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Anorexic Body: A Qualitative Study

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Abstract: This study attempts to explore the anorexia nervosa (AN) patient's subjective experience in family therapy by employing a qualitative inquiry. The data collection process required the participant to review videotapes of her family sessions and then to write down her thoughts in response to a core research question: "What was your experience of the family therapy sessions?" We tried our best to minimize any possible influence from the research setting. Unexpectedly, a core idea about the anorexic body emerged from the patient's writings. This core idea was divided into four themes: (1) the development of the anorexic body; (2) the anorexic body and body weight; (3) the anorexic body and clothing; (4) maintaining the anorexic body. This study suggests that a qualitative client-driven approach can reveal the AN patient's perceptions of her body. Most importantly, this paper ends by providing recommendations for qualitative researchers: adopting a not-knowing position and being open to learn that knowledge can be found accidentally.

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1. Introduction

Sir William GULL, a British physician, detected a group of symptoms including amenorrhea, extreme emaciation, hypothermia, over-activity and lack of appetite, and named them anorexia nervosa (AN) (GORDON & YUDOFSKY 1997). It is problematic to manage AN by using a symptom-oriented approach, because AN does not have a causative agent and there is no pill to cure it. [1]

BRUCH (1978) published a remarkable book, "Anorexia nervosa: A golden cage," describing females with AN who mainly came from the middle class and had been locked up in their families. This observation may not be applicable to Hong Kong context because most of the families seeking help from our family therapy practice team come from the lower class. Moreover, due to the high population density, most of these patients do not have their own bedrooms, and therefore have little privacy or ability to maintain distinct physical boundaries with their family members. Thus, "a wooden cage," or even "no cage," provides a more suitable analogy for these familial scenarios. [2]

SELVINI-PALAZZOLI (1986) treated approximately sixty anorexics. AN could be conceptualized as resulting from the contradictory roles of modern women (SELVINI-PALAZZOLI 1986). AN patients could not recover spontaneously, and the participation of the patients in the treatment was a pivotal factor for their weight restoration. She called for family psychotherapy as a new orientation for managing AN. [3]

ORBACH published the influential book "Hunger Strike" in 1986. She believed that the mother-daughter relationship should be explored during therapy and suggested that the dichotomy (love/hate) could be transferred to the unconscious meanings that women attach to food. She further argued that the confusing social expectations of women could cause them to develop AN. BORDO (1989, 1992) stressed the importance of conceptualizing AN in a historical, political and socio-cultural context. She suggested that dieting is a kind of disciplinary practice for women aiming to achieve an ideal body image within male-dominated society. [4]

STIERLIN and WEBER (1989) employed a systemic approach to the understanding and treatment of AN via a metaphor of "unlocking the family door." They regarded anorexic symptoms as an attempt by the patients to isolate themselves within the family. For the patients to reopen—or even simply to rediscover—the door is important to their recovery (STIERLIN & WEBER 1989). Unlocking the family door is an interesting metaphor, but we have to work with families to discover what they really need and by what various means they can attain it, rather than imposing the "door" on them. [5]

Two inadequacies are found within the above understandings of AN: (1) The current body of knowledge on AN is rooted in western culture. Due to the differences in historical, social, economic and political contexts for patients in the West and the East, the applicability of these Western-based theories and clinical findings has to be further evaluated. (2) It is a fact that over 90% of AN patients are females (AMERICAN PSYCHIATRIC ASSOCIATION 1994). Lack of a feminist view in clinical practice and research will render it impossible to understand the patients' voices and, thereby, the disease itself. [6]

The aims of this study are to supplement the existing monolithic portrayal of AN from an expert-driven approach as well as to explore the AN patient's experience in the course of family therapy in Hong Kong. This study is the first of its kind: a qualitative inquiry made by employing a client-driven approach where the

participant performs the function of the research instrument in reviewing the videotapes of the family therapy sessions. Unexpectedly, a core concept about the anorexic body emerged from the data of our research. [7]

This paper consists of four parts: literature review; the research method; the results; and discussion. [8]

2. Literature Review

2.1 A review of the body

Women suffering from AN with a skeletal appearance reflect a concept about the relationship between their bodies and social perceptions. Anorexic bodies can be understood from several perspectives. First, from the psychoanalytic perspective, FREUD accounted for the conceptualization of male and female bodies as types, as well as for the origin of the masculine / feminine distinction (WELTON 1998). Second, the feminist perspective interprets the body as a place of oppression, discursive formation and symbolization (MOHANTLY 1991; TENG 1996). The body is seen as a system of meanings and representations, an object of coercion, inscription and exchange in patriarchal society (BULTER 1993). Third, from the postmodernist perspective, the body is constructed by discourses and functions as a locus of social control (FOUCAULT 1990). Fourth, current social norms pressure women to conform to dieting behaviors: thinness is equated with being pretty, and fitness is equivalent to health (BLAU & GULLOTTA 1996). Female adolescents seem to develop the desire for thinness during puberty. Under the influence of such social norms, these adolescents distort the concept of normal growth and perceive the development and changes in body fat distribution in a way different from normal people's perception. [9]

The above literature review on the body is based on western studies and may not be applicable to the Chinese context. Therefore, it is important to develop our own culturally-specific understanding of the "body," especially from the AN patient's perspective. In this study, the anorexic body is defined by the meanings attached to it by the AN patients themselves, as expressed through all forms of representations, social practices, language, ideologies and images (BULTER 1993). After that, a review of local studies of AN will be provided. [10]

2.2 Studies of AN in Hong Kong

Many local studies of AN (e.g., LEE, WING, CHOW, CHUNG & YUNG 1989; LEE, LEUNG, WING, CHIU & CHEN 1991; LEE 1992; LEE, HO & HSU 1993; LEE 1997; LEE, LEE, LEUNG & YU 1997; LEE, LEE & LEUNG 1998; LEE & LEE 2000; LEE, LEE, NGAI, LEE & WING 2001) adopted a quantitative approach as their study method, using for their data collection methods either surveys or structured interviews. However, several inadequacies in these studies can be observed:

1. These researchers neglected the interrelationship between the body and the mind of the patients, treating the body and the mind as separate problems instead of a system;
2. these studies were implemented via a mechanical data collection process;
3. the AN patients were put in a secondary position as the subjects of the research, and no acknowledgment was made of the importance of their input into the research analysis; and
4. the voices and experiences of AN patients during the research process were not revealed. [11]

The findings of the above local studies were deductively obtained from a preset view, rather than being inductively drawn from an open attitude. In fact, there were other studies (e.g., LEE 1991, 1994; LAI, PANG & WONG 1995; KAM & LEE 1998) taking the qualitative approach to understand AN. The creditworthiness of qualitative research is very important (e.g., LAYDER 1993; LINCOLN & GUBA 1985; MAYS & POPE 1995); these studies raise the following questions about their creditworthiness:

1. Only one interview for each patient—how in-depth was the interview?
2. Only a single attempt at data collection—how can triangulation of methods and data sources be applied?
3. These researchers and interviewers were perceived as strangers by the informants—how can rapport and trust be built up between the interviewers and the informants for creditworthy data collection?
4. The findings were not drawn from agreements with the patients and co-researchers—how can member checking and peer checking be conducted?
5. The reports were written in the formal, impersonal and "expert" way—how can the actual experience of these participants be reflected? [12]

Knowledge gaps in the above-mentioned studies can be grouped into two levels. At the ideological level, there is still a lack of voices and a denial of the needs of the AN patients. At the methodological level, there is a lack of data triangulation and a hierarchical dichotomy was created between the researcher and the subjects. [13]

Our research team conducted four qualitative studies. In the first, MA, CHOW, LEE and LAI (2002) identified four themes of self-starvation in family treatment: self-starvation as an expression of love and control; coalition between the AN daughter and her mother; family loyalty; and the powerlessness and helplessness of the mother. CHAN and MA (2002a) also conducted a single case study on a family with an AN daughter by reviewing and analyzing eight videotapes of family therapy sessions. Two reasons for food refusal were identified: disciplining the body and punishing the family. The results suggested that food refusal was a form of revenge because the anorexic daughter felt she had been confined too much by her family. CHAN and MA (2002b) conducted another single case study in which a life history approach was adopted. The informant, an AN patient, was

specifically selected because of her particular circumstances. Three themes that accounted for her self-starvation emerged from her narrative: saving money, reserving food and striving for slenderness. CHAN and MA (in press), through email analysis, further revealed two adult AN patients' feelings about eating. The study not only provided an in-depth understanding of the patients' circumstances and their family dynamics, but also made successful use of emails as a data source for a qualitative study, and demonstrated how e-mails could effectively reveal the inner landscapes of the informants. This study followed the line of our studies mentioned above: it adopted a qualitative approach with a case study, and was designed to explore the AN patient's untold experience of her body. [14]

3. Research Method

A qualitative paradigm is of inductive logic in nature and emphasizes the specific experience of the participant (YEGIDIS & WEINBACH 1991). Its epistemology should take the knower and the known as inseparable. In view of axiology, the roles of researchers are value-bound (WEIHOLTZ & KACER 1995). LINCOLN and GUBA (1985) supported the idea that qualitative research can better explore people's unique experiences. The qualitative approach promotes a pluralistic view and aims to produce descriptive data based upon spoken or written words (SHERMAN & REID 1994). Case studies can be powerful tools for feminist researchers seeking to capture women's experience (PADULA & MILLER 1999). Writing can be regarded as an effective means of reconstructing one's identity (CHAN 2002a; 2002b), and can allow people to see themselves with their own eyes rather than via a representation constructed through the eyes of others (CUBBISON 1997). Based on the above understanding of a qualitative inquiry, a case study, and the power of writing, this study provides descriptive data based on an AN patient's experience expressed in her own written words. [15]

3.1 Sample

Purposive sampling (MARLOW 1993) was employed. The female patient, Susan (pseudonymous), 25, who had met the diagnostic criteria of DSM-IV (APA 1994), was extracted from the data set of our family therapy research (N=38). She was selected for the following reasons: Susan is the most self-motivated of all the patients in our data set; she is good at expressing her feelings in writing; and a mutual working relationship already exists. [16]

Susan weighed 32 kg at a height of 158 cm when she was referred to our family therapy (September 2000). She received 11 family sessions, recovered, and family therapy was terminated. Her weight was 45 kg in May 2001. There are five members in Susan's family: parents (the father is a skilled worker and the mother is a housewife), an elder sister (a professional trainee) and a younger brother (a first year undergraduate student). The family lives in a private flat of 600 square feet, with two bedrooms. [17]

3.2 Data collection

We maintained an open attitude during data collection, and allowed Susan to express her views freely in writing while reviewing the videotapes of her family sessions. This study was oriented towards "discovery" in its nature. The data collection process was as follows. Written consent was obtained from Susan after the aims and the procedures of the study were fully explained to her in one of the university cafeterias. Susan and the first author had tea and chatted before reviewing the family tapes. The relaxed atmosphere helped prevent Susan from feeling like an object, and emphasized her involvement in this study. [18]

Various ethical issues were considered. Over almost two years of offering family treatment to Susan and her family, throughout which her progress was closely observed, a deep mutual trust had developed. Creating a space for her unheard voice, granting her the opportunity to tell her own story, and appreciating her experiences as meaningful were necessary ethical considerations (KIRSCH 1999). We had to be sensitive to how Susan felt during and after this study to monitor any psychological harms caused to her. [19]

After that, Susan was invited to a private room on the university campus to review the videotapes of her family sessions. Only one core question was given to guide the procedures—*"What was your experience of the family therapy sessions?"* [20]

Susan preferred to type her comments directly into her computer notebook. A remote control of the video recorder was given to her for playing the videotapes backward and forward during her review. She wrote her comments and watched the tapes at her own pace. She came to the university four times in total (three days in April and one day in May 2001) and reviewed six videotapes. For the first and second time, she reviewed only one tape, spending seven hours each time. For the third and fourth time, she reviewed two tapes each time, spending about three hours on each tape. The time difference between the first and second, and the third and fourth time was because she needed to get used to the setting and operation of the video recorder and computer notebook. [21]

Susan could only review six tapes out of a total of eleven tapes (one tape for one family session) because she could only come to the university for four days. She selected those six tapes (session one, three, five, seven, nine and eleven) because she thought them more striking. Susan was free to describe her experience in the family sessions during the data collection. [22]

3.3 Data analysis

We read Susan's set of qualitative data six times. Susan's wordings and writing were highly respected; therefore, alterations were kept to a minimum. Other observations can be drawn from her writing (e.g., about her family relationships, peer relationships, personal difficulties and other ideas), but they are beyond the scope of this paper. Nonetheless, a core finding did emerge from her writing—the idea of an anorexic body. This central idea can be divided into the following four themes. [23]

4. Results

The four themes that make up the core idea of the anorexic body are: (1) the development of the anorexic body; (2) the anorexic body and body weight; (3) the anorexic body and clothing; and (4) maintaining the anorexic body. [24]

4.1 Theme I—The development of the anorexic body

Susan presented her reasons for developing AN in the following sequences:

> "The main reason that I lost weight was examinations. After every exam I'd lose weight, as little as 3 pounds, or as much as 7 pounds, in a week. Gradually becoming thinner and thinner made me not want to gain weight. In other words, I thought that it was quite fun to lose weight. Other girls want to lose weight but always seem to fail, while I really felt very successful in this matter. Maintaining that feeling was safe for me.
>
> Changes and the unknown scare me. I believe that if at that time my weight was 90 instead of 70, I would still have been happy to stay at that weight because that's just how I am—I dislike changes. I really want everybody to know that I'm not scared of becoming fatter but am afraid of changes—including in body weight. And in fact this is really a successful task for me! And also everyone misunderstands me—everyone may think that having this appearance must start from reduction of fat, but that's not the case.
>
> When I first got thin, I went from 93 to 87 pounds in the first year—after second semester exams. This change was unexpected, but still ok, and I stayed at the same weight until the summer holiday, when I participate in my faculty's camp. I was a group leader. Maybe the schedule was tight and the weather was hot, I went down to 84 pounds after that. Year 2 started and after 1st semester examinations I went down to 79 pounds. My weight stayed the same for a while but I had operation at the beginning of the second semester of the second year. After staying in the hospital for ten or more days, I went down to 73 pounds. My weight dropped again after final exams of my second year, down to 71. Over the holiday I started my work-study job at IBM. The job was really a big change for me and my weight was down to 67 pounds in July 2000. I lost another four pounds after I worked with Doctor Wong, and he introduced me to this family therapy." [25]

Some psychological characteristics are also found in AN patients (AMERICAN PSYACHIATIC ASSOCIATION 1994; BRUCH 1978); for example these patients may have a comorbid obsessive-compulsive disorder; and the patients may use food refusal to cope with the demands of adolescent development such as life events and academic stress. In Susan' case, she stated her reasons for not eating were academic stress and work stress. She also emphasized that she did not have any intention to keep fit. Losing weight was fun as she mentioned. Furthermore, she did not want to gain weight as she had a sense of achievement in losing weight. [26]

4.2 Theme II—The anorexic body and body weight

Susan mentioned that her anorexia experience was related to her body weight:

> "The reason why I'm becoming so thin is really not due to reduction of fat. But as I lost more and more weight, I started to play this game. I felt successful at bringing my body to my imagined weight. If I wanted to maintain my weight each month and managed to do, I'd be happier than anything." [27]

Susan further mentioned her concerns towards her body weight through the following vignettes:

> "After I've eaten lots of food, I'm really afraid that I'll suddenly gain lots of weight, and if this situation continues, I'll become a very fat girl and will be very ugly. I know that if I continue to eat what I want to eat, that will make me have an uncontrollable appetite and I won't be able to maintain my present appearance. In fact I really don't know why I need to keep my present appearance, especially because I know I really don't look good and I'm not even in the mood to dress more beautifully. But this is just what I want at that time, everything remains the same, including the appearance and the weight. That's why I'm really afraid and angry with myself why I need to eat so much and can't imagine that I destroy what I want to be by myself." [28]

Susan described how she was obsessed with her weight as follows:

> "That time of me always stuck in the problem of increasing 2 to 3 pounds, all the ideas in the brain is number—how many pounds I get, increase how many pounds, eating lots of food will increase how many pounds. I really don't know why I care about these figures so much in the past, although I'm also afraid of becoming a fat girl, but still will eat as what I want, and will allow difference in body weight each month, at least not greater than 95 pounds is ok. But that time I just allow to decrease weight, or remain the same, even increasing 0.5 pounds will make me very unhappy and my bad temper comes and quarrel again. I really don't know why I see the weight as important as my life and can give up to eat so many kinds of delicious food including ice-cream—the most favorite food of me." [29]

Susan mentioned that at that time, her weight fully occupied her mind. At that stage, she was afraid of becoming fat. She also became very sensitive about her

weight for no reason. The preoccupation of body weight of AN patients (APA 1994) was also found in Susan's case. [30]

4.3 Theme III—The anorexic body and clothing

Susan stated her experience about clothing as follows:

> "That's when I first started to be aware of my appearance. I remember that one day I said to my mom that I wanted to buy trousers for work. Actually if I didn't need formal clothes for my job, I wouldn't go out shopping for new clothes." [31]

Susan noted one occasion when she tried to buy new clothes:

> "When my mom and I walked through all the boutiques in Mongkok and Causeway Bay *(these two places are in her town)* and couldn't even find suitable trousers, I started to think: am I too thin? All the trousers were too large for me. Finally we went into one boutique and found a pair of tight trousers. I was so happy that they fit me, but the girl I saw in the mirror was just like an E.T.—a small head, a board-like body with chopsticks for hands and legs. I really didn't know I could be so horrible, that really shocked me.
>
> Maybe I knew that if I wanted to be able to buy clothes easily and wear what I wanted, I needed to gain weight. That reduced my fear of eating lots of food. I also remember that at that time, the only type of clothes I could wear in the summer were mid-length sleeved shirts or T-shirts. I was really jealous of other girls who could wear short sleeves, or little vests. Those clothes made them look very beautiful and healthy. Actually I could also wear those kinds of clothes, but I really felt cold if my skin was exposed. I didn't care if other people thought me beautiful or not; if I wore those trendy clothes in the summer, I just felt cold. I could even wear long-sleeved shirts when it was 34 degrees Celsius." [32]

Female adolescent seems to precipitate the desire for thinness during their puberty. The current social norms advocate women to conform with an importance of body control through dieting, and thinness means a feeling of looking pretty and attractive as well as fitness is equivalent to health (BLAU & GULLOTTA 1996). Susan was influenced by other girls' slim bodies so she forced herself to stay slim. [33]

The physical signs and symptoms of AN include loss of hair, amenorrhea, tooth damage because of over exposure to stomach acid from frequent vomiting, dysfunctions of the cardiac system and endocrine system, and intolerance of cold temperature (APA 1994). At that stage, Susan had hypothermia due to long-term starvation. [34]

4.4 Theme IV—The maintenance of the anorexic body

Susan mentioned how she maintained her anorexic body:

> "I start to be aware of my appearance. When I was very thin, I seldom paid attention to my looks. I was never in the mood to buy new clothes, or to cut or comb my hair—all day I looked the same as when I first got out of bed—just looked the same as when I woke up, didn't comb my hair or do anything to make myself look more beautiful." [35]

Susan did not have any motivation to restore her normal weight:

> "I could, but didn't want to wash my hair or have a bath for a whole week. I really don't know why I lost all interest in making myself up—that's what all the girls will do and need to do in order to get people's attention. Even my mother tried to force me to buy new clothes but I refused. That was because I didn't need and didn't want to change my clothes. The only thing that got my attention was the number displayed on the scale." [36]

Susan had developed a severe obsession with her weight which, as she explained, prevented her from developing any desire to gain weight. [37]

5. Discussion

Two missions of qualitative research are addressed: prevention of power inequality and empowerment of Susan. First, to minimize any power inequality during the research process, several strategies were considered. Susan took charge to select the days and times she would come to the university to review the videotapes. She chose the sessions in which she was interested. She planned the length of each review. She controlled the pace during the tape reviewing by controlling the video recorder. She decided that how much she wanted to tell about her experience toward family treatment. She wrote either by hand or typed on a computer her qualitative data of any length. She could eat and drink during the tape reviewing. She regulated the room temperature and lighting. In brief, Susan could select and present her experience at her own preference, pace and length. [38]

This type of client-driven approach of data collection is full of uncertainty. It is unpredictable what will be collected. As mentioned earlier, this primarily intention was to explore Susan's experience toward family therapy but she expressed how she viewed her body during the illness. This study inspires us to believe that knowledge can be found accidentally and that qualitative research is adventured based. [39]

The results are very vivid and authentic because they were collected from Susan herself. The results are close to her subjective feelings and are not manipulated for expert interpretation. However, we had identified four above themes of her anorexic body from Susan's set of qualitative data and asked Susan whether we

had understood her writing correctly by another brief interview before presenting the four themes. For example, the first author asked Susan that other relevant information about her body during AN she wanted to add or to delete. What we did was to try to put ourselves in Susan's shoes, then grouping and organizing the data into related themes and presenting these themes. We preferred to perform as little analysis of these data as possible, in order to let the readers feel Susan's experience and interpret the data for themselves. [40]

It should be noted that the data collection was conducted in the university setting, which might be artificial to Susan; however, Susan had received eleven family therapy sessions in the university from Sept 2000 to May 2001 and was thus familiar with the environment. Also, the participant had to recall her past anorexic experience, which could potentially have caused her psychological harm. Therefore, the first author paid close attention to any changes in Susan's mood during and after the data collection by telephone follow-up. [41]

This study provides in-depth information about how Susan experienced her body with minimal analysis because we wish to introduce this methodology and invite feedback and comments from other qualitative researchers who are conducting the similar types of studies. Despite the lack of theoretical implications, this study suggests that participants should be the research instruments and qualitative researchers have to tolerate the higher level of uncertainty. Knowledge is evolving. This is to be contrasted with a closed-end inquiry, which does not provide a full picture of AN due to the presupposition of researchers. From the results, we learned that Susan had her own subjective experience towards her body during the disease process. [42]

The difficult aspect of this study was the intensive labor required of Susan, in having her write about her experience. This study is important because: first, it allows the anorexic female's voice to be heard again by putting her in the center of the research process; second, it takes a human approach to the study of anorexia, as contrasted with the ordinary, fact-based approach; finally, it complements the existing knowledge, which consists of rather monolithic portrayals of AN by mainstream researchers (*here refers to the quantitative researchers*). It is recommended that, in future, the AN patients should be placed at the heart of the research process by employing a qualitative inquiry. [43]

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