Routes to Transcendence: Disordered Eating, Substance Abuse, and Self-Injury in Young Women

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Abstract

The purpose of this research was to explore the intersections between disordered eating, substance abuse, and self-injury among young women. In this thesis, I attempted to illuminate convergences and divergences between the experiences of young women who have struggled with these three problems, in the interest of shedding light on contributing factors, as well as possible barriers, to recovery and wellness.

Throughout the research process, the focus was on the women's thoughts, feelings, and meaning-making. Inquiry into past trauma and abuse was deliberately omitted in order to focus on the behaviours as adaptations rather than symptoms of pathology.

Nine women ages 21 to 27 were interviewed; all were university students. Experience of the three behaviours varied, as did experience of therapeutic intervention. Interviews were digitally recorded, transcribed, and analyzed to yield eight themes and seven sub-themes. The most pervasive of these was the theme of ambivalence, which functions on multiple levels and appears to constitute a significant barrier to help-seeking and recovery. Other themes included identity; body image; stigma; learning the behaviours; function and strategy of behaviours; choice; and recovery.

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Thank you to the nine women who volunteered to share their stories with me, in spite of the inconvenience and sometimes the pain of doing so. They had nothing to gain and much to lose, and yet they chose to give of themselves in the hope of helping other women.

I also wish to thank my colleagues in the First Friday Research Group for their inspiration and input. Watching the veterans complete their journeys and defend, and seeing myself reflected in new members, has lent me strength and inspiration. In addition, I wish to thank all my friends who not only listened to but showed genuine interest in this work, and especially those who read drafts and shared their insight and knowledge.

Finally, I wish to thank my parents, Bill and Carol McKay, for their support and encouragement. Their beliefs in me and in the value of education have fueled this journey, in more ways than one.

Dedication

This work is dedicated to the nine women who shared their stories: Anne, Gwen, April, Claire, Amber, Janet, Naomi, Maureen, and Kat. It is also dedicated to the women who inspired me to embark on this journey—you know who you are—and to the many women who suffer in silence, unable to share their pain. I hope that someday soon, things will be different.

Chapter 1: Introduction

> Nobody heard him, the dead man,
> But still he lay moaning:
> I was much further out than you thought
> And not waving but drowning.
> Poor chap, he always loved larking
> And now he's dead
> It must have been too cold for him his heart gave way,
> They said.
> Oh, no no no, it was too cold always
> (Still the dead one lay moaning)
> I was much too far out all my life
> And not waving but drowning.

Smith, 1972

Rationale: Not Waving but Drowning

I have long since lost count of how many times I have pulled this poem off my wall – or from a book – or from a page on the internet – to share with young women, and of how many times I have wished that Smith had chosen to write of a girl instead of a man. So many of the girls and women I have met and worked with are not waving—not laughing, not smiling, especially not partying—but drowning. Now, at 40, I am beginning to suspect that I was once one of them (no more; now, when I am drowning, you will know it).

The title of this work—Routes to Transcendence—reflects my pre-existing belief that the problem behaviours of disordered eating, substance abuse, and self-injury serve to self-induce a dissociative state, and that through creative reframing and exploration of behaviours that contribute to recovery, it would be possible to make a rhetorical shift from "dissociation" to "transcendence." This self-induced dissociation did not emerge as

a cohesive theme. I have decided to keep the title, however, as I believe it does reflect the

women's efforts first to transcend the material world, including—in some cases—their

own bodies, and ultimately to transcend their reliance on behaviours which limit their

potential to achieve a higher level of fulfillment. The search for something greater than

ourselves is, after all, one of the unifying elements of the human condition.

When I began this journey toward my Master of Social Work degree, I was under

the impression that this passion had been sparked in my professional life. I believed that

the teenaged girls—so many of them in inexplicable emotional pain—whom I

encountered in my decade of youth work had ignited this fire. Upon reflection, I have

realized that I have always been drawn to these girls and women, and they to me. I

believe that we recognize each other on sight. As far back as my own adolescence, I have

been the receiver (rarely the giver) of confessions, tearful revelations, stories that—as a

professional—I am impelled to refer to as "disclosures." I recall Karen,[1] late on the night

before we were all to leave university to go home for the summer, confessing her bulimia;

I remember wondering, of all people, why she chose to tell me. I think of Natalie, so thin

and so beautiful, aging before my eyes at only 21, and subjecting herself to relationships

in which she felt both protected and trapped. Long before I had any conscious

understanding of these problems, I remember Linda, remember just *knowing* that she was

not okay.

While I cannot thank my young clients for igniting this obsession, I can thank

them for helping to define it, to narrow it down to something that could be explored

through research. The problems of disordered eating, substance abuse, and self-injury

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[1] All names are pseudonyms.

probably represent only a sliver of the experience of women who endure psychic pain, but it is a sliver that can be defined and investigated. The complete-and-true story of women who cry only behind closed doors will likely never be fully known.

I was about half way through my graduate school journey when my mother asked me, in a casual and off-hand way, "Did we tell you that Kate died?" They had not. In my characteristic way, I filed this fact in the back of my mind, where it settled, not entirely forgotten, but neither grieved nor processed. It was not until I had written a first draft of my findings that it surfaced, fully integrated into my work. Kate was a woman I had known my entire life; she and her sisters sent a gift when I was born. Eight or nine years older than me, she was tall, beautiful, vivacious, intelligent – all of the things we are taught that we should be. She had a tall, beautiful, vivacious, intelligent husband and tall, beautiful, vivacious, intelligent children. And behind closed doors, she drank, and did not eat. Kate survived divorce; she survived aging not entirely gracefully. She had a career and maintained friendships and stayed relatively fit and healthy, until her teenaged daughter was killed in a car crash. After that, Kate could no longer maintain. She lived for another seven years, but her ability to function professionally and socially was increasingly impaired. She died in hospital at 48. The fact that this story—so relevant to my research—had stayed filed away so tidily in my memory boggles me. Even when asked by a fellow student what I thought happened to women who struggle with these three problems for years and never seek or receive treatment, I did not think of Kate; I simply speculated that they learn to manage. Had she not lost her daughter, Kate may well have "managed." Her daughter may have been one of those young women I attributed with inspiring this work.

Many of these girls and women have every reason in the world to be unhappy; they have deceased parents or siblings, broken families, historical abuse, chronic and acute illness, and injury. Just as many, though, will swear that they have no reason to be sad. bell hooks (1997) writes of "intellectually gifted women and girls"(p. xxii) who—like her—suffer a mind/body split, often expressed in disordered eating. I believe that this intellectual giftedness may be an essential component; this intellectual ability can, I believe, lead girls to strive to understand the world and their place in it before they are fully capable of achieving that understanding. They then face a range of disheartening truths, which, at such an early age, they are unable to put in perspective. The first of these truths is that the world is unjust and unfair; hard work and ability are rarely rewarded on their own merit. The second is that the human condition, often, consists of enduring one painful loss after another. The third, and perhaps most potent, is the realization that nothing we do will ever be good enough: straight-A student, most valuable player, most beautiful, most popular, prom queen, mother-of-the-year, CEO, and PhD – every accomplishment serves only to set the bar higher, forever unattainable.

For me, the identifiable source of my discontent was my parents' separation when I was seven. They reunited, but my sense of safety and—especially—my trust in my father had been irreparably damaged. For many years after, he was the object of my suspicion and contempt, but at the same time I yearned for his praise. It was a no-win situation for both of us. In the winter of my last year of high school, I was granted early—and conditional—admission to the three universities to which I had applied. When I received the letter of acceptance to my first choice, I went to my dad's office to share the news. He congratulated me, gave me a hug, was genuinely happy and proud. I

decided to be humble and reminded him that the offer was conditional. He responded, "Don't screw it up." I, of course, was offended and took this as an expression of his doubt. Rationally I know, twenty-three years later, that he was teasing; still, the fact that this memory is absolutely vivid—if no longer tinged with pain—is evidence of my own feelings of incompetence. Realistically, there was nothing the man could have said or done that would have convinced me of his pride. When I finally stopped looking to my father for unconditional approval, he started to give it. To be fair, I believe that he believed he was giving it all along. It was only when I was well into my twenties that I realized that when he asked, "Do you need any money?" he was really saying, "I love you." The doubt that I felt was not his but my own.

Years later, when I met Toni, it was as though she were channeling 17-year-old me. Sad without any understanding of why, convinced that nothing she could do would ever be good enough, in trouble with food and with alcohol, she was—more than anything—deeply confused. My at-times dubious success as a youth worker came almost entirely out of this sense that I was looking into a clouded mirror and telling my teenaged self what I wished someone had told me. Throughout the next eight years, Toni's voice was joined by dozens of others, their singular voices becoming a chorus, echoing, "What's wrong with me? Why am I so unhappy?" Long after Toni went off to university and began her adult life, I helped Jane to find a treatment facility where she felt safe to explore the emotional pain that led her to cut herself and to drink to blackout (Jane's older sister's difficulties had taken a different form, but her pain had been the same). Two years later, and two years clean, Jane told me, "I wasn't an alcoholic, but there wasn't a recovery house for fucked-up little girls."

In my family, thin was good; fat was bad. There was never any ambiguity about these facts. I had the good fortune to meet the criteria for "thin." When I was a child, in fact, I was often the object of concern; my friends' mothers commented on my small appetite and protruding ribs. I suspect now that many believed that I was malnourished, and that my mother was to blame; my mother, though, was (and still is) immune to criticism. Within my family, my size and appetite were non-issues (until I started to gain weight, that is; but by then I was in my late twenties and no longer quite so susceptible to self-flagellation). Eating has never been a problem for me, but it has taken many years of self-analysis and exploration to learn—often the hard way—that unless I make a conscious effort to balance the intellectual, social, spiritual, and physical aspects of my life, and unless I have something to look forward to and work towards, I can enter dangerous territory.

As I moved through the process of this research, I was startled by how easily I identified with the women with eating problems. There was very little in our conversations to which I did not nod my understanding. At first, I wondered if this meant that I had somehow dodged a bullet; that if I had been a fat child in a thin family, if my mother had openly dieted, if ours had been a home with soft drinks and potato chips instead of low-fat milk and whole foods, I would have developed an eating disorder. I was unsure whether I was like the women with eating disorders or whether they were like me – relatively "normal" women who deal with the consequences of bad habits. In discussion with friends and colleagues, the idea that emerged was that both were true; we are all normal, and we all dodge bullets – and sometimes we do not. This level of understanding—and I recognize that it is a choice, not a truth—informs this study. The

women who shared their stories with me are seen not as sick women, not as disordered

women, not as pathological women, but as women, perfect and beautiful just as they are.

Definition of Terms

Anorexia Nervosa (AN): a psychological disorder characterized by refusal to maintain

minimally normal body weight, intense fear of gaining weight, and a significant

disturbance in the perception of size or shape of the body. Females with this

disorder are amenorrheic (have ceased menstruation). Two subtypes exist: the

restricting type, in which weight loss is accomplished primarily through dieting;

and the binge-eating/purging type, in which the individual engages in binge

eating, as well as purging through self-induced vomiting or misuse of laxatives,

diuretics, or enemas. AN is the least common of the eating disorders at

approximate 0.5%; more than 90% of cases occur in females (American

Psychiatric Association, 2005).

Bulimia Nervosa (BN): a psychological disorder characterized by binge eating (eating in

a discrete period of time—usually two hours or less—an amount of food that is

definitely larger than most people would eat during a similar period of time and

under similar circumstances) and inappropriate compensatory methods to prevent

weight gain. Two subtypes exist: the purging and the non-purging (American

Psychiatric Association, 2005).

Disordered eating: refers to clinical or non-clinical levels of bingeing, purging, and/or

restriction of eating.

Self-injurious behaviour (SIB): a diverse range of deliberate acts of self-harm that fall

outside the broad sphere of social acceptability, are not intended to beautify the

body, and occur in the absence of conscious suicidal intention (Davis & Karvinen,

2002).

Substance Abuse: a maladaptive pattern of substance use as manifested by one or more

of the following, occurring within a 12-month period: recurrent substance use

resulting in failure to fulfill major role obligations; recurrent substance use in

situations in which it is physically hazardous; recurrent substance-related legal

problems; and continued substance use despite persisted or recurrent social or

interpersonal problems resulting from use (American Psychiatric Association,

2005).

Drug Use Disorder (DUD): includes substance dependence (with and without

physiological dependence) and substance abuse (see above). Substance

dependence is a maladaptive pattern of substance use as manifested by three or

more of the following, occurring at the same time, in any 12-month period:

tolerance; withdrawal; taking larger amounts of the substance or over a longer

period than was intended; persistent desire or unsuccessful efforts to cut down or

control use; a great deal of time spent in obtaining, using, or recovering from the

substance; giving up or reducing important activities because of use; and

continued use in spite of knowledge of adverse effects (American Psychiatric

Association, 2005).

Self-harm: describes any behaviour in which one knowingly and willingly does physical,

psychological, spiritual, or other harm to the self.

Chapter 2: Literature Review

As background to this study, literature has been drawn from a number of areas. The first section looks briefly into feminist theory as well as literature on women's psychology and spirituality, as they relate to this study. The second section considers research into the intersections between the three identified behaviours: disordered eating, substance abuse, and self-injury. The majority of this literature is quantitative, and this work is considered first. Because of the vast amount of research in the three areas, this portion of the review is limited to those works which consider the intersections between the three problem behaviours. A discussion of qualitative research in these intersections follows. Finally, I have included a brief discussion on the value of creativity in women's health and healing.

Feminism, Psychology, and Spirituality

One of the defining principles of feminist thought is collectivism: the idea that all women are connected, and that the oppression of some women affects us all. This idea threads through the literature not only on feminist theory, but on women's mental health, psychotherapy with women, and women's spiritualities. All of these perspectives on women's experiences acknowledge the necessity for women to connect with one another in order to achieve strength, empowerment, and wellness. One participant, in a study with feminist social workers, even suggested that feminism and spirituality are analogous (Coholic, 2003). Exploring these commonalities may offer insight into factors across disciplines and theoretical positions which contribute to women's wellness.

Feminist Theory

Two central ideas of the feminist movement are "the personal is political" and "sisterhood is powerful" (Adamson, Briskin, & MacPhail, 1988). Both these ideas illustrate the fact that feminism is at essence a communal—rather than individualistic—set of ideals. The first statement reflects the belief that the experiences of any given individual woman are the direct result of the larger system of male-dominated structures and male-centric rules, and as such cannot be seen only as personal. What affects one woman affects us all, and must be viewed in the light of the greater political and historical context. The second statement reflects the belief that by uniting as sisters, and by taking responsibility for one another as sisters, women can have (and have had) great effects on the male status quo. This communal stance sees male ideals of independence and autonomy as having created rifts and divisions in structures which otherwise may have supported women's communalism. The primacy of individual rights and freedoms over communal good, of the economic prosperity of a few over the general wellness of many, and of individual accomplishment over contribution to community all illustrate the dominance of normative male, Western values. Even such seemingly core concepts as that of property ownership (rather than shared stewardship) and the value of education emphasize individual advancement rather than responsibility to extended family and community. Common-wisdom phrases such as "good fences make good neighbours" clearly devalue communal relationships in favour of small, cohesive family units, typically headed by male breadwinners. Those "good fences" serve the function of isolating women from potentially-supportive others.

In seeking to break down these barriers between individuals and families, feminism recognizes the value and the power of community and sisterhood. While male ideals are often exemplified by exceptional individual accomplishments—the business tycoon, sports star, or pioneer of science—female ideals are more likely to be exceptional mothers, educators, or writers, sharing their experiences and knowledge with others. Feminism seeks to elevate those ideals of sharing to equal status with personal, individual accomplishments.

The womanist movement arose in reaction to the predominance of White, educated, middle-class women promoting feminism (Heath, 2006). This perspective represents the experiences of women of colour, abused and disabled women, women living in poverty, lesbian, bisexual, and transgendered women, and others who have experienced oppressions to which White, middle-class women are typically not subject. Arguably, this stance is even more consciously collectivist and communal than traditional feminism. Like anti-oppressive social work, it assumes responsibility for challenging oppression at all levels, not just in corporate office towers and suburban homes (Mullaly, 2002).

Women's psychology

Gilligan (1982) explores the evolution of modern psychology and its failure to adequately account for gender differences. Noting the "…repeated exclusion of women from the critical theory-building studies of psychological research" (p.1), she illuminates the way that male psychologists, psychiatrists, and scholars defined the typical male experience as the norm, thereby designating the typical female experience as deviant. Even when gender differences were accounted for in the literature, Gilligan explains, the

male trajectory was envisioned as superior, correct, and preferred. By definition, girls'

and women's developmental trajectories were seen as inferior and pathological. While it

was recognized that normal development for boys was indicated by increasing separation

from the mother and for girls by emulation and identification with the mother, the former

path was elevated to superior status. Gilligan writes: "Since masculinity is defined

through separation [from the mother] while femininity is defined through attachment,

male gender identity is threatened by intimacy while female gender identity is threatened

by separation" (p.8).

Girls' play was seen as less sophisticated because it was not subject to rigid

structure and rules as boys' play, and because girls' relationships took priority over the

continuity of their games (Gilligan, 1982). Independence and autonomy were valued over

interdependence and connectivity. Ultimately, theories of normal child development

came to reflect boys' development, while girls' development became associated with

less-than-optimal social maturity. Independence and autonomy continue to be valued

over interdependence and connectivity for adults in the western world. Women who

display the former characteristics are often viewed as superior, because they can measure

up to male values in the workplace and elsewhere, but at the same time are seen as not

entirely female, and therefore flawed. Men who pursue career advancement at the

expense of family are viewed as ambitious and autonomous, while women who do the

same are viewed as lacking the female virtue of self-sacrifice.

This no-win position, in which women are either ideal-but-lesser or equal-but-

flawed has naturally led to a great deal of frustration – frustration which women typically

express differently than do men. These differences, in the light of the male psychological

perspective, came to be seen as problematic and often pathological. The primarily-male

psychiatric community created mental illness designations—such as hysteria and, more

recently, borderline personality disorder—to explain female behaviour which did not fit

the male ideal (American Psychiatric Association, 2005).

Out of the gradual recognition that women's differences do not necessarily

amount to illness, a number of alternate theories of feminist psychology have arisen.

Gilligan, Rogers, and Tolman (1991) reframe this pathological behaviour as positive

resistance. Viewing women's antisocial and self-destructive behaviours as expressions of

resistance to disconnection and to societal norms and expectations, they see women

reclaiming power over their own lives (the issues of connection and disconnection are

discussed further in the last section of this literature review). A woman, for instance, who

presents a public image as a perfect, competent wife and mother, but drinks heavily in

private, is viewed not as someone with the disease of alcoholism but as someone who

resists the gender-determined role into which she has been forced. From a therapeutic

perspective, this promotes a view of the woman as empowered and in control rather than

compulsive and out of control. In seeing such behaviours as resistance strategies rather

than symptoms, Gilligan and her colleagues acknowledge and honour women's agency in

male-dominated contexts.

Kaschak (1992) explores women's identities as a function of their roles in men's

lives. In a vivid illustration of this, she writes: "The measure of a woman's sexuality is a

man's tumescence" (p.55). Further illuminating the many ways in which women's selves

are defined and molded by men's needs, Kashak delineates the training mothers pass on

to their daughters for these roles, teaching girls what is and will be expected of them. She

explores women's definition of self in response to the appraisals and expectations of men:

fathers, brothers, lovers, and even strangers. Given this extensive and thorough training,

the hypothetical woman above, who drinks in the privacy of her marriage, can be seen as

a true rebel: she may appear to conform—which affords her a measure of power—while

in reality, she resists the expectations of the man who demands the most of her, refusing

to conform.

Traditional therapeutic and treatment models would label the drinking a problem

and promote abstinence with our hypothetical woman, in effect seeking to take away her

resistance strategy. As an alternative, Moore (1994) writes of working with a client to

identify the benefit of the problematic behaviour. He would "try to give what is

problematic back to the person in a way that shows its necessity, even its value" (p.6).

This approach is more consistent with the theory of positive resistance, assuming that

every perceived problem behaviour reflects an effort to achieve well-being.

Rogers (1991) explores resistance to disconnection within the therapeutic

relationship. Writing that women and girls who resist disconnection are likely to end up

in therapy, she warns that the strictures of therapy may, in fact, contribute to the problem.

Women and girls may go into therapy needing and wanting to form connections with

female therapists, while therapists are likely to set up obstacles to that connection.

Specifically, Rogers considers adolescent girls' need for connection with women, and

illuminates that many of the women with whom girls seek connection may use

professional boundaries—those of the teacher, the counsellor, the doctor—to prevent or

limit those connections. The very nature of traditional professional relationships, then—

that they are temporary, context-specific, and exist within well-defined boundaries—may mean that they cause more harm than good.

The theory of self-in-relation, particularly in reference to women's mental health, has been well established for two decades (Surrey, 1991). This theory conceives of women's selves as primarily relational, and stands in stark contrast to traditional psychotherapeutic theories of development, which view independence and separation as pinnacles of developmental achievement. Surrey defines self as "a construct useful in describing the organization of a person's experience and construction of reality that illuminates the purpose and directionality of her or his behavior" (p.52). At essence, self is the concept of how we make meaning of our own behaviour – how we rationalize and make sense of our choices and thoughts. In traditional, male psychology, narcissism and self-interest are considered the norm, but that norm only truly applies to men; narcissistic, self-interested women are incomplete *as* women, lacking in the virtue of self-sacrifice. Self-in-relation theory offers an alternative view, acknowledging that men *in general* define self through separation while women *in general* do so in relation to others: as daughters to our mothers first, then as sisters, friends, mothers, grandmothers, etc. Self-in-relation does not attempt to dichotomize according to gender, but views aspects of self such as autonomy and assertiveness as developing within the context of relationship; disconnection and self-interest are unnecessary to normal development. Central to this theory is the recognition that women exhibit a great capacity for empathy, and that relationships depend on mutual empathy. Surrey envisions the mother-daughter relationship as the model for the development of this empathic mutuality (this raises

obvious questions around the implications for girls and women whose mothers are absent

or unavailable; however, those questions are beyond the scope of this discussion).

Surrey (1991) distills the concept of women's self-in-relation to three elements:

1. an interest in and attention to the other person(s), which form the basis
    for the emotional connection and the ability to empathize with the
    other(s);
2. the expectation of a mutual empathic process where the sharing of
    experience leads to a heightened development of self and other; and,
3. the expectation of interaction and relationship as a process of mutual
    sensitivity and mutual responsibility that provides the stimulus for the
    growth of empowerment and self-knowledge (p.59).

This definition stands in stark contrast to the ideals of the independent, autonomous, self-

made man with which most of us in the Western world have learned to compare

ourselves.

Jordan (1991) reinforces the idea that development toward independence reflects

a male ideal of development, writing of "growth through and toward relationship" (p.81).

This conception of development emphasizes mutuality and empathy in a variety of

relationships (rather than just the ideal romantic love dyad). Jordan labels this

relationship ideal as "mutual intersubjectivity" (p. 82); she describes an acute level of

empathy and awareness which has the potential to alter the individuals engaged in the

relationship. This conception of a profound, intense relationship which contributes to the

growth and development of those involved clearly reflects the power of connection.

Women's spirituality

Spirituality has always been an essential aspect of women's lives, and women's

spiritual pursuits have always taken place in both communal and individual contexts.

Modern religious traditions, however, have both excluded women from certain aspects of

religion (the clergy, certain rituals) and discouraged or persecuted women's efforts at

forming their own exclusive rituals (wiccan traditions). Recently, women appear to be

staking a claim to their right to pursue a spirituality that is separate from, and potentially

greater than, the traditional religions. These spiritualities are typically accepting of

divergent beliefs and void of strict rules and rituals, and they often focus on collectivity,

mutuality, and support.

One of the fundamental problems with spirituality research is that of definition of

spirituality and how to distinguish it from religion. For non-religious people, the

distinction may be clear; for those who follow a formal religion, however, the two are

inextricably connected. For the purposes of this paper, I will accept the following

definitions from Coholic (2003):

> Spirituality is eclectic and transcends ideologies and institutions. It is a complex
> construct that can be deeply personal and communal and that can encompass a
> sense of connection with something bigger that transcends ordinary life
> experience (something bigger is necessarily self-defined). Religion can be
> described as a construction of institutionalized worship that is dependent
> on a notion of God or godheads and is based on doctrine or system of organized
> beliefs and behaviors, usually shared by people (p. 49).

These definitions are to some extent arbitrary and cannot adequately capture either

concept; however, they do capture the idea that spirituality is largely an internal process,

while religion is often externally organized.

Coholic (2003) conducted qualitative interviews with 20 practicing feminist

social workers on the topic of spirituality in practice. She then used grounded theory

analysis to illuminate convergences in themes; from these convergences, she identified

ten practice principles on incorporating spirituality in feminist social work. From the

interviews, practice principles, and participant feedback, Coholic generated three topics

for discussion by focus groups consisting of 14 of her original participants. These topics

were: the shared values of feminist social work perspectives and spiritualities; holistic

practice approaches; and the feminist nature of practice principles. The first topic

represented the expression of participants that feminism and spirituality share values of

diversity and inclusion, and action and change, and that these are collective and personal

constructs. Participants also expressed the idea that the social work profession allowed

them to incorporate their personal beliefs and values into their work life. Another theme

was that core social work values such as respect, self-determination, and the assumption

that clients are experts on their own lives are consistent both with spiritualities and with

feminism. Connected to these ideas was the belief that meaningful helping attends to

body, mind, emotions, and spirit. Participants recognized that social work has been

negligent in addressing the spiritual quadrant of holistic practice, even though it may

have the greatest potential among helping professions to be truly holistic. Participants

also expressed some frustration at the lack of literature and theory on incorporating

spirituality into social work practice; this seems to reflect the struggle within social work

to live up to "hard science" and professionalism. One participant even noted that many

practitioners include exploration of spirituality in their practice, but that they do not name

it as such because there is little or no theory to back up the practice. The second focus

group topic was the feminist nature of the ten practice principles generated through the

grounded theory analysis. Participants drew parallels between spirituality and feminism

as perspectives which brought up issues typically ignored or glossed over in conventional

practice. They also saw both as having at essence the goal of helping people to transcend

overt and covert oppression and to reach their potential. The third topic was valuing

diversity. Participants emphasized the value of diversity not just among clients and

workers, but within practice. They recognized that social work practice benefits from

remaining flexible within different contexts and from growing and adapting over time.

Geertsma and Cummings (2004) set out to describe midlife transition, spirituality,

and healing of relationships among members of women's spirituality groups. In a

qualitative study conducted with ten women participating in a spirituality group outside

of a traditional faith setting, the authors had participants complete the Spiritual Well-

Being Scale (Paloutzian & Ellison, 1982, cited in Geertsma & Cummings, 2004). This

scale measures an individual's relationship with God, or Religiosity, on a vertical

dimension, and understanding of the purpose of life and life satisfaction, or

Existentialism, on a horizontal dimension. Participants were also interviewed regarding

their religious and spiritual beliefs and practices. Women in the study were all in midlife

and described themselves as in transition. Four themes emerged from the data regarding

spirituality, two of which were expressed by all ten women. These were: a belief in God,

Energy, or Higher Power; and personal choice – the sense that each person is responsible

for nurturing her own spirituality. The two themes which were expressed by the majority

of participants were: connectedness, not just with God or a Higher Power but with the

world in general; and mystery, the sense that there are aspects to spirituality that cannot

be known. In regards to religion, three themes were expressed by the majority of

participants. They were: authority, judgment, and incompleteness. Participants expressed

the view that religion involved the imposition of rules and expectations, that it was

negative or abusive, and that on its own, religion was not enough. In comparing

spirituality and religion, participants expressed views of spirituality as nurturing and

allowing freedom, while religion was seen as imposing restrictions and judgment. All of

the women ranked spirituality as more important than religion (including the four women who were actively involved in church communities); some reported that they wanted both in their lives.

In regards to their spirituality group, participants did not view it as a religious practice, stating that the group was free of expectations, competition, and authority. They expressed belief that the group offered therapeutic benefits through emotional and spiritual healing. They commented on the positive effect on their relationships outside the group, as well as the support they provided to each other. One woman commented on the "feminine energy" in the group (p.31), contrasting this with masculine energy (the authors do not offer clarification of this point, which would have been an interesting addition to the study). Perhaps most significant, participants described the spirituality group as a place of safety; Geertsma and Cummings (2004) infer that this safety was not present to the same extent in traditional religious contexts or society at large.

In a study with 151 battered women, Gillum, Sullivan, and Bybee (2006) assessed the extent to which religious and spiritual community involvement facilitated survivors' emotional and psychological wellness. Participants were assessed on a number of scales: physical abuse experienced; psychological abuse experienced; depression; quality of life; social support; self-esteem; spirituality or God as a source of strength; and involvement in organized religion. During analysis, the authors found significant variance between women of colour and Caucasian women; for this reason, they chose to analyze the two groups separately. Virtually all of the women (97%) endorsed the statement that spirituality or God was a source of strength or comfort. This variable was not included in correlational analyses, due to its overwhelming strength.

Gillum et al. (2006) found that religious involvement was related to social support, but only for women of colour. The authors note that this finding is consistent with previous research, which has found that spirituality and religiosity is correlated with increased physical and psychological well-being of African Americans, and question the reasons for these clear racial differences. Religious involvement appeared to promote greater psychological well-being and quality of life as well as decreased depression. Gillum et al. suggest that these findings have implications both for those providing services to women and to religious communities. They advocate incorporating a spiritual component into community services for battered women, such as shelters, adding that this may be particularly helpful in augmenting the social support resources of women of colour. They also suggest that religious and spiritual communities actively address the issue of domestic violence and provide services to women within their communities.

Heath (2006) examined the relationship between spirituality and mental health among Black women. Elucidating the fact that issues of gender, race, and class have been largely ignored in mental health research, Heath advocates a womanist research agenda to address Black women's mental health needs. Suggesting that society at large is blind and deaf to the needs of Black women, Heath writes that Black women turn to God, the one who always listens. Citing the multiple oppressions to which Black women are subject (racial, gender, socioeconomic, class, all on both internal and external levels), Heath emphasizes these multiple oppressions as sources of intense stress for Black women, and reminds us of the well-documented connections between stress and negative health outcomes (Brannon & Feist, 2004). Exploring other influences on Black women's mental health, Heath discusses the myth of the matriarch or the "strong Black woman,"

honed by history to withstand any hardship (p.163). She also elucidates socio-political

influences such as stereotypes, lack of cultural awareness, and adoption of patterned

responses among mental health professionals.

Distinguishing womanist spirituality from dominant conceptions of spirituality,

Heath (2006) writes that:

> It is a spirituality that stands as a protest against the demeaning status quo, one
> that seeks justice in the midst of evil, peace in the midst of violence, and freedom
> as a counterbalance to oppression. Womanist spirituality is a way of living, a
> form of social witness, used for critiquing society; for affirming dignity and self
> worth; for achieving sanity, communal solidarity, and social support; as well as a
> way for distinguishing the oppressed from their oppressors (p.161).

Heath describes spirituality among Black women as "a source to help facilitate health

promotion, healing, and coping" (p.165), and emphasizes that mental health research

must take this into account in order to address Black women's needs. She suggests that

only a womanist research agenda which acknowledges cultural diversity and multiple

oppressions can adequately describe these unique needs, and which recognizes the power

of Black women's spirituality. She calls for research which highlights the voices of Black

women and demonstrates that those voices can, in fact, be heard amidst the louder, often

more-potent voices of Whites and of Black men.

In a completely different type of research, Foltz (2000a), a scholar of new

religions, conducted participant observation with a coven of Dianic witches over the

course of one year. The Dianics consider themselves to be radical feminists on the

political fringe, and have adapted the feminist mantra "The personal is political" to

reflect their stance that "The spiritual is political" (Spretnak, 1982, cited in Foltz, 2000a,

p. 411). They reject all aspects of patriarchy, including hierarchical religious structures

and positivist, objective research traditions. They also believe in the potential of feminist

spirituality for transforming, reintegrating, and healing women's identities. Their rituals include mourning the abuse of women in patriarchal society and healing from historical violence.

Foltz (2000b) also conducted research with alcoholic women in contexts of feminist spirtualities. She found that the women often find traditional recovery programs like Alcoholics Anonymous (AA) to be oppressive and inconsistent with feminist values and spirituality. In particular, the first step in the 12-step program is admitting that one is powerless over alcohol. Foltz found that many women resisted this step, and that it may be "a good approach for men with stronger egos, but potentially oppressive for women" (p.123). She touches on the issue of healing at the personal level as well, noting that alcoholic women often find that the patriarchal structure of AA is not conducive to discussion of women's issues such as childhood sexual abuse, incest, rape, and physical abuse. She found that feminist spirituality provided opportunities for alcoholic women to explore these issues in the safety of trusting relationships with other women. This sense of safety in women's spirituality, and among women, is echoed in the finding of Geertsma and Cummings (2004), cited above.

While the view of spirituality and religion taken in these works is overwhelmingly positive, it must be noted that religion is not always kind to women. Milne (1995) writes of the religious basis of female oppression. In the Bible and the Qur'an, she writes, women and women's sexuality are the property of men and are subject to men's will; closely connected to this portrayal is the placement of women in God's hierarchy, below men (but above livestock). Women are also portrayed as dangerous and a threat to men's morality. This is problematic because in many religions,

the sacred texts are taken as evidence of God's will and instruction on how to live in accordance with that will. This is reflected in the views expressed by the women in Geertsma and Cummings (2004), that they found that religious settings emphasized rules and hierarchy. Ratliffe (2000) reinforces these issues, writing that "At its not-so-best, religion degenerates into an oppressive rationalization for male supremacy, racial hegemony, and political fanaticism" (p. 205). In a cursory exploration of the treatment of women within the six major world belief systems, Ratliffe finds evidence to confirm Milne's findings: that women are generally considered property and are often denied reproductive and sexual freedoms; that male children are valued over female children; that men are instructed to be wary of women's influence; that women are denied equal opportunities within religious organizations; and that women's position in the spiritual and domestic hierarchies is below men.

The common elements in the works cited on women's spirituality are those of connection and a sense of mutuality and acceptance among and between women. Rather than relying on ritual and context, the power of spirituality to enhance women's lives seems to come from the relationships it fosters. A group of women, in a context of safety and trust—whether that context is religious, spiritual, or secular—seem to have a particular capacity to heal and grow.

Quantitative Research: The Intersections

An overwhelming amount of research has been conducted concerning disordered eating, substance abuse, and self-injurious behaviours (SIB) among women; however, inquiry into the intersections of the behaviours is more limited. This literature review will focus on these intersections. Most of this work has been conducted with clinical samples

(diagnosed with and/or in treatment for one or more problem behaviours) and has been

positivistic in nature. It describes correlations and relationships between symptoms,

antecedents, and behaviours; as such, it represents important information, but forms only

pieces in the much-larger puzzle that illustrates the lived experiences of women who

struggle with these problems. Due to the volume and complexity of this quantitative

research, a summary in chart form is provided in Appendix A.

Disordered Eating and Substance Abuse

First, I will consider the research in the intersection between disordered eating

and substance abuse. In a comprehensive review of 51 studies on cormorbidity between

substance abuse and eating disorders conducted from 1977 to 1991, Holderness, Brooks-

Gunn, and Warren (1994) observed a wide range of often-conflicting findings. As an

example, the percentage of women with Bulimia Nervosa (BN) reporting alcohol abuse,

dependence, and/or treatment ranged from 2.9% to 48.6% in studies cited. Some of these

inconsistencies appear to reflect differences in definitions and methodology; for instance,

some studies considered clinical and/or hospitalized participants while others did not

specify whether their populations were clinical. Some studies were limited to specific

drugs while others looked at drug use in general. Also, because of the time span covered

by the research, Diagnostic and Statistical Manual (DSM) classifications of substance

abuse, substance dependence, and eating disorders had changed over time. Particularly

problematic is the fact that not all studies accounted for the discrepant disordered eating

diagnoses and behaviours in their analyses; comparing alcohol use among those with

Anorexia Nervosa (AN) without accounting for differences between women who binge

and those who restrict offers the most obvious illustration of this problem.

One important point of note is that of the studies reviewed by Holderness et al. (1994) almost all inquired into substance use and abuse among participants identified with eating disorders; only five studies took the reverse approach of exploring disordered eating among those whose primary identified problem behaviour was substance abuse. These studies also found a wide range of comorbidity, from 8% to 40.7% with a median of 20%.

The strongest association found in the survey by Holderness et al. (1994) was that between BN and drug use (rather than drug abuse). Consistent with this finding, those with the binging subtype of AN, used more substances than those with restricting AN, and BN was more common than AN among drug abusers.

Since Holderness et al.'s (1994) survey, research into this intersection has continued to find the strongest support for the BN-substance abuse connection. Weiderman and Pryor (1995) compared 134 women with AN to 320 women with BN and found that the latter were more likely to have used alcohol, amphetamines, barbiturates, marijuana, tranquilizers, and cocaine. They found three additional significant correlations: first, severity of caloric restriction was predictive of amphetamine use; second, severity of binge eating was predictive of tranquilizer use; and third, severity of purging was predictive of alcohol, cocaine, and cigarette use. These three findings existed independently of the AN-BN distinction. Among women with BN, Weiderman and Pryor found that 73.4% had used alcohol (34.8% weekly or more); 17.8% had used amphetamines; 10.0% barbiturates; 7.8% hallucinogens; 24.7% marijuana; 13.8% tranquilizers; 12.5% cocaine; and 32.1% had used cigarettes. Among

those with AN, all percentages were lower [29.6 (11.9); 3.0; 2.2; 0.7; 5.2; 2.2; 1.5; and 22.2 respectively].

Measelle, Stice, and Hogansen (2005) conducted a longitudinal study of 493 female adolescents in the interest of tracking the trajectories of depressive, eating, antisocial, and substance abuse problems. Participants, who were 13 to 15 years of age at the beginning of the study, were assessed annually using multiple clinical tools over a five-year period. They found that, while antisocial behaviour decreased over time, depression, eating disorders, and substance abuse symptoms tended to increase. Measelle et al. also examined the interactions between the four symptomologies. Most significant to the current work, they found that initial eating pathology predicted future increases in substance abuse (but not vice versa). The researchers offer two possible explanations for this relationship: first, they suggest that the desire for thinness may increase the risk for stimulant use; second, they speculate that problem eating may lead to shame and guilt, which may in turn lead to substance abuse as a coping mechanism.

In another longitudinal study, Herzog et al. (2006) followed 136 women with AN and 110 women with BN and assessed them for drug use disorder (DUD). The study lasted almost nine years and women were interviewed and assessed every 6 to 12 months. Of these women, 42 (22 with AN, 20 with BN) were found to have had a history of DUD. While most of these women reported that their drug use problems predated the study, several (five with AN and six with BN) developed DUD during the course of the study. The researchers also found, however, that overall frequency of DUD decreased over time. Herzog et al. state that their participants received "a high rate of treatment over the course of the study" (p. 368). It is unclear, however, whether said treatment was viewed

as responsible for the lessening overall frequency of DUD or unsuccessful in addressing

the compound problems of the women who developed DUD over the same time period.

In yet another longitudinal study with women who suffer with eating disorders,

Thompson-Brenner et al. (2008) looked at association between personality and substance

use. They followed 213 women with eating disorders (101 with BN; 35 with restricting

AN; and 77 with the binge-purge subtype of AN) who had completed personality

interviews. At intake, 42 of the participants had a history of alcohol use disorder (AUD);

by the end of the nine-year study, 24 participants who had no history at intake had

developed AUD. In regards to drug use disorder (DUD), 31 participants began the study

with DUD; 11 developed DUD during the course of the study. They concluded that

individuals with eating disorders who show a more obsessional (perfectionistic)

personality are unlikely to abuse substances. Those with a behaviourally dysregulated

style (characterized by impulsivity, risk-taking, and self-harm) are more likely than

others to abuse alcohol. Neither the eating disorder diagnosis (BN or AN) nor history of

major depression appeared to explain longitudinal patterns of substance abuse. These

findings support other research that identifies impulsivity as a key factor in substance

abuse and self-injury.

In a study with women with BN, Sandager et al. (2008) examined relationships

between tobacco use and comorbidity in women with BN. They found higher overall

cormorbid pathology scores among smokers; this was particularly true for depression.

They also found that women with BN who smoked had poorer health status and were less

likely to seek treatment. Finally, they found that women with BN who smoked reported

higher alcohol consumption: they drank more often, had more drinks on each occasion,

and reported more episodes of binge drinking. The authors speculate that these

associations may reflect higher levels of impulsivity among women with BN who smoke.

The above studies all address disordered eating and substance abuse in clinical

populations; the two which follow explored the same problems with non-clinical

populations. Dunn, Larimer, and Neighbors (2002) inquired into alcohol and drug-related

negative consequences among college students with eating disorders. Of 3,013 students

surveyed, 133 met diagnostic criteria for an eating disorder. Of these, 77 met criteria for

BN; 54 met criteria for binge eating disorder; and two met the criteria for AN. Of males

surveyed, only 18 met the criteria for an eating disorder; of females, 115 met criteria.

Statistical analysis found no significant difference in alcohol consumption among eating

disordered and non-eating disordered groups of either gender. However, females who

met criteria for BN and binge eating disorder were more likely to use marijuana, opiates,

and barbiturates. No other significant differences in drug use were found. In their

analysis of alcohol and drug-related negative consequences, however, females who met

BN criteria reported more negative consequences and more severe consequences. Some

examples of negative consequences included: neglected responsibilities; had a bad time;

missed school, work, activities, or get-togethers; stopped activity; and been arrested.

The following studies represent statistical analyses of pre-existing health and

behaviour survey data. In a large, community-based epidemiological study, von Ranson,

Iacono, and McGue (2002) looked at associations between disordered eating and eating

disorders and substance use and substance use disorders among 672 adolescent girls and

718 women. They found associations between eating attitudes and disorders and nicotine,

alcohol, and drug use; however, these associations were not strong. They found that

adolescent girls with eating problems and eating disorders were more likely to have a history of substance use (not abuse) and nicotine dependence than those without eating problems. Associations between eating disorders and misuse of substances were inconsistent, although von Ranson et al. did note associations between bulimic eating disorders and alcohol misuse as well as between restricting eating disorders and illicit drug use. These findings were not supported in all analyses, and the authors advise caution in interpretation; however, they note that the findings are consistent with previous findings among clinical populations. Among adult women, the authors found relationships between eating attitudes and pathology and alcohol use and misuse, but caution that these relationships were statistically weak. Other effects noted were inconsistent across analyses, and the authors suggest that adult women were well past the peak onset age for eating disorders and less likely to endorse current disordered eating symptoms.

In a survey of female twins drawn from the Virginia Adult Twin Study of Psychiatric and Substance Use Disorders, Baker, Mazzeo, and Kendler (2007) examined the association between bulimia nervosa and drug use disorders. They administered self-report questionnaires to a sample of 549 identical twins, 375 fraternal twins, and 930 women from opposite-sex pairs, and scored participants on a range of personality and psychiatric scales. Variables measured included: neuroticism, novelty seeking, major depression, childhood sexual abuse, conduct disorder, antisocial disorder, anxiety disorders. In their consideration of drug use disorders, they looked at use of cannabis, stimulants, cocaine, opiates, hallucinogens, inhalants, and non-prescription drug abuse or dependence; they did not consider alcohol use and abuse. Statistical analysis indicated

that, in women with bulimia nervosa (5% of the women in the sample), drug use

disorders were associated with neuroticism and major depression. They also found a

strong genetic component (83%, versus 17% environment) to the comorbidity of bulimia

nervosa and drug use disorders.

In a large-scale survey of Canadian men and women, Gadalla and Piran (2007)

examined correlations between eating disorders and substance abuse. Their data was

drawn from the Canadian Community Health Survey, and included survey responses

from 20, 211 women and 16,773 men. Two measures of eating attitudes and behaviours

were used: the first queried fear of being overweight either during respondent's lifetime

or within the previous 12 months. Respondents who replied "yes" to fear about being

overweight were administered the Eating Attitude Test (EAT-26); respondents who

scored 20 or above out of 78 on the EAT-26 were considered to be at risk of an eating

disorder. Measures of alcohol gauged alcohol use and alcohol interference. Cannabis was

considered separately from other illicit drugs, and two measures were included: cannabis

use over the previous 12 months and lifetime cannabis use. Four variables for illicit drugs

were included: use in the previous 12 months; lifetime use; dependence; and interference.

For all illicit drug use variables, one-time use of cannabis was excluded. Lifetime use of

specific illicit drugs was also considered.

Gadalla and Piran (2007) found that, for all variables of body and eating problems,

women scored higher than men (18.5% vs. 7.7% for fear of being overweight – 12

months; 32.3% vs. 15.2% for fear of being overweight – lifetime; 2.8% versus 0.5% at

risk of eating disorder). Alcohol and drug use and problems were consistently higher in

men. For both genders, co-occurrence of disordered eating and alcohol interference were

significantly higher than random chance; for men, this co-occurrence was four times

higher; for women, 4.4 times. For both genders, risk of eating disorders was strongly

associated with greater substance use, dependence, and interference; however, for men,

risk of eating disorders was associated with 10 out of 15 measures of substance use,

while for women, it was associated with all 15 measures.

Pisetsky, Chao, Dierker, May, and Striegel-Moore (2008) examined data gathered

from over 13,000 adolescents in regards to disordered eating and substance use. In their

sample, female students were approximately twice as likely as male students to report

eating disorder behaviour (21.8% vs. 11.2%). Female students were also more likely to

engage in all three disordered eating behaviours (fasting, using diet products, and

purging), although these numbers were small, at 1.5% for girls and 1.0% for boys. For

both genders, disordered eating was significantly associated with the use of each

substance; however, there were differences in the strength of these associations. For

female students, moderate associations were found with cigarettes, alcohol, and inhalants;

associations were weak for marijuana, cocaine, heroin, methamphetamines, ecstasy,

steroids, and hallucinogens. For male students, strong associations were found with

marijuana, inhalants, and steroids; effects for all other substances were moderate.

Disordered Eating and Self-injury

As in the disordered eating-substance abuse intersection, a large body of research

has been conducted into the intersection between disordered eating and self-harm

behaviours. In a study with a highly-clinical stance, Yaryura-Tobias, Neziroglu, and

Kaplan (1995) conducted inquiry with 19 female patients diagnosed with obsessive

compulsive disorder (OCD) who also displayed symptoms of self-mutilation,

dysmenorrhea (lack of menstruation), and dysorexia (impaired or deranged appetite). The

researchers observed a consistent chronological sequence of symptoms: participants

became anorexic, then amenorrheic, within an average of five years after developing

OCD symptoms. Within two years after improvement of AN, the women were no longer

amenorrheic but exhibited dysorexia (overeating, bingeing, BN), accompanied by a

compulsion for SIB. Yaryura-Tobias et al. go on to note that intensive behaviour therapy

and clomipramine treatment appeared to decrease self-harm and other problem

behaviours, and to speculate about brain and hormonal structures which may play a part

in the participants' problems. More relevant to the current work, however, is the small

but significant qualitative piece to their research. The authors present a brief case history

including the following description of a woman's self-harming behaviour: "…she had

made over 100 cuts on her upper and lower limbs as well as on her abdomen. All cuts

were superficial and symmetrical and caused her no pain." (p. 35). They also report that

the women in the study described their acts of SIB as "compulsive, ritualistic, meticulous,

and painless" (p. 36).

Favaro and Santonastaso (1998, 1999, 2000) have conducted extensive inquiry

into the links between BN and SIB. In their 1998 study of 125 BN patients (1998), they

found that 72% reported at least one form of SIB. Attempting to discriminate between

impulsive and compulsive behaviours, the authors found that the most common SIBs

were, respectively, severe nail biting, hair pulling (both considered compulsive), and skin

cutting or burning (impulsive). Favaro and Santonastaso assessed participants on

impulsive and compulsive dimensions and found that those who showed neither

impulsivity nor compulsivity (Group A) were least likely to purge, to attempt suicide,

and to engage in SIB. Those who were positive for impulsivity but negative for compulsivity (Group B) were more likely to purge and to attempt suicide (and to do so repeatedly). Those in this group were somewhat more likely to engage in impulsive than compulsive SIB. This group also contained all of the subjects who abused alcohol and illicit drugs. Group C included those who scored high for compulsivity but not for impulsivity. All engaged in purging. Suicide attempts and substance abuse were absent. For SIB, severe nail biting and hair pulling was very frequent, but skin cutting and burning were rare (13%). Group D, comprised of those who scored high on impulsive and compulsive dimension, was the smallest. All purged; 71% had attempted suicide (half of those repeatedly); half of the group reported skin cutting and burning, and most reported severe nail biting or hair pulling. Of particular interest to this work, Favaro and Santonastaso (1998) found that overlapping of impulsive behaviours was not common. For instance, those who engaged in skin cutting were unlikely to abuse substances; however, the majority of those who engaged in two impulsive behaviours (five of eight participants) and all of those who engaged in three (five participants) were in group B (impulsive but not compulsive). Those in group B had the highest rate of drop out from therapy, longer duration of illness, and a greater number of failed treatments. In a 1999 follow-up study, Favaro and Santonastaso confirmed their earlier findings: compulsivity in bulimics is closely linked with depression, suicidality, and longer duration of illness.

In a 2000 study, Favaro and Santonastaso went a step further, investigating impulsive and compulsive SIB among participants with AN. They found that patients with AN report similar rates of SIB to those with BN, with the exceptions of suicidality and substance abuse, which are more prevalent in bulimics. Also consistent with earlier

findings, Favaro and Santonastaso (2000) found that impulsive SIB was more common to those with the bingeing-purging type of AN than among restricting anorexics.

Davis and Karvinen (2002) investigated differences between anorexic and bulimic women in reference to the urge to self-harm. They were specifically concerned with whether self-harm behaviours are more closely linked to obsessive-compulsive behaviours or to impulse control disorders such as alcohol and drug addiction. Selecting patients in treatment at the Toronto General Hospital between 1994 and 2000, Davis and Karvinen included only women who met diagnostic criteria for eating disorders, and only those with symptoms specific to two groups: those with restrictor AN and BN patients with no prior history of AN. Within each group, women were categorized as having intention to SIB or not. They found similar rates of intention to harm between the AN and the BN groups. The authors then assessed obsessive-compulsive symptoms, obsessive-compulsive personality, and addictive personality traits, as well as exercise status. Davis and Karvinen revealed several significant findings. First, they found that OCD symptoms were significantly higher in women with an intention to self-harm (and in fact in their AN group, OCD symptoms were higher than those reported in a contemporary sample of OCD patients). Second, women with intention to SIB had greater addictive personality characteristics. Third, the authors found that excessive exercise was strongly associated with intention to SIB; they further note that excessive exercise has been linked to poor treatment outcomes among eating disorder patients.

Claes, Vandereycken, and Vertommen (2005) compared piercing, tattooing, and self-injuring in women with eating disorders. They collected questionnaires from 101 eating disorder patients, gathering data on the presence and characteristics of piercing,

tattoos, and self-injury and underlying motives for engaging in the three behaviours.

They also considered personality traits. They found that the motives differed significantly.

Those with tattoos and piercings reported esthetic, individual, and social motives; the

authors speculate that this reflects a high degree of self-esteem and body satisfaction.

Motives reported for SIB include relaxation (including inducing dissociation), attention,

stimulation, punishment, and self-destructiveness. The presence/absence of piercing and

tattooing were positively correlated; both piercing and tattooing were negatively

correlated with self-injury. The strongest negative correlation was that between piercing

and cutting. Several other positive correlations were found. These were: tattooing with

smoking and hard drug abuse; piercing with soft/hard drug abuse and sexual promiscuity;

and self-injuring with alcohol abuse. Tattooing was not correlated with any personality

traits, but piercing was positively correlated with extraversion and openness and

negatively correlated with conscientiousness. Self-injury was positively correlated with

neuroticism and conscientiousness and negatively correlated with extraversion and

openness. Finally, the authors found that patients with at least one piercing showed less

severe eating disorder symptoms.

In 2007, Claes and Vandereycken examined the association between traumatic

experiences and SIB in eating disordered patients. They administered several

questionnaires and scales to 70 female eating disorder patients and made a number of

observations. Overall, 38.6% of the patients reported SIB; this was higher among those

with BN than those with AN. Specific self-injury behaviours were as follows: cutting

31.4%; scratching 14.3%; hair pulling 12.9%; burning 11.4%; and bruising 7.1%.

Regarding trauma (which included physical or sexual abuse, neglect, serious family

problems, death or loss of a family member, bodily harm, and war experiences) 55.3% of

participants reported some form of trauma. Again, this was higher among those with BN.

Overall percentage reporting sexual abuse was 47.7%; 32.3% reported physical abuse.

The authors concluded that the probability of SIB was higher in eating disorder patients

with historical abuse, particularly sexual abuse. The highest probability occurred among

those who experienced both physical and sexual abuse. Sexual abuse was correlated with

all types of SIB; physical abuse was correlated with cutting and scratching only. When

abuse occurred before age 15, incidence of SIB was higher (and, in fact, SIB was 100%

among participants who were abused before the age of 10; however, only 13 participants

fit this distinction). The type of abuser (close family, extended family, stranger) had no

effect. Those who had experienced sexual abuse and SIB demonstrated higher levels of

dissociation. Contrary to other studies, the authors found no significant difference with

regard to impulsiveness.

In a 2007 literature review, Svirko and Hawton looked at the association between

SIB and eating disorders in studies dating from 1989 in an attempt to identify the extent

of and potential reasons for the association. They found that the occurrence of SIB in

eating disorder patients ranged from 25.4% to 55.2%, while the occurrence of eating

disorders in SIB patients ranged from 54% to 61%. They also identified impulsivity,

obsessive-compulsive characteristics, affect dysregulation, dissociation, self-criticizing

cognitive style, and need for control as potential contributing factors. Consistent with

studies cited above, they noted a stronger association with SIB among those with BN and

binge-purge AN than among those with restricting AN. Significantly, they note one study

in which psychiatric and normal controls were used: among psychiatric patients,

occurrence of SIB was 11%; among normal controls, 2%; and among BN patients, 26% (Welch & Fairburn, 1996, cited in Svirko & Hawton, 2007). In several of the studies reviewed by Svirko and Hawton, direct associations were found between BN and dissociation. Specifically, a number of researchers (Heatherton & Baumeister, 1991; Miller, McClusky-Fawcett, & Irving, 1993; Swirsky & Valory, 1996, cited in Svirko & Hawton, 2007) suggest that binging may be a way of inducing dissociative states while purging may relieve dissociation.

Substance Abuse and Self-injury

Existing research on the intersection between substance abuse and SIB is comparatively scarce, in spite of the connections drawn in the above studies. Haw, Hawton, Casey, Bale, and Shepherd (2005) investigated the connection between alcohol disorders and alcohol consumption among patients hospitalized for deliberate self-harm (DSH) injuries. Examining records from the general hospital in Oxford, UK, they found that 8.6% of DSH patients were assessed as having alcohol dependence, while for 23.4% excessive drinking was present. While a strong association, there are problems with the methodology of this study. Most notably, the vast majority (88.2%) of DSH incidents involved self-poisoning, with an additional 4.8% involving a combination of self-poisoning and self-injury. The authors do not specify if and how often this represents alcohol poisoning. This conceptualization of SIB is clearly inconsistent with those of previously-cited studies. Haw et al.'s method of surveying hospital admissions would be unlikely to find many (if any) instances of the types of self-injurious behaviour cited by authors of the above studies, as such superficial injuries are unlikely to result in hospital visits.

Additional research connecting substance abuse and deliberate SIB among women tends to do so within the context of diagnosed mental health problems (Harned, Najavits, & Weiss, 2006) or to group SIB and suicidal acts together as a single behaviour (Gilchrist, Atkinson, & Gruer, 2006).

Disordered Eating, Substance Abuse, and Self-injury

A small body of research has been conducted into the intersection between all three problem behaviours discussed above: disordered eating, substance abuse, and SIB. Anderson, Carter, McIntosh, Joyce, and Bulik (2002) conducted research with women with BN with an interest in identifying differences between those who attempted suicide, those with self-harming behaviours, and those who had no self-harming or suicidal behaviours. Including a control group of women with BN but no history of SIB or suicide attempts, they found that women with BN in combination with self-harm behaviours reported significantly more drug abuse than other groups. However, those with suicide attempts reported higher rates of alcohol dependence. They also found that the same group with BN and self-harm behaviours scored higher for self-transcendence, suggesting that they may experience greater levels of dissociation and disconnectedness.

Coker, Vize, Wade, and Cooper (1994) looked at a sample of women with BN in reference to their engagement in cognitive behavior therapy treatment. They found that women who did not engage in therapy were significantly more likely to report laxative abuse, have more severe depression, and report greater body dissatisfaction. They were also more likely to engage in impulsive behaviours, including substance abuse and SIB. Similarly, Dohm et al. (2002) looked at a population of Black and White women with either BN or binge eating disorder to determine whether differences exist between rates

of SIB, substance use, and a history of sexual or physical abuse. They found that White

women were more likely than Black women to meet criteria for sedative/hypnotic abuse;

otherwise, no ethnic differences were found for individual impulsive behaviours. About

one-quarter of women with BN and BED had both an alcohol and a drug problem, and 14

women (out of 215 total) displayed intentional SIB, alcohol, and drug problems. White

women were more likely to have each of the combinations of impulsive behaviours,

regardless of eating disorder diagnosis (BN or BED) with the exception of the SIB and

alcohol combination, in which Black and White women with BN were equally likely to

engage. Across the board, women with historical physical and/or sexual abuse were more

likely to use illicit drugs, to have engaged in deliberate SIB, and to meet criteria for

alcohol and drug dependence.

Much attention has been given to the links between childhood sexual abuse and

trauma and self-destructive behaviour in women. In particular, the link between eating

disorders and sexual abuse has been well documented (Anderson et al., 2002; Claes &

Vandereycken, 2007; Favaro & Santonastaso, 1999; Gilchrist et al., 2006; Gleaves &

Eberenz, 1994; Svirko & Hawton, 2007; Yarkura-Tobias et al., 1993). The connection

between sexual abuse, BN, and SIB has also been explored extensively (Favaro &

Santonastaso, 1999). Herman (1997) links childhood sexual abuse to self-injury, purging,

compulsive sexual activity, compulsive risk-taking, and the use of psychoactive drugs.

Connections between Borderline Personality Disorder (BPD), disordered eating

(particularly BN), SIB, and substance abuse have also been noted (American Psychiatric

Association, 2005; Becker, 1997). However, some authors (Anderson et al., 2002;

Herman, 1997) have also speculated that the presence of substance abuse, disordered,

eating, and/or self-injurious behaviours may often lead to false diagnoses of BPD, a

diagnosis that is applied predominantly to women (American Psychiatric Association,

2005).

<center>*Qualitative Research*</center>

Women and Self-harm

Two elements are glaringly—almost painfully—absent from the quantitative

research cited above. The first is the voices of the women of whom the works speak; the

second is creativity in the conceptualization of the problems. The lived experiences of

women cannot be captured through statistics and correlations. Each of the numbers cited

above represents a woman or girl struggling to live a complete, balanced, authentic life.

Linda Turner (1999) writes of the use of creativity in social work practice and literature;

just as important is creativity in social sciences research. Turner explores the importance

of creativity in five realms of social work practice: creative expression; creative

presentation of self by the social worker; creative conceptualization at two levels – direct

practice and community practice; and the creative cosmology. The qualitative works

cited below aspire to these levels of creativity.

A limited amount of qualitative work has been conducted with women who

engage in these behaviours. Much of this work is in the form of case studies and reflects

psychotherapeutic perspectives. Gilligan, Rogers, and Tolman (1991) write of girls' and

women's antisocial and deviant behaviours as forms of positive resistance to gender roles

and expectations. Through disordered eating, substance abuse, and other behaviours seen

as unacceptable or pathological, women resist the roles imposed upon them by a

patriarchal society; the patriarchal society, in response, diagnoses them as mentally ill or

damaged. Equally key to Gilligan et al.'s premise of positive resistance is the concept of

connection. Picking up on Gilligan's (1982) earlier assertion that the Western ideal of

independence is largely a male ideal, and that women naturally are at their strongest and

most effective in relationship with self and others, the authors postulate that what appears

to male-dominated psychology to be pathological behaviour is often, in fact, women's

resistance to the pressure to disconnect. This need to defend connection often puts girls

and women in places of conflict: whether to protect relationship with others at the

expense of self, or to remain true to the self and risk the relationship with others. The

inevitable pressure to be "good girls"—to be kind, cooperative, and compliant—often

conflicts with values of honesty, authenticity, and creative expression. Girls who behave

according to expectations are rewarded extrinsically but punished intrinsically, whereas

those who behave authentically are often deemed inappropriate and are penalized by

society. This dichotomy contributes to the sense that we can never be good enough and

that those closest to us can never really know us.

Woodman (1982) illustrates this idea eloquently when she writes of the

adolescent onset of eating disorders:

> When 'the best little girl in the world,' who has always done everything mother
> wished for and believed everything daddy said, reaches puberty, she may
> suddenly rebel. She may turn herself into a baby monster or a boyish skeleton.
> Either way she has effectively destroyed her blossoming womanhood. What looks
> like rebellion may be inner collapse. What appears to be a power tantrum may be
> a disguised cry of defeat (p. 61).

The pubescent girl Woodman writes of realizes that she cannot continue to meet

expectations—her own or her parents—and has to choose between *appearing* to be "the

best little girl in the world" (while sacrificing the self she knows is true) and

relinquishing the relationships she has built with her parents to maintain her authentic

relationship with self. Neither option satisfactory, she attempts to sabotage her own

growth by "destroy[ing] her blossoming womanhood." Writing of her own struggle for

perfection, Woodman tells us, "I have done battle with the black crow sitting on my left

shoulder croaking, 'It isn't good enough. You haven't anything new to say. You don't

say it well enough.'" (p.7). Exploring this struggle with reference to weight, food,

addiction, and sexuality, she draws psychological and cultural metaphors of women

attempting to live up to male values. Woodman explores the dilemma in which women

who aspire to and attain male ideals come to be seen as witches and demons akin to Lady

Macbeth and Medusa.

Picking up on the same compulsive-impulsive dichotomy which many of the

quantitative researchers above have explored, Woodman (1982) discusses women's

compulsive behaviours. Drawing clear analogies between "serious" (p. 11) or compulsive

drinkers, dieters, and drug addicts, she elucidates the sense of otherness felt by

compulsive women; they have nothing in common and share neither experiences nor

emotions with their non-serious counterparts. In contrast to women with normal concerns

about size, diet, alcohol, etc., who can commiserate about their struggles, compulsive

women struggle in secrecy with the knowledge that they are different.

In her treatise on women and self-destructive behaviours, Miller (1994) also

explores secrecy. Alcoholism, drug abuse, bingeing or excessive eating, and even

cosmetic surgery are engaged in secretly; Miller notes that excessive dieting, because of

its social acceptability, is often the exception. Key to Miller's theory are metaphors in

which self-harming behaviours reflect past traumas. Conceptualizing women's antisocial

behaviours not as resistance but as forms of warfare inflicted on the self, she sees binge

eating, for instance, as the swallowing of the abuse suffered, and purging as the rejection of the same abuse. Miller views all forms of self abuse—alcohol and drug addiction, eating disorders, self-injurious behaviours, etc.—as parallel expressions of this warfare, and sees sexual and physical abuse, neglect, and "psychological terrorism" (p.3) as the antecedents to the war. Miller labels this expression as Trauma Reenactment Syndrome (TRS) and identifies four characteristics of women with TRS: the sense of being at war with one's own body; excessive secrecy as a central organizing principle of life; inability to self-protect, often evident in a specific kind of fragmentation of the self; and relationships in which the struggle for control overshadows all else. Miller also notes that treatment approaches which address one problem have limited success for women who often suffer from multiple self-destructive behaviours. She notes four major assumptions in her approach to treatment of TRS. First, she writes that a woman's *contexts* must be considered in attempting to understand the symptom; second, the symptom must be viewed from a *historical perspective* and seen as an adaptation, an attempt to cope, and an indirect communication about past trauma; third, the symptom has various important functions for the woman and may be viewed as a sole dependable friend; finally, the TRS woman needs to establish a healthy, caring relationship before she will be able to explore her trauma.

One study was found which examines the roles of secrecy, shame, and stigmatization among women with bulimia. Pettersen, Rosenvinge, and Ytterhus (2008) interviewed 38 women with bulimic symptoms, focusing on how and why they concealed bulimic symptoms in daily life. Participants described a "double life" in which they attempt to manage not only their bulimic behaviours but also their sense of shame.

The women in the study distinguish between good and bad days; typically a good day is

one in which the bulimic symptoms are held at bay and normal eating occurs, at least in

public settings. A bad day is dominated by feelings of shame and self-contempt. For

some, the ability to hide the behaviours is dependent on the tacit understanding of

knowing others; others manage to conceal bulimic symptoms for years. Fear of

stigmatization prevents women from revealing the behaviours, while hiding the

behaviours contributes to the shame. Some women believe that they do not deserve

treatment. The authors note that the research that links BN to impulsivity miss a crucial

fact: while the desire to binge and/or purge may be an impulsive one, often acting on the

impulse is not possible. They suggest that while impulses may govern behaviours, the

behaviours need not be impulsive.

Creativity and Connection

One of the dominant themes in the qualitative research discussed above, as well

as in the current study, is that of creativity and connection as sources of wellness, balance,

and spirituality. What follows is a brief discussion of literature on creativity drawn from

other contexts and disciplines.

May (1975) writes of social courage: the courage to form intimate connections

with others in the face of risk to the self. He likens relationships between people to

chemical reactions, in which those involved are changed by the process, in essence

creating new individuals. We are indelibly altered by the very fact of forming a

relationship. May points out that relationships—like chemical reactions—do not always

lead to growth and generation, that they can at times seem destructive. May writes of the

prevalence of a fear of psychological and spiritual intimacy, stating that we have reached

a point in our society when physical intimacy feels easier and safer than risking our

authentic selves (though May wrote these ideas of post-sexual-revolution, 1970s

American society, they seem equally relevant today). This instinct for self-protection, at

the sacrifice of authentic relationships, is reflected in the context-specific masks and

boundaries adopted by most people. The prospect of being altered by each and every

relationship seems a threat to identity. The potential for creative generation and growth,

however, outweigh the need for self-preservation and the fear of relinquishing control.

After all, even the most volatile chemical reaction does not really destroy, it merely alters

and rearranges.

May (1975) describes a personal experience of epiphany, in which the solution to

a problematic piece of research comes to him unexpectedly. He calls this sudden

enlightenment "a state of heightened consciousness" (p.61). Though the experience he

describes is a solitary one, it could as easily have occurred as the product of creative

interaction between two people, in relationship. May also makes reference to self-

actualization, a term originated by Maslow (1968). Self-actualization refers to a

heightened state of being akin to spiritual transcendence, and is—for most of us—

temporary and fleeting. Through the generative relationships described by May, however,

it should be possible to reach this state purposefully and productively.

In *The Artist's Way*, Cameron (1992) outlines a course in spiritual recovery

through artistic expression (and the word "course" should be read both in the sense of an

academic curriculum and as a course of travel). Cameron sees creativity as a spiritual

force which exists in all of us, and through which we can access a greater level of well-

being. Drawing a distinction between "logic brain" and "artist brain" Cameron writes

that Western society prefers and promotes logic; we want evidence, measurability, and proof. This thinking acts as a censor to filter out input which does not make logical sense, thus protecting us from looking like fools. The artist brain, rather than being in opposition to logic, is the holistic brain. The artist brain makes new connections and sees relationships that the logic brain misses. It forms metaphors and analogies, shedding new light on the familiar. While the logic brain finds comfort in the known and the well-established, the artist brain seeks out new experiences and new ways of perceiving and thinking about what is already known.

The first chapter and week of Cameron's (1992) course is entitled "Recovering a sense of safety." This reflects the fact that artistic expression is by nature risky. In going beyond logic, we risk criticism and ridicule. We also make ourselves vulnerable by exposing our inner selves – by removing our masks. These risks prevent most of us from ever expressing our artistic selves. Cameron's concept of safety also connects to Maslow's (1968) hierarchy of needs; without the foundation of safety provided by the lower levels of the hierarchy, we cannot hope to attain the pinnacle of self-actualization.

In *Art on My Mind*, hooks (1995) writes of the acts of creation and evaluation of art. Recalling Woolf's (1991) *A Room of One's Own*, hooks says that having the time and space to reflect and create is a luxury. As crucial as artistic expression is to holistic well being, it is something that most of us do not have the resources to access. Echoing Cameron's (1992) insistence on accessing the artist's brain as well as May's (1975) heightened consciousness, hooks writes that the artist's "solitary space is sometimes a place where dreams and visions enter" (p.125). Creativity, for all three authors, requires a different mode of thinking – one which abandons linear logic and order and allows for

other kinds of connections to form. Picking up on Cameron's ideas about our fear of evaluation and criticism, hooks makes reference to the problem of "good versus bad images" (p.8). Products of creativity are subject to judgment not just on their own merits but as political and moral objects. In an era in which virtually everything public is available for mass consumption and judgment, the potential for misuse and misinterpretation of works of art is endless, and artistic pieces which cause discomfort to certain individuals or groups are subject to mass censure. Outrage is ubiquitous. In such a climate, it is not surprising that most of us are hesitant to even attempt to exercise our artistic impulses. Still, hooks (1995) says, "Art constitutes one of the rare locations where acts of transcendence can take place and have a wide-ranging transformative impact" (p.8). hooks (1997) also writes of the healing power of art. Telling the story of herself as a child, finding refuge from abuse in poetry, she writes:

> *Poems were a way to leave pain behind – to forget. They were a kind of*
> *suicide, a death. Her real self could drown in them. They were water to*
> *her thirst, cooling the burning sensation, soothing the red welts on her*
> *skin left by lashes from fresh young branches still green. Poetry made*
> *childhood bearable* (p.3, italics in original).

The drowning of her real self marks, for hooks, a split between the physical and the intellectual; as a child, she could not protect her body from abuse, but she could protect her mind. Her body existed in the physical world—and, perhaps, in Cameron's (1992) logic brain—while her mind thrived in the artist's brain. Later, hooks writes of herself as a young woman in college, feeling invisible and isolated, "*And if she is in a group you might say she is always performing*" (1997, p.60, italics in original). hooks, it seems, must wear a mask in order to be seen at all.

Eisner (2002) writes of the value of the arts in education, and of their devaluation by education. Exploring the connections between the sensory system, artistic creation, and the development of culture, Eisner writes that: "we can imagine possibilities we have not encountered, and we can try to create, in the public sphere, the new possibilities we have imagined in the private precincts of our consciousness" (p.3). What we cannot imagine—be it attaining the summit of a mountain or overcoming the effects of abuse and addiction—can never be achieved. Eisner emphasizes that the arts are not simply about creating products but about expanding consciousness, finding meaning, and connecting with others. Also relevant to this study, Eisner writes of the "zone of proximal development" (p.73). This represents the level of challenge to creativity and imagination which is sufficient, but not excessive. Again writing of students, Eisner says that a challenge must be difficult enough to promote growth but must also be attainable. Without challenge, there can be no growth, but unattainable goals and insurmountable challenges will be equally fruitless.

Creativity does not necessarily mean creating art; as the above works illustrate, creativity is as much a way of thinking and building connections between people and ideas as it is about a tangible end product. Belenky, Clinchy, Goldberger, and Tarule (1986) explore different ways of knowing: silence; and received, subjective, procedural, and constructed knowledge. The silent women described were oppressed, often abused, and afraid of—even incapable of—expressing their own opinions. Unable to participate in meaningful dialogue, some of these women are excluded from the belief systems and meanings of their own cultures; only through blind obedience can they avoid punishment. Received knowledge is that knowledge that comes from others' voices and is accepted as

true. Received knowers absorb information but have difficulty putting words to their own thought, so again, meaningful dialogue is absent. Subjective knowledge comes from within: as one of the authors' participants said; "I can only know with my gut.... My gut is my best friend – the one thing in the world that won't let me down or lie to me or back away from me" (p.53). The shift to subjective knowledge—if and when it occurs—seems to signal a shift away from following external authorities and toward autonomy, agency, and control. Belenky et al. (1986) note that this reliance on subjective knowledge is contrary to Western, scientific modes of knowing, but is very consistent with other, non-technological knowledge systems. Procedural knowledge is that which can be supported by reason. More than either intuition or blind authority, it is knowledge which can be communicated, explained, and shared, even if not agreed upon. Unlike pure subjective knowledge, it requires analysis and evaluation; it may even result in the rejection of subjective knowing. It is at this level of knowing that dialogue and connections begin and that knowledge can begin to be exchanged. Constructed knowledge is the level at which all other levels are integrated. Received, subjective, and procedural knowledge are justified (or not) to form concepts and to make connections. At this level, new knowledge and new meanings are created. This is the level at which real growth, change, and healing can occur, and it occurs as a result of creative synthesis of ideas. Because they require creative, non-logical thought, these connections and syntheses occur in the artist's brain. Connection and synthesis can also occur more readily in creative exchange with others, rather than through solitary contemplation, making relationship key to achieving this level of knowing.

A natural and organic medium for forming connections and generating

constructed knowledge is storytelling. Myths and stories illustrate universal, shared

experiences, often utilizing metaphor and parable to cross from the realm of the logic

brain to that of the artist brain. At the most superficial level, myths and stories let us

know that we are not alone: if someone knew the story well enough to tell it, and if

others, like me, are interested in hearing it, then we must all share some sensibilities. On

a deeper level, they demonstrate the timelessness of the human experience; the fact that

Hollywood is still producing movie versions of Shakespeare's plays 400 years after they

were written (and many are based on even older stories) is a clear illustration of this.

First Nations and Native American peoples have utilized storytelling as a method for

sharing knowledge throughout their history; Western cultures have done the same, if—

perhaps—less purposefully. Perhaps even more powerfully, they provide new and often

unfamiliar language with which to consider mundane, everyday experiences. Estés (1992)

presents a collection of myths of wild women, each one illustrative of a particular

challenge which every woman must negotiate. These challenges range from "the retrieval

of intuition" (p.74) (or the discovery of subjective knowledge) to belonging and self-

preservation. In retelling these timeless international stories, Estés connects women

across history, geography, and culture, providing mothers and mentors for those who

may not have their own. Of the medicine of storytelling, she writes that:

> In dealing with stories, we are handling archetypal energy, which is a lot
> like electricity. It can animate and enlighten, but in the wrong place and
> wrong time and in the wrong amount, like any medicine, it can have no
> desired effect (p.463).

Like May's (1975) chemical reactions, Estés's stories can be healing, volatile, or inert; knowing where and when they will be effective requires understanding and communication between the teller and the listener.

Turner's (1999) levels of creativity are evident in all of these qualitative works. The authors' use of metaphor, mythology, and story-telling in their explorations of women's self-destructive behaviours reflects both creative presentation and creative conceptualization. The writings themselves, along with included poems, drawings, and journal entries by other women, represent creative expression. Most importantly, the authors demonstrate creative cosmology in finding new ways of creating meaning for and with the women they describe. While other authors seek to enumerate, diagnose, label, and medicate, they seek evidence of women's will and agency in behaviours that are often seen as pathological and freakish.

The eclectic nature of this literature review reflects the diversity and universality of the women represented in this study. Disordered eating, substance abuse, and self-injury are not purely medical and/or psychiatric problems; they reflect the attempts by women everywhere to cope with and transcend the material demands of the modern world. Just as the problems experienced by women are not exclusively physiological and psychological in nature, neither are the solutions to those problems. The fields represented in the above works—social work, psychology, medicine, literature, cultural studies, and education—all offer insights into challenges as well as potential paths toward wellness.

Chapter 3: Research Methodology and Design

This chapter will attempt to locate the research and the researcher philosophically, theoretically, and ontologically. I use the word "attempt" because I see these positions as fluid, and even as I write, my position changes. In addition, it will describe the research design and methods, both in intent and in practice.

Autoethnography and Narrative Research

The approach taken is part autoethnography and part narrative, set against the background of a feminist perspective. This perspective informed (and informs) my assumptions and guided my decision making, particularly in regards to the interview process. Questions were selected and asked with a view to emphasizing agency over victimization and adaptation over pathology.

Holman Jones (2005) writes that autoethnography is:

> setting a scene, telling a story, weaving intricate connections among life and art, experience and theory, evocation and explanation...and then letting go, hoping for readers who will bring the same careful attention to your words in the context of their own lives (p.756).

At the moment, this seems a tall order; particularly the "letting go" part. Autoethnography is by definition personal and subjective; it represents exposure, and with exposure comes vulnerability. Emerging out of post-modernism, and the recognition that the ideal of the detached, objective researcher is a falsehood, autoethnography takes the opposite approach, attaching value to connection and subjectivity (Patton, 2002). The individual's story—however subjective and changeable—is seen as having truth value in and of itself. Gergen and Gergen (2004) write that, rather than just describing or communicating, (auto)ethnography "creates forms of relationship" (p. 12). Given the emphasis in the literature on relationship and connection in women's wellness, this form

of authorship is fitting for this research, in that it has the potential to generate

relationships on multiple levels: between researcher and participant, participant and

reader, researcher and reader, and—indirectly—between individual participants. In

addition to creating relationships, it places the researcher—me—on equal ground with

the participants; just as they make themselves vulnerable to me, I make myself

vulnerable to readers.

Patton (2002) writes, "In autoethnography, then, you use your own experiences to

garner insights into the larger culture or subculture of which you are a part" (p. 86). It

was my experiences which brought me to this research; in taking an autoethnographic

approach, I not only honour that experience and the women who contributed to it, I am

transparent about my motives, assumptions, and biases. This transparency, I believe,

lends an authenticity to the research that would be absent, had I taken a more traditional,

objective stance (after all, I am anything but objective).

The extent of the autoethnographic aspect of this study grew as the work

progressed. At the outset, I believed that the autoethnography would begin in my clinical

experience and consist of my evolving and expanding understanding of disordered eating,

substance abuse, and self-injury. As my involvement in the research deepened, however,

connections to my personal life began to emerge; once I began to recruit and meet with

participants, and as I proceeded with interviews, transcription, and analysis, these

connections gelled. At its core, this work is not about women with pathological

behaviours; it is about women in spiritual pain, and their ways of communicating that

pain. Once this distinction became clear, I realized that I have been surrounded by girls

and women in spiritual pain for my entire life; I have been one of them.

"Narrative is retrospective meaning making – the shaping or ordering of past experience" (Chase, 2005, p. 656). Like autoethnography, narrative research does not pretend to be objective or absolute. Narrative is the story told by an individual on a particular day, at a particular time, in a particular context; on another day, with a different audience, the story would—no doubt—be different. Narrative researchers recognize that the stories we tell ourselves and others about our experiences are more important than the objective facts of what happened; more often than not, those stories become our reality. While quantitative research has done an admirable job of describing the "what" of disordered eating, substance abuse, and self-injury, and qualitative research has attempted to explain the "why" of these problems, little attention has been paid to the interpretations of the women who suffer with these problems. In this work, I wanted to ask "why" not of myself or of other researchers, but of the women who live these experiences.

In addition to allowing women to speak for themselves, of their own experiences, narrative appeals to me as a student of literature. The power of stories to connect people and to share common (and uncommon) ideas is self-evident; without it, not only would we not write or read books, we would not go to the movies, watch television, or read each other's weblogs. Maybe even more important than the sharing of stories, though, is the necessity for each of us to be heard. The stories shared with me by these nine women, and passed on to the readers through the filters of my interpretation, have to a great extent been untold to this point. Almost all of the nine participants expressed that their participation was motivated by a desire to help others. I know that this has already been accomplished; they have helped each other (not to mention me).

The narrative aspect of this work consists of the individual stories of the nine women who volunteered to speak with me; it also consists of the language, plot points, and even characters (parents, siblings, friends, teachers, partners) that those stories share. As protagonists in their own stories, the participants relate conflicts, crises, and—occasionally—resolutions. For my part, I attempt to show where the plots converge and diverge, how interactions between protagonists and other characters impel the story, and what lessons can be learned from the conflicts and resolutions. This study does not try to represent the whole story—or the whole stories—but reflects a narrative "socially situated in this particular setting, for this particular audience, for these particular purposes" (Chase, 2005, p.657). The setting is layered: first, it is a university campus in northern British Columbia; second, it is an early-21st century, medium-sized Canadian city; third—and most importantly—it is a culture and context in which young women have not only the right and the ability, but almost the obligation, to be all things to all people, and to do it well. It is a culture in which "good enough" is rarely good enough, especially for the talented. The audience for this study is also layered. Obviously, members of the thesis committee must be considered; without their approval, this work accomplishes little. Equally if not more importantly, though, are the nine participants, and the girls and women they represent.

In juxtaposing autoethnography and narrative research, I hope to accomplish a number of purposes. First, I wish to show that the experiences shared by the nine women—as well as those of myself, my friends, my former clients, and others—are to a great extent universal. The details may change, but we share the struggles. I label my story "autoethnography" because I am in a research role, but mine is just another story,

no more and no less important or true than anyone else's. Second, I wish to illuminate, even in a small way, how our meetings and interactions impact us. With each relationship, however transient and brief, we rub off a little on each other, shifting our courses a little (or a lot). By sharing these stories, we expand the influence of those meetings, creating new potential and possibilities. Third, and most importantly, I wish to demonstrate that these nine women—and all women—and their experiences matter. They matter to me, and they will continue to matter to others.

Upon reading an early draft of the findings chapter, one participant wrote, "it's nice to read about other women going through the same problems as me…it makes me feel less alone" (Naomi). This comment and others like it make the work worthwhile.

Methodology and Design

Sample Selection

Participants were recruited via posters placed strategically on the UNBC campus and in the community of Prince George. These posters (Appendix B) targeted women in the age range of 19 to 35 who had struggled with disordered eating, substance abuse, and/or self-injury, and who were interested in talking about their experiences in an interview. This represents purposive sampling (Neuman, 2006). The intention of this wording was to make clear that the study was focused on all three behaviours, but that not all three need be present. Confidentiality and the voluntary nature of participation were assured in the poster. No remuneration was offered or given. Respondents were asked to contact me by email.

Of 13 women who responded to the posters, nine were included in the study. Four were excluded for various reasons: one was under the minimum age of 19; one indicated

that she was going to approach a professor about receiving marks for participation, and

did not get back to me; one was a woman I had met socially; and one was not available

for a face-to-face interview for several weeks. The nine women who did participate

represent quite a homogeneous sample: all are in their 20s and all are university students.

The sample was also not ethnically representative of the community or of the province or

country: two participants had Aboriginal ancestry; the others were Canadians of

European heritage. There was no response to the posters placed in the larger community

(libraries, gyms, businesses). I believe this reflects the fact that university students are

more familiar with the goals of social science research and understand the promise—as

well as the limitations—of confidentiality, anonymity, and informed consent. In addition

to their greater level of comfort with academic research, it is likely that women in the

university population are more familiar with the clinical terminology used in recruitment

posters. I also believe it is likely that the academic setting affords women who are

struggling with these problems a sense of safety and control that they might not

experience in the larger community; this may give students a greater capacity to explore

these difficult issues.

None of the participants was known to me before recruitment began. Initial email

contact was followed by a brief, introductory meeting. During this meeting, informed

consent was reviewed and the participant package (Appendixes C - F), which included

the interview questions, was shared. Consent forms were not signed at this meeting; I

encouraged respondents to take some time to review the package and to be sure that they

were comfortable with me, with the questions, and with the research. I outlined the

procedures through which I would protect their confidentiality and anonymity, but made

sure that they were aware that, on such a small campus and in such a small community, guarantees could not be given. Several respondents asked specific questions about my philosophy and goals, as well as the purposes of the research, confirming the idea that they were highly cognizant of research issues. Interviews were then tentatively scheduled for at least one week from the date of the initial meetings, to allow respondents to reconsider their participation. The principle of informed consent was reinforced at each contact.

Data Collection

All nine of the women who met with me participated fully in the research. Interviews were semi-structured, with a few closed-ended background questions followed by open-ended exploratory questions (Fontana & Frey, 2006; Appendix E). One of the questions that was expected to be closed-ended proved to be exploratory; this was, "Do you consider yourself to be in recovery?" Recovery was also the only theme to emerge from the research that came directly out of the questions. Providing questions to participants in advance allowed them to consider their responses and aided in focusing the interviews.

Interviews took place in private rooms on the UNBC campus. Duration varied from 34 minutes to just over one hour. Interviews were conversational in tone and focused on individual experience and understanding of the three problem behaviours. Participants were encouraged to explore the emotions and motivations around the behaviours rather than just the facts of what happened. For some, this was quite emotional and difficult, as the behaviours were often still present or not far in the past. Most expressed that they rarely if ever spoke about their problem behaviours. Due to my

clinical experience and my comfort in the counsellor role, I was vigilant against slipping

into that role during interviews. I believe that my role as researcher freed the participants

to speak candidly, without concern over my response to their stories.

Interviews were digitally recorded. These digital files were then uploaded onto

my computer for playback and transcription. Interviews took place over four weeks and

were transcribed in order, as they occurred. As transcriptions were completed,

participants were offered the opportunity to review their own transcript and make

corrections, additions, clarifications, and omissions. All nine participants accepted this

offer; eight responded with feedback. One participant made minor typographical

corrections and one clarification.

Data Analysis

Content analysis was used to identify codes within the transcripts. While

transcripts were coded individually rather than across interviews (Chase, 2005; Patton,

2002), some common codes and themes were evident early. Because I conducted and

transcribed all interviews myself, I was very familiar with the content of each, and as

such could not help but notice some patterns. I began to think of these as "echoes" from

one interview to the next. For instance, the theme of public and private selves was

evident in the first interview; while I did not actively pursue this theme in subsequent

interviews, I was certainly aware that it was common and—ultimately—universal among

the participants. All attempts to the contrary aside, it is possible and perhaps even likely

that my experience of early interviews affected the process of later ones.

Codes were ascribed to participants' descriptions of behaviours, thoughts,

feelings, and meaning-making. Typically codes were one or two words—often, but not

always, gerunds—which distilled one or two sentences down to an idea. For example, the

code "learning" was applied to the following statements: "I actually had read a story

about cutting, and it was supposed to be, like, the negativities of it, but it was like, oh,

well, maybe I could get a release from there" (Gwen); "one of my girlfriends at the time,

she had started cutting herself, and she said it really helped her, and so I started doing

that also" (Kat); and, "the whole bulimic thing started with the influence from my

girlfriend. Because she'd say, 'yeah, my mom made me eat dinner, but it's okay because

I threw it up'" (Anne). Eight of nine participants described similar forms of "learning" of

the behaviours.

While "learning" proved distinct enough to form a theme in-and-of itself, other

codes were consolidated under a single theme. For example, realizing, thinking, and

knowing became codes for the theme "knowing" while coping, managing, resisting, and

punishing were categorized as "functions" or "strategies."

As noted above, one theme, recovery, emerged directly from an interview

question. Originally the question "Do you consider yourself to be in recovery?" was

expected to be a closed-ended background question. Most participants struggled to

answer the question, or to even define what recovery meant to them. For this reason, I

felt it important to piece together what they could express, connect it to the literature, and

attempt to illuminate what recovery might look like.

To enhance internal validity (Kirby, Greaves, & Reid, 2006), an early draft of the

findings chapter, with all themes and most quotes in place, was offered to participants for

feedback. All nine participants expressed interest in reading the chapter, and were sent

copies by email. Six provided feedback; their responses are provided in Appendix G. All

agreed with the themes identified, and expressed that they were happy that they had

participated. Some even expressed gratitude for the opportunity. Early findings were also

shared with six of my personal and three professional contacts who have experience with

the three behaviours; they also confirmed that the themes rang true, suggesting a high

level of external validity. In addition, transcripts were coded by three of my student

colleagues, who noted similar (and, in some cases, identical) codes and themes to those

which I identified. This concurrence was particularly strong in reference to the

ambivalence and internal conflict which were evident in the interviews.

My ability to be reflexive was critical in the research process (Kirby, Greaves, &

Reid, 2006). I began this project with well-established assumptions and expectations.

Interview questions were chosen to minimize the effects of these assumptions, and

although the questions formed only the skeleton of the interviews, I refrained from

pursuing my expectations. To illustrate, I expected to find a link between the problem

behaviours and self-induced dissociation. Although this emerged in an early interview, it

was limited to a single episode of dissociation, and was not present in any of the other

interviews. In addition to expectations which were not realized, there were surprises in

the data. The theme of choice, for instance, was unexpected, but seven of the nine

participants indicated an element of conscious choice in their behaviours. Given the

compulsive and impulsive nature of the behaviours (and—according to the literature—

the women who engage in them), choice was not a theme I expected to find.

To further enhance reflexivity and validity, throughout the process I recorded my

thoughts, questions, and decisions in three distinct journals. The first, my process journal,

I carried with me virtually everywhere. It was the receptacle for my reflections and ideas,

questions to pursue with colleagues and in the literature, my reactions to initial meetings and interviews with participants, suggestions made by others, and at times concrete "to do" lists and notes of meeting times and places. It also became the forum for my exploration into the autoethnographic aspects of the study. The second was my decision-making journal, in which I recorded my thoughts and processes around the potential dual relationships (given the size of the campus community, the social and academic circles often overlap) and conscious adjustments to the interview process. To illustrate the latter, as the dichotomy between public and private selves emerged in early interviews, I made the decision to ask the question, "What if they did know?" if and when participants said of others in their lives, "They don't know" or "Nobody knows." The third journal contained any information that needed to be recorded, but which threatened confidentiality and/or anonymity. It remained locked in my file cabinet in my home office for the duration of the study, and will be destroyed immediately after my thesis defense, along with transcripts, consent forms, and any other sensitive documentation. This journaling process was immensely helpful in enhancing reflexivity and highlighting autoethnographic aspects, particularly during the transcription phase of the research, when I found myself quite preoccupied by the participants' stories.

Chapter 4: Research Findings

The following chapter outlines the findings of semi-structured qualitative

interviews I conducted with nine women. The purpose of these interviews was to explore

the lived experiences of women who struggle with disordered eating, substance abuse,

and self-injury. While these stories are, at times, retrospective, they do not always

represent distant memory; all of the women were in their twenties, and much of the

experience they described was recent and even current. Questions were asked in order to

locate the women in relation to the three problems and to identify commonalities among

their experiences.

Introduction

Nine interviews were conducted, one with each participant. The length of

interviews varied from just over 30 minutes to approximately one hour. Interview length

was determined by the flow of the interview; for some participants, the process was

emotionally draining, and sharing information was quite difficult, and in these cases,

interviews were shorter. Interviews were scheduled to allow for up to 90 minutes, so no

interview was cut short due to time constraints. Interviews took place in rooms on the

UNBC campus, booked in advance. These arrangements were convenient for the

participants, all of whom were students. Names used are pseudonyms; participants were

invited to create their own names, and most did so.

Demographics

Two of the women identify as Canadians of Aboriginal ancestry. Of these, one

has close connections to her Nation and said that this ancestry was very important to her.

She spoke of having a relationship with her community, enjoying participating in cultural

events, and finding help and support in traditional spirituality. The second had only recently learned of her Aboriginal ancestry and was looking forward to learning more. She said that she did not yet know what it meant to her, but that she had actively sought out information on her heritage.

The other seven women were Canadians of European descent. One specifically referenced her German heritage a number of times during the interview, though participants were not asked about this heritage.

At the time of the interviews, the age of the participants ranged from 21 to 27, with a mean age of 23.4 and a median age of 23 years. All were University of Northern British Columbia students. Several were in committed relationships, and one was married. Age of onset of the problem behaviours ranged from pre-teen to late in high school. Only two participants indicated that they felt themselves to be fully in recovery; thus, the duration of the problems ranges from just three or four years to well over a decade, and in some cases spans more than half of the participant's life.

The women's experience of the three problems varies significantly. Seven have a history of disordered eating. Of those, all but one also has experience with self-injury, and two have experienced all three of the problems of interest. These two were also the only two women to have been hospitalized as a result of the problems. Two participants have experience with both substance abuse and self-injury, but not disordered eating. All but one of the nine participants had some experience with out-patient counselling or therapy, and one had been to non-medical in-patient treatment. The woman who had not had any in- or out-patient treatment of any kind was the only one of the nine who identified as struggling with only one of the three problems (disordered eating). Clinical

diagnoses were relatively rare (three of nine), but several of the participants felt that they

would have been diagnosed if they had not successfully avoided detection.

Within the clinical definitions of disordered eating, several problem behaviours

exist: restricting, bingeing, purging (through vomiting or laxative abuse), and excessive

exercise. As a group, the women in the study had experienced all of these behaviours.

Self-injury consisted of cutting, scratching, biting, and burning. Substance abuse

included alcohol, marijuana, cocaine, and crystal methamphetamine; though several of

the participants were smokers or former smokers, nicotine use has not been included.

Some of the participants used self-harm as an inclusive term, encompassing risk-taking,

disordered eating, deliberate self-infliction of physical pain which did not leave marks,

and other self-harming behaviours. In keeping with this, self-harm is used as a blanket

term to encompass all of the problem behaviours. Attempts have been made to elucidate

all of these distinctions. Clinical terminology (i.e., disease, addiction, anorexia nervosa)

has been used rarely and only when participants themselves used such language.

Findings

Through analysis of the interview transcripts, 15 themes emerged. These themes

overlap and interconnect in a complex web, and efforts to separate and categorize

experiences are, to a great extent, artificial; whenever possible, interconnections have

been illuminated in this discussion. Three themes were universal; they were endorsed by

all nine participants (because of its multiple sub-themes, the theme of ambivalence is not

included in this enumeration). Four major themes were those endorsed by seven or eight

of the women; three common themes were endorsed by six; and four minor themes were

endorsed by four or five participants. No participant endorsed fewer than eight themes,

and six out of nine endorsed 10 or more. The two participants who endorsed the most

themes (14 and 13, respectively) were the two who have experienced all three problem

areas. Appendix H shows themes by participants, in chronological order according to

interview date. This illustrates the emergence of themes both within and across

interviews.

Jagged Ambivalence

> I mean...like almost everything, I hate about it. Like, I hate spending money and
> I hate my weight fluctuating and I hate vomiting and cleaning up after it. I hate
> pretty much everything about it, but there's just that little bit that I like, so I keep
> doing it (Naomi).

The first theme was that of ambivalence, of which seven different levels emerged,

expressed here as sub-themes. The term "ambivalence" is often used in casual

conversation to convey a lack of concern or caring; it can be conceived as a post-modern,

shades-of-grey position toward contradiction. This is not what emerged from the

interviews. The women in this study speak of simultaneous, opposing, unjustifiable

forces, and of living within multiple, often intense conflicts. Here, the word

"ambivalence" is used in its most literal sense: the coexistence in one person of

contradictory emotions or attitudes (as love and hatred) towards a person or thing

(Oxford English Dictionary online, 1989). For the women in this study, ambivalence is

often harsh, jarring, and distressing. Ambivalence describes powerful dichotomies

between thoughts, feelings, and behaviours, and the women are often highly invested in

maintaining these dichotomies.

Ambivalence permeates not only these seven sub-themes, but the entirety of the

women's experience of the three problems; they hate the behaviours, but they are reticent

about surrender. As Naomi articulated, "...well, whatever, this makes me unique and special and it's just who I am."

Public/Private Selves

> I was very proper and intellectual and graceful.... And I was very self-regulating in my perfection, as well, I was very conscious of what people viewed me as.... I felt very able, at least, to play the part of whatever I wanted to portray to people (Gwen).

The idea that the self is something to be "portrayed" in public was not unique to Gwen; as Maureen says, "I'm driven in that sense [professionally and academically], and I think that's how I portray myself to the world and how I try to portray myself to the world." This ambivalence about public and private selves was one of the three universal themes; all participants had closely-guarded secrets that they shared with only a few others, if at all. Part of the process of protecting these secrets involves creating a public self. Anne articulates this division between public and private selves when she talks about smoking cigarettes, a habit she tries to keep private: "I'll hide if I'm smoking on campus. It's not socially acceptable, right? And the thing is, I'm also a gym rat, so I'm a runner, and so...I hate getting that reaction: *You smoke?* " Anne's public self (a gym rat) is inconsistent with her private self (a smoker), so she feels compelled to hide the fact that she smokes, while admitting that, "at home, I'll smoke way more." This rather mundane example of the function of the ambivalence described is consistent with other participants' experiences. April speaks of not inviting friends to her home because, "I don't think they smoked pot, so why would they want to hang out there?"

Maintaining this public/private division requires a significant amount of energy, as expressed by both Gwen and Maureen. Gwen, who considers herself to be in recovery from anorexia, says that "...even just being a confident person and just being very

articulate and just kind of classy...that takes a lot of energy, and I don't really have that much energy." Pre-anorexia, she felt able to maintain an image of perfection, but post-illness, she can no longer do so. For Maureen, this internal pressure to portray competence can lead to relapse:

> ...it's very important for me to gain the respect of my professors and the people I look up to. And often, you know, that stresses me out, because it's hard to gain that respect and to always keep up that functioning, competent persona, and so often when I do go home, I'm exhausted and that's when I kind of fall apart and, um, I might have a slip here or there (Maureen).

The public self is often a source of pride. Gwen speaks in idealistic—and somewhat ironic—terms of her pre-anorexic and even her anorexic self, at different times saying that she was, "just a perfect little person," "this perfect little glass maiden," and even "this perfect, wonderful masterpiece." The term "masterpiece" speaks to the conscious construction of the public self, as does Maureen's desire for friendships within which "all the masks come off."

The private self (some participants labeled it as "my disordered self" or "my anorexic self") seeks isolation in order to protect behaviours that others see as unacceptable. For Claire, this protectionism is almost absolute; very early in the interview, she told me, crying, "I've never talked about this before." Even as an adult in recovery from disordered eating, she expresses fear of what would happen if her mother found out: "I feel like my mom would be mad at me. I don't think she would be, but she might overreact." For Gwen, her usual strategy of managing anxiety through exercise turned into a full-blown crisis when she was discovered, by her father, doing aerobics in the middle of the night: "that was just such a horrible experience.... I was trying to be so

quiet so that no one would hear me, and, like, someone did." Rather than her anxiety

attack being the problem, the problem was discovery.

In the interest of maintaining privacy, women become skilled at managing

relationships. Naomi has learned that it is not difficult to divert others' curiosity: "Like

my best friend, she'll just talk about herself, blah blah blah blah blah, and then she'll ask

me something about myself, and I'll be, like, 'Oh yeah, it's fine, how about you?'" This

skill has its disadvantages, of course; Naomi admits that, "I just think I'm being a burden

if I talk about myself. Like, they don't care." Most of the time, Naomi says, "I'd rather be

alone."

But the private self also has its joys. Amber describes her purging as "like

Christmas, to me. That feeling you get when you know that you got someone this great

present and you're waiting to see the look on their face, that weird excitement, that

secretive excitement."

Often, maintaining privacy requires maintaining a minimal level of wellness.

Women walk a fine line between protecting their unhealthy behaviours and risking public

exposure. For Janet, the potential exposure of a doctor's exam proved to be motivation

for recovery:

> ...what really scared me...my doctor had told me that I needed to go in for a
> physical.... And I was like, well, what's that? And it's like a bunch of questions
> and then she examines your body and I was, like, nope, I'm not doing that. And it
> took her awhile to convince me to do it, and then they finally set up an
> appointment for me, and then I was like, nope, I'm not going in. And that was,
> like, if someone has to examine my body, I don't want that. I would rather be
> healthy than have that (Janet).

Disordered eating and exposure being mutually exclusive, Janet chose to get well (and

avoided the examination).

For all its flaws and all its efforts to hide, the private self yearns to be seen. Anne says, "…if I'm thin, it says that I'm unhappy. And it's one way to display that…. It's that one way that I can say, you know what? I control this part of me. And I can show that…." She goes on to speak of her thinness as a form of communication, using words like "show," "display," and "signify"; later in the interview this need to be seen becomes even more emphatic, as she says, "I'm all alone, but I'm this fucking unhappy. Like, *this* is how unhappy I am." Retrospectively, Anne sees the self-injurious behaviour of her adolescent self as an attempt to communicate: "…it was an attention-seeking thing, too, because it was like, 'I'm so sad! I don't know what to do!'" This sense of symptoms as forms of indirect communication echoes Miller's (1994) work on women who self-harm.

New research in eating disorders also confirms the prevalence of this public/private dichotomy; Gunn, Rosenvinge, and Ytterhus (2009) found that women with bulimia report living a "double life" as a result of their efforts to maintain their behaviours and avoid stigmatization. This public/private split raises concerns in light of self-in-relation theory. Surrey (1991) writes that women tend to define self in relation to others; if few or no "others" know the whole self, what does this mean for women who keep secrets? They may come to question their very existence.

Isolation/Connection

The second sub-theme of ambivalence is isolation/connection; conscious isolation is a necessary adjunct to the public and private selves, and yet the women in the study crave connection. In order to protect their private selves, women make conscious efforts to keep others at a safe distance, often disconnecting with those closest to them and avoiding new relationships in order to maintain the separation. Amber looks back on high

school graduation, leaving home, and getting her own apartment. Rather than freedom

and independence, though, she remembers, "I just wanted to be alone with my eating

disorder." Kat says, "I wanted to withdraw completely." The conscious nature of this

isolation is made clear in this statement:

> I've always kept people at a distance just in case I relapse, so I don't want to hurt
> them by picking up and leaving. And I usually try to keep relationships at enough
> of a distance so that I can pick up and leave. I'm trying really hard not to do that
> [now], because I know that that's one of the ways that I keep my foot on the
> doorstep of my illness, is by keeping people at a distance (Maureen).

For Naomi, this is even more practical; her social life interferes in a concrete way with

her ability to binge and purge. She says,

> I don't like dating and stuff because guys always want to be around you all the
> time. So I – I just don't have time for that. So I kind of isolate myself like that.
> Sometimes if my friends ask me out I won't go because I want to stay home and
> eat. Vomit, rather (Naomi).

For Anne, having a social life and maintaining an active eating disorder have proven to

be incompatible: "...if I'm emotionally upset the way I have been in the past, when I got

really sick, I wouldn't be out in public anyways, right?."

Not all of the behaviours demand privacy; for April, marijuana use started as a

social activity. As her use expanded from recreational to daily, and as the relationship

that supported her daily use disintegrated, she turned to using alone: "If I could get hold

of it, it was like a little treasure. Me and the pot would get in the car and go to the

[wilderness park]." However, even social drinking can hold an element of secrecy. April

recalls a recent incident when she was out with a family member; covertly, she left the

table to buy and drink two shots at the bar, in order to get drunk more quickly."

For some, attempts to make connections are thwarted by the need to protect

behaviours: of her first year in university, and the time of her heaviest substance abuse,

April says, "I was in the peer support network, but I still didn't connect...." She also

speaks of moving into student residence, "and that was to meet people, and that didn't

really work." April's efforts to make friends could only be so effective while she was

trying to hide her daily marijuana use. This self-imposed isolation seemed to take Gwen

by surprise when, while in her first year of university, she realized that she had not been

touched by another human being all semester:

> I remember sitting next to someone in chapel—it was a Christian university—and usually I'd stand at the back because I was just so anxious I couldn't sit down. And I remember sitting beside someone and I was like a foot away from them and I was, like, this is the closest I've been to someone in, like, four months (Gwen).

This conscious isolation, as well as the sense of portraying a false self in public,

recalls bell hooks' description of her college-age self: "*Mostly she is alone. And if she is*

in a group, you might say she is always performing" (1997, p. 60, italics in original).

Woodman (1982), too, seems to understand the need for secrecy and the fear of judgment

that accompanies it, when she writes of the choice that women are forced to make: reveal

our private selves at the risk of censure, or perform, and live an inauthentic life devoid of

true connection.

Physical/Emotional Sensation

For most of us, physical and emotional sensations are usually consistent; if we are

ill, we are likely to feel depressed; if we have just trained for and run a 10-kilometer race,

we are likely to feel powerful. For many of the women in this study, there appears to be a

clear disconnect between physical and emotional sensation. Speaking of how she feels

after purging, Anne says she feels "so much better" physically, and yet, "Emotionally, I

probably feel worse." For those who self-injure, physical pain and emotional pain seem

incompatible. April speaks of alleviating frustration through self-injury: "I would get

really frustrated, and I would just scratch, and then I'd bite.... Yeah, it kind of helped

ground me a bit." Kat used self-injury to distract herself from negative emotions: "it

almost felt like a release, it felt like everything would go away if I did that." For Maureen,

who picked up cutting from her peers in in-patient treatment, self-injury was "another

way of numbing out." She goes on to describe what numbing out means:

> Just taking that edge off, that raw, that immediate fight-or-flight adrenaline
> response. Like I don't ever – I hate that surge of anxiety, that surge of feeling. Or
> feeling sad, I think I went so long without crying, just because I just [pause] I also
> didn't know what sadness felt like. But then at the same time, I didn't know what
> happiness felt like either (Maureen).

For one participant, a dancer, self-injury served a very specific purpose. Her legs had

been a source of pride and accomplishment, fueling her belief in her abilities, until a

respected dance teacher criticized them: "I went home, and I burned [my legs] with

cigarettes" (Amber). In an instant, her legs had turned from a source of pride to one of

humiliation and a symbol of self-delusion. That incident marked the beginning of a form

of self punishment that has persisted, with the infliction of physical pain an almost-

automatic response to criticism and conflict. She puts it most succinctly: "whenever I feel

physical pain, I forget the emotional pain."

Unintentional physical pain does not appear to mediate emotional pain in the

same way that self-injury does. As a result of her eating disorder, Amber found herself

hospitalized and facing the possibility of death: "I had to figure something out, or my

obsession was going to kill me. And I'm too young to go, yet. I have a lot that I want to

do before I'm ready to punch out." Maureen had a similar—though delayed—response to

breaking a bone (due to osteoporosis, a direct result of her eating disorder):

> ...when I broke my leg, it was hell at the time, it was hell for the next four
> months and for everybody around me. But looking back on that, I'm just, I'm

grateful for having gone through that because it reminds me of what this illness has done and will do, if I continue, if I make that choice (Maureen).

Even the language of emotional sensation often seems unavailable. Although otherwise eloquent, when speaking of emotion, the women typically use the most basic descriptors: good and bad; happy and sad; better and worse. Maureen speaks of describing her feelings to psychiatrists, and resorting to the language of physical sensation: "I felt heavy emotionally so I needed to starve it out of me." When asked to describe the emotions surrounding restricting, Janet says, "I don't think that I, I don't remember, maybe I blocked that out. I – I don't know." For Anne, the connection between disordered eating and emotion came almost as a surprise:

> I was thinking about this interview and trying to timeline it, and like when I get sick and when I don't get sick, and I recognized this beforehand, but during my divorce, after the divorce, I was extremely sick. I was throwing up five times a day. And during my break-up…I did the same thing. So it was, like, instant. So that kind of got me to thinking…you know what? This is totally emotional (Anne).

Emotional sensation and expression are also linked to the private and public selves. Maureen says, "Emotions are what happens at the end of the day, when I'm by myself at home. You know, listen to music, and now I can finally let go and cry, when I'm alone."

The behaviours, whether chosen for their numbing effects or in spite of their negative emotional effects, seem to reflect a devaluation or fear of emotion; the women in the study would rather damage their bodies than expose themselves to emotional sensation.

Knowing/Feeling

> I said to myself at the beginning of this summer, oh, I just want to lose ten pounds, and I've lost 23. So, you know, I'm like, okay. Good for you. I can do this. Even though I know—I'm a smart girl—it's detrimental to my health. Right? (Anne).

Often the women express inconsistency between what they know to be true and what they feel about their behaviours. At times this seems to reflect an internal morality conflict: Claire says, "Definitely, like I know in my head that it's wrong." Janet echoes this regarding her suicidal behaviours: "I never brought up me trying to hurt myself [with counsellors], because I knew when I was doing it and after that it was bad and I shouldn't even be thinking about it." At other times, the rationale for the behaviours shifts as the women gain knowledge and understanding. Claire started purging in an attempt to lose weight; when she realized that it was not going to work, she changed the way she thought about purging. She says, "I think in my head I knew that it wasn't possible that way. Like, I knew consciously that was not the way, but for some reason I still did it." When speaking of her more recent (and more rare) purging, she says, "it's more of a control of stress kind of thing."

Exemplifying the knowing/feeling dichotomy, Gwen says, "I knew that anorexia was not a good goal in life or anything, but I felt so perfect and contained." Janet talks about her struggles as a child and of knowing her parents loved her, but of "not feeling loved." This struggle to justify knowing and feeling about problem behaviours was particularly clear in my interview with Anne. Talking about restricting, she says, "it's not about being thin; it's [that] people over-consume. You know, like they're always over-eating. It doesn't make sense to me." Later, she says, "there's the, *I will not consume, because it's over-consumption,* but there's also, like, *I can control this one thing.* You

know what I mean?" Again attempting to reconcile what she knows with what she feels,

Anne questions her own worthiness: "why don't I deserve to sit down and eat?"

Rather than struggling to justify knowing and feeling, Amber makes the choice

not to trust logic. About the early days of her eating disorder, she says:

> You know logically that, when you're doing things like hiding diet pills, when
> you're—I would miss the bus and take the second bus so that I could go down to
> the creek and throw up—you know, logically, that something's out of whack.
> That something's not right anymore (Amber).

Later, she speaks of logic's betrayal: "You've got 25% of you that's logical and 75% of

you that's done with logic, because as far as you're concerned, what has logic done for

you at this point?" (Amber).

While Amber has given up on knowledge and logic, Gwen and Maureen have

decided not to invest in emotion. Gwen says, "I've never been a very emotional person,

I've always been more intellectual and more, like, prided myself on not being silly…but

more wise than that." Maureen echoes this: "Even now I struggle with emotion. I'm

definitely not a very emotional person." Expanding on this, she says, "Feelings are messy;

they interfere with your life. And I'm driven, I – if I want to get my school work done, I

don't want to feel. I just want to get it done."

This conflict between knowing and feeling connects to the ways of knowing

explored by Belenky et al. (1986). The women in the study seem caught between

received and subjective knowledge, unable to attain the level of constructed knowledge

that would allow them to reconcile the apparent conflict between the two.

Success/Failure

The fifth expression of ambivalence is success and failure. For the women in the

study, there seems to be no middle ground between the two: no minor failures, no

moderate successes. Both success and failure are absolutes.

> It was…my make-or-break year to get into [performing arts schools]. So I was
> getting kind of overwhelmed with that. And I remember I was eating frozen
> yoghurt with my sister and I just out of nowhere went, well, if there's a way to
> put it in, there's a way to take it out (Amber).

This moment marked the beginning of Amber's eating disorder; the recognition that there

would be no second and third chances led to an idea: throwing up was "a quick road to

being a prima ballerina."

Often success seems to be about public perception: "women are seen to be

successful if they go for their exercise and they come home and they eat a carrot, and,

you know, *oh, you're just perfect*" (Gwen). About others' perception of her, Gwen says,

"everyone looked up to me, it seemed. Even people who were older than me, were just

like – oh, you're so put together and you're so smart." Maureen echoes this:

> …a lot of people have said…you always seem like you have everything together,
> you're always the one who's out there counselling everyone else, helping them
> through their shit…we never would have guessed that you'd go home every night
> and binge and purge until you pass out (Maureen).

The idea of success spans realms: academic, athletic, social, artistic, and

professional. It also extends to the problem behaviours. April takes pride in her expertise

in cutting marijuana and rolling joints: "the skills, the terminology, that's one of the skills

I learned in university was how to roll it, how to cut it up. I love the paraphernalia."

Gwen felt successful while living with anorexia; in recovery, she felt that she lost her

"sense of success. And [her] sense of pride." Having turned to purging from restricting,

Maureen says, "I almost feel like a failed anorexic." This notion of failure extends into

recovery for Maureen, who says:

> I think in the past that's also been something that, that I've failed with, and I
> realize that it's not something I can do, [I] can't completely separate myself from
> [the eating disorder] because it's so a part of who I am now, it's a part of my
> story and a part of who I am today (Maureen).

Amber expresses a degree of pride when talking about her superior ability to purge,

compared to that of a friend:

> ...some people can, some people can't. And she...I mean, the sounds that I heard
> were just painful to me.... But again, she was more of a dabbler than an extremist
> like myself. She was definitely not the all-or-nothing type (Amber).."

A close companion to success is the fear of failure. For Kat, family problems,

depression, cutting, and alcohol abuse are so closely linked it is impossible to say which

came first; what is clear is how she felt about these intertwined issues: "I ...felt like a big

failure." For a teenager who had identified herself with school success, skipping classes

and not performing up to par made her a failure. Maureen speaks of academic success as

a double-edged sword. Of an early experience in academia, she says, "I was performing

to a higher standard and I was being held to that standard, and I think I got overwhelmed

and felt like I wasn't going to be able to succeed." Rather than risk failing to meet her

high academic standards, she succumbed to her eating disorder and dropped out of school.

This uncompromising view of success is obviously problematic. If success is an

absolute, then day-to-day prioritizing becomes a source of immense stress. The option of

skipping the gym to complete an assignment or of submitting a B-grade paper in the

interest of preserving physical health may be unimaginable. Just as Woodman's (1982)

"best little girl in the world" collapses in the face of expectations, women who struggle

with self-harm may opt for complete failure over incomplete success.

One striking absence in the transcripts is the association of success with recovery. Among those women who do feel that they have achieved a degree of recovery, it is universally—though not strongly—associated with failure. Gwen refers to her recovery as "a lower level of functioning." It seems that the definition of success is so narrow for these women that an imperfect recovery may forever represent compromise.

Living/Dying

Four of the women talked about living and dying. It is significant to note that the two who spoke of past suicidal behaviours were not among the four who spoke of death. In an apparent contradiction, three of the four who spoke of death had experience with self-injury, and all three specified that their self-injurious behaviours did not reflect a desire to die. The fourth had past thoughts of suicide and self-injury, but had never acted on those thoughts.

For Gwen, having anorexia was easy compared to recovering from it. Of recovery, she says, "That's when I wanted to hurt myself and cut myself and kill myself." She goes on to remember, "It was just, like, what's the point of keeping going? Because there wasn't really anything to live for, I guess." Although Gwen did not attempt suicide, a part of her yearned for death. This passive yearning for death is echoed by Amber, who had envisioned her "glamorized death scene" with the assumption that she would die of a massive heart attack. She likens anorexia to a prolonged, passive suicide:

> ...once you get into it, it's more about dying, essentially. I mean, you're too much of a coward to do it. But it's easier if you can place the blame on something else. And then they can say, you know, she was sick, you know, she struggled for a long time.... It's a slow way to kill yourself, without actually having to have the guts to do it (Amber).

For Maureen as well, death was not something to be actively pursued, but a likely

byproduct of choices; she recalls, "...for me it's always been, like, I'm just going to take

riskier behaviours with the hope that it will kill me."

As death becomes something to be anticipated, if not pursued, the concept of

living becomes increasingly minimalist. Amber says, "It started with eating disorders and

ended up with drugs and basically my only thing was [to] get out alive. Just get out."

Similarly, Anne eats only out of necessity, taking in the least amount of nutrition possible

to sustain her life:

> ...every time I force myself to eat, it's when I'm at the verge of, like, passing
> out...it's because I need it physically. Because I know that if not, I'm going to,
> basically, frigging pass out and die. But it's not because I enjoy it (Anne).

In recovery, though, the concept of living expands dramatically:

> I'm a political junkie, so staying up to date in current events is, it fuels my
> passion for social issues. And that's been a major source of health for me, really
> trying to see things on a broader level. It brings me out of my personal – like, it
> takes me out of my head and makes me feel more like a part of the world
> (Maureen).

For Janet, this expanded concept of living took on a spiritual form: "I was using a razor

on my wrists. And it was just like a peace coming over me, and it was like...this real

confirmation that God had a purpose for me."

Control/Out-of-control

The problem of control has been well documented in relation to eating disorders

(Svirko & Hawton, 2007) and has an equally strong presence in much of the common

wisdom around addiction and substance abuse (Alcoholics Anonymous Canada, 2008).

The idea that girls and women (predominantly, though not exclusively) restrict or

otherwise control their consumption and expulsion of food in response to their lack of

control of external factors is a potent one. In recovery circles, the idea that the addict is

"powerless" against the addiction and is under the control of the substance is equally

prominent. As expected, almost all participants (eight of nine) named control as a factor

in their struggles. This theme is, in some ways, closely connected to the private/public

dichotomy, as women attempt to control public perception of themselves. When they are

unable to do so, a crisis may result, as when Gwen's father discovered her exercising in

the middle of the night or when the possibility of not meeting high academic standards

led to Maureen becoming sick and leaving school. Attempts to control emotions

represent another connection between themes. Claire describes the effect of purging: "It

sort of clears my mind. Makes me feel like I sort of have some more control." Before

purging, she says, she feels angry and frustrated; after the fact, she experiences a calm

that can last "probably a day."

For Naomi, the theme of control describes the context that allows her to continue

her bingeing and purging; she says of her family, "They can't prove anything, right? I

just lie. There's nothing they can do anyway." For others, lack of control in the family

context seems to lead directly to a need for control over food and the body. Janet's

difficulties started early, but she turned to disordered eating when her parents separated

(the fact that this separation was secret no doubt contributed). She says, "It was as if

everything was spinning out of control. And my parents tried to put everything on me

and my brother, and my eating was the one thing I could control. Right? So I didn't lose

everything." Family issues also played a large part in Maureen's early struggles. As a

pre-teen, her normal routine of play turned to compulsive exercise as her parents dealt

with the mental illness of another child. She says,

> I just started on this very regimented fitness schedule every morning, and then
> that kind of led into really weird eating habits in terms of, like, just eating one
> kind of food and restricting my food and it just kind of spiraled from there
> (Maureen).

For Kat, too, self-harm became a way of coping with family problems. Of an incident in

which she took pills (she does not call this a suicide attempt), she says, "Maybe [I felt]

just totally lost. I felt I had no control. I didn't feel that my parents, I guess, really cared.

My sister was the main – their life revolved around her, and I was on the back burner."

Anne's eating disorder and self-injurious thoughts are often triggered by loss of control;

of going through divorce, she says:

> …[food was] like, that one thing that I control. And it was the only thing I could
> control at the time. Everything else was in the hands of somebody else. Right?
> We had the judge who made all the orders. We had my ex-husband who had way
> more power over me. Right? We had all these different influences, and here I am,
> I'm like, okay, I have no control over anything (Anne).

Though Gwen does not identify any need for control before the onset of anorexia , the

illness gave her a sense of control, which being forced into recovery took away. She says:

> …I felt like I was such a precious, strong being at that point, and completely in
> control of my thoughts and my emotions—even though there wasn't much to
> control at that point—and completely in control of my body and of what I
> considered success and not success. And then all of a sudden I was like – poof.
> Bingeing and – I don't want to eat but I want to eat but I blah blah blah and my
> mind was just crazy and I had no sense of control, no sense of success or pride or
> ability to self regulate, just completely unable to be, because I was always, not
> necessarily thin but in control of myself (Gwen).

For many, the sense of control afforded by disordered eating and other self-harm

behaviours evaporates as the problem progresses. The sense of the problem behaviour

taking control is pervasive. Naomi says, simply, "…it seemed like a good idea at first,

but then it took on a life of its own and I couldn't control it anymore." Claire realized

that her purging had become a problem when, on a family vacation, she became

preoccupied with finding ways to continue the behaviour; she says, "I realized that it was really taking control, because I was trying to think of ways that I could get [my parents] out of the room or I could go somewhere, and I remember thinking, this is so stupid."

As the ability to control one behaviour wanes, a new behaviour often takes its place; but the sense of control remains elusive. For Naomi, the loss of control of one behaviour led her to seek it in another:

> I think I started [cutting] when my purging was out of control. Like I was sort of trying to use it to cut back on that, and it did work, sort of. Instead of bingeing and purging, I would cut myself (Naomi).

Amber elaborates on this constant quest to find a behaviour that can be controlled, rather than one that controls her:

> ...when I still felt like I was in control of it...I always pictured my disorder as like a puppy. Something I was walking on a leash, and when I was done with it, I could put it back in the house. And it was, you know, something that came when I called. Basically something that I controlled, not something that controlled my life. And I think that's what led me to self-harm, was the fact...I felt that I could control it, and I needed something that - after awhile you start to feel like a robot, because everything becomes so controlled. And it's amazing, though, the way you learn to rely - it's like you have this whole bank of influence. And then all of a sudden you start to lose control, you find something else you have to control (Amber).

Amber's metaphorical puppy, it seems, grew into an unmanageable dog with its own appetites. Her ability to express her experience in such a creative and vivid way, though, suggests a route toward wellness; Turner (1999), hooks (1995, 1997), Cameron (1992), and Estes (1992) all advocate creativity and metaphor in healing and discovering self.

Like an addict trying to recapture the effect of the first high, these women seem to find themselves chasing the sense of control they once found in their behaviours, and perpetually unable to do so.

These various manifestations of ambivalence among women can easily be conceptualized as forms of cognitive dissonance. Cognitive dissonance is universal, and occurs when thoughts and beliefs are inconsistent with behaviours, or when inconsistent thoughts and beliefs co-exist, creating internal tension (Aronson, Wilson, Akert, & Fehr, 2004). The need to reconcile these tensions is a powerful one, and can lead to positive change. Perhaps in women who suffer from these problems, though, the layers of dissonance are so complex and reconciliation becomes such an overwhelming proposition that living with the conflict seems less onerous.

Identity

> I was diagnosed, and then I was like, well, I'm anorexic, I shouldn't be eating, then. Because I wasn't that ill to begin with, and then I was kind of, that became my identity, and that became, oh well, this is how I should cope (Gwen).

Closely connected and interwoven with the theme of the public and private selves is that of identity. While the public self is competent and high-functioning, the problem behaviours become incorporated into the private self, creating a sense of inevitability: rather than, "This is a problem I have," the women seem to believe, "This is the person I am." For Gwen, whose diagnosis came relatively early, the label came to define who she was. For other women, identity seems to evolve from one rigid definition to the next. Maureen was "a tomboy" as a child, and when this role was no longer socially acceptable, she was "an outcast." When she attempted to conform to peers, growing her hair long and changing her wardrobe to meet expectations, she says, "that was the year that I ended up being institutionalized…I started to gain popularity in school, but I didn't stick around long enough to actually become one of the cool kids." Now in recovery, she struggles to understand who she is without her eating disorder: "I keep trying to separate myself, like,

who is this person outside of, you know, the illness. It's hard. It's like a cancer, and you can't cut it all out." Naomi was "the bad kid" in her family, "the fat one" among her sisters, and says she "still is." Now in her mid twenties, she has embraced these identities and seems reluctant to let them go. As noted above, her eating disorder is what makes her unique and special; if she gives it up, whom will she be?

Recalling Kaschak's (1992) assertion that women's identity is formed in response to men's expectations, Gwen says, "I wanted to be prettier 'cause I wanted to attract a wonderful future husband." For Naomi, too, thinness became a pre-requisite for relationships with men; she recalls her mother telling her, "If you ever want a boyfriend, you can't be fat." It seems that Naomi has internalized this, as she adds, "it's not like she was a bad mom. I think she had good intentions, 'cause, you know, that stuff is true. People do like you better if you're not fat." Being thin and beautiful, it seems, is the path to becoming girlfriends and wives.

Body Image

"It was never to be beautiful" (Maureen). In health and education research as well as the popular culture, the media is often blamed for the behaviour of young people: violence in movies desensitizes us to real violence; illicit drug and alcohol use in the media promotes substance abuse; ultra-thin celebrities promote disordered eating. Little in this study, however, suggests that the problem behaviours evolved in emulation of celebrities. The one notable exception is Amber, whose desire to be a prima ballerina led to drastic efforts at losing weight. For others, however, body image seems to be a very personal concern, and not connected to striving toward an external ideal.

For three of the women, body image and weight-loss attempts—at least early ones—seem firmly rooted in the family culture. Naomi refers to herself as "the fat one" among her sibling group, and recalls her mother making well-meaning comments about her weight. She also recalls an awareness of her body at an early age: "I remember in grade two…looking at my thighs and realizing they were bigger than everyone else's." Claire remembers both her mother and her maternal grandmother dieting; she says of the latter, "I can even hear my grandma, who's, like, 90…talk about how she wants to skip lunch because she needs to slim down." Anne recalls returning home from an international exchange and hearing her sister say, "Oh my God, you're *so fat*." Retrospectively, Anne estimates that she weighed 100 pounds at the time, but even with this knowledge the words seem to sting as much now. During each of her pregnancies, Anne says, her sister repeated this comment; each time she gained weight, Anne responded with restricting and purging. Now, as noted above, being thin has evolved into a way of displaying emotional pain.

For Anne and Gwen, normal post-puberty weight gain came as a shock. Gwen realized in her mid-teens, "Oh, I'm not completely, perfectly thin anymore. I wonder what I can do to change that?" Similarly, Anne says that at 15, "I guess I never realized that I could become fat." After her sister's comment about her weight, she says, "I was still a kid, and was—like—ah, I *am* fat." This sense of shock at transitioning from child to young woman affected Kat as well. As a pre-teen, she loved sports, but she stopped playing. She says she quit, "…probably when I got my first period, I started growing and I was more awkward, and I wasn't comfortable with my body anymore." For Maureen,

the transition from "tomboy" to "girly-girl" coincided almost perfectly with her first eating-disorder related hospitalization.

Eight of the nine women in this study spoke of body dissatisfaction (and this was not an interview question; there is no reason to assume that the ninth woman is satisfied with her body). However, this is not a particularly strong finding. Research has demonstrated that the majority of young woman in the developed world experience body dissatisfaction at some point in their lives (National Eating Disorder Information Centre, 2009). While body dissatisfaction has long been associated with eating disorders (American Psychiatric Association, 2005), the real question is not "Are women with disordered eating dissatisfied with their bodies?" but "How and why does body dissatisfaction turn to disordered behaviour?"

Stigma

Five of the women in the study spoke of the stigma around self-harm and mental illness. This theme emerged around discussions of the private and public selves, often in response to questions about what it would mean for others to know about the problem behaviours. The idea of stigma was connected to fear of (or actual) exposure. For Maureen and Amber, past exposure has led to being singled out and treated differently; Amber says of living in a small community where her eating disorder became known, "everyone in school knows…and then you get finger pointed as that kind of girl, like, oh – there's the sick girl." For Maureen, past experience has led her to the conclusion that it is safest to keep her illness a secret:

> …well, because there's so much stigma around mental illness, I think it's really difficult to put yourself out there and say, listen, this is something I struggle with, or something I have struggled with, and not have them look at you differently (Maureen).

Naomi seems wary of discovery, believing that her family and friends may suspect her eating disorder. This leads to self-consciousness around public eating. She says, "It definitely makes me feel like I'm on display or something, like everybody's watching me when I eat. I don't like it."

For Claire and Janet, who have kept their eating problems almost entirely secret, the problem of stigma is more theoretical. In trying to define the stigma of eating disorders, Claire says, "someone who can't control themselves, or someone who is too controlling. Um...I wouldn't want people to think I care that much about my appearance. The shallowness of it, it seems like a really shallow kind of disorder." Her explanation of what bulimia means to her is less ambiguous: "I can be in control of myself." For Janet, the stigma of disordered eating is something to be feared, even though she has trouble articulating what the stigma is:

> I had an eating disorder, and I thought I was fat. And my brother and [sister-in-law] were, like – no, you're not fat. Get over it, right? And then...maybe stigma's not the right word. But um...I was the one with the issue, I was the one saying, no, I am. But I...I know that eating disorders, mainly people stereotype it to women, not men. And it is possible. Actually I don't know if I would – I know what it is, but... (Janet).

Surprisingly, for Naomi—whose eating problem is bulimia—the stigma of anorexia seems to be a positive one; she says, "if I could be anorexic, I'd be much happier. Which sounds so sick. But at least I'd have control and I'd be thin and people would respect me."

Clearly, the issue of control is interwoven throughout the stigma problem, and again, the women are ambiguous about control. For Claire in particular, being perceived as "too controlling" has negative connotations, while being "in control" seems positive.

Learning the Behaviours

Perhaps not surprisingly, the problem behaviours explored in this study did not

appear out of nowhere; the women learned them. Often it was peers who did the teaching;

for Anne, dieting began in response to a comment from a sibling, but the idea of purging

came from a friend, with whom she entered a weight-loss competition. She says:

> ...the whole bulimic thing started with the influence from my girlfriend. Because
> she'd say, 'Yeah, my mom made me eat dinner, but it's okay because I threw it
> up.' Or we would go to the store and buy laxatives together (Anne).

Maureen and Kat both learned cutting from peers, and April was introduced to marijuana

and other drugs by partners.

Media—both popular and educational—also play a role in teaching problem

behaviours. For Amber, the idea of vomiting to lose weight came from a movie about a

competitive ballerina in a prestigious dance school; for a girl who wanted nothing more

than to be a prima ballerina, the story was less a cautionary tale and more a how-to

manual. Similarly, a story in a teen magazine about bulimia, meant to be a warning,

provided Claire with the idea; she says, "I was like – oh, that's sounds like a great

idea...it was one of those stories that, this ruined someone's life, and I was like, oh, well,

it won't ruin my life." Later, when Claire told a boyfriend about her purging, he taught

her about fitness and nutrition; this evolved into compulsive exercise. Gwen first thought

about self-injuring when she read about it: "I actually had read a story about cutting, and

it was supposed to be, like, the negativities of it, but it was like, oh, well, maybe I could

get release from there."

Cautionary tales are not the only source of learning. For Maureen, normal athletic

play turned to compulsive exercise when she picked up an issue of a popular magazine

which included a fitness program. Naomi—who started bingeing while still in elementary school—learned about purging in a high-school classroom. She says, "We were studying eating disorders at school and they showed us a video of this thin girl who was bulimic, it was supposed to be a warning, I guess, and I thought, *Oh, great idea!*."

Sometimes, not surprisingly, the learning goes in the other direction. In her first year of university, Amber found herself with a roommate who wanted to lose weight. She says, "...we lived together for a year, and we dabbled - in drugs, for one, and in that, too. And...she tried the throwing up thing, she, you know, asked for pointers, that kind of thing." Amber adds that, while she enjoyed the camaraderie, she is relieved, now, that her roommate walked away without a lasting problem.

Often, women take an academic interest in their problem behaviours. It seems that the goal of this academic study is to gain an understanding of the behaviours and the self, but one side-effect is that they become better at performing and maintaining the problems. Anne, for instance, learned that bingeing and purging was an ineffective weight-loss strategy; she made the decision to stick to restricting and purging. Claire, too, studied eating disorders; she says, "When I started studying about the bulimia in particular, I was worried about the health consequences, because that was when I was throwing up blood, and I was wondering where that was coming from." Though she did not stop her purging entirely, she tried to limit its frequency and turned to compulsive exercise.

Function and Strategy of Behaviours

Thomas Moore (1994) writes that, as a therapist, he would "try to give what is problematic back to the person in a way that shows its necessity, even its value" (p.6).

This section of the study represents my attempt to do the same for the participants and for women who may relate to their experiences. While function and strategy may not meet the strictest definition of themes—in that they did not emerge directly from the participants' language—it would be negligent to ignore the fact that self-harm behaviours do, in fact, serve specific purposes.

The term "function" is used to describe effects of the behaviours that are largely unconscious, or which are clear only in retrospect; when the behaviours are employed consciously to meet specific needs, they are considered "strategies." Behaviours seem to evolve from function to strategy and back again, as problems evolve. For instance, a behaviour such as purging may begin as a weight-loss strategy, but over time can begin to serve the function of alleviating anxiety around food and weight. Gradually, purging becomes a strategy for alleviating anxiety, while food and weight become secondary.

Alleviation of stress and anxiety is the most universal function of all the problem behaviours. At times stress and anxiety are alternatively labeled as similar negative feelings such as "pressure," "expectations," or "frustration," but for the purpose of this analysis, such negative feelings will be treated as analogous. Every one of the women in the study spoke of using behaviours to cope with stress and anxiety. Claire's experience is quite typical. Her purging has gone from a common occurrence in her mid-teens to a relatively rare one in her early twenties; she says, "It's only when something really stressful happens." What began as a weight-loss strategy has evolved into a stress response, often triggered by "fights, arguments, that kind of thing." Before purging, Claire says she feels "angry. Just really frustrated...." After the fact, she says, "then I feel calmer." Naomi speaks of her binge-purge ritual the way other women might talk of a hot

bath or a glass of wine: "Often if I have a stressful day at work, I'll just want to go home

and relax." This experience is echoed by all the women, whether they are speaking of

bingeing, purging, cutting, exercise, or substance abuse.

Some behaviours, particularly restricting, seem to function to control anxiety on a

long-term level. As Maureen says,

> ...when you're starved, it takes away a lot of that, a lot of those obsessive
> [thoughts]. It's easier to focus on food and to obsess about food and weight and
> body image than it is to allow all the other obsessions to come in and all the other
> pressures and all the other things that are, you know, the messiness of life
> (Maureen).

This is consistent with Gwen's experience; when she was actively restricting, she was

"very unemotional, like, completely flat. I didn't feel any emotions, like I didn't feel

happy, but I didn't really feel sad. I was completely numb." With recovery from anorexia,

for Gwen, came emotions, and with emotions came bingeing and purging.

It is important to note that, while anxiety and stress often pre-date the problem

behaviours, this is not universally true. For Gwen, dieting evolved into problem eating,

which then led to a diagnosis of anorexia. For her, depression and anxiety became factors

only after receiving the diagnosis, which seemed to erode her former confidence. Amber,

too, believes that eating problems came first and emotional problems followed. She says,

"When I started restricting, I kind of gave myself OCD." For Amber, counting calories

has evolved into a general obsession with numbers, which increasingly impedes her daily

functioning.

Because the behaviours employed by the women in this study are a source of

anxiety as well as a method of alleviating anxiety, the cycle can seem unbreakable. As

Amber says, "every time I find a new coping mechanism of some kind, it's more destructive than helpful."

One of the functions of crystal meth and cocaine abuse, as well as anorexia, for Amber was to avoid the demands of the world and—at least theoretically—to cease to exist.

> ...the thing with crystal meth is you can feel your body deteriorating. You can feel yourself getting smaller and smaller and smaller. And it's just - there's no drug that compares to that, like that feeling is.... When your main goal in life is to disappear, and you can feel yourself physically disappearing, nothing compares to that. It feels so good, as bad as it is (Amber).

Other women in the study also expressed a need to escape. For Naomi, bulimia provides an excuse to avoid not only social obligations, but the larger demands of adulthood. She says, "I don't want to deal with adult—I don't know—responsibilities, I guess. Like, I still live with my parents and stuff and...it's ridiculous." In her mid twenties, Naomi has dropped out of university repeatedly and admits that thinking about graduating and taking the next step is stressful. This pattern fits for Maureen as well, who says of relapsing and leaving school, "in a sense getting sick is a bit of a cop-out. It's a way of checking out of life for a little bit." Of binge drinking, Kat says, "I had the attitude when I was younger, if I can't handle things or if things are going bad, I'll just drink because it'll be fun and I'll forget everything."

In addition to long-term avoidance, the behaviours can function on an immediate level. For Kat, both cutting and binge drinking provided this temporary escape. Of cutting, she says, "that's all I would think about, was my pain and my hurt. I wouldn't think about anything else." Kat admits that the effects were brief: "I guess temporarily [it would help], but right afterwards it wouldn't really help." Though effective in the

moment, self-injury does not seem to have the longevity of disordered eating and substance abuse.

For several of the women, the behaviours engender a degree of defiance or rebellion. Gwen recalls being angry with her father and deciding, "Well I'm not going to eat, then." Maureen says she "fell into almost a delinquent lifestyle, and self-harm and drugs and alcohol just happened to be a part of that." For Amber, drug use allowed her to "feel like a rebel." For Naomi, this rebellion started early and still continues. When she first started purging, it served two purposes: "[it] pissed my mom off, because I was eating lots, but then I could control my weight." Now in her mid twenties, the element of rebellion is still detectable when she says that her family suspects her eating disorder, but, "They can't prove anything." This defiance is particularly significant given that most of these women are high achievers who spend much time and energy in trying to meet the high expectations of themselves and others. Gilligan's (1991) view of self-harm behaviours as expressions of positive resistance may explain this defiance; while women may appear to conform to expectations in their public lives, they maintain agency through private rebellion. While these behaviours clearly do not have positive effects on the women's lives and health, this terminology represents opposition to pathology, and as such is a useful position from which to view self-harm. This perspective also has the potential to turn the control/out-of-control dichotomy upside-down; the conforming, public self can be seen as the out-of-control self, reacting to the external demands of (male) others, while the rebellious private self maintains control of personal choice.

Often, the women use one behaviour to moderate or wean themselves from another. Naomi switched to cutting for a time. In addition to helping her to cut back on

her bingeing and purging behaviour, which was getting out of control, it allowed her to

protect her privacy. She says, "I would spend my rent money on binge food. And then I

would have to ask my parents for money to pay for my rent. I don't know where they

thought my money was going." For Amber, too, finances induced a change in behaviour.

After turning from purging to drug abuse, she says, "we knew I had a problem when I

was spending $2500 a month on cocaine." After getting free of cocaine and crystal meth,

Amber turned almost exclusively to restricting. Claire started restricting when she was 12;

when her parents became concerned, she switched to purging, deciding that "it would be

easier just to listen to them and then – throw up." When Claire's purging caused her to

start vomiting blood, she got scared and told her partner; he helped by teaching her about

nutrition and fitness, which over time evolved into compulsive exercise. For Maureen,

too, part of recovery from anorexia has included bulimic behaviours. She no longer

actively restricts, but—increasingly rarely—falls back on bingeing and purging to deal

with anxiety.

Most striking about these behaviour shifts is that they seem to be precipitated by

external influences. As discussed above, the knowledge that a behaviour is harmful

seems to induce changes in thinking; the threat of a behaviour becoming public (often by

requiring medical intervention) induces changes in behaviour. Not all of these behaviour

changes are toward health.

One of the more concerning functions of the behaviours is that of punishment and

atonement. Anne wonders if her disordered eating "could be from a sense of not feeling

worthy to eat, or of having a whole body." She questions herself, asking, "Why don't I

deserve to sit down and eat?" She has come to see restricting as a way of "punishing me

and punishing others." Similarly, Amber sees self-injury as a form of confession. She

says,

> ...people will say it's a punishment. You feel like, okay, it's like going to
> confession. That's essentially what it was. You feel all these really bad things.
> You feel like you've done something really bad.... You know, you feel like
> you've committed this horrible sin, and afterwards, it's all better. It's okay.
> You've done that, right, and after awhile you're okay. You feel like you let it all
> out, and you didn't have to tell anybody else, so nobody's going to know
> (Amber).

Though inquiry into past trauma and abuse was deliberately left out of the

interview questions, and only one participant mentioned past abuse, Miller's (1994)

description of Trauma Reenactment Syndrome (TRS) does offer some insight into the

function of self-harm behaviours. She writes of four important assumptions which are

critical to her approach. Within these four assumptions are several key factors which

shed light on the problem behaviours. Miller writes that the symptoms of TRS must be

seen as adaptations, attempts to cope, and forms of indirect communication. Like Moore

(1994), she sees the symptoms as having important functions and as being a source of

comfort and even friendship for women. She also emphasizes the necessity to establish

healthy, caring relationships as a precursor to healing.

While it is, perhaps, not surprising that the behaviours serve such specific

functions and work as such effective strategies, it is interesting that the women are so

conscious and aware of how their behaviours work. Rather than being the irrational

products of mental disease, the behaviours—in many ways—make perfect sense. The

fact that the functions served by the behaviours are so fluid may be a clue to why these

problem behaviours are so tenacious. Finding new ways to meet old needs is unlikely to

solve the problem, when the needs evolve so readily.

Choice

> ...to me there [are] two components of an eating disorder: there's the part that you can't really, there's a part that you can't control. The thoughts, you know, like there [are] lots of thoughts that I'm going to have, and the more I try to push them away, the more they come back. What I can control is how I deal with those thoughts and how I act on them, and the help that I choose to get for myself (Maureen).

One of the most surprising themes to emerge from the interviews was that of choice. For Maureen and for others, as insidious as the thinking behind the problem behaviours may be, the behaviours themselves are almost always consciously chosen. Amber says, "As much of an addiction as it is, you wouldn't do it unless you wanted to.... You wouldn't push everybody you love, and everybody who loves you, out of your life, unless you wanted that." Amber goes on to add, speaking of her partner, "I have a reason not to want that. I have a really good reason." Even when she was getting high daily, and several times a day, April made the choice not to go to work high. She says, "I wouldn't smoke on days when I had to work.... I did go to work high once and it wasn't good. It totally freaked me out when I did that." When Anne eats with friends, she says, "I'll choose something that I don't feel like I need to throw up, you know. I have no problem with that at all, eating in public." About purging, as well, Anne says she is making a choice; asked if this is a conscious decision, she says, "Yeah, I stick my fingers down my throat...."

Often, the choice of behaviour reflects what is most convenient or easiest to hide. For Claire, restricting drew the attention of her parents; she found it easier to allow them to see her eat, then purge after the fact. For Amber, the opposite was true; she says, "there's a million excuses not to eat, there's only so many excuses as to why you're in the bathroom all the time." When Janet's brother started to monitor her eating, she made

choices about what to eat, but also about what to tell him. She says, "…he would ask me

what I ate, and he would make me eat what I didn't eat. And I have a hard time lying,

and so I would, it would be like a half-lie." For April, too, the problem of public

exposure led to moderation in behaviour; after her most severe incident of cutting, she

realized that the effects were visible in her short-sleeved work uniform. After that, she

was careful not to leave marks that would draw attention.

For Anne, the most significant choice was to completely cease purging and

restricting while pregnant. She says, "I had no issue eating and…making sure the baby

was okay. And then afterwards, it was always afterwards that I'd get sick again."

This element of choices raises a central question: if women can choose to

alternate, moderate, and cease behaviours entirely, why do they not choose to do so in the

interest of their own health? The answer to this question may lie in the multiple layers of

ambivalence discussed above.

Recovery

> …what will recovery look like? Me embracing it all and eventually fully
> accepting my body and allowing myself to get over a certain weight and not
> caring whether I don't go to the gym, or - there's so much I wish for myself that I
> just can't - can't let myself have it yet. I guess those are just questions for the
> future. I don't know (Maureen).

The theme of recovery is present in the interviews, but is often elusive. As Amber

puts it, "I'm in a constant state of recovery; I don't think I'll ever be recovered. I don't

ever see myself as letting go." To the question, "Do you consider yourself to be in

recovery?" only two of the women—Gwen and Kat—responded with an unqualified

"Yes." Two did not feel that they were in recovery, and five—like Amber—felt that they

were somewhere in between illness and wellness. Anne's response was, "It depends on

what day it is." Most of the women, though, have experienced at least glimpses of

recovery, and those glimpses will be discussed in this section.

For Gwen, recovery has meant relinquishing the needs that were served by her

eating disorder. Asked how she finds that sense of pride and power now, she says, "You

know what? I've had to give it up." She goes on to explain,

> I don't put the same goals in my life…like, I'm not the same person that I was,
> and I can't make myself be that confident person. Because I was very confident,
> very into leadership. But I can't really say that because…as time goes by I
> experience more different things that, like, oh—oh, wow—that, I thought I'd lost
> it forever. Like recently I've found myself being more social and, well, I don't
> know, maybe that was just something that, I'm not social anymore, right? (Gwen)

Having relinquished her pre-anorexia identity, she is now finding that she is able to

reclaim parts of her former self, with caution.

For Kat, recovery has come hand-in-hand with exploring her traditional

spirituality and reconnecting with her community and family. When her difficulties

began, with her father's remarriage and the birth of her sister, she felt she had lost her

place in the family. She says, "…everywhere I looked everyone had big families…and I

really wanted that sense of family in my life, then." In an apparent contradiction, she

responded to this need for family by withdrawing and isolating. Now, though, she finds

comfort and support in family. Of an older sister, she says,

> She's really good to talk to…I find it really good, therapeutic almost, for us to
> just sit and talk. And she also has two children now, my niece and my nephew,
> and I find it really good to be around them. It just really helps me (Kat).

Reconnecting with family has been only one part of Kat's recovery; of her

Aboriginal heritage, she says,

> My culture is really important to me. I'm probably not as cultural as some other
> native people, but I like to participate in drum dances and all of that. And the

spirituality part has really, the past couple years, searching for spirituality, it's really helped me to get back in touch with that part of myself (Kat).

For Janet, too, spirituality and family have been an integral part of recovery. Of factors contributing to her wellness, she says, "I would say the two main things are my relationship with God and my family." Another element of recovery for Janet seems to have been engaging in international volunteer work. She says, "I went on a missions trip when I was 15 or 16—it was grade 10—and that was kind of the time when I started coming out of it."

Volunteering has been beneficial to April as well. Part of recovery for her has been seeking "balance – mental, physical. And I'm trying to do some volunteering, which helps with the emotional stuff." While actively using substances and self-injuring, April's attempts to form friendships with others largely failed; in recovery, however, she is able to connect.

Connection—not just with other people but with the world as a whole—seems to be the common element in recovery. While in the past she has avoided forming close relationships with others, Maureen has found this critical to her recovery. Asked about what, besides the problem behaviours, helps her to manage stress and anxiety, she says, "It sounds weird, but school. I mean, my involvement here and the communities that I've found, found membership and acceptance." Like April, Maureen has also found balance to be key:

> I'm not very good at balancing my life, I'm either gung-ho full-speed-ahead or I'm completely incapacitated in a hospital. I'm definitely, I would say this is the first time I'm finding balance between the two, that I'm able to embrace the success but still take time to take care of myself, too (Maureen).

These three factors—spirituality, connection, and balance—come together in

Coholic's (2003) definition of spirituality:

> Spirituality is eclectic and transcends ideologies and institutions. It is a complex
> construct that can be deeply personal and communal and that can encompass a
> sense of connection with something bigger that transcends ordinary life
> experience (something bigger is necessarily self-defined) (p.49).

For Janet, "something bigger" is the Christian God; for Maureen, it is an awareness of

and connection to the social and politic world she inhabits; and for Kat, it is embodied in

her Nation's and her family's culture and spirituality. Whether they find it in family,

spirituality, or activism, perhaps the most striking finding in this study is that—for those

women who have experienced a degree of recovery—connection to "something bigger"

is always associated with that recovery.

This need for connection is highly consistent with the qualitative literature on

wellness, particularly for women. Jordan (1991) distinguishes between the male ideal of

independence and autonomy and normal female development, in which mutuality takes

precedence. Surrey, too, emphasizes "interaction and relationship as a process of mutual

sensitivity and mutual responsibility that provides the stimulus for the growth of

empowerment and self-knowledge" (1991, p.59). Geertsma and Cummings (2004), in

their work on spirituality and women's healing, note the importance of connectedness

with something outside of and greater than the individual. For May (1975), psychological

and spiritual intimacy are key to wellness; he contrasts this version of intimacy with that

of physical intimacy, emphasizing the greater risk—and greater potential benefit—of the

former. May draws parallels between intimate connections, spirituality, epiphany, and

self-actualization, suggesting that without such connections—with the larger world and

with other human beings—we are destined to live less-than-fulfilling lives.

Cameron (1992) likens artistic expression to spirituality. She distinguishes between the logic brain and the artist brain, but makes clear that the two are not in opposition; rather, the artist brain encompasses the logic brain and allows us to connect with each other and with the world in greater, more complete ways. Cameron also writes of "recovering a sense of safety" as an early step toward wellness. This recalls Maslow's (1968) hierarchy of needs, which illustrates that, without a solid foundation of safety and belonging, we will never succeed in attaining the higher levels of understanding and self-actualization. Unfortunately, it seems that most of the young women in this study have either not yet found or have abandoned their artistic selves. As with the other layers of ambivalence, the artist brain and the logic brain may, in fact, be in opposition for them. This probably reflects their perfectionism and the rigid ideal of success: being a perfect artist is much more difficult than being a perfect student. I expected that journaling, music, and visual art would emerge as alternate ways of coping, but they did not; two of the women used to journal, but have stopped. April speaks of playing her guitar as a way of dealing with stress and finding expression, but qualifies that this is much more difficult and rare since she stopped using marijuana; it seems that accessing that creativity without substances still presents a challenge. Amber, who not only continues to dance (against doctors' orders), but who speaks in elaborate and creative metaphors, seems to have retained her connection with the artist brain, but rejects the logic brain. While her years in dance and theatre may have made her more comfortable than the other women with creative and emotional exposure, she has yet to achieve balance, and may lack the self-protection provided by the logic brain. The ability to utilize the filters

provided by the logic brain while still attaining the authenticity allowed by the artist

brain seems to elude the women in the study, at least for now.

The exception may be Gwen, who not only speaks in metaphor, but who

consciously analyses and attempts to redefine herself, post-anorexia. Gwen also had one

of the latest onsets of problem behaviours, the earliest and most aggressive intervention,

and is arguably the furthest along in her recovery. Though she sees recovery as a "lower

level of functioning," she recognizes that this level of functioning is fluid, not static, and

that her world and her sense of self are expanding.

The ability to expand the concept of creativity beyond the dominant patriarchal

ideal of a product to be viewed and judged may be one key to achieving recovery.

Creativity as process rather than product, as expression rather than display, has a

generative potential which transcends ideals of aesthetics and perfection, inviting

spirituality and connection.

Creativity, spirituality, balance, and connection certainly seem to represent key

elements in recovery and wellness. Providing safe contexts and guidance for girls and

women to explore these concepts may well be the most helpful and concrete strategy in

prevention and early intervention with girls and women who self harm.

Discussion and Limitations

Analysis of interviews with nine women who suffer from disordered eating,

substance abuse, and self-injury revealed a complex web of fifteen themes. Within the

larger theme of ambivalence were seven sub-themes: public/private selves;

isolation/connection; physical/emotional sensation; knowing/feeling; success/failure;

living/dying; and control/out-of-control. Other associated themes were: identity; body

image; stigma; learning the behaviours; function and strategy of the behaviours; choice; and recovery. Three themes were universal: all nine participants endorsed them. These were public/private selves; isolation/connection; and function and strategy of the behaviours (ambivalence is not considered a theme in-and-of itself here, as it is more than accounted for in the seven sub-themes). Four themes were endorsed by all but one or two participants; these were: control/out-of-control; learning the behaviours; choice; and body image. Three themes were endorsed by six of the nine participants; these were: physical/emotional sensation; identity; and recovery. Four themes were endorsed by four or five participants; these were knowing/feeling; success/failure; living/dying; and stigma.

Untangling connections between themes proved a challenge; identity and body image are tied up in the public and private selves; recovery seems incompatible with ideas of success and failure and the need for isolation; the concept of control clashes with the element of choice, etc. There were surprises, but no earth-shattering revelations. A few things do seem clear, however. The layers of ambivalence experienced by these women are problematic only by degree; internal conflict (cognitive dissonance) is a perfectly normal and healthy human condition. Efforts to reconcile these inconsistencies represent personal growth, learning, and healing. Relinquishing control and isolation, allowing ourselves to connect in meaningful ways, and finding balance, all in spite of our fears of failure and rejection – these are goals we all strive for and—more often than not—fail to achieve. Perfect recovery—like perfect health, self-actualization, transcendence, and all other human ideals—is for most of us a place to be glimpsed and not a place to put down roots. The most we can hope for is to visit for a few minutes or hours at a time.

As described in the literature review and illustrated in Appendix A, the co-occurrence of the three problem areas is well documented in quantitative literature. While the extant qualitative literature on women's experience of these three problem behaviours is quite limited, there is support for these findings. The themes of public/private selves and isolation/connection, as well as the emphasis on connection in recovery, reflect social and psychological tensions between the male values of independence and autonomy and the female values of interdependence and relationship (Gilligan, 1982, 1991; Rogers, 1991; Surrey, 1992). Jordan (1991) writes of the power of mutuality and empathy—forms of connection—in healing. May's (1975) work on psychological intimacy and Geertsma and Cummings's (2004) exploration of connection, spirituality, and healing also support these findings; isolation and secrecy support illness, while connection and relationship promote wellness. Secrecy and fear of judgment are explored by Woodman (1982) and Miller (1994) as reflections of psychological trauma and pain, and hooks (1997) writes of herself, as a traumatized young woman, unable to show her true self, "*always performing.*"

Support was not found in the literature for the theme of ambivalence in physical/emotional sensation. However, the theme of ambivalence in knowing/feeling recalls Belenky et al.'s (1986) work on women's knowledge. This work suggests that oppression inhibits women's ability to integrate different types of knowledge, offering an explanation for the all-or-nothing thinking patterns exemplified by the women in the study. This shines light on all the levels of ambivalence, including the success/failure dichotomy, which is also supported by Woodman's (1982) work. Support for the ambivalence around living/dying was not strong, but hooks's (1997) description of

poetry as "a kind of suicide, a death," (p. i) in which she—as a child—found escape, vividly illustrates this ambivalence.

The theme of control/out-of-control is supported by both quantitative and qualitative research. Svirko and Hawton (2007) discuss this in their work on the intersection between self-injury and eating disorders. Addictions programs such as Alcoholics Anonymous view the addict as powerless and out-of-control in the face of the addictive substance. Woodman (1982) also sees girls' transition from child to woman as a loss of control, which can trigger self-harm behaviours.

The theme of identity is supported in the work of Kaschak (1992), who writes of women's sense of self being defined by their relationships to men. Also, Gilligan (1982) writes of male-centric psychiatry defining women's identities by pathology. These works support the sense expressed by the women in the study that their identities were defined by their behaviours, diagnoses, and relationships. Though the theme of body image, closely connected to identity, is prevalent in the extant literature on eating disorders, the necessary limitations set on the scope of this study have, to a great extent, filtered this factor out of the literature review. While the women in the study were body conscious, as are most women (National Eating Disorder Information Centre, 2009), body image factors seemed to be stronger in the development of self-harm behaviours than in their persistence. This observation is supported again by Woodman's (1982) description of a pre-pubescent girl who adopts disordered-eating behaviours in protest against her own maturation.

Petersen et al. (2008) write of the effect of stigma on women with bulimia nervosa, exploring how stigma and the risk of public exposure impel women to lead

double lives. This supports not only the theme of stigma, but those of public/private selves and isolation/connection. The theme of stigma is also supported by the work of Heath (2006). While Heath writes of stigma in respect to race, disability, sexuality, and other visible diversities, the women in this study are marginalized due to their problem behaviours; they are an invisible rather than a visible minority.

The theme of function and strategies of the behaviours was supported by several pieces of qualitative literature. Moore (1992) writes of the therapeutic value of recognizing and validating the purposes served by problem behaviours. Gilligan (1991) reframes self-harm behaviours as positive resistance to gender oppression and social norms. Miller (1994) sees self-harm behaviours as adaptations and attempts to cope with and communicate about trauma and abuse. None of these works, however, note the fluidity and evolution of the functions and strategies that was evident in this study.

Literature on recovery from self-harm behaviours was beyond the scope of this thesis. However, the theme of recovery, and in particular its associations with spirituality, connection, and creativity, is well supported in the literature. Cameron (1992) sees creativity and spirituality as analogous routes to wellness; Coholic (2003) writes of the role of spirituality as a tool for healing in feminist social work; and Geertsma and Cummings (2004) see women's spirituality groups as sources of support and wellness. May (1975) describes creativity and intimacy as healing forces; Jordan (1991) explores the importance of connection and mutuality in women's journeys to wellness. Heath (2006) goes a step further, seeing spirituality not just as a path to personal wellness, but as an expression of protest with the potential to promote justice for oppressed women. As

diverse as these works are, the links between spirituality, connection, creativity, and recovery are undeniable.

No literature was found to support the theme of learning the behaviours; however, it is likely that this theme, like that of body image, was filtered out with the limitations imposed on the literature review. Disordered eating, substance abuse, and self-injury—as well as healthier coping mechanisms—are learned and taught in families, cultures, and classrooms. The implicit and explicit ways in which this learning occurs present possible avenues for future research. The theme of choice, as well, was largely unsupported by the literature. The exception was Petersen et al. (2008), who acknowledge that the bingeing and purging rituals of bulimic women are impulsive, but note that those impulses are not always acted upon, suggesting that women have a degree of control over their impulsive behaviours. The theme of choice is somewhat problematic, in that it could be interpreted to mean that women choose to be unwell; this idea is not supported, either in the literature or in the present study. While the participants were sometimes able to choose not to engage in a self-harm behaviour, more often than not this meant either delaying that behaviour or choosing a different, equally detrimental behaviour. Simply choosing to be well was not an option.

This is a small study, with specific goals. Cultural, family, and contextual factors have—for the most part—not been addressed. This reflects my conscious decision not to attempt to explore causes of the problem behaviours, but instead to focus on women's subjective, individual, and shared experiences of the behaviours. While much of the literature suggests causative factors such as abuse, family instability, and oppression, it is my view that these causes have been over-estimated due to the focus in research on

highly clinical populations. Also, while exploring causes is crucial to prevention, it does

little to benefit women who are already suffering, and those women were my focus in

this project.

The small sample size and relative homogeneity of participants must be noted.

Only nine women participated in the study, all of them university students in their 20s.

This seriously limits the generalizability of findings. In addition to the benefit of

advanced education, all have had access to therapeutic services, and all but one have

taken advantage of that access. These factors suggest a degree of privilege. This privilege,

however, does not exclude young women from the influence of oppression, and it may,

in some ways, make them more vulnerable; as a privileged population, they may not be

aware of the influence of the levels of oppression which affect them. The narrow range

of cultural heritages represented this study also must be noted; it is likely that the

influence of culture plays a significant role in the evolution of these problem behaviours,

and the limited diversity of this study precludes exploration of these influences. My prior

experience with young women suffering with these problems, both as a youth worker and

as a practicum student, strongly suggests that Aboriginal women may be particularly

susceptible to these problems, and that this may be linked to Historic Trauma

Transmission (Wesley-Equimaux & Smolewski, 2004); this is an area that demands

further exploration, but is outside the scope of the current work.

Both in this study and in the literature, the intersections between the three

problem behaviours clearly exist, and considerable parallels in women's experience of

the three behaviours are evident. However, only two of the women in this study had not

struggled with disordered eating. For this reason, extreme caution must be used in

generalizing between women with disordered eating in combination with the other problems and those without. While addiction terminology has been used—here and elsewhere—in describing all three problems, the extent of the parallels cannot be inferred.

While attempts were made to maintain consistency in the interview process, some variability was unavoidable. For instance, all participants were given the interview questions at least a week in advance of the interviews, but not all gave the questions the same degree of thought and attention. Two participants told me that they had barely glanced at the questions, because they wanted to answer spontaneously; one said that she had gone over the questions several times in an effort to give "the best possible answers." A fourth was studying the questions when I arrived for the interview. None of the participants seemed scripted during the interviews, but some had certainly planned their responses more thoroughly than others.

In addition to the omission of causal factors, other deliberate omissions have been made. Though some of the literature reviewed touches on women's recovery, the review does not specifically focus on this area. This reflects time and space limitations, but also the fact that the participants in the study, overall, do not consider themselves to be in recovery. Though that area is of great interest to me, and I intend to pursue further research into women's recovery, this study and these participants were not appropriate for that exploration.

Chapter 5: Summary and Recommendations

When I began this work, it was with the vague feeling that the therapeutic and medical communities were failing young women. I recall my client Toni telling me that she had gone to her family doctor to discuss her disordered eating; she was told that she had "an eating problem, not an eating disorder." The subtext to this statement, it seemed to both of us, was that only if she got sicker would Toni warrant help. In the interviews, several of the women spoke of not meeting the criteria for eating disorder treatment. For Gwen, maintaining a weight of 100 pounds allowed her to avoid hospitalization. Faced with such rigid criteria, young women have decisions to make: fall below the threshold and get help (while surrendering control and exposing the private self) or maintain a weight that reflects minimal physical health (while maintaining control and protecting the private self).

Disordered eating is not the only area where service provision is accessible only to the very sick. Young women who draw the attention of concerned others due to their self-injurious behaviour are likely to be assessed for suicide risk, then dismissed as attention seeking. Similarly, a young woman who drinks only twice a month but who blacks out every time she drinks, will probably be reassured that her substance use is normal and experimental. Most of the women in the study have drawn attention— medical or otherwise—for their problem behaviours; by controlling the severity of effects, however, they are able to fend-off further intervention. Eventually, concerned professionals, friends, and even family members stop asking pertinent questions. Behaviours may be minimized or even cease to exist, but the conditions which wrought them persist.

Rigid diagnostic and treatment criteria, an overwhelming dirge of services, and the potent stigma attached to self-harm combine to create an atmosphere in which asking for help is as often punished as rewarded. Whether women seek and receive treatment or not, the level of wellness necessary to avoid attention is minimal at best. Short of committing a crime or collapsing in a public place, women who self-harm rarely attract attention for their problem behaviours.

My purpose in making these observations is not to critique the medical model of treatment, but to highlight opportunities for social workers and other helping professionals to intervene before the medical model becomes necessary. I believe that the levels of ambivalence described above offer one such opportunity. By challenging the rigidity of women's ambivalent thinking, I believe it is possible to break down the all-or-nothing belief systems and allow women to live authentically. The goal is not to "fix" or correct ambivalence, as ambivalence is perfectly normal; rather, the goal is to help women learn to be comfortable within ambivalence. By reconciling the levels of ambivalence—embracing moderate successes and small failures, allowing the private self to have a public life, challenging isolation and promoting connection—I believe that young women can learn to live authentically, imperfectly, and joyfully.

I believe that a new way of thinking about self-harm is the first step in meeting the needs of women. Rather than pathologizing women's behaviours, we need to normalize our experiences, break down barriers to connection, encourage cautious relinquishing of control, and create safe contexts in which the public and private selves are equally welcome and valued. Educational, preventative, and early intervention

initiatives need to focus less on the behaviours themselves and more on the underlying

thoughts, feelings, and belief systems.

Implementing this ideal involves asking difficult questions and looking beyond

overt behaviours and "presenting problems" to explore women's self-destructive

thoughts and emotions. Happily, social work already knows how to do this. The

challenge lies in identifying girls and women who struggle with these thoughts and

emotions before they develop the medical and psychiatric problems described in the

DSM. This may require a new language for these problems – a language which speaks

directly to girls and women and communicates empathy, love, and acceptance, rather

than pathology, stigma, and judgment. Further qualitative research with women who

suffer and who have recovered will be required, and I believe that social work is the

discipline to carry out this research.

In addition, a great deal more attention needs to be placed on what recovery looks

like. The medical model of recovery, which typically focuses on the cessation of

behaviours for a pre-determined period of time, falls short in its attempts to improve

quality of life. A greater focus on relationship, connection, and spirituality over

symptomology would benefit not only the young women who already suffer from

disordered eating, substance abuse, and self-injury, but those at risk for developing self-

harming patterns. Social workers, in cooperation with educators and other helping

professionals, are in an ideal position to explore these issues and to implement early

intervention and prevention strategies that would focus not on what self-harm behaviours

look like from the outside but what self-harm thinking feels like on the inside.

Specifically, I recommend that social work intervene in four ways. First, social workers must continue to provide services and support for those women who do not meet treatment criteria, and who cannot access appropriate medical, psychiatric, spiritual, family, and other systems. Second, social workers must deliver a broad range of prevention and early intervention programming, focused not on specific behaviours but on thinking patterns and expression of emotion. This programming should focus on helping girls and women to learn to recognize and challenge rigid and perfection-oriented thinking; to shift from a focus on detail to seeing the bigger picture; and to safely express negative emotion such as sadness, anger, and frustration. Third, social workers should foster cooperative partnerships with schools and community organizations to serve young women before they meet treatment criteria, assisting existing structures in promoting emotional wellness, connection, and relationships among girls and between girls and adults. Finally, social workers must challenge the patriarchal status quo which values compliance and conformity over authenticity, encouraging healthy rebellion, authentic relationships, and honest connections in all the girls and women in our personal and professional lives.

This study is merely a starting point. Qualitative research with adolescent and pre-adolescent girls and women to determine risk factors—particularly in thinking patterns, meaning-making, and emotion, rather than trauma and abuse—is required. In addition, qualitative research with women in lasting recovery—whatever that recovery means to them—will shed light on factors involved in healing and in setting appropriate goals and expectations.

My hope is that the stigma and pathology attached to women who self-harm will—within my lifetime—be looked back upon as a misinterpretation, in much the way that we now look back on the idea that homosexuality and bisexuality were signs of pathology.

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Appendix A: Summary of Quantitative Literature

Disordered Eating and Substance Abuse	Holderness et al. (1994, literature survey)	• 2.9 – 48.6% correlation b/w BN and alcohol abuse • 8 – 40.7% correlation b/w substance abuse and disordered eating • greater correlation with BN than AN
	Weiderman & Pryor (1995)	• BN correlated with use of alcohol, amphetamines, barbiturates, marijuana, tranquilizers, cocaine • Severity of caloric restriction => increased amphetamine use • Severity of bingeing => increased tranquilizer use • Severity of purging => alcohol, cocaine, and cigarette use • Greater correlation of BN than AN for all substances
	Measelle, Stice & Hogansen (2005)	• Substance abuse and eating disorder symptoms increase over time in adolescent girls • Disordered eating predictive of later substance abuse
	Herzog et al. (2006)	• 17% of women with ED had history of drug use disorder correlation greater with BN than with AN
	Thomas-Brenner et al. (2008)	• ED combined with obsessional personality => unlikely to develop DUD • ED combined with impulsivity => more likely to abuse alcohol
	Sandager et al. (2008)	• Smokers with BN more likely to show comorbid pathology • Smokers with BN had poorer health status, less likely to seek treatment • Smokers with BN reported higher alcohol consumption
	Dunn, Larimer & Neighbors (2002)	• BN/bingeing associated with negative drug and alcohol-related consequence
	Von Ranson, Iacono & McGue (2002)	• Adolescent girls with eating disorders/eating problems more likely to have a history of substance use and nicotine dependence • Bulimic symptoms correlated with alcohol misuse • Restrictive eating correlated with illicit drug use • Eating attitudes and pathology associated with alcohol use and misuse among adult women
	Baker et al. (2007)	• In women with BN, DUD associated with neuroticism and major depression • Strong genetic component to comorbidity of BN and DUD
	Gadalla & Piran (2007)	• Risk of ED associate with greater substance use, dependence, and interference
	Pisetsky et al. (2008)	• In male and female adolescents, disordered eating associated with substance use

	Citation	Findings
Disordered Eating and Self-injury	Yaryura-Tobias, Neziroglu & Kaplan (1995)	• Chronological sequence of symptoms among women with OCD: anorexia → amenorrhea → dysorexia → compulsion for SIB
	Favaro & Santonastaso (1998, 1999, 2000)	• 72% of patients with BN reported at least one form of SIB • Neither impulsive nor compulsive → least likely to purge, suicide or engage in SIB • Impulsive but not compulsive → more likely to purge and attempt suicide; most likely to abuse alcohol and illicit drugs; more likely to engage in impulsive SIB (cutting, burning, etc.); most likely to engage in more than one impulsive behaviour. • Compulsive but not impulsive → all engaged in purging; suicide attempts and substance abuse absent; impulsive SIB (hair pulling, nail-biting, etc.) frequent. • Impulsive and compulsive → all purged; 71% attempted suicide (half made multiple attempts); half engaged in impulsive SIB and most engaged in compulsive SIB. • Bingeing associated with impulsive SIB; restricted eating associated with compulsive SIB.
	Davis & Karvinen (2002)	• OCD symptoms higher in women with intention to self-harm • Women with intention to self-harm had greater addictive personality characteristics • Excessive exercise strongly associated with intention to self-harm
	Claes, Vandereycken, & Vertommen (2005)	• Women with ED and tattoos/piercings less likely to self-injure • Women with ED and tattoos more likely to ab/use nicotine and hard drugs • Piercing in women with ED + correlated with extraversion and openness • Self-injury in women with ED + correlated with neuroticism and conscientiousness • Women with ED and one or more piercing => less severe ED symptoms
	Claes & Vandereycken (2007)	• ED + historical trauma => increased likelihood of SIB • Highest rates of SIB among those who experience sexual abuse before age 15
	Svirko & Hawton (2007, literature review)	• SIB 25.4% to 55.2% in eating disorder patients. • Eating disorders 54% to 61% in SIB patients. • Impulsivity, obsessive-compulsive characteristics, affect dysregulation, dissociation, self-criticizing cognitive style, and need for control potential contributing factors. • Association found between BN and dissociation
SA/ SIB	Haw et al. (2005)	• Association between alcohol use, alcohol dependence, and hospitalization for self-harm injuries. • Problematic conception of self-harm injuries
ED/ SIB/ SA	Anderson et al. (2002)	• Women with BN and SIB reported more drug abuse that other groups, scored higher for self-transcendence.
	Coker et al. (1994)	• Women with BN who did not engage in treatment were more likely to abuse laxatives, have more severe depression, and report greater body dissatisfaction; more likely to engage in impulsive behaviours such as substance abuse and SIB
	Dohm et al. (2002)	• Approx. ¼ of women with bingeing disorders had both an alcohol and a drug problem. • 14 out of 215 displayed intentional SIB, alcohol, and drug problems • White women were more likely than black to have combination impulsive behaviours

Appendix B: Recruitment Poster

Research Study

Are you a woman between 19 and 35 who has struggled with **disordered eating, substance abuse, and/or self injury (cutting, etc)?** I am a graduate student in **Social Work** at **UNBC**, and am conducting research with women who have had these problems. If you have dealt with one or more of these problems, either currently or in the past, and think you may be interested in participating in an interview to talk about your experiences, please contact me. Confidentiality is assured, and participation is entirely voluntary.

This study has been approved by the UNBC Research Ethics Board.

For more information, please contact Maria at mmckay0@unbc.ca or at 250-277-1634.

Appendix C: Research Ethics Board Schedule "B"

<u>Disordered Eating, Substance Abuse, and Self Injury Study</u>

Researcher's name: <u>Maria McKay</u>

Address: <u>5094 Henrey Road, Prince George BC V2N 6P2</u>

Phone No: <u>250-277-1634</u>   email: <u>mmckay0@unbc.ca</u>

Title of project: <u>Routes to transcendence: The intersection of substance abuse, self harm, and</u>

                    <u>disordered eating in young women</u>

Type of project: <u>Qualitative inquiry</u>

                    ☐ Class Project   ☑ Thesis   ☐ Faculty Research

Purpose of research: <u>To explore the lived experience of young women with substance abuse, self</u>

                    <u>harm, and disordered eating problems.</u>

Potential benefits and risks: <u>Participation in this research may provide participants with insight into the</u>

                    <u>purposes served by their behaviours and empower them to seek healthy routes</u>

                    <u>to these purposes. The research may lead to new interventions with troubled</u>

                    <u>women and youth. Participation in the study may contribute to emotional</u>

                    <u>distress, due to the difficult subject matter and the possibility of unresolved</u>

                    <u>issues and/or trauma.</u>

How was respondent chosen: <u>Respondent was chosen based on involvement in the problem behaviours</u>

                    <u>described, on having adequate personal and social resources, and on willingness</u>

                    <u>and interest in participating.</u>

What will respondent be asked to do: <u>Respondent will be asked to participate in one or two in-depth</u>

                    <u>qualitative interviews; interview questions will be provided in advance.</u>

Who will have access to respondents' responses: <u>Access to responses will be limited to the researcher and</u>

                    <u>the individual respondents.</u>

Voluntary nature of their participation (including participant's right to withdraw at any time): <u>Participation</u>

                    <u>is completely voluntary, and a participant's decision to withdraw will be</u>

                    <u>honoured immediately and without question. This will be reinforced throughout</u>

the research. Should a participant decide to withdraw, all of their information and input will be withdrawn immediately.

Whether there is remuneration for participation (remuneration should not be reduced if participant withdraws): Participants will not be remunerated.

How anonymity is addressed: Recordings and transcripts of interviews will be identified only by number, and identifying information will be permanently edited out at the first opportunity (for instance, in the event of participants giving identifying information during interviews). Numbers will be linked to pseudonyms in a document stored securely away from recordings and transcripts. Contact information will be stored in a third, secure location. Participants will be invited to create their own pseudonym so that they can identify their own stories in the thesis.

How confidentiality is addressed: All recordings, transcripts, and contact information, and documents will be secured in locked cabinets in the researcher's home office. Drafts and documents which leave the office will contain only pseudonyms. After the research is completed, any recordings or documents containing identifying information will be destroyed immediately.

How information is stored and for how long: Information will be stored in locked cabinets in the researcher's home office only until the thesis has been approved by committee, defended, and passed.

Name and phone number of a person to contact in case questions arise: Maria McKay, 250-277-1634.

How to get copy of research results: as above.

Name and phone number of person to call for more information: as above.

Any complaints about the project should be directed to the
Office of Research, 250-960-5820 or by email: reb@unbc.ca

The participant must receive a copy of his or her signed form.

Appendix D: Research Ethics Board Schedule "C"

Disordered Eating, Substance Abuse, and Self-Injury Study

To be completed by the Research Participant.

Do you understand that you have been asked to be in a research study?	☐ Yes	☐ No
Have you read and received a copy of the attached information sheet?	☐ Yes	☐ No
Do you understand that the research interviews will be recorded?	☐ Yes	☐ No
Do you understand the benefits and risks involved in participating in this study?	☐ Yes	☐ No
Have you had an opportunity to ask questions and discuss the study?	☐ Yes	☐ No
Do you understand that you are free to refuse to participate or to withdraw from the study at any time? *You do not have to give a reason.*	☐ Yes	☐ No
Has the issue of confidentiality been explained to you?	☐ Yes	☐ No
Do you understand who will have access to the information you provide?	☐ Yes	☐ No

This study was explained to me by: Maria McKay, MSW Candidate

I agree to take part in this study:

_____   Date: _____
Signature of Research Participant

_____
Printed Name of Research Participant

_____   Date: _____
Signature of Witness

_____
Printed Name of Witness

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____   Date: _____
Signature of Investigator

The Information Sheet must be attached to this Consent Form and a copy given to the Research Participant.

Appendix E: Interview Questions

Background/Demographic Questions
- What is your age?
- Do you have Aboriginal ancestry?
    o (If yes) What does that mean to you?
- You indicated when we spoke earlier that you had struggled with [disordered eating, substance abuse, and/or self-injury]. Which would you say was the primary problem?
    o How old were you when you first started to struggle with [the primary problem]?
    o (If more than one behaviour) When did you start to struggle with [the second, third problems]?
- Have you ever had counselling or treatment for [the problems]?
    o (If yes) Please tell me a little about that.
- Can you tell me where you are now in relation to [the problems]?
    o Do you feel that you're in recovery?
    o How would you describe your general health and well-being?

Exploratory Questions
- First, let's talk about [the primary problem]. When you first started to struggle, what was going on in your life?
    o Family?
    o Friends?
    o School or work?
    o Other relationships and contexts?
- Thinking about the first time it occurred, what was going on for you?
    o What thoughts were you having before? During? After?
    o What feelings were you having before? During? After?
- How did the behaviour change over time?
- Try to think of a particular incident. Can you describe what went on for you?

- What function did/does [the behaviour] serve for you?
- Has anything else in your life served that same function?

(It may be necessary to repeat some or all of the questions for each behaviour.)

Appendix F: Counselling and Support Resources in Prince George

<u>Northern Health Authority</u>

Adult Community Addiction Services
1350 Alward St. PG
250-565-7200

Prince George Eating Disorders Clinic
Nechako Centre
Second Floor
1308 Alward St. PG V2M 7B1
250-565-7479

Mental Health Services
Community Response Unit
250-565-2668

<u>Non-profit women's services</u>

Elizabeth Fry Society
1575 5th Ave. PG
250-563-1113

<u>Private counselling services</u>

Brazzoni & Associates
301-1705 3rd Ave. PG
250-614-2261

Walmslcy & Associates
1512 Queensway St. PG
250-564-1000

<u>Crisis Intervention and Counselling referral services</u>

Crisis Centre
250-563-1214

Alcohol & Drug Referral Service
1-800-663-1441

Registered Clinical Counsellors of BC
1-800-909-6303

<u>In the event of emergency, contact your family doctor, go to Emergency, or call 911</u>

Appendix G: Participants' Responses to Findings

Amber

Hi Maria,I just finished reading the chapter, and Im shocked. In a total good way.

You and the other women put so many feelings and thoughts that Ive had into

words.

The conclusions that you found and connections you made were right on the

money. I

was reading so many parts of it through tears because of how real, connected and

true your words were. I cant wait to read more. Do you know when it will be

published?

Thank you again for such an amazing oppertunity.

Anne

I took a read...it reads nicely. Excellent work my friend! ...excellent work.

Maureen

I plowed right through your analysis - I couldn't put it down! It is so interesting

and so dead-on... I love how you bring in your narrative. It really helps the reader

to connect to the material and reflect on their own experience with and

relationship to emotions, food and body.

One spelling correction - you spelled dying "dieing" but other than that, it was

really quite remarkable. I am looking forward to seeing the finished product and

to seeing you defend.

Naomi

Thanks for sending your findings to me. Here are some random thoughts I jotted down while reading:

-Talking about the experiences was helpful, especially in a setting that wasn't a counseling session. It's nice to be able to talk about things without the other person trying to fix you.

-it's nice to read about other women going through the same problems as me in Prince George, it makes me feel less alone.

-I agree with the idea of self-harm being expanded to include eating disorders. I often think of purging as a form of self-harm because I deliberately put myself through pain.

-ambivalence describes my attitude quite well. I'd like to quit, but at the same time I don't care to put in the effort to change my life. I fear I would be lost without my eating disorder so I just accept the crap that goes along with it.

-I feel that I portray a part around other people too. I feel like a have a separate personality around my friends or coworkers or family. None of which are my true self. I actually get stressed out if I'm in a situation which includes friends and family for example because I'm not sure which personality I should use.

-I personally don't find much joy in the private side. Amber's description of purging being like Christmas is far from my experience. It's just a world of pain, loneliness and misery for me. I guess I enjoy being alone to a certain extent though.

-I also avoid going to doctors and dentists and even hairdressers for fear of exposure. Especially dentists. I haven't gone in years because I'm afraid he'll know I'm bulimic if my teeth are eroded.

-I also think being thin is a way of showing people how unhappy you are. I think it's one of the main reasons I do this. I feel like if I were too skinny then people would understand how miserable I am just by looking at me, no matter how much I smile or laugh, they'd know that my happiness was fake.

-I hate being touched by other people too. I definitely have personal space issues. For example, at my church most people hold each other's hands while saying the Our Father. I won't. I put my hands in my pockets and stare straight ahead.

-"whenever I feel physical pain, I forget the emotional pain" - I love that quote, it's so true.

-I also keep my emotions private. The last thing I want to do is show weakness in public. I cry all the time at home though.

-I can relate to the part about logic. Part of me knows what I'm doing is only ruining my life and isn't even helping me lose weight, but I just ignore that part of me.

-one thing I felt while reading this is a bit of jealousy of the anorexic girls. The things they talk about with sadness and regret are the things that I aim for. Being bulimic, I too feel like a failed anorexic.

-having high standards for perfection makes life almost impossible. It's like if I can't get 100% on something it makes me just give up and get 0 instead of 80%. Not just in school, but in every aspect of my life.

-When I first started severely restricting calories it was with the specific intent to kill myself. I wanted to die, and I thought starving to death was a very romantic way to go. At least I'd be thin when I died. Unfortunately, human instincts kick in after a few days and starving to death in a land of plenty became impossible for me.

-I feel like my eating disorder does define who I am. It's not, "I have bulimia"; it's, "I am bulimic".

-I agree that the media isn't the cause of my problems. Though sometimes it does seem to feed it. When you look at magazines and the people on the covers are all either praised for being half their size! or criticised for ballooning to 200 lbs! or scrutinized for being scary skinny! it definitely affects me sometimes because I see how people are judged exclusively by how much they weigh.

-that's a good point about all women being dissatisfied with their bodies, not just women with eating disorders. I often hear that people with eating disorders all have body dysmorphia because they think they're fatter than they actually are, but I think most women think they're fatter than they actually are and it has nothing to do with having an eating disorder.

-I do think there is a negative stigma to having eating disorders. One of my fears is that people would think I'm really shallow and vain which is so far from what this is about.

-I really liked the section about learning the behaviours. Obviously these cautionary stories you see everywhere do not prevent eating disorders, they actually encourage them.

-Amber's quote about self-injury being like going to confession is a bit like how I feel about purging. I feel like I'm sinning when I eat, and the purging is like atoning for my sins.

-The section about choice was kind of eye opening. Yes, I suppose it is a choice. I do choose to shove my fingers down my throat. I guess I could choose to recover too if I weren't so scared. Maybe one day I can make a better choice.

-Well I don't know much about the topic of recovery, but I feel like I would need to rely on my family's support a lot. They were pretty supportive when I went to therapy for cutting, and I'm sure if I ever admitted it they would support my recovery for my eating disorder. I like being around my only nephew sometimes too because he makes me want to get well so I can be around to watch him grow up.

 Final thoughts:

I thought it was fantastic. I'm glad you used some quotes from me, it made me feel useful :) You made some interesting points that I hadn't thought of before and it seems like you really understand where we're coming from. I really don't have anything negative to say about it, except maybe it needs a bit of proofreading, for example the word self-injury should be hyphenated, not two words. Little things like that, nothing major though. I really enjoyed reading it, thanks for sending it

to me. I think it deserves an A+!

Claire

I think it sounds really great. It was nice to read other participant's

experiences..Now that it's over, I just keep thinking of so many other responses

and things I could have expanded on. Apparently I am not good on the spot!

Good luck with the rest!

Janet

Sorry I didn't get to you sooner. I read most of it but then I had too much school

work. But the parts that I did read helped me to understand some of the things hat

I went through a little better. THanks so much! Are you almost done? WHen do

you graduate?

Appendix H: Participants x Themes

Participants in chronological order by interview date	1	2	3	4	5	6	7	8	9
Themes									
Ambivalence									
Public/private	X	X	X	X	X	X	X	X	X
Isolation/connection	X	X	X	X	X	X	X	X	X
Physical/emotional	X		X		X	X	X	X	
Thinking/feeling	X	X		X	X			X	
Success/failure		X			X			X	X
Living/dieing	X	X			X			X	
Control/out-of-control	X	X	X	X	X	X	X	X	X
Identity		X	X		X		X	X	X
Function and strategy	X	X	X	X	X	X	X	X	X
Learning of behaviours	X	X	X	X	X		X	X	X
Choice	X		X		X	X	X	X	X
Stigma				X	X	X	X	X	
Body image	X	X		X	X	X	X	X	X
Recovery		X	X			X	X	X	X
Participants' problem behaviour(s)	ED/SI	ED/SI	SA/SI	ED	ED/SA/SI	ED/SI	ED/SI	ED/SA/SI	SA/SI