe stress is experienced. See the *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia* by David Garner and Paul Garfinkel, and *The Etiology and Treatment of Bulimia Nervosa: A Biopsychosocial Perspective* by Craig Johnson and Mary Connors for discussions of menstrual irregularities.

and changed from Math (the field of study of her father) to English. At this time she was living in her own apartment, and working as well as going to school. She did not finish university in April as expected, but took spring session English courses studying Sylvia Plath and Ernest Hemmingway. She was feeling weak and sick from the complications of bulimia[5], and her papers focused on despair, suicide, and death. It was a time of "endings"--school work, student role, relationships with boyfriend and father.

The next four years saw Teresa leave from and return to Edmonton between living in Toronto, Ottawa, and New York. She felt a change was good for her and found her symptoms (binge/purge cycle, questioning, confusion, uncertain future) would disappear when she was preoccupied with familiarizing herself with a new place to live. "At those times of involvement I am other-focused, outside myself. . . .There is a tendency to get totally absorbed in the others, get lost in the expectations and needs of others in the situation at hand, so to protect myself I'd isolate" and become judgmental rather than setting up a healthy dialogue. When she was totally absorbed establishing herself in a new place and in her relationships with others her symptoms would disappear. However gradually, after a period of being symptom-free, her binge eating and purging would return as she felt taken advantage of by others.

For all the time Teresa was in New York she was not bulimic until just before she was getting ready to come home after turning down a proposal from her current boyfriend to go with him to Brazil. She felt being "outwardly directed and just dealing with life" had kept her from engaging in bulimic behaviour. She does, however, remember having about thirty jobs in nine months. If she didn't

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[5] Prolonged periods of binge eating and purging create fluid and electrolyte imbalances interrupting the ability of the heart to beat properly resulting in fatigue, dizziness, fainting, and, at times, cardiac arrest. Most individuals feel depleted emotionally as well as physically exhausted from repeated binge/purge behaviour. They experience many self-depreciating thoughts about their behaviour--guilt, depression, fear, loathing, etc. See *The Etiology and Treatment of Bulimia Nervosa: A Biopsychosocial Perspective* by Craig Johnson and Mary Connors for a fuller description.

like one job she was on to the next. This chaotic pattern increased after the breakup with her boyfriend. She experienced a difficult few months where she “threw herself away” to anything that came her way, including drugs, alcohol, and bulimia. She returned to Edmonton "a wreck" from New York in 1978.

Teresa was emotionally and physically depleted, and experiencing suicidal ideation when she returned home at the age of 23. She had broken up with her boyfriend, participated in the use of drugs and alcohol, departed from the excitement of New York, had only occasional part-time work as a model in Edmonton, and was not in school. She was experiencing episodes of dizziness and fainting. Her moods fluctuated between feelings of euphoria at her ‘empty’ stomach and thin body, and feelings of despondency at her isolation and suicidal thoughts. She went to the university health clinic for help (encounter #2).

“This Isn’t Helping Me”

For the first time in her life Teresa says she asked for what she needed. She wanted to talk to someone. What she received was a battery of assessment forms. Teresa remembers being very angry, vigorously crossing out questions that irritated her, and writing expressively on the forms. The following day she received an invitation to participate in a four month psychiatric day program where she would be congregated with other individuals who were distressed. There was an offer to secure welfare payments for her living expenses if she attended the program. Teresa went to the psychiatric day program, but she did not understand why she was there. The patients had breakfast together, followed by group activities (large process group and small self-disclosure group), ate lunch, and had more group activities in the afternoon (art group, video feedback group, or psychodrama group).

Teresa had part-time work as an artist’s model, and volunteered as a production assistant for a play at the art gallery at this time. She felt quite accepted by this group of artists, while becoming more and more alienated from the intensive psychiatric program. Nobody knew she was binge eating and purging. She really didn't want to be in the program because she did not feel respected. Teresa did not feel she could trust the staff and be authentic with them, nor the other participants. However, she felt too weak to protest the lack of attention to her needs. She did feel she was just another person in the system whose real needs were silenced. Teresa left the program before the recommended four month stay was completed because the process was not conducive to her voicing her most passionate concerns. "I left early. I got pissed off. This isn't helping me. I don't like the things they are saying to me. The timing was bad for me. I didn't get what I asked for." There was no follow-up to her leaving.

Teresa was assaulted by a man she had met briefly one day. She remembers when the man was choking her and she was losing her breath, that a voice came to her and said: " 'Remember your voice'. . . .His grip loosened a tiny bit [at one point]. . .and I just screamed. . .just roaring and yelling" and the man fled. Teresa later took this man to court where he was found guilty of assault with the intent to commit rape, and given a $500 fine. Teresa left Edmonton to attend art classes at summer school in a mountain town in B.C. before settling down in Vancouver.

She lived in Vancouver in a rooming house for 6 years until 1985. Teresa spent a lot of time in the public library. She was "just reading and came across the call number 616.85 and that was where all the books on eating disorders were." That is how she found out about bulimia, "that there is a name for this. . . I didn't know anybody else did it."

She would "go in waves. Sometimes it [bulimia] would be bad and sometimes it would be better. . . .On the one hand I was too ordered in my normal life, my other life, and then when the binges [happened] I was too crazy. There was no sort of medium zone of normalcy. . . .I ate stuff like chicken livers and rice all the time because they were inexpensive and good for you. And then on my binges, ‘cause there was a 24 hour grocery store just two blocks away like I would go and buy Twinkies little doughnuts, little sugary, sugary things and just have them done by the time I got home.” She did not know how to talk about her bulimia, but once when it was really bad "I just wrote down a list of everything I'd eaten and took it to my doctor" (encounter #3). The usual doctor was on leave, and the female locum seemed to be flustered and quickly referred her to a psychiatrist whom she saw for three years (encounter #4).

“I Was Still Bulimic by the Time I Finished”

The sessions with the psychiatrist were not focused on her bulimia “he really didn’t know anything about eating disorders, but he did provide a sort of father figure, I guess. . . .The best thing about that was that it was an appointment that I had to go to, or that was there for me every two weeks, once a month or whatever. There was a kindly old man who would always shake my hand and say: ‘Hello miss’. And I’d make us a cup of tea, and we’d sit there. And that was the best part of it because I didn’t confide in him too much. Like he kind of held judgments about. . . .He didn’t hold judgments but he didn’t think that I appreciated my life. And I know all about his wife and his children and his car and his dog and his life in Hungary with no food. But we didn’t set up goals for getting out of the behaviour. . . .I was still bulimic by the time I finished seeing him.” Teresa doubted his motives and would walk away from the sessions wondering what therapeutic value it was for her to know all about his life. As well, the psychiatrist “would be answering phone calls, and he’d say: ‘You don’t mind if I work on something else?’ and he’d be writing while I’m talking.”

The psychiatrist did put her on a trial of antidepressants, but the side effects prohibited continuation of the medication. Near the end of that three year period the psychiatrist suggested she go to the fledgling eating disorders Program at UBC and be interviewed for admission to the program. She vaguely remembers going there, but "wasn't accepted." She had "a meeting in a room with two people. . .and a one way mirror. . .so people were viewing us." After the interview she was asked to wait while they conferred. They told her: "Sorry, your needs aren't here. We can't help you here" (encounter #5). She did not seem overly concerned about being denied admission to the program, and thought: "Maybe I'm not bad enough yet. I never understood it in the sense that maybe I've got too many things going on for them to help me. . . .I didn't fit in. I must be better than I thought I was."

It appears that old patterns were emerging for Teresa again as she developed a network in the community, and had to decide if she should stay in her job and in Vancouver. Teresa wondered: Can I make a "commitment, and not just experiment with a job and so on? I have to be connected to what I'm doing, and have to be. . . grounded in what I'm doing" in order to stay. She routinely binged and purged which detracted from her commitment to put down roots. She states: "Bulimia is a fear of commitment", although she says she did not perceive that at the time. The expectations of others influenced her actions and her emotions. The more she became involved with people the more demands were placed on her to please others and subjugate her needs.

She decided to go to Spain over the winter of 1985-86 after reaching this decision point about commitment, and experiencing some disturbing incidents. One day she was in a state of shock and very angry after finding that the brake lines on her car had been cut. She was "freaked out about that." She went to work and remembers "spouting off anger" to her boss, being very animated and ranting at great length. This verbal expression was very unusual for her. She felt her boss thought she was suicidal (when in fact she felt the opposite, very clear and decisive). A couple of days later people phoned Teresa's mom in Edmonton saying her daughter was going to commit suicide, and the mother believed them. "I was never suicidal, but I knew a women who had [committed suicide], and she knew these same people who phoned my mother, so all these questions came into my mind. Was I suicidal?" Teresa believes the boss arranged for some of his workers, her coworkers, to appear at the rooming house where she lived the next evening trying to get her to go out with them. At nine o'clock two women asked her to come smoke a joint and Teresa refused. To Teresa's knowledge, she had not given these people her address. Two other women appeared an hour later and ask her out for tea and a walk. She refused again. Both sets of women know each other. Exactly an hour later they all returned to her door plus a "man dressed in an angel outfit and he's on his knees praying for me. . .and there is two policemen with them, and they say: 'All these people say you want to commit suicide and we want to investigate'. . . .It turns out the cops were fake, they had badges on that weren't real badges. . . .It was too nightmarish for me and I had to leave town. . . .I didn't want to get involved. It was too much, to fast, too crazy. I was just really angry." She felt they were trying to control or harm her.

She had taken a computer programming course and found it really hard to concentrate because she was working in a restaurant between nine at night and two or three in the morning. She had to be at class from seven in the morning until noon. "I was trying to dig my way out of the madness I'd found myself, made myself get into, but it never worked. When I graduated from the computer programming course and went to apply for jobs, I started a fifteen day fast. Here I am trying to be together, wear the suit, and hand out my resume. . . and I'm high because I hadn't had anything to eat for fifteen days. . . . Looking back I really didn't want to be a computer programmer." She had always saved her money and lead a very spartan life with few possessions, so she was able to mobilize herself quickly when she decided to leave.

While in Spain, Teresa felt liberated from her eating disorder as she was symptom-free. She learned to write to her satisfaction and to find her "voice."

She lived with no telephone, radio or television [like many of locals] so kept journals of her daily life. These journals recorded the "happenings of the day [so were] reality based." She paid particular attention to "processing events versus just going with the events." This was a very different kind of writing for Teresa who had always written "airy fairy poetry that just came out of nowhere, or rigid calorie counting." In Spain she learned to write a story.

"I Did Not Dissociate. . . .I Didn't Yell"

Teresa returned briefly to Edmonton from Spain because her favourite grandfather had died, then returned to Vancouver for a year before moving to Victoria in 1987. At another point her binge/purge behaviour exacerbated and she went back to her doctor. The same female locum tenans doctor that she had seen previously in encounter three was in attendance (encounter #6). She was referred to another doctor "who was supposed to know something about eating disorders" according to this anxious locum physician. Teresa went for an appointment in a large clinic in the next municipality and met this doctor "in a sort of closet. . . .There was no window and no desk. Just these. . . cardboard boxes all around and he sat about three feet away from me" (encounter #7). As well as creating an inappropriately seductive climate for an interview, the second question he asked her was about intimate sexual practices. This was a terrifying experience for Teresa. She "lived through it." She remembers: "I did not dissociate. . . I didn't yell at him. I didn't scream. I didn't say why are you asking that. But I asked all those questions afterwards. I was just furious. I guess I was afraid of confronting him. . .so I tried to be good and just bear with the situation." Teresa tried to rationalize the situation by thinking that maybe there was some "therapeutic reason" for his behaviour. She never returned to that doctor nor to any other professional helping situation.

Throughout these eighteen years, except for when she first moved to a new location, Teresa either attended school and/or worked, often holding two jobs at the same time in the service sector.

Epilogue

Teresa stopped her bulimia about four years ago and considers herself recovered from her eating disorder. She tries to respond to what she needs in any situation, "being very present" or immediate with her feelings and thoughts. Teresa pursued further schooling in counselling and became involved in facilitating support groups and peer training for individuals with eating disorders. These endeavours stemmed from her own vision for better treatment and services for sufferers with anorexia and bulimia nervosa. She is active in advocacy work and speaks to young people in schools about body image, weight perception concerns, and her struggles with bulimia nervosa.

DIANA - "RESPONSIBLE, GOOD, PERFECT"

Diana grew up in a mid-sized town in British Columbia and was the oldest of three girls in a family where her father, an iron worker, was away from home for weeks or months at a time. The mother maintained the home. Nancy was the middle sister and Eva the youngest girl. Diana remembers the communication in her family as poor. Her mother and father are described as follows: "They care, but are scared to say anything about their problems or mine. They pretend alot." Her dad did not know what to say to her when, at one point before her eating disorder had started, she asked her dad if she had cellulite on her legs. Diana did not really wait for an answer, but assumed she did have cellulite making panicked comments like "Oh my God, I do." She remembers her dad saying, "I don't know. It could be."

The posture of not talking about one's difficulties persisted through everything. The parents never said anything to Diana, nor she to them, about the constant fights she would have with her boyfriend in the downstairs recreation room of their home. Diana feels her mother was never there for her. She couldn't talk to her mother because she was trying to be the "responsible and good child....I wanted to be perfect....I was scared to make mistakes." Diana remembers rebelling against "growing up, [and] wanting to stay the same; taking responsibility, [and] being in trouble for things. If I kept to myself and not with anyone, I can't upset anyone or make people angry."

Diana's mother would talk to all Diana's girlfriends about their problems, but could never talk to her own daughter. It was not until her weight had dropped considerably and she was visibly struggling to carry on that her mother would scream at her saying, "You're going to kill yourself." It was her mother's way to scream at someone when she became upset. The mother's own father was the alcoholic nobody in the family challenged, so every time her husband would have a drink she would "freak out" thinking he too would become an alcoholic. The children believed their "dad was an alcoholic because mom would always scream at him. Of course, nobody talked about grandfather's alcoholism." One night Diana remembers her mom and dad coming home drunk and she and Nancy thought both their parents were alcoholic and cried and cried. Nobody talked abut this incident at the time, and it was only a few years ago that the girls discussed it between themselves, surprised to find they had the same fear about having alcoholic parents.

Diana described Nancy, who was less than two years younger, as someone who was very private about her feelings. In this regard, Diana likened Nancy to herself. They never talked much about how they felt, however they were together a great deal while growing up. She relays a story of never seeing her sister cry until Diana's re-admission to hospital. Diana was packing her suitcase to go, feeling very disillusioned, angry and upset herself, and Nancy started to cry. Eva, the youngest sister by five years, was seen as the emotional one in the family, and very verbal. However, Diana couldn't articulate what was Eva's perspective on the illness.

"I Really Had a Low Self-esteem. . . .I Dwindled"

Diana feels that her weight preoccupation started when her first boyfriend, Nathan, broke up with her in 1986. They had met when she was fifteen (1984), dated when she was sixteen and broke up a year later. This was a stormy and demoralizing relationship for Diana. Her memories focus on his abusiveness towards her, yet being unable to separate from him. Nathan was very possessive of Diana and required that she give up all her friends while she dated him. He was verbally abusive and called her derogatory names in front of people she knew when she shunned his demand for a physical display of affection, especially at parties. Diana was "really shy about that kind of stuff. I would go into myself and not talk to him. He'd say I'd never get anybody better" (referring to other boyfriends). He would be drunk on these occasions and their arguments would deteriorate into major fights such that they would have to leave the party.

She remembers her dilemma about stopping the relationship. "I really had a low self-esteem." If Diana suggested breaking up, Nathan would cry and assure her that his behaviour would improve. Thoughts of the good times, the new experiences she had with Nathan, and knowing the considerate way he could sometimes be kept her going--believing that their relationship could be like that again. Near the end of the relationship Nathan constantly pressed Diana for sex. "I felt bad. Imagine me going to the doctor to get the pill. I looked really young." She remembers Nathan "always touching me. . .it made me feel so terrible and disgusting" along with "intense anger." She would try to lash out at him when they were alone, and then worry that she would never have kids because she hit her boyfriend, and saw herself as abusive. However, Diana maintained her stand against sexual exploitation. "Here I was being a doormat, but that is one thing I wouldn't give up." During this time Diana was eating normally for a teenager and does not remember any patterns of restricting nor any weight loss.

Nathan was a good runner and attended provincial track meets. Diana remembers how the relationship ended. She was meeting Nathan at the airport with his parents following a trip away to a track meet. "He wouldn't talk to me. He threw me away. I didn't know what to do. I was totally devastated. . . .How can this boy say he loves me, and just nothing, break it off. . . .I went into myself. I had no friends. I left my friends back then [for Nathan]. . . .The worst thing you could ever do. . .[is] use your friends when its convenient for yourself, and not through thick and thin. . . .I have to handle this on my own."

Diana was determined to "prove something" to herself, that she was not a throwaway. She felt her sister, Nancy, was a better figure skater than herself, and she was tired of being second best. Diana was out to prove she could be the best runner, so she tried to run every day, feeling guilty on the days she missed training. Diana remembers “keeping up appearances” for her family and friends. She was not going to let this breakup destroy her. “I couldn’t control what was happening outside my life, so I could control my body and my running.” She felt she needed to keep her body toned, even though her boyfriend had left her, hoping that he might come back. She would eat dinner with her family while consuming a small breakfast and a sketchy lunch--not at all meeting the energy demands of her running. She worked diligently at her school studies, but dropped any socializing. She did quite well in cross country running that season until she lacked the stamina to keep at it. She continued to restrict her food intake and characterized herself saying: “I dwindled.”

In grade twelve (1986-87) Diana lost her periods. Her family doctor said: “It’s just stress. . . .You’ll be OK”, her periods would come back (encounter #1). While she was not really thin at the time, her change in activity and her weight loss was not noted nor addressed by the doctor. By Christmas of that year it was evident that her weight was dropping significantly. In the new year she was weighed by her GP every two weeks, but “he didn’t know what to do.” She was put on antidepressants, which, in combination with a low weight state, caused her to blackout and have bad dreams. This was the beginning of many episodes of medication as treatment.

After graduation Diana went to work in Banff from August to November 1987 with her best friend, Laura. They were earning money for a trip to Australia. She worked all day as a chambermaid and in the evenings as a waitress at a fast food drive-in. While she had promised her parents she would gain weight while away, her weight had dropped further before leaving for overseas. Because Diana looked very thin when she returned home from Banff, her mother suggested she see the family doctor again before travelling (encounter #2). She had continued on the antidepressants during her time away with little effect. He immediately arranged a bed for her at the only major hospital in the region in a neighbouring town under the care of a psychiatrist who had some experience treating eating disordered patients on a general adult psychiatric ward (encounter #3a).

"You Have No Problems -Get Better, Gain Weight, Go Home"

Diana remained in hospital for six months, until May of 1988, while her friend went to Australia. She describes her stay as "terrible and scary." The psychiatrist's attitude towards her seemed one of contempt. He gave her the message that she had no reason to be upset--no history of sexual abuse, a good family, no major problems--and her case was relatively unimportant. Therefore, there was little to talk about. The recipe was "just get better, gain weight, and go home." This psychiatrist continued Diana on antidepressants medication. She felt that her stay in hospital was a waste of taxpayers' money, and she had "tremendous guilt" about this reinforced by the psychiatrist's attitude that there was really nothing wrong in her life.

The rules used in the behaviour modification program in the hospital were based on weight gain and seemed like "punishment." "If you don't gain the weight you're confined to the ward. They used to monitor everything you ate; they'd count how many peas you left on your plate if you didn't eat the whole thing. . . .They supervised you afterwards so you couldn't go and throw up or anything." And then you could graduate from that if the staff didn't think you needed strict supervision any more.

Out of this experience Diana gained an appreciation for people with mental illness; she was allowed to volunteer helping children at a recreation center "which was neat because it got me out of the hospital"; and she took part in some of the psychiatric day program assertiveness sessions. In the hospital Diana met a bulimic girl who committed suicide after being discharged. "That was so traumatic for me. . .I had a weekend off and when I came back she had committed suicide. . . .I felt so bad because she was supposed to phone me and we were going to go out." Diana's perception of the hospital staff's response to the death of this girl was one of indifference with no grieving allowed. "OK, she's died, get on with your life. . . .Keep on eating. . . .It doesn't matter if your friend just died. She's going to die anyways."

Following discharge she would make a weekly trip to see the psychiatrist. This was for weigh-ins done with her back to the scale. In her mind "alot of the stuff still hadn't been taken care of. When you have a psychiatrist that says you have no problems, so what's there to work on? You don't work on anything." She started a summer job, was running again, and trying really hard eating snacks, but she lost weight. After one of her visits to the psychiatrist, she returned home to find that he had called her mother with the message that Diana needed to come back into hospital. Diana felt embarrassed, humiliated, and angry--"I'm not skinny. . .not dying", she thought. However, dutifully she packed her bags and stayed for a few weeks to "get fattened up"...like a "good girl" (part of same encounter as a re-admission - #3b). Following discharge, Diana got an apartment with her friend, Laura, who had returned from Australia because Diana didn't think she could live with her parents. Diana had met another boy in the meantime and she felt herself become a "doormat" again in that relationship over the same issues as with Nathan. He just wanted sex and she "didn't know how to say no, or I didn't know how to say 'get away from me'. It was like an instant replay in my head and I didn't know how to handle it. So luckily I moved away and that would take care of it."

Diana stopped seeing the psychiatrist as it was not meeting her needs, and she moved to Victoria in August of 1988 with her girlfriend, Laura. Her boyfriend came down to see her the next month, got really drunk, and again wanted sex. She didn't know how to say: "Leave me alone." She was greatly disappointed that her feelings were not being considered by this fellow. Diana cried uncontrollably, felt like a "total failure. . .like I did the worst thing, I was bad, and would never have a relationship", and thought of Nathan again. The boyfriend did not stop to see if something was wrong with her. He left angry and did not return. She thought, "If I lose alot of weight, I will not be attractive and I will not have to handle this because I don't know how to. . . .The more weight I lost, the safer I felt." She started college, worked hard, and found herself losing weight again.

Diana's dad came to Victoria and to try to find help for her through Mental Health Services. They did not know anybody who could help Diana and further stated that she needed a general practitioner's consent for any service or referral to take place (encounter # 4). Because Diana had not established herself with any doctor she saw a "transient" doctor at a drop-in clinic (encounter #5). She remembers him saying to her father: "I don't think she needs to see a psychiatrist at this point [while the doctor pinched her stomach to assess her body fat]. She's not skinny. She's OK. We'll deal with it." Diana told the doctor: "I can feel. . .it's coming again. . .it's starting. I've got the same obsessive behaviour. I'm scared. He seemed to think he could handle it, but that's not what happened. They started to panic when I started losing alot of weight" and sent her to a local psychiatrist who worked with young adults in an post-secondary educational institution (encounter #6).

Diana's comments on the sessions with this psychiatrist were telling of what transpired in the meetings. "He helped a bit. [It was] nice to have someone to talk to, but never really major big time help, like let's work on something; like let's take something and work on it. So I just kept on getting worse and worse." Diana felt that she was not progressing. There was never a referral to a dietitian to work on nutritional intake, a clinical psychologist to work on cognitive restructuring, or a women's group to get support or deal with day-to-day living. He pushed medications as an integral part of the treatment plan. She was put on Anafranil, an anti-depressant, with no effect. He later said she needed to try Prozac, a new drug receiving much attention at the time, particularly with cases of bulimia, because it would "get my spirits up to gain weight." Diana remembers being very angry at the doctor's suggestion that the medication was to be taken unequivocally. The psychiatrist gave her an ultimatum. "You go on Prozac or you are not going by my rules and I don't want to see you anymore. It tells me you don't want to get better and I can't help you." This coercive posture was extremely scary to Diana because she thought at the time that "he was the only one who could help" her. She "didn't want to let [the Prozac] work [she] was so mad."

After a month of no results on Prozac, Diana was "scared to tell him it wasn't working [for fear that] he would cut me off." Diana remembers feeling like the "bad child" disregarding the "father figure [by] telling him I'm not going to take [the antidepressant medication] anymore". As it turned out Diana did tell him and "he was OK with it", however, the distress she was under in no way gave her confidence in the helping relationship, nor did it improve her health. The medication issue inspired much resistance towards medical/psychiatric care because Diana felt she wasn't listened to and her knowledge was considered worthless.

In one attempt to try other technologies besides medications, the doctor told Diana that he would make a relaxation tape for her, but he never did. Diana states, "I didn't feel confident enough to challenge him", but was left with the feeling that "he didn't care' what happened to her. They discontinued the visits after a time, but the psychiatrist did say that Diana could call on him if she felt she needed to be admitted to hospital.

"You Might as Well Be Dead"

Diana passed the winter sitting on the heater to do her studies because she was so cold from being emaciated. One day she felt like she was going to die. Diana woke up and just "wanted to fade, go away, leave the earth. I went upstairs and said to Laura I'm too tired. I'm exhausted....I can't go to school....I'm going to die, I know it." She could not get up to go to school, unusual behaviour for Diana, who was obsessed with doing the 'right' thing and never missed a class. Diana's best friend, Laura, and their other roommate had a big fight where they screamed at Diana, "You're going to die." Laura phoned the psychiatrist and he suggested they take Diana to the emergency department. She went into the hospital in January of 1989 with an irregular heart beat and very dehydrated. "I felt totally out of control. There was no way up for me. I couldn't do it on my own."

They placed her on a medical ward under the care of a gastroenterologist (encounter #7). This man was very angry with Diana and said to her, "How could you do this to yourself? You might as well be dead." He immediately put her on nasogastric tube feedings[6]. This approach was humiliating for Diana and created much distress, particularly as she initially continued to lose weight while being tube fed. The doctor's unilateral decision to use tube feedings (for days or weeks at a time) was made twice in her three month stay.

One time when her sister, Nancy, was visiting, the doctor began fighting with Diana because of weight loss following relief from a period of constipation[7]. This outburst by the doctor prompted the second insertion of the tube feedings, talking to Diana "like [she] was in jail." Diana was so humiliated at the confrontation which occurred in front of her sister, because she was "the older sister, the one who was supposed to be perfect. I started crying, and then Nancy lost it. . . .and started crying too." Diana could not believe the doctor's lack of

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[6] Liquid formula is delivered directly into the body via a tube passed into a nostril to the back of the throat, down the esophagus and into the stomach. Feedings are usually regulated by a mechanical pump that is attached to the tubing between the holding bag for the formula and the patient, and which pushes the formula through the tube at a prescribed rate.

[7] This is a natural occurrence in these circumstances--the constipation upon refeeding, and the weight loss when the bowels begin to work again.

understanding about bodily processes, particularly when she had been given laxatives for the constipation, undoubtedly on his orders. Another shock was the assumption that she was sabotaging the system, therefore, not to be trusted and the tube must be reinserted. Finally, his arrogance about deciding unilaterally what was best for her, made her want to stop altogether. She remembers thinking, "This is incredible. I want to die, right now. Nobody understands."

After a while, Diana was so discouraged that she phoned a friend who had received help from the in-patient psychiatric program at the acute care hospital at the University of British Columbia (UBC) in Vancouver. As it turned out, Diana needed to gain weight before being accepted at the UBC Psychiatric Hospital. She knew intuitively that to get better, treatment had to be different than what she was receiving. Becoming an active agent in organizing her care was positive and health reviving, however, it was difficult to leave her friends, her apartment, and her schooling for a new city and another hospitalization.

Prior to her transfer to Vancouver, Diana was moved to the psychiatric ward to "fatten up" with her nasogastric tube feeds in place to accelerate the process of weight gain (encounter # 8). She describes this as terrible. During her temporary stay at the psychiatric ward, it was evident that they did not know how to help her. "They were making me eat whatever they had up there and it was freaking me out. It was just too scary for me to just pick [my own food]. . . their whole system was really screwy." She was expected to make food selections buffet style like the other patients on the ward. Later they weighed her food, but with no negotiation as to what food that would be. One day "they brought watermelon and they weighed it out and it was a huge amount of watermelon, just massive, and I just freaked. . . .They just didn't know how to treat eating disorders. They just plopped anything on your plate and expect you to eat it." Diana remembers feeling caged as there was no program of rehabilitation for appropriately increasing activity levels as calories were increased. "I was exercising in my room. I'd start running behind my closet . . . then feel tremendously guilty. What am I doing? I felt so caged I had to do something. I really believe that in order to gain weight, you need to gain weight and exercise, in a way. Because if they don't let you get exercise at all, you're going to. . . .I did anyways, felt tremendously guilty. Not to an excess. You have to learn to exercise with moderation. But that's part of the problem." She again was given anti-depressant medication during this time.

"You're Here to Get Better"

Making the move to go to Vancouver turned out to be the best resource for Diana so far (encounter #9). For the first time, she found herself in a program dedicated to treating eating disorders. Diana was with a recognized group of three to four women with similar problems. Patients were expected to sign a contract stating a readiness to take responsibility for getting better. She felt like there was a partnership in the work to be done, and, probably for the first time, the staff engendered trust in the deliberations. "You're here to get better; we want to help you get better." Diana signed the contract saying she wanted to get better. The staff respected her desire to be medication-free, and nasogastric tube feedings were not used. Here there was an effort to make the process comfortable, engaging and safe. Diana remembers this 4 to 5 months from April to August 1989 as a place where *her* voice was expected to be heard and where *her* ideas were considered. Weight was rarely discussed. Roles of the treatment team were well defined. Progress was discussed by the team on a weekly basis, first having patients self-evaluate their efforts, then comments were added by the staff. "You discussed your own progress with the doctors. It was hard to take control sometimes, but I think that was a really good part of the program. . . .You had to eat everything on your plate which took away from counting the calories 'cause you had to eat it all. That was really hard, especially when you had a piece of chocolate cake. . . .It was like a challenge. You have to eat what is good for your body, and this is what is good for your body, it has all the nutrients. To me that helped me, because I trusted the nutritionist. She seemed trustworthy to me. Then, we got to points where we would go off campus to eat with a nurse, and we could pick whatever we wanted." Adjustments were made as needed. "If you were really having a major problem with the weight gain they would just up your calories and the nutritionist would come and talk to you about that. . .if you were at a plateau." If progress was not being made, it was assumed that the commitment for recovery was not there and discharge was arranged.

In addition to the usual day program therapy sessions, they taught basic life skills related to purchasing, preparing and consuming food, finding your way around the city, asking for help, assertiveness, "helping us to get out there in the world and supporting us." A family session was arranged to "get people to talk" about what was happening. Although the discussion was only a beginning, she remembered Mom, Nancy and Diana cried, Dad was confused and angry, and Eva appeared neutral in this meeting--the effort it took for the family to come to Vancouver, and the memory it has created for Diana cannot be underestimated. The down side to this program was the lack of follow-up after discharge, however, Diana felt launched on the road to recovery with new skills and new hope.

Diana was discharged below her goal weight because she was doing well. However, no person was actively managing her care in Victoria. On her return Diana lost weight. She saw the local psychiatrist again because she didn't know what else to do (encounter #10). He prescribed anti-depressant medication. At another time the psychiatrist gave her some anti-anxiety pills, Ativan, to use as needed. This arose out of an incident in a restaurant when Diana experienced what she was told was an anxiety attack. When seated at a table with her girlfriend her face broke out in rash causing her much distress. No other explanations were discussed for this reaction. Diana did not take any of this medication.

Diana saw a nutritionist on her return from Vancouver over a period of about ten months until the summer of 1990 (encounter #11). Diana also attended a support group for people with eating disorders (encounter #12). Although she began going weekly to the support group, she stopped when it became too depressing to hear other people's woes with little progress being made. She started to gain weight back herself. Diana continued to exercise while she gained back the weight, and felt that exercise was an essential ingredient for her. The nutritionist referred Diana to a local family physician who was seeing the majority of eating disordered patients in Victoria (encounter #13). Diana found those visits helpful, and she was highly motivated to get better.

Diana had the feeling that the doctor was genuinely interested in her as a person and had some idea of possible trajectories of the illness. He was not going to use coercive methods to get her to gain weight. He was prepared to follow the slow and steady approach. Medications were optional--there if the patient thinks they need them. He was prepared to talk to her about her career as well as her fear. "He stood by me and wanted to help me through things." He was responsive to her needs. At first the doctor would weigh her with her back to the scale--a not uncommon practice to decrease focus on the actual numbers. When it was evident that this was causing her more anxiety and distrust because she thought she was alot heavier than she was, the doctor turned her around to let her look at the scale. Diana described that response a "turning point' for her. She believed she could get better and the doctor could help her.

Epilogue

Diana sees her recovery as slow, steady progress. She began to take risks--being with people, going to school, and entering into another relationship with a boyfriend which she ended when it didn't work for her. Currently, Diana is involved in another relationship which continues to be positive, while involving much work and learning. Her best friend, Laura, has since married and moved to

Vancouver. Diana misses her support and has had trouble making secure relationships. However, she continues to work at developing friendships.

Diana knows that when she is stressed, she may unthinkingly focus on her body and food. "Sometimes I feel fat....I'm eating too much." It takes time, sometimes days, to realize that her concern is really about something else that needs her attention, and the focus on the body is the vehicle to express that concern. "If I start thinking too much about that kind of thing, then I know something is wrong." She works to correct the negative pattern by talking to people about the stress.

Diana became a founding member of a non-profit group composed of individuals who have had an eating disorder, parents, siblings, grandparents and friends of individuals, professionals working in the field, and interested persons. The mandate of this non-profit group includes educating the public about eating disorders, providing resources, and advocating for services. Diana has been involved in public speaking about her struggle through a school outreach program, and she has appeared in a cable TV video. She trains volunteers to work in the office of the non-profit group, and she has been trained as a peer counsellor to work with people with eating disorders.

CHAPTER FIVE
ANALYSIS REVEALS ‘HELP’ AS OPPRESSION

This chapter is an analysis of the reconstructed narratives of two women, Teresa and Diana, as they each struggled to overcome an ‘eating disorder’. The analysis focuses on their relationships and their help seeking encounters for anorexia nervosa or bulimia nervosa. The time frames of the ‘eating disorders’ stretch between 1971 and 1989 for Teresa and between 1986 and 1992 for Diana. Some encounters took place in Alberta, but most occurred in mid-sized to major centers in British Columbia. The numbered encounters described in the stories of Teresa and Diana from chapter four are referred to throughout this analysis. The social relations in the experiences of Teresa and Diana are teased apart from their narratives to show how instances of silencing, domination and objectification are repeated in ‘helping’ encounters, much as they were in their early developing years.

I discuss a cycle of silence I see perpetuated in the lives of Teresa and Diana, driving them to try different things to stay connected, at least to themselves. When these individuals, as young people, could no longer pretend that everything was fine nor that they could fix everything for others, they rebelled in a silent way--they stopped eating. They resisted objectification and domination by professionals as well as by family and friends. Their exasperation about trying to fit into a space (as patient, adolescent girl, young woman, daughter, etc.) that just didn't feel like ‘home’ was interrupted by several departures, particularly running away from oppressive medical treatment.

I argue that the inadequate nature of treatment which Teresa and Diana received arises partly from the varied and narrow ideas about the etiology of ‘eating disorders’, from the lack of training and experience of professionals in trajectories for ‘eating disorders’, and from the limitations of traditional medical practice. My argument also addresses the power differentials and the oppression experienced in these young woman's encounters with 'helpers'. While a lack of knowledge about 'eating disorders' does account for some of the inadequate treatment, the narratives suggest that some professionals used their 'expert' knowledge or status, their age, their gender, prescription drugs, or bureaucratic maneuverings to dominate, silence or objectify these women.

The messages Teresa and Diana received in any one helping encounter about their situation ranged greatly including one or more of the following: (1) a problem that can be dealt with easily being common, unimportant, self-correcting or simple, therefore, minimized; (2) a problem too difficult to handle by usual medical practices, not only for general practitioners and locum tenans doctors, but also for specialists; (3) a physiological or psychological problem originating within the individual which can be fixed with drug therapy; (4) a problem of immorality; (5) a problem of sexuality; or (6) a problem the therapist can cure with 'expert' knowledge and presence. These messages and their impact on the 'eating disorders' of Teresa and Diana are discussed in more detail in the following sections.

CYCLE OF SILENCE

Teresa's extended travel, her many job changes, and her risk-taking behaviour, and Diana's running training, her moves away from home, plus her many hospitalizations created changes for each of these individuals. Teresa didn't binge eat and purge when she first established herself in a new place, until repeat patterns of sacrifice and silence surfaced. Her new experiences and the fast pace of life kept Teresa 'busy', not thinking about how connected or disconnected she really felt. Diana felt inspired by her running training, ready for her moves away from home, and impassioned by her hospitalizations. Some of these changes, many of which started out as a desire for positive renewal, became alienating or disastrous experiences. I speculate that these efforts were attempts at connection somewhere--with the self, their environment and/or society. In some way, these trials seemed necessary occurrences in the struggle to find a place where Teresa and Diana could be authentic in their relationships.

However, the oppression of Teresa and Diana as girls and women, exemplified in these narratives as domination, objectification and silencing, is a recurrent theme. A sustained cycle of silence is created out of itself, and is very evident in the behaviour of these individuals as girls and young women with 'eating disorders'. These individuals spent a lifetime being the 'good' girl--the pleaser, the placater, the one who sacrificed 'her-self' for others--not surprising as females are schooled in nurturing, looking after others, and denying their authentic selves. However, implicit in this objectification as a good girl is the negation of one's own needs, and training in silence about injustices and hurts. This dynamic seemed to be amplified in the helping relationships encountered by the women in this study, and, consciously or unconsciously, reinforced by the professionals in many of these encounters, becoming a recurring cycle. The silencing of these women begets a re-silencing in their multiple contacts with helpers, as Teresa and Diana organize their talk around what not to say, as much as what to say, to obtain help for their distress. For example, Diana learned in her first hospital experience (#3) that she should not challenge the doctor about his plans for her--"fattening up" without complaint was what was required. In a subsequent hospital admission (#7) and in outpatient visits (#6/10), Diana learned that to challenge the authority met with the penalty of tighter controls and possible withdrawal of care. Fear of expressing oneself reigned in many encounters.

Stern (1991) states that girls enter a developmental crossroads going into adolescence where maturity involves separation, while the "path to womanhood requires connection" (p. 113). Brown (1991) discovered in her collaborative research on the development of girls[8] that the participants they interviewed over a five year period shifted:

> From engagement in a rich social world of childhood, in which thoughts and feelings--both good and bad--are spoken about directly and publicly, to a struggle at the edge of adolescence to hold on to what they feel and think and therefore know, to authorize their experiences, and not to replace real with inauthentic or idealized relationships (p. 73).

To speak publicly about one's experiences is to resist the security of the conventional story of female becoming, and be without a mold or model for how one's life should go. Diana tried to be "good" and Teresa "pure"--perfect girls--in order to be included, loved and given attention. The power of perfection encourages girls and women to negate their knowledge of themselves and humanity around them by pretending agreeableness in all they do--quiet, controlled, never stir things up, never noisy, bossy or nervous--lest they be abandoned for their imperfections. In both situations, family and peer relationships thrived on pretending that 'everything was fine', therefore, problems were not dealt with in any significant way. In order to protect themselves and their relationships Teresa and Diana experienced what Stern (1991) calls 'disavowing the self', or rejecting and devaluing their feelings, thoughts and beliefs. Women become female impersonators living within the narratives provided for them in our society (Heilbrun, 1988). Any views that might cause conflict or draw criticism are denied, however, this too, becomes intolerable. When one's feelings and ideas are held outside a relationship, then the relationship is disconnected, and both the self and the relationship, which are inextricably intertwined, may diminish (Stern, 1991). The paradox within this disconnection is that it seems to enable these women to be strong in their

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[8] This project is called the Harvard Project on the Psychology of Women and the Development of Girls, a five year collaborative study of preadolescent girls. It is adding significant knowledge to the feminist literature on the developmental psychology of girls and women. It includes researchers such as Carol Gilligan, Annie Rogers, Deborah Tolman, and Catherine Steiner-Adair.

resistance to that which distances them. Teresa and Diana were well ensconced in silencing behaviour and disconnected relationships within themselves, with their families, their peers and boyfriends prior to their formal helping encounters.

MINIMIZING WOMEN'S HEALTH CONCERNS

A number of times when Teresa and Diana took their concerns to helpers, professionals responded by minimizing or deflecting the women's concerns as common occurrences (Teresa #1; Diana #1), self-correcting (Teresa #4; Diana #1), unimportant (Teresa #1, 4; Diana #1), or simple matters requiring simple solutions (Teresa #1, 4; Diana #3, 5, 6, 7, 8, 10), such as following the doctor's orders to take pills, deny your feelings, eat. Fears were silenced and medical opinion dominated these interactions leaving little room for discussion. Below, I look more carefully at each of these themes.

There was often the assumption that the care Teresa and Diana required was no different than for non-eating disordered individuals where depression or stress (Teresa #2, 4; Diana #1, 3, 5, 6, 7, 8, 10) occurred. In only one encounter each--Diana (# 9) in a successful admission and Teresa (#5) failing to gain admission to UBC--were these women referred to a hospital program dedicated to treating patients suffering from 'eating disorders'. However, this may say as much about the lack of resources allocated for women's health concerns as it does about a lack of understanding about 'eating disorders'. Diana was also referred by a hospital nutritionist (#11) to a local general practitioner (#13) who was battling an increasing caseload of patients with 'eating disorders'. While this proved beneficial for Diana, partly because of the doctor's dedication and experience with these cases, he constantly struggled to have his patients 'fit' within existing medical services offered in Victoria, which was without any specific program for 'eating disorders', nor with hospital staff trained to deal with these patients (Dr. J. Kirkpatrick, personal communication, Sept. 11, 1991, and subsequent discussions to date). This was occurring at a time when a proposal for an 'eating disorders' program was turned down by provincial and hospital budget decision making.

Common, Unimportant, or Self-Correcting Concerns

For both women (#1 for Teresa and Diana) entry into help seeking was legitimated by the loss of periods during adolescence. While it may be true that a patient appearing in the doctor's office with no periods and possible weight loss presents as otherwise healthy and functioning, given a cursory glance, one of the cardinal signs of an 'eating disorder' is menstrual changes, especially cessation of menses (American Psychiatric Association, 1993; Johnson and Connors, 1987). Neither participant reported receiving an adequate assessment nor consultation. The capable appearance of Teresa and Diana belied the turmoil that remained invisible. Questions were not asked which could have uncovered feeling states and associated practices indicating the possible trajectory of an 'eating disorder'.

Teresa's and Diana's initial experience with doctoring regarding their amenorrhea replicates the common experiences women have in everyday helping relationships--power imbalances and a minimization of concerns. 'Health care' is equated with prescribing medications, and I discuss more about this in a subsequent discussion on drugs. When the doctor/patient relationship is entered into, much like some of the other dominant/subordinate relationships in the narratives such as parent/child (Teresa) or boyfriend/girlfriend (Diana), often analysis and decision-making are assumed by the helper (parent, dominant partner), who thinks, by virtue of their experience and superior knowledge that he/she 'knows' what is best. The marginalization and oppression of these young women occurs in relation to the invisibility of their dilemmas, left unperceived by the dominant person in the relationship. Diana's visit to the family doctor for amenorrhea (#1) did not enlighten her about what was happening with her body, nor did the doctor seem particularly interested in finding out why her menstrual cycle had stopped--it appeared of little concern to the physician. By the very casual nature of the response Diana received from her doctor, "It's just stress. You'll be OK", she was given the impression that amennorhea was a common occurrence and the problem would self-correct when *she* was no longer stressed. Naming the problem as stress displaced the 'problem' from the doctor's domain into the patient's. Diana was the one who had to 'doctor' her life and change attitudes, experiences, relationships, or whatever it was that needed attention to relieve the stress. Medical doctors, who often have little training in and experience with 'eating disorders', may be unaware that loss of menses is a symptom of anorexia nervosa, and menstrual irregularities including amenorrhea is common in bulimia nervosa (Johnson & Connors, 1987). However, doctors do have a lot of training in knowing where their particular skills and knowledge will show results. They displaced problems that didn't match their expertise into other things, for example 'stress', immorality and sexuality. Problems of reproductive functioning are less well researched than many other health problems, and males have no personal experience with female reproductive functioning, particularly menstruation. For all of these reasons understanding is limited, and concerns may be interpreted as psychological in origin (Mowbray, Lanir & Hulce, 1984). In Diana's case, the 'stopped periods' were viewed as feminine psychological pathology, and she received anti-depressant medication, viewed by many feminists as a modern technology to silence women's fears (Chesler, 1972; Penfold and Walker, 1983; Ussher, 1991). Consultation with 'experts' higher up in the helping hierarchy (a gynecologist, endocrinologist, or counsellor for 'stress'), nor lower down in the ranks (it very seldom goes this way--a women's group of some kind) did not enter into this situation as an option. Diana's problems were effectively weeded out of the system as not serious. In my experience when the problems are viewed as meriting attention, few practitioners want to take on ‘eating disorder’ cases.

For Teresa, there was little importance attached to her presenting symptoms--it did not matter what brought her to seek help--the doctor seized the opportunity to try to save her from the sin of sexual impropriety. Teresa received a very intense and moralistic response, giving the impression that young women often feign amenorrhea to receive birth control pills, and the doctor had caught on to this scam of hers. Teresa says, “He was awful. He called me all sorts of names ‘cause he thought I was sleeping around”. In both instances, the doctors had their own agenda of ‘cause’ (individual feminine pathology) and ‘cure’ in these encounters, and the women were rendered speechless and assigned to the very margins of importance by the responses of the doctors. These women were silenced about their concerns, dominated by professionals from whom they sought help, and given drugs as a solution to their problems. For their amenorrhea, Teresa received hormone replacements (in the form of oral contraceptives) and Diana received antidepressant medication.

Teresa’s mother, a pharmacist, had already identified the 'stopped periods' problem as one that needed a pill as the solution, and participated in having the doctor prescribe medication to ‘cure’ the symptom of Teresa’s trouble. The mother was intimately connected to the way the health system operates, and the discourse common to doctors and other health professionals. Teresa’s problem was seen as physiological by her mother, and partly so by the doctor. He really did not address her symptoms, but he proceeded to give her a lecture on morals, assuming her request for ‘the pill’ was because she was sexually active. I discuss doctors as gatekeepers of morality in a later discussion.

That the mother and the doctor envisioned a drug solution in the same way was not by accident. That Teresa and Diana were dominated by a medical opinion of their situation and silenced about their concerns, and Teresa was objectified as a women of loose morals, may come as no surprise to many women. A long history of medical practice has produced a discourse shared by health professionals--men and women--that defines the boundaries of medical control over women's physical and emotional lives, in part because that discourse characterizes women as biologically inferior, weak, diseased, and sexually dangerous (Apple, 1990; Chesler, 1972; Ehrenreich & English, 1979; Ussher, 1991).

'Imprisonment' in 'eating disorders' became firmly established for these young women following their first encounters with helping professionals. Teresa, shied away from any further help seeking for the next six years. In that time, she learned to binge eat and purge, to abandon all caution at times when she was really distressed, seeking solace in drugs and alcohol, and to internalize her troubles as hers alone. The medical system offered no material evidence to lead Teresa to return for help earlier, rather, it reinforced her need to be primarily responsible for repairing the problem as medical discourse named it. By her next encounter at the university health center in 1978, Teresa had developed a chronic case of bulimia nervosa, was feeling very ashamed and isolated, and characterized herself as a "wreck".

In Diana's circumstance, the time following her first visit to the general practitioner saw an intensification of her running, a further deterioration in her nutritional status and weight, and a dissolution of her self-esteem[9]. She, too, was a 'wreck' in extreme danger of collapse. She was fighting to stay connected, but this notion was missed by her doctor and her family. It is common for families to push 'expert' doctoring advice as a way to deal with problems perceived as

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[9] In this stage of her illness trajectory, Diana deteriorated very quickly. She had lost all her body fat, and, with her high energy demands for running, she began to catabolize muscle tissue for energy production. When this happens weight and metabolism drop quickly. Psychologically, fears, preoccupations with body and food, and depression intensify. See *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia* (1985) by Garner and Garfinkel. I would add that she probably was feeling more and more disconnected from herself and those who were supposed to help her.

physiological and psychological. Apart from being configured as the way to solve problems of the body and mind, doctoring puts an identified patient in the middle of the 'work' and leaves others peripherally and superficially involved.

In these cases, young women were encouraged to seek help from doctors whose training might well interpret the 'stopped periods' as a disease. The treatment for disease is often medication, the stock and trade of 'medicine men'. The "medicalization of the physical aspect of women's lives was virtually complete by the end of the nineteenth century" (Penfold & Walker, 1983, p. 28). Male doctors had defined reproductive processes--menstruation, pregnancy, childbirth and menopause--as illnesses (Penfold & Walker, 1983). We are still living under this legacy. Medical intervention is broadening its scope, making illnesses out of many social problems such as poverty, oppression and grief (often using drugs as a solution), but with no broader view of nor solutions for dealing with the social determinants of health. Understanding 'eating disorders' as diseases diminishes opportunities to view the wider context in which they arise. Diana's and Teresa's stories suggest how inappropriate this view is for women seeking help for 'eating disorders'. These women entered (or were directed or coerced into) the medical/psychiatric system again and again, trying to develop a relationship with someone who understood how to help. They were rejected or removed themselves many times from care because they seldom connected with a place where their problems 'fit' what was offered.

It's Simple--Just Do As I Say

It was not only general practitioners who had a simplified view of the problems at hand, many of the specialists could not comprehend the source of trouble, let alone work constructively to treat it. The psychiatrist Teresa saw for three years (#4) with visits every 2 to 4 weeks lasting close to an hour each time thought she just undervalued her life, and she simply needed to think better of herself, while conforming to appropriate feminine roles. Teresa stated, "I was still bulimic by the time I finished seeing him." She had gained little insight into her problems. In her estimation: no goals for working on issues were overtly agreed upon between Teresa and the specialist; Teresa would be lectured to about her lack of appreciation of her life which was regularly compared to the doctor's earlier life in war torn Europe; she knew much more about the psychiatrist's family and his possessions than her own situation; and she prepared tea for them each time she came for an appointment.

Here we see a negation of Teresa's need to voice and explore her real concerns, and a diminished importance placed on symptoms affecting her well-being. We also see a subordination of Teresa to the 'expert' doctor as she listens patiently to whatever he wants to offer as 'helpful professional talk', usually gaining little understanding of what was happening to her. When she makes tea for them, she is objectified as the servant handmaiden preparing refreshment for the master. She does not protest at the treatment (of course she also does not know what to expect as 'expert' treatment for bulimia nervosa).

There was no improvement in Teresa's bulimia nervosa during this time; even the anti-depressant medication and the referral to the 'eating disorders' program at UBC (#5), which the psychiatrist had suggested, didn't work out. In typical cognitive therapy the patient tells the doctor what is troubling her/him, the doctor outlines the problem and gives it back to the patient with or without suggestions, and the patient takes the responsibility for change and does the work to repair her/himself to the doctor's interpretation of the problem. However, the wider social relations the problems are situated in are not easily reparable. Therefore, 'not eating' is structured as a characteristic symptom of depression (as it commonly is), and the doctor uses talk and drugs to fix the behaviour of 'not eating', a technology supported by the causal model of medicine and drug companies. The 'just eat' prescription, so often heard by individuals with 'eating disorders' shows a lack of understanding of what is driving the 'not eating'. If the doctor were to look at a different configuration of what makes 'not eating', then the usual method of 'expert' friendly talk and drugs might not be appropriate, and the doctor would have to work at finding alternatives for where 'not eating' arises from.

Teresa would walk away from her sessions with the psychiatrist puzzled and disappointed, but without the wherewithal to demand something better. His lack of seriousness about or disinterest in her case was exemplified when he said, "You don't mind if I work on something else?" when she was there for therapy. We, in society, are acculturated to put our faith in professional 'expert' advice. This is particularly so for women, who are not schooled to challenge 'experts' in positions of authority. Psychotherapy as a technology in modern society, establishes a whole set of operations whereby a person is encouraged to give up their own self-understanding and ask 'experts' to rewrite her/his story--indeed the paradox of psychotherapy as a enlightening technique. Many more years went by before Teresa developed some insights into what was happening in her life, and these occurred through her own readings, research and practices.

In Diana's treatment, both psychiatrists (#3, #6/10) and the gastroenterologist (#7) who treated her thought she just needed to eat, take drugs, gain weight, get on with her life, and stop inconveniencing them with her exhausting problems. They could see little basis for Diana's distress because she had experienced no major traumas nor dysfunction in her family in their understanding of her story. Comments made by professionals such as, "What's your problem?" (#3), "You go on Prozac or you are not going by my rules" (#6/10), or "You might as well be dead" (#7), did nothing to cement therapeutic relationships, and indeed, it deepened her distrust in the sincerity and competence of these 'experts', further distancing herself from them. All these 'experts' endorsed the use of psychotropic medication, therefore, an individual maladjustment problem was understood as the etiology of the difficulty. Or if the etiology was hazy to the doctors, at least the medications would quiet the protests. From Diana's perspective, her needs were being pushed aside.

The "transient" doctor who assessed Diana (#5) thought the case a simple one, and he could handle it himself. In his estimation, she wasn't skinny and didn't need the services of a psychiatrist. His method of assessment included pinching her stomach to determine her levels of body fat. Diana *knew* that she was getting back into her old patterns of restricting her nutritional intake, exercising excessively and obsessing about food stating, "I can feel. . .it's coming again. . . it's starting. I've got the same obsessive behaviour. I'm scared." It did not take long before Diana began to deteriorate, which left the doctor scrambling for backup when he realized he did not know what to do. This was a frightening and frustrating time for Diana, and the precursor to another debilitating state and disastrous hospitalization. Again there was a misreading of the situation by the professional, a lack of expertise about possible trajectories for anorexia nervosa, and an unwillingness to listen to the patient's knowledge of herself. Diana was dominated by professional opinion, which denied her knowledge and intuitive self-understanding.

What transpired in the trajectories of illness for Teresa and Diana was that problems, initially thought of as simple, turned out to be very complex and beyond the capacity of the 'experts' to understand and cope with, perhaps because of those unexpected and difficult to control *contingencies* that Strauss et al (1985) described. These patients were reacting to their treatment and affecting the 'health' work, making the situations too difficult to handle for many of the 'experts. However, both Diana and Teresa were characterized as 'misbehaving' in relation to their expected social roles as submissive and controllable young women. Diana felt like she was "in jail" at times, delinquent in her female role when she spoke up for her beliefs. Their problems were seen only as individual pathology, not related to the social oppression of women, against which I believe these women were resisting.

SPECIAL CASES--TOO DIFFICULT TO HANDLE

General Practice Medicine

'Eating disorders' present special difficulties not only for individuals with the phenomena and their families and friends, but for doctors as well. Some of these difficulties seem to arise because of inflexible methods that general practitioners use to organize their practice, and some arise because of limitations in traditional medical/psychiatric practice. A number of times Teresa (#3, 6) and Diana (#2, 5) were referred by general practitioners to 'experts' in a hasty or anxious fashion, leaving the impression that their problems were too complex for general practitioners, particularly locum tenans doctors or outpatient services. General practitioners are not often equipped to deal with emotional problems by virtue of their training, their disposition towards problems that are discrete, physiologically based and amenable to prescription medication, nor the way their appointment schedules are established for doing business. The rushed atmosphere of a general practice is designed to see patients as diseases or cases (i.e. objects) not people, and it discourages any real dialogue between the doctor and the patient. For a longer appointment one must make a special appointment where the doctor can book more time and charge the medical system for a consultation.

Many physicians categorize 'eating disorders' as psychiatric illnesses beyond the scope of general practice medicine[10]. This signals for patients and their families the existence of other, more appropriate, treatment. The general practitioner is there as a categorizer of problems or a referral station, not, in most

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[10] General explanations of how physicians think about 'eating disorders', how they bill the Medical Services Plan for services, etc. come from my discussions as a nurse with physicians in clinical practice.

cases, as a treatment station. The general practitioner legitimates the request for help, assuring the patient they have come to the right place for triage, and reinforcing his/her own position in the health care system as diagnostician, while at the same time displacing the responsibility for effective treatment elsewhere. Hope is maintained that help exists somewhere, and if the first referral doesn't work then patients re-enter the system for another referral.

In making a referral for the treatment of anorexia nervosa or bulimia nervosa, a doctor would be guided by two major preoccupations: What 'treatment' does the patient's 'diagnosis' require? How can that treatment be accessed? The latter question relates to Canada's health care system and its payment regime. How care is paid for in Canada plays a role in treatment modalities. The payment for premiums for medical care, shared by many employers in the workplace and deducted from employees wages as a painless extraction, covers services for all family members dependent on the wage earner. However, the premiums only cover visits to traditional medical doctors, and more recently physiotherapists, massage therapists and chiropractors on a limited basis, not alternative health practitioners. Therefore, a mandate to monopolize health care options is created. Any other consultation in private practice, such as a psychologist, social worker, acupuncturist, or naturopath requires a fee payable at each appointment. The cost for service is born directly from one's pocketbook as opposed to being silently deducted from wages. That Teresa and Diana were offered prescriptions as care and psychiatric consultations instead of other treatment modalities which may have interrupted their illness trajectories, begins to show the limitations of the medical model for dealing with 'eating disorders'.

If one chooses a 'medical expert' for problems thought to originate in the psyche as many of the general practitioners did, then the patient is entered into the psychiatric treatment world. There are a number of reasons why psychiatry is perceived by doctors as the treatment of choice for 'eating disorders' . The psychoanalytic view is favoured by medically trained professionals. Psychiatric visits are covered by medical premiums, so a psychiatric specialist would easily be considered the treatment of choice for a woman who is young (impressionable and likely to follow the recommendations of an authority figure), unmarried (not supported by a husband), and not employed in high paying work (low paying service sector job). The suggestion of a clinical psychologist, a social worker, or a women's support group was never mentioned, partly because alternatives to doctor-based care are not well known nor readily accepted within the medical/psychoanalytic tradition, and possibly because the financial resources of these young women were perceived as limited in the face of high professional fees. This moves the understanding of psychotherapeutic programs, whether individual counselling, a day program or inpatient care, into a class-based analysis. Poorer people are hospitalized in publicly funded facilities more frequently and for longer periods than middle or upper class people, who, via their privileged financial position, have access to alternative and varied private therapy arrangements (Chesler, 1972).

At the time Teresa began seeking help (mid seventies) there was little in the way of programs or doctors specializing in 'eating disorders' in Alberta or B.C., and the situation had changed little when Diana was struggling a decade later. Behaviours indicating diagnoses for anorexia nervosa and bulimia nervosa are described in the manual used by psychiatrists to diagnose mental illnesses--the DSM IIIR[11]--and are generally seen as requiring treatment under the psychiatric domain. While general practitioners (GP's) do see one of their roles as providing referrals for specialty illnesses to specialty doctors, 'eating disorders' are considered a woman's health problem, and there is much evidence that

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[11] Diagnostic and Statistical Manual of Mental Disorders (3rd Edition Revised) published by the American Psychiatric Association, 1987.

women's health has not been a priority for curricula in medical schools[12]. Therefore, it is not surprising that general practitioners feel ill equipped to deal with these phenomena.

On two occasions, when Teresa was experiencing difficulty controlling her binge eating and purging, she went to her general practitioner for advice and support (#3, #6). By this time she had learned a name for her problems. Her account of her illness trajectory suggest that having a name for her 'problems' positioned her to seek help. Her return to the health care system was neither naive nor cynical as diagnostic categories presuppose treatment modalities. Teresa went expecting to be helped. These visits were especially ineffective because of a structural arrangement in general practice whereby physicians are relieved by 'locum tenans' doctors who substitute for regular practicing physicians when they are away for holidays, sabbaticals, leaves for illness, maternity, etc. By her description, the requests for help created anxiety in the fill-in doctor. Apart from not knowing how to treat bulimia nervosa, the anxiety in the locum doctor results from a number of circumstances associated with locum tenans work.

Doing locums can be ways for newly graduated physicians or those who are inexperienced, new to the province or without a billing number[13] to temporarily work as the group of doctors in the province who have been granted permanent billing numbers to earn an income. While it is difficult to get a permanent number to practice in major cities, there are many opportunities to do locums in metropolitan areas as there are many permanent doctors who need relief. It is incumbent on the locum doctor who wishes entry into the group with permanent billing numbers to follow the normal practices of the regular doctor: that is, make

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[12] See *Working Together for Women's Mental Health: A Framework of the Development of Policies & Programs* by The Federal/Provincial/Territorial Working Group on Women's Health, 1993 and *Women and Madness* by Phyllis Chesler, 1972.

[13] A billing number is the doctor's authorization used to collect fees for work billed to the authority which pays doctors--in B.C., the Medical Services Plan. Locum tenans doctors are granted a temporary billing number to work at their locum jobs.

more money doing only short patient visits versus spending time doing longer interactive type visits); to err on the on the side of caution (i.e. refer anything out of the ordinary to a specialist doctor as in Teresa's case); and to remain somewhat detached from the patients' troubles, while doing the best job that he or she can. The locum doctor will be gone in a few days, weeks or months. Locum doctors may find themselves unfamiliar to resources in the system so they might attend to the patients themselves as best they can. Or they might just try to hold things together for a patient until the regular physician, who would be more familiar with the patient and perhaps more comfortable directly handling the care, returns to the practice, or the specialist referred to sees the patient[14]. There was, however, no follow-up or holding things together for Teresa and her bulimia nervosa by the locum doctor nor her regular physician (#3, #6). The doctor's job, it appears, was understood as complete by making the referral to a specialist (#4, #7). These hasty referrals did not help Teresa, and in the latter instance proved damaging (#7). This way of working, however, helps ensure a solid recommendation by the regular doctor to his colleagues about the work of the locum tenans doctor, which can produce an offer of more work or possibly a partnership in an office. The primary concern of the locum doctor may be to act 'properly' to convince their 'supervising doctor' that they are a team player, which puts the needs of the helper in a dominant position vis-à-vis the seeker of help.

When Teresa was very depressed and went to the university health clinic to talk to someone, she was given assessment forms to fill out instead, and, based on the results, she was immediately offered a place in their psychiatric day program (#2). The outcome was unsuccessful in her view, remembering that her attendance in this program was poorly timed--it was not what she wanted nor what she felt she needed. "I left early. I got pissed off. This isn't helping me."

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[14] This information came from a discussion on locum tenans doctoring with Dr. J. Kirkpatrick (1994).

Psychiatric day programs, such as the one Teresa attended (#2) are publicly funded institutions which must keep a steady stream of candidates available in order to secure continued funding for the work they do. People who are young, single, depressed, unsure of their future, unemployed, and without other lifestyle impediments (e.g., severe disability, many children) make good candidates because they are available for short notice entry into a program, and it is likely that they will complete the course of treatment. Psychiatric programs, particularly those attached to a large university with medical departments, are usually a training ground for would-be therapists. Teresa received what the system was prepared to give in the way of treatment, while the system was unable to really respond to her needs. She found the day program a place where she was unable to be authentic and develop insight into her problems, hence, she was silenced. It was not part of her solution to her problems, therefore, she became a dropout thinking, “This isn’t helping me.” Teresa needed to feel safe enough to reconstruct her history with the participants and staff in this program, so she could connect with her distress and deal with it. This did not happen, so she moved on, looking for other connections, while using her bulimia nervosa to forget what she knew about herself and her world.

In Diana’s case, her experience with general practitioners is varied. Two of the general practitioners (“You’ll be OK” #1; “She’s not skinny” #5) thought they could handle Diana’s case, but were unable to really help her being unfamiliar with possible trajectories of the illness, hence, misreading the seriousness of the situation. They quickly referred her to a psychiatrist when she began to rapidly decline. Diana did work well with one GP (#13) who had taken an interest in ‘eating disorders’ and who had some experience treating these individuals. Although one could argue from her many previous encounters with professionals, that she was better able to ‘present’ herself to get her needs met, I would argue that it is significant that this relationship developed late in her ‘eating disorder’, when she was better equipped to determine what kind of therapeutic relationship was helpful to her.

This is an important point about this research methodology and has application in therapeutic practice. As time proceeded in both these women's lives, the value of looking retrospectively at their own (and possibly others) 'eating disorder' story cannot be underestimated. While Teresa had a longer 'time' in 'eating disorders', she seemed leery of medical practice, always questioning the motives of doctors and the 'fit' of suggested treatment. Diana had more periods of intense immersion in medical/psychiatric environments due to her debilitated states, which perhaps made some of her experiences more vague and harder to link together. However, these women learned (and are still learning) to reconstruct their histories to make sense of what happened to them. This study tries to replicate that method of narrative reconstruction from a standpoint of women, a technique which I believe can work well in clinical practice and mutual-aid groups.

Specialist Medicine

While not initially the case, the specialists' beliefs about the trajectory of illness changed from one of providing simple solutions to believing that complete recovery was non-existent, and a life of chronic illness lay ahead. After three years of psychiatric visits, Teresa was referred by her specialist (#4) to an 'eating disorder' program. The lack of connection in this ineffective, albeit lengthy, relationship demonstrates how women can fail to progress under the guise of 'expert' care. It was clear to Teresa (and possibly the doctor) that there was no change in her bulimia nervosa, so the referral to the UBC 'eating disorders' program (#5) held some promise for involvement with professionals who might know something about her disorder. But she was not accepted, a puzzling response for Teresa. What might be the explanation? The new program at UBC (and the fairly new and young psychiatrist hired to run it), would need to carve out a niche in the ‘eating disorders’ field and be successful to ensure continued funding. We can speculate on what this would mean to staff assessing patients for a new program. It would be important to take few risks with patients, for example, those considered 'borderline' personalities or chaotic in their bulimic behaviour, or individuals that are too low weight and require medical interventions such as nasogastric tube feedings, heart monitors, or extended bed rest. From my experience as a nurse clinician trying to find placements for older adolescents with ‘eating disorders’, I know that the program staff preferred, as the cohort for admission, the moderately low weight individual, characterized as the 'classic anorexic', who was out of medical danger. These individuals do not usually binge eat or purge, but often exercise excessively while actively restricting their nutritional intake. They are disconnected from access to their emotions, so do not act out their feelings demonstrably--just restrict or exercise more. Diana met the criteria for admission (#8) once she had gained more weight and no longer had tube feedings. The staff would have good reason to reject Teresa as a poor risk because she was not low weight, she was binge eating and purging, she had a sixteen year history of bulimia (some might say a chronic case) which was poorly controlled, and she had been through other treatment modalities with little ‘progress’ to show for it. She was told: “Sorry, your needs aren’t here. We can’t help you here” (#5). Being excluded from the service was experienced as rejection by Teresa. However, she rationalized it, not as a sign of chronicity or hopelessness, but as a good sign--she wasn’t as sick as she thought. Teresa may not have fit the profile of desirable cases, perhaps because she was viewed by the program staff as a chronic case. Patients are ‘creamed’, or, the candidates with the best perceived prognosis, are selected for admission. While this may not meet the needs of people who are in crisis, nor those who have a prolonged or recalcitrant history with ‘eating disorders’, it ensures, however, a ‘healthy’ relationship with funders.

An observation in these encounters is the way patients are socialized to present themselves in a particular way (I would suggest following stereotypical views of behaviour for women--passive, pleasing, submissive) in order to successfully receive care (Penfold & Walker, 1983). This message was implicit in most of the encounters these women had with helpers, however, it was very explicit in Diana's care. She clearly remembers being acculturated into this uncomfortable role early in her 'career' during the second part of her first hospital admission (#3b), when she dutifully stayed for a few weeks to "get fattened up", behaving like a "good girl". Inside, she was seething with anger. This feeling was vividly repeated in her encounters with her Victoria psychiatrist (#6/10) who threatened termination of care if she did not comply with his wishes.

An essence of chronicity, perhaps even hopelessness, developed in Diana's treatment at intervals in her 'eating disorder' journey. Her visits with the Victoria psychiatrist (#6, 10) both before and after Diana attended the UBC program just faded into closure because nothing constructive was being worked on in her estimation. Diana charitably says the doctor was "nice", "but never big time help, never worked on something [sic]." The message this doctor gave was just take pills and live with this baffling disorder as best you can, understanding perhaps that this was a chronic illness similar to unipolar (endogenous) or bipolar (manic) depression, or schizophrenia. The gastroenterologist (#7) gave up his involvement in Diana's case and transferred her to alternate care in another city (#9). For the doctors, these circumstances may have created the impression that living with an 'eating disorder', once you succumbed, becomes a way of life, if you don't die. The fragmentation of services for individuals with 'eating disorders' somewhat promotes the notion of chronicity as nobody is following these patients through their trajectories. In my view, fragmentation of service does exacerbate the problems and prolongs the 'eating disorder'. While the doctors may have construed this phenomenon as a chronic illness, fortunately Diana and Teresa did not succumb to this idea, and persisted in their recovery.

Teresa and Diana were motivated to seek help many times out of desperation, more as an attempt to reconnect with someone who could provide some sense to what was happening, but they were in effect silenced or received a solution designed to allay the anxiety of the doctor. There was little attempt to broaden the analysis of why this was (and is) happening to young women in epidemic proportions, or to see that medical ways of working replicated the domination, silencing and objectification women feel in everyday life.

CHEMICAL WARFARE

Many professionals see a battle is waged on the body by individuals with 'eating disorders', but few 'experts' on 'eating disorders' understand this war as a metaphor about more pervasive battles against oppression, inequality and a lack of power in society which girls and women are fighting as described by such authors as Wolf (1990) and Steiner-Adair (1991). Wolf (1990) likens the saga of the fight against female fat to a sex war, more about female obedience that beauty. She states, "Dieting is the most potent political sedative in women's history. . . .[resulting in] passivity, anxiety, and emotionality", traits which cancel out the dangers of women's liberation (Wolf, 1990, p. 187-189). Steiner-Adair (1991) talks about overthrowing standard structures of psychotherapy practice including the "patriarchal values that dominate psychological theory as well as the white male power base: independence, self assertion, aggressiveness, autonomy, mind over matter, absence of dependency and need" (p.253). She understands 'eating disorders' as a body politic, not a body pathological, a "symbol of a culture that does not support female development and mature adulthood" (p. 253).

In the medical field, the fight against disease is usually waged on the body with drugs, surgeries, and therapy. Treatment for 'eating disorders' replicates the war on women's bodies with drug therapy and/or psychoanalysis. The enemy is seen as something discrete, such as random firing neurotransmitters in the brain or deficient personalities. An assault can be raised on these discrete problems, but to think of restructuring patriarchal practices is counter-revolutionary to dominant relations. When illness is perceived analogous to war, one's thinking is organized by seeing the task at hand as a battle to be won. Wars have economic benefits, and therapy that keeps individuals separated and focused on their own battle. Medicine and psychiatry are poised to deal with individual cases, not looking beyond the individual to the sources of the destruction. This is good for business--in particular creating work for professional counsellors and markets for drug companies.

Doctors, perceived by society as 'experts' in health and care, use prescription drugs and 'expert' talk about drugs as forms of social control. Doctors are the almost exclusive terrain of drug advertising, because it is doctors who decide the drug of choice, not the patient (Lexchin, 1984). Advertising for drug products is a sophisticated and potent business which offers significant benefits to physicians. Doctors are insistently courted and pressured by sales representatives to use their companies products, whereby the physicians become the de facto wholesalers of the drug industry (Lexchin, 1984). Analysis of the pharmaceutical market in Canada showed the best way to sell a drug was to promote it, and thousands of dollars per year are spent by drug companies on each physician across the country, wooing them to prescribe their products (Lexchin, 1984).

For doctors, giving samples (perks from drug company representatives) and writing prescriptions is one of their powerful technologies for controlling patients and ensuring incomes through return visits for repeat medications. The pharmaceutical industry saw a market in the ill-health of young women with 'eating disorder's and offered the treatment program I worked in free samples of medications and nutritional supplements for trial use. The aim of this 'free sample' initiative was to encourage professionals to prescribe these products for extended use by patients. The 'quick fix' solution was to get your nutrition from a can instead of real food, like the tube feedings Diana endured, and achieve your designer personality from a pill, like the antidepressants both Diana and Teresa were prescribed, instead of cultivating relationships that promote a self of connection and meaningful experiences. There are no quick fixes to the complexities that 'eating disorder's represent.

The discourse on drugs organizes the work of doctors and patients in their local environments--a scene replicated in innumerable doctor/patient interactions worldwide. About 75% of visits to physicians result in a prescription and 25% of all prescriptions are for psychotropic drugs (Penfold & Walker, 1983). Women, more often than men, are given medications as treatment (Ussher, 1991). Drug companies push the idea that all illnesses have a physiological basis that can be treated by medication. The industry has been effective in making over-inclusive claims about their products as solutions to the multitude of today's problems (Penfold & Walker, 1983). Taking medication regularly organizes one's day around many activities: appointments must be made and kept to get prescription medication; pharmacies must be visited to purchase the 'care' dictated by the prescription; a system must be set in place to remember taking the pills; progress or side effects of medications must be monitored; return appointments or the decision to not return must be attended to; feelings must be dealt with about the 'care' received, and so on. Teresa was given prescription medication twice in her 'eating disordered time' (#1, 4) and Diana received psychotropic drugs at least six times (#1/2, 3, 6, 7, 8, 10).

Drug Propaganda

Physicians rely on medical associations and scholarly journals for updates on treatment approaches and perspectives. These resources are heavily funded by the pharmaceutical industry, and they are filled with advertisements for drugs, making up "45 to 60% of the total content of most Canadian medical journals (Lexchin, 1984, p. 129). The format of drug advertising has changed over the years from ads grouped at the beginning and the end of journals, to those interrupting articles with multiple page spreads. The warning part of the ad is often separated from the part giving praise to the drug, or the detracting side effects of drugs are written in small print, making them easy to overlook (Lexchin, 1984). However, the mere presence of an ad in a scholarly journal gives the appearance of approval. Lexchin (1984) quotes Dr. Charles May who states "the success of promotion does not depend on the authenticity of the message but on the skill in manipulation of belief" (p. 114). Intentionally deceptive or misleading advertising about the drug itself continues today, as does the sex role stereotyping of women portrayed in pharmaceutical advertisements.

Women portrayed in drug advertisements reinforce stereotypical cultural views of females as "bad-tempered, nagging, vain, self-centered, and 'irrationally' unhappy [or unable to function] with their role in life" (Penfold & Walker, 1983, p. 198). We can see how the physicians who gave Teresa and Diana prescription medications would think that their patients fit the images portrayed in these advertisements. Teresa's psychiatrist believed she just undervalued herself--a quite 'irrational' way of thinking for a young woman. Diana was characterized as disagreeable and mischievous. Mowbray, Lanir and Hulce (1984) feel any deviation from the "role of wife, mother, sex-object and 'self-sacrificing nurturer' is perceived by prescribing physicians as sick" (p. 123). When women are put into a sick role, society is ready to view the women's problems as individual and not connected to any broader social imbalances that need changing. Thus the status quo is maintained.

In one study, 45% of psychiatrists were reported to state that the sexual biases in pharmaceutical advertising "might negatively influence physicians' perceptions of women" (McRee, Corder & Haizlip, 1974, p. 1274). Advertisements may well contain a sexual overtone or more blatant pictures of partially dressed or nude women in provocative positions, termed by some as soft-core pornography (Lexchin, 1984). An alternate characterization to the sexualization of women in these ads is a father/daughter scenario, where an adoring, grateful, and attractive young women receives a prescription from a male doctor, standing over her as the strong, paternal figure (Penfold & Walker, 1983).

This feeling of paternal control is mirrored in the doctor/patient relationships described by Diana and Teresa. Diana's psychiatrist (#6, 10) put her on two anti-depressants and suggested an anti-anxiety medication for related symptoms. Diana had much resistance to psychotropic medication because it had not helped her in the past and created frightening side effects. She clearly remembers her anger at having to take the antidepressants against her will. She "didn't want to let [the Prozac] work [she] was so mad". Diana was certain that the medications did not help her, however, she also remembers her guilt when considering stopping the medications--going against the wishes of this doctor and feeling like a naughty child. He delivered the ultimatum, "You go on Prozac or you are not going by my rules and I don't want to see you anymore. It tells me you don't want to get better and I can't help you". Her problems with the drugs and her feelings of protest were outweighed by the doctor's threat to discontinue help if she did not go along with his treatment regime. Being abandoned by the only person she thought could help her appeared as a far worse fate than succumbing to the side effects of drug therapy. She complied for a time, but her feelings of distrust and anger at the omnipotence of the psychiatrist caused her to denounce the drugs. The whole process added to her feelings of distress. The notion of compliance is tantamount to a legitimized term for oppression, but a posture health care professionals often require of their patients. In the name of health, women are forced to do things against their better judgment, and this coercion does not seem to cause outrage in the general public. Instead, a cycle is established where patients are drawn into reliance on the medication-doctor-pharmaceutical industry triad.

In the above instances, Diana tried being active in her treatment choices by resisting 'expert' advice. She was assertive and independent in determining her own needs for drug-free treatment. Teresa (#4), as well, made her own decision to stop the antidepressants because of the side effects. These attributes are not commensurate with stereotypical notions of femininity, even though they are seen as normal for healthy males (Broverman, 1970; Walker, 1990). Drug treatment assures that patients return to the doctor more passive recipients of care. This same psychiatrist (#6/10) who treated Diana told her he would make her a relaxation tape. This tape never materialized, and, because she was not confident enough to challenge him about it (or was lulled into silence by the medication), the experience left her with the feeling that he did not care about what happened to her. I would suggest that he also may not have trusted alternative technologies. Lexchin (1984) notes that non-drug methods of treatment are largely ignored in research. While other methods may be less costly to patients in money and side effects, research on alternatives does not provide the same good product for industry as drugs.

A Pill is All You Need - Prescription as Control

Prescription mood-altering medication (the chemical straight-jacket of our modern times) has allowed doctors, particularly psychiatrists, to cast their net to a much wider population, keeping individuals out of hospital even when needed (Ussher, 1991). Patient control or adjustment is often the goal in medical and psychiatric management. One study Penfold and Walker (1983) cite reported that the medication habits of psychiatric inpatients changed when they were given the choice of usage. Patients requested diazepam on average once every three days, while permitted to take the drug as many as four times a day, the usual regime. The comment of a Vancouver women in another study stands out when the patient says, "I feel that, essentially, when a doctor prescribes a pill for me, it's to put him out of my misery" (Boulter & Campbell, 1977). This reinforces the idea of drugs as agents of control versus therapy. Feminists postulate that traditional roles of women are maladaptive and contain many stresses, and this is borne out by the fact that two-thirds of all psychotropic drugs are prescribed to women (Penfold & Walker, 1983). Women employed away from home used fewer drugs, suffering fewer depressions. In a Winnipeg study, 25% of full-time housewives, 19% of women with part-time jobs, and 11% of women with full-time jobs had used psychotropic drugs in the two weeks prior to the study (Guse, Morier, & Ludwig, 1976).

Diana was given psychotropic medications (#1/2, 3, 6,10) or continued on drugs when her care was transferred (#7, 8) several times during her 'eating disordered time'. In each case she took drugs against her will, and in each case she experienced no therapeutic results, but succumbed to the threat of disapproval or termination of care. Diana says, "I was scared to tell him it wasn't working [for fear that] he would cut me off [from therapy]" (#6/10). Being 'cut off' would have left her feeling nobody could help her. Penfold and Walker (1983) reiterate that:

> It is virtually impossible for the patient in this system to challenge the psychiatrist and express, or even come to understand, that which happens in her or his life experience; problems or distress do not conform to the formulations offered by the experts. The professional has a monopoly on diagnosis and supervision of appropriate treatment. Patients who do not fit categories or respond to treatment are thus seen as recalcitrant or resistant, both of which can then be categorized as symptoms of their

> illness. This circular process maintains the power relation of "doer" and "done to". (p. 13)

The description by Penfold and Walker (1983) fits Diana like a glove. At one point she says, "I didn't feel confident enough to challenge him" (#6/10). This scene may well be replicated in doctors offices around the Western world where women are characterized as 'mentally ill' because they express some unhappiness with their roles as wife, mother, nurturer and/or sexual companion, and threatened with unpleasant consequences if they don't comply.

When the family doctor (#1) put Diana on the antidepressant, Anafranil[15] midway though her grade twelve year, he may have perceived her situation as just another stressed student experiencing temporary troubles in her graduation year. Penfold & Walker (1983) note in a Canadian study in one province that 80% of psychiatric diagnoses were made by family doctors. The prevalence of psychotropic drugs in our 'health care' culture has given general practitioners license to dabble in the psychiatric domain. The result for doctors is less work with clients at an interpersonal level, less effort at trying alternative treatments, less awareness of the causes of women's oppression, and support from multinational drug corporations whose products the doctors endorse. As it turned out for Diana, the antidepressants caused more problems with disturbed sleep, nightmares and hypotensive episodes including fainting. These are common side effects, or non-specific actions of antidepressants, often not discussed with patients[16]. Doctors operate as private entrepreneurs, and as such are reluctant to

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[15] Clomipramine HCl, is a tricyclic agent used to treat endogenous depression. It has a mild sedative effect. For further details see the *Compendium of Pharmaceuticals and Specialties* updated yearly by the Canadian Pharmaceutical Association.

[16] There is much documentation that food, not antidepressants, is the 'medicine' of choice for low weight associated with anorexia nervosa (See Goldbloom & Kennedy, 1988); and while the *American Psychiatric Association Practice Guidelines* (1993) recognizes that a low weight state exacerbates the side effects associated with antidepressants, and patients with anorexia are less responsive to these medications than other patients with depression, they recommend that antidepressant use should be considered in persistent depression.

give away information and resources. Many comment on nuisance side effects of medications to their patients while down playing or omitting a full account of possible reactions, risks and permanent damage[17] (Penfold & Walker, 1983). For many women taking psychotropic drugs, the side effects are just endured, while their feelings of powerlessness and any solutions attacking larger social problems remain hidden (Lexchin, 1984).

Teresa was put on antidepressant medication by her psychiatrist (#4), however, the side effects were so distressing that she stopped the drugs before a month had passed. For Teresa medication was not a treatment acceptable to her, and she had the knowledge and strength to resist extended use. Today, individuals with bulimia are often prescribed the antidepressant, Prozac (Fluoxetine HCl, a serotonin neuronal reuptake inhibitor), at 3-4 times the normal dose to reduce binge eating and purging symptoms (Walsh, 1991). Other forms of treatments now passé, such as insulin coma therapy or electroconvulsive therapy, were common to many female psychiatric inpatients only a few decades ago (Chesler, 1972). Today high doses of drugs with brain scrambling capacities fulfill the same purpose as the comas or shocks did: to suppress and silence women so they forget their problems--and, incidentally, everything else (Ussher, 1991). Drug treatment can promote a passive or sick stance, obscure underlying problems, diminish the nuisance value of a symptom as a warning, and confirm for the woman that the problem lies within (Mowbray, Lanir & Hulce, 1984). The gender-based attitudes of many clinicians combined with busy schedules and inadequate training in pharmaceutical knowledge, psychosocial problems, and alternative drug-free therapies means that prescription medications are often

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[17] Apart from physiological effects on the body, particularly heart, kidney, liver, and brain, many psychotropic medications create a long list of other problems--impairment of work efficiency, sexual functioning and energy reserves, dulling of emotions and senses, accidental poisonings, use in suicide attempts, addiction and withdrawal problems, street use, reinforcement of the sick role, and damage to the fetus/infant of women in childbearing/lactating stages (Penfold & Walker, 1983).

used to decrease demand on time and creative capacities of physicians, to lull women into conforming to traditional female roles, and to diminish women's complaints of inequality (Penfold & Walker, 1983). Drugs did not work for Teresa and Diana, causing side effects beyond those attributed to the drugs prescribed. Apart from the nightmares, hypotension and dizziness, both women resisted and rejected the 'expertness' of the knowledge and judgment of their care providers. However, due to the fragmentation of the system there was little chance the physicians have to face the failure of their treatments--the patients just moved on to other 'experts'.

MORAL CONDUCT

Young women are subject to moral judgments being made about their character, especially when help seeking is believed to contain a hidden agenda or help is sought to correct what many view as intentionally self-inflicted troubles (Ehrenreich & English, 1979). When Teresa asked the doctor for birth control pills because her mother had told her this would fix her 'stopped periods' (#1), the doctor assumed Teresa wanted birth control pills because she was sexually active, and unable to tell him directly. She remembers the doctor as "cruel" and "awful". He called her many derogatory names and proceeded to give her a lecture about appropriate morals for a young woman. The doctor's 'expert' opinion was that young women should not be sexually active--certainly not proactive in preparing for sexual intimacy or preventing pregnancy. For someone who was not sexually active and only doing what her mother told her to do to help the 'stopped periods' problem, having inaccurate and unfair judgment passed on her moral character left her emotionally traumatized. This instance signals medicine's strategic place in society for undertaking surveillance over public and private conduct, pronouncing moral instruction, and instituting discipline at every opportunity.

Diana was also subject to comments and innuendoes about her character by the two psychiatrists (#3, 6) and the gastroenterologist (#7) who tended her case. The psychiatrist in charge of her first hospital admission (#3) lead her to believe that she was a malingerer, without real cause for distress. Diana remembers experiencing a lot of guilt at the notion of taking up a hospital bed which others could use, and wasting taxpayers money on her care. Females are trained as young girls to adopt self-sacrificing attitudes, and this is particularly common amongst women with 'eating disorder's (Bruch, 1978; Garner & Garfinkel, 1985; Gilligan, 1982). They believe they do not deserve what others can expect as rights, such as adequate healthcare. The gastroenterologist (#7) was very clear that all Diana's problems were her fault saying, "How could you do this to yourself?" At one point, he indicated that her weight loss occurred because she somehow sabotaged the system, therefore, more tube feedings were necessary. Her second psychiatrist (#6/10) intimated that she was in no position to know what was good for her when she tried to refuse prescription medication. His judgment was the only one of value. All three doctors were extremely angry with her during the course of their interactions, often embodying a battle of wills. All maintained dominating attitudes and indicated that the treatment was to proceed their way or care would be withdrawn.

In the above encounters, the attitudes of the doctors reinforced the existing trauma, and in these women's minds did little to foster positive recollections of 'expert' care. It seems to me that none of these doctors had the understanding, nor desire to understand or connect with the distress these patients experienced. One could presume that the day-to-day oppression women experience is so foreign to males in positions of authority and privileged status, that unless dedicated to reconstructing relationships of domination and power, these doctors would be of limited use in these cases.

Penfold and Walker (1983) note that "the equation of scientific diagnoses of sickness and health with moral judgments of legitimacy and virtue leads to the recognition of physicians as the moral and spiritual guardians of physical and mental health" (p. 11). They go on to say that medicine/psychiatry assumed the mantles of law and religion virtually without question, and the backwards writing of history favours these disciplines with a moral tone of 'rightness' as scientific enterprises, complete with moral sanctions subsumed under the protection of scientific truth. "Godly and/or medical men were concerned only with justice, humanity and medical treatment", obscuring their ties to capitalist enterprise, their struggle for an elevated status, and their role as agents of social control (Penfold & Walker, 1983, p. 12). Sexuality is considered well within the realm of conduct to be justified by patients in treatment or in therapy with medical or psychiatric professionals, such as sex outside marriage, adultery, abortion, pregnancy and childbirth, birth control, sexual preference, etc.

SEXUALITY

Crisp (1980) believes that women who develop anorexia nervosa in adolescence are repressing their emerging sexuality, symbolically linking the surge of appetite during puberty with the biological maturity of a womanly shape. He notes that a sexual adventure is a common precipitant of weight preoccupation activities particularly if it is accompanied by remarks about body fat. Some researchers have reported that individuals with bulimia nervosa are more sexually active than those who have anorexia nervosa, while being more dissatisfied with their bodies (Hazard, 1985; Russell, 1979). Both groups tended to be sexually passive, and dependent on men and relationships (Johnson & Connors, 1987).

Teresa was referred by the locum tenans doctor to another physician "who was supposed to know something about eating disorders". Teresa was cross examined about intimate sexual practices in the initial minutes of the interview by this doctor she had just met (#7). Doctors have included sexuality within their moral territory, and, as this doctor did, feel entitled to 'assess' topics related to sexuality. Freudian ideology, equates 'eating disorders' (and most other ailments affecting the psychological status of women) with repressed sexual desires, inferiority complexes, and 'imaginary' oppression or abuse (Brumberg, 1988). The behaviour of this doctor was perceived as intrusive and voyeuristic by Teresa. This interaction was set up in a confining space in a closet-like room at uncomfortably close quarters. The lack of sensitivity to routine assessment procedures, let alone to sensitive topic areas such as sexuality, terrified Teresa. The treatment was ineffective and inappropriate at best, disrespectful and damaging at worst, bordering on sexual misconduct. Teresa said "she lived through it", was silenced, remembers no meaningful interaction, and she *never* returned to formal therapy.

Sexual exploitation of female patients by male therapists is all too common an occurrence. Sexual relations with or sexual propositions from therapists were reported by 16 out of 60 female psychiatric patients that Chesler (1972) interviewed. While Teresa's experience was less obvious, there is no question that the interview in the 'closet' had sexual overtones for *her*, and was conducted in an inappropriate manner. Sexual exploitation is devastating for patients and may occur blatantly or subtly taking the form of coercion to engage in sexual relations, sexual harassment, inappropriate sexual jokes, being viewed as a sex object, or prolonged therapy that serves the therapist, and cannot be clinically justified (Mowbray, Lanir & Hulce, 1984). Moreover, a "study of women with bulimia found that 60% had been sexually abused or had negative sexual experiences" (Federal/Provincial/Territorial Working Group, 1993). Insult may well have been added to injury by the type of damaging treatment that Teresa experienced in her interview. This doctor seemed disconcertingly disconnected to Teresa's needs in this instance.

Years later Teresa wrote a letter to the College of Physicians and Surgeons about her experience with this doctor. It took much time, effort and understanding to realize how she was being conceptualized as a young woman patient with bulimia nervosa. Teresa felt she was naive about and had been protected while growing up from knowing that young women are often victimized as prey in sexual assaults. This subject was taboo in her family. Her submissiveness in the face of disarming questioning submerged the shock and anger that later surfaced regarding her treatment by this doctor. She became aware of how her age, her gender, her diagnosis, and her status contributed to her victimization and oppression.

KNOWLEDGE AND PRESENCE OF THE 'EXPERT'

In many of the encounters some 'cure' was expected to occur when the general practitioner made a referral to an 'expert', during the imparting of medical wisdom in an office visit, or by osmosis in a hospital milieu controlled by medical 'experts'. For the most part, the answers to the dilemmas of young women were to come only from 'expert' professional advice.

For Teresa, lectures by physicians on morals (#1) or life in general (#4) were to supposed to 'cure' her problems as the 'experts' understood them--sexual impropriety (#1), an undervalued life and a lack of acceptance of traditional roles (#4). Because many individuals with bulimia nervosa appear 'normal' or overweight, not underweight or severely emaciated like their anorexic counterparts, the physiological and psychological problems women with bulimia experience may be underestimated or undetected by health practitioners not accustomed to treating these patients[18]. The 'normal' weight appearance could lead practitioners to believe that problems are not very serious, especially when combined with the reluctance of patients to disclose shame-filled and guilt-provoking dieting behaviours. Treatment may well be prolonged or ineffective in these circumstances.

In Teresa's understanding of her psychotherapy experience (#4) she did not receive treatment for her bulimia. "Looking back, he really didn't know anything about eating disorders, but he did provide sort of a father figure, I guess." This does not seem to matter to the health care system that supports the work of the psychiatrist by continued reimbursement for his services regardless of the output. There is, in fact, no requirements in the province for doctors to recertify their skills and knowledge once they have completed their initial training. Teresa's psychiatrist maintained stereotypical views of women and dominance in the relationship by his actions and omissions in care. Teresa was made to feel she should be 'happy' with her roles as child, waitress, model, handmaiden or girlfriend. Service, nurturing or deferring to others was what was believed to 'make her better' while the doctor was free to pontificate and collect a healthy fee, with little accountability to anyone.

For Diana, the authoritarian and powerful presence of many of the GP's (#1/2, 5) and specialists (#3, 6/10, 7, 8) was purported to provide reason enough for the patient to change. Except for her experience at UBC hospital (#9), Diana's experiences with specialists were particularly fraught with demeaning incidents, uncaring attitudes, and power struggles. Programs using behaviour modification as a means of changing behaviours, such as the one Diana experienced (#3), used rewards (planned, positive activities and privileges) and negative consequences (a repeal of the privileges) for each patient, tied to weight gain and

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[18] People with bulimia nervosa are more at risk for death by suicide and complications of vomiting practices--aspiration asphyxiation, fluid and electrolyte imbalance, or accidental poisoning from ipecac causing cardiac arrest--than they are from weight loss alone.

appropriate behaviour in day-to-day living. Depending on the program, socializing and/or group activities can be therapeutic activities, rewards, or, more coersively, used to try to manipulate and control patient behaviour. These young women were already skilled in organizing their behaviour to meet the expectations of others. As mentioned earlier, when the patients are female, stereotypically feminine characteristics of passivity, pleasing and submissiveness are 'learned' in order to succeed. Diana became quite aware of her role in the 'getting better' game (#3b). Many patients just eat to get out of hospital, consequently relapses in weight loss and re-admissions to hospital are common. Diana learned to be "good", as she just quietly followed the plan of weight recovery for a few weeks so she could be discharged from hospital, contain her anger, leave the care of her psychiatrist, and depart for Victoria. This departure began a series of 'leavings' which were part of the resistance Diana created in response to her disconnected and oppressive relationships with those in her environment.

What we can see is when respect, understanding and encouragement were the prevailing attitudes, then progress was made. For example, she was told by the staff at UBC (#9), "You're here to get better; we want to help you get better." The staff and patients worked as a team, deciding on treatment plans together. Diana felt supported in her struggles during this time. As well, her impression of the last general practitioner (#13) she saw, who had and interest in 'eating disorder's was, "He stood by me and wanted to help me through things". This is contrasted with other hospital and outpatient experiences where Diana was treated as a delinquent or misbehaving child--dismissed as an unimportant nuisance (#3), thought of as incapable of or excluded from participating in decision making (#3, 6/10, 7), and threatened with abandonment if doctors' orders, like fatherly rules, were not followed (#6/10, 7). There was a great lack of understanding about her distress, and an unwillingness to investigate its origins.

Chesler (1972) argues that young women are seen as ideal candidates for intensive inpatient or long term outpatient therapy--the bread and butter of psychiatric practice. She (1972) writes of a study done by Dr. William Schofield which states:

> Of those psychiatrists and psychologists who expressed a preferred sex in their "ideal" patient, the majority "preferred" a young, attractive female patient--with no more than a BA degree. . . A male therapist may receive a real psychological "service" from his female patient: namely, the experience of controlling and feeling superior to a female being upon whom he has projected many of his own forbidden longings for dependency, emotionality, and subjectivity, and from whom, as a superior expert, as a doctor, he is protected as he cannot be from his mother, wife, or girl friend. (p. 65)

Generally "female patients are more empathetic, more aware of their troubles, more verbal, more capable of expressing themselves, more motivated for treatment than men. They are also more submissive, more passive, more admiring, less questioning" (Mowbray, Lanir & Hulce, 1984). Therefore, they are the preferred patients of male therapists. Many mental health professionals may well prolong treatment and foster dependency instead of encouraging growth and individuation.

Obedience and silence were the postures preferred in patients in many of the encounters discussed in this analysis. Oppression was built into the dominating relationships Teresa and Diana had with professionals, not by accident, but by the social relations of gender, age, status and medical/psychiatric practice. It raises the question: Who's needs were being met in encounters where domination and coercion prevailed, especially when patients failed to improve or actually deteriorated?

To recover and become reconnected, these women had to step beyond traditional medical practice, and engage in collaborative and supportive endeavours and relationships. It was in these kinds of experiences that they learned to uncover their own knowledge of themselves and understand their problems in a different way, other than as biological or psychological. We now see how their lives were instances of the social oppression of women.

CONCLUSION

Girls and women with 'eating disorders' resist oppressive relationships and social pressures and norms through their bodies. Bodily changes caused the women in this study to experience physiological, emotional, intellectual and relational troubles during adolescence and adulthood, which located these individuals under the care of doctors and psychiatrists. The treatment they received further objectified, silenced and dominated them, so they resisted this oppression even harder. They resisted doctors advice, they resisted treatment protocols and drug therapy, and they even resisted getting well for a time. While this was understood by professionals as failure to comply with 'expert' advice, and further evidence of mental illness, these women were trying to make their own sense of what was happening to them, and transformed that resistance into a way out of their misery. They eventually left traditional treatment behind. These women did, however, retain tremendous strength throughout their troubles, strength which was hidden for a time by oppressive treatment, yet strength which resurfaced to help them recover and become stronger individuals. People caring for girls and women with 'eating disorders' must see this resistance differently, not as misbehaving or craziness or depression, but as strength. Working with this strength is the challenge of all affected by 'eating disorders'--individual sufferers, their families and friends, and professional caregivers.

I demonstrate that there is order and sense to be discovered in the 'madness' which characterizes the lives of two women with 'eating disorders', and which treatment is aimed at alleviating. Sometimes the telling of the stories by Teresa and Diana was disjointed, with pieces missing. At times, the women themselves had difficulty making sense of what happened to them. However, when we see their seemingly 'crazy' behaviour located in the context of its social organization, one can see that their behaviours do not arise independently of the social context. These women were objectified in their developing years, silenced about their real needs, and developed disconnected relationships as protection against criticism and abandonment. My analysis of their treatment shows this oppression being replicated and reinforced in their treatment encounters.

Many of the medical practitioners or psychiatrists did not take these patients seriously, as people with real and important problems. They objectified these women as diagnoses and 'treated' them with medications and expert advice which often created more troubles. Moreover, the dominating behaviour of several of the professionals silenced authentic communication and delayed progress, adding insult to injury. All but a few of the 'helpers' failed to understand and respect the young women's struggle to gain some power over their own lives by resisting relationships which further disconnected the women from themselves and their place in the world.

While this kind of analysis does not look directly at causation of 'eating disorders', there is a benefit to seeing how societal perspectives and professional practices take shape from notions of femininity, desire and resistance in young women with 'eating disorders', often exacerbating their distress and prolonging their 'imprisonment' in anorexia nervosa or bulimia nervosa. This knowledge is valuable in understanding the social relations which organize the lives of individuals with 'eating disorders', particularly when seeking treatment.

The state of knowledge about 'eating disorders', the psychosocial development of girls and women, and the notion of resistance are still in their infancy. Using the researcher's empirical knowledge as a resource, as this study does, is consistent with qualitative, interpretive and feminist work, and it is the very type of practice that I hope clinicians will replicate in their therapeutic alliances--uncover and support the patients' way of knowing.

This research does not make claims about the universality of experiences for all women who seek treatment for anorexia nervosa or bulimia nervosa, however, other girls and women may see some similarities as well as differences between their own lives and the reconstructed narratives of Teresa and Diana, gaining further insight into their own journey through the analysis in this work. There are, although, some features in the narratives of Teresa and Diana and the analysis which make it possible to comment in a generalizing sense about the treatment they received. These will be discussed below.

Implications for Policy and Practice

This research questions the 'self-evident' nature of 'eating disorders' as diseases, narrowly defined by medical and psychiatric language and technology. There is pathology in professional helping. Care is highly fragmented. We need to examine the utility of traditional psychoanalytic and pharmaceutical practices for tackling problems of social relatedness and oppression. New ways must be developed to broaden the understanding of all involved. I have made a case for treating the social organization of anorexia nervosa and bulimia nervosa as important in understanding these phenomena, and I think that medicine and psychiatry can be challenged as gatekeepers and managers of anorexia nervosa and bulimia nervosa. If they are to remain in the 'eating disorders' business, and I don't think that their involvement is necessarily critical, then theoretical formulations about the etiology of the illness must be displaced by different, more socially constructed understandings of what is happening to girls and women. Treatment, such as 'protected' inpatient hospital settings, behavioural reprogramming, and psychotropic drugs, based on a disease model which cuts people off from their connection to the social world, will continue to fail. The part medicine and psychiatry play in the oppression, domination and silencing of girls and women, and their position in the health care system in relation to education, politics and economics must be critically examined and adjusted.

Writing and refining one's narrative about oneself, one's experiences, and one's relationships is intervention, and has implications for policy and practice. Both women ably reconstructed their histories to make some sense of their very different lives. Teresa has had more time than Diana to reflect on her life, and is able to make more connections and a more cohesive story which she uses as a resource for herself and others. Diana, having had less time to think retrospectively about her experiences, feels some things just seemed to happen the way they did without understanding connections to anything visible. She has more to decipher about her experiences which will make her life story more coherent. Opportunities to look retrospectively at one's life create a sense of peace with the past, strength in the present, and direction for the future. Patients should be given opportunities for their own sense making of their lives.

Girls and women need to be valued as people capable of understanding and explicating their own dilemmas, given support and connection. This challenges professionals to work in a different way--non-hierarchical, engaged, open to alternative interpretations, not providing all the answers, admitting mistakes, and giving safety a priority. Training of professionals must embrace a socially organized view of 'eating disorders' and sanction different, more responsive ways of working with girls and women.

Steiner-Adair (1991) thinks that being a good therapist entails a number of practices. She must listen seriously to the needs of her patient and respond to her as a genuine person with caring and affection. The patient must hear directly from the therapist how her comments affect and influence the professional. Patients do not require a therapist to be perfect, but they need to know when they are right, and the therapist is wrong. Patients do not want the therapist to be defensive, nor engender defensiveness in the patient. She must not "create rigid molds and expectations that are clearly hierarchical and unpenetrable" (Steiner-Adair, 1991, p. 257). Her job is to create, nurture and sustain a relationship with a patient in which that individual "can constantly 'refine the truths' she tells herself and others" (Steiner-Adair, 1991, p.260). She affirms patients as knowers, already understanding the things they need to know to get better, but knowledge that has been buried in distracting behaviours.

My experience tells me that females with ‘eating disorders’ function as social barometers sensitive to society's attitudes towards women--sexist, racist, classist and ageist attitudes--which continue to deplete women of pride and confidence in themselves, and their contributions to society. Feminist writing suggests that girls and women with anorexia nervosa and bulimia nervosa should not be seen as having pathological behaviours or thinking, but responding to the demands for thinness in society today. An understanding gaining a higher profile is the notion of a continuum of weight preoccupation and associated eating behaviours, of which anorexia nervosa and bulimia nervosa are just a part (Brown, 1993). Feminists argue for placing weight preoccupation on a continuum in a culture that produces this activity amongst girls and women. While this is perhaps a more orderly way to view the scope of preoccupation with weight, food and the body across contexts, I somehow feel it is of limited use.

Weight preoccupation and the drive for thinness must be viewed in light of the media's image-making and compelling function in patriarchal capitalist structures, and as resistance to a world that supports these ideals (Szekely, 1988, p. 18). While the medical model emphasizes individual pathology and reducing symptoms, feminist therapy "tries to hear the voice that speaks through the symptoms. . . . accepting and normalizing the problem, [and avoiding] judging, trivializing or sensationalizing the symptoms" (Brown, 1993, p. 122). Girls and women with ‘eating disorders’ have lost their ability to speak directly with words, so use their body and behaviour to communicate a message that may have gotten lost through self-destructive behaviours. Steiner-Adair (1991) states girls and women use the body to not only to say “I can’t fit”, but as punishment for resisting and not wanting to fit. Anger dissolves into dizziness, tears and self-loathing as the resistance gets turned inward, hating the self. Illness becomes the only way to ask for what one needs. This is a struggle that "comes from being female and trying to hold on to the truth and integrity of [one's] experience within a culture, language and tradition comprised of structures that distort truths and experiences that don't fit" (p. 257). Brown (1991) states that during the vulnerability of adolescence, girls are encouraged to devalue what they feel, think, or know about the world of relationships, in order to:

> Enter into dominant views of womanhood. Wooed by idealized relationships, by the possibility of *perfection* and *purity*, and by the new image of the superwoman--the woman who has it all with no outward signs of distress or struggle--she is encouraged to enter, to buy into, a story that she has not known to be true from her experiences in childhood. For a girl to do otherwise, to tell a different story true to her rich and varied experiences of childhood relationship--to stay with what she knows in the face of pressure to not know--would be to engage in an act of *resistance*, an act of moral courage in the face of potential risk to her body and her psyche. (p. 83, my emphasis)

Professionals must work at changing practices of disengaged care, responding in authentic ways to the oppression in their own lives (past and present) made evident by the struggle of girls and women with 'eating disorders'. This means creating policy which would support the risk-taking professionals would need to engage in to change established practices of therapy. As it stands, the patients take the risks for making things happen. Girls and women have to be encouraged to stay in their bodies, minds and hearts to be able to feel and work through that which has seemed intolerable to them, and from which they have used their 'eating disorder' to distance themselves. Professionals need to model their own struggles with issues, and not give the appearance that their life is always ordered, right and perfect. The challenge of professionals therapists working with 'eating disorders' mirrors that of these girls and women as they both try to be responsive in a healthy and creative way to the needs at hand, and break down the molds that disable authentic and connected relationships (Steiner-Adair, 1991).

The notion of patient responsive care has some importance here. It is clear for the most part that systematized and routinized care did not work well for these women. There is a mismatch between accepted scientific ideas about 'eating disorders' treatment and what those affected do experience and demand if they were heard. We need a way for women to be heard by those in multiple levels of government, apart from what is written about deaths or sensational stories of disappearances and desperate attempts to avoid starvation in newspaper clippings. Girls and women need to be involved in the planning, ongoing decision making and evaluation of services affecting them--active in designing resources and ways of relating that support understanding and connectedness within themselves and with others. They are expert knowers whose knowledge must be allowed to unfold. They must be helped to uncover what they already know, or have been confused about in their understanding, but have been unable to feel safe to articulate. The promotion of healthy images of girls and women in all their diversity, and the prevention of 'eating disorders' must be given more of a priority financially and politically, challenging some of the industries benefiting from a socially constructed imperative of 'thinness'.

Feminist researchers and therapists need to address the "absence of grievances, appeals and rebellions by problematizing those factors that contribute to the social construction of quiescence" (Fine, 1992, p. 23). Given the embeddedness of power structures, stepping from one view to the other is not easily done. However, as Steiner-Adair (1991) states, a therapy of adaptation or a type of psychotherapy that does not challenge the traditional order and practices of itself will not model a "way of resistance which through which [a girl or woman] could potentially 'free' herself" (p. 258).

It is easy to be lulled into complacency when working with girls and women with 'eating disorders' because of the appearance of well-being that co-exists with their distress. Despite periods of poor health, girls and women with 'eating disorders' often excel in many areas of their life--academic, sports, music, etc. However, these goals are often not their goals, which remain unexamined and unpursued. This disavowal of the self is not a problem of the self, because these individuals exhibit a strong sense of themselves, even as they disavow their thoughts and feelings, but it is a problem of relationship (Stern, 1991). This is particularly important because there are "strong indications that once activated, the process of disavowing the self will be sustained into adulthood" (Stern, 1991, p. 114). While therapists need to help girls and women pursue their own goals, strategies for intervening in this process need further research. Weskott (1986) states the task of therapy lies in release of feelings--recognizing and unblocking them--not in control or management. My analysis show that much of the treatment centered on control of patients through talk, drugs or putting concerns aside, and that expression of honest, albeit vehement, feelings was not normally sanctioned.

Creating histories (be it by writing, telling, dancing, painting, singing, etc.) that offer a coherent way to understand what happened in one's life is critical to coming to some peace or place in the world where one feels safe and confident. Some of the work that I do is firmly embedded in the belief, and reinforced over and over in conversations with women with eating disorders and the families of these individuals, that telling one's story is a healing and reaffirming practice, very therapeutic. Having girls and women participate in public speaking about their 'eating disorder' at schools, writing poetry for a newsletter, presenting in conference workshops, peer counselling, being involved in political activities and support groups are some of the activities which allow for expression of the authentic self in relationship with others, and towards which I encourage girls and women with 'eating disorders'. I recommend that family members who have also suffered when someone in their family experienced an 'eating disorder' try these strategies for gaining support and insight in their lives.

Having girls and women themselves name their distress is one way to address that which holds them prisoner. However, it must be their name that counts, not some superimposed label that only (possibly) makes sense to professionals. I would like to see these phenomena named as something reflecting the oppression girls and women feel, so as to locate an understanding of their problems in a sociocultural orientation.

Limited talk about the involvement of family and friends in this study may be a reflection of their sense of disconnection or lack of 'fit' in their own environments. This echoes a comment I heard many times in my work with adolescents as they tried to articulate this sense of disconnection--trying to find a place within themselves and the world at large to call home. While the adolescents I worked with could not say specifically what function the 'eating disorder' served in their lives, some articulated that it went beyond their families, sometimes stating it had little to do with parents or siblings. This thesis proposes that medical and psychiatric 'help' is a major trouble, perhaps one which extends the 'eating disorder'. In a lack of clarity about the meaning of the pursuit of thinness as practitioners (and as women and men), I feel that blame was often placed on families, and an understanding of the oppression of girls and women in society was very limited. Families need help in understanding different ways of supporting their member with an 'eating disorder', and should not be the scapegoat for practitioners' frustration about their own ineffectiveness with these patients.

Classroom activities, materials, and ways of understanding which support girls as they mature and help them express who they are without fear of consequences are critical in schools. Gender bias in teaching materials and classroom practices must be an open topic. Public health nurses are well positioned to be involved in educating not only students but teachers about 'eating disorders' and the psychology of girls. However, goals would be to have this material included in the formal education of teachers and in Ministry of Education curriculums as well as written into lesson plans at the school level.

Future Research

It would be interesting to pursue information about relationships with, and the influence of non-medical staff such as nurses, particularly in systematized care facilities such as inpatient and psychiatric day programs where patients have lengthy stays, or in outpatient services, both urban and rural. Nurses are well positioned to take up the challenge of responsive, women-centered care, especially in light of the development of community nursing centers in this province. While this was not the focus of the participants' narratives, this is a direction for further study.

Teresa and Diana were involved in the four most notorious sports associated with 'eating disorders'. Teresa practiced years of ballet, then employed in dance. She also studied gymnastics. Diana was a figure skater before she took up running. It is not very clear how much these activities organized Teresa's and Diana's early experiences of their bodies, their femininity, and their resistance to oppression, however, it is reasonable to believe that social relations viewed from a sports perspective would be as equally real and investigatible as experiences viewed via health concerns. International sport organizations such as "WomenSport International", and federal organizations such as "Sports Canada" are beginning to understand the connections between training/competing and health, considering both short and long term consequences for girls and women who must be a certain weight or shape, and eat and exercise in a certain way to achieve success. Some are beginning see the links between amenorrhea, nutritional status and rigorous exercise. Osteoporosis, stress fractures, and chronic health problems are receiving notice in some quarters as former athletes speak up about their experiences. Women in sport and the connections to oppression and 'eating disorders' is an area of fertile ground for future study.

While this work concerns the stories of women who have sought traditional professional treatment for 'eating disorders', there are women who have followed a different trajectory for recovery. These are women who have received no professionally endorsed treatment for anorexia nervosa or bulimia nervosa. Some feel they have recovered on their own or with the help of friends and family. And, some have sought the aid of identifiable resources in the community which are non-medical and not sanctioned in traditional medical/psychiatric spheres, such as help from peers who have learned to help others through their own experiences with an 'eating disorder', or alternative therapies. My study confirms that medical and psychiatric 'help' is not necessarily the best route for relief from anorexia nervosa and bulimia nervosa. Perhaps this is its most important conclusion for policy and practice.

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