Journal of Health Psychology
http://hpq.sagepub.com/

# 'Why I Won't Eat' : Patient Testimony from 15 Anorexics Concerning the Causes of Their Disorder

Andrée Dignon, Angela Beardsmore, Sean Spain and Ann Kuan

*J Health Psychol* 2006 11: 942
DOI: 10.1177/1359105306069097

The online version of this article can be found at:
http://hpq.sagepub.com/content/11/6/942

Published by:
SAGE
http://www.sagepublications.com

# 'Why I Won't Eat'

## Patient Testimony from 15 Anorexics Concerning the Causes of Their Disorder

ANDRÉE DIGNON
*University of Coventry, UK*

ANGELA BEARDSMORE
*Leicester Area Health Authority, UK*

SEAN SPAIN & ANN KUAN
*University of Coventry, UK*

COMPETING INTERESTS: None declared.

ADDRESS. Correspondence should be directed to: ANDRÉE DIGNON, Senior Lecturer in Research Methods, School of Health and Life Sciences, University of Coventry, Priory Street, Coventry, CV1 5FB, UK. [email: a.dignon@coventry.ac.uk]



JHP

*Journal of Health Psychology*

London, Thousand Oaks and New Delhi,
www.sagepublications.com
Vol 11(6) 942–956
DOI: 10.1177/1359105306069097

## Abstract

The following article describes the reasons given by 15 anorexic patients for their illness. The patients were asked the following question in an open-ended interview—'What would you say were the causes of your illness?' In reply detailed complex narratives were gathered from which a number of themes could be identified. These included unhappiness, control, being in a downward spiral, obsession and perfectionism. Most patients, for example explained that they were unhappy. To address their unhappiness, they adopted a strategy of control over food. Being able to exert this control gave patients a sense of enjoyment and pride and enabled them to address their underlying fear that a loss of control may be just around the corner. This pride persuaded patients to restrict further their food in the hope they would experience even greater enjoyment. Patients were thus caught in a dangerous 'spiral' of restriction, weight loss, euphoria and further food refusal. This spiralling behaviour resulted in many patients describing their illness as an obsession. Several patients equated this obsessional behaviour with a perfectionist trait in their personalities. In the following article, these themes of unhappiness, control, spiral, obsession and perfectionism, are presented, along with the patient testimony on which each theme was based.

## Keywords

- *anorexia*
- *control*
- *obsession*
- *perfectionism*
- *spiral*
- *unhappiness*

## Introduction

ANOREXIA is an illness of uncertain cause. Previous research has however identified possible antecedents to the disorder. These have included socio-cultural factors (Dolan, Lacey, & Evans, 1990; Ford, Dolan, & Evans, 1990; Furnham & Alibhai, 1983; Garner & Garfinkel, 1980; Nasser, 1988), family background (Bruch, 1978) and sexual abuse (Palmer, Oppenheimer, Dignon, Chaloner, & Howells, 1990). Few of these studies however have been based on analyses of detailed patient narratives. They have relied instead on data gathered through closed-ended instruments such as the Eating Disorders Inventory (Garner, Olmstead, & Polivy, 1983). In the current report, patients have been encouraged to describe their experience of their disorder in their own words and at their own pace. The present study thus represents an advance over previous investigations in that rich, narrative accounts have been gathered directly from patients themselves, concerning the origins of their disorder.

Anorexia has been the subject of significant theoretical debate in recent years (Lawrence, 1995; MacSween, 1993; Orbach, 1993). Sociologists and psychiatrists have analysed the disorder from distinct theoretical perspectives. Psychiatrists have viewed anorexia as an illness affecting the individual, and have described typical antecedents that produce the disorder in individual sufferers. The family (and its individual members) are normally identified by psychiatrists as the 'cause' of the disorder (Bruch, 1978; Crisp, 1995; Minuchin, 1991; Minuchin, Rosman, & Baker, 1978). The anorexic's 'controlling' family has failed to prepare her for adulthood, and has engendered in her a horror of growing up. The anorexic is therefore unsuccessful in fully adjusting to adult femininity (Crisp, 1995). Such a perspective views anorexia entirely at the level of the individual and fails to theorize socially constructed femininity as a potentially problematic identity. Little account has therefore been taken by psychiatrists of the social context in which anorexia occurs. Feminists however have theorized anorexia as a social phenomenon (Hepworth, 1999; Lester, 1997; MacSween, 1993). They acknowledge that society conveys contradictory expectations to women, by exhorting them to achieve in the public sphere, while at the same time effectively excluding them from what remains a masculinist culture. Being disempowered in a sexist society, the anorexic thinks that her body weight is the one thing over which she has control.

Feminists have therefore described anorexia as an unconscious social protest against the constraints and contradictions of women's lives (Orbach, 1993). Self-starvation, in Orbach's view, is a political act. 'Like the hunger striker', Orbach suggests, the anorexic 'has taken as her weapon a refusal to eat' (1993, p. 83). Bordo however, (1988) suggests that the anorexic protest does not take the form of a conscious political battle. Anorexia is a disease, not the active championing of a political cause. Nevertheless in rejecting female sexuality, the anorexic is engaged in a sub-conscious protest against a problematic social role—the restricted, exploited and degraded role of adult femininity. Ironically however, by making herself ill the anorexic is helping to maintain a stereotype of women as neurotic and in need of control.

Feminists have placed an analysis of embodiment at the centre of their analysis. The male body is socially constructed as active, separate and complete, while the female body is constructed as open, passive, incomplete, and complementary to the male. The masculine is thus viewed as the subject and the feminine as the object (Martin, 1987), which renders the notion of women's bodily ownership contradictory. Such objectification (or in Martin's words the 'separation of self from the body' (1987, p. 79)) alienates women from their bodies, turning these bodies into spectacles for public view. This process of objectification creates an object body which women compare themselves against. In Chernin's view, therefore, men are brought up to like their bodies, while women are conditioned to dislike theirs. She concludes 'women suffer much more from living in the body than do men' (Chernin, 1986, p. 62). Such constant self-criticism leading as it does to obsessive dieting and body management routines, creates ideal conditions for anorexia to flourish.

## Method

### *Research question*

The study has aimed to collect detailed patient narratives to conduct an appraisal of the reasons

patients give for their illness. The research question addressed by this study was therefore: 'What causes do patients attribute to anorexia nervosa, and can a rich account of these causes be gathered in an open-ended interview?' The key objective was to allow patients to describe these causes in their own words, since it is this aspect of patient experience that has frequently been missing from earlier studies. In the current report patients themselves have set the agenda in identifying why they have become anorexic. The study acknowledges that anorexics themselves are the most reliable authorities on their disorder. By sharing their experiences patients will illustrate the diversity and complexity of the causes of anorexia.

### *Operational definitions*

In previous studies of anorexia, closed-ended interviews have almost universally been applied (Garner & Garfinkel, 1979; Garner et al., 1983; Lee, 1997) to uncovering patients' experience of anorexia nervosa. The limited technique of deploying a closed-ended instrument to gather participants' understandings is inadequate, since such a technique fails to capture the richness of the patient's experience. Lee thus suggests that further 'research . . . using open-ended questions is essential for verifying [this closed-ended] methodological approach' (1997, p. 497). Such research is presented in the current article.

The interview was conducted in the following way. Patients were given a closed-ended questionnaire eliciting information concerning their emotional state and their attitudes to slimming. It was envisaged that this questionnaire might help stimulate the patient into considering the reasons for her disorder. After administering this questionnaire the interviewer asked the patient what s/he felt had caused her (or his) anorexia. Most patients seemed very ready to share their thoughts about this issue, but a few participants needed prompting to maintain the flow of information. This led the interviewer to ask follow-up questions, based on the information the patient had already supplied. Questions such as 'So you feel your anorexia stemmed from being large as a child?', and 'So you feel anorexia is about control?' were therefore sometimes asked. The interviewer was very careful to keep such prompting to a minimum, since such 'stimulus' questions represented a point on a continuum between the uncovering of information and the unconscious 'constructing' of information. Data were gathered from a series of patients ($N = 15$) until no new themes emerged and data saturation had been achieved. It was decided that only themes identified by over half the sample ($N = 8$) would be discussed in the current article.

Patients were thus engaged in an open-ended unstructured interview conducted by a specialist registrar (AB). The interview allowed patients to discuss in their own words what they felt had caused their illness. At the end of each interview, the tape was immediately sent to the principal investigator (AD), who transcribed it. A debriefing session then took place between the interviewer and the principal investigator, where emergent issues were discussed.

In the following report detailed testimony from the transcripts of interviews with anorexic patients is discussed. For purposes of confidentiality, patients' names have been altered, and all identifying information in the transcripts has been removed. Permission to use extracts from patient interviews was obtained from patients prior to their recruitment to the study. A copy of this article was also returned to patients before dissemination. This ensured that patients were comfortable with the extracts used, and that a true account of their responses had been presented.

## Procedure

### *Aims*

The study's aim was to enable patients to describe their disorder in their own words. The objective was to allow the patient to set the agenda, and to reflect on her (or his) illness in an unhurried supportive environment. Patients were therefore presented with a very general question: 'What do you feel were the reasons for your illness?' A subsequent question, 'What explanation do you offer for the illness of other anorexics?' was also asked. This allowed the researcher to assess if different reasons were attributed by anorexics to the illness of others when compared to their own.

### *Inclusion criteria*

The following inclusion criteria were applied. Data were collected from 15 in-patients, all with

DSM-IV criteria for anorexia nervosa (American Psychiatric Association, 1994). All participants were consecutive referrals to an Eating Disorders Unit in a District General Hospital. As in-patients, these participants were a highly selected group at the severe end of the anorexia spectrum. All but one were voluntary admissions, with one participant being formally detained under the Mental Health Act.

### *Sampling and recruitment*

The study adopted a theoretical sampling strategy. Theoretical sampling describes the recruitment of participants who can supply information on which a theory may be based (Polit & Hungler, 1997). Individual participants in the acute stages of anorexia were purposefully approached because they could give information about the origins of anorexia in its acute form. Such participants were selected based on the information requirements of the study. The data they thus supplied were used to develop a theory of anorexia (Fig. 1) based on the testimony of participants with first-hand experience of acute anorexia nervosa.

In order to uncover the complexity of the causes of anorexia, the following methodological procedures were adopted. Approval for the project was sought from the Caldicott Guardian, the local ethics committee and the clinical director of the eating disorders service. During the period of the investigation, nursing staff on an eating disorders unit were asked to explain the study to in-patients who met the study criteria. Patients were then asked by the nurse if they would be willing to meet the interviewer. All of those approached agreed. The interviewer then showed them an information/consent form and asked them if they would be willing to take part in the study. Of 16 patients approached, 13 women and two men agreed to participate. The interviews were conducted in the standard interview room, in the mental health unit at a district general hospital.

### *Methods of data analysis*

Data gathered by the study were collected and analysed using grounded theory. Grounded theory was first developed by Glaser and Strauss in 1967. The approach, though qualitative, is essentially positivist in origin, believing that the reality of social behaviour can be discovered through research. Such reality, Glaser and Strauss argued, will emerge from the data without the influence of the researcher. Consistent with a positivist approach, the researcher remains a disinterested collector. The central tenet of grounded theory is that the researcher should approach the study with as few preconceived hypotheses as possible, and should use the data gathered to develop a theory.

The narratives were analysed by transcribing in exact detail the content of the taped interviews. These transcripts were then coded into themes using the NUD.IST qualitative data analysis package. Themes were identified after each interview, and themes from early interviews were compared to those from later transcripts. At the end of the data-gathering stage, all transcripts were re-read and the most commonly occurring themes were identified. There is no doubt that the analysis of qualitative data is complex due to its variety and richness. This was a time of reflection for the researcher as concerns shared by the patients were identified and considered. After careful analysis essential themes emerged from the data. These themes, illustrated through the use of patient responses, will now be discussed.

## Results

### *Developing a theory of anorexia*

The key issue to emerge from all of the interviews was that anorexia was characterized by a strong sense of unhappiness and loss. Something was missing in the life of the anorexic. This may have been the result of definite trauma, such as bullying or abuse, or it may have derived from a more generalized experience of neglect or failure, such as that experienced by some anorexics who felt 'passed over' by their parents or age mates. To compensate for this sense of loss the anorexic focused on food as a source of control, and the discipline s/he displayed in restricting her (or his) food intake became a source of excitement and pride. Her/his efforts to maintain this discipline were therefore re-doubled and the anorexic became caught in a spiral of food restriction and weight control. For many anorexics this activity was an obsession. By maintaining her (or his) regime of food restriction, the anorexic felt s/he was offsetting the likelihood of something unbearable happening,

such as the death of a loved one. Even where the obsession was an end in itself, rather than a conscious means of staving off potential disaster, the issue of control was at the centre of anorexic activity. The lack of control the anorexic experienced in other areas of her (or his) life was redressed in her/his engagement with self-starvation.

According to the results of this study, anorexia is therefore characterized by unhappiness, control, excitement and obsession. We may say that the illness has identifiable antecedents (such as teasing at school), and that once established, certain cognitive and environmental factors help to sustain the disorder. It is therefore helpful to analyse anorexia by identifying what has triggered the disorder, while also investigating what helps to sustain it. This was precisely the approach adopted in this study. Using a grounded theory approach (based on thematic 'coding'; Glaser, 1978; Strauss & Corbin, 1990), a core category and two sub-categories were produced. The core category 'Becoming Anorexic' identifies the focus of the research and encompasses a universal category under which all sub-categories may be grouped. The core category cannot be integrated under any other category, but all sub-categories may be traced back to the core category. The core category therefore integrates and encapsulates all other concepts and categories. The sub-categories 'trigger' and 'sustain' are integrated through the core category 'Becoming Anorexic'. 'Trigger' and 'sustain' may themselves be considered sub-core categories as each encompasses lower categories. The categories 'unhappiness', 'body dissatisfaction' and 'control', are integrated through the sub-core category 'trigger', while the categories 'control', 'buzz', 'spiral', 'obsession', 'perfectionism', 'media' and 'more-than-just-slimming', are integrated through the sub-core category 'sustains' (see Fig. 1).

The core category 'becoming anorexic' may be described as a Basic Social Process (BSP; Glaser, 1978). A BSP involves two distinct phases. These phases may be described as 'not being anorexic' and 'being anorexic'. The evolution in people's social experience and behaviour as they move from one state into another, may be described as a Basic Social Process. The variations that occur in patients' prognoses may be accounted for by identifying phenomena that determine movement from one phase (not being anorexic) into another (being anorexic). It is not within the remit of this study to discuss the process by which patients move from being anorexic into recovery, but such a development may also be described as a Basic Social Process. In the view of Strauss and Corbin (1990) theories developed through the discovery of a Basic Social Process have significant explanatory power.

The sub-core category 'trigger' may be said to encapsulate the process through which participants have moved from a state of not being an anorexic into being an anorexic. The maintenance of the state of anorexia such that the patient may be said to have truly become an anorexic (i.e. by having remained an anorexic for a significant period of time) is encapsulated by the sub-category 'sustain'. Under both 'trigger' and 'sustain' most patients in the sample reported significant issues in relation to all of the categories identified.

*Open coding* The process of open coding (Glaser, 1978; Strauss & Corbin, 1990) was

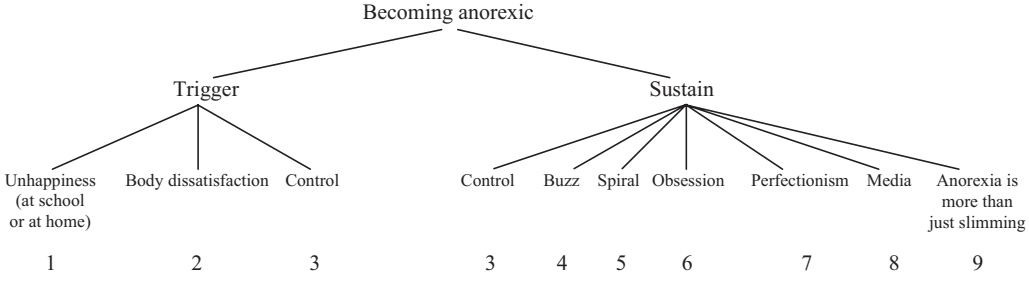


*Figure 1*. Becoming anorexic as a basic social process.

achieved by the detailed examination of transcripts to uncover the concepts of concern to anorexics in the sample. Lines, sentences and paragraphs were thus assigned labels directly derived from the wording used by the anorexics themselves. This ensured that the meanings of these concepts to the anorexic sample were captured as faithfully as possible.

*Axial coding* Open coding identified the properties of each category. A process known as axial coding was also conducted, whereby the relationship between categories was theorized. By specifying the way in which categories were related to each other, it was possible to build a three-dimensional model of anorexic theory. The use of this technique was based on the 'paradigm model' developed by Strauss and Corbin in 1990. Such an analysis identified the previously hidden complexity inherent in the categories, and uncovered the manner in which categories were linked to each other.

For example, all of the categories in the trigger sub-group were closely linked. A generalized sense of Unhappiness in the life of the patient was reflected in Dissatisfaction with Body shape, which the patient sought to address by exercising Control over food. Categories in the sustain sub-group were similarly interrelated. In order to maintain the Buzz she derived from weight loss the anorexic had to rigidly Control the amount of food she allowed herself. This led to an Obsessive pre-occupation with food and weight loss, often attributed by the patient to Perfectionist traits in their own personality. This precipitated a dangerous Spiral of restriction, followed by Buzz followed by further food restriction. The process was exacerbated by Media valuation of thinness. Such valuation was reinforced by the problematic antecedents to the disorder, which amounted to serious psychological difficulties and were More-than-just-slimming gone mad.

The coding process therefore identified nine lower-level codes, numbered one to nine in Fig. 1. Each of these codes captured a significant and powerful dimension in relation to analysing the causation of anorexia. It is thus appropriate to discuss each code in detail, and to present direct quotations from patient transcripts, in order to validate the codes selected.

### *Unhappiness*

The major issue to emerge from all of our interviews was that something had gone wrong in the lives of these anorexic patients. This may have been the result of a traumatic event such as bereavement, an experience of being bullied at school or a history of sexual or physical abuse. Equally however, the dysfunction in the lives of the anorexics in my sample frequently resulted from more diffuse and long-term negative experiences. One patient for example, explained the generalized sense of loss she experienced because she felt she had never really been important in the life of her parents. While her parents conveyed high expectations, they were less exact about precisely what it was they did expect. If she performed well in school, her parents' reaction was 'that's what we expect of you'. She consequently felt she had never developed a proper relationship with them, either as a child or an adult. Another patient explained that while his parents were loving, because of work they failed to spend much time with him: 'Mum and Dad . . . put a lot of time into the business and . . . they did their very best for me certainly, but I didn't seem to, I didn't, I wanted more time with them which I didn't get'.

Other patients experienced a generalized sense of dissatisfaction and loss as a result of their experiences at school. Several described a failure to fit in, particularly at secondary school. One participant explained that she had always felt out of place. She felt inadequate and was constantly comparing herself to other girls in her class. For other patients, this sense of being an outsider was frequently accompanied by being teased, bullied and passed over. Gail explained that as a result of an argument with an age mate she was harassed and excluded by the whole of her class. Viv explained that: 'I got a lot of a lot of . . . stick from other kids and bullying and things so that that was bad as well . . . at school I'd get called fatty and you know fat-related . . . names.' Yet another patient was bullied jointly by siblings and school mates:

> when I was younger I used to get bullied a lot for being fat . . . they used to call me names and everything . . . It was . . . when I was in secondary school . . . it just went on through most of school . . . even me own sisters used to pick on me for being fat . . . my friends

> would join in and make fun out of me as well . . . they made fun of . . . me 'cos they could always get a boyfriend when they went out and I couldn't.

What is interesting in these accounts is that victims were not abused by the archetypal 'school bully'. None were 'picked on' in the schoolyard or divested of their money with menaces on their way home. These youngsters were bullied instead by large groups of 'popular' schoolgirls. One was left with the impression that the perpetrators of this abuse were well integrated into the school system, had large friendship groups and were possibly even teacher's favourites. The abuse was based not around physical violence, but rather on 'pointedly' nasty remarks and 'backbiting'. It was nevertheless equally aggressive and damaging to the victim's self-esteem. Already often rendered powerless by familial abuse, victims were singled out for further harassment. In cases like this the bullies were in the majority and the victim in a minority of one.

Regardless of whether bullying was involved, negative experiences of some form in the lives of these anorexic patients had given rise to a great sense of pain and loss. All of the patients in the sample were unhappy. Phrases like 'low in confidence', 'shy', 'unhappy' and lacking in 'self-esteem' were frequently uttered during the course of the interviews. One patient explained, 'I'm quite sort of depressed and I keep crying all the time and I'm low in myself', while another described how her anorexia always seemed to return during periods of depression.

### *Body dissatisfaction*

Perhaps unsurprisingly this generalized sense of unhappiness was echoed in the unhappiness patients experienced over the way they looked. As one patient remarked, 'I just didn't like the way I looked—I was unhappy really.' This sense of body dissatisfaction however did not seem to diminish as the patient became slimmer. No matter how thin the patient became, she still appeared to want to lose more. One patient explained, 'I know five-and-a-half stone is low but I'm not happy now with the way I am. I want to be a lot less.'

Because of their sense of unhappiness, several patients explained that there was a gap in their lives. One anorexic described this as an 'unhappiness gap':

> perhaps the person like myself who kind of gets hooked into [anorexia] . . . had a gap that needed filling . . . because . . . that gave me something to fill the gap . . . whereas probably . . . other people don't necessarily have one . . . [U]nhappiness . . . perhaps it's as simple as that . . . perhaps it's something to plug an unhappiness gap . . . to prevent you . . . I 'don't know . . . but it just seems to me like something that plugs a gap—with control.

The notion of control is key to this extract. Participants adopted a strategy of rigid control over food to address the unhappiness in their lives. Since this concept was so central to the testimony of almost every patient, it will now be discussed in detail.

### *Control*

Patients sought to fill their 'unhappiness gap' by the close and minute control of food. Almost all the anorexics in the study showed great self-awareness of this process. They explained that they were redressing a shortfall in areas of their lives where their needs remained unmet, by exercising control over food. Somehow this single activity enabled them to keep at bay the torrent of pain which threatened to overwhelm them and which they would otherwise experience over the negative events of their lives. Their self-starvation assuaged the sense of chaos to which earlier traumas had given rise. It was around this issue of control that some of the most illuminating testimony was gathered. One patient for example explained:

> control is the major part . . . of anorexia, really it's . . . control . . . if you put control and food together then that that brings you an eating disorder because they're the two big things . . . the two words that associate me to anorexia is food and control.

The same participant later suggested:

> the control sort of thing [is most important in anorexia] rather than my appearance. It's the buzz that I get . . . the controlling . . . the feeling that I'm good at something . . . and that I'm being tight, I'm being organized, I'm being precise, I know what's going to happen,

> I know that I'm having say this for dinner, this for tea . . . Everything, it's . . . like my life it's . . . a book.

Other participants reported similar feelings. Lucy, for example explained that she derived a sense of comfort from the control. Ann explained, 'I mean it's all about control at the end of the day . . . In here you don't have any—well not over what you eat anyway. Control—that's what it's all about. That's all you do have control over—anorexia.' Almost all participants in the sample discussed control at some point in the interview. Participants felt that they could remain in control of food even if they were unable to control anything else. Several participants however realized that anorexic control was merely a substitute for feelings of genuine control in other areas of their lives. Gail, for example suggested, 'That's what's funny. It's in some ways I do [feel in control], but then in some ways it feels very out of control as well, but it's an 'out of control' that I know about.'

The overriding sensation experienced by patients was a sense of terror at the prospect of relinquishing this control. Were her stomach to distend after a meal, Gail explained:

> I just think that I'd—I suppose that I'd be losing control, that I hadn't sort of kept something tight— . . . it's sort of that I've let something go . . . I don't feel as skinny as I did and I don't like that feeling . . . It feels dangerous to me. It makes me feel out of control.

By exercising control over food, patients felt they were somehow offsetting potential disaster in other areas of their lives. Phoebe explained that as she carried on losing weight it made her feel good. It gave her a focus, eventually becoming the overwhelming influence in her life 'as long as I could hang on to that everything else was going to be all right—and that's why it's so difficult here [in the hospital] . . . that aspect [is] taken away from you.'

This may explain why patients experienced anxiety over the treatment regime at the hospital. As part of this regime, patients were required to eat three meals a day. Several participants believed that this would remove the only locus of control they had. They spoke of the anxiety they experienced at the prospect of eating so 'much'. Ann for example explained:

> you have the control—you've done something with your body nobody else could do—you've done it. That's . . . really really hard—handing that control over . . . watching your body grow and grow and you're thinking don't let it go too far, don't let it go too far.

Other participants made a point of explaining that anorexia became a way of controlling things in their own lives when they felt they did not have control over anything else. When asked why it should be in the area of food that the patient should choose to exercise control, Christine explained:

> It's it's the the one part of your life that you can control what you eat . . . it's commonly the one thing in life that you can control and . . . it's just sort of well a means of that control isn't it you know.

Other participants echoed Christine's opinion. One participant suggested that even if she couldn't control anything else, at least she could control food. She thus felt the major part of her illness was wanting to be in control much more than it was about wanting to lose weight. As she explained:

> I think . . . it's a way of gaining control over your life. If you don't feel in control over sort of like your feelings . . . you have control over your food and it's something that like n-nobody can take away from you.

### *Buzz*

Patients used food as a means of controlling things when they felt they did not have control over anything else. Control over food was therefore used as a coping mechanism that patients utilized to offset the lack of control they experienced in other areas of their lives. Patients were very proud of their ability to control their food. The degree of control they were able to exert along with their resulting weight loss was a source of considerable enjoyment. Patients explained that their ability to control their weight gave them a buzz. Weight loss was something that most people found difficult—but these patients were good at it. As Angela remarked, 'once I started to lose weight I felt good about it so y'know I sort of continued it and I loved it'.

This point was re-iterated by participant after participant. Like the issue of control, the 'buzz' topic was initiated by the patient and the information surrounding it was volunteered in an unsolicited fashion. Viv discussed at length the enjoyment derived from being good at losing weight, 'It's the buzz that I get . . . the controlling . . . the feeling that I'm good at something.' Emma concurred, 'Yeah it gives me, it gave me a buzz . . . I've got a flat stomach that gives me the buzz . . . it gives me a buzz the whole time.' Like Emma, Phoebe explained that when she lost weight it really pleased her. She then began deliberately to want to lose more and it felt really good to be in control. All of a sudden she thought, 'Hey, I'm onto a good thing here.' This feeling was echoed by Sue, 'I used to get some perverse buzz out of not eating because it felt like . . . it was like it was challenging.' Julie summed up the feelings of most participants: 'getting on the scales and seeing that you've lost weight give[s] you a buzz . . . you feel better about yourself.'

This sense of enjoyment prompted patients into further food restriction. Patients were caught in a cycle of food refusal, enjoyment and further food refusal. This anorexic 'spiral' was described by many patients, and thus warrants detailed discussion. The key aspects of this phenomenon will now be described.

### *Spiral*

The excitement many patients experienced led them into a dangerous cycle of restriction, buzz and further restriction. One patient explained that an unanticipated consequence of losing weight was the satisfaction she derived from this. From then on the reduction in the amount of food she allowed herself became stricter and stricter, and she derived a sense of achievement from going that little bit further:

> losing that bit of extra weight that's kind of got the same effect from doing another day without that piece of food—yesterday and the day before I needed that but today I don't need it . . . and . . . that was the new level going on from there.

Many participants explained that the more they lost the more they wanted to lose. As Angela reported, the anorexia cycle just takes over, and regardless of how much weight one loses one wants to be less and less and less. In Emma's words, 'it kind of escalated a bit and I didn't realize how far it had gone.' Another participant concurred:

> the trouble was the goalposts kept shifting because . . . when I started restricting I started off with saying 600 or 700 calories a day but then that wasn't good enough that had to go down and it just kept going down and down and down until I wasn't eating much at all and trying to live when you're not eating—you just sort of, well you lose a grip of things—I didn't see that at the time—I thought I was coping.

### *Obsession*

This ever-increasing concern with stricter and stricter food refusal led many participants to equate their illness with an obsession. Obsessional behaviour describes a state of mind where a specific course of action, such as food refusal, must be followed. Failing to carry out this action is unthinkable since the anxiety thus produced is impossible to bear. One patient described the way she became obsessed purely with the amount of food she was putting into her stomach. She was terrified by how full she might get:

> I never wanted to be full . . . I had to be absolutely starving hungry . . . for when I went home so that I could eat at least eat something at home, er but whatever I ate . . . it had to be the smallest amount I could . . . possibly eat.

The obsessional avoidance of food and mealtimes led patients to develop various ruses to put off the fateful moment when they might have to consume a meal. Ann for example explained that she had reached the stage where she simply couldn't be at home during meals. She would prepare cold food for her family but would be unable to eat any of this food herself. To avoid mealtimes, she would study late in the library or stay behind at work.

The elaborate strategies through which patients managed to avoid food were discussed by several participants. One participant described the rituals she engaged in around food as 'fine tuning' of the control. She had to eat her tea off a certain plate, or use a certain knife to

eat a certain food. Selecting this plate and knife, she would carefully arrange the cutlery on the table, elaborately tinkering with the food on the plate, just so she could put off the moment where she was going to have to sit down and eat. She recalled standing around waiting for the minutes on the clock to tick by because she was only allowed to eat at certain times. It was important to her that a certain amount of time elapsed between meals because that gave her the best chance of passing the next few hours 'without flaking out'. She explained that she would move her day around so that things would happen in the way she wanted. Even at work she would always have a plan to suit emerging circumstances:

> I was quite good at it you know er like moving my day around even when I was at work I could sort it out so that things would happen in the way I wanted them to rather than like be affected by other things and certainly if they were going to be affected by other things I would always have plan B ready to er like suit whatever circumstances I thought were coming up.

Gail also explained how she had 'a lot of rules in her head' concerning how much food and drink she was allowed. She would plan in her head weeks in advance to account for every eventuality. This obsessionalism extended into other areas of her life as well as food. She engaged in cleaning rituals, rituals of organizing household objects and was even obsessive about certain TV programmes, becoming highly anxious if she missed her favourite soap. The primary focus of her obsession however was with what she ate. As another participant, Sue, explained:

> The bad part is that every waking hour of the day and sometimes even the night you think about food. You you constantly crave food . . . and you think of ways . . . where you can get out of eating it.

Other participants described themselves as obsessed with calories. Emma disclosed an obsession with fat, and could recount exactly how many grams of fat were present in any food. Samantha described her tendency to draw up lists of forbidden foods and allowed foods. As her strategy of food refusal became stricter and stricter, her list of forbidden foods kept getting bigger and her list of allowed foods smaller and smaller: 'It was just a way of me punishing myself for things that I didn't feel adequate in.' As she managed to relinquish some of her obsessions, she 'grabbed hold of others', and her weight continued to drop off.

Several participants described how this obsessionalism would also manifest itself in their responses to other women, either friends, passers by or women on billboards or on TV. Emma explained that she would constantly compare herself with women she saw on TV, particularly in relation to the flatness of their stomachs. Ann would similarly compare herself to passers by in the street. This obsessional state was described as trance-like by several participants. Christine, for example, described herself as being in 'robot mode', where nothing anyone said had any effect on her—her only concern was her relentless pursuit of thinness.

### *Perfectionism*

Many patients linked their obsessional ability to exercise control over food with perfectionist traits in their own personalities. Several participants explained that they set very high standards for themselves in all areas of their lives. Rachel remarked that she had always tried to be as perfect as she possibly could. She felt that she always had to do the very best: 'it became hard then if you didn't do something quite as well—it became a major catastrophe—not just 'oh dear, try again'.

Emma also described herself as a perfectionist, suggesting that she 'had all these obsessions and things', that she had to do. This was re-iterated by Gail who believed that, 'the obsessional stuff has come in because the anorexia wasn't enough to sort of make me feel better'. Viv too explained that:

> I have a very high . . . standard that I've set myself and you know whatever I do I think I'm not good enough . . . I think I ought to perfect a sort [of] certain thing all the time and it er it really affects me . . . I thought . . . I weren't being hard enough on myself . . . I've got to be stricter.

Samantha similarly explained that she enjoyed not eating because it was challenging, proving that she could set herself goals and attain them.

She described how if she lapsed and failed to meet her target, she would punish herself in some way. She would swim or exercise or would go and walk so many miles to burn off the extra calories.

It is hardly surprising then that some participants described themselves as high achievers. The application and fortitude that they applied to their studies was also brought into play in steeling themselves to refuse food. Equally however these patients were sometimes the children of similarly perfectionist parents. This was often a source of deep pain in the patient's life. Lucy for example, felt that her parents had very high standards, but were less practised at congratulating her when she had done well.

Other patients however described their parents as loving and supportive. Gail expressed considerable anxiety over the thought that anything should happen to her parents: 'I don't know what I'd do really.' Paula also described herself as close to her Mum, and for Angela the trigger to her anorexia had been the grief she experienced after the death of her father.

### *Media*

When reflecting on why their obsessions should centre around food and slimness and why it should be in this area rather than some other (for example, cleanliness, finance) that control was extended, patients reached a variety of conclusions. Several, for example acknowledged the importance of the media in inculcating favourable attitudes to slimming. Rachel explained that the media had a huge influence, 'whenever you open a magazine there's always these super thin models with slim boned bodies . . . TV, advertising, films, . . . it's all a body language that's being shown'.

Both Ann and Angela supported Rachel's observation. Angela explained that every time she looked in the newspaper or at the TV, all she would see would be thin people. Her eye would focus on their stomachs, and she would compare herself to them. When adverts for slimming products were shown, she would quickly consider trying whatever was being sold. Products like 'Slimfast' were especially attractive because they would help her to be thin. 'You don't see . . . fat people . . . on the catwalk', she remarked, 'it's always thin, so it just gets into your head that that's the way it should be and if you're anything else you're not normal.'

Diane also felt that the media had an influence. As she explained, there are diets in every magazine and on television there are always adverts for slimming products, 'You're sort of getting it in your face all the time . . . they're always telling you that calories are bad and fat is bad and you shouldn't be having them.' Diane's view was echoed by Christine, who commented on the relentless media messages concerning the ideal shape. According to these messages, 'to be happy, to be right, to be accepted' was 'to be thinner and thinner and thinner'.

More than any other participant however, Lucy talked about the media at length. She described the way in which, 'papers, magazines, anything . . . you . . . look at' presents you with the same image over and over again. The people in the media 'they're all perfect . . . the skin's perfect and everything'. Because the same image is constantly reinforced:

> no matter how intelligent you are somehow on some level you do kind of buy that . . . and . . . think they they just look so happy and glamorous and everything you think well you know maybe if I if I looked like that maybe that's what's making them [feel] so good about themselves . . . it's everywhere isn't it now y-you know . . . you seem to be constantly bombarded by not just images of like slim women but like the whole sort of film industry record industry—all those things and I suppose it does make people susceptible in that it's it's there all the time—it's not something you can escape from . . . all those images that you're fed, drip fed.

Not all participants however, acknowledged the importance of the media. Lucy herself was keen to stress that anorexia amounted to much more than a fashion for slenderness and a slavish adherence to media influence. But even participants like Julie, who felt that media influence was peripheral, were nevertheless aware of the importance of media imagery. In Julie's view, potential anorexics will develop the disorder, regardless of how much TV they watch. Nevertheless when considering whether she herself was attracted by slimming articles, Julie felt forced to admit that she was.

### *Anorexia is more than just slimming*

Regardless of their acknowledgement of media influence, almost all patients expressed anger and frustration at the implication that anorexia was simply a desire to look like the women they had seen on the television. In Robin's view, a significantly more serious dysfunction lay behind anorexia than simply an obsession with images of thinness portrayed in the media. Lucy was also irritated by the suggestion that anorexia was no more than 'slimming gone mad'. By emphasizing the link between slimming and anorexia, commentators missed the point about what was actually causing the disorder. Such a one-dimensional analysis was she felt, quite dangerous since it belittled the illness. To people with no understanding of the disorder such an analysis rendered the sufferer as little more than a silly girl who wanted to look like a model in a magazine:

> to think that people would actually really think that you would starve yourself to the point where you can barely stand up because you wanted to be a bit thinner and look like somebody who was on the television is quite insulting in a lot of ways . . . I suppose . . . by . . . improving people's self-esteem, you know, by placing more importance on that, making them realize that they don't have to look like somebody on the telly . . . that would break the connection between the two anyway.

Christine also felt that reducing anorexia to a desire to be thinner was absurd. Christine believed that, sadly, in many people's minds anorexia was simply a disorder exhibited by silly girls who want to be thin. Christine however felt that this was a markedly inaccurate view of the disorder, and one that made her angry. The disorder was so complex that Christine herself could not really say she fully understood it even though she was going through it. What may start as a desire to lose weight soon metamorphosed into a focus for all kinds of unhappiness. It was more than just a diet that had got out of hand. If it were simply this, anorexia would be an easy disorder to dismiss and still easier to treat. Anorexia, for Christine, was disorder where all kinds of feelings and emotions and insecurities were involved, and where dieting was merely a conduit for an underlying welter of confusion, unhappiness and pain.

### *Patients' explanations for the illness of other anorexics*

At the start of their interview, patients were asked to supply their reasons for the development of their illness. They were subsequently asked to comment on the causes of anorexia in other patients. In responding to the second question patients frequently reverted to a discussion of their own disorder. Where they did consider the cause of the illness in others, the reasons they supplied were varied. Media influence was often cited as relevant, as were issues such as family background, experiences at school and psychological dysfunction. Those patients who could not identify a distinct life event (such as physical abuse) in their own lives were nevertheless aware that this type of trauma may have contributed to anorexia in others. Most frequently however, patients considered the causes of the illness in others in relation to what had caused their own disorder. In practice therefore responses to the second question frequently overlapped with material uncovered by the first.

## Discussion

Patients therefore explained that a complex series of pre-cursors had led to their anorexia. Several of these, such as body dissatisfaction, can be readily located in a feminist perspective. Malson (1992) and Shilling (1993) have evaluated the manner in which female body is negatively defined. Maleness is constructed as the norm, against which femaleness is constructed as the other (Malson, 1992, p. 73). This construction finds a corollary in the dichotomy between the 'spirit' and the 'flesh'. As Lester explains, women are taught by western culture 'that the mind—the male—is to be valued, while the body—the female—is to be hated and . . . destroyed' (1997, p. 484). Many therapists (e.g. Bruch, 1978) have noted that patients equate such corporeal subjugation with 'male' ways of thinking. Bruch (1978, p. 58) describes the 'little man' inside one of her patients who demands that the impulse to eat is resisted.

Several patients described themselves as perfectionists. Such a characteristic can also be

theorized in the context of negative definitions of femininity. The struggle for bodily control which the anorexic strives so hard to maintain may be theorized in terms of the dualism of mind and body (Bordo, 1988; Lester, 1997; Malson, 1992), where the body is seen as alien, an enemy; 'the locus of all that threatens our attempts at control' (Bordo, 1988, p. 92). Anorexics, Bordo tells us, therefore behave as if bodily hunger comes from somewhere outside of the self (1988, p. 94). In struggling to control the demands of appetite, the anorexic is therefore attempting to subjugate the demands of the flesh.

It is noteworthy that two of the current sample were men, and it is interesting to ponder how feminism may be used to theorize the experience of these participants. Cantrell and Ellis (1991) have discussed anorexia in relation to the social role evolution of males and females. As women become more emancipated, the current evolutionary point of the masculine gender role also changes, and men may become more objectified. As men see their bodies increasingly attached to adverts for *Diet Coke* and other consumables, they too may fall prey to anorexia and bulimia nervosa. Such a thesis, however, tends to feminize the role identity of male sufferers. Psychiatrists thus ascribe 'feminized' sexuality to male patients. The sexual orientation (Robinson & Holden, 1986) of male anorexics is frequently discussed (unlike that of females), and patients are often described as homosexual (Gregurek, 1994; Robinson & Holden, 1986). That male homosexuality might be a highly positive identity however, appears not to be considered.

Some patients suggested their disorder was as an obsession, and described the complex rituals they engaged in around food. Such ritualistic behaviour may be analysed using theories of embodiment. In particular, elaborate rites (such as the taking of excessive exercise after eating) may be characterized as distorted forms of bodywork. Such bodywork aims to project a particular version of the self to others. The process of grooming the body so as better to present the self is central to the notion of embodiment. In applying an analysis of the self to a study of an eating disorder, it may be argued that anorexia is indicative of a precise moment in social history. It is a representational illness—a disease directed at the surface of the body. Under late 20th-century capitalism, a new personality type has emerged—the 'performing' self. Goffman (1969) explains that in modern society the self must be constantly constituted in face-to-face interaction. Social actors are continuously performing. Social relations form the stage on which this performance takes place—a performance constantly threatened by failure. The sole objective of such a performance is to maintain face. Consequently, social interaction in the modern world is entirely representational—with image presentation as its primary goal. Anorexia is quintessentially a representational disease, conforming to the current body image of beauty as thinness.

In the process of examining patient transcripts what also became clear was that the *way* in which patients described their experiences was just as interesting as the experiences they described. Patients deployed technical terms (such as 'target weight' and 'obsessive compulsive disorder'), which one would normally expect to see in psychiatric textbooks. Patients thus constructed their disorder using the concepts and vocabulary of psychiatry.

As well as using psychiatric language, patients also tended to 'clinicalize' their anorexia. Several patients linked their anorexia to the development of other clinical conditions (such as diabetes and depression), and many described the enjoyment and attention they derived from being labelled as clinically ill. Patients in the eating disorders unit were social actors in a clinical environment. Their disorder was being managed by doctors in a psychiatric hospital. They thus might reasonably have been expected to have viewed their disorder in clinical terms, and to have 'medicalized' their experience of anorexia.

The medical model of anorexia is reproduced in magazine articles and self-help books (Levenkron, 2000), the overwhelming majority of which are written by clinicians. Patients may access such texts and the models contained therein may therefore form part of their account of their disorder. In so doing patients contribute to the discourse which constructs anorexia as a clinical diagnosis (Hepworth, 1999). The acquisition by the patient of complex medical language is therefore an extension of medical power. Patients are not only compliant in the

consultation, they also extend this compliance by 'boning up' on medical wisdom in their spare time. By presenting their disorder in terms of control and obsessionalism, patients in the current study have acquired a clinical model and have reproduced this model in their accounts of their anorexia.

While noting the presence of clinical discourse in patient accounts, we also acknowledge that our own approach is itself based on a specific methodology, namely a positivist version of grounded theory. In this model, the respondent is viewed as a 'passive' source of objective knowledge with information that the researcher may readily tap. In reality, however, the position is more complex. As Silverman explains, the interview is 'a social encounter in which knowledge is actively constructed' (2004, p. 141). The process of interviewing therefore acts 'on and transform[s] the social world at the same time as studying it' (Oakley, 1992, p. 16).

The interview situation thus shapes what is said and influences the respondent to answer in particular ways. However, interviews also tell us something about the patient's 'external' experience. While they 'fracture . . . the stories being told' (Silverman, 2004, pp. 126–127), they nevertheless give information about things outside of the interview. It is important to acknowledge, therefore, that while patient testimony is a manifestation of clinical discourse, in the current study it was not primarily treated as such, but was viewed also as an objective manifestation of external phenomena.

## Conclusion

According to the data gathered by this study, a series of complex and interrelated social and psychological factors contribute to the development of anorexia nervosa. Patients were honest and generous in re-telling their stories. While often underpinned by psychological discourse, patients' accounts nevertheless uncovered a broad range of both social and psychological antecedents. These have included the centrality of unhappiness, control and excitement, leading to a spiral of food restriction, enjoyment and further food restriction. Patients have also identified the importance of social institutions such as school, family and the media in contributing to their illness. Many of the pre-cursors to anorexia identified by patients (such as body dissatisfaction and perfectionism) could readily be interpreted from a feminist perspective. We may conclude that patients' own descriptions of their experiences are lucid and insightful. By volunteering their testimonies they have enriched and enhanced our understanding of anorexia nervosa.

## References

American Psychiatric Association (APA). (1994). *Diagnostic and statistical manual of mental disorders*, 4th edn (DSM-IV). Washington, DC: APA.

Bordo, S. (1988). Anorexia nervosa: Psychopathology as the crystallisation of culture. In I. Diamond & L. Quinby (Eds.), *Feminism and Foucault: Reflections on resistance* (pp. 87–117). West Hannover, MA: Northeastern University Press.

Bruch, H. (1978). *The golden cage: The enigma of anorexia*. Wells: Open Books.

Cantrell, P. J., & Ellis, J. B. (1991). Gender role and risk patterns for eating disorders in men and women. *Journal of Clinical Psychology*, *47*(1), 53–57.

Chernin, K. (1986). *Women, eating and identity*. London: Virago.

Crisp, A. H. (1995). *Anorexia nervosa: Let me be*. Hove: Lawrence Erlbaum.

Dolan, B., Lacey, J. H., & Evans, C. (1990). Eating behaviour and attitudes to weight and shape in British women from three ethnic groups. *British Journal of Psychiatry*, *157*, 523–528.

Ford, K. A., Dolan, B. M., & Evans, C. (1990). Cultural factors in the eating disorders: A study of body shape preferences of Arab students. *Journal of Psychosomatic Research*, *34*(5), 501–507.

Furnham, A., & Alibhai, N. (1983). Cross cultural differences in the perception of female body shapes. *Psychological Medicine*, *13*, 829–837.

Garner, D. M., & Garfinkel, P. E. (1979). The eating attitudes test: An index of the symptoms of anorexia nervosa. *Psychological Medicine*, *9*, 273–279.

Garner, D. M., & Garfinkel, P. E. (1980). Cultural expectations of thinness in women. *Psychological Reports*, *47*, 483–491.

Garner, D. M., Olmstead, M. A., & Polivy, J. (1983). Development and validation of a multi-dimensional eating disorder inventory for anorexia nervosa and bulimia. *International Journal of Eating Disorders*, *2*(2), 15–34.

Glaser, B. (1978). *Theoretical sensitivity*. Mill Valley, CA: Sociology Press.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. Chicago, IL: Aldine.

Goffman, E. (1969). *The presentation of self in everyday life*. London: Allen Lane.

Gregurek, R. (1994). Anorexia nervosa in males: The question of disturbed gender identity. *Psychiatrica Danubina*, *6*, 1–2, 109–111.

Hepworth, J. (1999). *The social construction of anorexia nervosa*. London: Sage.

Lawrence, M. (1995). *The anorexic experience*, 3rd edn. London: Women's Press.

Lee, S. (1997). How lay is lay? Chinese students' perceptions of anorexia nervosa in Hong Kong. *Social Science and Medicine*, *44*(4), 491–502.

Lester, R. (1997). The (dis)embodied self in anorexia nervosa. *Social Science and Medicine*, *44*(4), 479–489.

Levenkron, S. (2000). *Anatomy of anorexia*. London: Norton.

MacSween, M. (1993). *Anorexic bodies: A feminist and sociological account of anorexia nervosa*. London: Routledge.

Malson, H. (1992). Anorexia nervosa: Displacing universalities and replacing gender. In P. Nicholson & J. Ussher (Eds.), *The psychology of women's health and health care* (pp. 62–91). London: Macmillan.

Martin, E. (1987). *The woman in the body*. Milton Keynes: Open University Press.

Minuchin, S. (1991). *Families and family therapy*. London: Routledge.

Minuchin, S., Rosman, B. L., & Baker, L. (1978). *Psychosomatic families: Anorexia nervosa in context*. Cambridge, MA: Havard University Press.

Nasser, M. (1988). Culture and weight consciousness. *Journal of Psychosomatic Research*, *32*(6), 573–577.

Oakley, A. (1992). *Social support and motherhood*. Oxford: Blackwell.

Orbach, S. (1993). *Hunger strike: The anorectic's struggle as a metaphor for our age*. London: Faber & Faber.

Palmer, R. L., Oppenheimer, R., Dignon, A., Chaloner, D. A., & Howells, D. (1990). Childhood sexual experiences with adults reported by women with eating disorders: An extended series. *British Journal of Psychiatry*, *156*, 699–703.

Polit, D., & Hungler, B. (1997). *Essentials of nursing research: Methods of appraisal and utilisation*. Philadelphia, PA: Lippincott.

Robinson, P. H., & Holden, N. L. (1986). Bulima nervosa in the male: A report of nine cases. *Psychological Medicine*, *16*, 795–803.

Shilling, C. (1993). *The body and social theory*. London: Sage.

Silverman, D. (2004). *Qualitative research, theory, method and practice*. London: Sage.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research*. Newbury Park, CA: Sage.

## Author biographies

ANDRÉE DIGNON is Senior Lecturer in Research Methods at the University of Coventry.

ANGELA BEARDSMORE is Consultant in Adult Mental Health at Leicester AHA.

SEAN SPAIN is Research Technician at the University of Coventry.

ANN KUAN is a former undergraduate student at the University of Coventry.