RECOVERY FROM BULIMIA NERVOSA

By

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Abstract

Current research on formal treatment approaches to normal-weight bulimia presents inconclusive results on the efficacy of various treatments and limited empirical knowledge of the curative mechanisms involved. In the literature on therapeutic change agent studies which interviews individuals who have recovered from an eating disorder, only isolated aspects of the recovery experience are uncovered so that the meaning and process of recovery are limited. This case study applied Colaizzi's (1978) existential-phenomenological approach to elucidate thematic categories underlying the recovery experience as recounted by a former bulimic in order to provide a more complete and holistic understanding of the process and nature of recovery from bulimia. Initially, four individuals who self-reported feeling genuinely recovered from bulimia were prescreened by an independent rater in order to ensure that they had a previous diagnosis of bulimia nervosa as defined by the Diagnostic and Statistical Manual of Mental Disorders, Third Edition Revised (1987) and no previous history of anorexia nervosa, that they were free of bulimic symptoms, and that they exhibited no significant indicators of other active psychological problems since having recovered from bulimia. The four co-researchers described their recovery experience and each interview was transcribed. Categorical themes were formulated from the richest and most comprehensive transcript and information from another co-researcher's transcript served to cross-validate the categories. The remaining two transcripts were not included in the analysis

process. The co-researcher validated the thematic categories and their descriptions and also verified that the clustered categories clearly outlined the pattern or meaning of her recovery experience.

Results showed that recovery involves a synergetic interaction of curative factors both inside and outside of formal therapy. Once the individual acknowledges her eating problem, her bulimic behaviours begin to decrease as she experiences an increasing sense of efficacy and self-respect in areas of her life other than her body weight and shape. Her bingeing and purging gradually diminish to the point where she no longer engages in them. Aside from an occasional lapse, she now implements other activities to deal with uncomfortable emotional states. She feels stronger in knowing who she is, she cherishes herself as she is, and she is eager to affirm her personal growth by sharing her experience with recovering bulimics. In addition to a more comprehensive theoretical understanding of recovery, this study provided a deepened appreciation of the complexity of the recovery process. It also underscored the need for a multifaceted and individualized treatment approach which is adjusted throughout the recovery process as the adaptive functions or meanings of clients' eating behaviours change.

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Acknowledgement

In Man's Search for Meaning, Frankl (1963) quotes Nietzsche's words: "He who has a why to live for can bear with almost any how" (p. 121, 164). This thesis is dedicated to the women in therapy who longingly asked me how they would recover from bulimia nervosa. Their question provided the initial and continuing inspiration for me to pursue and complete this research study.

I would like to thank my committee members--Dr. Ishu Ishiyama, Dr. Larry Cochran, and Dr. Elliot Goldner--for their guidance and validation throughout the research process. I am also grateful to Beth and Sarah for their careful and thorough work in the editing and typing of the manuscript. The constant undergirding of love and support from my family is also deeply appreciated.

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Chapter I

Introduction

Overview

Bulimia in normal-weight women without histories of associated weight disorders first appeared in the research literature in 1978 (Oesterheld, McKenna, & Gould, 1987). In 1980, bulimia was acknowledged as a diagnostic entity (American Psychiatric Association, 1980), and in 1987 the diagnostic criteria were revised (American Psychiatric Association, 1987).

Although Striegel-Moore, Silberstein, and Rodin (1986) observed that the onset of bulimia can occur well after the young adult years, the disorder usually begins in late adolescence or early twenties. While good epidemiological data is as yet unavailable (Eating Disorder Task Force, 1989; Tonkin & Wigmore, 1989), statistics on the prevalence of bulimia as defined by the criteria of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition Revised (DSM-III R, 1987) range from 1.3% to 5.0% of college women (Drewnowski, Yee, & Krahn, 1988). Since only 10% of bulimics are male (Drewnowski et al.), I will use the feminine pronoun she when referring to individuals with bulimia. Given that the true incidence of bulimia is difficult to assess because of the shame and secrecy associated with it (Newman & Halvorson, 1983) and since many normal-weight women not diagnosed as bulimic report suffering from the symptoms of the disorder (Johnson & Connors, 1987), the extent of bulimia may be far greater than that revealed by current statistics (Tonkin & Wigmore).

In any event, the increased prevalence of bulimia in the past two decades with its deleterious psychological and physiological health effects as well as the significant associated mortality (Herzog, Hamburg, & Brotman, 1987) has spurred research into etiological factors, treatment, interventions, and therapeutic change agents. However, the studies to date are inconclusive or analytical, and a holistic understanding of how recovery occurs is lacking. According to Tonkin and Wigmore (1989) "we are still struggling with our understanding of eating disorders and how best to help those who suffer from them " (p. 147).

Therefore, the purpose of this study is to investigate the meaning of the recovery experience from the perspective of recovered bulimics by exploring the nature and process of recovery from bulimia. Hopefully, a more comprehensive understanding of recovery will result so that theoretical approaches can be critiqued, individuals with bulimia can be primed for therapy, and treatment effectiveness can be enhanced by providing an optimal therapeutic environment.

Definition of Terms

According to the DSM-III R (1987), the diagnostic criteria for bulimia nervosa are: (a) at least two weekly binge eating episodes for a minimum of 3 months; (b) a feeling of lack of control during the binges; (c) regularly engaging in vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise; and (d) preoccupation with body shape and weight. In contrast to the Diagnostic and Statistical Manual of

Mental Disorders, Third Edition (DSM-III, 1980), the DSM-III R criteria are firmer in that a minimum frequency of binge eating episodes is stated and the requirement of depressed mood and self-deprecating thoughts following eating binges is eliminated as it is regarded as a common associated feature.

Since all of the DSM-III R (1987) criteria must be met for a diagnosis of bulimia nervosa, an individual is by definition recovered from bulimia if she does not meet any one of the criteria. Within the literature, there is no theoretical definition of recovery from bulimia. Recovery is operationalized using behavioural criteria: abstinence from bingeing and purging, or self-report of lapses with no perceived loss of control over eating behaviour for at least one year (Brownell, Marlatt, Lichtenstein, & Wilson, 1986; Connors, Johnson, & Stuckey, 1984; Cooper, Cooper, & Hill, 1989; Johnson & Connors, 1987).

However, as the course of bulimia "is chronic and intermittent over a period of many years" (DSM-III R, 1987, p. 68), the process of recovery involves episodes of remission--wherein the frequency of bulimic behaviours is reduced--as well as periods of relapse. Definitions of relapse include "a return to pretreatment base rate" (Mines & Merrill, 1987, p. 564), bingeing and purging at least eight times a month as this approximates the DSM-III R (1987) frequency criterion (Pyle, Mitchell, Eckert, Hatsukami, Pomeroy, & Zimmerman, 1990), or a "perceived loss of control" over eating behaviours (Brownell et al., 1986, p. 766). Within the context of this study, relapse

occurs when the individual experiences a loss of control over her eating behaviours.

As there are few studies which examine the recovery experience from the recovered bulimics perspective, studies which interview recovered anorexics are addressed in order to provide a broader basis for understanding the recovery process. Therefore, the criteria for anorexia nervosa according to the DSM-III R (1987) are: (a) maintenance of body weight 15% below that expected; (b) intense fear of gaining weight even though underweight; (c) disturbance in the way in which one's body weight, size, or shape is experienced; and (d) absence of at least three consecutive menstrual cycles in females when otherwise expected to occur. Correspondingly, if an individual does not meet any one of these criteria, she is by definition recovered from anorexia.

Significance of the Study

A review of the treatment outcome studies pertaining to normal-weight bulimia showed inconclusive results on the efficacy of various treatment approaches and limited empirical knowledge of the curative mechanisms of formal therapeutic interventions. Furthermore, in the literature on therapeutic change agents which interviewed individuals who had recovered from an eating disorder, only isolated aspects of the recovery experience are presented such that knowledge of the meaning of the experience and the process of recovery is limited. Currently, no research studies exist which provide a holistic understanding of the recovery process. Therefore, this study proposes to uncover the

thematic categories underlying the experience of recovery in order to provide a more complete understanding of recovery.

Since the etiology and maintenance of bulimia is multidimensional and involves specific biological, psychological, family, and sociocultural factors (Schwartz, Barrett, & Saba, 1985; Steiger, 1989; Striegel-Moore et al., 1986), the pattern of precipitating and perpetuating factors is unique for each individual. Thus, based on clinical observations, a multifaceted and individualized treatment approach is paramount in which various psychotherapeutic treatments are integrated in order to address both the bulimic symptoms and the multiple maintaining factors (Herzog et al., 1987; Johnson, Connors, & Tobin, 1987; Manley, 1989; Steiger). However, the treatment outcome literature abounds with studies comparing the effectiveness of one modality with another with little consideration of the perpetuating factors involved.

Treatment Outcome Studies

Upon reviewing the treatment outcome studies, all psychological approaches--psychodynamic, family systems, cognitive-behavioural, cognitive, or behavioural--seem to ameliorate the behavioural symptoms of bingeing and purging with no one modality showing clear superiority (Cox & Merkel, 1989; Johnson & Connors, 1987; Laessle, Zoettl, & Pirke, 1987; Yager, 1988). Furthermore, according to Hudson and Pope (1986) and Johnson and Connors (1987), little consensus has been reached concerning which treatment is most suitable for which subtype of bulimia: bulimia complicated by substance abuse, obsessive-

compulsive behaviour, depression, or sexual abuse (Lacey, 1983; Ordman & Kirschenbaum, 1985).

In the controlled psychodynamic treatment study by Norman, Herzog, and Chauncy (1986), statistically significant improvements on measures of disordered eating behaviours were found at a one-year follow-up. Concerning family therapy outcome studies, an uncontrolled study conducted by Schwartz et al. (1985) which employed structural family therapy and symptom-focussed directives found that at the end of treatment 66% of the subjects had reduced the frequency of their bulimic episodes from a mean of 19.3 per week to one or fewer per month. The controlled cognitive-behavioural studies also report statistically significant reductions in binge/purge behaviours: 80% abstinence at post-treatment (Lacey, 1983), a 60% reduction in the frequency of vomiting at the three-month follow-up for 77% of the participants (Kirkley, Schneider, Agras, & Bachman, 1985), a 50% or greater reduction in the frequency of bingeing and purging at post-treatment for 55% of the individuals (Connors et al., 1984), and 20% abstinence and 55% who had reduced bulimic behaviours to one day per week (Ordman & Kirschenbaum, 1985).

Finally, the outcome results from studies which compare the efficacy of different treatment modalities are also inconclusive. For instance, in the study by Fairburn, Kirk, O'Connor, and Cooper (1986) which compared a cognitive-behavioural approach with short-term psychotherapy, the results indicated that both groups made substantial improvements on measures of binge/purge behaviour which were maintained over a twelve-month follow-up

period. Similarly, the study by Freeman, Sinclair, Turnbell, and Annandale (1985) found that all three treatments--individual psychodynamic, individual behavioural, no treatment control group--effectively reduced bingeing and purging.

Overall, effective evaluation and comparison of different treatment approaches is precluded by subject diversity with respect to age of onset, duration of illness, method of subject selection (Ordman & Kirschenbaum, 1985; Johnson & Connors, 1987), and presence of active psychological problems (Lacey, 1983). Another factor which impedes between-study comparisons is the lack of uniformity in methodology related to usage of a control group as well as treatment duration, session length, and number of sessions per week (Cox & Merkel, 1989). Variability between the studies in reporting post-treatment results also jeopardizes evaluation: the level of significance of results and the percentage of subjects who don't respond to treatment is sometimes neglected (Cooper et al., 1989), some studies report reduction in the actual number of bulimic episodes while others report percentage reductions, and follow-up length is diverse and short (Herzog, Keller, & Lavori, 1988; Johnson & Connors, 1987).

In addition to these inconclusive findings on the efficacy of various treatment modalities, empirical knowledge of the curative factors of formal therapeutic interventions is limited. In the family and psychodynamic therapy studies, knowledge of the effectiveness of specific therapeutic interventions is precluded because a wide variety of interventions were implemented during treatment (Norman et al., 1986; Schwartz, 1982; Schwartz et al.,

1985). Similarly, with the controlled cognitive-behavioural studies, it is impossible to determine the specific interventions of the treatment packages which are responsible for reducing behavioural symptoms (Cooper et al., 1989; Fairburn et al., 1986; Johnson & Connors, 1987; Kirkley et al., 1985).

Nonetheless, assumptions about factors which facilitate recovery are inherent in the various treatment approaches. For example, from a psychodynamic approach, the bulimic symptoms will diminish as underlying intrapsychic conflicts are worked through and self-esteem increases. Systemic family therapy proposes that while effective family restructuring is necessary for recovery, specific interventions aimed at the bulimic behaviours may also be necessary. Finally, cognitive-behavioural therapy facilitates recovery by implementing behavioural techniques to reestablish control over eating behaviours as well as using cognitive interventions to modify the underlying disturbed thinking and values about body shape and weight.

Therapeutic Change Agent Studies

With respect to qualitative studies which examine the factors both inside and outside of formal therapy which are facilitative of recovery, the body of knowledge is minimal and analytical such that only a limited understanding of the meaning of change events and the process of recovery exists. Information on the curative factors which "influence the final result as a function of the therapist's actions, the other group members, and the patient herself" (Vandereycken, Vanderlinden, & Van Werde, 1986, p. 61) has been gathered by interviewing recovering or

recovered bulimics and recovered anorexics about critical change events in recovery.

Hobbs, Birtchnell, Harte, and Lacey (1989) found that the aspects of group psychotherapy which bulimic clients considered therapeutically important differed from those cited by their therapists. While clients reported instillation of hope, vicarious learning, and universality as most important, therapists rated self-disclosure and acceptance as more important. However, only a limited understanding of the therapeutic effects in a group environment is gained as the meaning of the factors and their impact on individuals is sketchy.

Stanton, Rebert, and Zinn (1986) interviewed 15 individuals who had recovered from bulimia in the absence of therapy and had been abstinent from bingeing and purging for an average of 7 months. Factors which initiated change included a desire to improve self-esteem and recognition of the ill-health effects of bulimic behaviours. Social support, behavioural strategies, and positive self-talk were reported to facilitate change. As with the study by Hobbs et al. (1989), the meaning and impact of these factors is limited.

Hall and Cohn's 1983 survey (cited in Hall & Cohn, 1986) revealed that of the 30 individuals who reported that they were cured of bulimia or a dual diagnosis of both anorexia and bulimia, professional therapy was rated by 80% as helpful, friends and family were rated by 54%, and spiritual pursuits were rated by 47%. In addition to the fact that the scope of possible

facilitative factors was limited to the therapists' perspectives, only limited insight was gained into the meaning and impact of these events for the individuals.

Kirk (1986) administered a questionnaire of 74 potential treatment or recovery methods to 123 recovered bulimics. The 9 items rated as most helpful to more than 50% of the respondents were: "learning why I turned to or away from food when bored, tired, angry" (73.3%), "finding a sense of my true self (no longer standing outside observing my own behaviours)" (69.8%), "learning to call on my inner resources-determination, courage, patience" (64.9%) (p. 65), "learning to control self-defeating thoughts and feelings" (69.2%), "learning not to be over-concerned with other peoples' opinions and reactions" (69.0%), "learning constructive ways to deal with anger" (65.7%), "letting go of my should statements" (65.5%), and "widening my range of social activities" (63.8%) (p. 69). Only one of the most helpful items was a food issue: "learning to eat a healthy breakfast, lunch, and dinner" was helpful to 66.9% of the respondents" (p. 71).

Additional information on facilitative factors was also gained from open-ended questions. Trusting and loving relationships with supportive boyfriends, spouses, family members or God helped individuals realize that they "had good qualities of [their] own and that [they] didn't have to earn love, friendship and attention" (Kirk, 1986, p. 130). Thus, while partial meanings of some of the facilitative events were

elucidated, no clear pattern of the recovery process was presented.

Beresin (1985) presented the meaning and impact of some of the curative factors reported by recovered anorexics and sketched a partial pattern of recovery. For instance, a validating relationship with one's therapist helped individuals to identify and trust their feelings and initiated risk taking with other individuals. Also, while body image was the most difficult aspect to change, becoming a mother fostered an increased sense of self-worth, and intimate sexual relationships facilitated the ability to appreciate one's body rather than being ashamed of it.

Maine (1985) interviewed 25 recovered anorexics to illumine the treatment and recovery processes, and to uncover the meaning and impact of events which individuals considered facilitative of recovery. Factors which facilitated recovery included personal responsibility for getting better, a positive therapeutic relationship either within formal therapy or within informal relationships, acceptance of the dysfunction within their family as well as the conflicting messages from the sociocultural system, and self-acceptance. The meaning of each of the factors is also discussed. For example, in experiencing a validating therapeutic relationship with opportunities for intimacy and interdependence, individuals developed the confidence to establish new relationships which required nutrition and strength.

In summary, the treatment outcome literature offers assumptions about the curative factors involved in recovery and

the studies interviewing recovered anorexics have begun to illumine a pattern of recovery. But, to date, none of the studies of normal-weight bulimia have provided a holistic synthesis of patterns of meaning of recovery. Therefore, this study proposes to investigate the phenomenon of recovery from bulimia by asking four women to describe their experience of recovery. Thematic categories underlying the unique recovery experiences will be elucidated and described in order to render a more complete pattern and understanding of recovering from bulimia.

Assumptions

The assumptions underlying this study are:

1. The individual who has recovered from an eating disorder is the expert on the meaning and effect of the variables which were critical in her recovery (Maine, 1985).

2. The curative factors are not limited to those inside of formal therapy (Maine, 1985).

3. The therapist and client often emphasize different critical change experiences in their assessments of treatment (Hobbs et al., 1989).

4. The initial change events are different from those that maintain recovery (Brownell et al., 1986).

Limitations of the Study

Self-selected individuals may be different from the larger population in terms of willingness to share personal information with others as well as being psychologically minded and verbally expressive. Therefore, sample bias could be an important factor

to consider when applying the results to the recovery experience for women with normal-weight bulimia (Borg & Gall, 1983). Furthermore, the pattern of recovery from bulimia may be different for males or individuals with obesity. Thus, the results of this study which describe the pattern of recovery for the one co-researcher may be applicable to some other women with normal-weight bulimia.

Chapter II

Literature Review

What constitutes recovery from bulimia? What factors are facilitative of recovery and what is the process of recovery from this eating disorder? This chapter explores issues related to these questions. The literature is reviewed on treatment outcome studies and studies which examine therapeutic change agents. The limitations and assumptions concerning recovery from bulimia inherent in the various approaches are also discussed. Finally, based upon the literature and my clinical experience in eating disorders, my presuppositions about the nature and process of recovery from bulimia are stated so that they can be set aside during the research process.

Treatment Outcome Studies

The scope of this part of the literature review is limited to clinical studies on treating normal-weight bulimics, and thus excludes studies of bulimics with associated anorexia nervosa or obesity. Furthermore, this review is confined to non-drug treatment interventions which therapists or counsellors can implement within a clinical setting. Therefore, it does not include the many pharmacological studies, most of which indicate the utility of tricyclic antidepressant drug therapy in the treatment of normal-weight bulimics who manifest depressive symptoms. However, the outcome studies pertaining to psychodynamic and family therapies as well as the controlled group and individual cognitive-behavioural treatments have been included. According to Fairburn (1988), these various

therapeutic approaches have assumed that the etiological variables upon which they are based are also the catalysts, change mechanisms, or curative factors in the recovery process. However, these clinical observations have not been rigorously researched.

The research on treatment approaches is very young (Johnson & Connors, 1987); Fairburn's (1981) cognitive-behavioural approach was the first study on the treatment of normal-weight bulimia. And while a plethora of studies using cognitive-behavioural therapy appeared in 1984 to 1986, little research on the various psychological treatment approaches has been done since then (Johnson & Connors). The trend in the literature seems to be toward the study of drug treatments as well as the personality, family, and socioeconomic correlates of bulimia. Another possible explanation for the scarcity of treatment research is that with up to 3-year follow-up periods being included in the studies, those which began in 1986 may still be in progress (Herzog et al., 1988; Johnson & Connors; Mitchell, Pyle, Hatsukami, Goff, Glotter, & Harper, 1989).

The following section discusses the psychodynamic, family systems, and cognitive-behavioural theories. The corresponding treatment outcome studies are presented and critiqued. Also, the various theoretical assumptions concerning recovery from bulimia are elucidated.

Psychodynamic Therapy Studies

The psychodynamic treatment approach stems from the view that psychosomatic disorders are a manifestation of early

unresolved unconscious conflicts and intrapsychic or underlying difficulties (Norman et al, 1986). The individual has a sense of pervasive ineffectiveness which leads to efforts to gain self-control in the realm of weight (Yager, 1988). Psychodynamic theory includes, but is not limited to, Freudian psychoanalysis and object-relations theory. Thus, treatment addresses the conflicts or developmental needs of the individual and the function of the bulimic symptoms within her psychological economy (Herzog et al., 1987). The literature on psychodynamic psychotherapy is heavily anecdotal and lacks validity in its causal analysis. Empirical outcome studies have been criticized by Herzog et al. (1987) because they lack control groups or randomization and also indicate a lack of significant difference in outcome between patients who received psychotherapy and those who did not" (p. 545).

In a controlled follow-up study by Norman et al. (1986), individuals who engaged in at least 12 weeks of either individual or group insight-oriented therapy were compared to those who had either no treatment or only medical/nutritional follow-up. Using the Eating Attitudes Test, Hopkins Symptom Checklist, and Social Adjustment Scale, results at a one-year follow-up showed that psychodynamic treatment was associated with a decrease in disordered eating behaviours and attitudes, depression, and somatic concerns. However, there was no significant remission on measures of social maladjustment, anxiety, interpersonal sensitivity, or obsessive-compulsive traits. Nonetheless, individuals in treatment reported improvements in their moods and

concerns with relationships and isolation. Norman et al. suggest that the findings demonstrate a characterological maladjustment that persists in spite of improved bulimic behaviours and appears to not be directly linked to eating symptomatology.

Norman et al. (1986) underscore the need for follow-up studies to also measure the psychological and social components of bulimia in order to expand our understanding of "the course of the disorder as well as . . . possible risk factors for relapse and/or manifestation of other psychiatric disorders" (p. 56). Concerning curative factors, in spite of the decrease in bulimic behaviours, knowledge of the effectiveness of specific psychodynamic techniques is limited because the psychodynamically-oriented therapists used a variety of styles.

From a psychodynamic approach, treatment should involve modifying the underlying conflicts, resulting in improvements in overall psychological functioning and self-esteem, as well as diminished bulimic symptoms (Fairburn, 1988; Norman et al., 1986). Issues which may be linked to the disordered eating behaviours include limited intimacy with and incomplete autonomy from family, poor peer relationships, loneliness, poor body image, role confusion, and unclear personal goals and values. Although psychodynamic therapy does not engage in active symptom management, the cognitive alternatives and prompts of the therapist may constitute behavioural contingencies. The therapeutic alliance involves empathetically responding to the individual's developmental needs in order to facilitate her awareness and acceptance of her needs and feelings. Forming

"achievable goals that will begin to replace the patient's desperate inner struggle for control with a growing sense of mastery" is also emphasized (Goldman, 1988, p. 566).

In addition, the therapeutic relationship entails understanding how the individual is experiencing her relationship with her therapist. The assumption is that the individual's interactions in therapy are a reflection of how she perceives herself and others as well as indicative of relational patterns. Therefore, the therapeutic alliance helps the individual become aware of her beliefs and defensive interactional styles which facilitate alternate thinking styles and coping behaviours (Bruch, 1973; Johnson et al., 1987; Steiger, 1989).

In summary, from the psychodynamic approach, recovery from bulimia entails addressing the individual's intrapsychic developmental conflicts and interactional patterns within the therapeutic relationship. Although no direct symptom management of bulimic behaviours is involved, the therapeutic alliance facilitates the individual's awareness of maladaptive cognitive patterns and interpersonal interactions so that thinking and behavioural styles become more functional.

Systemic Family Therapy Studies

The family therapy studies are based on family systems theory and therefore view the bulimic symptoms as "related to family processes such as overprotectiveness, escalating power struggles, or the inability of family members to really know each other" (Schwartz et al., 1985, p. 292). According to Johnson and Connors (1987) and my own search of the literature, there are

only two outcome studies on the use of family therapy for bulimia: Schwartz (1982) and Schwartz et al. (1985). This lack of attention to the family context in bulimia may stem from the fact that many bulimics no longer live with their families of origin and feel that their families should not be involved in treatment as they are unaware of the bulimia (Schwartz et al.). Consequently, therapists are less inclined to involve families in the treatment process.

Schwartz (1982) described the first outcome study of family therapy and bulimia. He used Minuchin's (1974, 1978) structural family therapy model, making some adaptations specific to bulimia as he worked with a 17-year-old bulimic and her two parents. Therapy involved 31 sessions over a one-year period: one-third were individual sessions with Mary and one-quarter were marital sessions with her parents. In Stage 1, interventions were aimed at restructuring the family hierarchy so that Mary became more distant from her parents' relationship and her mother. As she also became more involved with her peers and her father, reduced family enmeshment occurred.

When after 3 months the frequency of bingeing and vomiting had decreased some but was still an issue, Stage 2 goals--uniting the parents, disengaging from parents' marital issues, and changing the family's view of Mary's bulimia from an illness to a pleasurable habit--were implemented. Owing to their outrage at the food Mary was wasting, her parents intervened by making food available only at meal times. From here on, Mary's bulimia ceased. Furthermore, her social confidence and autonomy were

enhanced by a class graduation trip. During this time, her parents discovered they could live together without Mary.

Stage 3 of therapy involved marital counselling and individual sessions with Mary which focused on life planning rather than family involvements. Once Mary was free of bingeing for 3 months and was involved in art school, therapy was terminated. At a one-year follow-up, results showed that the improvements were maintained. Mary had established some close female relationships, had begun interacting with men, and had disengaged herself from parental marital fights. Although she binged about once a month when she felt uptight, she "was unconcerned about this and felt that food was no longer an obsession " (Schwartz, 1982, p. 80).

Schwartz et al. (1985) conducted a study with 30 outpatient bulimic females and their families in which structural family therapy and strategic symptom-specific directives were used. In cases where family of origin members were not present, therapy was done with the individual alone or her spouse and/or children. Treatment involved an average of 33 sessions over a 9-month period. The stages of therapy entailed (a) priming the individual and her family for differentiation and facilitating the differentiation, (b) focusing on the symptom, and (c) consolidating the changes. In Stage 1, Schwartz et al. challenged family and individual beliefs and patterns of interaction. Also, they emphasized the importance of helping the individual acknowledge that <u>she</u> was the one who was bingeing and purging, and of facilitating her awareness and experiencing of

feelings which the bulimic behaviours helped her avoid. In Stage 2, Schwartz et al. found that it was easier for the individual to let go of her symptoms if she was not living in her parents' home in a dependency situation. Interventions which helped the individual gain more control over her bingeing and purging included reframing the bulimic episode as a signal that she wanted to feel nurtured, or changing her intrapersonal and/or interpersonal patterns of interaction. In Stage 3, the individual's issues of intimacy, career planning, and assertive behaviour were addressed. When the therapist prescribed a relapse, the individual and family often became more aware of how to avoid re-creating the interactions which formed the context of bulimia.

At the end of treatment, 66% of the subjects had reduced the frequency of their bulimic episodes from a mean of 19.3 per week to the first level of control over eating behaviours: one or fewer per month. Their attitudes about control were that they felt "nearly always in control" (Schwartz et al., 1985, p. 304). Ten percent of the subjects were at the second level: they had episodes which ranged in frequency from two per month to one per week and said they felt "usually in control" (Schwartz et al., p. 304). At a 16-month follow-up, all of the individuals at the first level had maintained their improvements. However, two-thirds of the subjects who were at the second level had relapsed to the third level: two to four episodes per week with control being somewhat of a problem. Results of the other outcome criteria--change in family relationships, change in life goals or

career, and change in the individual's behaviour in extrafamilial relationships--were not reported. However, Schwartz et al. found that the obstacle to feeling in control of bulimic symptoms was not symptom chronicity but rather living at home with parents.

Although the outcomes from these two family treatment studies are promising, determining the relative effectiveness or necessity of specific interventions is precluded because of the wide variety of interventions used and the uncontrolled nature of the studies. Clearly more controlled studies to isolate specific components of family therapy and their effects are required to assist in developing a model for treating bulimic families. The importance of understanding bulimia from a family perspective is underscored by Schwartz et al. (1985) who have found it uncommon that families are unaware of their daughter's bulimia and even more unusual that they are unwilling to become involved in therapy. Furthermore, many bulimics are often still quite tied to their families in spite of geographical distance from them.

The assumptions concerning recovery from bulimia which are inherent in the family therapy studies are that a cessation of bingeing and purging, or no relapses even though lapses may occur denotes recovery (Schwartz, 1982; Schwartz et al., 1985). And while improvements in the family structure and hierarchy which activate and support the individual's differentiation from the family system are necessary and foundational to recovery for most cases, they may not be sufficient. Individuals' ambivalence about giving up their symptoms and the fear of many families regarding the growing autonomy of their daughters may contribute

to the persistence of the bulimic symptoms in some individuals in spite of effective family restructuring (Schwartz et al.). Thus, some form of intensive symptom-specific interventions such as monitoring food consumption or redefining the bulimic episodes may be necessary to eliminate or gain control of the bulimic behaviours (Schwartz; Schwartz et al.).

Furthermore, these two studies emphasize the importance of working in stages, albeit diffuse and flexible stages. The individual needs to have first attained a degree of differentiation from her family prior to introducing symptom-focused interventions because the bulimic behaviours can be reactivated by family interactional patterns. Finally, once the individual is less protected by and protective of her family, the extent to which she is able to develop satisfying and close extrafamilial relationships is purported by Schwartz (1982) as crucial to recovery because "the feedback the patient received from new friends helped to decrease her preoccupation with her weight and with her appearance in general, a preoccupation that seems highly correlated with the eating disorder" (p. 81).

In summary, from the family therapy approach, recovery from bulimia involves changes in interpersonal interactions within the family and extrafamilial contexts. Intrapsychic changes in the emotional and cognitive realms which are effected by the changes in social relationships are also considered to facilitate recovery. And, with some individuals, behavioural interventions aimed at interrupting the bulimic pattern may need to be combined

with changes in the family's functioning and interactional patterns.

Cognitive-Behavioural Therapy Studies

Most of the treatment research on bulimia has focused on cognitive-behavioural (CB) interventions in both group and individual contexts. Cognitive-behavioural therapy (CBT) is based on sociocultural and psychological theories which highlight respectively the risk factors of sociocultural norms for thinness as an indicator of feminine attractiveness, success and control (Striegel-Moore et al., 1986), and low self-esteem due to body image dissatisfaction (Schwartz et al., 1985; Fairburn, 1985).

Inherent in the CB studies is the notion that recovery is indicated by freedom from bingeing ad purging, or no relapses (Connors et al., 1984; Cooper et al., 1989; Johnson & Connors, 1987; Manley, 1989) and a decreased intensity of dysfunctional attitudes toward body shape and weight. This approach advocates that recovery involves addressing the abnormal eating behaviour using predominantly behavioural techniques to establish some degree of control over eating. Modifying dysfunctional beliefs and values about body shape and weight which perpetuate the bulimic behaviours are also considered necessary for recovery (Fairburn, 1985). CBT is a "treatment package" involving a variety of behavioural and cognitive interventions. Therefore, a change in disturbed eating habits as well as attitudes towards shape and weight is necessary for lasting recovery (Cooper et al.). According to Fairburn (1988), change in attitude toward body shape and weight is the best predictor of prognosis.

Another assumption of the CB approach is that the establishment of a trusting therapeutic relationship is paramount to recovery because the therapist is continually encouraging the individual "to take risks in modifying eating behaviours" (Manley, 1989, p. 153). Thus, individual responsibility for progress is emphasized.

According to Fairburn (1985), in Stage 1 of CBT, interruption of the binge/purge behaviours and regaining control over eating is facilitated through techniques such as education about variability in body weight, weight regulation, the link between dieting and bingeing and body image misperception. Self-monitoring of eating habits and the circumstances associated with binge/purge episodes and prescription of a regular eating pattern are other interventions which are used. Additional behavioural techniques include stimulus control measures which involve limiting the amount of "dangerous" food in the house and implementing alternative behaviours which are incompatible with binge eating.

In Stage 2, cognitive interventions are employed to identify and modify dysfunctional beliefs and values that one's "shape and weight are of fundamental importance and that both must be kept under strict control" (Fairburn, 1985, p. 161). Therefore, techniques include the gradual introduction of moderate amounts of "fattening foods" and relaxing of control over the content of one's diet in order to challenge the belief "that certain foods are inherently fattening" (Fairburn, 1985, p. 177). Problem-solving training which helps the individual generate alternative

ways of dealing with adverse events, thoughts or emotions without resorting to bingeing tends to counter all-or-nothing thinking and decrease their preoccupation with food and weight. Relaxation and assertiveness training as well as efficacy-enhancing imagery may also be included. Cognitive restructuring which involves discussing and generating counter-arguments to dysfunctional beliefs--"I feel fat and therefore I am fat" and "I must be thin, because to be thin is to be successful, attractive and happy" (Fairburn, 1985, p. 182)--and examining the benefits and costs of adhering to them is also used.

Finally, in order to deal with future lapses or relapses so that the episodes do not get out of control, a plan is devised to anticipate and cope with high risk situations. Some studies (Wilson, Rossiter, Kleifield, & Lindholm, 1986) also include Stage 3 which focuses on relapse prevention using "exposure with response prevention" in which subjects are encouraged to eat forbidden foods, but then to delay or refrain from purging.

Within the empirical research literature, the CB treatments are often compared with another group which may receive fewer cognitive or behavioural techniques, or just a purely behavioural treatment. And while these studies demonstrate statistically significant reductions in binge/purge behaviours, the effects of specific components of the treatment packages on symptom reduction have not been identified. For instance, in the studies of Kirkley et al. (1985) and Fairburn et al. (1986), it is impossible to determine which interventions of the CB treatment packages are responsible for the statistically significant

results. Further research using component analyses is needed in which the comparison form of therapy differs in terms of one or more essential elements so that the specific interventions or combinations which are necessary and most effective in producing symptom change can be teased out (Cooper et al., 1989; Fairburn et al., 1986; Johnson & Connors, 1987; Kirkley et al., 1986).

Another shortcoming of the CB studies is that the scarcity of longterm follow-up research precludes understanding the longitudinal course of bulimia and the nature of the change mechanisms which initiate, facilitate, and maintain recovery (Mitchell et al., 1989). Finally, while the studies also measure changes in assertion (Kirkley et al., 1985), self-esteem (Connors et al., 1984), depression (Lacey, 1983), social adjustment, and attitudes about food, dieting and body image (Ordman & Kirschenbaum, 1985), comparison of results is difficult because of the diversity and inconsistency of psychosocial outcome criteria between the studies.

Cognitive-behavioural studies by Fairburn et al. (1986) and Cooper et al. (1989) found that the control condition which contained a purely behavioural treatment resulted in significant improvements in bingeing and purging behaviours. Consequently, the necessity of the cognitive component in producing symptomatic change is questioned. Furthermore, although the behavioural treatment may have produced cognitive change as suggested by improvements on the Eating Attitude Test, further studies are needed to address whether cognitive change is necessary for recovery.

According to Fairburn (1985), certain behavioural interventions such as the introduction of a regular eating pattern and avoided foods give increased control over eating which in turn increase one's sense of mastery and progressively decrease disturbed thinking about body weight and shape. These results are substantiated by Schneider, O'Leary, and Agras (1987) who found that decreases in purging behaviour were significantly related to increases in three domains of perceived self-efficacy: controlling bingeing during various mood states, controlling bingeing using stimulus-control techniques, and developing satisfactory social relationships. While the increased self-efficacy pertaining to acceptance of body shape was correlated with decreased purging frequency, it did not change significantly during treatment. Thus, it seems tenable to conclude that behavioural techniques which decrease purging behaviours also enhance the individual's perceived self-efficacy or belief that she can use her skills to effectively respond to situations. However, Fairburn (1985) advocated that beliefs and values should still be explored even if formal cognitive restructuring is unnecessary because often times "although there has been some cognitive change, certain core attitudinal abnormalities remain intact" (p. 183).

In summary, the cognitive-behavioural approach advocates that while behavioural techniques are necessary to reestablish control over eating behaviours, they are not sufficient for lasting recovery. The disturbed thinking and values about body shape and weight which maintain the bingeing and purging

behaviours must also be modified through cognitive interventions (Fairburn, 1985). Finally, although the CB approach presents change as an ordered process with the first stage focused on eating behaviour and the second stage proceeding through an ordered series of well-defined cognitive restructuring steps, the entire program is cognitively oriented. In practise, significant cognitive change often occurs during Stage 1 and the early part of Stage 2 so that the course of formal cognitive restructuring "tends to be highly variable and erratic" (Fairburn, 1985, p. 183).

Therapeutic Change Agent Studies

While the treatment outcome studies assume that the curative factors are the change mechanisms within formal therapeutic approaches, the therapeutic change agent studies, which interviewed individuals who are recovering or who have recovered from an eating disorder, found that factors both inside and outside of therapy facilitated recovery. However, since the change agent studies uncovered only isolated aspects of the recovery experience and revealed only partial meanings of some of the facilitative events for some of the individuals, the pattern of the process of recovery was limited and incomplete.

Given that the individual who has recovered from an eating disorder is the expert on the meaning and effect of the variables which were critical in her recovery (Maine, 1985), and given that the therapist and client often emphasize different critical change experiences in their assessments of treatment (Hobbs et al., 1989), only the studies which report the recovered

individual's perspective on facilitative factors are reviewed. Therefore, studies in which the therapist or family recounted the curative factors and their impact on the recovery process are not included (Bruch, 1988; Erickson, 1985; Goldman, 1988; Jackson, 1986; Maddocks & Bachor, 1986; Rabinor, 1986; Vognsen, 1985).

In the study by Hobbs et al. (1989), therapists and individuals with bulimia were asked at 3-week intervals to describe the events in group therapy which were personally important for them. Judges then assigned one of ten therapeutic factors to each event. While therapists valued self-disclosure and acceptance as important, clients rated instillation of hope, vicarious learning, and universality as most important. Furthermore, the importance of the various factors shifted throughout the 10 weeks: Self-disclosure, vicarious learning and universality were valued in the early stage, self-understanding in the middle phase, and instillation of hope in the final phase.

Concerning the limitations of this study, the research tool was problematic in that interrater reliability was low. For instance, judges assigned the same event to different therapeutic factors because of subtle differences in reporting. In addition, using this methodology dilutes the meaning of the event for the individual or why it was important for her. For example, "vicarious learning" is defined as "the patient experiences something of value for herself through the observation of other group members (including the therapist)" (Hobbs et al., 1989, p. 627). And the definition of "universality" is "the patient perceives that other group members have similar problems and

feelings and this reduces her sense of uniqueness" (Hobbs et al., p. 627). Thus, only a partial understanding of the meaning of the experience for the individual is gained and the impact of the event on her recovery experience is not elucidated. Further research into the nature of therapeutic effects within small-group treatments of bulimia is therefore required.

Nonetheless, Hobbs et al. (1989) discussed several assumptions of recovery implied by the results which are noteworthy. First, while disclosure of personal information can be important in overcoming bulimia, experiencing one's self-disclosures as accepted by others was paramount to perceiving self-disclosure as therapeutically valuable. Second, universality or realizing that others have similar problems and feelings may enhance an individual's sense of belonging, support, and/or acceptance even though she has revealed information about herself which she had considered unacceptable. Third, as individuals shared how their improvements occurred, vicarious learning contributed to a sense of optimism about one's progress or the potential for progress.

Stanton et al. (1986) explored the nature of self-change in bulimia by interviewing and administering a modified version of the Processes of Change Test to 15 former bulimics who had recovered in the absence of formal therapy. On the average, individuals had been abstinent from bingeing and purging for 7 months prior to the study. Although the study uncovers the curative factors in the "contemplation and active stages" of treatment, insight into the meaning and impact of the events is

minimal.

Data from the structured interview showed that in the "contemplation stage" of recovery "a desire to improve self-esteem was most influential in initiating change in binge eating" (Stanton et al., 1986, p. 921) and that recognition of the ill-health effects initiated change in purging behaviours. According to Stanton et al., these factors may correspond to the subscales on the Processes of Change Test of self-reevaluation--"I consciously struggle with the issue that purging contradicts my view of myself as an effective person in control of my own life"--and consciousness raising: "I think about information from articles or ads concerning the benefits of quitting binge eating or purging" (p. 919).

In the subsequent "active change stage" of recovery, test results revealed that the factors which were used most frequently in overcoming bulimic behaviours were "self-liberation ('I tell myself I am able to quit purging if I want to'), counterconditioning ('I do something else instead of binge eating when I need to relax or deal with tension'), . . . [and] helping relationships ('I can be open with at least one special person about my experiences with my eating habits')" (Stanton et al., 1986, p. 919).

In 1983, Hall and Cohn (cited in Hall & Cohn, 1986) surveyed 217 recovered and recovering bulimics--just over half of whom had also had anorexia--to uncover factors that were helpful in recovery. Individuals ranked 10 therapy options and 13 helpful activities on a 5-point scale with 1 = no help and 5 = most help.

Of the 30 individuals who reported that they were cured, 80% stated that professional therapy was "most helpful", 54% rated friends and family as helpful, 47% identified spiritual pursuits, 40% acknowledged professionally-led groups, and 27% referred to self-led support groups. Results from the 30 recovered individuals concerning helpful activities included: talking about bulimia (80%), physical exercise (80%), relaxation techniques (67%), reading a newsletter from a self-help organization (63%), and journal writing (60%).

Implicit in this study is the assumption that recovery involves factors both inside and outside of formal therapy. However, given the close-ended nature of the questionnaire format, minimal insight was gained into the meaning of these events for the individuals and how they impacted the process of recovery. For example, only the meaning of spiritual pursuits was further explored. Specific religions and practises were reported to give individuals a sense of comfort, peace, and security as they experienced being loved unconditionally regardless of how they looked or what the did. Furthermore, the scope of curative factors was limited as possible factors which the recovered individuals considered helpful were not included in the questionnaire. Instead, only the therapists' perspectives on facilitative events were used to design the survey.

Kirk (1986) administered a questionnaire comprised of 74 potential treatment or recovery methods identified in the literature to 123 recovered bulimics in order to ascertain what they "[perceived] as significant factors in their recovery" (p.

11). Open-ended questions were also used in order to elicit facilitative factors not included in the questionnaire. In addition, Kirk conducted a structured personal interview with consenting individuals in order to gain insight into self-image changes since having recovered, confidence in maintaining freedom from bingeing and purging, and current coping mechanisms.

Results showed that 3 of the 10 items rated as most helpful to more than 50% of the respondents were concerned with exploring the issues underlying the bulimic behaviours: "learning why I turned to or away from food when bored, tired, angry" (73.3%), "finding a sense of my true self (no longer standing outside observing my own behaviours)" (69.8%), and "learning to call on my inner resources-determination, courage, patience" (64.9%) (Kirk, 1986, p. 65).

Cognitive-behavioural techniques found to be most helpful to the majority of individuals included "learning to control self-defeating thoughts and feelings" (69.2%), "learning not to be over-concerned with other peoples' opinions and reactions" (69.0%), "learning constructive ways to deal with anger" (65.7%), "letting go of my should statements" (65.5%), and "widening my range of social activities" (63.8%) (Kirk, 1986, p. 69). Only one of the most helpful items was a food issue: "learning to eat a healthy breakfast, lunch, and dinner" was helpful to 66.9% of the respondents" (p. 71).

Additional information on facilitative factors was gained from the open-ended questions. Trusting and loving relationships with supportive boyfriends, spouses, family members, or God

helped individuals realize that they "had good qualities of [their] own and that [they] didn't have to earn love, friendship and attention" (Kirk, 1986, p. 130). Also, spiritual relationships and activities through groups such as Overeaters Anonymous decreased individuals' preoccupation with food as they concentrated on a spiritual power and let "go of the control [they] thought [they] needed in life to a higher power (God)" (Kirk, p. 130). In turn, they gained control over their eating behaviours.

With respect to information culled from the personal interviews, respondents reported "an increase in self-esteem after recovery: They [were] more in touch with their feelings and [had] confidence in themselves" (Kirk, 1986, p. 134). Furthermore, 10 of the 12 respondents indicated "that they were fairly to very confident that they [would] not return to the binge-purge cycle" (p. 134). Current coping mechanisms included increased communication with others, exercise, and finding time for relaxation within a busy schedule. Thus, as is characteristic of the therapeutic change agent studies, only partial meanings of some of the facilitative events for some of the individuals were explored and no clear pattern of the process of recovery was uncovered.

Beresin (1985) conducted a pilot study in which a group of recovered anorexics and a control group of anorexics were interviewed and asked to complete several scales. Findings indicated that the recovered anorexics showed improvement on the extended family subscale of the Social Adjustment Scale and on

the perfectionism subscale of the Eating Disorders Inventory. Factors in formal therapy which were reported as facilitative of recovery included a non-judgmental therapist who was both empathic and confrontative, and with whom they felt validated for who they were. This therapeutic relationship helped individuals to identify and trust their feelings and to begin taking risks with others. Through therapy, they also realized their families' contribution to their eating disorder, family members became more aware of each others' feelings, and individuals began to physically and emotionally separate from their families and to de-idealize and forgive their mothers. Curative factors within group therapy or self-help groups included feeling supported and understood by others struggling with the same feelings, and owning their feelings without shame or fear.

As out-of-therapy experiences were rated as important as in-therapy experiences, Beresin (1985), as does Maine (1985), assumes that recovery involves an interaction of both types of curative factors. Personal experiences of self which facilitated recovery include getting bored with anorexia, expressing feelings to others, gaining a sense of independence through a rebellious act, self-acceptance and letting go of perfectionism, and finding an identity other than that of being an anorexic. Interpersonally, individuals reported that being a mother increased self-worth and that intimate sexual relationships helped one to take pleasure in rather than be ashamed of her body. And, individuals began to feel a greater sense of achievement and satisfaction through school and career pursuits

rather than through food and weight. Finally, individuals reported that body image was the most difficult aspect to change as well as obsessive thoughts and behaviours pertaining to food and weight. And, recovery involved "retaining excessive concern about food and weight but no longer being obsessed by them" (Beresin, p. 12). In summary, while Beresin's (1985) study gave some insight into the meaning of the curative factors and attempted to sketch a pattern of recovery, knowledge of the recovery process is limited.

Unlike the studies of recovering or recovered bulimics and anorexics (Beresin, 1985; Hall & Cohn, 1986; Hobbs et al., 1989; Kirk, 1986; Stanton et al., 1986), Maine (1985) elucidated more fully the meaning and impact of the curative factors for individuals and began to outline a more complete pattern of recovery. Maine's study suggested that recovery involved an initial awareness of personal responsibility and self-motivation for getting better. Despite warnings from medical staff and family members regarding the severity of their disorder, individuals actively decided to recover only when they had panicked at the realization that they did not have the strength to walk or the ability to eat. This self-responsibility paved the way for recognition of distorted thinking patterns.

Feeling validated within a therapeutic relationship was another essential agent in recovery. A validating, affirming, and accepting relationship with a therapist provided a sense of unconditional acceptance so that they could relinquish perfectionistic tendencies for gaining acceptance and allow

themselves to experience opportunities for "self-exploration, sharing, intimacy, and interdependence . . . [which] were qualitatively different from their lives in their families" (Maine, 1985, p. 51). This foundation of respect and intimacy gave individuals the confidence to trust others enough to reach out to them. Finding companionship more rewarding than being isolated spurred individuals to improve their health and nutrition so that they could maintain their relationships.

Similarly, informal supportive relationships with extended family and friends was cited as a major factor that was facilitative of recovery. Unlike the anorexics' families who were relating only to their disorder and insisting that they eat, supportive others provided affection and self-worth by "[treating] them as whole people and [giving] acceptance and encouragement" (Maine, 1985, p. 51) in a non-judgmental and non-threatening manner. Consequently, feelings of loneliness, isolation, and self-doubt decreased and a sense of control and autonomy rather than powerlessness was fostered. As a result, individuals were often able to eat within these relationships and to hear the concern regarding their physical functioning.

Acceptance of the difficulties within the family system and the pressures from the sociocultural system were also essential in the recovery process. Initially, individuals gained insight into family communication patterns and roles, acknowledging their impact on their lives. As they came to accept that they could not change their families by losing another pound, they recognized that they could only change themselves. So, instead

of using food to express emotions and unmet needs, individuals accepted themselves and the fact that they had to fill their own needs. As a result, they began to move away from their self-destructive symptoms and live more fully. Likewise, as the individuals accepted the cultural system with its emphasis on slimness, "they recognized their dieting as a futile attempt to be perfect, to deny their feelings, and to gain control over their lives" (Maine, 1985, p. 52). This realization engendered self-acceptance, self-esteem, and more realistic goal-setting.

Finally, given that factors both inside and outside of formal therapy were reported as facilitative of recovery, the results of Maine's (1985) study imply that the curative factors are not limited to those inside of formal therapy. Furthermore, the pattern of recovery underscores the synergetic interaction of curative factors both inside and outside of formal therapy.

Summary

Upon comparing the assumptions regarding recovery purported by the treatment outcome studies and studies on therapeutic-change agents, several common perspectives are apparent.

According to the Random House College Dictionary (1975), recovery is defined as "restoration or return to health or a normal condition, as after sickness or disaster" (p. 1104). Within the CB studies, this perspective on recovery was most salient as emphasis was placed on reestablishing control over eating behaviours. The therapeutic change agent studies also proposed that recovery entailed reinstituting a previous level of functioning purporting that the curative factors were "essential

to the progression toward health-restoration and recovery" (Maine, 1985, p. 51).

However, like the psychodynamic and family therapy studies in which prior optimum levels of intrapsychic and interpersonal functioning were not assumed, the CB studies acknowledged that thinking patterns needed to be challenged. Furthermore, Maine (1985) identified factors such as a validating relationship which fostered intimacy and interdependence that were not previously part of individuals' interpersonal relational styles. Therefore, the psychodynamic, family systems, and cognitive-behavioural approaches and some of the therapeutic change agent studies suggested that the recovery process was future-oriented and developmental. Thus, while recovery was viewed as a rehabilitation process to restore individuals to a previous level of functioning, psychosocial development and moving beyond the prior developmental stage was also inherent in most of the studies.

My Presuppositions

Concerning my presuppositions on the definition and nature of recovery from bulimia, since all of the DSM-III R (1987) criteria must be met for a diagnosis of bulimia nervosa, an individual is by definition recovered from bulimia if she does not meet any one of the criteria (see Appendix A). Furthermore, since the usual course of bulimia in clinic samples "is chronic and intermittent over a period of many years" (DSM-III R, 1987, p. 68), I adhere to Johnson and Connor's (1987) suggestion of at least a one-year posttreatment period in which the individual

reports either abstinence from bingeing and purging, or no relapses wherein relapse is defined as "perceived loss of control" over eating behaviours (Brownell et al., 1986, p. 766).

I concur with Schwartz et al. (1985) who view bulimia as "a rigid and extreme pattern of thinking, feeling, and relating to others: a self-image and a life orientation that develops in certain family and sociocultural contexts" (p. 280). Furthermore, the functioning of the bulimic's life context and her bulimia are maintained by an interplay of biological, intrapersonal, interpersonal, and sociocultural factors (Schwartz et al.). Given that bulimia is a psychosomatic disorder whereby the behavioural symptoms of bingeing and purging are a manifestation of underlying biopsychosocial factors, I subscribe to the "two-track approach" to treatment in which both the disordered eating behaviours and factors maintaining them are addressed (Johnson et al., 1987; Manley, 1989; Schwartz, 1982; Schwartz et al.).

This two-track approach evolved from poor outcome results when only one treatment approach was used. For instance, "high relapse rates were being reported in behavioural treatments that focused on target symptoms without regard to underlying dynamics" (Johnson et al., 1987, p. 668). And in psychodynamic treatment with no active symptom management, disturbed eating behaviour resulted in life-threatening side effects as underlying conflicts and issues were not satisfactorily resolved. In addition, this therapeutic stance, with its de-emphasis on the eating problems, often re-created for individuals their "early experience of

feeling that they were expected to meet their narcissistic parents' needs and that their specific, individual needs were neither seen nor attended to" (Goldman, 1988, p. 565). Thus, I believe that abstinence from bingeing and purging is enhanced when the change mechanisms inherent in the psychodynamic, family systems, and cognitive-behavioural approaches are integrated into an individualized approach. Therefore, I view recovery as involving changes in eating behaviours as well as improvements in the specific realms which perpetuate the bulimic behaviours for each individual: dysfunctional beliefs about shape and weight, unresolved emotional conflicts, and interpersonal patterns of relating. Also, these changes may occur through both formal therapeutic mechanisms and out-of-therapy experiences. Although the factors which precipitate bulimia are not necessarily the factors which maintain it, the etiological theories assume that the precipitating factors are also the factors involved in recovery. Therefore, knowledge of the incidents involved in the onset of one's bulimia may provide some insight into the recovery process.

Finally, I believe that spiritual changes may also be an aspect of recovery. The spiritual dimension of individuals includes one's awareness of God as each person understands Him, meaning and purpose in life, and values such as hope, compassion, and justice (Chapman, 1987). As Cassell (1976) says, through the experience of ill physical health and recovery, the client's sense of meaning in life will change which may result in changed values and priorities.

In summary, my presuppositions on the nature and process of recovery from bulimia are:

1. An individual is by definition recovered from bulimia if she does not meet any one of the DSM-III R (1987) criteria for bulimia nervosa.

2. Abstinence from bingeing and purging or freedom from relapse is enhanced when the change mechanisms inherent in the psychodynamic, family systems, and cognitive-behavioural approaches are integrated into an individualized approach (Herzog et al., 1987; Johnson et al., 1987; Manley, 1989; Steiger, 1989).

3. Recovery involves changes in eating behaviours as well as improvements in the specific realms which perpetuate the bulimic behaviours for each individual: unresolved emotional conflicts, interpersonal patterns of relating, and dysfunctional beliefs about shape and weight (Johnson et al., 1987; Manley, 1989; Schwartz, 1982; Schwartz et al., 1985).

4. Behavioural and psychosocial changes may occur through both formal therapeutic mechanisms and out-of-therapy experiences (Maine, 1985).

5. Recovery may also entail spiritual changes pertaining to one's awareness of God as each person understands Him, meaning and purpose in life, and values of hope, compassion, and justice (Chapman, 1987).

In using the existential-phenomenological approach to examine the meaning of the phenomenon of recovery from bulimia from the co-researcher's perspective, it is imperative for the researcher to be disciplined in guarding against the interference

of personal biases. Therefore, by stating my presuppositions at the beginning of the present study, I attempted to minimize the influence of my biases during the interview and analysis process in order to ensure a faithful and objective expression of the phenomenon.

Chapter III

Methodology

This chapter summarizes the existential-phenomenological approach to human experience and outlines subject selection and research procedures. Although the phenomenological approach served as a starting point, the focus of this study shifted from simply looking at the meaning of the phenomenon to articulating a more coherent conceptual understanding of the process of recovery from bulimia.

Design

As the purpose of this study is to understand the meaning of the event or phenomenon of recovery from bulimia, the existential-phenomenological approach as described by Colaizzi (1978) was employed as a guideline for examining the recovery experience. This approach with its emphasis on understanding the meaning of phenomena as they are lived is derived from existentialism and phenomenology. Existentialism views human experience in the world as significant, and as "legitimate and necessary content for understanding human psychology" (Colaizzi, p. 52). Phenomenology identifies and describes phenomena as they are lived and experienced by the individual in the world. Phenomena can be facts, events, occurrences, or experiences (Stein, Hauck, & Su, 1975). Existential-phenomenological research seeks to understand human experience in a manner that is free from the splits between subject and object, experience and behaviour, and linear cause and effect (Colaizzi). Since existential-phenomenological psychology views the individual and

the world as interdependent, people are not merely acted upon by outside forces. Instead, they are partly active and partly passive: They are confronted with situations in the world within which they are free to make choices (Valle & King, 1978).

As the existential-phenomenological researcher seeks to understand the phenomenon, she or he "thinks meditatively (Heidegger, 1966) about its meaning" (Colaizzi, 1978, p. 68) by asking, "How does the individual experience recovery: What does recovery involve?" The totality of the person should be explored: "his [or her] perceptions and cognitions, emotions and attitudes, history and predispositions, aspirations and experiences, and patterns, styles, and contents of behavior" (Colaizzi, p. 70). As variations of the phenomenon are described by different individuals, the researcher looks for the common pattern or structure of human experience which reveals itself as the meaning of a human experience. With careful reflection on the individuals' experiences, the meaning is thoroughly described and disclosed by the researcher after having been verified by the individuals.

However, before the information is analyzed, the phenomenological perspective advocates that human experience be investigated objectively by faithfully expressing whatever phenomenon is present. The researcher listens respectfully "to what the phenomenon speaks of itself" and refuses "to tell the phenomenon what it is" (Colaizzi, 1978, p. 52). Being "content to understandingly dwell" (Colaizzi, p. 68), the researcher does not seek to control or dominate the information that is

encountered. In order to adopt this stance and guard against the interference of personal biases, one's presuppositions must be clearly stated or bracketed at the beginning of and throughout the research process.

Finally, this type of dialogal research "takes place only among persons on equal levels, without the divisiveness of social or professional stratifications" (Colaizzi, 1978, p. 69). Thus, Friere (cited in Colaizzi) uses the term "co-researchers" (p. 69) in lieu of researchers and subjects. Furthermore, since co-researchers disclose their personal presuppositions, full participation in the research requires relating as persons within a milieu of trust.

Co-researcher Selection

Co-researchers were volunteers, 19 years or older, who were recruited through advertisement notices (see Appendix F) placed at Simon Fraser University, Burnaby, B.C., The University of British Columbia, Vancouver, B.C., and Vancouver community centres. Notices were also placed in two Vancouver community newspapers--The Courier and The West Ender--and in Kinesis, a local newspaper sponsored by the Vancouver Status of Women. In addition, therapists working with eating disordered clients were contacted by phone and sent a contact letter explaining the nature of the study (see Appendix D) and letters for potential participants (see Appendix E).

According to Colaizzi (1978), the necessary and sufficient criteria for selecting co-researchers are "experience with the investigated topic and articulateness" (p. 58). Therefore,

selection criteria included: (a) a previous diagnosis of bulimia nervosa as defined by DSM-III R (1987) (see Appendix A), (b) no previous history of anorexia nervosa as defined by the DSM-III R (see Appendix B) or dual diagnosis of anorexia nervosa and bulimia nervosa, (c) a significant period of time without any behavioural symptoms of bulimia, (d) a self-reported feeling of being genuinely recovered from bulimia, and (e) an ability to articulate their experience of recovery and elaborate on their descriptions.

In order to guard against "symptom transformation" (Vognsen, 1985) in which bulimic symptoms are replaced by other active psychological problems--such as drug or alcohol abuse, depression, obsessive-compulsive disorder, or impulsive behaviours like shoplifting, promiscuity or self-mutilation--a sixth selection criterion was added. This criterion states that since having recovered from bulimia, the individual has not developed psychological problems which meet the DSM-III R (1987) criteria for other major psychiatric disorders on Axis I.

As I screened the telephone calls of potential co-researchers, further specification of the third criterion--a significant period of time without any symptoms of bulimia--was required. While my co-researchers needed temporal closeness to their recovery experience in order to recall significant details, they also needed enough distance to have a holistic perspective on it. However, several issues arose related to the amount of time which constituted a significant period free of bulimic symptoms. First, no definitive time period is stated in the

literature: Johnson and Connors (1987) suggest at least a one-year posttreatment period in which the individual reports either abstinence from bingeing and purging or no relapses; Herzog, Franko, and Brotman (1989) recommend at least 18 months; and Brownell et al. (1986) propose a 3-year period. Second, as complete abstinence is difficult to maintain, Brownell et al. (1986) differentiate between relapse and lapse: Relapse is defined as "perceived loss of control" and lapse is "a slip or mistake" (p. 766) in which control over eating behaviour is not completely lost. Therefore, even if an individual has lapsed, she is still considered free of bulimic symptoms provided she feels she has not relapsed. Therefore, when an individual telephoned and reported a 3-month period of abstinence, she was excluded from the study because she didn't meet the minimum one-year posttreatment period.

Once I felt that a caller fit all the selection criteria, we met together so that I could more fully describe the purpose of the research project, what their participation in the study would involve, and the research methodology. During this initial informal meeting, I explained to each co-researcher that although I had not had an eating disorder, my interest in recovery was sparked by having counselled women who were asking how they could recover from bulimia. With research studies providing neither a holistic understanding of the recovery process nor its meaning for the individual, I was inspired to seek out knowledge that would assist the practitioner and client to more fully grasp the process of recovering from bulimia so that the conditions which

facilitate recovery could be maximized. Since the four individuals had been recruited through advertisement notices and therefore had not received the contact letter to the volunteer (see Appendix E), I gave each person a copy. Referring to the letter, I explained that after an initial prescreening interview with Dr. E. M. Goldner, she would have an audiotaped interview with myself in which she would be asked to describe her recovery experience in as much detail as possible. Furthermore, she could use other relevant sources of information such as personal journals or photographs during the interview. We would then meet several more times to verify the transcribed interview and themes, and the final narrative account.

In order to ensure that each woman was distant enough from her recovery experience to be able to see it as a whole but also close enough to remember significant details, we informally discussed some of the turning points in her recovery process. One of the women--L. S.--regretted that she had not kept a personal journal to facilitate recall of individual therapy sessions and she wondered about accessing the records kept by her therapist. After encouraging each woman to ask any questions she might have, verifying that each individual was still interested in being a co-researcher, and establishing that we both felt comfortable working with each other, the individual read and signed the consent form (see Appendix G).

A prescreening interview time was then arranged for each potential co-researcher with Dr. E. M. Goldner who is a psychiatrist and eating disorder expert in the Eating Disorders

Clinic at St. Paul's Hospital, Vancouver, B.C. The purposes of this screening interview were to verify that co-researchers had a previous diagnosis of bulimia nervosa as defined by the DSM-III R (1987) with no previous history of anorexia nervosa, to assess the current status of their eating behaviour, and to ensure that they exhibited no significant indicators of other major psychiatric disorders on Axis I of the DSM-III R since having recovered from bulimia. Within this study, since all of the DSM-III R criteria must be met for a diagnosis of bulimia nervosa, if an individual does not have any one of these criteria she is by definition recovered from bulimia. None of the co-researchers were previous treatment contacts of Dr. Goldner.

During the half-hour, unrecorded screening interview conducted at St. Paul's Hospital, Dr. E. M. Goldner asked the following semi-structured questions in a straightforward manner, clarifying responses and asking for elaboration as necessary:

1. Describe the course of your eating behaviour beginning from when you first noticed any eating problems and ending with a description of your present eating pattern.

2. Specifically describe your weight history; history of binge eating, vomiting, food restriction, laxative use; menstruation; body image disturbance; mood; substance abuse.

Dr. E. M. Goldner noted the individuals' responses on the prescreening interview summary sheets (see Appendix C), contacted me by phone to elaborate upon the interview information, and mailed me the summary sheets. Based upon his assessment, Dr. Goldner was satisfied that each individual met the criteria of

having recovered from bulimia nervosa and did not qualify for any psychiatric disorders on Axis I as defined in the DSM-III R (1987).

However, the acceptance of one co-researcher--P. Y.--was initially questionable as she met the DSM-III R (1987) criteria for Late Luteal Phase Dysphoric Disorder, commonly referred to as Pre-Menstrual Syndrome. But after Dr. E. M. Goldner realized that this disorder was described in the Appendix of the DSM-III R--meaning that it was not yet considered an accepted psychiatric disorder--he verified that P. Y. met the selection criteria. During her interview, P. Y. referred to the uncertainty surrounding her inclusion in the study saying, ". . . even though he [Dr. Goldner] didn't think that I was gonna be able to be a part of this study" (Appendix J, p. 201).

Once the four co-researchers had been selected and interviewed, other background information arose as each woman told her recovery story. So, while the following demographic information was not part of the co-researcher selection criteria, I culled these facts from the protocols in order to provide a context for more fully understanding each woman's recovery experience. At the time of the initial interview, the ages of S. T., L. S., P. Y., and S. H. were respectively early forties, early thirties, early thirties and early twenties. As reported to Dr. Goldner, S. T., L. S., and P. Y. had been free of bulimic symptoms for the past 4 to 5 years; S. H. reported a 2-year length of abstinence from bingeing and purging. The duration of bulimia was 27 years for S. T., 10 years for L. S., 2 years for

P. Y., and 6 years for S. H. The recovery period--the time span from the first inklings of change to the cessation of bulimic symptoms--was respectively 19 years, 8 years, 6 months, and 5 months for S. T., L. S., P. Y. and S. H.

Procedure

Having established that the four individuals fulfilled the criteria for inclusion in the study, each was contacted by telephone to arrange an interview time. The interviews took place in the co-researchers' homes during July, August, and September of 1990. The interviews were not time limited and each co-researcher was encouraged to speak for as long as she wanted (Colaizzi, 1978). Therefore, the length of the interviews varied: 1 hr 50 min, 2 hr 10 min, 2 hr 35 min, and 2 hr 7 min.

Prior to the tape recording of each interview, my co-researcher and I spent some time establishing rapport and I answered any questions about the format of the interview or the study in general. Once she was ready to begin, I read the following preamble off an index card:

> The purpose of this study is to gain a more complete understanding of the experience of recovery from bulimia by exploring what it means to women who have recovered. Together we're searching for a deeper understanding and you have personal knowledge about this experience. As you tell me your story in as much detail as possible, try to remember what you were thinking, feeling, and doing at the time. I'd like you to describe your recovery experience beginning from when you first noticed inklings of change, continuing with experiences that facilitated recovery, and ending with a description of your life at the present time. As you speak, I'll reflect your thoughts and feelings, and ask questions to clarify and elaborate upon what you're saying. Do you have any questions?

The interview format was unstructured so that the co-researcher could recount her story freely and in an unbiased

manner, without my asking leading questions. As she spoke, I reflected her thoughts and feelings, clarified statements, and asked probing questions in order to more fully elicit the meaning of events for her. In order to check the possibility of asking specific questions in order to validate my assumptions about the meaning of the recovery experience, I bracketed my presuppositions (see Chapter II) and so stayed with her experiences by "[respectfully] listening to what the phenomenon speaks of itself" (Colaizzi, 1978, p. 52). In essence, I adopted Sheridan's stance of imaginative listening (cited in Colaizzi) in which I was "totally present to . . . [her]" (p. 64) and "attentive to . . . [her] nuances of speech and gestures" (p. 62).

At the end of the interview, I summarized the essence of the session with the co-researcher as a means of verifying the information and any inconsistencies were explored. I also asked specific research questions which were based on my presuppositions about the meaning of the recovery experience (Colaizzi, 1978). Not all of the following questions needed to be asked at the end of the interview since some were addressed by the co-researchers as they told their recovery stories and some were asked during the interview when it seemed appropriate. The research questions are as follows:

1. Did you share your experience of bulimia or recovery from bulimia with others? If so, what was important about this?

2. Was there anything else that would have helped you in your recovery process?

3. When and how did you know that you had recovered from bulimia?

4. In comparison to when you were bulimic, do you feel you are different now either intellectually, emotionally, socially, or spiritually? If so, how do you account for these changes?

5. Describe the events which played a role in the onset of your bulimia.

6. Would you like to clarify or add anything else to your recovery story?

After the interview, I transcribed the audiotape verbatim in order to preserve the cadence and tone of the dialogue. In order to maintain confidentiality, any identifying information in the transcripts was anonymously presented by substituting initials for names. Each co-researcher was then given the opportunity to read the typed transcript for clarification or addition of further information.

I used Colaizzi's (1978) existential-phenomenological approach to analyze the transcripts in order to elucidate the themes or patterns of meaning of the recovery experience. During the analysis process, it became apparent that information from two of the four transcripts lacked richness and depth. Consequently, only the two more comprehensive transcripts of L. S. and P. Y. were analyzed. Themes were formulated from L. S.'s transcript as it was the most detailed. Statements from P. Y.'s transcript served to cross-validate the findings.

In September 1991, my co-researcher, L. S., and I met for 1 hr 45 min to validate the themes and clusters of themes. I

consulted her for wisdom as to whether the phrasing of the themes accurately described her experience and whether there were any errors of omission or commission. Based upon her feedback, I made the necessary revisions so that the description of the pattern of the recovery experience was an accurate and complete account of her experience.

Analysis

In analyzing the co-researchers' transcripts or protocols, I used Colaizzi's (1978) existential-phenomenological approach as a guideline to explicate the meaning of the recovery experience. The following steps outline the process of analysis.

1. I reread the typed protocols "in order to acquire a feeling for them, a making sense out of them" (Colaizzi, 1978, p. 59).

2. Beginning with the richest and most comprehensive protocol, I extracted significant phrases or sentences which pertained directly to the experience of recovery from bulimia. Repetitious statements within a protocol were eliminated. The significant statements from each protocol were written on coloured index cards representative of each co-researcher.

3. I formulated the meaning of each significant statement by making the implied meaning explicit. Creative insight was involved in moving beyond what the co-researchers said "to what they [meant]" (Colaizzi, 1978, p. 59) while still staying with the original information. In order to optimally "allow the data to speak for itself" (Colaizzi, p. 59), the co-researcher's own words were used whenever possible. Once a meaning was

illuminated, I wrote the words on a label which was affixed to the corresponding statement on the index card. Cards with the same or similar meaning-labels were filed together and I tried to keep them in their narrative order as much as possible.

4. After each theme was formulated from the meaning of significant statements in L. S.'s protocol, I referred back to the original protocol in order to ensure that the themes completely and accurately described the experience contained in the transcript. I then listed the themes and their descriptions (see Chapter IV). In order to cross-validate these findings, corroborating statements from P. Y.'s transcript were noted after the description of each theme.

5. The themes were then organized into clusters of themes according to their meaning for the co-researcher. The clusters corresponded approximately to the order in which the co-researcher experienced them. Validation of the clusters occurred by referring again to the original protocol.

6. I returned to the first co-researcher, L.S., for validation of the accuracy and appropriateness of the wording of the thematic categories.

7. As the clustered themes provided an exhaustive description of the experience of recovery from bulimia which clearly identified the structure of the experience in a chronological and unified manner, I omitted Colaizzi's (1978) step of compiling the theme descriptions into a narrative.

8. I summarized my exhaustive description of the recovery experience into a condensed outline of the clustered themes which

succinctly and clearly reveals the meaning or fundamental structure of the experience (see Chapter IV).

Chapter IV

Results

Interviews

At the beginning of each interview, my co-researcher and I spent some time establishing rapport in order to facilitate disclosure of her story in as much detail as possible. A sense of mutual rapport occurred quickly as a foundation had already been laid by prior telephone calls and our initial introductory meeting. Furthermore, our working relationship was enhanced by our common goal of searching for further knowledge that would assist other women to overcome bulimia.

While I did not select my co-researchers according to the nature of the events which facilitated recovery, their stories revealed a wide variety of helping contexts: individual outpatient therapy, eating disorder support groups, and informal therapeutic relationships. As each woman spoke, her authentic tears, the intensity of her voice and the attention paid to details indicated that she was emotionally involved in reliving her experience. P.Y.'s comment--"You remember a lot of things just talking about it" (Appendix J, p. 244)--was another indicator of being personally involved during the interview. The importance of reflecting upon the recovery experience was expressed by 3 of the co-researchers. For instance, S.H. wanted more insight into why her recovery process unfolded as it did, S.T. desired a deeper understanding of recovery because she wanted to work in the eating disorder field, and P.Y. was curious to compare her experience and present state of recovery with

others' stories.

While all of the women had disclosed their eating disorder to others either during or after recovery, none had recounted their recovery story in as much detail as they did during our interview. In fact, S.H., S.T., and P.Y were surprised that they had approximately 2 hours worth of information to relate! At the end of our interview, P.Y. said, "That's the most I've ever said about it in my whole life (laugh)" (Appendix J, p. 245). Throughout the interviews, I was awed by each woman's personal investment and openness in relating information. I left each co-researcher's home feeling closer to her than when I had first entered and I felt honoured to have been privy to such a secretive and tender part of each one's life.

According to Colaizzi (1978), dialogal research facilitates "existential insight" by allowing "the co-researchers to illuminate existential dimensions of their lives which previously could not be facilely questioned but which now can be interrogated and hence ratified, rejected, or modified" (p. 69). During a telephone conversation with S.T. in which I was updating her on the progress of the study, she commented that after having told her recovery story she realized that she was a strong person to have overcome so many addictions. For P.Y., her sense of being genuinely recovered from bulimia was strengthened as she recounted her recovery experience: She realized that her increased sensitivity towards balanced meals and a range of acceptable weights were healthy attitudes and not indicators of being overly concerned about body shape and weight.

None of my co-researchers mentioned referring to personal journals or other tangible sources of information in preparation for our interview, and during the interview they spoke spontaneously without any outside resources. Given the shame and secrecy associated with bulimia, it is understandable that the fear of others possibly discovering their eating disorder by happening upon personal journals would serve as a deterrent to writing down such information. Each co-researcher seemed distant enough from her experience to have a holistic perspective on it, and yet also close enough to vividly recall significant events. Of course, there were instances when the women with relatively longer recovery periods--L.S. and S.T.--expressed that their memory of certain events or the sequence of events was sketchy. Nonetheless, their clear memories of certain critical events enhanced the understanding of aspects of the recovery experience that the other women had also described. For instance, although L.S. felt that her recounting of her therapy sessions was not complete, she was articulate about what behavioural strategies she had implemented to gain an increased sense of control over her bulimic symptoms. She was also clear about the process of change in her thoughts, feelings, and actions pertaining to food, eating habits, and body image. Also, L.S.'s story provided a deeper understanding of how disclosing one's bulimia to others enhances motivation and commitment to change.

Concerning the sequencing of interview questions, in the first two interviews with S.H. and S.T., rather than asking them to begin their recovery story at the point when they first

noticed inklings of change with respect to their bulimia, I asked them to first describe the events which contributed to the onset of their bulimia and then to continue recounting their recovery experience. I asked my questions in this sequence as I felt that recall of events would be facilitated by chronologically relating one's experience with bulimia, and because one of my presuppositions was that the precipitating factors are often the factors involved in recovery. And although L.S. confirmed that "chronological progression . . . is easier . . . to remember things in" (Appendix H, p. 143), I felt that the richness and depth of the recovery events were compromised in the interviews with S.H. and S.T. because after discussing the precipitating events they had less energy to fully relate the core of their recovery experience.

Consequently, in the subsequent interviews with L.S. and P.Y., we began at the point when they first noticed inklings of change, and the precipitating events were addressed either during the interview as they arose or at the end of the interview. From reading the protocols of L.S. and P.Y., the details of the recovery events were qualitatively richer than those described by co-researchers S.H. and S.T.

In spite of having realized the importance of initially addressing the recovery question beginning from when changes were first noticed, my tendency towards chronologically related stories is particularly evident in P.Y.'s protocol. Although she immediately begins her story at the point of first being aware of some change, I focus in on information prior to this experience

by asking, "Can you just sort of fill me in who Dr. B. is, and how . . . you got to see him and sort of tell him about things, and then how all this came about?" (Appendix J, p. 190). Although we eventually came back to address the initial change experience, the interview environment could further facilitate the understanding of recovery by more closely following the co-researchers' leads.

With respect to the co-researchers' perceptions of the beginning of the change process, the stories of L.S. and P.Y. are diverse. For L.S., the first inklings of change occurred when she realized that her bulimia was controlling her life and interfering with school activities. She continued on with describing changes related to eating behaviour: stabilization of frequency of bingeing and purging, delaying bulimic behaviours, and eventually some decreased frequency of bingeing and purging. L.S. marked the beginning of the "actual recovery" (Appendix H, p. 160) period at the point where the frequency of her bingeing and purging began to diminish steadily and she realized she had enough control to eat dinner without bingeing or purging. In contrast, the first inklings of change for P.Y. were indicated by a decreased frequency of purging followed by a decrease in the size of binges.

As the interview became focussed on the time following decreased frequency of bingeing and purging, each co-researcher became less descriptive about events. P.Y.'s statement is representative of how the co-researchers initially referred to this phase of the recovery process: "And I can't remember how

long a time it was though until I stopped completely" (Appendix J, p. 190). P.Y. also illustrates how this phase of the recovery period with its specificity of details over a gradual period of time required more reflection for the co-researchers. She says,

> So like part of it [the factors which contributed to decreased bingeing and purging] was the support, and part of it too was natural consequence, you know. If you take away the vomiting, then you have to deal with that horrible full feeling. And it's terrible. It just, you, it wipes you out for the rest of the day. So then the next time you binge, you tend to binge a little less. And, so the bingeing gets less just because you don't have that same way of getting rid of it. (Appendix J, p. 217)

Consequently, I found myself more intensely probing this aspect of the recovery experience in order to examine the occurrences as fully as possible. Once again, this observation underscores the importance of initially addressing the point when change was first noticed. Understandably, studying this phase of change is hard work and thus requires the optimal amount of time and emotional energy.

As I began analyzing the transcripts, it became apparent that one of my specific research questions--What else would have helped you in your recovery?--did not provide statements directly pertinent to recovery. Nonetheless, I would still include this question in future interviews as it provided an opportunity for co-researchers to summarize and bring closure to their recovery story, and then move beyond it to the future. For example, after L.S. said that she wished she had attended more of the ANAD support group meetings, she mused about possibly being involved in them now so that she could share her experience and learning to perhaps "help somebody get through it [bulimia] more quickly"

(Appendix H, p. 182).

From Transcription to Formulation of Themes

I found the transcribing of each co-researcher's audiotape to be a very demanding process. I spent approximately 2 weeks transcribing each tape. With each transcription, I found myself deeply involved both emotionally and intellectually. As I relived each recovery story, I began to connect more deeply with each woman's experience and to reflect upon my own life experiences as I was reminded of them. During this transcription process, the meaning of many statements became clear to me and I wrote the words in the margin.

Although I had listened to the tapes twice and felt quite familiar with each co-researcher's story, I found the process of extracting significant statements onto index cards and formulating their meanings to be physically demanding but also intellectually stimulating as I thought about how each event was a part of and contributed to the co-researcher's recovery experience. After completing this process with the transcripts of L.S. and P.Y., I felt excited and satisfied as aspects of recovery that were common to both women began to emerge.

As I began to formulate themes from the meanings common to both co-researchers, it became apparent that L.S.'s statements provided a more comprehensive description of the themes. Statements from P.Y. confirmed aspects of L.S.'s experience. Consequently, themes were formulated only from the meaning of L.S.'s significant statements and the corroborating statements of P.Y. were noted after the description of each theme.

Formulating the themes and describing them required both intense concentration and intuition as I continually checked back to the original protocol to ensure that the themes fully described the co-researcher's experience. I was assisted in this process by an experienced Public Health Nurse who confirmed or helped me refine my description of the themes. With my first attempt at formulating themes, I described very precise aspects of the recovery experience such that genuineness, risking, and unconditional acceptance were separate themes. However, with this precision the thread of the experience seemed lost. After reviewing the protocols and re-thinking the themes, I saw that several themes could be viewed as aspects of a single theme. For instance, being genuine and taking risks resulted from feeling unconditionally accepted. This revision of themes provided a more coherent and illuminating understanding of the recovery experience.

The Validation Interview

Before returning to my primary co-researcher, L.S., for validation of the themes and clusters of themes, I noted any themes that I particularly wanted to check the phrasing of. As she read the themes and significant protocol statements to herself, I asked her to note any changes, additions, or comments she wanted to make and to indicate whether the pattern of recovery fitted her experience.

L.S. carefully read the description and ensured that the themes were correctly clustered under the four categories. She underscored the importance of Theme A2 which emphasized the

causal link between feeling increasingly controlled in an interpersonal relationship and an increase in bulimic behaviours. L.S. also clarified the meaning of one of her statements in Theme B2 pertaining to the impact of potentially feeling ashamed if she didn't follow through on changing her eating behaviour while she was in therapy. I rephrased the sentence in accordance with her feedback. We also discussed the positioning of Theme C5--Awareness of relapse--under Cluster C: Awareness of evolving self and changes in eating behaviours. L.S. felt that Theme C5 could fit under Cluster B--Openness and readiness for change--if the emphasis was placed on how her relapse propelled her to seek treatment again. However, she verified that the placement of the theme was accurate because her awareness of having relapsed also reminded her that she had made some changes and was previously more involved in life than she currently was.

Overall, L.S. felt that the pattern of recovery was an accurate description of her experience. She also stated that the outline of the themes "helped clarify the process better for [her]" (Appendix K, p. 247). She noted that aside from her initial querying of Theme C5, the clustering of themes seemed appropriate and intuitively fitted the chronology of her experience of recovery. From our validation meeting, I felt assured that my articulation of the process of L.S.'s recovery experience was accurate and appropriate.

Clusters of Themes and Significant Protocol Statements

This section presents a condensed outline of the clustered themes. Clusters emerged as themes with related meanings became

evident. While some themes such as an increasing sense of efficacy reappeared throughout the recovery experience, a clear chronological pattern was apparent. An exhaustive description of the developmental process inherent in the experience of recovery follows the condensed outline. Based upon the meaning of the significant protocol statments, the themes are described in an atheoretical manner which accurately reflects the co-researcher's experience as she and I understood it. Consequently, the interpretation of the results may be described differently by others.

Condensed Outline of Clustered Themes

A. REALIZATION OF EATING PROBLEM AND AMBIVALENCE ABOUT CHANGE

1. Awareness of an eating problem.
2. Awareness of the association between one's eating problem and emotional issues.
3. Diagnostic awareness of one's eating problem.
4. Acknowledgement of need for outside help.
5. Awareness of obstacles to action.

B. OPENNESS AND READINESS FOR CHANGE

1. Breaking the secrecy.
2. Disclosure of bulimia to therapist.
3. Remission.

C. AWARENESS OF EVOLVING SELF AND CHANGES IN EATING BEHAVIOURS

1. Increasing sense of efficacy.
2. Interruption of eating patterns.
3. Symptom substitution.
4. Increasing intimacy with self and others.

5. Awareness of relapse.
6. Separation of self from bulimia.
7. De-idealizing and forgiving family of origin.
8. Verbally acknowledging bulimic behaviours.
9. Permission to eat previously forbidden foods and to feel full.
10. Identification with and acceptance by other bulimics.

D. EMERGENCE OF A NEW SELF AND NEW VALUES

1. Accountability to significant others.
2. Responsibility for offspring.
3. New appreciation and understanding of her physical body.
4. Expanding sense of self and belief in self.

E. THE NATURE AND MAINTENANCE OF RECOVERY

1. Counting the cost of returning to the bulimic behaviours.
2. Processing lapses.
3. Increased self-knowledge and acceptance.
4. Authenticity with others.
5. Balancing work and play.
6. Altruism.
7. Certainty of recovery.

Exhaustive Description of the Recovery Experience

A. REALIZATION OF EATING PROBLEM AND AMBIVALENCE ABOUT CHANGE

1. Awareness of an eating problem.

She knows that something is seriously wrong with her eating behaviour because the frequency of bingeing and purging has

steadily escalated to the point where these behaviours are controlling and dominating her life. She feels desperate and powerless as she realizes that her daily activities and goals are compromised and thwarted because bingeing and purging consumes all her time and energy. (See Appendix J, #028 for P.Y.'s corroborating statement.)

> Well, I guess inside I'd always known that something was very wrong. But the, those 2 years of university saw a very steady um progression of it [bingeing and purging] such that by the end of my second year I just barely finished the year. You know, I guess I had to reach a point where I'd really hit bottom to realize that this [bingeing and purging] was probably the cause in that these activities were, were becoming the most important factor in my life. Uh, this, this sort of thing had taken over my life and that in order to continue doing anything I had to address it. (Appendix H, p. 132, #001)

2. Awareness of the association between her eating problem and emotional issues.

She realizes that her feeling of loss of control during eating episodes is more intense than the lack of control she experiences in other areas of her life. While she knows that her desire to control her weight is one reason why she binges and purges, she senses that these eating behaviours are somehow linked to feeling insecure about herself and not in control of her life. She becomes more clear about the connection between bingeing and purging and emotional issues when she sees that a worsening of her eating behaviours coincides with feeling more controlled in a relationship. She now knows that she is the one responsible for overcoming her bingeing and purging by addressing how she feels about herself.

> Well, I've always been um, not very happy with myself, not very secure in myself, and always eager to please others and

> to be led by others without much confidence myself. And, so in some ways I often felt as if I weren't in control of my life anyway. Um, but this [bingeing and purging] just was like a, a, that aspect intensified a hundred times. (Appendix H, p. 133, #003)

> So I guess I kind of knew that uh it [bingeing and purging] wasn't just a, a way to control weight: that the fact that I was involved with this meant, meant something more. I mean I knew that it was, it wasn't just the fact that I would eat and vomit. There was a, there was a reason for that, somehow, beyond just wanting not to be fat again. And I think, I realized that it was um, in some way connected to my feelings about myself and my lack of, of really feeling of control over myself, or wanting to have control, or feeling that I was worth um having control on so I could make something out of my life. And there were other factors in those 2 years of university that have intensified it in that I was in a relationship that wasn't, that wasn't a good one, um and I let myself be controlled by that person too. So you see they almost, as that relationship progressed so did the condition. So there were a lot of factors sort of pointing in the same direction that I had to uh, I knew I had to try and touch base with, with myself in some ways. (Appendix H, p. 133, #004)

3. Diagnostic awareness of her eating problem.

Knowing that her eating problem is a documented condition--bulimia--which other people have decreases her sense of isolation and deepens her acknowledgement that she has a problem. Since professionals are familiar with her problem, she feels hopeful about gaining a clearer understanding of it and getting some help to improve her eating behaviours. (See Appendix J, #027 for P.Y.'s corroborating statement.)

> But um, I was aware of it at that point; I knew it wasn't anorexia. And I knew that it was a documented condition. And that was itself kind of a relief: It's like other people do this, you know. So that was, I think it may have helped to know that there was a name for what I had, and that other people had it, and there may be some recourse. (Appendix H, p. 159, #030)

4. Acknowledgement of need for outside help.

Her bingeing and purging has paralyzed all areas of her

life. She feels defeated as she realizes she has "hit bottom". She knows that she needs some help to stop bingeing and purging so that she can engage in other activities. Although uncertain about whom to contact, she feels urged to get some outside support because her previous attempts at overcoming her bulimia have shown her that she is unable to stop bingeing and purging on her own. (See Appendix J, #029 for P.Y.'s corroborating statement.)

> And I think it was, it probably was the fact that things kind of came crashing down before I came home that summer after second year that made me realize, or it made me take that step of actually seeking help. And it was similar when I, when I went for therapy in V. (Appendix H, p. 151, #016)

> But actually stopping and saying, "Whoa, wait a minute, you know, there's something real wrong and it's me, and I need help." Because hitherto, and, and after that too, I would, you know, after a particularly bad period I'd say, "O.K."--and I think, I'm sure everybody does this--"This has got to stop! Dadu dadu dadu dada." And it would last, you know, overnight maybe, that resolution. And so the realization that I couldn't do it myself was important. And the fact that I had that support. (Appendix H, p. 144, #008)

5. Awareness of obstacles to action.

She is ambivalent about giving up her bulimic behaviours. Although she desires to be free of bingeing and purging, her commitment to relinquish them is low because they still serve some positive functions for her: a mechanism for escaping and reducing tension, and a part of her self-definition. Her reluctance to seek outside help is intensified because she is ashamed about disclosing her bulimia. Knowing that she must confront the underlying emotional issues in order to truly overcome her bulimic behaviours, she feels apprehensive about entering therapy a second time. She is terrified of confronting

her sense of emptiness and doubtful about her ability to deal with the pain that will be unleashed when she starts talking about her feelings about herself. (See Appendix J, #002 and #039 for P.Y.'s corroborating statements.)

> And it [bulimia], in some ways still, I didn't want to give it up. I guess maybe because it was, it was an escape, it was a release of tension, it was part of how I defined myself, it was a habit, it was you know a shameful thing to reveal: all of those things put together. (Appendix H, p. 161, #034)

> [When I contacted the therapist] I was terrified cause it was sort of like "well this is it again." Terrified in terms of, of to tell somebody about it. Terrified in terms of realizing that I'd have to start dealing with it; you know, the implications of that were, were great. [I would have to look at myself] . . . and could I do it? (Appendix H, p. 160, #032)

> Um, but I still, I don't think I was still yet at the point of truly being able to work through it. Like I wanted this thing to go away, I wanted to be O.K., but I didn't really want to put into it what I knew I would have to. Because on one level, I think I understand very well that the bulimia itself, it was just a set of symptoms, that there were, there were deeper things that were really causing all of that. Um, so. (Appendix H, p. 132, #002)

> Yes, um, because for me anyway, there was such a lack of um, like part of me was scared that if I did examine myself I wouldn't find anything there. You know, because I didn't have any real sense of myself or of no strong grounding in myself. So part of the running away from it was--running away from <u>dealing</u> with the bulimia--was the knowledge that I'd have to do self-examination and my god, what would, at this point, what would I find there? I mean there would be nothing, I didn't feel there'd be anything to work on. (Appendix H, p. 148, #014)

B. OPENNESS AND READINESS FOR CHANGE

1. Breaking the secrecy.

Although she is fearful about seeking help, her desperation propels her to begin searching out the necessary resources and people. Not knowing who to contact, she feels bewildered. With

much apprehension, she rehearses her request for help before she begins contacting Telephone Information, the Association of Anorexia Nervosa and Associated Disorders, a therapist, and a physician. With each successful contact, she feels progressively determined to find the appropriate therapeutic milieu and her self-confidence increases as she sees herself effectively taking action. Furthermore, as she discloses her secret to each resource person she gains more courage to face her bulimia. Her commitment to change and to actively participate in therapy grows. (See Appendix J, #026 for P.Y.'s corroborating statement.)

> So I called, the only thing, I didn't know what to do and I looked up "B" in the phone book. (Laughs.) There's nothing that says, you know, Bulimia Support Group or anything. So I called um, I think it's V. Information Number. And I just said, "Is there any number for, for, to help somebody with an eating disorder?" And she referred me to ANAD [Association of Anorexia Nervosa and Associated Disorders], and I called them, and I found out about the sessions. But still, it was at that point where I didn't really want to like come totally out of the closet. I knew I needed help, but I wasn't about to sort of announce it to everybody. But they also gave me the name of a therapist at that point, Dr. T. And I um called her and she managed to fit me in. (Appendix H, p. 160, #031)

> So it was a <u>very</u> frightening thing. It took me a long time to actually call Information. It took me, you know all these steps took quite a while. It's sort of getting up the courage, and I'd rehearse them over and over. (Appendix H, p. 161, #033)

> Yah, and that was hard. That was really hard. Um, and maybe you know in terms of your looking at the steps, I don't know how that, I don't, I don't suppose that could ever be overcome, that kind of um apprehension and the steps that need to be gone through. I think that's maybe part of the process is the actually getting yourself together enough to go through those steps. Maybe if it were easier people wouldn't be at a point where they'd actually be able to follow through on it. I don't know. (Appendix H, p. 162, #035)

2. Disclosure of bulimia to therapist.

As she discloses her bulimic behaviour to her therapist, she feels liberated from the captivity of her isolation which she created by hiding her secret. Feeling supported and accepted, she is relieved to address her secret rather than hiding and running from it. In examining her eating behaviour with her therapist, she experiences a sense of calmness as she steps back and begins to more clearly see what her bulimia is all about. She now feels accountable to someone else to take some constructive action. As she contemplates the shame associated with not actively participating in therapy, her sense of responsibility and commitment to changing her eating behaviour increases. (See Appendix J, #007, #030, #031, #032, and #033 for P.Y.'s corroborating statements.)

> And I think another important aspect of that [therapy] was the fact that you're breaking the isolation, breaking the secrecy and letting someone else in on it. It's, it's telling you know, it's realizing that you need the support. But it's also that by breaking out of that um circle of, of secrecy that you create, you're almost it's like letting a chink of daylight in. It's like, you know, it's a connection between sort of you and the outside world, in on, on who you are and your secret. And I, I believe very strongly that that's a vital part of it. At least it was for me. I know it was a vital part for me because in the subsequent therapy, I think the biggest step was taken when I told my husband about it, and the most difficult. So I think part of the reason that there was some improvement during that time was that I had told somebody else about it. I mean he [therapist] was the first person I told about it. And that, um, I, I would say that is very important. (Appendix H, p. 145, #009)

> [Disclosing my bulimia to my therapist was] Very positive. I mean that was real good. It's, you know, it eases the burden that you carry. It also allows you to talk about it because you're not going to sit by yourself and talk about it, and try and lay it all out and understand it. At least I wasn't, cause you're so caught up in it all. (Appendix H, p. 145, #010)

> It was a similar element to the other sessions of therapy that I underwent here in V.--that I think did help me um overcome this [bulimia]--was that in looking at it as we went on I saw that very often he was just allowing me to put things out and he would arrange them so that I could see actually what I was saying and thinking. So he was very good about not trying to impose um his own ideas on me, rather making suggestions that, upon reflection, would have been apparent in what I said. So it was very much a way of um, of of just airing, airing myself and allowing myself to look at myself. You know, it was just, it was sort of a self-examination thing. (Appendix H, p. 135, #005)

> Yes. Because it wasn't just me. And that for me, that the shame of it all was so horrible, was so terrible, that again letting someone else in on that presupposes that then you're going to do something about it. You have to now cause you can't look at that person in the eye knowing that, you know, you're going to be running to the bathroom. So that, for me that was really important. (Appendix H, p. 146, #011)

3. Remission.

Having few expectations in therapy except to address her bulimia, her fears of failure are minimal and she experiences an increased sense of control over her bingeing and purging. Although the frequency of her eating behaviours doesn't decrease, they are arrested at their current intensity. As such, the previous escalating frequency of bingeing and purging is stabilized and she is able to resume her daily activities.

> The being able to focus on the problem and have no other expectations--which I wanted, but it was better that I didn't have them--contributed something to perhaps a bit of remission during that period of therapy. (Appendix H, p. 144, #007)

> I think it [bulimic behaviours] had [changed]. As I said, I think that the therapy had some, had some benefits. Um, I'm pretty sure I was still bingeing and purging. But I think there was a bit of an element of control, a bit. (Appendix H, p. 143, #006)

> It was [different]. You know I do look at the first 2 years [of university] as being sort of a, the time during which I kind of plummeted. And then it kind of, the therapy I think sort of arrested that um direction. And then I sort of see the other years as more or less a plateau. It didn't get

worse than that. It didn't notably get better. Um, but I was able to maintain things on a more even keel. (Appendix H, p. 151, #017)

C. AWARENESS OF EVOLVING SELF AND CHANGES IN EATING BEHAVIOURS

1. Increasing sense of efficacy.

Her external environment becomes more stable and secure as she is no longer involved in a controlling intimate relationship and as she begins to establish a career direction which she enjoys. She is more autonomous and does not depend on others as much to structure her daily activities. She experiences a sense of control in her life. Feeling competent in her career field provides an accomplishment which clearly delineates an aspect of her self and allows her to feel more certain in knowing who she is. In the realm of career, her self-worth is enhanced and she feels better about herself. (See Appendix J, #003 and #006 for P.Y.'s corroborating statements.)

> So that was still all going on [bingeing and purging] but um, I was out of that relationship. I think that made a bit of a difference. I was a little more autonomous that way. Um, I was defining more sort of what my direction was in school. I had established you know, the Russian major and I knew more or less I was <u>good</u> at it, even though I I thought I was only good because the competition wasn't there. So I had a little niche, you know, and that helped. It wasn't so much just flailing around. (Appendix H, p. 152, #018)

> I think the key element there was that I felt that I was doing something that was more or less worthwhile, that I was, I thought I was fairly good at it. So it gave me sort of that approval and I was able to sort of define myself more. Like I could say that, um you know, I'm studying Russian and I could have that um as something that <u>was me</u>. It was a very much me that during those 4 years it pretty well, you know, took up most of my time. So I suppose in a way that's again there was issues I wasn't addressing. You know I never did go back and do the sort of soul searching and house cleaning that I thought that I should do in order to really be well. And I still had, you know, there's still a lot of underlying lack of confidence and self-hatred and all that sort of stuff. But at least on that plane I felt

> some element of performance and an element of success. So I think that's why things were largely better. (Appendix H, pp. 155-156, #022)

2. Interruption of eating patterns.

As she begins to spend more time in areas of her life where she feels successful, she experiences subtle changes in her eating patterns. In addition to occasionally eating a normal meal without purging, she is increasingly able to delay her urge to binge and purge such that the behaviors are contained within certain time periods. Although the frequency of her bulimic behaviours remains relatively unchanged, she interrupts her eating pattern in order to have time to engage in productive activities. As she feels less ruled by her eating behaviours, she gains more confidence in her ability to engage in other activities. Over time, her sense of competence, stability, and commitment to her career increases and she notices a gradual improvement in her bulimic behaviour as the frequency of bingeing and purging decreases slightly. (See Appendix J, #047, #048, and #049 for P.Y.'s corroborating statements.)

> Well as I said, I'm pretty sure that um I could, if I really wanted to, could keep a meal down. And the other thing I can determine is that there could be, uh the whole eating thing wasn't, didn't have me by the throat so much. Like there, I could at least <u>time it</u>, like put it in special pockets. I could um--not all the time and not nearly successfully enough--but I <u>could</u>, you know. Like fourth year I lived with a roommate and we could do study sessions before an exam without my, you know. I could do that. And I could, it wouldn't be <u>such</u> a driving thing to be doing continually. Because as I, as I look back on it now--I could be wrong--I just seem to think of those 2 years as being a continuous cycle of bingeing and purging. And it seems to me that I was able to--it still happened and maybe as frequently--but at least I could take periods of time where I, that I could do something with. (Appendix H, p. 153, #019)

> And as I did more and had to do more, the time for me to engage in, um you know, weird eating behaviours was lessened, was decreased. And uh, so I think the demands were more but for some reason I wasn't panicking as much, and I was able to do what I had to do to meet those demands. (Appendix H, p. 156, #023)

> But um, at that point I was just, I'd done a lot of teaching that year and I was really excited by it and I suddenly realized that I loved this. And I suddenly realized that I was good at it, you know, which is a tremendous realization. And so um I, I don't know but I think it may, had I continued on that track, who knows, but it could have been that things [bingeing and purging] would have just continued slowly to get better on their own. (Appendix H, p. 157, #027)

3. Symptom substitution.

Although the intensity of her bulimic behaviours has subsided, she notices an increase in her alcohol consumption. Drinking allows her to disengage from her anxieties and fears so that she feels comforted and secure. She becomes aware that she uses both alcohol and binge eating to help her escape from distressing situations and emotions.

> And you know, again the details I'm unclear of. I know that I was um, that I substituted drink [alcohol] uh, and to some respect, extent, for that. I don't think I ever had what you classify as an alcohol problem. But I know that I came to the realization that alcohol could in some ways do the same things the bingeing could. It was almost like a cycle. It would take um. When you're engaged in that activity, you can't really be engaged in anything else. So it's the sole focus. So when you have real worries, and anxieties, and feelings of fear and stuff, it's almost like a a reassuring cycle to get into because it takes you away from having to deal with those. And drinking did the same thing. (Pause.) So I think um, I think that uh, I know I didn't like it you know wasn't like drinking on a continual basis. But I, I do think that I came to that realization at that point, um for whatever that's worth. (Appendix H, pp. 153-154, #020)

4. Increasing intimacy with self and others.

She begins to feel weary from secretly hiding parts of herself or creating new ones in order to gain the approval of

others. Her awareness of her needs and how she feels towards others is increasing. Desirous of opening herself up to others, she chooses individuals with whom she feels validated and self-confident when in relationship with them. Feeling freer from the burden of pleasing others, she feels energized and excited as she is able to reveal more of her true self to others and connect more deeply with them. She also invests herself in an intimate, committed relationship. Although she doesn't disclose her bulimia to these significant others, she begins to trust that they accept parts of her and she feels more valued by them. She begins to consider that she is acceptable to others as she is and that she doesn't need to alter who she is. (See Appendix J, #051 for P.Y.'s corroborating statement.)

> But, yah, and I would be very, like I didn't have good friends because there was so much of me that I thought I had to create for others and so much of me that I had to hide. So I was always very I think kind of anxious around people and like who am I supposed to be for this person kind of thing. Um, and so I never um had what I would have called "real relationships" because I was always trying to create a part of myself to please them. So it's a terribly, I think a very tiring thing because you're carrying around these secrets, you're carrying around all your different identities that you're trying to portray to different people so that you'll please them. (Appendix H, p. 150, #015)

> I also in third year um, there was a, I think I was also very frightened of of entering into another relationship because I knew that I would again be controlled. Like I couldn't, and it was too much of a strain to try and keep up some kind of facade for someone on such a close basis. Um, so there was, there was a um, um a boy who, you know, wanted to develop a relationship with me. And I remember being very um, very much not wanting that, I think, because I felt much closer to him than I did with the guy that I was with for the first 2 years of university. And therefore the chances of his having to discover this about me were that much greater. So I do remember subsequently being very, you know, standoffish in that regard. Um, I did have a friendship with a, with a woman during my fourth year; we roomed together. That was good. It was almost like the

> first friendship that I had that I thought I could reveal some of myself to which was nice. (Appendix H, p. 154, #021)

> Because I had just, at that point you know, I felt that I'd made a commitment [to my boyfriend] I think in some ways. And you know, I mean love was certainly involved. But beyond that um, I think I felt that I had made a commitment. You know, we'd been sort of "long distancing" it for 4 years at that point and I felt that you know this is what we've had; I was going to do it [marry him]. (Appendix H, p. 157, #026)

5. Awareness of relapse.

When she relocates to a new geographical area, she feels lonely and ill at ease. Bereft of the support and security of her job, family, and friends, her growing sense of competence and self-confidence begins to crumble. She feels immobilized and unable to find ways of regaining or rebuilding her sense of emotional security. Insidiously, the frequency of her bingeing and purging increases until once again the behaviours are consuming all her time. When she returns to her familiar surroundings she remembers a previous time when she was involved with others, engaged in productive activities, and felt an element of control over her bulimic behaviours. Poignantly aware of the contrast between her old and new life, she realizes that her bulimia is out of control and is again impeding her ability to function. She is spurred to confront her problem again by seeking outside help.

> But what I do know is um coming here then that summer was um, was really bad because I kind of dropped into [a void], you know, I didn't have a master's degree and I didn't. Well, I just felt that I'd dropped into nothing. And um, you know trying to find some kind of work and you know, my husband being very involved in his, was again I was suddenly face to face with myself again without any of the external, you know, pluses and strokes and stuff. And, in some ways it might have been a very good thing. Because what it did

> was it yanked <u>that</u> identity [from my work] away from me. And I wasn't a strong enough person, or a forceful enough person, or a person who believed in themself enough to sort of kick and scream and fight for that in this environment. So, things deteriorated really quickly over that summer and the fall. And I was sort of picking right back up on the same old habits. I would spend the day--you know, with A. gone and not really knowing anybody or not many people here--isolated and again going right back into the bingeing and purging. (Appendix H, p. 158, #028)
>
> Both. [The frequency of bingeing and purging began increasing and I began to feel a loss of control over my eating behaviours.] Yup. And that was real scary. And again it wasn't something that um, I think I faced up to until it got really bad. And I think that, I think the realization that things were bad (laugh) came to me cause we went to my family's place back home in I. for Christmas that year. And it was like seeing that environment that I used to be in, that I felt that I was flourishing in--you know it was the same city that I had been in school in--and suddenly seeing the way I was. And I think it was over that Christmas that I realized that when I got back I had to do something. Because I think I realized that I'd taken some steps and that, you know, things were better but that since my environment had changed, I had just sort of crumbled. And um,I had to deal with it. (Appendix H, pp. 158-159, #029)

6. Separation of self from bulimia.

She experiences a close affinity with her therapist and a deep sense of trust because they share a common cultural background and interests. Feeling respected and valued in spite of her eating disorder, she is freed to be open and vulnerable with her therapist. As she focuses on her issues underlying the bulimic behaviours and is reassured that these behaviours are symptomatic, she feels liberated as she begins to separate her bingeing and purging from her sense of who she is. Although at times she feels consumed by her bulimia, she feels empowered and more hopeful about gaining control over her eating behaviours knowing that they will subside once she begins dealing with her self-hatred and lack of confidence. Her shame and preoccupation

with her eating disorder continue to diffuse as she recognizes that she has personal and interpersonal abilities and strengths in other areas of her life. And while she acknowledges her achievements, she knows that in order to recover she has to respect and cherish herself as she is without any of these external achievements. (See Appendix J, #004, #008, #009, #035, and #075 for P.Y.'s corroborating statements.)

> I mean I knew, you know, she [therapist] was <u>good</u>. Um and I remember your saying once that um too often people say, "Oh, it was just because I had a great therapist that I recovered." I think there has to be that personal uh. If I hadn't liked her and respected her then I couldn't have done that [recovered]. So knowing that she obviously accepted it [bulimia] because she worked with people like me and that we were still able to to get along on on a personal level, and laugh. And you know she was, she's C. so my interest in Russian studies. You know, so we had sort of a personal relationship that I felt was sort of beyond that. You know, I felt very comfortable with her. I think it would have been impossible, had I not had that, to really you know. Because that's maybe what happened with Dr. C.: that I just wasn't able to to really open up. So that was important. (Appendix H, pp. 167-168, #045)

> I think she approached it very much from a point of view of working on yourself, and this only being symptomatic. And that certainly work would have to be done on behaviour modification--your, you know, attitude towards food and stuff--but that really it was, it was much deeper than that. And I think <u>that</u> made a terrific impact. You know something that I think I'd known, but to actually <u>talk</u> about that was important. You know, going back in in my past and talking about things that, that had to do just with <u>me</u> and not with any eating disorder. That was important. Um, and then later on she talked about, yah, like writing down times that I would binge and why, or what I had just eaten and what I was feeling. I don't think I actually did that. I remember thinking about it, but I never actually committed it to writing. Um, so a lot of, um, examination of self rather than examination of this, this <u>part</u> of myself. (Appendix H, p. 164-165, #040)

> I think that's what I liked most of all. Because I'd always known, I mean why should, you know, why should I have those feelings about myself? And I always knew that a real healthy person wouldn't do this [binge and purge]: like a person who felt good about themselves. And it always

> occurred to me that it [recovery] had so much to do with knowing who I was (eyes become moist). Like without anything else in the world--what I was doing, or parental approval, or straight A's, whatever--that I was O.K. And that in some respects, what I did was secondary. You know, I think I'll always be a sort of goal-oriented person and wanting to be doing things that'll make me feel good. But that's not what I build my whole self on. (Appendix H, p. 165, #041)

7. De-idealizing and forgiving family of origin.

In her innermost being she holds a lot of anger towards her mother for having played a part in the development of her bulimia. However, she feels guilty about expressing her anger because she is afraid that she will blame her mother solely if she begins to explore the negative aspects of their relationship. Although she is initially shocked at her therapist's suggestion that she is still angry with her mother, she is released to identify and express her anger. She verbalizes her anger towards her mother's and society's overvaluation of thinness and acknowledges that these messages were harmful to her. As a result, she becomes less consumed and driven by her anger towards these past events. She realizes that even though her mother made some mistakes which contributed to developing an eating disorder, her mother is not solely responsible for her bulimia. Letting go of past hurts and anger, she moves forward to the present and assumes more responsibility for overcoming her eating disorder. (See Appendix J, #073, #074, #076, #077, and #078 for P.Y.'s corroborating statements.)

> Except she seemed, her focus was more on the family--the mother-daughter relationship--which in some ways I rejected because I didn't want to. I think I felt a lot of guilt towards my mother because of the way I was. And I mean I'd think back on things and all I could see was the negative aspects of having interacted with her. So I didn't really

> want to put this in her lap, you know, in terms of well because of this, this happened to me. You know I still don't, I think there are some aspects of that that are good to examine. Definitely. But I really don't think it's such a good thing to try and find a finger to point. And I don't think Dr. T. was trying to do that. But I know that I resisted in some respects that, that approach because I felt that that <u>was</u> trying to point the finger of blame at her, you know. (Appendix H, p. 162, #036)
>
> And I do remember a comment that she [therapist] made that really hit home. I think in talking about it, and again sort of trying to shield her [mother], I don't know what I said, but her [therapist] retort was. Or in saying, I guess expressing my guilt toward her [mother] and stuff and her. (Appendix H, p. 163, #037)
>
> My mother. Yes. And Dr. T.'s retort was, "Then you haven't forgiven her." And I had to realize the validity of that. That maybe there was some blame that I was subconsciously attributing to her and the environment in terms of, you know, what happened, in terms of my bulimia. So it was a matter of trying to, I think there was a process of letting go of all of that; of being able to say, to look back on those things in order to let them go, and and any anger that you might feel at um, um finally developing a distorted body image, you know. In other words, just taking your responsibility for "the here and now." (Appendix H, p. 163, #038)

8. Verbally acknowledging bulimic behaviours.

When she identifies her eating behaviours using the terms "bingeing" and "vomiting" rather than speaking of them euphemistically, she draws closer to the reality of her behaviours. As she verbalizes and names her actions, she is moved to confront them rather than minimize them. She experiences a deeper sense of owning her behaviours, and is aware of their severity and the fact that she no longer has control over them. She realizes that her "perfect" solution to weight control is imperfect.

> Something else just occurred to me. I remember, I think I used to talk in euphemisms a lot, in terms of like what I would actually do. And I think part of it [therapy] was sort of to force me to actually dare feel what it was about:

> you know, gorging and vomiting. Like I remember her talking, her end goal was to make me actually say the word "vomit", and I kept using euphemisms and not understanding what, why she meant, what she meant when she would ask me to be more clear about it. And finally when I had to say that word, it was like again coming (slaps hands together) face to face with what it actually was. So, so part of it too was was really examining behaviour and what it was, not hiding, not hiding from the realities of it. (Short pause while tape is turned off to answer the phone.) (Appendix H, pp. 166-167, #043)

9. Permission to eat previously forbidden foods and to feel full.

She begins to reorganize her categories of "O.K. foods" and "binge foods". As she allows herself to eat "binge foods" without eating to excess and purging, she feels more relaxed and experiences a sense of control over her eating behaviour. She realizes that she can eat the previously forbidden foods in moderation and still maintain her weight. Furthermore, when she eats an average amount of food and feels full, she alleviates some of her anxiety and prevents a binge-purge cycle by reassuring herself that she has not overeaten and by progressively delaying purging by engaging in other activities. As the frequency of her bingeing and purging and her thinking about them continue to decrease gradually, she feels more in control of her eating behaviours. She is relieved and secure in knowing that her body is similar to others' bodies in that her food intake nourishes her body and is efficiently metabolized. She is more hopeful and confident about recovering and she begins to care for herself more by opening up her life through structuring time to socialize with others and engaging in previously enjoyable activities. (See Appendix J, #001, #005,

#019, #020, #036, #037, #038, #040, #067, and #068 for P.Y.'s corroborating statements.)

> She also talked about feelings of--or I did, whatever--we talked about um like dividing foods into O.K. foods and foods that if you eat this it means you're on a binge: things like like ice cream or spaghetti. Like in order to to maintain your weight you can't eat things like that ever cause if you do, then you might as well just you know gorge and get it all up. So you know, your relationship to food certainly played a part. (Appendix H, p. 166, #042)

> But um, like for example I would allow myself to eat spaghetti, or have an ice cream cone, or a cookie, or something without that automatically meaning I'd had just, you know, started the whole cycle. So it was allowing myself certain foods. It was allowing myself to eat a meal, like a dinner especially, and keep it down, and wake up the next morning, you know, still feeling. And and allowing myself to experience that feeling of fullness, normal fullness, without that having to lead to such anxiety that I have to just continue. (Appendix H, p. 170, #050)

> One thing [that I told myself when I felt full after a meal] was, "Wait, let's just wait." Like a lot of it would be, "O.K. I've eaten this much, like intellectually I know I haven't overeaten." Like it wasn't for a long time that I was able to eat more than I should have eaten and still be able to keep it down. So I would eat what I knew--I mean I could, I could write it out, I could see it, I knew that I hadn't overeaten even though I felt you know terribly full and anxious--and able to say, "Well let's just wait. O.K., I'll purge but I won't purge for a half-hour. I'm not going to puke for a half-hour." And then in a half-hour, "Well, we'll wait another half-hour and like take a walk or something." And then I realized I didn't have to anymore. (Appendix H, p. 170, #051)

> I [felt confident about changing my bulimic behaviour when], I think I felt elements of control coming back. Um, I think I would, I can't pinpoint it, but I believe it would have been at the time where I was able to stop something that would normally, like stop a binge in progress. Or to actually say, "No" to a time when I would normally have binged. You know, to start having some control back, which was great. (Appendix H, p. 169, #049)

> But I do remember (laugh) when it was still, you know, very much more an issue, suddenly realizing that, "My god, I'd gone for a day without bingeing, oh my god, I'd gone for a week." You know, of knowing that um, it wasn't a minute by minute, day by day issue anymore. And that was a tremendous feeling when I knew that I could, I could eat three meals a

> day and, by eating three meals a day or two or whatever, I wouldn't blow up. Like I was normal in that regard too. It wasn't like by eating one bite I'd suddenly gain 20 lb. So it wasn't such a forbidden area. Food became more of a functional thing rather than this whole issue of weight and guilt, and you know, all these other things that it had had. (Appendix H, pp. 177-178, #072)

> So it's a matter of of being able to do other things. I mean you get so, when you're, when you're life is sort of taken over by this, everything else drops away: I mean everything you used to do for enjoyment. So it was a matter of realizing there's, I mean there's always time that you could like spend with others now that you feel more comfortable around it, different things you can do, and things you can do even for yourself, I mean. You know that's like a notion you never had before in such a long time. (Appendix H, p. 171, #053)

10. Identification with and acceptance by other bulimics.

Regardless of whether she has personal contact with other bulimics or hears accounts of them from a secondary source, knowing that her eating behaviours are shared by others decreases her anxiety about her abnormal eating habits. As she realizes that her bulimia is a condition which others also have, her sense of shame continues to diminish and her disgust with her bingeing and purging lessens. When she perceives that her disclosure of bulimia is accepted by others, she feels understood and experiences a sense of belonging. From observing that other group members appear normal in spite of being bulimic, she realizes that she too probably appears normal to other individuals. As a result, she feels more accepting of herself even though she is still bingeing and purging. Her feelings about herself are less governed by her bulimia.

> That's right. That's right. And not that we talked that much about other people [with eating disorders], but the fact that I knew they existed. And you know, she'd say things about, you know, what happened with this person or something, you know, that that made it. It put it sort of

into perspective more I guess. It's just this being--as you said I think at one point--part of me, but not like that was just what I was. That there were other, you know human beings that that had this as part of them as well. So it was again that identifying with (laugh), with humanity in a way. You know, seeing yourself as part of it; you're not so isolated. I'm trying to remember, for some reason I remember that moment really well which means that it must have been fairly significant. (Appendix H, p. 164, #039)

And that um (pause) part of it was um then if others, if you could accept yourself enough to open yourself to others and they would accept you, then it would just be confirmation that you were O.K. But you had to be able to accept yourself enough or accept this, this thing enough to be able to tell somebody about it in a way: like to know that by actually revealing that, they wouldn't totally destroy you. (Appendix H, p. 167, #044)

So that I think in both instances, both sort of um steps, was, was just the act of telling was really important. And I guess that's why--I'm jumping the gun, the gun a bit--but that's why I think groups must be important in the process too. Because again you're, not only have you told others and they, you know, don't run away screaming or something; you're still a person to them. But also you see others who seem to you quite, I mean they look like people, like they have it all together. Yet they carry this too. So I think that whole element of sharing is is so important. (Appendix H, p. 147, #013)

And I did go to ANAD a couple of times, as I said. It would probably have been that spring and summer that I was first seeing Dr. T. I probably went about three times. And it was <u>good</u>, um. I was doing a lot of tutoring in the evening and I think that's partially why I didn't do it like on a regular basis. Um, and I found that to be good. Again to walk into a room of people that I felt, "Gee, I could walk by (laugh) these women on the street and I'd never know. So other people must see me and they don't look at me and think yuck." You know that (a) you know, other people have it, so it's not such a horrible thing, and (b) that other people sort of wouldn't look at me and <u>know</u> how bad I was. You know what I mean? (Appendix H, p. 175, #064)

That's right. It wasn't. It was just a thing, yah. It was just a, you know, an eating disorder (laugh). Cause again, you're putting it in perspective. And as it lost sort of its ultimate control of my life, I was able to put it more in perspective. (Appendix H, p. 175, #065)

D. EMERGENCE OF A NEW SELF AND NEW VALUES

1. Accountability to significant others.

As she begins to accept herself more and feels more confident in her ability to overcome her eating behaviours, she begins to feel uneasy about hiding her bulimia from significant others. Since she desires to be her genuine self in relationships, she feels challenged to share her hidden bulimic part. When an intimate other acknowledges her disclosure without becoming overly concerned or overly critical, she feels relieved and loved. Her overwhelming sense of abnormality and shame is diffused and she values herself more knowing that she is unconditionally accepted by a significant other. Feeling strengthened and supported, she is more determined to overcome her bingeing and purging because she doesn't want her bulimia to poison their relationship or for them to feel burdened by it. (See Appendix J, #041, #042, #053, and #054 for P.Y.'s corroborating statements.)

> Yah, and that it [bulimia] didn't affect his [my husband's] feelings about me at all. You know, so that was really important. And I think I was only able to tell him, um you know, at a moment, at a time when we were feeling you know really close, and I really felt that, "Yah I really want to share this thing with this person because I don't want to keep this from this person anymore." Not as if it were a big deal that I'd told him the facts, but the fact that I was withholding something became important. That I'd never had a relationship with someone where I wasn't holding back this, and creating this, and hiding and deciding how to be. And so that, for the reason, it was a big step too. (Appendix H, pp. 168-169, #047)

> [His reaction to disclosure of bulimia was] Very low key. Very low key. Um in fact he even made some jokes about it--like during that conversation--"well, that's a great way to lose weight, I should think about that." You know, stuff like that. So it was as if I was thinking, "god, all this time and it really isn't such a big deal." Like I mean he

> thought it was weird and all and and I'm sure he knew that it was indicative of of problems and stuff. But he was very, very sort of matter of fact about it. And just very glad that I had told him because now he wouldn't have to wonder why. He was very, I think, worried that I was seeing someone for, you know, goodness knows what reasons. (Appendix H, p. 168, #046)

> Well, and also to have someone, someone else accept it, uh and not um; it just lets you know that maybe you're not such a monster. You know that someone else could hear this part of you and still, and still accept you. You know especially in terms of you know, the person that you're living with. And you know, supposedly you've known this person for however many years--4 or 5 years--and that's the one secret you've never told them. You know so, it's, it also allows you to feel more like a human being. Again, the whole um breaking out of the isolation, and that even the fact that you do that doesn't mean that you're such a rotten person. (Appendix H, pp. 146-147, #012)

> Um, and also, I had to be at a point where I felt fairly confident of succeeding, of going to him and succeeding, because I couldn't tell him and then intend to continue with the behaviour. I mean I knew that it would still continue for a while, but at least that attention would be there to work through it and <u>stop</u> it, and that it would always be getting better. And I knew I <u>couldn't</u> tell him if I felt that I couldn't succeed because then I couldn't look him in the eye and to feel, you know, rejected--like I guess that's self-imposed--to feel um guilty about that in regards to another person. You know, I I couldn't do that. I was bad enough doing it with myself sort of. So I had to be at a certain level of stability with it <u>before</u> I could tell him. And then telling him increased that level of stability [confidence in her ability to make changes]. (Appendix H, p. 169, #048)

2. Responsibility for offspring.

When she discovers that she is pregnant, her anxiety over not being more in control of her eating behaviours is intensified. She is spurred to continue working at overcoming her bulimic behaviours so that she can responsibly provide an optimal pre-natal environment and the necessary nutrients for her baby. Furthermore, she is committed to fully attending to her newborn and she realizes that her present time involvement with

bingeing and purging would compromise her time with her baby. She feels confident that she can continue working towards gaining more control of her eating behaviours and increasing her current level of control. Although she does not abstain from bingeing and purging during pregnancy, she experiences a continued decrease in the frequency of these behaviours. (See Appendix J, #050 and #052 for P.Y.'s corroborating statements.)

> Um, and to feel that there was another reason why I had to get myself well. You know, there was a baby and there was, you know. (Appendix H, p. 172, #057)

> I mean quite apart from all this, like it [being pregnant] wasn't a planned thing and it was sort of uh. But, above and beyond that, I really thought to be a mother you had to be a fairly whole person. And you know, so there's a lot of <u>fear</u> of you know, you know, "I've got to get my act together." There was even more reason to get my act together because there was so much, there was more at stake now [such as another life]. (Appendix H, p. 172, #058)

> Well another life. You know, I couldn't have a child and and. There was, it was one more element that would um make, make it harder for me to continue if I felt I had to continue bingeing and purging. Um, and from the point of view of that child's well-being, I mean to have a mom doing that would not be good. Like I didn't want to um, you know, fail in that respect, you know. (Appendix H, p. 172, #059)

> M-hm, that I had to. Yah because, you know, I knew at least I had to have control of it. Um, because it's just one more um thing that, like it's a very total thing that you have to do: bring up a child. And even before I had one I guess I realized that (laughs): certainly do now. But uh, and I knew I couldn't really do it if I were out of control with this thing. I mean I couldn't: I knew that. So, but I must have, I'm <u>sure</u> that I had inklings and and some feelings of control before the pregnancy occurred. Otherwise I think I would have just freaked right out, you know, just knowing I can't handle this. So there must have been part of me that thought that I could probably handle it at least well enough. (Appendix H, pp. 172-173, #060)

> You know, I didn't, like for those 9 months I was still bingeing and purging, but not as much. You know things just, it was sort of again a gradual progression of get, getting better. (Appendix H, p. 173, #061)

3. New appreciation and understanding of her physical body.

Upon becoming pregnant, she reflects on her body's reproductive capacity and is awed by its ability to nurture a new life. She experiences her body as serving a useful function and having an important purpose, and she begins to appreciate and respect it more. When her body shape changes and her weight increases, she is at ease because she expects these changes to occur during and after pregnancy. As she feels freer from strictly controlling her food intake and weight gain, she no longer denies herself the food she craves. As a result, her bingeing and purging continue to decrease and she feels physically strong and healthy. She continues to trust her body's capacity to efficiently metabolize her food intake without rigidly monitoring what she eats. Her drive to attain a thin body decreases as her focus shifts to the importance of having a healthy body. She accepts the weight she gained throughout her two pregnancies and she is confident that she can gradually lose the extra weight by becoming more physically active rather than by resorting to her bulimic behaviours. (See Appendix J, #013, #014, #015, #016, #017 and #018 for P.Y.'s corroborating statements.)

> Um, and then, the thing that I think happened when I got pregnant that was neat was that hey I realized I had an appreciation for my body: just in the mechanical aspect! Like it was incredible I could do this thing! I didn't really feel I had that much involvement. You know, I knew I had to keep myself healthy. But to watch it sort of do its thing was really neat! And also to <u>feel</u> so healthy! You know, I had an easy pregnancy and I felt so strong and healthy. You know, I was you know as big as a truck and it didn't really bother me. So it was a different view of my body as begin um, a really useful tool. And I felt good about it: I mean I knew what I looked like and it didn't

bother me at all. I kind of reveled in it because for the first time in my life I could eat what I wanted and it didn't show, you know, that kind of stuff. (Appendix H, p. 176, #066)

As I said um, I, well I became pregnant. That was another thing of allowing myself to have that body image and have that be fine. (Appendix H, p. 171, #054)

Then being able to accept you know the the belly of pregnancy and stuff and not, you know, really be concerned, not be that anxious about it. (Appendix H, p. 172, #056)

And then after the pregnancy, um, I had put on quite a bit of weight. And it didn't, I guess it didn't bother me as much. Like it didn't really bother me. I didn't look at myself in the same way, looking for that little tummy. (Laughs.) Cause now I had quite a tummy, you know. And, and breast-feeding and all that. It just again, an appreciation of a healthy body rather than it's only, um, it only existing to see how thin you could make it, and how much like a model you could make it, and realizing that health was important. (Appendix H, p. 176, #068)

And since, you know, then we had another baby about a year and a half after that. And, um, you know, from those, I put on a bit of weight with each, each child. So that after the second one, S., was born, you know, I was not like heavy, but I had, I was probably about you know 15 lb more than I am now: 15 lb or maybe even 20 lb. And again, that didn't cause the anxiety. Like my weight wasn't such a big deal anymore. . . . Well, I knew that I was a mom; there was a reason for this. (Appendix H, p. 177, #069)

When after the second one was born and I took a year out at home and really kept that weight, I was doing aerobics and stuff, but I didn't really lose it. I felt better about myself when I got back to work and and kind of lost it. But it wasn't like a big, it wasn't what it was. . . . That's right. And I didn't have to, you know, go back into old patterns to try and lose it. (Appendix H, p. 177, #071)

4. Expanding sense of self and belief in self.

As she takes on the roles of mother and wife, she feels more peaceful and secure in knowing who she is. Her confidence and self-respect grow as she successfully carries out her responsibilities in these areas. As she also feels stronger in her ability to regulate her eating habits, she is challenged to

re-enter the work force. She no longer feels that she needs the support and validation of her therapist. As she gains more of her self-worth from these new roles, she focusses less on her body shape and weight as a source of her worth and value. Her relationships with family members and work colleagues take on an increased importance and she invests more of her time with them. As a result, she has less time to be preoccupied with weight and food issues and less time to engage in bingeing and purging behaviours. Knowing that her bulimic behaviours would be a deterrent to functioning optimally, she feels assured that she is well on the road to recovery when she does not desire to engage in bingeing and purging. In fact, her bulimic behaviours are an old response which now require effort and planning to engage in. (See Appendix J, #043, #044, #045, #046, #055, #056, #057, #063 and #064 for P.Y.'s corroborating statements.)

> I knew that there were other things that I could use for my self-definition than how thin I was. Um. . . . Such as the work that I did, my family, and knowing that I was, you know, feeling better about myself. So I didn't have to just look at that [my weight], you know. Um, and you know realizing that uh, well again, you know, a certain difference in life too: Here I was about 30 and I wasn't like 22 anymore. And, I wasn't trying, who was I really trying to impress in the way I looked? You know, just took a bit of a different perspective. I didn't feel, you know I felt much better. (Appendix H, p. 177, #070)

> And then when I came back, she was born. And she was about 3 months old, and I got a job opportunity and did that. So again it was, it was like the the initial um, um, stability, control feeling, you know, good feeling about yourself. Something has to happen first I think. And then for me anyways, it was important to almost put that into reality by taking on the responsibilities that would prove to me that I was getting better, that would diminish the time that I could indulge in an eating disorder: you know put more things that I had to do on me. Um, but there was that core that had started there, you know, that wasn't there. . . . That core of self-knowledge, and self-acceptance, and

strength. And, and, you know, knowing that you weren't such a terrible person. (Appendix H, p. 173, #062)

M-hm. Because you know, you've got to look, you've got, I think it's a real luxury to have that time-out out of life in a way of self-examination and all this other stuff. But then, you've got of kind of put it in practise, you know. It's got to be just a, just a part, just a time that helps you actually do what you want to do and not like a, you know, ongoing crutch. You know, cause that means you haven't really made that final transition which is putting, just incorporating all those things in part of your life without, you know. (Appendix H, p. 174, #063)

Um, getting a full-time job where in the daytime hours I couldn't do it anyway. So it would have to be restricted to nighttime after work. You know so that, and I felt confident enough that I'd be able to handle the job and do the work. You know, that had to be there first. And then to actually do the work and have so much of your time taken up. (Appendix H, p. 171, #055)

But then also I think taking on the work and stuff like that was very important because it would be, you realize that you know, "Gee, there's an 8-hour day and it hasn't even occurred to me once. It's not something that I would want to do or would even occur to me to do because I couldn't function and all those other things." So that would have been, you know, about a year I guess from starting to see Dr. T. (Appendix H, p. 179, #074)

But I think one sort of point [that marked recovery] is suddenly when you realize that, you're actually, to binge and purge is much more conscious than not to. Like before it's just a part of your life, and you do it all the time, and you have to really concentrate not to do it. And then it's like an activity that you engage in sometimes, but it's a very conscious thing. And I think that's a real, um, point when you realize that--you know, you know way back when--when I'd realize that I'd want to actually binge because I'm feeling anxious about something but it would have to be something that I'd have to arrange rather than something I'd have to fight off. (Appendix H, p. 178, #073)

E. THE NATURE AND MAINTENANCE OF RECOVERY

1. Counting the cost of returning to the bulimic behaviours.

When she experiences the urge to binge, she steps back from her cravings and reflects upon the consequences of her behaviour:

wasted money, isolation, and no return on the energy invested. Feeling drained and dissatisfied as she considers the option to binge, she decides to abstain from the bulimic behaviours and involve herself in other activities. She feels relieved and proud of herself for having implemented an alternate behaviour. (See Appendix J, #021, #022, #062, #070, #071, and #072 for P.Y.'s corroborating statements.)

> And another thing that happened further down the line--and still happens now like if I'm, if I'm in a situation where um it's possible for me to binge and for some reason I'm having feelings that I want to--is to stop and think back and think:
>
> > Well if I'm going to binge now, you're probably going to spend, it'd be a total of like $10 worth of food. I'm going to have to sit here by myself without pretty time, not do anything, stuff myself, and then I'd have to go and and try and vomit, and make sure that I vomit it <u>all</u> out. And that just, that prospect is exhausting and it's not very appealing to me.
>
> So it's sort of like <u>thinking</u> it through, rather than just letting yourself be caught right up in it. And knowing that, "No, I really do not want to do that, or, I'm having." (Tape ends here.) (Appendix H, pp. 170-171, #052)

2. Processing lapses.

Occasionally when she feels ineffective, dissatisfied with her present circumstances, or bloated from overeating, she has an incident of bingeing and purging. However, unlike previous bulimic episodes, she experiences a sense of control over the eating behaviours and does not continue to engage in them. After a lapse, she feels discouraged but not defeated because she is confident that she can cope with emotionally stressful situations by resorting to activities other than bingeing and purging. Furthermore, since her lapses are so infrequent, she feels distant from her bulimic behaviours and no longer considers them

a part of her life. (See Appendix J, #058, #065, #066, and #069 for P.Y.'s corroborating statements.)

> As I said I still will have incidents of it [bingeing and purging], you know, even now, but it's like, it's just a different thing. (Appendix H, p. 176, #067)

> I can't really understand it [occasional bulimic episodes]. It actually um, I guess often when it happens it's not like a conscious cycle. It's more like for some reason I've let myself really eat, overeat so much that it's almost like an escape mechanism if I know that it's been. Like I can overeat, like I can eat too much and feel, "Oh, what a pig and stuff." But the occasional time when um it just, I don't know. It's, it's almost like an escape mechanism if I really feel I have overeaten. You know what I mean. So it's like, it's not like a cycle that I have to go through. But still, parts of it are still there that I think I use or something. I mean it's real weird. But I don't have to. So it is quite a conscious thing. (Appendix H, p. 187, #090)

> Although I did find during the year I stayed at home that, um, there, the incidents [of lapses] were more frequent. And when I realized that, I made, I had to make an effort again to sort of eliminate it, you know. So I know that for whatever reason it's really much better for me to be out and involved in things and, you know, busy. And it's not good for me to start having negative feelings like, "I'm not doing anything or have too much time." You know what I mean? (Appendix H, p. 188, #093)

> And I guess it's [lapses are] just a feeling, a negative feeling that manifests itself in a way. Because I did notice during that year, there was a point where I realized, you know, it [lapses] was starting to happen: starting to, not starting to happen again but it was like it, I I could see the frequency was going up. And that, that distressed me. But then I was able to, you know. I had to exercise will but then it was, it was defeatable. It was a funny thing. (Appendix H, pp. 188-189, #094)

> Well the thing is, it [bulimic episode] doesn't, it doesn't touch me that much. Like it's not something that is like a light thing to do or it doesn't matter. But, I know that those activities, um, are not something I have to do: it isn't really me anymore. So it's not a thing that in retrospect I like. It's just like, "What did I do that for? You know, that was, that was stupid; that was unnecessary." But it doesn't really traumatize me. If I'm feeling really badly about myself anyway, it would just be something else to say, you know, "I feel badly about myself because of." But it really is, um, it's almost like when you're a small

> child, there's the, the neighbour's dog scares the heck out of you. And every time you walk past it your heart is going like this (lightly pounds heart). And then when you get older it's sort of like he could jump out at you and maybe scare you once, but it's just an old dog. You know, sort of like a totally different thing about it. So yah, it's not something I like, or something I'm proud of, or um. But it doesn't, it doesn't seem to be a big deal, you know. (Appendix H, p. 187, #089)
>
> It's sort of like I guess like smoking. You're sort of like, "ah, this is sort of <u>needless</u>." But um, no, there's no longer, you know, there is a feeling of control. It's a, it's a funny thing to even talk about now because it's so incongruous but. (Appendix H, p. 188, #091)
>
> Well, it's like an old carry over from the past in a way, you know, because it isn't like a part of my life or a necessary part of. I wouldn't even consider it really much in thinking of myself these days. (Appendix H, p. 188, #092)

3. Increased self-knowledge and acceptance.

As she becomes more secure in acknowledging her values and priorities, she feels freer from the contradictory societal messages about motherhood and career. She feels stronger in knowing who she is and she cherishes herself rather than seeing her values and dreams as a distortion. She realizes that life holds both joyous and sad feelings, and when she feels vulnerable and self-loathing she embraces these feelings and experiences a sense of control over them. She either accepts that, for the moment, she cannot change an uncomfortable emotional state, or she engages in behaviours that enhance her feelings about herself. She respects herself as she is and she does not feel driven to strive for perfection or unrealistic ideals and goals. As she listens to her feelings rather than seeking others' approval, she begins to discern what her feelings are saying and she begins to act upon them. She trusts her feelings enough to

explore new options and challenges as she feels led. (See Appendix J, #034, #080, #081, #082, #083, and #084 for P.Y.'s corroborating statements.)

> I was saying that if I were the person that I am now, if I were that, had been that person then, if I'd had the, I think I believe in myself a bit more and I know better who I am. (Appendix H, p. 157, #025)

> Like the year I was home with the 2 children was not, I think it wasn't a terribly happy year. I just, that's I guess the way I am. And I no longer see it as a negative thing of <u>having</u> to define myself by what I'm doing; that's just who I am. And I believe that other people are like that too. It's my personality rather than it being a distortion. I think it was a distortion before; it was carried to the extreme. And now I'm able to say, "I'm this way, and I'm that way, I'm another way" and not like "god, what, what am I?" (Appendix H, p. 179, #075)

> I mean that'll always be a part of me. I'll never be an overly self-confident person. And there's there's times now where, you know, where I feel real, really negative about myself and, you know, I hate myself and wish I was anybody else in the world. You know, but it's not everything anymore. So I guess it's too, able to say, "This is the way I am. I'll always have these aspects of my character, but I can deal with them now." Or I can <u>choose</u> not to deal with them and say, "Well it's <u>there</u>, there's nothing I can do about it." (Appendix H, p. 180, #076)

> And also what's come up in the last fairly recently--which I think is in some ways part of the process--is you know, I've been doing this work, it's been great, but it hasn't been, like I <u>haven't</u> really gotten off on a new, a big new direction since the whole Russian thing. And I'm now exploring, you know, the idea of going back to school and stuff like that. So it's neat. So I'm no longer defining myself as "Gee, I was, I was a Russian teacher and now I'm not, you know. So I'm, therefore I'm nobody." So it's sort of starting with something new again. (Pause.) Again more listening to me, I'm fine, and knowing what I'm saying. (Appendix H, p. 180, #077)

> And also the ability to maybe do things to please yourself: for nothing other than that reason. [Just the sheer enjoyment of it without any] goal that has been set by somebody, that you want to achieve. (Appendix H, p. 184, #083)

4. Authenticity with others.

As she comes to know herself better and respect herself more, she feels more comfortable and at ease with people. She acknowledges that she has positive attributes and talents to share with others and she no longer feels inferior to others. Feeling more confident and competent, she interacts with others on a more equal level rather than being passive and devaluing herself. There is little discrepancy between the self she knows and the self she is presenting to others and she is relieved to no longer feel afraid of disappointing others. She is encouraged knowing that her open and direct way of interacting with others will allow her to develop more intimate personal relationships and be more effective in teaching others.

> And I think I'm a lot more um. I deal with people on a totally different level now. (Appendix H, p. 184, #084)

> Well, you know. I feel that. I'm still not a person that has many close friends. And again, I've decided that's part of me and not, you know, for any other reason. But, I'm able to be, you know feel that I'm more myself with others and be more relaxed, and you know deal with them as I feel other people must have always dealt with other people. And so that's good. And you know, the work that I do now and I suppose any kind of work I do will be with people, and will hopefully be from a perspective of trying to give them something through teaching or whatever. And I feel that, you know, I can do that much more effectively. (Appendix H, p. 184, #085)

> But um, it was almost as if the people that I felt I could be close to, those were the ones that I wanted to push furthest away because I felt like I would infect other people: If I allowed them to be close enough I would infect them with whatever sickness I had. Like um, I felt like a pile of cut glass and anybody who touched would would, you know, cut themselves on. So, you'd sometimes surround yourself by people, but you wouldn't you know, you didn't have that much to do, or in common with. So, you know, it's a question of the friends that you choose would be more real friends. (Appendix H, pp. 184-185, #086)

> I know something. I know something. Again, in my relationship with people, I think I always wanted the other person--in whatever the relationship was--to be in control. You know, for reasons that I think you probably understand: a lack of self-definition etcetera and wanting to just sort of hitch myself on to somebody else. And you know that analysis of relationships that's, you know, parent, child, and peer. I think I would always deliberately set up a relationship with others in that I was the child and they were the parent. And I'd always try and um, uh, I think put myself forward as a bit of an "airhead". Like I never would try and put myself forward as somebody who knew anything about anything because they would probably find out I didn't actually anyways. (Tape ends here.)
> The whole image of, um, not being equal with others: always putting yourself on the down side, um, not being assertive, um, and not believing that others will take you seriously. So there's a certain amount of, of um, again almost trying to relinquish control of the situation when you're with other people. So I think I deal with people, like you know, on a much different level now. I mean professionally I can talk to people as I imagine an adult would talk to another adult and not the way I used to. So that's a, that's a big difference as well. (Appendix H, p. 185, #087)

> That's right. And I believe now I'm able to see some good in myself and see "Yah, I can do that well. It's not just, I was just, somehow got through it and I fooled them this time. God, will I be able to fool them again?" That, you know, horrible tension that everything you do then having more expectations and being really scared of it even though you <u>have</u> to have those expectations: They <u>have</u> to be there.
> So it's a lot, um, easier now in fact. (Appendix H, pp. 185-186, #088)

5. Balancing work and play.

Her ability to concentrate on work issues or to engage in reflection and contemplation is strengthened now that she is no longer thinking about bingeing and purging. As a result, she is able to more fully invest herself intellectually in her work activities while also being less obsessed and driven by them. She takes time for leisure without feeling guilty because she enjoys and is nurtured by time away from work. Feeling in control of her eating behaviours, she is at ease with leisure time and sure that she will not fill it with her previous bulimic

behaviours. (See Appendix J, #079 for P.Y.'s corroborating statement.)

> But I also realized what an effect bulimia had on your ability to think, just in terms of--it's not just the amount of time--but it really has, you know, it really damages you physically and stuff, and I think intellectually because you're so weakened and stuff. So I think were I to, if I were to start on some kind of school program, um, I think that in many ways, um, I don't want to say I'd do better, but it would just be, it would be a more balanced thing. It wouldn't be such a focused thing. So maybe I wouldn't do um, something like standardized grades and stuff, I might not do better. But I think I would be able to put more into it because I'd have more of myself to devote to it. (Appendix H, p. 183, #081)

> I could concentrate. I mean it was like I could never concentrate before cause this was always on my mind. And if I were in a position to concentrate that would usually mean I'd be off doing some work, whatever, studying or whatever. And that would be a prime time to binge, and I usually would. So there wouldn't be periods of concentration or reflection. Like I was afraid just to sit back and think about things and not do anything, from many points of view, because if I weren't doing anything then I wasn't justifying myself [or that would be a prime time to binge]. But also, I didn't have any leisure, intellectual or otherwise, to do things. (Appendix H, p. 183, #082)

6. Altruism.

She desires to share her recovery experience with others who are struggling to overcome an eating disorder. She feels confident that she will be able to empathize deeply with them and provide information which may help them in their recovery process. She also trusts that the individuals will identify with her and be encouraged about their potential for improvement from seeing that not only celebrities but also "ordinary" people recover from bulimia. In reliving her recovery experience, she expects to affirm her courage and strength and to acknowledge the personal growth and maturity which resulted from her struggle to overcome bulimia. (See Appendix J, #024 and #025 for P.Y.'s

corroborating statements.)

> Yah, M-hm. (Pause.) And I wish [that as part of my recovery], yah, I wish I had been more involved in ANAD, and I, I still have feelings now. I think I'd like to try going back and seeing if there's any capacity that I could be involved or help out or something. I think that's part of, I think part of it is, um, once you've worked through it, being involved somehow in helping others or with, you know. (Appendix H, p. 181, #078)

> You see I think that's it. And I think, um, in in examining it since I've talked with you and, you know, thought about it more than I've thought about if for a long time, is to realize that that [helping out at ANAD] might be another important sort of last step. (Appendix H, p. 182, #079)

> I'm hoping to help others through what I went through. I think also, it's it's not so much from a point of self-examination cause I really feel that you can never work things through to the last "dotting of the last i." You know, when you do that with yourself, you might as well die (laugh), cause it's like put it all in a box. But I think there's maybe some element in that, but I think most of it is feeling that you have something to contribute, you know. And, and, and still remembering how awful it was and hoping that maybe what you can do can help somebody get through it more quickly. (Appendix H, p. 182, #080)

7. Certainty of recovery.

While she feels confident that she will not slide back into bulimic behaviours because she is now more aware of who she is and more self-respecting, she acknowledges the possibility of a recurrence of bulimia. From her experience, she knows that she is not totally immune to a relapse. (See Appendix J, #010, #011, #012, #023, #059, #060, and #061 for P.Y.'s corroborating statements.)

> I could revert [to bulimia] I suppose if I, yah. Although I really don't think I could ever really get back into that situation. I don't know. I can't even conceive of it. (Appendix H, p. 189, #095)

> It was a different person doing it. (Appendix H, p. 189, #096)

Chapter V

Discussion

The behavioural and psychosocial changes inherent in the process of recovery from bulimia occurred through both formal therapeutic mechanisms and out-of-therapy experiences. This broad scope of facilitative factors represented by the two co-researchers' stories provided a comprehensive and integrated basis for understanding the experience of recovery. In this chapter, the findings on the pattern of recovery are briefly summarized and the limitations of this study are addressed. Further, the theoretical and counselling implications of the results are discussed with recommendations for future research.

Summary of Results

This study elucidated the pattern or meaning of recovery from bulimia from the first co-researcher's experience of recovery. Information from the second co-researcher's transcript was used to cross-validate the themes. Twenty-nine factors representing the process and nature of recovery from bulimia were identified and subsumed under five major categories: "(A) Realization of Eating Problem and Ambivalence About Change, (B) Openness and Readiness for Change, (C) Awareness of Evolving Self and Changes in Eating Behaviours, (D) Emergence of a New Self and New Values, and (E) The Nature and Maintenance of Recovery."

Limitations of the Study

The internal validity of the research findings is high because potential bias in the assessment of the co-researchers' degree of recovery was controlled for; the independent rater who

is a psychiatrist with expertise in eating disorders had no previous treatment contact with any of the women. Further, the results of this case study represent an application of the existential-phenomenological approach. Specifically, the findings did not re-create the immediate meaning of the co-researcher's experience but articulated a conceptual understanding of the raw, veridical recovery experience.

The findings are based on a small sample size of two co-researchers and the extracted thematic categories were presented only to the primary co-researcher for validation of the accuracy and appropriateness of the wording of the categories. As such, this pattern of recovery may be considered true for the one woman and it may also be applicable to some other women struggling to overcome normal-weight bulimia. In addition, self-selected individuals may be different from the larger population in terms of willingness to share personal information with others as well as being psychologically minded and verbally expressive. Therefore, volunteer co-researchers may represent those who feel comfortable with themselves and others, have experienced a sense of achievement in overcoming bulimia, and feel motivated to be involved in existential-phenomenological research. Consequently, sample bias could be an important factor to consider when applying the results to the recovery experience for women with normal-weight bulimia (Borg & Gall, 1983). Furthermore, the pattern of recovery from bulimia may be different for males or individuals with obesity.

Finally, because no person can be thoroughly researched,

"research can never exhaust the investigated phenomenon" (Colaizzi, 1978, p. 70). Therefore, with all phases of this research project, there were no established guidelines which marked a termination point. As Colaizzi (1978) predicted, at the end of each phase I had "a certain empty but distinct feeling of being satisfied that . . . [each] phase [was] adequate in the fact of simultaneously experiencing the tension of its not really being complete or final" (p. 70). Therefore, it is suggested that the certainty of these findings be held with reservations.

Evaluating the Fitness of Theoretical Approaches

In Chapter II, the assumptions concerning the nature and process of recovery from bulimia inherent in the empirical studies of the psychodynamic, family systems, and cognitive-behavioural treatment approaches were outlined. This section discusses the present research findings in light of the current theoretical knowledge on recovery. As the purpose of this study is to explore the meaning of the recovery experience, this evaluation of the fitness of theoretical approaches is for exploratory purposes.

A basic principle of treatment which is implicit in all of the theories as foundational in the change process is supported by the five themes which are clustered under Category A. "Realization of Eating Problem and Ambivalence About Change." These themes are: "(1) Awareness of an eating problem, (2) Awareness of the association between one's eating problem and emotional issues, (3) Diagnostic awareness of one's eating problem, (4) Acknowledgement of need for outside help, and (5)

Awareness of obstacles to action." Theme C8 ("Verbally acknowledging bulimic behaviours") also confirms the role of insight and acknowledgement of one's problem which is alluded to by the theories. For instance, the psychodynamic theory addresses the unconscious role of ego-defense mechanisms such as denial and projection in denying or distorting reality (Corey, 1986). Family systems theory also recognizes the imperativeness of the individual realizing that she has an eating problem and that she is ambivalent about giving up the problem (Schwartz et al., 1985). Similarly, Fairburn's (1985) cognitive-behavioural approach emphasizes the necessity of cognitive change pertaining to body weight and shape. Thus, CBT stresses that the individual must first acknowledge that she has an eating disorder and that she feels ambivalent about changing her eating behaviours.

However, Themes A1, A2, A3, A4, A5, and C8 seem to indicate more specific psychological processes, beyond what is suggested by these theories. Thus, the themes enrich our theoretical knowledge about the initial phase in recovery. For example, Theme A3 ("Diagnostic awareness of one's eating problem") and Theme C8 ("Verbally acknowledging bulimic behaviours") highlight the mechanisms by which an individual's thinking about her eating behaviours is changed. Knowing that other people engage in similar behaviours and using the terms "bingeing" and "vomiting" reinforce her recognition that she has a problem, and also provide hope for overcoming her problem. In addition, Theme A2 ("Awareness of the association between one's eating problem and emotional issues") emphasizes the key underlying psychological

issues which clarify for the individual the seriousness of her eating problem and point the way to recovery. Finally, Theme A5 ("Awareness of obstacles to action") articulates the adaptive functions of bulimia which contribute to the individual's ambivalence about giving up her eating behaviours.

Regarding the psychodynamic theory, Themes A2, C1, C5, C6, C7, D2, D3, and D4 support this theory's assumptions of recovery. In Theme A2 ("Awareness of association between one's eating problem and emotional issues"), the co-researcher articulates her underlying feelings of insecurity, powerlessness, engulfment by others, and self-criticism. Theme C1 ("Increasing sense of efficacy"), Theme C5 ("Awareness of relapse"), and Theme C6 ("Separation of self from bulimia") underscore the causal link between intrapsychic conflicts and disordered eating behaviours and reinforce that psychological functioning and bulimic behaviours improve as the individual experiences a sense of self-respect and self-confidence. Theme C7 ("De-idealizing and forgiving family of origin") describes how the individual begins to take more of an active role in her recovery once she deepens her emotional separation from her mother by no longer blaming her mother for her eating disorder. Reorganization of self-perception is reflected in Theme D2 ("Responsibility for offspring"), Theme D3 ("New appreciation and understanding of her physical body"), and Theme D4 ("Expanding sense of self and belief in self"). That is the individual's self-worth increases, and the frequency of bulimic behaviours decreases as her perception of herself and her body is clarified by her roles as

mother, wife, and employee.

Although the literature indicates no empirical research studies pertaining to the efficacy of an object-relations theoretical approach to treatment, several themes identified in this study support the theory. According to Bruch, and Mahler, Pine, and Bergman (cited in Johnson & Connors, 1987), object-relations theory focuses on the ego weaknesses and interpersonal disturbances of an individual with an eating disorder. Her capacity for self-regulation is insufficient: She is unable to "accurately identify needs and effectively organize adaptive need gratifying responses" (Johnson & Connors, 1987, p. 89). She experiences a deficit in interoceptive awareness and is deficient in her sense of separateness of self from others. She also feels ineffective or controlled by others. At an early developmental stage, the infant's undifferentiated nutritional and emotional needs are inappropriately responded to by the primary caregiver such that when the child is older, she is "not able to discriminate between being hungry or satiated, or between nutritional need and some other discomfort or tension" (Bruch, 1973, p. 56). She is also likely to misinterpret this confusion of her body-self concept as externally induced. Thus, the bulimic individual uses food or binge eating as an external means for tension reduction and self-soothing.

Given this theoretical understanding of the development of bulimia, the object-relations theory holds that recovery results from the client's realization that her difficult emotional feelings are appropriate and not indicative of being out of

control. Furthermore, it is necessary for the individual to be part of an intimate relationship wherein she feels psychologically attended to and assured that others are capable and desirous of responding to her needs (Johnson & Connors, 1987). Themes A4, B1, B2, C4, C6, C10, D1, E3, E4, E5, E6, and E7 give partial support for object-relations theory. They represent an increasing move from isolation towards psychologically connecting with others even though she feels ashamed, and towards a deepened sense of trusting that others will be able to meet her needs. As a result, her bulimic behaviours begin to diminish. However, while the themes describe a strengthening of disturbed interpersonal relationships, they do not provide causal support for the individual acknowledging the importance of addressing her caregiver's emotional unavailability in order for her to recover. For instance, none of the themes allude to the individual realizing that she has to deal with the lack of love she experienced as an infant in her relationship with her mother by either gently confronting her mother or interacting with others in a way which is more intimate than how she interacts with her mother.

Nonetheless, these particular themes enhance our understanding of recovery from bulimia from an object-relations perspective. For instance, her perception of herself begins to change when she begins to feel accepted by others and realizes that she is acceptable as she is. She becomes aware that she does not need to engage in bulimic behaviours in order to alter her physical self or to meet her emotional needs. Her sense of

self or identity develops and grows stronger as she experiences that she can be involved in intimate relationships while maintaining her sense of who she is as separate from them. Thus, her individual identity as a person with unique abilities and strengths becomes constant and not dependent on others' approval of her. She is able to set limits for herself and nurture herself in healthy ways. Finally, she solidifies her identity as a recovered individual by affirming to herself and other recovering individuals that her increased sense of self and self-respect bolster her confidence in her ability to maintain abstinence from bingeing and purging.

With respect to family systems theory, none of the themes directly addresses the curative mechanism of family restructuring in order to create more adaptive patterns of interaction which support the individual's differentiation from the family system (Schwartz, 1982; Schwartz et al., 1985). The individual did not volunteer information which would support a systemic change factor. For instance, she did not indicate that her mother interacts differently with her now or that she relates differently to her mother. However, Theme C7 ("De-idealizing and forgiving family of origin") extends the meaning of establishing an identity independent of the family. Specifically, the individual deepens her emotional separation from her family of origin once she decides to take responsibility for overcoming her bulimia rather than blaming her mother for her eating disorder.

With respect to the cognitive-behavioural theory, Themes B3, C2, C3, C5, C9, D4, E1, E2, E6, and E7 confirm this theory's

assumptions as indicated by Fairburn (1985). As outlined respectively by Themes B3, C2, and D4 ("Remission," "Interruption of eating patterns," and "Expanding sense of self and belief in self"), the individual realizes that she can effectively gain a sense of control over her bulimic behaviours by engaging in alternate activities. Her sense of efficacy continues to increase now that she knows how she can regain control of her eating behaviours when she relapses. Correspondingly, as detailed by Theme C3 ("Symptom substitution"), she is aware of also substituting her bulimic behaviours with other addictive substances. Theme C9 ("Permission to eat previously forbidden foods and to feel full") explains the cognitive restructuring of "O.K. foods" and "binge foods" and recounts the individual's insight that her body can efficiently metabolize a normal intake of food without her needing to strictly control what she eats. However, the individual does not use self-talk to challenge her belief that certain foods are inherently fattening. Instead, she discusses with her therapist that all foods in moderation are good, and then she begins to gradually incorporate the previous "binge foods" into her diet. Theme C9 also alludes to the technique of "exposure with response prevention" in which individuals are encouraged to eat forbidden foods but then to delay or refrain from purging (Wilson, Rossiter, Kleifield, & Lindholm, 1986). She implements the self-instructional technique of telling herself that she can delay her purging behaviour. Finally, Themes E1, E2, E6, and E7 ("Counting the cost of returning to the bulimic behaviours," "Processing lapses,"

"Altruism," and "Certainty of recovery") focus on the cognitive interventions which the individual implements to prevent a relapse from occurring: doing a cost-benefit analysis of her eating behaviours, using self-talk to remind herself of her growth and development, and implementing alternate activities.

In summary, the pattern of recovery which emerged from this study supports the theoretical assumptions of recovery from bulimia outlined by the psychodynamic, object-relations, and cognitive-behavioural approaches to treatment. The themes identified in this study also provided further insight into the meaning and impact of some of the formal therapeutic curative factors and deepened our understanding of the initial phase of recovery described by Category A. "Realization of Eating Problem and Ambivalence About Change." Finally, the co-researcher's perspective on the critical change factors in recovery supports the current multifaceted and integrated therapeutic approach used in treating bulimia (Herzog et al., 1987; Johnson, Connors, & Tobin, 1987; Manley, 1989; Steiger, 1989). The curative impact of out-of-therapy experiences has also been confirmed in this study.

Implications for Counselling

This section discusses the practical implications of the pattern of recovery from bulimia which emerged from this study. The present analysis of recovery themes from the client's perspective has the following three important implications for counselling practice.

1. The pattern of recovery as discussed in this thesis gives

a more complete and holistic understanding of the process and nature of recovery than what has been known previously. The meaning of the recovery events throughout the entire process is examined and the synergetic effect of curative factors both inside and outside of formal therapy is revealed. Therefore, clients may be encouraged to increase out-of-therapy corrective experiences as potentially valuable adjuncts to formal therapy.

2. The recovery pattern provides a useful framework for counselling individuals who are recovering from bulimia. It outlines the factors which are most facilitative of recovery and also indicates the associated physical, cognitive, emotional, social and spiritual changes. For example, the results reinforce that before change can occur, the individual must realize that she has an eating disorder and that it is indicative of underlying emotional issues and interpersonal conflicts. It is also imperative that she acknowledges her need for outside help and her ambivalence about change. The importance of addressing both the disordered eating behaviours and the individual's sense of self throughout therapy is also underscored. In addition, the developmental process involved in overcoming bulimia is highlighted by the self-exploration and risk-taking activities which contribute to the individual's growing perception of self and increased sense of efficacy and self-respect.

3. The results may also contribute to the development of a clinical approach to bulimia by emphasizing the need for a multifaceted, integrated, and individualized treatment approach which is adjusted throughout the recovery process as the adaptive

functions or meanings of clients' eating behaviours change. Hopefully, the individual's unique way of perceiving reality and her sense of agency will be highlighted as the therapist strives to know how to most effectively work with those who are recovering from bulimia. In addition to sharing the client's world view in terms of mutually identifying the adaptive function or underlying causes of the client's bulimic symptoms, dialoguing with her as to what aspects of therapy she finds helpful may decrease the possibility of relapse or symptom transformation occurring once the bulimic symptoms have subsided (Vognsen, 1985).

Recommendations for Future Research

The following recommendations for future research are based upon the findings and research methodology used in this study, as well as the current literature on recovery from bulimia.

1. In order to increase generalizability of the present findings and validity of the five categories, further qualitative studies are needed to more fully explicate the meaning of the recovery events from the perspective of the individual who has recovered from bulimia. Studies of this type will enhance the current knowledge of the longitudinal nature of the behavioural and psychosocial changes involved in recovery. Additional insight could be gained into the meaning of the curative mechanisms inherent in formal therapeutic treatment approaches for both individuals and groups.

2. Qualitative researchers need to focus more attention on the initial phase of recovery when inklings of change are first

noticed by the individual with an eating disorder. Although the factors which lead to the onset of bulimia may be the factors involved in recovery, the richness and comprehensiveness of the information is compromised if the precipitating factors are discussed prior to addressing the time when change was first experienced. Since the nature of the precipitating factors or their importance in maintaining bulimic behaviour may change throughout the course of the eating disorder, one alternative way of studying the phenomenon is to begin the research process at the point where the individual first became aware of change. Researchers must guard against the interference of extraneous variables such as the presupposition that the precipitating factors are often the factors involved in recovery as well as personal biases towards stories being told in a chronological fashion.

3. The generalizability of the themes of the recovery experience needs to be tested by replicating this study with greater numbers of recovered individuals and returning to them for validation of the themes. Researchers may not exclude recovered bulimic males and individuals with prior concomitant obesity.

4. Researchers may develop a survey questionnaire for both clinical and research purposes by using the themes as categories which are facilitative of recovery in order to explore the meaning of the recovery events in more depth. Such a checklist may be used to heighten clients' awareness of recovery factors and to also identify possible patterns of recovery related to

prognostic indicators such as age of onset, duration of eating disorder, and severity.

5. Since little consensus has been reached concerning which treatment is most suitable for the various subtypes of bulimia (e.g., bulimia complicated by substance abuse, obsessive-compulsive behaviour, depression, or sexual abuse) more knowledge may be gained from further qualitative studies which interview individuals with these additional psychological problems. (Hudson & Pope, 1986; Johnson & Connors, 1987).

Summary and Conclusions

The results of the present study provide a more complete and holistic understanding of the structure or process of recovery from bulimia and examine the synergetic effect of curative factors both inside and outside of formal therapy. Further, the categorical themes contribute to a more comprehensive theoretical conceptualization of the recovery process which is lacking in the current literature on recovery from bulimia. Specifically, our knowledge of the initial phase in recovery (i.e., "Realization of Eating Problem and Ambivalence About Change") is extended by the theme descriptions. The findings also underscore clinical observations which advocate the necessity of a multifaceted and individualized approach to treatment in which various therapeutic approaches are integrated in order to address both the bulimic behaviours and the multiple perpetuating factors (Herzog et al., 1987; Johnson, Connors, & Tobin, 1987; Manley, 1989; Steiger, 1989). In particular, this study suggests that the object-relations approach may be a useful model for understanding the

importance of focusing on the intrapersonal and interpersonal patterns of relating. Techniques from the psychodynamic, family systems, and cognitive-behavioural approaches can then be implemented to address the bulimic behaviours as well as the underlying intrapsychic conflicts, maladaptive patterns of interaction, and dysfunctional beliefs about body shape and weight.

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APPENDIX A

DSM-III R (1987) Diagnostic Criteria for Bulimia Nervosa

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).

B. A feeling of lack of control over eating behavior during the eating binges.

C. The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.

D. A minimum average of two binge eating episodes a week for at least three months.

E. Persistent overconcern with body shape and weight (p. 68-69).

APPENDIX B

DSM-III R (1987) Diagnostic Criteria for Anorexia Nervosa

A. Refusal to maintain body weight over a minimal normal weight for age and height, e.g., weight loss leading to maintenance of body weight 15% below that expected; or failure to make expected weight gain during period of growth, leading to body weight 15% below that expected.

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight, size, or shape is experienced, e.g., the person claims to "feel fat" even when emaciated, believes that one area of the body is "too fat" even when obviously underweight.

D. In females, absence of a least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary amenorrhea). (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.) (p. 67)

APPENDIX C

Pre-screening Interview Summary Sheet

Name:

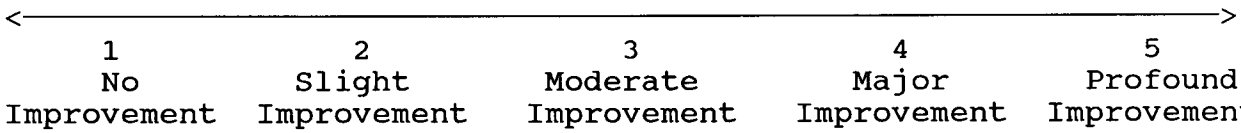
1. Duration of eating disorder

2. Primary eating disorder symptoms

3. DSM-III R diagnosis

4. Current status re: eating behaviour

5. Degree of recovery



6. Length of recovery

7. Other active psychological problems (i.e., substance abuse, mood disorder, anxiety disorder, etc.)

APPENDIX D

Contact Letter to Counsellor/Therapist

Research Study: Recovery from Bulimia

Dear Counsellor/Therapist:

As a graduate student in the Counselling Psychology Department at the University of British Columbia, I am conducting a research project for my master's thesis on recovery from bulimia. This study will be beneficial in contributing to the development of a clinical approach to treating bulimia.

I am interested in interviewing three individuals who meet the following criteria: (a) a previous diagnosis of bulimia nervosa as defined by the DSM-III R (1987) with no history of anorexia nervosa; (b) a significant period of time without any symptoms of bulimia; (c) no significant indicators of other active psychological problems; (d) self-reported feeling, of no specific time period, of being genuinely recovered from bulimia; and (e) an ability to articulate their insights and elaborate on their descriptions. Individuals may refuse to participate or withdraw from the study at any time without jeopardizing any potential future treatment. All information is confidential and data will be presented anonymously.

Initially, potential participants will be screened in an unrecorded interview at St. Paul's Hospital, Vancouver, B.C. by Dr. Elliot Goldner who is a psychiatrist and eating disorder expert. He will ask each individual to recount the development of her eating problems/symptoms, her weight and medical history, and her current eating behaviour. Then, in an unstructured, audiotaped interview with myself, each participant will be asked to describe the events which precipitated the onset of her bulimia and to tell her story of recovery. Other relevant personal documents (i.e. journals) may be used. In addition, each individual and myself will meet several additional times in order to verify the transcribed interview, themes, and final narrative account. A total time commitment of approximately five to seven hours will be required.

If you have any questions about the study or individuals who you feel would be interested in contributing to a deeper understanding of the process of recovering from bulimia, please contact me at the above address/phone number. Thank you for your time and interest.

Sincerely,

Laurie Truant

APPENDIX E

Contact Letter to Volunteer

Research Study: Recovery from Bulimia

Dear Volunteer:

As a graduate student in the Counselling Psychology Department at the University of British Columbia, I am interested in gaining a deeper understanding of the process of recovering from bulimia. This study will be beneficial in contributing to the development of a clinical approach to treating bulimia.

Your participation in this study is entirely voluntary and you can refuse to participate or withdraw from the study at any time without jeopardizing any potential future treatment. All information is confidential and data will be presented anonymously. If you had a previous diagnosis of bulimia with no history of anorexia nervosa, currently feel genuinely recovered and willing to discuss your insights into what facilitated your recovery, I would enjoy speaking further with you.

Your initial participation in the study will involve an unrecorded pre-screening interview at St. Paul's Hospital, Vancouver, B.C. with Dr. Elliot Goldner who is a psychiatrist and eating disorder expert. He will ask you to recount the development of your eating problems/symptoms, your weight and medical history, and your current eating behaviour. Then, in an unstructured, audiotaped interview with myself, you will be asked to describe your recovery experience and make use of other relevant personal documents. In addition, we will meet several additional times in order to verify the transcribed interview, themes, and final narrative account. The total time commitment will be approximately five to seven hours.

I hope that you will find your participation in this study interesting and that the information will be beneficial both to you and to other women struggling to overcome bulimia.

If you have any questions about the study or would like to participate, please contact me at the above address/phone number. Thank you for your time and interest.

Sincerely,

Laurie Truant

APPENDIX H

L.S.'s Protocol

L.S. O.K. So you want me to, so what I will do is start with, um, the onset and try and be quite brief about the onset and development of, of the bulimia, and concentrate on the recovery.

L.T. M-hm.

L.S. It, I think it first began when I was about 18, 17 or 18 in high school and really progressed uh quite dramatically when I went away from, for university when I was 18 years old. And after um, my second year of university--that would have put me about 20 years old I guess--I did uh go, I did finally at that point realized there was something very, very much wrong. And I went, when I was home for the summer, I went to um a psychiatrist who was a friend of my father for some therapy.

L.T. How did you know that something was really wrong? What made you think that at the time?

001 L.S. Well, I guess inside I'd always known that something was very wrong. But the, those 2 years of university saw a very steady um progression of it [bingeing and purging] such that by the end of my second year I just barely finished the year. You know, I guess I had to reach a point where I'd really hit bottom to realize that this [bingeing and purging] was probably the cause in that these activities were, were becoming the most important factor in my life. Uh, this, this sort of thing had taken over my life and that in order to continue doing anything I had to address it.

002 Um, but I still, I don't think I was still yet at the point of truly being able to work through it. Like I wanted this thing to go away, I wanted to be O.K., but I didn't really want to put into it what I knew I would have to. Because on one level, I think I understand very well that the bulimia itself, it was just a set of symptoms, that there were, there were deeper things that were really causing all of that. Um, so.

L.T. And, and how did you have that awareness? Had you read anything, or talked with other people, or what made you think that?

L.S. To know that I had bulimia?

L.T. No, to, to, um make you aware that there may have been issues underlying it? How did you know about it?

003 L.S. Well, I've always been um, not very happy with myself, not very secure in myself, and always eager to please others and to be led by others without much confidence myself. And, so in some ways I often felt as if I weren't in control of my life anyway. Um, but <u>this</u> [bingeing and purging] just was like a, a, that aspect intensified a hundred times.

L.T. O.K.

004 L.S. So I guess I kind of knew that uh it [bingeing and purging] wasn't just a, a way to control weight: that the fact that I was involved with this meant, meant something more. I mean I knew that it was, it wasn't just the fact that I would eat and vomit. There was a, there was a reason for that, somehow, beyond just wanting not to be fat again. And I think, I realized that it was um, in some way connected to my feelings about myself and my lack of, of really feeling of control over myself, or wanting to have control, or feeling that I was worth um having control on so I could make something out of my life. And there were other factors in those 2 years of university that have intensified it in that I was in a relationship that wasn't, that wasn't a good one, um and I let myself be controlled by that person too. So you see they almost, as that relationship progressed so did the condition. So there were a lot of factors sort of pointing in the same direction that I had to uh, I knew I had to try and touch base with, with myself in some ways.

But at that point, I wasn't ready totally to do that. I was still so concerned about running away from it all, you know.

L.T. Cause it was pretty overwhelming. You knew that something was wrong and you had a keen sense that you'd have to do some work and deal with the underlying things.

L.S. Very hard work. Yah. But, so that's I was very unclear about it all but I knew that there was something very wrong.

L.T. M-hm.

L.S. But I wasn't really able to admit to myself. I mean as I say on one level I knew it was me, there was something with me that would cause this whole thing to develop in the first place. But I guess I wasn't really ready in

some way to deal with that. So I went for a period of time--it was only about a month--to see this guy. And I'd see him on a daily basis. And it was funny because it was treated I think more as anorexia than bulimia.

L.T. Now this was a psychiatrist, a friend of your father?

L.S. My father's: in the medical faculty of that university and he was the head of Psychiatry there.

L.T. M-hm. And so how, how did it happen that you were connected with this psychiatrist then like?

L.S. Through my father. I, I told my parents that there, I was, I was experiencing some, some problems, some emotional problems. I didn't, up until that point, I didn't talk to them about any kind of eating disorder and I didn't know whether or not they were aware of one. And I told them I really needed to talk to somebody, and so they recommended uh Dr. C. to me. And so I went and saw him. And I started out by describing all the surrounding things such as I would, you know, I couldn't keep things together, I couldn't finish things. And then very shortly I told him that, you know, I would, I would eat and throw up. But I didn't know what it was all about, I couldn't put a name on it. But I think he treated it more as anorexia because I was quite underweight at that time. So we talked a lot about uh body image, and weighing in and that kind of stuff, rather than um talking about the reasons why this would have developed in the first place. Well, we did talk about body image and self-image and stuff. But the focus was as much on sort of behaviour modification in terms of eating and forcing myself to eat and keep it down, than on really digging things up. So that combined with the fact that I didn't think, you know, there's a part of me that didn't want to dig it up, I think made it, made for it to be unsuccessful. And I pretended that it was and that things were better.

L.T. Pretended that things were successful?

L.S. M-hm. Telling him that things were definitely getting better. He had prescribed a mood stabilizer or elevator--I forget what it was--to me uh which I took for a period and discontinued. Uh, but I had, I had another goal for that summer. I was always I guess latching onto things that I would <u>do</u>, and in doing things and achieving goals set for me by these things and these people that was how I defined myself. And the goal of that summer was to go to a--I was studying Russian--it was to go to a slavic institute in B.I. which is very, was very well-respected and was a very, sort of it would have been a "good feather in my hat." So I really had a focus of getting this thing out of the way so I could <u>do</u> it. And there was some

question by Dr. C. as to whether it would be good to undertake that at this time. But, "Oh no, things were getting better and I'm sure, you know, I'm sure I could." And it was a way of jumping from the work that I knew I had to do on myself to again into another um external uh set of expectations that I could meet and therefore get positive reinforcement.

L.T. Can you tell me a bit more about the sessions that you had with him. As you think back, what, what were they like for you?

L.S. You know it's funny. I don't know if this happens with, with everybody or with many people who have been involved with this kind of behaviour but I find my memory in some ways is very sketchy. It's as if I've, I lost about 4 years there. And so often when I think back I have flashes but I don't, I don't see much continuity in there. And I don't know if that was a like a self-defense mechanism because things were so terrible for so long or if. I don't know um. In any event, so what I'm going to say about the sessions I know is not complete but it's what I remember of them.

L.T. M-hm, sure. And that's all that, that you know, is important really and significant to you will probably be things that you remember: the significant things.

L.S. But I guess what I'm also saying is that there's a lot that I mean people will talk about during say those university years that I will have no recollection of at all. That's a very funny thing. Um, the sessions were, I, I would go into his office, it was one on one, and we would, we would talk. And what I liked about it and what I.

005 It was a similar element to the other sessions of therapy that I underwent here in V.--that I think did help me um overcome this--was that in looking at it as we went on I saw that very often he was just allowing <u>me</u> to put things out and he would arrange them so that I could see actually what I was saying and thinking. So he was very good about not trying to impose um his own ideas on me, rather making suggestions that, upon reflection, would have been apparent in what I said. So it was very much a way of um, of of just airing, airing <u>myself</u> and allowing myself to look at myself. You know, it was just, it was sort of a self-examination thing.

We would weigh in um, because as I said that was an important thing, it seemed an important thing from his standpoint. And he did set a certain weight, and I forget what it was, that were I to dip below that that they might

consider hospitalization etcetera and what went on during the enforced hospitalization. Um he did, he O.K., so we would weigh in and it was the, the expectation was that I would be gaining a certain amount of weight per week which I never really filled. I remember at the, at, I mean as the sessions ended, as my date for leaving approached--and I was very anxious to make sure that everything seemed to be hunky-dory from his aspect--I was coming up for a period. And so I gained 5 lb and I never told him that you know. But that was seen as being a success. So I was really trying to um hide the fact that things weren't getting that much better.

L.T. M-hm. So towards the end then you gained a whole bunch of weight so that you could say to him and maybe to yourself that, "Hey, I've succeeded at this, this bit of therapy."

L.S. M-hm. But it was a false gain. I mean I lost that right. That was just because of the water retention from the period. And, I mean, I knew that very well but I didn't tell him. But um, so it would be largely devoted to talking about myself and I think my family. I don't have much recollection of exactly what we talked about. This was in 1978 so it's quite a while ago. Um, he didn't prescribe any reading or um anything of this nature. No, there wasn't any support group or anything of that that should've went on. And also, I think the fact that it wasn't stressed that I take this outside of the office I think had something to do with it because therefore I could keep it again sort of as my secret. And as long as I didn't have to let anybody in on it then I wasn't faced with any other motivation than my own to work on it. For example, I could still be a home with my parents and still go through you know bingeing and purging cycles because as long as I could fool myself into believing that they didn't know about it, I could get away with it.

L.T. Because it was just between <u>you</u> and the psychiatrist and.

L.S. Uh-huh. Uh-huh.

L.T. So that was O.K. to have it that way.

L.S. And it's an interesting thing because if you um, if you intentionally overeat during a meal--and it's very easy to do at a family meal when someone else is paying for the food and it's all there--and then you have to go to the bathroom soon afterwards, you know if they're aware of what's going on then should you somehow happen to overeat, even if you weren't trying to you couldn't, that escape valve wouldn't be open to you. Because it would be very difficult to go through that when you knew that they knew.

L.T. Right.

L.S. You know so it was almost as if it left me an "out"; if I didn't go through with it and and really overcome it, I could still continue it which is I think what I wanted to do.

L.T. And so your parents at this time then are not aware that you're bingeing and purging. They just know that there's some emotional problem as you had told them?

L.S. I think that--I can't remember--I think that I did tell them there was an eating disorder involved. I pretty sure I did. But I know I didn't go into any detail about it with them. I, they may have thought it was anorexia, they may well have known everything and I just didn't want to admit that. But I know we didn't, I didn't involve my parents in terms of sitting down and saying, "Look this is what's going on, this is what has been going on, and this is what I'm working on." That never occurred.

L.T. So, the bottom line is that you felt they really didn't know exactly what you were doing and so therefore.

L.S. That's right.

L.T. It was still a secret between you and the psychiatrist.

L.S. So, so when I went to this program, things were better. Actually that was, at least I'd faced up to the fact that I had a problem, that it was an identifiable problem, and that I knew I needed to work on it more.

L.T. What, just before you move into the program, what happened at the end of therapy then? And, and also how long were you, you said you were going every day but I wasn't sure for how long?

L.S. I think I went daily and then we dropped it back to maybe every other day or something. It was about a period of 6 weeks, perhaps to 2 months, because as I remember the program was the last month or so of the summer and I was home since May. So it would have been within 2 months at any rate.

L.T. That was fairly intensive then going everyday and then every second day for about 6 weeks.

L.S. M-hm. Maybe we dropped it back to once a week. See these are the details I can't remember.

L.T. M-hm. Well that's O.K.

L.S. M-hm.

L.T. Um, but it sounds like the beginning part was quite intensive anyways for you.

L.S. Yes.

L.T. And in terms of your eating, what sort of things did you discuss with him and how did you implement them or did you implement them?

L.S. Well, I. What I remember of it is that um, I don't remember really discussing what bingeing was all about, like you know just the awful details that I think it's important to get out when you're trying to deal with it. Um, I do remember you know talking about writing down a daily list of say what you were going to eat and writing down what you had eaten, almost as a dieter does. Or um, I think we were looking at it in the reverse perspective of a person who is trying to put on weight so that eating should be a conscious process um, rather than dictated by just yourself, that you'd actually plan it out. I don't remember much more beyond that.

L.T. And so did you do those things and sit down, like make up menu plans?

L.S. Well, I think I did half-heartedly, but I didn't really do it carefully. Again I was, I was kind of sabotaging it I think from the beginning.

L.T. And so you may have done these meal plans but still continued on with the behaviour.

L.S. Yes, I probably would have, I think I probably would lie to him.

L.T. M-hm. So you were able to maintain your weight at the low level it was by continuing on with the purging and not eating a whole lot.

L.S. That's right. I don't think, after I dropped initially the the very first semester I think I was away, um, I don't think my weight continued to go down below that. I was definitely underweight although I didn't see myself as being that way. Like it was still ludicrous for me to hear Dr. C. talk about me as being thin or anybody talking about being thin. And I do remember a comment he made asking me why. He talked, I remember this, he talked a lot about body image in the sense of being proud to be strong, and you know how a beautiful body was a um, a <u>strong</u> one and not an emaciated one. And asking me about um why I would wear sort of baggy clothes. And of course the reason why I wore them because, was because I was overweight. And his suggestion that I wore them to hide how thin I was, I never could, I could not accept that.

Like I never believed that I was thin enough to want to hide it, hide my state. So that, I was still operating from a perspective of being overweight and being ashamed of myself because I was overweight. But I do remember his talking about um one's image of, of the way other people look. And that beauty being um a, a well-proportioned body, and a fit body, and not just trying to achieve thinness. And I do, another thing I do remember his talking about, we must've talked about, I, I know we did, we talked about um my lack of identity and my insecurity and such. And he was talking about, um, almost being able to see that on a person's face, like how formed the person's face was.

L.T. How?

L.S. How formed and how much character would come out. And the fact that um he thought that towards the end of the sessions that my face looked better. I think, I mean he was probably right. I think I probably had, you know, made progress during that time but just was not allowing it to go further than I wanted it to go.

L.T. M-hm. You felt safe to the point that you had gone and didn't want to progress beyond that.

L.S. That's right, yes, yes. I think that's probably what it was.

L.T. So you're feeling overweight in spite of the fact of him telling you that you're underweight. And did, did his sort of comments about what a fit body was like, how did they impact on you at the time?

L.S. Well, in a sense of there's always self and others. Like I could look at another person and say, "yah, that person is a beautiful person." But I could never accept myself as I suppose ever having the hope of being a beautiful person.

L.T. Who, who would be beautiful people to you then?

L.S. Then?

L.T. Yah.

L.S. Oh, the traditional, you know, people that are held up as supposedly beautiful, you know: models and movie stars and that kind of thing. You know, you always I think, part of the problem is comparing yourself to an unrealistic goal. Like I would never take myself and say, "well, how could I make myself beaut?" You know, I just had this idea of a very, you know, self-loathing. And I think, in some ways, perhaps some of this is almost like

punishing yourself, you know, because there is nothing about you that you like both inside and out. So my um, the only way I felt approval towards myself, towards my physical appearance, was like not to have any tummy. You know, if there was any bulge there it really upset me.

Um, so yes I could see beauty in others but I could, I couldn't apply that to myself. I remember my mother when I was back--I suppose the first time I was back at Christmas when I had dropped so much weight--saw me without my clothes on and later on she said that she later on burst into tears because I looked like someone from Dachau or something. And of course I didn't feel that way. I felt "Gee, you know this is, I'm so much better than I used to be; I'm not fat." So there was a complete distortion there.

L.T. Did your mom ever make any comments to you at the time?

L.S. When I first, the first Christmas I think everyone was quite concerned, although I wasn't really aware of it. I know my older brother was in medical school then and had said something about anorexia to my mother, looking at me. And I know that my mother was sort of appearing at my elbow with little snacks and stuff which, in my mind as as child, as an overweight child and always feeling that food was held back, was a wonderful sense of my mother bringing me food. You know, so I think it, it, some of it I think also was was a desire for attention and, and, and being mothered and all that, being taken care of. You know knowing on some level that I was sick and if I could show it to others then they would take care of me.

L.T. So it felt good in fact that your mom at that Christmas knew what a low weight, was bringing you food, that you found that quite acceptable.

L.S. Oh yes! And also to be told that I was thin. I loved that! I just loved that!

L.T. M-hm. Cause when you were young you said you were overweight, right.

L.S. Yes.

L.T. What do you mean by overweight?

L.S. Never obese but I was quite chubby. And up until about the summer after Grade 8, I lost weight. And I, and I, upon looking at pictures of myself <u>after</u> that point, I can see that I really wasn't overweight. I was just a bit large. Um, so again my, my self-image was already starting to become distorted at that time. And I think my ideal would have been to have been a small fragile person

rather than the large um, I guess healthy looking person. I remember my father, when oh gosh, Grade 7 or Grade 8, taking me to one of those little dances they have and asking him um, "Dad do you think I'll ever be pretty, or do you think I'm pretty now?" And he's a, a very honest person, like it's not in his character to lie. And he, his answer was, "Well, I think you will have a kind of Brune Hilda type of beauty, large and strong." And of course that was, that stayed with me as being the antithesis of what I wanted you know.

So, yes my mother commented um, not very much though. Like she would say, and I would say on occasion during those years when I was so underweight, she would say things um in a very sort of sad way. But I think she didn't want to let me know or didn't, I don't know if she didn't know what to say or thought that her interference would be negative or what, but she didn't like, you know, sit me down and say I need to talk to you about this. Maybe it was self-denial on her part, I don't know.

L.T. In any event, she didn't say anything to you about your being underweight.

L.S. As I said, little things but not, she wasn't making a big deal about it.

L.T. M-hm. O.K.

L.S. Or maybe it's a fact that if she were to have said anything, I would interpret that as a compliment. And I don't remember that now. She repeated to me something my little brother said um upon seeing me at the airport. He said, "Oh, her hands look like claws, you know, she's so thin." And I remember her saying that to me that he had said that.

L.T. M-hm. And at the time you took that as a compliment or something that you loved.

L.S. Oh I liked it. And still they didn't mean it as such, but I liked it.

L.T. Right. Just when you think back to your ideal image of someone being really thin, where, where do you feel you got that sort of ideal image from? Cause your dad had said that he, sounds like that he really liked people who were stronger and bigger, so I'm wondering where that came from for you?

L.S. Well, I think probably a multitude of places. I think that for, I tend to believe in a person having a, a certain character, a certain element of character that's consistent throughout their life. So I think if a child,

and I don't think I every really was a very confident child either: In some ways I was, socially I never was. So I think if you take that character and then you have something that makes that child uh feel more different, the child will always interpret it in a negative way. So that, you know, going through trying to diet as a young, not as a young child but you know, it was always an issue that L. was a bit overweight and she should try and work on it. I think that had something to do with it.

But I think even more importantly um was the fact, the whole media glorification of them, of the perfect woman. And it was during the time of Twiggy really and that whole image. So everywhere you look, you see exactly what is beautiful. And if you're not a person to believe in oneself and look at oneself and find beauty in oneself, then that's what you're going to latch onto again are external images. And of course you know, the teenage and preteen years, everybody is trying to achieve that look. So the people that you respect around you--your peers--all look more or less like that too. So I think from the family, from your own feeling of insecurity, and from the media. I would say those are the three big areas.

L.T. O.K. So your ideal image then is of someone who's really thin. And even though the psychiatrist had told you that he felt that people could be beautiful with a bigger body that, you know, and a well-proportioned body, somehow you only half believed him or.

L.S. Well, no. I believed him. I mean I could see a picture of someone overweight, underweight, and realize that person was not beautiful. That yes, you were supposed to be thin and fit but no you're not supposed to be so emaciated that your knees bruise each other at night when you lie down on your side. But I could just never see <u>myself</u> as being anything but overweight and needing to lose more weight. You know, I couldn't see myself as I was. So, and I suppose I could've even have seen um a woman athlete, maybe a very muscular woman athlete let's say, and, and recognize the beauty in that. But I certainly couldn't see a person who was considered overweight and consider that attractive at all.

L.T. M-hm. So it was hard for you to really look at yourself as you said earlier.

L.S. Impossible. Impossible. I remember occasionally getting a glimpse of myself--before I knew I was seeing myself in like a shop window--and having for a split second the knowledge that that was a, a thin person, until it clicked in that that was me. And then that idea was out of my head.

L.T. M-hm. M-hm. That's me and I'm not thin, never thin enough.

L.S. That's right. Ergo, that reflection isn't thin.

L.T. M-hm. O.K. How are we doing with the story? Now I've asked you a number of questions and sort of got us back and now.

L.S. No I think, no I think it's good because this sort of chronological progression I think is easier for me to remember things in. Um, I could talk more about <u>why</u> I felt that, you know, <u>how</u> the whole process started, but you could weight that if you wanted, that doesn't matter so much.

L.T. No. No, I think that I, I have enough of the key things to, for us to move on if, if you feel you'd like to now and your rest of the story.

L.S. M-hm. So. O.K. so after that therapy then I just continued on and things um, I think at least I was able to finish my courses and, you know, the last couple of years. Um.

L.T. So you're still. One thing keeps going through my mind is that when this tape finishes, there's this really loud beep and I just thought.

L.S. We're not supposed to jump, right. (Laughs.)

L.T. (Laughs.) Well, you can jump, no, but I just always forget to warn people. That just keeps going through my head as we're talking. Um, so anyways, we've come to the end of, of therapy then with your psychiatrist and you're still underweight.

L.S. M-hm. Then I went to that program and um, I think that I reacted--it was a pretty stressful program--and I think I reacted by getting right back on into the same behaviour pattern.

L.T. Had it changed somewhat then L.?

006 L.S. I think it had. As I said, I think that the therapy had some, had some benefits. Um, I'm pretty sure I was still bingeing and purging. But I think there was a bit of an element of control, a bit.

L.T. How, how do you recall that there was a bit of control? What makes you think that there was some control for you?

L.S. Because I remember the um, you know, bingeing during the program. And I don't have recollections of that kind of real, really being out of control during that period.

L.T. O.K. M-hm.

L.S. And I think it was um a reaction to again the fear. You know the expectations, I, I really craved them, yet I was always afraid that I was going to fail. And um, I remember bingeing as a direct reaction of that during that, during the program. So I think something about the lack of.

007 The being able to focus on the problem and have no other expectations--which I wanted, but it was better that I didn't have them--contributed something to perhaps a bit of remission during that period of therapy.

L.T. M-hm. It was a little bit of a time-out from what you had been doing at school, and then you went into the program.

L.S. M-hm. That's right.

L.T. So that change was helpful to you in gaining more control over your bingeing.

L.S. That was for the period that it lasted, but it didn't carry over.

L.T. M-hm. And you said "remission." Do you, do you feel that that was a time during which you recovered, in part, or, or how would you describe it?

L.S. I would say that's the first time that, it was a first step. It was a, a, an acknowledgement of the problem both to myself and to someone else, and realizing that I had to look at myself for the answers.

L.T. Mmm.

L.S. Um, and so I think that was an important.

008 But actually stopping and saying, "Whoa, wait a minute, you know, there's something real wrong and it's me, and I need help." Because hitherto, and, and after that too, I would, you know, after a particularly bad period I'd say, "O.K."--and I think, I'm sure everybody does this--"This has got to stop! Dadu dadu dadu dada." And it would last, you know, overnight maybe, that resolution. And so the realization that I couldn't do it myself was important. And the fact that I had that support.

L.T. O.K. those were two key things in your therapy.

L.S. M-hm.

L.T. And huge steps, as you say, to beginning to make some changes.

L.S. Right.

L.T. Was the recognition of it and seeing that you couldn't do it alone. (Tape ends here.)

009 L.S. And I think another important aspect of that [therapy] was the fact that you're breaking the isolation, breaking the secrecy and letting someone else in on it. It's, it's telling you know, it's realizing that you need the support. But it's also that by breaking out of that um circle of, of secrecy that you create, you're almost it's like letting a chink of daylight in. It's like, you know, it's a connection between sort of you and the outside world, in on, on who you are and your secret. And I, I believe very strongly that that's a vital part of it. At least it was for me. I know it was a vital part for me because in the subsequent therapy, I think the biggest step was taken when I told my husband about it, and the most difficult. So I think part of the reason that there was some improvement during that time was that I had told somebody else about it. I mean he [therapist] was the first person I told about it. And that, um, I, I would say that is very important.

L.T. Because you're feeling less alone and less isolated and what impact did that have on you or how did you feel?

010 L.S. Very positive. I mean that was real good. It's, you know, it eases the burden that you carry. It also allows you to talk about it because you're not going to sit by yourself and talk about it, and try and lay it all out and understand it. At least I wasn't, cause you're so caught up in it all.

But when someone else, you have to, you know, tell them about it, then you have to examine it. That's where, you know, that's the wall. It's sort of like you run up to this wall and you say, "O.K. this is, now I have to just turn around and face the hounds that have been chasing me in a way." And when you're just on your own, you can just keep running and running.

L.T. So it was having someone there then who, in a sense, gently helped you confront the issue and helped you look at yourself more clearly.

L.S. Yes. And the therapy aspect was, was that you know, helping me look at it more clearly. But, you know, it's just the act of telling somebody. Because when I told A., my husband, I never, I have since, you know, talked to him about it a bit. It wasn't so much that he could do anything for me. It's just the fact again there was someone else involved beside me. And I couldn't, even if I wanted to, it would no longer be a total secret that I could revert to. So you know it's, and I guess you know stopping a stranger on the street and saying, "I throw up" (laugh), you know, wouldn't be the same thing because that person wouldn't be a part of your life.

L.T. Right.

L.S. So that you could just seal up the wall again really easily. Oh my metaphors, I'm getting them mixed: putting down a wall, having to turn and face it, and sealing yourself up. But I think you can follow it. So I really think it's, it's what that person, the fact that the person can help you examine it all. But I think it's just, it's just breaking that, that horrible feeling of being so cut off from everybody else. And if once somebody else is privy to that secret, you have to address it too.

L.T. Mmm.

L.S. Because you can't keep, you can't say, "Oh, I do this," um and, and intend to go on doing that. There has to be some kind of attention then that you're going to deal with it. At least I couldn't. And it's the shame of it all.

L.T. M-hm. Is it almost like it made you more accountable in a sense?

011 L.S. Yes. Because it wasn't just me. And that for me, that the shame of it all was so horrible, was so terrible, that again letting someone else in on that presupposes that then you're going to do something about it. You have to now cause you can't look at that person in the eye knowing that, you know, you're going to be running to the bathroom. So that, for me that was really important.

L.T. M.-hm. Sounds like it gave you that extra bit of motivation.

L.S. M-hm.

L.T. To really begin to think about doing something.

012 L.S. Well, and also to have someone, someone else accept it, uh and not um; it just lets you know that maybe

you're not such a monster. You know that someone else could hear this part of you and still, and still accept you. You know especially in terms of you know, the person that you're living with. And you know, supposedly you've known this person for however many years--4 or 5 years--and that's the one secret you've never told them. You know so, it's, it also allows you to feel more like a human being. Again, the whole um breaking out of the isolation, and that even the fact that you do that doesn't mean that you're such a rotten person.

L.T. You felt really accepted then when you told the psychiatrist and also when you told your husband.

L.S. M-hm. Yah it was an element of, of being accepted to know that you didn't necessarily <u>have</u> to keep this secret. Cause it's funny you, I think, for me anyway, I knew on some level that I'd <u>have to</u> be working with someone, I'd <u>have to</u> tell someone. Um, but, I lost my train of thought. I would have to tell someone about it in order to deal with it. Um, but (pause) if, gosh there's something I wanted to say. If that person were not to have accepted it, it would have been just the worst thing. Something else has escaped me and I might remember it later.

L.T. Sure, that's fine. (Pause.) With the reliving of it and trying to sort of pick apart little details is quite, and and they're so intertwined as well.

L.S. They are very much so.

L.T. In many ways that it's hard to get all of them as you relive it, I'm sure.

L.S. So that I think in both instances, both sort of um steps, was, was just the act of telling was really important.

013 And I guess that's why--I'm jumping the gun, the gun a bit--but that's why I think groups must be important in the process too. Because again you're, not only have you told others and they, you know, don't run away screaming or something; you're still a person to them. But also you see others who seem to you quite, I mean they look like people, like they have it all together. Yet they carry this too. So I think that whole element of sharing is is so important.

L.T. M-hm. It's almost like it's not the sole focus of one's, of one's life. Like it's part of it but there are other things as well that make them human.

014 L.S. Yes, um, because for me anyway, there was such a lack of um, like part of me was scared that if I did examine myself I wouldn't find anything there. You know, because I didn't have any real sense of myself or of no strong grounding in myself. So part of the running away from it was--running away from dealing with the bulimia--was the knowledge that I'd have to do self-examination and my god, what would, at this point, what would I find there? I mean there would be nothing, I didn't feel there'd be anything to work on.

L.T. So that must have been incredibly scary then to even entertain the thought of therapy.

L.S. Very much so. Yah, it was a very frightening thought of actually dealing with it.

L.T. M-hm. Coupled with the whole sense of shame and having to tell another person about your behaviour and then they'd also find out about yourself, and who knows what that would all involve.

L.S. That's right. That's just it. You, I think I always had the very firm belief, sort of like the Groucho Marx saying, that I wouldn't belong to any club that would have me as a member. You know that if someone were to really know me, I mean, I, I knew myself and I hated myself. So if someone else were to know me, my god, you know the chances of they're liking me would be so much, they just wouldn't exist. So you know it's keeping up this, this sort of front that you've created (a) in terms of pretending that you're normal regarding your eating but then everything else that you're just a, a normal person, you're just you know like any other "Joe." Um, and it, it becomes, you know, a real strain I think when you have all this sort of eating away at you: the fact that you think you're horrible and I mean you're convinced that you're horrible because of you don't, you know, you don't have any self-definition, you do this horrible thing with regards to eating.

And also in my case um, I did other things that would sort of reinforce, I think in a way, this negative self-image. I was involved in shoplifting um just a, like I couldn't really say here, here are my standards and I uphold them because I didn't, I couldn't have any standards because there was no person to set standards. See what I mean?

L.T. M-hm.

L.S. So in a way, and it was always that feeling of guilt for everything that you did because you knew that things you did were wrong, or ways that you were were wrong. But you

didn't feel that there was a solid core there of yourself to set standards for and then have the integrity to uphold. Like the, the idea of of succeeding and doing that and just living sort of a moral life was totally out of my grasp. So it was always a , sort of a facade of, you now, being a decent person doing this um that you had to uphold at all times in addition to the whole eating disorder secret.

L.T. Is it like, and correct me if I'm wrong, but it sounds like there's two sides and on one of them you're trying to portray to the outside world a really upright, moral kind of person.

L.S. M-hm.

L.T. But inside you're feeling like there isn't any person so there's no point setting standards. And therefore it's really easy to just break them.

L.S. That's right. Also I think, in my case anyway, I mean I came from a pretty you know upright background and all this, so I certainly knew what was right and wrong and especially in regards to myself. Um you know, I didn't do like horrible things but there were things that I did that I knew were not really me. Uh, and I think in some ways doing that uh, perhaps is a call for help or attention. But also is, it just, at least you're right in something. At least you're right in how bad you are. It, it reinforces this idea, you know. So its almost like a you've uh at least chosen, there's at least one thing that you're very clear about because look at what I do.

L.T. M-hm. Something that you could grasp onto and say, "Hey this is what I do, this is perhaps me."

L.S. M-hm. (Pause.) Yah. But all the time I knew it wasn't me. Like I knew that wasn't, wasn't really me but I knew that I was a not a good person especially since I would do these things. You see what I mean? So there's always that dichotomy between what I really knew my moral standards were or my you know whatever, what my personality was, and looking at the way I thought I was especially as reflected by my actions. I don't know if that makes any sense.

L.T. It, it does. But the part where I get confused though is where you said that you felt like that you sort of didn't have an identity, therefore you didn't need to set any standards. But it sounds like you actually have set some standards.

L.S. You had, yes, I mean I had standards. But because I had such a poor self-image I didn't really think that I could

ever live up to them anyway. See what I'm saying? So, it's like, it was sort of like um trying to be beautiful or trying to be whatever, like I knew because I was the way I was, I could never be that way. So it was in a way almost I thought I could try, you know. Because I knew, I guess I knew that no matter what I did, um I would still not like myself. So, in some ways it didn't matter as much what I did because I knew that I could succeed in here and I could get A's in there, and I could do this, but I knew that that core would still not like me, you know.

L.T. Didn't matter what you did then.

L.S. No. It's funny because it did and it didn't. I had to, in in things that other people saw I had to achieve certain goals for any kind of self-definition. Yet, since I had no self-definition, (laugh) this is getting crazy, since I had no self-definition I could, the other things I'd do when nobody else knew, it didn't matter because I was only accountable to me. I wasn't strong enough to have sort of standards of accountable to my own self.

L.T. M-hm. M-hm.

L.S. Because if you can pretend to the world that you're a normal human being but then in isolation you can binge and purge, it's it's almost like every other part of your life follows that that pattern.

L.T. It must have been a real relief to you though to have that place where you didn't have standards, where people didn't know about the bingeing and purging.

L.S. I think it must have been. I mean it caused tension because every time you did it you knew what a horrible thing it was to do.

015 But, yah, and I would be very, like I didn't have good friends because there was so much of me that I thought I had to create for others and so much of me that I had to hide. So I was always very I think kind of anxious around people and like who am I supposed to be for this person kind of thing. Um, and so I never um had what I would have called "real relationships" because I was always trying to create a part of myself to please them. So it's a terribly, I think a very tiring thing because you're carrying around these secrets, you're carrying around all your different identities that you're trying to portray to different people so that you'll please them.

L.T. That's a lot to keep track of.

L.S. Yah, it is.

L.T. I'm sure. You know, in addition to doing all the other things of going to school and um being in a family, and and you know all the responsibilities that just go along with that as well.

L.S. M-hm.

016 And I think it was, it probably was the fact that things kind of came crashing down before I came home that summer after second year that made me realize, or it made me take that step of actually seeking help. And it was similar when I, when I went for therapy in V.

But anyway, I guess to catch the thread um. So my last couple of years of university were similar to my first, except I think you know I did carry something with me from those sessions. And I was able to, I think um, to keep things together a little bit better. Although anytime I would stray beyond very cut and dried expectations that you know I'd meet, then I'd fall apart. Like independent work was really hard for me. If someone said this had to be done, I'd do it. But if I had to be doing research sort of off hours, um, research for a professor or something, it just would never get done because, because you completed what you <u>had</u> to complete and there was nothing, you couldn't hold yourself together enough to go further than that. You couldn't structure yourself independently. I keep saying "you"; I mean "I".

L.T. M-hm. And that was, a somewhat different than the first 2 years then for you.

017 L.S. It was. You know I do look at the first 2 years [of university] as being sort of a, the time during which I kind of plummeted. And then it kind of, the therapy I think sort of arrested that um direction. And then I sort of see the other years as more or less a plateau. It didn't get worse than that. It didn't notably get better. Um, but I was able to maintain things on a more even keel.

L.T. Can you give me an example of what was happening with your eating behaviour during this time?

L.S. During those other 2 years?

L.T. Yah, third and fourth year.

L.S. It was the same kind of pattern, um, of of a lot of um bingeing and purging, and and inability to eat normally. You know to, what others might consider a normal meal, I

would be incapable of keeping down, my anxiety would get really high, um, I would feel dreadfully bloated and awful. Um, so I wasn't able to eat normally and I would binge a lot especially if I was alone. You know, that reinforces the solitude too because it has to be a, an activity you engage in alone. So there has to be, there have to be periods of time that you know you're going to be alone, you know; that's what you sort of crave. You can just do it.

018 So that was still all going on [bingeing and purging] but um, I was out of that relationship. I think that made a bit of a difference. I was a little more autonomous that way. Um, I was defining more sort of what my direction was in school. I had established you know, the Russian major and I knew more or less I was good at it, even though I I thought I was only good because the competition wasn't there. So I had a little niche, you know, and that helped. It wasn't so much just flailing around.

L.T. You felt more secure in yourself then, is is that what you're saying?

L.S. A little more [secure]; not so much in myself and my own core but uh, sort of in the external. I was, I kind of knew what I was doing, I was doing Russian and I was doing pretty well. I mean I got, I got the good grades and everything. And uh, so I could identify myself, again sort of "hang my hat" on just one thing and know that I was doing that pretty well. So I think the underlying issues were still there but I was able to sort of stabilize because of being in a more stable situation.

L.T. M-hm. O.K. So, the years seem a little bit different because external things have changed: that you have more of a major and feel a bit more secure in some of the things.

L.S. M-hm.

L.T. And, but you're still bingeing and purging and not being able to keep down normal meals.

L.S. That's right.

L.T. Is the eating different in third and fourth years than it was in the first 2 years?

L.S. I think--I don't remember--I think they were, they were very similar. But I think I may have been able, if I really wanted to, to keep down a meal because there would be very few meals that I'd be able to keep down at all, in

in addition to the bingeing and stuff. So I think, I think I would be able to get through a meal and um not overeat to a, you know, gross extent so that I could keep it down. But I know that (pause) didn't happen that often anyway. But I think it could happen at that point.

L.T. Did it happen as you recall? I guess I'm just trying to focus in. You said that the years were different, and and I can see in terms of um studies and sort of how things are progressing academically for you. But I'm still not clear if the eating, if you felt different about it in any ways?

019 L.S. Well as I said, I'm pretty sure that um I could, if I really wanted to, could keep a meal down. And the other thing I can determine is that there could be, uh the whole eating thing wasn't, didn't have me by the throat so much. Like there, I could at least time it, like put it in special pockets. I could um--not all the time and not nearly successfully enough--but I could, you know. Like fourth year I lived with a roommate and we could do study sessions before an exam without my, you know. I could do that. And I could, it wouldn't be such a driving thing to be doing continually. Because as I, as I look back on it now--I could be wrong--I just seem to think of those 2 years as being a continuous cycle of bingeing and purging. And it seems to me that I was able to--it still happened and maybe as frequently--but at least I could take periods of time where I, that I could do something with.

L.T. O.K. So there were other--I was going to say priorities--but there were other things.

L.S. I was able to,yah, I was able to, to do other things.

L.T. M-hm. It didn't, the bingeing and purging didn't totally control your life to the extend that it had in first and second year.

L.S. I don't believe so. I don't believe it did. (Pause.)

020 And you know, again the details I'm unclear of. I know that I was um, that I substituted drink [alcohol] uh, and to some respect, extent, for that. I don't think I ever had what you classify as an alcohol problem. But I know that I came to the realization that alcohol could in some ways do the same things the bingeing could. It was almost like a cycle. It would take um. When you're engaged in that activity, you can't really be engaged in anything else. So it's the sole focus. So when you have real worries, and anxieties, and feelings of

fear and stuff, it's almost like a a reassuring cycle to get into because it takes you away from having to deal with those. And drinking did the same thing. (Pause.) So I think um, I think that uh, I know I didn't like it you know wasn't like drinking on a continual basis. But I, I do think that I came to that realization at that point, um for whatever that's worth.

L.T. It, it was, you're referring to alcohol when you say drinking then and not just extra quantities of.

L.S. Oh no, no, no. Alcohol. Yah.

L.T. O.K. And that was something that was different than first and second year for you? Like you began to drink more in, in third, third year, third and fourth year?

L.S. Yah, I think so. M-hm. I think so.

021 I also in third year um, there was a, I think I was also very frightened of of entering into another relationship because I knew that I would again be controlled. Like I couldn't, and it was too much of a strain to try and keep up some kind of facade for someone on such a close basis. Um, so there was, there was a um, um a boy who, you know, wanted to develop a relationship with me. And I remember being very um, very much not wanting that, I think, because I felt much closer to him than I did with the guy that I was with for the first 2 years of university. And therefore the chances of his having to discover this about me were that much greater. So I do remember subsequently being very, you know, standoffish in that regard. Um, I did have a friendship with a, with a woman during my fourth year; we roomed together. That was good. It was almost like the first friendship that I had that I thought I could reveal some of myself to which was nice.

You know, so here were a multitude of things, different things going on during that period. But I think on the whole things were, there was a small amount, element of control that wasn't there (pause) subsequently or before that. (Pause.) So, but still it was you know, it was still very much there.

L.T. So you're still taking time out to be by yourself to keep up with bingeing and purging, and um still trying to maintain yourself and to move throughout university which you were able to do in spite of it all.

L.S. Yes. M-hm. So I finished and um, then there were, let me see, 4 years I guess after university before I went into therapy: 4 or 5. And during that period I did some graduate studies and 2 years abroad. And again, the eating problem continued throughout all that time. But, maybe because I felt more established in what I was doing--that I was doing graduate studies in Russian--and I thought for the first time in my life that maybe I could do something well, and and realize that I liked it. Um, especially when I began, began teaching I realized I <u>really</u> liked it. And I think that had a lot to do with the fact that that element of control and stability was growing: It was growing. I never finished my master's thesis; that was funny that you were talking about that.

L.T. (Laughs.)

L.S. I did, you know, <u>very</u> well in everything. But again, when, I think for two reasons. The still that that desire to fill others' expectations by, you know, teaching and doing course work and this and that with very little left over, you know, not much left over for me. Um, and I guess wanting it that way cause it was easy to get the, the approval which I needed without, where I was doing my own work was just more or less for me. Um, and also, um the fact that the eating was still, was still um, the eating problem was still very much there. And it's incredible how much time and energy that takes up, you know. So, but things <u>were</u> better.

L.T. How did you know things were better?

L.S. Because I was able to um. Just in terms of the eating behaviour?

L.T. Well that, that as well as whatever you mean by "things were better."

022 L.S. I think the key element there was that I felt that I was doing something that was more or less worthwhile, that I was, I thought I was fairly good at it. So it gave me sort of that approval and I was able to sort of define myself more. Like I could say that, um you know, I'm studying Russian and I could have that um as something that <u>was me</u>. It was a very much me that during those 4 years it pretty well, you know, took up most of my time. So I suppose in a way that's again there was issues I wasn't addressing. You know I never did go back and do the sort of soul searching and house cleaning that I thought that I should do in order to really be well. And I still had, you know, there's still a lot of underlying lack of confidence and self-hatred and all that sort of stuff. But at least on that

plane I felt some element of performance and an element of success. So I think that's why things were largely better.

023 And as I did more and had to do more, the time for me to engage in, um you know, weird eating behaviours was lessened, was decreased. And uh, so I think the demands were more but for some reason I wasn't panicking as much, and I was able to do what I had to do to meet those demands.

L.T. You felt more able to do your work and it almost seems like it then began to encroach on time that you could use for your eating.

L.S. That's right! That's right! And I see that pretty strongly in when I feel the real recovery came too um in terms of the full-time employment that I got. That really took way, you know; you couldn't, you couldn't do that and hold down a job. So, but there must have been, you know, I think there's an element of self-definition too because if that hadn't of been there, then I don't think I would have been able to have changed ever so, even if it's subtly, my eating patterns. So I think it's a sort of a combination of things of of again too external to be that good. You know it should be pretty an internal sort of core of self and of self-knowledge and self-worth. But the fact that that was there brought to me more of an element of of self-worth and and an element of stability. And so now I'm feeling, in some way, I was O.K.

L.T. M-hm. Things started from the outside then to build you up.

L.S. Yes.

L.T. And to, to help you move away from the eating.

L.S. M-hm. Yah. So they did get better. During those 4 years I was uh first year in grad school in I., and then in F., and then in R., and then back that last year in graduate school in I: And things were, things were better. Um then, and I guess this is a mirror of what happened when I left home to go to university. Um, I married a Canadian that I had known in undergraduate school, and uh left, and came to Canada. And I left without finishing my thesis which is a big. Yah, I thought, "Oh I'll do it later," and I still haven't which is still a big, you know, real sore spot. But (pause), well this is all really interwoven with things that have nothing whatsoever to do with an eating disorder but.

L.T. That's O.K. Tell them if you like because you know sometimes it's, it's amazing how they kind of are

peripherally related.

L.S. Well, I'll tell what I think is related.

L.T. O.K.

L.S. I think that the fact that I married, and in a very real sense abandoned what was becoming a career track for me and came here, had a lot of effect on what happened next. Because I was in some ways reverting to the same patterns of (a) relinquishing control of my life, um and of not believing in myself enough to, to keep that going. In retrospect, you know, it was a terrible thing to have done. Although the whole aspect of marriage and stuff is, you know, a different thing. I mean there was love and other things that go into it. But in terms of where I <u>was</u>, I mean I look back now and I don't think if I were the person I am now (laughs). (Tape ends here.)

025 I was saying that if I were the person that I am now, if I were that, had been that person then, if I'd had the, I think I believe in myself a bit more and I know better who I am.

If I were that person at that point, I don't think I would have taken that step. Um.

L.T. Of getting married?

L.S. Yah, and of effectively leaving what I was doing.

026 Because I had just, at that point you know, I felt that I'd made a commitment [to my boyfriend] I think in some ways. And you know, I mean love was certainly involved. But beyond that um, I think I felt that I had made a commitment. You know, we'd been sort of "long distancing" it for 4 years at that point and I felt that you know this is what we've had; I was going to do it [marry him].

027 But um, at that point I was just, I'd done a lot of teaching that year and I was really excited by it and I suddenly realized that I <u>loved</u> this. And I suddenly realized that I was <u>good</u> at it, you know, which is a tremendous realization. And so um I, I don't know but I think it may, had I continued on that track, who knows, but it <u>could</u> have been that things [bingeing and purging] would have just continued slowly to get better on their own.

I don't know that and that's second guessing. But as it was um, I kind of left that and dropped into a void here.

L.T. What makes you think that things may have just gotten better on their own?

L.S. Because of the slow improvement over those 4 years.

L.T. You could see progress so you expected that it would, could continue in the same way.

L.S. Yah, perhaps. As I said it was still there and there were still things that needed to be addressed, I'm sure, I mean I know. But, I tend to think that um (pause), that if I'd gone on it could've been maybe I would have folded. Maybe I would've, you know, if the pressure I'd felt the pressure in say a Ph.D. [Doctorate of Philosophy] program was too great I would've, I'd folded and totally reverted to that, I don't know. But it could be that had I gone on and experienced more success that this would become less and less important, and kind of wither up like the state is supposed to do under communism and fall off like a tail no longer used. Um, I don't know that.

028 But what I do know is um coming here then that summer was um, was really bad because I kind of dropped into [a void], you know, I didn't have a master's degree and I didn't. Well, I just felt that I'd dropped into nothing. And um, you know trying to find some kind of work and you know, my husband being very involved in his, was again I was suddenly face to face with myself again without any of the external, you know, pluses and strokes and stuff. And, in some ways it might have been a very good thing. Because what it did was it yanked that identity [from my work] away from me. And I wasn't a strong enough person, or a forceful enough person, or a person who believed in themself enough to sort of kick and scream and fight for that in this environment. So, things deteriorated really quickly over that summer and the fall. And I was sort of picking right back up on the same old habits. I would spend the day--you know, with A. gone and not really knowing anybody or not many people here--isolated and again going right back into the bingeing and purging.

L.T. M-hm. You began, it began increasing, or you began to feel that loss of control that you had felt before.

029 L.S. Both. [The frequency of bingeing and purging began increasing and I began to feel a loss of control over my eating behaviours.] Yup. And that was real scary. And again it wasn't something that um, I think I faced up to until it got really bad. And I think that, I think the realization that things were bad (laugh) came to me cause we went to my family's

place back home in I. for Christmas that year. And it was like seeing that environment that I used to be in, that I felt that I was flourishing in--you know it was the same city that I had been in school in--and suddenly seeing the way I was. And I think it was over that Christmas that I realized that when I got back I had to do something. Because I think I realized that I'd taken some steps and that, you know, things were better but that since my environment had changed, I had just sort of crumbled. And um,I had to deal with it.

L.T. You saw a really marked difference then in a short period of time, and going back to I. sort of reinforced the fact that you had at one time been functioning at a more um, healthier maybe level or.

L.S. That's right. That's right.

L.T. You had felt better about yourself anyways.

L.S. Yah. That's right. And so, I guess that was the "bottoming out" that I needed to go through to actually do something about it. So when I came back um. Again, I mean I hadn't talked to anybody about this. But when I came back (pause), I called uh, I didn't know what to do. At that point I knew the name of what I had, you know.

L.T. How, how did you know that you had bulimia? How did that happen?

L.S. Bulimia? Well because it started to be um, publicized a little bit. Like you'd see articles about it and I was aware that Jane Fonda had it. And I thought that was pretty "cool". Um, and I think I may have done a bit of <u>active</u> reading about it. It, from what, what I remember is just things that I'd chance upon and I read. Like I wouldn't go to the library and research bulimia. I didn't do that till later.

030 But um, I was aware of it at that point; I knew it wasn't anorexia. And I knew that it was a documented condition. And that was itself kind of a relief: It's like other people do this, you know. So that was, I think it may have helped to know that there was a name for what I had, and that other people had it, and there may be some recourse.

L.T. M-hm. A clearer sense then of of what you were struggling with, and maybe again that decreased sense of isolation.

L.S. Yes. Yes, very much so.

031 So I called, the only thing, I didn't know what to do and I looked up "B" in the phone book. (Laughs.) There's nothing that says, you know, Bulimia Support Group or anything. So I called um, I think it's V. Information Number. And I just said, "Is there any number for, for, to help somebody with an eating disorder?" And she referred me to ANAD [Association of Anorexia Nervosa and Associated Disorders], and I called them, and I found out about the sessions. But still, it was at that point where I didn't really want to like come totally out of the closet. I knew I needed help, but I wasn't about to sort of announce it to everybody. But they also gave me the name of a therapist at that point, Dr. T. And I um called her and she managed to fit me in.

And that would have been January, February, something like that.

L.T. And this is about how many years? Or can you kind of give me a time frame?

L.S. Well we were married in 1984, the spring of 1984. We came up here then. So it was the fall of 1984 that really was bad. So it must have been early 1985. And I think I saw her, started seeing her early that spring. So it was like 5 years ago, around in there. So, now we're at the point where we should have been at the beginning. But I mean, you see I think that there was a lot of things that went into the recovery that happened prior to what I would call the actual recovery that were really important.

L.T. Sure. Yup.

L.S. So um. So I called her and I started seeing her. And that was probably the biggest step towards the, the recovery period.

L.T. As you look back on that time of phoning her up and sort of making contact with her, how do you feel about that, or or what sort of things were happening at that time for you?

032 L.S. [When I contacted the therapist] I was terrified cause it was sort of like "well this is it again." Terrified in terms of, of to tell somebody about it. Terrified in terms of realizing that I'd have to start dealing with it; you know, the implications of that were, were great. [I would have to look at myself] . . . and could I do it?

L.T. You knew it was going to involve a lot of work in looking at yourself cause you.

L.S. Oh. yah. And could I do it? And all that stuff.

033 So it was a very frightening thing. It took me a long time to actually call Information. It took me, you know all these steps took quite a while. It's sort of getting up the courage, and I'd rehearse them over and over.

And then after that the thing that I would rehearse over and over was how I was going to tell A. about it. Cause I knew that I'd eventually have to tell him about it. You know, so it was very frightening all those things. So that's why I think, for me anyway, things had to come to a a pretty desperate point before any of those measures would be taken.

L.T. Because you knew what was at stake. And it sounds like you felt committed--once you actually told someone and got in to see someone--to do something.

L.S. M-hm. When I was there. Yah. And then I'd know I'd have to give it up.

034 And it [bulimia], in some ways still, I didn't want to give it up. I guess maybe because it was, it was an escape, it was a release of tension, it was part of how I defined myself, it was a habit, it was you know a shameful thing to reveal: all of those things put together.

And I knew I'd have to face it up once somebody else was there to--as you said--hold me accountable, which is, for me, it was a very important part. So I had been encouraged to go to ANAD. I didn't then.

L.T. Encouraged by?

L.S. Well, when I called up. I can't remember her name. Um, you know, she told me about the sessions and said, "come down." But that was just too scary. That was too scary. I wanted that one on one. And another, I remember I started to go to Dr. T. and then she told me I'd have to get a referral from my physician. So it was another, you know, traumatic experience to have to go in and tell her.

L.T. M-hm. M-hm.

L.S. So there were a lot of steps of bringing it out before the actual, you know, therapy began in earnest.

L.T. M-hm. Making contact with different people and letting them know what you had before you were even able to begin making changes.

035 L.S. Yah, and that was hard. That was really hard. Um, and maybe you know in terms of your looking at the steps, I don't know how that, I don't, I don't suppose that could ever be overcome, that kind of um apprehension and the steps that need to be gone through. I think that's maybe part of the process is the actually getting yourself together enough to go through those steps. Maybe if it were easier people wouldn't be at a point where they'd actually be able to follow through on it. I don't know.

L.T. Sounds like for you, as you were saying, you had to come to a really low point that you knew you had to do something about it. And um that whatever it took, that you would do it. If it meant having to tell people first to get into therapy, then the desire, that's what you would want to do.

L.S. M-hm. So I tend to believe that that as much as what happened subsequently, that's as important I think as what happened subsequently. And you know, so the therapy was good. Again it was very much, you know, self-examination and um.

036 Except she seemed, her focus was more on the family--the mother-daughter relationship--which in some ways I rejected because I didn't want to. I think I felt a lot of guilt towards my mother because of the way I was. And I mean I'd think back on things and all I could see was the negative aspects of having interacted with her. So I didn't really want to put this in her lap, you know, in terms of well because of this, this happened to me. You know I still don't, I think there are some aspects of that that are good to examine. Definitely. But I really don't think it's such a good thing to try and find a finger to point. And I don't think Dr. T. was trying to do that. But I know that I resisted in some respects that, that approach because I felt that that was trying to point the finger of blame at her, you know.

L.T. You didn't want to involve your mom in it then to any great extent if you could possibly avoid it.

L.S. I think not. I think not. I think I could see that sure there are aspects of family life and my relationship with my mom that could have contributed. But I didn't really want to um, to only look at it from that point of view.

L.T. Did you do some work around your relationship with your mom? Was that significant in, in therapy for you?

L.S. Yes, it was, it was.

037 It was a significant aspect. And I do remember a comment that she [therapist] made that really hit home. I think in talking about it, and again sort of trying to shield her [mother], I don't know what I said, but her [therapist] retort was. Or in saying, I guess expressing my guilt toward her [mother] and stuff and her.

L.T. Towards your mom?

038 L.S. My mother. Yes. And Dr. T.'s retort was, "Then you haven't forgiven her." And I had to realize the validity of that. That maybe there was some blame that I was subconsciously attributing to her and the environment in terms of, you know, what happened, in terms of my bulimia. So it was a matter of trying to, I think there was a process of letting go of all of that; of being able to say, to look back on those things in order to let them go, and and any anger that you might feel at um, um finally developing a distorted body image, you know. In other words, just taking your responsibility for "the here and now."

L.T. What, do you recall what happened when Dr. T. said that?

L.S. I just remember it sort of being like a shock. Like my first reaction was, "What do you mean?" And then it was like "Wait a minute, I've <u>never</u> looked at things from that point of view."

L.T. Cause you were always trying to not bring your mom into it cause you felt too guilty in terms of saying well my mom may have contributed.

L.S. That's right.

L.T. But now Dr. T. was saying well maybe you still have some anger towards your mom. Was that, was that it?

L.S. M-hm. Yah, very much so. Yah.

L.T. So you were <u>shocked</u> to realize that maybe you <u>hadn't</u> dealt with some of the anger towards your mom.

L.S. M-hm. That's right. That's right. So there was, you know, there was examination of that, that relationship, and then the family, and and all of that stuff that I think were good.

L.T. As you think back during that time is there anything that comes to mind as having had a big impact on you, that was significant to you?

L.S. (Pause.) There was that; that was significant. There was.

L.T. Realizing that you had some anger towards your mom.

L.S. M-hm. Um, I remember, and and again the whole thing of of realizing that, that you're not such a, such a beast; that this is a condition; that other people have it; talking about it more, about the condition and and and other people that are involved in it, and um.

L.T. How did you know there were other people? Oh, cause of the support group. I get it. And the books.

L.S. The support group. But also the fact that she, that was her area of specialization. So I knew that she had seen a lot of.

L.T. Other people.

039 L.S. That's right. That's right. And not that we talked that much about other people [with eating disorders], but the fact that I knew they existed. And you know, she'd say things about, you know, what happened with this person or something, you know, that that made it. It put it sort of into perspective more I guess. It's just this being--as you said I think at one point--part of me, but not like that was just what I was. That there were other, you know human beings that that had this as part of them as well. So it was again that identifying with (laugh), with humanity in a way. You know, seeing yourself as part of it; you're not so isolated. I'm trying to remember, for some reason I remember that moment really well which means that it must have been fairly significant.

L.T. M-hm.

L.S. Um, and as I said she did talk about things from that point of view a lot. Um, she did talk about, um, how I felt others <u>saw</u> me. And the realization that they, I wanted them to see, I wanted to create for them what they wanted to see, you know. And about my, my self-image. A lot of talk about my self-image, and how I felt about myself, and why, you know. So really starting with something very basic and working up to um, <u>more</u> external things were there. For example, when she did suggest that I go down to the, saw a dietitian at...to talk, you know, maybe about behaviour modification in terms of the eating and stuff. But she didn't really dwell on that.

040 I think she approached it very much from a point of view of working on yourself, and this only being

symptomatic. And that certainly work would have to be done on behaviour modification--your, you know, attitude towards food and stuff--but that really it was, it was much deeper than that. And I think that made a terrific impact. You know something that I think I'd known, but to actually talk about that was important. You know, going back in in my past and talking about things that, that had to do just with me and not with any eating disorder. That was important. Um, and then later on she talked about, yah, like writing down times that I would binge and why, or what I had just eaten and what I was feeling. I don't think I actually did that. I remember thinking about it, but I never actually committed it to writing. Um, so a lot of, um, examination of self rather than examination of this, this part of myself.

L.T. It sounds like you felt really um, you enjoyed that part of therapy.

L.S. Very much, very much.

L.T. And it was very important to you.

L.S. Very much.

041 I think that's what I liked most of all. Because I'd always known, I mean why should, you know, why should I have those feelings about myself? And I always knew that a real healthy person wouldn't do this [binge and purge]: like a person who felt good about themselves. And it always occurred to me that it [recovery] had so much to do with knowing who I was (eyes become moist). Like without anything else in the world--what I was doing, or parental approval, or straight A's, whatever--that I was O.K. And that in some respects, what I did was secondary. You know, I think I'll always be a sort of goal-oriented person and wanting to be doing things that'll make me feel good. But that's not what I build my whole self on.

L.T. Not now you don't build yourself on those things.

L.S. No. That's right. And that was very, very liberating, you know. And the whole process was very liberating. It was like a, a feeling I could breathe. It was a feeling of openness and a feeling of relaxation to know that, you know to be able to start giving up this, this secret, and start giving up what starts out as a, as a release from tension. Like she talked about that as being a trigger mechanism: that tension because of anxieties you had because of certain things. But of course it just causes

more tension, you know, because you're caught up in the cycle that you cannot control then. She talked about um the the trigger that would cause a cycle to suddenly pick up where I had no more control, as opposed to normal eating. And why would that trigger sometimes happen, you know, or always happen and then usually happen and then sometimes happen. And to really examine that part where it became a binge that would have to lead to a purge as opposed to eating a meal or having a snack.

042 She also talked about feelings of--or I did, whatever--we talked about um like dividing foods into O.K. foods and foods that if you eat this it means you're on a binge: things like like ice cream or spaghetti. Like in order to to maintain your weight you can't eat things like that ever cause if you do, then you might as well just you know gorge and get it all up. So you know, your relationship to food certainly played a part.

But, you know, she did, it was almost as if she worked in layers. Like starting back with yourself more and then progressing from there: your self and your family, your self and what you do, your self and food. So they became working sort of from the inside out which I thought was, for me that seemed to work.

L.T. Sounds like it was a really enjoyable experience for you, difficult I'm sure but also very liberating. And even as you talk about it now it seems like it's still really touching, and still a really precious part of the therapy for you, and something that made a major impact on you: to be accepted just for who you were, sitting there and looking at yourself without all the external things that had been really a big part of defining you and saying that you were O.K.

L.S. M-hm. It was to be accepted but more importantly to accept yourself, to learn how to accept yourself, accept myself.

L.T. And how did that happen for you then?

L.S. Let me say one more thing first.

L.T. O.K. Sure.

043 L.S. Something else just occurred to me. I remember, I think I used to talk in euphemisms a lot, in terms of like what I would actually do. And I think part of it [therapy] was sort of to force me to actually dare feel what it was about: you know, gorging and vomiting. Like I remember her talking, her end goal was to make me actually say the word "vomit", and I

kept using euphemisms and not understanding what, why she meant, what she meant when she would ask me to be more clear about it. And finally when I had to say that word, it was like again coming (slaps hands together) face to face with what it actually was. So, so part of it too was was really examining behaviour and what it was, not hiding, not hiding from the realities of it. (Short pause while tape is turned off to answer the phone.)

L.T. Yah, I guess um, how--we were talking about sort of accepting yourself--and and how did you sort of come to that realization that it was accepting yourself? How did that <u>happen</u> for you?

L.S. Um, that, I think that happened pretty um, pretty, pretty swiftly because I think it became very apparent and was something that I kind of knew anyway: that most of this came, not most of it, but a certain part of it came from self-image, and and and not liking yourself, and not being able to find yourself just in in terms of yourself.

044 And that um (pause) part of it was um then if others, if you could accept yourself enough to open yourself to others and they would accept you, then it would just be confirmation that you were O.K. But you had to be able to accept yourself enough or accept this, this thing enough to be able to tell somebody about it in a way: like to know that by actually revealing that, they wouldn't totally destroy you.

And opening yourself to the possibility that the person just, you know, totally shutting himself or herself off to you because of this this this part of you. So yah the feeling accepted was really important.

045 I mean I knew, you know, she [therapist] was <u>good</u>. Um and I remember your saying once that um too often people say, "Oh, it was just because I had a great therapist that I recovered." I think there has to be that personal uh. If I hadn't liked her and respected her then I couldn't have done that [recovered]. So knowing that she obviously accepted it [bulimia] because she worked with people like me and that we were still able to to get along on on a personal level, and laugh. And you know she was, she's C. so my interest in Russian studies. You know, so we had sort of a personal relationship that I felt was sort of beyond that. You know, I felt very comfortable with her. I think it would have been impossible, had I not had that, to really you know. Because that's maybe what happened with Dr.

C.: that I just wasn't able to to really open up. So that was important.

Then, as I said, I think telling my husband was probably the biggest step. Um, and I did tell him that I was in some kind of therapy. Um, I think because of some scheduling, or something. But I knew that once I told him that, eventually I would have to tell him why; you know that was just a given. So by telling him that, that was like the first step. I knew I had to tell him almost gradually that I was in therapy. And then oh, it was a month or 2 down the road before I actually told him why. But that was, actually saying that was the first time I had said to a nonprofessional, like a person that I just had a personal contact with, about this part of me, this thing. And that was a tremendous um, you know his acceptance of it. I think if it had been different, his reaction would have been different, it might have had a very different effect on me; it would have. But his um, acceptance of that was, you know, made a huge difference to me.

L.T. What was his reaction?

046 L.S. [His reaction to my disclosure of bulimia was] Very low key. Very low key. Um in fact he even made some jokes about it--like during that conversation--"well, that's a great way to lose weight, I should think about that." You know, stuff like that. So it was as if I was thinking, "god, all this time and it really isn't such a big deal." Like I mean he thought it was weird and all and and I'm sure he knew that it was indicative of of problems and stuff. But he was very, very sort of matter of fact about it. And just very glad that I had told him because now he wouldn't have to wonder why. He was very, I think, worried that I was seeing someone for, you know, goodness knows what reasons.

L.T. He appreciated then that you had told him, and seemed to, and he seemed to accept it um as something that you were working on and, and that was that almost.

047 L.S. Yah, and that it [bulimia] didn't affect his [my husband's] feelings about me at all. You know, so that was really important. And I think I was only able to tell him, um you know, at a moment, at a time when we were feeling you know really close, and I really felt that, "Yah I really want to share this thing with this person because I don't want to keep this from this person anymore." Not as if it were a big deal that I'd told him the facts, but the fact that I was withholding something became important. That I'd never had a relationship with someone where

I wasn't holding back this, and creating this, and hiding and deciding how to be. And so that, for the reason, it was a big step too.

L.T. M-hm. A major change in how you were relating to um close relationships in your life.

L.S. M-hm. M-hm. Yah, it was very symbolic because it let me know that perhaps people could know me and like me, you know.

048 Um, and also, I had to be at a point where I felt fairly confident of succeeding, of going to him and succeeding, because I couldn't tell him and then intend to continue with the behaviour. I mean I knew that it would still continue for a while, but at least that attention would be there to work through it and stop it, and that it would always be getting better. And I knew I couldn't tell him if I felt that I couldn't succeed because then I couldn't look him in the eye and to feel, you know, rejected--like I guess that's self-imposed--to feel um guilty about that in regards to another person. You know, I I couldn't do that. I was bad enough doing it with myself sort of. So I had to be at a certain level of stability with it before I could tell him. And then telling him increased that level of stability [confidence in her ability to make changes].

L.T. M-hm. How did you know that you were at um a stable enough level that success was, you know, fairly probable?

049 L.S. I, [felt confident about changing my bulimic behaviours when] I think I felt elements of control coming back. Um, I think I would, I can't pinpoint it, but I believe it would have been at the time where I was able to stop something that would normally, like stop a binge in progress. Or to actually say, "No" to a time when I would normally have binged. You know, to start having some control back, which was great.

L.T. How, how were you able to stop a binge in process? You had talked earlier about talking with Dr. T. about um triggers and and that sort of thing, um, but I wasn't sure of the specifics of that.

L.S. Well she talked a lot about um having people around when you ate. But I never did that cause I didn't really have enough friends that I could always be with when I ate and stuff. And so that made it more difficult. She talked about things like that: like external things that you could impose, and writing things down, and setting aside

your meals beforehand so that's all you would eat and you wouldn't just be grabbing what things. You know, she talked about strategies like that which I didn't <u>really</u> impose, like I wasn't structured enough to really do it that way.

050 But um, like for example I would allow myself to eat spaghetti, or have an ice cream cone, or a cookie, or something without that automatically meaning I'd had just, you know, started the whole cycle. So it was allowing myself certain foods. It was allowing myself to eat a meal, like a dinner especially, and <u>keep</u> it down, and wake up the next morning, you know, still feeling. And and allowing myself to experience that feeling of fullness, <u>normal</u> fullness, without that having to lead to such anxiety that I have to just continue.

L.T. Do you remember what you were telling yourself at that time cause that, that's a major change from, um you know, before you entered therapy?

051 L.S. One thing [that I told myself when I felt full after a meal] was, "Wait, let's just wait." Like a lot of it would be, "O.K. I've eaten this much, like intellectually I <u>know</u> I haven't overeaten." Like it wasn't for a long time that I was able to eat more than I should have eaten and still be able to keep it down. So I would eat what I knew--I mean I could, I could write it out, I could see it, I knew that I hadn't overeaten even though I felt you know terribly full and anxious--and able to say, "Well let's just wait. O.K., I'll purge but I won't purge for a half-hour. I'm not going to puke for a half-hour." And then in a half-hour, "Well, we'll wait another half-hour and like take a walk or something." And then I realized I didn't have to anymore.

052 And another thing that happened further down the line--and still happens now like if I'm, if I'm in a situation where um it's possible for me to binge and for some reason I'm having feelings that I want to--is to stop and think back and think:

> Well if I'm going to binge now, you're probably going to spend, it'd be a total of like $10 worth of food. I'm going to have to sit here by myself without pretty time, not do anything, stuff myself, and then I'd have to go and and try and vomit, and make sure that I vomit it <u>all</u> out. And that just, that prospect is exhausting and it's not very appealing to me.

So it's sort of like thinking it through, rather than just letting yourself be caught right up in it. And knowing that, "No, I really do not want to do that, or, I'm having." (Tape ends here.)

053 So it's a matter of of being able to do other things. I mean you get so, when you're, when you're life is sort of taken over by this, everything else drops away: I mean everything you used to do for enjoyment. So it was a matter of realizing there's, I mean there's always time that you could like spend with others now that you feel more comfortable around it, different things you can do, and things you can do even for yourself, I mean. You know that's like a notion you never had before in such a long time.

L.T. M-hm. M-hm.

L.S. So, you know, opening up your life a bit more, getting involved in things, getting busier.

054 As I said um, I, well I became pregnant. That was another thing of allowing myself to have that body image and have that be fine.

055 Um, getting a full-time job where in the daytime hours I couldn't do it anyway. So it would have to be restricted to nighttime after work. You know so that, and I felt confident enough that I'd be able to handle the job and do the work. You know, that had to be there first. And then to actually do the work and have so much of your time taken up.

L.T. M-hm. Was there a progression in that from when you were telling me about the the sort of the "stop and think through it," and getting pregnant, and beginning work? Like how, how did those things all fit together?

L.S. I think I was able to start like thinking, trying to avoid binges and how I'd set up my time, and being able to experience the feeling of fullness and deal with that, and being able to maybe start a binge as it started, stop a binge as it started: that happened before. Like I mean I became pregnant by accident. It wasn't as if I'd intended that. But that um happened before the um. That was sort of the first step: the small elements of control. Even though, I mean, the cycles were still continuing and all that.

But the small little elements of control started first and then um, and.

056 Then being able to accept you know the the belly of pregnancy and stuff and not, you know, really be concerned, not be that anxious about it.

057 Um, and to feel that there was another reason why I had to get myself well. You know, there was a baby and there was, you know.

Then when baby was born, then I worked, you know.

L.T. What, what was that like when you found out that you were pregnant and you, I I assume sort of began to think about some of the effects? Sorry, I mean like what was happening at that time?

L.S. Yah. Well again it was really scary because um it was like, I wasn't thrilled with the idea for a lot of different reasons. But, you know.

L.T. Thrilled with the idea of?

L.S. Of being pregnant.

058 I mean quite apart from all this, like it [becoming pregnant] wasn't a planned thing and it was sort of uh. But, above and beyond that, I really thought to be a mother you had to be a fairly whole person. And you know, so there's a lot of <u>fear</u> of you know, you know, "I've got to get my act together." There was even more reason to get my act together because there was so much, there was more at stake now [such as another life].

L.T. Such as?

059 L.S. Well another life. You know, I couldn't have a child and and. There was, it was one more element that would um make, make it harder for me to continue if I felt I had to continue bingeing and purging. Um, and from the point of view of that child's well-being, I mean to have a mom doing that would not be good. Like I didn't want to um, you know, fail in that respect, you know.

L.T. You were really concerned then about being totally there for your baby and that you couldn't be if you were still bingeing and purging.

060 L.S. M-hm, that I had to. Yah because, you know, I knew at least I had to have control of it. Um, because it's just one more um thing that, like it's a very total thing that you have to do: bring up a child. And even before I had one I guess I realized that (laughs): certainly do now. But uh, and I knew I

couldn't really do it if I were out of control with this thing. I mean I couldn't: I knew that. So, but I must have, I'm sure that I had inklings and and some feelings of control before the pregnancy occurred. Otherwise I think I would have just freaked right out, you know, just knowing I can't handle this. So there must have been part of me that thought that I could probably handle it at least well enough.

L.T. And what happened then with your eating, um, as you were carrying your baby then?

L.S. There was still, it was still um present.

061 You know, I didn't, like for those 9 months I was still bingeing and purging, but not as much. You know things just, it was sort of again a gradual progression of get, getting better.

And then when, during the fall-see she was born in January--so during the fall I went back to visit my parents in I. and their Russian Department needed a, a first year Russian teacher for that fall. So I stayed on and I taught. And it was wonderful! And I was doing um, interpreting for a Soviet broadcast and stuff. It was a really neat, neat time. So again I was really busy. Um, I didn't, it was still present, you know, the eating disorder was still present. But again, or not again, but even more so I was able to control it more and more, and perform, you know, fulfill my commitments to perform and feel good about that.

062 And then when I came back, she was born. And she was about 3 months old, and I got a job opportunity and did that. So again it was, it was like the the initial um, um, stability, control feeling, you know, good feeling about yourself. Something has to happen first I think. And then for me anyways, it was important to almost put that into reality by taking on the responsibilities that would prove to me that I was getting better, that would diminish the time that I could indulge in an eating disorder: you know put more things that I had to do on me. Um, but there was that core that had started there, you know, that wasn't there. . . . That core of self-knowledge, and self-acceptance, and strength. And, and, you know, knowing that you weren't such a terrible person.

L.T. And during this time that you were pregnant, had you finished therapy or were you still in therapy, or?

L.S. I saw, I'm just trying to think. I started seeing her probably about February or so. Um that spring, near right before Easter, I did 6 weeks in B. in a native, I was doing a native teacher assistant program up there. So I was away for that period. I hope I'm not a year out on this: 1984, got married; 1985, started seeing Dr. T. I think I may be a year out. Just a minute, because, yah, I wasn't, it didn't just happen like that. That's right cause I saw her through that spring fairly intensively. And then that summer I was seeing her but we were already starting to drop off.

L.T. Summer of 1985.

L.S. That's right. And then the fall of 1985 I was doing tutoring and stuff, not full-time. I must have been seeing her. Um, and then it was that fall and spring: I was <u>still</u> seeing her, but it had really dropped back; that I did the B. thing; and I got pregnant. And then went back in the fall and taught.

L.T. 1986?

L.S. Came back here and had baby, 1987 it would have been. And then started my job that spring. O.K. So it, it was really a year from the time I first saw her to the point at which these other, you know, pregnancy and and working and stuff, came in. So it must have been, it was that spring and summer [1985] that I was seeing her pretty intensively and then you know, backing off from there.

L.T. M-hm. O.K. And you were saying then that there was sort of a core of self-acceptance that was beginning to build and then all the other things came: the opportunity to begin teaching and things like that.

L.S. Yah. Yah. I didn't create those things but the fact that they, they came I think was very opportune at that point.

L.T. M-mm. M-hm. They were real sort of bits of encouragement for you.

063 L.S. M-hm. Because you know, you've got to look, you've got, I think it's a real luxury to have that time-out out of life in a way of self-examination and all this other stuff. But then, you've got of kind of put it in practise, you know. It's got to be just a, just a part, just a time that helps you actually do what you want to do and not like a, you know, ongoing crutch. You know, cause that means you haven't really made that <u>final</u> transition which is putting, just incorporating all those things in part of your life without, you know.

064 And I did go to ANAD a couple of times, as I said. It would probably have been that spring and summer that I was first seeing Dr. T. I probably went about three times. And it was <u>good</u>, um. I was doing a lot of tutoring in the evening and I think that's partially why I didn't do it like on a regular basis. Um, and I found that to be good. Again to walk into a room of people that I felt, "Gee, I could walk by (laugh) these women on the street and I'd never know. So other people must see me and they don't look at me and think yuck." You know that (a) you know, other people have it, so it's not such a horrible thing, and (b) that other people sort of wouldn't look at me and <u>know</u> how bad I was. You know what I mean?

L.T. M-hm. A little bit more of a realistic perspective then on how other people would see you and it wasn't that terrible.

065 L.S. That's right. It wasn't. It was just a thing, yah. It was just a, you know, an eating disorder (laugh). Cause again, you're putting it in perspective. And as it lost sort of its ultimate control of my life, I was able to put it more in perspective.

L.T. M-hm. I wanted to, how are we doing for time? It's 2:55 p.m. I just checked a couple times. I just wanted to ask you a <u>few</u> more questions and then see if there was anything else that you wanted to add.

L.S. M-hm. Go ahead.

L.T. Um, O.K. Let, let me know when time has run out, O.K. (Laughs.)

L.S. Well, by 3:15 p.m. we should, we should probably stop.

L.T. O.K. Um, as you think back to being pregnant and afterwards, are, was there any sort of links between that and your eating disorder? I mean what was happening for you in terms of the, the progression there? I mean you told me that you were still bingeing and purging about as frequently, but had more of a sense of who you were during the time that you were pregnant.

L.S. Well, no. I wasn't bingeing and purging as frequently when I was pregnant. I was just getting my years overlapped. During that first spring and summer [1985] I was still bingeing and purging, the frequency was starting to diminish, you know; I was starting to feel a little bit better about myself. And then, I think the fall was just a continuation of that. I can't remember many highlights of that fall. I was doing a little more tutoring work--

feeling better about that--doing a bit of translating, you know that kind of stuff.

066 Um, and then, the thing that I think happened when I got pregnant that was neat was that hey I realized I had an appreciation for my body: just in the mechanical aspect! Like it was incredible I could do this thing! I didn't really feel I had that much involvement. You know, I knew I had to keep myself healthy. But to watch it sort of do its thing was really neat! And also to <u>feel</u> so healthy! You know, I had an easy pregnancy and I felt so strong and healthy. You know, I was you know as big as a truck and it didn't really bother me. So it was a different view of my body as begin um, a really useful tool. And I felt good about it: I mean I knew what I looked like and it didn't bother me at all. I kind of reveled in it because for the first time in my life I could eat what I wanted and it didn't show, you know, that kind of stuff.

So during the pregnancy the bingeing it, you know, it's, ever since I got therapy it's sort of been you know going like this (makes a downward slope with hand).

067 As I said I still will have incidents of it, you know, even now, but it's like, it's just a different thing.

And when I was pregnant, it was, you know, getting less and less frequent and. But the thing about the pregnancy was that appreciation of my body.

068 And then after the pregnancy, um, I had put on quite a bit of weight. And it didn't, I guess it didn't bother me as much. Like it didn't really <u>bother</u> me. I didn't look at myself in the same way, looking for that little tummy. (Laughs.) Cause now I had quite a tummy, you know. And, and breast-feeding and all that. It just again, an appreciation of a <u>healthy</u> body rather than it's only, um, it only existing to see how thin you could make it, and how much like a model you could make it, and realizing that health was important.

L.T. M-hm. So health took more of a focus for you.

L.S. Yah.

L.T. That became more meaningful for you now to, uh, to <u>be</u> healthy so that you could look after this baby. Is that right?

L.S. M-hm. M-hm. That's right.

069 And since, you know, then we had another baby about a year and a half after that. And, um, you know, from those, I put on a bit of weight with each, each child. So that after the second one, S., was born, you know, I was not like heavy, but I had, I was probably about you know 15 lb more than I am now: 15 lb or maybe even 20 lb. And again, that didn't cause the anxiety. Like my weight wasn't <u>such</u> a big deal anymore. . . . Well, I knew that I was a mom; there was a reason for this.

070 I knew that there were other things that I could use for my self-definition than how thin I was. Um . . . Such as the work that I did, my family, and knowing that I was, you know, feeling better about myself. So I didn't have to just look at that [my weight], you know. Um, and you know realizing that uh, well again, you know, a certain difference in life too: Here I was about 30 and I wasn't like 22 anymore. And, I wasn't trying, who was I really trying to impress in the way I looked? You know, just took a bit of a different perspective. I didn't feel, you know I felt much better.

071 When after the second one was born and I took a year out at home and really kept that weight, I was doing aerobics and stuff, but I didn't really lose it. I felt better about myself when I got back to work and and kind of lost it. But it wasn't like a big, it <u>wasn't</u> what it was. . . . That's right. And I didn't have to, you know, go back into old patterns to try and lose it.

L.T. M-hm. Do you remember the time as the bingeing and purging, or do you remember some of the times or events when the bingeing and purging almost ceased or disappeared?

L.S. Well yah, I mean that's what, for the past, I can't even put a number of years on it.

072 But I do remember (laugh) when it was still, you know, very much more an issue, suddenly realizing that, "My god, I'd gone for a day without bingeing, oh my god, I'd gone for a week." You know, of knowing that um, it wasn't a minute by minute, day by day issue anymore. And that was a tremendous feeling when I knew that I could, I could eat three meals a day and, by eating three meals a day or two or whatever, I wouldn't blow up. Like I was normal in that regard too. It wasn't like by eating one bite I'd suddenly gain 20 lb. So it wasn't such a forbidden area. Food became more of a functional thing rather than this <u>whole</u> issue of <u>weight</u> and

guilt, and you know, all these other things that it had had.

L.T. And was that a gradual process?

L.S. Yes.

L.T. Or was there a time that you can say, "I kind of realized this in that whole progression"?

L.S. I would say yes to both of those because "a progression" in the sense that those times became more frequent and for more longer periods. But I do remember, I mean I can't say the exact day, but I do remember, it would have been that spring, that summer, when I was first seeing Dr. T. when it was like, "I got through the whole day and it wasn't such a big deal." You know, or the first couple of times that I was able to eat dinner and that was fine you know. So yah, that was, it was like a highlight, but it was just a continuation in a way.

L.T. M-hm. M-mm. O.K. And so after you had. I guess, I'm just trying to sort of focus in. I understand how it was a gradual progression.

L.S. M-hm.

L.T. But was there a time that you would say that um you were no longer um sort of bingeing and purging, or you were less preoccupied with it? Or, or how would you define like (snaps fingers together) that recovery time? Or is there a recovery time?

L.S. I guess, you know what. That's a hard one. I think it is such a process because it's, so much is involved in it.

073 But I think one sort of point [that marked recovery] is suddenly when you realize that, you're actually, to binge and purge is much more conscious than not to. Like before it's just a part of your life, and you do it all the time, and you have to really concentrate not to do it. And then it's like an activity that you engage in sometimes, but it's a very conscious thing. And I think that's a real, um, point when you realize that--you know, you know way back when--when I'd realize that I'd want to actually binge because I'm feeling anxious about something but it would have to be something that I'd have to arrange rather than something I'd have to fight off.

L.T. M-hm. M-hm. O.K. And was there any specific time that seemed to be, um, really clear to you, now as you think back?

L.S. (Pause.) Well, no not really. If there was anything I think it would be (pause) I think during that spring and the summer and the fall: That first, you know, three-quarters of a year [1985] when I was seeing Dr. T., the realization that, you know, "I can get through a day, I can get through a week or something" was there. And I think after when I got caught up in other things such as, um, you know, work or something, that during my working hours or whatever hours it would just cease to be there. So I think it was a matter of uh, it tapering off and realizing that periods of time could go by.

074 But then also I think taking on the work and stuff like that was very important because it would be, you realize that you know, "Gee, there's an 8-hour day and it hasn't even occurred to me once. It's not something that I would <u>want</u> to do or would even occur to me to do because I couldn't <u>function</u> and all those other things." So that would have been, you know, about a year I guess from starting to see Dr. T.

L.T. So other issues just became more important for you and it became.

L.S. I was able to let go of it.

L.T. Almost a chore, it sounds like to, to have to find the time to do it.

L.S. That's right. That's right. So for me, part of the whole process of it was was getting involved in other things. Cause I know--I must just be this way apart from anything else--I function much better when I have these things to do.

075 Like the year I was home with the 2 children was not, I think it wasn't a terribly happy year. I just, that's I guess the way I am. And I no longer see it as a negative thing of <u>having</u> to define myself by what I'm doing; that's just who I am. And I believe that other people are like that too. It's my personality rather than it being a distortion. I think it was a distortion before; it was carried to the extreme. And now I'm able to say, "I'm this way, and I'm that way, I'm another way" and not like "god, what, what am I?"

L.T. You're clearer now then as to who you are and it sounds like you're really are not so dictated by society and all the different sort of attitudes about "You should stay home, you shouldn't stay hone, well maybe you should stay home."

L.S. No. But that too.

076 I mean that'll always be a part of me. I'll never be an overly self-confident person. And there's there's times now where, you know, where I feel real, really negative about myself and, you know, I hate myself and wish I was anybody else in the world. You know, but it's not everything anymore. So I guess it's too, able to say, "This is the way I am. I'll always have these aspects of my character, but I can deal with them now." Or I can choose not to deal with them and say, "Well it's there, there's nothing I can do about it."

L.T. They just don't become such a major focus and you continue on doing your other daily activities and things.

L.S. That's right. That's right.

077 And also what's come up in the last fairly recently--which I think is in some ways part of the process--is you know, I've been doing this work, it's been great, but it hasn't been, like I haven't really gotten off on a new, a big new direction since the whole Russian thing. And I'm now exploring, you know, the idea of going back to school and stuff like that. So it's neat. So I'm no longer defining myself as "Gee, I was, I was a Russian teacher and now I'm not, you know. So I'm, therefore I'm nobody." So it's sort of starting with something new again. (Pause.) Again more listening to me, I'm fine, and knowing what I'm saying.

L.T. Being aware of that.

L.S. That's right.

L.T. And not being so pulled by the past, and and looking at what you wished you had done or hadn't done.

L.S. That's right. That's right. I mean, you know, you'll always have regrets in the decisions you make, but it's not like "god, if I'm not that I'm nobody," which it was for quite a while.

L.T. M-hm. M-hm.

L.S. So I really, I guess my whole viewpoint on recovery is not "recovery", it's it's recovery in a broad sense of. Because when you're talking about changing parts of yourself, or working on parts of yourself, it's such a long, gradual, slow process, and yet there are high points that you can pinpoint. But, I just see it as being a very

long continuum.

L.T. M-hm. O.K. Um, anything else that, that you want to add at all? I think you've pretty much covered my few specific questions here. Um, (pause), except I do have two more short ones. (Laughs.)

L.S. Go ahead.

L.T. Um, was there anything else that would have helped you in your recovery, do you feel? Like anything that you really felt was lacking or wished would have been there.

L.S. I think it would have been good had Dr. T. like, um, said to me, "As part of our therapy you must go to these ANAD sessions." I think it would have been good because again it was sort of an avoidance, in some ways, of, in dealing with it and facing it. You know what I mean, on an ongoing basis apart from the therapy. So I think bringing more parts of your life into the whole recovery process would have been good. Um, I think maybe, um, had this been available, I think maybe bringing parents or spouses or something into the therapy sessions might not have been a bad idea.

L.T. You would have liked to have had the opportunity to bring A. then?

L.S. I probably would have said I wouldn't have. But I think it would have been a good thing.

L.T. M-hm. And if someone had suggested it to you at the time, do you feel you would have?

L.S. No. But if they'd said it was a very important part of the process, I would have.

L.T. O.K. If they sort of told you the benefits of it.

078 L.S. Yah, M-hm. (Pause.) And I wish [that as part of my recovery], yah, I wish I had been more involved in ANAD, and I, I still have feelings now. I think I'd like to try going back and seeing if there's any capacity that I could be involved or help out or something. I think that's part of, I think part of it is, um, once you've worked through it, being involved somehow in helping others or with, you know.

L.T. What would be the--by the way they, they always are looking for people who have recovered and would love to come and be part of, um, of the sessions.

L.S. Are they?

L.T. Yah. The V. one: B and T.

L.S. Yes, those are the names.

L.T. Yah, cause I was speaking with them about a month and a bit ago and they were saying that once people, you know, finish our program like they never come back. They just want to put the fact that they were bulimic totally out of their life.

079 L.S. You see I think that's it. And I think, um, in in examining it since I've talked with you and, you know, thought about it more than I've thought about if for a long time, is to realize that that [helping out at ANAD] might be another important sort of last step.

L.T. M-hm. So, so they're looking for people if you're interested.

L.S. M-mm, that's good.

L.T. Yah. And what, what would you <u>hope</u> to get out of that experience?

080 L.S. I'm hoping to help others through what I went through. I think also, it's it's not <u>so</u> much from a point of self-examination cause I really feel that you can never work things through to the last "dotting of the last i." You know, when you do that with yourself, you might as well die (laugh), cause it's like put it all in a box. But I think there's maybe some element in that, but I think most of it is feeling that you have something to contribute, you know. And, and, and still remembering how <u>awful</u> it was and hoping that maybe what you can do can help somebody get through it more quickly.

L.T. So that definitely you have some information to <u>pass</u> on which could be beneficial to certain people.

L.S. M-hm. M-hm.

L.T. And it sounds like that really wasn't something that you <u>had</u> from just <u>lay</u> people. Like you almost went through the whole recovery experience <u>on your own</u>.

L.S. I didn't know <u>anybody</u> with an eating disorder. The only people I ever ever see with (laugh) eating disorders are the few times when I was in ANAD.

L.T. M-hm. M-hm. Or the people who were like the big celebrities and stuff.

L.S. Like Jane Fonda, that's right.

L.T. Yah. So you feel it would be important to have someone who is a so called "ordinary individual", um, telling their story so that people can relate.

L.S. I think so. I think so.

L.T. M-hm. (Pause.) As you think back on, on your recovery experience, are there any differences, or ways that you feel you're different now than when you were bulimic--say, you know, emotionally, intellectually, um, what else, spiritually--that, that we haven't already touched on? Cause you've really been talking about that, but I'm just wondering if there's anything else that comes to mind.

L.S. (Pause.) Well, intellectually I would say that um, I mean I certainly, it was the years I was at school that I felt I was using my brain the most.

081 But I also realized what an effect bulimia had on your ability to think, just in terms of--it's not just the amount of time--but it really has, you know, it really damages you physically and stuff, and I think intellectually because you're so weakened and stuff. So I think were I to, if I were to start on some kind of school program, um, I think that in many ways, um, I don't want to say I'd do better, but it would just be, it would be a more balanced thing. It wouldn't be such a focused thing. So maybe I wouldn't do um, something like standardized grades and stuff, I might not do better. But I think I would be able to put more into it because I'd have more of myself to devote to it.

L.T. So one of the difference then is that now you feel you could put more of yourself into it, give more um.

082 L.S. I could concentrate. I mean it was like I could never concentrate before cause this was always on my mind. And if I were in a position to concentrate that would usually mean I'd be off doing some work, whatever, studying or whatever. And that would be a prime time to binge, and I usually would. So there wouldn't be periods of concentration or reflection. Like I was afraid just to sit back and think about things and not do anything, from many points of view, because if I weren't doing anything then I wasn't justifying myself [or that would be a prime time to binge]. But also, I didn't have any leisure, intellectual or otherwise, to do things.

L.T. So that's a, a big change now. I mean if you feel not so driven to always be filling your time that, as you say.

L.S. Cause you were scared when you didn't, you knew what would happen.

L.T. M-hm. M-hm.

083 L.S. And also the ability to maybe do things to please yourself: for nothing other than that reason. [Just the sheer enjoyment of it without any] goal that has been set by somebody, that you want to achieve. So that.

084 And I think I'm a lot more um. I deal with people on a totally different level now.

L.T. In what way? How?

085 L.S. Well, you know. I feel that. I'm still not a person that has many close friends. And again, I've decided that's part of me and not, you know, for any other reason. But, I'm able to be, you know feel that I'm more myself with others and be more relaxed, and you know deal with them as I feel other people must have always dealt with other people. And so that's good. And you know, the work that I do now and I suppose any kind of work I do will be with people, and will hopefully be from a perspective of trying to give them something through teaching or whatever. And I feel that, you know, I can do that much more effectively.

L.T. Now?

L.S. M-hm.

L.T. Cause you're not so concerned about others' evaluations of you and. Is that part of it?

L.S. And also, do you remember when I was talking about the third year university, when I said that relationship had ended and there was somebody who I felt wanted a relationship. Well, it was really funny because he had been going through some psychological problems. And I think had, had everything been different, then in many ways we were very suited to each other apart, I mean, apart from his little neuroses there.

086 But um, it was almost as if the people that I felt I could be close to, those were the ones that I wanted to push furthest away because I felt like I would infect other people: If I allowed them to be close enough I would infect them with whatever sickness I

had. Like um, I felt like a pile of cut glass and anybody who touched would would, you know, cut themselves on. So, you'd sometimes surround yourself by people, but you wouldn't you know, you didn't have that much to do, or in common with. So, you know, it's a question of the friends that you choose would be more real friends.

L.T. M-hm. Now, than back then.

L.S. M-hm.

L.T. Any other differences at all that you feel were, are sort of, really had a major impact as you think back? (Pause.) You've touched on a quite a few things: like a different lifestyle and um, different ways that you look at goals.

087 L.S. I know something. I know something. Again, in my relationship with people, I think I always wanted the other person--in whatever the relationship was--to be in control. You know, for reasons that I think you probably understand: a lack of self-definition etcetera and wanting to just sort of hitch myself on to somebody else. And you know that analysis of relationships that's, you know, parent, child, and peer. I think I would always deliberately set up a relationship with others in that I was the child and they were the parent. And I'd always try and um, uh, I think put myself forward as a bit of an "airhead". Like I never would try and put myself forward as somebody who knew anything about anything because they would probably find out I didn't actually anyways. (Tape ends here.) The whole image of, um, not being equal with others: always putting yourself on the down side, um, not being assertive, um, and not believing that others will take you seriously. So there's a certain amount of, of um, again almost trying to relinquish control of the situation when you're with other people. So I think I deal with people, like you know, on a much different level now. I mean professionally I can talk to people as I imagine an adult would talk to another adult and not the way I used to. So that's a, that's a big difference as well.

L.T. It's a major change.

L.S. Yah.

L.T. For sure, because it sounds like now you <u>feel</u> that you have something to contribute and therefore you'll <u>speak</u> when you have something that you really want to communicate to people.

088 L.S. That's right. And I believe now I'm able to see some good in myself and see "Yah, I can do that well. It's not just, I was just, somehow got through it and I fooled them this time. God, will I be able to fool them again?" That, you know, horrible tension that everything you do then having more expectations and being really scared of it even though you have to have those expectations: They have to be there. So it's a lot, um, easier now in fact.

L.T. Cause there's a sense now that you're more yourself and you don't have to worry about fooling people because what they see is real.

L.S. Is real. That's right. That's right. And that's, that's real good!

L.T. I'm sure that's an incredible relief.

L.S. M-hm.

L.T. It takes lots of stress and, and energy out of life.

L.S. Oh yah. Oh yah. That's right.

L.T. When you think of it just, you know, pervades every aspect of everything we do.

L.S. Oh it does, it does. I think the distressing feature of, of something like this--if if other people are like I was--is the fact that it just, there's no part of yourself that it doesn't, doesn't flood. It's like a piece of felt: You know, you touch one corner to water and the water just sucks all the way through. It's like there's nothing that I can identify that wasn't dramatically changed or altered--not due to this involvement because what you are causes this whole syndrome--but, you know, there was nothing that was, not even a corner of my life during that time that was untouched by it. And that's, you know, terribly overwhelming.

L.T. And so then recovery, how does that um occur for you?

L.S. It's almost like pushing the water out of the blotter. You know, slowly you gain a little corner more and more till you push it, not totally out, but just that little corner is wet. You know, something like that. It's sort of like that image of of emerging from the water, emerging from: a whole part of you comes out and hopefully you get your whole self out of it.

L.T. M-hm. And, and now how--this is my absolutely final last question (laugh)--and now how do you feel? Like, like

you've said that sometimes there are occasional binges for you. And, and what's that like for you in terms of, um, how you feel about things and, um, how you think of recovery?

089 L.S. Well the thing is, it [bulimic episode] doesn't, it doesn't touch me that much. Like it's not something that is like a light thing to do or it doesn't matter. But, I know that those activities, um, are not something I have to do: it isn't really me anymore. So it's not a thing that in retrospect I like. It's just like, "What did I do that for? You know, that was, that was stupid; that was unnecessary." But it doesn't really traumatize me. If I'm feeling really badly about myself anyway, it would just be something else to say, you know, "I feel badly about myself because of." But it really is, um, it's almost like when you're a small child, there's the, the neighbour's dog scares the heck out of you. And every time you walk past it your heart is going like this (lightly pounds heart). And then when you get older it's sort of like he could jump out at you and maybe scare you once, but it's just an old dog. You know, sort of like a totally different thing about it. So yah, it's not something I like, or something I'm proud of, or um. But it doesn't, it doesn't seem to be a big deal, you know.

L.T. It's just kind of a habit that's there and sometimes it comes.

L.S. I guess.

090 I can't really understand it [occasional bulimic episodes]. It actually um, I guess often when it happens it's not like a conscious cycle. It's more like for some reason I've let myself really eat, overeat so much that it's almost like an escape mechanism if I know that it's been. Like I can overeat, like I can eat too much and feel, "Oh, what a pig and stuff." But the occasional time when um it just, I don't know. It's, it's almost like an escape mechanism if I really feel I have overeaten. You know what I mean. So it's like, it's not like a cycle that I have to go through. But still, parts of it are still there that I think I use or something. I mean it's real weird. But I don't have to. So it is quite a conscious thing.

L.T. M-hm. And it sounds like there's that element of control and that you don't sort of build up to it and it doesn't continue.

L.S. No.

L.T. But it's more of an isolated incident.

L.S. Yah.

L.T. And, um, it sounds like you know why you're using it and choose.

L.S. Yah.

091 It's sort of like I guess like smoking. You're sort of like, "ah, this is sort of needless." But um, no, there's no longer, you know, there is a feeling of control. It's a, it's a funny thing to even talk about now because it's so incongruous but.

L.T. With, with what is it not congruous with?

092 L.S. Well, it's like an old carry over from the past in a way, you know, because it isn't like a part of my life or a necessary part of. I wouldn't even consider it really much in thinking of myself these days.

L.T. M-hm. It's really something then from the past.

L.S. Yes.

L.T. And you just kind of use it now and again and um, that sort of like "so what."

L.S. Yah.

093 Although I did find during the year I stayed at home that, um, there, the incidents [of lapses] were more frequent. And when I realized that, I made, I had to make an effort again to sort of eliminate it, you know. So I know that for whatever reason it's really much better for me to be out and involved in things and, you know, busy. And it's not good for me to start having negative feelings like, "I'm not doing anything or have too much time." You know what I mean?

L.T. M-hm. M-hm.

094 L.S. And I guess it's [lapses are] just a feeling, a negative feeling that manifests itself in a way. Because I did notice during that year, there was a point where I realized, you know, it [lapses] was starting to happen: starting to, not starting to happen again but it was like it, I I could see the frequency was going up. And that, that distressed

me. But then I was able to, you know. I had to exercise will but then it was, it was defeatable. It was a funny thing.

L.T. You definitely have replaced it with other things it sounds like.

L.S. M-hm.

L.T. And during that year when a lot of things had changed for you, you realized that, and quickly.

095 L.S. I could revert [to bulimia] I suppose if I, yah. Although I really don't think I could ever really get back into that situation. I don't know. I can't even conceive of it.

L.T. M-hm. It just seems like totally.

096 L.S. It was a different person doing it.

L.T. M-mm. M-hm.

L.S. That's it.

L.T. Now, for sure?

L.S. Right. (Laughs.)

L.T. O.K. Well um, I don't have any more questions at all. Is there anything else that you want to add or?

L.S. No, I think you've been quite complete.

L.T. O.K. Good.

L.S. Good timing.

APPENDIX J

P.Y.'s Protocol

L.T. O.K. So wherever, you know, you'd like to start from when you first began to notice little bits of change.

P.Y. On the recovery or on getting it?

L.T. Um, well once you've had it for a while.

P.Y. O.K.

L.T. And sort of if you can, you know, jump into the recovery part. I know that's hard sometimes.

001 P.Y. O.K. Um, really the key thing that I remember is um, I, when I would go to talk to Dr. B. and he would say uh that I had to learn to let myself fail. And it didn't really click until we put it into ways like um just because you've binged doesn't mean you have to go and purge afterwards. So um, that was a real struggle and I had a lot of anxiety over it. But that seemed to me really what helped me because if, always it was the relief of throwing up afterwards. You know that, that was um, if you didn't have that, you weren't as likely to eat as much. So there was a few times when I would eat till I just thought I was going to explode but then I didn't let myself go and throw up. And I felt horrible but then afterwards it was like a victory even though I had still consumed as much food as I, you know, did normally on a binge. But um that's kind of how I.

And then when I could cut down on the number of times that I threw up, slowly I cut down on how big the binges were because it was such an uncomfortable feeling being <u>that</u> full, you know, like really feeling like you were going to explode. So if you didn't have the, kind of that out, you know, to get rid of it all, then you would cut back that way. So, I don't know, that's, that's pretty much um, what I remember of it you know. And I can't remember how long a time it was though until I stopped completely.

L.T. Can you just sort of fill me in who, who Dr. B. is, and how, how you <u>got</u> to see him.

P.Y. Oh. (Laughs.)

L.T. And sort of tell him about things, and then how all this came about?

P.Y. O.K. Um, actually, uh he was a patient at the dental office that I worked at in S. And um, as it turned out, I'm the one that does medical histories on people when they come in. So I happened to meet three or four people that had bulimia and they all told me that they saw Dr. B. And of course none of them knew that I had bulimia (laugh). And they would all tell me how wonderful he was and how helpful he'd been. So uh, then he in turn came into the office as a patient--I didn't know he was a patient when I'd been hearing this about him--and I thought he seemed like a pretty nice person (laugh). So then I started seeing him as a physician and, and uh I told him right away, you know, that I had bulimia.

And this was after I had already seen Dr. T. off and on for, oh I guess about a year. But I, I didn't really find that um, I improved at all when I saw Dr. T. I don't know, I thought, I thought maybe that I was uh. I guess I thought when I saw Dr. T.--you know I heard that he was like world renowned and he was the guy to see and everything--I thought I would go and see him and 2 weeks later I'd be cured and. But it, I didn't really find that I got any better at all so. I don't know if it was just the personality thing or what.

But it's really, with Dr. B. that uh. Maybe it was just the timing too, maybe that was partly it.

L.T. M-hm. So when you went to see Dr. T. you were how old and?

P.Y. I guess I started seeing him (pause) in the spring of 1983. So I was not quite 23: about 22½.

L.T. And so you didn't find that that was very effective. But you went to see him for a while and, and you say that you felt you didn't improve at all.

P.Y. Oh, I <u>know</u> I didn't improve. I mean he uh.

L.T. How, how did you know that, that you didn't improve?

P.Y. Well, because I was, I was still bingeing once, twice, three times a <u>day</u>. I mean, you know, for me to, I couldn't go a day without bingeing. It, it just um, it just didn't, there was no stopping of anything.

I mean (pause) I guess I didn't find him encouraging. And uh, I don't know, maybe I, you know, I needed someone to pamper me a bit or something. He was not a "pamperer" at all. Like I can remember one time I was in his office and one of his patients called and he was going to commit suicide. And I was sitting in the chair, he was sitting at the desk beside me, and uh he basically said, "Well

that's fine, I'm with someone else right now. If you want to do that you go right ahead. Goodbye now." And he hung up. And I said, "Listen I can go if, you know." "Oh no, no." And then he turned to me and he said, "You know we're really all just like flies, you know. We're here today, gone tomorrow; it doesn't really matter." And I thought, "Oh good (laugh). Why am I coming to you, you know?"

So, I don't know. Like he, he wasn't an unpleasant person but he just um, he was just so matter-of-fact about it you know. And, I guess too because he's a very round person. So when you have an eating disorder that's one of the first things you notice. So when I first met him I thought, "Oh yah, sure, you're going to help me to eat properly (laugh)?"

L.T. You didn't have a whole lot of confidence then it seems.

P.Y. Well no. But I still, you know, I still kept hearing that. Like I would, you know, if I read anything about it, I would read his name, or you know, hear his name on the radio and things. But (pause) I mean I'm sure he's helped a lot of people but he just wasn't the person that could help me.

And he uh, he and his wife started a self-help group for people with eating disorders. And I thought "Oh this will be great", as I'm sure we all did. And we'd meet there: Oh I think there was probably about 25 or 30 of us. And we'd meet in this room and it was like, you know, we could all "out eating disorder" each other, you know, cause that's kind of part of the eating disorder. So we'd go in there supposedly to support and encourage one another. But really what we were doing was, you know, giving each other more ammunition: "Oh, I never thought of doing it that way." Or like there was one girl who had, she'd had anorexia and bulimia off and on for over 20 years and her body was in such a state that she very proudly said that, you know, she couldn't, her weight could not fluctuate more than 10 lb because her heart couldn't take the stress anymore. And it was like the looks on everyone's faces was like wow, you know: like we were all striving to be that good at it, kind of.

So I don't know, maybe self-help groups can be good in a lot of things but I don't know that eating disorders is really one of them. Unless you're already to the point where you're recovering. But we were <u>all</u> right in the thick of it, you know. And, and uh it really was like, you know, this person had done this, well this person had done one better. We could always "one better". And you know as each week went on, I mean it just got ridiculous

you know, the, the lengths people would go to and they just.

L.T. Sounds like it was a pretty discouraging experience then because you weren't really getting any other focus. It was all just on an eating disorder.

002 P.Y. Well right. And but the silly part of it <u>is</u> it wasn't really that discouraging while you were there because being in the eating disorder, I mean sure you've got this part of you that wants to get better, but you've also got this part of you that clings to that, you know. So when you're around other people that all have that same thing it's like um, you know, it's like a bunch of drunks going to the bar together, you know. The only thing that was missing there was a big vat of chips and dip in the middle, you know.

Like it just, I don't know, like I, I think probably because it was the first self uh kind of a support group they had started, obviously they had to work out the "bugs". And I think that was one of them that, you know, they didn't, they didn't really (pause) establish, you know, that you had to be on the road to recovery. So it was, you know, it was just a bunch of people thrown in together that all had a lot of really major problems and we were supposed to be helping each other but.

L.T. It wasn't working.

003 P.Y. No. No. And I, I can remember one girl telling me that um I should quit my job and go on welfare. You know, I mean for her I guess that was an answer but to me I thought, "No, you know, like that's giving up the <u>one</u> last thing I have that I, I am, have control over and I'm doing O.K. with it, you know." Like I thought, "boy." But she just thought that was the way to go and then you just kind of sit back and wallow in having an eating disorder and being taken care of, you know. So, I don't know. There was different things like that.

L.T. Both those experiences then--the individual with Dr. T. and the group--seemed not to help you decrease your bingeing and purging.

P.Y. No.

L.T. At all then.

P.Y. Well Dr. T. um he tried hypnosis and uh I'm not very receptive to that. I mean at this point in my life I would just out and out refuse. At that point in my life,

I didn't know. You know, like I thought, "Well O.K., I'll try it." You know and uh, but I, I never, he, he didn't hypnotize me. And he would give me um a tape that I was supposed to take home and play. But I just, it just didn't feel right, you know. And so I didn't, I never played the tape and that's, I don't know.

It was just like (pause) I would go there and, and uh I was supposed to say something good about myself. I mean I guess that's one good thing cause that, I found that hard to do. You know, so that was probably good practise going in and seeing him, and, and every time I'd have to say something that I had done well or, you know. So that part of it was probably helpful.

But, but still it didn't um, it never got to the point where it affected my eating habits at all, so (pause). I don't know, that probably sounds like a really awful thing to say because obviously he must have helped a great deal of people for people to say that he's um, you know, an expert in the field or whatever.

L.T. But for you, sounds like you didn't feel that he was a credible person for you because of his, the way that he looked and, and you weren't happy with his techniques of hypnosis. But.

P.Y. Yah.

L.T. The positive affirmations that he had you do were helpful.

P.Y. Yah. And it wasn't even though, like I mean that almost sounds like I thought he was just a quack. I didn't think that. I mean he, I <u>thought</u> he was professional but I didn't think he could empathize.

L.T. M-hm.

P.Y. And then, and I guess it was when I was there and he had that suicidal person call in. Then I just thought after that, "He really doesn't care. I mean this is just a job to him; it's just a paycheck." You know, and I didn't want to feel like that. I mean I know in the big scheme of things obviously doctors don't get attached to their patients or they shouldn't and there's all that professional part of it. But it, I didn't want to feel. I mean I just felt like my whole life was going down the tubes, and I wanted someone to help pull me out. And I just felt like if he lost one, he lost one: no big deal, you know. And so that kind of made me feel a bit panicky, you know like, "He's not going to help me." And I guess that was one of his things too was that he expected <u>you</u> to do it. And I know in the end you do have to do it. But (pause) I guess because it's such a secretive thing, you

know, when you finally go to see someone about it you want to pour your guts out to them and, and feel like they're behind you kind of, you know. But I just felt like, "Next." (Laugh.) So.

L.T. It was almost, would it be fair to say you almost felt insignificant with him, like you really didn't matter a whole lot to him.

P.Y. Well. Yah, because I'm sure (pause). When I would go in to see him. I mean the first time you go in you're supposed to stand up, turn around, so I guess he can see you know do you, are you terribly, terribly underweight, or terribly, terribly overweight, you know. And there was a whole bunch of little stigmas about.

I mean one thing was because he specialized in people with eating disorders, you know, it's like you'd walk into his office and you wondered if the people going down the hall were going, "M-mm, I wonder which eating disorder she has?" Well at that time I don't think anyone had really heard much about bulimia. But then you would go in the waiting room, and you <u>knew</u> that everybody in the waiting room, you know, had some kind of eating disorder. So then it was like "gee", you know (laugh); you were trying to imagine what their life was like, you know. Or, "Oh, she doesn't look so bad" or "Gee, there's a guy here, you know!" (Laughs.)

L.T. What was that like for you sitting in his waiting room and, and looking at all these people?

P.Y. It was awful. I mean you felt, I don't know. It just felt really conspicuous. Like I guess that was one thing too when I went to see Dr. B. because he was a G.P. [General Practitioner]. I mean I could have been there for a sore throat.

L.T. Oh.

P.Y. I mean I could have been there for a sore throat, you know. Like it, there was no stigma to it at <u>all</u>. And, and he also um (pause), I guess maybe like it was something different for him. You know, like he dealt with sore throats, and stubbed toes, and sicknesses all day long and, and uh he really seemed to get something out of it when, when he would, you know, do the counselling. So, and, and he basically just made himself available which I <u>know</u> you should not expect someone to do. But uh, for me it meant a lot that he would do that even though I never ever called him at absurd hours or anything like that. But if I called, you know, and I would, I would just tell him, you know, I needed to talk to him. Or, or sometimes I would give other reasons: "Oh, you know uh, I've got a

rash or something." And oh, then I'd show him my little rash (laugh) and then we'd talk about what I really came for. And he didn't mind that and he would take the time, you know.

So (pause) I, I think just to feel like there was somebody that um (Pause): He felt responsible I guess. You know, like he, he told me about um, he had a patient that he saw for years, and she had an eating disorder and he didn't know it. And after she'd had the eating disorder for a really long time, she told him. And, and he felt terrible that he'd been seeing her all this time and he'd never picked up on it. And then he looked back on, you know, all the times she'd come in and how he should've known and how he should've picked up on it. And after that, that's how he finally got into, to counselling people with eating disorders. So it was never that, I don't.

And then it, it just spread--word-of-mouth I think--among people with eating disorders.

004 I mean that's, that's how I heard about it [Dr. B.] was by someone else that had been helped by him. And I guess that was the thing too is that how I heard about him was from someone that had seen him and felt like they had improved, you know.

And, and with Dr. T., I just kept hearing about how great he was, how wonderful he was. And I kept meeting all his patients and they were all wonderful anorexics and bulimics. But obviously I wouldn't meet the ones that were cured. But I never did meet someone that recovered and could say, "Well yes, it's thanks to whatever was done at, you know, Dr. T.'s office." So.

L.T. A bit more hope for you then in seeing Dr. B. cause you had met people who had seen him and had <u>changed</u>.

P.Y. M-hm. Yah!

L.T. Because of seeing him.

P.Y. Yah. Yah, that's true (pause). So I, I don't know. I, I guess it it's like you <u>close</u> yourself off so much, you know. Like I know myself, I had bulimia for so long before I told anyone and no one knew, you know. And, I mean I can remember the girls I used to work with would uh, they would just laugh and joke, but I'm sure they had no idea about how often I went to get groceries. Because I, I worked right across the street from the mall so at lunch hour I would go over and get like three (laugh) or four bags of groceries.

L.T. M-hm. P. how long did you have bulimia for before you started going to see Dr. B.?

P.Y. I guess about a year and a half.

L.T. M-hm. O.K. So then people started coming into your office and telling you that they had bulimia, that they had recovered or that they had seen some changes in themselves from seeing him.

P.Y. M-hm.

L.T. You went and saw him and what happened?

P.Y. Gee. (Pause.) I can't even remember very much about the first time I went to see him except for him telling me about that patient that he hadn't know. And then, I don't know, he just kind of, he just talked to me just like a person, you know. Like he wasn't constantly taking notes on everything I said. But um, I guess really he just encouraged me, you know. Like he also would get me to say um, you know, something good that had happened that week, or you know like. And then he would pick up on the good, good things. He wouldn't say "Well how many sandwiches did you eat?" (Laugh.) Or, you know, or, "Gee that's too bad." Like, I don't know. It's, it's hard to say. I don't know if it was just his personality or what. But when I went to see him, I felt like he was kind of spurring me on, you know.

And if I, if I would go back and I'd say that, "Oh, I didn't do very well," he'd say, "Well that's O.K.," you know. And then, he would get me on to other things. And, I don't know, I guess it, it started to make me feel like my whole life <u>didn't</u> focus on just what I ate and how I got rid of it.

005 And it, it didn't matter if I, you know, like. I guess it was always him um telling me that I could do that, you know. Like obviously I, for me, I would make really absurd goals, you know: Like every night it was, "Oh, I'm not going to eat anything." And then as soon as I'd have a couple of raisins or whatever--something really small--I'd just go over the deep end. So, I think the big thing was him just encouraging me that I <u>could</u> eat and I could eat more than maybe an average person would, and I definitely shouldn't be making these, these goals not to eat.

And if I <u>did</u> break these promises to myself that didn't mean it was part and parcel of, "Oh you binge, you have to throw up." So, I don't know, I guess it after. I didn't even really see him that

long: probably only 6 months, or something like that.

L.T. Sounds like he was really accepting of your bingeing and purging. And if you had some relapses in there, or slips, or whatever, that that wasn't of great, great concern.

P.Y. M-hm.

L.T. He just accepted it as part of the process of you [recovering].

006 P.Y. Yup. And I guess, I don't know. Gee looking back, maybe too because, um, he was a patient at the office I worked at, and he showed respect for me and my abilities. You know, like he would still come in and I would clean his teeth and, you know, I would be (laugh) showing him how to take care of his mouth. And he would be very attentive and like he wasn't condescending at all. He was very much "I'm here and you're here too" kind of.

L.T. You felt on an equal level with him, maybe.

P.Y. Yah! Yah. Yah, more, yah I think that's, that's probably part of it because he wasn't a real um, I don't know, he wasn't my image of what a doctor, you know, suit and tie and briefcase. And, he just uh was um kind of a very understanding person, I think. So.

L.T. M-hm. And what was important about that since he was so different than Dr. B. uh?

P.Y. No, Dr. T.

L.T. Dr. T. What was important to you about being more on an equal level with him and feeling accepted by him?

007 P.Y. I think because I hadn't told any of my family or any of my friends that I had this eating disorder. But I really, I needed someone to confide in. And I didn't want to confide in my family because uh, well lots of reasons: I mean I don't want to let them down, I don't want them to worry, and I don't want to prove I've failed because I had just come from a failed marriage. And I knew my family was all really worried about me, and that if I had another crisis I mean it was, would just be too difficult to face them. And I didn't feel like they would look at me the same way.

008 So to meet him and even though it was a professional relationship, to be able to go in and talk to him and not feel like um (pause) he was looking down on

me or thought that I was an oddity. You know that, just that I had a value, you know and, and uh he just talked to me like a regular person. Like it, it was not like the eating disorder was incidental but he just tried to, to uh.

Like he didn't think that was the full focus and, and he didn't think that I should feel that was the full focus of my life either, you know. And, and I guess I, like I think this is probably common, but your self-image is like way down in the toilet. And just, I don't know what it is he said but he made me see that there were other things I could do, that I could do well, you know. And just because of this one area of my life was kind of out of control didn't mean my whole life was out of control, which is how I felt, you know. Like it's, I just felt like it, I don't know, it's so all consuming. Like my life just revolves around what I'm going to eat. So.

L.T. M-hm. Even now as you talk it sounds like he still has a really, had a really big impact on you; that you felt really close to him and um.

P.Y. Yah. And yet, you know, I wonder like if I went back to his office now, he'd probably remember my face but I don't know for sure that he'd remember my name. You know like it, it's, it's not that we had a real friendship or anything, but he, he just um, he was just a very respectful person. You know and like I, I hated feeling like um when I would go to Dr. T.'s and he would ask me questions, and then he'd kind of lean over and he'd jot some things down. And I'd want to say, "Give me that book and let me (laugh) see what you wrote about me!"

L.T. (Laughs.) M-hm.

P.Y. So. I don't know.

L.T. That was too secretive for you and you felt like you were being almost treated like a patient or someone who didn't know what was happening to you?

009 P.Y. Yah! Like yah. Like um, like just because I, I, had, go crazy with my eating doesn't mean I am crazy, you know. And, and you can tell me things and, and you can talk to me and, and you can reason with me. You know, I'm intelligent, I'm (pause).

L.T. M-mm.

P.Y. I don't know. I, I just felt like a number I guess. And I mean I, I don't want to make him sound like he's a bad

doctor cause I'm sure he must be good. He must be. I mean have you heard of him?

L.T. M-hm. but

P.Y. (Laughs.) So.

L.T. But you know, good doctors, not every good doctor works well with every person. So, you know.

P.Y. Yah. Yah, that's true. So and, and you know even like when I came to see you, I think part of it in me was just that I wanted to hear someone tell me that I was recovered too. You know, so like when I went to see Dr. Golberg?

L.T. Goldner.

P.Y. Goldner. I bet he gets that mistake a lot.

L.T. M-hm.

010 P.Y. It was such a relief for me, even though he didn't think that I was gonna be able to be a part of this study. For him to say to me, "It's very clear to me that you did have an eating disorder, and it's also very clear to me that you're completely cured." Like it was like (sigh). (Laugh.) You know like I, I, part of me reasoned that I was, but part of me thought, "Well, you know, maybe you just are so 'out to lunch', you just can't be objective, and you don't know what's normal and what's not normal. I mean maybe, you know, maybe you're still not recovered or whatever."

011 I mean even though I, I know that I don't binge like I used to, you know, is, you still always have that part of you that worries about um, about dieting and food and things.

012 Like I try not ever to weigh myself because I don't want to think, "Oh no, I'm, you know, I've gained 10 lb or I've gained 15 lb; I'm gonna have to get rid of it." Cause I, for me to go on a diet, I just couldn't do it. It would (pause), it would be too stressful, you know. Like I'd be so afraid that I'd slide back into old habits again. So I think in that way, I don't know. Like I don't know if other people that have recovered feel this way but you know, it's always haunting me a little bit, you know. And like in my own daughters, I worry about them too. You know, I really watch for things. Like my oldest daughter is getting to be a bit of a "junk food junkie" and, and it makes me worry a bit, you know like. But I don't know if that's normal or

if that's not normal, you know, it's hard to, it's hard to know.

L.T. M-hm. Um, so now then you don't, you don't diet at all. And can you tell me a little bit about the focus on your weight or like how, how do you deal with that whole realm of dieting, not dieting, food, weighing, um?

P.Y. Well I, I don't diet. And I, I, you know I say I try not to weigh myself, and I do try not to. But I do weigh myself. You know, sometimes I have to look and uh.

L.T. I mean how often do you do that now about?

P.Y. I don't know, it varies. Sometimes I'll weigh myself everyday and then sometimes I'll go for 6 months and I won't weigh myself. So, you know, it goes in little spurts. And then I always say, "Oh the scale's wrong anyways" which half the time it probably is. But I never know if it's too heavy, too light. So, you know, about the only way I, I set the scale is when I take the kids to the doctor, have them weighed, and then I take them (Laugh) home and set them on the scale and, and set it.

013 But um, I guess it, you know, like I, I don't know if I'll ever be a 100% satisfied with the way I look. But then I don't know if anyone is, you know. And there's, there's the, also the element of I'm 30 now, I'm not 18. You're not gonna look like you're 18 when you're 30. You know, so, there's that part of it.

014 And (pause) I don't know, I just started trying to exercise a little bit. But that I also didn't do because I was really afraid of going overboard. You know, so now I'm trying to um like I don't go to aerobics or, or anything like that. I try not to exercise with my goal being to exercise cause I don't want to get caught up on how many sit-ups or how many miles, or whatever.

L.T. So that's a fear for you that if you got into exercise I mean it could become real goal oriented which.

P.Y. Right.

L.T. It was in the past? Is that?

015 P.Y. Yah. Yah, it was: Not, not for the entire time I had bulimia for, but for the first several months I was pretty fanatical about exercising. And uh, I don't know, I just don't want to get into that again. But (pause) I, there's also (laugh) the part of me that knows realistically, "You've got to

exercise." You know, so, my husband's really good that way. I mean like on Saturday I couldn't sleep in the morning so I got up and I did go for a run. And he said, "Good. Go. We'll see yah; have fun." You know, but that's the first time I've gone running in years. And it was like huh run a block (breathes heavily); huff and puff for three blocks (laugh). But you know, I, now I'm trying to be more aware of just my health, you know like. If I don't exercise, I'm going to pay for it down the line. You know, if you're going to stay healthy you have to exercise to a certain degree.

016 And like, with eating too, you know even though sometimes I'll even if I haven't been eating well that day, I won't not eat supper. I'll make sure that I eat a supper that has vegetables and fruit and the things that I didn't get during the day. So in <u>that</u> way I'm conscious like I, even though, you know, when you look at what I ate at each time it might look like a "screwball" way of eating sometimes: not all days but some days. In the long run you'll see foods from each food group tucked in somewhere there. So, that way I try and be conscious. But I don't, don't really count calories, you know. I don't know.

L.T. O.K. You more go by the four food groups then. And, and how about in terms of how much you eat and? Cause it sounds like although you don't weigh yourself, like you're conscious of a weight that you feel comfortable at, are you? Or, can you tell me a bit more about weight?

P.Y. Yah. Yes and no. I mean I don't (pause), I don't really know.

017 I mean I guess somewhere around the weight I, I am. I mean I, it probably wouldn't, it probably wouldn't hurt if I was maybe 5 to 7 lb lighter. I wouldn't want to go any heavier but I probably, I wouldn't want to go any <u>lighter</u> than that much lighter either. And I <u>don't</u> um, I wouldn't say that I cut down so that I can get down to that weight or anything. It's just that I've seen my weight slowly creeping up over the years. So I, I just want to stop it from creeping any further than it's creeped, you know. And, and I don't know if that's fanatical or not. I mean it's, it's not like I get stressed out over everything I eat. But it's, it's [weight increase is] just kind of in the back of your mind, you know like.

L.T. You don't want to go past where you are now and so you're aware of that and.

018 P.Y. Well, and it's, and it's not only that too. It's that I want to eat normally, you know. So it's not necessarily like, "Oh, I want to cut back on the calories," but it's if I look at the way I've eaten that day, you know. One thing is when I work, my lunch hours: I work 8 a.m. to 1 p.m. straight through. So then maybe I'll get a chance for lunch, maybe I won't. But I'll be hungry, so I'll grab something. And so then at the end of the day when I look back, I'll think, "O.K. what did I grab?" You know like sometimes it will be junk food, you know. And then that will make me want to compensate for it. You know sometimes I'll, I'll get a chance to go across to the deli and I'll get a sandwich or something which is obviously a better way to go. But, you know, part of that is just the way my work day is too. Like on days like this when I don't work, then I'll have like a normal lunch with the kids. But, you know, the days that I work it's like I finish at 1 p.m., I pick up K., I've got this errand and that errand, and it's just grab something on the run. And you just grab the first thing that you come across: You know, it might be a twinkie. You know (laugh), so. I try, you know, I, I guess that's it: That I want to eat normally and I don't think that that's normal or that should be. (Tape ends here.)

L.T. O.K. Just let me ask you a few more things in the dieting area and uh (pauses to look at written questions). Um. O.K. So you're wanting to eat more normal meals. And you have a sense that your weight is creeping up and so you're more aware of that now; you're just beginning to think about doing some exercise as a way to control your weight? Or, how does the exercise come in?

P.Y. No, not really to control my weight.

L.T. No? O.K.

P.Y. Just, I worry about arthritis and things like that, you know. Like I, um, I just want to be not a "slug". I, you know, like I have back problems and things like that--posture related--and I know that if I exercise, that will help that. I mean, it's just things, you know, I, I guess 30 isn't very old, but 30 isn't a teenager anymore. And just thinking about how healthy I'm going to be, you know. Like I do want to be healthy and I don't think I can be healthy if I never exercise. And I also know that that's, you know, being extreme: refusing to exercise for fear of, you know, overdoing it. And uh, now it's been so long since I've exercised, when I was out running I thought, "What am I worried about? There's no way I could

overdo (laugh) it anyway in only one, two blocks." (Laughs.)

L.T. Yah. So hitting 30, I identify with that too. There's a few more concerns and you're sort of beginning to look at, "M-mm, maybe exercise might be helpful!"

P.Y. "Not a bad idea!" (Laughs.) Yah.

L.T. M-hm. And, and so then when you actually do go out and do it, you realize that perhaps some of those fears you have about going to the extreme might not be um realistic fears, at this point anyway.

P.Y. Yah.

L.T. At this stage anyway.

P.Y. Yah, especially because I'm finding I really hate (laugh) exercise. So I'm thinking, "How could I get obsessed with it. (Laughs.) Just let me go home and have a hot bath!" But um, my husband and I go out and play volleyball once a week and I really like that. And that's, you know, it's not <u>extreme</u> exercise but it's a lot more than what I was doing. And I don't know, just trying to make a point of if I'm home with K. to go out with her for a walk, or for a bike ride, or something just to get out and do something where I get my limbs moving a little bit. But I'm certainly not vigorous to the point where I'm sweating buckets or anything (laugh) like that: nothing real athletic.

L.T. And then the focus too for you is more on eating balanced meals and so that you don't count calories. And how does that relate with um your concern about your weight and where it is now?

P.Y. M-mm. Well, there's kind of two sides. There's, I, I tend to eat more starchy things: I mean I always have my whole life. I just tend to like pasta and things like that. So there's the part of me that will think, "Well, no wonder your weight is creeping up." But then there's the other, other part of me that says, "Well, it's not creeping up that fast." You know, and I don't know.

It, it's a little bit tricky too because my husband is a <u>really</u> picky eater: like he'll only eat ground beef. He won't eat chicken, he won't eat fish, he won't eat roast. He, he really <u>won't</u> eat any other kind of meat but ground beef. So, you get a little tired of, you know, cooking ground beef for one thing and thinking of different things to do with it. And also, because of the ages of my kids, they don't have really varied appetites yet. So I think as they get older and they eat a more varied diet, my diet

will also be more varied. So at this point in my life, it's probably starchier than uh--you know, I don't know--than I'd like it to be, I guess. You know it, it tends to be a bit, the vegetables are snuck in on the side. I can get them to eat celery if I put cheese whiz on it, you know. And if I cook any vegetable that's green, they're all gone from the table (laugh).

L.T. O.K. So your weight is something--like most of us--that we're concerned about when we see it, you know, beginning to increase a bit. But at the same time you feel that there's some reasons and that.

P.Y. M-hm.

L.T. Sounds like you probably, you have a good idea as to why it might be increasing a bit, and you see that changing as your kids get older. And um.

P.Y. M-hm. I hope (laugh). As long as my metabolism doesn't come to a dead stop (laugh).

L.T. Yah. There's some concern but still focussed on the healthy eating and, and balanced meals.

P.Y. M-hm. Yah. You know, and I guess I worry about being obsessed with it. And I, you know, I do think about it kind of in the back of my mind. But when, like even when I walk my daughter up to the school, when I hear people that as far as I know <u>haven't</u> ever had an eating disorder, I mean their, the conversation often revolves around diets and you know. So then I think, "Well, I'm not as obsessed as they are and they haven't had (laugh) an eating disorder."

So I, I guess that's the thing is that you lose your objectivity about it, you know, because well no one in my family has proper eating habits. You know like, well I shouldn't, I mean my kids have kids' eating habits, you know. And my husband has <u>terrible</u> eating habits and that's who I live with. So that also doesn't help, you know. But I think as they grow up, I'll probably feel more comfortable too like. Because I, you can kind of weigh how <u>you</u> think by what other people think, you know. So you can adjust it or, you know, like it's just I don't have any gauge to measure it by except my immediate family here because the rest of my family doesn't live close by. So, so I guess that's one thing, you know. That, that's why I tend to sneak in the, the carrots and things because I'll think, "Gee, you know, did, did I feed them well today? Well here, have another carrot (laugh); have another piece of celery." (Laughs.)

L.T. O.K. Um (pause). Any, anything else in that area at all that you want to add about your current eating habits, or weight, or um?

019 P.Y. I guess the only thing is that um, I still tend to be a bit of an emotional eater. Like if I'm stressed, I'll go for the junk food but not to extremes like I did. I wish that I didn't do that. And sometimes that makes me feel a little bit uptight. But uh, see whereas when I had the eating disorder, if I, if I went to the junk food it would make me feel uptight and then I'd <u>really</u> go for the junk food: And I'd just go crazy. I don't do that anymore. And I wouldn't, I think what would be a binge now, I mean (laugh), doesn't measure up at all, you know.

020 Like I had a <u>stressful</u> lunch hour with the kids today--after K. peed all over the bed (laugh)--and I went down and I had one of those little chocolate bars (laugh). But I only had <u>one</u>, you know. And so part of me thought, "Now why did I go and do that? I didn't have to do that." And the other part of me thought, "Yah, but I only had one." You know so, it, in a way it's a loss, and in a way it's a victory because I could stop. And that was the thing before: I couldn't stop. I would just eat myself to pieces (laugh).

L.T. M-hm. So sometimes now you eat for emotional reasons.

P.Y. M-hm.

L.T. If you're uptight, or.

P.Y. M-hm.

L.T. Feeling stressed out. But it's very different than before because it sounds like you have a real sense of <u>control</u> in there.

021 P.Y. More so. Yah, more so. I mean there's, you know, one um. I have this PMS [Pre-Menstrual Syndrome] thing and, and one of the things is craving chocolate. So uh, sometimes that makes me feel a little bit panicked. But if I <u>don't</u> keep chocolate in the house, at those times, it's not as big a deal. And also, after that week is over, the craving's gone too. So I can look back and say, "It was just PMS. It wasn't that my whole life has gone crazy." And uh, even in those times I don't, I don't <u>binge</u>, but I just will tend to eat more junk food type things. And uh, you know, from anyone I've talked to that's had PMS, it's the same thing

they go through. So, that's a relief for me because.

L.T. M-hm.

022 P.Y. In that way I, I do know, you know, several other women that have PMS. So again, you know, I gauge myself off them. So I can say, "Oh, well that happens to them too. So it's not something coming back from my eating disorder. It's just, you know, it, that's just the way my hormones are at that time or whatever." So I'm hoping that as I get my PMS under control I'll see that go away, you know.

023 I guess uh the thing that's on your back of your mind all the time is, "I don't want to ever be like that again, you know. I don't want to be obsessed." So even, you kind of become slightly obsessed with not being obsessed, you know, so. But I don't know if that part every goes away. You know, like it's, it's not like, it's at the front of my mind all the time and it's not like I do conscious things. But every now and then I think about it, you know, because you eat every day, you know. It's not like you, you know, if you stop drinking you just don't go near alcohol again: I mean, you know, it's off your mind. It's, you're always being faced with uh--especially as a mom--you're faced with having to cook meals for your family: And are they balanced? And are they nutritious?

024 And you know, gee, I, I just want to make sure that I'm, I'm uh not only nutritionally giving them [my children] what they need but also setting an example of what kind of foods to choose. So that's why when I see my oldest daughter, in boredom, go for junk food, you know, it makes me feel a little bit anxious just because I know the pressures that are out there, you know, and I just don't want to see her fall into the same trap that I did.

L.T. M-hm. Sounds like you feel there's a fair bit of responsibility on you to be a model for other people around you in terms of good eating and.

P.Y. I think mostly for my daughters, you know. I, and I probably feel that way because my mom was so unaware, you know. And, and even when I tried to explain to her, she, she really couldn't grasp what it was all about. And my dad, it was just more than he could handle. He just left the room; he couldn't listen. And, it wasn't that he wasn't, he didn't want to be supportive. It's just, I mean no one had ever: My mom kept saying, "What's the name of that disorder you have again?" You know like she,

she just, you know, all, in her mind she just kept thinking, "Well we gotta make sure she eats." You know, so she'd bring me, you know, 20 lb of potatoes, and a big sackful of bread, and 75 chocolate bunnies at Easter: All the things I didn't need (laugh). But she didn't understand.

025 You know, and I guess, for me, having daughters and knowing the pressures there were when I was a teenager, and knowing the pressures that they're in for, I just want to make sure that they don't get caught up in that, I guess. You know cause even at 9, my daughter just yesterday said, "Gee I'm fat." And she's not. I mean she's not the least bit fat: She's 52 lb, I mean. And, I don't know, if even one time she came home from gym and told me she wasn't supposed to eat butter on her popcorn because she'll become a fat gymnast. I mean this is the kind of stuff, at age 5, that is being tossed their way. So, stuff like that tends to make me really (pause) anxious and angry kind of too.

L.T. M-hm!

P.Y. Because I don't know if people realize the pressure that they put on kids. So, if I had sons, I probably wouldn't worry so much, you know. But, daughters: I don't know what it is about girls, I guess.

L.T. M-hm. There is a lot of immediate things happening around you that are reminders of your eating disorder and make you aware of, of.

P.Y. M-hm.

L.T. How easy it is to--because of all the pressures out there-how easy it is to.

P.Y. M-hm.

L.T. You know, perhaps get back into it. I mean, you know.

P.Y. Yah.

L.T. There's always that possibility and, and you're conscious of it.

P.Y. M-hm.

L.T. Um, and um sounds like work really hard towards trying to moderate your eating and your daughters' eating, and um, and having healthy anger towards people who seem to be quite fanatical about the information they give out.

P.Y. M-hm. Yah, I guess because they just don't understand, you know. And, the other thing too is it's not like you wake up one day and say, "Oh, I'm gonna go out and eat, you know, two bags of groceries and then go make myself get sick!" It's just one day you suddenly discover that it's just beyond your control and you can't do anything to stop it. You know, and to see how, when I think back, I can think back to the very day that I became bulimic--the very moment, you know--and just slid into it: How quickly and how easily it happened. You know and, and I just wanna protect my kids I guess, you know and.

L.T. M-hm.

P.Y. I don't, you know, it's funny like it, yes I try and, and moderate what, what they eat and everything. But um, my sister-in-law--they just live a couple blocks away--she tends to be a very fanatical "exerciser" person, and she's a vegetarian and. So they always joke about our house being the junk food house, eh (laugh), cause we have a junk food cupboard. I mean there's virtually nothing in it right now. But, but we do tend to be more that way, I mean partly because my husband has poor eating habits. I mean he's not fat and he doesn't eat a lot of sweets. But if he doesn't want to have supper, he won't have supper. He'll just have a bowl of popcorn, right, or that kind of stuff, you know. So in a way, I get a little bit (pause) frustrated with him. I mean I don't, I don't say anything about it because it's not worth it. But, I guess just that I wish he had really good eating habits so that he was setting a good example. It just makes me feel more responsible that well if he's not gonna to set the example, I have to really make sure I do. So.

L.T. M-hm. Yah, you have to bear more of the load in, in.

P.Y. Yah.

L.T. That area then, and be more concerned. And, also because it sounds like you're the one who does most of the cooking, that you're responsible for the planning of things as well.

P.Y. M-hm. Yah. Yah, I always know if, if he's cooking, we're having Kraft Dinner. (Laughs.) M-mm.

L (Laughs.) O.K. So, that's sort of where we are at present day here. And I'm wondering if, if, is there anything else that you want to add around present day and um (pause), and how things are in terms of eating for you?

P.Y. I don't think so. (Pause.)

L.T. O.K. Could you pick up the thread for me back with Dr. B. there? And, I understand how you went to see him and that. But how did it happen that--people were coming into the office--and like how, how did you decide?

P.Y. I don't know. I mean that part is really uh. I have never once since that time had a patient come in to the office and say, "Yes, I'm, I'm a recovered bulimic." Or, "I have bulimia."

L.T. M-mm.

P.Y. Never, ever. But in that, I worked for that woman for 2 years and I, I bet you I had four people come in and tell me. I mean that just floored me that they would offer that information.

L.T. M-mm.

P.Y. That would be the day that I would go into my dental office and say, "Yah do you wanna check my teeth for erosion; I've got bulimia." (Laughs.)

L.T. M-hm. So some of these women were recovered but some of them weren't?

026 P.Y. They were all on the road. They were all improved or, you know, I can't remember if they were completely recovered but they all had progressed. So, and that was one of their concerns was the erosion on their teeth. They wanted to make sure their teeth hadn't eroded (laugh). Oh . . . .

L.T. M-hm. And so you head this and though?

026 (cont'd) Well then I, you know, and I would ask who their physician was and usually then they would tell me that they had bulimia. Uh, with one girl I remember I said, "Oh, I do too." You know, and she (pause), she looked surprised and uh then, you know, it was kind of like we had this common bond, you know (laugh). We both had this thing, but don't tell anyone, you know.

L.T. Was that the first time you had told someone cause you said that your close family didn't know and your friends didn't know?

P.Y. No. Um, the first time I, I uh told anyone um that was a very kind of unpleasant thing.

027 Um I had heard about Dr. T. on the radio and I thought, "Aha! That's the name of the thing I've

got and that's who I have to see." So I made an appointment to see him.

L.T. How, how did you know you had to go and see him? Like what made you think that?

028 P.Y. Well I knew that something was wrong with the way I was eating. But I didn't know, I had never heard of bulimia at that point. I just knew that I was uh devouring my paycheck and throwing it up down the toilet every, every week day.

029 So uh, I knew something was wrong but I didn't know where to go. And I wasn't gonna tell anyone about it. So one day at work they had a talk show on the radio, and this girl came on the radio. And she was talking about um her eating disorder, and who she saw, and she mentioned his name. So I went and phoned.

And uh, I think it was that day that (pause). Oh no, it wasn't that day. It was after I'd seen Dr. T. several times. I was talking to one of my girlfriends who happens to be a real motherly type person: a real caretaker, eh. She was always taking care of me. And uh, I, I can't even remember how the conversation went. She was asking about how my life was. She really wanted to know, you know: make sure I was O.K. And, and uh, I think I said something to the effect of, "Well, I had one little area of, of concern or something, but I've taken care of that now" or something. And she immediately, I didn't back. I thought, "Oh, I shouldn't have said anything." Then she was just pumping me for information and I didn't want to tell her. So we hung up the phone and I went to sleep.

And a couple of hours later--bang, bang, bang, bang, bang (laugh) on my door--here it was my girlfriend. She was so worried about me and she had called my then boyfriend. And there they both were, and they wanted to know what was going on, and what was wrong, and oh, boy. And they just would not leave. They were there for, I don't know, probably an hour and a half. They just would not go home. And it was so late, and I had to work the next day, so I finally just told them (laugh). But I really didn't want to and I, I was really angry that they would push me for information when I didn't want to tell them.

But they, you know, they were, they were both fine about it. And uh, I mean I think S. didn't really, she was very supportive and everything. But I always felt like there was part of her that thought, "That's really odd." (Laughs.) You know, and even now, I mean she's still a really good friend and, and uh, you know we never talk about my bulimia anymore. But um, I always felt it

probably wasn't her, but me that looked at her looking at me differently. You know what I mean? It probably, she's, looking back she was fine. But it felt, it made me feel awkward, you know.

L.T. M-hm. You felt uneasy with having to tell her.

P.Y. Well, yah. I couldn't, I, you know, I couldn't go to her house for supper anymore without worrying that they were watching (laugh) what I was eating, you know, and seeing if I went to the bathroom afterwards. So, but that was, you know, I'd had the eating disorder for a long time by then.

L.T. Did telling S. play any role in going for therapy, or?

P.Y. No.

L.T. Did you, you had already been seeing Dr. T. at that point?

P.Y. Yah. I'd, yah.

L.T. O.K.

P.Y. No, it didn't affect it at all. It was uh, it was a part of my life that I didn't want anyone close to me to know about or have to deal with. And I guess because I needed to feel like they still felt I was normal. And when you go telling people that, you know, "Here look at this huge bag of food. I can eat all this at one sitting and then watch me go throw up." I mean like it's, you, people are (pause), it really makes them uncomfortable. You know, and I, I just (pause), I didn't want to have to deal with that, so.

L.T. M-hm. You felt people just wouldn't be able to understand it and that they would think it was so unusual and.

P.Y. Well yah. You know. And even now, like um, my husband's brother, I don't, I don't think he realizes. Well he probably does now because. Actually he has two brothers that live together. And one time T. was over and, and uh, I was telling him the story about that, when that guy who was suicidal phones, and the guy said, "no big deal." And he said, "Wait a minute. You were seeing a psychiatrist?" And then he wanted to know why. And I thought he knew. And he didn't. So I told him, "Oh, I had an eating disorder." (Laughs.)

So he's probably told his other brother cause he lives with him. But, B.'s other brother will often, like if he sees someone that's fat, in his eyes that's their fault; they can do something about it. Like he really has no comprehension, you know. And I think, I really like him a

lot. But if he, if I were to ever sit down and talk to him about me having had an eating disorder, he could never be the same around me. I mean even though he's now kind of heard about it through the grapevine, he's never had to face me about it, you know. I don't know, people tend to be that way. They, they just think that, "Well, do something about it, you know, like stop doing it then." Like they, they really don't understand that, that feeling of um (pause) just being out of control. So.

L.T. Telling people that were close to you then felt like it, it wouldn't be a worthwhile thing to do for you at all.

P.Y. Oh, no. M-hmm-mm.

L.T. O.K. So and, and you told me about seeing Dr. T. and the things that weren't very positive about that experience for you.

P.Y. M-hm.

L.T. And then going and seeing Dr. B.

P.Y. M-hm.

L.T. Um, because you had been recommended by some people who were on the road to recovery.

P.Y. M-hm.

L.T. And you had felt really supported by him.

P.Y. M-hm.

L.T. And that he was an equal, and um. And you knew him as a patient.

030 P.Y. Yah. You know maybe that was it that I didn't wanna risk my family and friends by telling them. But I found someone who I respected and liked, that I could tell, and would still respect me, you know.

L.T. M-mm.

031 P.Y. So it was kind of like finding someone to fill in that gap for. You know, like I guess ideally you always would like to tell--if, you have a problem--you'd like to tell someone you're really close to. Like my sister and I are very close, you know, and she would have been the person of choice. But I just didn't want to lower myself in her eyes, or, or worry her anymore. Or, you know, I didn't want to add to her burden kind of thing. So, to find Dr. B. was like finding someone that I could like, and I

could talk to comfortably, and I could pour my guts out to. But I hadn't really risked anything, you know, because there was still the professional ethics part that he would never, you know, see me on the street and say to his self, "Yah, that's the woman with bulimia I was telling you about", you know (laugh).

L.T. M-hm. M-hm.

P.Y. So, you know, it was safe to tell him. I wasn't risking any part of my life by telling him. But I just, I could never ever. I mean my, you know, my family knows that I, I've had the eating disorder. But I'm sure that they have a curiosity about it because I never talked about it, at great length about it. I mean, you know, to tell them, I could never say, "Oh, see this whole table of food, I could eat that." I, you know, like even when I would tell them, it's like I was watering it down a bit because I, I just couldn't bear to tell them about it.

L.T. M-hm.

P.Y. You know, and how intense it really was. Um be, I think be, just because people can't um, it just "grosses" them out. They just, they don't want to have to deal with it, you know, so.

L.T. And yet you felt that Dr. B. could handle all that, and that he would still--in spite of what you told him--still respect you, and be there for you.

P.Y. M-hm. M-hm.

L.T. And it sounds like that was incredibly important for you and a real bond with him.

P.Y. Yah, you know! And I'm sure more. Like I had the bond more than he did; I'm sure of it. I mean he, he was uh, you know--when B. and I were married--he, he was B.'s doctor too, you know, because uh I told B. how great he was. And B. went there, and B. liked him. But I guess that was just the thing is you weren't a number going through.

But he wasn't someone that I would ever have to see on a social basis; like there just was no risk to telling him. You know, and there was, there was no risk going into his office that I was gonna be found out. I mean, you know, the, the girls at the front desk would always. When you phoned in, of course, you'd have to say why you were, why you were coming in to see him. And I, I can't remember if I ever actually admitted to them that I was coming in (laugh) to talk to him cause I had bulimia, or not. I bet

ya I didn't, just because I didn't wanna have to look them in the eye and have them think, "Oh, so you're the one with the eating disorder." (Laughs.) You know. (Pause.)

L.T. M-hm. M-hm.

P.Y. There is such a stigma to it, you know.

L.T. M-hm. And so you said that you saw him only for about 6 months. And can you, sort of, if you think back to those 6 months when you were seeing him, how, can you describe how things happened? You told me about him um, you know, saying that you could sort of stop the binge half way through, or you could eat but not throw up afterwards.

P.Y. I never stopped a binge half way through.

L.T. O.K.

P.Y. I would always complete the binge (laugh).

L.T. O.K. So just, you know, if, if you could just kind of tell me how things happened as much as you remember it, in, in a sequence, um, you know: things he said to you, or you said to him, or how you felt during the times that you saw him.

P.Y. Gosh, you know, it's so hard.

L.T. O.K.

P.Y. I was just thinking about what I said, "I would never stop a binge half way through." I never stopped the binge half way through, but as I did the binge without throwing up, the binges would <u>become</u> smaller, um, just, just because of that uncomfortable feeling, you know.

L.T. How, I mean how did it happen? Like you were saying you were bingeing two or three times a day and purging after each one of those.

P.Y. M-hm.

L.T. Uh, and then you went to see Dr. B. Now how, how did things begin to change? What happened?

032 P.Y. (Pause.) M-mm. I really think that um a lot of it was just confiding in him. So in that way I'd lessen my burden because I felt like I was walking around carrying this burden.

L.T. M-mm. M-hm.

P.Y. When I went to see Dr. T., I felt like I was talking to him but he wasn't hearing me. He didn't understand how desperate I felt, although he would say, "Yes I know," you know, "you feel this way or you feel that way." But he didn't say it with feeling in his voice, you know.

033 So, when I went to talk to Dr. B., it's like I left a lot of it there cause I would tell him about it and I would pour my heart out. And it's like, you know, when you're really mad, when you don't tell anyone about it, you stay really mad and it's really hard to get over it. But if you tell someone what you're really mad about or you just blow up, then it's over with and you can get on with it. So I felt like for most of that time, I walked around with it all kind of bottled up inside me, afraid to tell anyone or, you know, and just getting in deeper and deeper. But when I would go see him, we would get that part over with: I mean he would ask me and I would tell him, "Oh, I did really, really poorly this week. I did this, I did this, I did this." And then the conversation would just kind of turn a bit, you know. Like he would be really interested and, and really supportive and that. And then he would just ask me about other parts of my life, you know, and.

L.T. Such as (pause) what things?

P.Y. Oh, my daughter, my job, my church--whatever, you know--like just what was going on in my life. And, and it's like he had as much interest for that, as he had for my eating disorder. It wasn't that he was disinterested in my eating disorder, but there was other parts of me that could interest him too, you know. And, and so then when I told him all the awful, awful stuff I did, then after talking about other things that were unrelated to my eating disorder, he just kind of had a way of making you see that "Well, gee, I didn't do everything badly." Cause that's how I always felt like, "Oh (sigh), I did this."

034 And I still catch myself doing that, you know, like it, "Oh (sigh) I, you know, I didn't eat right and oh I didn't clean house right, I yelled at the kids": I can list all the things that I did really badly. But, now I can kind of stop myself and know that I'm being unreasonable with myself, you know.

035 And that was I guess one thing: Talking with him [Dr. B.] helped me to not be so unreasonable with myself. Like "yes, this one area in my life was really awful, but it, it, you know, other areas were O.K., and other areas were normal, and I wasn't a complete freak." And it wasn't him standing there

telling you that all the time. It was just he talked to me like that was the case, you know. He didn't have to keep saying that I was normal or I had other things to offer because it was clear in that he was interested [in my daughter, my job, my church], you know.

L.T. M-mm.

036 P.Y. And then he would always (pause)--at the end--you know, would always come back to it because that was why I had come. You know, he would just (pause), basically, just kept reinforcing that I could fail; that I didn't have to be perfect; and, and that he separated the bingeing from the purging, which I never did. So, you know, I could, I could (pause) binge and that was too bad. But that didn't mean that I had to purge. I, I mean it sounds like such a stupid thing, but for me like it had, I just had never thought of it, you know. It was, always felt like once I had eaten one little bit, I was in over my head and I couldn't stop. And, and then, like with the eating, you kind of get into it and you eat, and eat, and eat, and eat, and eat; and it's hard to stop yourself in the middle. But if you could separate it into two separate acts, then suddenly it, you know (pause), even though you failed at this one, that was a totally separate issue from vomiting afterwards.

L.T. Oohh! Uh-huh.

P.Y. So. (Tape ends here.) But I guess that was, a, a lot of it was just natural consequences. If you eliminated the purging and--which for me was always vomiting: I never used laxatives. I always vomited. (Tape is turned off briefly while children are attended to.)

L.T. You were talking about separating the two: the.

P.Y. Oh yah!

L.T. The bingeing from the purging.

037 P.Y. Yah, and so like part of it was the support, and part of it too was natural consequence, you know. If you take away the vomiting, then you have to deal with that horrible full feeling. And it's terrible. It just, you, it wipes you out for the rest of the day. So then, the next time you binge, you tend to binge a little less. And so the bingeing gets less just because you don't have that same way of getting rid of it.

038 So it's, you know, part of it is, is, is um the support and encouragement; part of it is making the decision not to vomit. But it, it never really, like it, of course I wanted my bingeing to be less, but I always felt like that part was not really in my control. But then the, the bingeing just tended to get less because I couldn't stand that awful sick feeling. And then when I saw that it was getting less, then it made me feel more like it was in control. And then it just kind of gradually did become more in my control. Like I would, I would try and ignore it as much as I could, you know: It's kind of I was looking out the side to see what I was eating, but.

L.T. M-hm. (Interview stops briefly while children are attended to.) Um, how--I guess one question I have is--how did it happen that you decided not to purge? (Pause.) Like what, what sort of thoughts did you have?

039 P.Y. It, I, well, it was just because Dr. B. kept telling me that, that I could fail, and that, and when he told me. I guess at the point he told me that just because I binged didn't mean I had to purge, I had just reached the point where I trusted him enough that I was gonna try it, and even though I was convinced it wouldn't work. And he never ever said once you stop purging, you won't binge anymore. He just separated it into two issues. I don't even know if he knew what the result would be of doing that. But it's just that I trusted him enough to try it. (Interview stops briefly while children are attended to.) So, yah, it was just I think that I trusted him enough to try what he said, and I didn't really think it would affect anything.

But um, the very first time I did that, I, I--that was one thing too-that when I did it, I made sure that I was going out with someone, you know. So at that time B. and I were seeing each other. So I may, I asked him to take me out, you know: I forget where we went. But just to be away from the house so that also I didn't have that outlet. I, I couldn't run to the bathroom and make myself sick, cause obviously you never do this when you're around people. And, and you know, maybe that was partly it too was that B. and I at that time were seeing each other so uh, I, I would never phone him and say, "Oh gee, I've just binged; come, take me out." But there was two things: One is, he would call and ask me out, and I would be too embarrassed to say, "No, because da da da da da, you know, I just, I just ate, you know uh, three boxes of cereal" or whatever, you know. And so there was that part of it: having him there asking me out and not wanting to have to tell him. There was also having him there to be able to plan ahead.

Like you, I could feel it all day long if I was gonna go home and binge: I could feel it. I knew the whole day if. One day I even left work early cause I just couldn't take it. I had to go and, and uh binge. So I could say to him, you know, "Oh, what are we doing tonight, or can we go and do something?"

040 And then, just by being away from my house, and out in public, you don't do the same things, you know. And even if I had binged--I mean it would be pretty obvious I wasn't feeling so great--but I would still go out and do things. And then after, after a few hours had passed, you feel a victory already. Even though you still feel awful and you still could go home and make yourself get sick, you don't feel quite as bad because part of the food has gone through you. So, there is some relief that way: just that you feel better because you're not quite as intensely full as you were.

And uh, there's also just the part of feeling like "Wow, now I've gone 3 hours. I'll just go home and go to bed now, and I don't have to do that." So, you know, I think that was maybe part of it too. Because , when I was really in the thick of my bulimia, I would come home from work and I would shut all the curtains, I would take the phone off the hook and stick it in the drawer, and then I would just go crazy. And that would be all I did: You know, shut myself off from the world. And, you know, I would, uh, put my daughter in front of the T.V. for a while, and then I'd give her supper, and then I'd put her to bed. And so basically I had the house to myself from the time I got home till the time I went to bed. So that's all I did.

L.T. Things were changing then that you trusted Dr. B. enough, and he had suggested this, and for some reason you thought you'd give it a shot.

P.Y. Yah.

L.T. Was there any, anything more that, other than trusting him? Was there anything else that was important about making this decision? Because I think that's a huge step and, you know, some people never--even though they trusted their
therapist--have never really done it, you know. Was there anything else that was important?

P.Y. I don't know why it, I, I, it just. I just remember it like a light bulb going off, that it, it could be two separate things. Like I, I never ever looked at it as two separate things. And, and uh, I think it was that, and

also that I did go out that first time that I did it. I did go away from the house.

L.T. Now did you plan that? Like how did that day: Do you have quite a, a memory of that day when you tried it?

P.Y. Well. I just, I, I just remember B. and I standing in the kitchen. I don't remember where we went after, and I don't think I told him (pause) much about it, at that point.

L.T. That you had binged, and when he wasn't around.

P.Y. M-hm.

L.T. Right? You had planned and asked him to come over? Like tell, tell me a little bit about how it went, I'm, cause I'm putting words in your mouth here now (laugh) imagining how it could have been.

P.Y. (Pause.) Let me think. (Pause.) I, I didn't tell him why. And it wasn't like I was planning on bingeing because, of course, everyday I would make this vow not to binge, but I would just always fail which would make me (laugh) feel worse and, and it carried on that way. So, um, we were gonna, I don't know what we were going to do, but I had asked him to take me out. I'm quite sure I did. And I, I did binge (pause), but then we went out. And I just remember that really awful, uncomfortable feeling: And I felt like a slug. I couldn't, I mean don't ask me to do anything that requires motion because I just can't do it. It's all (laugh) I can do to walk to the car.

L.T. M-hm. M-hm.

P.Y. And um, then, we were out for a while--quite a while--and then just, as time went by I felt physically better because I wasn't as full. And it, it kind of dawned on me that (pause) if, for me to be with someone else was one thing that really helped. And to be away from my house was one thing that really helped. Because it was when I was by myself, in my house that I binged. And like I know, I, I had um, sort of like a roommate for a while. Like I lived in the suite upstairs and she lived in the suite downstairs. And she knew that I had bulimia. And we used to eat suppers together which was really kind of her, you know. She would come up and, because then it would be like I would have someone that had normal eating habits that we could make supper together. And she had a little girl the same age as mine and we could eat kind of like a family together. And that was really nice of her, and uh, you know, was good, you know, for my daughter too. But I would still binge afterwards. And she, I mean, I

mean she must have heard me (laugh) cause she lived just downstairs.

041 So (pause), I don't, you know, maybe it was having, being with someone that there was more risk. You know, because I wouldn't want to have to tell B. at that time. I wouldn't want to have to. I mean he knew that I had an eating disorder, and <u>that</u> took a lot of courage to tell him that. But I didn't want to have to tell him any of the gory details. And I didn't ever want him to witness any of it. So, it was kind of like a safety net. If I put myself in the company of people that I care about--but I don't want to know--and I take myself away from the place that I, I'm comfortable bingeing and purging, then it makes it easier for me. And I think that was because of that time I went out with him.

042 Like I don't know if, if I hadn't of gone out with him that night maybe I, maybe I would've made myself get sick. But because I was away from the house, by the time I get home, got home, I didn't feel--I mean I still <u>could</u> have--but I didn't feel the same urgency to do it. And then it was like a victory. And then to look back on it, it seemed logical to, to try, you know, to go <u>out</u> with him, and to fill my time with other people and, and be in other places.

L.T. M-hm. What was that like when you came home that night--and, and you say it was a victory--can you tell me anything more about it: What you were thinking and what you were feeling when you got back that night?

P.Y. Yah. Well, whenever--I don't know if this is like this for everyone who has bulimia--but when I would, when I would throw up, I would always go to bed afterwards cause it, um you feel like you've been run over by a steamroller. You know, like it's energy to lift your arm and, you uh, it's almost like it's a sedative in a way, you know. It's like you throw up and then you go <u>instantly</u> to sleep: into this really deep sleep. And it, you have, I don't know, like a bit of a headache, kind of. And, so, to go to bed that night and not have that feeling was really nice. And I, I mean I hadn't experienced that in a <u>really</u> long time. I couldn't remember what it felt like to go to bed just cause you wanted to go to bed because I <u>never</u> went to bed without bingeing and purging.

L.T. M-hm. So you felt <u>physically</u> a lot better then.

P.Y. Yes! And relieved: just tremendous <u>relief</u> that I actually didn't throw up that day. And, you know, probably a lot of it was because circumstantially I couldn't. But it didn't matter: I still didn't do it,

you know. So, and I survived the evening: I went out on a date, you know, and I, you know, I did a normal thing. And I didn't back out of it or, you know. And because, I mean probably if I would have had a toilet close by I would've, you know. But I didn't. And then just having got through that evening (coughs), excuse me, I could just, I don't know, it was like an unintentional victory in a way.. You know, cause I don't think I ever thought that I could do it, even though I thought I'd try, you know. I, it was in a way, you know, like a sick way of thinking, "Oh, I'll prove him wrong." (Coughs.) Excuse me, I'm losing my voice now. So, you know, after that I think.

Gee it's funny how you remember things then when you look back. I'd forgotten about having B. take me out and not being at home. But that probably was a big part of it too. You know, and even now that we're married--I mean obviously he knows I had an eating disorder--but I think he would be shocked if he could've seen me: the things I did to myself, you know, when I was right in the thick of it.

L.T. So P. what happened then after that night when you had felt like a real victory? Here, do you want some kleenex?

P.Y. (Laughs.) This is just cause I'm losing my voice (laugh). I'd like to say it's cause I'm all emotional. But I'm (laugh) just losing my voice. Well then once you have one victory, it gives you more strength to have another one. And it, so I just, I really, really wanted to recover badly. I mean I, I mean I always did but (pause), I just, I was very determined. And so that, because I could look back and see that success and what I did that night, it gave me another thing, you know, another method of kind of controlling it later. Like, "O.K., I'll just make sure that I am out of the house, or um, or that I go visit someone, you know, or have someone over, you know."

And I found arranging it ahead of time was the best way because at the moment--at the very moment when you wanna, when you're gonna binge--you can't pick up the phone and say, "Oh, I'm coming over" because you, you're already kind of over the hill by then. But if you planned ahead: which is one thing in having a relationship with someone, you know, like you're dating so they want to see you. You do plan dates ahead of time.

So uh, it, you know, then you have to figure out different times to do your bingeing and purging; "Well gee, you know, I work all day, and uh then I've gotta go pick up my daughter, and go do this, go do that. Then we're going out." And so there, there just physically wasn't, as, an easy way to do it. But it was I, gee, you know, it really

was after that first time that I could see that and then, then I would plan ahead cause I knew that if I did it at the moment, I wouldn't do it.

043 So uh, that was a big part of it, was just being out around people. And uh, that, but you know what was, it had to be something that I wouldn't back out on, you know. Like if I told a good friend that I was going to do something with her or, or something, I wouldn't back out of that as easily as uh, I don't know. Like I backed out of work one day, which seems incredible to me now that I could look my boss in the eye and say, "I'm sorry but I have to leave now." (Laughs.) It was so embarrassing (laugh). He was standing in the middle of the hallway and he says, "Why, do you have your period?" (Laughs.) And I thought, "No!" (Laughs.) But really, I just had to get out of there, you know. And for me to even be able to do that at work. But (pause), it was, you know, it's like they could function without me.

044 You know but, if it's someone that you care about, you won't back out on them the same way, kind of, you know: and especially a date, you know. Cause even you can get a friendship that's comfortable enough to the point that you will do that, and you'll just back out and even tell them why. But if there's a little bit of risk involved, like there is with a boyfriend or something, you don't want his, you don't want to back out for one thing. And if you did, you sure wouldn't want them to know why, so.

L.T. So a lot more reasons for you then to check.

P.Y. Yup.

L.T. I mean going out with B. seemed to be something that really was a motivating force for you.

045 P.Y. Yah. But, you know, it wouldn't even of had to have been a boyfriend; it could have been like a commitment. But something that I put up high on the priority list that I just would not back out of. Like say I, I had, I was a hospital volunteer or something--and that was important to me--I would never phone and back out if it was something, you know, that I was really gonna be letting someone down. But I, I just didn't do that. I just locked myself into my house. So, you know, B. just happened to be what was there at the time. But it really, I don't think it would have had to have been

him, you know. It was just that idea of I had made a commitment to someone.

L.T. M-hm. And you were going to see it through.

P.Y. Right.

L.T. And that would take priority even over your having to purge.

P.Y. Right.

L.T. Cause you had binged.

046 P.Y. Well and, and, you know, part, partly too, like sometimes he would just show up there. I wasn't gonna say, "Excuse me while I go to the bathroom and throw up." (Laughs.) You know, so there, I had to be on my toes a little bit too.

L.T. M-hm. O.K. So we have that first night then. And you realized that that was an <u>incredible</u> victory for you, and you were feeling physically better. And, and you could see that there were two separate acts now: the bingeing, and even if you binged that meant that you didn't <u>need</u> to purge. They were two separate things.

P.Y. M-hm.

L.T. And how did things change, at that point, for you? How did, you know, after that one night, what happened?

P.Y. Well, then it was just um, just, you know, I think just slowly cutting back. But, I mean slowly, but in one way quickly too because I bet ya it wasn't more than a couple of months before I was, I had stopped completely. You know, when I think of how <u>long</u> I was bulimic and how, how long I tried to stop.

L.T. Just how long was that? You told me like about a year and a half, did you say?

P.Y. About a year and a half.

L.T. O.K.

P.Y. Because yah, B. and I didn't start going out till, gosh that was <u>2 years</u> by the time I started going out with B. cause we didn't start going out till 1985. (Pause.) Yah, so 2 years. You know, so, and I had started to um--isn't that funny, gee, now that I talk about it--yah, so I had been seeing Dr. B. before I even met B. And even though.

L.T. Well were, can you give me some times? Cause I think that if you can; if not, I don't want to push you.

P.Y. A few months like.

L.T. O.K.

P.Y. A few months, maybe.

L.T. Weekly? Or just as you wanted to talk with him, or?

P.Y. I'd say probably every 2 weeks; sometimes every week. Probably every week to begin with, and then maybe, maybe every 2 weeks. And yah, just as, if I felt I needed to go then I'd phone him. But, I went on a fairly regular basis.

L.T. Always making up some physical reason to see him (laugh).

P.Y. I know, it's not like they wouldn't know, eh! (Laughs.)

L.T. You're really creative! (Laughs.)

P.Y. It's funny (laugh). More, this woman has more rashes than anyone I've ever seen, eh! (Laughs.)

L.T. All different kinds! (Laughs.)

P.Y. Yup. (Laughs.)

L.T. O.K. So, so you would sort of see him at your convenience then and, um, whenever you wanted to see him.

P.Y. Yah. Yah, usually at the end of the day he liked to do it so that he wouldn't have other people waiting. So um, you know, which is reasonable. But I think probably the first while was just the building up the trust part and um--and just through talking to him--starting to feel for myself that there was more to me than just an eating disorder, you know. So, there, it was probably a lot of it coincidence in the timing, you know, that B. popped into the picture. But, you know, maybe a good coincidence because who knows without one, or without the other, you know, it might not of, of happened that way. But yah, I did see him for a few months before I met B. But I remember it was with B. when I, uh, that night when I didn't, didn't throw up.

L.T. O.K. Just before we jump back into that. Can you tell me--when Dr. B. was talking and just asking you about other parts of your life, and you began to realize that there was more to your life than just an eating disorder--what, what sorts of feelings go, went along with that, at that time?

P.Y. Surprise (pause), you know, um. It wasn't him giving me pep talks. It was just, you know, as I was talking about my life kind of thing, "Hey, yah, you know, like"--I mean and stupid things nothing there was nothing really major going on in my life but just--"Well that's fairly normal, or." I don't know. (Pause in interview while children are attended to.)

L.T. O.K. Surprise then that?

P.Y. Well, just, when I would listen to myself talk after the conversation, you know. I'd think about the things that we talked about, and surprised that he would be interested for one thing, and surprised that I had anything else worth talking about because I really felt like that's all my life consisted of.

L.T. Was the eating?

P.Y. Yes, oh yah. Everything: I mean my job even was to support (laugh) my eating disorder, you know.

L.T. M-mm. M-hm.

P.Y. It, and, guilt, I always felt too because of my daughter, you know. Like here she was just this little tiny girl, you know. She was not, not even a year and a half when I first got the eating disorder. And, and everyone would tell me what a good mum I was and it would oh (sigh), it'd just be like a knife in my heart because I would be, I knew that I wasn't, you know; that I was doing all these awful things. But then when I talked to him, it wasn't always the really awful things. I mean there was the awful things, but there was enough things that weren't awful that I, you know, made me feel more like, more normal, I guess: more like the average person.

L.T. M-mm. It gave you a different focus then--

P.Y. M-hm.

L.T. Something else--to see what else is happening in your life.

P.Y. M-hm. Yah! Yah, that's for sure!

L.T. O.K. And so that sort of happened for the beginning part: the first couple months that you were seeing Dr. B. And then you started going out with B.

P.Y. M-hm.

L.T. And had your eating changed at all in those 2 months?

047 P.Y. (Pause.) M-mm. I don't really think so. I mean may, well, if I cut down at all, I was still bingeing once a day anyway. Like it was a ritual every night. No, I, I don't, you know, maybe I cut down from two or three times a day to once a day, if anything, you know. But it was still once a day, every day.

048 But, the feeling in my head was better, you know like. (Pause.) I, I guess I could see other things in my life besides that: So, you know, enough so that I wanted to go back and see him again. Whereas when I was seeing Dr. T., I did it because I felt I should, cause I had to get my life together because I had this child to take care of. With Dr. B., there was that part of it and there was "I wanted to because I felt better when I left." You know, even though I hadn't stopped the bingeing, I, I did feel better about myself, so.

L.T. Mainly from talking to him you felt better because.

P.Y. M-hm!

L.T. He helped you see other areas in your life. But the fact that you had cut down from about three times a day to once a day, did that happen while you were seeing him? Or, do you, do you recall how that happened?

049 P.Y. Well you, uh, I don't know if I would even go as far as to say I'd cut back in that time because sometimes it was two or three times a day; sometimes it was once a day. It was always every single day. So, you know, it's, it's really difficult to remember: Did I suddenly always go down to once a day? I mean I just, I just know that every single day I, I binged, you know.

L.T. So it was still a major issue for you.

P.Y. Oh, yah!

L.T. And sounds like even if you had cut back that you didn't feel any better about your bulimia at all.

P.Y. No.

L.T. O.K.

P.Y. Cause it wouldn't have made any difference because a failure is a failure, you know, like.

L.T. For you, once a day was just as.

P.Y. Right.

L.T. Bad as three times.

P.Y. That's right. It wouldn't of, it wouldn't have mattered. So and, and you know, as far as that goes it could have just been a lack of energy to do (laugh) it another one or two times after that, because it does just wipe ya out. It's, so you know it's, I would never say going from three times a day to once a day is a victory. It's not a victory till you can go a day without, you know. That, I mean that's how I feel now, and that's how I felt then. I would never have looked on--"Oh I just binged a little bit"--I would never ever have felt like that was a victory. It, it was all or nothing.

And I guess that was the thing that, why it seemed so strange to me to look at it as two separate issues because I always did feel it was all or nothing. There was no such thing as a partial binge, you know; like you, you did it all the way (laugh), all the time. So.

L.T. O.K. But by this point you had trusted him enough, and you thought you'd give it a try.

P.Y. M-hm.

L.T. Mainly for what reason?

P.Y. Well. (Pause.)

L.T. Cause B. was coming around more frequently: You mentioned that.

P.Y. Yah, but that wasn't my motivation for it. He just happened to come in the picture at the time that I was seeing Dr. B. I mean he wasn't my motivating factor.

050 It was my daughter, really, that was my motivating factor. And all along she was my motivating factor for, for getting better.

B. just happened to come into the picture at that time. And, you know, I guess I didn't think that it would work: bingeing and not purging. I didn't think that would make me better and I also didn't think I could binge without purging.

051 And it, I think it was just a happy coincidence for me that it happened to be a time when B. was gonna take me out. And I didn't have the same comfort zone with him that I could have said, "Sorry, I'm not going" because I did wanna go, you know cause uh, I, I, I guess, you know, I really wanted my life

to be normal. And I liked him and, uh, in the, the long view of my life I did wanna have a family. I wanted to be married again, and I wanted to have a dad for my daughter. So there, I would never ever--I mean that sounds (laugh) like such a silly thing to say, but that was a high risk thing--I would never ever back out of a date with him and risk how he would see me. So, you know, but he was never my motivating factor for getting better.

L.T. O.K. But it was your daughter, then.

P.Y. Yah. My daughter and myself: mostly my daughter.

L.T. In, in what way? How, how was she a motivating factor for you?

052 P.Y. Well because, um, you know, I was a single parent and if, if not me, no one: You know, I, I just couldn't see anyone taking care of her the way I would want her to be taken care of. And, the selfish part of me too, you know: I wanted her to be with me. And I knew that it wasn't healthy for her to be with me the way I was, and there wouldn't be no way I would've ever let her go anywhere else. So I had to get better, I mean, and there was just no two ways around it, you know.

L.T. M-hm! You were committed to her, and giving her the best that you could. And so you were going to.

P.Y. M-hm!

L.T. Provide that.

P.Y. Yah! Yah. (Pause.) So.

L.T. O.K. So, so we have the reasons that you decided to try to stop the purging.

P.Y. M-hm.

L.T. Because of your daughter and because Dr. B. had said that these two, could be two separate acts.

P.Y. M-hm.

L.T. So you tried it that night. And B. had by this time come into the picture--and he was--and so you had arranged that day, or whenever that, that you would see him.

P.Y. Yah.

L.T. So you spent that, that evening and didn't purge, and felt good afterwards. And um.

P.Y. Yah, but the only thing is when I arranged to see him, I didn't plan on bingeing and not purging.

L.T. Oh?! O.K.

P.Y. I, I, you know, I, I um, I would always want to not binge. But, I would never ever of thought, "Oh I'm going to binge and not purge."

L.T. Oh! O.K.

053 P.Y. It just happened that I'd binged (pause), but then I didn't purge because of, you know.

L.T. He was there. Oh!

P.Y. Right.

L.T. O.K.

054 P.Y. See when he, he came maybe at an inopportune time because otherwise I would have been in the bathroom. But he came, and we were going out, so we went out. But then at the end of it, I could look back and see, "I did it", you know. Like I, I did agree to try, but I think still that sick part of me thought: "Well I'll have, I have to do it all, I have to do it all," you know; or, "I'll never be able to do it"; or, you know, "He'll see it just can't be done." And I was so convinced I couldn't do it. And then as things turned out, I did do it, you know. I, like I, had B. not been there, I probably would've defeated myself.

But, that one day doing it, then I could see that I could do it, and I could see the things that helped me to do it, and that I could plan for that. And then just, as my binges became less, I started to feel less panicked about it. And then just gradually it just seemed more in control, you know. And (pause), I guess that's the thing like it seemed more in control, but always that, that little bit of anxiety about food that kind of carries with you. You know, and, and that's why um, you know, for me to hear someone say that I'm, "Yes, you're recovered" is like I, I realistically I guess I should know that. And I know that I don't binge, but I, I guess. (Tape ends here.)

L.T. So it was almost like in your head you knew that, "yes", you were recovered because you didn't binge, and you

didn't purge, and you weren't totally obsessed with your weight: and those sorts of things.

P.Y. M-hm.

L.T. But, maybe emotionally you still.

P.Y. Yah!

L.T. Felt that, well you still thought about it.

P.Y. Yah!

L.T. And so you really wondered how, how recovered.

P.Y. Yah. (Laughs.) Yah, like am I 80% recovered? (Laughs.) "Oh well, we say that you're 63% recovered here." (Laughs.)

L.T. .5: 63.5. Yah.

P.Y. Right. (Laughs.) Oh.

L.T. O.K. I'm still, I. Because we're trying to like look at what happened next, can you tell me after that night: It was a victory for you, you <u>felt</u> good. And you told me a couple of times that then you started, your binges became less and so therefore that, you had more of a sense of <u>control</u> and that. But when you think back to that period, first of all how <u>long</u>, how long are we talking about? Like, can you sort of focus in for me from that night until when you weren't bingeing and purging? Like what happened in your life at that time?

P.Y. I guess maybe 2 or 3 months.

L.T. O.K. (Pause.) And so do you recall what happened the next time you binged?

P.Y. (Pause.) Oh, I probably, I probably purged. I don't know if I did the very next time. I know that after that it wasn't a case of always just bingeing and not purging. I <u>still</u> had times when I would purge. But, I also had times when I didn't. And it just kind of um (pause), it just gave me something to hang on to, you know. Like I knew I had done it once, and just because I didn't do it this time didn't mean the next time I wouldn't, you know.

And I, I tried not to set myself up, you know. I tried not to have times when I would be just at home, just myself, right after work, you know, because that's when, that was my comfort zone for, for bingeing and purging. So I tried to, um, be out. And, uh (pause), if I binged I

just, I wouldn't always purge and sometimes it was just because I made sure that I was with people, or I was out.

So, each time I did that it's like taking steps kind of, you know: You're getting closer, and closer, and closer. Because it wasn't like I had one victory and that one was forgotten. It's like because it was close enough, you know: Like they, they were close enough together that it, it I felt like I was walking out of it, kind of. I was gradually stepping out of it. Cause I never ever thought I'd get to the point where "boom", one day, you know, I, I wouldn't be doing this anymore. I mean that was always my goal every day of my life, but it's not realistic. So, you know, and, and then it just.

L.T. How, how did you think things might end up if, if you felt that really it wasn't realistic that you would totally stop bingeing and purging? What, how did you think your life would be around eating?

P.Y. Oh (pause), well, I, I, for a while I thought that I would always be binge, purge, binge, purge every night and that one day I'd probably kill myself because I couldn't, I just couldn't stand the anxiety of it anymore. And then, you know, I, I would visualize myself, way off in the future, not having an eating disorder. But I had this kind of grey zone in between. I didn't know how I would get there. But it's just, I guess at the time--binge, don't purge--I didn't feel cured, you know. And then, when, the next time, you know, I would binge and I would purge: But I still had that victory from yesterday to hang on to, you know.

L.T. What would you tell yourself in those times?

055 P.Y. Just that it was O.K., you know. Like it was just kind of like giving yourself a pep talk. I would go from, what I used to do before was I would go to bed and I would just berate myself to sleep, you know: "Oh, you're so this; you're so that; you're so awful; you're so fat; you're so." I could think of a million things that were wrong with me, you know.

056 But to have that victory, it was such tremendous relief and, uh, such success! I didn't feel like I had to cut myself down. I felt really kind of proud, you know, that I had done it. And just because I failed the next time, that feeling was still close enough in my memory, you know. And, and uh (pause), so that made me think of, you know, going out and doing those things, and trying not to set myself up. And then have another victory: And it just felt better, and better, and better, you know, and it just, it just made me feel so much

better about myself. It sounds like such a small thing, but wow it was.

L.T. No, it's not. It sounds like a huge thing. (Tape is turned off briefly while children are attended to.) O.K. So each time then was more of a victory for you and you could remember what it was like. Then, then what happened? Like how did things progress so that you weren't bingeing and purging? Like it, it sounds like it was, kind of, you had a day; it was a victory. Then you might have another day and you were back to the bingeing and purging. Um, how did it go?

057 P.Y. Well it just kind of, it was just a gradual thing after that. It just um, sometimes I would binge and purge, sometimes I would just binge. But it just got to be less and less. And then uh, you know, when I got to the point where I could go for--oh, no--I guess about a week, then it just started to seem like not as big an issue. So, so then the anxiety still stayed for a really long time--and in some ways still does--but I wasn't bingeing and purging anymore, you know.

058 And I've had--gee, I was trying to think--I bet ya I've had two incidents in the last 5 years where I've binged and purged: which is, you know, one every 2½ years, I guess. Or actually they were probably both, you know, well into the first part of the last 5 years. But it, it's the behaviour change, but the anxiety didn't go for a long time.

L.T. Anxiety around?

P.Y. Just around eating: Just being afraid that, um, that that will happen again, you know, and that.

L.T. It? What?

059 P.Y. That I'll lost control again, you know that (pause). Like I um, even after all these years to think about eating normally, I try to do it, but I'm sure I don't do it. (Tape is interrupted while children are attended to.) So it's just, I don't know (pause). Even though to this day like I'm not bingeing, I'm not purging, and I think my eating habits are not too bad, there is always the worry that, um, you know, I will go over the deep end. And especially, you know, like at times when I have PMS--and I'll go for the chocolate--I'll think, "Oh, no!" because those are the things I would go for when I had bulimia. And I've never gotten to that point where I've had a full-fledged binge but (pause).

060 It's just, it, it's just that you feel you're prone to it, you know, and, and you're so cautious about it. I guess you, I never feel like I will ever: even when I'm 85 and body image won't matter much then anyway (laugh) cause I'll be a wrinkled prune. I'll still always feel like I, I can't be as cavalier about the way I eat as other people are just because they can't relate because they haven't been through it. But it's just, in a way it never leaves you kind of. I don't know if you've heard other people say that, you know. Like that's the part of me that makes me worry that, "Oh, am I only 85% recovered?" Because I never will be so nonchalant and, and, uh, carefree about the way I eat. I mean in a way I am, but in a way it's always somewhere in the back of my mind that you have to be careful, so.

L.T. Yah. It's a caution for you cause it's a weaker part for you. And you know.

P.Y. Yah!

L.T. You have that tendency. And so, you're a bit more guarded around it.

061 P.Y. Yah. Yah, I guess that's true. So, you know, and I guess that was one thing that kind of surprised me is that I thought that when I was recovered I would be able to be carefree like that again. You know, and, and to all appearances, to other people I probably am carefree. But, to me, knowing what goes inside me, I still feel that little bit of anxiety over it, you know. Like we'll go to the fair, and obviously when you go to the fair you eat a lot of junk, and I'll eat junk like anyone else will. But there's a little part of me that goes, "Be careful, you know, don't. Go ahead, but don't go too far." It's like you always have to keep yourself in check, kind of. So uh (pause), kind of consciously disciplining yourself, you know, where maybe I don't have to do that. But because it was so awful when I was bulimic, I mean I just, I just can't let go of that part, I guess. (Tape is turned off briefly while children are attended to.)

L.T. O.K. So consciously disciplining yourself was a way of making sure that you don't fall back.

P.Y. M-hm!

L.T. Into the, the same pattern because it was so awful. And it sounds like it's still really quite vivid in your memory.

P.Y. Oh, yah.

L.T. And, and so although you're not overly concerned about your body image, and weight, and eating, it's, it's an issue that's important for you to make sure that you pay attention to: and spend, pay extra attention to, and extra care to, for you.

P.Y. M-hm. Well, and I guess one thing too is that body image was the thing that got me into it. But after a while body image was kind of lower on the scale. It's just that bingeing and purging just took control and it wouldn't have mattered what I thought my body image was, you know: It just wouldn't have mattered. It was just a habit I couldn't break. So I guess that's maybe part of it too is that, to me, I think it doesn't matter what I think my body image is now, I still could fall back into that, you know. Like, cause it just seemed like it happened when I wasn't looking, you know, and. It was, I always thought it would be more dramatic: the way it came on! But it wasn't, you know, it's boom, there is was.

So, you know, yah, I guess, I guess I, that's the one thing is I always thought that cautiousness would go away. And it didn't. But, and that's why it was gradual, you know: Like the anxiety stayed, the bingeing became less, and the purging became less, and it just slowly got less and less. But the anxiety still stayed. You know, I, I could (pause), um, ignore it a little bit when I didn't eat the right things, or maybe I started to binge, or whatever. But I was consciously ignoring it, you know what I mean. Like, it was like, "O.K. I'm gonna let that one go", but in the back of my mind I was acutely aware of what I was doing, you know. So, there was that kind of anxiety of "O.K. you know, I've let myself do this part, you know. Am I gonna go all the way and?" (Pause.)

062 So, but now I don't, I don't have to, um. Like still if I, if I'm upset and I eat, I'll do it by myself, you know. So, for me, if I ever felt I was gonna slip back into that I, I know what I would do, you know. I, you would have to make sure that you're out, out around people that you would be totally embarrassed if they (laugh) if they knew anything like that was going on. (Pause.)

L.T. O.K. So we're sort of up to present day. And I just, I, I don't know if I'm sort of flogging a dead horse here, but I'm still unclear about. There was that 2-month period where things just gradually seemed to become less and less: Less bingeing, or decrease in the purging and therefore bingeing became less for you.

P.Y. M-hm.

L.T. And do you recall any important times, during that 2-month period, as you saw things tapering off, at all? Um.

063 P.Y. No. Just that <u>each</u> time was like taking a step out of it. And it was, um, to be able to go and say, "Oh, I, I did <u>much</u> better this week." Or sometimes I wouldn't even say that. He'd ask me how I did and I'd say, "Oh, well, you know, I binged and purged this day and this day." And he'd say, "You <u>didn't</u> on this day and this day" and "Oh, that's great!" And, and it was just, it was just <u>really</u> exciting to, to be able to see that I didn't have to do it every day because there's no way I could've gone a <u>single</u> day from the very moment I became bulimic. It was every day right from the start.

064 And uh, seeing that I could <u>do it</u> sometimes, it's like (pause) I wasn't, um, I wasn't beyond repair, I guess. Because to go for that long bingeing and purging every single day from the <u>very</u> moment that I became bulimic, I really thought there was no way out. So even though I still continued to do it a little bit, I could see the light at the end of the tunnel, kind of. And so it, it was, uh, I mean I still felt the anxiety about it and I still worried about it, but I could <u>see</u> that I, I <u>was</u> getting better, and that I could get better, and there <u>was</u> things I could do.

So, you know, I just kind of carried on that way: And then, I, I think it was just when I got to the point where I went a week.

065 After that I didn't, I didn't [binge or purge] <u>at all</u> except for those two times that I did when I was really going through major stress. So, but even <u>then</u>--you know when I--those two times it was like: "Hang on, what am I dong here? Look how long I've gone. Look how <u>awful</u> that year and a half was." And uh, you know, the next couple of days after that were difficult for me just in that I felt that same <u>failure</u>, you know. And so, I just had to not let myself be by myself too much and, and then it was O.K. after that.

L.T. How would you describe those two times where you got back into bingeing and purging: What were the binges like?

P.Y. Not as big: not nearly as big. But, um, junk food, you know: Just consuming a fairly large quantity of junk food. And uh.

L.T. About how much?

066 P.Y. M-mm. (Pause.) I don't know if I could say how much but definitely not to that point that I felt like I was so full I was gonna explode. So that's how I know it wasn't bingeing the same way it was. But, then fear that, "Oh no, you know, look what I'm doing, and stop it before it's too late!" And then purging and thinking, "No I didn't stop it before it was too late." I carried on through even though I thought "I'll just get rid of this now and then I'll be fine." But um, then after that--I was, I didn't--to go the next day, the next day, the next day, and not binge and not purge made me feel O.K. And it's not even not just not bingeing and not purging, but also not fasting, you know. Because that was one thing that always followed: If I'd binged and purged, the next day it's like, "I'm not eating anything!" And I didn't do that. So, and it was only those two isolated times, and I can't even remember why. But they were a long time ago.

L.T. During your recovery point, was the "not fasting" part of your tapering off as well then?

067 P.Y. I stopped setting those unrealistic goals, you know. Um, I tried not to (pause) say, "Oh I'm going to eat this." Like I would plan out of my whole day--what I was gonna eat and not eat--and then if I varied from that even slightly it was a major crisis. So I think that was one thing too was that he told me, um, you know, not to plan it so heavily: Don't, don't set yourself up to fail, and if you do fail it's not a big deal, you know. So, yah, and I, I tried not to make those goals of not eating. I tried to make my goal being to eat properly. So that was a transition, too, to go from making my goal not eating, to make my goal being to eat properly.

068 And that had it's own, uh, difficulties because it was really stressful to, to consciously decide I was going to eat this meal, this meal, this meal cause I was used to saying, "O.K., tomorrow I won't eat anything!" So that was harder. But that, you know, that probably helped in the not bingeing too because if you make your goal to not eat, your blood sugar's way down here (lowers her hand towards the floor). So the first thing you go for is the junk food and then you just go crazy. But, to change my goal from fasting to eating well-balanced meals, I wouldn't have that real plunge in, in blood sugar so I wouldn't get that, that urgent feeling of having to binge either. So that probably helped too. But really hard to do, you know: Like it's a going against everything you've done.

So, you know, in that way too, um (pause), it would help to be eating a meal with someone: supper especially, breakfast and lunch not as bad, supper really difficult, and evening really difficult. You know, I, if, I don't why but that just was the time when I would go crazy. So, if I, you know, could eat supper with someone--and it would be a balanced supper--I wouldn't be as likely to purge either, or to binge.

L.T. O.K. So you'd go on, on and off with the decreased bingeing and then you went for a whole week. And when did that come in your 2-month tapering off period? Do you?

P.Y. I'd say at the end because it was after I went (pause), it was after I went for a week that I realized that I could go for an indefinite length of time, you know, so. Yah. And then after that, then it was like, what, it was always, I guess that was part of the anxiety thing: I was always waiting for the next time, you know. Like "Gee, I'm not really cured yet even though I've gone this long, you know. When's the next time gonna be?" And then when it just, it was so long down the line, you know. I think that's the thing is that if you, if you could say to yourself, "Yes, I'm cured!", but you never really say that because you're really never sure, you know. Like is it gonna come back on you again? It's that, it's like I, you know, like it's not like the measles: like it's over with, the symptoms are gone. Because even when I went for that week, that whole week I was waiting for the next I was gonna fail. And then at the end of the week it's like "Hey, I went a whole week!", but I still didn't feel like I was cured. Like I never would've ever said I was cured then. And then, "Oh!", you know, I went for a month, 2 months; it just, the time just got longer and longer.

L.T. Is that how it went: from a week to then not bingeing and purging?

P.Y. Not for a long time, yah.

L.T. Or, like?

P.Y. A really long time.

L.T. A year?

P.Y. It was probably several months.

L.T. O.K. several months and then?

P.Y. And then one slip, one time.

L.T. Right.

P.Y. And then probably several more months.

L.T. And what, what was that slip like in terms of comparing it to what you'd been doing before: was it the same or different?

069 P.Y. Bingeing: not consuming as much food. And uh, it was scary though. It was really scary cause I thought, "Oh, no. This is it!", especially the first time. But then I just, you know, the old standbys of go out and do things, don't let yourself, the big thing for me was don't be alone in the house in the evening. So I just made sure I wasn't, and I made sure I was with people for supper time over the next few days. And then I could look back and think, "I didn't even slightly binge the last few days. It's O.K. I had one slip but that's O.K." And then the next time when I slipped it wasn't quite as bad because again it had been several months, and I saw that I had slipped before but that didn't mean that I was right back in to it again.

070 And then now I haven't. And still I think the big thing that keeps me in check--like even at times when I'll go for the junk food--is I know in my mind I'm not gonna let myself get sick. So that stops me because just that full feeling; I mean it's something you never forget, you know. And if I know that I'm not gonna let myself get sick: You only have to do that one time and you don't do it for a long time again because it feels so awful. So.

L.T. M-hm. You just don't want to repeat it.

071 P.Y. (Pause.) No! Oh, it's terrible. It's, uh, you can't function. You just feel (laugh) so awful you don't want to move. (Pause.) So I think, you know, that's probably, that probably keeps me from bingeing. Like you know, that, that, you know like when I have PMS or things like that, those would be the times when I know I would be susceptible. And in that way, even though it's a really horrible time to go through, in a way it still makes me feel good cause I think, "Look I can even go through PMS (laugh) and I didn't do it!"

You know, but I, I can eat pretty poorly when I have PMS. And then I'll eat the other things on top of it, you know, like the healthy things.

072 But, sometimes I, some days I'll, I'll eat pretty poorly. So you just, you know, again it's the same things--I gotta watch it in the evenings, I gotta

make sure I've got no sugar around--because, I don't know, I don't know if other people are that way but I know I'm prone that way. So I have to just watch I don't set myself up to fall. So.

L.T. M-hm. O.K. Well, um, thanks. I, I understand now better that tapering off process, and the slips, and, and that. Um, and, uh, there's just a couple more questions here. Um, was there anything else that would've helped you during your recovery time that you can think of now: you would've wished would have been there for you?

P.Y. Oh. (Pause.) I don't think so really. I mean I, I needed to, you know, have someone that I felt comfortable talking with. But I also needed to feel that I was the one doing it: that it wasn't someone else doing it for me. So, I think it, I think that's pretty much it, was just um, you know: the not being alone (pause), not making myself vulnerable, too. But um, you know, it's too bad I couldn't have figured all that out a lot sooner (laugh).

L.T. It's, well, you figured it out quite quickly it seems, it sounds like.

P.Y. Oh, is that right (laugh)?

L.T. Yah, a 2-month period, really: That's fast. It might be interesting for you to look at the other stories when they come out, and to see.

P.Y. Yah! Yah, maybe.

L.T. See if any of it might be unique.

P.Y. But then it was those few, you know, before that it was a lot leading up to that too, you know, till I got to the point I was ready to do that.

L.T. M-hm. M-hm.

P.Y. So. Oh well, that's good (sigh): good and bad. I mean, boy, if that's fast, I feel sorry for the people that had a long time.

L.T. Yah. Um, were there any other changes, um, when you think of when you were bulimic to after you had finished the bingeing and purging? Um, we talked about, you know, physically: the body image and change around dieting and that. I'm wondering changes in any other areas at all for you like socially, or intellectually, or spiritually, or emotionally: any differences?

073 P.Y. Well, I'm, I'm probably a lot more active Christian than I was. But I was, um, I was a fairly active: well (pause) I don't know if active is the word. I was a devoted Christian when I, when I had bulimia too. And I, sometimes it would just make me angry, you know, that--cause of course I would pray about it all the time--and why wasn't God fixing me.

L.T. M-hm!

074 P.Y. But um, I, I don't know, maybe, maybe I'm just more mature than I was then. I don't know. Cause I don't, I don't really, I don't really look back on it and think that God "dinged" (laugh) me with some injustice by me having this disorder. Socially?

L.T. Just in terms of spiritually then, would you say that there was, um, a difference from, you know, when you had bulimia as to after?

P.Y. (Pause.) That's hard to say. That's really hard to say because I think, uh, I think regardless of whether I would've had bulimia or not, I would still be at the point that I'm at now.

075 But, um, I'll tell you one thing is Dr. B. was a Christian doctor too, and that was important to me. And I, I think maybe that's one thing with Dr. T. that really turned me off was his attitude about that person who was just gonna go jump off (laugh) a bridge somewhere, or do something to kill himself and, you know, to me: And then for him to say that we were all just like spiders, I thought, "I don't wanna be like a bug! If all I am (laugh) is like a bug to you, what am I doing here?" And probably a lot of that was because I was a Christian, you know, and, and I, I needed to, to feel like I was talking to someone who related the same way I did. But, mind you, you know, when I spoke with Dr. Goldner?

L.T. M-hm.

P.Y. I really liked him too. It's like, you know, when you talk to someone and you immediately know if you could be comfortable or not comfortable. And I don't know if he's, you know, christian or not christian; but he seemed like a good person with a good heart. So, you know, I don't know if that's part of it. But.

L.T. Well that was important for you: That's an important, you know.

P.Y. Yah.

L.T. Bit of information that you wanted someone with the same background and values.

P.Y. Yah!

L.T. As you. And that made you feel more comfortable with him.

P.Y. Oh, yah! Definitely. Definitely.

L.T. Like you could trust him more.

076 P.Y. I mean I guess in a way I hesitate even to say that, "God did this, or God did that: because I don't want you to think that, um, "Oh, she's a religious quack, you know, (laugh). Get me another candidate!" (Laughs.) You know, because I know that I feel very confident that God did bring me through and helped bring me through. But it certainly wasn't that He let me sit back and He did it all for me. I mean I'm, you know, I'm sure there was reasons for it all, and there's things that I learnt through it all.

077 And I probably am more mature, as a result, spiritually but also in, in other ways too. You know, like, I, I think at, at the time, I mean, I really wanted someone to come and just take care of me, you know, and uh, that just wasn't the way. And by the time I got to the recovery point it was important for me to feel like I had been the one.

L.T. M-hm!

078 P.Y. That did something about it. Not that God didn't play a part in that, and that I didn't pray about it, but I didn't just sit back like a slug and say, "Fix me! Fix me!", you know.

L.T. You played an active role and He allowed.

P.Y. Yes!

L.T. You to do that, in a way that He works.

079 P.Y. Right. Right. So, and another ways in my life? I don't know if I, it's really changed. I mean I, I was, there was anti-social parts of me when I had bulimia: obviously in the evenings when I could come home and shut myself in the house. But, while I was out I was still social: you know, I was still very social. And, and now I'm, I'm probably about the same except I'm married to someone who's not all that social. So we (laugh) don't go out that much but I tend to fill my time, when he's not here, with

social things. So. I don't, I can't really see any other ways.

080 Maybe, maybe more, uh, maybe relying more on myself than on other people, you know, like, and on my circumstances. It, maybe, I don't expect to just be happy all the time and I in, you know, in lots of ways I've had more to deal with in my life since I've had bulimia. I mean I've had a lot of stresses but I haven't gone back to being bulimic through those things. And I, I haven't thought, "Oh no!" I mean a lot of, at times I've probably, I've thought, "Oh no, my world's coming (laugh) to an end!" But, but realistically I knew that I could get through those things. So.

L.T. So, how did you cope instead? You don't need to tell me the incidents but, but sometimes bulimia is used in stressful situations. So, so how do you cope with stressful situations now?

081 P.Y. Well, you know, maybe that is why I'm a more (laugh), more devoted Christian now. I, I um, I do pray a lot about things. And I find that helps. (Pause.) And, I guess too because I can, I can look back at major incidents and see that I came out of those O.K. So this one. (Tape ends here.)

L.T. Yah. You were telling me, O.K. that, that now you pray more about things as a way of coping; you find that that helps.

082 P.Y. Oh yah. And also with the bulimia that was (pause) the worst thing that I've ever been through, even though other things in my life were going O.K. at that time. And that was a long-term thing ad I came out of it, you know. So I can look back at that and feel like, "O.K. I did that; I can do these other things. These may seem more intense at the moment, but they're not as long term. And I went all that time, you know that." So in that way I'm sure it has made me stronger.

L.T. You feel a lot more confident now cause you've overcome something that was long term, intense, and totally awful. And in comparison, you look at some of the things that you struggle with now and feel that.

P.Y. Right.

L.T. They're not as bad; so you have that hope that you can.

P.Y. Yah. Yah.

L.T. Still hang on in the midst of really trying times.

083 P.Y. Yah (pause). Yah I, I don't feel like my whole world is gonna (pause), that I'm gonna lose control of it or whatever. (Tape is turned of briefly while children are attended to.)

L.T. M-hm. Anything else that, you know, you wanted to add about um?

P.Y. No, I don't think so.

L.T. So that confidence that you have in having come through the trauma of bulimia has really given you confidence in being able to handle other situations now.

084 P.Y. M-hm. I still wouldn't say I'm a real self-confident person. But I think that's just my personality. But I'm more confident and I'm less dependent on other people than I was.

L.T. M-hm. And those are major changes then in your relating.

P.Y. Yah.

L.T. For sure. O.K. Um, I'm just gonna ask you about some of the, the things that you feel may have contributed to your eating disorder. But before we do that is there anything else that you want to add, um, in terms of the recovery, that you feel you've?

P.Y. No, I don't think so. Actually I, you know I didn't think I'd have as much to say as I have. You remember a lot of things just talking about it. No, I don't think so.

L.T. O.K. So when you think back to, you know, the onset of your bulimia, what, what things come to mind as factors that might have contributed to the bingeing and purging for you?

P.Y. Well um, my husband left with my best friend. So I went into a major depression and uh, I didn't eat for uh it was under 2 weeks: or very little I ate. And it was, it was an attention-getter. You know, I think people would feel sorry for you and "Oh poor P., poor P." And so then, you know, when I <u>knew</u> I couldn't keep that up. So one night after a friend had left--I had made a big chicken dinner (laugh)--he left and I ate the rest of it and threw up afterwards. And that was the very first time and I didn't stop after that. And it was like, almost like I had to um (pause) had to have an image on one side of this fragile person that had been hurt so badly and, and so I couldn't let them see you know the other part.

L.T. Which, which other part? They, they were seeing a vulnerable part of you at that time in your life.

P.Y. Right. But bulimia doesn't look vulnerable to people; it just looks disgusting, you know. So it's kind of like a vicious circle uh: You binge, you purge, you feel awful, so you binge and purge again. You just keep going and going and going. (Tape is turned off briefly while children are attended to.)

L.T. O.K. So you needed to eat cause there had been that period of time when you hadn't eaten.

P.Y. Right (laugh). I was ravenously hungry (laugh).

L.T. O.K. So. And that, that was how your first binge then started.

P.Y. M-hm.

L.T. And purging? How did that come about?

P.Y. Well I, I ate to the point that I was full, but also um it scared me that I ate that much. And I, you know, I, I lost 6 lb really quickly when I wasn't eating and, and that was um (pause), I don't know, that made me feel good. So that I, then I didn't want to give it up and I knew I would if I continued eating like that so. (Tape is turned off briefly while children are attended to.)

L.T. O.K. So that's how you got into the purging part of it then.

P.Y. M-hm. Yup.

L.T. So having a major crisis then in your life precipitated, was one, was one factor for you that led to uh, the bingeing and purging.

P.Y. Yup. Definitely. Yah because it was um, it was so close I mean that's all it could have been. So. Yah I can't think of anything else other than that.

L.T. O.K. Anything else? Everyone is arriving home now. Anything else that, that you want to finish up with? Or, I, I feel like I've asked all my questions and have a good sense from you of, you know, how you recovered.

P.Y. Yah, no. I think that's pretty well it. That's the most I've ever said about it in my whole life (laugh)!

L.T. M-hm. O.K.

P.Y. So no, I, I think that pretty well covers it. I can't think of anything else.

L.T. M-hm. O.K.

P.Y. I'll be very interested to read what other people have had to say: compare notes.

APPENDIX K

3 October 1991

Co-researcher's Validation Letter

To Whom It May Concern:

I am writing this letter in the capacity of Co-researcher in Laurie Truant's Masters Thesis on recovery from the eating disorder known as Bulemia. I participated in her study by providing her with insight and information regarding my own experience in this regard.

I have read her completed thesis, and am happy to confirm that the results of her study in fact describe my experience of recovery. Further, reading her work was beneficial for me in that the themes set forth helped clarify the process better for me.

I fully endorse the validity of Ms. Truant's work.

Sincerely,
L.S.