A PSYCHOCULTURAL STUDY OF PROBLEM EATING
IN WHITE, MIDDLE OR UPPER CLASS GIRLS AND WOMEN

by

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This thesis is framed by a contemporary debate between feminist theorists and clinicians concerning the role of culture in the etiology of problem eating. Feminists argue that it is a mistake to pathologize disordered eating since it is arguably the norm in contemporary society. From this perspective, problem eating lies along a continuum and constitutes a response both to the current era of gender upheaval, and to tremendous social pressure on girls and women (hereafter: women) to cultivate slender bodies. Clinicians counter that it is highly objectionable to gloss over the reality of extremely disordered eating in the name of a political agenda to universalize the problem. Moreover, they argue that while cultural messages appear to shape symptoms, our efforts are appropriately directed toward understanding core psychological (and/or familial, or biological) difficulties.

The effort within the thesis to resolve this debate begins with a review of empirical literature which has researched whether women with problem eating are particularly feminine, or reject their femininity (or both). This review yields the assessment that white, middle or upper class women with more severe eating problems are deeply conflicted about their gendered personality. In particular, it seems likely that these women seek to address the "gender double-bind" according to which women must be what is devalued (i.e., feminine), and only be what
is valued (i.e., masculine) within acceptable limits.

The psychocultural model of the gendered nature of problem eating which is developed on the basis of this material shows how women seize upon social-cultural input concerning female body management in their attempt to answer the double bind. An autobiographical inquiry on the part of the author helps to confirm the validity of this approach, but also reveals the deeper psychological structures of a "lack of developed self," and "lack of womaninity." These structures give rise to intense needs for guidance concerning how to develop as persons and as women. And the confluence of these needs with the concern to address the gender double bind is shown in the model to generate more severe problem eating along the continuum.
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INTRODUCTION

Research within the field of eating disorders often takes as its shared starting point the striking yet commonplace epidemiological fact that girls and women are overwhelmingly more likely to manifest eating disorders than boys or men (Bailey & Hamilton, 1992; Bloom, Gitter, Gutwill, Kogel, & Zaphiropoulos, 1994, passim; Bordo, 1993; Boskind-Lodahl, 1976; C. Brown, 1993; Brown & Jasper, 1993, passim; Bruch, 1973; Fallon, Katzman, & Wooley, 1994, passim; Mori, Chaiken, & Pliner, 1987; Chernin, 1981; Dittmar & Bates, 1987; Garfinkel & Garner, 1982; Hesse-Biber, 1989; Nagel & Jones, 1992; Nasser, 1988; Orbach, 1986; Paxton & Sculthorpe, 1991; Striegel-Moore, Silberstein, & Rodin, 1986; Székely, 1988, 1989; Szymanski & Chrisler, 1991; White, 1991; Wurman, 1988-89). Of course, in response to this information a number of questions have been raised concerning possible connections between femaleness and eating disorders. As one would anticipate, feminists have not focused on the biological femaleness of women with eating disorders, but rather on their gendered femininity. In fact, reams of both feminist arguments and empirical data have been offered in support of the hypothesis that eating disorders such as anorexia nervosa and bulimia must be interpreted as sociocultural and not just biological, nor even just psychological phenomena (Bloom et al., 1994; Bordo, 1993; Boskind-Lodahl, 1976; Boskind-White & White, 1986; L. S. Brown, 1985; Brown & Jasper, 1993; Chernin, 1981;

To build their argument, feminists have examined historical and archival evidence to the effect that the image of the ideal (white, middle or upper class) woman's body varies with social, cultural, political and historical changes (Bordo, 1993; Boskind-White & White, 1986; Brown & Jasper, 1993; Garfinkel & Garner, 1982; Seid, 1994). For example, Brown and Jasper (1993) note with Banner (1983) that after the American Civil War, "a more 'voluptuous' ideal represented the postwar increase in the importance of fertility" (Brown & Jasper, p. 22). In contrast, they note with Lurie (1981) that the "flapper era, with its flat-chested, straight-bodied, and shorter-hemline look, celebrated women's emerging social mobility and independence" (Brown & Jasper, p. 23). Not surprisingly, these studies all culminate in the observation that in contemporary North American society, girls and women experience relentless pressure to force our bodies to match an extremely constricted and artificial conception of the ideal female body.
This observation is often supported by extensive feminist analysis of contemporary cultural directives targeted at girls and women regarding gender-appropriate traits and behaviours. Among other things, these directives tell us that we must be thin to be acceptable, to hate and fear fat, and to make what might be called "female body management" the centre of our lives¹ (Bordo, 1993; Brown & Jasper, 1993; L. S. Brown, 1985; C. Brown, 1993; Buchanan, 1993; Chernin, 1981; Ciliska, 1993; Gutwill, 1994; Hesse-Biber, 1989; Kilbourne, 1994; Lenskyji, 1993; MacInnis, 1993; Martin, 1989; Mori et al., 1987; Nasser, 1988; Orbach, 1978, 1986; Osvold & Sodowsky, 1993; Perlick & Silverstein, 1994; Rodin et al., 1984; Rothblum, 1992, 1994; Seid, 1994; Shisslak & Crago, 1994; Steiner-Adair, 1986; Striegel-Moore et al., 1986; Tolman & Debold, 1994; White, 1991; Wolf, 1994; Wooley, Wooley, & Dyrenforth, 1979).

Feminists have also noted that the current epidemic of problem eating is occurring at a time of great upheaval for women vis-à-vis changes in gender roles and expectations, opportunities, limitations, and backlash. The basic insight here is that (mostly white, middle and upper class) women in contemporary North American society are caught in a conflict between maintaining traditional nurturing roles associated with femininity, and taking up new opportunities for achievement in spheres outside of the family (Bordo, 1993; Brown & Jasper, 1993; Chernin, 1981, 1985; Gutwill, 1994; Martin, 1989; Orbach, 1978, 1986; Perlick & Silverstein, 1994; Shisslak & Crago, 1994;
At the heart of this conflict is a double bind in which women are, on the one hand, expected to manifest feminine traits and roles which are systematically devalued within patriarchy and, on the other hand, trained to esteem and yet not manifest in significant ways masculine traits and roles which are highly valued (Enders-Dragaesser, 1988; Heriot, 1983). Insofar as a (white, middle or upper class) woman has internalized and acted in accordance with societal values and constraints, then, she is trapped in a particular mode of existence which is deemed insignificant, while drawn to another valued existence which is pulled from her reach.

Women have often used their bodies as a vehicle for the expression of this paradox at the heart of the construction of gender in a number of historical periods (Bordo, 1993; Boskind-White & White, 1986; Nasser, 1988; Perlick & Silverstein, 1994; White, 1991; Wurman, 1989). As researchers have noted, this has meant outbreaks of "the disease of young women," "chlorosis," "neurasthenia," "hysteria," and eating disorders over a span of some 2400 hundred years (Perlick & Silverstein, 1994). For these maladies have not only shared the symptoms of "disordered eating, depressed mood, anxiety, headache, breathing difficulties, sexual indifference, and amenorrhea," but also a common etiology in the situation of (white, middle or upper class) women who "strive to
achieve in areas traditionally dominated by men and who come to feel limited by being female, particularly if their mothers were unable to achieve in these areas" (Perlick & Silverstein, 1994, pp. 79-80).

Focusing on the current epidemic we may note that problem eating is considered both a mode of expressing and a mode of attempting to resolve gender contradictions and conflicts centered around the double bind. With respect to the latter, feminists have asked why and how the relentless pursuit of thinness has come to be the solution of choice. We can first note that striving to be slender is a way of aligning oneself with society's devaluation of traditional feminine traits and roles. Especially for women who associate the traditional (reproductive and nurturing) role of their mother in the family with being trapped,

...the childlike body was also insurance against being defined through reproductive capacity, against being burdened by the real responsibilities of having children. Its immateriality promised the freedom to ascend to heights never before reached by women. (Brown & Jasper, 1993, p. 26)

Of course, the marketing of the slender, liberated-from-the-burdens-of-reproduction woman has been very successful in appealing to just this anxiety.

In a related point, Chernin (1981) argues that the desire of women to be ever smaller is our way of expressing discomfort with
being female in present-day society. However, the idealized image of a slim, small, and even boyish female body which women can use as a model for their own efforts to be smaller does not emerge from a vacuum. Rather, Chernin notes, this image historically emerges in response to (mostly white, middle or upper class) women's advances in society. Indeed, as many feminists have argued (cf., for example, L. S. Brown, 1985; Faludi, 1991; Kilbourne, 1994; Wolf, 1994), the requirement of thinness as an essential feature of the desirable female body is a species of backlash phenomena meant to hinder women from "taking up space" in the social sphere: "The backlash does to young women's minds -- so much more free, potentially, than any ever before -- what corsets and girdles and gates on universities no longer can" (Wolf, 1994, p. 110).

Thus what is marketed and consumed as a means to liberation and transcendence actually functions as a way of distracting (especially white, middle or upper class) women from our full realization. Indeed, under the sheep's guise of offering a path to acceptance within the male sphere, the wolf exacts a certain price from women in the form of demanding that we literally don't take up space, and that we sacrifice time, money, and energy in crafting bodies which meet this requirement. The cruel irony here is that many women have internalized the Orwellian message that enslavement is freedom and that punishment is self-care. And we can be certain that this exercise in bad faith will be sustained since the multibillion-dollar industries related to
dieting, exercise, fashion, cosmetic surgery, and marketing themselves all have a huge stake in cultivating and maintaining the ideology of female body management (Bordo, 1993; Faludi, 1991; Kilbourne, 1994; Rothblum, 1994).

In sum, then, from a sociocultural standpoint, two major social pressures have put women at increased risk for eating disorders: (1) emphasis on thinness as an essential feature of female attractiveness, and (2) conflict between traditional and nontraditional roles (Shisslak & Crago, 1994). We have also begun to see how these pressures are connected in the domain of female body management since the relentless pursuit of thinness is marketed and consumed as a means for women to resolve gender conflict generated by the double bind.

Because feminists have successfully argued their case, there is widespread agreement among researchers and clinicians in the field that sociocultural factors play a role in generating eating disorders. Nonetheless, a rift is revealed when we try to pin down the precise meaning and implications of this assessment. On the one hand, feminists such as Susan Bordo (1993) argue that contemporary North American culture plays a "preeminent role in providing the necessary ground for the historical flourishing of [eating] disorders" (p. 52). According to this position, the cultural aspect of eating disorders is not just arbitrary and circumstantial, but rather essential and integral to their formation and our understanding of them. Moreover, the contemporary emphasis on thinness is not simply the expression of
a contemporary aesthetic preference. Describing the 1983 meetings of the New York Center for the Study of Anorexia and Bulimia, Bordo laments that:

[i]n no place was the meaning of the ideal of slenderness explored, either in the context of the anorectic's experience or as a cultural formation that expresses ideals, anxieties, and social changes...much deeper than the merely aesthetic...Why thinness should have become such a dominant cultural ideal in the twentieth century remained unaddressed; the interpretation of representations was viewed as outside the domain of clinical investigation. (p. 46)

In contrast, more purely psychologically-oriented workers in the mental health field argue that behaviours associated with disorders such as anorexia and bulimia are symptomatic of underlying pathology which could have been manifested in other ways. That is, insofar as they recognize its importance at all, these researchers and clinicians take the sociocultural element to play only a "contributory" or "facilitating" (and certainly non-necessary) role in the generation of disorders (Bordo, 1993, p. 49). Thus the "clinicians," as I will refer to them,' conclude that our actual focus is properly and exclusively psychological.

In the context of this focus, the medical model for most clinical and empirical research mandates a search for a common underlying pathology and/or a specific, shared pathogenic
situation (whether biological, psychological or familial) to account for the appearance of a given disorder in certain populations. On this model, it is also of primary importance to be able to distinguish between "normal" and "ill" persons (Bordo, 1993; L. S. Brown, 1985; C. Brown, 1993; Smead, 1983; Steiner-Adair, 1986; Székely, 1988, 1989, Ussher, 1989).

Highlights of the feminist response to these features of the medical model include the following. As some writers have argued, the major etiological theories of anorexia nervosa (viz., intrapsychic, familial, and organic) are not adequate to account for the present historical increase in the incidence of the disorder (Hesse-Biber, 1989; Schwartz et al. 1982). That is, without an alteration in the psychodynamic, familial, or biological features that are deemed to cause eating disorders, we must turn our attention elsewhere to account for the current epidemic. What is needed, they claim, is a serious examination of sociocultural factors.

Others argue that examination of the cultural-historical-political context reveals a continuum of problem eating on which the eating behaviour of most North American women can be located (Bloom et al., 1994; Bordo, 1993; C. Brown, 1993; Hesse-Biber, 1989; Polivy & Herman, 1987; Rodin et al., 1984; Smead, 1983; Striegel-Moore et al., 1986). From this perspective, the continuum not only (rightfully) blurs the distinction between pathology and normalcy, but also eliminates the justification for searching within individuals (or their biology or family systems)
for a common etiology. Instead, cultural artifacts and factors which play powerful, ubiquitous roles in shaping women's behaviour regarding eating, dieting, exercising, and so on should be compiled and analyzed.

In response, the clinicians would counter that criteria are needed to distinguish normal from pathological behaviour so that a population in need of help can be better understood and treated more effectively. It is not useful in this context to demonstrate that most of the entire female population of a society engages in dysfunctional behaviour. Indeed, it is highly objectionable to gloss over the reality of disordered patterns of eating, purging, and/or exercise in the name of a political agenda to universalize the problems (Bordo, 1993; Swartz, 1985). Instead, populations of anorexic and bulimic girls and women need to be identified, and psychological (and/or familial or organic) problems at the etiological core of each disorder must be discovered.

Of course, from one perspective problem eating can be perceived up and down the line as pathological and indeed some feminists have argued that "normal" eating for women in contemporary North American society is in fact pathological (Polivy & Herman, 1987). From another (feminist) perspective, one can argue that women's eating behaviour is normal (in the sense of adhering to norms) and indeed normative (in the sense of being required) for all women in this society (Rodin et al., 1984). The point from either perspective is that pathology is
not located within individual women but in the cultural mandates which teach us to loathe, mistrust, and indeed wage war on our bodies and our desires. In this context, it seems strange to examine the case of a relative few who are located at the extreme end of the continuum, tag them as "sick," and ask on an individual basis how they came to be that way. Rather, feminists argue, it makes more sense to look at the painful daily struggles of the vast majority of women who chase after thinness somewhere along the rest of the continuum, and ask from a cultural, historical, and political perspective how they came to be that way.

At this juncture, it may seem obvious that I am biased in favour of the feminist side of the above-described debate. In a sense this is quite true as I am in full agreement with the feminist argument as I have sketched it here. However, I do not intend simply to pass over the position of the clinicians since I share some of their concerns. Indeed, I am perplexed to find myself in the middle of the debate in an important respect. To be more specific, I agree that all problem eating should be conceptualized as lying on a continuum and that it is accordingly more fruitful (and socially progressive) to note similarities between modes of problem eating and their shared social-cultural-historical-political context than to pathologize the behaviour of women on the extreme end of the continuum and examine it in an isolated, ahistorical fashion. Yet I also agree that it would be a mistake to operate as though eating disorders such as anorexia
and bulimia do not require further psychological exploration. While the emotions, cognitions, and behaviour of (white, middle or upper class) women with eating disorders are arguably not different in kind from those of other (white, middle or upper class) women on the continuum (Bordo, 1993; Polivy & Herman, 1987; Rodin et al., 1984; Smead, 1983), I believe their extreme nature requires investigation and special attention. I also believe that precisely because the concept of a continuum fits the present case, further exploration of extreme cases would potentially provide useful information about other species of problem eating.

The belief that eating disorders require special attention is rooted in my own personal history. At the age of 15, I lost over 25 per cent of my body weight, became amenorrheic, and was determined not to maintain a minimally normal weight for my age and height. I had an intense fear of gaining weight, even though I was thin. Indeed, since I thought I was fat, I did not have a realistic sense of either the shape or size of my body. Moreover, since much of my self-esteem was linked to being as thin as possible, I was depressed about being "so fat" and planned to lose more weight. In short, I would have met all the diagnostic criteria for the restricting type of anorexia in the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994). Over the past twenty years I have had ample opportunity to reflect on my experience of anorexia, its causal history in my own case, and the path of my healing to full
recovery. I know from my own history that becoming a feminist was a crucial factor in later stages of my full recovery. However, I also know that raising my feminist consciousness would never have been sufficient to initiate my healing or to bring about full recovery. I also required in-depth psychotherapy.

Having said this, though, it should be noted that the feminist has in a sense been set up here as a "straw woman" for the purposes of the clinician's argument. For feminists in fact readily recognize that other factors (individual-psychological, familial, and perhaps even biological) are involved in the production of disordered eating in any given case. For example, Bordo (1993) clearly states that culture works "not only through ideology and images but through the organization of the family, the construction of personality, [and] the training of perception" (p. 50).

To take a more elaborate example, Hesse-Biber (1989) in fact contends that eating problems lie on a continuum and that analysis of their sociocultural setting is necessary in order to understand them fully. Nonetheless, she discovered in her own research that especially women college students manifested a host of behavioural symptoms, but not the psychological pathology associated with anorexia and bulimia as measured on subscales of the EDI. In subclinical cases of women who were weight-preoccupied, only a heightened (but not abnormal) sense of perfectionism was present. This led Hesse-Biber to hypothesize that there is a separate range of subclinical eating difficulties
present among college women, and to develop an extensive argument to the effect that this class of difficulties is culturally induced. For the purposes of the present argument, the flip side of this outcome is that Hesse-Biber's (1989) work ironically lends support to the clinician's point that something else must account for the manifestation of symptomatology in clinical cases. In accordance with the clinician's perspective, I believe that what's missing falls under the heading of psychological and not sociocultural variables.

If this holds and if, moreover, feminist cultural analysis cannot yield theories which provide an adequate foundation for therapy, one might conclude that feminists should continue doing cultural analysis, and clinicians, their psychological work -- each on separate tracks. Yet there are at least three ways that this suggestion limits possibilities. First, insofar as clinicians do not recognize and integrate feminist analyses of the sociocultural nature of problem eating, their theories and practices rest on an incomplete and inaccurate conceptualization of problem eating. Second, clinicians and feminists alike would lack a clear sense of how cultural-political messages targeted at girls and women come to be causally efficacious within the psychology of the individual. Finally, clinicians miss an opportunity to explore how gaining feminist insight can be a key, integral component of psychological healing for women with problem eating.

With respect to the second of these points it may appear all
too obvious that girls and women soak up cultural directives simply because they are there. In fact, they are not only "there" but ubiquitous to the tune of over 1500 advertisements that the average U. S. citizen is exposed to daily (Kilbourne, 1994; Bordo, 1993). However, concerns have been raised about this way of understanding the relationship between culture and psychology. Szekely (1988, 1989) argues that it does not help the feminist cause to portray women as passive, sponge-like recipients of culture. And we might also note on behalf of the clinicians that such an understanding fails to account for why only some girls and women end up struggling with eating disorders. That is, one can argue that if all of us are exposed to the same cultural messages, how do we account for the fact that women are located at different points along the continuum?

In answer to this question, and returning to the suggestion that feminists and clinicians go their separate ways, I want to claim that what we ultimately require is a psychopolitical account which shows how psychological and political (cultural, social, and historical) factors are interwoven in the etiology of problem eating. Such an account could in fact be especially constructed to address the concerns and to integrate the insights of both feminists and clinicians. Classical models of psychopolitical accounts are offered in the feminist object relations theories of Nancy Chodorow, Jessica Benjamin, and Jane Flax. For example, Nancy Chodorow (1978, 1980) argues that, as shaped within patriarchal culture, the very structure of
childrearing reproduces stereotypically-gendered modes of relating on the part of females and males in society. More explicitly in the case of eating disorders we can refer to the feminist cultural-analytic work of Kim Chernin (1981; 1985) and Susie Orbach (1978; 1986) which "has always stressed the intersection of culture with family, economic, and historical developments and psychological constructions of gender" (Bordo, 1993, pp. 32-33).

As we began to note earlier, for Chernin (1981; 1985) the pressure to be thin is a kind of backlash phenomenon against women which is rooted in a cultural fear of female power. In The Hungry Self (1985) she further interprets eating disorders as symptoms of a female identity crisis which is related to a struggle in which daughters fear surpassing their mothers. Dominated by cultural sanctions and images, and by guilt and separation anxiety regarding the prospect of transcending the lives of their mothers, women succumb to problem eating and thus retreat from realizing their full potential.

Within her more classically object-relational approach, Orbach (1986) interprets the anorexic female body as an expression of contradiction, conflict, and protest rather than retreat. As Bordo (1993) notes, she argues that the conflict contained within the thin ideal is generated by a culture that "disdains and suppresses female hunger [and] makes women ashamed of their appetites and needs" (p. 176), while at the same time requiring women to be nurturant providers for others.
Tragically, as primary transmitters of culture, mothers play a key role in training their daughters to experience shame and insecurity regarding their bodies. According to Orbach, this practice grows out of mothers' commitment to raising "appropriate" daughters who can be successful within their culture.

Feminist object relations approaches have the virtue of expanding beyond intrapsychic and family-systems approaches to eating problems by making explicit reference to the surrounding cultural and political context. Conversely, they do not leave us with only a sociological understanding of the influence of culture in shaping individual psychology. As Susan Gutwill (1994) and her colleagues at the Women's Therapy Centre Institute note:

Feminist object-relational and intersubjective theorists have been most useful in exploring the role of the unconscious in the internalization of cultural prescriptions. These theorists... have made seminal contributions in turning attention away from an exclusive focus on oedipal patterning and toward the effects of society on the mother/child dyad. Their work refuses to marginalize women's contribution to psychological growth or to view her outside of her social context. (p. 16)

Nonetheless, a host of other objections have been raised in response to these sorts of theories. First, to expand on a point noted earlier, Szekely (1988; 1989) argues that object relations,
Jungian, and self-psychological theories continue to depict women as "merely responding passively to socio-psychological influences" (1988, p. 179), where the "social character of our existence means little more than the psychodynamics of family relations" (p. 180). Partly because of this, these theories cannot account for the fact that some women have been able to resist the "global" forces which are deemed to cause eating disorders. Székely also takes exception to the essentialism of these theories in their postulation of an innate feminine nature or a natural Self which is meant to determine the course of (female) lives. She argues that these phenomena are not biologically given and that we require an account of their social and historical conditioning throughout women's lives.

A final objection arises from the women at the Women's Therapy Centre Institute. They are concerned that even feminist object relational and intersubjective theories imply that mothers are "too much responsible for the pathologies and vulnerabilities of men and women" (Gutwill, 1994, p. 16). Instead, they see a need "to theorize psychoanalytically about how the symbols of commodification and objectification of the female body and appetite are internalized by women directly from their culture" (p. 17). In fact, the women at the Institute have answered this need. Very briefly, at the heart of their theory is the object relational concept that people need to attach themselves to transitional phenomena throughout their lives. They argue that symbols of consumer culture take on psychological significance as
transitional phenomena to the extent that it makes sense to invoke the concept of a "culture mother," "culture parent," or "culture home" (p. 18). That is, the "symbol is in a parental role to the subject," where, as they also emphasize, this role is used "for the advantage of the symbol makers" (p. 23).

Despite the exciting and innovative nature of this work, I do not plan to develop either a traditional or nontraditional object relational model of problem eating. In fact, the development of any full-fledged psychopolitical model of problem eating is well beyond the scope of this project. However, contributing to the eventual construction of such a model is the central task of this thesis. In particular, I propose to sketch a model of certain aspects of the relationship between culture and psychology in the production of problem eating. Returning full circle to our earlier discussion, I also propose to demonstrate how the debate between feminists and clinicians may be resolved in a manner that enriches both research and practice.

In order to accomplish this latter goal I will need to address the issues raised by feminists and clinicians considered above. In order to integrate this task with that of developing a model, I will formulate feminist and clinical concerns as conditions of adequacy for a psychocultural theory or model of problem eating. According to the list that follows, then, I propose that an adequate psychocultural model of problem eating:

(i) interprets the role of contemporary cultural messages related to female body management as intrinsic and essential to the construction of problem eating
(ii) accounts for how cultural messages related to female body management come to be causally efficacious within the psychology of individual girls and women

(iii) integrates the current historical context of gender upheaval and conflict for girls and women

(iv) recognizes that problem eating of all varieties lies along a continuum

(v) (on the other hand) explains why some girls and women end up struggling with more extreme species of problem eating

(vi) can contribute to therapeutic practice.

I will attempt to develop a model which meets these criteria of satisfaction by exploring the interface between the culture and psychology of problem eating at the locus of gender for white, middle or upper class girls and women. Following Spence and Helmreich (1978), by 'gender' I mean to refer to "clusters of...attributes stereotypically considered to differentiate males and females and thus to define the psychological core of masculine and feminine personalities" (p. 3). Bakan (1966, referred to in Spence and Helmreich, 1978) usefully groups attributes associated with masculinity under the heading of agency, and attributes associated with femininity under the heading of communion. Personality features reflecting agency are related to assertiveness, decisiveness, instrumental activity, self-confidence, independence, ambition, and competitiveness. And features reflecting communion include selflessness, concern with others, emotionality, sensitivity, expressiveness, warmth, gentleness, and sensitivity to others' needs. Traits such as aggression and dominance are also associated with (negative)
masculinity, while passivity and dependence are associated with (negative) femininity. Cultural norms associated with femininity and masculinity are intended to define proper attitudes, behaviours, values, and roles for members of the respective sexes.

I choose gender as the focus of my study for a number of reasons. First, it represents common turf for feminists and clinicians: those in the former camp would have us note that the content of gender and of norms related to gender are (at least in part) culturally constructed (Basow, 1992; Richmond-Abbott, 1992), while those in the latter camp would highlight the fact that gender is a central feature of personality which "serves as an organizing principle through which many experiences and perceptions of self and others are filtered" (Spence, 1985, p. 64).

The other side of the coin here is that proponents from each side of the debate are forced to move a bit closer to the locus of concern of their colleagues. Specifically, focusing on gender represents a step "out" from intrapsychic and family systems approaches because a person’s gendered personality is not fully interpreted unless reference is made to the surrounding social-cultural-political-historical context which helps to provide its content. And this focus represents a step "in" from cultural analysis because the efficacy of cultural messages needs to be understood with reference to psychological mechanisms responsible for generating behaviour.
A second reason why the choice of gender is advantageous is based on the feminist hypothesis noted above that cultural messages pertaining to female body management are (in part) specifically targeted at the need on the part of girls and women to resolve conflict related to the gender double bind. I will have much more to say about this hypothesis in Chapter Five. For now my point is simply that as a feature of personality, gender provides a medium for receiving cultural messages related to gender -- including those which convey the gender double-bind to girls and women.

This understanding of the relationship between cultural input regarding gender and the gendered personality of girls and women will ultimately be useful in the construction of a psychocultural model of problem eating. But we will also need to understand more clearly the precise relationship between problem eating and gender. The third and final motivation for focusing on gender precisely relates to this task. For a body of empirical literature has been developing over the past twenty years on the relationship between gender and disordered eating. In a nutshell, researchers have sought to determine whether a particular gender profile is related to disordered eating (including eating disorders). Since an examination of their results provides a natural starting point for exploring the relationship between gender and problem eating, a review of this literature will be offered in Chapter Two.

Before turning to this review, though, I would like to offer
some prefatory remarks regarding the nature of this study and the manner in which it is written. Most research in the field of eating disorders has focused on white girls and women (Striegel-Moore, 1994, referring to Dolan, 1991). The normative epidemiological portrait also makes reference to the middle or upper class status of women with eating problems (Thompson, 1994). However, recent findings show that African-American, Latina, Asian-American, and Native American women are not immune to these struggles (Thompson). This information reveals a wide gap in our understanding of problem eating because relatively little is known about its relation to minority women and invites us to consider the nature of work that has already been done. As noted above, feminists have greatly enriched and expanded the field by arguing that eating problems have a sociocultural element. However, one might expect that researchers working from a sociocultural perspective would examine the (white) race, (middle or upper) class status, and gender of women with eating problems. Nonetheless, even feminists have focused on gender to the neglect of variables related to race and class (as well as sexual orientation, ethnicity, religious background, histories of sexual abuse, and poverty; Thompson, 1994).

In a more general context, feminist theorists have argued that this kind of selective focus on the part of (predominantly white and middle class) researchers and theorists is rooted in a subtle racism and classism which unconsciously takes whiteness and middle-class status to be given, normal, and standard -- and
thus not in need of further exploration (cf., for example, Fuss, 1989, and Spelman, 1988). This blind-sighted neglect is problematic in a number of ways. First, and ironically, we lack information about the potential causal role of variables related to the white race and middle or upper class status of women in the etiology of their problem eating. Second, if the "essential woman" is tacitly assumed to be white and middle class, then universal claims are made about "women" in theoretical and empirical literature which often make reference only to women who meet this description. This allows for the burdensome and damaging inference that women to whom these claims do not apply are not women. Moreover, questions as to whether or not these claims are descriptive of women in other races and socioeconomic groups do not even enter the consciousness of those in the hegemonic group.

One could counter that in the case of eating disorders, the standard profile of women with eating disorders straightforwardly dictates that only white, middle or upper class women be studied. However, this line of argument misses the point. Again, because race and class are not problematized in the research, claims are made about "women" as opposed to "white, middle or upper class women." As a result, women of colour, women in various ethnic and religious groups, lesbians, poor women, and disabled women with eating problems are confronted with theoretical claims and empirical observations about "women with eating disorders" which do not necessarily describe or account for their situations and
experiences. The reasons why the claims don't necessarily apply may have everything to do with the fact that the social location of these women differs from those in the hegemonic group, and the possibility that the nature of eating problems is conditioned by such factors as race, class, sexual orientation, and so on. But because the social location of the overwhelming majority of research subjects is both essentialized and rendered invisible, minority women with eating problems are deprived of an understanding of their experiences, and even of a way to name them.

In light of the above discussion, it is difficult but also imperative to note that my work here is consciously restricted to the study of gender in relation to problem eating. This narrowing of scope imposes significant limitations on my study, and would be highly objectionable if it were to repeat the mistakes of previous researchers. In fact, though, I am committed to adopting a more politically responsible approach which blocks both the assumption that use of the term 'women' secures reference to all women, and the related inference that women whose experiences are not described in claims and observations using this term are not women.

To accomplish this I have explicitly "located" the girls and women who are the focus of this study in its title. In addition, as in the case of this Introduction, I will at times make explicit reference to the (white) race and (middle or upper) class status of the girls and women referred to in the material
that I describe and analyze in the text of this thesis. To avoid awkwardness I will do this only sporadically. However, when these descriptors are omitted, the reader should understand that, unless otherwise specified, by 'woman' or 'women' I mean to refer to white women with middle or upper class backgrounds. For similar stylistic reasons, I will also most often only make explicit reference to women, even though on most occasions I mean to refer to both girls and women.

I would also like to note here that the phrase 'disordered eating' is used almost exclusively in the Literature Review to reproduce the manner in which claims and observations are constructed by the researchers whose work I describe there. Most researchers use the phrase 'disordered eating' to refer to all species of problematic dieting and eating behaviour -- including the manner in which food can be refused via abstinence, purging, the use of laxatives or emetics, compulsive exercising, and so on -- along a continuum. This is also meant to encompass full-blown clinical eating disorders. For the most part, I am not troubled by the use of this phrase since I take it to connote eating which lacks order, not in the sense of being chaotic, but rather in the sense of being out of sync with the human order of eating related to hunger, desire, and ritual. However, for Bloom, Gitter, Gutwill, Kogel and Zaphiropoulos (1994), "[d]isorder connotes personal pathology and medicalizes the etiology of eating and body image problems" (xi). Accordingly, as the title of their book indicates, they introduce the term 'eating problems' to
supplant the conventional 'eating disorders.' In light of this perspective, I have adopted the phrases 'problem eating' and 'eating problems' along with 'disordered eating' to refer to all species of dieting, bingeing, purging, restrictive eating, and so on along a continuum. For reasons that will become clearer as we proceed, I will also at times use the phrase 'eating disorders' or 'eating disorder symptomatology' to refer to more severe modes of problem eating associated with anorexia nervosa or bulimia at the far end of this continuum.

Finally, I wish to note that throughout the thesis, first person plural pronouns such as 'we,' 'us,' and 'our' most often make reference to the reader and author conceived as a kind of collective. I do this because I take the acts of writing and reading to be essentially collaborative. At times I also make a point of employing these pronouns so as to include myself as a referent of the phrase 'white, middle class women.' Although this practice may seem awkward at times, I adopt it here for the reason that I find it impossible to speak in a voice which regards these women as "other." Of course, the question remains to whom -- if anyone -- the term 'women' actually refers. But I will reserve further discussion of theoretical issues related to essentialism for another occasion.
LITERATURE REVIEW

Early psychoanalytic theories interpreted anorexia nervosa as the expression of a fear of oral impregnation (Boskind-Lodahl, 1976). Along similar (but by no means identical) lines, Hilde Bruch (1973) argued that her clients were retreating from their imminent adolescent (and adult) femininity. Bruch’s work has since been considered the locus classicus of the psychodynamic understanding of anorexia. In contrast with Bruch’s position, Boskind-Lodahl (1976) observed in her clients a kind of hyperfemininity and a striving after the realization of a feminine ideal, including the fulfillment of traditional female roles. Thus she hypothesized that women suffering from bulimarexia (roughly, binge-eating/purging-type anorexia nervosa) pursue rather than reject their femininity.

These two positions have articulated a basic framework for research into the question whether or not girls and women with eating disorders are particularly feminine or reject their femininity. However, in the twenty years since Boskind-Lodahl’s (1976) article first appeared, this framework has expanded in three major respects. First, researchers and theorists within the debate have been concerned to examine various aspects of disordered eating in addition to eating disorders. Second, empirical researchers began to attend to the relationship between masculinity and eating disorders. They initially did so for the simple reason that most standardized sex-role orientation
measures include masculinity scores (Timko et al., 1987). However, the practice has continued for more substantive, theory-based reasons. Finally, the framework has expanded as hypotheses have become more complex. For example, Orbach (1978; 1986) proposed that eating problems such as anorexia nervosa reflect both an adherence to thinness as an expression of 'ultra-femininity,' and a rejecting indictment of this femininity.

In the context of expanding the initial framework in these ways, researchers have generated and tested a rich variety of hypotheses. Partly because of this variety, and partly on account of the sheer volume of results, a consensus concerning the relationship between gender and disordered eating has not been reached. In fact, numerous researchers introduce their studies with a cataloguing of inconsistent and often contradictory findings in the contemporary literature (Paxton & Sculthorpe, 1991; Pettinati, Franks, Wade, & Kogan, 1987; Silverstein, Carpman, Perlick, & Perdue, 1990; Striegel-Moore, Silberstein, & Rodin, 1986; Szymanski & Chrisler, 1991; Thornton, Leo, & Alberg, 1991; Timko, Striegel-Moore, Silberstein, & Rodin, 1987). I will similarly note a diversity of findings below. However it will be useful first to develop an organizing principle according to which their rather large number may be sorted and recorded.

For reasons discussed in Chapter One, it can be assumed that the vast majority of women referred to in these studies are white and middle or upper class. Indeed, only one study (Thomas &
James, 1988) explicitly locates its subjects in terms of their race and class. Keeping this in mind, I conceptualize this body of research as yielding three basic sorts of results:

I. White, middle or upper class women with disordered eating manifest a particular gender profile (feminine, masculine, androgynous)

II. White, middle or upper class women with disordered eating bear a particular relationship (rejecting or embracing) to femininity and/or masculinity -- whether or not they manifest the profile in question

III. Given their gender profile, and their own and/or others' (rejecting or embracing) stance with respect to femininity and/or masculinity; white, middle or upper class women with disordered eating experience a gap between their perceived and ideal gendered selves.

I propose to label corresponding categories of findings as follows: "I: Gender Profile," "II: Gender Stance," and "III: Gender Profile, Gender Stance, and Conflict."

From another perspective we can note that findings under headings I and II ought to help address the historical questions noted above. Again in the case of white, middle or upper class women: (i) are women with disordered eating hyperfeminine?, and (ii) do women with disordered eating reject femininity or embrace it (or both)? Moreover, under heading III, data will be gathered which should help address the more recently-formulated question: (iii) is disordered eating the expression of internal conflict regarding gender identity and roles? Indeed, one of my goals for this Review is to organize and distill research results so that these questions may be answered.
I: Gender Profile

Beginning with "Gender Profile," research findings may be recorded in propositional form as follows:

(1) Dissatisfaction with figure relates to actual body mass and not masculine or feminine sex-typing per se (van Strien, 1989).

(2) The highest (yet nonsignificantly different) degree of cognitive restraint of eating is found in women with a high degree of both masculinity and femininity (i.e., "additive" or "balanced" androgyny) (van Strien).

(3) Larger discrepancies between real and ideal body size are associated with less masculinity (van Strien).

(4) Socially desirable trait femininity positively relates to cognitive concern about dieting (and not obesity per se) (Hawkins, Turell, & Jackson, 1983).

(5) Socially desirable trait masculinity is negatively related to dissatisfaction with appearance (Hawkins, Turell, & Jackson).

(6) Socially undesirable feminine traits are associated with dissatisfaction with physical appearance (Hawkins, Turell, & Jackson).

(7) Increases in femininity are positively related to increases in body weight (Thomas & James, 1988).

(8) Increases in femininity are not related to dieting tendencies or happiness with one's body (Thomas & James).

(9) Increases in masculinity are positively related to happiness with one's body (Thomas & James).

(10) Increases in masculinity are negatively related to body weight and restrictive dieting tendencies (Thomas & James).

(11) High-degree compulsive eaters do not show a higher degree of masculinity or femininity (Dunn & Ondercin, 1981).

(12) Eating disordered women think of themselves as negatively feminine and as possessing socially negative traits (Dunn & Ondercin).

(13) There is no correlation between self-described feminine positive scores and disordered eating (Paxton & Sculthorpe, 1991).

(14) Sex-role typing is correlated with anorexia in the order of
most to least as follows: feminine, blended androgynous, masculine, and balanced androgynous (Heilbrun & Mulqueen, 1987).

(15) Sex-role typing is correlated with bulimia as follows: feminine, balanced androgynous, blended androgynous, and masculine (Heilbrun & Mulqueen).

(16) Being masculine or feminine gender-typed in itself is not a risk factor for eating disorders (Thornton, Leo, & Alberg, 1991).

(17) Being more masculine is inversely related to bulimic behaviour (Brown, Cross, & Nelson, 1990).

(18) Women classified as feminine were more bulimic than other subjects (Szymanski & Chrisler, 1991).

(19) Women classified as feminine had the highest (though not significantly different) scores on drive for thinness, ineffectiveness, and interpersonal distrust (Szymanski & Chrisler).

(20) Femininity itself is unrelated to eating-disordered symptomatology (Timko, Striegel-Moore, Silberstein, & Rodin, 1987).

(21) Self-perception of more feminine traits is associated with placing greater importance on appearance (Timko et al.).

(22) Importance of appearance, as associated with femininity (see #21) is a significant predictor of eating disordered symptomatology (Timko et al.).

(23) Self-perception of masculinity is not related to self-perception of (attractive) appearance or importance of appearance (Timko et al.).

(24) Bulimics are not hyperfeminine but rather fall into the "undifferentiated" (i.e., low on both masculinity and femininity) category of gender-typing (Lewis & Johnson, 1985).

(25) Anorexics display a lower level of masculine (not feminine) qualities (Sitnick & Katz, 1984).

(26) Amount of masculinity is inversely related to body dissatisfaction (Striegel-Moore, Silberstein, & Rodin, 1986).

(27) Amount of masculinity is inversely related to eating pathology (Striegel-Moore et al.).

(28) Femininity is not related to body image or eating pathology (Striegel-Moore et al.).
II: Gender Stance

In the case of "Gender Stance," findings may be similarly recorded as follows:

(30) There are no significant differences between anorexics, bulimics, or controls in terms of their rejection of or identification with traditional feminine roles (Srikameswaran, Leichner, & Harper, 1984).

(31) Women's heightened concern about food intake and body weight are in part reflections of a desire to be perceived as possessing and exhibiting feminine sex-role attributes and behaviours related to the practice of "eating lightly" (Mori, Chaiken, & Pliner, 1987; Chaiken and Pliner, 1987).

(32) High-degree compulsive eaters showed a higher masculine ideal (Dunn & Ondercin, 1981).

(33) High-degree compulsive eaters did not manifest a higher feminine self-ideal (Dunn & Ondercin).

(34) There is no relationship of significance between anorexia and "feminism" (i.e., rejection of traditional femininity) (Bailey & Hamilton, 1992).

(35) Women with disordered eating don't exhibit more liberated views of women's roles (Paxton & Sculthorpe, 1991).

(36) Being feminist in attitude is inversely related to bulimic behaviour (Brown, Cross, & Nelson, 1990).

(37) Importance of femininity and importance of masculinity are each related to importance of appearance (Timko, Striegel-Moore, Silberstein, & Rodin, 1987).

(38) Importance of socially desirable masculine traits is positively related to disordered eating (Timko et al.).

(39) Having a superwoman ideal (i.e., taking on many roles as central to one's sense of self) is associated with symptoms of disordered eating (Timko et al.).

(40) Having a superwoman ideal is associated with placing more importance on having a fit, slim and attractive appearance (Timko et al.).

(41) Having a superwoman ideal is associated with ascribing high
importance to masculine traits (Timko et al.).

(42) Women with eating disorders described their ideal self as significantly more feminine than non-patient students (Pettinati, Franks, Wade, & Kogan, 1987).

(43) Engaging in dieting and bingeing with the goal of being thin and noncurvaceous is correlated with an emphasis on physical attractiveness (Silverstein & Perdue, 1988).

(44) Engaging in purging or becoming underweight with the goal of being thin and noncurvaceous is correlated with an emphasis on intelligence or professional success (Silverstein & Perdue).

(45) Bulimarexics are significantly less liberated than controls (Rost, Neuhaus, & Florin, 1982).

(46) When thinness and dieting become associated with the image of an autonomous, independent Superwoman (as opposed to an image of a woman for whom connectedness to self and others is central in her life) girls are more at risk for developing eating disorders (Steiner-Adair, 1986).

(47) Given that being concerned with one's appearance and a desire to be beautiful is part of the female sex role stereotype, and given that being slender is central to the contemporary Western concept of beauty, women are directed toward the pursuit of thinness via their own concern to be feminine (Boskind-White & White, 1986; Chernin, 1981, 1985; Martin, 1989; Nagel & Jones, 1992; Nasser, 1988; Orbach, 1978, 1986; Rodin, Silberstein, & Striegel-Moore, 1984; Striegel-Moore, Silberstein, & Rodin, 1986).

(48) In the face of puberty, adolescence and anxiety-provoking anticipations of female adulthood, the anorexic girl renounces adult femininity and reverts to a pre-pubescent state (Bruch, 1973).

(49) The anorexic 'dreams of doing well in areas considered more respectful and worthwhile because they are masculine' (Bruch, 1978, p. 55).

III: Gender Profile, Gender Stance, and Conflict

Finally, we can record the findings for III:

(50) A higher level of education in combination with dissatisfaction with body image is even more relevant than the androgyny factor in terms of predicting cognitive restraint (van Strien, 1989).

(51) Whether or not they are feminine or masculine-oriented,
bingers are more likely than non-bingers to report that their parents believe that a woman's place is in the home, that their mothers are unhappy with their own careers, that their fathers thought their mothers were not intelligent, and that their fathers treated a male as the most intelligent sibling in the family (Silverstein, Perdue, Wolf, & Pizzolo, 1988).

(52) Parents' values (in terms of the above-noted parameters) did not differentiate between purgers and nonpurgers in the case of feminine-oriented women (Silverstein et al.).

(53) Masculine-oriented women were much more likely to engage in purging if their father's values were less liberated (Silverstein et al.).

(54) High-degree compulsive eaters showed a greater discrepancy between masculine self concept and self ideal (Dunn & Ondercin, 1981).

(55) There is a greater discrepancy between self and ideal masculine traits due to low level of self-perceived masculine traits (and therefore not due to greater presence of positive masculine traits in their ideal female) -- especially for bulimic symptomatology (Paxton & Sculthorpe, 1991).

(56) Women with eating disorder symptomatology experience conflict regarding their self-ascribed negative feminine characteristics which they attempt to resolve by striving after ideal femininity (Paxton & Sculthorpe).

(57) Women with nontraditional sex role aspirations who also indicate conflict regarding their femaleness are more likely to report purging or frequent bingeing (Silverstein, Carpman, Perlick, & Perdue, 1990).

(58) Women who are either especially masculine or feminine in gender-type and aspire to a superwoman ideal are particularly at risk for eating disorders (Thornton, Leo, & Alberg, 1991).

(59) Non-superwomen as well as androgynous or undifferentiated superwomen are at low risk for eating disorders (Thornton, Leo, & Alberg).

(60) Bulimarexics show a wider gap between their attitudes and behaviour regarding women's roles (Rost, Neuhaus, & Florin, 1982).

(61) Women with disordered eating experience confusion and stress concerning their sex roles and gender traits because they are caught between societal messages which urge them actively to engage in stereotypically male pursuits and to exhibit masculine attributes, but also not to relinquish more traditional feminine-

(62) Anorexia (including the binge-eating/purging subtype) reflects an adherence to thinness as an expression of 'ultra-femininity' and also a rejecting indictment of that femininity (Orbach, 1978, 1986).

(63) Being relationally-oriented and defining oneself in connection with others as girls do, and then renouncing this in favour of a male developmental ideal characterized by autonomous detachment to others is correlated with both the superwoman ideal and eating disorder symptomatology (Steiner-Adair, 1986).

Having organized the results in this fashion, it may seem as though we can begin to tackle questions (i) - (iii) raised above concerning the gender profile of white, middle or upper class women with disordered eating. Unfortunately, the sheer volume of information still makes it onerous to make cross-study comparisons and discern patterns of results, if they exist. Moreover, the results seem riddled with contradictions. For example, (13) and (18) are at odds with one another regarding the connection between femininity and disordered eating, and (33) and (42) clash over the question whether or not femininity is valued.

On the other hand, though, caution must be exercised even before we can make these sorts of judgments. For agreement or contradiction among results is only apparent until it can be established that the studies referred to are semantically and methodologically commensurate. That is, it is necessary to determine whether researchers are working with concepts that have the same referents, and whether the measures that they implement yield data which can be compared.

To aid this process, I will briefly discuss features of the
above-reviewed studies that potentially render their results incommensurable. These features concern the manner in which disordered eating and gender are construed and measured in each study. Next, I will offer a more fine-grained organization of the results recorded above. In the ensuing discussion I will attempt to further distill and summarize results, flagging them as necessary with specific concerns about incommensurability that might be raised. After having done this for each subcategory of findings, I will offer a final summary from which answers to the historical questions regarding the gender profile of women with disordered eating may be gleaned.

Beginning, then, with potential areas of incommensurability, it is important to note that various sorts of disordered eating and a number of different aspects of gender are examined in this body of literature. In the former case, some researchers specifically focus on either anorexia nervosa or bulimia. Others claim to study "disordered eating," which can of course refer to anything along a continuum that ranges from dieting or occasional bingeing through to anorexia nervosa or bulimia. In the case of gender, researchers variously set out to study "sex roles," "gender identity," "sex role identity," "sex role traits," "sex role typing," "sex role attributes," "sex role behaviours," "masculinity," "femininity," "androgyne," "masculine-oriented women," "feminine-oriented women," and so on.

This sort of observation is of course precisely what motivates the operationalization of concepts, and we can gain
clarity about the referents of terms related to disordered eating and gender by noting how their meaning is operationalized in the measures employed. However, it is important to keep two points in mind: (1) some of the claims about gender and eating disorders are culled from theoretical or clinically-based work as opposed to empirical research, and (2) a number of different measures are employed in the empirical studies themselves.

As for the former point, observations or hypotheses offered by Boskind-Lodahl (1976), Boskind-White & White (1986), Bruch (1973; 1978), Chernin (1981; 1985); Orbach (1978, 1986); Rodin, Silberstein, & Striegel-Moore (1984); and Striegel-Moore, Silberstein, & Rodin (1986) and recorded above all grow (at least in part) out of clinical and/or theoretical work.10 As for the latter point, in the case of disordered eating most researchers employ the Eating Disorders Inventory (EDI; Garner, Olmstead, & Polivy, 1983) in whole or via subscales, or the Eating Attitudes Test (EAT; Garner & Garfinkel, 1979; Garner, Olmstead, Bohr, & Garfinkel, 1982) to measure eating disorder symptomatology.11 However, other measures used in the above-noted studies include the Restraint Scale (Herman and Polivy, 1975), the Negative Self Image Scale (NSI; Nash, unpublished scale), the Dutch Eating Behavior Questionnaire (DEBQ; Van Strien, Frijters, Bergers, and Defares, 1986), the Compulsive Eating Scale (CES; Dunn & Ondercin, 1981); and the BULIT (Smith & Thelen, 1984).12

In the case of gender, most of the studies reviewed here rely on the Personal Attributes Questionnaire (PAQ; Spence &
Helmreich, 1978) or the Bem Sex Roles Inventory (BSRI; Bem, 1974, 1978) to construct a trait-gender profile of their subjects. However, other measures include the Sex Role Ideology Scale (SRI; Kalin & Tilby, 1978), the Groninger Androgyny Scale (GRAS; De Graaf, 1984); the Dutch Self-Partner Scale (Preventie-Project, 1976); the Attitudes Toward Women Scale (ATW: Spence & Helmreich, 1978); the Personal Description Questionnaire (PDQ: Antill, Cunningham, Russell, & Thompson, 1981); the Adjective Check List (ACL; Gough & Heilbrun, 1980), the Sex Roles Concerns Measure (Silverstein & Perdue, 1988); and the Self-Roles Inventory (SRI: Linville, 1985).

Given the number and variety of measures employed, the process of discerning precisely what researchers are studying and whether they are studying the same phenomenon is more difficult. Of course, these problems can be compounded if researchers’ understanding of what they are studying does not coincide with what a given measure is intended to quantify. For example, Dunn and Ondercin (1981) mistakenly assume that 'compulsive eating' and 'bulimia' have the same referent and thus incorrectly employ the Compulsive Eating Scale to identify the syndrome of bulimia in their subjects (Lewis & Johnson, 1985).

Another problem is that the various tests noted above are potentially grounded in different underlying conceptualizations of gender (Spence, 1985; Timko et al., 1987). For example, the MMPI (mentioned, but not used in these studies) draws on a conceptualization of gender according to which masculinity and
femininity are bipolar opposites and preclude one another. Thus, if a person has one set of characteristics, she is thought to be relatively deficient in the other (Spence, 1985). An example of bipolarity in the research reviewed here can be found in Brown et al. (1990) where women who are not masculine gendered are deemed to have a traditional feminine sex role identity.

Other measures -- including the PAQ and BSRI -- are based on a dualistic conceptualization according to which masculinity and femininity are orthogonally related and can coexist in every individual. While this modification has widely been considered an improvement, some researchers have found that the actual content of gender has been incompletely operationalized and that it is in need of expansion. For example, Timko et al. (1987) demonstrated that concern for appearance is an important element of femininity and that it is particularly important to assess for it in the context of exploring the relationship between gender and disordered eating. Other researchers (for example, Paxton & Sculthorpe, 1991) have found it necessary to assess subjects for negative as well as standard positive attributes associated with masculinity and femininity in order to offer a more complete profile of women with disordered eating.

Ongoing development of the concept of gender has of course enriched research in the field of eating disorders. The point here with respect to this and all the above observations regarding the semantics and measurement of gender and disordered eating is that neither the meaning of terms nor the means of
measuring their referents are necessarily identical or even similar across studies. For this reason, caution must be exercised in making cross-study comparisons of results.

One final potential problem of note concerns the prose-style reporting of research results, or of comparisons across studies. For even if a given researcher is very clear about all the variables noted above, s/he can still be tempted to formulate results at a higher level of generalization than the actual data warrant. In the case of gender, one might draw general conclusions about the gender profile of a group of subjects based on compilations of data about sex role behaviour, gender personality traits, and attitudes about gender. However, this is not necessarily legitimate. Spence and Helmreich (1978) noted that psychologists tend to lump gender-related phenomena under the heading of sex-roles. Yet, as they argued, inferences cannot be made about an individual's gendered personality traits on the basis of observations or measurements of their sex role behaviour -- and conversely. Sex role behaviour can simply be played out in terms of societal expectations about what a person should do, and may have no bearing on actual personality.

Of course, this problem can occur in the opposite direction as well. For example, researchers examine a variety of modes of disordered eating along a continuum. As a result, they often have no choice but to summarize sets of findings by vaguely alluding to the impact of gender on "disordered eating." But it is a mistake to infer that any particular mode of disordered
eating is represented in the summarized finding.

Having flagged some potential trouble spots regarding the incommensurability of results, a more fine-grained reorganization of the results listed under headings (I) - (III) is required. Bracketing for the time being the concerns raised above, I want to suggest that results be grouped under subheadings from which preliminary observations of any emerging patterns of results can be discerned from a bird’s-eye perspective. As anticipated earlier, these preliminary observations will then be further distilled and qualified with reference to the concerns that have just been flagged.

First recall that results under "I: Gender Profile" captured how white, middle or upper class women described themselves with respect to their gender. Given the content of the actual findings, I propose that gender profile can be further articulated in terms of its relation to: (a) body (dis)satisfaction, (b) dieting or "cognitive restraint", (c) concern for appearance, and (d) disordered eating.

Ia: Gender Profile and Body (Dis)satisfaction

(3) Larger discrepancies between real and ideal body size are associated with less masculinity.

(5) Socially desirable trait masculinity is negatively related to dissatisfaction with appearance.

(6) Socially undesirable feminine traits are associated with dissatisfaction with physical appearance.

(9) Increases in masculinity are positively related to happiness with one’s body.

(26) Amount of masculinity is inversely related to body dissatisfaction.
(28) Femininity is not related to body image or eating pathology.

Ib: Gender Profile and Dieting

(4) Socially desirable trait femininity positively relates to cognitive concern about dieting (and not obesity per se).

(8) Increases in femininity are not related to dieting tendencies or happiness with one's body.

(10) Increases in masculinity are negatively related to body weight and restrictive dieting tendencies.

Ic: Gender Profile and Concern for Appearance

(21) Self-perception of more feminine traits is associated with placing greater importance on appearance.

Id: Gender Profile and Disordered Eating

(12) Eating disordered women think of themselves as negatively feminine and as possessing socially negative traits.

(14) Sex-role typing is correlated with anorexia in the order of most to least as follows: feminine, blended androgynous, masculine, and balanced androgynous.

(15) Sex-role typing is correlated with bulimia as follows: feminine, balanced androgynous, blended androgynous, and masculine.

(17) Being more masculine is inversely related to bulimic behaviour.

(18) Women classified as feminine were more bulimic than other subjects.

(19) Women classified as feminine had the highest (though not significantly different) scores on drive for thinness, ineffectiveness and interpersonal distrust.

(22) Importance of appearance, as associated with femininity (see #21) is a significant predictor of eating disordered symptomatology.

(25) Anorexics display a lower level of masculine (not feminine) qualities than control subjects.

(27) Amount of masculinity is inversely related to eating pathology.

(29) Bulimarexics are (and strive to be) hyperfeminine.
Le: Contrary or Null Findings

(1) Dissatisfaction with figure relates to actual body mass and not masculine or feminine sex-typing per se.

(2) The highest (yet nonsignificantly different) degree of cognitive restraint of eating is found in women with a high degree of both masculinity and femininity (i.e., "additive androgyny").

(8) Increases in femininity are not related to dieting tendencies or happiness with one's body.

(11) High-degree compulsive eaters did not show a higher degree of masculinity or femininity.

(13) There is no correlation between self feminine positive scores and disordered eating.

(16) Being masculine or feminine gender-typed in itself is not a risk factor for eating disorders.

(20) Femininity itself is unrelated to eating-disordered symptomatology.

(23) Self-perception of masculinity is not related to self-perception of (attractive) appearance or importance of appearance.

(24) Bulimics are not hyperfeminine but rather fall into the "undifferentiated" (i.e., low on both masculinity and femininity) category of gender-typing.

(28) Femininity is not related to body image or eating pathology.

While results are best articulated in preliminary fashion in this way, I will summarize them according to the nature of the profile (viz., masculine or feminine) referred to in each proposition so that results can be more easily compared across the three main categories. Within this framework, it can be noted that increasing masculinity yields a better outlook in terms of increasing body satisfaction (3, 5, 9, 26), decreasing concerns about dieting (10), and lowering the risk for disordered eating (17, 25, 27). Increasing negative femininity increases
body dissatisfaction (6) and risk for eating disorders (12). Increasing positive femininity yields increased concerns about dieting (4) and appearance (21). There is also strong evidence of a direct relationship between positive femininity and disordered eating -- bulimia in particular (15, 17, 18, 29), but also anorexia (14, 19) and eating disorder symptomatology (22). Finally, there is contrary evidence: balanced or "additive" androgyny as opposed to masculinity or femininity may be related to dieting (2), and undifferentiated gender, to bulimia (24). Moreover, femininity may not be related to body dissatisfaction (1, 8, 28) or dieting (8), masculinity may not be related to concern for appearance (23), and having a masculine or feminine profile may be unrelated to disordered eating (11, 13, 16, 20, 28). A visual representation of this summary is offered below in Figure 1.

Speaking broadly, and in terms of positive results only, masculinity seems to be an asset, and femininity, a liability in terms of lowering the risk of disordered eating (or some aspect of it). However, we have also noted apparently abundant contrary evidence. Of course these observations cannot be endorsed until the results in question are deemed at least roughly commensurate -- in particular, with respect to the manner in which gender (on the dimensions of masculinity and femininity) and disordered eating are conceptualized and measured. A detailed analysis of commensurability for the findings in "I: Gender Profile" is recorded in Appendix A. For our
GENDER PROFILE: Preliminary Results

<table>
<thead>
<tr>
<th>Decreasing masculinity:</th>
<th>Increasing negative femininity:</th>
<th>Increasing positive femininity:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- decreases body satisfaction</td>
<td>- increases body dissatisfaction</td>
<td>- increases concern about dieting</td>
</tr>
<tr>
<td>- increases concern about dieting</td>
<td>- increases the risk for eating disorders</td>
<td>- increases concern about appearance</td>
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<td>- increases the risk for eating disorder symptomatology</td>
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<td>- increases the risk for eating disorder symptomatology</td>
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<tr>
<td>Null or Contrary Evidence*</td>
<td></td>
<td>Null or Contrary Evidence*</td>
</tr>
</tbody>
</table>

Masculinity:

- is unrelated to concern for appearance
- is unrelated to disordered eating

Femininity:

- is unrelated to disordered eating

* In addition, balanced androgyyny as opposed to masculinity or femininity may be related to dieting, and undifferentiated gender may be related to bulimia.
purposes here, I would simply like to summarize its outcome.

In this category, results which support relationships between trait masculinity or femininity and disordered eating (and related phenomena such as body dissatisfaction) are at least roughly commensurate. Moreover, of the original ten null or contrary findings in subcategory Ie, only four represent direct challenges to the hypothesis that masculinity and femininity are related to disordered eating (and related phenomena). Since these challenges are greatly outweighed by positive results, it does seem safe to record that, overall, trait masculinity lowers the risk for disordered eating while trait femininity increases it. But we can more specifically record that in the case of white, middle or upper class women, the following hypotheses appear to hold: (positive) feminine traits are directly related to dieting, concern for appearance, and both bulimic and anorexic symptomatology; negative feminine traits are directly related to body dissatisfaction and increased risk for eating disorders; and trait masculinity is inversely related to dieting, body dissatisfaction, and both bulimic and anorexic symptomatology. Figure 2, below, also provides a summary of these findings.

Turning now to "II: Gender Stance," we can recall that results linked disordered eating and white, middle or upper class women's relational stance toward femininity, masculinity, and/or traditional sex roles. Given the content of the results recorded earlier, I propose that gender stance can be separated into five categories as follows: (a) valuing (or at least emulating)
GENDER PROFILE: Post-Analysis

<table>
<thead>
<tr>
<th>Decreasing trait masculinity:</th>
<th>Increasing negative trait femininity:</th>
<th>Increasing positive trait femininity:</th>
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<tr>
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<td>increases concern about appearance</td>
</tr>
<tr>
<td>decreases the risk for eating disorder symptomatology</td>
<td></td>
<td>increases the risk for eating disorder symptomatology</td>
</tr>
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</table>

Figure 2
femininity, (b) not valuing (and in fact possibly rejecting) femininity, (c) valuing masculinity, (d) null result: no indication of a relationship between disordered eating and valuing or rejecting femininity, and (e) valuing superwomanhood.

IIa: Valuing (and/or aspiring toward) Femininity

(31) Women's heightened concern about food intake and body weight are in part reflections of a desire to be perceived as possessing and exhibiting feminine sex-role attributes and behaviours related to the practice of "eating lightly."

(37) Importance of femininity and importance of masculinity are each related to importance of appearance.

(42) Women with eating disorders described their ideal self as significantly more feminine than non-patient students.

(43) Engaging in dieting and bingeing with the goal of being thin and noncurvaceous is correlated with an emphasis on physical attractiveness.

(45) Bulimarexics are significantly less liberated than controls.

(47) Given that being concerned with one's appearance and a desire to be beautiful is part of the female sex role stereotype, and given that being slender is central to the contemporary Western concept of beauty, women are directed toward the pursuit of thinness via their own concern to be feminine.

IIb: Not Valuing (and possibly rejecting) Femininity

(44) Engaging in purging or becoming underweight with the goal of being thin and noncurvaceous is correlated with an emphasis on intelligence or professional success.

(46) When thinness and dieting become associated with the image of an autonomous, independent Superwoman (as opposed to an image of a woman for whom connectedness to self and others is central in her life) girls are more at risk for developing eating disorders.

(48) In the face of puberty, adolescence and anxiety-provoking anticipations of female adulthood, the anorexic girl renounces adult femininity and reverts to a pre-pubescent state.
IIc: Valuing (and/or aspiring toward) Masculinity

(32) High-degree compulsive eaters showed a higher masculine ideal.

(37) Importance of femininity and importance of masculinity are each related to importance of appearance.

(38) Importance of socially desirable masculine traits is positively related to disordered eating.

(39) Having a superwoman ideal (i.e., taking on many roles as central to one’s sense of self) is associated with symptoms of disordered eating.

(41) Having a superwoman ideal is associated with ascribing high importance to masculine traits.

(44) Engaging in purging or becoming underweight with the goal of being thin and noncurvaceous is correlated with an emphasis on intelligence or professional success.

(46) When thinness and dieting become associated with the image of an autonomous, independent Superwoman (as opposed to an image of a woman for whom connectedness to self and others is central in her life) girls are more at risk for developing eating disorders.

(49) The anorexic also ‘dreams of doing well in areas considered more respectful and worthwhile because they are masculine.’

IId: Null or Contrary Results

(30) There are no significant differences between anorexics, bulimics, or controls in terms of their rejection of or identification with traditional feminine roles.

(33) High-degree compulsive eaters did not manifest a higher feminine self-ideal.

(34) There is no relationship of significance between anorexia and "feminism" (i.e., rejection of traditional femininity).

(35) Women with disordered eating don’t exhibit more liberated views of women’s roles.

(36) Being feminist in attitude is inversely related to bulimic behaviour.

(45) Bulimarexics are significantly less liberated than controls.
IIe: Valuing Superwomanhood

(39) Having a superwoman ideal (i.e., taking on many roles as central to one’s sense of self) is associated with symptoms of disordered eating.

(40) Having a superwoman ideal is associated with placing more importance on having a fit, slim and attractive appearance.

(41) Having a superwoman ideal is associated with ascribing high importance to masculine traits.

(46) When thinness and dieting become associated with the image of an autonomous, independent Superwoman (as opposed to an image of a woman for whom connectedness to self and others is central in her life) girls are more at risk for developing eating disorders.

In light of these findings, there seems to be strong evidence for a relationship between valuing femininity and disordered eating (31, 37, 42, 43, 45, 47). These findings are, however, challenged by the null results described in (30) and (33). Interestingly, it also seems that traditional femininity both is (44, 46, 48) and is not (30, 34, 35, 36, 45) rejected by women with disordered eating. Finally, there are substantial grounds for the claim that disordered eating is related to valuing masculinity (32, 37, 38, 39, 41, 46 and 49), as well as valuing superwomanhood (39, 40, 41, 46).

As indicated in Figure 3, then, we have a range of findings which indicate that femininity is valued, rejected, and neither valued nor rejected; and that both masculinity and superwomanhood are valued by women with disordered eating. To gain a clearer understanding of what this rather unwieldy summary means, and to determine whether it stands, individual results must be closely scrutinized. In particular, we must take into consideration both
GENDER STANCE: Preliminary Results

Valuing femininity
is related to disordered eating

Rejecting femininity
is related to disordered eating

Valuing masculinity
is related to disordered eating

Valuing superwomanhood is related to disordered eating

Null or Contrary Results

Valuing femininity
is not related to disordered eating

Femininity is not rejected by women with disordered eating

Figure 3
the concern that results within each subcategory need to be commensurate, and the existence of null or contrary results. The details of an analysis of the results in light of these concerns are provided in Appendix B. And the results of that analysis are as follows. In the case of IIa, valuing trait femininity and traditional female roles both appear to be associated with disordered eating in a variety of modes ranging from "eating lightly" to bulimia and anorexia for white, middle or upper class women. This overall finding was minimally challenged by (33) regarding the link between disordered eating and valuing femininity, and by (30) regarding the link to valuing roles.

Turning to IIb, interestingly enough, strong positive findings related the rejection of feminine traits (or mixtures of traits and roles) with seriously problematic eating behaviour, while strong null results exclusively attended to women's attitudes toward female roles. It is also noteworthy that most of the null findings studied bulimic symptomatology. Overall, it appears that feminine traits are rejected by women with severe problem eating associated with anorexia and/or bulimia, while traditional roles are not rejected -- and perhaps especially not in the case of women struggling with bulimia.

As for IIc and the case of valuing masculinity, it will be useful to say a few words about how I have related and configured these results. Under section IIa on valuing femininity, less severe dieting and bingeing were linked with emphasizing stereotypical feminine concerns about attractiveness in (43).
Silverstein and Perdue (1988) contrast this sort of orientation with a more masculine-valuing stance captured in (44). For this latter proposition links purging and becoming underweight with emphasizing stereotypically masculine concerns about intelligence and success. Valuing stereotypically masculine autonomy and independence was also linked with the pursuit of thinness by Steiner-Adair [1986, (46)] and by Bruch in [1978, (49)].

Interestingly, Bruch (1973; 1978); Chernin (1981; 1985), Orbach (1978; 1986), Silverstein and Perdue (1988), and Steiner-Adair (1986) all observe a kind of bipolarity at the level of valuational stance. In particular, it seems that valuing masculine traits entails that femininity is shunned for women with disordered eating -- or, alternatively put, that valuing and perhaps even being more masculine is a way of not valuing and not being feminine. For this reason I tend to read (44), (46), and (49) as mutually reinforcing on a conceptual level.

I also believe that (37) can be read in conjunction with (44), (46) and (49). In (37), importance of masculinity is correlated with importance of appearance. It may very well be that concern for appearance here has more to do with striving after a sort of thin, streamlined body associated with successful, independent, intelligent men (and perhaps also the rejection of a traditionally feminine, curvaceous body) than with sheer physical attractiveness. One final point is that (41) and (39) can be read together in such a way as to yield the inference that valuing masculinity is associated with symptoms of
disordered eating -- which is stated outright in (38).

At later points throughout the thesis, I will have much more to say about the manner in which I have interpreted these results, and most particularly the point about valuing masculinity and rejecting femininity in bipolar fashion. At this point however, I would simply like to report that analysis with respect to commensurability yields the overall outcome in IIC that white, middle or upper class women with disordered eating ranging from compulsive eating to anorexic and bulimic symptomatology appear to value trait masculinity.

Finally, and briefly, we turn to the case of valuing superwomanhood in IIe. Here, (40) and (41) may be understood as providing information about the content of the superwoman ideal, while (39) and (46) express direct connections between having this ideal, and disordered eating. It is interesting to note that there is considerable overlap between valuing superwomanhood and valuing trait masculinity [(41), (46)]. Indeed, in combination with the rejection of femininity, valuing masculine traits is a central feature of Steiner-Adair's [1986; (46)] concept of what I will refer to as "renunciatory" superwomanhood. But in (39), superwomanhood is also construed in the sense of taking on both masculine and feminine roles. I will hereafter refer to this as "multi-role superwomanhood." In my analysis of the two central findings in this subcategory [viz., (39) and (46)], I took into consideration the fact that different interpretations of superwomanhood are operating. However, given
the compatibility of the results, and given their commensurability on the dimension of disordered eating, I hypothesized that each study has worked with an important dimension of superwomanhood and that renunciatory and multi-role superwomanhood each appear to be associated with eating disorder symptomatology.

Having taken a closer look at the findings for "Gender Stance," and having sorted through concerns about commensurability, it seems fair to summarize by saying that the following appear to be related to disordered eating for white, middle or upper class women: valuing feminine traits and/or roles; rejecting feminine traits, valuing masculine traits, and valuing superwomanhood in the renunciatory sense of valuing masculinity while rejecting femininity, and/or the multi-role sense of pursuing both masculine and feminine roles. In contrast, women with disordered eating do not seem to reject traditional female roles. Figure 5 (below) provides a visual representation of this summary.

Results in this category do not cohere as smoothly as those in "Gender Profile." Indeed, even after this process of distilling the initial set, they still seem somewhat disjointed and unwieldy. In particular, I think they can mistakenly convey that women with disordered eating reject trait femininity, or value masculinity, or value multi-role superwomanhood, and so on. This is problematic since it fails to take into consideration ways in which the findings cohere and can be co-present within
GENDER STANCE: Post-Analysis

Valuing femininity traits is related to disordered eating ranging from "eating lightly" to bulimia and anorexia

Valuing traditional female roles is related to disordered eating ranging from dieting to bulimic symptomatology

Traditional female roles are not rejected by women with disordered eating, perhaps especially not in the case of bulimia

Rejecting masculinity is associated with anorexia, bulimia, and eating disorder symptomatology

Valuing masculinity is related to disordered eating ranging from compulsive eating to eating disorder symptomatology

Valuing multi-role superwoman-hood is related to eating disorder symptomatology

Valuing renunciatory superwoman-hood is related to eating disorder symptomatology

Figure 4
any given girl or woman. In fact, though, a number of observations can be made about relationships among the subcategories under "Gender Stance." In order to deepen our understanding of the collection of findings under II and the ways in which they cohere, it will be useful to record these observations.

First, given that there is a kind of bipolarity operating at the level of valuing trait characteristics (see above, p. 54), it may be that shunning femininity and valuing masculinity are linked in some cases. Again, this pairing of valuational stances seems to be operating in the case of Steiner-Adair's (1986) superwomen in IIE. Thus it may be that at least some results in either IIb (concerning the rejection of feminine traits) or IIc (concerning the valuing of masculinity) are tapping into a configuration in which this pairing, and/or a commitment to pursuing (renunciatory) superwomanhood, is at work.

Second, results in IIA regarding the valuing of female roles seem compatible with those in IID which support the hypothesis that female roles are not rejected by white, middle or upper class women with eating disorder symptomatology. In fact, combining these sets of results seems to yield strong evidence to the effect that female roles are not rejected, but rather embraced. Moreover, both sets of results are compatible with results regarding the valuing of multi-role superwomanhood.

Still further, these three sets of results (valuing female roles, not rejecting female roles, and valuing multi-role
superwomanhood) are compatible with those in IIb regarding the rejection of feminine traits since findings related to roles need not have a bearing on those related to traits, and conversely (see above, p. 41). Indeed, for the same reason, all three sets can be considered compatible with results in IIc (regarding the valuing of masculine traits), and IIe (regarding the valuing of renunciatory superwomanhood). Having made these observations, we can begin to see that a number of valuational stances are mutually compatible, and that for this reason they may be operating in clusters within any given girl or woman with problem eating. Thus, for example, it can be the case that a white, middle or upper class woman who values masculine but not feminine personality traits also believes that it is important to be a wife and mother, as well as a "career woman."

The only glaring incompatibility arises in conjunction with results in IIa regarding the valuing of feminine traits, and those in IIb regarding their rejection. In fact, despite the mutual compatibilities that we have observed, this antinomy apparently splits findings related to valuational stance into two groups. In one grouping, we can note the compatibility of valuing feminine traits, valuing traditional female roles, not rejecting female roles, valuing multi-role superwomanhood, and valuing masculine traits. And in a second grouping, we can cluster valuing traditional female roles, not rejecting female roles, valuing multi-role superwomanhood, valuing masculine traits, valuing renunciatory superwomanhood, and rejecting
feminine traits.

Rather than settle with this understanding of the relationships among findings in II, however, we do well to consider whether the conflict between results in IIa related to valuing femininity and those in IIb related to its rejection is in fact genuine. For three alternative arguments can be mounted to show that the incompatibility may only be apparent. The first argument has us recall that results in IIb were obtained via qualitative or clinical interviews, while results in IIa were generated on the basis of quantitative studies. For this reason, these two sets of studies may have accessed distinct phenomena.

This is possible since Bruch (1973), for example, does not specifically speak of the rejection of feminine traits, but rather of a retreat from adolescence. Indeed, it might be conjectured that results under IIb reflect a deeper aspect of white, middle or upper class women's orientation toward femininity than that captured in the quantitative findings under IIa. If this is the case, then that which is valued in the findings under IIa may not be that which is rejected in the findings under IIb, and the antinomy between these sets of findings is merely semantically-based.

The second argument regarding the compatibility of findings in IIa and IIb also draws from the observation that quantitative research detected a positive valuation of femininity, while qualitative and clinically-based findings reflected its rejection. However, rather than conjecture that distinct
phenomena are involved, the hypothesis under consideration here is that while a quantitative assessment may detect that a given woman values femininity, a qualitative interview could dig deeper and reveal that the very same woman also rejects (or at least calls into question the value of) femininity. If such a scenario is possible we will have discovered an additional sense in which valuing femininity can be construed as compatible with its rejection.

Of course, it is not logically possible that the same woman both values and rejects her femininity. However, given the feminist argument from the Introduction that disordered eating reflects conflict related to society’s double-binding messages about gender, this scenario is certainly psychologically possible and even likely. Indeed, it is precisely this conflict that researchers such as Steiner-Adair [1986; (46)] and Silverstein and Perdue [1988; (44)] take themselves to be accessing. More specifically, they themselves suggest that their results reflect the inner turmoil of girls and women who have internalized norms related to manifesting and valuing femininity, as well as societal messages to the effect that to be truly valued, one must not be feminine (and maybe not even a woman) at all.

If these researchers are correct, then we have located a situation in which in the context of a quantitative study, a given woman with problem eating might very well affirm that she values femininity, but in a clinical or qualitative study might also be prepared to express conflict and hostility regarding
femininity. As anticipated above, we have therefore described another scenario in which femininity can be both valued and rejected by women with problem eating.

The third and final argument has us consider the possibility that there are two distinct camps of women with problem eating on this dimension of valuational stance. Simply put, it is possible that some women with problem eating value femininity, while others reject it, and that this is why disparate results were obtained under "valuing femininity" and "rejecting femininity."

To support this suggestion, I would like to return to the finding that less severe dieting and bingeing is linked with emphasizing stereotypical feminine concerns about attractiveness, while purging and becoming underweight is connected with emphasizing stereotypically masculine concerns about intelligence and success (Silverstein and Perdue, 1988). In both cases there is a striving after a slender ideal. However, in the former case women strive to meet contemporary standards of attractiveness, and in the latter case women feel compelled to renounce their traditionally feminine, curvaceous bodies for new streamlined, angular, pseudo-masculine bodies which exude confidence, success, and even intelligence.

Given the sort of bipolarity at the level of value that is operating in the latter context, it may be that women who strive after masculinity in this way also reject femininity. If so, then we would expect that those with milder forms of problem eating manifest a positive valuational stance toward such
features of femininity as concerns about attractiveness, while those with more severe forms of problem eating show a negative or rejecting valuational stance.

In fact, this is exactly what we find. All but one of the results in IIa concerning the manner in which trait femininity is valued are linked to less severe modes of problem eating and related behaviour (viz., "eating lightly," emphasis on appearance, dieting, and bingeing).19 In contrast, all the results in IIb regarding the rejection of femininity are related to eating disorder symptomatology. On the basis of these observations, it seems that valuing trait femininity is more consistently related to milder modes of problem eating on the continuum, while rejecting trait femininity is related to eating disorder symptomatology. If this holds, then it becomes clear from yet another perspective that findings related to valuing and rejecting femininity do not necessarily conflict.

In summary, the three scenarios described in these arguments each capture a distinct sense in which valuing and rejecting femininity are compatible, thus supporting the claim that the conflict between results in IIa and IIb may only be apparent. If this assessment stands, it seems that contrary to our earlier preliminary assessment, all modes of valuational stance under II are compatible and that various clusterings of stances are possible. In the context of the third argument, we have also noted that valuing trait femininity seems to be related to milder modes of problem eating, while rejecting trait femininity is
related to eating disorder symptomatology. Interestingly, this observation seems to have yielded insight into at least one dimension of the relationship between white, middle or upper class women and gender which can help account for differences in modes of problem eating along a continuum. I will have much more to say about this in subsequent chapters of this thesis. At this point, though, we must turn to an examination of the results in III.

Findings gathered under "III: Gender Profile, Gender Stance, and Conflict" all capture or conjecture the existence of a gap between what white, middle or upper class women are like, and what they think they should be like in terms of having a particular gender profile. Accordingly, each subheading has two parts: first, a partial gender profile of the white, middle or upper class women in each category is identified; second, white, middle or upper class women's own (and/or others') stance toward that profile is identified. Given the results collected here, three configurations can be discerned: (a) Low-level masculine profile/Perceived deficit of masculinity, (b) Feminine profile/(Conjectured) conflict related to the devaluation of feminine traits and/or roles by self and/or others, (c) Masculine or feminine profile/Perceived deficit in the "opposite" direction.

IIIa: Low-level masculine profile/Perceived deficit of masculinity

(50) A higher level of education in combination with dissatisfaction with body image is even more relevant than the androgyny factor in terms of predicting cognitive restraint.
(54) High-degree compulsive eaters showed a greater discrepancy between masculine self concept and self ideal.

(55) There is a greater discrepancy between self and ideal masculine traits due to low level of self-perceived masculine traits (and therefore not due to greater presence of positive masculine traits in their ideal female) — especially for bulimic symptomatology.

IIIb: Feminine profile/(Conjectured) conflict related to the devaluation of feminine traits and/or roles by self and/or others

(51) Whether or not they are feminine or masculine-oriented, bingers are more likely than non-bingers to report that their parents believe that a woman's place is in the home, that their mothers are unhappy with their own careers, that their fathers thought their mothers were not intelligent, and that their fathers treated a male as the most intelligent sibling in the family.

(56) Women with eating disorder symptomatology experience conflict regarding their self-ascribed negative feminine characteristics which they attempt to resolve by striving after ideal femininity.

(60) Bulimarexics show a wider gap between their attitudes and behaviour regarding women's roles.

(61) Women with disordered eating experience confusion and stress concerning their sex roles and gender traits because they are caught between societ al messages which urge them actively to engage in stereotypically male pursuits, but also not to relinquish more traditional feminine-gendered traits and roles.

(62) Anorexia (including the binge-eating/purging subtype) reflects an adherence to thinness as an expression of 'ultra-femininity' and also a rejecting indictment of that femininity.

(63) Being relationally-oriented and defining oneself in connection with others as girls do, and renouncing this in favour of a male developmental ideal characterized by autonomy and detachment from others is associated with both the superwoman ideal and eating disorder symptomatology.

IIIC: Masculine or feminine profile/ Perceived deficit in the "opposite" direction

(52) Parents' traditional values [in terms of the parameters noted above in (51), pp. 47-48] did not differentiate between purgers and nonpurgers in the case of feminine-oriented women.
(53) Masculine-oriented women were much more likely to engage in purging if their fathers' values [see (51)] were less liberated.

(57) Women with nontraditional sex role aspirations who also indicate conflict regarding their femaleness are more likely to report purging or frequent bingeing.

(58) Women who are either especially masculine or feminine in gender-type and aspire to a superwoman ideal are particularly at risk for eating disorders.

(59) Non-superwomen as well as androgynous or undifferentiated superwomen are at low risk for eating disorders.

Fortunately, results can for the most part be read and summarized directly from the above subheadings because there are no null findings. This means that if results within categories are commensurate, researchers will have provided evidence to the effect that women with disordered eating experience a gap and/or conflict between: having a low-level masculine profile, but wanting to be more masculine (IIIa); having a feminine profile and feeling conflicted in relation to the devaluation of that profile by self and/or others (IIIb); and/or having a masculine or feminine profile, but feeling deficient in femininity or masculinity, respectively (IIIc). This information is also represented in Figure 5 (below).

Once again, to flesh-out the meaning of this summary and to determine whether cross-study comparisons are legitimate in the first place, it is necessary to review the results more closely. Regarding the first subcategory of results, (54) and (55) are self-explanatory, but I would like to explain that (50) is listed here because van Strien (1989) notes that women with more education can be in a better position to take on non-traditional
GENDER PROFILE, GENDER STANCE, AND CONFLICT: Preliminary Results

Having a low-level masculine profile in combination with aspiring toward masculinity is related to problem eating.

Having a feminine profile and feeling conflicted in relation to the devaluation of feminine traits and/or roles by self or others is related to problem eating.

Having a masculine or feminine profile but perceiving a deficit in the "opposite" direction is related to problem eating.

Figure 5
women's or men's roles. Yet, in a point that should be familiar, she conjectures that if they don't have the "appropriate" streamlined angular masculine body connoting the capacity to be in control and successfully compete in such endeavours, they may be inclined to diet. In my view, this is an instance of perceiving oneself, and in particular one's body, as insufficiently masculine.

A detailed analysis of all the results in III regarding concerns about commensurability is available for reference in Appendix C. In terms of an overall summary of results, with respect to IIIa, close examination yielded the conclusion that valuing masculinity in conjunction with low self-described masculinity is related to dieting, compulsive eating, and bulimic symptomatology for white, middle or upper class women.

IIIb could be crudely interpreted as a combination of the sort of results found in I related to self-described femininity and those in IIb on rejecting femininity. However, this interpretation is not quite appropriate since in this category of results, women do not reject femininity in a trait or role sense outright. Rather, in each finding we can discern grounds for deep conflict experienced by women who are in some sense(s) feminine-gendered, but who have in some way(s) absorbed or at least been confronted with negative, undermining messages about femininity and/or traditional women's roles.

The selection of results categorized under IIIb requires some explanation. In the case of (51), Silverstein, Perdue et
al. (1988) assessed for masculine vs. feminine orientation on the basis of only one question related to subjects' concerns about academic achievement vs. household skills. They found that regardless of orientation, women binge if their parents have more traditional values, and if the mother is unhappy in her career choice. In light of earlier results in IID to the effect that bulimic women do not reject traditional roles, I conjecture that regardless of their answer to the researchers' question, these women at least minimally adhere to traditional female roles and that this may create internal conflict given the apparent devaluation of women and their roles within their families.

Continuing with this task, (56) is located in IIIb because women who describe themselves as possessing negative feminine traits (and who, I suspect, are not likely in a position to deconstruct the meaning of those traits or their presence) seem to feel inadequate regarding their femininity. Paxton and Sculthorpe (1991) conjecture that this may motivate women to strive after the socially acceptable feminine ideal of a slender body. The nature of the gap in (60) is as one might expect: behaviour is more traditionally feminine than attitudes on the part of the bulimarexic women studied. And in the case of (61), (62), and (63), girls and/or women with disordered eating all explicitly emerge as being torn between being feminine-gendered and having to renounce this in the face of a societal rejection of femininity and supervaluation of masculinity.

In the analysis of these results, it was noted that (a) all
of the studies noted here focus at least in part on bulimic behaviour or symptoms; (b) in each case being feminine in the sense of trait and/or role comes up against a devaluation of feminine-gendered traits and roles; and (c) there are no contrary findings in this subcategory. In light of these observations, I think it is fair to say that disordered eating (and perhaps bulimic symptomatology in particular) appears to be associated with white, middle or upper class women who describe themselves as feminine (in the sense of trait or role profile), but who also face the devaluation of (role and trait) femininity.

Turning finally to IIIc, I wish to explain that (53), (57) and (58) are clustered together because they describe a situation in which what a woman is in terms of her gender profile seems to come up against what she (or a significant other person) thinks that orientation ought to be (namely, its "opposite"). (Fifty-eight) fits neatly here since having a (multi-role) superwoman ideal entails that both masculine and feminine orientations are desired and, given that only one profile applies, there would be a deficit in the "opposite" direction. On the other hand, I must note that (57) is included here on somewhat tenuous grounds since I have presupposed that the element of conflict regarding femaleness bears some relation to conflict regarding femininity. In contrast with this clustering of results, (52) and (59) capture situations in which self-described gender profile jibes or at least does not apparently conflict with what is desired. Since lack of an "is/ought" friction seems to lower the risk for
disordered eating, I construe these results as supportive of those in the first group.

Summarizing the analysis of these findings, we can note that as in IIIB, bulimia was consistently but not exclusively a focus of these studies, and that a variety of gender configurations were examined. However, in the latter case, orientation toward roles (traditional, nontraditional or superwoman-type) played a part in each finding and no particular trait gender orientation emerged as relevant. Hence it might be fair to conclude that regardless of her trait-gender profile, insofar as a white, middle or upper class woman's sense of who she is contrasts with who she thinks she ought to be in the sense of role-profile, she appears to be at risk for disordered eating (and perhaps bulimia in particular).

In summary, in the case of "III: Gender Profile, Gender Stance, and Conflict," it seems that for white, middle or upper class women, valuing masculinity in conjunction with low self-described masculinity is related to dieting, compulsive eating, and bulimic symptomatology (IIIa); disordered eating (and perhaps especially bulimic symptomatology) is associated with women who experience conflict related to the devaluation of feminine traits and/or roles by self and/or others (IIIb); and women who are masculine or feminine-gendered but who perceive a deficit in the "opposite" direction in the sense of role profile manifest disordered eating (and perhaps bulimic symptomatology in particular). A visual summary of this is offered in Figure 6.
GENDER PROFILE, GENDER STANCE, AND CONFLICT: Post-Analysis

Having a low-level masculine profile in combination with aspiring toward masculinity is related to problem eating

Having a feminine profile and feeling conflicted in relation to the devaluation of feminine traits and/or roles by self or others is related to problem eating

Having a masculine or feminine profile but perceiving a deficit in the "opposite" direction is related to problem eating
At this point the summarized findings from all three sections of this review regarding white, middle or upper class women can be gathered and recorded as follows:

I: Trait femininity is directly related to dieting, concern for appearance, and both bulimic and anorexic symptomatology; negative feminine traits are directly related to body dissatisfaction and increased risk for eating disorders; and trait masculinity is inversely related to dieting, body dissatisfaction, and both bulimic and anorexic symptomatology.

II: Valuing feminine traits and/or roles; rejecting feminine traits; valuing masculine traits; and valuing superwomanhood in both the sense of valuing masculinity while rejecting femininity, and the sense of pursuing both masculine and feminine roles are all related to disordered eating. In contrast, women with disordered eating do not seem to reject traditional female roles.

III: Valuing masculinity in conjunction with low self-described masculinity is related to dieting, compulsive eating, and bulimic symptomatology; disordered eating (and perhaps especially bulimic symptomatology) is associated with women who appear to experience conflict related to the devaluation of feminine traits and/or roles by self or others; and women who are masculine or feminine-gendered but who perceive a deficit in the "opposite" direction in the sense of role profile manifest disordered eating (and perhaps bulimic symptomatology in particular).

While this collection is certainly more manageable than the initial set of sixty-three propositions, it will be useful to pare it down even further. In a first attempt to do this we might be tempted to list only those summarized findings which can be used to construct profiles of women with eating problems -- that is, only those which describe positive relationships between disordered eating and gender. We could also offer less detailed summaries by dropping references to the specific mode of disordered eating (or related concerns or behaviour) involved. Having made these modifications, we could more simply record that
in the case of white, middle or upper class women, the following
are associated with problem eating:

I self-described femininity
   low-level self-described masculinity

II valuing feminine traits and/or roles
   rejecting feminine traits
   valuing trait masculinity
   valuing superwomanhood

III low-level masculinity paired with valuing masculinity
   femininity paired with its devaluation
   masculinity or femininity paired with striving toward its
   "opposite"

Having offered this summary, I would like to recall that I undertook this review in the hope of gathering material which could be used in the construction of a psychocultural model of eating problems. In the Introduction, I had argued that such a model would need both to incorporate feminist insights about the sociocultural nature of problem eating, and to capture its psychological complexity -- especially in more extreme cases. The material reviewed here has yielded information about correlations between aspects of gender and modes of disordered eating, but as yet it is unclear whether and how a model could be constructed from it.

Among other things, I am uncertain about the fallout of the preceding analysis. For on the one hand, we have evidence to the effect that there might be something about the content of gender (for example, hyperfemininity or low-level masculinity or aspiring toward multirole superwomanhood) which makes a girl or woman at risk for problem eating. But on the other hand it seems that gender conflict (for example, femininity paired with its
devaluation, or low-level masculinity paired with striving after masculinity) might be relevant. And it seems that very different models might be constructed depending on which cluster of results we choose to emphasize.

It might help to recall that a more specific case of this tension helped spawn the research that has been reviewed here, and that discussion of the results in II offered some suggestions as to how it might be resolved. Here I refer to the apparent conflict between the view that girls and women with problem eating are hyperfeminine, and the view that these girls and women reject their femininity. One of the suggestions for resolution of this tension offered above (see pp. 63 and ff.) was that girls and women in the former category have milder eating problems, while those in the latter category have more severe problems. This hypothesis was in fact supported via a closer examination of the results. And this of course provokes the hypothesis that something similar applies in the more general case. That is, it might be that simpler and more isolated aspects of gender profile are associated with more mild forms of problem eating, while those related to conflict are related to more severe modes.

To test this hypothesis, the remaining two categories of findings must be more closely examined. Under "I: Gender Profile" self-described femininity was related to dieting, concern for appearance, and body dissatisfaction, as well as severe eating problems. This observation seems to nullify the hypothesis in question because self-described femininity is
present even in those findings related to more severe problems, and thus there is no way to make a distinction based on changes in this variable. I would suggest, however, that this judgement is precisely what needs to be called into question. For it may be that a distinction is operating between cases in which self-described femininity simpliciter is operating, and cases in which self-described femininity is operating in conjunction with other gender-related variables that are present but hidden from the researcher.

In the former case and as we have noted, femininity as currently constructed includes traits such as wanting to please others, as well as roles such as being a physically and sexually desirable woman. Given that society also currently prescribes the pursuit of slenderness as a way to fulfill such traits and roles, it is not surprising that dieting and concern for appearance are associated with femininity (simpliciter). On the other hand and in the latter case, though, other aspects of gender such as rejecting one’s femininity or aspiring toward a more masculine profile may also be operating in tandem with self-described femininity. And it may be that in these more complex cases, conflict arises and more severe modes of problem eating are generated in response.

This hypothesis is in fact supported by findings in IIIb and IIIc because they can be perceived as expanding those in I. In the case of IIIb, self-described femininity is conjoined with its devaluation by self or others; and in the case of IIIc,
femininity is conjoined with a striving after its "opposite." Both of these more complex cases are associated with more severe problem eating. A similar point holds for IIIa which expands the finding in IIc that valuing masculinity is associated with disordered eating by conjoining it with self-described low-level masculinity.

Once we begin noting the manner in which more simple gender-related features of women can be joined with others to produce more severe modes of disordered eating, other possibilities emerge. For one thing, self-described gender profiles are not necessarily related to the manner in which they are valued or shunned. As a result, we can note that self-described femininity may be associated with valuing feminine traits and/or roles, rejecting feminine traits, being confronted with the devaluation of feminine traits, valuing masculinity, or aspiring toward superwomanhood. Beginning with the first set, it is fairly obvious how the pairing of self-described femininity and valuing feminine traits and/or roles can be mutually supportive in the production of more mild varieties of disordered eating. For they both comprise phenomena such as concern for appearance and the desire to please others. However, in addition to the cases we've already noted in IIIb and IIIc, we can conjecture that when paired with aspects of gender such as the rejection of feminine traits or aspiring toward superwomanhood, being self-described feminine can be associated with inner conflict. And this may account (in part) for why some white, middle or upper class women
who are self-described feminine struggle with more severe modes of problem eating.

From here, the possible (and actual) scenarios only become more complicated. We have already observed how valuing masculinity and shunning femininity can be joined in the case of aspiring toward (renunciatory) superwomanhood in the manner described by Steiner-Adair. But to illustrate with a more complex case, it seems likely that self-described feminine and low-level masculine women who shun femininity while embracing masculinity and who are faced with familial devaluation of femininity on an ongoing basis would be more conflicted than women with more simple gender profiles. Other scenarios can be similarly spun. The point here is that there are intuitive and empirical grounds for supposing that any number of gender profile composites are extant, and that a range of modes of problem eating from mild to severe may be associated with them at least in part as a function of their complexity.

Of course, if white, middle or upper class women's behaviour, values, and concerns related to female body management lie on a continuum in the manner discussed in the Introduction, we would expect just this outcome. Accordingly, rather than compile a single profile of "the eating-disordered woman," it makes sense to propose that a variety of gender profiles fit along a continuum of mild to severe problem eating. Returning to the problem that incited the preceding discussion, it also makes sense to propose that gender content and gender conflict are both
associated with problem eating. It's just on a final interpretation and summary of the results reviewed here, self-described femininity simpliciter (or in combination with valuing feminine traits and/or roles) appears to be related to more mild modes of disordered eating such as dieting and occasional bingeing, as well as related phenomena such as body dissatisfaction and concern for appearance. At the same time, however, more complex conflict-inducing configurations lying "underneath" self-described aspects of gender profiles appear to be related to more severe modes of problem eating, including eating disorders. As we've noted, in combination with simpler aspects of gender profile, the following variables emerged as particularly relevant: the rejection of feminine traits, valuing trait masculinity, valuing superwomanhood, having low levels of masculinity while valuing masculinity, being self-described feminine or masculine but aspiring toward the opposite profile, and/or being feminine but feeling conflicted in relation to the devaluation of feminine traits and roles by self and/or others. This summary is represented in visual form below in Figure 7. As indicated at the extreme right, and in keeping with the preceding discussion, I also include a number of conjectured possibilities involving combinations of gender profiles and/or stances which would be associated with more severe modes of problem eating.

I would like to draw two implications from this final summary of results. The first concerns a set of questions posed for our consideration at the outset of this Review: (i) are women
HYPOTHEtical RELATIONSHIPS BETWEEN OVERALL GENDER PROFILE AND LEVELS OF SEVERITY OF PROBLEM EATING

Less Conflict ← More Conflict

Combinations of gender profiles and/or stances as in:
- the results in III
- conjectured possibilities

- Self-described femininity and rejecting femininity
- Self-described femininity and ambivalent valuing and rejecting of femininity
- Self-described femininity, low-level masculinity and valuing renunciatory superwomanhood and so on...

Valuing feminine traits and/or roles
- Rejection of femininity
- Valuing/Aspiring toward masculinity
- Valuing multi-role superwomanhood
- Valuing renunciatory superwomanhood

- Having a low-level masculine profile and aspiring toward masculinity
- Having a feminine profile and feeling conflicted in relation to the devaluation of feminine traits and/or roles by self or others
- Having a masculine or feminine profile and perceiving a deficit in the "opposite" direction

Milder modes of problem eating (eg., dieting, occasional bingeing), and related phenomena (eg., as body dissatisfaction, concern for appearance)

More severe modes of problem eating, including eating disorder symptomatology

Figure 7
with disordered eating hyperfeminine?; (ii) do women with disordered eating reject femininity or embrace it (or both)?: and (iii) is disordered eating the expression of internal conflict regarding gender identity and roles? In light of the preceding discussion, our answer in the case of (i) must be that in the context of contemporary North American culture, self-described femininity and valuing femininity appear to be risk factors for more mild modes of disordered eating for white, middle or upper class women. However, vis-a-vis (ii), some white, middle or upper class women with more severe problem eating seem to be self-described feminine (and/or committed to fulfilling traditional female roles), while at once shunning their feminine traits. Indeed, and with reference to (iii), white, middle or upper class women may be attempting to resolve internal conflict and turmoil related to their gender profile via the adoption of more severe modes of problem eating.

The second implication concerns a question raised earlier about how to use the material reviewed in the present chapter. Given the manner in which I have interpreted the overall set of empirical findings, it seems that at this point we have a coherent set of data. That is, as noted above, there no longer seems to be just cause for pitting results relating gender content and disordered eating against those relating gender conflict and disordered eating. Rather, it seems that conflict is more likely at work in severe cases than aspects of gender profile simpliciter. This outcome certainly helps to provide
support for the feminist position outlined in the Introduction that gender conflict is a key component in the etiology of problem eating. However, for further discussion regarding how I plan to work with this material, we turn to Chapter Three.
Examination of the empirical literature on gender was intended to begin a process of determining how to construct a psychocultural model of problem eating. On my interpretation of the results reviewed in Chapter Two, aspects of gender profile such as self-described femininity or valuing feminine traits and/or roles appear to be related to more mild modes of disordered eating, while more complex conflict-inducing configurations appear to be related to more severe modes of problem eating, including eating disorders. This is certainly a good start, particularly since it begins to suggest how problem eating is located along a continuum. However, it is also important to recall a central question from the Introduction concerning whether or not gender-related conflict comprises enough of the deeper psychological complexity of problem eating.

I posed this question on behalf of those operating from a more purely clinical perspective, and of course we still have yet to determine the answer. No doubt, the "clinicians," as I referred to this group, would be encouraged by the manner in which psychological complexity seemed to increase as we moved in the Literature Review from the empirical findings reviewed under the heading of "Gender Profile" to those under "Gender Stance," and "Gender Profile, Gender Stance, and Conflict," and by the hypothesis that inner conflict is most likely at work in the context of severe eating problems. However, at least some
clinicians are still likely to protest that any model we could construct at this point would lack psychological depth and complexity sufficient to account for the generation of eating disorder symptomatology.

Recalling an earlier argument from the Introduction, the clinicians could indeed have us consider that the vast majority of white, middle or upper class women are presumably exposed to cultural directives regarding gender, including double-binding messages regarding gender traits and roles. A good number of these women no doubt also experience stress and conflict related to this input. So how, the question is raised, can we account for the fact that only a relatively small percentage of women end up struggling with clinical eating disorders? Something else, they would conclude, must be at work in these cases which is not captured by the sociocultural theories.

Of course, the question whether there is more that we need to include in a psychocultural model cannot be settled on the basis of the largely correlational data reviewed in the previous chapter. Moreover, even if we were supplied with additional evidence to the effect that gender-related conflict is the relevant variable, an equally vexing question would arise concerning how it specifically functions in a causal capacity. On the other hand, though, my limited goal for the present thesis is to construct a model which suggests how gender-related conflict might contribute to the etiology of problem eating. Given that we lack a solid empirical basis upon which to question
the relevance and sufficiency of the sort of gender-related conflict outlined at the close of Chapter Two, it might make sense simply to generate a model based on the research we have already reviewed. Concrete, testable hypotheses could then be extracted from the model and assessed in the context of future research projects.

This is roughly the manner in which I intend to proceed. However, I am not entirely sanguine about the prospect of generating a model solely on the basis of the empirical findings regarding gender conflict. Indeed, based upon my own experience of anorexia, I share with the clinicians a sense that the sort of configurations of overall gender profile we have discussed lack sufficient psychological complexity to account for the generation of problem eating in girls and women. This is not to say that I believe that the empirical research is off-target. In fact, even the briefest reflection on my experience elicits a strong resonance with findings relating to both gender content and gender conflict. However, my hunch is that while the findings are valid, they are incomplete.

The source of this hunch is rooted in memories of my own experience of anorexia; something makes me think that there was more to the gendered nature of my personality than the empirical results have accessed. The same hunch provokes the further question whether exploration of that experience might provide a more solid empirical basis for questioning the sufficiency of current findings. Even more significantly, such an endeavour
might supply material to help construct a richer and more adequate psychocultural model.

In fact, this is precisely the perspective from which I will carry out the remainder of the thesis. That is, I plan to follow the thread of my own misgiving about the adequacy of current findings back to my own experience and examine the material that emerges. Then I will use this material to supplement the findings analyzed in the Literature Review to construct a psychocultural model of the gendered nature of problem eating. The task of the present chapter is to describe more fully how I plan to investigate my experience. In Chapter Four I will carry out this plan, and in Chapter Five I will take up the task of model construction.

I am more inclined toward a qualitative than a quantitative approach to accessing my experience of anorexia. As I began to indicate above, repeating the sorts of studies reviewed in the previous chapter would likely help confirm the validity of their results, but would not likely help me discover what might be missing. In contrast, a qualitative study is well-suited for the more open-ended kind of exploration that I propose to undertake. For, as noted in Borg and Gall (1989), qualitative methods allow material that might lie outside or underneath the frame of preconceived notions (and established research findings) to emerge. This in turn aids in the development of new ideas and hypotheses -- including those that arise in the context of a grounded theory approach. Since, as I will explain below, this
thesis roughly constitutes early phases of a grounded theory approach, and since qualitative methods are "especially effective in the development of grounded theory" (Borg & Gall, 1989, p. 407), this seems like the appropriate route to take.

Not one to throw the baby out with the bath water, though, I still plan to utilize the summarized results in Figure 7 from Chapter Two (p. 80) as a frame for my autobiographical inquiry. More specifically, I intend to record material that emerges when I reflect upon the question whether and, if so, how the subcategories of self-described femininity, low-level masculinity, rejecting femininity and so on would have applied to me at the age of fifteen (and at later stages of healing). The basic reason why I plan to use these subcategories is that my misgiving about lack of complexity arose in response to a preliminary reflection upon them in relation to my sense of myself at the time of the anorexia. Thus it seems logical to explore in more detail how far they apply in my case and whether deeper reflection upon them can reveal more information.

But use of this frame is in addition meant to serve as a check against bias. More specifically, since serious concerns about bias and lack of objectivity are standardly raised about any qualitative study -- never mind an autobiographical study carried out by the researcher -- it seems best to try to build in a measure of objectivity. I have done this by ensuring that while I will provide answers to the questions posed, the questions themselves are rooted elsewhere -- in this case, in a
body of empirical research.

A final reason why I have decided to utilize the summarized results is that this will make it possible for me informally to test a methodological hypothesis that has been taking shape over the course of my discussion. Here I refer to the hypothesis that a richer understanding and more valid outcome for at least some studies is achieved by interweaving quantitative and qualitative approaches than by exclusively pursuing the former.

This hypothesis has already emerged in the present study from my analysis of the results reviewed in Chapter Two. Results in "II: Gender Stance" created the impression that we needed to determine whether hyperfemininity or rejecting femininity was more relevant to problem eating. In my discussion of those results I briefly conjectured that the difference between these perspectives might be more a function of the nature of the study than a reflection of the phenomenon in question. As it turned out, quantitative studies yielded findings regarding gender content (i.e., in that case, hyperfemininity), while more clinically or qualitatively-based work yielded findings regarding conflict (i.e., in that case, conflict related to the rejection femininity).

Later, I observed a more general distinction across all three categories between findings that suggest that gender content is relevant to problem eating, and findings that suggest that gender conflict is at work. And I argued that the two sets of findings are ultimately compatible on the hypothesis that
studies which examined gender content were validly tapping into genuine features of the personality of their subjects, but were at the same time missing underlying conflict. In contrast, other studies tapped more directly into gender conflict.

In the more general case the distinction between quantitative and clinical or qualitative work holds up. That is, overall, the former accessed features of gender content while the latter accessed gender conflict. And this raises a methodological question whether quantitative studies are valid insofar as they tap into actual features of the phenomenon under study, but inadequate in a larger sense of failing to yield a complete or adequate understanding of the phenomenon in question.

Of course, this is a familiar sort of complaint about the limitations of quantitative research. And many researchers argue that it is best to combine quantitative and qualitative approaches precisely as to avoid this sort of outcome. For example, Borg and Gall (1989) quote Reichardt and Cook (1979) to the effect that "there is no reason for a dichotomy between the method-types and there is every reason (at least in logic) to use them together to satisfy the demands of evaluation research in the most efficacious manner possible" (pp. 26-27; in Borg & Gall, p. 382).

One doesn't often have a chance to go beyond logic and provide empirical backing for this objection within the context of a given research project. On the other hand, though, the present study offers just such an opportunity. For by using the
subcategories of aspects of overall gender profile culled from the empirical research to frame my qualitative study, I will be in a position to determine whether there can be a situation in which quantitative findings are independently confirmed but at the same time assessed as incomplete given the manner in which additional material arises. Of course, confirmation of the relevance of additional material that emerges in a qualitative context would require further research -- possibly even further quantitative work. The point, however, is that my autobiographical study may yield information that can aid in the construction of a psychocultural model of the relationship between gender and problem eating. If it does, then the overall thesis might be construed as lending at least informal support to the methodological perspective that our understanding of a given phenomenon can be enriched if we allow quantitative and qualitative approaches to interact -- whether in the sort of piggy-back fashion described here, or in some other mode.

Having outlined the reasons why I have chosen to use the subcategories of results from the Literature Review as a frame for my autobiographical inquiry, I would like to continue outlining my plan for Chapter Four. My intention is to engage in a two-phased exercise which will allow me (1) to assess the extent to which the empirical findings are supported by autobiographical material, and (2) to explore my sense that there was more to the gendered dimension of my experience than the empirical results have captured. In both phases of the exercise
I will ask myself whether and, if so, in what ways I was feminine in a trait-gendered sense, whether I was masculine, whether I valued femininity, whether I aspired toward multi-role superwomanhood, and so on. However, in the first phase I will seek to determine whether and how these aspects of overall gender profile applied to me at the age of fifteen, and in the second phase I will inquire into my profile in late stages of healing.

My thinking vis-à-vis the second phase is that even if the empirical results are corroborated by my sense of myself at fifteen, it will be interesting and important to determine whether these dimensions of my profile changed over the course of my healing. If they do, the results would in a sense be doubly confirmed. If they don’t, we might have cause to question the validity of the corroboration attained in the context of the first phase.

As we will see, the autobiographical exercise will offer solid support for the empirical results culled from the studies reviewed in Chapter Two. However, additional material will also emerge that has implications for the interpretation and use of the empirical results in the construction of a psychocultural model. Before turning to Chapter Four and the first phase of the exercise, though, I would like to entertain two concerns which might arise in response to my overall plan.

The first concern relates to the epistemological status of the model I plan to construct out of this material. More simply put, what will I or anyone be able to claim to know at the close
of my study? I believe that the answer to this question depends entirely on the manner in which I conceptualize my work here. At the outset I can state that while I do intend my study to satisfy more than my own curiosity about the nature of my experience, I have not proposed any hypotheses about the etiology of problem eating which the autobiographical exercise is intended to confirm or disconfirm. Rather, I hope to be able to lay out the first few stages of what might be loosely be construed as a grounded theory approach to understanding the gendered nature of problem eating.

To explain my meaning here, I would first like to record that:

[t]he grounded theory approach is a qualitative research method that uses a systematic set of procedures to develop an inductively derived ground theory about a phenomenon.

(Strauss & Corbin, 1990, p. 24)

The point of this kind of research is to construct a theory about a given phenomenon which emerges from intimate encounters with it over many stages of empirical inquiry and reflection. This is the sense in which the approach is inductive. Among other things, this methodology helps to ensure that the right sort of variables are identified, and that the right sort of hypotheses can be developed for further research. The contrast is with research which begins with a hypothesis about the nature of a given phenomenon and seeks to test it. This can be fruitful but, as noted above, we can be left with only a limited and partial
grasp of that which we seek to understand.

I loosely conceptualize my work here as the first few stages of a grounded theory approach because I am not attempting to test a specific research hypothesis, but rather to work toward identifying the relevant variables for a preliminary model of the relation between gender and problem eating. The model will be grounded not only in the fund of empirical research reviewed in Chapter Two, but in the autobiographical exercise mounted in response to this research that I have described. As I began to indicate above, my hope is that further research could then be mounted on the basis of my model which could ultimately confirm or disconfirm the relevance of the variables that are identified within it.

In sum, then, my response to the first concern regarding the epistemological status of my model is that we will not be able to claim to know much of anything at all at the close of my study. However, if all goes well in the sense that the model is sufficiently grounded in the actual phenomenon of problem eating, then we will have arrived at the right sort of questions for further research.

While all this might be well and good, however, a second concern about my plan relates to the autobiographical nature of the study itself. In fact, two subsets of methodological and epistemological worries can be raised. The first set relates to the status of the research itself, and the second set concerns the reliability of the memories evoked in the context of the
autobiographical exercise. Beginning with the former, we can note that concerns about the qualitative nature of the exercise slated for Chapter Four can be raised from a critical, positivist perspective. Given that "the data collected are usually subjective and [that] the main measurement tool for collecting data is the investigator [herself]" (Borg and Gall, 1989; p. 380), there is already great potential for bias, lack of objectivity, and lack of generalizability in any qualitative study.

Moving closer to the more specific nature of the study I have anticipated here, Smith (1994) notes that academic "[p]sychologists have trouble with biography" given their "passion for truth, and a particular kind of truth at that, exemplified in experimentation, quantification, and tested propositions" (p. 296). No doubt, from this perspective an autobiographical study constitutes a worst case scenario for biographical research given that the researcher not only collects but also provides the data herself. This bodes ill with respect to the need to minimize experimenter effect, or "the degree to which the biases or the expectations of the observers have led to distortions of the data" (Borg & Gall, 1989, p. 404). It also bodes ill -- and arguably fatally so -- for the prospect of achieving external validity or generalizability to the broader population. For without the benefit of random selection and a large sample, there is no way to cancel out the influence of unique features of the subject studied.
It is no doubt cold comfort to the academic psychologist that autobiography can be considered a way of telling agreeable lies (Smith, p. 288, drawing from Pritchett, 1977), or that it has been interpreted as a "mix of history and literature and an attempt to integrate 'objective fact and subjective awareness'" (Smith, 1994, p. 300, drawing from Butterfield, 1974). For from the perspective of the positivist, insofar as untruth and subjectivity are introduced, research loses its validity and therefore its worth.

Of course, however, there is another perspective from which to assess the status of autobiographical inquiry. And here I refer to the postmodern perspective according to which "positive knowledge about anything in the human condition is a misconstrual" (Smith, 1994, p. 288). For example, as Smith notes (with Hexter, 1971), historians bring their questions, values, beliefs, and life experiences to their research into something "out there" that has happened in the past. And in this sense, history is always autohistory" (1994, pp. 288-289). Post-positivist philosophers of science have also been arguing for some time that the analogue of autohistory holds in the case of all fields of research -- including the physical sciences. That is, again drawing from Smith, "the autobiographical...enters into any creative intellectual construction" (p. 289).

The point of this general philosophical response to the objections of the positivist is that the goal of accessing "the reality" of any aspect of human experience is illusory. For
research is limited by the fact that it is perspectival and always-already shaped and influenced by the humans who mount it. A more specific point that I would like to draw in connection with this discussion is that by recording the results of an autobiographical inquiry, I am making explicit the personal source of my constructions. That is, rather than leaving it to the reader to guess the origin of the hypotheses which I will ultimately propose, I am able to be frank and explicit about their autobiographical source. I think this is a more honest and in this sense more epistemologically sound approach than one which assumes or pretends that its hypotheses are non-autobiographical and in this sense not "situated."

It can also be noted that personal experience is an important source of theoretical sensitivity in the context of developing grounded theory. As Strauss and Corbin (1990) explain:

Theoretical sensitivity refers to the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn’t...It is theoretical sensitivity that allows one to develop a theory which is grounded, conceptually dense, and well integrated... (p. 42)

Another way to put the present point is to say that I am proposing to render transparent the source of my own theoretical sensitivity.

A final argument in favour of autobiographical research in
particular is that it is not only limited by the fact that it is perspectival, but also enriched. This is indeed the perspective of feminist researchers who "generally consider personal experiences to be a valuable asset for feminist research" (Reinharz, 1992, p. 258). Indeed, as Reinharz observes:

Feminist researchers frequently start with an issue that bothers them personally and then use everything they can get hold of to study it. In feminist research, the 'problem' is frequently a blend of an intellectual question and a personal trouble...Researchers who adopt this view draw on a new 'epistemology of insiderness' that sees life and work as intertwined. Because of the widespread acceptance of the personal starting point for feminist research, some people have come to almost expect a link between the personal experience of the researcher and the research project in which she is engaged. (1992; 259-260)

Indeed, as Reinharz (1992) goes on to explain, some feminist researchers take this one step further by claiming that personal experience is a source of legitimacy and in this sense a necessary feature of adequate research.

I take this thesis to be an instance of research in the feminist tradition of the epistemology of insiderness, but it also vital to keep in mind that I do not intend to claim that the autobiographical exercise has any external validity or that the model which I will go on to construct yields conclusions which can be generalized beyond the present sample of one. Rather, in
keeping with the overall grounded theory approach which I have loosely adopted here, I urge upon the reader an attitude of skepticism according to which "[a]ll theoretical explanations, categories, hypotheses, and questions about the data, whether they come directly or indirectly from the making of comparisons, the literature, or from experience should be regarded as provisional" -- until checked out against actual data (Strauss & Corbin, 1990, p. 45).

At this point we need to recall that the second set of methodological and epistemological concerns about my study pertained to the reliability of the memories evoked in the context of the autobiographical exercise. It is indeed "very important to cross-check [nontechnical literature such as diaries, biographies, letters, videotapes and so on] against other sources of data if possible, such as interview and observation" (Strauss & Corbin, 1990, p. 55). For otherwise one can end up with unreliable information. From a naive perspective this should not apply in the case of autobiographical material from the researcher since she is the very source of the information in question. On the other hand, for the very same reason, one needs to be wary about the possibility of unconscious bias and in particular the skewing of memories in favour of particular hypotheses.

Perhaps the weakest feature of the present study is that I can offer no supporting evidence for the recollections I offer in the context of the autobiographical exercise. A scan of personal
diaries yielded little in the way of direct support, and
interviews were not possible. On the other hand, though, I would
like to offer a number of remarks intended to mitigate concerns
about the impact of this weakness on the overall study.

First of all, as for concerns about bias, I think it's
important to keep in mind that my motivation is to explore my
experience rather than test a particular hypothesis about the
relationship between gender and problem eating. Relatively
speaking, this seems to me to be a more trustworthy context in
which to evoke my own memories. We can also recall here that I
plan to use the summarized findings from the empirical studies as
a frame for the autobiographical exercise. As noted above, part
of my motivation for doing so is to provide a check against
possible bias given that I am not the source of both the
questions and the answers in that exercise.

Second, I would like to state that, rather than find a way
to prove that my memories are reliable, I am more inclined to
embrace the fact that all memories are nonveridical in the sense
that they are meaningful constructions of the past, and proceed
on that basis. Indeed, I have no doubt that many factors have
influenced my recall, including my experiences of therapy, my
development as a feminist, my training to become a therapist, my
observation of other eating-disordered women, my reading and
talking with others, and two decades of reflection on all of the
above. The rich history of this reflection and the consequent
deepening of my understanding of anorexia is in fact consciously
interwoven with my recollections in the form of interpretive remarks, especially in the second phase of the exercise.

In keeping with this point, and in light of my discussion about the virtues of autobiographical research, I take it that part of the epistemological worry about reliability is met by the fact that I have rendered (consciously-accessible) shaping factors visible. Given this, the reader has a better chance of detecting possible areas of problematic influence or bias. Moreover, I do not plan simply to report the results of the two-phased exercise in summary fashion, and to rely on the reader's trust that I have arrived at them in good faith. Rather, I have recorded the process of confronting each dimension of gender, searching for a sense of myself in a given period, and reflecting on the material that emerges. My hope is that the yields of the exercise will be sufficiently rich as to persuade the reader that, regardless of the extent to which they are conditioned by later experience, my memories are nonetheless tapping into genuine material.

A final point relates back to my discussion of the manner in which I have conceptualized this thesis. Roughly construed as the first few steps of a grounded theory approach to understanding the relationship between gender and problem eating, my primary concern in relation to the autobiographical exercise is simply to get material out on the table for model construction. Again, my recollections will not be construed as providing evidence to support or disconfirm concrete hypotheses
about this relationship. Rather, my epistemological orientation with respect to the value of this material is pragmatic. That is, I agree with Smith (1994) that "stories and ideas that one creates should be useful for solving further problems in one's professional life" (p. 302). Taking this one step further, one might say that insofar as stories and ideas are useful in this capacity, they have value. Accordingly, my perspective on the autobiographical material that I provide is that insofar as it works, then I for one will have no further motivation to question its value. That is, insofar as the recollections that I provide contribute to a model whose core hypotheses are ultimately validated in the context of future research -- and/or in the sense that they contribute to therapeutic practice -- then we don't require further assessment of their worth. Of course, final assessment of the pragmatic value of the material in question cannot be offered in this thesis. But that is of course precisely what one would expect of work at the early stages of a grounded theory approach.

Having at least attempted to address epistemological and methodological concerns that might be raised in response to my work here, I propose to turn to Chapter Four and the two-phased inquiry into aspects of my overall gender profile at the age of fifteen and in late stages of healing.
INTRODUCTION:

The main task that I have set for myself here is to explore my hunch that there is more to the relationship between gender and problem eating than has been brought to light by extant empirical research. As discussed in Chapter Three, I also wish informally to test a methodological hypothesis regarding the value of research which integrates quantitative and qualitative methods. In both cases, I will need to assess the extent to which qualitative exploration of my experience validates empirical findings but in substantive ways also transcends and enriches it. I plan to do so in the context of a qualitative, autobiographical study of my experience of anorexia. In more detail, I will first offer a brief case history and a history of my process of healing. Then I will engage in a two-phased exercise in which I will gather findings related to my gender profile at fifteen, and findings related to my gender profile in later stages of healing.

As for the specific manner in which I plan to generate this material, for the case history, I will attempt to reconstruct information about my life that a clinician would have gleaned from me at the time I was struggling with anorexia. More specifically, I will reproduce what I imagine my first therapist might have learned about me in the first few sessions with her almost one year after the onset of anorexia. I will do this in a
purely autobiographical fashion, based on my recollection of what I talked about and how I imagine she might have configured it in the format of an intake interview write-up. In contrast, the somewhat more extensive history of healing will be written in my own voice because I wanted to convey my experience and understanding of this process from the inside. The history will span twenty-two years of healing and will include a discussion of my present relationship to my body, eating, and exercise.

As for the two-phased exercise, I will simply proceed by taking on the role of a subject in a structured interview. As anticipated in the previous chapter, the subcategories of summarized results that were recorded in Figure 7 from the Literature Review will provide the frame and structure for the "interview." More specifically, I will set out each subcategory under the broader headings of "I: Gender Profile," "II: Gender Stance," and "III: Gender Profile, Gender Stance, and Conflict," including self-described trait femininity, self-described trait masculinity, valuing feminine traits and roles, valuing masculinity, and so on. Each subcategory of course corresponds to a particular aspect of overall gender profile. In the case of the four aspects just mentioned, I will further structure my discussion by making reference to a number of descriptors associated with stereotypical femininity and masculinity used in the Personal Attributes Questionnaire (PAQ; Spence & Helmreich, 1978), and Bem Sex Roles Inventory (BSRI; Bem, 1974, 1978). Use of these descriptors will make it easier and more legitimate
to compare the autobiographical material with findings from the empirical research that adopted these (or similar) measures than responses to more open-ended questions regarding whether I was feminine, masculine, and so on.

Getting back to the interview process, I will set out each aspect of overall profile and/or specific descriptor in turn, and reflect on whether, to what extent, and in what way(s) each applied to me at the age of fifteen, and at later stages of healing. And then I will record my response. As anticipated in the previous chapter, at various points in the exercise I will also elaborate my recollections by interweaving interpretive remarks.

Following the two-phased exercise, I will assess the extent to which the empirical findings reviewed in Chapter Two are supported by material that I have gathered. Despite the fact that my recollections validate this research, it will in fact be necessary to offer additional information regarding the nature of the relationship between gender and problem eating in my case. This will aid in addressing the methodological hypothesis noted above. But most importantly it will complete our preparation for the construction of a psychocultural model of the gendered nature of problem eating in Chapter Five.

BRIEF CASE HISTORY:

Demographic/Descriptive: Deborrah is a 16 year old Caucasian adolescent of Anglo-European ethnicity from a middle-class background. She appears anxious and somewhat depressed, and is
very thin and restless. She is clean but does not seem to take interest in her appearance, wearing baggy clothes and no make-up or jewelry. She is in the junior year of high school and a top student, though she shows no pride in this. She is involved in theatre in connection with her school, has some friends, and is well-liked. She is cooperative and in fact seems eager to please, relating to others more like a compliant adult than a stereotypical adolescent.

Presenting Problem: Deborrah says she has come for help because her mother is no longer able to listen to her. In particular, her mother is not willing to listen to Deborrah’s detailed descriptions of what she has eaten each day, and thinks that she needs help from someone else. Deborrah has been worried about being fat since she was about ten years old and tried for a time to restrict her eating by just bringing a piece of fruit to school for lunch. But she traces her severely restricted eating to a Spring day almost one year ago when she simply decided that she was fat and that she needed to eat less and exercise more. For almost a year she has survived on one meal a day of approximately 400 calories, with nothing for breakfast and perhaps a carrot for lunch. Her supper consists of 4 oz. of some protein source and vegetables or salad with diet dressing. She takes in no fat or carbohydrates. She drinks water, having read that even drinking diet soda you can end up taking in "a lot" of extra calories. She has an elaborate exercise routine which she practices in her room and she rides her bicycle daily, often over
great distances. She says that she has always had an ugly body with odd-shaped hips and a big round belly -- very much unlike the other girls at school. Her mother tried to get her to wear girdles to hide her stomach ever since she was a child. Now, the thought of gaining a small amount of weight terrifies her, even though she weighs only 95 pounds (at a height of 5' 4").

Deborah's parents talked with her about the prospect of entering therapy and offered to set this up for her. It took Deborah quite a few months before deciding to seek help because she didn't want to think of herself as "sick." She makes no reference to an eating problem, except to say that she knows that other people think she has lost too much weight, and that she is "going too far" because she hasn't menstruated for some time (approximately 6-7 months). While acknowledging that she has lost a "little" weight (35 pounds), she adds that she does not think it's too much. On the other hand, though, she admits to feeling quite depressed and lonely, and conflicted about socializing with others. She sometimes thinks of suicide, especially at night. And she has terrifying dreams that a woman with a knife is trying to kill her.

Family and Personal History: Deborah is the second oldest of four children who are very close in age (approximately one year apart). She has an older brother, a younger brother, and a sister who is the youngest child. Her parents are married, though their marriage has been difficult. They have been in individual and group therapy for a number of years. As a young
child, Deborrah was very close with her father, while her mother favoured the first-born son. She still idolizes her father and is in fact proud of both her parents. She describes them as "different" -- more liberal than other parents. However, Deborrah also seems hurt because her father "hasn’t been around" for a number of years, and doesn’t seem to be coming back. (When Deborrah was approximately 11 years old her father entered a Ph.D. program in Clinical Psychology and finished within three years, taking only one year off from full-time work. As a result, he has been extremely busy). Her mother is currently in university, planning to complete her B.A., and then begin an M.A. in Social Work. Neither parent seems to spend much time with the children. There is intense sibling conflict with her older brother, and disapproval of her younger brother who has been cast as the "problem child" in the family. The younger sister spends most of her time with friends.

Deborrah reports that she has always had trouble leaving home for sleepovers or, even as a child, going to friends’ houses to play. She spends most of her time at home doing schoolwork, riding her bicycle, cooking for the family, collecting recipes, exercising, and listening to Beethoven. She has contact with friends, but mostly in connection with the theatre and music productions put on by her school. She is also vice-president of her class but hates going to the meetings. She used to take ballet lessons and plays the cello in the school orchestra. She also sings in the chorus. But she doesn’t take much pleasure in
these sorts of activities since she is always terribly anxious about doing well. In fact her life is pervaded with anxiety about doing well, especially in school. Her father told her as a child that it is a mistake to try to be perfect, and she tries hard not to care so much. But "not caring so much" seems artificial and she finds it easier to keep pushing herself.

**Preliminary Diagnosis:** Deborrah appears to be struggling with anorexia nervosa, restricting type. She is burdened with tremendous anxiety, including difficulties with separation and a relentless drive toward perfection. It appears that she attempts to manage her anxiety by controlling her eating and her body and by staying on the straight and narrow path of keeping up with her schoolwork and extracurricular activities. However, she is also depressed since her accomplishments and her involvement in these activities bring her no relief and little pleasure. Her depression may also be related to the loss of a close relationship with her father, especially given the remoteness and even hostility that she encounters in her relationship with her mother.

**BRIEF HISTORY OF HEALING/PRESENT STATUS:**

I entered therapy with a female psychodynamically-oriented clinical psychologist at the age of 16, almost one year after the onset of my anorexia. The focus of that therapy was not my eating disorder (indeed, we hardly ever talked about it, and my problems weren't framed as such), but rather my relationship with my father. I expressed a great deal of anger about the way he
had (in my perception) abandoned me. My therapist was able to validate both the fact that I was angry, and the specific anger that I felt toward my father. I think that the fact that she had room for me to feel at all was the most significant factor in this therapy. But we also talked about and implemented specific ways to try to re-build my relationship with my father and regain what had been lost in recent years. I began eating again within a few months and gained a fair bit of weight during my last year of high school. My menstrual periods also resumed. I was in therapy for a total of 18 months, terminating in order to go away to university.

I was no longer depressed by the time I started university at a small Liberal Arts university in Western New York State. In fact, I was able to live quite far from home (an eight hour drive), and I was usually extremely happy. On the other hand, though, I was still underweight for the first two years. I was concerned about not eating too much, and anxious about the fact that I seemed to be losing absolute control over my eating. I still compulsively counted calories and restricted my intake to 1500 calories each day (which seemed like a lot). I also experienced hunger, but was so absorbed in my studies and in socializing that it was fairly easy to distract myself from it. And there was still a sense of pleasure and something like moral virtue in being thin and not my "fat" former self. I enjoyed riding my bicycle and also began jogging at some point in my first year.
I believe that I started to grow in height when I gained quite a bit of weight at the age of twenty in my third year. In the middle of that year I joined my boyfriend at an enormous Midwestern university, and turned to food for comfort given the stress, anxiety, and loneliness that I experienced in that transition. This was also the year that I began to learn about feminism. I had heard a bit about it the previous year, but turned down an invitation to join a study group. I had been happy focusing on my courses in philosophy, religion, and history. But more importantly, I also experienced quite a bit of anxiety regarding feminism. I had always been more comfortable in the company of men and often found myself feeling competitive with, and threatened by, other women. Feminism seemed to have something to do with really caring about other women, and I was confused about what this could mean and concerned about what I would be required to do. However, at U. W.- Madison, I was exposed to feminism (and Marxism) on a more intellectual plane, and I think I experienced this as much less threatening and anxiety-provoking. As a result, I began to develop a critical perspective on many features of North America's capitalist, patriarchal, racist, and homophobic society. With respect to my own issues, I also began to understand and question the oppressive values that I had internalized related to eating and my body.

Upon returning to my own university the following fall, some people noted that I had gained weight and I experienced shame and
quite a bit of discomfort in response. So I fell into my earlier pattern of studying and keeping busy. My knees were wearing out from running so I began to swim regularly. And I eventually slimmed down again. I graduated early and rejoined my boyfriend at U.W.- Madison. For the twenty months that I remained there, my understanding of feminism and my commitment to changing the situation of women deepened. Although the feminist political circle there was quite radical, my earlier sense of estrangement and anxiety regarding other women gradually lessened over time. I attribute this change to three factors. First, I was having a great deal of contact with all sorts of women, and my life was much less male-oriented than it had ever been before. Second, I had a wonderful M.A. supervisor in the Philosophy Department who respected women (including me!) and showed a clear desire to support and mentor me, not only because I was her student, but also and maybe even especially because I was a woman. Third, I worked at a food co-op which was owned and managed by a group of lesbian women. Working with these women I learned that women can actually love other women. That is, I found myself in the midst of women who were not anxious about, threatened by, or in competition with other women. Rather, they respected, deeply valued, and loved each other.

I recall that during this time, I had very little money for food. However, I was also quite hungry because by this time I really enjoyed swimming in addition to walking or cycling to get around. I remember eating a great deal of peanut butter each
day, feeling bad about that, and then trying hard not to eat much else. But then I would be hungry again the next day and eat too much peanut butter and so on in a kind of cycle. It got to be a pattern. I gained weight and actually felt quite "chunky" by the time I was ready to leave Madison and go to Toronto for another round of graduate school.

In Toronto, I became close friends with a woman, really for the first time in my life. At this point, I was 23 years old. I eventually became fairly slender again, still compulsively counting calories, restricting my eating, and exercising (the last, however, with great enjoyment and enthusiasm). I would say that at this time and really for the next ten years, I was busy and active enough to eat well and to remain fairly slim. Despite my feminism and everything that I had learned, I still valued being on the slender side. And I still felt larger and somewhat misshapen, especially in contrast with other women in the aerobics classes at the university. I couldn’t do anything about the shape of my body, but at least I could keep it as fit as possible, without going overboard again.

I believe that in large measure I was dealing with a great deal of anxiety in my life by managing my body in these ways. After about three years in Toronto I started therapy again, this time with a more Jungian-oriented therapist. Our focus was my relationship with my mother as well as my own femininity, which were both negative and characterized by hostility and rejection. This was revolutionary for me since my first course of therapy
had focused on my relationship with my father; it had not even occurred to me (nor, perhaps, to my first therapist) to look at my relationship with my mother. As a result, in this therapy (which lasted about two years) a great source of pain and anxiety within my own personal history became clear to me. I learned how my mother's negative sort of masculinity and lack of connectedness with her female side created within me an aggressive, critical, negative Animus who had run me ragged my whole life. I also began to learn how to tame this Animus and to value and even love my female self. In my relationship with this therapist, I also began to open myself to the possibility that other women might welcome me as a woman into their lives. It was time to see that I could also include myself within the circle of these powerful, beautiful, and somewhat mysterious female creatures. And it was this therapist who invited me into this world, much in the way that I imagine some mothers do with their daughters.

Over the next seven years, I began to understand and integrate more of what my last course of therapy had taught me and I became more able to act on it. I was finally able to choose and marry a (male) partner who loves me for who I am. I also changed careers, and bit by bit have learned to be in touch with my own needs and to make decisions based on those needs. But I believe that the most radical factor contributing to the last and most recent phase of healing over the past five years was the birth of my child. For one thing, despite a horrific
case of hyperemesis gravidarum, I was thrilled to be pregnant and enjoyed the many changes in my body. Indeed, I was completely in awe of my body and its ability to grow a baby and then push it out into the world. I just couldn’t get over how amazing and fulfilling this was and I felt very, very connected with my own femaleness and with other women. Carrying a child and giving birth was like a ritual which made concrete what my therapist had taught me about being a woman. And I experienced in a deep and primitive way the sense of belonging within the circle.

Equally significantly I found that I loved being a mother. I had always planned to have children and I had always enjoyed being with children, but I had also always feared that the actual experience of childrearing was going to be onerous: tedious, exhausting, oppressive. I suppose that this was my perception of my own mother’s experience. But to my delight I found that I loved being with my son and that for me, while childrearing is difficult and challenging, it is also wonderfully rewarding and fulfilling. So of course I experienced tremendous relief and joy.

Moreover, my son was a great model of how one can relate to food and eating in a simple and natural way. Basically, he taught me that if you’re hungry, you eat. And that’s all. One day when my son was probably about a year old, I realized that it had been quite some time since I had last tallied up my calories for the day -- I wasn’t even sure how many weeks or months it had
been since I had done that. I also noticed that I was eating when I was hungry. And that was all. And that I was exercising when it felt good, and not compulsively. In short, I was released from concerns about food, eating, and exercise that had pervaded my life for eighteen years.

Four years later, I find that my relationship to food, eating, and exercise is very simple and natural. I have not counted calories or restricted my eating. I have grown to accept the shape and size of my body and even to feel protective of and loving toward it. At some point, I was fortunate to discover that the shape of my hips is something I share with millions of other women and that it is known as "the violin deformity" among those who deem themselves fit to appraise women's bodies. This bit of information filled me with rage as I have never seen an image of a woman with hips like mine -- not in advertisements or films or at the beach or even in the locker room. But while I was angry, I also felt liberated by this knowledge. Now I knew that there were millions of women like me, and I could feel a great solidarity with them. I also understood with much greater depth the situation of girls and women of colour, lesbians, older women, and poor women who similarly do not meet images of themselves in their surround and who as a result can internalize great self-hatred. Fortunately for me, my oppression was limited to the shape of my body; I had been trained to believe that this was something that I could and should alter. But now I saw that the crime did not lie with my body or my inability to reshape it,
but rather with all the industries which have greatly profited from teaching women like me that it is our responsibility to use their products and services because we will otherwise never be adequate women.

To be honest, I can say that if I had a choice, I would pick an hourglass shape over violin hips, and I would pick a flatter stomach. But I have also decided that Nature gave me this body and that I have been able to do quite wonderful things because of it. So I trust Her judgment. At this point, I am friends with my body, and I want to do well by it. So, despite the fact that I eat far more chocolate than is healthy, I otherwise manage to nourish my body well. I still exercise but for the sheer pleasure of it, and on a much smaller scale than I used to. And I haven’t done a situp in years. All of this enhances rather than depletes my energy, and certainly reduces my stress. And I can say that I am a happy woman.

EXPLORATORY EXERCISE

I plan to draw from and elaborate the history that I have just related in order to engage the summary of findings in the Literature Review regarding the relationship between gender and problem eating. Specifically, I will (with only minor alterations) be working with the representation of this summary as it is depicted in Figure 7 in Chapter Two (see p. 80). In the first phase of this exercise, I will use this frame to articulate my overall gender profile at the age of onset of my anorexia (fifteen), and in the second phase I will describe my overall
profile in later stages of healing within recent years.

Overall Profile at 15/ Age of Onset:

1. **Self-described trait femininity:** Throughout my childhood and certainly still at the age of fifteen, I would have described myself as quintessentially stereotypically feminine. That is, I was very concerned with the well-being of others, understanding, sensitive, expressive, attuned to others’ needs, emotional, and warm. Drawing from items on the BSRI and the PAQ (see above, p. 103), I can add that I liked children, had a strong conscience, enjoyed art and music, and that I was considerate, grateful, tactful, helpful, kind, neat in habits, affectionate, (outwardly) cheerful, compassionate, yielding to the point of submissiveness, eager to soothe hurt feelings (and smooth over differences), home-oriented, on the quiet side, adverse to using harsh language (in public), and needful of others’ approval. I also had feelings that were easily hurt, a low mechanical aptitude, and a strong need for security.

With respect to the needs for approval and security, I would like to explain further that I depended almost exclusively on the reactions of others (or my anticipation of how others might react) in order to get a sense of what I should do and who I needed to be. In related fashion, I lacked the substance even to be able to discern what I wanted or needed on my own terms, much less to actually express my needs and desires, and still less to put the slightest pressure on anyone to actually meet them. In fact, it was much easier to train my attention on the needs of
others. And so while I became exquisitely skilled at perceiving the needs, desires, emotions, judgments, perceptions, and anxieties of others, I would go completely blank if called upon to articulate my own -- especially in the case of needs, desires, and emotions.

In contrast, some traits measured on the PAQ and BSRI would not particularly have applied. That is, I would not say that I was childlike (in fact, quite the contrary), flatterable, gullible, shy, soft spoken, creative, religious, or apt to cry easily. And while I recall experiencing intense anxiety about math and science, I wouldn't say that I disliked them outright. Perhaps most significantly, though, it is useful to recall from Chapter Two the dimension of concern about appearance that Timko, Striegel-Moore, Silverstein, and Rodin (1987) introduced as a component of gendered femininity (see above, p. 40). I would like to highlight here that this feature did not apply to me. As noted in the Case History I was clean and groomed well enough, but I wore baggy clothing and didn't take interest in appearing attractive. I was concerned to be slender in part because this was a kind of minimal requirement for acceptance -- being fat meant guaranteed rejection. But even if I lived alone on a desert isle where no one would ever see me, I would have pursued thinness. It was for me a reflection of a way of being, a way that I was trying to live -- not a way to entertain the gaze of others.  

2. Self-described trait masculinity: Referring once again to
attributes measured by the BSRI and the PAQ, at the age of fifteen I was ambitious, analytical, competitive (though I kept this to myself), somewhat outgoing, active, and intellectual. I also had some leadership qualities and took some pleasure in studying certain areas in math and science. On the other hand, I was not aggressive, assertive, able to defend my own beliefs, dominant, forceful, independent, individualistic, able to make decisions easily, self-reliant, self-sufficient, able to act as a leader, worldly, willing to take a stand, willing to take risks, good at sports, indifferent to others' approval, tough-skinned, adventurous, outspoken, interested in sex, self-confident, or forward. I also did not have a strong personality or high mechanical aptitude, I didn't stand up well under pressure, I didn't feel superior to others, I was in some ways easily influenced by others, and I gave up fairly easily in non-academic areas.

3. (Positive) Valuational stance toward feminine traits and roles: Throughout my childhood and adolescence, I would have described myself as valuing almost all of the feminine traits noted above. I thought it was good to be thoughtful, kind, warm, and so on. Besides, I was rewarded by my family, teachers, friends, and even strangers for being feminine in these ways. Those traits that I did not value can all be drawn from the list of traits that did not apply to me (i.e., shyness, gullibility, being child-like). Interestingly, these are precisely the traits that my parents would not have found appealing. Given my
orientation toward others, and my intense need for approval, it is no surprise that I did not value or develop these traits. The only exception relates to creativity, which I would most certainly have valued. However, I also know that I was far too anxiously perfectionistic and concerned with doing everything the "right" way to have been able to "let go" and create anything at all.

In the case of female roles, I am certain that at the age of fifteen I would have reported that I planned to marry at some point and have children. I was well trained by my mother in all things domestic (cooking, cleaning, shopping, laundry, childcare, keeping contact with relatives, planning and preparing for gatherings, gardening, and so on) and would have reported that I would take up these tasks as well, on the model of my mother. However, also on the model of my mother, I planned to attend university and have some sort of career. In short, I would have anticipated the superwoman track for my future that I watched my mother cultivate over the years.

4. Valuing/Aspiring toward masculinity: At fifteen, I shunned such traits as a sense of superiority over others, aggressiveness, forcefulness, and dominance. These were completely at odds with the feminine gentleness that I valued. However, I would also have reported that the remaining masculine traits are of great value. Indeed I recall esteeming others who were assertive, athletic, self-reliant, independent, willing to take risks, and so on. Boys seem to come by these traits more
easily so I especially admired girls (real and in fiction) who somehow managed to be so...solid.

Interestingly, I believe that as a younger child, and especially within my family, I actually exhibited a number of masculine traits such as confidence, leadership, and assertiveness. I was also able to draw on this experience to take on leadership roles in certain contexts and to cultivate a kind of outgoing personality. I relate all of this to the close relationship I had with my father at the time, and with the ways in which I must have identified with him. However, at some point, I seem to have retreated to a more purely feminine-gendered profile. It is difficult to be certain about the reasons for this shift. For one thing, by the age of fifteen I was quite depressed and that in itself could account for the change. On the other hand, though, I think that at some level I believed that it was not wholly appropriate to maintain these traits as I approached adolescence and adulthood.

It is likely that this belief was related to societal and familial messages that I was receiving about gender. First, I was certainly getting the message from society that it was not going to be enough to be a "nice girl" my whole life, and that I should toughen-up. However, I suspect that I was also learning vicariously and through a number of sources that girls and women oughtn’t be too confident, too assertive, too self-reliant, and so on. For example, it is clear to me now that the heroine of any given story or film is always smart, "together," and
assertive, but she is also always warm and caring and mindful of stepping on male toes. The "bitch" is her foil -- a woman who needs to be taught a lesson about overstepping the bounds of her gender or the domain of men. And while I would not have been able to articulate this observation at the age of fifteen, I think it's reasonable to assume that I got the point.

The second association I have with this belief concerns a familiar and severe rebuke from my mother that I "had better not get too big for my britches." In my perception, this meant that more masculine traits like assertiveness and having a strong personality were not welcome features of my personality at home. I also recall my mother's biting, vitriolic remarks about women who were "too full of themselves" -- which I surmise made reference to self-confident women with high self-esteem. It is also important to recall from the Case History that by this time, my father had in large part withdrawn from my life. As a result I would have been deprived of a model for these masculine traits, and lacking support for their manifestation in me.

In sum, it seems that my relationship to masculine traits would have been ambivalent and related to internal conflict. On the one hand, I greatly valued and esteemed their manifestation in others, and I was aware that I needed to be more independent, decisive, and assertive. On the other hand, I lacked a sense of permission and in fact experienced pressure not to be masculine in these and related respects -- at least not as an adolescent or as a woman. It is telling in this context that I never
relinquished those masculine traits associated with school and achievement which had given me a sense of accomplishment and value as a younger child. Thus I remained ambitious, competitive, intellectually-oriented, somewhat outgoing, and so on. But, once again, my orientation toward interpersonally-related masculine traits was fraught with ambivalence and conflict. Interestingly, as Bruch (1973) would say, in this way anorexia might have been a retreat from adolescence which allowed me to maintain a safe and familiar mode of existence. In short, I was perhaps attempting to hold onto that which I had permission to be as a child rather than face ambivalence and conflict related to moving on in my development into adolescence.

5. Rejection of femininity:

Some preliminary remarks must be made before I can describe the ways in which I rejected femininity at the age of fifteen. In the discussion of results in the Literature Review related to II: Gender Stance, I argued that rejecting femininity and valuing femininity are compatible on the basis of three distinct arguments. Based on this discussion, I will review and elaborate three different interpretations of 'rejecting femininity.' On one interpretation [which I will hereafter refer to as (i)], girls or women could ostensibly value feminine traits like gentleness and sensitivity, but at a deeper level entertain serious doubts about their ultimate worth. It seems likely that these doubts are related to society's double-binding messages about gender. As the reader may recall, these messages contain
the requirement that girls and women manifest traits and roles which are associated with femininity but systematically devalued. They also contain the information that traits and roles associated with masculinity are highly valuable but only unconditionally acceptable for boys and men to manifest. From a feminist perspective, the paradox at the centre of the double bind is that to be what society will value a woman for is not the same as being what society values. If a woman steps out of bounds and becomes more like a man, there is often a price to pay in terms of some kind of rebuke or retribution. On the other hand, if a woman stays within bounds and becomes a stereotypically feminine woman she may pay the price of having low self-esteem or being plagued with depression. In this context, it is no wonder that at least some women end up caught between being feminine and questioning the worth of their femininity.

On a second interpretation of rejecting femininity [(ii)], girls and women adopt a bipolar stance with respect to masculinity and femininity in such a way as to embrace the former and disavow the latter. This stance can be understood as an attempt to resolve the paradox posed by the double bind by embracing the societal message. That is, girls and women with a bipolar orientation toward gender absorb the values of society, shunning what it shuns and aspiring toward what it esteems. Conflict is in a sense resolved since these girls and women no longer identify themselves with that which is devalued. As noted
in Chapter Two, Silverstein and Perdue (1988) observed that women who emphasize stereotypical masculine concerns about intelligence and success seem to play this out in their bodies. Thus they renounce their feminine curvaceous bodies for streamlined and angular masculine ones, hoping to appear confident and successful.

As we have previously noted, bipolarity also appears to be operating in the context of discussing Steiner-Adair's work on what I have termed "renunciatory superwomanhood." As noted in Chapter Two, [see p. 49, (46)], girls assessed by Steiner-Adair give up their feminine ways of relating to others via connectedness and interdependence in exchange for masculine-gendered autonomy and independence. She believes that this creates tremendous inner conflict because it runs up against ways of being that have been central in the lives of these girls and women. Nonetheless, as indicated above, I believe that the route taken by the renunciatory superwoman can be read as an attempt to resolve conflict since it provides distance from that which is devalued and allows one to identify with what is esteemed.

On a third and final interpretation [(iii)], rejecting femininity reflects a distinct and separate aspect of a girl's or woman's orientation toward femininity than her valuational stance toward feminine traits. Relating this to a clinically-based finding of Bruch [see p. 49, (48)], I argued that this may be related to a retreat from female adolescence. I also noted that this is compatible with valuing feminine traits. For while a
given girl or woman might for example value interpersonal warmth, she could still reject one or more aspects of being or becoming a female adolescent. This interpretation of rejecting femininity may relate to my conjecture that I had retreated from cultivating certain masculine traits beyond the developmental stage of childhood (see above, pp. 122-123). I seemed to have chosen to remain where I was, manifesting only child-size and (in my perception) acceptable sorts of masculine traits. This raises the possibility that something similar is operating in relation to rejecting femininity. That is, it may be that whereas feminine traits (and possibly also roles) associated with childhood are acceptable to the anorexic, cultivating other feminine traits and roles within the developmental stage of adolescence is not. If so, then in exploring this issue with any given anorexic, it would be fruitful to key the question whether femininity is valued to distinct developmental periods.

Having completed this review, I would like to invoke these three interpretations to help structure my discussion of the nature of my own rejecting stance toward femininity at the age of fifteen. Regarding (i), as noted above, throughout my childhood and continuing into adolescence, I was extremely feminine-gendered and valued most of my feminine traits. However, in relation to the first "double-bind" interpretation of rejecting femininity -- or perhaps more accurately, calling into question its value, I can say that I was not without anxiety or doubt regarding this aspect of my personality. Moreover, I am certain
that I was aware of the double-bind, especially as related to women's roles. Beginning with the first point, I want to elaborate something I said earlier regarding my self-described femininity and the experience of "going blank" when called upon to articulate my own needs, desires, emotions, judgments, and so on. I recall being seized with anxiety in part because I was unable to answer, but also -- and I find it difficult to tease out this thread -- because I felt that I should be someone who is substantial enough to answer. Surely (I must have thought) my interlocutor had by virtue of his or her query shared this judgment and (I must also have thought) my ineptitude would no doubt evoke disapproval. But at the same time, at some level I would also have been anxious that having the ability to reply in the manner required would have violated all the precepts according to which I interacted with others. Having surmised this much I can vividly remember saying things like "You decide" or "I really don't know" or "I don't care, really." Every once in a great while someone -- always a man -- would not let me get away with this: "What do you mean you don't know what you want, how could you not know?" And, not having an answer to these questions, but also having told the truth, I could only squirm with discomfort and hope that he would let it go. The other's frustration and clear disapproval of my manner at first puzzled me since I thought I'd done my job. But over time these sorts of responses made me question the value of being so nice.

Two other immediate associations I have with this theme of
double-bind-related conflict regarding my own femininity concern more specific memories. When I was in grade school, I recall that my mother picked me up at a friend's house. I told her that I found it really tiring to be with other people, and she replied that the reason I was so tired is that I was too nice to other people. I thought this was a strange thing for a mother to say, and that's probably why I remember it. A few years later at a sleepover party and during a "tell one thing you like and one thing you don't like about each friend" sort of game, I recall being on the hotseat. Each friend told me that I was just right in every way except that I was too nice. I remember thinking that if this was the criticism that I had to live with, it wasn't so bad. I mean, you were supposed to be nice, so how bad an offense could this be? But the idea gnawed away at me. As noted above, I admired other girls who had more substance and confidence than I did. They seemed more alive and certainly much happier than me. But I also in a sense feared them and what they represented to me. I felt a kind of pressure, a sense that I should be more like them, but I couldn't imagine how I could cultivate that kind of substantiality in myself. And I saw it as completely at odds with who I was and what had so far made me feel well-liked by others, and safe. And thus while I didn't at this point outright reject my feminine traits, the ground was being laid for doubt about their worth in others' eyes -- and hence my own, given the very nature of the femininity that I was beginning to call into question.
A final association in relation to the double-bind concerns the case of roles. I recall writing an essay on the socialization of women at some point in high school. This must have influenced me, especially as I watched my mother’s career evolve from full-time mother and housewife; to part-time nurse and full-time mother and housewife; and then full-time student, mother, and housewife. For at the age of fifteen, I am certain that I would have stated that I would not value "only" being a traditional wife and mother. These were roles that I would have anticipated, but only in combination with a career. Otherwise, as I believe I would have stated, a woman is trapped. I’m certain that this statement was related to my awareness of my mother’s depression (I think she was depressed for much of my childhood). It is likely that on some level I associated this with her roles of mother and housewife, especially given the fact that she was much happier once she began to attend university. Once again, though, I did not renounce traditional roles, but rather planned to supplement them with post-secondary education and the development of a career.

Turning to the second interpretation of rejecting femininity [(ii)], it might be surprising that I can strongly relate to the dimension of rejecting femininity related to bipolarity. That is, I believe that at fifteen, I was precisely engaged in a bipolar striving after masculinity while rejecting key aspects of femininity. Given my terrific anxiety about cultivating masculinity, my extremely feminine-gendered personality, my
nascent doubts about the worth of my femininity, my understanding of the manner in which masculinity is esteemed, and my other-oriented and perfectionistic sense that I must become what others valued, it strikes me that I must indeed have been beside myself. However, I don't recall being consciously conflicted -- as evinced by the minimal associations I have with the theme of the double bind.

On the other hand, though, it makes sense to me that the manner in which I attempted to resolve inner conflict related to the double bind was via the unconscious embrace of bipolarity. For, given my earlier close relationship with my father and my difficult relationship with my mother, I think that insofar as the bipolar route to reducing conflict was in some sense offered to me, I would have seized on it. Again, Silverstein and Perdue (1988) note that such an offer is available to girls and women, and at least some of us readily seize it. On their thinking, the curvaceous feminine body is rejected in favour of a streamlined, masculine, intelligence-and-success-exuding body. In this way we are able to cultivate masculinity in a non-threatening fashion, and at the same reject devalued femininity in favour of culturally acceptable "feminine" slenderness.

Finally, in terms of (iii), I can certainly relate to the idea that I was resisting the cultivation of femininity within the developmental stage of adolescence. First of all, I wasn't even a typical adolescent. I didn't listen to contemporary music, or smoke, or go to parties and rock concerts, or
experiment with drugs. With respect to femininity in particular, I was becoming aware that it wasn't going to be enough to achieve academically anymore -- in fact, I would probably have to abandon this to some extent in order to be considered feminine. But I resisted change. Moreover, I was aware that success and accomplishment were going to be measured in terms of the question whether or not I had a boyfriend. But I also very much resisted the idea that I was no longer supposed to regard boys as "just friends," but rather as potential boyfriends.

Despite my strong resistance to fulfilling social requirements for female adolescents, though, I was still confused and conflicted. When I was younger I had crushes on boys but I think that at fifteen I was too anxious to allow myself to have much in the way of feeling for them. I also anticipated later sexual relationships with a great sense of uneasiness and discomfort, preferring to think of my sexuality as something that would develop in the distant future. As a result, I found it very difficult to relate to the jokes, secrets, conspiracies, adventures, and longings of my female friends. They were apparently consumed with the projects of finding, keeping, dealing with, or leaving their boyfriends. And while I was happy to be involved in a supportive role from the sidelines, for my part their experiences seemed worlds away. Even when I attempted to enter that world -- I went on a couple of dates and was invited to a couple of proms -- I was just miserably uncomfortable.
I think it is important to notice that I associate this mode of rejecting femininity primarily with roles rather than traits, where the roles are linked to a specific developmental period. With respect to development and as noted earlier, at the age of fifteen I would have stated that I fully intended to marry a man, have children, and so on -- all roles associated with adult, heterosexual women. And I was certainly comfortable remaining a child. But all of that was either in the future or the past to which I clung, and at the time I was very busy avoiding roles related to typical female adolescence. These roles most prominently including those of girlfriend and future sexual partner. As for traits, I did not renounce or distance myself from such stereotypical traits as warmth or sensitivity to others' needs. But upon reflection I can say that traits associated with typical female adolescent roles did not appeal to me. For me, these would have included "giggly vapidity," great concern with appearance (clothing, makeup, hair, fingernails, and so on), a casual attitude toward school, and distancing oneself from adults (teachers, parents) in the context of a derisive or angry stance. Rather, I was mature in the mode of a pseudo-adult, completely unconcerned with my appearance beyond the basics of cleanliness, a serious student, and very much oriented toward adults and getting approval from them.

6. Valuing renunciatory superwomanhood:

Any remarks I could make here would overlap completely with those related to the bipolar rejection of femininity, and so I
will simply turn to the next category related to superwomanhood.

7. **Valuing multi-role superwomanhood:**

As indicated above, I believe that adopting a bipolar stance which values masculinity and rejects femininity (either in the general sense of traits and roles, or within the context of a particular developmental period) can be construed as a way of attempting to resolve conflict related to the double bind. I also construe valuing and adopting multi-role superwomanhood as a response to the double bind. However, instead of splitting off and dissociating oneself from that which is devalued by society, on this path one embraces and pursues both that which is degraded and that which is valued. I think this option is more likely to be pursued than bipolarity when a given girl or woman strongly identifies herself in relation to traditional female roles, and thus can embrace them without undue conflict. If she also pursues masculine roles, she has adopted multi-role superwomanhood.

Insofar as the above applies to the anticipation of adult roles, this was precisely my orientation. As I have already mentioned at various points above, by the age of fifteen I was committed to taking on (in the future) the traditional roles of a heterosexual woman in the future (including marriage to a man, and bearing and raising children), as well as the more traditionally masculine path of pursuing post-secondary education and some sort of career. In keeping with my hypothesis as to why girls or women choose this option, I think that I identified with
my mother in such a way that I couldn't imagine not following in her footsteps regarding traditional roles. But in my case, I also had in my mother an actual positive role model for superwomanhood. For I watched her transformation from a depressed and resentful housewife to an energetic and happy woman when she began university (maintaining, of course, all her other roles and duties). Finally, since the superwoman path seemed to be esteemed by the world at large, I had even more reason to pursue it.

On the other hand, though, there is another dimension to the pursuit of multi-role superwomanhood that I need to describe. For at least in my own case there was a difference between anticipating adult roles and living stereotypical adolescent roles: I embraced the former and avoided the latter. Accordingly, while there is a sense in which I might have appeared to be a kind of proto-superwoman even in adolescence, this doesn't mean that I was an adolescent superwoman. That is, I pursued a number of different activities related to music, dance, theatre, academics, ecology, student government, various competitions, and physical fitness. But the first thing to note is that part of this was related to the fact that I was driven by a relentless perfectionism according to which a perfect person would do many things and excel at all of them. Along with the perfectionism came a strong sense of accountability. I took myself to be someone who had to do all these things well, and I took it that any failure would reflect my worth as a person.
Unfortunately, though, being driven by a sense of what I should do rather than by desire yielded little pleasure. So whereas failure (i.e., lack of total success) would devastate me, achievement itself left me cold. Indeed, my life was pervaded by a great sense of emptiness with just a raw kind of striving to keep me going.

My point here is that busying myself with a range of activities did not necessarily render me an adolescent superwoman, in part because I was operating on the basis of a relentless perfectionism. A second reason why the frenetic engagement in a range of activities did not make me an adolescent superwoman is that I didn’t embody many central aspects of typical adolescent feminine and masculine traits and roles. Rather, I delayed cultivation of both interpersonal masculine skills and the development of my adolescent female (hetero)sexuality. Indeed, if anything, my dogged pursuit of well-roundedness served as a smokescreen which distracted others as well as myself from the fact that I remained a child in the comfortable roles of academically-oriented yet also seemingly outgoing student, and adult-pleasing, feminine-gendered, and seemingly mature girl. In this way my resistance to far more difficult developmental challenges could go unnoticed.

8. Combinations of gender profiles and/or stances:

The most important feature of the summarized results in the last two columns of Figure 7 is that they begin to make explicit the ways in which previously-described aspects of gender can be
combined. My remarks here will be brief, given that the components of each combination have for the most part already been discussed.

The basic principle that operates here is that the larger the gap between what a person is and what she wants or thinks she needs to be, the more stress and conflict she is likely to experience -- at least on some level. In my own case, there is no doubt that the fact that I was, so to speak, hypomasculine and hyperfeminine made it far more difficult to manage society's supervaluation of masculinity and devaluation of femininity, and the resultant sense of pressure to adjust my personality accordingly. Indeed, I have described the disparity between my own awareness about what was required or expected of me and what I was capable of accomplishing. Thus my experience resonates with all of the formulations summarized in relation to combining low-level masculinity with aspiring toward masculinity; combining self-described (hyper)femininity and one's own or others' devaluation of femininity; and (in my case) being feminine and perceiving a deficit in terms of my ability to manifest more masculine traits. In similar fashion, my experience resonates with all the conjectured possibilities offered in Figure 7 from Chapter Two. There is thus no doubt that the presence of combinations of antagonistic gender features increased conflict and stress in my case.

It seems that my overall gender profile at the age of fifteen would have included every element accessed by the studies
analyzed in the Literature Review. More specifically, I believe that on the level of trait profile, I would have been assessed as having an extremely feminine and low-level masculine personality at the age of fifteen. Regarding gender stance, I think it would have emerged that I valued feminine traits and roles, that I valued masculine traits; that I either doubted or rejected aspects of my femininity; that I valued multi-role superwomanhood; and, in the context of the bipolar rejection of femininity, that I valued renunciatory superwomanhood. With respect to combinations of profiles and stances, I also believe that conflict would have been salient in relation to gaps between who I was and who I thought I should be. However, I would like to turn to the second phase of the exercise before offering a full assessment of these findings.

Overall Profile in Late Stages of Healing:

We now turn to the relationship between facets of gender and problem eating in recent stages of my healing. Once again, I will invoke the frame set up in Figure 7 in Chapter Two, and I will naturally be making reference to the material that emerged in the first phase of this exercise.

1a. **Self-described trait femininity:** Such core traits as sensitivity, concern for the well-being of others, warmth, helpfulness, and so on are still part of my personality. Moreover, with the exception of creativity and concern for appearance, traits that did not apply earlier still do not apply. Regarding these exceptions, I am more creative -- or perhaps I
should say, less self-conscious and more excited about exploring my creativity than before. And in the past few years have learned to take a bit more care about my appearance in certain contexts -- even to take some pleasure in trying to look nice.

On the other hand, though, there has also been dramatic change in the direction of being less stereotypically feminine. And here I refer to the fact that I am much more "pulled in" -- less extended toward others -- than I was before. There are many aspects of this change which I will attempt to describe. For one thing, when I was fifteen and for many, many years after I had no trouble being utterly attuned to others. I simply jumped into another person's psyche and expressed what was there. But I am not able to do this any longer. If I want to discern someone's feelings, thoughts, desires, judgments, and so on, I have to go through the medium of my own experience. On the same theme, I do not depend on the (actual or anticipated) reactions of others to determine what I should do or who I need to be. For the most part I do what I need or want to do and I am who I am. And I have no trouble getting in touch with what I'm feeling, perceiving, thinking, and so on. It can take some time to separate what I need for myself from what others need (sometimes if someone needs something, I'm still inclined to make it my need that theirs be fulfilled, but I can usually identify my own needs without too much difficulty). Finally, I don't force myself to be outwardly cheerful when my mood doesn't match. Rather than mold myself to what will be pleasing to others, I feel what I
need to feel.

2a. **Self-described trait masculinity:** I have a much stronger personality in recent years than I did as a young woman. I retained the school-related features that I manifested at the age of fifteen, but have also cultivated much more assertiveness, independence, self-reliance, willingness to take risks (including interpersonal ones), self-confidence, and so on. Interestingly enough, I associate these changes with those made in the previous category in relation to being more "pulled in" and centered in myself. In fact it seems that change within this category is very much the other side of the coin of what transpired in the case of self-described femininity. For as I have become somewhat less stereotypically feminine, I have also become somewhat more stereotypically masculine.

3a. **(Positive) Valuational stance toward feminine traits and roles:** Over the course of my history of healing, I have continued to value most stereotypical feminine traits. Nonetheless, it is clear to me now that throughout childhood and adolescence my orientation was far too drastically skewed toward others and away from myself. For example, it is one thing to be open to others' input and flexible, but it is quite another to shape oneself in accordance with others' input and to yield to the point of submissiveness. I also regard my past inability to know what I needed or even what I was feeling as downright frightening -- I can hardly believe it was real. Indeed, I look back on myself at that time with a mixture of compassion and astonishment. In any
case, my point here is that while I believe that it is good to be affectionate, attuned to others, compassionate, and so on, I do not value the way in which I manifested these and other traits as an adolescent and as a young woman.

Briefly expanding this discussion, though, I would first like to note that different sorts of feminism played a key role in bringing about this shift. As my liberal feminist consciousness was raised, I came to develop a critical perspective on the nature and use of feminine traits within patriarchal societies. I became angry and resentful at the way in which stereotypically feminine girls and women can be exploited given our other-orientedness and caring nature. I saw how this worked in my own life and in the lives of countless women friends and students. On the other hand, though, I was not inclined to reject feminine traits in themselves; being feminine was a part of my personality that I could not simply leave behind. Moreover, despite the essentialism and other problems that go along with it, I must say that I derived great comfort, support, and inspiration from cultural feminism. Indeed, this brand of feminism struck at the heart of the double bind, teaching me to revalue stereotypically feminine ways of relating to others, and to perceive that masculine ways of relating to oneself, other people, and the earth can lead to destruction.

Further support for this perspective came from the therapist with whom I worked in Toronto in my early twenties. As I briefly indicated in the "History of Healing," this woman welcomed me
into womanhood. Here I can related that she did this in part by sharing her own cultural feminist values, in conjunction with her Jungian orientation. In response to both strands of feminism, and to my experience with this therapist, I became more critically-minded and selective about the contexts in which I extended my feminine "giving" mode of relating to others. I also cultivated masculinity on my own terms, and began to explore other ways of being empowered as a woman.

I can note a similarly remarkable shift related to my valuational stance toward traditional female roles. From my present vantage point I recognize that I had earlier manifested a kind of automatic response to these roles as inevitable and given. However, I now feel that I can determine how I regard them, and whether and how I carry them out. I am pleased to say that I greatly value and enjoy the roles of wife and mother as I have cultivated them in my life. I am also pleased to say that I have developed a critical feminist consciousness about the nature of traditionally female domestic labour as for the most part dull, repetitive, unrewarding, boring, devalued, unpaid, advantageous to men, and oppressive to women. Of course the chores themselves are necessary, and given the extent to which I identify with my mother, I have never been capable of simply renouncing them. But, again, feminism has taught me that I have choices. And so I have been able to divide up domestic labour, and to adopt a far more casual attitude toward things like cleaning and preparing meals than I would earlier have
4a. **Valuing/Aspiring toward masculinity:** As noted in (2), I have in some ways become more masculine over the years. But as I also mentioned above in (3a), I have cultivated a more critical stance toward the manner in which both feminine and masculine traits operate within patriarchy. Thus while I continue to value traditionally-defined masculine features which empower people in their own lives, I don't value the manner in which some traits are used to dominate or exploit others.

But more relevant to my history of healing, I can note that I no longer experience ambivalence or conflict regarding the cultivation of masculine traits by adult women. On the contrary, I think it is vital for the psychological, physical, and economic well-being of girls and women that we all do so. In this context, I think it is criminal for the mainstream media to continue feeding us images of strong women who become nasty and exploitative in their manifestation of masculinity. However, I am no longer inhibited by this ideological input -- or, for that matter, by my mother's critical attitudes toward assertive women described in the first phase of this exercise. Thus, with regard to the point I made about retreating from adolescence and adulthood on the dimension of masculinity, I have been able to be more assertive and tough-skinned in the context of interpersonal encounters. That is, the manner in which I am masculine is not restricted to the context of academia, but rather pervades my life in a much more balanced fashion.
5a. Rejection of femininity:

(i) Double-bind-related: The first aspect of rejecting femininity discussed earlier concerned nascent doubts about the worth of feminine traits and quite conscious awareness of the devalued status of traditional women's roles. I associated all of this with double bind messages about the devaluation of femininity and supervaluation of masculinity. In reflecting on the status of this dimension of my gender profile over the course of my healing, I can say that there has been a tremendous shift.

I believe that I was intensely anxious when I first began to entertain doubts about my very feminine nature because I took societal and more personal messages to heart as negative and critical messages about how and who I was. Just as in the case of my stance toward masculinity, I was very much at odds with myself. In this case, given my perfectionism and the manner in which I was attuned to society's devaluation of traditional feminine traits, I knew that I would need to be different (i.e., not so nice) in order to be respected. However, I had always thought that I must be "so nice" and I couldn't see how I could change. Moreover, my accommodating behaviour was still being reinforced by the positive responses that I received from others.

Nonetheless, as I noted in (3), above, becoming a feminist helped me realize that the fault wasn't with the traits and roles themselves, nor with me as someone who embodied them. Rather, the problem lay in the way in which they functioned within patriarchy. Thus at some point I came to understand that I
didn't have to take anybody's word that what I was like or what I did was worth a great deal or was worthless. I didn't have to think I was the problem and that I would have to change in accordance with external standards. Rather, I could evaluate my gender features for myself vis-à-vis my own judgments about how they worked in my life, and the set of values that I was developing. In short, and again as noted in (3a), I was able to revalue femininity and masculinity on my own terms. In this way, I began to resolve conflict related to the gender double bind.

(ii) Bipolar mode: Regarding the second interpretation of rejecting femininity, I conjectured earlier that I was deeply conflicted regarding double bind messages about femininity and masculinity. Yet I had few resources to deal with this conflict and the intense anxiety that it aroused in me. Thus, according to my hypothesis, I relocated my problems within my body and attempted to resolve them via a bipolar rejection of femininity and a supervaluation of masculinity. In concrete terms what this meant was that I renounced my feminine, rounded, culturally-devalued body, and cultivated a culturally-valued slim, masculine, "intelligent" body.

Interestingly, and as noted in the Case History, for many, many years I remained more or less committed to maintaining a body that was relatively slender and not freely feminine and curvaceous. In fact it has only been since the birth of my five year old son that I have completely given up counting calories, trying to tone and control my body, and so on. And so, finally,
the conflict that I seemed to be playing out with my body seems to be over. As discussed above, I relate this change in part to the incorporation of feminism into my life. Over time, I gained a critical perspective on the political and historical context in which I'd learned, on the one hand, to reject aspects of who I was; and on the other hand, to admire what I wasn't and didn't have unqualified permission to be. As noted above, therapy in my early twenties also helped reinforce this revaluation of values toward embracing aspects of my femininity. Moreover, in therapy I have also developed many more resources for dealing with inner conflict so that I no longer need to play it out in my body. However, I think the most powerful experience that has helped me come to deeply appreciate and value being female and having a female body is that of creating and giving birth to my child. For in doing this I have come to trust that my body is just the way it needs to be.

Before leaving this section, I think it is interesting to note that the bipolar mode of resolving conflict set up by the double bind was also played out on another plane of my life and over most of the course of my healing. Although conflict on this plane was not literally played out in my body, it was still predicated on a kind of mind-body split, and was also not wholly conscious. It concerns my relationship to philosophy, which was the focal point for my studies over many years, and my first career.

I first encountered philosophy as an undergraduate, studying
mostly within the Continental tradition (Phenomenology, Existentialism, the Philosophy of Art, and so on). But also as an undergraduate, and within a different department, I was also compelled to study within the Anglo-American tradition (Logic, Analytic Philosophy of Mind, Analytic Philosophy of Language, and so on). Interestingly, these traditions are often characterized on the dimension of gender, with Continental philosophy labelled 'feminine,' and Analytic philosophy labelled 'masculine.' Furthermore, those within the Continental tradition are likely to characterize their brand of philosophy as rich, concerned with meaning, and grounded in human experience; while those outside of it will aver that it is imprecise, messy, recondite, and willfully abstruse. On the other hand, those within the Analytic tradition will laud the precision, rationality and commitment to clarity of Anglo-American philosophy, while outsiders will characterize it as dry, abstract, apolitical, and irrelevant to humanity.25

Within the predominantly analytic department I felt very much caught between these two traditions. Eventually, though, my passion for Continental philosophy was severely undermined since analytical thinking was presented as powerful and far superior to that in the phenomenological tradition. Indeed, for about a year I tried to identify with the philosophers in the former tradition -- writing and talking and teaching as they did as much as possible -- while distancing myself from those in the latter. In the present context I would refer to this as a bipolar phase of
rejecting "feminine" (sensuous, body-and-experience-oriented) philosophy and trying hard to fit into the world of "masculine" (pure, clear and head-oriented) philosophy. Fortunately, this phase did not last too long since I discovered the viability of a superwoman track within philosophy. I will explain how this happened in (6a). For now I would simply like to note that this meant that I tried to do it all, taking courses in both traditions and teaching feminist philosophy. I even planned to write a thesis which could bridge Anglo-American and Continental sensibilities. However, after having proven to myself that I could hold my own among the men-folk and, for that matter, the women-folk, I realized that I no longer needed to remain on this track. Indeed, I think I had completed the psychological work that I needed to do in the context of doing philosophy, and for this reason it became possible to pursue a career that better fits who I am and what I want to do.

(iii) Rejecting female adolescence: In my earlier discussion of this aspect of rejecting femininity, I described my anxiety regarding the developmental demand that I cultivate specifically adolescent modes of femininity in relating to boys and other girls. I believe that I resisted this demand so fiercely that I even prevented my own body from developing as nature had intended. For I would have needed to efface any trace of change in my body which could have attracted the attention of boys. But beyond this, I avoided having relationships and remained on the periphery of my adolescent social milieu.
Reflecting upon my history of healing, I believe it is most accurate to say that I more or less skipped this stage of development. In fact, once I was able to give up the early phases of acute anorexia and restricted eating, I leapt into more adult-style relationships with men on the model of serious, committed, marriage-like relationships. Indeed, I had no trouble taking on the traditional, heterosexual, female adult roles that I had always anticipated for myself: becoming the partner of adult males in sexual relationships, eventually marrying and becoming a mother, maintaining a household, and so on. But I never did go through adolescence in the sense of more casual experimenting with relationships, sorting out thoughts and feelings with female friends, rebelling against authority, manifesting "giggly vapidity," and so on.

6a. Valuing renunciatory superwomanhood: As in the first phase, material related to the bipolar rejection of femininity completely overlaps this category, and so I will not duplicate it here.

7a. Valuing multi-role superwomanhood: As indicated in my earlier discussion of this category, I think of multi-role superwomanhood as a response to conflict regarding double-binding messages about gender. Moreover, I construe it as an alternative to the bipolar mode of aligning oneself with what is culturally valued and distancing oneself from what is devalued. Rather, in the case of superwomanhood, women attempt to be and do what is required and valued of us (i.e., adopting traditional roles) while also taking
on what is valued by the broader society (i.e., non-traditional, stereotypically male roles). And we do this, I hypothesize, only if we have a positive role model to follow.

As I described above, I believe that I attempted to resolve conflict and anxiety related to the double bind by rejecting my feminine body and striving after a trim, "intelligent," controlled, (and in these senses) "masculine" body. But in the case of female roles, I had a ready alternative since my mother had blazed a superwoman trail which I could also adopt. And so, after adolescence, I followed her. Of course, as I discovered, superwomanhood is no piece of cake. And over the years I have had to struggle with all the messages I have internalized to the effect that "women's work" is not worth much. On the other hand, though, becoming a feminist has made it possible for me to carve out a scaled-down version of superwomanhood that does not rankle as much. First, as noted above in the section on valuing feminine traits and roles, I take no role and no value as simply inevitable and given. In this context I've been able to revalue and reshape these roles on my own terms, discovering that (even taking into consideration the ups and downs of parenting) I love taking care of my child, I love being a wife in the mode of partner (as opposed to servant), that I often enjoy things like cooking and gardening, and that I can divide up other domestic chores with my husband. This has eliminated the sense of being trapped, and the conflict about feeling that I have no choice but to engage in tasks that "don't count for anything," or to
supplement this with nontraditional labour that does "count."

Another aspect of multi-role adult superwomanhood is related to the theme of my relationship to philosophy introduced in 5a. As I noted there, the bipolar option of identifying with analytic philosophy and distancing myself from Continental philosophy was relatively short-lived. After this phase I tried to take on the analogue of superwoman in the field of philosophy. Just as in the case of taking this route regarding female roles, this became possible because I was able to identify with a female role model. As I mentioned in the Case History, my M.A. supervisor respected and supported me as a female student. Moreover, she was the original superwoman of philosophy, comfortably crossing the intellectual boundary between the two main traditions, and demonstrating the viability of bridge work. After my brief "bipolar" phase, I attempted to emulate Terry, and I continued to do so over the length of my studies and my teaching career. In this way, I think I strived after the superwoman option on another plane.

A final dimension of this category relates to the sort of adolescent proto-superwomanhood that I would have appeared to have manifested at the age of fifteen. I say "appeared" since, as discussed earlier, I believe that being engaged in a number of activities was actually a function of my perfectionism and the need to distract others from the fact that if anything I wasn’t managing to take on any roles at all -- at least not any developmentally-appropriate roles for my age. In terms of the
history of my healing, at a certain point — basically at the end of high school — I didn’t need to put up a smokescreen because there was nothing to hide. I wasn’t supposed to be an adolescent anymore. As for my perfectionism, I had learned in the first phase of therapy that I didn’t have to do things that I didn’t want to do. But this needed to soak in over a long period of time. In subsequent years the major change that occurred was that I no longer allowed myself to be dominated by what might alternatively be called my negative animus, top dog, or hypercritical superego. This allowed me to make choices out of desire rather than some external sense of what I should do or what a "perfect" person would do.

8a. Combinations of gender profiles and/or stances: As discussed in the first phase of this exercise, antinomies between, for example, self-described femininity and doubts about the value of that femininity, and low-level masculinity and valuing masculinity certainly helped shaped my overall gender profile at fifteen. And the tensions between these poles most certainly increased my conflict and anxiety. In light of the preceding discussion, I have no doubt that in the course of my healing, the conflicts and anxieties that had dominated me have in large part dissipated. As just noted, this is due in part to the fact that developmental demands diminished as I moved out of adolescence. However, becoming a feminist and engaging in therapy that reinforced my feminism have also emerged as central factors in reducing conflict. For, as I have noted at several points, I
have come to be able to question the valuational frameworks which taught me to disparage what I was (i.e., feminine) and esteem what I was not wholly encouraged or permitted to be (i.e., more masculine). The resultant freedom from the double bind made it possible for me to reject the notion that there was something that I had to be, and opened up various options concerning what else my life could be like.

**OVERALL SUMMARY AND ASSESSMENT:**

I believe it is overwhelmingly the case that the empirical findings are corroborated by the material that has emerged in the context of both phases of this exercise. Following the first phase, I noted that at fifteen it seems likely that I would have been assessed as extremely feminine and low-level masculine, that I valued feminine traits and roles, that I valued masculine traits, that I either doubted or rejected aspects of my femininity, and that I valued multi-role superwomanhood. With respect to combinations of profiles and stances, I also believe that conflict would have been salient in relation to gaps between who I was and who I thought I should be. Following this second phase regarding late stages of healing, it seems even more clear that the empirical research lit upon key elements of my gendered personality.

Once again, I have been able to associate to every element of gender accessed by the studies analyzed in the Literature Review. Moreover, I have recorded growth and change in each category, and I have linked these changes with my healing. The
basic underlying change since the acute phase of anorexia is that I have balanced personal experiences and input from other sources (mostly therapy and feminism) against prevailing and oppressive double-binding messages about gender. As a result I have felt free to be less stereotypically feminine and more masculine, to develop my own set of values regarding feminine and masculine traits and roles, to consciously work out conflict related to the double bind as opposed to somatizing it in my body or elevating it to the plane of intellect, to respect and embrace my female body, to carve out my own way of being a superwoman, to take up developmentally-appropriate roles in the context of adulthood (at least insofar as they apply to heterosexual women who choose to marry and have children), and to collapse the gap between what I am like and what I think I should be like.

Empirical researchers contributing to the Literature Review would thus be warranted in taking the material that emerged from this exercise to validate their findings. This of course also validates my sense that the empirical findings were tapping into central features of my experience. But as I would like to argue, it does not follow automatically that we do well to construct a psychocultural model of the relationship between gender and problem eating on the basis of the summarized empirical results. Indeed, two main concerns can be noted. First, and speaking generally, I think that in doing this, we could all too easily overlook both the internal complexity of the gender features, and the rich relations among them. For we might be tempted to carve
a model out of telescoped, isolated propositions such as "anorexics are hyperfeminine," or "anorexics aspire after masculinity," or "anorexics reject their femininity." Of course, as we have seen, it is true that I was hyperfeminine, aspired after masculinity, and so on. However, I want to argue that there are four reasons why it is misleading to describe my own case in this way. First, the use of telescoped propositions fails to take account of the more detailed distinctions within given aspects of gender profile. The most obvious case is that of rejecting femininity. Given that I was able to elaborate three distinct dimensions of this aspect of my profile, it would be almost meaningless simply to speak of "rejecting femininity" in a general sense. Another example relates to valuing feminine roles. For while I did not reject traditional adult roles, I most fiercely resisted stereotypical adolescent roles. Indeed, I basically (unconsciously) decided to remain a child on this dimension. Hence it seems we do well to key valuational stance to the specific developmental periods of childhood, adolescence, or adulthood, rather than speak of a general case of "valuing female roles."

A second, related way in which the internal complexity of gender features might be overlooked concerns the meaning of any given dimension. For example, we can recall that Timko et al. (1987) offered evidence in support of the idea that feminine women are concerned with their physical appearance. But in my own case, it would have been a mistake to interpret
hyperfemininity in relation to this feature. In fact, it is arguable that absence of this particular trait -- particularly in conjunction with needing not to be attractive to boys -- was a risk factor for anorexia in my case. To take a second example, it wasn’t the case that I simply embraced multi-role superwomanhood by anticipating taking on a number of different roles as an adult. This embrace must be understood in the context of an attempt to resolve conflict related to the double bind. It is also important to recall that what might have showed up as adolescent proto-superwomanhood was actually the reflection of a determination not to take on masculine and feminine roles pertaining to this stage of development.

A third reason why I would resist the use of isolated propositions is that it is clear from the above exercise that none of the more simple elements of my gender profile seems to have worked in isolation. For example, it wasn’t self-described femininity or low-level masculinity simpliciter that operated in my case, but rather these elements in conjunction with rejecting femininity, and aspiring toward masculinity (respectively). This observation supports the hypothesis that more severe modes of problem eating may be related to more complex gender profiles. It also of course supports the approach of those researchers whose work was reviewed under heading III: Gender Profile, Gender Stance, and Conflict." For these studies examined combinations of gender-related phenomena and their relationship to inner conflict as opposed to isolated features.
However, and here I turn to my fourth and final point, even combinations of extant categories may not adequately capture the complexity and conflict related to gender in my case. For example, it would be misleading to say that low-level masculinity in conjunction with aspiring toward masculinity was correlated with problem eating. To be sure, this was a prominent feature of my overall profile, but I also associated it with a profound sense of lack of permission to cultivate masculine features in my personality. The felt lack of permission came from my parents, and also from the surrounding culture's double-binding messages to the effect that I must esteem but not wholly manifest masculinity. In light of my struggle with perfectionism, I would have experienced this bind as particularly tight. A perfect person would be or become what was valued, and so I would have felt enormous pressure to be anything and everything that was valued -- including being more masculine. But again, I had no permission to be what was valued in this sense.

The other side of the double bind for females is its paradoxical requirement that to be valued at all, we must be what is in the broad scheme of things devalued. Part of me was able to balance my sense that this was my fate with a promise to myself that I would do other things with my life in a typical superwoman mode. But given the material that emerged concerning the rejection of femininity associated with adolescence, it seems I was not prepared to be or become what was valued or required of me as a female at that stage of my development. Nor was I able
to pursue superwomanhood in the context of addressing the double bind on the dimension of traits. In sum, then, I experienced phenomenal internal pressure to be what was valued (namely, masculine), and what was required but not valued (feminine); yet had no external permission to cultivate what was valued (again, masculinity), and no internal permission to cultivate what was devalued yet required (at the time, adolescent femininity). Unable to move in any direction, I had little choice but to remain precisely where I was, developmentally speaking.

It is interesting to observe how a simple reference to one feature of my gender profile spiraled into other features both within and outside the frame outlined in the Literature Review. Additional features that emerged were the lack of permission to cultivate masculinity, my perfectionism, and the way in which these two elements greatly deepened the conflict set within me in relation to double-binding messages about masculinity and femininity. In light of these observations, we may need both to expand our frame of reference beyond that set up by the summarized findings, and to ensure that the model that we eventually construct captures the relationships among all aspects of gender that we have identified.

The second main concern that I want to raise about constructing a model on the basis of the summarized empirical results should be familiar. For I wish to question from a more phenomenological perspective whether a model that could capture all this would be complete. This may seem odd given the fact
that the empirical results were strongly corroborated and also enriched by the material that emerged in the gender profile exercise. On the other hand, though, I am not certain that even a complex interweaving of the elements discussed above would be sufficient to generate the intense, relentless anxiety, anguish, and fragility that I experienced when I was anorexic. That is, when I picture someone who is hyperfeminine, hypomasculine, values feminine traits and roles, aspires toward superwomanhood, and so on, I only a picture part of who I was at fifteen. To be sure, it helps a great deal to have added the elements of perfectionism and the sensed lack of permission to cultivate masculinity. While these were outside the frame of the empirical research, they are vital components of the overall picture because they clearly "turned up the heat" that I experienced in relation to the double bind.

Even with the addition of these elements, though, the scenario developed here still doesn’t conjure enough angst to resonate with my inner sense of what I was like at the time of the anorexia. But as I stated in the Introduction, I think it is more likely that we need to access deeper features of the psychology involved. Of course, it might be that what’s missing lies outside the province of a psychocultural model of the gendered nature of anorexia. In fact, I don’t believe this is the case. But to show this, I will need to explore two features of my experience of carrying out the gender profile exercise itself.
The first meta-level observation that I wish to make relates to the section on rejecting femininity. Quite simply, I am left with a sense that there is more to talk about. But more specifically, I'm left with a puzzle as to why I wasn't able to stand up to the double bind, and why this somehow made it necessary for me to shift the resultant conflict over to my body. For it seems that most women in Western societies would likely be exposed to some version of the double bind. So, why did it affect me so drastically that I need to starve myself in response? I am equally puzzled as to why I rejected adolescent femininity. In the exercise, I was able to associate to fear and anxiety about becoming involved with boys as boyfriends and not just friends. But again, I'm wondering about the source of this anxiety, especially given that this was something I was supposed to do, and given that I was quite anxious about my failure to carry it out.

Beginning with the puzzle about failing to stand up to the double bind on the dimension of traits, I think it's important to recall that I was able to challenge and in a sense transcend double bind messages regarding traditional roles. For in anticipating superwomanhood I was embracing devalued female roles and transcending sanctions against taking on male roles. As I have noted, the difference is that in the case of roles I had a model of a superwoman in my mother. I have conjectured that this is why I pursued this path and why, it seems, I didn't choose the alternative bipolar route of rejecting devalued female roles.
while cultivating male ones. Of course, the inference we are bound to draw in this context is that I must have lacked both a model for the embrace of feminine traits, and for transcending limits on the cultivation of masculinity.

In fact, this formulation accords with my experience. In particular, it accords with my perception that my mother did not rest easy with her own femininity, and -- as I have already noted -- that she displayed overt hostility toward the cultivation of masculinity in women. In fact, I think that the combination of these features bred tremendous resentment in my mother which was only alleviated by her pursuit of superwomanhood in middle age. Given his relative absence, there was also little chance to receive encouragement from my father for embracing my femininity or for cultivating masculinity. If this holds, then I can see more clearly why I was unable to resist double bind doubts about the worth of femininity and the supervaluation of only-conditionally-accessible masculinity. In short, I lacked both a model and a sense of permission to do so.

However, a puzzle remains as to why I rejected adolescent femininity. In light of the preceding discussion, it makes sense to entertain the possibility that these two factors of lacking a model and lacking permission operated here as well. In this vein, my first thought is that this was clearly not the case since I was surrounded by other adolescents and since I felt pressure -- and certainly not a lack of permission -- from my peers to develop. Nonetheless, upon reflection, I can in fact
speak to both possibilities -- especially when I think about adolescence not as an end in itself, but as a way of entering into womanhood.

My first association with the concept of entering womanhood is that while I had a role model in my mother for doing all kinds of things that adult (super)women do: cook, clean, shop, work, and so on, I don't think that she was able to offer me a clue about how to be a young woman. My sense is that this had a lot to do with the fact that she associated entry into womanhood primarily with the development of sexuality and, like any good (even ex-) Catholic, she was not in the least comfortable with this. Indeed, she even had trouble talking about it. For example, when I was a very young child I asked my mother what 'sex' meant. Her face turned red and she haltingly said that it had something to do with the difference between boys and girls. I remember trying to imagine why that would make someone so uncomfortable. That was more or less the extent of our discussion of sexuality during my growing-up years. The only other memory of have is that she expressed concern that I should use birth control when I started living with my first boyfriend.

I think it is also not so far from the truth to say that in keeping with the prevailing cultural and political context, my mother sexualized many aspects of female development. For one thing, I remember feeling that there was something almost dirty about the word 'woman' and for years I was embarrassed to speak it. Another example is that I was the last one of my friends to
get a brassiere because my mother never brought it up and I had to go to her with great embarrassment to ask for one. The feeling I have now is that there was something sexual about wearing a bra. Similarly with things like shaving legs, wearing nylons, wearing makeup -- we never talked about these things, and she never showed me. It all seemed to be related to something mysterious and anxiety-provoking for her. She did the flip-chart number about menstruation with me, exuding a kind of contrived easiness and comfort with the whole topic. I knew she was trying to be brave, but of course I ended up feeling more distressed because of the cover-up ("This must be so heavy that Mom has to pretend it's all natural and O.K.").

Piecing things together now, I believe that I would have consciously and unconsciously absorbed all of this, and undoubtedly much, much more regarding my mother's anxiety about sexuality, separation, and my development. I also believe that I would have experienced all of this not just as a lack of support but as an overt lack of permission to mature. For if sexuality was dirty and anxiety-provoking for her, and if most aspects of female development were sexualized, it would be hard to see how she could have freely given permission for me to develop.

Moreover, on a deeper level, I believe that what I absorbed from my mother -- or at least what I inferred from the manner in which both she and my father distanced themselves from my development -- was that it wasn't O.K. to be a young woman in the first place. As a result, becoming an adolescent meant moving
into a foreign and profoundly anxiety-provoking place with no invitation, no one to guide me, and no one to reassure me that she (or he) was still with me. I also knew that at best I would be utterly alone. Because even beyond this, and based on fears that only later emerged in therapy, it appears that I was unconsciously certain that my entry into womanhood would be met with rejection, hostility, and silence on the part of my mother. Indeed, I was terrified that any attempt to mature would not just have incurred my mother's anxiety, but also her wrath. And this expectation was unfortunately projected onto all women.

Given all this, it is not surprising that I would have unconsciously decided that I must not grow up. Accordingly, it is not surprising that I hit a wall of inner resistance when confronted with peer pressure to join the other girls in cultivating adolescent femininity. As it turned out, it seems I didn't even feel safe enough to allow my female body to develop. Indeed, I believe that my intense commitment to controlled self-starvation was precisely a measure of my fear and sensed lack of safety.²

These are my associations with how I felt at the time regarding this dimension of my life. What all of this means to me now is that while I knew how to be a girl-child among girls; and while I knew how to be a girl among boys as friends; and while I even had an idea how to be a woman in the roles of wife, mother and housewife, I did not know how to be -- and in fact greatly feared being -- a woman among women. I had no sense of
actually or even potentially belonging to a community of women. Hooking this up with the earlier theme about sexuality, without being welcomed into womanhood I had no sense of safety to develop relationships with guys. Ironically, in my case this did not have to do with a fear of young men, or even of their rejection of me, but in fact a fear of women. Finally, there was certainly no inkling of a possibility of exploring what else might go along with being a woman beyond the roles of wife, mother, and housewife.

I find confirmation of this aspect of my experience regarding the rejection of adolescent femininity in the "History of Healing" that I offered in the beginning of this chapter. One of the main themes of that history is the way in which I only gradually entered into womanhood, developing a sense of safety and even belonging among women over time. This happened in a number of contexts and over a number of years via the raising of my feminist consciousness, my experience with various communities of women, the explicit invitation and welcoming into womanhood offered by a gifted therapist, the development of friendships, and the discovery of a shared sense of womanhood with other women in pregnancy, giving birth, breastfeeding, and childcare. When I review that history, I see that this is what changed and, by inference, that this is what was missing earlier in the context of my relationship to developing into womanhood. And what I wish to suggest here is that what was missing was not femininity -- I had an overabundance of that -- but what might be called
"womaninity": a sense of welcome and belonging within womanhood and among women.

Factoring this lack of womaninity into my experience at the age of fifteen greatly deepens my understanding of my fearful, conflictual and ultimately rejecting stance toward female adolescence and womanhood. I think it also adds a crucial dimension of conflict to the other two aspects of rejecting femininity that I have discussed. Any doubts about the worth of femininity that I would have absorbed from the double bind would not have been met with a strong sense of confidence in my female self. In fact, there would have been no sense of reassurance or resistance from within. I believe that the bipolar mode of outright rejection of femininity was also a symptom of my lack of womaninity and just this inability to resist negative messages about women and femininity. It was much safer, more familiar, and more worthwhile to align myself with the supervaluation of things masculine.

Turning to the second feature of my experience of carrying out the gender profile exercise, I can report that throughout the process of recording my answers, I was able to make two related observations. First, I found myself resisting the use of the pronoun 'I' in the context of describing myself at fifteen, and second, I noticed that I seem to have regarded myself as entirely malleable and plastic. Regarding the former, even though I could say, for example, that I was oriented toward others and that I was very sensitive, the 'I' always stood on the page too solid
and too complete to depict what I was. The words are accurate, but there is no hint of the extreme fragility and wispiness of the sort of person-fragment that I was. No doubt this showed up in my body and I find it amazing that my unconscious found a way to express this so literally. But the words do not capture how radically and profoundly I was living outside of myself -- how utterly unsubstantial I was. My dreams reflected this. In one dream that recurred many times I would be on an elevator that had no walls and raced up toward the sky. It was in a kind of construction zone. There was nothing to hold onto so I would cling to the bare concrete floor, terrified.

On a related theme I have talked about how I needed to get a sense of how others might react to what I might say or do before I did anything. If I didn’t have anyone to bounce off of, my default choice was to do what a perfect person would do. This helps to describe how intensely I was attuned to others and how much I needed their input (real or anticipated) to help me make decisions. However, I need to explain further that it wasn’t as though there was somebody within me doing the consulting. It was more like I was stretched out relationally across people, changing chameleon-like as circumstances required. For this reason, it was utterly exhausting to be around people. In this context I can recall having had many, many dreams in which I was involved in some sort of theatre production. I would be offstage anticipating an entrance and realize in a panic that I had no idea where I was supposed to stand or what I was supposed to say.
Then I would race around trying to get hold of a script. But there were never any scripts to be found -- no one else but me needed them any more.

All of this of course relates to the observation that I regarded myself as malleable and plastic, able to shape and re-shape myself as needed. In the exercise, I found myself writing things like "I lacked the substance even to be able to discern what I wanted or needed on my own terms," and I was astonished. To paraphrase Gertrude Stein describing Oakland, "there was no there there." That is, there was no reference point inside myself. Survival and identity was a matter of reading external cues. Again, I am struck by how this showed up in what I was doing to my body. I now see that I could have unconsciously been saying something like:

Look, can you see my achievement? Against all odds, I live on almost nothing. I shape my body as I will against nature. Can you see what a craftsperson I am? I can craft the impossible. By the way, can you also see that this is what I am doing to my Self? I shape and reshape it as needed, only showing that there is nothing that exists independent of the shaping. Nothing solid resists it. Nothing protests. You will have to read my body to understand what I am doing.

My construal of the material that I have elaborated here is that at the age of fifteen I had only a minimally developed self. By 'self' I mean to refer more or less colloquially to the seat
of identity, that which is experienced as one's unique personality, and referent of the pronoun 'I.' Similar to the case of lack of womaninity, recognition of the concept of a lack of developed self makes a world of difference in terms of being able to account for the extremely high level of anxiety and sense of conflict that I experienced and that I attempted to resolve with the anorexia. As I will briefly attempt to describe, though, lack of a developed self did not just deepen and intensify my anxiety in a particular area of my experience, but pervasively. Indeed, this lack was foundational in shaping the entire phenomenology of my gendered personality.

Basically, on my understanding, the way that the lack of self figured is that there was nothing within, nothing to which I could refer in order to contain and mediate any conflict I was experiencing. There was just conflict -- conflict regarding who I perceived myself to be; who I thought I should be based on societal input; who I thought my mother needed, required, and/or forbade me to be; who I thought my father needed, required, and/or forbade me to be; who anyone in the immediate surround at any given time perceived, needed, required, and/or forbade me to be, and so on. More specifically related to gender, we have reviewed at length the many conflicts with which I struggled. These conflicts were related to double-binding messages about gender, an anxiety-provoking and painful sense of a gap between who I was and who I thought I should be on a number of dimensions, and a sensed lack of permission to mature with
respect to both developing masculinity and entering womanhood. The point here is that there was a great deal of conflict within me, and nothing to mediate it but a self that was spread thinly over all the people whose opinions I cared about -- that is, everyone. If the conflicts were like scattered electric impulses, it was as though nothing could channel and ground them. Or, to take a more hackneyed metaphor, it was like loading far too much weight onto a structure with a shaky, unsubstantial, undeveloped foundation.

My strongest association with this lack of grounding in terms of its origin lies in my relationship with my father and, more specifically, his abandonment of me during childhood. As I noted in the Case History, I had enjoyed a close relationship with my father as a young child. During this developmental period I had begun to shape a self in the context of what I must have experienced as his ability to reflect who I was and to value me. When he basically stopped interacting with me I think my sense of self -- and perhaps even my sense of permission to develop my self -- was thrown into chaos.28

When I imagine a person with the set of burdens that I have described, I experience a profound resonance with the person I was, and the misery I endured at the age of fifteen, and beyond. For having added lack of a developed self and lack of womaninity, I am better able to account for the tremendous anxiety and conflict that I experienced. Indeed, by factoring these foundational elements, the picture of my gendered personality
that has emerged has from my perspective finally reached an adequate level of phenomenological complexity.

Having explored there areas of my experience both within and outside of the frame of findings that emerged from the Literature Review, and having ultimately arrived at a richer and more satisfactory picture of the gendered nature of anorexia in my case, it seems that the main task of this chapter has been achieved. That is, I have explored my hunch that while the empirical findings would be borne out by the autobiographical exercise, we would need to go beyond them to conjure adequate psychological complexity. As for the subsidiary task related to my methodological hypothesis, it seems that in the same vein we have gathered informal evidence to the effect that it is fruitful to draw from both quantitative and qualitative approaches in the context of at least some research projects.

One final point is that it would be worthwhile to discuss the relationships, including some overlap, between the concepts of lack of womaninity and lack of a developed self, and various central concepts in the theories of Bruch, Chernin, Orbach, and Steiner-Adair. This endeavour could help refine the reader’s grasp of the concepts that I have introduced, and would allow me to muster independent support for their validity. However, a careful and thorough mapping of these relationships would lead us away from the more urgent task that awaits, and so I choose to slate it for another occasion. Thus I turn, with alacrity, to the task of model construction in Chapter Five.
MODEL CONSTRUCTION, ASSESSMENT, AND CONCLUDING REMARKS

INTRODUCTION:

The task of the present chapter is to construct a model of the gendered nature of anorexia based on material that has been gathered and analyzed over the previous four chapters. As I argued in the Introduction, the model needs to be psychocultural in nature, meaning that it must show how cultural and psychological forces work together to produce a given phenomenon. I hope to show in this particular case how social and cultural messages related both to the gender double bind and to female body management operate in conjunction with gendered features of personality and deeper psychological structures to contribute to the generation of problem eating. Somewhat more specifically put, the core of the model is intended to depict how social/cultural input, aspects of overall gender profile, lack of a developed self, and lack of womaninity jointly produce intense anxiety and conflict, the need for resolution of conflict, and the actual resolution of conflict in the form of problem eating.

I would like to begin by briefly discussing four preliminary points. First, throughout the process of model construction, and also in response to the final result, it is vital to keep in mind that the model is based on findings from empirical research, theoretical contributions, and autobiographical material. In all three cases, material arguably and at best only applies to white, middle or upper class girls and women. But especially given the
incorporation of the vastly more constricted autobiographical material, we must bear in mind the methodological premise of this thesis to the effect that generalizability of the model -- even to other white, middle or upper class girls and women -- is not to be assumed. So while I will speak in general terms of "the girl or woman at risk for problem eating," or "the girl or woman with problem eating," applicability of the model to girls or women other than myself can only be determined in the context of future research.

A second point of note is that even though the model is, in part, based on autobiographical material related to my experience of anorexia nervosa, I will offer only a more general model of the etiology of more severe problem eating in relation to gender, short of the case of full-blown eating disorders. The basic reason for this is that the etiology of anorexia and bulimia is far more complex than I am prepared to explain here. However, the foundation for a model which could capture the etiology of these disorders in relation to gender will be laid down in the present project.

The third preliminary point is that it will often appear throughout my discussion that I mean to speak as though the girl or woman at risk for problem eating is consciously aware of anxiety or conflict, or of her need for resolution of conflict, or of her "decision" to resolve conflict in certain ways. Rather than qualify these remarks with phrases to indicate that I mean to imply "awareness at some level," or "likely unconscious
awareness," I would prefer to state at the outset that I am in no position to determine the extent to which the girl or woman at risk for problem eating is consciously or unconsciously aware of her anxiety, and so on. My hypothesis is that much of what I will go on to describe is wholly unconscious. But since this matter cannot be settled here, I would only ask that the reader keep in mind that I do not intend to convey that the awareness, conflict, anxiety, and so on that I refer to below are conscious.

Finally, I will not be offering a rigorous operational definition of problem eating in terms of its behavioural manifestations. This would actually be impossible given that the same practices (eg., dieting, or jogging daily) can be undertaken along the entire continuum of problem eating. Instead, I take that the distinguishing features of mild vs. severe problem eating lie in their etiology, and this is what I will attempt to capture in the model that I plan to construct.

A first attempt at model construction might have us draw from a conventional sociocultural understanding of the etiology of problem eating. Sociocultural theorists reject the notion that girls or women with problem eating merely somatize their psychological problems in accordance with the logic of an inner, individual pathology which operates outside of a social and cultural context. The basic premise of this sort of account is that "cultural contents become swept up as symptoms, especially when they overlap some of the underlying motives in a predisposed individual" (Schwartz, Thompson & Johnson, 1982, p. 28). More
specifically related to the case of problem eating, Polivy and Herman (1987) take it that individuals with a number of "personality defects...develop some sort of mental disorder under stress [and then] society's eating/weight pathology simply channels the pathology into an eating disorder..." (p. 640). In this way, such accounts take into consideration social and cultural input, attempting to indicate how it interacts with underlying pathology to produce disorders.

While such accounts are tidy and in some ways compelling, they are nonetheless problematic for two related reasons. First, from a feminist perspective it is a mistake to begin with the premise that pathology in the case of problem eating is located within the girl or woman in question. Quoting Székely (1988):

Once a phenomenon has...been constructed as a disease, the sociocultural can only be viewed as a factor that further undermines the weak personality of the individual (p. 176).

To be sure, Polivy and Herman (1987) are, among others, quite clear about the problematic and even pathological nature of the social-cultural input itself. They are also aware that girls and women are urged, exhorted, cajoled, and arguably required to manage our bodies. But, as feminists have been arguing in this and other cases, it unfortunately still seems hard to resist locating the core of pathology within women (Chesler, 1989; Ehrenreich & English, 1979; Penfold & Walker, 1983).

The second feminist objection that we need to consider is that on these sorts of accounts, social and cultural forces are
not considered to be the basis for eating problems on par with
deeper psychological problems. Rather, they are only perceived
as "contributing factors" which influence these psychological
problems -- or attempts at their resolution -- in a certain
direction. That is, inner pathology or personality defects are
taken to constitute the basic engine of problem eating while
social-cultural input merely fuels it -- or, better still, that
the basic stuff of pathology waits like wet sand or clay to be
molded into any shape depending on the nature of social-cultural
input.

Szekely (1988; 1989) makes the point that on such models we
can easily take ourselves to understand problem eating once we
grasp the "underlying pathology" of the individual. To account
for the specific manifestation of pathology in eating behaviour,
we need only observe that dieting strategies, extensive exercise
routines, and so on are precisely what have been made available
to her within the dominant culture. As I noted in the
Introduction, though, feminists are concerned to argue that this
"add culture and stir" sort of approach misses the point that
cultural contents are necessary and essential features of problem
eating. That is, feminists want us to see that while it is
important to recognize that practices related to female body
management are culturally constructed, it is also crucial to map
meaningful connections between the inner psychology of the woman
with problem eating and external social-cultural input. More
specifically, it is vital to identify and explain ways in which
social-cultural input is keyed into and even (in a sense) designed to address the psychological needs of girls and women with problem eating.

The work of Slade and Dewey (1986) can be construed as going part way toward meeting the objections discussed above. In his functional-analytic model of anorexia nervosa, Slade (1982) acknowledged that individuals engage in conventional dieting practices in response to familiar psychosocial stimuli about the importance of being thin, the value of exercise, and so on. He also suggested that we need to recognize the existence of psychological "setting conditions" to account for the fact that some girls and women go on to engage in more extreme modes of self and bodily control. Thus his perspective is sociocultural. However, he does not wave his hands at some amorphous "pathology" or "personality defect" at the centre of eating disorders. Rather, he and Dewey (1986) quite concretely hypothesize that such conditions as "dissatisfaction and loss of control" and "perfectionism" are at work in the production of anorexia — in conjunction with social-cultural input. Regarding the second objection, we can observe that Slade and Dewey further wish to suggest that psychological setting conditions combine to generate a specific need for control which is answered by social-cultural input about dieting, exercising, and so on. This input is compelling because it specifically offers ways for women to achieve a sense of control in their lives.

I would argue that this represents an improvement over
conventional sociocultural accounts since Slade and Dewey have managed to show how there can be a meaningful relationship between symptom and culture -- in this case, on the parameter of control. However, I would also argue that there is room -- and need -- to take this one step further. While cultural input is appropriately keyed into the inner psychology of the girl or woman with problem eating, the problem with this sort of conceptualization is that it seems that any socioculturally-provided mode of control might do just as well. That is, while such a model recognizes, and possibly even deems essential, the existence of a meaningful relationship between psychological problems and cultural input, the particular relationship to messages pertaining to female body management can still be regarded as non-essential and non-necessary. That is, girls and women needn't seize this mode of control -- others could be substituted.

I believe that what is required to render this social-cultural input necessary and therefore essential to the etiology of problem eating is to construe the inner psychology and needs of girls and women with eating problems itself in psychocultural terms. In answer to this requirement, I take it that the actual needs at the core of the psychology of problem eating in girls and women are psychocultural in nature and origin, that social-cultural input related to female body management precisely keys into these specific needs, and that this hand-in-glove fit accounts for the generation of problem eating -- at least on the
dimension of gender. And I hope to be able to show how this works in the model that I build below.

MODEL CONSTRUCTION:

I would like to launch the first stage of model construction by recalling from the Introduction the feminist hypothesis that conflict related to the gender double bind, and messages conveying the necessity of female body management are key elements in the etiology of problem eating. In that chapter, I also offered the hypothesis that the gendered personality of any given individual is the locus for absorbing social-cultural messages about gender. These of course include double-binding messages about gender to the effect that girls and women must be what is not valued (that is, feminine), and not be what is valued (that is, masculine). If this is so, then given the paradoxical and limiting nature of these messages, it seems obvious that, ceteris paribus, any given girl or woman would express some degree of tension or conflict in response. This state of affairs is depicted below in Figure 8.

In the next step, I would like to recall that empirical researchers observed that hyperfemininity and hypomasculinity are both features of the personality of (white, middle or upper class) girls and women with eating problems. This was of course supported by the autobiographical exercise in Chapter Four. For the purposes of the model, it is important to recognize that double-binding messages which devalue femininity and supervalue masculinity interface, at some level, with the hyperfemininity
Stage One of Model Development

SOCIAL-CULTURAL INPUT

messages related to the double bind to the effect that females must be what is devalued (feminine) and value what they must not be beyond acceptable limits (masculine)

GENDERED PERSONALITY AND RELATED FEATURES OF THE INNER PSYCHOLOGY OF GIRLS AND WOMEN

gender tension and conflict

Figure 8
and hypomasculinity of the girl or woman at risk for eating problems (or 'GWRPE,' as I will at times refer to her below). The outcome of this juxtaposition is that the GWRPE becomes acutely aware of the fact that she is extremely feminine and not particularly masculine.

Given the content of this input, the girl or woman at risk for problem eating experiences intensified conflict and anxiety. In particular, given the way in which hyperfemininity is associated with other-orientedness, the girl or woman at risk for problem eating becomes acutely aware of the values contained within the double bind, and feels tremendous pressure to absorb them. In conjunction with the perfectionism that is often identified in girls and women with problem eating, there would also be tremendous pressure from within to actually be what is valued and not be what is devalued. But all of this of course runs right up against the hypomasculinity and hyperfemininity that she recognizes in herself -- at least at some level. I attempt to outline this set of relationships below in Figure 9.

Awareness of a gap between what one is and what one thinks one should be in terms of gender profile was of course correlated with more severe modes of problem eating in research reviewed in Chapter Two under the heading of "III: Gender Profile, Gender Stance, and Conflict." I would like to conjecture that in response to the anxiety that she experiences, the girl or woman at risk for problem eating seeks a resolution to the paradox presented to her via the double bind, especially vis-à-vis the
Stage Two of Model Development

SOCIAL-CULTURAL INPUT

messages related to the double bind to the effect that females must be what is devalued (feminine) and value what they must not be beyond acceptable limits (masculine)

GENDERED PERSONALITY AND RELATED FEATURES OF THE INNER PSYCHOLOGY OF THE GWRPE

hyperfemininity
ychomasculinity
perfectionism

awareness of extreme femininity and low-level masculinity

internal pressure to be more masculine and less feminine

intensified conflict and anxiety

Figure 9
nature of her gendered personality. However, to explain the specific path taken by girls and women with more severe problem eating, I need to return to my discussion within the autobiographical exercise of the second interpretation of rejecting femininity. In that context I suggested that 'adopting a bipolar stance can be understood as an attempt to resolve the paradox posed by the double bind by embracing the societal message' (see above, p. 124). And so on that interpretation, girls and women at risk for severe problem eating reject femininity and embrace masculinity.

Two additional points must be recognized, however, before this mode of resolution can be incorporated into the model. First, as noted in Figure 9, the GWRPE experiences pressure to be what is valued, and not be what is devalued -- not just to adopt a valuational stance toward what is valued or devalued. But she will need guidance in the form of specific instructions as to how to implement the embrace of masculinity and the rejection of femininity. Second, as the reader may have noted, to implement this would be to put into practice only half of the mandate set out in the double bind. What's missing are the requirements to still be feminine and to manifest masculinity only within acceptable limits.

Putting all of this together, in response to the need for resolution of conflict and anxiety engendered by the double bind, the girl or woman at risk for problem eating must find a way to value masculinity, reject femininity, be feminine, and be
masculine within acceptable limits. And at this juncture I would like to offer the hypothesis that the GWRPE turns to social-cultural input conveying the worth and necessity of female body management for "guidance" regarding how to meet all four requirements. This hypothesis is recorded below in Figure 10, but I would like to elaborate it in some detail.

Beginning with valuing masculinity and rejecting femininity, we have actually already encountered the idea that female body management represents an attempt to implement a bipolar stance. Indeed, in Chapter Two we noted that among others, Silverstein and Perdue (1988) observed that girls and women renounce their feminine curvaceous bodies in favour of cultivating streamlined, angular pseudo-masculine bodies (see above, p. 62). What appears to be happening in this context is a shift from gender as the site of conflict, to body as the site of both conflict and its resolution. I would like to briefly note here that this is likely facilitated by Western patriarchal culture's historical and dualistic manner of associating femaleness, body, uncontrollable Nature, and unknowable matter on the one hand; and maleness, mind, reason, and science on the other (cf., for example, Bordo, 1993; Lloyd, 1984). That is, in the context of this sort of metaphysics, we do not readily question the assumption that substantive problems faced by women are problems with our bodies. Our bodies are accordingly considered the site for change and improvement.

But for the purpose of the present point about contemporary
Stage Three of Model Development

**SOCIAL-CULTURAL INPUT**

messages related to the double bind to the effect that females must be what is devalued (feminine) and value what they must not be beyond acceptable limits (masculine)

**GENDERED PERSONALITY AND RELATED FEATURES OF THE INNER PSYCHOLOGY OF THE GWRPE**

hyperfemininity hypomasculinity perfectionism

awareness of extreme femininity and low-level masculinity

internal pressure to be more masculine and less feminine

intensified conflict and anxiety

need for resolution of conflict and anxiety in the form of guidelines regarding how to fulfill the requirements of the double bind to:

(a) embrace masculinity
(b) reject femininity
(c) (still) be feminine
(d) be masculine within acceptable limits

Figure 10
social-cultural input, I would like to note that contemporary messages directly and unabashedly instruct girls and women to displace our problems onto our bodies -- and also to manage them by managing our bodies. In the case of answering the bipolar requirement to be more masculine and to reject femininity, we are in fact bombarded with messages to the effect that women needn't be burdened with the drudgery of stereotypical female existence. Rather, we are urged to liberate ourselves by fighting hard not to look like our mothers, casting off the curves that signal our imprisonment, "defying" our age, getting into that fitness class in the hospital hours after delivering our children, and so on. All that is required is a relentless pursuit of slenderness. Moreover, we are assured that by cultivating a compact, tight and controlled musculature, we can also achieve an acceptable measure of masculine self-sufficiency, confidence, assertiveness, and control (Bordo, 1993).

In sum, then, social-cultural input pertaining to female body management is precisely keyed to the need for girls and women at risk for problem eating to manifest their rejection of femininity and supervaluation of masculinity. As for the other half of the whole paradoxical equation set out in the double bind, it is also crucial for the GWRPE to learn how she may be masculine within acceptable limits and how (still) to manifest femininity. Beginning with the former, I think the requirement not to transcend certain limits regarding the extent to which a girl or woman may be masculine is straightforwardly met -- and is
judged and experienced as having been met -- via the containment of striving after masculinity within the body. That is, while girls and women commonly receive negative sanctions for being too "pushy" or "aggressive" in interpersonal encounters, there seems to be great cause for celebration insofar as a woman has achieved virtually meaningless and ineffectual measures of "power," "independence," and "control" in the form of a few visibly toned muscles in her body.

Finally, girls and women need to know how to manifest (degraded) femininity. Presumably, the best sort of guidance here would help ease the frustration and humiliation of having to embody that which is devalued. In a remarkable and stupefying semantic sleight of tongue, this is in fact accomplished within the social-cultural messages themselves. For these messages requiring women to cultivate slender, streamlined, and arguably masculine (or in some cases barely-pubescent) sorts of bodies simply deem such bodies "womanly" and "feminine." That is, while at once instructing women to rid themselves of traditional feminine curves, these messages also identify a "new," "liberated," yet still "feminine" body. We are assured that this latter sort of body does not offend. In fact, we are trained to think of it as alluring, sexy, and attractive. In this way, those who pursue "liberated" femininity are able to replace awareness of rejection and degradation with a sense of accomplishment. They are feminine in the mode of not being feminine, and this is valued.
But I think there is even more to the manner in which girls and women are taught that we can be acceptably feminine. I will not be able to develop my argument in much detail here, but my thinking is that the ultimate culturally-constructed contemporary expression of femininity itself is precisely the manifestation of a bipolar renunciation of allegiance to women on the one hand, and affiliation with and devotion to men on the other. To support this idea, I would first like to make the observation that women who do not strive after thinness— or who are not perceived as making this effort -- are penalized. What's striking about this is there is no "to each her own" sort of response to girls and women who are not slender. On my hypothesis, this is because their (real or apparent) lack of interest in manifesting their devotion to meeting the needs of men is experienced as an affront.

In this vein, Beth MacInnis (1993) observes that "[n]either fat women nor lesbian women are seen as actively trying to please men, and are subjected to ridicule, scorn, and contempt" (p. 76). The analogue in the case of women of colour is the requirement not only to meet white beauty standards, but to manifest one's striving to do so. In this context, Kim Buchanan (1993) quotes bell hooks (1992) to the effect that "[o]n our jobs, when we express ourselves from a decolonized standpoint, we risk being seen as unfriendly or dangerous" (Buchanan, p. 44). Of course, the other side of the coin here is that "black folks who...self-consciously labor to be as much like their white peers as
possible, will receive greater rewards in white supremacist society" (hooks quoted in Buchanan, p. 44).

The point here is that it isn't even necessarily being slender (or having toned muscles, or, for that matter, being white and having long blonde hair, blue eyes, and so on) that is of greatest importance, but rather the gesture of showing that one has worked hard to make one's body the way that men like it to look -- even and perhaps especially to the point that one's own pleasure, needs, and desires are sacrificed. Thus the mark of acceptability (or, better still, the turn-on) is the message exuded by the colonized body to the effect that "I am what you (men) want me to be, what you have required of me; see how I have worked so hard and how I have sacrificed myself to do this for you?" And on my argument, this is at least an additional layer, if not the core lesson concerning how to be acceptably feminine in contemporary Western culture.

In sum, the messages and directives pertaining to female body management that I have been discussing are compelling because they offer a well-circumscribed context into which conflict can be displaced and addressed. As a result they are readily absorbed by the girl or woman at risk for eating problems. And, as indicated in Figure 11, this results in a commitment to pursuing slenderness. But in light of our earlier discussion, it is important to highlight two points. First, the conflict in question is psychoculturally as opposed to intra-psychically generated via the interface of social-cultural
Stage Four of Model Development

SOCIAL-CULTURAL INPUT

messages related to the double bind to the effect that females must be what is devalued (feminine) and value what they must not be beyond acceptable limits (masculine)

GENDERED PERSONALITY AND RELATED FEATURES OF THE PSYCHOLOGY OF THE GWRPE

hyperfemininity hypomasculinity perfectionism

awareness of extreme femininity and low-level masculinity

internal pressure to be more masculine and less feminine

intensified conflict and anxiety

need for resolution of conflict and anxiety in the form of guidelines regarding how to fulfill the requirements of the double bind to:
(a) embrace masculinity
(b) reject femininity
(c) (still) be feminine
(d) be masculine within acceptable limits

commitment to pursuing slenderness and the toned body

Figure 11
messages and the gendered personality of the GWRPE. And second, messages urging women to cultivate slender and toned bodies play a role in producing the commitment to restricted eating not because they comprise generic conflict-reducing sorts of directives, but rather because they are precisely keyed into the culturally-instilled needs that helped to generate conflict in the first place.

 Nonetheless, stepping back from the model as sketched above, a question arises concerning my goal of modelling the etiology of more severe eating problems. For all we have to this point is a commitment on the part of the girl or woman at risk for problem eating to pursue slenderness. In response to this observation I would like to refer back to the interpretive analysis of empirical research offered in Chapter Two. Specifically, I would like to note that the commitment to pursue slenderness in Figure 11 is not to be confused with the manifestation of self-described femininity or of valuing femininity simpliciter, but rather as a mode of attempting to resolve conflict via a bipolar embrace of masculinity and renunciation of femininity. As a result, the commitment to these behaviours is far more intense than it would be in the simpler case.

 This difference would of course be easier to discern if I had supplied a sketch of the simpler case, and therefore had the opportunity to indicate the difference in level of commitment to restricted eating and/or exercise. But even so, more needs to be built into the model to conjure the deep level of commitment to
these behaviours and their intense manifestation in the case of more severe problem eating along the continuum. As a first step toward developing these additional elements, I need to refer to the observation just made regarding the difference between striving to be feminine, and striving to meet the requirements of the double bind via the bipolar embrace of masculinity and renunciation of femininity. In response to this observation, it seems natural to raise the question why some girls and women take the bipolar route.

The feminist response to this question -- and therefore part of my own response -- is that it is rational to manifest a bipolar stance toward masculinity and femininity by cultivating a slender, taut, toned, and tight body. In my earlier discussion concerning the colonized body, I noted that women are rewarded for manifesting a commitment to fulfilling the desires of men, and punished for manifesting failure or resistance. Indeed, as any woman who has dieted knows, one receives many social and even material rewards for losing weight and becoming more fit. For one thing, if a girl or woman was fat and becomes thin, she will no longer have to deal with the scorn, derision, and ostracization that she likely encountered in her "former life" related to being fat (MacInnis, 1993). But beyond this, she may receive compliments about how great or "how much better" she looks; she might receive more attention from heterosexual men; she is more likely to marry and ultimately receive the material benefits of heterosexual marriage (insofar as they are
available); and she is more likely to obtain, keep, and/or be
promoted in a job (Szekely, 1988; MacInnis, 1993; Wooley, Wooley,
and Dyrenforth, 1979).

Of course, one can do all of this under the heading of
striving to be more feminine, and indeed it is difficult to
discern the behavioural difference between slenderness achieved
under this heading, and slenderness achieved under bipolarity. I
would suggest, however, that in the former case, women diet to
achieve a certain look and convey they are doing this for
themselves. In the latter case, women also diet to achieve a
certain look, but in addition wish to convey that their self-
denial and self-sacrifice is for the sake of men. This accounts,
I suspect, for why even thin women -- even very hungry thin women
-- "eat lightly" in the company of men. To do otherwise is to
fail to convey the devotion to fulfilling the needs of men --
over and above one's own present needs and desires. It might
also account for why some women eventually break their diets.
For this sort of "failure" may be a measure of healthy resistance
to engaging in self-denial for the sake of others.

In any case, on the far right of Figure 12, I wish to
indicate that the commitment to pursuing slenderness yields
actual behaviour. This can take the form of dieting strategies,
cardiovascular exercise, "work-outs," diet pills, and so on. An
additional outcome can be weight loss, increased muscle tone and
fitness -- or not. Given the manner in which this commitment is
generated out of a bipolar mode of attempting to resolve gender
Stage Five of Model Development

SOCIAL-CULTURAL INPUT

messages related to the double bind to the effect that females must be what is devalued (feminine), and value what they must not be beyond acceptable limits (masculine)

GENDERED PERSONALITY AND RELATED FEATURES OF THE INNER PSYCHOLOGY OF THE GWRPE

messages related to the double bind

hyperfemininity
hypomasculinity
perfectionism

awareness of extreme femininity and low-level masculinity

internal pressure to be more masculine and less feminine

intensified conflict and anxiety

need for resolution of conflict and anxiety in the form of guidelines regarding how to fulfill the requirements of the double bind (as in Sketch 4)

commitment to pursuing slenderness and the toned body

messages urging and instructing girls and women to manage their bodies

messages which reinforce the pursuit of slenderness and the toned body, and/or punish failure or resistance to do so

EATING BEHAVIOUR

problematic dieting, exercise, and other modes or pursuing slenderness

weight loss, increased muscle tone, and fitness (or not)

ongoing problematic pursuit of slenderness

Figure 12
conflict, I would suggest that at this point, the girl or woman at risk for problem eating can be deemed a bonified girl or woman with problem eating (or GWPE).

But it is also important to capture the influence of the additional reinforcing sort of social-culture input that we have been discussing. Here I have hypothesized that additional messages and interpersonal experiences will either celebrate the "success" of the GWPE or punish her for "failure," and that this feedback will incite her to pursue slenderness in an ongoing fashion. Indeed, the ongoing nature of the pursuit is virtually guaranteed given the fact that most women are overwhelmingly likely to gain back lost weight (MacInnis, 1993). This of course renders her vulnerable to critical social-cultural input that ultimately provokes a re-commitment to the pursuit of thinness which in turn literally and figuratively puts her back on the treadmill. I have attempted to capture the pernicious cyclical nature of this pattern in Figure 12.

In addition to the feminist consideration that women are exhibiting rationality, I would also like to suggest that deeper psychological elements must be invoked to account for more severe problem eating via the "choice" of bipolarity. In particular, I think it is necessary at this juncture to introduce the deeper psychological structures of a lack of developed self and lack of womaninity into the model. Basically, what I have in mind is that the existence of these structures helps explain why some girls and women are unable to resist social-cultural messages
which promote bipolarity -- or better still, why some girls and women absorb these messages so readily, deeply, and concretely. Somewhat more specifically, I take it that lack of developed self and lack of womaninity operate in both general and specific ways to foster the outcome of bipolarity and (therefore) more severe problem eating.

Beginning on the more general level, and relying heavily on the phenomenology and analysis of my own experience, I want to suggest that lack of a developed self makes it the case that there is no substantial person within the girl or woman with eating problems who can question, criticize or at least in some sense temper the receiving of social-cultural input related to the double bind (and, for that matter, female body management). In fact, given that the receptor for all messages about how girls and women should be is a lack or gap, I want to suggest that they all just "go in," unmediated. As a result, they are interpreted too literally and absorbed too readily. And while they are supposed to become features of the GWRPE's gendered personality, they in a sense become more substantial than she is. Moreover, lack of a developed self means that there is not much of a person within to mediate conflict that arises in response to the internalized, paradoxical, double-binding messages.

Still referring to a more general level of functioning, I also take it that lack of womaninity engenders in the girl or woman at risk for problem eating a particularly favourable disposition toward the devaluation and renunciation of
femininity. Messages to this effect are of course contained within social-cultural input regarding both gender and the importance of managing women's bodies. Again relying on what I take myself to know about my own case, I want to suggest that the rejection of femininity at the core of this input makes sense to the GWRPE because she is already alienated from the world of women -- already sure that she could never belong there no matter how "feminine" she strove to become. In this context, aspiring toward masculinity offers an attractive alternative.31

In sum, then, I take it that lack of a developed self and lack of womaninity function to produce more severe problem eating in a general way by setting up for: unmediated absorption of social-cultural input; greater internal conflict related to the double bind; a more intensified need for resolution of this conflict; and a readier grasp to seize the option of rejecting femininity and embracing masculinity as a mode of resolution for this conflict. But, as I anticipated above, I also believe that psychological structures play a more specific role in generating more severe problem eating. As in the case of gendered personality, the basic idea here is that certain needs are generated within the girl or woman at risk for problem eating which are answered by messages pertaining to female body management. But in relation to lack of developed self and lack of womaninity, this social-cultural input does not address the need for guidance regarding how to fulfill the requirements of the double bind, but rather the need for guidance regarding how
to develop a self, and how to be a woman.

The metaphysical foundation for the distribution and consumption of this cultural advice to girls and women is, I think, already laid in the form of the conflation of woman and body noted above (p. 183). That is, we are already prepared to receive input which reduces who we are as persons and as women to the sort of bodies we have — and which, on the other hand, holds boys and men up as paradigms of persons. This occurs over time via our socialization into the language and metaphysics of patriarchal culture. Just to take one small and well-known example, the pervasive use of the pronoun ‘he’ to refer to persons in general helps to disappear the personhood of girls and women. In fact, as this example shows, the invisibility of messages about the full personhood and womanhood of women plays a significant role in this process of socialization.

On the other hand, contemporary culture also provides an endless stream of messages which feature women and thus render us visible. But since the conflation of women and our bodies still holds, advice about how to develop ourselves as women and persons accordingly concerns how we can improve our bodies. More specifically, and once again, we are instructed to render our bodies as unstereotypically female and pleasing to men as possible via the relentless pursuit of slenderness and tone.

Although I will only briefly indicate the nature of their work here, cultural analysts such as Bordo (1993) and Kilbourne (1994) provide rich evidence to the effect that the print media,
television, films and, most of all, the marketing industry are concerned to tell women to "be all you can be," and/or to "be who you really are," and/or to "be the real sexy desirable woman who is hiding under all that disgusting fat." Again, my hypothesis is that this speaks to the genuine need on the part of some girls and women to develop our selves and learn how to be women. But beyond this, these media are concerned to teach women that we can reach these goals by losing weight, and that this is easily accomplished by joining such and such fitness club, or by trying to emulate the look of all those ordinary women in Hollywood, or by treating ourselves occasionally -- and sinfully -- to such and such "lus-cious" diet food or drink, and so on and endlessly on.

Two obvious but nonetheless striking points of note here are (1) that the cultural prescriptions for girls and women regarding how to be properly feminine, how to be masculine within acceptable limits, how to develop one's self, and how to be a real woman are identical, and (2) that these prescriptions promote and even glamorize a tragically inauthentic existence for millions of women. Indeed it is tragically ironic that the expression of femininity reduces to its renunciation, the pursuit of masculinity reduces to the cultivation of a tight abdomen, the project of developing oneself reduces to that of meeting the needs of others (and men in particular), and the project of discovering how to be a woman reduces to its abandonment.

In this context, I think it is vital to note that women also tragically absorb the lesson that we must relate to ourselves and
to each other as bodies rather than persons. In this vein, we are taught that other women (i.e., their bodies) chiefly represent threats to our well-being given that women with "better" bodies have a better chance of obtaining the most precious commodity of all: male attention, male approval, and the potential for heterosexual partnership. Thus we are directed away from cultivating a sense of belonging, welcome, and love among women.

As I have tried to argue, many girls and women are desperately in need of what I have called womaninity, as well as guidance in developing other aspects of being a woman and being a person. But, again, we only receive information which fosters inauthenticity by leading us further away from meeting our needs. I wish to hypothesize that at some level, girls and women at risk for problem eating know all this. At some level they know that losing weight and exercising compulsively have nothing to do with becoming who they really are, or coming to feel more whole and satisfied as women and as persons. In keeping with this hypothesis, and for the purpose of elaborating the model, I take it that conscious or unconscious awareness of the inauthenticity of the path of female body management only deepens the anxiety and conflict experienced by the girl or woman at risk. But her commitment to managing her body is only intensified in the face of her lack of developed self, her lack of womaninity, and the dearth of cultural alternatives.

Given the additional material that has emerged in the
preceding discussion, I am poised to offer a final sketch of the psychocultural model. However, to do this I must determine the location of deeper psychological structures within the model. And this will require an explanation of how lack of a developed self and lack of womaninity are, on my thinking, related to certain dimensions of the gendered personality of the girl or woman at risk for problem eating.

I believe that lack of a developed self is intimately related both to hyperfemininity and low-level masculinity. But in order to explain what I mean by this, I need to say a word about how I conceive the relationship between these two features of gender when they are co-present in girls and women with problem eating. In Chapter Two I briefly mentioned that the idea that masculinity and femininity are related in bipolar fashion has largely been rejected in favour of the idea that they are orthogonally related (see above, pp. 39-40). On the bipolar model, the presence of femininity is taken to indicate the absence of masculinity — and conversely. Thus for example we might assume that if a person is warm, sensitive and thoughtful, then she is not assertive, tough-skinned and adventurous. On the orthogonal model, these are all compatible within the same person.

Measures such as the Personal Attributes Questionnaire (PAQ; Spence & Helmreich, 1978) and the Bem Sex Role Inventory (BSRI; Bem, 1974, 1978) incorporate a scale which conceptualizes some masculine and feminine traits in bipolar fashion. I want to
suggest that use of this sort of scale seems particularly appropriate in the case of women with problem eating who appear highly feminine and minimally masculine. For from a certain perspective it seems as though being so feminine basically amounts to the same thing as the absence of masculinity -- that being so feminine is at least in part a way of not being masculine. This certainly accords with my own experience. It seems, for example, that being so oriented toward others was at once a measure of my inability to be assertive and self-reliant.

Having considered the nature of my own lack of developed self at the age of fifteen, I would like to take this thought one step further. Specifically, I would like to consider for a moment whether lack of a developed self might more or less amount to the same thing as bipolarly-configured hyperfemininity and low-level masculinity. At the very least it seems one could say that a person certainly needs a solid sense of self to be (genuinely) self-reliant, self-confident, assertive, and so on; or that, lacking this, one might become oriented toward others, caring, thoughtful, and so on, in the extreme. Along this latter line of thinking it is not surprising that selflessness is considered a quintessentially feminine trait. Having said this much, however, I must state that I actually don't believe that lack of a developed self can simply be cashed out into the traits associated with low-level masculinity and hyperfemininity. Even though one needs a self to be self-confident, it doesn't follow from this that being self-confident and having a self are the
same thing. Nor is it the case that such stereotypically feminine traits as gentleness and warmth make direct reference to lack of a developed self.

The alternative hypothesis that I would like to offer is that readings of hyperfemininity and low-level masculinity tap into gender features that could belong (or not) to anyone, but that in the case of the anorexic, they also tap into the underlying structural feature of a lack of developed self. That is, in the case of the anorexic, results which seem to pertain exclusively to gender also reveal much about the status of the self. To continue this hypothesis, I believe that this is the case because this structural feature of the psychology of the anorexic shapes and conditions aspects of gender in such a way as to render them extreme. In my own case I was unable fully to account for the intensity and depth of my femininity and lack of masculinity when analysis was restricted to descriptions of gender features proper. It was only with the discovery of a lack of developed self that the nature of these features in my case, as well as the intensity of the conflict that I experienced in relation to various aspects of my gender profile, could adequately be captured.

From the perspective of my history of healing I can also add that while there is no doubt that there were substantial changes in my gender profile, these changes seem also to have reflected growth and healing that was taking place at the level of my self-development. Returning to the point about necessary conditions,
I can’t see how I could have become more self-reliant, self-confident and so on without developing more of a self in the first place. But moving from this logical point to the phenomenology of anorexia, it is also clear to me that it wasn’t only that I came to cultivate a number of masculine gender traits, nor that I came to lessen the intensity with which I manifested feminine traits. Rather, I was becoming more substantial in the process of developing my own identity over the years.

I suspect that the second deep structural feature of my psychology at the age of fifteen is chiefly related to the rejection of femininity within my gendered personality. In fact, discovery of a lack of womaninity emerged within the autobiographical exercise specifically in response to the theme of rejecting femininity. Discovery of this lack helped me make sense of the depth and intensity of the conflict that I experienced about moving into adolescence, as well as the doubts and anxieties I was experiencing about the worth of my femininity and my increasingly female body. But just as in the case of lack of a developed self, I would argue that lack of womaninity is not reducible to doubts about the worth of femininity, anxiety about adolescence and sexuality, and so on. Rather, my hypothesis is that these features of my gendered personality were tapping into the structural feature of a lack of womaninity.

This hypothesis is again rooted in the phenomenology of my experience, and in particular my sense that conflict that I
experienced in relation to double-binding messages about devalued but required femininity, and supervalue but restricted masculinity was profoundly shaped and conditioned by lack of a sense of welcome, safety, and acceptance into womanhood. That is, it makes sense to me that the messages I was getting about the ways I needed to be feminine ran up against an even deeper and more disturbing source of conflict rooted in my (largely unconscious, I think) sense that it wouldn't be safe and acceptable to be feminine in an adult fashion, among other women. In this vein it is no wonder that I somatized my conflict and chose the bipolar route, taking my chances within the more familiar and less threatening context of affiliation with masculinity.

Validation of this conceptualization of the relationship between conflict about gender and lack of womaninity also comes from my history of healing. As noted in the second phase of the autobiographical exercise, I was able to go on to develop into an adult female heterosexual woman, to make my own decisions about the relative worth and viability of feminine and masculine traits and roles, and eventually to relinquish the project of validating my worth via the embrace of a more masculine and male-oriented body and existence. Indeed, I believe that it was the gradual coming to consciousness and working over stages on my deep anxiety about being a woman among women that I was ultimately able to release myself from all behaviour related to problem eating.
In sum, my hypothesis is that lack of womaninity in the psychology of the girl or woman at risk for problem eating is intimately related but not reducible to all modes of the rejection of femininity that I have discussed; and that lack of a developed self is intimately related but not reducible to hyperfemininity and hypomasculinity. More concretely, I have hypothesized that these underlying structural features in the psychology of girls or women at risk for problem eating profoundly shape and condition the above-mentioned aspects of gender, altering their nature and their phenomenology.

In order to incorporate this hypothesis into the final stage of model construction, I locate lack of a developed self and lack of womaninity in Figure 13, below, under the heading of "Deeper Psychological Structures." I also attempt to indicate their relationship to hyperfemininity/hypomasculinity, and the rejection of femininity (respectively) via the use of arrows. The arrows are meant to indicate how features of gendered personality are shaped and conditioned by the deeper psychological structures. In keeping with an earlier observation, lack of a developed self also serves to intensify anxiety within the GWRPE given her limited capacity to mediate conflict.

All other features of the etiology of more severe problem eating discussed above are also represented in the final sketch. Accordingly, I have attempted to show how the need for guidance regarding how to develop as a person and as a woman are
Social-Cultural Input

Messages related to the double bind to the effect that females must be what is devalued (feminine), and value what they must not be beyond acceptable limits (masculine).

Gendered Personality and Related Features of the Psychology of the GWRPE

- Hyperfemininity
- Hypomasculinity
- Perfectionism
- Awareness of extreme femininity and low-level masculinity
- Internal pressure to be more masculine and less feminine
- Intensified conflict and anxiety
- Profound need for resolution of conflict and anxiety in the form of guidelines regarding how to fulfill the requirements of the double bind, including the rejection of femininity (as in Sketch 4)

Eating Behaviour

- Lack of developed self/including a readiness to absorb social input in an unmediated fashion
- Lack of developed self/including a limited capacity to mediate conflict
- Lack of womaninity/including a disposition to renounce one's femininity
- Need for guidance regarding how to develop one's self and how to develop as a woman
- Commitment to pursuing slenderness
- Awareness of some level of the inauthenticity of this path
- Increased anxiety and conflict, and intensified need for resolution

- GREATLY intensified commitment to pursuing slenderness
- GREATLY intensified commitment to pursuing slenderness

- More severely problematic eating (possibly including more extremely restricted eating, compulsive exercise, purging, the use of purgatives and/or laxatives, cycles of bingeing and purging, and so on)
- Weight loss, increased muscle tone, and fitness (or not)
- Ongoing more severely problematic pursuit of slenderness

Figure 13

Psychocultural Model of the Gendered Nature of More Severe Problem Eating
generated, and that this need is answered by social-culture input pertaining to female body management. The resulting interface between need and input in turn yields a commitment to the pursuit of slenderness and the toned body. Moreover, given that the GWRPE is at some level aware of the inauthenticity of this path toward self and womaninity, her anxiety and conflict is amplified. And as she finds no alternative within herself or the surrounding culture, she can only respond by intensifying her commitment to managing her body.

This outcome operates in tandem with the deep commitment to pursuing thinness that constitutes the parallel (and identical) mode of resolving conflict related to the gender double bind. As indicated in Figure 13, the combined result is of course the behavioural manifestation of this commitment in the form of more severe problem eating. In addition, the GWPE will likely (but not necessarily) lose weight and increase her muscle tone. Finally, as recorded in Figure 12, one last set of social-cultural input arises in response to the "success" (or "failure") of the GWPE in her pursuit of slenderness. Again, this feedback (and the fact that women are likely to gain back lost weight) paves the way for an ongoing effort.

Having completed the sketch in Figure 13, I am of course inclined to refer to the empirical touchstone of my own experience in order to determine whether or not the model is complete. On this basis, I can say that the model finally achieves a level of psychological complexity that resonates more
fully with my own experience and understanding of the gendered nature of anorexia. Of course, as I indicated at the outset of the present chapter, I believe that a good deal more would have to be added to the model to account for the production of full-blown eating disorders such as anorexia and bulimia nervosa. However, the foundation for this work has been laid down in the model developed here. In the meantime, I believe that the more general goal of accounting for relatively more severe problem eating on the continuum has been accomplished.

Before turning to a more detailed assessment, I would like to recall that my attempt to meet this goal was incited by a specific question raised in the present chapter concerning why some girls and women seem so readily to absorb social-cultural messages which promote bipolarity as a mode of resolving conflict related to the double bind. For the central hypothesis contained within the model is that the embrace of bipolarity accounts for more severe eating problems. The flip side of this in relation to the rest of the continuum would be the hypothesis that girls and women who do not take the bipolar route exhibit milder eating problems -- or none at all. And of course this provokes a flip-side question concerning how some girls and women are able to resist social-cultural messages which promote bipolarity.

This question relates to the desire expressed in the Introduction to account for the problem eating of girls and women along a continuum, as opposed to focusing only on extreme cases. It also relates back to Szekely’s concern (see above, p. 18) that
we be able to account for the existence of girls and women whose behaviour is located off the continuum of problem eating altogether. In the remainder of this section, I would like very briefly to suggest how the model developed here can be used to account both for the absence of problem eating, and for its more mild manifestations along a continuum.

The basic idea here is that if we can account for why bipolarity is not taken up in response to conflict or anxiety related to the double bind, or for why conflict or anxiety of a sufficient level of intensity is not generated in the first place, then we can account for more mild eating problems -- and even the absence of such problems altogether. And the key to this is to recall that on the account developed here, bipolarity is chosen because (a) from a certain perspective, it is rational to do so, and/or (b) lack of developed self and lack of womaninity operate in general and specific ways to make this mode of resolution of conflict particularly compelling.

This raises two related possibilities: (1) when these factors are not at work, girls and women do not exhibit problem eating, and (2) when these factors are present in various combinations, and/or to different degrees but not to the extent where bipolarity is chosen, girls and women exhibit behaviour which lies along the milder range of problem eating on the continuum. Indeed, these are precisely my hypotheses. But I need to suggest briefly how this might work. In the case of (1), and in relation to (a) in the previous paragraph, I do not of
course wish to claim that girls and women with healthy eating patterns are irrational! Rather, I would suppose that these girls and women answer to a higher-order rationality according to which one simply develops and maintains one's health and well-being by responding to the natural needs of one's body. Girls and women from families in which the relationship to food is (at least relatively speaking) straightforward no doubt come by this more naturally. Others less fortunate come to it in the context of feminist analysis of the post-industrial patriarchal capitalist nightmare -- and a long-term struggle to wake up.

As for (1) in relation to (b), I would suggest that the girls and women in question have developed selves and a sense of womaninity adequate to ward off the gender double-bind. In general, conflict and anxiety that they might experience would not rise to a problematic level, and more specifically, the need for guidance regarding how to develop a self or womaninity would not arise.

Turning to the case of mild eating problems depicted in (2), in relation to (a) and in keeping with my hypothesis, I would suggest that a range of milder eating problems can be accounted for depending on the degree to which girls and women have learned that it is best to maintain or cultivate a natural relationship to their bodies, hunger, food, exercise, and so on. The other side of the coin here is the extent to which the "old-order" rationality prevails. And in between there is room for an endless variety of configurations. For example, if a young
feminist has only just begun to raise her consciousness about these issues, then she might still be (guiltily) inclined toward occasional dieting, or she might still feel somewhat antagonistic toward her body. Or a very feminine woman might rigorously diet and work at keeping her muscles toned insofar as she believes that being thin will help her obtain employment.

Turning to (b), in some cases and again on my hypothesis, another source of conflict and anxiety can be at work in the generation of mild eating problems -- alone, or in conjunction with the need to cultivate a higher-order rationality with respect to eating practices. In keeping with the model, this conflict would be rooted in the relationship between sociocultural input on the one hand, and gendered features of personality and deeper psychological structures related to self and womaninity on the other. This relationship would in turn generate problem eating of varying degrees of severity chiefly depending on the extent to which each element of the deeper psychology is operative, and has been developed. Thus, for example, a young woman with a weakly developed self but a strong sense of womaninity might have trouble resisting societal messages related the double-bind, but on the other hand might not be tempted to renounce her femininity. She might end up exercising compulsively on some occasions in response to the desire to cultivate masculinity within acceptable limits, but her eating problems would perhaps remain mild. Or we might discover that a feminist with a strongly developed self diets with the
goal of weight loss not for reasons of health, but because she still struggles to resist messages urging the rejection of her female body given her (ironically) low level of womaninity.

Hopefully, this discussion begins to convey a sense of the wide range of configurations of relationships among social-cultural input, gendered personality, and deeper psychological structures that can produce problem eating along a continuum. At this point I would like to turn to an overall assessment of the model, including a discussion both of its limitations and possible applications for research and therapeutic practice.

ASSESSMENT AND CONCLUDING REMARKS:

My primary goal for this thesis has been to offer a resolution to the feminist-clinician debate in the form of a psychocultural model of the gendered nature of problem eating. In order to render this goal concrete I formulated a set of conditions of adequacy for any model that I might construct, and at this point I would like to assess the model in terms of those conditions. Although the conditions have not been satisfied in the order in which they are presented, I think that the model in fact:

(i) interprets the role of contemporary cultural messages related to female body management as intrinsic and essential to the construction of problem eating

(ii) accounts for how cultural messages related to female body management come to be causally efficacious within the psychology of individual girls and women

(iii) integrates the current historical context of gender upheaval and conflict for girls and women
(iv) recognizes that problem eating of all varieties lies along a continuum

(v) explains why some girls and women end up struggling with more extreme species of problem eating

It can also be noted in the case of (iv) that the model not only recognizes the existence of a continuum but, as I have just discussed, also makes it possible to account both for milder species of problem eating, and for healthy eating. Finally, it provides a foundation for a model of full-blown eating disorders which remains to be developed. The only condition that has not yet been met concerns the capacity of the model to contribute to therapeutic practice [see (vi), above, p. 20)]. And I will shortly address this condition by discussing the implications of the model for therapy.

Limitations:

Despite its success in meeting the above conditions of adequacy, the model is of course severely limited in crucial respects. As discussed in Chapter Three, methodological and epistemological concerns about my use of autobiographical inquiry in constructing the model can be raised. For one thing, the model is as a result devoid of external validity and, for this reason, generalization of the model beyond my own case is not warranted. In fact, given the possibly unreliable and certainly constructed nature of my recollections, the model may not even apply to my experience. On the other hand, though, as I have also discussed, I have not claimed that the autobiographical material exhibits either the virtue of generalizability or that
of reliability. Moreover, I have not used this material for the purpose of confirming or disconfirming specific research hypotheses, but rather only to lay out the first few stages of a grounded theory approach. Of course, support for the methodological decision to use autobiographical material, and for the pragmatic stance that I have taken toward assessing the value of the model may be generated in the context of future research. In the meantime, it seems worth highlighting that the approach taken here has at least been fruitful in the sense that I have been able to develop a preliminary model. As noted earlier, this in itself might also constitute support for methodologies which intertwine quantitative, qualitative, and, I would add, clinical approaches to research problems related to human psychology.

A second and more focused remark regarding the generalizability of the model is rooted in concerns located on the border between methodology and politics. As discussed in the Introduction and as noted at the outset of the present chapter, it is vital to bear in mind the socioeconomic and racial location of the subjects studied in the first stage of empirical research, the autobiographical exercise, and -- as would be likely as well as appropriate -- in research that would test hypotheses that could be drawn from the model. For even if the present model is validated by future research, given the location of the subjects, it is likely that the model at best only describes the case of white, middle or upper class girls and women with problem eating.
Research Implications:

Of course, the other side of the coin regarding limits of the model is that horizons of possibility are opened up for future model development and research. With respect to the point just noted concerning generalizability, it will be vital to expand and deepen research concerning the nature of problem eating not just in relation to gender, but also to race, class, ethnicity, religion, sexual orientation, age, disability, and personal and social histories of sexual violence. I suspect that the present model could be adapted to accommodate findings gathered in the context of this research, but I am not in a position to show how this can be done in the context of the present project.

Horizons of possibility can also be discerned for research and further model development regarding the gendered nature of eating problems for white, middle or upper class women. As I have already noted, research hypotheses could be extracted from the model developed here and then tested. Indeed, there are many points in the above discussion where I offer specific hypotheses which could be worked up into formal research hypotheses. For example, I have hypothesized that taking a bipolar path to resolving conflict related to the double bind (and to fulfilling the need for womaninity and a developed self) is the distinguishing feature of more severe eating problems; that, at some level, GWRPE's know that female body management represents an inauthentic means to develop as women and as persons; and that
lack of a developed self and lack of womaninity shape and condition aspects of overall gender profile such as femininity, masculinity, valuational stance toward masculinity and femininity, and so on.

In the context of later stages of a more rigorously conceived grounded theory approach, these hypotheses would no doubt be rejected or revised, and new ones would be added. The model would be altered over time to accommodate new findings and new conceptualizations of research problems. Indeed, even from the present vantage point, there is much more that needs to be added to the model offered in Figure 13. My own goals for future work can be briefly summarized as follows. First, I would like to offer some indication of the broader political context out of which social-cultural input containing the gender double bind and messages requiring female body management are generated. In particular, I think it is vital to make it clear within the model that the social-cultural input is not in any sense neutral, but rather shaped by the ideologies of patriarchy, capitalism, classism, racism, ageism, ableism, heterosexism, homophobia, and so on.

A second, related goal is to make the model thoroughly psychopolitical. What I mean by this is that I wish to show that there is a complex interweaving of psychological and social-cultural-political elements at every layer of the unpeeling of the etiology of eating problems, and hence that we can never reach a definitively psychological or political core. My
immediate concern in this context is to develop a thoroughly psychopolitical model of the etiology of the deeper structural features of a lack of developed self and lack of womaninity.

The third manner in which I would like to expand the present model is to map the location and function of other aspects of overall gender profile that we have discussed besides hyperfemininity, hypomasculinity, and rejecting femininity. These would of course include valuing feminine traits and/or roles, aspiring toward superwomanhood, rejecting female adolescence, and so on. Finally, I would like to build upon the present model to account for extremely severe problem eating in the form of such full-blown disorders as anorexia and bulimia nervosa.

Implications for Therapy:

My final task for the thesis is to indicate that a number of implications can be drawn from the model for healing and therapy. Given the centrality of social-cultural input in the model, I wish to state at the outset that it is of chief importance that changes be made in the cultural-political-social context in which healing takes place. Accordingly, there is a clear necessity for ongoing feminist cultural analysis and critique, as well as activism to promote social change. But even in the context of therapy, I believe that we do well to heighten the feminist consciousness of clients, teaching them that the personal is (still) political. More specifically, I think that as therapists we need to help girls and women develop a critical
perspective from which to assess, among other things: social-cultural input regarding the relative worth of femininity, masculinity, men, and women; the gender double bind; the equation of self-worth with appearance; the manner in which women are directed to resolve "personal" problems by controlling and managing our bodies; the manner in which girls and women are in any case required to manage our bodies; and the endless stream of instructions concerning how to manage our bodies in the form of cultivating slenderness, toning our muscles, becoming more fit, (and so on).

Development of a critical consciousness about these elements of patriarchal culture can of course be facilitated via the use of psychoeducational material, especially in group therapy. In addition, therapists can be encouraged to examine their clients' gender profiles with them. Together, they might also have occasion to talk about the pitfalls of stereotypical femininity, and the skewed nature of profiles which lack such stereotypically masculine attributes as assertiveness and self-confidence. Taking this one step further, it is possible that individual clients or groups would benefit from assertiveness courses or training in self-defense.

On the other hand, though, I would suggest that it is of vital importance to temper these ideas with awareness of material that has also emerged here concerning the deeper psychological structures of lack of a developed self and lack of womaninity. Steiner-Adair (1986) would, for example, take great issue with
the idea that girls and women need to cultivate more stereotypically masculine traits. Indeed, the point of her article on the body politic is that anorexia is a protest against the failure of contemporary Western culture to support the ("female") value of relationships and interrelatedness among people in favour of a ("male") orientation toward autonomy and independence that does not include interdependence.

On a third hand, though, the concern that I wish to raise about the cultivation of such traits is somewhat different from that expressed by Steiner-Adair. For while I agree that there are problems with masculinity as it is currently culturally constructed, I think there is much value in traits such as assertiveness and self-confidence. Given my hypothesis about the role of lack of a developed self in conditioning masculinity and femininity within the GWRPE, I would specifically suggest that it is best not to introduce psychoeducational material on assertiveness until the self is more developed. To do this earlier would be to address more surface-level hypomasculinity and hyperfemininity without accessing their more substantive foundation in the form of a weakly-developed self. Moreover, precisely given the lack of substance and other-orientedness of the GWRPE, it is very likely that clients will work very, very hard to manifest the relevant skills, but only in the context of trying to please others. Thus, ironically, the manifestation of behaviours associated with self-confidence would in fact be evidence of the very lack of self that we would be trying to
address.

A second cautionary note about the use of psychoeducational material and working on issues on the level of gender relates to the structural feature within the GWRPE of a lack of womaninity. Given that this lack is related to tremendous anxiety and conflict experienced by girls and women who feel estranged from their femaleness and unwelcome among women, I would urge therapists not to proceed in such a way as to assume any degree of womaninity on the part of their clients. The reason why this would be a mistake is that girls or women with this lack are, as I would suppose, likely to resist psychoeducational material about how "we" women are oppressed by cultural messages which promote slenderness and disparage femininity. Moreover, their resistance would likely take the form of a silent protest to the effect that: "Who cares? I'm not with them anyway so why should they care about me? And why should I care about them? NO. I don't trust them. They just want to make me fat. I have to keep going; I'm never going to give in."

The bottom line of the present hypothesis is that it will be necessary to foster the development of self and womaninity in our clients before introducing psychoeducational material. More specifically, we must facilitate the reception of consciousness-raising by girls and women with eating problems by cultivating in them both the need and desire for self-care, and a solid, emotionally-based ability to trust other women. This will ensure that there will be someone there who is substantial enough and
woman-identified enough to receive the material at all. And it should help ensure that these girls and women will be able to meet, critique, and ultimately resist social/cultural messages not just at an intellectual level, nor out of a desire to please, nor out of a desire to appear committed to change; but rather with their whole being.

Individual therapists and group leaders will of course need to work out ways of fostering the development of self and cultivation of womaninity with their clients. Given my own psychodynamic orientation, I am inclined to explore the unique etiology of the lack of developed self and lack of womaninity (and any other formative structures that might emerge in the course of therapy) for any given client in individual therapy. Although I have not been able to theorize about this etiology within the present thesis, the unconscious sequelae of emotional and possibly sexual abuse, parental narcissism, unresolved oedipal conflict, and separation anxiety are the sorts of phenomena within the psyche of girls and women with severe problem eating which would need to be accessed and worked-through. Again, in keeping with my orientation, this would require in-depth, long term therapy which incorporates techniques such as analysis of transference, body work, and the interpretation of dreams.

Among other things, focusing on the unconscious brings to light painful issues that need to be addressed in order to clear the path for healing and growth. I also believe it is vital to
explore alternative modes of relating to oneself and other women which do not involve the formation of judgments about the status of one's body on a hierarchy of worth based on culturally constructed and politically-informed oppressive standards of beauty. Part of this can include body image work which facilitates a friendly and even loving acceptance of one's own body (cf., for example, Hutchinson, 1985). Especially in groups, this exploration can also include the development of rituals. For example, a group of girls or women might wish to create a ritual to mark the transition from adolescence to womanhood, or the renunciation of patriarchal oppression as opposed to the denial of self. Both sorts of rituals might help address the womaninity that would likely be lacking in girls and women with problem eating.

Before closing, a final potential concern that I would like to address concerns the goal of helping clients cultivate womaninity. A great deal of criticism has of course been levied at the sort of cultural feminist position which appears uncritically to embrace essentialist characterizations of "women's ways" of knowing, thinking, feeling, living, and so on. For this brand of feminism can deem essential, merely culturally-constructed and therefore non-necessary features of femininity. And it can alienate all those women who do not find that their experiences mesh with those described in the essentialist characterizations.

I wish to be clear that therapy which explores women's
sense of estrangement from our own femaleness and from other women, and alternatively develops a sense of belonging and connectedness, needn't be based on this orientation. In my own case, I can say that it was tremendously healing to have my therapist teach me that, for her, femininity means being in touch with one's feelings, being able to receive as well as give, being able to 'be' and not just 'do', and being able to play and not just work. This sharing on her part certainly didn't lock me into stereotypical passivity or into racist assumptions about women. Rather, it taught me some things that I needed to know and, perhaps most significantly, allowed me to experience her warm and welcoming invitation for me to be a woman. This was significant because the invitation created a place for me to belong, and to learn how to love and honour myself and other women as women. Having received this sort of invitation, I think we can go on to discover for ourselves who we need and want to be, individually and collectively. And we can work hard to make it possible for our sisters and daughters to do the same.

TESTIMONY

There's godlike
And warlike
And strong like only some show
And there's sadlike
And madlike
And had like we know

But by my life be I spirit
And by my heart be I woman
And by my eyes be I open
And by my hands be I whole
They say slowly
Brings the least shock.
But no matter how slow I walk
There are traces
Empty spaces
And doors and doors of locks

But by my life be I spirit
And by my heart be I woman
And by my eyes be I open
And by my hands be I whole

You young ones
You're the next ones
And I hope you choose it well
Though you try hard
You may fall prey
To the jaded jewel

But by your lives be you spirit
And by your hearts be you women
And by your eyes be you open
And by your hands be you whole

Listen, there are waters
Hidden from us
In a maze we find them still
We'll take you to them
You take your young ones
May they take their own in turn

And by our lives be we spirit
And by our hearts be we women
And by our eyes be we open
And by our hands be we whole

Ferron
Lucy Records, Ltd., 1980
P.R.O. Canada
ENDNOTES

1. Of course it is not lost on minority women that they must also be white, wealthy, heterosexual, young, Anglo-European, able-bodied, and so on.

2. Again, it is important to reflect on the situation of non-white women whose skin, hair, and eye colour as well as body shape and size may be considered "abnormal and ugly" (Buchanan, 1993, p. 38) in contrast with the white, blonde, blue-eyed standard set for all women.

3. Of course the distinction I want to make here between "the feminist" and "the clinician" is somewhat artificial given the existence of feminist therapists. However, by the latter term I intend to refer to non-feminist clinicians and therapists in the field.

4. For an interesting discussion of how adolescents are forced to relinquish the experience of their own (especially sexual) embodiment in exchange for living and acting as desireless images, see Tolman and Debold (1994). Also see Shroff (1993) for a related discussion of the manner in which patriarchal societies depict women's appetites as dangerous, and as a result attempt to suppress and control women's bodies, women's eating, and women's sexuality.

5. Here I mean to distinguish between different stages of recovery. For me, early stages were marked by the ability to eat and gain weight, the recovery of menstruation, and so on. Full recovery has meant (in part) reclaiming my life as mine to create, and simply taking eating for granted as a way to satisfy hunger and to share pleasure with family and friends.

6. That is, in contrast to the familiar argument that sociological theories cannot account for why some women fall prey to severe eating disorders, Szekely (referring to Sayers, 1986) demands an account of why many women do not. Of course, in this context, other feminists are likely to argue that in fact most women in North America have fallen prey to problem eating because we are influenced by "women's devaluation and the pervasive hostility to women's bodies" (Szekely, 1988, pp. 180-181). Yet Szekely is also calling into question the feminist premise that this influence is universal.


8. In Fat as a Feminist Issue (1978), Orbach focused on compulsive eating which is associated with cycles of dieting and bingeing. Hunger Strike (1986) is chiefly concerned with anorexia nervosa but Orbach notes that many anorectic women go through bulimic episodes. Indeed, she construes compulsive eating, anorexia, and bulimia as "sister syndromes" all requiring social analysis.

9. The concept of conflict as opposed to mere gap is introduced here on the basis of researchers' and theorists' discussions of their findings. Specifically, it is noted that girls and women with eating problems do not simply make observations to the effect that there is a gap between their real and ideal gendered selves, but also experience this gap in a conflicted manner.

10. I have drawn from these clinicians and researchers either because they are mentioned frequently in the empirical literature, or because they offer empirical results in addition to more clinical or theoretically-based material.

11. Because these two tests will be referred to extensively, I would like to describe them briefly here. The EAT was originally designed to screen for anorexia nervosa, but is now considered a self-report measure for symptoms of anorexia and bulimia. It was shortened from 40 to 26 six-point, forced choice items in 1982, and assesses attitudes towards food, weight, eating behaviour, and body image. The EDI is a 64-item self-report measure which is designed to measure psychological and behavioural traits associated with anorexia and bulimia. Six-point, forced choice items assessing these traits are grouped into the following eight subscales: Drive for Thinness, Ineffectiveness, Interoceptive Awareness, Interpersonal Distrust, Maturity Fears, Perfectionism, Body Dissatisfaction, and Bulimia.

12. More complete references to the articles in which these measures first appeared are supplied as follows by the researchers whose work I review here: Herman, C. P., & Polivy, J. (1975). Anxiety, restraint, and eating behavior. Journal of Abnormal Behavior, 84, 666-672; Nash, J. D. Unpublished scale.

13. As in the case of the EDI and EAT, I would like to offer brief descriptions of these two measures given their extensive use in the research. Both the BSRI and the PAQ are measures of self-concepts of masculinity and femininity where these aspects of gender are treated as two independent dimensions of personality. The BSRI has 60 seven-point Likert scale items and subscores for measuring trait masculinity and femininity, as well as a median-split procedure for deriving an androgyny score. The original PAQ contained 40 five-point items, but was shortened to 24. It similarly contains items which independently assess trait masculinity and femininity, but also includes a set of items intended to reflect a bipolar dimension of gender related to aggression/dominance vs. vulnerability.


15. In light of (7) and (10), we could also add the subcategory of "Gender Profile and Body Weight." However, these findings may not be relevant to the remaining set given the nature of the
sample used by Thomas and James (1988) (see Appendix A for details), and so I choose to omit them here.

16. However, if the reader is interested, findings may be summarized by category as follows. For Ia, it seems that increases in masculinity are correlated with increases in body satisfaction (3, 5, 9, 26), whereas positive femininity is not related to body acceptance (1, 8, 28). On the other hand, socially undesirable femininity is directly related to body dissatisfaction (6). Results are mixed in the case of dieting: there is evidence that masculinity is inversely related to restraint (10) and that both femininity (4) and balanced androgyny (2) are directly related to restraint. However, there is also evidence that femininity is not related to dieting tendencies (8). Next, it seems that femininity is (21) and masculinity is not (23) related to importance of appearance. Finally, and most importantly, there was strong evidence to the effect that femininity is related to bulimia (15, 17, 18, 24). Correlations were also found between femininity and anorexia (14, 19), as well as between positive (22) and negative (6) femininity and eating disordered symptomatology. Masculinity appears to be inversely related to disordered eating (17, 25, 27), and undifferentiated androgyny positively related to bulimia (24). On the other hand, there is also evidence to the effect that there is no relationship between having a particular gender profile and disordered eating (11, 13, 16, 20).

17. It is important to note that bulimic behaviour and symptomatology were explicitly identified more often than anorexic symptomatology, but this may only be a reflection of the fact that more studies focused on bulimia than anorexia.

18. This possibility is underscored by studies measuring physique preferences among females. Silverstein, Perdue, Wolf, et al. (1988) refer to an experimental study by Kleinke and Staneski (1980) which found that "having a large bust leads women to be considered unintelligent and incompetent" (Silverstein, et al., p. 724). Indeed, as Bordo (1993) remarks, "for most people in our culture, slenderness is indeed equated with competence, self-control, and intelligence, and feminine curvaceousness (in particular, large breasts) with wide-eyed, giggly vapidity" (p. 55).

19. The exception comes from Pettinati et al. (1987) who drew from a clinical population of women with eating disorders.

20. And, we can add with Eva Szekely, how is it that some women at the opposite end of the continuum -- or off it altogether -- manage to resist the dominant cultural directives?

21. Thanks are due here to Dale Brooks for introducing me to the concept of theoretical sensitivity.
22. See endnote 13 for more information about these measures.

23. This is a medical condition caused by an intolerance to the pregnancy hormone HCG (human chorionic gonadotropin). The symptoms are extreme nausea, vomiting, and fatigue. In the worst cases (such as mine), the symptoms last from implantation (two weeks after conception) to delivery.

24. One might conjecture that maintaining a more child-like appearance also made it possible for me to ward off the male gaze. I think this is not only compatible with the observation offered in the next, but also true. And I will have more to say about this below, under the heading of "rejecting femininity."

25. As the joke goes, Continental philosophers speak in nonsensical terms about meaningful issues, while Analytic philosophers speak with utter clarity about nothing at all.

26. No doubt, there is much more to say about my father's influence on my development into womanhood than I have been able to convey here. However, for the purposes of this thesis I am more drawn to my mother's role, especially since this is what became salient for me in the context of therapy.

27. At this juncture, one might wish to make the feminist point that it was also dangerous to allow my female body to develop given the threat within patriarchy of sexual harassment, molestation, and rape. Indeed, I think that a full psychopolitical account of problem eating would need to incorporate this dimension of female experience. However, for the purposes of the present exercise, I am more concerned to work with what emerged as salient for me as the source of danger. And at the age of fifteen, I believe that my scope of concern did not extend too far beyond the confines of my family and anxiety about growing up.

28. Of course, the analogue of the point recorded in note 26, above, is that there is no doubt that my mother would also have played a key role in the development (or lack of development) of my self as a child and adolescent. However, I have chosen to emphasize the role of my father since my original associations direct me primarily to this.

29. Supposedly what men like, that is. But not necessarily. For it's men's aesthetic preferences and desires are undoubtedly induced and shaped by the print media, films, television, and marketing strategies.

30. I allude here to the work of Chaiken and Pliner (1987), and Mori, Chaiken, and Pliner (1987). These researchers set up controlled experiments to test their hypothesis that women eat less in the company of men. The hypothesis was strongly
supported by results and, in conjunction with additional evidence based on interviews, the authors conjecture that women "eat lightly" to appear more feminine.

Taking on this topic from a somewhat different perspective, Bordo (1993) and Kilbourne (1994) engage in powerful cultural analysis of the print media, advertising, television, films, and so on to show (among other things) how girls and women come to believe that it is important to manifest self-denial in practices associated with eating and exercise.

31. The option of cultivating masculinity (and also being affiliated with boys and men) is, I think, especially attractive in cases like mine where there was a much stronger relationship with the father than with the mother in childhood.

32. Note that this is not to be confused with bipolarity at the level of valuational stance involving the embrace of masculinity and rejection of femininity.

33. Again, it is possible that the implications only apply in the case of therapy with white, middle or upper class girls and women. At the very least, I think they would need to be expanded in the case of women in different social locations.

34. In their study of the dreams of women with clinical eating disorders, Susan Brink and John Allan (1992) discuss the key role that dream analysis can play in diagnosis and treatment. They demonstrate how such themes as rage, self-hatred, and the inability to self-nurture can be brought to relief. And they suggest that accessing such themes in the dreams of eating-disordered women "is more likely to promote positive transformation...than trying to change their behaviour" (p. 294).

35. I would like to express my gratitude to Judith Daniluk for suggesting that the creation of rituals can play a role in the therapeutic process.
REFERENCES


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APPENDIX A: Commensurability Assessment for Results in "I: Gender Profile"

Working with results under "Gender Profile," and beginning with masculinity, all but one study (van Strien, 1989) used either the PAQ or the BSRI to assess for trait masculinity. Van Strien [(1), (2), (3)] variously speaks of women who are "masculine" or "feminine," or who are "sex-typed," or who display a certain "sex role orientation" -- all of which are assessed by the GRAS (Groninger Androgyny Scale). Thus it is unclear whether she's operating with gender in the sense of trait or role. As it turns out, for van Strien, having a feminine sex role orientation means that a woman does not pursue high status careers or financial independence, but rather more traditional roles. The contrast is with "non-sex-typed women" who are conceived of as either "masculine" or "androgynous" (in the additive sense).

The bottom line here, as noted in the text (p. 41), is that inferences cannot be made about personality traits on the basis of role profiles. Hence it may not be that (3) is legitimately compared with other findings on masculinity in the category of body satisfaction in Ia. Regardless of this point, however, there still seems to be substantial evidence to the effect that trait masculinity is positively related to body satisfaction.

Since all other findings are commensurate with respect to their interpretation of masculinity, I would like to turn to the case of femininity. All but three studies under the heading of "Gender Profile" utilize either the PAQ or the BSRI and thus are
clearly concerned with trait femininity. Interestingly, a closer look at the remaining studies in fact reveals that they also focus on traits. In (12), Paxton and Sculthorpe (1991) used the PDQ which assesses for "sex role characteristics" (i.e., traits), and Heilbrun and Mulqueen [1987; (14, 15)] developed a sex role questionnaire which is derived from the masculinity and femininity scales of the ACL. Based on researchers' descriptions, the conceptualizations of gender traits operative in these measures are compatible with those in the BSRI and the PAQ. Boskind-Lodahl's (1976) observations about femininity in (29) were clinically-based and related both to descriptions of traits (such as passivity, dependency, and pleasing others), and roles (such as being a wife and mother). In sum, then, there seems to be no substantial basis for raising concerns about incommensurability related to the measurement of femininity.

The concept of disordered eating is of course only specifically referred to in Id. Within that subcategory, six of the ten findings are derived from results on the EDI (in whole or in part) or the EAT. As for the remaining four: in (17) bulimic behaviour is measured by the BULIT; in (25) researchers worked with hospitalized and outpatient anorexic women; in (27) "eating pathology" was intended to refer to bulimia; and in (29) "bulimarexia," essentially refers to bulimia. In these cases, description of eating disorder symptoms (insofar as it is offered) at least appears compatible with those targeted by the EDI and EAT. However, even if this assessment does not hold,
once again, six of the ten remaining findings are commensurate on this dimension.

In sum, results in "Gender Profile" which support relationships between trait masculinity or femininity and (aspects of) disordered eating are at least roughly commensurate. But the category of contrary or null results must be examined to determine whether or not the positive claims are substantively challenged. And this of course also depends on the extent to which positive and null results are commensurate.

In the case of the dimension of gender, we must first determine whether null results in Ie are representing masculinity and femininity in the sense of traits or roles. As noted above, van Strien [1989; (1), (2)] in fact worked with roles as opposed to traits. Thus her results have no bearing on other findings regarding body dissatisfaction and dieting, respectively, in which subjects' trait profiles are described.¹ As for (8), Thomas and James (1988) in fact worked with trait femininity as assessed by the PAQ. However, it is possible that their results are not legitimately compared with those reported in other studies because of the nature of their sample. In their study, Thomas and James focused mostly on young, single, college-educated urban African-American women. While most (approximately sixty-seven per cent) of the empirical research reviewed here

¹On the other hand, precisely because van Strien is working with androgyny at the level of role orientation, her result in (2) may have more to do with results related to "Superwoman" profiles and conflict captured under II and III.
employed college students as subjects, as noted in the
Introduction it is likely that these women were predominantly
white. The substantive difference that this racial difference
makes can be noted in Kim Buchanan’s observations that "[w]eight
preoccupation is not a central concern for Black women" (1993, p.
37), and that "[f]ortunately, Black communities accept fat on
women far more than the white beauty standard allows" (p. 47,
referring to Rand & Kuldau, 1992; and Gray et al., 1987).
Moreover, Thomas and James raise their own question about cross-
race generalizability.

In light of these observations, it may be that
(8) does not mitigate other results concerning the relationship
between femininity (as conditioned by the white race and middle
or upper class status of women described in other studies) and
dieting. Nonetheless, (8) -- as well as (7), (9), and (10) --
stand as significant and important findings about gender and body
image (dieting, and so on) in the case of young, urban, college-
educated Black women.²

The remaining contrary findings all utilize trait
conceptions of gender, and so may still challenge positive
results. We will focus on this set in order to assess the
dimension of disordered eating. A variety of modes were in fact

²Of course, on the other hand, these findings do not
necessarily hold even for African-American women. As Becky
Thompson (1992; 1994) argues, we need to be cautious about making
assumptions to the effect that, for example, African-American and
Latina women are by virtue of their culture protected from
societal and familial pressure to be thin.
examined including compulsive eating (11), eating disorder symptoms as measured by the EAT and/or the EDI [(13), (16), (20)], and bulimia assessed by other means [(24), (28)]. In (23) a concern for appearance and thus not disordered eating per se is reflected. Since this range approximates that found in the set of positive results, and since these seven findings all represent gender in the sense of traits, it may be that quite a substantial set of contrary findings remains.

Before settling on this conclusion, though, we do well to take a closer look at the studies involved. Lewis and Johnson [1985, (24)] -- as well as Paxton and Sculthorpe (1991) -- suggest that undifferentiated gender may be better construed as reflecting low self-esteem than low levels of masculinity or femininity per se. For this reason, I am not inclined to contrast (24) with other results.

Closer scrutiny of (16) next reveals that femininity and masculinity are not irrelevant, but rather must be combined with a superwoman ideal to increase risk for disordered eating. Similarly, for (20) we can note that Timko et al. (1987) want to show that femininity as previously operationalized is not related to eating disorder symptomatology. However, when we take (21) into consideration, femininity and disordered eating are most definitely linked (as in 22). Interestingly, then, when (16) and (20) are properly interpreted they can in fact be viewed as supportive of claims to the effect that a relationship exists between femininity and disordered eating.
Because they are commensurate with the positive findings on trait masculinity or femininity and aspects of disordered eating, only the four remaining findings represent direct challenges to the hypothesis that masculinity and femininity are related to disordered eating (and related phenomena). More specifically, (11), (13), (23), and (28) stand as genuinely contrary results which respectively call in to question claims to the effect that: compulsive eating is positively related to femininity (or masculinity); (positive) femininity is related to disordered eating; masculinity is related to concern for appearance; and femininity is related to body image or eating pathology. Overall, however, it seems that masculinity is an asset, and femininity, a liability in terms of lowering the risk of disordered eating (or some aspect of it).
APPENDIX B: Commensurability Assessment for Results in "II: Gender Stance"

In the case of valuing femininity, in IIa only two studies [(37) and (42)] use either the PAQ or the BSRI to ascertain women's attitudes toward gendered personality traits. In contrast, Mori et al. [1987; (31)] infer that women wish to present themselves as feminine on the basis of their experiments on "eating lightly." And the remainder of the research focuses either on attitudes toward roles (45), or on attitudes toward feminine traits and roles (43, 47). The measures vary as well. Rost et al. [1982; (45)] develop their own measure to ascertain subjects' attitudes toward traditional roles. Silverstein and Perdue [1988; (43)] explore "role concerns" related to the importance of traditional feminine roles and attributes using their own set of questions. And (47) is a collectively constructed claim in which the feature of slenderness arguably relates both to femininity in the trait sense of being concerned with appearance and the role sense of taking on the job of becoming or staying slender.

Results pertaining to the dimension of gender in this category thus vary. Since attitude toward trait femininity is assessed in five of the seven studies noted here, and since only

As noted in the text (p. 41), people can certainly take on roles which do not reflect their personalities. But by making this distinction between valuing trait femininity and valuing the appearance of trait femininity, Mori et al. also make it clear that people can take on personality traits insofar as they are perceived as valuable or somehow desirable.
one result (33) challenges their findings, it seems that valuing trait femininity may very well be associated with disordered eating. On the other hand, four studies provide results on attitudes toward roles and again only one null result (30) poses a challenge. Thus it seems that women with disordered eating value femininity in either or both the sense of personality attributes or traditional roles.

Turning to the dimension of disordered eating, Mori et al. [1987; (31)] developed their own concept and experimental measure for heightened concern about food intake, and the rather vague but nonetheless accessible concept of a pursuit of thinness is operating in the collectively-constructed claim in (47). Silverstein and Perdue [1988; (43)] asked their subjects directly about their behaviours of dieting, bingeing and purging. Timko et al. (1987) were concerned in (37) with the dimension of appearance and not disordered eating per se, yet the connection between importance of femininity and eating disordered symptomatology was made in (22) as assessed by the EAT. Pettinati et al. [1987; (42)] drew from a clinical population of anorexic and bulimic patients, and Rost et al. [1982; (45)] recruited their subjects from a newspaper advertisement in which binge/purge bulimia was described.

It seems impossible on the basis of these findings to offer a general statement which links valuing femininity in either the trait or role dimension with a particular eating disorder. While (43) and (45) concern bulimic behaviour in particular, the EAT
detects both bulimic and anorexic symptomatology, and Pettinati et al. (1987) do not distinguish between anorexic and bulimic patients. Moreover, results in (31) and (47) are potentially associated with all modes of disordered eating. Accordingly, and in summary, I can be no more specific than to say that valuing trait femininity and/or traditional feminine roles appears to be related to disordered eating in a variety of modes ranging from "eating lightly" to bulimia and anorexia for white, middle or upper class women.

As for the rejection of femininity in IIb, once again Silverstein and Perdue [1988; (44)] developed their own questionnaire regarding attitudes toward gender traits and roles, and asked subjects directly regarding practices of dieting, bingeing and purging. Steiner-Adair [1986; (46)] used a clinical interview to collect girls' ideas about trait masculinity and femininity, and both the EAT and AWQ measures to discern the presence of disturbed eating patterns. Finally, Bruch [1973; (48)] offered her clinical assessment of anorexic girls and women and their attitudes toward femininity in the sense of both traits and roles.

As noted above, the results in IIb are challenged in (30), (34), (35), (36), and (45). To discern whether or not these latter results are commensurate with one another, it can be observed that attitudes toward traditional roles were measured on the SRI (30), the ATW [(34), (36)], the WSQ [which is based on the ATW; (35)], and, for (45), on the basis of a scale developed
by Rost et al. (1982). As for disordered eating, the EAT was used in the case of (30), (34) and (35), while the Drive for Thinness, Body Dissatisfaction, and Bulimia scales of the EDI were also employed in the case of (35). Brown et al. [1990; (36)] rely on the BULIT, and Rost et al. [1982; (45)] on newspaper recruiting of bulimic women to focus on bulimia in particular.

Taking both sets of results pertaining to the rejection of femininity into consideration, seriously problematic eating behaviour associated with either bulimia or anorexia was consistently examined across all studies. Anorexia was specifically targeted in (48) and (35), but symptoms associated with it have also been detected in a more general way via the use of the EAT in (30), (34), (35), and (46). Bulimia was specifically examined in (35), (36), (44), (45) and, again, by the EAT in (30), (34), (35), and (46). In the case of gender, however, there is an important contrast between results which support the claim that femininity is rejected, and the null or contrary results which do not. Researchers generating the former set of results attended to trait femininity (46), or to mixtures of attitudes toward feminine traits and roles [(44), (48)]. In contrast, researchers generating null or contrary results exclusively attended to women's attitudes toward traditional female roles.

Given this difference of focus, it is clear that while null or contrary results in this category call into question the
proposition that female roles are rejected by women with problem eating, results pertaining to the rejection of feminine traits still stand. That is, considerable evidence has been gathered to the effect that female roles are not rejected by women with problem eating -- especially not, perhaps, in the case of bulimia\textsuperscript{2} -- and so it seems appropriate to record this as a substantial finding. On the other hand, though, the null results were not relevant to -- and therefore do not mitigate -- findings related to the rejection of feminine traits in IIb. Thus it is also appropriate to record that the rejection of feminine traits appears to be related to anorexia (48), bulimia (44), and eating disorder symptomatology (46).

As for IIC and the case of valuing masculinity, on the dimension of gender, all of the studies noted in IIC work with the concept of trait masculinity, and all but two studies employed the PAQ to discern importance of masculinity. Regarding these latter cases, Silverstein and Perdue (1988) gleaned information about traits as well as roles via their questions about "role concerns," and Steiner-Adair (1986) used a clinical interview to explore girls' views of masculinity and femininity. However, in both cases, the conceptualization of masculinity as related to professional success, intelligence, independence, and autonomy bears resemblance to its operationalization on the PAQ. Thus it seems that commensurability is secured on this dimension.

\textsuperscript{2}Though as noted above in Endnote 17 in the main text of the thesis, this may only be a reflection of the fact that more studies focus on bulimia.
Regarding modes of disordered eating, in this category researchers looked at compulsive eating (32); disordered eating as globally assessed on the EAT [(38), (39), (41), (46)] and on the AWQ (46); more extreme pursuit of thinness and purging as assessed via direct questioning (44), and anorexia as examined in a clinical setting (49). While a variety of modes were studied, we might also note that no contrary evidence was offered. For this reason, I’m inclined to summarize this section by saying that white, middle, or upper class women with disordered eating ranging from compulsive eating to anorexic and bulimic symptomatology appear to value trait masculinity.

Finally, regarding the results in IIe, there is little to analyze in this category given that there are only two central findings. (39) and (46) are both concerned with eating disorder symptomatology: Timko et al. (1987) use the EAT, and Steiner-Adair (1986) uses both the EAT and the AWQ to discern eating disorder symptomatology. Thus results seem commensurate on this dimension. As noted in the text, though, different interpretations of superwomanhood are operating in the two central findings in this category. And for this reason, it might not be that they are legitimately compared. On the other hand, Timko et al. [1987; (39), (41)] also recognize that valuing trait masculinity is part of superwomanhood. And Steiner-Adair’s (1986) notion that trait femininity is rejected in favour of masculinity is certainly compatible with the idea that superwomen take on both traditionally feminine and masculine roles.
Moreover, there are no null or contrary results in this subcategory. For these reasons, I would not be inclined to judge the claims as incommensurable. Rather, I would hypothesize that each study has worked with an important dimension of superwomanhood. As a result it seems fair to conclude that renunciatory and multi-role superwomanhood both appear to be related to eating disorder symptomatology.
APPENDIX C: Commensurability Assessment for Results in "III: Gender Profile, Gender Stance, and Conflict"

There are no exact matches in IIIa on either the parameter of gender or disordered eating. As explained in the text, there is no direct link to gender in the case of (50), while in (54) and (55) researchers examined trait masculinity using the PAQ and PDQ, respectively. And with regard to disordered eating, van Strien [1989; (50)] looked at dieting; Dunn and Ondercin [1981; (54)] at compulsive eating using the CES; and Paxton and Sculthorpe [1991; (55)] at bulimic symptomatology via the appropriate subscale of the EDI. However, since: (a) two of the three findings here in IIIa concern trait masculinity, (b) there are no contrary results to contend with, and (c) a connection has already been established between valuing masculinity and disordered eating in IIb, it may be safe to summarize by saying that valuing masculinity in conjunction with low self-described masculinity is related to dieting, compulsive eating, and bulimic symptomatology for white, middle or upper class women.

As for the question of commensurability in IIb, on the parameter of gender (51) and (60) focused on gender roles; (56), (62), and (63) examined traits; and (61) looked at both. In (51), Silverstein et al. (1988) measured the extent to which a woman is feminine or masculine-oriented in terms of their own role-related question mentioned above (p. 77), and in (60), Rost et al. (1982) developed their own scales to determine women's attitude toward traditional roles. In (56) Paxton and Sculthorpe
(1991) used the PDQ to assess feminine negative characteristics, and in (62) and (63), respectively, Orbach (1986) and Steiner-Adair (1986) worked within a clinical context to discern women's attitudes toward trait femininity and masculinity. (Sixty-one) is derived from the discussions of a number of researchers on the sociocultural context of disordered eating.

On the parameter of disordered eating, in (51) Silverstein, Perdue et al. (1988) utilized their own concept of bingeing and purging and, as noted earlier, Rost et al. [1982, (60)] offered a description of bulimia to recruit subjects from a newspaper advertisement. For (56), Paxton and Sculthorpe (1991) employed both the EAT and Drive for Thinness, Body Dissatisfaction, and Bulimia subscales of the EDI, while in (62) Orbach (1986) worked with anorexics (including those who suffer from the binge-eating/purging subtype). Finally, in (63), Steiner-Adair (1986) assessed disordered eating on the basis of the EAT and the AWQ, and as a general observation, (61) potentially makes reference to any sort of disordered eating on the continuum.

Interestingly, all of the studies noted here focus at least in part on bulimic behaviour or symptoms. In contrast, on the parameter of gender we find a hodgepodge of orientations which makes the straightforward comparison across all studies difficult, and its legitimacy doubtful. However, it seems fair to say that in each case, being feminine in the sense of trait and/or role comes up against a devaluation of feminine-gendered traits and roles. And especially since there are no contrary
findings in this subcategory, I would like to summarize by saying that disordered eating (and perhaps bulimic symptomatology in particular) appears to be associated with white, middle or upper class women who describe themselves as feminine (in the sense of trait or role profile), but who also face the devaluation of (role and trait) femininity.

Finally, in the case of IIIc and beginning with the dimension of gender, for three out of the five findings here [(52), (53), (57)], researchers worked with femininity and masculinity in the sense of role orientation. The remaining two [(58) and (59)] incorporated role orientation via the use of the SRI to detect adherence to the superwoman ideal, but relied upon the PAQ to determine gendered trait identity. On the parameter of disordered eating, for (58) and (59), Thornton et al. (1991) assessed disordered eating using the Drive for Thinness and Bulimia subscales of the EDI, while Silverstein, Perdue et al. [1988; (52), (53)] and Silverstein, Carpman et al. (1990; (57)] employed their own definition of bingeing and purging.

As in IIIB, bulimia was consistently but not exclusively a focus of these studies, and a variety of gender configurations were examined. However, in the latter case, orientation toward roles (traditional, nontraditional or superwoman-type) played a part in each finding and no particular trait gender orientation emerged as relevant. Hence it might be fair to conclude that regardless of her trait-gender profile, insofar as a white, middle or upper class woman’s sense of who she is contrasts with
who she thinks she ought to be in the sense of role-profile, she appears to be at risk for disordered eating (and perhaps bulimia in particular).