Role of Spirituality

in the Recovery of Eating Disordered Women

by

Kristina Julyanna Sandy
B.A., University of Victoria, 1998

A Thesis Submitted in Partial Fulfillment
of the Requirements for the Degree of

MASTER OF ARTS

in the Department of Educational Psychology & Leadership Studies

We accept this thesis as conforming to the required standard

[redacted]

Dr. G. Hett, Supervisor (Department of Educational Psychology & Leadership Studies)

[redacted]

Dr. N. Trace, Department Member (Department of Educational Psychology & Leadership Studies)

[redacted]

Dr. A. Preece, Outside Member (Department of Curriculum & Instruction)

[redacted]

Dr. R. Dalton, External Member (Department of Curriculum & Instruction)

Supervisor Dr. Geoff Hett

Abstract

This paper explores the role of spirituality in the recovery of eating disordered women. There exists more disordered eating and other food related illness today than ever before in North American culture (Mattelart, 1986). The complexity of food related illnesses and the potential for long-term side effects warrants the attention of the medical community to search for effective ways to treat this illness.

The medical community has approached treating eating disorders from an emotional, physical and intellectual perspective, yet recommending spiritual guidance is not standard practice.

Five women, who have successfully recovered from an eating disorder, were interviewed as to their experiences. The results found that religious and spiritual resources were instrumental in the healing and recovery process of these women (Hardman & Berrett, 1999).

We have only begun to investigate the healing powers of religion and spirituality. More research is needed to explore the role of spirituality in our lives.

Keywords (spirituality, recovery, eating disorders)

Examiners:

[redacted]

Dr. G. Hett, Supervisor (Department of Educational Psychology & Leadership Studies)

[redacted]

Dr. N. Trace, Department Member
(Department of Educational Psychology & Leadership Studies)

[redacted]

Dr. A. Preece, Outside Member (Department of Curriculum & Instruction)

[redacted]

Dr. R. Dalton, External Member (Department of Curriculum & Instruction)

Table of Contents

Acknowledgements

I wish to acknowledge Dr. Pierre Leichner for his dedicated work with eating disordered patients and to thank him for taking the time to meet with me. I wish to acknowledge the commitment of both the Association of Awareness and Networking Around Disordered Eating (ANAD) and the Eating Disorder Research Center (EDRC) in Vancouver, British Columbia, to promoting the awareness of eating disorders, to improving women's body image, and for providing a safe and knowledgeable environment for women to heal. I wish to thank the women who participated in this study, Sage, Anne, Sally, Lorraine and Jo, for their courage and strength in choosing to have their voices heard.

And finally wish to thank my supervisor Dr. Geoff Hett and my committee members for their valuable guidance, and Joan Wolfe for her computerized APA formatting template, expertise, and suggestions.

Dedication

This thesis is dedicated to my loving mother and father for their unconditional love and support; to my wonderful husband, for his never ending love and faith in me; to my precious daughters, "you are the lights of my soul"; and to my grandfather, who I never met in person, but have always known in my heart.

Chapter 1:

Introduction

The Problem of Eating Disorders in Western Culture

In a nation where food is abundant and choices are endless, some people are starving themselves to death. There exists more obesity, eating disorders and other food related illnesses today than ever before in North American culture (Mattlehart, 1986). With the beginning of industrialization and the marketing of consumer products, our eating habits as well as body image and weight have not escaped the giant arm of consumerism.

Appearance and weight are an easy target for a western culture that trades food for shallow self-confidence and love. We are a nation obsessed with staying young, being healthier and looking good (Hesse-Biber, 1996). What price are we paying to reach this goal? Unfortunately, for many, this price is dangerously high.

The complexity of eating disorders and the potential for long term side effects warrants attention from the medical community to search for effective ways to treat this disorder. Western cultural attitudes regarding weight, dieting and body image are influential in creating a context within which eating disorders may develop.

Counsellors, physicians and the medical community have approached the problem of eating disorders from an emotional, physical and intellectual perspective. Nutrition, medication, cognitive behaviour therapy and other counselling methods are used to assist the individual in changing destructive behaviour. A few counsellors recommend some form of spiritual intervention, but it is not standard practice. Rather, the medical community recommends that ministers and rabbis care for the needs of the soul.

In recent times there has been a surge of interest in naturopathic medicine and alternative healing, encouraging people to take responsibility for the health of their physical bodies. Similarly, the surge of interest in spirituality outside of the mainstream religious structure reveals a willingness to take responsibility for the care of their *soul*s. The idea that the spirit of an individual may have a profound influence over the body, intellect and emotions is a serious consideration for the medical community today. My question is; Are spiritual interventions effective in the recovery of eating disorders?

Purpose of Study

The purpose of this research is to gain a deeper understanding into the role of spirituality in the lives of eating disordered women. There is a growing body of research that supports the health benefits of spirituality in the intervention of disease, however many are hesitant to employ spiritual practices in healing.

The writings of Deepak Chopra, Marianne Williamson and Andrew Wells claim that the power of the mind, if harnessed to heal the body, can work miracles.

Dr. Randy K. Hardman and Dr. Michael E. Berrett, psychologists at the Center for Change, in Utah, United States of America, value the use of spiritual intervention in the treatment of eating disorders. They have, by their own claim, successfully implemented a recovery program for eating disordered individuals (Hardman & Berrett, 1999).

Other researchers agree the use of spiritual practices such as contemplation, meditation, prayer and rituals essential to human happiness and good health (Elkins, 1999). For example, William James, Karen Horney, and Victor Frank maintain a strong spiritual perspective in their work (Walsh, 1999).

Eating disorders affect people of all ages and sexes, yet more than 90% of eating disordered patients are female. Why are women more vulnerable to this type of illness? Perhaps there is a clue in the results of a study that examined the relationship between gender role stereotyping among adolescents and the susceptibility to depressive symptomatology. The study found women to be twice as likely to be depressed than men. Researchers concluded that women were seen to judge themselves by external standards more often and more harshly than do men (Hart & Thompson, 1996).

Our culture prizes and rewards physical beauty and fitness. Young girls, as early as 10 or 12 years of age, are reported to be using laxatives, appetite

suppressants, vomiting, fasting and excessive exercise as a means of coping with the changes in their bodies and in their lives (Friedman, 1997).

Dr. Hardman and Dr. Berrett, describe women who suffer from long term eating disorders, as feeling terribly alone, inadequate, unworthy, undeserving and hopeless. They found eating disordered women, who at one time felt a connection to God, now felt unworthy and undeserving of God's love and acceptance, as expressed by a 20-year-old patient at the Center for Change:

> The eating disorder consumed every aspect of my life. My entire life was centered on food and weight. I felt unworthy and undeserving of having a relationship with God. I hated myself and did not think it was possible for anybody, including God, to love me. (Hardman & Berrett, 1999, p.1)

This author first noticed the plight of women with this disease when visiting the eating disorder clinic in Victoria, British Columbia, gathering written material for a class project. Several frail-looking women were waiting in the reception area accompanied by, one could only assume, their mothers, who were noticeably distressed and concerned. One's heart went out to these women who were watching their children disappear before their eyes, unable to stop the terrifyingly destructive nature of this illness. What turmoil lives inside these young girls, who like ephemeral angels, do not allow themselves to be nourished by life so they can grow into beautiful vibrant women?

Imagine for one moment the experience of a mother or father, staring into the teary eyes of their child uttering the words no parent wants to hear, "Mom, Dad, I have an eating disorder". No one can explain this feeling of utter

helplessness one may experience when faced with an illness that is so mysterious and elusive in cause and cure. It is my hope that this study sheds light and a deeper understanding into the struggle of eating disordered individuals and the role that spirituality may play in the healing process.

Our Relationship to Food

Most people in Western culture realize that we need an adequate volume and variety of food to survive. We understand the necessity of a healthy diet as recommended by the Canada Food Guide, ensuring balanced nutrition. We choose our foods because of their nutritional value and also because of the sensual and emotional pleasures and comfort they offer.

We have all heard of *comfort foods* that console us when we are sad or depressed. The warm sweet taste of chocolate, soft macaroni with lots of cheese and the frozen soothing taste of ice cream are examples of the enormous pleasure that food can provide. The feeling of fullness is associated with feelings of peace, calm, and relief from anxiety, thus our eating habits and our emotions are closely connected. Advertisers are aware of the psychological and emotional pleasures of eating, thus flooding the consumer market with tasty and tantalizing products. Who can resist?

Eating is also an important social event filled with festivity that we share with our communities. We have passed down our traditions around celebrations,

such as Thanksgiving, birthdays and the thousands of *special* meals we serve each other as symbols of love (Kirkpatrick & Caldwell, 2001).

Food is also found among our spiritual and religious traditions. For example, Christians ate fish on Friday, whereas Jews and Moslems avoid pork. Some foods are given the moral judgement of being considered *good*, while others *bad* (Kirkpatrick & Caldwell, 2001). The production of food had become a multi-billion dollar industry constantly bombarding the public with new kinds of foods. What is the difference between the average person's relationship with food as compared to the person who develops an eating disorder?

In western society where thinness is a symbol of attractiveness and success, the average woman at least occasionally worries about her weight. Therapists have reported their eating disordered patients to take these concerns to extremes, developing abnormal eating habits (Brownell, Hotelling, Lowe, & Rayfield, 1998)

For some, particularly young women, food is no longer a pleasurable daily requirement; rather, it becomes associated with a complex web of emotions. For the anorexic woman, food is something to be feared and avoided. For the bulimic, it is a forbidden temptation that cannot be enjoyed.

Some feminists hold the view that all women have an eating disorder of some kind, varying only by degree. They question the integrity of western culture in labelling anorexia and bulimia as pathologies on the one hand, and then support the constant dieting and weight pre-occupied behaviour of women in

general (Brown & Jasper, 1993). It becomes evident that, in order to have a deeper understanding of eating disorders, it must be placed within the context of our western culture.

What Are Eating Disorders?

According to the Eating Disorder Research Center of British Columbia, eating disorders are defined as coping strategies used by individuals when they are struggling with a life situation that leaves them feeling powerless.

Eating disorders are devastating behavioural maladies and are brought on by a complex interplay of factors. These factors may include emotional and personality disorders, family pressures, a possible genetic or biological vulnerability, and a culture in which there is both an abundance of food and an obsession with thinness. A maladaptive coping mechanism is defined here as a destructive and ineffective strategy used by an individual to establish a sense of self, and to experience a sense of one's own power, agency and worth (Reindl & Repetto, 1991).

There are several different types of eating disorders characterized: *Bulimia Nervosa*, *Anorexia Nervosa* and *eating disorders not otherwise specified*. These latter disorders are called *compulsive overeating* (*binge eating disorder*) as well as *binge eating without purging*. The more research done on eating disorders, the more researchers realize that these disorders are on a continuum of disordered eating. *Anorexia*, *Bulimia* and *Binge Eating* have been accepted as

the *true* eating disorders, well-defined and studied. Therefore, for the sake of convenience, the term *eating disorders* will be used to refer to these three most commonly accepted conditions (Kirkpatrick & Caldwell, 2001).

Defining Eating Disorders

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), used by the medical community in mental health and treatment assessment, views eating disorders as self-destructive and potentially life-threatening behaviour. In order to provide a diagnostic assessment, there is a minimal criterion for anorexia nervosa, bulimia nervosa and binge eating. This is as follows:

1. Refusal to maintain body weight at or above a normal weight for age and height.
2. Intense fear of gaining weight or becoming fat.
3. The absence of at least three consecutive menstrual cycles.

Deborah Kuehnel, a licensed clinical social worker, and her colleagues, who have extensive experience in the area of addictions, have characterized eating disorder patients as having low self esteem, a distorted body image, obsessions involving food, binge-eating and purging behaviours, difficulties with relationships, increased isolation, feelings of self-loathing, feelings of hopelessness and helplessness, and feelings of being out of control (Kuehnel, 1998).

Bulimia Nervosa

Bulimia nervosa is a disease defined as a behaviour whereby the individual consumes large amounts of food (binge) and then attempts to rid their bodies (purge) of the excess calories by either vomiting or the use of laxatives and diuretics (Hughes, 1996). The word "purge" comes from the Latin *purgare*, which means "to cleanse."

In the past, bulimia has been thought of as *hyperorexia* where "hyper" means an excessive or a heightened exaggerated hunger. The word bulimia is derived from the Greek word *bous*, meaning "ox," and *limos*, meaning "hunger," implying someone who possesses an appetite as big as an ox's, or has the capacity of eating a whole ox. Bulimia has been identified by many different names. It has been called *boolmot* (Hebrew), *bulimy* (Greek), *morbid hunger*, *phegedaena*, *hound's appetite*, *canine appetite*, *bolilsmus*, *bolimos*, *cynorexia*, *Ess Sucht* (German for "craving for eating") and *gluttony* (Kirkpatrick & Caldwell, 2001).

Bulimia nervosa typically begins early in adolescence, when young women react to failing attempts at restrictive dieting by binge eating. Many bulimics progress on to anorexia by starving themselves to lose weight or to prevent weight gain. To the bulimic, body shape and weight are considered important factors in defining their self-worth (Kirkpatrick & Caldwell, 2001).

Physical Effects of Bulimic Nervosa

One of the most noticeable physical signs of bulimia is the swelling of the salivary glands creating a puffy face resembling a chipmunk (Kirkpatrick & Caldwell 2001). This condition is brought about by the frequency of bingeing and purging, creating dramatic weight fluctuations of 10 pounds or more. Scars on the back of the hands appear, caused by the teeth rubbing against the skin during purging. This symptom, called "Russell's Sign," is named after Dr. Gerald Russell, who first observed and described this symptom in his practice (Blair, Robinson, Fleming, McCloy, & Mollenhauer, 1998).

According to the Eating Disorder Association Inc. (Qld), a non-profit organization in Queensland, Australia, aimed at improving the intervention, education and support for all people affected by eating disorders, describe physical symptoms of bulimia, such as forced vomiting, as potentially dangerous behaviour. Stomach acids forced back up the esophagus may cause blistering, tearing, and bleeding of the throat. This acid causes rapid dental decay, sometimes noticeable during a routine dental check-up. Menstrual cycles can become irregular, or stop altogether, as the body's chemical and hormonal levels become imbalanced (Blair et al., 1998).

Behavioural Characteristics of Bulimia Nervosa

According to both the Eating Disorder Association (Qld) (Blair et al., 1998) and the Eating Disorder Resource Center of British Columbia (EDRC), a woman suffering from bulimia nervosa is characterized by episodes of the consumption

of large amounts of food followed by a severe restriction of food intake. The purging behaviours of the eating disordered woman, usually kept secret, create feelings of shame and guilt. It is not uncommon for someone with this illness to withdraw from social activities, especially those related to food, for example family dinners and picnics.

Psychological Characteristics of Bulimia Nervosa

Eating disordered clients are described as having low self-esteem and poor self-image. They are constantly battling the unreasonable and overwhelming fear of becoming fat. They may experience severe mood swings and increased irritability as their bodies are thrown into a state of chemical imbalance. This disorder is highly correlated with psychological illnesses such as depression, anxiety and substance abuse (Denmark & Paludi, 1993). The Eating Disorder Association (Qld) found some patients with bulimia overcome with feelings of guilt, shame and self-loathing that may spiral further into deeper states of depression and perhaps towards suicidal thoughts (Blair et al., 1998).

Anorexia Nervosa

The word *Anorexia* comes from the Greek *an* meaning "not" and *orexis* meaning "desire," thus a "loss of desire for eating." Nervosa comes from the French word *nerveux* meaning having to do with the nerves; in other words, having a psychological cause. Literally translated, *anorexia nervosa* means "loss of appetite caused by psychological illness." Although many details of the

disease have only recently begun to be understood, anorexia nervosa was actually documented three centuries ago (Kirkpatrick & Caldwell, 2001).

Physical Characteristics of Anorexia Nervosa

Anorexia Nervosa leads to a state of starvation and emaciation with a woman losing at times up to 15% to 60% of her normal body weight (Denmark & Paludi, 1993). This marked weight loss accompanies a pallid unhealthy look to the skin. Due to a decreased metabolic rate, the anorexic is more sensitive to the cold. Insomnia becomes a problem as the body tries to fight off hunger. The prolonged lack of nutrition leaves the hair and nails noticeably unhealthy. Later in life, the anorexic may find her self at greater risk for osteoporosis and hormonal imbalance (Kirkpatrick & Caldwell, 2001).

Behavioural Characteristics of Anorexia Nervosa

Dr. Jim Kirkpatrick (a family physician, who has been working with eating disordered patients for more than fifteen years and is a founding member of the British Columbia Eating Disorders Association) and Dr. Paul Caldwell (a family practitioner for over 25 years) found behaviour that characterizes an anorexic (Kirkpatrick & Caldwell, 2001). The first noticeable sign is the unusually low intake of food. One can observe odd eating habits with unusual food rituals, such as cutting up food into tiny pieces or refusing to eat in public. Some anorexics that do eat *normal* amounts of food will exercise excessively in order to burn off calories.

Some anorexic women obsess about reading nutritional information on packages, hiding behind claims of food intolerance or restrictive diets. As with bulimia, anorexics at times vomit or use laxatives to rid their body of food. Many eating disordered individuals weigh themselves constantly, hiding their body shape beneath layers of clothing (Kirkpatrick & Caldwell, 2001).

Psychological Characteristics of Anorexia Nervosa

Women suffering with anorexia nervosa are characterized as having both a distorted body image and an intense fear of gaining weight. They feel insecure about their abilities even though they may excel in performance. This tendency towards perfectionism may push them to obsess over issues around food and weight. It is disturbing to see people with this disease suffering under the delusion that they are fat when, in reality, they are bone-thin (Denmark & Paludi, 1993).

Binge Eating

According to Siegel, Brisman, and Weinshel (1998), who are family therapists, lecturers and authors specializing in eating disorders, a *binge* is defined as the rapid consumption of high caloric food in a short period of time. The term *binge eating* was established to define eating disorders that are *not specifically defined* as anorexia or bulimia. This category may include binge eating without purging, infrequent binge-purge episodes (occurring less than

twice a week or, when such behaviour lasts, less than three months). Repeated chewing and spitting out food are also seen in people who suffer with this illness.

Behavioural Characteristics of Binge Eating

Binge eating, also known as compulsive overeating, is very similar to bulimia nervosa, but without the purging behaviour. Binge eating is medically defined as "eating a large amount of food within a specific period of time." A woman who is bingeing may, within a two-hour period, consume an amount of food larger than most people would be comfortable eating. This behaviour is accompanied by the feelings of fear that they will not be able to stop eating or even control the quantity of food they consume (Kirkpatrick & Caldwell, 2001). At these times, patients may cycle in a pattern between severe dieting and bingeing.

Siegel and her colleagues (1998) speak of one of their clients, an impeccably well-dressed executive who worked on Wall Street in New York City, spending evenings rummaging for food through garbage bins in the alley behind her apartment building. Binge eating, usually occurring in secret, is accompanied by feelings of guilt and shame.

A person who is bingeing may eat over 50,000 calories, that is, 20 to 25 times the normal daily energy intake the average person needs in order to function. One episode of bingeing may entail eating two dozen chocolate chip cookies, two large boxes of cereal and eight pints of ice cream more than once in

a day. Patients diagnosed with bulimia average about 14 episodes of binge/purging per week (Kirkpatrick & Caldwell, 2001).

Psychological Characteristics of Binge Eating

Similar to anorexics and bulimics, binge eaters often describe a loss of control over food followed by feelings of guilt, shame and disgust. Many who develop this problem have also failed at restrictive dieting. These feelings of failure may lead to depression and possible long-term risks associated with obesity. Even though binge eaters can be of normal weight, about 30% of these people have problems with obesity (Abraham & Llewellyn-Jones, 1992).

Physical Characteristics of Binge Eating

Bingeing and purging causes severe stress to the body. Over a period of time, purging or frequent self-induced vomiting may result in dehydration and possible disturbances in the electrolytes in the blood. This places patients at risk for heart attacks, renal problems and possible death (Abraham & Llewellyn-Jones, 1992). There are also dangers in vomiting (purging), such as choking as well as the involuntary vomiting of foods at other times when the patient is attempting to eat. Purging through the use of laxatives can lead to potassium deficiencies and electrolyte imbalances (Kirkpatrick & Caldwell, 2001). The above mentioned physical dangers are also present in the anorexic and bulimic patient.

Factors Contributing to Eating Disorders

Although there is no one cause for an eating disorder, there are many factors that contribute to these illnesses. Researchers have studied the personalities, genetics, environment and biochemistry of individuals with these illnesses. Eating disorders, as mentioned before, are not about food, rather they are "maladaptive coping mechanisms" used by women to alleviate stress and anxiety (Hughes, 1996).

According to current medical reports from Harvard Medical School and Massachusetts General Hospital, some are rooted in emotions triggered by factors and/or events, such as cultural attitudes towards body image, family pressures, chemical imbalances, emotional disorders (Harvey, 2001). These physicians, psychiatrists and psychologists found the causes of eating disorders to be divided into four areas:

1. biological/medical
2. social/cultural
3. individual/emotional
4. family

Spiritual theories that focus on a woman's search for meaning connectedness and purpose are not commonly accepted as an important factor in the etiology or treatment of eating disorders.

Biological and Medical Factors

A number of biological factors, found in the brain of eating disordered women, are considered to be abnormal. Some abnormalities are the result of malnutrition, while some play a role in causing this disorder. These changes in the hormonal, neurological and immune systems of the individual are common to anyone suffering from anxiety, stress and anorexia.

A number of studies have detected abnormally low levels of neurotransmitters (particularly serotonin) in severe anorexics and bulimics. This lack of neurotransmitters has been associated with depression and obsessive-compulsive disorder (OCD) as well. Between 40% and 96% of eating disordered patients suffer from depression and anxiety disorders. For example, the amino acid tryptophan is a component found in food, essential for the production of serotonin is lacking in the chemistry of an anorexic. The answer to the question "did the eating disorder cause the imbalance or did the imbalance cause the eating disorder" is uncertain (Harvey, 2001).

Socio-cultural Factors

Many people living in western culture are aware of the pressures to be thin and the prejudices against being fat. The media, a powerful force in our culture, takes little responsibility for its part in perpetuating an attitude that feeds this illness. The myth "if one achieves thinness, then one will be beautiful, successful and loved" holds great appeal to the millions who are inundated with media advertisers marketing consumer products (Harvey, 2001).

This very same culture questions the worth of a woman who does not have a good education, successful job, happy husband, and well-behaved children. Any woman "worth her salt" is expected to accomplish these tasks as she aspires to emulate the models on the magazine covers, even if she must get help from the plastic surgeon. In fashion magazines, the images can be obvious and overpowering but, more often, they are pervasive and subliminal, establishing themselves in our subconscious minds associating these attributes with the desires for happiness and success (Kirkpatrick & Caldwell, 2001).

The combination of increased body dissatisfaction and the conforming to restrictive social rules have a dramatic negative impact on female socialization (Hart & Thompson, 1996). In technically advanced cultures, advertisers use the media to market their products. They promote the image of a young anorexic model as the paradigm of sexual desirability, and then flood the market with ads for high fat junk food. A young woman, who achieves this ideal thinness, believes that she has accomplished a major cultural and personal victory. She has overcome the temptations of junk food and created a body image that is idealized by the media, creating a sense of accomplishment reinforced by the praise and envy of her heavier friends (Harvey, 2001).

Women must take into consideration the expectations of society, stereotypes, the limitations placed upon them, their status relative to men and the symbols and concepts of femininity within the culture (Gross, 1996).

Therefore, research on anorexia nervosa and bulimia nervosa cannot be understood without an awareness of their socio-cultural setting that encompasses the value system and assumptions implicit in a particular cultural context. This type of eating difficulty may be culturally induced (Hesse-Biber, 1998).

Individual / Emotional Factors

The British Columbia Eating Disorders Association (1994) claim that negative internal thoughts and feelings contribute to the development of an eating disorder. These negative internal thoughts and feelings may manifest as a lack of assertiveness, withdrawal, isolation and depression (Harvey, 2001).

What is the personality profile of eating disordered patients? Dr. Jim Kirkpatrick, agrees with other health professionals who found that eating disordered women share some common characteristics, such as low self-esteem, feelings of helplessness and fears of becoming fat (Gross, 1996). They have a tendency towards being a perfectionist, being achievement oriented, living in high stress familial settings, experiencing unstable intimate relationships, and suffering a history of trauma, sexual, physical or mental abuse. It is incorrect to assume that each woman fits into all the above categories; however, some of these characteristics are found to be true of a high percentage of the women.

Not Good Enough

Dr. Kirkpatrick found that his eating disordered patients, even though they may have been a good athlete or student, felt like they had nothing to offer the world. They may be blind to their own strengths and abilities, even though family and friends may tell them how wonderful they are (Kirkpatrick and Caldwell, 2001).

When patients attempt to go against this illness, the harshness or frequency of negative *voices* within them increase, telling them that they will never be good enough. This "negative mind" is at the core of eating disorders, according to Pierre-Claude, founder of the eating disorder program at the Montreux Clinic, in Victoria, British Columbia, as well as author and mother of two daughters who successfully recovered from eating disorders (Pierre-Claude, 1997).

Perfectionist

The eating disordered individual believes that any job must be done to some impossible preconceived notion of perfection. When unable to meet these unrealistic demands, the eating disordered individual is faced with failure and depression (Kirkpatrick & Caldwell, 2001). The combination of setting unattainable high standards and fear of failure fuels the development of poor self-esteem and a low sense of worth. It is difficult for her to state negative feelings because she believes her own needs and feelings are not deserving of the attention of others (Kirkpatrick & Caldwell, 2001).

To add to her confusion, this combination of nurturing and self-sacrifice is considered a strong positive *feminine* characteristic on the *Bem Personality Test*. However, on assessment tests measuring depression, the act of sacrificing oneself is considered a negative trait that increases the chance of depression. It is easy to see how women may be torn between what are and what are not considered positive attributes in western culture.

Need to Control

Eating disordered individuals would describe themselves as passive, powerless and controlled by others. Some practitioners believe that eating disordered women use the disorder to gain control over some aspect of their lives in order to combat feelings of helplessness. This sense of control may also extend into feelings such as anger, anxiety, shame or guilt (Harvey, 2001).

Anorexics react to any difficulty in interpersonal relationships by attempting to control their physical weight. This allows them to experience the illusion that a portion of their world is predictable and manageable. The eating disorder acts as a substitute for deeper feelings of unworthiness (Kirkpatrick & Caldwell, 2001).

No Boundaries

Joanna Poppink, a practising licensed psychotherapist, found boundary issues the core problem for women with this illness. She posits that recurring themes in eating disorders are the relentless boundary invasions on every level.

She refers to "boundaries" as the physical, emotional, psychological, intellectual, sexual and creative boundaries of individuals. The eating disordered individual experiences her boundaries as being consistently ignored and penetrated by others. Boundary invasions can vary in degree from the extreme, as in sexual and physical abuse, to lesser degrees such as a lack of privacy, not being listened to, or when one's goals or ideas are not taken seriously (Poppink, 2001).

With so many boundaries disrespected, the eating disordered individual does not develop the knowledge or skills for creating, recognizing or honouring her boundaries. With this loss of control, she experiences the previously mentioned helplessness, despair and feelings of worthlessness (Poppink, 2001).

Without learning to set healthy limits, the anorexic will starve herself to death in search of relief from her emotional pain. How can she stop herself when she is not able to stop anything or anyone outside of herself?

During a bingeing episode, bulimics will often describe themselves as being "numbed out." Eating is experienced as a blur, allowing them to be temporarily removed from negative feelings and emotions (Kirkpatrick and Caldwell, 2001).

Family Factors

Sir William Gull and Dr. Charles Lasegue, Parisian neurologists who published papers in the 1870s on a number of cases of self-starvation, found treating anorexia more effective when the patients were taken away from their

families. It was theorized that a lack of conflict resolution was a major challenge for family members. Speculations were also made that there was too much protectiveness and control of the child by the parents.

Today the "blame and shame" mentality is not as popular. Genetic predisposition, emotional makeup and life experiences are not within the power of the family to control. Eating disorders are complex and confusing afflictions in their cause and cure. These new findings have brought relief to families who have carried the burden and shame of this illness for many years (Kirkpatrick & Caldwell, 2001).

Spirituality

The term *spirituality* is often associated with religious affiliations, that is, Christianity or Judaism. The *Random House Webster's Dictionary* defines spirituality as the "animating principle of life, the mind or soul of humans" (Braham, 1998). The word spirituality comes from the Latin root *spiritus* which means "breath" referring to the "breath of life." It involves opening our hearts and cultivating our capacity for experiencing awe, reverence and gratitude. It is the ability to see the sacred in the ordinary, to feel the poignancy of life, to know the passion of existence and to give ourselves over to something greater than we are (Elkins, 1999).

James Pratt, an early twentieth century philosopher, spoke of an instinctive desire he called the "will to believe." Pratt claimed that the deepest of

all impulses born to human beings is the "instinct of self-preservation." Pratt further explains that this belief does not depend on human reason, but rather on a need that is as vital to the essential demands of the organism as the need to breathe. Even though many people may share a common religion/spiritual ideology, it is a personal and unique experience for each individual (Pratt, 1907).

Newberg and D'Aquili (2001) have been exploring the relationship between spirituality and the human brain, and have found that mystical experiences are observable and can be explained through human biology. Dr. Andrew Newberg is an assistant professor working in the Department of Radiology in the Division of Nuclear Medicine and an instructor in the Department of Religious Studies at the University of Pennsylvania; Dr. Eugene D'Aquili was a clinical assistant professor at the Department of Psychiatry at the University of Pennsylvania for over twenty years. These researchers believe that our physical brains are arranged in such a way that the mind is able to sense a deeper reality.

> As long as our brains are arranged the way they are, as long as our minds are capable of sensing this deeper reality, spirituality will continue to shape the human experience. (Newberg & D'Aquili, 2001, p.172)

In his writings of the third structure of human-time consciousness, Panikkar (1993) refers to the idea of trans-historical consciousness based on personal experiences of the *doubtlessness* or *epiphany* that some claim can transform a human being's life. These moments of *enlightenment* may have such

profound depth and meaning to the individual, that it is difficult to find words to portray the overwhelming insights and sensations that one may experience. These moments have been described as more real and vivid compared to other experiences. Perhaps these insights may be the only sure basis of spiritual and religious belief.

Jung's theory of archetypes posits that the collective unconscious, deep within the instincts of mankind, manifests itself through instinctive actions, recurrent themes, images and symbols (Wehr, 1987). He believed that spirituality was an essential ingredient in psychological health. He went so far as to say that he could heal only those middle-aged people who embraced a spiritual or religious perspective toward life (Elkins, 1999). Symbols and images vary according to the society that embraces them.

Individuals who may communicate with whatever the object of belief, *Brahman* or *the larger self*, the *Tao* or *Jesus*, all testify to the immediate experience of the smaller self that expands into a larger self. It is a loss of many small selves in union with a greater whole that is at the root of this experience (Pratt, 1907). It is this definition of spirituality that seeks to express itself from the deepest possible source of each human soul.

Perhaps women who suffer from eating disorders have become disconnected with this larger self? Practising counsellors Carol Normandi and Lauralee Roarke, who both had recovered from an eating disorder themselves, believe that true and permanent recovery must address the emotional, physical

and spiritual wounds beneath the surface. They are the founders of Beyond Hunger, a non profit organization in San Rafael. The name Beyond Hunger signifies the importance of looking beyond the hunger of our physical body, to the hunger of our soul. They believe that at the core of every eating disorder is a cry from the deepest part of the soul for help (Normandi & Roarke, 1998).

Spirituality and Eating Disorders

Perhaps women who suffer with eating disorders ignore the powerful answers that are within themselves. For many women the journey to recovery often involves some degree of spiritual crisis. There is no amount of starvation, makeup, clothing, dieting; no amount of removing and altering body parts, making bigger smaller, rounder, firmer; and no amount of money, status, number of children, husbands, or houses that can ever give a woman the answers she so desperately seeks. This crisis may be the beginning of her spiritual journey.

This paper explores the path of recovery of five women. What helped in their recovery and what did not? Did spirituality play a part in their healing? Like Carol Normandi and Lauralee Roarke, many women find inadequate solutions to dealing with their problem with eating disorders. Perhaps the traditional medical approach that focuses on healing the physical body and the psychological approach that focuses on the emotions and cognitive functions are not enough. The use of spirituality, whether it is through meditation, dance, yoga, visualization

exercises or simply learning to connect and trust one's inner intuition may prove to be a valuable tool in the healing of eating disorders. Perhaps when women begin to listen to their inner voices, they will also find their outer voices (Normandi & Roarke, 1998).

Chapter 2:

Literature Review

History of Anorexia Nervosa and Bulimia Nervosa

The earliest description of anorexia nervosa was written in 1689, by Thomas Morton, an English physician, in his book called *Wasting Disease of Nervous Origins*. Morton considered the condition "nervous consumption" to be caused by "sadness and cares" (Kirkpatrick & Caldwell, 2001).

In the 1870s, Sir William Gull and a Parisian neurologist, Dr. Charles Lasegue, published papers on a number of cases of self-starvation, now clearly recognizable as anorexia nervosa. Gull coined the term anorexia nervosa to distinguish the disorder from tuberculosis, just as Morton had tried to do centuries before. Gull felt that the disorder resulted from a "morbid mental state" and a "pervasion of the ego." Lasegue decided anorexia could be "hysteria," a common psychiatric grouping of female neurotic disorders at the time (Kirkpatrick & Caldwell, 2001).

Eating disorders, such as anorexia, have their roots as far back as the 13th century. They were seen in religious women who were canonized as saints for their fasting practices. These women were referred to as "holy anorexics." The culture where these young women lived valued spiritual health, fasting and self-denial much as our culture values thinness, self-control and athleticism. Holy

anorexia provided women with a highly valued status in both church and society (Kuehnel, 1998).

Saint Catherine of Siena, a religious devotee who lived in the 14th century, starved herself for very long periods of time as a form of spiritual fulfillment. When she did eat, she stuck twigs down her throat and forced herself to vomit as a punishment for breaking her sacred vow to not eat. She gained notoriety as a result of these practices, enabling her to affect the political and religious government of her time, until she eventually starved to death (Lelwica, 1999).

In the 1980's, Joan Brumberg (1988), a historian, dispelled beliefs among many who thought that anorexia was simply a fad that would pass with time. She believed that "fasting girls" were medieval martyrs who used starvation to demonstrate religious devotion. Still today, a number of young women regard their body as the best vehicle for making a statement about their identity and personal dreams (Brumberg, 1988).

Themes of self-denial, asceticism and abstinence are common to many religions. Purification of the body and soul through rituals involving fasting or avoidance of certain foods is well known. Holy men use fasting to reach higher and altered states of consciousness. In many faiths, this is still a method used to "purify oneself in the eyes of God."

Although descriptions of extreme overeating have been recorded for over two millennia, in 1979, Dr. Gerald Russell, a psychiatrist working at the Royal Free Hospital in London, England, was the first person to define bulimia nervosa

with a specific set of behaviours. One such behaviour was the deliberate or forced vomiting, which dated back to ancient times.

Seneca, a Roman Philosopher and statesman, is quoted as saying "men eat to vomit and vomit to eat." In the time of Caesar (100 BC), bulimia was demonstrated by the presence of "vomitoriums." "Eat, drink and be merry" included vomiting which allowed a person to return for additional eating, drinking and merriment. The ancient Egyptians would consume substances (called *emetics*) to make them vomit for a few days each month, thereby preventing diseases attributed to food (Kuehnel, 1998).

Historical View of Spiritual Healing

The method of healing differs according to culture and the time in history. Hippocrates, the Father of Medicine, viewed the treatment of disease as a dual process. One part was represented by systematic medicine; the other part was the full activation of the patient's own healing system. Over the centuries, in the West, there has been a shift away from the concept of the patient as the center of the healing process and the physician has become increasingly to the forefront as the dominant force (Smolan, Moffitt, & Naythons, 1990).

In Western society, health is defined in strictly clinical terms by physicians, with the fate of the spirit being relegated to religious specialists, who have very little to say about the physical well being of the living. However, for early humanity and for many societies around the world even today, the priest and

physician are considered to be one. It is understood that the "condition" of the spirit determines the physical state of the body (Smolan et al., 1990).

Early animistic cultures believed spirits controlled everything, including sickness and health. In this system, the *shaman*, a person attuned to the spiritual world, was the archetypal healer. When members of a tribe fell ill, the shaman used spiritual interventions to bring the patient back into harmony with the sacred world bringing back their health (Elkins, 1999).

In some cultures in the East, mankind is viewed as a mirror of the universe, infused with *qi* or *chi*, vital energy that courses through channels in the body (Smolan et al., 1990). Sickness is a disruption or an imbalance in the flow of energy that manifests as a negative force in the body. Good health is a state of balance and harmony that is considered to be "holy." In Latin America, the Western distinction between the physical and spiritual health simply does not exist (Smolan et al., 1990).

The roots of spirituality are apparent in mainstream traditions of the First Nations tribes in North America. They believe that humans are related in spirit to the environment that supports their lives. The trees, rivers, mountains, earth and sky are all sustained by a spiritual force that supports the very existence of all that is alive on our planet (Maher & Hunt, 1993).

Certain ancient and esoteric healing practices represent profound insights into the very nature of well being. *Ayurvedic medicine*, a 6,000-year-old tradition meaning "the science of life," is practised by more than 350,000 physicians in

India. Ayurvedic medicine teaches that patients become ill when their bodies and spirits are not in harmony. They prescribe meditation, massage, yoga and herb preparations, combined with diet and sleep modification (Smolan et al., 1990). They believe that every food is a medicine and everything in the universe connects with everything else.

> Spirit is made up of two winds that blow in us and through us. Everything we eat and do bestirs the yin wind and the yang wind. In my heart I understand that the body is a manifestation of the spirit (Smolan et al., 1990, p. 28).

Spirituality Today

Spirituality represents the fastest growing sector of the publishing industry. Millions of people are buying books on spiritual themes. Television programs such as Bill Moyers' "Genesis: A Living Conversation" and Hugh Hewitt's "Searching for God in America" have attracted large audiences. Newspapers and national magazines, including *Newsweek, Time* and the *New York Times Magazine* publish stories on "Faith and Healing," " Science, God and Man" and "Choosing My Religion"(Elkins, 1999).

This rekindling of interest is not only a return to traditional religion. An estimated 32-million baby boomers remain unaffiliated today, turning to Eastern practices, new age philosophies, "Twelve Step Programs," Greek mythology, Jungian psychology, shamanic practices, massage, yoga and a host of other traditions and practices. Many find spiritual fulfilment in music, poetry, literature, art, nature and intimate relationships (Elkins, 1999).

Some of the respected individuals in the history of psychology, for instance, William James, Gordon Allport, Erich Fromm, Viktor Frankl, Abraham Maslow, Rollo May, and Carl Jung have made spirituality a major focus of their work. They made way for Frankl's *logotherapy* and Maslow's *self-actualization* as the behavioural sciences began to move toward the understanding of the place of spirituality in determining overall health (Maher & Hunt, 1993).

As previously mentioned, spirituality is not necessarily about any particular mainstream religion, although it can be and should not be excluded. As Dr. Elkins, psychologist, professor and former minister said so beautifully:

> It is about the look of wonder on a child's face, the love we feel for a family member, the woods and fields after freshly fallen snow, the joy of soul-stirring music. It's about seeing the sacred in our lives and opening the door to a life of passion and depth. These are the moments that feed our soul and make our lives worth living. (Elkins, 1999, p.4).

How Is Spirituality Effective in Healing Eating Disorders?

Spiritual interventions have been used to promote a patient's religious and spiritual growth. This in turn assists the patient in coping better with problems (Richards, Hardman, Frost, Berrett, Clark-Sly, & Anderson, 1997). Professionals at the British Columbia Children's Hospital and St. Paul's Hospital, in Vancouver, British Columbia, work with eating disordered patients within a program based on the inclusion of spirituality.

They propose that the concepts of asceticism (the striving for perfection and purity) as well as putting the needs of others before your own (self-sacrifice) are common themes for patients with eating disorders. Dr. Pierre Leichner, a psychiatrist who specializes in eating disorders at the Children's Hospital Eating Disorder Program, and Marie Brown, the pastor at St. Paul's Hospital, facilitate a program called "Care of the Spirit." This program is designed to encourage eating disordered patients to explore their inner desire for a creative connection, while learning to recognize, express and develop their unique and beautiful spirit (Leichner, 2001).

Butler (1990) reported that many counsellors who work with those with alcoholism and other drug addictions suggest that it is the breakdown of the human spirit, the lack of purposeful direction, and the search for life's meaning that contribute to different forms of addictions (Maher & Hunt, 1993).

In the October 1999 issue of *Psychology Today*, Dr. David Elkins, writes:

> Spiritual intervention heals—sometimes when traditional psychotherapy fails—because they untie the mental and emotional knots that prevent the life force from doing its' work. (p. 45)

The best explanation for the effectiveness of spiritual interventions, whether performed by ancient shamans or modern day therapists, is that they draw upon the healing powers of the human "life force"; our body's natural inclination to survive. Research in body and mind medicine shows that we can significantly affect our health and well being through our beliefs, emotions and behaviour (Elkins, 1999).

Why More Women than Men?

"We've come along way baby," is a familiar cliché that has been used by advertisers since the suffragettes' great advances toward emancipation and self-empowerment, in the 1920s. This was one of the most significant social phenomena of the past century, having universal importance for the achievement of a separate identity for women (Angeloni, 1990). This quest for identity gave women the potential to enjoy freedom and independence as they perceived men to have had. Or has it?

Eating disorders are found to be more prevalent in women than men. More than ninety percent of eating disordered patients are female. Dieting and weight concerns are considered normative for women (Denmark & Paludi, 1993). If assumptions made about the *nature of one's truth* and *reality* shape the way we see the world and our participation in it, then it is important for women to examine their beliefs and the way they think and feel to understand the impact of these beliefs on their lives.

In the past, social and cultural systems have encouraged the control of appetite in women for different reasons. In the earlier era, control of appetite was linked to piety and belief achieved through fasting. The medieval ascetic wished for perfection in the eyes of her God. In western culture, the modern female's control of appetite is embedded in the social structure of family, class and gender. The anorexic today seeks perfection in terms of society's ideal of physical, rather than spiritual beauty (Lelwica, 1999).

Feminist author and lecturer Sandra Friedman, proposes that in a male-oriented culture based on competition, independence and detachment, qualities in girls that were once encouraged, such as consideration, co-operation, nurturing and politeness are now framed as needy, dependent, hysterical and indecisive (Friedman, 1997).

It is not surprising that women are held to be at greater risk for developing depression compared to men. In a gender role study by Hart and Thompson (1996) on depressive symptomology, women were found to be 2.1 times more depressed than men are. Researchers concluded that the most significant factor in depression studies is that women judge themselves more harshly by external standards compared to men, that is they see themselves through the eyes of societal norms to a greater extent (Hart & Thompson, 1996). It has been found that women are more dissatisfied with their bodies than are men are with their male bodies. In fact, dissatisfaction with ones body is so commonplace among women that is has been labelled the "normative discontent" (Bergeron & Senn, 1998).

It would appear that the realities constructing women's world have been shaped throughout most of history by male-dominated culture (Hughes, 1996). A woman's experience, however subjective, must take into consideration the expectations of society, stereotypes, limitations placed upon them, their status relative to men and the symbols and concepts of femininity (Gross, 1996). Let us explore further the place of women within a philosophical and religious context.

Women's Place in Philosophy

Embedded in the philosophical and medical theories of the ancient Greeks is the notion of the female as being inferior to the male in both mind and body. Greek philosophy assumed that women were inferior to men and defined them merely as child-bearers and housekeepers. This view was authoritatively expressed in the works of the philosopher Aristotle (Cox, 1997).

Aristotle thought in dualities. He considered action superior to inaction, form to be superior to matter, completion superior to in-completion, and possession superior to deprivation. He associated the male principle with the superior quality and the female with the inferior. The male principle found in nature was associated with active, formative and characteristics that were seen to be perfect. The female principle was regarded as passive, material and deprived and therefore desiring to have the male in order to feel complete in her self (Cox, 1997).

Men were identified with virile qualities, such as judgement, courage and stamina, women with their opposites-irrationality, cowardice and weakness. In the Aristotelian view, the male principle sought always to reproduce itself. The creation of a female was referred to as a mistake resulting from an imperfect act of generation (Cox, 1997).

For Greek theorists, the biology of males and females was key to psychology. The female mind was viewed to be softer and more docile, more apt to be depressed and deceitful. The male was strong in his intellect, active and

able to control his bodily desires (Cox, 1997). Is it surprising to find that some women lack self-esteem given centuries of women being considered in need of fixing in order that they are acceptable by men? We also find a similar stance towards women within a religious context.

Women's Place in Mainstream Religion

As patriarchal science stood on the principle of empirical investigation, scientists have been increasingly aware of the possibility of gender assumptions influencing their choice of data, methodology, investigation or the subsequent results (Wehr, 1987).

Patriarchal religion is also reflected in the sentiments of science. Men are often viewed as having a logical rational mind, to be held in great esteem, whereas women are viewed as being subject to desires and emotions of the body, which was deemed by patriarchal standards to have less value. As patriarchal religion became accepted and transcendent men were deemed to be above human criticism (Goldberg, 1979). The scorn for the female in general and the female body in particular became a basic element of Christian practice and symbolism (Gross, 1996). The ideal female symbol and one that is highly revered by the Christian faith is the Virgin Mary, who is considered to be virginal and holy through her unconsummated association with God and her mothering of baby Jesus, both of whom were male figures.

In 1486, Jakob Sprenger and Heinrich Kamer published *Malleus Maleficarum* (The Hammer of the Witches) which theorized the connection between witchcraft and womanhood. Detailed instructions were offered for the persecution and detection of witches. It was hardly surprising to find that more women than men were "infected with this heresy" given the negative attitude towards women. This next quote captures the mindset of the culture that many men lived by and many women died by.

> There are more women than men found infected with the heresy of witchcraft...and blessed be the Highest who has so far preserved the male sex from so great a crime (Griffin, 1995, p. 254).

If symbols and images are used as a vehicle for the expression and articulation of religious beliefs (Pratt, 1907), then what does it say about the symbols available to women for creating a healthy spiritual life? Mainstream religions such as Judaism and Christianity have always been chiefly concerned with the welfare of males and the exaltation of the male God (Goldberg, 1997).

These religious symbols and images carry great power as they are seen having been given to men by the divine God. These symbols represent the intricate connection between the divine and male authority and at the same time the lack of connection between the divine and female authority (Gross, 1996).

> No matter how some religious philosophers try to rescue the symbolic "God of religion" with an impersonal, shadowy and abstract principle, feminists have argued that "God is a man, no matter how much theologians try to veil his sex." (Goldberg, 1979, p. 29).

The following sentiments are expressed by a woman recovering from an eating disorder.

> I lost touch with my spiritual self at the moment in my childhood that I realized I was not God. I was a female. Man was made in the image of God. I was not a man. I was a woman. (Normandi & Roark, 1998, p. 130)

Perhaps, the rise in popularity of religions from the East in Western culture is a meaningful trend. Some Eastern religions hold the image of Goddess as being powerful like the male deities. It can be an inspiration for women to see themselves as divine creatures with their bodies described as sacred. Outside of Judeo-Christian dogma, the seasons and changes of a woman's life are considered powerful and holy.

It is through the symbol of the Goddess that many women claim they discover their inner strengths, enlighten their minds, own their bodies and celebrate their emotions. There is great freedom and empowerment in identifying with the symbol of the Goddess compared with the narrow constricting masculine roles offered by Judeo/Christian religions (Puttnick, 1997).

Pioneering Spirit of Mary Daly

Mary Daly, an author, religious scholar and an advocate for women's rights, writes from personal experience on the difficulty for women entering into mainstream religion in positions of power equal to men. Many women who tried to reclaim their spiritual heritage were discriminated against. They were refused

the right to participate in the leadership of the traditional religions as rabbis, priests and ministers (Puttnick, 1997).

Mary Daly would encourage women to wake up to the use of symbolic images by their culture, thus breaking the hold that current symbols have over their minds, bodies and spirits. She dreamed that this would allow women to create a community that was in union with the natural elemental world of animals, trees, stars and galaxies (Ruether, 1998).

There are widely varying views among feminists as to the nature of women's spirituality, however most agree to the basic premise of "refusal to create dogma." Learning from the effects of intolerance within the patriarchal systems, this attitude has led to a greater degree of tolerance among women's ideologies (Eller, 1993).

Spiritual practice can be expressed in different ways. They can range from the rain dances of the Native American Indians, the whirling dervishes of Islam to meditating monks of Zen Buddhism, from the ecstatic worship of services of charismatic churches to the solemn silent meetings of the Quakers. One can either support or obstruct the life force through our beliefs, emotions and behaviour (Elkins, 1999).

Studies in Spiritual Interventions and Modern Medicine

There are many reports of successful studies done linking the effectiveness of spirituality in the treatment of illness.

1. The Alameda County Study examined how the effects of religion impacted the stress levels of nearly 7,000 participants. Results found those who took part in church-sponsored activities were less stressed over finances, health and other daily concerns than those not involved with the church. Being less stressed was positively correlated to feeling better (Elkins, 1999).

2. The *International Journal of Psychiatry in Medicine* (1997) reported findings from an immunity research study conducted on 1700 adults. It was found that those adults that attended religious services were less likely to manufacture a substance prevalent in people with chronic disease, thereby maintaining better health (Elkins, 1999).

3. In 1990, Dr. Edward Shafranske of Pepperdine University and Dr. Newton Maloney of Fuller Theological Seminary surveyed 409 members of the American Psychological Association about their approach toward religion and psychology. Nearly all respondents said they assessed their patients religious backgrounds; 57% used religious language or concepts with patients; 36% recommended participation in religion; 32% recommended religious or spiritual books; 24% prayed privately for a patient; and 7% prayed with a client (Elkins, 1999).

4. Rorty, Yager and Rossotto (1993) found positive support for a spiritual focus as an important component of the healing process for many women. They interviewed 40 women who had recovered from bulimia. The most common

helpful factor in their recovery was religion, in the form of faith, pastoral counselling and/or prayer (Richards et al., 1997).

5. Hsu, Crisp and Callender (1992) did several follow-up interviews with recovered anorexia nervosa patients to find out what they attributed as the reason for their recovery. Many indicated the importance of religion, that is, prayer, church, and faith (Richards et al., 1997).

6. Researchers Hall and Cohn (1992) conducted two surveys in which they asked 366 women and 6 men, what activities had been helpful in their recovery from bulimia as well as other eating disorders. The results showed that fifty nine percent of the respondents claimed spiritual pursuits had been helpful. Thirty-five percent said a spiritually oriented 12-step program was helpful (Richards et al., 1997).

7. Yale epidemiologists Oxman, Freeman and Manheimer (1995) studied 232 elderly patients who had undergone open heart surgery. Those who found strength and comfort in their religious outlook had a survival rate three times higher than those who did not have a religious outlook.

8. Werner and Smith (1992) in a longitudinal study of resilience in poor multiethnic families on the Hawaiian Island of Kavai, found the faith was an important protective factor from childhood to adulthood.

9. Dr. Helen Baxter (2001) who works at the Leicester General Hospital found her eating disordered patients using significant more religious concepts compared to her other patients.

These studies suggest that there may be a link between spiritual intervention and health. It could be the support of a community within a mainstream religion, like Judaism or Catholicism, or perhaps the knowledge and belief of something *higher* than oneself is a valuable resource.

Jean Kristeller, professor of psychology at Indiana State University and Brendan Hallett, counsellor and prevention specialist, evaluated 18 obese women using standard and eating-specific mindfulness meditation exercises. They found that meditation was helpful in creating a sense of detachment and non-judgement towards the self. Their results showed that the bingeing behaviour of the women decreased, and the sense of control increased. They concluded that meditation training maybe an effective component in treating binge eating disorder. A surprising observation for the women was that giving up conscious control over their eating led them to having greater control (Kristeller & Hallett, 1999).

Dr. Randy K. Hardman and Dr. Michael Berrett, both psychologists at the Center for Change found deep spiritual struggles to be a major focus in their patients' ability to recover. Many eating disordered women are conflicted with intense emotions and inner turmoil (Hardman & Berrett, 1997). The bio-psycho-socio-spiritual model that has been widely accepted for several decades in understanding the etiology of mental disorders but has not been widely applied to the area of eating disorders (Leichner, 2001).

Dr. Pierre Leichner, Psychiatrist, and Dr. Ron Manley, Psychologist, at the Children's Hospital, in Vancouver, British Columbia, found several recurring themes working with eating disordered patients. The patients felt helpless and hopeless, felt undeserving of help, had an inability to recognize and express their feelings, felt shame and guilt, and anger and mistrust towards health care providers.

> Eating disorders are a leveler of experience, reducing life to a small caloric awareness and focus on food. (Leichner & Manley, 2002)

According to Dr. Leichner and colleagues (2001), spiritual values can reinforce self-nurturing beliefs and behaviour that is necessary for healthy living. Eating disorders represent a search for meaning, a desire for recognition and perfection, a hunger for a deeper and larger sense of themselves (Leichner, Brown, Atkinson, Henderson, & Jacek, 2001).

There are a number of studies that support the importance and effectiveness of religious and spiritual issues, in both the etiology and treatment of eating disorders. Although many studies found contradictory results, the majority agree that eating disorders and religious beliefs interact together in a significant way (Richards et al., 1997).

Eating Disorders from a Spiritual Perspective

The Center for Change

The Center for Change, in Orem, Utah, is a treatment center that specializes in the treatment of women with eating disorders. The medical team at the Center for Change is comprised of Dr. Scott Richards, the associate professor of counselling psychology at Brigham Young University, Dr. Michael Berrett, a psychologist, Julie Clark-Sly, PhD., Randy Hardman, PhD., and Harold Frost, PhD., all licensed psychologists. David Anderson is the emergency staff physician at the Utah Valley Regional Medical Center, and the medical administrator at the Center for Change. They all collaborated to study the most common and significant religious and spiritual issues among their patients. The following six religious and spiritual themes emerged among the women:

1. negative image of God
2. feelings of unworthiness or shame
3. fear of abandonment or disapproval
4. some form of dishonesty or deception
5. difficulty in trusting
6. feelings of guilt or shame around sexuality.

These concepts are now discussed in greater detail.

1. Negative Images or Perceptions of God

When discussing the negative images of God, the medical staff found eating-disordered patients tend to describe God as they would describe their parents. If they perceive their parents as rejecting, critical, controlling and angry, they often project these characteristics onto God. This negative image of God plays a significant role in their disconnection from spiritually based relationships. The following is an 18-year-old woman's description of her emotional experience with her family and her religious feelings.

> My eating disorder made me want to pull away from and go against my family's and parents' belief, causing me to pull away from God even more than I would have because my parents were so strong in their spirituality. (Hardman & Berrett, 1999, p. 2)

These negative concepts and images may be similar to Peggy Claude-Pierre's concepts of the "negative mind." She believes that it is this negative mind that sends forth a stream of negative, unkind and self-defeating words that holds the eating disordered patient in helpless horror. She believed that the negative mind uses every trick to destroy its victim, by either prompting her to starve or to refuse any help and affection (Claude-Pierre, 1997).

2. Feelings of Unworthiness or Shame

According to the Center for Change, many women with eating disorders believe that God and everyone else views them as flawed, unworthy and unacceptable. This is consistent with the lack of self-esteem characteristic of eating disordered women. From a spiritual viewpoint they have disappointed God

and are unworthy of his kindness and love (Hardman & Berrett, 1999).

In the following passage a 23-year-old female patient at the center gives an insight into her experience with her eating disorder.

> My spirituality decreased throughout my eating disorder because of the actions and behaviour I did in order to support my illness. The more wrong choices I made the more I felt undeserving of God's love. (Hardman & Berrett, 1999, p. 2)

Women with eating disorders use the very eating disorder itself as evidence of being bad, unacceptable and deserving of punishment. Some women believe that if God and other people are not going to punish them, they must go to great lengths to prove that they should be punished.

Eating disordered women have deceived themselves into thinking that perfection in their bodies will make up for their other perceived inadequacies and failures. Professionals describe eating disordered women as perfectionists, but this is really a false perfection because even when they receive acceptance or approval, the best they can ever do in their own minds is to *break even.*

3. Fear of Abandonment and Disapproval by God

According to Dr. Hardman and Dr. Bennett, a third theme that arose among women with eating disorders was a fear of being abandoned by God. Eric Erikson's first stage for normal emotional growth in a child is the development of trust. A lack of trust can lead to a fear of abandonment if they displease others. These fears are then projected onto God. Many women, sexually abused as

children, believe that God abandoned them when they were abused and helpless, thus, finding it more difficult to trust again.

4. Guilt and Shame About Sexuality

Many women with eating disorders dislike their bodies and confuse sex and love. They perceive an association between eating and sexuality (Abraham & Llewellyn-Jones, 1992). A 25-year-old patient at the center expresses her conflict between her eating disorder and her body image.

> My eating disorder became my God and my body became the Devil. Now, I feel a lot of guilt and shame in denying him. (Hardman & Berrett, 1999, p. 3)

Learning to love their bodies, not as a trophy, but as the temple of their soul is an important aspect of healthy self-esteem.

5. Difficulty Surrendering, Trusting and Acting in Faith

Many women who suffer from eating disorders experience a tremendous fear of a "loss of control." They are disillusioned thinking that they can avoid the things in life that bring them pain or criticism through controlling the intake and purging of food.

According to Hardman and Berrett, these patients control and numb their emotions to prevent experiencing their feelings. For these women the concept of *letting go* and having *faith* is truly frightening. They do not believe anyone can love or accept them as they are because they cannot love themselves.

6. Dishonesty and Deception

Common coping strategies among eating disordered patients include covering up, secrecy, lying and deception. For example, (a) they cover up how much they ate or did not eat, (b) the binges are done alone in private and, (c) purging behaviours are covered up by the sound of water running, etc. Many feel a great deal of shame and remorse about their deception and lying, compounded by feelings of guilt from failed promises to give up their eating disorder (Hardman & Berrett, 1999).

Dr. Hardman and the medical team at the Center for Change found religious and spiritual issues frequently intertwined with the pathology of their eating disorder patients. They found, on the one hand, religious issues to contribute to, exacerbate and help maintain eating disorders, while on the other hand, religious and spiritual resources and interventions were instrumental in their patient's healing and recovery. They concluded that spiritual issues and spiritual interventions should be given more consideration in the treatment of eating disorders.

Spiritual Awakening

It is helpful to go inside the minds of eating disordered women to understand how spiritual intervention can be helpful to someone who is suffering from an eating disorder. Compared to illnesses such as alcoholism and drug abuse, eating disorders are especially difficult and destructive because they deal

with food and nourishment, a part of life that is fundamental to well being. One can give up smoking, taking drugs or drinking "cold turkey," however food is necessary for the survival of the body making this recovery very difficult.

Eating disorders are an attempt at communicating one's pain and suffering. Sadly this form of communication is often misunderstood and not met with supportive or comforting responses. People with eating disorders are often told that they are selfish and seeking attention (Hardman & Berrett, 1999).

Eating disordered women often speak about how fat they feel or of how undeserving they are of love, rather than the deeper, real issues of their feelings of pain, loneliness and emptiness (Hardman & Berrett, 1999). The healing power that comes from developing a woman's spiritual life can give approval and comfort to her that is long lasting and reliable. Part of a spiritual reawakening is the discovery that, who they are *being* is as important if not more important than, what they are *doing*.

Does it matter whether one calls it God, Higher Self, or Buddha if through one's belief in it a greater trust and control in one's life is achieved? Spiritual interventions may provide another tool that can empower an individual in a world where the pondering of mankind's fragile existence can at times be paralyzing.

The power of a spiritual mind can replace the negative mind with thoughts of hope and creation. To see the changes in one's life that come through *thinking differently* is truly magical. A spiritual intervention that was being used in a spiritual program for eating disordered patients at St. Paul's Hospital, Vancouver,

British Columbia, is learning the art of yoga. This teaches inner control through meditation, as well as physical control through different breathing methods and postures, which can bring together the mind and body in greater harmony. This type of spiritual practice supports the mind body spirit connection and can create a healthier body image for women.

Therapy for the Recovery of Eating Disorders

According to the medical team at the Center for Change, there are several methods found to be successful in the treatment of eating disorders:

1. assigning religious spiritual therapy
2. encouraging prayer
3. spiritual imagery and meditation
4. encouraging forgiveness and compassion
5. encouraging patients to be involved in their religious/spiritual community (Richards et al., 1997).

Teaching Spiritual Concepts

According to Richards et al. (1997), eating disordered patients may have acquired dysfunctional religious or spiritual beliefs. For example, a woman may feel that she has done things that are unforgivable in the eyes of God, and thus, she may carry a sense of guilt. They find teaching spiritual concepts often crucial to successful psychotherapy. It is not uncommon to hear people speak of their

illnesses as a beginning to a new spiritual side of themselves (Richards et al., 1997).

Religious-Spiritual Bibliography

The Center for Change teaches spiritual concepts to patients by asking them to read scriptures and other spiritual literature about forgiveness, love, guilt, trust, spiritual identity and the role of suffering and pain. Some patients find reading and pondering spiritual writings an emotional and spiritual experience that gives them comfort, perspective, meaning and strength (Richards et al., 1997).

Prayer

The Center for Change recommends prayer for eating disordered patients as a tool for healing. Patients are encouraged to pray honestly and directly according to their beliefs. Prayer can be a useful tool in helping patients accept their bodies and improve body image. Prayer can also help a patient feel less isolated and more hopeful (Richards et al., 1997).

Spiritual Imagery and Meditation

Spiritual imagery and meditation requires trust, a sense of letting go, a focus of attention, an overall awareness and relaxation of the muscles. Spiritual imagery and meditation can be therapeutic for allowing patients to become more in tune with their inner emotional and spiritual feeling (Richards et al., 1997).

Encouraging Forgiveness

Much has been written about the importance of forgiveness in healing and therapy. According to Richards et al. (1997), it is one of the most frequently used spiritual interventions in psychotherapy. Helping eating disordered patients to forgive parents, abusers, themselves and God is found to be important in the healing process.

The idea of forgiveness is explained as a gift or a choice rather than a requirement. The patients are encouraged to be open to love and to understand self-forgiveness as a healing process requiring responsibility and accountability rather than self-punishment. True forgiveness is a result of inner understanding and compassion (Richards et al., 1997).

Seeking Spiritual Direction for Healing

Spiritual leaders can provide meaningful spiritual and emotional guidance to clients. When inpatient treatment is completed, religious leaders can assist in patient aftercare by making use of the social and emotional resources in a patient's community (Richards et al., 1997).

Although, some religious leaders are supportive, others may relate in a controlling and shaming manner. It is the same for doctors, lawyers and psychologists. Some eating disordered patients do not want spiritual guidance from a religious authority because of unresolved feelings of resentment and anger towards them (Richards et al., 1997). Alternative spiritual resources may

be explored further to find a better fit. A good counsellor will ask the questions to find out the belief structure of the patient and use this to help them.

Dr. Hardman and Dr. Berrett of the Center for Change, found women who are in the severe stages of an eating disorder powerless to change on their own. They were empowered by the thought of something more powerful than they are to help them. A 23-year-old patient expresses this as follows:

> My spirituality and my relationship with God have given me, hope and strength. Whenever I am too weak or out of control or just lonely, I can close my eyes and imagine God and his Angels with me. My faith is unstable right now, but even that helps me. If ye have faith as small as a mustard seed, nothing is impossible for you. (Hardman & Berrett, 1999 p.10)

As mentioned before, spirituality and religion are not necessarily the same thing. Some people who find the church to be oppressive and filled with negative symbolism and dogma, may seek alternative spiritual paths for healing.

One such spiritual approach is expressed by Dr. David Elkins, professor and author of the book *Beyond Religion*, who believes that spirituality is a universal phenomenon available to every human being in all cultures and not exclusive to any religious group of people. Whether or not someone is religious, they can still learn to access the sacred and nurture their souls. Elkins credits spirituality as an essential element of human happiness and mental health (Elkins, 1998).

It is not surprising that for thousands of years, long before the advent of modern medicine, people looked to spirituality for cures. Contemplation,

meditation, prayer, rituals and other spiritual practices have been known to release the *life force* in the deepest levels of the human soul.

Similarly to the use of spiritual interventions at the Center for Change, Dr. David Elkins cites four ways to begin one's spiritual journey of healing without placing emphasis on mainstream religious dogma. They include some form of relaxation, meditation, prayer, spiritual readings and being in nature.

"There is no greater source of strength and power for me in my life now than going still, being quiet and recognizing what real power is," said Oprah Winfrey on her daily television show segment called "Remembering your Spirit." According to Dr. Kenneth Pelletier (1993), physician at Stanford Center for Research in Disease Prevention, the use of meditation, visualization, hypnosis, biofeedback and numerous relaxation techniques show promise in helping to prevent and treat diseases, such as heart disease, headaches, stomach pain, panic attacks, depression and psychological disorders (Pelletier, 1993).

Meditation is becoming widely used to support the work of therapy. It offers a way for the mind to seek clarity and the heart to find tranquility. Meditation can empty the mind of *negative chatter*, ease suffering and rid the body of tension and pain. According to Jennifer Keane, a registered clinical counsellor, the practice of meditation is beneficial for some women suffering with eating disorders. Women may achieve a greater sense of awareness, greater sense of presence in the body, increased acceptance of being "perfectly good enough" and a greater sense of self worth. It may give the women a greater

ability to cope with stress in her life through physical and mental relaxation (Keane, 2002).

Prayer may be the oldest spiritual practice and the most popular one in America. It is defined as a mental and emotional release along with a sense of connection to a transcendent dimension and may be at the core of prayer's effectiveness. An emphasis on spirituality has been a key component in the Twelve-step program of recovery from addictions used by Alcoholics Anonymous (Walsh, 1999).

The Eating Disorder Research Center in Vancouver, British Columbia offers referrals to anyone needing information or help. There are services that focus on body such as nutrition, medical doctors, exercise management, dance therapy, bodywork, and dental management. There is also art therapy, play therapy, support groups, family therapy, psycho-education group. There are complementary health models that include homeopathy, meditation and spirituality as an alternative intervention (Miller, 2000).

A technique used by the Montreux Clinic is unconditional love that attempts to work against the "negative chatter" (Claude-Pierre, 1997) in the mind of the eating disordered individual. The power of touch, one of the oldest of the healing arts, now called "massage" or "physical therapy" known for centuries as "medical rubbing" may also be a useful complementary tool for healing this illness (Smolan et al., 1990).

Treatment Using Psychotherapy

The American Psychiatric Association's (APA), based in Washington D.C, is a scientific and professional organization that represents psychologists in the United States. The practice guidelines for the treatment of eating disorders states that patients with eating disorders may display a broad range of symptoms that occur along a continuum between those of anorexia nervosa and those of bulimia nervosa.

The goal for the treatment of anorexia nervosa is to restore patients to a healthy weight, reduce the threat of physical complications, enhance the patients' motivation to cooperate (usually administering antidepressants, e.g., serotonin reuptake inhibitors) and provide education about healthy nutrition. Other goals of treatment include the correcting of maladaptive thoughts, attitudes and feelings related to the eating disorder, enlisting family support and attempting to prevent a relapse (Miller, 2000).

One cannot stress enough the importance of preventative measures to keep symptomatic behaviour from evolving into a full-fledged eating disorder (Brownell et al., 1998).

A multidisciplinary team, consisting of physicians, dieticians, behavioural-cognitive therapists, psychotherapists or nurses may be required depending on the severity of the disorder. A physician is needed to determine that the patient is not in immediate physical danger. A nutritionist is assigned to help assess and improve the nutritional intake.

Psychology plays an important role in the successful treatment of eating disorders. The psychologist identifies issues that need attention and develops a future treatment plan. She may help the patient replace destructive thoughts and behaviours with more positive ones. For example, a psychologist and patient might work together to focus on health issues rather than weight, or a patient might keep a food diary as a way of becoming aware of the types of situations that trigger bingeing.

Once the patient's pattern of behaviour is changed, psychologists and patients may explore the psychological issues underlying the eating disorder. This may improve the patient's personal relationships and may explore the situation that initially triggered the disorder (Brownell et al., 1998).

Medical Treatment

Deborah Kuehnel, a licensed clinical social worker, working with addictions for over fifteen years, found that, as mentioned before, the medical treatment for eating disorders depends upon the severity of the symptoms surrounding the eating disorder itself. If the client is seriously in danger, for example, purging herself to the point of hemorrhaging, or suffering decreased body weight to the point of complete malnutrition immediate medical hospitalization may be required followed up with an in-patient psychiatric hospitalization (Kuehnel, 1998).

An optimal in-patient hospitalization program at a psychiatric facility is set up by the treatment team that may consist of the client's medical doctor, psychiatrist, social worker, psychologist, nurse, recreational or art therapists as well as a dietician. This attempts to create a very controlled and safe environment in order that the client may begin to destroy the cycle of their dysfunctional behaviour (Kuehnel, 1998).

There are additional forms of treatment considered as out patient care. Partial hospitalization is the most intensive "out patient care"; the patient goes home at night and returns to treatment the following day. This is beneficial as it allows the patient insight into certain aspects of their everyday life identifying troubles and concerns.

The "intensive out patient" program consists of approximately three meetings a week for a three hour session each time. The other programs are considerably less time consuming and are not considered a form of hospitalization. Individuals suffering from less severe eating disorders often consider individual or group therapy. This may take one or two sessions per week.

The use of medication is a major part of the APA guidelines, but not all patients will respond to or even accept a recommendation to begin psychopharmacological treatment. The most widely used researched medication for eating disorders are antidepressants. These include tricyclic antidepressants, monoamine oxidase inhibitors, and the serotonin reuptake inhibitor fluoxietine

(prozac, paxil). Antipsychotics, lithium carbonate, appetite stimulants, anticonvulsants as well as neuroleptics are used to control the anorexic's bizarre eating patterns and delusional manifestations (Zerbe, 1995).

It is not uncommon for a patient with an eating disorder to also have additional maladies. Depression often accompanies eating disorders. This depression may be alleviated through the combined treatment of medication and counselling the client to express their emotions. Other common diagnoses involve mood disorders, chemical dependency, obsessive compulsive disorder as well as some personality disorders.

Today's research supports a combination of different modalities. It suggests that no one single form of treatment is necessarily effective. A combination of antidepressants, group therapy, nutritional counselling, cognitive-behavioural approach and psychodynamic techniques may provide the most beneficial treatment approaches in terms of recovery (Zerbe, 1995).

Clients who frequently express an overwhelming aloneness with regard to their eating disorders may benefit greatly from group therapy. Feedback and hearing the voices of others is immeasurable in terms of its effect on the recovery of the client. Group work may also assist in establishing better interpersonal relationship skills.

Many women begin to feel comfortable expressing their own feelings through having their primary emotional needs met. Supportive therapy can provide a safe environment in which the client may try new ways of behaving

while learning how to care for themselves in a healthier manner. Once the client feels safer, many issues of spirituality, sexuality and body image surface (Kuehnel, 1998).

Therapists may find themselves in a battle of the wills if there is too much emphasis placed on food related issues. The Association of the Awareness of Disordered Eating (ANAD) teaches their group facilitators to avoid issues around food, weight and body shape during their workshops. The idea is to keep the women focused on exploring their feelings hidden beneath the surface.

Dr. Pierre Leichner and other therapists working with eating disordered patients, have found that some episodes of relapse may be part of the recovery process and can be incorporated into the healing process as a valuable learning tool. It is important to keep in mind that, although someone with an alcohol problem may recover by avoiding alcohol altogether, an eating disordered patient must confront food on a daily basis. Teaching the client to be patient and gentle with themselves is helpful in order that they may find their own unique path to good health (Kuehnel, 1998).

Limitations of Study: Controversial Debate

Spiritual intervention in the recovery of eating disorders is not without its challenges. The perceived benefits, such as, the attention and approval of their thin body for the anorexia, and the physical release and numbing out of emotions for the bulimic and binge eater, can be a hard thing for the patient to give up. Dr.

Hardman and Dr. Berrett found that there are other barriers to spiritual reconnection, as the patient's struggle with spirituality can often influence the onset and maintenance of the eating disorder (Hardman & Berrett, 2000).

The use of spirituality is debated among some physicians. Some say spirituality is good for the patient's health and should be encouraged. Others say physicians have no right to tread on such sacred ground. Anita Slomski interviewed two physicians with opposing views for the *Medical Economics* magazine. Dr. Harold G. Koenig, director of the Center for the Study of Religion and Spirituality and Health at Duke University, believes doctors should pray and actively encourage religious patients to maintain their spirituality (Slomski, 2000).

Dr. Koenig is one of many researchers to claim that religious activity promotes a long list of health benefits. Among them are greater life expectancy (from seven to 14 years), lower blood pressure, a stronger immune system, sixty-percent lower risk of dying from heart disease or pulmonary emphysema, less depression and an increased survival after cardiac surgery (Slomski, 2000).

Some experts, however, like psychologist Dr. Richard Sloan claim the link between religion and health is "junk science." Dr. Sloan, director of the Behavioural Medicine program at Columbia-Presbyterian Medical Center in New York warns that physicians cross ethical lines by delving into the very private realm of patient's belief systems, especially given the lack of empirical evidence that religion actually improves health outcomes (Slomski, 2000).

Dr. Sloan is concerned that doctors advocating religion and spirituality to patients may actually cause the patient a greater degree of guilt. Patients may feel that they did something bad to deserve their illness. It sets up the pattern of thinking that good people do not get sick only bad ones. Many people already feel "what did I do to deserve this?" when illness strikes close to home (Slomski, 2000).

Perhaps the solution lies between these two lines of thought. The goal here is not to convert anyone to a religious way of thinking, rather, to explore the patient's existing beliefs and use these beliefs as a starting place for a healthier life. To ignore the spiritual life of an individual is to ignore a significant tool for healing.

Summary

In this author's current practice of facilitating workshops with eating disordered women, very few sessions ended without some mention of spirituality by one of the participating women. It would appear that there is a need for this aspect of one's life to be addressed.

The supporting health benefit of spirituality is a growing body of research. The Harvard Medical School of Continuing Education presents a course, "Spirituality and Healing in Medicine," bringing together religious scholars and medical leaders from around the world to discuss the role of spirituality in the treatment of illness and pain (Elkins, 1999).

Some practising psychologists and psychiatrists believe that there is a need to come together as specialists in the varying fields of healing to learn from each other (Leichner & Manley, 2002). In the past spirituality and religion have been left out of conventional clinical training, practice and research. The inclusion of spiritual issues in the latest revision of the *DSM-IV* is indicative of the growing recognition of their importance in mental health assessment and treatment (Walsh, 1999).

In *DSM-IV*, it states that the Religion or Spiritual Problem category can be used when the focus of attention is a religious or spiritual problem. Examples include, any situation that may be causing distress that results in loss of faith or questioning of one's spiritual values that are not related to any organized church or religion (Walsh, 1999).

For women with eating disorders there are recurring themes of low self-worth, seeking of perfectionism, inner negative talk, feeling that they are not good enough, lack of good boundaries and control issues. According to Deborah Kesten, a nutritionist and lecturer, who writes about the connection between spirituality, food and health, the complete picture of the causes for eating disorders lies in the "culturally nurtured spiritual starvation" that is within women's lives today (Kesten, 1997). Perhaps this is a place to look for a cure as well.

Due to the mysterious nature of eating disorders as to cause and cure, the methods of recovery need to be multifaceted. Exploring the role of spirituality in

the recovery of eating disordered women may be a good place to look for clues in effectively healing this illness.

Chapter 3:

Methodology

This study examines the experiences of five women who have successfully recovered from an eating disorder.

In choosing a methodology for this paper, several different factors were considered to be important.

1. What method would be an effective and useful way of obtaining this information?
2. What type of methodology lends itself to creating a deeper understanding of the experience of women who have suffered from this illness?
3. Who would be able to articulate their experiences?
4. Could a safe and comfortable environment be provided that would encourage women to speak freely and honestly?

The qualitative approach is both effective and useful in studying and exploring the personal experiences of women with this illness. The nature of qualitative formats may be effective in uncovering the intimate truths about this illness. As important as it is to determine the number of women who have successfully recovered from eating disorders, it is important to understand the personal experiences of each woman: this is how we gain deeper insight into how women with this illness may be helped.

Lincoln and Guba (1985) support qualitative research as "naturalistic." There is a greater interest in understanding how things occur rather than simply identifying outcomes (Padula & Miller, 1999). Qualitative research explores the experience of the individual with the underlying premise that we are all unique beings. In the midst of a snowstorm it is impossible to see that each snowflake is distinct and unique. Qualitative research acts as a sound backdrop against which to describe the personal experiences and expressions of these women.

Although both quantitative and qualitative methodology may share a similar fundamental goal in gaining a deeper understanding into the human condition, the tools used differ. The understanding of personal experience may be better understood through the tools of qualitative research. It has the potential to provide a deeper understanding of the uniqueness of human experience.

An understanding of the experiences of eating disordered women is essential to finding a cure. The process by which people construct meaning and describe what those meanings are enables psychologists, educators and counsellors to better meet the needs of eating disordered women (Padula & Miller, 1999).

The truth of any individual is imbedded in the emotional context of the story. It is therefore important to listen to *women's voices* to increase and deepen our understanding of women's experiences with this disorder. This process is explored through one-on-one interviews with the women.

Qualitative researchers agree that reality is socially constructed. The variables are complex and interwoven, and that makes it even more difficult to measure (Campbell, 1996). This research gives careful consideration to the historical significance of this disorder as well as the societal influences that may affect it. The women are asked to define *spirit* so that there is a clearer understanding of the meaning of this concept for each woman during the interview.

Researchers describe qualitative methodology as inductive because the hypotheses are not established before the theory emerges from the data. This differs from quantitative research that tests or verifies pre-existing theory (Padula & Miller, 1999).

Inferences are drawn from the interviews with the women with the purpose of increasing understanding of this illness and of the women who have suffered with it. The literature review covers the various theories on eating disorders within the context of historical influences. It is important to conduct qualitative research with a *Beginner's mind*; the mind that is open to new possibilities, as free of preconceived ideas and judgements as is possible. It is important to remember that one person can never assume to fully understand how another person may experience their life.

Cresswell (1994) posits that the qualitative researcher interacts with the participants and cannot function apart from context and participants. This adds sensitivity and responsiveness to the research process. Qualitative research

focuses on the participants' perceptions, their experiences and how they make sense of their lives (Padula & Miller, 1999).

The researcher and participant are acting as partners, as co-researchers and co-participants, explaining and sharing ideas and experiences. The researcher initiates the questions and is as much a part of the process and outcome as the participant. The participant and researcher both affect and create the depth and richness of the interview.

The women were able to express themselves in an open-ended yet structured manner. Particular use of direct quotes from individuals have been used to increase the understanding of eating disordered sufferers in a more direct and authentic manner compared to questionnaires or rating scales. This study attempts to remain true to the authenticity of the data and acknowledges the story of these five women. There are many other voices that are equally valid and profound that are yet to be heard.

Asking the Questions

The questions asked in this study focus on several considerations. The first is to explore the life circumstances of the individual and the personal experiences of their lives at the time of the disorder. The second important consideration is to examine how these women coped with their eating disorders. What are the identifying factors that were influential in their overcoming this disorder?

The questions were as follows:

1. What do you believe led to you having an eating disorder? This question examined the (external and internal) influences and circumstances in the lives of the women before their illness began. This question explored the woman's own views, attitudes and reasons as to why she developed such an illness.

2. How do you define the word spirit or spirituality? Each woman's definition of the term spirituality and spirit was explored. This was important because for some people the term spirituality is equated with religion and to others it is not. Spirituality can conjure up very different images for everyone; for one person it is going to church every week, for another is can be saying prayers while they bake bread every day. It is important to define the terminology and not to assume that we are speaking of the same thing. Another point to consider is the understanding of the term spirit. How this understanding and the existence of spirit affected the women's lives and their healing process?

3. How did you experience your spirit as a child? Was it different from the spirit you live with today? These questions are intended to explore the remembered spiritual essence of the individuals when they were children, compared to how they feel they experience their spirit now. The implications of this question is whether spirit grows within oneself over time or has it always existed and needed only to be remembered and rediscovered? Is spirit a

constant in someone's life that grows and changes or is it a something that stays the same?

4. What do you believe has helped you overcome this illness? This question explores the understanding of the individual woman regarding the factors that assisted them in their healing from this illness.

5. Do you believe that your idea of spirit or spirituality helped or played a part in your healing of the eating disorder? This question focused on whether or not the women believed that their understanding of spirit had helped in their recovery and how they understood this help to have taken place.

The questions were chosen to assist in the deeper understanding of spirituality in the lives of eating disordered women. The questions are strongly linking the women's thoughts to spirituality and their experiences around it. This may influence their answers when answering the question of what led them to recover from this illness. This question affords them an opportunity to say any thing that they remember that would have helped or hindered them in their recovery. Asking the questions in a different order may have influenced the women in giving slightly different results, perhaps that spirituality was more or less prominent in their lives. Since the focus of the paper is on the role of spirituality, it may have already had the effect of getting the women thinking along those lines. Asking what has helped you recover from your eating disorder without any mention of spirituality may have given the women a different focus, although it may not have explored the depths of each women's illness. Asking

the questions may afford the opportunity for the women to apply the concept of spirituality to their illness.

Research Design / Data Collection / Data Analysis

This research design uses purposeful non-random sampling to increase the utility of the information obtained. The chosen participants were knowledgeable and informative about the topic under discussion (Schumacher & McMillan, 1993).

All five women chosen to participate in the interview process professed to having had an eating disorder and successfully overcame it. The criteria considered when choosing the women were that they be articulate in expressing their emotions and experiences about their illness. It was also important that these women be free of any perceived risk of relapse or emotional setback, thus the imposed criteria of being free from an eating disorder for four years or more.

The women chosen to participate in this study varied in age from 23 to 60 years, as well as in religious affiliations, socio-economic backgrounds and ethnic heritage.

It is understood and acknowledged that there are many women who successfully overcame this illness that have not been interviewed. Four of the women reside in urban British Columbia and one in Portland, Oregon. Of these women, one actually volunteers at her local Eating Disorder Research Center.

She lectures about her past battle with anorexia nervosa and her success in overcoming it.

The other women are from various women's groups or past acquaintances that have crossed paths through mutual friends and through word of mouth when the author has mentioned interest in this topic. The women had at some point in the conversation mentioned that they had an eating disorder and successfully overcame it. These women have agreed to speak about their experiences.

Why Exclusively Women?

This study interviews only women for the following reasons. In the research it became evident that although eating disorders are not solely a female problem, ninety percent of eating disorders are statistically found to be within the female population. The fact that this study looks only at eating disordered women is in no way intended to diminish the seriousness of this illness in the lives of men who suffer from it.

A theoretical framework for understanding women's development has never existed that is not based on a comparison to men. Carol Gilligan, renowned women's author in women's development, observed that scientific research done primarily on men has been generalized to women (Belenky, Clinchy, Goldberger, & Tarule, 1986). It is therefore important not to generalize across sexes, races or cultural experiences. Although there may be similarities between populations, the results cannot be generalized across all populations without certain critical understanding and mutual respect.

Furthermore in this study, even though the sample is small, it is the author's hope that the results are poignant and indicative of potential future research.

Data Analysis

It is impossible to be completely free and objective from all biases. We see our world through the lens of our belief systems that are based on past family, school and life experiences. It is difficult for two people to agree on the same external event occurring right before their eyes and even more difficult to agree on past feelings and experiences that tend to be more internal and subjective in nature.

In this study, the researcher has guarded against personal biases through the recording of detailed notes through the use of a tape recorder. The integrity of this research has been protected through an extensive process of self-reflection and introspection.

A greater degree of intimacy between the researcher and the women in the study has been achieved, through the assurance of anonymity for the women being interviewed (and thus the use of fictitious names).

Descriptive and interpretive analysis are used to provide a detailed narrative account of the women's experiences, with eating disorders, allowing for a deeper understanding of this phenomenon. The gathering of data has been conducted in an informal interview lasting approximately two to three hours in duration. As a follow-up interview, each woman was given a copy of the

researcher's final completed notes for approval. These notes consisted of the researcher's interpretation of the interviews, and each woman was asked to comment or change what they felt was not accurate or did not express what they were trying to say. This was done in order to ensure the validity of the results.

Each woman was given personal control in choosing the place of the interview ensuring greater feeling of safety, comfort and relaxation. This was done in hopes of supporting an atmosphere that fosters honest and insightful conversation.

Interviews

The form of data collection chosen for this study is semi-structured personal interviews. Reinharz (1992) identifies semi-structured interviews as the primary data-collection strategy used that allows women the opportunity to construct data about their lives. Compared to surveys or questionnaires, this form of data collection allows for greater depth and personal intimacy of feeling.

In understanding any situation the reader can read not only the words of the individuals being interviewed but also the words and perceptions of the interviewer. This gives the reader a greater view as well as a larger, richer set of perceptions and subsequent understanding.

Interviews allow researchers to more readily access women's perceptions, feelings, ideas and memories. Bogdan and Biklen (1992) described interviews as being purposeful conversations allowing researchers to gather descriptive data in

the participant's own words that develops insights into the participant's world. Leahey (1989) describes the process of collecting and analyzing data in qualitative research as an important skill involving:

> Being able to listen and interview in depth, being able to summarize and to take the whole context into consideration during interpretation, being sensitive to implicit aspects of human expression, and finally being able to create a research situation of mutual trust and understanding. (p. 2)

Researcher's Own Experiences

My experience of eating disorders enables me to empathize with women who suffered from this illness. An eating disorder affects one's family, friends and every aspect of one's life. Living with a close family member who has suffered with this illness enabled me to be empathetic during the interview. I share the world of being a woman raised in western culture fallen prey to years of constant dieting to achieve that perfect weight in a society where one can never be too thin.

These perceptions and experiences allow me to understand the world of the eating disordered woman, speak their language and empathize with the cries of their souls. These experiences may lend credence to my questions in the lives of these women. It is my hope that they may feel heard, valued and understood.

The Women in the Study

Anne

Anne is a 47 year-old Caucasian woman born in upstate New York, U.S.A. During her life she travelled extensively through the United States. Her parents divorced when she was six years of age leaving her mother to remarry three times as Anne was growing up. She has no children by choice and is currently divorced and "living single by choice" as well. She lives comfortably as a retired heiress in Oregon USA.

Jo

Jo is 32 years of age, a Caucasian woman living and working in Vancouver B.C. She used to work in a pastry shop and is currently planning to go back to school for a degree in counselling. She was 8-years-old when her parents divorced. Both her mother and father remarried soon afterwards. She is single, never married and has no children.

Sage

Sage is a 23-year-old Caucasian woman born in Ontario, Canada. She is currently working full time planning to go back to school. Her parents were divorced when she was ten years of age. Her mother remarried. Sage lives with her boyfriend in Vancouver.

Lorraine

Lorraine is a sixty-year-old Caucasian living alone in her elegantly decorated apartment. She currently works as a mortgage broker with previous realtor experience for 20 years. She has three married children, as well as three grandchildren. She has been married and divorced three times. Her first marriage lasted for 22 years; the second marriage lasted 2 weeks; the third marriage ended after several years. She lives with her dog in Vancouver.

Sally

Sally is a 47-year-old Caucasian woman, born in Ontario, Canada. She is a single mother with two children ages 5 and 10 years. She is currently employed full time as a secretary for a Victoria firm. Her parents have been married for almost 50 years. She has been divorced twice and plans to be married to her childhood sweetheart in the next year.

The next chapter details these women's struggles, spiritual experiences and recovery.

Chapter 4:

Results

The following results summarize the interviews with the women divided into the respective questions asked.

Anne's Story

Anne grew up in an American family with a very strong maternal figure. Although her family was extremely affluent, her mother suffered with alcoholism and manic-depression. She would "live on cigarettes and coffee and then binge on pastries." Anne described her mother as being very vain in her appearance and weight.

She spoke of her home life growing up as troubled with the divorce of her parents and the multiple marriages of her mother. Anne remembers herself as being an athletic child until the age of ten when her behaviour changed from co-operative and healthy to overweight, disruptive and lethargic. She attributes this change to being sexually abused by her older sister who acted out the sexual abuse that was being perpetrated on her by their stepfather.

When her weight reached 180 pounds her mother, "embarrassed by her appearance," asked their family doctor to "fix her." He then prescribed amphetamines for weight loss. After months of taking these prescribed drugs

Anne succeeded in losing weight. She eventually stopped taking the pills and gained the weight back.

In college she eloped with her boyfriend and moved away from her family. Her husband joined the navy; that left her living alone for long periods of time. She recalls these times as strangely pleasant, "I was able to have the perks of being married and yet live by myself."

Anne spoke about her reasons for not having children.

> I didn't want to have children because I was afraid of being tied to another human being and I was also afraid of becoming grossly overweight as pregnancy to me was another form of obesity. If I had a child I feared that I would love that child obsessively and would become a martyr to that child. I had a negative body image.

After years of marriage she and her husband decided to attend an actualizing workshop, popular in the 80s, to increase intimacy and deepen their relationship. During this time her husband fell in love again but not with Anne, instead with a 17-year-old girl.

Devastated, Anne had no marketable skills with which to find employment and lived far away from family support. She fell into a state of despair.

> I stopped eating and slept most of the time. I hung blankets over the windows so no light could get in. I was obsessed with the fact that I could still see some shadow or crack. I was trying to create total blackness. When I wasn't numb and exhausted I was crying.

She sought out the counsel of a therapist who was also a student of eastern religion. Expecting to discuss her immediate problems of not eating and feeling depressed the therapist surprised Anne by what she said, "we are not

going to talk about your marriage, your past or your childhood. We are just going to get you functioning again."

Anne was told to focus on eating one meal a day, and to choose one thing per day that she really liked to do. For Anne this was organizing. She was asked to go home and eat one meal a day and organize her home until one day she took down the blankets from her windows and let the light in.

Anne's Definition of Spirituality

Anne defined the word spirituality or spirit as follows:

> I am always questioning and seeking for higher and higher truth. I see myself as someone who is never satisfied with just what the world has to offer, there must be something bigger and grander.

For Anne, the word *spirituality* refers to a hunger not satisfied by materialism. It must see a grander nobler purpose in life in order to be fulfilled.

Anne was not given any formal religious teaching as a young child, yet she believed that she had a consciousness that inhabited her body. Her spirituality needed to have a relationship and connectedness with a higher being, whether it was a God or the creator or the universe.

She described her idea of this creator as follows:

> It is like holding a paradox, I want a personal God who cares about me individually and knows me intimately but I also want a God who is bigger than that, a God who creates suns and galaxies and stars. I want both, the macrocosm and the microcosm.

Anne's Experience of Spirit as a Child

Anne described herself as one of the "nature children" who loved to lie in the grass, inspecting the plants and watch the ants building homes. She preferred to be in nature writing poems about flowers and clouds rather than in the company of other people. Anne remembers her development of spirit from a child to an adult as a feeling of greater peace within herself and her body. Human beings stopped being "intruders" in her world and became a part of nature and interconnectness of everything in the universe.

Anne Recovered from Her Eating Disorder

Anne credits recovering from her eating disorders to therapy, and the reading of many books on psychology. After many years of seeing the best and most expensive psychiatrists/psychologists the really big "mucky mucks" as Anne called them, it was a psychiatric nurse practitioner who put the pieces of the puzzle together bringing her childhood trauma and her mother's illness of manic depression to light.

It helped Anne to understand brain chemistry and learn to observe and monitor her own behaviour.

> I have a stronger voice internally now that says, wait a minute, you don't have to abuse yourself to the point of physical pain in order to get through this, there must be something else we can do. It is as if I had developed a parent.

Anne had learned to feed herself in a different way.

There were different levels of feeding and nurturing her self. She learned to stop judging food as good or bad. "Interestingly when I did this my food allergies disappeared as well." She started over with a clean slate to learn what nourishment is and how freeing it felt to her.

> At first I felt like I was getting away with something wicked or naughty. I almost expected my mother to rise up out of her grave and say, "Anne… What are you eating? Are you eating something in there?"

She then went through a period of being very defensive and belligerent with the attitude "nobody better say anything to me about the fact that I am buying nothing but ice cream bars." There was a great freedom in feeling that she had no more restrictions around food. "It wasn't the enemy anymore."

Did Spirituality Play a Role in Anne's Recovery?

Anne believed spirituality played an important role in her healing.

> I have developed a different definition of hunger, the hunger of the spirit. Physical hunger is a reflection of that internal hunger to know God and to reconnect with God.

She felt that God wanted her to really enjoy life and how could she if she was in constant fear of what she might eat or breathe or drink? Her spirituality gave her the strength to look at life from a different perspective.

Anne lacked a religious upbringing as a child until six years of age; after her father left, her mother remarried. She remembers being dropped off at Sunday school, a place for parents to have children babysat, and where she learned about a God that was loving, caring and forever present.

"I consider myself to be a feminist, but God will always be masculine to me." Her therapist told her that she had adopted God as her personal father figure. When people ask "don't you ever get lonely living by yourself?" She replies, "I am never alone, I always feel that God is constantly present." For Anne, God has become the healer, the parent and her hero.

> I can't imagine people healing from anything without some kind of spiritual anchor at all because everything else fades away or is lost.

Jo's Story

Jo grew up in Vancouver, British Columbia. At eight years of age her parents divorced. After this devastating divorce Jo continued to see her father on weekends until he met another woman and "dropped her on her ass." He told her that he had another family now and did not have much time for her anymore. This left Jo feeling devastated, as her father was an important person in her life.

Jo compared herself to her sister who she described as being very beautiful.

> I was the smart one. I always felt like the ugly duckling. I remember looking in the mirror at twelve years of age and thinking that I looked fat and ugly.

Jo's preoccupation with food started in grade nine. Her mother started supporting her diet attempts by supplying her with pills. Jo found them to be ineffective and started dieting on her own. She recalls her school friends calling her "Annie Anorexic." "I suppose I didn't really eat that much."

Jo remembers fighting with her sister a great deal. "I was always in the way which is the reason I think I worked so much." She received a great deal of positive recognition from her workplace. Her new stepfather began drinking heavily which compounded the disharmonious atmosphere in the home.

At sixteen years of age she met a girl who suffered with anorexia and bulimia. Joe watched and learned how to binge and purge. Her pain continued to drive her to a constant cycle of destructive behaviour. "I had to be perfect and I wasn't good enough." If I was good enough my parents would love me, if I was good enough my dad would be around, if I was good enough my brother and sister wouldn't have left the house."

Jo described herself as a very sensitive and emotional woman. She wanted so much to fix everybody and upset no one. She told herself not to show anger because it will upset her mom, and not to get mad at her stepfather because he'll become angry. "So just don't eat. So just don't eat."

Jo's Definition of Spirituality

Jo defined spirituality as a form of "letting go." Jo went to church with her mother over the most difficult point in her eating disorder. In hindsight she felt this was a way her mother coped with her illness. She explored God through studying philosophy at college. She concluded, "this was nuts" and walked away from mainstream religion altogether. Her beliefs were simply that you lived, died and were buried. Her eating disorder continued to worsen until she was finally hospitalized.

Several years later she found herself involved in a serious car accident. It was this incident that she attributes to her wakening to what "spirit" really meant to her.

> I realized that I was the kind of person that did not get away with stuff. I was being told to get it together, just get it together, you are more than this. The accident was my signal to get my life together. This was my last chance.

She attended Alcoholic Anonymous and began reading about Zen and Buddhism. She was attracted to the simplicity of life in the Buddhist traditions. The concept of *karma*, a law of the universe that explained that events happen for a reason, helped change her perception from a harsh unforgiving world to a softer kinder one. Buddhism freed her from the confines of gender roles as it professes re-incarnation allowing a person to "flip between being a man in one life and women in another life."

Jo believed another spiritual tool that helped her through some tough times were tarot cards she received from her mother. They were nature oriented, with pictures of trees and animals. She would read these cards daily and telling herself that it was going to be okay. It was going to be okay.

Joe described feeling a "huge guilt" that she would be discovered to be something that she was not. "What if I was a fraud and a fake? "I remember the day when I had the realization of what if this is all I am and all I am ever going to be?"

For Jo being spiritual meant finding a spiritual balance where she could be gentle with herself. "It was very difficult to deal with living up to everyone else's

standards. I learned that some days all you have to do is to breathe. I used to be afraid to cry because if I cried then I would never stop." Jo believed that an important aspect of her spirituality involved experiencing her feelings and letting them go.

Jo's Experience of Spirit as a Child

Jo was delighted when questioned about her spirit as a child. She explained that she was involved with a philanthropic organization called the "Daughter's of Job." These groups were organized through the Masonic order and cloaked in secrecy. Her father was a Mason as was her grandfather before him. Jo explained that it has elements of religion but is mainly based on spirituality.

As a child she felt dissociated from everyone around her. "I was too busy coping to get connected to any thing spiritual." She remembers being very happy and light-hearted as a child. She lost that happiness after the divorce of her parents. Jo was relieved when her sister understood that her "soul was hurting."

Jo Recovered from Her Eating Disorder

Jo attributes her healing to several factors, but holds spirituality as the key factor. "It is what keeps me healthy." Jo felt it was important to build a base from which she could deal with her emotions. In her opinion, anorexia is an emotional illness. Her boyfriend was important in giving her attention that did not focus on her appearance, rather about the person she was inside.

Her car accident was also a significant turning point in her life. She gave credit for her healing to the hospitals and support groups, yet was critical of some therapists who told her she couldn't be helped. She asked the question now, "how much help is counselling if you are not ready to take it?"

She turned to yoga and running to stay fit realizing that if she wanted to keep doing what she loved, she would have to learn to take care of her body. "My body and I are one, not separate."

Did Spirituality Play a Role in Jo's Recovery?

> The biggest thing spirituality did for me is to remind me that I am not a mistake. I am human and I can only do the best that I can and that is all that is expected of me. When you are sick with an eating disorder you don't think you are okay. You think you are a mistake and you don't want to be around. There is no hope.

Spirituality gave Jo a reason to believe that things may get better. It offered a chance to change and have faith that she had the strength to face life's challenges. "Maybe spirituality is a crutch, something to lean on in bad times but it keeps me strong."

Message to other Women suffering from Eating Disorders

Jo would advise other women with eating disorders to listen to themselves and trust themselves. Being sick does not necessarily enable someone to access the true needs of the individual. She believes that the family and friends of an eating disordered person should let them know how much they are loved and validated. "It is so important when someone is struggling with an eating disorder

to introduce spirituality, whether it is through yoga, meditation or a twelve step program."

Jo believes that in order for someone to heal from this disorder, they must believe in something larger than the self. "I think the biggest thing for someone suffering with an eating disorder is to deal with their emotions." Jo criticized friends, therapists and family who offered advice or gave medications for being "plastic and diluted." Even cognitive behavioural therapy, a counselling technique that Jo said, "challenged her thoughts" wasn't enough to deal with her illness. "You have got to get to your spirit and soul and heal the wounds."

Before when she was sick she dealt with things on a superficial level and refused to eat, however now she is able to go deeper. "You have to have a spiritual base in which to deal with the work because it is too friggin' hard." Jo believed that in order to heal one must reach deeply into one's soul honestly in order to access the spirit.

Sally's Story

Sally is a 47-year-old woman with two children ages 5 and 10 years. She described herself as always having been a slender person, like her mother. She remembers as a child hearing praises from her family and friends, about how thin and attractive they were. People would tell her mother "Oh, you are so lucky you can eat whatever you want and still have such a wonderful figure."

Her mother's value of thinness was evident in her attitude around her body image during pregnancy. "She was quite proud of the fact that it wasn't until her ninth month that she needed to wear maternity clothes." "I remember stories about my aunt who was so physically beautiful that men would just stop and stare at her."

Her eating disorder manifested at 27 years of age. She fell deeply in love with a man called Tom, who unbeknownst to her was still legally married while living separate from his wife. When she found out the truth, as difficult as it was, she forgave him for his dishonesty and accepted the situation under the conditions that he agreed to get a divorce and marry her in the near future.

Sally's hopes and dreams crumbled when Tom returned to his wife. She fell into a state of depression. "Food no longer appealed to me. Life no longer appealed to me." She could not trust her ability to make correct decisions. The more removed she became from life, the less she ate and the more weight she lost. After a period of time her weight loss attracted the attention of her doctor who diagnosed her with anorexia nervosa.

His professional advice was that there were many more "fish in the sea" so she should not be so sad. In hindsight, Sally found his comments lacking in sound judgement and direction. It did not provide her with any real insight or understanding to her dilemma.

Sally's Definition of Spirituality

Sally defined "spirituality" as the recognition and the feeling of connectedness to a force or power that is not only greater than her, but equally, has the ability to affect how she feels and who she feels herself to be. Sally speaks of a daily practice where she slips in and out of this sacred place, a place of thankfulness and gratefulness. There are times when she fails at this task and yells at her children. There are other times; a moment picking blackberries with her daughter when she is moved to tears in the recognition of the connectedness. "For me it is an everyday thing, it is not necessary to go to church."

Sally's Experience of Spirit as a Child?

Sally does not remember being connected to her spirit when she was a child. She sees God and Jesus as intriguing figures that had the power to "snatch her life away" as in the prayer her mother told her at bedtime.

> And now I lay me down to sleep
> I pray the Lord my soul to keep
> And if I die before I wake
> I pray the Lord my soul to take.

This prayer intended to create peace and safety in a child only filled Sally with dread and fear. This was her early experience with religion until "the church the family went to burnt down and they never went to church again."

Sally Recovered from her Eating Disorder

The diagnosis of anorexia forced Sally to ponder and recognize the fact that she was missing something in her life.

> Something was missing that no man could fill. What was most frightening was that I couldn't fill it either but I knew it had to be filled.

These days were very dark for Sally to the point of contemplating ending her life. Judging this to be a "cowardly act" on her part she instead decided to force herself into community and moved in with a friend.

Sally's doctor was threatening to have her hospitalized when her weight plummeted to 88 pounds. She decided to see a fitness instructor to help her gain weight. This instructor gave Sally a milkshake with 3,000 calories to drink daily. This was what she needed to keep herself out of the hospitals, however the emotional pain was still there.

Once she started gaining weight, she became involved in another difficult relationship with a man. She became pregnant and decided to have an abortion. Confused and desperate for some direction, she decided to find solace by going to church. She looked for an alternative church, one without harsh dogma and strict judgements.

> I did not want to be involved in a religion that had rules or things I had to do in order to be a part of that religion. I wanted something that just recognized the inner truth of a person rather than dogma.

She found a New Thought Church in Victoria. Through this spiritual community, Sally began her period of spiritual reading.

> I began to develop a relationship with God. I began to realize that I had more power than I ever knew I had or ever believed that I could have.

She attributes her recent success in healing ovarian cancer to her strongly developed spirit.

Did Spirituality Play a Role in Sally's Healing?

Sally believed that her eating disorder and her abortion were catalysts in having to look at the empty place inside herself.

> If I couldn't trust *me* and I couldn't trust men, there had to be something I could trust or I couldn't stay on the planet anymore.

Sally believed that any woman with an eating disorder is "one hundred percent completely unconnected to God."

Message to Other Women Suffering from Eating Disorders

Sally was uncertain as to how receptive women with an eating disorder would be to advice.

> I don't know if I would have listened if someone had said to me to ask God for help every day and start devoting time to helping others rather than myself.

It would be helpful if women had a place where the focus was taken off their bodies and they could begin to learn to be mindful of God and have an "attitude of gratitude."

Lorraine's Story

Lorraine, a woman in her sixties, began dieting as a young girl by stealing diet pills from her mother. She grew up in a household where references made about weight and appearance were common in context of "getting a man." Lorraine would eat very little food and when she did manage to eat a meal she would go into the bathroom and throw it up.

"I believe I was more bulimic than anorexic." She recalls her father making comments about throwing up his food after they had a huge Christmas or Thanksgiving dinner.

She developed a hiatus hernia from the physical stress of vomiting. She became involved in a 12-step program but did not get the results she wanted. Her pride was evident during the interview, "I was extremely good at dieting, I mean nobody could get me off track."

Lorraine's Definition of Spirituality

Lorraine defines 'spirit' as her connection to God, and 'spirituality' as being connected to the source. Her understanding of her connection to God grew out of her involvement in the twelve-step program where she came to view God as her protector and saviour

Lorraine's Experience of Spirit as a Child

Lorraine was not aware of having a sense of spirit as a child. Rather she describes a maturing of her spirit. Having been a sexual abuse survivor,

Lorraine's body was an important symbol of who she was as a person. The God she once understood to be her protector and judge was seen as external to her body and mind. Her sexual abuse memories surfaced during her marriage to men who were addicted to alcohol. She understood her pattern of playing a victim's role in her life. This was also her relationship with God. She has now become a co-participant in her relationship with God. "I am part of the whole process an active participant."

Lorraine Recovered from her Eating Disorder

Lorraine felt an important part of her healing was changing her perception from victim to active participant.

> I used to believe that my eating disorder was the cause of my problems. It was a very big shift to recognize the disorder as the effect.

She helped herself by sheer willpower and through realizing that her illness was created through her environment and her expectations of her ability to control external circumstances.

Spirituality played an important role in her recovery from her eating disorder. First, she had to stop the behaviour before she could heal. "The healing process that has occurred is still happening so I am on a spiritual journey that is forever changing."

Message for Other Women Suffering from Eating Disorders

Lorraine believes women need to acknowledge that they must stop the behaviour first. Lorraine spoke of using of food as a "medicator" or a "punisher."

> Food to me was never a nourishment for my body or a way of keeping myself alive. As long as I could shift my behaviour slowly healing will occur.

Lorraine believes physical activity, such as expressive dancing as a form of creative release would have been helpful. "I had always used dance as movement and expression when I was alone by myself because with another person it was always sexual."

Sage's Story

Sage is a 23-year-old young woman living in Vancouver with her long-term boyfriend. She works full time in a retail store and plans to attend school next year. Her first memory of her relationship to food was at school during lunch. She recalls feeling uncomfortable eating in front of other people, mostly men. She would rather throw out her lunch than eat anything in front of others.

Sage remembers family dinners as a very emotional and uncomfortable time. She recalls feeling ashamed and judged by others when she ate. She believed this behaviour began at dinnertime with her father when she was a little girl. She felt uncomfortable when he would watch her eat her food.

> He could be very aggressive and angry and he would watch me. I wasn't anorexic or bulimic at that time, but I felt very self-conscious eating.

She believes that her father's emotional state at the time of preparing the meal would somehow be transferred into the food.

Her parents divorced when Sage was 10 years of age. As much as she misses her father, she was relieved not to be living in such a tense atmosphere. Her mother eventually moved to another part of the country when Sage was 15-years-old. Sage found it difficult to make new friends. She learned how to throw up her food from some of the other girls. The worst times for Sage was when she went on road trips with male friends.

> I would find some food somewhere and I would hide. I would eat as much as I possibly could and then I would throw it up. Those were real awful times.

Sage acknowledges that the more emotionally upset she became, the more she needed to make herself feel good through excessive exercise and/or throwing up her food.

Sage's Definition of Spirituality

For Sage spirit meant "energetic, loving, happy, freedom and carefree." "A place in oneself where you are one with the world leaving behind society's bullshit and all the things they want you to be." She described a belief in paganism, that of the power of spirit in nature, the sun, moon, trees and animals.

Sage's Experience of Spirit as a Child

Sage believed that her spirit as a child was suppressed out of fear. Her father worked nights and her mother had to keep her and her sister quiet so as

not to awaken her father while he slept during the day. If they ever awoke the angry giant, he would leave everyone quivering in their boots. Sage has come to understand her panic attacks as fear being released from her body.

One of the most important things to Sage was that others acknowledge and accept that her eating disorder was a real problem. Her father would brush it off or just deny it. "Psychiatrists didn't really know me so I didn't really care. I just kept on doing it over and over again."

Her mother sought help from eating disorder clinics but to no avail. Sage remembers having a fantasy where she would marry the first man who she could eat in front of. (She eventually met a young man, who began to spoon feed her until she could eat in front of him.)

Learning about good nutrition and health that honours her body, helps her to feel better about herself. She feels that her relationship with her father has changed over the years. She has learned to be more honest about her feelings towards him. "He is not as scary as he presented himself to be." She can be more carefree and not so afraid to live her life.

Did Spirituality Play a Role in Sage's Recovery?

Sage believed that her recovery began when her spirit opened up thus allowing her to heal through "letting the dirt out." She spent hours reading and learning as much as she could about her illness. She describes herself as a very emotional person and has since been able to express her feelings better. It was a

very slow and gradual process. Eating disorders for Sage were about having some control in her life.

Message to Other Women Suffering from Eating Disorders

Sage's advice would be to "not hide your disorder. Go and talk to someone and express yourself. You are just as good as anybody else." Sage believes that support groups for eating disordered women should be segregated by types of eating disorders. In her opinion,

> Bulimics are an emotional mess whereas anorexics are more about being depressed and giving up. When a person is sick with an eating disorder they compare themselves with others and feel that perhaps they shouldn't be here. Perhaps if they made themselves sicker then they would deserve to be here with everyone else.

Chapter 5:

Discussion

This study found similarities in the women's stories supporting the importance of the role of spirituality in the lives of these eating disordered women. This chapter outlines and discusses some re-occurring themes observed by the author.

Attitudes Toward Food

In most of the women's families, food held an important emotional significance. For Sally it was never getting the food she wanted. For Sage it was the emotional tension of her father's attitude during dinner. For Lorraine it was her family's focus on the body and remembering her father's reference made about "throwing up" after a meal. And in Anne's case, it was her mother's obsession for her to have a "perfectly thin" daughter. The many theories that place importance on family interaction are valid at least to some degree. It does not explain why other family members in similar environments do not suffer from eating disorders.

Not Good Enough

The idea of "not being good enough" or not measuring up against some empirical ideology is evident in all of the women's stories. For Sage, her fear was not measuring up to her father's ideals. Jo went so far as to say:

> ...if I was good enough my parents would love me...if I was good enough my dad would still be around...if I was good enough my brother and sister wouldn't have left the house.

This concept of not being good enough is supported by other studies of eating disorders.

Dr. Hardman and Dr. Berrett of the Centre of Change found that eating disordered women believe that others view them as "flawed, unworthy and unacceptable." When others tell them that they are good, they are not able to believe it (Hardman & Berrett, 2001). Pierre-Claude, founder of the famed Montreaux Clinic, says that this attitude is the work of the "negative mind" or voices that women listen to inside of themselves (Claude-Pierre, 1997). Dr. Kirkpatrick and Dr. Caldwell, both agree that eating disordered women are blind to their own strengths, even though others can see them. All the praise in the world from family, friends, teachers do very little to diminish the self-reproach (Kirkpatrick & Caldwell, 2001).

Body Image

In each of the families, whether the parents were divorced or not (Sage, Jo and Anne's parents were divorced whereas Lorraine and Sally's parents

stayed married), there was a very strong focus on body image. Sally's family praised physical beauty whereas the elderly women in Lorraine's childhood sent her the message "you need to be attractive to get a man." Both Sally and Lorraine had very strong maternal figures that stressed the importance of body image and weight reduction to achieve one's goal in life. Several of the women's mothers were apparently very concerned with their own appearance and weight. They too were influenced by the culture they lived in, passing on these unwritten rules of survival to their young daughters.

Two out of the five women experienced some form of sexual abuse at the hands of family members. However, all the women suffered from a degree of low self-esteem with a strong focus on body appearance, supported by the other members of the families.

These results are reflective of literature claiming that half of all dieting girls were encouraged to do so by their mothers. The fathers and brothers were found to encourage dieting through comments and attitudes about the girls' appearance (Sandbek, 1993).

The Idea of Betrayal

In each of the woman's story it was observed that the disorders were preceded and reinforced by a perceived betrayal in the women's lives. For Sage it was the combination of her relationship with her father, the divorce of her parents and the pressure of a subsequent move to a new province that required

her to "fit in" with a new group of friends which left her feeling betrayed by life's circumstances.

For Lorraine it was the need to measure up to the men in her life. All three husbands were in some way symbols of the addictive behaviour that enabled her to play the role of the victim. They all betrayed her expectations of being loved and accepted.

Sally felt betrayed by her fiancé who lied to her about his marital status and later returned to his wife. She once again felt betrayed by another boyfriend when their relationship ended with her having an abortion. She finally came to the conclusion:

> I couldn't trust any man and I couldn't trust myself anymore. I had to find something or I couldn't stay on the planet anymore.

These words reflect the depth of despair and pain some women experience while confronting overwhelming feelings of betrayal.

Jo described her feeling betrayed by her father's love, when after her parents divorced, he became involved with another woman and stopped spending time with her.

Anne also felt betrayed by her husband who left her for a younger woman after years of marriage.

Carolyne Myss, author of *Why People Don't Heal* and the *Anatomy of a Spirit,* invites people to consider the idea of betrayal in a different way. Myss believes betrayal happens to every single person on the face of the earth to one degree or another. Whether we feel betrayed by our bodies, by our friends or our

lovers. It is one's attitude towards betrayal that determines whether or not the emotional scars remains for the rest of one's lives.

This perspective seems to be a healthier approach towards handling disappointments in life. Rather than fostering an attitude of bitterness or "expecting the worst," this other perspective supports a deeper understanding.

Some of the women commented that these betrayals and disappointment lead them to the help that they needed in order to heal. At times, the women expressed regret at spending so many valuable years of their lives struggling with an eating disorder, however in hindsight they realize how important the disorder was in helping them find a more meaningful and peaceful life.

Perhaps teaching young girls at an early age that they are strong enough to handle life's betrayals and disappointments is more important than fostering expectations of the "Cinderella story" that may leave girls with feelings of inadequacy when "Prince Charming turns out to be a toad."

Spirit

Religion and spirit may be described as being one and the same thing to some people but it is necessary to remember that this is not the case for everyone. The women's definitions of spirit varied from each other, yet they all described spirit as being something powerful, positive and healing.

Sage described spirit as "being one with the world and earth that is not of man, loving, happy, freedom, carefree." At one point she referred to herself as a pagan, having a great love and respect for the laws of nature.

For Lorraine spirit meant her connection to God, "being connected to the source."

Anne defined her spirit as something that is forever seeking higher and higher truth, never satisfied with the physicality of life, always looking for answers in the invisible realms.

Sally defined spirituality as "the feeling of connectedness to a force or power that is not only greater than me but also has the ability to affect who I am and how I feel." It is this connectedness that she strives to maintain through a daily practice of thankfulness and gratitude.

Jo defined her idea of spirit as a feeling of "letting go." A letting go of life's expectations and of the expectations of other people.

> Letting go of the pain and being gentle with yourself. I don't need to cope, I can just breathe.

All of these women defined spirit as a positive, connected experience and a source of strength in their lives.

Spirit as a Child

This question sparked interest in many of the women as they recalled memories of themselves as children. Sage felt that during her childhood her spirit

was suppressed. In order for Sage to heal it was necessary that she allow herself to open up.

Lorraine moved from feeling like a victim in her life, where God was her saviour and protector, to feeling like an active participant and a part of the whole process of living. As a child she experienced herself as being powerless and lacking control. Her healing enabled her to become an active participant in her relationship with God creating a healthy blueprint for future relationships with others.

Most of the women were raised without strong mainstream religious influences, except for Jo whose family was strongly involved in the Masonic order. Anne experienced her spirit as a child through the world of nature around her. With her, spirituality involved growing and blossoming from small stirrings to something much stronger and more profound.

She remembers being connected with the flowers, trees and animals. "I started writing nature poems about the flowers and trees, clouds and ducks and things that children do." As she grew older she "stopped seeing human beings as being over in section A and all of nature and plant life as over in section B." The human race that she once considered to be intruders in her life now become a part of nature and created an interconnectedness with life.

Sally did not remember experiencing her spirit as a child. She remembered that she experienced a great deal of fear from a prayer that her

mother would say to her every night at bedtime. It is a prayer that many of us are familiar with as children.

> And now I lay me down to sleep
> I pray the lord my soul to keep
> And if die before I wake
> *I pray the lord my soul to take.*

This prayer signifies God as someone to be feared. "I felt like God was going to snatch me away from my life when I wasn't looking." As she grew older her feelings changed and she began to form a new relationship with God. She realized that she possessed more power than she ever thought possible. She credits this belief and power to her belief in God. This belief sustained her through her latest successful challenge with ovarian cancer.

Jo describes her spirituality as something she did not feel connected with as a child, until later when she rediscovered these feelings. She vaguely realized that there was a God somewhere around but she always seemed too busy just surviving to connect with it. She described herself as a happy child until her parents divorced and she lost contact with her father. These feelings of belonging and connection to something other than herself held great importance in her life.

It appears that in all the women's stories, whether or not there was a conscious knowledge of God, there was an awareness of something greater or "other." Even Jo who felt very dissociated and unconnected felt a sense of "something else."

Each woman commented on how much they liked the question that asked about their memories of their spirit when they were children. There appeared to

be some change in each woman's memory of their spirit as a child compared with their memory of spirit as an adult woman. According to Dr. Newberg and Dr. D'Aquili, the "spiritual experience is intimately interwoven with human biology" (Newberg & D'Aquili, 2001, p. 8).

How They Healed?

Each woman spoke of the events that lead to their healing. Anne attributed her "saving grace" to her love of cats and a counsellor who was interested in metaphysical books. These books opened a new door for Anne to explore and understand her own ideas and beliefs. It was helpful for her to read stories about women, who like her were struggling with an eating disorder. She developed an inner parent, "the mom and dad that I wished I had when I was growing up." She learned to redefine hunger. What did it mean to be truly nourished?" There is more than one way to feel hunger as now she understood a "hunger of the spirit."

The women spoke of having realizations that showed them that they were a part of life and a part of the human race. There is a sense of acknowledging one self in the world, and accepting one self as being human and belonging to a family of humanity. Their spiritual beliefs allowed the women to come to terms with the paradox of being human beings, having seemingly unlimited potential on the one hand and being frail and vulnerable on the other.

Both Jo and Anne struggled with the reasons that they decided to pursue spirituality. Was God real or did they create Him as a crutch? This dilemma did not seem as important to either woman when faced with the potential positive healing that these beliefs produced in their lives. Perhaps it is not about needing to prove through science that God does or does not exist, (although that may happen one day,) rather it is about harnessing another healing tool in order to help each other through our journey in life.

Jo attributed her healing to several different things but stressed that spirituality was a key factor. Both Sage and Jo spoke of meeting someone special who helped them feel loved and accepted. Jo spoke of how her relationship with her family changed as she healed. She was able to create healthier boundaries, " I love my mom but I won't go there with her. I don't have to 'cause she is her and I am me." This supports Poppink's (2001) theory of the importance of creating healthy boundaries that she often found missing in many of her eating disordered patients.

Sage realized that her eating disorders reflected a life that is out of control. She attributed her healing to her love of music and her learning to meditate. She felt psychiatrists and drugs did not work for her, rather, learning about her body's nutritional needs was something she could understand with successful results.

Lorraine attributes her healing to beginning Alcoholics Anonymous where she learned about the spiritual help available to her. She became aware of past memories around her sexual abuse, which in turn lead to a greater

understanding of her repetitive pattern of marrying men with addictive personalities.

> The eating disorder was not the cause of my problem rather it was the effect.

She stressed the importance of "stopping the behaviour" before she could be healed.

Sally did a great deal of reading, throwing herself into community life. She joined a *new age* church. "God was knocking on my door. I wasn't listening." She knew that she had to find something or someone she could trust in order to have purpose and meaning in her life. The core of Sally's emotional frailty stemmed from her inability to trust herself or any of the men in her life. Her growing belief in spirituality allowed her to trust herself again.

Spiritual Hunger

In her book *Starving for Salvation*, Michelle Lelwica (1999) refers to this "spiritual hunger" as the "embodied character of girls' and women's desires for a life that is meaningful" (Lelwica, 1999, p. 7). She believed that the human desires that are shaped by cultural norms and social institutions are historically specific. Furthermore, Western society is organized through the "logic" of dualism and domination: "spirit over body, men over women, thought over feeling, white over colour, individual over community, rich over poor and thin over fat" (Lelwica, 1999, p. 7).

A closer look at the spiritual and emotional worlds of those who have transcended their eating problems reveals many similarities. All of the women seemed to learn that connecting to their true selves is the real answer rather than turning to food or other people. This meant seeing, accepting and loving themselves for who they were and to stop starving themselves of their "self" (Kesten, 1997).

Mary Daly a woman who sought to find equality between the genders in the church, encouraged women to find symbols that empower and validate their lives as creators, much like their male counterparts, rather than as passive vessels for creation.

Some beneficial aspects of traditional community life and rites of passages have been lost in modern culture. Perhaps through discarding obsolete religious dogma, we have disregarded the value in spirituality as well. The need for a meaningful belief system appears to be an important part of these women's healing.

Myss (2002) suggests conducting a "tribal" ceremony for children, much like birthdays that celebrate the child's day of entering into the world; this tribal ceremony would be a celebration for the spirit of the child. The purpose of this ritual would be twofold; one, it would acknowledge to the child that she is more than the appearance of her physical body and second, it may create a greater sense of connection within her community (tribe) on a spiritual level.

This exercise is mentioned because the author, experienced a learning moment when she asked her children if they would agree to a ceremony with family and friends (their tribe), welcoming and honouring their spirit into their body. Having raised these young girls without any particular religion, (wishing them to have the freedom to chose their own beliefs when they became adults) half-expecting a negative response accompanied by rolling eyes and an exasperated "Oh, Mom," it was surprising to see both girls agreed to it with big smiles. Perhaps there is a greater need for the recognition of "spirit" in our lives and in the lives of our children than we might suspect.

The Women's Advice for Other Eating Disordered Women

The following are some suggestions from the women to other women suffering from this illness.

Sage said:

> Don't hide; try and express yourself to someone. Do research. Try and find groups that are specific to your eating disorder. Food may be a common denominator but bulimia is about depression and anorexia is about emotions.

Lorraine said:

> Express yourself alone with dance or yoga, especially for those who have been abused because dancing with others can feel sexual.

Sally said:

> Ask God for help and spend time every day helping someone else. Take the focus off yourself and find ways to connect to God. Anyone who has an eating disorder is unconnected to God.

Jo said:

> Tell the eating disordered woman that you love her and be there for her. Validate the individual and introduce the idea of spirituality either through the 12-step program or yoga or meditation. You need a spiritual base from where you can do the hard emotional work.

All the women agreed that there must be a desire on the part of the women to listen and to change. "Denial is the biggest obstacle in overcoming an eating disorder" (Sandbek, 1993).

A woman recovering from an eating disorder needs to understand the ways in which her illness serves her life. Then she may know the tools needed to live a life that is free from binge-eating, dieting and other food obsessions (Johnston, 1996).

Recovery for each woman may require different solutions depending on the cause or reason for the disorder. For one woman, being larger in size, may have helped her to avoid sexual advances from men, here she must learn assertiveness. For another woman who may have an intrusive alcoholic mother, there needs to be healthier boundaries created in relationships. For another, bingeing and purging may be used to eliminate tension when faced with conflict (Johnston, 1996).

How can one learn to listen to this inner voice and identify one's true feelings, needs and wants behind the desire for food? Deborah Kesten (1997) found journalling to be an excellent way to achieve this goal, as well as talking back to one's negative inner voices. Anne would tell herself "no" and "stop" when she heard herself wanting to eat to punish herself (Kesten, 1997).

Lorraine supported the idea of acting on the behaviour one wants changed. Hall (1980), an eating disorder survivor, speaks to women about how to take action and speak up. She agrees with the importance of keeping a journal, acknowledging one's feelings honestly (Hall & Cohn, 1982). Dr. Joan Borysenko (1996), cofounder and former director of the Mind/Body Clinic, New England Deaconess Hospital, Harvard Medical School, includes in her book several different meditations for women to help themselves in the healing process. It is important to remind oneself that an eating disorder is a process, a means by which one learned to cope with life.

Conclusion

The medical community has been trying to understand the reason for eating disorders in order that they may find a way to treat them. The theories range from cultural influences to biological and psychological theories.

A reoccurring theme for women in this study is the feeling of disconnectedness. Each of the women spoke of feeling *different*, not belonging and somehow not connecting to a part of their "Self." For many suffering from eating disorders there is a sense of not having been cared for in the way they needed. What remains is a sense of *dis-connection*, a spiritual deficit that locks them into the illusion of being unworthy, feeling unworthy, resulting in a resistance to accepting love (Kesten, 1999).

Victorian Moran, who wrote *The Love Powered Diet,* believes that we must connect with our "spiritual selves" through making practical contact with the Divine, whatever we perceive that to be (Kesten, 1997). Eating disorders may result from a "non-spiritual" or disconnected relationship to the "Self" and food.

It is not surprising that the word "healing" comes from the old Anglo-Saxon word *haelan* which means "wholeness." Spirituality and healing are really one and the same thing (Borysenko, 1999).

> At the heart of every eating disorder, whether it is compulsive eating, bulimia or anorexia…there is a cry from our deepest part of the soul that must be heard. It is a cry to awaken, to embrace our whole selves, to see past the limitations we have put on ourselves, through defining our bodies or eating habits as good or bad. It is a way to deepen the understanding of who we really are. It is call from the part of us that holds our desires and passions to grow, heal and fulfil our dreams. (Normandi & Roark, 1998, p. 119)

To see the spiritual dimensions of women's struggles with food and their bodies is to recognize the search for meaning and wholeness that these struggles entail. Women are starving themselves to be thin as well as to be well, as they hunger for a sense of fulfillment and well being (Bruch, 1979).

According to Dr. Hardman and Dr. Berrett, religious and spiritual issues are frequently intertwined with the pathology of eating disorder patients. Although these religious issues can contribute to and even help maintain eating disorders, when religious and spiritual resources are properly focused, they can be instrumental in the healing and recovery process of eating disordered women (Hardman & Berrett, 2001).

Researchers have only begun to investigate the healing powers of religion and spirituality. There is a need for more research to encourage medical practitioners, therapists and patients to see the value that spiritual intervention offers mental health (Elkins, 1999). It is the hope of the author that a few more voices have been heard that may add to the validity in exploring further the role of spirituality in all of our lives.

References

Abraham, S., & Llewellyn-Jones, D. (1992). *Eating disorders: The facts* (3rd ed.). Oxford, England: Oxford University Press.

Angeloni, E. (1990). *What keeps women in their places?* Newhaven, CT: Dushkin Publishing Group Inc.

American Psychological Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Baxter, H. (2001). Nibbles: Religion and eating disorders [Electronic version]. *European Eating Disorder Review, 9*(2), 137-139, from http://www.wiley.com/eda/product/o.,RVII2542,00.html.

Belenky, M., Clinchy, B., Goldberger, N., & Tarule, J. (1986). *The development of self, voice and mind: Women's ways of knowing.* New York: Basic Books Inc.

Bergeron, S. M., & Senn, C. Y. (1998). Body image and sociocultural norms. *Psychology of Womanly Quarterly, 22,* 385-401. Cambridge, England: Cambridge University Press.

Blair, J., Robinson, S., Fleming, C., McCloy, R., & Mollenhauer, E. (1998). *Bulimia nervosa.* Eating Disorder Association (Qld), Australia, from http://www.uq.net.au/eda/documents/bulimia.html.

Bogdan, R. C., & Biklen, S. K. (1992). *Qualitative research for education* (2nd ed.). Boston: Allyn & Bacon.

Borysenko, J. (1996). *A woman's book of life: The biology, psychology, and spirituality of the feminine life cycle.* New York: Berkley Publishing Group.

Borysenko, J. (1999). *A woman's journey to God.* New York: Riverhead Books.

Braham, C. G. (Ed.). (1998). *Random House Webster's dictionary* (3rd ed.). New York: Ballantine Books.

Brownell, K. D., Hotelling, K., Lowe, M., & Rayfield,G. (1998). *How therapy helps eating disorders: Psychotherapy's role in effective treatment.* American Psychological Association, October, from http://helping.apa.org/therapy/eating.html.

Bruch, H. (1979). *The golden cage: The enigma of anorexia nervosa.* New York: Vintage Books.

Brumberg, J. J., (1998). *The fasting girls: The history of anorexia nervosa.* New York: Random House Inc.

Button, E. J., & Warren, R.L. (2001). Living with anorexia nervosa after 7.5 years. *European Eating Disorder Review, 9,* 74-96, from http://www3.interscience.wiley.com/cgi_bin/abstract/77004248/START.

Campbell, T. (1996). *Technology, multimedia and qualitative research in education*, from http://www2.educ.ksu.edu/projects/JRCE/u28.5/Campbell/article/texonly.htm.

Claude-Pierre, P. (1997). *The secret language of eating disorders.* New York: Random House.

Cox, V. (1997). *The other voice in early modern Europe.* Chicago: University of Chicago Press.

Denmark, F., & Paludi, M. A. (1993). *Psychology of women.* San Francisco: Greenwood Press.

Eating Disorder Resource Center of British Columbia (EDRC). (2002, February). *Don't set a place at your table for disordered eating.* Pamphlet published by St. Paul's Hospital Vancouver, British Columbia.

Elkins, D. N. (1998). *Beyond religion: Personal program for building a spiritual life outside the walls of traditional religion.* Wheaton, IL: Theosophical Publishing House.

Elkins, D. (1999). Spirituality: It's what's missing in mental health. *Psychology Today, 32,* 44-48. Retrieved September 23rd 2001 from http://www.findarticles.com/cfo/m1175/532/55625500/p1/article.jhtml.

Eller, C. (1993). *Living in the lap of the Goddess.* New York: Crossroad Publishing Company.

Friedman, S. S. (1997). *When girls feel fat.* San Francisco: Harper Collins Publishers Ltd.

Griffin, G. B. (1995). *Seasons of the witch.* Pasadena, CA: Trilogy Books.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Boston: Harvard University Press.

Goldberg, N. R. (1979). *Changing of the Gods.* Boston: Beacon Press.

Gross, R. E. (1996). *Feminism and religion.* Boston: Beacon Press.

Hall, L. (1980). *Eat without fear: The true story about the Gorge-Purge Syndrome.* Carlsbad, CA: Gurze Books.

Hall, L., & Cohn, L. (1982). *Understanding and overcoming bulimia: A self-help guide.* Carlsbad, CA: Gurze Books.

Hardman, R., & Berrett, M. (2001). *Eating disorder recovery: A spiritual perspective.* Retrieved September 20th 2001 from http://centerforchange.com/articles/spirit_1.html.

Hart, I. B., & Thompson, J. M. (1996). Gender role characteristics and depressive symptomology among adolescents. *Journal of Early Adolescence, 16,* 407-426.

Harvey S., M.D. (Ed.) (2001). *What Are Eating Disorders?* Received March 11 2002, from http://webmd.lycos.com/content/article/1680.50411.

Hesse-Biber, S. (1989). Eating patterns and disorders in a college population: Are college women's eating problems a new phenomenon? *Sex Roles, 20,* 71-86.

Hughes, R., Jr. (1996). *The effects of divorce on children.* Columbus, OH: Ohio State University, Department of Family Relations and Human Development.

Johnston, A. (1996). *Eating in the light of the moon: How women can transform their relationships with food through myths, metaphors and storytelling.* Carlsbad, CA: Gurze Books.

Keane, J. (2002, February). *Mindfulness meditation: Discussion of a group practice with recovery of eating disorders.* Seminar held at the Roundhouse, Yaletown, Vancouver, British Columbia, Canada.

Kesten, D. (1997). *Feeding the body nourishing the soul: Essentials of eating for physical, emotional, and spiritual well-being.* Berkeley, CA: Conari Press.

Kirkpatrick, J., & Caldwell, P. (2001). *Eating disorders.* Toronto, Ontario: Key Porter Books Limited.

Kristeller, J. L., & Hallett, B. C. (1999). An exploratory study of a meditation based on intervention for binge eating disorder. *Journal of Health Psychology, 4,* 3.

Kuehnel, D. J. (1998). *Addictions and more.* Retrieved on November 10th 2001 from http://www.addictions.net/info.htm.

Leahey, J. (1989). *The co-constitution of knowledge issued from qualitative research interviews.* Paper presented at the Eighth International Human Science Research Conference, University of Aarhus, Aarhus, Denmark.

Leichner, P., Brown, M., Atkinson, S., Henderson, R., & Jacek, C. (2001). *Spirituality groups for people with eating disorders.* Abstract obtained from St. Paul's Hospital and British Columbia Children's Hospital, Vancouver, British Columbia, Canada.

Leichner, P., & Manley, R. (2002, February). *Adolescents suffering from eating disorders.* Eating Disorders Awareness Week Seminar held at the Roundhouse, Vancouver, British Columbia, Canada.

Lelwica, M. M. (1999). *Starving for salvation.* Oxford, England: Oxford University Press Inc.

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry.* New York: Sage.

Maher, M. F., & Hunt, T. K. (1993, October). Spiritual Reconsidered. *Counselling and values, 38,* 21-28.

Mattelart, M. (1986). *Women media and crisis.* London: Comedia Publishing Group.

Miller, K. E., MD. (2000). Practice guideline for the treatment of patients with eating disorders (revision American Psychiatric Association). *Psychiatry, 157*(suppl.), 1-39.

Myss, C. (2001, November). *Sacred contracts.* Seminar in Vancouver, Hotel Vancouver, Vancouver British Columbia, Canada.

Newberg, A., & D'Aquili, E. (2001). *Why God won't go away: Brain science and the biology of belief.* New York: Ballantine Books.

Normandi, C., & Roark, L. (1998). *It's not about food.* San Francisco: The Berkley Publishing Group.

Oxman, T. E., Freeman, D. H., & Manheimer, E. (1995). Lack of social or religious strength and comfort as risk factors for death after cardiac surgery in the elderly. *Psychosomatic Medicine, 57,* 5-15.

Padula, M. A., & Miller, D. L. (1999). Understanding graduate women's re-entry experiences. *Psychology of Women Quarterly, 23,* 327-343.

Panikkar, R. (1993). *The cosmotheandric experience.* Maryknoll, NY: Orbis Books.

Pelletier, K. R. P. (1993). Between mind and body: Stress, emotions and health. In D. Goleman & J. Gurin (Eds.), *Mind/body medicine* (pp. 20-61). New York: Consumer Book Reports.

Poppink, J. (2001). *Number one reason for developing an eating disorders.* Retrieved on October 12th 2001, from http://home1.gte.net/res03gkn/html/reason.html.

Pratt, J. B. (1907). *The psychology of religious beliefs.* London: The MacMillian Company.

Puttnick, E. (1997). *Women in new religions.* New York: St. Martin's Press.

Reinharz, S. (1992). *Feminist method in social research.* Oxford, England: Oxford Press.

Richards, P. S., Hardman, R. K., Frost, H. A., Berrett, M. E., Clark-Sly, J. B., & Anderson, D. K. (1997). Spiritual issues and interventions in the treatment of patients with eating disorders. *Eating disorders, 5*(4).

Roth, G. (1993). *Feeding the hungry heart: The experience of compulsive eating.* New York: Plume Penguin Books.

Ruether, R. R. (1998). *Women and redemption.* Minneapolis, MN: Ausburg Fortress Press.

Sandbek, T. J. (1993). *The deadly diet: Recovering from anorexia and bulimia* (2nd ed.). San Francisco: New Harbinger Publications Inc.

Schumacher, S., & McMillan, J. H. (1993). *Research in education* (3rd ed.). New York: Harper Collins.

Siegel, M., Brisman, J., & Weinshel, M. (1998). *Surviving an eating disorder: Strategies for family and friends* (Rev. ed.). New York: Harper Perennial.

Slomski, A. (2000). *Should doctors prescribe religion?* Medical Economics Company Inc. and The Gale Group dated January 10, 2000. *Find Articles.com.* Retrieved March 11, 2002, from http://www.findarticles.com/cf_0/m3229/01_77/59330876/p7/article.jhtml?term=should+ doctors+prescribe+religion.

Smolan, R., Moffitt, P., & Naythons, M. (1990). *The power to heal.* New York: Preston Hall Press.

Walsh, F. (1999). *Spiritual resources in family therapy.* New York: Guildwood Press.

Wehr, D. S. (1987). *Jung and feminism.* Boston, Massachusetts: Beacon Press.

Zerbe, K. (1995). *The body betrayed.* Carlsbad, CA: Gurze Books.

Vita

Surname:	Sandy	**Given Names:**	Kristina Julyanna
Place of Birth:	Budapest, Hungary		

Educational Institutions Attended:

University of Toronto	1973-1975
Camosun College	1995-1996
University of Victoria	1996-1998

Degrees Awarded:

B.A. (with Distinction) Faculty of Social Sciences	University of Victoria	1998

University of Victoria Partial Copyright License

I hereby grant the right to lend my thesis to users of the University of Victoria Library, and to make single copies only for such users or in response to a request from the Library of any other university, or similar institutions, on its behalf or for one of its users. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by me or a member of the University designated by me. It is understood that copying or publication of this thesis for financial gain by the University of Victoria shall not be allowed without my written permission.

Title of Thesis:

Role of Spirituality in the Recovery of Eating Disordered Women

Author: [redacted]

Kristina Juliyanna Sandy

March 15, 2002