HOW DO WOMEN DESCRIBE THE CONVENTIONAL TREATMENT EXPERIENCE FOR ANOREXIA NERVOSA?

A THEMATIC DESCRIPTIVE STUDY

by

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ABSTRACT

This study was undertaken in order to describe and explore the conventional treatment experiences that women with Anorexia Nervosa (AN) undergo from the perspective of the women themselves. The impetus for the study grew from the literature indicating that there is a strong consumer critique of various aspects of conventional treatment approaches. Furthermore, conventional treatments have been almost entirely guided by clinical opinion rather than by research; many approaches are having limited success rates in terms of long-term outcome. In addition, more nurses are caring for women with AN in all settings and yet the nursing care is orchestrated in accordance with ineffective approaches. Finally, the perspectives of practitioners are often different than those of the consumers of health care services. Thus, more practitioners are understanding the importance of not only giving a voice to consumers, but actually conducting research concerning the views of consumers in order to improve efficacy of treatments.

Freed from the confines of an orthodox methodology, the thematic descriptive approach to guide this study was composed. Five informants were chosen by virtue of their ability to convey their treatment experience for AN. Data collection and data analysis was carried out simultaneously
using an approach adapted from Field and Morse (1985) and Giorgi (1985).

The findings from this study revealed that the quality of the treatment experience was contingent upon: the qualities possessed by the practitioners; the nature of the setting; the degree to which informants experienced difficulty in accessing programs and practitioners; and the predominance of a quantifiable focus on treatment that ascertains recovery in terms of weight gain; all at the expense of long-term psychosocial well-being.

The conclusions drawn from the findings are tenfold: 1) Conventional treatments may not meet the needs of consumers; 2) Many treatments for AN tend to reflect a medical modality; 3) Conventional treatments include some elements that may be counterproductive to recovery from AN; 4) Conventional treatments may exclude some elements that facilitate recovery; 5) The need to establish recovery within a quantifiable context may be contingent upon the severity of the AN; 6) Treatment philosophies may be inconsistent and poorly coordinated within and between settings; 7) Women with AN believe that the behaviors and ideologies practitioners possess are critical to the success of treatment programs; 8) This study reiterates claims made by consumers and advocates of AN that conventional treatments alone are ineffective; 9) The demand for conventional treatments persist possibly
because of the eternal hope they symbolize; and 10) The views of recipients for care of AN are invaluable in understanding the implications of conventional treatments. These conclusion have far-reaching implications for nursing research, practice, education, and social policy.
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I would like to acknowledge all of the women who have thus far suffered and died from an eating disorder. To those who continue to courageously battle their condition, remember to never give up as there is always hope.

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CHAPTER ONE: INTRODUCTION

Background to the Problem and Purpose

Depending on which historian you cite, Anorexia Nervosa (AN) was first described in 1689 by Sir Richard Morton (Nottingham & Emerson, 1991) and later in 1868 by Ernest Lasègue or in 1873 by William Withey Gull (Vandereycken & Van Deth, 1989). All detailed a wasting condition in a person that they attributed to psychological self-starvation. Today, AN is reputed to have the highest mortality rate of any psychiatric illness (Freeman & Newton, 1992). Suicide and complications of the illness are the two most common causes of death in AN (Crisp, Callender, Halek & Hsu, 1992; Walsh, 1995).

The Diagnostic and Statistical Manual of Mental Disorders, DSM IV (1994) reports that between 90-95% of those with Anorexia Nervosa are women*. Indeed, current estimates indicate that 1 in 100 females exhibit signs and symptoms consistent with this condition (Love & Seaton, 1991). The age of onset ranges from adolescence to the early thirties. The DSM IV estimates as many as 18% of people with AN will die of it. Theander's (1983) follow-up study of thirty-three years

*Because the majority of individuals with AN are women, the feminine pronoun will be used throughout this thesis.
indicates that mortality is in excess of twenty-two percent even with extensive treatment. Bruch (1978) contends that a third of individuals diagnosed with AN will recover, a third will die, and a third will suffer with chronic AN for the duration of their lives.

Most experts agree that AN is a complex, multifactoral condition in which the prognosis is dismal (Freeman & Newton, 1992; Gabereau, 1994; Love & Seaton, 1991; Nottingham & Emerson, 1991). Interplay among individual, family, and sociocultural factors is one possible theory of causation (Connolly & Corbett-Dick, 1990). Therefore, a number of different ideological perspectives have been established that provide a framework for conventional treatment approaches including the biomedical, psychological, and sociocultural perspectives. Conventional treatment approaches based on the above perspectives include medical and pharmacological treatments, behavioral therapy, and psychotherapy. However, Geary contends that "no model [perspective] has been so effective that it has achieved preeminence as the basis for treating eating disorders" (1988, p. 42). Further, a number of studies indicate that the relapse rate is high for women after they have received extensive treatments using these approaches (Herzog, Rathner & Vandereycken, 1992). Finally, there is a strong consumer critique of not only the
ineffectiveness of some aspects of conventional treatment approaches, but the painful experiences that people have with these approaches (Bordo, 1993; Dunbar, 1986; Lawrence, 1984; MacLeod, 1981). Thus, the failure to grasp the women's perspective of the treatment experience for AN has resulted in inadequate nursing care of women with AN. It has also resulted in the design and implementation of treatments that often reflect the views of the health care professionals, rather than that of the women who experience the treatments.

Nurses play an integral role in the abyss of conventional treatment approaches because they spend more time with the individual than any other discipline. Still, there are no discrete nursing frameworks to provide direction for care of persons with AN. Further, nursing care is often orchestrated using conventional treatment approaches based on ideological perspectives devised by other disciplines. In addition, research to evaluate the effectiveness of nursing care is nonexistent (Glatter Nusbaum & Drever, 1990). The intent of this study then is to contribute a body of knowledge that will assist nurses to understand the nature of the conventional treatment experience of women with AN, in order to intervene more effectively with women who have AN, and therefore, enhance the quality of nursing care that women with AN receive.
The DSM IV documents four criteria for diagnosing AN (Appendix A). The essential features of AN are: refusal to maintain minimal normal body weight for age and height; intense fear of becoming fat and gaining weight; a distorted body image; and amenorrhea. Garner and Fairburn (1988) emphasize that the exact classification of AN is confusing and inconsistent. The DSM IV subcategorizes AN into the restricting type and the binge eating/purging type.

"Restrictors" engage in severe restriction of food consumption coupled with compulsive exercise. Conversely, "bingers" engage in regular binge eating such as excessive consumption of food at one sitting, followed by purging behavior such as self-induced vomiting and/or laxative abuse.

Some authors suggest that the prevalence of AN in women is increasing (Bordo, 1993; Brown, 1992; Riley, 1991) and encompasses a broader social and cultural base than hitherto thought (Boast, Coker & Wakeling, 1992). Giles-Banks (1992) suggests that heightened public and medical awareness leading to increased case findings and diagnosis may mean the increase is apparent, not actual. In any case, more women are requiring treatment for AN.

Whether women who are treated for AN are considered to have recovered depends largely on the type and number of criteria that are used (Herzog, Rathner & Vandereycken,
Indeed, depending on the perspective of the health care member, any number of criteria may be used to indicate recovery. A woman may be considered recovered if she presents with a normal psychiatric status — if, for example, she is free from mood alterations such as depression. Further, recovery may be considered if a woman is able to maintain normal weight control behavior — if, for example, she is free from obsessive compulsive behaviors such as rigorous exercise or binging and purging. Or, recovery may be considered if a woman menstruates regularly and is able to maintain an average weight for her age and height. In many cases, the scholarly literature describes recovery from AN in terms of maintenance of average weight for age and height and presence of regular menstruation (Crisp, Callender, Halek & Hsu, 1992). Vandereycken and Meermann (1992) acknowledge that considering the outcome of AN in terms of eating symptoms and menarche is obviously too limited because the psychiatric status, and behavioral problems of the individual may not be rectified.

Thus, the criteria for establishing recovery from AN are ambiguous. Any or all of the aforementioned criteria can be considered evidence of recovery. The health care practitioners (professionals, clinicians, care workers) often evaluate the effectiveness of the existing conventional
treatment approaches based on such ambiguous criteria. To this end, using such criteria to indicate recovery is problematic because the individual is often essentially untreated after spending several months in a facility. For example, Solanto, Jacobson, Hellers, Goldon and Hertz (1994) evaluated the efficacy of their treatment approach based solely on the amount of weight that their patients gained while in the hospital. Further, Windauer, Lennerts, Talbot, Touyz & Beumont (1993) demonstrated that many women who are discharged from the hospital are weight-recovered but continue to exhibit a wide range of behavioral and psychopathological features associated with AN. Most conventional treatment approaches, both in the hospital and community setting, are based on non-specific evaluative criteria. Further, they are preserved because no other criteria are available to evaluate effectiveness. Yet, most practitioners caring for women with AN acknowledge that complete recovery is infrequently achieved (Freeman & Newton, 1992). Windauer and colleagues concluded that practitioners caring for women with AN must rethink the criteria used to establish recovery if complete recovery is to be ascertained. Vandereycken and Meermann (1992) state "what clinicians [practitioners] mean by normal, cured, or recovered is often only clear to them and represents the conclusion of an
impressionistic appraisal" (p. 8). Thus, the etiology, treatment, and recovery of AN are open to interpretation.

The complex nature of AN does not suggest a single, simple etiology. Still, various ideological perspectives of AN have been generated by a variety of disciplines in an attempt to explain the etiology of AN and provide a framework for treatment. Among the competing perspectives for AN are the biomedical, psychological, and sociocultural perspectives.

The Biomedical Perspective

Some advocates of the biomedical perspective subscribe to the view that AN is generated by an organic cause called "somatogenesis" (Brumberg, 1988). Medical practitioners generally approach AN from the biomedical perspective. They seek to locate the cause of AN in abnormalities that have biochemical influences on weight control and eating behaviors. Specific abnormalities include presence of endogenous opiates that may contribute to the denial of hunger in women with AN (Kaplan, Sadock & Grebb, 1994); neurological dysfunction within the hypothalamus (Johnson, Stuckey & Mitchell, 1985; Mitchell, 1985); and endocrinological abnormalities such as irregular output of vasopressin (Freeman & Newton, 1992).
The physiological changes associated with AN can be life-threatening. Physiological findings can include hematological abnormalities, reproductive problems, cachexia, renal complications, gastrointestinal problems, metabolic and cardiopulmonary complications, dental caries, endocrine abnormalities, fluid and electrolyte imbalance, and neurological problems (Glatter Nusbaum & Drever, 1990; Kaplan, Sadock & Grebb, 1994; Thurstin, 1992). Since a woman with AN can cause life threatening damage to her body, attention to the biomedical aspects of AN is warranted.

Most of the physiological abnormalities in women with AN also occur in starving individuals. This is documented by Keys, Brozek, Henschel, Mickelsen and Taylor (1950) who, in a classic Minnesota experiment, studied the effects of starvation on a group of young, healthy college men who volunteered to undergo starvation for a period of weeks. Keys and colleagues found that the men continued to manifest typical symptoms of AN even after the feeding regime was reintroduced. Typical symptoms associated with both AN and starvation are food preoccupation, eating rituals, binges, social withdrawal, lability and depression of mood, poor concentration, irritability, stealing food, loss of energy, sleep disturbance, and obsessional symptoms (Freeman & Newton, 1992). The significance of this study is that it
suggests that the typical symptoms exhibited by women with AN are likely to be secondary to the starvation process (Giles-Banks, 1992).

The biological perspective fails to address the psychological and sociocultural aspects of AN. It also fails to address why more women than men are affected with AN (Brumberg, 1988). Feminist criticism of this perspective suggests that some medical practitioners seek to pathologize and medicalize AN, rather than address the psychological and societal factors that may contribute to it (Brown, 1992). Moreover, Brumberg asserts that if the case for somatogenesis (an organic cause) was conclusive, AN would be an involuntary disease, inheritable, and best treated by medical techniques. Concurrently, practitioners would be free to disregard the psychological and sociological effects that may contribute to AN.

The Psychological Perspective

Many practitioners caring for women with AN generally approach AN from a psychological perspective. Psychological perspectives of AN are derived from three psychological schools of thought: psychoanalytic theory, family-systems theory, and learning theory. The psychoanalytic perspective reflects much of the psychoanalytic theory as presented by Freud. According to this perspective, AN is an expression of
a repressive state that young women maintain in order to avoid maturational problems such as sexual development and autonomy (Furnham & Hume-Wright, 1992; Giles-Banks, 1992). Proponents of the psychoanalytic movement believe that the symptoms of AN will resolve when women receive therapy that facilitates insight into their food refusal (Orbach, 1986) and focuses on fundamental aspects of their self-identity rather than on their weight alone (Bruch, 1988).

The family-system perspective derived from family-systems theory focuses on the "anorectic family" (Crisp, 1980). This perspective maintains that certain family environments foster passive defiance making it difficult for certain members to assert their individuality. The profile of a "anorectic family" is one in which the mother is strong-willed and domineering while the father may be meek, withdrawn, aloof, and/or alcoholic. Minuchin, Rosmar, and Baker (1982) identified four characteristics often present in the anorexic/bulimic family system. They are enmeshment, overprotectiveness, rigidity, and lack of conflict resolution. The family-system perspective supports the notion that family norms and behaviors are related to the development and maintenance of AN (Furnham & Hume-Wright, 1992).
Proponents of perspectives adapted from learning theory believe that symptoms or behaviors of AN are learned and can be unlearned through a process of cognitive and behavioral change. Specifically, cognitive-interactionist perspectives focus on helping individuals change their understanding of significant situations and problems while behaviorist perspectives focus on changing observable detrimental behaviors of individuals in significant ways (Bigge & Shermis, 1992). The process of cognitive and behavioral change is often achieved through a technique referred to as behavioral modification, more commonly known as behavioral therapy (Dinkmeyer & Muro, 1979; Geary, 1988; Riley, 1991).

Generally, the psychoanalytic, family-systems and cognitive-behaviorist perspectives by themselves are insufficient. That is, they often fail to account for the sociocultural influences that bombard women with messages equating being thin to beauty, success, wealth, and happiness (Wolf, 1990). Moreover, they often fail to consider and situate the woman, her behavior, and/or her family within the context of her sociocultural setting (Bordo, 1993).

The Sociocultural Perspective

While sociocultural perspectives do not fully explain the etiology of AN, they do implicate cultural dicta aimed primarily at women as the contributing factor to AN (Gile
Banks, 1992). There is a plethora of literature to indicate that women in western society define their beauty and self-worth by their weight (Bordo, 1993; Brown, 1992; Brumberg 1988; Orbach, 1986; Wolf, 1990). Many scholars who have a feminist perspective attempt to explain AN as a consequence of a misogynistic culture that belittles women by devaluing female experiences, objectifying women's bodies, and not acknowledging women's achievements (Giles-Banks). In the *Beauty Myth*, Naomi Wolf writes, "A culture fixation on female thinness is not an obsession about female beauty but an obsession about female obedience" (p. 187).

Why do women often go hungry? S. Jones, Doheny, P. Jones, O'Bryan and Bradley (1986) and Brown (1992) suggest that stages of AN are extensions of normal eating patterns for women, that for many women normal means a pattern of constantly dieting in order to feel good, and that good means acceptable in society. However, AN existed long before there was mass cultural preoccupation with dieting and a slim body image. Historians, such as Brumberg (1988), emphasize the distinctive social and cultural contexts in which young women have historically chosen to refuse food. In *Fasting Girls*, Brumberg writes the following:

In essence, this book charts the transition from sainthood to patienthood, a process that historians describe with two familiar words, secularization and
medicalization...Using cases drawn from the sixteenth through nineteen centuries, I show how the understanding of food-refusing behavior evolved in response to new developments in religion and medicine. By the nineteenth century a general decline in faith and the rise of scientific authority had, for the most part, transformed refusal of food from a religious act into a pathological state. (p. 5)

Some anthropologists assert that feminists assume AN is a contemporary condition, rooted in circumstances of modern society. Giles-Banks (1992), one of these anthropologists, counters this perspective by documenting the connection between food refusal and Christian asceticism for women between the twelfth and the fifteen centuries.

There is a growing body of literature suggesting that the sociocultural dicta of contemporary society, such as the media's presentation of an ideal body image, are not a significant cause of AN. In the literature are examples of women with AN who have been born blind and state that they have a relentless desire for thinness because they have an inward loathing for themselves — not because they have been influenced and pressured by sociocultural aspects such as television commercials and beauty magazines. In describing their AN, these women never express an outward disgust for their body size, shape, or weight. Instead, they refer to an inner self-hatred (McFarlane, 1989; Sharp, 1993; Vandereycken, 1986). As well, the sociocultural perspective
does not explain why most women do not develop the condition even though they have been exposed to the same cultural environment as those women that do develop AN. Hence, the pressures and circumstances of contemporary life that women face on a daily basis may be only one pivotal factor in explaining the etiology of AN.

**Conventional Treatment Approaches**

The conventional treatment approaches for AN are well known to both lay people and experts in the field. However, the effectiveness of the treatment approaches are often disputed. A typical conventional treatment approach described in the lay and scholarly literature is illustrated in the following vignette: A woman is hospitalized with AN. She is labeled as having a mental illness; therefore, she is admitted to a psychiatric unit. Probably, a behavioral-therapy approach will describe the most common type of care she will receive concurrently with medical interventions (Solanto, Jacobson, Hellers & Golden, 1994; Touyz, Beumont, Glaum, Phillips & Cowie, 1984). This approach is based on a system of rewards and punishments (Dinkmeyer & Muro, 1979). In addition, she may receive daily nutritional counseling, psychotherapy, and/or occupational therapy depending on the facility.
Her care might entail being involuntarily certified to ensure that she rapidly regains weight. The woman may be aggressively persuaded to consume high caloric fluid supplements and/or to receive forced naso-gastric tube feedings to expedite the weight gain process. The woman may be heavily sedated to ensure that she does not burn calories and that she is able to tolerate the tube feedings. In addition, she may be prescribed and administered antidepressants, anxiolytics and antipsychotics for related mood disorders. She will be weighed at least daily, and she may have daily skin fold measurements to measure the percentage of body fat gained during treatment. In addition, her visitors may be restricted. The woman may be observed during every meal that she eats. Further, she may be segregated, isolated, or secluded at mealtime, or forced to eat alone in her room. Concurrently, she may not be permitted to speak during the meal, or she may be restricted in the type of conversations that she has during a meal. Finally, at certain times she may be denied privacy while going to the bathroom to ensure that she does not purge her meal. If she begins to gain weight, she will regain privileges she lost before gaining weight. Approximately three weeks to three months later, she will be discharged upon meeting the target weight gain. She may then be referred to a new psychiatrist.
or psychologist for weekly follow-up visits and/or she may be enrolled in community-based treatment programs.

Unfortunately, she will in all likelihood be readmitted to the hospital again for severe weight loss. Relapse is common for women with AN. Hence, the vicious cycle of weight loss and weight gain perpetuates itself. This vignette represents reality for many women receiving conventional treatments for AN in eating disorder clinics worldwide (Dunbar, 1986; Gibson, 1983; Glatter Nusbaum & Drever, 1990; Kaplan, Sadock & Grebb, 1994; Lawrence, 1984; MacLeod, 1981; Solanto, Jacobson, Hellers, Golden, & Hertz, 1994).

A plethora of literature exists about AN, some of which is written by lay people. However, there is a paucity of scholarly literature related to anthropological, historical, biological, psychological and sociological perspectives exploring the etiology, incidence, prevalence, morbidity, treatment, and reoccurrence of AN (see Chapter Two). Scant nursing literature exists to guide nursing practice or to evaluate the outcomes of nursing care concerning women with AN (Glatter Nusbaum & Drever, 1990). Most of the nursing literature that is written about women with AN is anecdotal or based on descriptions of conventional treatment modalities that are derived from and implemented by other disciplines, such as medicine and psychology. The irony is that while
nurses look outside the discipline of nursing to supplement inconclusive treatments for AN, it is they who spend more time with women who have AN than any other professional in any other discipline (Glatter Nusbaum & Drever).

**Statement of the Problem and Purpose**

As the incidence of AN increases annually, nurses are caring more and more often for women with AN in the hospital and community setting using conventional treatment approaches to provide direction for patient care. Yet, many experts concede that conventional treatment approaches do not have favorable outcomes. Further, there is a strong consumer critique of various aspects of conventional treatment approaches. Clearly, nurses must begin to give consideration to the feelings, thoughts, ideas, and life experiences thus far of sufferers in order to make decisions about how existing conventional treatment approaches should or should not direct their care. Thus, the general problem which this study addressed was the limited knowledge of women's perspectives on the treatment experience for AN.

The purpose of this study was to answer the general question: How do women describe the conventional treatment experience for AN? This was accomplished utilizing a thematic descriptive approach. I believe that such an approach revealed insights about women's perspectives. The following
specific questions were used to help me accomplish the task of gaining insight and understanding into the aforementioned research question:

1. What is the nature of the conventional treatment experience according to women with Anorexia Nervosa?
2. What aspects of conventional treatment have an effect on the experience of women with Anorexia Nervosa?
3. How does a woman with Anorexia Nervosa describe her response to the conventional treatment experience?
4. What is life like for a woman with Anorexia Nervosa before, during, and after conventional treatment?

**Definition of Terms**

Anorexia Nervosa: for the purposes of this study, I defined AN according to the diagnostic criteria listed in the DSM IV (Appendix A).

Woman With Anorexia Nervosa: a woman who has been diagnosed with Anorexia Nervosa and presently has Anorexia Nervosa. For the proposed study, the woman had to be over the age of eighteen and have received conventional treatment in the hospital or community setting within the last three years.

Conventional Treatment: a provincially approved program for the diagnosis of Anorexia Nervosa that primarily focuses on a combination of any two or all of the following
conventional treatments in the hospital or community setting: medical therapy, psychotherapy, and behavioral therapy.

Treatment Experience: feelings, thoughts, and reactions to receiving conventional treatment for Anorexia Nervosa and the ramifications of this event in the woman's life.

Introduction to This Study's Methodology

Qualitative and quantitative approaches to research generate dichotomous views of social reality and ultimately produce different types of knowledge. While "quantitative methods test and refine a growing body of knowledge" (Morse, 1994, p. 2) "a critical concern for objectivity" is retained by experiential data collection and analysis (Tinkle & Beaton, 1983, p. 34). Conversely, qualitative methods connote "strategies for collecting images of reality" (Morse, 1989, p. 1) based on the subjective experiences and/or behaviors of people. An approach within the qualitative paradigm does not limit the naturalistic and authentic aspects of the phenomenon under study as would a quantitative study concentrating on objective data obtained from an artificial setting. Rather, it facilitates a thorough description of the phenomenon. Giles-Banks (1992) emphasizes the importance of learning about the subjective experiences of women with AN in moving toward an understanding of their condition. A study of
women's treatment experience for AN from the perspective of the women who receive such treatment is essential to understanding and evaluating the present type of care that women receive.

My research question was based on the need to explore conventional treatment approaches for the purpose of examining the usefulness of current approaches in the provision of empathetic and effective nursing care. I believed that the most authentic approach to exploring conventional treatment approaches was to have the women who had received such treatments for AN describe their experiences. This study was conducted then, using a thematic descriptive approach within the qualitative paradigm, to describe the treatment experience that women with AN undergo.

A thematic descriptive approach was characterized by subjective and inductive assumptions (see Chapter Three) and involved discerning themes from the data and translating these themes into practical implications for nursing practice on the basis of what the women who were interviewed for this study recounted about their treatment experience. It is my hope that the insight that is gained from this study will enhance the general knowledge from which nurses can plan and provide quality care for individual women and expand the
profession's understanding of the general nature of the phenomenon.

**Assumptions**

In addition to those assumptions inherent in the qualitative research method, I presupposed the following assumptions in this study:

1) informants are women with AN who are able to enlighten people about the nature of the treatment experience for AN;

2) informants with AN are able to articulate their conventional treatment experience;

3) informants who have received conventional treatments for AN have shared experiences;

4) informants are able to accurately express their perceptions of reality about the conventional treatment experience;

5) a comprehensive understanding of the conventional treatment experience for AN can be ascertained through a thematic descriptive approach to inquiry;

6) a dearth of current knowledge about the phenomenon precludes the use of a theoretical basis such as a conceptual framework for the study (Brink & Wood, 1989); and
7) even though I acknowledge in this study that the DSM IV definition is problematic, the criteria in the DSM IV was the basis for establishing that a prospective informant has AN. The reason for this decision was that most facilities that provide conventional treatments use the DSM IV as a basis for diagnosis, admittance, and evaluation of the outcomes of their programs. Therefore, prospective informants would only receive conventional treatments if they met the criteria found in the DSM IV.

**Researcher's Perceptions**

I believe that an a priori explication of my perceptions of conventional treatments used to treat women with AN was necessary to reveal my biases. A number of factors in my life have influenced my perceptions of the conventional treatment approaches that women with AN experience. Therefore, the posing of the research question arose from my life experiences as a female, a feminist, and a nurse.

I was a fat, female child. As a result, I have always been conscious of my weight and what I consume. Although I never required treatment for AN, I now believe that my behaviors as an adolescent were indicative of a preoccupation with weight gain. During my youth, my perception of my body image was inadvertently affected by television commercials and magazines that equated success to thinness. I believe
that I was a product of a patriarchal society in which I had to look thin in order to succeed as a woman.

As a feminist, I believe that the care and treatment of women with AN has been defined largely by the traditional androcentric perspective. To date, most research continues to embody only measurable, objective, anecdotal or descriptive data from the researcher's rather than the subject's perspective. I believe that the importance of researching and understanding women's experiences as resources of social discourse must be recognized (Harding, 1987). Nursing research is limited in the field of AN. The lay literature indicates that people want and need care that frees them from simply being diagnosed, weighed, fed, and taught various types of discourse. My ultimate goal is to impart insight and understanding to nurses regarding the present treatment experience that women with AN undergo from the women's own perspective with the intent of improving patient care.

As a nurse, I have witnessed that AN is not just a woman's problem; it is a societal problem. All women I have come in contact with express some degree of dissatisfaction with their weight or disturbance with their body image. Even patients who have cancer and are receiving chemotherapy drugs often indicate to me that they hope to "shed a few pounds during their chemotherapy treatment". In addition, I have
observed that nurses perpetuate conventional treatment approaches contributing to the dissatisfaction that women with AN express of their treatment experience. While my life experiences as a female, a feminist, and a nurse have led me to study this phenomenon, I attempted to bracket these influences throughout the research to the best of my ability.

**Significance**

Nurses are involved with care for women with AN more than ever before. The approaches used by nurses are primarily borrowed or perpetuated by ideological perspectives devised by other disciplines. The significance of this study, then, was its potential to strengthen nurses' understanding of women's treatment experience with AN from the women's perspective, toward the purpose of enabling nurses to intervene in a caring, holistic, empathetic, helpful, and possibly life-saving way.

**Summary**

The consumer and scholarly literature suggests that current treatments for AN are ineffective. Given that nurses spend more time than any other discipline caring for women with AN, it is not known whether their care is contributing to a better or less than effective treatment experience for women with AN. To fully understand this issue, I asked the research question: How do women describe the conventional
treatment experience for AN? In this chapter, I have presented the problem and purpose of the study, and I have introduced the methodology.

In Chapter Two, I place the need for this study within the context of the existing literature that I review. Chapter Three describes the thematic descriptive approach that provided direction for this study. A presentation of the findings is found in Chapter Four. In Chapters Five and Six, I discuss the findings and their implications for nursing practice, research, education and social policy.
 CHAPTER TWO: REVIEW OF THE LITERATURE

Introduction

Hospital and community facilities using milieu-treatment approaches are the primary settings for treatment of women with AN. Treatment approaches encompass the entire spectrum of services. Specifically, individuals are treated using medical therapy, psychoanalysis, cognitive and behavioral therapy, group psychotherapy, family therapy and experiential therapies. Psychopharmacologic treatment can also be included in many of the above. Countless self-help organizations exist, each with its own ideology and program of recovery. This plethora of treatment approaches suggests a lack of uniformity among treatments. While many approaches are in use, longitudinal studies indicate that none have been effective in more than a moderate percentage of individuals (Herzog, Rathner & Vandereycken, 1992). Experts concur that no effective "cure" has been developed for AN (Volger, 1993).

In this chapter, I review the literature pertinent to the stated purpose of this study, that is, to gain insight into the conventional treatment experience of women with AN with the intention of improving the nursing care that such women receive. I review the literature that describes both conventional treatment and unconventional treatment approaches used to treat AN. In addition, I present current nursing approaches and illustrate various nursing treatments
offered in practice. Finally, I review the anecdotal literature that depicts the views that consumers hold of their experiences with various treatment approaches.

Conventional Treatment Approaches

Surrounding the topic of AN are numerous theories of causation, case histories, descriptions of symptomologies, and descriptions of conventional treatment approaches (Nottingham & Emerson, 1991). The type of treatment approach used and the setting in which the treatment is conducted are determined largely by the favored approach of individual health care professionals (Gowers, Norton, Halek & Crisp, 1994). In an age of fiscal restraint, the merits of treating women in the hospital must be seriously considered. Moreover, the benefits of hospitalization to treat women with AN are being increasingly challenged (Freeman & Newton, 1992). However, research evidence does not yet support the choice of either a hospital or community setting (Gowers, Norton, Halek & Crisp).

Most experts have little doubt that, in the short-term, in-patient conventional treatment approaches have an immediate and life-saving value for some people who are suicidal or have marked weight loss because the focus is on immediate weight gain (Freeman & Newton, 1992). However, many authors conclude that in-patient conventional treatment programs do little to alter the long-term course of AN.
In addition, the relapse rate on discharge from the in-patient environment is high (Morgan, Purgold & Welbourne, 1983). Freeman, Shapiro, Morgan and Engliman (1990) [cited in Freeman & Newton, 1992] used weight gain as a measure of recovery from AN to compare identical treatment approaches for an in-patient and an out-patient program. They found that inpatients gained weight more rapidly in the hospital, but that the difference between weight gained by in-patients and out-patients over time was negligible. Women in the out-patient program indicated that they felt more in control of their eating behavior, suggesting that they may be at a lower risk of relapse than patients in an in-patient setting. Except in those for whom rapid weight gain has a life-saving value, the advantage that short-term admissions into the hospital setting have on women is questionable. Indeed, a high suicide rate and/or relapse rate may be associated with conventional in-patient treatment programs that focus on rapid weight gain, rather than on recovery from AN. However, research to support a correlation between the two has not been conducted. The conventional treatment approaches in the hospital and community setting include any or all of the following: medical treatment, psychotherapy, and behavioral therapy.
Medical Treatment

Medical interventions primarily conducted on an in-patient basis include electrolyte monitoring and weight restoration through naso-gastric tube feedings, high calorie diets, periodic hyperalimentation (such as Total Parenteral Nutrition), drugs, and insulin therapy (used to initiate hypoglycemia which stimulates appetite). Specific interventions unique to psychiatrists both on an in-patient and out-patient basis include various forms of pharmacological therapy, electro-convulsive therapy, and psychosurgery (up until 1980) which is similar to a partial lobotomy. In addition, psychotherapy, family therapy, and behavioral therapy are used by psychiatrists (Banji, 1980; Kaplan, Sadock & Grebb, 1994; Sanger & Cassino, 1984).

Many psychiatrists attempt to treat AN from a pharmacological perspective for two reasons. First, they subscribe to the belief that AN may be somatogenic, that is, organic in nature (Brumberg, 1988). Second, they view many of the behaviors that women with AN exhibit as reflective of psychiatric disorders that can be controlled with psychotherapeutic drugs (Bock, 1992a). The disorders they link to the AN behaviors include obsessive-compulsive disorders, mood disorders, depression, and anxiety. Consequently, psychotherapeutic drugs such as anti-obsessionals, antidepressants, and anxiolytic agents are
often prescribed to women with AN (Bock). Antidepressants such as Prozac have been widely administered to women with AN because of the recognition that they manifest symptoms of depression (Kaplan, Sadock & Grebb, 1994). This recognition is now controversial (based on a study conducted by Keys, Brozek, Henschel, Mickelsen & Taylor, 1950) as some experts observe that depressive symptoms may be secondary to the starvation process and that Prozac treats the symptoms, not the condition (Freeman & Newton, 1992). Crisp, Lacey and Crutchfield (1987), in a placebo-controlled study, showed that the use of certain antidepressants does not produce any benefits in the treatment of people with AN.

Antipsychotics (Phenothiazines, particularly Chlorpromazine) are advocated as an important part of the treatment plan for AN because of their antiemetic and appetite-stimulating properties (Bock, 1992a). However, controversies have arisen because people with AN do not have an intrinsic loss of appetite, so stimulating their appetite has been shown to increase their fear regarding loss of control over eating (Freeman & Newton, 1992).

It is interesting to note that, according to Anderson (1990), "treatment of most males with AN does not require psychopharmacological agents unless there is clear evidence to indicate that it is warranted" (p. 153) because it is believed by some practitioners that males have an orientation
to AN that differs from that of females. Specifically, the depressive symptoms that are manifested in women are believed to be substantially decreased in men. However, whether Anderson's view tends to reflect the androcentric perspective often criticized in the feminist literature or an actual iatrogenic fact is debatable. Conversely, Olivardia, Pope, Mangweth, and Hudson (1995) found that "eating disorders, although less common in men than women, appear to display strikingly similar features in affected individuals of the two genders" and are therefore treated using similar methods (p. 1279). Clearly, pharmacological therapy is controversial because symptoms that warrant medications may be secondary to the AN. Indeed, some symptoms of AN could be secondary to the conventional treatments that women receive.

Skin-fold measurements of the percentage of body fat and weight recordings can be terrifying events for women with AN since they define their worth through their weight (Lawrence, 1984). These measurements are used by all disciplines on a regular basis to monitor the 'progress' of women undergoing treatment and to evaluate treatment programs. Peggy Claude-Pierre (Gabereau, 1994) of the Montreux Counseling Center in Victoria, BC states that weight recording is one of the most traumatic experiences for people with AN. She advocates weighing all of her clients backwards so that they are not able to know their weight, which she believes circumvents
some of the terror such women experience during weighing. This view is advocated by Day (1974) who suggests that patients be weighed less frequently than daily to avoid increased preoccupation with weight. Garfinkel and Garner (1982) contend that the frequency of weighing should be negotiated with individual patients. Touyz, Lennerts, Freeman and Beumont (1990) hypothesized that the rate of weight gain in patients with AN during refeeding is not compromised by less frequent weighing. To test this hypothesis, they weighed 15 patients daily at 7:00 AM and 15 different patients at the same time on Mondays, Wednesdays and Fridays. Both groups were told their weight immediately after they were weighed. Touyz and colleagues found no significant demographic or clinical differences between the two groups. However, typical of many research studies regarding AN, Touyz and colleagues did not evaluate the long-term outcome of recovery for the women in their study comparing how long the two groups actually kept the weight on. Moreover, they did not analyze the AN behavior of the two groups. Whether heightened preoccupation with weight may be secondary to current weighing practices has yet to be researched. Further, it is unclear why individuals are weighed at all. To my knowledge, there has not been research conducted that validates the need for weighing practices. Yet, health care practitioners appear to feel compelled to weigh people with AN.
AN has a substantial degree of chronicity (Freeman & Newton, 1992). Longitudinal studies such as those conducted by Walford and McCune (1991) and Hsu, Crisp and Callender (1992) suggest that recovery from chronic AN is dubious. Further, they outline many psychiatric complications that women with chronic AN manifest, such as anxiety, depression, and phobias. In a comprehensive review of the longitudinal research related to favorable outcome, Herzog, Rathner and Vandereycken (1992) found that "even the best conducted outcome studies merely project probability of the outcome of the entire group of Anorexia Nervosa patients. The individual course may, however, be entirely unpredictable in individual cases" (p. 25).

Most medical treatments focus on short-term interventions directed almost exclusively at weight restoration. Further, most research to evaluate outcomes of conventional treatments focuses on weight restoration practices alone. However, most experts emphasize that a certain nutritional stability is necessary before psychotherapeutic exploration becomes possible and meaningful (Bruch, 1978). Yet, the desired weight to begin any form of psychotherapy seems to be dependent upon the personal whims of the practitioner(s) in charge and not on any scientific basis. Therefore, while medical treatment is warranted, much of the literature
indicating that medical care is only the initial stage to recovery (Bruch, 1973).

**Psychotherapy**

The origins of modern psychotherapy stem from the work of Sigmund Freud, C.G. Jung, Carl Rogers, and Erik Erikson. Therapists who have studied methods written by these men often disagree on the etiology of AN, and the process by which to conduct the therapy, but their psychotherapeutic methods attempt to achieve the same outcomes for the individual with AN, that is restoration of optimal health (Lambley, 1983).

Various types of psychotherapy for AN are structured as individual, group, and family psychotherapy. Generally, individual therapy consists of the therapist (often a psychologist or a psychiatrist) maintaining a neutral or passive presence while helping individuals to gain insight and/or coping strategies to overcome the AN (Lambley, 1983). Group therapy involves a therapist acting as a facilitator to encourage a group of people with AN to explore, identify, and free associate their thoughts and feelings in order to gain insight and/or coping strategies regarding their AN (Bruch, 1988). Family or systems treatment for AN was pioneered by the psychiatrist, Hilde Bruch, who believed that the cause of AN is within the individual and the family unit as a whole. She was a proponent of individual and family therapy
supporting the notion that while the family ought not to be blamed for causing AN, it should be included in the treatment for AN (Bruch, 1978). During family therapy, the individual and her family members are counseled jointly and separately throughout the treatment process. Much of the literature focuses on family interventions as they relate to children and adolescents who have AN. Little is documented relating family therapy to those who are adults with AN.

Garfinkel and Garner (1982) chastise therapists for their inability to provide adequate descriptions of effective psychotherapeutic interventions they have used in their practice, thus leading to difficulties replicating these interventions. Various researchers have attempted to estimate the value of psychotherapy for AN. Gowers, Norton, Halek and Crisp (1994) randomized ninety subjects with AN in order to study the outcome of in-patient and out-patient psychotherapy. Thirty people were randomized to an in-patient treatment group that received intense individual, cognitive, behavioral, group, and family therapy. Twenty people were randomized to an out-patient treatment group that received only group therapy, and twenty people were randomized to an out-patient treatment group that received individual and family psychotherapy. Finally, twenty people who refused treatment were assigned to a no treatment control group. Gowers and colleagues concluded that all three treatment
groups were highly effective in terms of social and psychosexual adjustments (the control group was unchanged). However, in a one year follow-up, there was a relative failure of the in-patient treatment group to produce sustained weight gain, unlike the out-patient treatment groups. Thus, it would seem that the type of therapy may not be as important in treating AN as the setting in which it is conducted.

Russell, Szmukler, Dare, and Eisler (1987) conducted a controlled trial study researching the benefits of either family therapy or psychotherapy in fifty-seven individuals with AN with follow-up at one year. They reported that family therapy was marginally more effective than psychotherapy but only in those individuals whose condition began before the age of nineteen and whose duration of the condition was less than three years. This study indicates that understanding the context of AN in each person may be an important part of therapy.

Critics of psychotherapy argue that therapists often try to fit every woman with AN into the framework that they have been trained in rather than to mold the framework into the context of each woman with AN (Lambley, 1983). Moreover, Lambley contends that standard insight psychotherapy has limited use in the treatment of AN because it has no theoretical base or method specific to AN. Further, in his
own psychology practice, Lambley observes that the only aspect that differentiates untreated people with AN from treated people with AN is the ability to talk more fluently about their condition. In therapy, he contends, individuals learn all the psycho-jargon but not how to get well. Hence, they remain anorexic because their therapy has almost entirely focused on discussion alone. Geary (1988) notes that psychotherapeutic treatments place little emphasis on sociocultural influences contributing to AN. Instead, she believes they employ the premise that AN is symptomatic of unconscious conflict which will resolve with insight into the nature and meaning of the conflict.

While there is a debate, psychotherapy may be warranted because it results in women with AN identifying particular situations that may cause them stress or trauma. Identifying such situations helps women with AN to cope with subsequent situations. Yet, it appears that the setting and the context in which psychotherapy is conducted is pivotal in influencing the outcome of care. In evaluating the aspects of treatment that were positive for recovery from the perspective of the patient, Noordenbos (1992) found that psychotherapy ranked most positive amongst respondents recovering from AN.

**Behavioral Therapy**

Behavioral therapy programs were first introduced for the treatment of AN approximately twenty years ago (Solanto,
Jacobson, Hellers, Golden & Hertz, 1994). Since then, behavioral therapy has become the standard approach used for conventional treatments of AN in all settings (Kaplan, Sadock & Grebb, 1994). One reason offered is that the behavioral programs "are easily mastered by paramedical staff and have been shown to facilitate weight gain" (Touyz, Lennerts, Freeman & Beumont, 1990, p. 752).

The general emphasis of behavioral therapy is on changing the behavioral patterns of women with AN in response to stimuli, whether they are physiologically, psychologically or socioculturally derived (Geary, 1988). Changing behavioral patterns is usually accomplished through establishing a contract with the individual in which reinforcements are provided contingent upon attainment of weight goals or on appropriate eating behavior (Solanto, Jacobson, Hellers, Golden & Hertz, 1994). Behavioral approaches are generally accepted as the treatment modality for facilitating weight gain and treating maladaptive eating patterns during hospitalization (Glatter Nusbaum & Drever, 1990). Touyz, Beumont, Glaum, Phillips and Cowie (1984) compared a strict and a lenient behavioral program in refeeding patients with AN. They concluded that there was no significant difference in the weight gain of the two groups, although the lenient program was much more acceptable to patients. Also, Eckert, Goldberg, Halmi, Casper and Davis (1979) did not find any
benefit in using strict behavioral regimes aimed at weight gain.

Solanto, Jacobson, Hellers, Golden and Hertz (1994) compared the weight gain of in-patients with AN under two behavioral contracts over a one month period. Under Contract One, subjects had to gain 0.8 pounds (0.36 kilograms) every four days to earn reinforcement privileges. Under Contract Two, subjects had to gain 1.2 pounds (0.55 kilograms) every four days to obtain reinforcement. Reinforcements contingent upon weight gain included receiving visitors, watching television, and time away from the unit. Solanto and colleagues found that increasing weight gain in behavioral contracting was associated with an increase in the rate of weight gain without any accompanying complications of refeeding such as bloating. Although the authors acknowledge in the study that they did not delineate the effects of the long-term outcome of varying the weight gain, they do not address the short-term or long-term effects on eating behavior of the two groups. This omission is typical of current documented studies.

Critics of behavioral therapy contend that the focus of treatment for women with AN has been primarily on weight restoration alone; little attention to short-term or long-term effects of behavioral therapy on eating behaviors is given (Bruch, 1973). Generally, behavioral therapy does not
treat the condition, rather it forces the individual to comply with someone else's rules or suffer the consequences (Bruch; Dunbar, 1986; Lawrence, 1984; MacLeod, 1981). Lawrence states that in an environment where behavioral therapy is practiced, women are often coerced into reaching a target or ideal weight usually within a period of weeks. This narrow focus attributes phenomenal importance to weight itself. Further, Lawrence asserts, behavioral therapy "is making a fundamentally 'anorexic' mistake; it treats weight as a magical quality, allowing numbers on the dial to take over from reality" (1984, p. 76). Moreover, she states that many studies indicate that behavioral therapy is temporary in its efficacy as most women with AN learn to conform with staff expectations of the weight gain regime simply to get out of the hospital or the day program. Further, studies that evaluate the outcome of behavioral approaches are often empirical and do not reflect the humanistic components of treatment, or the opinions of the patients who experience the treatment. Thus, the revolving door syndrome of eating while in a treatment program and starving while discharged is commonplace for women with AN.

It is debatable whether behavioral therapy is warranted. According to Meades (1993), the essential changes in behavioral treatment approaches have made it more acceptable over time. Specifically, the person suffering from AN has
been consulted and advised during the compilation of a treatment program. Further, Meades asserts that autocratic programs dictating treatment and excluding the sufferer from consultation have been largely eschewed. Contrary to many anecdotal writings (Dunbar, 1986; MacLeod, 1981), Noordenbos (1992) found that behavioral therapy was generally evaluated positively by people who had experienced the therapy for AN. Many experts, nurses included, find some merit in behavioral therapy, and they are able to justify that it is a legitimate form of therapy because it is currently a means to successfully curb life-threatening aspects of AN in the short-term.

The proceeding section presented the conventional treatment approaches available to women with AN. They are medical interventions, psychotherapy and behavioral therapy. All of these approaches are available in the hospital or community setting. All are considered mainstays of current treatments offered for AN.

**Unconventional Treatment Approaches**

After being successfully treated in an unconventional treatment program, one woman said of the conventional treatment approach "hospitals will get your weight up, but they won't do anything for your mind. It's hell, I wouldn't wish it [hospital] on my worst enemy." Another said, "Hospitals are holding tanks; they kept me alive" (Goldberg,
1994). These are quotes from consumers of conventional treatment programs, people who were dissatisfied with their care, only to claim to be treated successfully in unconventional treatment programs. The following section will describe some of the unconventional treatment programs available to consumers. They include private clinics, experiential therapies, support groups, and self-help groups. For the purposes of this study, unconventional treatment approaches are defined as those that are not based on the aforementioned medical, psychological, behavioral, and pharmacological treatment approaches.

**Private Clinics**

In the United States, numerous private clinics have arisen to combat AN (Volger, 1993). Among the clinics is the Renfrew Center located in Florida. Described by Brookes (1993), the Renfrew Center uses an empowerment model to promote self-initiative and self-responsibility. According to Brookes, many conventional treatment approaches use nutritional rehabilitation and symptom management which are primarily based on external control, coercion, and violation of privacy. By contrast, the Renfrew Center uses a non-coercive approach to symptom management of AN based on an internal locus of control. Four primary aspects of the approach include self-management techniques as opposed to strict environmental controls; treatment respectful of the
individual and designed to promote self-initiative and responsibility; treatment viewed as partnership between the sufferer and the treatment team; and an appropriate division of responsibility in the feeding relationship. The extent to which the center is effective in terms of complete recovery from AN and the cost of attending the program is unclear.

In Canada, most treatments for AN are covered under the Canada Health Care Act; therefore, they are offered free of charge to the consumer. Still, most are based on conventional treatment approaches. The options for consumers who are interested in alternative approaches are limited. Private clinicians who are certified counselors and/or therapists will offer their services, but they are costly. The exception is a unique and controversial clinic in Victoria, British Columbia called the Montreux Counseling Center*. The center is owned and operated by Peggy Claude-Pierre, who in 1992 bought a large house known as the "mansion" with the mandate of providing treatment to people with eating disorders.

*The following section is based on a segment of the Vicki Gabereau Show, aired February 16, 1994 on the Canadian Broadcasting Corporation Radio Program, in which Vicki Gabereau interviewed Peggy Claude-Pierre about the Montreux Counseling Center that she founded and operates. In addition, this section is adapted from the television show 20/20, aired on December 2, 1994 on the National Broadcasting Company where a one hour documentary was presented entitled The Hunger Inside about the Montreux Counseling Center (Goldberg, 1994)
The approaches at the Montreux Center mimic those which proved successful for Claude-Pierre's own daughters who recovered from AN with the help of their mother alone.

Claude-Pierre's approach is intensely personal, and some consumers state that her center has become a sanctuary for individuals who have been poorly served by conventional treatments. She claims that she has provided alternative treatment for more than 400 people with AN over the last decade. Claude-Pierre, a psychologist by profession, contends that AN becomes a symptom that develops from accumulated negativity and stress. Based on this philosophy, she has trained 40 "care workers", many of whom have had AN themselves. Their objective is to bring constant comfort, positive reinforcement, and unconditional love to the sufferer. For continuity of care, five workers are assigned to one sufferer throughout her/his stay and will receive one-on-one, 24 hour care. In the first couple of weeks, the goal of treatment is to establish a bond of trust. The client is inundated with endearments, and showered with physical affection in terms of hugs and kisses which is thought to reinforce positive emotions amongst the individuals.

Claude-Pierre places limited emphasis on eating issues. However, part of treatment includes the individual eating small portions of food every two hours as she gets better. How this is accomplished is unclear. Claude-Pierre believes
that weight scales are one of the most terrifying objects to people with AN and that any type of measurement is dangerous and threatens the recovery of AN. Therefore, Claude-Pierre weighs all of her patients backward, promising them that they can trust her and reassuring them that they do not have to worry anymore about numbers. Why Claude-Pierre weighs individuals at all is unclear.

The average length of stay for an individual at the center is nine months to one year according to Claude-Pierre. Further, she explains that the center is medically supervised. Claude-Pierre believes that recidivism should not occur if the treatment is properly carried out. She is quick to not place blame on any institution or system for the perceived ineffectiveness of conventional methods of treatment. However, she does openly acknowledge that institutions are counter-productive in that "they unwittingly tell sufferers that if they eat food, it will fatten them up, and then they can be discharged".

Claude-Pierre's approach is not without criticism. The Montreux Counseling Center is not funded by the Canadian health care system; therefore, a one month stay is approximately $15,000. Although Claude-Pierre claims that no one is refused treatment, one third of the patients cannot afford the treatment and must be subsidized. Claude-Pierre claims that ninety percent of patients who have been through
the center have recovered. Recently, testimonials from recovered sufferers have been offered through the media to validate this claim. However, she has not empirically evaluated the outcomes of the treatment provided at the center. Critics have accused her of being a publicity seeker. For example, Vincent (1994) insists that Claude-Pierre uses high profile cases of women who have been unsuccessfully treated in conventional treatment programs to campaign for publicity and attention for her own program. Further, Vincent states "the publicity also fails to acknowledge all the good treatment which is going on: and the personal success stories of the many people who have recovered from eating disorders" [in conventional treatment facilities] (p. 7).

In March, 1995 Sheena's Place, named after Sheena Carpenter who died of AN in 1993 at the age of 22 opened in Toronto, Ontario. Sheena's Place was a non-profit transition home set up "be a buffer for those women who aren't quite ready to face the world" (p.52). The facility was a home, not a medical centre and to accommodate ten to twelve women at a time for a stay of approximately three months. Admittance to Sheena's Place was based on a doctor's referral. Treatment was in the form of private counseling, group therapy, and seminars on topics such as job searches, nutrition, sexuality and society and self-improvement (Tranquada, 1995). Since December, 1995, the centre has been unable to stay open due
to lack of funding. A fund-raising campaign is currently in existence to reopen Sheena's Place (Verbal Communication, Mrs Carpenter, December, 1995).

**Experiential Therapies**

Experiential therapies are new (within the last 30 years) psychotherapeutic approaches that offer alternative and/or adjunctive treatment for sufferers of AN. Most experiential therapies can be applied to both a hospital and community setting. Still, many require investigative research and experimentation before they will be integrated into the mainstream.

Among the 'verbal' experiential therapies are the Nurturant-Authoritative Therapy developed and practiced by Levenkron (1982), and Poetry Therapy described by Woodall and Anderson (1989). Levenkron asserts that conventional psychotherapy presumes a neutral attitude on the part of the therapist, whereas Nurturant-Authoritative Therapy demands more initiative and more active and deliberate behavior on the part of the therapist. Levenkron claims that this therapy works because it helps the client learn to accept and receive emotional support. Woodall and Anderson describe the use of Poetry Therapy in the treatment of many sufferers who are reticent, and who will only communicate monosyllabically. The authors claim that reading and writing poetry is thought to help the client access and express her feelings. Neither
Levenkron nor Woodall and Anderson describe the outcomes of the therapies.

Other experiential therapies target interventions directly at the somatic, 'nonverbal' level of dysfunction. Hudgins (1989) discusses Gestalt Therapy and Psychodrama. Hudgins notes that many clients depend entirely on what others say and do to function in society (indicative of an external locus of control) to the extent that they can become emotionally paralyzed. Therefore, the author contends that these therapies focus on "active experiencing" (p.237), a technique used to create an awareness and develop the client's internal locus of control. Role-playing is an example of active experiencing. Deen Miller (1991) and Rice, Hardenbergh, and Hornyak (1989) endorse Body-Image or Dance/Movement Therapy as an approach to treatment. According to the authors, Dance/Movement Therapy focuses on the interrelationship of the body and the mind. Although typically addressed in verbal forms of psychotherapy, the authors contend that issues such as sensory awareness and experiencing pleasure are brought to a tactile or somatic level using Dance Therapy. The result is that the client is able to experience the sensation in addition to understanding it cognitively. For example, dancing with a partner arm-in-arm is thought to evoke emotion in the woman with AN that would not surface without the sensations of touch and
movement. Art Therapy, suggested by Fleming (1989), has been used to treat AN because it targets areas such as creativity and self-confidence which are considered lacking or nonexistent in people with AN. Specifically, Fleming asserts that Art Therapy emphasizes the creative process as an outlet for expression, for mastery over impulses and fears, and for increasing self-control. This is accomplished through drawing or painting. As well, Music Therapy is practiced by Ball Parente (1989) for the treatment of AN. She states that the music therapist seeks to build and reinforce the sufferer's slow discovery of her own opinions and perceptions and also gently challenges her feelings of self-worth, which are often dependent on others' expectations and evaluations. This is accomplished through engaging the sufferer in breathing exercises to the rhythm of a certain type of music, playing an instrument, and participating in muscle relaxation exercises that are accompanied by selected pieces of music.

Many experiential therapies are based on theoretical concepts or models (Ball Parente, 1989) and have received accolades from professionals who practice within the confines of conventional treatment approaches. A number of studies have endorsed the benefits of experiential therapies with a broad range of populations, including children and the elderly as well as people with pathological and emotional problems that vary in the degree of severity (Hudgins, 1989;
Rice, Hardenbergh & Hornyak, 1989). However, the outcomes of treatment have not been empirically tested or adequately documented.

**Support Groups and Self-Help Groups**

Peer and family support groups and self-help groups for AN have arisen all over the world. Generally, the groups have not been evaluated for their effectiveness because meetings are closed to researchers. However, the literature indicates that these groups are in high demand from consumers. Noordenbos (1992) found that respondents recovering from AN ranked self-help groups as the second most positive treatment approach next to psychotherapy.

Among the peer or support groups are the National Association of Anorexia Nervosa and Associated Disorders (ANAD) (Ardell & Ardell, 1985) in Canada, the Anorexia Nervosa Aid Society (Volger, 1993), and the American Anorexia/Bulimia Association in the United States (Kinoy, Miller & Atchley, 1984). Most peer groups were formed by those afflicted with AN or by the families and friends of those individuals to support and act as an adjunct to medical and psychological therapy (Kinoy et al.). Generally, these groups meet on a weekly basis. Often, the group is led by a recovering sufferer or a significant other. Depending on the organization, membership provides access to newsletters, book reviews, workshops, and guest lectures. Often, peer groups
are open only to those recovering or recovered from AN. Anyone can attend "significant other" support groups but not under the auspices of a researcher or observer (including students studying AN) (Kinoy et al.).

One of the largest self-help groups related to an eating disorder is Over-eaters Anonymous or the 12 step program. Over-eaters Anonymous is a twenty three year old organization with an estimated membership of 190,000 across North America that meets once a week (Vogler, 1993). Over-eaters Anonymous began when three women took the principles of Alcoholics Anonymous and adapted it to fit overeaters (Volger). The organization has expanded to include members with any type of eating disorder.

The Over-eaters Anonymous program demands the individual's acceptance of the following three concepts: First, individuals with eating disorders are powerless over addiction, and their lives are unmanageable. Second, they are not responsible for their diseases; they are responsible for their recovery. Finally, they can no longer blame people, places, and things for their addiction; they must face their problems and their feelings (Rogers, 1988). The goals of treatment are to gain control over the eating behavior, thus stop the self-destructive behavior; identify and modify dysfunctional thoughts, beliefs, and values through cognitive awareness; and establish and then maintain recovery (Riley,
The Over-eaters Anonymous program involves group meetings with people who have eating disorders (usually Compulsive Over-eating, Bulimia, and/or Anorexia Nervosa); working the 12 steps (Appendix B); the use of fellowship and sponsorship; the use of the disease concept (the cornerstone of the program is acknowledging that an eating disorder is an involuntary psychobiologic state that released the person from responsibility but press[es] the person to manage the problem now that it exits); and telephone therapy.

The conceptualization of eating disorders as addictive behaviors is a relatively new concept (Riley, 1991). Orford (1985) notes that eating disorders, like other self-destructive addictions to substances or behaviors, develop as a process. The process may be initiated by a specialized trigger such as feeling fat, which underlies purging. But, eventually, less specialized feelings will gradually broaden to encompass many emotional or social stimuli such as feeling anxious no matter what the cause. Research conducted by Marra[zz]i and Luby (1986) reveals that AN behaviors such as binging, purging, and restricting may be pathophysiologically related to an increase in endogenous opiate levels, or addiction to the release of neurotransmitters that reinforce the self-destructive behaviors of AN (Copeland, 1985).

Little is written about the efficacy or effects of the Over-eaters Anonymous program. To my knowledge, no research
has been conducted whether to investigate or to evaluate its effects. Critics of 12 step programs in general (such as Alcoholics Anonymous, Narcotics Anonymous, and Adult Children of Alcoholics Anonymous) describe the programs as cults (Galanter, 1990, Peele, 1989). Further, some providers of treatment for AN view substance addictions as a masking of or distraction from pain rather than a display of pain, as is the case with AN (Goldberg, 1994). In addition, experts argue that the Over-eaters Anonymous program completely absolves any sociocultural or psychological influences that may be contributing to the AN, emphasizing the powerlessness that individuals have over their behavior. Consequently, the program does little to teach women with AN how to cope with their reality. Also, many experts contend that women with AN must take responsibility for their behavior, and various more popular treatments are built on this premise (Riley, 1991). Since the Over-eaters Anonymous program is inclusive of all eating disorders, Riley (1991) cautions that people with AN could experience tremendous discomfort if most people in the group are compulsive over-eaters and are grossly overweight.

In reviewing the literature related to Over-eaters Anonymous, it appears that a prerequisite of addictions therapy is acknowledging AN as a disease. Whether AN is a disease, a condition, or an addiction is still a controversial issue. The notion that addictions therapy
attempts to medicalize and pathologize women's bodies may be of concern. One wonders whether individuals with AN, who go through the 12 step program, benefit by viewing themselves as addicts for the rest of their lives.

The previous section presented some of the many unconventional treatment approaches available to consumers. They include private clinics, experiential therapies, support groups, and self-help groups. Each treatment explores and attempts to rectify the myriad aspects of AN. As in conventional treatment approaches, none is so effective as to be pre-eminent as the basis for treating AN.

**Nursing Approaches: Ideological Perspectives and Practice**

The rise in the number of women being cared for by nurses in many settings necessitates the development of nursing approaches which reflect both theoretical and empirical nursing knowledge. Yet, nurses continue to take guidance and direction from conventional treatment approaches that are based on ideological perspectives derived from other disciplines. This section then will put the phenomenon under study within the context of existing nursing perspectives, and approaches to nursing practice.

**Nursing Approaches: Ideological Perspectives**

Most nursing care is based on ideological perspectives of other disciplines. Still, many nurses recognize the importance of using a model or framework in practice that is
unique to nursing in that it provides direction for comprehensive nursing care to women with AN.

Geary (1988) conducted an extensive review of models used by nurses caring for women with AN that included psychoanalytic models, family or systems models, behavioral models, and feminist [sociocultural] models. She argues that the use of a single type of treatment approach in each setting is limited because the breadth and complexity of the problems associated with AN necessitate the use of a model that can incorporate the emotional, cognitive, physiologic, and cultural domains into both prevention and treatment. For this reason, she petitions for a holistic nursing model that 1) relies on viewing the individual as a whole person within the family and cultural context, and 2) focuses on tertiary care and wellness promotion in numerous settings such as community agencies and hospital settings both medical and psychiatric in orientation. However, Geary does not describe what the structure of such a model would look like.

Meades (1993) designed a model (unnamed) for describing eating disorders. He conceptualizes AN and Bulimia Nervosa on an axis at the polar ends of which are the dynamic causal factors: distorted body perceptions and stresses in interpersonal relationships. Further, he uses diagrams to conceptualize the different modes of dietary control suggesting the varying roles of physiological and cognitive
factors in non-dieters, dieters, anorectics, and binge-eaters. Meades illustrates how his model and diagrams can be used to outline community psychiatric nursing interventions for a variety of eating disorders. Interventions he includes are cognitive-behavioral approaches, anxiety alleviation techniques, and "family-therapy-type techniques" (p. 370). Together, the model and diagrams offer direction for nursing care. Still, they are based on conventional treatment models. Further, whether the interventions have been utilized or evaluated in any setting is unclear.

In addition to recognizing the need to devise models that direct nursing care, the literature validates that models are used in nursing practice to provide direction for nursing care. For example, Conrad, Sloan and Jedwabny (1992) describe a model that was designed by nurses for nurses, and which is currently being used in practice. Nursing staff observed that the dysfunctional communication patterns used between individuals with AN and their respective families mirrored the control issues played out between nurses and attending physicians on an eating-disorder ward. The staff hypothesized that patients were "out of control" (p. 14) because of the clashing nurse-physician rapport; that is, the attending physicians' control over the therapy regime was compromising the nurses' ability to manage acting-out behaviors of the patients in the milieu. Using knowledge of family systems,
transference concepts, and change theory, staff designed and implemented The Therapeutic/Administrative Split Model (T/ASM) to promote a coordinated therapeutic approach for responding to acting out behaviors of the patients, and to explicitly define the role that nurses were responsible for in treatment.

The philosophy of care on the ward involved what is commonly known in the literature as the Two Track Philosophy. Track One related to issues of weight, restricting and binging, and strenuous dieting, while Track Two related to psychological factors underlying personality development and family themes. The nurses decided that their role was limited to the first track. The second track, which emphasized the psychological problems, was seen as the domain of the physicians.

The T/ASM involved a written set of protocols regarding pre-admission, screening, admission, treatment and discharge planning for issues related to weight, nutrition and binging. It provided both a specific demarcation of the scope of the role of the nurse and a standard care plan to guide nurses. The authors concluded that the model has led to more effective treatment for AN because consistency now exists between the nurses and the physicians and because nurses now function as an integral part of the team. While the authors stated the T/ASM was simple and effective for setting and
reviewing goals, this was not explicitly delineated. The T/ASM is limited as a comprehensive and discrete nursing model because it is based on behavioral principles and directs the nurses to many tasks that focus primarily on weight restoration while ignoring the psychosocial aspects of nursing care.

Various nurses have undertaken to describe and publish nursing frameworks. Such frameworks are often based on borrowed models or concepts modified from other disciplines. Some are incomplete in that they only provide direction for a particular aspect of nursing care for those with AN. Gray Deering and Niziolek (1988) describe a framework for caring for the chronically-ill person with AN in which the concepts of "holding environment" and "good enough mothering" are adapted and modified from Winnicott (1965). The authors describe the concept of "holding environment" as a place where the nurse provides a structure that ensures physical and emotional safety within and beyond the hospital proper. The concept "good enough mothering" provides direction for the role of the nurse which the authors believe is to set limits while encouraging the individual and promoting independence. Although the concepts defined by Winnicott are not described in the article, the authors say that they chose them because they are "major healing factors... created by the therapeutic milieu" (p. 11). The authors do not describe
the structure of this framework or how it should be implemented.

Treatment for AN is varied and complex; many experts concur that it is most successful when initiated early in the course of the condition. A number of assessment guides have been developed and implemented by nurses to facilitate early detection of AN. One such guide, outlined by Connolly and Corbett-Dick (1990), supplies school nurses with a framework for the prevention and assessment of AN. It is derived from Wold's (1981) five roles for nurses in school health programs. The roles include the school nurse as deliverer of health services; as manager of health care within the school health program; as health counselor for individual and groups; as an advocate for the health rights of children; and as health educator in the school health program.

Another guide, developed by Van Daalen and Marko (1991), describes a general assessment tool in the form of a checklist. Developed by school nurses, and approved by the National Eating Disorder Information Centre, the tool is designed to help school and community health nurses identify individuals at risk of developing AN. Neither publication indicates whether the outcomes of these guides have been proven effective in preventing AN.

Using Gordon's functional health patterns in conjunction with the nursing process, Bryant and Kopeski (1986) have
developed an assessment guide for nurses caring for those individuals hospitalized with AN. They detail nine patterns that the nurse should use to facilitate assessment and the delineation of potential or actual health care problems associated with the hospitalized individual. These include the health-perception-health management pattern, the nutritional-metabolic pattern, the elimination pattern, the activity-exercise pattern, the cognitive-perceptual pattern, the self-perception-self-concept pattern, the role-relationship pattern, the sexuality-reproductive pattern, and the coping-stress-tolerance pattern. The patterns are similar to 'needs' or 'systems' that are generally used by nurses to define, plan, and evaluate their care. The authors conclude that the assessment guide provides nurses with a complete problem list and facilitates development of a comprehensive care plan. It is unclear whether this formalized guide has been implemented or evaluated in any setting. Further, the origin of Gordon's functional health patterns or the benefit of its use is not mentioned.

The models and frameworks reviewed are all associated with or dependent upon conventional treatment approaches. Further, it is unclear whether most have been implemented or evaluated for their efficacy. An extensive review of the literature revealed that there are no discrete nursing models or frameworks that provide direction for comprehensive or
holistic nursing care of women with AN in the hospital or community setting.

**Nursing Approaches: Practice**

Given the lack of universally accepted treatments for AN, most nurse experts advocate the use of an eclectic approach to caring for those with AN because of the multiple dimensions to the condition (Lilly & Brown Sanders, 1987). In addition, consistent with a holistic perspective, many nurses seem to recognize the need for individualized care (Love & Seaton, 1991). McNamara (1982) contends that the hallmarks of successful treatment of AN are the nurturing and caring qualities which nurses bring to their patients. The importance of establishing an alliance and trust with the individual who has AN is well recognized in the nursing literature (Lilly & Brown Sanders, 1987; Lyall, 1991; McNamara, 1982; Palmer, 1990). This section is therefore dedicated to an exploration of the variety of nursing care approaches provided to women with AN.

The extent to which nurses facilitate conventional treatment approaches as opposed to delineating a treatment approach specific to nursing care for women with AN is debatable. Love and Seaton (1991) argue that a "rigid adherence to one theoretical orientation and treatment modality represents a potential disservice to the patient" (p. 686). Despite their support for an eclectic treatment
approach, they believe that certain fundamental principles exist that are recognized as the cornerstones of nursing care. To this purpose, they highlight salient aspects of treatment that they call "nursing therapeutics" which are therapies that can be used in all settings. They cite two areas as therapeutics: the assessment process and the treatment approaches. Aspects of the assessment process include determining the individual's ability to build alliances, her motivation for treatment, her body image perceptions, her coping strategies, and her relationships to family and significant others. Finally, a mental status examination, a treatment history, and a physical examination are included as part of the assessment process. The treatment approaches are based on establishing a nursing diagnosis, identifying the goals of care, the outcome criteria, and the suggested interventions. The interventions that Love and Seaton emphasize include physiologic monitoring, psychoeducation, group therapy, behavior modification techniques, and pharmacotherapy. Why the "nursing therapeutics" described by the authors were identified as the cornerstone of nursing care is unclear. Further, the extent to which they have been tested or evaluated in the clinical situation is not reported. Finally, the principles of intervention seem to be based on the perspectives of those that mimic conventional treatment approaches.
The importance of creating nursing approaches which are responsive to both the predictable and the unique experiences faced by women is evident in the literature. For example, Nottingham and Emerson (1991) document the stages from diagnosis to death for a sixty year old women with AN. Their findings illustrate that people with AN may, at different ages, radically differ in the symptoms, behaviors, psychological profile, and family dynamics they exhibit. Consequently, age may have an important influence on the treatment experience of AN. Lilly and Brown Sanders (1987) present excerpts from four cases focusing on nursing approaches based on a "generic eating disorder protocol" in which the structure of the protocol includes twelve nursing responsibilities for the care of adolescents with AN. The authors illustrate the need to modify nursing approaches according to the individual needs of each patient. For example, in the absence of weight gain, Ann was confined to bedrest and was unable to receive visitors. However, her overall health status changed very little under these restrictions. A therapy session revealed that, as part of her AN behavior, Ann took refuge in seclusion. The incentives/reinforcements held out to gain weight and thereby to get Ann off bedrest included freedom to have visitors and leave her room. Yet, the incentives were obviously
ill-chosen. This new insight resulted in the protocol for Ann being revamped by the nursing staff. The authors concluded that continuing interaction between patients and staff and the therapeutic environment were the major tools at the nurse's disposal to help patients identify and redefine healthier adaptive-response patterns. Although the authors acknowledge the need to individualize nursing care, the "generic eating disorder protocol" is based on a behavioral therapy framework. Therefore, an assumption of this protocol is that all individuals with AN will conform to behavioral therapy principles as part of their treatment.

The nursing literature is rife with descriptions of general and specific nursing approaches used to care for individuals with AN. Glatter Nusbaum and Drever (1990) conducted a survey of in-patient nursing care approaches for persons with AN on seventeen psychiatric units around California. This survey sought out the opinions of nurses, not patients. The authors concluded that nursing was the mainstay in carrying out treatment plans with these patients. All the respondents in the study described behavioral components to their programs; the nurses believed that using a behavioral approach, regardless of the type used, was effective in putting weight on patients with AN in the in-patient setting. General nursing approaches for the treatment of AN were further outlined by McNamara (1982) and Palmer
(1990) who both propound that treatment is lengthy and complex, requiring a combination of: 1) aggressive medical management; 2) individual, group, and family psychotherapy; 3) behavioral management; 4) food-intake management; and 5) nutritional counseling.

A common theme in the nursing literature regarding general nursing approaches is the nurse-patient relationship discussed by Muscari (1988) and Gray Deering (1987). Muscari advocates three general principles that apply to effective nursing care: knowledge of the condition, effective patient teaching, and the nurse-patient relationship. Gray Deering (1987) focuses on the complexities of the nurse-patient relationship which she terms the "therapeutic alliance" (p. 11). According to Gray Deering, individuals with AN often have a narrow view of the nurses as people whose chief aim is to make them gain weight — the very thing they fear the most. Thus, she contends that the individual perceives the nurse as an enemy, not an ally. The author presents case examples that illustrate three phases in the development of a therapeutic alliance and the required nursing approaches for each phase. The phases are labeled: 1) angry/counterdependent, 2) depressed/needy, and 3) approaching/relating. Nursing approaches in phase one focus on establishing a relationship of trust with the individual. They include empathetic listening, limit setting/surveillance (devising a treatment
contract that minimizes power struggles and promotes consistency), educating individuals about their condition, and creating dialogue (getting past conversations around food and weight and providing meaningful interaction). Nursing approaches used during the second phase focus on providing the individual with intense support, nurturance, and guidance. The nursing approaches include listening and feeding rituals (listening and reflecting back the individual's experiences and feelings) and giving support and outreach (the nurse reaches out to the individual who does not know how to ask for help). Nursing approaches during the final phase focus on the therapeutic alliance maturing into a cooperative process. Nursing approaches in this phase include spontaneity and humor, being a role model, and mutual planning (setting goals). The extent to which this has been implemented or evaluated is unclear. Ultimately, most of the general nursing approaches described in the nursing literature reflect the conventional treatment approaches described in the subsequent section.

Specific nursing approaches that each provide direction for a particular aspect of AN are described by Butts Krakoff (1991), Delaune (1991), Fontaine (1991), Korb (1994), Staples and Schwartz (1990) and Sutton Edmands (1986). Butts Krakoff highlights the unique aspects of assessment required by the nurse when an individual has Insulin-Dependent Diabetes
Mellitus. Using the nursing process, Delaune describes strategies for effective limit setting since individuals with AN are perceived to be manipulative and deceitful, which seems to result in power struggles. Fontaine provides strategies to nurses for initial and ongoing assessment related to sexuality and sexual behavior since individuals with AN often suffer from concurrent sexual problems. Korb (1994) used self-reported questionnaires to establish that women with AN describe negative impressions of their mothers' lives. Korb concluded that perceptions of a maternal role model may be related to AN and should be carefully considered by the nurse with respect to individualized treatment. Staples and Schwartz, and Sutton Edmands describe out-patient support groups they formed for individuals with eating disorders to provide transitional support from the hospital to the community setting. Specific nursing approaches for AN tend to reflect traditional nursing principles such as addressing the psychosocial problems of the individual and conveying empathy to the individual; they rely less on conventional approaches such as behavioral therapy and pharmacological therapy.

Most nurse experts agree that in-patient treatment becomes necessary when potential life-threatening behaviors of purging and restricting food need to be monitored and interrupted (Conrad, Sloan & Jedwabny, 1992). However, the
trend toward prevention, promotion and tertiary care within the community is gaining wider acceptance (McNamara, 1982). Further, experts contend that initial contact sets the tone for the development and resolution of successes within therapy (Love & Seaton, 1991). Lehmann (1982) comments that nurses are in a vital position in the community: they run parent groups, and they are in all the schools, community health centers, clinics, pediatric wards, and emergency units. Hence, they can be the first to detect a problem. Chitty (1991) writes of the primary prevention role of the nurse in eating disorders insisting that if nurses are to move from a treatment mode to a prevention mode, they must expand their attention from individual and families as the units of treatment to the entire community as the unit of treatment. She asserts that nurses can take the initiative in important prevention activities (which to date have not been attempted) such as integrating schools, the helping professions, the media, business, and families in a coordinated effort to prevent AN. According to the author, when the community, rather than the individual or family is identified as the unit of intervention, health programs usually identify clusters of at-risk populations and target them for special educational efforts. At-risk populations for the development of eating disorders have been identified as adolescent girls, dancers, flight attendants, gymnasts, ice
skaters, models, wrestlers, and male homosexuals (recent studies indicate that gay men may seek treatment for eating disorders more often than heterosexual men, therefore inflating the numbers of gay males with AN [Olivardia, Pope, Mangweth, and Hudson, 1995]; while lesbians have a decreased incidence of eating disorders than do heterosexual women [Bordo, 1993]). However, Chitty cautions that Anorexia Nervosa and Bulimia Nervosa are so pervasive in society that attempts to deal with at-risk groups would neglect thousands of people with eating disorders who do not fall into any of the identified high-risk groups. Thus, she asserts that evaluation of prevention programs is essential to guarantee the refinement of preventative efforts over time. Compared to other disciplines, there is a dearth of nursing literature that not only emphasizes the importance of prevention programs in the treatment of AN, but provides tangible and pragmatic ideas to prevent AN. Yet, the extend to which the role of the nurse in prevention has been forthcoming appears limited.

A subtle thread that is conveyed throughout the nursing literature is that power struggles exist between nurses and individuals with AN (Conrad, Sloan & Jedwabny, 1992; Gray Deering, 1987; Muscari, 1988). Sanger and Cassino (1984) write "given the anorexia nervosa patient's fierce desire for control, it is not surprising when treatment programs
flounder on "power struggles" (p. 31). Whether this theme is fact or speculation is unclear as there is no research to validate it. Yet, Sanger and Cassino describe their need to adopt a "hands off" behavioral modification approach to nursing care that evolved through trial and error because of power struggles that ensued between patients and the staff, and even amongst staff. The extent to which the power struggle is a problem for patients and nursing staff alike is unclear. Yet, it does appear to be a concern as reflected in the literature.

Unlike bodies of literature from other disciplines, the nursing literature indicates by a subtle nuance the notion that nurses' attitudes about food and their own body image are continually called into question when caring for women with AN (Love & Seaton, 1991). For example, Harding (1985) warns that nurses working with persons who have AN must come to terms with their own attitudes about eating disorders and they must possess positive body images. Gray, Deering and Niziolek (1988) assert that, since many nurses are young women, they may be particularly effective role models for persons receiving treatment for AN. McNamara (1982) goes so far as to recommend that charge nurses consider the age and background of patients and their potential nurses when determining patient assignments. Further, she asserts that individuals may feel threatened by overbearing and/or
overweight staff. So, she suggests that a younger nurse who is closer to the sufferer's actual age (and weight) may be able to establish a closer relationship. Overall, she concludes that the determining factor in the nurse-patient assignment lies in the way the nurse feels about herself and her appearance (p. 36). The extent to which nurses' attitudes towards food and their bodies influence the care they provide to women with AN is unclear. If there is a need to document such viewpoints, it may be because nursing is a female-dominated profession and most sufferers of AN are women. However, this does not explain why female psychologists, psychiatrists, and nutritionists have not been as forthright in expressing their viewpoints.

Generally, nurses look outside the discipline to provide direction and guidance for nursing care to persons with AN. The irony is that nurses comprise over fifty percent of health care providers and manage over half of the 29 billion dollars spent on health care in Canada (Shannon, 1994). Yet, nurses have not devised, implemented, evaluated, and published a treatment plan that is holistic, comprehensive, or effective for the prevention or treatment of AN. Gaining a sound understanding of the conventional treatment experience of women with AN, based on their subjective responses to the experience, could provide a foundation upon which nurses can establish general guidelines for nursing care, provide
individualized support, and establish evaluative components to care.

**Viewpoints Of Consumers**

Consumers of health care are increasingly demanding more effective treatments with the ability to play a more decisive role in their care (Province of British Columbia, 1991). Reviewing anecdotal literature offers providers of care insight into existing treatment approaches from the perspectives of the client and their significant others who have experienced the approaches.

Sheila MacLeod (1981) recounts the first time she restricted her intake: she was thirteen and she continued to restrict for four years. She vehemently criticizes treatments for AN such as electro-convulsive therapy (ECT), behavioral techniques, and programs that emphasize weight restoration arguing that her own recovery was facilitated by a self-help group for women with AN. According to MacLeod, the self-help group provided her with an atmosphere of unconditional acceptance. MacLeod advocates that any sort of treatment for AN must take into account the circumstances of the particular woman, her age, the stage her condition has reached, the length of her illness, her family, and her social situation.

Catherine Dunbar lost her seven year battle to AN at the age of twenty-two years. Her mother (Dunbar, 1986) narrates her daughter's experiences both in and out of hospital for
the treatment of AN. They included undergoing behavioral therapy, sedation, involuntary certification, and forced feedings using a naso-gastric tube. Dunbar notes that, like so many women with AN, Catherine's main goal was to meet her target weight and then get discharged from the programs so that she could starve herself. Her experiences of conventional treatments did nothing, obviously, to change her life. Although ten years have lapsed since Catherine's death, and although many similar deaths have occurred, the treatment that she received for AN continues today.

Waskett (1989), a therapist, illustrates how AN can be treated in a humanistic and effective manner. She claims to have provided unconditional support and a listening ear for Jenny who had AN. Specifically, she never discussed weight or food with Jenny even though she was cachexic and emaciated. Instead, during the weekly sessions, Waskett built a relationship of trust and relentless encouragement with Jenny. Sometimes Jenny's parents and her husband went to see Waskett to understand why the old, amiable Jenny was changing. They were encouraged to understand why the family structure should not feel threatened by the new, challenging and confident Jenny. Today, Jenny has an eighteen-month old baby and a strong marriage; she is free of an lifestyle that revolves around AN.
The Ardells (1985) chronicle their journey as mother and daughter through the daughter Maureen's diagnosis, therapy, and recovery from AN. Two aspects of this biography are important. First, the lack of this family's inclusion in the care for a loved one undergoing therapy for AN both in the hospital and community setting is illustrated. When the mother discusses her perception of the social stigma attached to AN, and the lack of understanding that her friends and family had regarding her daughter's condition, she demonstrates how little help was offered by the health care team in dealing with her own feelings and perceptions. Further, she found it difficult to know how to help her daughter. Her sole refuge was in reading self-help books.

Second, the power struggles that exist between nurses and patients and amongst nurses and physicians in the hospital setting is well documented. As Maureen appeared to play one nurse against the other, so did the nurses attempt to supersede each other's authority to 'know' the one right way to care for Maureen. From Maureen's perspective, nursing care was full of inconsistencies and misunderstandings. She often referred to discrepancies in guidance that she received from her 'primary' nurse and other nurses. Furthermore, while Maureen felt nurses were attempting to become more involved in her care, she also found them blunt and untrustworthy at times. She describes an incident in which she returned from
an outing to find that her personal belongings had been moved to another room without any notification or explanation.

The interpretation of an individual's mental state can influence the orientation by which the nursing profession defines its nursing care. For Rachel Smith (1992), a twenty-year-old third-year nursing student with AN, counseling was the treatment that helped her. Rachel states she felt the need to please people, whatever the cost. She wanted to be the perfect person: a perfect daughter, sister, girlfriend, and friend. Rachel started to restrict her food and to exercise obsessively when she felt unable to control her relationships, school, or any impending change. She contended that "food is my enemy, food is my control. Food is more frightening to me than death itself. I'd rather die than eat" (p. 33). Rachel claimed that she fully understood what she was doing; however, she could not stop. Through counseling she had come to terms with the fact that the world was not perfect nor was she. Rachel emphasized that she was not biologically ill or mad. Thus, this anecdote reveals that the mental state of women with AN is variable; the interpretations then of an individual's mental state is worth considering when providing nursing care.

The stories of Sheila, Catherine, Maureen, Jenny, and Rachel reveal the individual nature of their experiences with the treatment approaches available to them for AN. Sheila and
Catherine's stories suggest that conventional treatments were not appropriate for them. Rachel's story reveals that the mental state of a woman with AN may have everything to do with her motivation and will or ability to recover. Jenny's story demonstrates that women with AN can recover, but recovery is contingent on the type and setting of the treatment. Maureen's story reveals that power struggles between disciplines can impact upon the sufferers negatively and that the inclusion of significant others in the treatment program can impact positively upon the sufferers. These stories illustrate that each individual's experience of AN is unique, responding to unique needs and perceptions of the world. Whether AN is a mental illness, a disease, a product of societal conditioning, a condition, or a disorder is still open to interpretation.

All aspects of treatment for AN are under scrutiny by consumers. In documenting her own experiences for the treatment of AN, Gibson (1983) states "the patient is coerced into gaining a large amount of weight in a very short time and scant attention is paid to her mental state" (p. 64). Yet, Kinoy, mother of an AN sufferer, and founder of the American Anorexia/Bulimia Association writes "in choosing a therapist, rapport, trust, and knowledge of the illness are more important than a particular approach or school of thought" (Kinoy, Miller & Atchley, 1984, p. 12). Consumers
have criticized and commended treatment approaches for AN, their use, and the settings in which they take place. Still, it is unclear whether individual concerns undermine any consistency for nursing care, or consistency for nursing care is undermined by individual concerns.

An extensive review of the literature reveals that many aspects of the treatment experience by consumers of AN treatment are poorly understood. However, research into the subjective experience of women with AN is increasing. A study of an emic perspective of one woman with AN conducted by Davidson and Cosgrove (1991) was very revealing. In a case study, they asked the woman to "describe [her] experiences of not eating when hungry" (p. 91). Based on her responses, they concluded that the subject's experience with AN was dualistic in nature: she described a world she shared with others and a "pathological world of dieting and thinness" (p. 99), a world she experienced alone. In a similar study by Santopinto (1988), two women with AN were asked "What is it like to live the experience of the relentless drive to be ever thinner?" From their answers, Santopinto yielded three concepts that express the experience of AN: "withdrawing-engaging, persistent struggle, and imaged self" (p.33). By inquiring about these women's experiences with AN, these authors learned something of the isolation that women with AN experience. These studies reveal that while subjective
experiences have been documented by nurses for AN, the results do not actually address the treatment experience of AN. The treatment experience must be documented if nurses are to understand the perceptions of sufferers and provide comprehensive nursing care. The intent of the proposed study is thus to describe the treatment experience of women with AN for the purpose of improving nursing care.

The benefits of conducting a research study of the treatment experience of women with AN is illustrated in a study conducted by Meyers (1989) in which naturalistic inquiry was used to investigate the occupational therapy experience of a woman with AN. In the study, the woman revealed those aspects of her treatment she considered most relevant. This study provided the occupational therapy staff (at the facility where the treatment occurred) with valuable insight and understanding into the various treatment modalities given to a woman with AN. For example, in response to stated feelings of the woman's lack of control in her life, the occupational therapist was able to invite the woman to "task groups", such as groups for crafts, which provided an environment to practice more mature skills and the opportunity to gain control over her life in a positive manner.
This review of the scholarly and lay literature reveals that conventional treatment approaches (either in the hospital or community setting) often do not influence the long-term course of AN, and the outcomes of treatment are rarely evaluated by any discipline, least of all by nursing. Those approaches that are evaluated tend to be based on the weight gain that women attain rather than on recovery from AN symptoms such as feelings of unworthiness, poor self-esteem and behaviors such as binging, purging, and restricting. Consequently, establishing the success rate of conventional treatment approaches for women with AN remains difficult. Conventional treatments have been almost entirely guided by clinician opinion rather than by research. Research that has been published by most disciplines is largely descriptive, retrospective, or uncontrolled. Moreover, it is from the perspective of the researcher rather than the consumer of care. Criticisms of conventional treatment approaches from consumers are extensively documented in the literature. In many cases, the effectiveness of unconventional treatment approaches is unsubstantiated; in others, evaluative research is limited. Most of the nursing publications take the form of narratives or descriptions of existing treatment approaches based on conventional treatments. No discrete and comprehensive nursing perspective exists that could provide
guidance to nurses caring for women with AN in any setting. Given this backdrop, the need to research the conventional treatment experience of women with AN is evident if nursing care is to be comprehensive, humanistic, holistic, and effective.

The goal of this literature review was to put the present study into the context of the existing literature. The objective of this study is to describe the treatment experience of women who have AN and to generate insight into and understanding of the phenomenon. As indicated in Chapter One, the thematic descriptive approach was chosen as the most appropriate approach to guide this exploration. The following chapter will describe this method as it was used in this research investigation. Chapter Four is a presentation of the findings. In chapter Five, a discussion of the findings is presented. Chapter Six suggests recommendations for future research as well as the implication of the findings on nursing research, practice, education, and social policy.
CHAPTER THREE: RESEARCH METHODOLOGY

Introduction

In this chapter, I present the research approach I utilized to study how women describe their experience for the treatment of AN. Specifically, I will explain the direction that this approach provided me with respect to the selection of the informants, the data collection techniques, and the data analysis procedures. Finally, I will explain the criteria that I used to establish rigor, and I will describe the ethical considerations of this study.

Approach Discerned From the Research Question

The approach to this study was discerned from the research question: How do women describe their conventional treatment experience for AN? My intent in choosing the subsequent approach was to describe and explain the shared experiences of the informants while anticipating the individuality of each informant's experience.

Because a study of this nature sought to describe the subjective experiences of the informants, some scholars would have suggested I consider a "pure" descriptive design in which I adhere to a method using content analysis to answer this question. However, this was not appropriate for my research question since I view content analysis more as a mechanistic technique than as a humanistic method. Indeed, I believe content analysis to be a technique which separates
the researcher from the humanistic and interactive aspects of the data (Sandelowski, 1993; Stern, 1994). As Giorgi (1985) asserts, "In its classic sense, content analysis demands that the researcher investigate a phenomenon within the constraints of a priori adoption of natural scientific criteria as final arbiters of a phenomenon" (p. 14). Clearly, a "pure" descriptive method using content analysis would direct me away from the humanistic interaction between myself and the informants' descriptions of their experiences and toward a focus on the mechanistic aspects of the data per se. Thus, I attempted to avoid being entrapped into a mechanistic analysis of the phenomenon.

From the words I chose to articulate my research question, one might construe that I attempted to capture the eidetic or essential essence (Cohen & Ornery, 1994) of women's conventional treatment experience for AN. Some scholars might argue that a traditional qualitative method such as phenomenology would best be suited to answering my research question because phenomenology "attempts to disclose the essential meaning of human endeavors" (Bishop & Scudder, 1991, p.5). However, the phenomenological method requires that the researcher interpret the philosophical underpinnings of the phenomenon for its own sake through a process of reflection and imagination (Oiler, 1986). Moreover, "description, analysis and explanation are pointedly
excluded" from the phenomenological method (Oiler, 1986, p. 71). A traditional method such as phenomenology was therefore inappropriate and inadequate to answer my research question fully; it would guide me only to capture the meaning of the informants' experiences for its own sake. Conversely, describing the informants' experiences could provide nurses with tangible knowledge and understanding to provide improved patient care.

It is my view that the nursing profession is an applied science and a practice discipline. Therefore, nurse researchers ought to focus on generating and grounding sound, pragmatic, and tangible observations upon which nursing interventions can be deduced directly to improve patient care. Thorne notes that "questions inherent to nursing science are distinguished, revealing major departures from the process, product, and even purpose of the original inquiry" (1991, p. 178). Thus, the nature of my research question focused on concrete instances of women's treatment experiences for AN. In collecting data, I discerned sufficient themes that constituted the informants' common experiences through a process of description, understanding, clarifying, and explaining. In contrast to the confines of a traditional methodology in which the human condition is researched for its own sake, I translated these themes into practical implications so that nurse practitioners, educators
and policy administrators might utilize and apply the shared experiences of the informants to individual sufferers within the hospital or community setting.

Thus, I used a thematic descriptive approach to answer the research question, "How do women describe their conventional treatment experience for AN?" I presumed the following assumptions utilizing this approach. First, as previously indicated, the lack of current knowledge as evidenced in the literature review precluded the use of a theoretical base for this study (Brink & Wood, 1989). Therefore, this study was not directed by a formal conceptual framework. Second, an inductive and interactive process of inquiry between myself and the informants was utilized to discern common themes. Finally, the themes that I discerned from the data reflected the contextual and subjective descriptions that the informants ascribed to their experience.

It was difficult to describe data collection techniques and methods of analysis before the research process begun. The reason was that I had a limited amount of "control" over the precise nature of the interviews that I conducted because I used open-ended questions. In addition, the best method to analyze the data did not unfold until collection began. Also, I anticipated that I might need to make adjustments in response to ongoing data collection and analysis (May, 1989).
Indeed, the significance of the research findings was hard for me to justify until a certain level of analysis was reached (Field & Morse, 1985). I recognized that I made these decisions as the study was constructed. However, I ensured that the research was auditable as I articulated the intent and the plan that I used to guide my decision making. I also planned to make explicit the reasoning behind any departures from the general approach in my written report, and consider any implications these may have had upon the findings.

**Method Slurring versus Methodological Orthodoxy**

The emergent approach for this study was proposed within the context of an existing debate among nurse scholars. That is, nurse scholars are currently debating whether qualitative methods should be rigidly adhered to so that researchers do not violate the assumptions of all qualitative methods, or whether qualitative methods should be vaguely described a priori data collection in order to give researchers the freedom to develop their own style. Contrary to the emergent method that I chose, proponents of "orthodox traditions" argue that qualitative researchers should rigidly adhere to the tenets of a specific method in order to have an auditable and credible study (Morse, 1989). Conversely, critics of "orthodox traditions" deliberate the applicability of such methods to the questions of nursing science and suggest that the requirements for methodological orthodoxy could include
"a uniquely nursing approach to qualitative inquiry" (Thorne, 1991). In my opinion, the nature of the research question was best answered using the thematic descriptive approach because of its practical applicability for nursing practice.

Some nurse researchers are utilizing more than one qualitative method at a time and not explicitly stating the assumptions of their approach. Baker, Wuest, and Stern (1992) state that qualitative data collection procedures and methods of analysis should be explicit and consistent with the underlying assumptions of the specific approach selected to ensure rigor. Morse (1989) argues that researchers are mixing specific aspects from various methodologies to formulate one way in which to conduct their research. As a result, methods of qualitative research are becoming increasingly unstructured. She illustrates the case in point using a research paper titled "A Combined Qualitative Methodology for Nursing Research" by Swanson-Kauffman. Swanson-Kauffman states "the methodology used evolved as [she and her] study progressed. It is a somewhat unique blending of phenomenological, grounded theory, and ethnographic methodologies" (1986, p. 59). In Morse's opinion, Swanson-Kauffman exemplifies a nurse researcher who eludes the tenets of each method by combining methods. This practice is known as method mixing (Morse, 1989) or method slurring (Baker, Wuest & Stern, 1992). Morse and Baker, Wuest and Stern
declare that researchers who practice method mixing/slurring are blurring distinctions between various qualitative approaches by combining their methodological prescriptions eclectically. While these authors contend that researchers violate the assumptions of data collection techniques and methods of analysis of all qualitative methods when they slur methods, opinions to the contrary exist demonstrating that researchers who do use methodological variations do so in order to research aspects of human nature of particular interest to nurses who want to directly improve patient care.

Critics of the requirement to observe "orthodox traditions" acknowledge that qualitative researchers are doing legitimate research for which there is no name (Stern, 1994). The reason this research is being done, is that in many cases, nurse researchers are required to modify the methods that they use in order to answer the research question that they have formulated. Dreher (1994) states that the nature of nursing phenomena often require nurse researchers to utilize a multiplicity of methods. As a result, nurse researchers frequently and necessarily deviate from the classic descriptions of specific strategies within the qualitative paradigm. Indeed, Thorne (1991) challenges the "fit" that supporters of orthodox qualitative methods have regarding their purpose, emphasis, context, perspective, and relationships for the practical applicability to nursing
inquiry. Further, she analyzes the practical applicability of orthodox qualitative research traditions to nursing science by discerning some of the distinctions that might necessitate methodological variations for nursing's purpose. Thorne concludes that "nursing science departs from the larger assumptions underlying the various qualitative methods and is distinct in its (a) central values, (b) capacity for ambiguity, (c) complexity, and (d) insistence on practical application" (p.191). Thus, the design that was articulated for this study was an approach developed in the context of an as-yet-unresolved methodological debate in the nursing research literature.

This research approach did not evolve in a vacuum. Nor do I believe that I lent "support to the minions of mediocrity" (Stern, 1994, p. 214) who slur methods. This approach was a qualitative one in which common themes were derived from semi-structured interviews and data analysis using a framework modified from Field and Morse (1985) and Giorgi (1985). I derived my research question in response to the perceived need to describe and explain the effectiveness of conventional treatment approaches that women undergo for AN, a perception well evidenced in the literature review. The nature of an evolving qualitative approach was justified because it provided a guide by which I was able to discern common themes that will have direct and practical implication
Informant Selection

I anticipated that the AN population may be reluctant to participate in this study. Indeed, two women dropped out of my trial research project without explanation (conducted for a course, Nursing 522, December, 1993). In addition, women with AN tend toward mood disorders and cognitive impairments which could have impeded their ability to volunteer (Bock, 1992b).

For these reasons, I combined two types of sampling techniques to potentially increase the success in sampling: theoretical techniques and nominated techniques. Theoretical techniques involve using samples that are composed of informants who are best able to reflect and articulate their experiences of the phenomenon under study (Morse, 1989). I took the opportunity to assess whether the informants met this criterion during the telephone conversation in which I told prospective informants about the study. Nominated techniques involve using samples that are obtained by eliciting the support and assistance of a single informant already in the study to assist with the selection of another informant and are also known as snowball sampling (Morse). I enlisted the assistance of a woman who had AN. She had been hospitalized for the treatment of AN and had access to women for the nursing profession and thus answer the research question.
in the AN community. This woman was the single informant in a phenomenological trial project about AN that I conducted in December, 1993. These techniques insured the success of the sampling process and no difficulties were encountered in obtaining informants. I interviewed five informants for this study and I was able to establish sufficient variation in the data to understand the nature of specific common themes that the informants described. I acknowledge that the small group is a potential limitation of the study.

**Characteristics of Informants**

The selection of informants was established based on the following criteria. The informants were required to: 1) be female; 2) have been treated for AN at least once in a provincially approved institution; 3) be eighteen years of age or older; 4) have been able to communicate fluently in English; 5) currently have AN or be recovering from AN; and 6) have not been hospitalized at the time of participation. There is literature to indicate that women who are hospitalized with AN are often heavily sedated and/or suffering from side effects of malnourishment such as irritability, anxiety, impaired cognition and/or depression (Love & Seaton, 1991). Interviewing hospitalized women could potentially have led to ethical issues such as informants consenting to the study while under duress. Furthermore, I was concerned about the ability of women in the immediate
situation of acute illness to reflect on and describe their experiences.

Morse (1989) states that demographic characteristics have little significance in qualitative research because they are insufficient indicators to identify the informants. Rather, she believes that it is important to describe the individual characteristics of each informant and the context in which they are researched. However, consistent with the feminist perspective, I have included specific demographic characteristics such as race, employment, and educational level to explicate any ethnocentricity and classism that is inherent in this study (DeMarco, Cambell, & Wuest, 1983). I have included religion based on the case studies conducted by Giles-Banks (1992) observing that sociocultural factors may contribute to AN. There is some new literature to suggest that a decreased incidence of AN exists amongst the lesbian population (Bordo, 1993) and I have therefore included the question of sexual preference of the informants in this study. Further, there is a paucity of literature linking sexual molestation to eating disorders and I have therefore addressed this question (Love and Seaton, 1991). I have included the type of AN that the informant has in order to discern the possibility of any observable differences in the experiences of informants who are restrictors from the informants who are bingers.
All of the informants were Caucasian women between the ages of twenty-three and fifty-one. Four had been born and raised in Canada, one had been born and raised in England, immigrating to Canada in her twenties. All of the informants had completed a high school equivalency education. Four of the informants had a post secondary education and two of the informants had university degrees. Three informants claimed to be agnostic, one informant had been raised in an "oppressive Catholic home" which she explained had contributed to guilt feelings leading to her AN. Another informant had been raised in an evangelical environment and was married to a minister. She denied that her religion played a role in her AN. Three informants had never married, one informant was divorced and all were heterosexual. Two of the informants had been sexually molested as children and one informant had been a prostitute. Two informants had children — their ages are twenty-two and twenty-three and three years respectively. Three of the informants described themselves as restrictors and two bingers.

Data Collection Techniques

The hallmark of scientific work according to May (1989) is the ability of the researcher to explicate precise description of data collection procedures. Thus, each informant received an Informant Information Letter
(Appendix C) from the resource woman with AN that I previously mentioned or from another informant. The potential informant then contacted me by telephone. During our telephone conversation, I established that the informant had been treated for AN within three years and that she was able to reflect on and describe detailed experiential information about her treatment experience (Morse, 1989). All of the women who called met the selection criteria. Therefore, I set up an interview with an informant either at her home or at a location that she deemed convenient. Three of the interviews took place at the informants' homes; another two were conducted at the community transition homes where informants were living.

At the beginning of our meeting, I presented the informant with a one time only $20.00 honorarium prior to the interview (to ensure that she did not feel obligated to sit through the interview until she received the money) as a nominal expression of my appreciation for participating in this study. Next, I explained the nature of the study and clarified any questions that she might have. In addition, I obtained written consent from her (Appendix D). I told the informant that I would contact her throughout the study in order to verify my interpretations of the transcripts or to have her affirm or refute my interpretations. Subsequently, I turned on the audio-tape and recorded the conversation.
audio-taped discussion lasted from one to two hours and followed a format as outlined in the interview guide (Appendix E). Two of the follow-up interviews were conducted in person and the remainder were telephone interviews.

Interview techniques included open-ended questions, grand tour questions (e.g., "please describe for me what it was like for you to be treated for Anorexia?"), and contrast or comparison questions. The interview guide followed a format leading from general to specific questions. An interview guide was necessary because it ensured some consistency between the interviews. In addition, it established the salient parameters of the study while still allowing for flexibility in depth and scope (May, 1989). I constructed the sequencing and content of the questions to allow for flexibility with respect to the direction that the interviews took. In addition, I designed the questions to reflect the problem statement, the research question, the literature review, and the research approach. As informants stories began to unfold, I required less direction from the interview guide and often only spoke to clarify points raised by informants. Interviews were concluded when an informant's story began to repeat or when an informant explicitly stated that she had nothing else to say. All informants desired to offer "one last comment" or "piece of advice for nurses" when asked if they had anything else to say before the interview
was terminated. Consequently, an interview often lasted two hours with the later part generating "rich" data.

One explicit deviation was made from the general interview guide after the first interview was conducted. Specifically, the mother of the first informant telephoned me to request that I include in this study a section that explores the extent to which families are included in the treatment for AN; she indicated to me that she and her family had not been included or encouraged to participate in many of the treatments that her daughter had received. For this reason, I discussed with the subsequent informants the extent to which their families were included or encouraged to partake in the various treatments they had received.

Data Analysis

I began transcription and data analysis as soon as the first interview was conducted. Woods and Catanzaro (1988) note that the researcher must decide what units of analysis to employ in a given study whether it be words, themes, or time-and-space. My goal was to describe sufficient themes that constitute the conventional treatment experience of women with AN. For the purpose of this study, themes are defined as sentences about some fact which have more meaning than the words they are comprised of (Woods & Catanzaro).

I used an approach adapted from Field and Morse (1985) and Giorgi (1985) as a guide for my data analysis. In the
trial project that I conducted in December, 1993, I found that the specific approach that I used unfolded as I began to go over the transcripts. Therefore, I was flexible and did not conclude the best approach to analyze the data until data collection began (May, 1989).

1) Transcribe Interviews: I transcribed all interviews myself in order to hear the informant's voice, her emphasis on words and the inflection of her voice, to get a sense of what the informant was conveying (Field and Morse; Giorgi). I left a 5-inch margin to the left of the text in order to record initial and ongoing commonalities or differences amongst informants.

2) Method of Coding: I broke the text down into manageable categories since I was not able to analyze the entire text simultaneously (Giorgi). I used colored pens and a ruler to form categories (Field and Morse), and I recorded the categories of the images evoked as broadly as possible into a journal.

3) Category Classification: My specific aim was to discriminate and delineate towards smaller categories. I discerned the categories within the context in which they were described by the informants. I did not define the categories as elements, the definition of which implies that one builds on the other eventually forming the whole (Giorgi). Using a cut and paste method, I sorted
categories into smaller, discriminate categories that were context laden (Field and Morse; Giorgi).

4) Formulating and Linkage of Themes: I made the transition from text to categories to themes through a process of interaction and constant clarification with the categories, linking categories, synthesizing, understanding, discussion with the chair of my thesis committee, and finally verification with informants. My aim was not to exclude any obscure details (outliers) within the transcripts and categories, and thus not to arbitrarily or prematurely conclude themes. Field notes were used to further understand the context within which themes were formed. This analytical plan served as the direction for my data analysis process.

Limitations

I limited the number of informants interviewed and audio taped to five. Ray (1994) suggests that usually eight to twelve informants are required for themes to begin to recur in the data. But Sandelowski (1986) states that data collection is ceased when data saturation occurs. The number of informants in the study and the number of interviews that I conducted may have limited the number of themes discernible from the data; also, variation in the data may be insufficient. Hence, the applicability of this study is limited to the informants being studied.
The fact that I am a neophyte researcher may limit the depth and richness of the themes described in the study. Further, the exclusive use of a verbal text is an inherent weakness in this study: my interpretations may not reflect the differences in experiences that the informants describe. Rather, my interpretations may reflect the differences in the informant's capacity to use language and discourse (Dreher, 1994).

Since I selected informants for the study using the theoretical and nominated sampling techniques, they may have represented a specialized subgroup of the theoretical population of women with AN who have been hospitalized for treatment. This subgroup may reflect unique or particular characteristics; women who would not have volunteered for the study may indeed reflect different characteristics. Moreover, some of the literature suggests that women who are treated for AN in the hospital setting are often sedated and/or suffering side effects of malnourishment such as irritability and anxiety. The extent that these women are able to reflect on and describe their conventional treatment experience is thus unknown. Since I established over the telephone whether the informants were able to reflect and share their experiences, I had to consider to what extent I could establish whether or not a woman was qualified to inform on
the phenomenon of interest based simply on a telephone conversation.

Some feminists may perceive this study as ethnocentric because of the requirement that all informants were required to speak fluent English. Still, it was beyond the scope of this study because of the time constraints that I was under (and the practicality and expense of hiring a translator) to consider any informant who could not speak English and I acknowledge this as a potential limitation of the study. As more studies incur, it is evident that more males are affected with Anorexia Nervosa. It is therefore a limitation to not include a male perspective in this study.

**Context Within Which Interviews Were Conducted**

The following observations must be considered when linking the phenomena under study to the context within which the initial and follow-up interviews were conducted:

1) All of the informants had AN at the time of the first and follow-up interviews conducted. The extent to which the manifestations of AN (e.g., malnutrition) and/or the side effects of treatments (e.g., medications) influenced the phenomena are noteworthy.

2) Two of the interviews were conducted at community transition homes where the chance of an interruption by a practitioners was possible. Therefore, the extent to
which these informants felt completely uninhibited in their interviews is worthy of consideration.

3) All of the informants received a nominal sum for partaking in the study. One informant was on welfare, another was collecting unemployment insurance, and a third was unemployed and being supported by her parents. Consequently, informants may have been influenced by the need for money.

4) Three of the informants indicated that they had participated in numerous studies across disciplines related to their AN and therefore, they could be considered practiced subjects.

Rigor

The substantive value of this study rests on my ability to describe the informants' treatment experiences for AN. To this end, I left a clear decision trail by which future readers can recognize the thematic descriptions that I have discerned (Sandelowski, 1986). In addition, I provided an opportunity for women to describe their reality. Moreover, I acknowledged covert assumptions about ethnocentrism, classism, and androcentrism within the study. These assumptions are consistent with feminist inquiry which is grounded in women's actual experiences (Parker & McFarlane, 1991).
I remained open and flexible to establishing precise a priori data collection techniques and data analysis procedures (May, 1989). Yet, I approached data collection procedures from a systematic and consistent method using the plan that I have modified from Field and Morse (1985) and Giorgi (1985). My aim was to explicitly account for, rather than eliminate, my biases (Dreher, 1994). I was reflexive in this study by acknowledging any preconceptions I had which may have impeded or influenced the content and conduct of this study. Further, I kept a journal in which I recorded the thoughts and feelings I had during the interviews as well as during data analysis (Lamb & Huttlinger, 1989).

I explicitly reported the context in which the interviews were conducted and I linked the phenomena under study to that context (Dreher, 1994). Following the theoretical assumption of "appropriateness" (Morse, 1989, p. 127), I established that the informants in this study were able to describe, articulate, and reflect on their experiences in the treatment setting. I observed common pitfalls in interviewing such as "interruptions, competing distractions, posing awkward questions, jumping, teaching and preaching, counseling, presenting one's own perspective, superficial interviews and secret information" (Field & Morse, 1985, p.68).

A provision in this study was that I would interview and audio-tape more informants if I was unable to discern
sufficient themes to describe the experiences that initial informants described to me. However, this was unnecessary as informants succinctly described common experiences that enabled me to discern specific themes. I attended to categories and themes that I was not able to discern in the data to identify exceptions and patterns. Dreher (1994) states "it is often the things that are not talked about that are the most critical and the most revealing". (p.285). To ensure that the themes I discerned were not univocal or arbitrary (Giorgi, 1985), I constantly clarified the data myself and under the guidance of the chair of my thesis committee who is an expert qualitative researcher.

"Elite bias" may have been a problem in this study as the informants that agreed to be interviewed may have been the most accessible and highest functioning members of the AN community. I facilitated the truth value of the research by presenting a faithful description and interpretation of the informants' descriptions. The applicability of this study was admittedly limited to those in similar circumstances. Still, the informants verified my research findings and unanimously concluded that it could "fit" into contexts other than this specific study situation.

Ethical Considerations

The ethical considerations for this study included the following:
1) voluntary consent through written consent;
2) confidentiality (I destroyed all tapes after the research was complete);
3) privacy (the meetings and conversations were privy to me and the informants alone);
4) inclusion and exclusion of information. (At any time an informant wished to end our conversation, remain silent or have the tapes erased, I adhered to her request. This happened on one occasion as an informant did not wish to discuss a certain treatment setting because it evoked painful and unresolved memories).

All audio-tapes were numerically coded and available only to me and the chair of my thesis committee. The proposal for my study was ethically approved by The University of British Columbia Behavioral Science Screening Committee For Research and Other Studies Involving Human Subjects.

Each informant received an Informant Information Letter (Appendix C) and had an opportunity to meet with me to receive further information and have any questions that she may have had answered. Once she felt she fully understood the study, the informant signed a written consent (Appendix D) which included the title, purpose, explanation of the research, steps to be followed, and the risks and benefits explicitly stated (Munhall, 1988). In addition, process
consenting (Munhall) was affirmed from time to time as verbal consent on the audio-tape.

I explicitly stated in the consent form (Appendix D) the benefits for informants taking part in this study. I realize that they may benefit from talking about their experiences with AN; Ramos (1989) suggests that a "listening ear" (p. 59) can be a cathartic experience for informants. In addition, in the event of encountering a "Pandora's Box" dilemma (Ramos, 1989) where the informant may regress in her behavior by participating in the study, I would have arranged a referral for the informant to contact her local chapter of ANAD. However, this was unnecessary.

Summary

Freed from the confines of an orthodox methodology, I composed the thematic descriptive approach to guide this study. Informants were chosen by virtue of their ability to convey their treatment experience for AN. Data collection and analysis were consistent with the framework for this approach. Confirmability was addressed to the extent that I captured the truth value, auditability, and applicability of the informant's experience (Sandelowski, 1986). The rights of the informants were protected by the aforementioned ethical considerations. Chapter Four will present the findings of this study. In Chapter Five a discussion of the findings is presented. Chapter Six suggests recommendation for future
research as well as the implications of the findings for nursing research, practice, education, and social policy.
CHAPTER FOUR: PRESENTATION OF THE FINDINGS

Introduction

In this chapter, the informant's descriptions of their treatment experiences for AN are presented in an interpretive summary. This summary is based on the findings that evolved throughout the data collection and the application of coding data, as well as the classification and linking of categories, to establish themes. This presentation of the findings focuses on the shared experiences of the conventional treatments for AN as described by the informants who participated in this study.

The informants in this study have been exposed to the conventional treatments of AN for an extended period of time (4 to 10 years) and as a result, have witnessed and experienced many challenges and few benefits. Further, such treatments appear to be constantly evolving which results in experiences that are often unpredictable and inconsistent. For the five informants of this study, numerous conventional treatments have either periodically improved quality of life, provided temporary hope for recovery, or left them with feelings of "craziness". Informants who claimed to feel crazy felt it was a result of frustration, exasperation, or desperation associated with treatment; all the informants now are dubious about the benefits to treatment yet feel resigned since they believe no alternatives to the current treatments
for AN seem to exist. Still, the mere existence of current treatments regardless of their challenges provides the informants with much needed hope for recovery. At the time of this writing, none of the informants have recovered from AN.

Generally, the quality of the treatment experience is contingent upon: the degree to which informants experienced several conditions of treatment; the nature of the setting within which informants have received treatment; and to a greater extent, the qualities possessed by the practitioners who provided the treatment. While informants were able to label the psychotherapies that they've received — art therapy, family therapy, group therapy, individual therapy, journaling, narrative therapy, nutritional education, psycho-education and self-esteem programs — the psychotherapies were not explicitly or even implicitly described by the informants. Rather, their focus remained on the qualities that practitioners possess as having fundamental importance in shaping the treatment experience.

Three themes thus emerged from the informants' descriptions of the treatment experience for AN: 1) the quality of the treatment experience seems dependent upon several conditions that permeate every realm of the treatment experience; 2) the quality of the treatment experience seems contingent upon the nature of the setting; and 3) certain
qualities possessed by practitioners are an essential component affecting the quality of the treatment experience.

Conditions That Permeate The Treatment Experience

According to the informants, three conditions that permeate every realm of the treatment experience — the accessibility to treatment programs and practitioners, the quantification of recovery, and the medicalization of the AN plight. First, all informants described treatment for AN as being neither easily accessible nor readily available. For example, informants often described situations in which they waited to access programs or specialists upon diagnosis or for follow-up programs when they were discharged from the hospital. Second, informants maintained that the treatment experience usually revolved around quantifiable foci that ascertained their recovery in terms of measurements such as the percentage of body fat and weight gain. Informants felt that their central problems were often overshadowed by a preoccupation with weight gain — a preoccupation that they concurred was largely endorsed by practitioners. Third, the medicalization of the AN plight was taken for granted by informants. That is, large quantities of a variety of medications were prescribed and/or administered to the informants in this study. Yet, for them, it meant they needed to maintain a passive or accepting stance towards pharmacological interventions. Indeed, their respect and
faith in medications and those who prescribed and administered them overshadowed the focus on personal problems at the root of their AN.

**Accessibility of Programs and Practitioners**

Once informants decided to seek or were coerced into seeking treatment for AN they waited, sometimes "for months and months and months". Many felt they were no closer to gaining access either to eating-disorder treatment programs or to particular practitioners for help. Informants were faced with a "waiting list for an eating-disorder clinic"; they found themselves waiting for "a bed to be available", waiting "to see a dietitian or a psychiatrist", or waiting for "a referral to a psychologist". Informants experienced waiting for treatment as a very painful process ranging from desperation to horrific trauma. One informant explained, "I could just barely function, I didn't think that I was going to make it". Another informant expressed trepidation about what lay ahead for her after waiting a lengthy period for treatment: "When I finally had the appointment with the psychologist, I remember sitting there and I almost didn't go in, I almost got up and walked away". Most detrimental, waiting for treatment propagated a futile and fatalistic attitude that there may not be any hope of recovering, an attitude informants began to accept as reality.
The will to recover was often overshadowed by the fear that another opportunity may not arise to access the system because of the large demand for services. For example, one informant said, "I try to get calmed down and have another plug at it rather than just discharging myself and then having to wait months and months and months to get back into a sort of treatment program". Another informant was distracted from the treatment process because she was so preoccupied by the date at which the treatment terminated: "I secretly brought my own tape recorder and taped the talk because when this was all over [and] my six months was over at the clinic, I would have something I could hear that would inspire me again". Ironically, most informants emphasized that the longer an individual waits to seek help, the longer her patterns and habits of AN become entrenched in her lifestyle making it all the more difficult to recover.

For informants, treatment was never guaranteed to be available at any time, even if the individual felt herself to be in a crisis. Informants explained that even passing the time until the first or next "appointment" could be agonizing. As well, the limited duration of treatments or services rendered by practitioners was something of which informants were always cognizant: "We'd have an appointment only once a week with a psychiatrist and a dietitian. Then I'd be on my own to find some care outside the hospital. I
always had that looming over my head that one day I wasn't going to be getting anymore help. All the informants expressed the yearning to participate in at least one type of treatment that was open-ended and long-term, and/or one crisis service that would have provided a place to fall back on if the need arose. According to informants, this service would be particularly relevant at two vulnerable points in treatment: first, when informants were discharged from a program after which they were physically renourished yet still vulnerable when expected to adapt to "my new body", and second, when informants were near weight recovery and working through personal problems often the root of their AN. Informants claimed that such a service could respond to their need to engage in a "support group" or to contact "someone to talk to every week". One informant currently participates in what she calls an "open group". She describes the group as offering an open-ended treatment that responds to a variety of needs of men and women. She said, "This is an open group so I don't feel always worried that my time is soon to be up". Two other informants participate in an open group geared towards meeting the specific needs of people with AN. However, both informants indicated that the nature, timing and design of the group did not foster commitment to attend and participate; to these informants, the group seemed to represent something of the hopelessness of AN.
Once accepted into treatment, the informants experienced vulnerability and dependency regarding the availability of the practitioners. Although they described the waiting period for referrals to see psychiatrists, dietitians, and psychologists as agonizing, informants were particularly critical of the length of time that nurses were willing and/or able to spend with them. Informants frequently indicated that nurses were not readily available for "even an hour" to talk, especially within the hospital setting. This left informants frustrated and resigned to depending on other practitioners for treatment.

Overall, the informants believed that the number of applicants for treatment far exceeded the accessibility of programs and practitioners. Further, they felt the costs of treatments were likely high and the resources within the health care system were limited. When prompted as to how they came to formulate these opinions, they claimed that the practitioners themselves had often conveyed this information to them. As one informant explained, "They can't afford to keep putting me in a regular hospital. It's too costly. My GP said that she was starting to get vibes from the top people how they use the beds". Thus, the entire experience of waiting for treatment evoked perpetual insecurity in informants and a loss of hope leading to resignation.
Quantification of Recovery

Informants consistently referred to two quantifiable elements as a basis for appraising their recovery. Whether this was a manifestation of the AN plight or a by-product of the conventional treatment process is debatable. However, all informants claimed to experience a treatment process that positioned their recovery in terms of issues related to weight and nourishment.

The method for recording the course of AN in terms of weight involves measuring the percentage of body fat on an individual. Specifically, a device is used to measure the skin folds on three locations on the body. According to the informants, health care practitioners thought this method was more accurate than recording the weight of an individual using a weigh scale. For informants, it was less threatening because it did not explicitly divulge pounds/kilograms and therefore, was the method preferred by the informants. Indeed, four of the informants were so used to knowing their percentage of body fat that they were unable to tell me what their weight was in pounds/kilograms.

Having skinfold measurements taken was one of the most anxiety provoking experiences for informants before, during, and after the procedure. Specific aspects of anxiety related to the procedure included the weekly methodical manner within which the measurements were conducted — indeed, this
procedure was one informant's only connection to a treatment program at one point in her recovery. Specifically, the uncertainty of not knowing what an informants' skinfold measurements would be before the procedure was most anxiety producing. Both hearing the results of the procedure and realizing the consequences of the resultant measurement were also traumatic. As one informant expounded,

Every Wednesday morning at 07:30 the Doctor would come and do your skinfolds. You'd be on pins and needles. You'd either be very upset because you gained weight or a bit bothered because you didn't, or if you lost you'd be worried again because of the consequences.

For four of the informants the consequences or penalties of weight loss or not meeting the required goal set forth by the practitioners was perceived as threatening and disempowering: "They're so focused on numbers, the decisions are made for you. It's like you gain one percent a week or you go on the tube; you gain one percent a week or you get kicked out".

Another quantifiable measure of recovery described by informants was related to nourishment. The measurable aspects of procuring nourishment during their treatments included the rate and quantity of naso-gastric tube feedings and/or intravenous feedings, and the numbers of calories consumed during meals and throughout the day. As well, practitioners kept note of how much education each informant had received emphasizing relearning to eat and preparing a meal plan.
Naso-gastric tube feeding was perceived as either a punishment and an impediment or a benefit to recovery, depending on the manner in which it was administered by practitioners. Informants who had a choice in participating in the care of their "tube", the time at which the feeding would take place, and the quantity and rate at which a feed was administered seemed to welcome and experience some relief from it. One informant claimed that she was able to tolerate tube feedings if they were administered at night while she was sleeping and thus was not expected to watch, listen to, or feel the nourishment infusing. Another informant who was able to negotiate with practitioners to supplement her coffee with the tube feed nourishment in order to wean herself back to oral feedings perceived the tube feeds as a benefit. However, when threatened or forced to receive a nasal-gastric tube without choice, the informants claimed to have become rebellious and to have refused to cooperate with the procedure. One informant summed up the experience like this: "I felt like I was under force; there was always this battle going on, and for me to win this battle meant that I wasn't going to eat or accept the tube". These sentiments were described more often by informants as the norm, rather than the exception.

Generally the five women criticized the rapid pace of weight gain while in treatment. Specifically, they explained
that the quantity of tube feedings was too large and they were infused too quickly. Further, the amount of solid food that they were required to consume (often in addition to tube feedings) three times a day seemed too much, too soon. The notion of limited resources and fiscal restraint was often cited as a rationale for rapid refeeding. As one informant stated, "They want to force as much food into your system as possible during the short time that you're there because they only have limited time that you're able to be there".

While being convinced or coerced into eating was difficult for all informants, being supported and being given choices in an atmosphere of acceptance facilitated eating. As one informant stated:

I worked really well with the last dietitian because she listened to me and she would work with me and she would go 'how about this?' And I'd go 'oh well I'd rather have this' and she'd go 'okay well we'll try that'. But the dietitian that I had before that was just like 'nope, my way or the highway'. And that didn't work for me at all. It was just like, 'forget it, then I ain't going to eat anything'.

Ignoring or remaining silent during and after an informant's meal was also perceived as a supportive gesture. One informant related the comment, "You've eaten something more daring than normal and the staff congratulate you. That sort of thing is like rubbing sandpaper on a sore. It would be best if they don't say anything at all". Clearly, praise is
not warranted when the issue is food consumption. Moreover, informants suggested that smaller meals be served more often throughout the day and that their food preferences be considered and served when possible. Thus, such acts were perceived as supportive gestures by informants.

One of the most positive quantifiable aspects of recovery the women described included the educational sessions each received related to understanding nutrition and relearning the amounts of food required to lead a healthy life. All of the informants claimed that they had actually "forgotten" the quantity and types of foods to eat to support a healthy life. Dietitians were singled out as practitioners most apt to provide this service. They could be trusted to offer a food plan that would provide nourishment for a specific weight. While informants relied more on dietitians at the beginning stages of their recovery and less as they recovered, informants all felt that they could depend on the expert nutritional education provided by dietitians throughout their treatments.

Overall, informants concurred that the need to measure recovery in a quantifiable context was contingent upon the severity of the AN. Most informants agreed that the need to focus on weight and/or nourishment was pivotal in the early stages of treatment and required much less emphasis towards the later stages of recovery. The issue at hand seemed to be
not whether measurements of weight and nourishment were needed but to what degree they should be emphasized at various stages of treatment. Informants implied that too often practitioners placed more emphasis than necessary on weight and nourishment throughout the entire treatment process; they were unable to let the quantifiable aspects of recovery progress to more subjective aspects that have a psychotherapeutic focus. As one informant warned, "counting calories continuously is a diet and a diet means restricting". Consequently, the informants themselves were not able to shift their focus away from the quantifiable aspects. While informants found services existed for having skinfolds measured weekly at a local hospital, no corresponding systematic check on mental status was offered. All informants emphasized the need to focus in the early treatment of AN on the physical and quantifiable dimensions and during the entire recovery process on the psychotherapeutic components of the AN plight. Thus, the quantification of recovery had negative ramifications, a perception shared by each of the informants.

Medicalization of The Condition

Often what is not said in a conversation is as valid or important as what is said. In describing their treatment experience for AN, none of the informants offered views on pharmacological interventions they had received during the
course of their treatment experiences. Given the number of medications used and the frequency with which informants willingly received them, this is a significant omission. In follow-up interviews, conducted to verify my interpretations of the findings, some informants were quick to point out that pharmacological therapy is a very individual concern: what may help one individual, they said, will not necessarily help another. One informant claimed that pharmacological interventions were not actually regarded as therapy because the individual is a passive recipient and unable to control the benefits or hindrances offered by medications.

At the time of the first interviews for this study, four of the five informants self administered, on a regular basis, a total of 15 different types of prescribed medications related to their AN. The most common medications were antidepressants such as Prozac, Rivitrol, Luvox, and Zoloft; anxiolytics such as Ativan and Chlorpromazine (CPZ); and sedatives such as Chloral Hydrate and Immovane. Even an antipsychotic such as Resperidone, a drug that is currently not indicated for treating AN was prescribed to two informants. The only informant to claim she was near recovery was not currently taking any medications. Indeed, she was the only informant to refuse to take medications throughout most of her illness. She said, "At one point I was on medication. I always fought medication and then I was really down and out
and my doctor said well try it, you know maybe it will help. Then I just became a stoned bulimerexic and I decided that bulimerexia was good enough for me". For the informants, medications were a mainstay of their lives. Yet, all neglected to initiate conversations of the topic unless prompted.

Four informants began taking prescribed medications (most often antidepressants) almost immediately upon their diagnosis of AN. For these women, the quantity of medications administered was least when participating in community-based services and greatest when receiving treatment in a hospital, especially if they were on a ward designed for individuals with eating disorders. As well, the frequency, quantity, and variety of medications administered increased during each hospital admission. The taking of medications and the amounts the women themselves felt they needed, firmly related more to the setting (in or out of hospital) than to the severity of their condition. Two of the informants required large amounts of sedation to "numb out the experience" of refeeding while hospitalized. After spending three hours with one informant in her home discussing intensely personal issues for this study, I went to visit her one week later on an eating-disorder ward where she was scheduled to undergo refeeding for a three week period. In order to endure her tube feedings, she had received many medications. As a
consequence, she was unable to recognize me, she had slurred
speech, a shuffling gait, and she needed to be accompanied
everywhere by a nurse throughout the day. Informants seemed
to welcome the opportunity to escape or achieve this state of
oblivion (offered freely by practitioners), believing that it
was the only way to cope with the refeeding process.
Currently, two informants use night-time sedation to allow
the food that they have consumed to digest in their system
while they are sleeping. None of the informants could
recollect being offered any alternatives to accepting
medications as a method of coping with refeeding.

All informants were able to defend the use of anxiolytic
agents for all had felt relief of anxiety related to weight
gain and/or consumption of nourishment. None of the
informants were aware of any other way in which to alleviate
their anxiety except through pharmacological intervention.
When prompted to explore other avenues to alleviate anxiety
such as yoga or meditation, all stated that they would be
open to trying such approaches. Although three of the
informants were taking antidepressants at the time of their
first interviews, only one informant defended the use of
anti-depressants which she said helped her "some of the
time". Of the three, only she truly believed she was
depressed. The question and answer:

R: Are you depressed?
I: "I don't know, they tell me that I am". was common among informants.

All of the informants were extremely knowledgeable about the names of, quantities of, and indications for the medications that they received and believed they required. For example, one informant asserted,

What I really need is a total of 12 to 16 milligrams dispensed 3 to 4 times per day. One drug in particular is Rivitrol. The last time around in the medical unit for me I was taking upwards of 12 milligrams of Rivitrol per day. Well no one could believe that I could be taking that much. I was still active and going at it and often taking a second drug to make the first drug more effective.

Informants acquired knowledge about medications through purchasing books or researching a medication in a library. The reason most cited was the desire to understand the side effects of the medication. They needed assurance first that weight gain was not a side effect and second, that the medications were not addictive. When prompted to define addiction, most informants referred to physical withdrawal symptoms that occur upon discontinuation of the medication; none believed that mental dependency could occur. Ironically, over the course of added hospital admissions, informants claimed to build up a tolerance to medications requiring increasing dosages for similar effects. Added hospitalizations thus seemed to increase their dependency on
medications. One informant asserted, "One of his interns came up [to me], and this guy sat there like every hour on the hour just bombing me with Valium, just an incredible amount of Valium. Like he just couldn't believe how much he was giving me and this stuff just wasn't touching me". Three of the informants believed that they would be on medications for an indefinite period of time and could not imagine coping in the future without them. None of the informants had been introduced to any adjunct types of interventions to alleviate their suffering or help them have a modicum of control.

Whatever the setting for treatment of AN and regardless of the educational background of practitioners, informants cited the same three aspects of treatment as negatively affecting their experience and their recovery: 1) waiting for openings in treatment programs which was always agonizing, sometimes to the point of worsening the illness; 2) enduring being weighed and measured which produced significant anxiety; and 3) being medicated which seemed to relate as much to the severity of the AN as to the setting. Each of these aspects to treatment created an obstacle to recovery and left informants assenting to illness.

Nature of The Setting

The informants in this study have received or are currently receiving conventional treatment in the following settings: emergency wards, eating-disorder wards, medical
wards, general psychiatric wards, provincial psychiatric institutions, community support centers, and community transition houses. When discussing the treatment experience, the informants always distinguished among their experiences according to the setting in which treatment occurred. A typical conversation went as follows:

R: Could you describe some of your treatment experiences for AN?

I: Well that depends on where you mean. Do you mean on the medical ward or the eating disorder ward or outside of the hospital?

In all settings, waiting to access treatment programs, quantifying recovery, and medicalizing the AN was pivotal in the treatment experience of the informants, but only where programs were carefully planned and consistently followed was treatment actually effective. From in-hospital treatments to eating-disorder wards to medical and psychiatric wards and provincial psychiatric institutions to between hospital and community and community-based treatment programs, consistent differences in quality and effectiveness of treatments were noted by informants.

**Hospital-based Treatment**

**Emergency Wards**

Emergency wards were accessed when an informant was experiencing a crisis. Types of crisis included one informant overdosing on aspirin because she couldn't cope with the
newly gained weight that she had acquired while hospitalized; another informant acted completely reticent, her family took her to the emergency ward not knowing what else to do for her; a final informant said that she 'just couldn't cope with the AN and needed to talk with someone'. All of the informants indicated that they were completely misunderstood in the emergency ward by most of the practitioners.

Since a crisis related to AN was linked for informants to interpersonal and psychological distresses such as feeling hopeless, suicidal, and anxious, ongoing interventions were required but not sought. It was assumed and to a lesser extent experienced by informants that the emergency routes such as emergency departments existed to treat only their physical symptoms (e.g., acute electrolyte imbalances, cardiac arrhythmias or kidney failure) and distress centers such as suicide hot lines (e.g., suicide, depression) were not tailored to meet their individual needs related to their AN while in crisis.

Nurses, they said, seemed to indicate that those with AN were not a priority for treatment. Doctors were described by informants as either rushed to get them out of the emergency room or lacking in the expertise needed to understand the AN experience of each individual. Thus, crisis intervention was perceived by informants as either not existing or in its present existence, a complete waste of time because
informants did not perceive conventional routes of crisis intervention to meet their needs.

The combined total of hospital admissions for the informants to any ward prior to diagnosis of AN was nine admissions; the combined total of their hospital admissions to any ward since diagnosis of AN was 93 admissions over a span of 10 years. Clearly, hospitalization played a large part in the treatment experience for the informants in the study. The hospital was perceived by most of the informants as an artificial and unrealistic environment where individuals get refed (at best) and learn "mechanical eating" (at worst) with the intention of gaining weight. The hospital represented a place where informants received a nasal-gastric tube, were certified, and were sometimes placed in restraints and/or seclusion. Informants concurred that a substantial difference existed in the implied quality of care provided by practitioners in eating-disorder wards than in other wards in the hospital setting, such as the medical and general psychiatric wards, and the provincial psychiatric institutions. Generally, it seemed that, on eating-disorder wards, practitioners possessed the knowledge, clinical expertise, and empathy needed to care for individuals with AN, while, on other wards, practitioners lacked these qualities. Curiously, the nursing profession was singled out by informants as the discipline least available to provide
quality care in a hospital setting, especially on medical wards. Conversely, nurses were perceived as being quite competent practitioners in community settings. As well, informants indicated that the quantity and variety of medications received were highest in hospital settings.

**Eating-Disorder Wards**

For all of the informants, eating-disorder wards were the only hope or last hope for recovery. Four of them spoke of the months and months that they had waited on a list to be accepted into a specialized treatment facility for AN. Indeed, eating-disorder wards were described as the most difficult of facilities to access because of the long waiting lists. According to informants, the eating-disorder wards have constantly evolved and changed. For example, their in-patient programs have decreased from six months to three months, then down to three week programs for refeeding. Those who had experienced such changes believed that they were better off spending less time in the hospital environment. The reason they offered was that the artificial and unrealistic nature of the hospital was an intensely structured regime that they came to view as a safe environment. For many of them, the structure was completely opposite to that found in their home environments. As one woman stated, "I felt very institutionalized when I came out and I dropped weight really fast. It was too safe." While
this safety was necessary, it was important for informants that they not get used to the unrealistic compliance of the hospital treatment program.

The eating-disorder wards were described as the most supportive place to receive quantifiable procedures such as tube feedings and skinfold measurements because of the expertise of the practitioners. While all the informants who had been treated on an eating-disorder ward gained weight, maintaining that weight proved to be a more difficult challenge. For example, one informant asserted,

The hospital [eating disorder ward] is the worst place you can go if you're trying to gain weight the normal way. All you're doing is getting the body renourished but you're doing nothing for the problem; they're just putting a bandaid on the problem, and you go off, and you just get right back to where you were to begin with.

Another informant said, "I'll tolerate whatever they want to do or whatever I'm forced to do until I get out then I just immediately lose the weight". Although the informants conceded that their transient weight gain was related to the artificial environment within which they were treated, they also felt that the quantity and rapidity at which they were forced to gain weight was too high, they were not allowed time to adjust to their "new body". Further, the agencies involved in aiding the transition of informants from eating-disorder wards to community settings lack resources. As a result, informants were often left to their own devices while
waiting to secure a community-based program. This agonizing wait was offered as a major reason why weight loss occurred upon discharge from eating-disorder wards. Three of the informants indicated that, on discharge, they experienced a dramatic loss of weight while waiting to get into a "day program".

Although the informants claimed that too rapid weight gain was unsettling, they felt unable to clearly focus on personal problems until they had gained a certain weight. Upon reflection, informants stated that certain psychotherapies were of benefit even before an optimal weight was reached. Indeed, informants felt that because each step in recovery was incremental, all aspects of treatment should include psychotherapeutic support. Even though, during refeeding, the informants were too heavily sedated so they could tolerate the process of psychotherapy and thus were unable to actively participate in any available psychotherapy, they insisted that the very availability of psychotherapy was important to them and wished that they did not have to depend on sedation to "survive the tube". Most informants described an unresolved dichotomy between receiving sedation to tolerate refeedings at the expense of participating in psychotherapy programs. Informants indicated that complimentary therapies (therapeutic touch and reflexology) and experiential therapies (art therapy and
music therapy) could have resolved the dichotomy by aiding them to relax while learning how to eat and cope with weight gain.

Often, the women described a preoccupation with the threat of being tube fed, certified, secluded or discharged if they were unable to meet the weekly weight gain requirements determined by the practitioners on eating-disorder wards. At times, this preoccupation consumed their thoughts and undermined the long-term success of treatment. One informant speculated,

I think that one of the reasons I never learned how to eat for myself or I never learned how to get better for myself was because all my hospitalizations, I would eat because I had this big fear of going on the tube, or I had a fear of being certified, or I had a fear of getting kicked out.

Ultimately, the perpetual threat of such treatment experiences in hospital settings left informants feeling powerless, resigned, and terrified. If informants were able to participate in the administration or regulation of the tube feeds it was viewed more as a benefit than a punishment. If, on the other hand, an informant had not been given any choice, she described feeling resigned or resentful. This feeling evoked frustration which often resulted in the weight gain being transitory or the entire admission being sabotaged by the informant.
While both certification and discharge represented a threat to informants, only the threat of discharge was felt to be ineffective in supporting informants while coping with AN. When informants had been certified for weight loss, they felt powerless, and the entire treatment was often undermined, especially when certification was to a medical ward, a general psychiatric ward, or a provincial psychiatric institution. According to one informant, "Being committed for me is like someone having a rope around my neck and I'm constantly being strangled. All I do is hold out until the commitment is gone and then I just go right back to the way I am". Further, during certification, some informants had experienced periods of seclusion. Here, they were restricted by numerous rules and regulations disguised in the form of "compliance with treatment". However, most often informants were certified (committed) if they were suicidal. When this was the case they felt relieved, safe and comforted, especially if the certification was to an eating-disorder ward. Thus the threat of certification was not as great as the threat of discharge. Often, the more times an informant had been discharged from a program, the more severely she experienced panic, desperation, and finally resignation. According to the informants, the threat of discharge as a means of ensuring weight gain was completely ineffective; it undermined not only the treatment but the entire recovery.
The consequences of being discharged from a program included the possibility of having to wait many months to be readmitted into a program and being completely on one's own in the interim. Finally, being discharged without any sense of accomplishment left informants feeling that they were failures and unworthy of the programs, indeed, hopeless cases. Three informants who participated in this study were subsequently discharged from hospital and community settings for not meeting the weekly weight gain requirements. One of them recalled,

I got kicked out of the [transition house] last year for the same reason, I couldn't get past 17%. I can't really answer the question of what's happened, what has helped, because I am at a loss as to what's going on. Everybody keeps asking me what can we do to help. It's like I don't know anymore. I really don't. I don't know what I need, I don't. I wish I could tell you.

At the time of this writing, this informant was again discharged from the transition house, for a total of three times in the last two years.

Inconsistencies related to treatment existed for all of the informants during their many admissions to eating-disorder wards. Three of them spoke of the discrepancies between the treatments they were told to expect once hospitalized in eating-disorder wards and what they actually experienced when they were admitted. One informant said,
The eating-disorder ward is good, it's very good. But it's only as good as the actual follow-up once I'm there. I have one doctor in particular who kind of leaves me frustrated in that he'll say we'll be giving you such and such a drug on this schedule. You'll be talking to a dietitian, you'll be talking to a therapist twice, and you'll have X amount of nursing care'. And yet when you go down to the ward the paper work isn't done. The drugs aren't followed through on the schedule, and even stupid things like you're not able to meet with the dietitian because the dietitian is on holidays this week and there's been no accommodation made to replace that person.

The disappointment existed for informants when eating-disorder wards did not live up to the expectations practitioners had promised. If inconsistencies were experienced upon a first admission or an early admission, informants felt mistrustful and suspicious of the entire team of practitioners. Periodically they would sabotage their own treatment in response to such inconsistencies. One informant was able to rationalize the inconsistencies in her experience by offering that the economics of health care were such that practitioners were unable to promise today services for tomorrow. Her rationalizations did not alleviate her mistrust of and disappointment in practitioners.

Eating-disorder wards were perceived to be the best places to be admitted within a hospital framework for the treatment of AN based on the expertise with which the practitioners were able to deliver their services. Within this environment, most practitioners were perceived as
knowledgeable and experienced about AN and able to project confidence and empathy in the treatments that they offered. While threats of certification, seclusion, and/or discharge existed in these wards and while practitioners could not always be trusted, informants described such wards as a place where they were at times able to participate in decision making in regards to their treatment. Overall, informants perceived eating-disorder wards as a place of hope for recovery.

Medical and General Psychiatric Wards, and Provincial Psychiatric Institutions

The worst experiences that informants described in their treatment for AN all took place in medical wards, general psychiatric wards, and/or provincial psychiatric institutions. While informants perceived these places as sources of hope and relief in the short-term when no other options were available, these were environments where they could experience forced tube feedings, certifications, restraints and seclusion. Such treatments were rarely given by practitioners who possessed knowledge about AN, clinical experience of treating those with AN, or empathy. As one informant commented, "They weren't trained in eating disorders and they didn't know what to do with me". Further, because the focus of treatments within such wards was singularly quantifiable and devoid of psychotherapy,
informants described intense periods of boredom and anxiety. Although the informants claimed that they were often left to themselves on eating-disorder wards "in between appointments", they did not claim to experience the intense boredom resulting in anxiety that they felt on medical and general psychiatric wards or provincial psychiatric institutions.

On medical wards, informants described feeling alienated, and isolated. For them, medical wards were places where patients with AN received only task oriented, medical care. One informant offered, "all they do is NG tube me". Having known the support of practitioners on eating-disorder wards, the experience of practitioners on medical wards seemed to be characterized by indifference and/or oppression. Generally, nursing staff were perceived as aloof, reserved, or simply preoccupied with other matters:

You're virtually on your own. Nurses are never there; they're off doing their paperwork or if you ask them for help they're too busy or they're just wrapped up in other patients on the ward. You end up spending a lot of time just lying on your bed or sitting in the lobby.

Four of the informants discussed incidents in which practitioners, particularly the nursing staff, made them feel like frauds.

I felt that while I was in the hospital I was just taking up a bed which somebody else could have used. They didn't have to care for me the way that they care for a normal
ill person. I didn't feel that I had the right to be there because I could do everything for myself. The care that they would give the other patients, they didn't give to me. I used to do so many things for myself. I used to think 'oh they're probably thinking what on earth are you in here for? Why does she, couldn't she just eat?' I felt like a fish out of water.

The concept of feeling like a fraud seemed a result of the impatience of practitioners. Further, informants often indicated that they were perceived as a nuisance to the staff and a waste of practitioners' time. Informants were given the impression that if they were not compliant with treatment that was offered (for example, consuming meals or being receptive to tube feeds), then they weren't really sick and they should just leave. On the medical wards, treatment was primarily centered around weight gain, often coupled with pharmacological therapy (commonly known as Track One philosophy [Woodside, 1995]); it was rarely accompanied by psychotherapy which would have acknowledged problems at the root of the AN (commonly known as Track Two philosophy [Woodside]).

Some hospitals are designed to follow a "Two Track philosophy": clients are exposed to a three week to three month refeeding regime followed by discharge and a careful follow-up in the community (Woodside, 1995, p. 82). Track One, the refeeding program, seemed to informants to be governed by a philosophy completely different from Track Two, the follow up. Not only were the goals and means very
different but Track One was intense, requiring sedatives to be effective, while Track Two was too loosely structured, often leading to a drastic worsening of their symptoms. Relaxation techniques and various forms of experiential or complimentary therapies to reduce anxiety were rarely used as part of Track One, so informants were discharged feeling extremely anxious about their weight. Indeed, informants in this study claimed they never learned how to eat under the Two Track philosophy. The reason why three weeks to three months has been chosen as a time frame for weight gain is unclear in the literature on 'Two Track Philosophy'. Too often the time frame was insufficient and the informants felt no benefit from the program. With its focus on refeeding, individuals would be gaining weight even as they were spiraling further into the psychological whirlpool of AN. A final and often detrimental weakness is the system's inability to guarantee that Track Two will begin as soon as Track One ends. Often informants had to wait at home for community follow-up. When informants were left to their own devices, they often became worse off than what they were before the three week admission for refeeding.

In medical wards, informants' opinions were not sought out; when they were listened to they were often discounted, experiences that often resulted in exasperation and frustration. One informant recounts an experience on a
medical ward in which a medical student arrived to perform a history and physical examination on her. She explains,

He kept feeling my throat for glands. And then he asked me a question about what I bring up or something. And I said, 'No, I have anorexia, I don't have bulimia'. But he wouldn't believe me. He kept checking my neck for swollen glands. I said, no, you don't need to bother checking; they aren't swollen. I don't ever bring up; I don't know how. And he still kept doing it. It wasn't inspiring; I just didn't get any confidence from his visit at all.

The interaction supported the informant's self-image on the ward as medically uninteresting and insignificant.

In general, informants experienced the same oppression and inflexibility on general psychiatric wards and in provincial psychiatric institutions that they described on medical wards. Here again, the focus of treatment was mostly quantifiable, a Two Track philosophy, and practitioners seemed to have little expertise regarding AN. Rarely were informants invited to participate in the treatments that they were given. One informant explicitly detailed the behavior modification regime that she experienced at a provincial psychiatric institution: There, she was certified, forced to live in her pajamas for three months, and given the privilege of receiving family visitors only if she complied with the rules of the behavior modification regime. Within this environment she felt powerless, isolated and without choice. Out of the hundreds of patients at this institution, the
informant claimed to be the only one with AN. For her, the experience was a nightmare. She was unable to identify with any of the mentally-ill patients on these wards; she felt humiliated, embarrassed, and frightened at being admitted to such a place and then, once there, doubted her own sanity, believing herself to be "crazy like the others". Informants who had been certified in such places felt the most hopeless, saying, "If you're committed to non eating disorder wards, you lose some of your humanity, legitimacy. I guess somehow you lose your personhood". Informants rarely had to wait for an admission to a medical ward, a general psychiatric ward or a provincial psychiatric institution. One informant claimed that she was placed in a provincial psychiatric institution because of its accessibility.

Two of the informants had experienced the use of restraints in medical and general psychiatric wards and provincial psychiatric institutions: one because she had overdosed on ten aspirin, another because she was resisting rapid tube feeding. Although both believed that the restraints had been used for their protection, neither of them could justify their use. Both claimed that if practitioners could have spent the time "talking them through their anxieties" and offering them relaxation techniques the restraints would not have been necessary. Both implied that their use was a result of the lack of staff available to
spend the time needed to calm them down and a lack of knowledge related to the use of unconventional therapies in treatment. Restraints, according to informants, were used most often where wards were short staffed.

While medical and general psychiatric wards and provincial psychiatric institutions were necessary to the survival of informants, especially when eating disorder wards were inaccessible, they provided the worst experience for individuals with AN. Informants spoke of feeling like frauds in those places, of not being listened to when they felt they knew something about their illness practitioners did not, and of being restrained and isolated rather than helped through a difficult treatment. While these wards were desperately required when there were no other resources available and a crisis situation was ensuing, the long term effects of such admissions left informants bitter and resentful towards practitioners.

**Between Hospital and Community Treatment Programs**

In most of the hospital environments, informants said they felt a certain amount of safety, at least in terms of eating and gaining weight. There, much was done for them: "You don't have to think or prepare a meal, like one minute you have all these people taking care of you and then you leave." However, upon discharge, informants found they were left to their own devices without a treatment plan and often
without access to another treatment program. While informants had gained weight in hospital, they still needed treatment for AN. Sometimes informants had to wait up to one year for the next available treatment. Thus, an example of the gap in the Track One and Track Two philosophy. Furthermore, they frequently made reference to the limited resources for psychotherapy available to them during the transition from the hospital to the community. Thus, the transition for informants from hospital to community was one of the most difficult times. Only when a discharge was carefully handled, with practitioners ensuring the informant had a treatment program or some supportive group to go to from the Track One to the Track Two philosophy, did the discharge facilitate hope for recovery.

The greatest difficulty during the transition from hospital to the community was the loss of practitioners. Informants spoke of having to seek out new dietitians, psychiatrists, psychologists, and social workers. As one informant indicated,

When my admission is finished, that's it. It's pack up and move your stuff out of the room as quickly as possible so the next person can come in. They may send you home with a prescription but they don't take the onus on themselves to make sure that you've got continuing care or that you see a therapist or that you even have a family doctor. I mean it's totally up to you.
Not only were informants hurt by the loss of services from in-hospital practitioners that they began to trust but they also felt the burden of responsibility to secure further supportive practitioners for themselves. In any case, during the transition period, if follow-up in the community was not provided immediately, the achievements made while in the hospital were lost very quickly.

**Community-based Treatment**

Community-based treatments that informants had investigated or received included out-patient programs run by eating-disorder clinics, community transition homes, and support groups such as ANAD. Although not infallible, informants overwhelmingly agreed that treatments they received outside of the hospital setting were by far the most beneficial. According to them, the greatest benefit of treatment outside of the hospital setting was its realistic nature; accomplishments made in these settings felt more permanent. Informants described a sense of accomplishment when they achieved something outside of the hospital; achievements made in the hospital did not count because the hospital did not represent reality. One informant concluded,

Outside the hospital you're left much more on your own and progress you've made, you've made yourself. When you're on your own and you're able to make steps forward, I feel that they're much more solid steps, much more realistic, and they are going to provide you with more benefit than steps made in the hospital.
Generally, this was the response to community-based programs, regardless of the type of program it was.

Out-patient programs run by eating-disorders clinics had names such as "the day program, psycho-education, the four day intensive program, and group therapy". Informants described these programs as being very beneficial. Generally, such programs were a source of security within a caring environment. They seemed realistic because informants were forced to meet all of their basic needs just to arrive on time at the program (e.g., get out of bed, dressed, showered and commute to the program), further, they provided support and encouragement from the members. In addition, these programs seemed to provide psychotherapy that all of the informants wished they had received throughout their treatment. Limitations included the reality that the programs had a definite ending, which often posed a challenge to informants in overcoming their preoccupation with the termination of the treatment rather than focusing on issues related to their AN. In addition, waiting lists for such programs were up to one year and by the time an informant had been eligible to partake in the program, she was often so ill that she was unable to meet the expectations of the therapy design and became frustrated with her own perceived incompetence. A final limitation described by informants was the lack of emphasis placed on formally including significant
others within the treatments. Although informants indicated that family members and friends were invited to attend some 'therapies', none of the informants had been invited to participate in family therapy.

Community transition homes are homes in the community in which women can live in a house with other women with eating disorders. Here, women receive 24 hour care by practitioners. Three informants in this study had lived in a transition home for an average of 6 months each. A fourth informant is on the waiting list for such a home at the time of this writing. Community transition homes seem to represent freedom, choice, empowerment and realism for informants. While community transition homes were deemed by informants more realistic than hospitals, they also protected informants from the unbearable isolation of their home environments. In the community home environments, informants felt that they could more readily take chances (e.g., rent a movie and work through the implications of eating popcorn, that is, food associated with the activity) because they had the support of the practitioners in the home, their peers, their families, all of whom were often included as part of the treatment plan.

The relationship between practitioners and informants in this setting was more equal and less paternalistic. For example, informants and practitioners cooked and ate the same
meals together; they took walks, went for coffee, and made trips to movies and plays. Most of the practitioners in the community transition homes were RN's and RPN's who were perceived as available and who played a more prominent role in treatment than practitioners with the same backgrounds in other settings. Here, informants were often able to receive one-on-one care from practitioners when it was immediately required. After only a short duration, informants found that just having the opportunity for and security of one-on-one support at any time of the day or night was a strength.

Peer support was a concept never mentioned in reference to hospital settings though it was integral outside hospital treatment programs. Informants gained strength from the accomplishments of their peers as friendships developed among occupants of the home. Sometimes, informants admitted feeling threatened by or in competition with these same peers. The competition they said, was like a pendulum swaying between feeling fatter than peers (thus feeling bad) and feeling skinnier than peers (thus feeling good). However, competing with a peer and/or putting oneself in check with a peer's successes or failures often motivated informants. Only in this setting was peer support fostered and encouraged by practitioners. However, informants indicated that the support practitioners fostered amongst peers was guarded. As one informant said, "Our friendship was only encouraged while we
lived together under supervision. They [practitioners] did not want us to live together in our own apartment, as roommates.

Finally, families were part of the inclusionary aspects of community transition homes, an aspect of care that was not explicitly or consistently addressed in most other settings. In community transition homes, informants described how families could telephone the home at any time. Families were invited to participate in many social outings. With this inclusion, informants could slowly adapt to coping with stressful family situations while at the same time having the support of practitioners.

Criticism of the community transition homes only involved those aspects that mimicked the hospital settings. Informants found that at times the community transition homes were oppressive and inflexible. For example, threats of discharge or of bedrest (seclusion) could be issued. One informant explained, "Right now they're talking about if I don't gain weight they're going to make me stay in the house for two weeks and basically be on bedrest and pretend it's the hospital". When forced, when given no choices, informants felt the community transition homes were a vehicle for sabotaging the recovery process.

All of the informants for this study were in or are currently participating in various types of support groups
for eating disorders. ANAD, a nationwide organization to support individuals and families with eating disorders, was the only support group common to four of the informants. While most of the informants found that the environment of ANAD was very impersonal, it was helpful to one informant simply because of its willingness to include a family member in its treatment and teaching. In ANAD, informants were never able to get to know "the group" because the group changed from week to week. Further, because of the transitory nature of the group, no group norms were formed; informants could not get past the awkwardness of meeting new members each week. Finally, with the changing membership, there was no stability or constancy from week to week, leaving informants frustrated or disappointed. Most informants tried ANAD, dropped it, decided to give it another try because they felt they needed somewhere to turn, then dropped it entirely as an avenue to pursue. Only one informant's family member had attended ANAD meetings. The informant claimed that her partner found tremendous benefit from the support that ANAD offered. There, he had the opportunity to express his own frustrations to try to understand AN, and to learn how best to help the informant better cope with her AN. She believed that ANAD made a positive difference in the way he related to her and helped her. Another informant, although having had AN for four years and experiencing treatment in all of the
facilities discussed, had never heard of ANAD. Of the many practitioners this informant had met in many different facilities, not one had mentioned the existence of ANAD. Despite my private skepticism that I understood her correctly, she maintained this perception on subsequent interviews.

All informants were aware of a private clinic called the Montreux Centre in Victoria, British Columbia. Informants had either heard of it through the media or by word of mouth from practitioners or other individuals with AN. When prompted to explore unconventional treatments such as the Montreux Centre, cost was the number one reason cited by all the informants as to why they did not explore this avenue. However, when I informed them that the Montreux Centre may offer subsidized treatment, informants claimed that they were skeptical of the Montreux Center's claims to success and felt that no scientific basis had been made to back the claims of Peggy Claude-Pierre. Informants found the Montreux Center appealing because of the one-on-one care that it offered. One informant had met with Claude-Pierre in Victoria for an hour. She concluded after the session that it was useful to hear Claude-Pierre's approach to the treatment of AN and to receive her many "tangible and constructive suggestions". However, the informant perceived the center as a private and exclusive place to which she could never financially afford
to be admitted. The informant contended, "It's not available, so I don't agree with her form of treatment. The eating-disorder clinic and the community programs are better. Way better. It's just that we need more of them, and we need more people out there with training." The perceived exclusivity of the Montreux Center seemed to undermine its worth to informants. Similarly, cost, skepticism and lack of encouragement from mainstream practitioners resulted in informants discounting unconventional treatments as a viable option or adjunct to conventional treatments.

In summary, the benefit to treatment seemed to be contingent to some degree upon the nature of the setting within which treatment occurred. In-hospital treatments were of least benefit to informants because the environment itself was an artificial one, quite removed from their perceived reality. Though hospitals offered the professional support of dietitians, psychotherapists, physicians, nurses and social services, practitioners on wards other than eating-disorder wards seemed to know little about AN and optimal treatment for AN. Because of the focus in hospitals on weight gain, the transition between hospital and community treatment programs was often very difficult for the informants in this study. Achievements made in hospitals were easily lost and waiting lists for community-based treatment programs are long. Once accessed, community treatment programs such as day programs
and community transition homes were of greatest benefit to the informants in this study (provided they did not copy the hospital setting). There, a focus on issues at the root of the AN and an inclusion of peers and family in the treatment plan supported hope for recovery, not just weight gain.

**Qualities of Practitioners**

According to the informants, practitioners of treatment for AN include dietitians, general medical practitioners, medical internists, "mental health workers", occupational therapists, psychiatrists, psychologists, registered nurses, registered psychiatric nurses, and social workers. Although recognizing that this study has a registered nursing focus, the informants both implicitly and explicitly alluded to the educational background of the practitioners being less important than the personal qualities that she/he possesses. According to the informants, no one discipline stands out as being more effective than another during the course of treatment for AN but, for each informant, certain individuals whose personal skills matched their professional abilities helped a great deal.

In both the initial tape-recorded interviews and in the follow-up interviews conducted for purposes of clarification, informants claimed that the qualities of practitioners influenced their treatment experiences more than did the therapies or the settings. On no other subject during the
interviews was the nature of informant's perceptions of treatment more dichotomous. That is, practitioners were either good or bad providers, never in between: "Either they can help me or they can't. If I think that the nurse or doctor or whoever isn't nice then I don't even bother to talk to them". Informants tended to scrutinize practitioners, generally commenting on their appearance, gestures, verbal tone, degree of eye contact, concentration, posture, and their interactions with other patients and colleagues. As a result, they were able to provide detailed descriptions of what they felt amounted to effective and ineffective practitioners. Regardless of the discipline, all informants described practitioners within two very distinct categories. I have classified and labeled these categories as either expert practitioners or orthodox technicians.

**Expert Practitioners**

According to informants, expert practitioners were described as health care practitioners who had fostered hope for their patients' recovery. The discipline of the practitioner was not as relevant as the rapport that the informants established with them. According to informants, of the three qualities — knowledge, clinical experience, and empathy — a good practitioner had the first, a very competent practitioner had the first two, and an expert had all three. Expert practitioners inspired confidence because
they communicated their knowledge, clinical experience and empathy verbally and nonverbally.

**Knowledge**

Informants often encountered health care students and professionals alike who had worked on medical wards, general psychiatric wards and/or provincial psychiatric institutions but who for the most part had not received an optimal level of formal education related to eating disorders. For informants, a comprehensive knowledge of eating disorders — indeed, formal education in this area — was necessary for expertise in the field. As one informant conveyed,

> It becomes really obvious very quickly who has dealt with eating disorders and who hasn't. They don't realize how it affects people who have an eating disorder psychologically. All they see is someone on an NG tube, being given trays of food, an electrolyte solution, and tranquilizers.

When contrasting medical and eating-disorder wards, informants criticized the lack of knowledge that practitioners on medical wards, general psychiatric wards and provincial psychiatric institutions displayed regarding the amounts and types of medications required during the refeeding process. On the other hand, knowledgeable practitioners were perceived as being well informed about the type, amount, and frequency of medications needed to relieve anxiety and sedate informants during hospitalizations. Informants noted that knowledgeable practitioners were able
to genuinely communicate to informants admitting when they did not have all the answers or when they had made mistakes. Sometimes knowledgeable practitioners supplied an informant with an inspiring biography about AN or recommended a stirring movie. These sorts of behaviors made it possible for informants to have confidence in the practitioners.

All of the informants pointed out that practitioners who were knowledgeable recognized the need to understand people with AN, at the very least they wished to understand what their patients were trying to say. Knowledgeable practitioners used explicit, direct, and verbal cues to convey that they were knowledgeable regarding AN. They were punctual with appointments, prescribed and/or administered medications correctly, and were able to recognize what stage in recovery an informant was at and what types of treatment would be most suited to her at a specific time.

These practitioners demonstrated a genuine interest in the informants, acknowledging their individuality. Further, those thought to be knowledgeable practitioners conveyed a nonjudgemental approach to the informant and her peers as well as to their own colleagues; they appreciated how little is known about AN and how much more they needed to understand to help informants. According to informants, such practitioners recognized that part of the expert knowledge was obtained through clinical experience, and these
practitioners were not afraid to communicate this to informants. As one informant stated,

The best help would come from a nurse who comes forward and says, 'you know, I'm really sorry, but I don't know a lot about eating disorders yet, but I'd love to hear more about it', — [rather] than pretending like she knows all there is to know about it.

Being honest and genuine with informants seemed to establish tremendous credibility.

Clinical Experience

Practitioners whose comprehensive knowledge base was embellished with substantial clinical experience in treating AN were perceived by informants as very competent. One informant offered that she was able to witness the transition of a nurse from novice to expert. The nurse in question had been hired in the hospital setting at the same time the informant was admitted. One year later the informant was readmitted to the same ward: the nurse, once inflexible and distant (for example, drawing up a daily schedule for the informant that met with the nurse's needs), was now relaxed and concerned (for example, setting priorities with the informant that were mutually agreed upon). Informants concluded that clinically experienced practitioners recognized the importance and value of timing. For instance, they knew when to listen to an informant, when to provide her with feedback, and when to challenge her. Further, they
recognized the type, intensity, and frequency of psychotherapy that was required. Positive perceptions of various psychotherapies were most often accomplished through one-on-one interaction with the practitioners. Interaction was most often in the form of discussion, although (with the right person and the right timing) touch was valued. Arranging a time to talk and following through with this commitment was gratefully appreciated by informants, and when these things happened, a sense of trust was established between the informant and the practitioner. As one informant explained,

A nurse I know is miles ahead of any of the other staff. When you talk to her you can tell from the feedback that she's giving you that she's actually listening to you. She gives good advice and comments that she makes are things that I've heard from other specialists, and everything they've taught her, and everything that she's learned from the others [specialists], she retains and uses that information again on other people. That's very reassuring when you can talk to somebody like that who you feel like they know what they're talking about and you want to get reassurance from that type of person.

Clinically experienced practitioners were able to find the aspects of the informant's AN that were common to all individuals with AN. She or he was also able to handle each situation as it arose in a calm and reassuring manner. Three informants described events in their treatment where an inexperienced practitioner had responded to a small problem
with medications or assertive commands. In all cases, the small problem soon escalated into a major crisis. At that point, an experienced practitioner intervened and was able to draw on her/his clinical expertise to rectify the problem without medications or commands. Informants indicated that sometimes simple responses such as a back rub or a discussion over a cup of coffee could help them put a problem into perspective and soothe them.

Informants described clinically experienced practitioners as flexible. Specifically, they were able to facilitate participation and foster emancipation within informants. They seemed to know when an implicit or explicit "rule" promoted recovery and prevented deception, a knowledge most evident when they were encouraging informants to eat. That is, clinically experienced practitioners knew when to gently persuade and/or negotiate with an informant. Further, they knew when to praise an informant for an accomplishment and when to remain silent. Finally, if an informant confessed to not following an agreed upon treatment, a clinically experienced practitioner knew how to avoid behavior that conveyed disapproval and punishment and how to behave in a way that focused on the positive abilities that the informant had accomplished.
Empathy

A professional who had a comprehensive knowledge base, clinical experience and empathy was described as expert. Informants had interacted with practitioners of various disciplines and in all settings of their journey to recovery; they praised or criticized practitioners depending on their ability to convey empathy.

Being available, dependable, reliable, and consistent were all viewed by informants as aspects of empathy. Nurses who did not follow through on what they had committed to were thought unreliable. Psychiatrists who were not available and who had not arranged a backup plan to ensure that informants had support in the event of a crisis were perceived as not dependable.

Practitioners who established an interactive relationship with their clients were perceived, by informants, as empathetic. Informants reported experiences in which practitioners actively participated in conversations and were perceived as energetic, dynamic, and optimistic people. One informant related, "All I wanted was for someone to hold me, someone to listen to me, and to understand. And really feel like I was listened to and heard, and [treated like] I was an equal". Informants agreed that an empathetic practitioner was one who spent time with informants, actively listened to what
they said, and conversed with them in a patient, confident, and sincere manner.

Those felt to be empathetic practitioners consistently provided hope for recovery to informants without ever posing threats or consequences as a means to compliance and recovery. Specifically, they projected the belief that recovery was not transient or dubious but that it was always imminent for informants. As one informant said, "When I meet someone who is able to just recognize that I exist, that my problem is real, and that there is hope and that there is treatment available, then I know that I can trust them". Further, empathetic practitioners were able to convince an informant to believe in herself; treatments could facilitate recovery but an informant's "own inner spirit" would ultimately lead her to recover. Indeed, empathy in a practitioner was the single most helpful characteristic when difficult treatments had to be endured. A truly expert practitioner could support the informant through almost anything, whether it was naso-gastric tube feedings, being certified, being challenged to eat meals, or being restrained. Ironically, even these treatments were viewed as beneficial when executed by empathetic, knowledgeable, and experienced practitioners. Further, informants maintained that learning to cope with personal issues at the root of
their AN was most often tackled by expert practitioners and ignored by others.

**Orthodox Technicians**

In contrast, an orthodox technician according to informants, is a practitioner who would not facilitate an effective treatment. Orthodox technicians could be found in all of the settings, delivering all of the treatments. Not only were such practitioners perceived as ineffective, they were also felt to be detrimental to the entire treatment process. Sometimes experiences with orthodox technicians in a specific discipline tainted an informant's impression of an entire discipline of practitioners. One informant explained, "I had terrible experiences with the psychiatrist and the nurses, therefore I don't trust any of them". Informants described practitioners who fell into the orthodox technician category as vacillating between an affective indifferent or an authoritarian approach. Because orthodox technicians existed wherever informants sought treatment, they could never predict when a practitioner was going to represent hope for recovery. An air of suspicion always accompanied their request for help.

**Affective Indifference**

All informants spoke of interacting with practitioners who seemed to be more interested in, as they put it, having a job for its own sake than having a career in "alleviating the
suffering, preventing AN, and finding a cure". These practitioners were described as "always preoccupied with being paged, completing their charting, or being conscious that my [informant's] time was up until the next appointment". As well, affectively indifferent practitioners were less reliable with regard to appointments and availability (and were often delayed lengthy periods). Most informants claimed that these practitioners were "just filling in their time until the moment was complete, the shift had ended, or the day was over". Informants had all experienced affective indifferent practitioners across all disciplines.

According to informants, these practitioners were affectively indifferent because they played a very passive role in treatment, an attitude most obvious during discussions between the informant and the practitioner. Two informants described conversations in which they felt "psycho-jargon" was prevalent. One informant asserted,

There's something about it, when you talk to somebody who just keeps nodding their head and agreeing with you, and I'd say I feel this way. 'Yes, yes, yes, oh, well, I hear you, unhuh, what are you going to do?' Or she would say 'Is that so, what I hear you saying is this'. Well that's the response you get from her. And I don't feel like I'm being heard when someone responds like that. And I don't feel like they can help me. And it just makes me think I'm wasting my time and I want to get away. That does not help.
Informants found practitioners to be affectively indifferent when they negated their feelings and were predominately oriented toward tasks, medical treatments or research. Informants spoke of nurses tending to their NG tubes without talking to them, they spoke of physicians focusing on their skinfold measurements rather than their feelings, and they discussed psychologists soliciting them to participate in research studies as part of their treatment plan. Initially informants were surprised by this behavior; finally they became frustrated and resigned as it became the norm. When informants had encountered affective indifferent practitioners many times, especially across disciplines, they felt a sense of hopelessness for recovery. One informant felt that of all the practitioners she had encountered during four years of treatment, she was only able to cite a single psychologist who gave her hope for recovery; in contrast, she spoke of horrific experiences with psychiatrists, registered nurses, registered psychiatric nurses, and dietitians.

Informants saw practitioners as affectively indifferent when they hid sincerity. Such practitioners said things like, "And how are we today, dear?" or, "You're looking much better today, you have color in your cheeks" day after day until the phrases became redundant clichés. Their words were perceived as empty and their actions were nonchalant. Often, they were maladroit around the informant. One informant said, "They
really didn't know what to say to me. They had no idea what
to say to me. And I think they felt awkward themselves
because they didn't know how to care for me". Though
affectively indifferent practitioners could be found
anywhere, informants claimed that this attitude was
particularly prevalent on medical and general psychiatric
wards and in provincial psychiatric institutions. When
practitioners had such an attitude, it seemed that informants
and practitioners alike felt the resentment at having to
interact with each other.

**Authoritarian Approach**

The most painful experiences described by informants were
those involving practitioners who projected an authoritarian
approach. An authoritarian approach was more frequently
applied to practitioners in hospital settings, especially on
medical and general psychiatric wards and in provincial
psychiatric institutions.

According to informants, authoritarian practitioners are
those who manipulate with force and who say things like "I am
making you do this for your own good." One informant
described a nurse observing her while restrained and yet
never attempting to talk to her or familiarize herself with
her in any way. Another informant commented on how her
psychiatrist "psychoanalyzed" every behavior that she
exhibited "acting as if he knew it all" rather than
recognizing that some of the behaviors may be perfectly normal for the particular culture and age group that she was in. The case in point was her psychiatrist's interpretation of the informant's pierced belly button as being a symbol of self-mutilation because of self-loathing related to her stomach, as opposed to conforming to the pop culture.

Sometimes the authoritarian approach was exhibited in aggressive and threatening behaviors: "either you comply with the treatment or suffer the consequences". One informant described a situation in which the psychiatrist on call in the hospital certified her and placed her in seclusion (all visitors including family members were restricted from contacting the informant) for four days without receiving any psychotherapy. According to the informant, the psychiatrist's rationale was that the informant needed time alone in order to reflect upon her life. Ironically, this informant lived an anorexic life of isolation and seclusion in her home. Another informant described an authoritarian nurse:

This nurse came across as being extremely aggressive, utterly in control. She would not listen to anything I was telling her and she would not give me credit for being able to tell her what was the best way to help me. It was just terrorizing, mind bending, to be in that position.

Most importantly, practitioners using authoritarian approaches never actually helped patients move towards
recovery of AN; they merely won the battles they set out to win, getting patients into restraints and through treatments.

According to informants, orthodox technicians projected the characteristics of affectively indifferent and authoritarian practitioners onto their relationships within disciplines and across disciplines. Informants described situations in which they witnessed countless hostile or antagonistic occurrences between practitioners. Specifically, practitioners covertly and overtly denounced their colleagues in front of informants: that is, nurses criticized psychiatrists to informants, psychiatrists rebuked nurses in front of informants, and those in one discipline undermined the treatment efforts of those in another discipline. As a result, informants were often confronted with vituperative behaviors exhibited by practitioners similar to behaviors that they had witnessed in their personal lives.

When available, expert practitioners facilitated a treatment experience that was rife with hope and possibility. However, informants tended to encounter orthodox technicians within all settings of their treatment experience. Thus, their journey towards recovery was often thwarted by hopelessness, frustration and resignation.

**Summary**

In this chapter, the findings were presented and interpreted based on the descriptions of the treatment
experience for AN as told by five informants. Informants were exposed to a number of inconsistent treatments in a variety of settings. Although recovery from AN was the desired goal for all who took part in this study, because they were always dependent on accessing and sustaining treatments, informants claimed that the most that they could realistically secure was the hope that one day recovery would be achieved. Overall, informants described many challenges and few benefits to treatment.

The treatment experience was permeated by three conditions: the accessibility of programs and practitioners, the quantification of progress, and the medicalization of the AN plight. The perceived challenges and minimal benefits to treatment seemed to rest on the waiting lists that informants were forced to endure; the types of treatment that were offered such as refeeding and acquisition of skinfold measurements alone, without psychotherapy; and the resignation or dependency both mentally and psychically that informants placed on the hope that medications would greatly improve their situations.

The quality of the treatment experience was also influenced by the setting in which treatment occurred. Settings such as eating-disorder wards and community transition homes seemed to be of most benefit because expert practitioners were realistic and supportive. The informants
highlighted the impact of the setting — medical wards, general psychiatric wards and provincial psychiatric institutions — on the treatment experience. Although informants did not generally relate positive descriptions of such settings, they emphasized that receiving some treatment was better than receiving no treatment at all.

Ultimately though, the description of the treatment experience for AN is contingent upon the qualities that a practitioner possesses above all other aspects of treatment. It seems that most practitioners of care are orthodox rather than expert. With expert practitioners a sense of trust and hope were often equated with positive treatment experiences, making the best hope for recovery. Conversely, orthodox practitioners were thought to prolong the AN and even worsen it because of their indifference and authoritarian styles in relating to the informants. Thus, the findings suggest that, at times, individuals who have AN receive an orthodox and unevaluated quality of care. When treated in an orthodox manner, informants identified many challenges and few benefits to treatment with only a moderate chance for recovery.

Chapter Five presents a discussion of the findings. Finally, Chapter Six presents a summary, conclusions and implications for nursing research, practice, education and social policy.
CHAPTER FIVE: DISCUSSION OF FINDINGS

Introduction

In this chapter, I discuss selected findings of the study, particularly those which focus on the quality of care that individuals receive; the effectiveness of treatment for individuals; and the relevance of treatment to expanding the professional understanding of the general nature of the phenomenon. These findings are disturbing in that they highlight the obstacles individuals with AN face. In an exploration of these obstacles to recovery, several problems in the care of individuals with AN are noted: salient gaps exist in the system; the ideological perspectives and behaviors of practitioners who provide conventional treatments are often not conducive to recovery and may even be detrimental; and norms entrenched within the system facilitate the medicalization of what perhaps should be regarded as a social/psychological phenomenon. After establishing the existence of obstacles to recovery, the chapter turns to the concerns of the consumers of conventional treatments. These concerns include the disregard for individualized treatments and the lack of experiential and complimentary therapies utilized in treatment. Finally, the discussion moves to discovering why individuals continue to access conventional treatments in the face of all its controversy and criticism.
All individuals in this study experienced some degree of disappointment and discouragement regarding their treatment for AN, whether in hospital programs or community-based programs. While some were left feeling worthless and hopeless after treatment because they had been discharged from a program for not gaining an allotted amount of weight, others were kept in hospital until they had regained that weight. None were taught relaxation techniques that would facilitate eating; rather, sedations were used cloaking the experience of eating with resignation and detachment. The overall success of the programs was thwarted by obstacles. The quality of care in each case was reduced by the general focus on observable measures like weight, a focus that left the less observable issues beneath each individual's condition in the dark, untreated.

Obstacles To Recovery

This study led to a reaffirmation of claims made by many experts and consumers alike that obstacles exist which diminish the quality of the treatment offered, impede recovery, and may even worsen the health of AN for some individuals (Dunbar, 1986; Geary, 1988; Goldberg, 1994; Lambley, 1983; Lawrence, 1984). Three obstacles were identified by the women in this study; 1) the gaps in the system, 2) people within the system, and 3) the medicalization of a social/psychological phenomenon.
Gaps In The System

As developed in the literature review, the incidence of AN is on the rise (Lucas, Beard & O'Fallon, 1991); it cannot be remedied in the short-term (Hsu, 1980); and, longitudinal studies reveal that only a small percentage of AN sufferers recover (Herzog, Rathner & Vandereyken, 1992; Woodside, 1995). Most experts concur that AN is a complex, multifactorial condition that requires multiple approaches to treatment (Freeman & Newton, 1992; Love & Seaton, 1991). Still, it is unclear whether the condition has complexities that inherently compromise recovery, or whether the approaches to treatment are unsuitable for the nature of AN. Presently, two particularly troubling gaps exist in the conventional system for the treatment: the discontinuity of services and the limited resources. Both gaps diminish the quality of care and limit the effectiveness of treatment in terms of recovery from AN.

Discontinuity of Services

As is illustrated in the lay literature (Ardell & Ardell, 1985; Dunbar, 1986) and illuminated in the findings, the discontinuity of services is revealed in the unpredictable nature of the treatment experience. Issues of discontinuity of services include the difficulty consumers have in accessing treatments, and the difficulty that they have in sustaining treatments whose philosophical bases are similar
across environments aimed to provide high quality care leading to recovery.

Perhaps the biggest gap in services exists at the entry point. Accessing any type of treatment is apparently never without the agonizing experience of waiting. Regardless of the practitioner, the program, or the facility, informants always waited a considerable amount of time to be admitted. The waiting carried, for informants, a sense of unpredictability. And since initial treatments were also unpredictable, informants never felt in control of the direction of their care and recovery. Each practitioner in the chain of many involved with each informant could propel her in any number of directions depending on the ideological perspective of that practitioner and the services available at the time they were needed. Even though AN can be life-threatening, the severity of the AN was not always the decisive factor leading to the type of treatment an informant began; rather, the availability of a treatment was often the deciding factor.

As mentioned in Chapter Two, both the literature (scholarly and lay) and the informants in this study attest to the belief that community-based programs incur less costs and have greater effectiveness in terms of recovery than hospital settings (Freeman, Shapiro, Morgan & Engliman, 1990; MacLeod, 1981; Waskett, 1989). For the last decade, within
the conventional health care system, an emphasis on community-based services to treat mental conditions rests on the notion that individuals learn more easily to care for themselves in a less acute setting than a hospital can provide (Bachrach, 1994). Although consumers and practitioners alike endorsed this philosophy, the resources existing in the community have always been limited (Bachrach). Informants explain that programs that could help them carry sizable waiting lists. Further, the programs are often limited in their duration, thus, informants were not able to accomplish the goals they anticipated within the allotted time frame. Reasons for limited treatments are unclear although cost containment and a desire to reach more individuals are plausible explanations. Research on the issues surrounding appropriate duration for various community programs does not yet appear in the literature, causing one to assume that none has been conducted for most programs. Hence, it can be assumed that the majority of individuals do not have access to the excellent care that is offered in innovative community-based programs (Bachrach).

Another gap within the health care system revealed by the findings in this study is that between the philosophical environments of hospital and community-based programs. All too often, informants described having to accommodate for the differences between the two settings in terms of the
philosophies of practitioners, design of programs, and foci of treatments. Further, many informants found themselves unable to sustain a treatment indefinitely that was covered financially under the Canada Health Care Act. These women reported being unable to expect quality and consistent care across environments that covered costs through the provincial health plans.

Many hospitals do not have specially trained experts in AN (Gowers, Norton, Halek & Crisp, 1994). Thus, consumers are often admitted to a general psychiatric ward or even a medical ward where the focus is on refeeding and weight gain. Similarly, when one informant was admitted to a local hospital within her community while she waited to be accepted into an eating-disorder program, she received treatment that was largely inconsistent with and perhaps contradictory to that which she experienced later when accepted into the facility specializing in eating disorders.

A lack of consistency amongst some hospital-based programs specializing in AN leads to the employment of various methods of behavior modification. A consumer may be subjected to a variety of these approaches as she is transferred from one facility to another. Some facilities rely heavily on strict behavior modifications, others on lenient behavior modifications (Solanto, Jacobson, Hellers, Golden & Hertz, 1994). While consumers move from one facility
to another for any number of reasons, issues of consistency never seem to be one of those reasons. If a psychiatrist does not have hospital privileges and his/her client requires hospitalization, the client may receive care under a different psychiatrist with a very different approach to care. This was the case with three informants who participated in the study. According to informants, those individuals who are used to seeing therapists (psychologists and counselors) in the community will likely find a very different treatment philosophy if and when they are admitted to an institution.

After being discharged from the hospital setting, consumers should theoretically be involved in community-based programs that have threads in common with hospital treatments in order to maintain continuity. In order for this to occur, psychotherapy, the mainstay of treatment in most community-based programs, should be provided as part of the hospital programs so that weight maintenance and weight gain are treated at the same time as underlying psychological issues.

A lack of continuity of services is one of the greatest gaps in the system: from waiting for treatment, to experiencing the unpredictability of treatment, to the chaos in approaches. Such inconsistencies impede recovery by fragmenting an individual's experience of treatment from environment to environment. While many hospital-based
programs, as described by informants, were controlling, rigid, safe, and unrealistic, community-based programs were felt to be autonomous and motivational. Yet, as Bachrach writes, "even partisans who strongly defend community-based mental health programs will probably acknowledge that it is easier for patients to use available services in hospital-based systems of care where programs are localized and administrative authority is centralized" (1994, p. 6). The literature reflects that treatment for AN has never reflected a holistic approach. As consumers have maintained for years, attention must be given to the quality of treatment offered to AN sufferers (Ardell & Ardell, 1985; Bordo, 1993; Brown, 1992; Brumberg, 1988; Gibson, 1983; Orbach, 1986). The extent to which inconsistencies in treatment and philosophy affects recovery must be studied in order to support changes in the existing system.

**Limited Resources**

The best explanation for the discontinuity of services for AN is that limited resources exist for treatment. Such resources include the closing of programs or a shortening of the length of existing programs, the lengthy waiting lists for access to expert practitioners, a shift in philosophy from institutionalized care in mental health to community-based health (without the accompanying dollars and programs in the community), and limited resources available in crisis
situations. All these obstacles serve to decrease both the quality of care and the effectiveness of the treatment for AN.

A troubling finding from this study is the difficulty informants experienced in accessing programs and expert practitioners for treatment. Most distressing was the difficulty of accessing a bed, any bed, much less in highly specialized areas such as eating-disorder wards. Also, once in a bed, informants felt rushed toward discharge. Whether these experiences are directly or indirectly related to changes in the Canadian health care system is unclear; certainly informants in this study reasoned that their treatments were less than satisfactory because of the budget cuts to health care. This opinion, they claimed, was formed from their own experiences and observations within the system and echoed by practitioners. As Sack (1993) observed, "Obstacles always loom larger during bad economic times" (p. E5). Indeed, the literature is rife with anecdotes acknowledging the crisis in health care because of cost cutting measures (Prescott, 1993; Scott & Jaffe, 1991; Silver-Wells, 1987). But in an era of budget crunching, downsizing, restructuring and cost containment (Banning, 1992; Decter, 1994; Evans, 1992), whether we are really saving dollars in the long run is questionable since hasty patient discharges seem to lead to repeated admissions.
Informants in this study all concurred that a hospital ward was the worst place to be admitted even when such admissions meant saving their lives. While admission to hospital wards are necessary when a life is in danger (Casper, 1982; Crisp, 1977), studies indicate that the weight gained in a hospital setting is rarely sustained (Freeman & Newton, 1992; Hsu, 1986). In addition, studies reveal that many types of mental conditions are not adequately dealt with in the hospital setting because of its structure (Grippin, 1991). Repeated admissions occur, sometimes because of a dependency on the treatment of refeeding. But, according to informants, experiences of gaining and losing weight are ultimately detrimental to their self-esteem and ability to cope. Thus, all of the informants felt that health dollars spent toward their care in the hospital setting were for the most part ill spent.

According to the informants, perhaps the most noticeable area in which services are limited is within the community. Both transition houses and day programs are often able to provide refeeding programs, and while they provide various types of psychotherapy with good results, informants claim that spaces are inadequate to accommodate all who need the service. In Vancouver, two transition houses accommodate only 20 women at one time, and the waiting lists for these houses
represent a wait from anywhere between three months to one year.

Finally, crisis intervention was seen by informants in this study to be limited. Not only is a crisis service for those with AN almost non-existent, but there is little mentioned about it in the literature. Most often, the development of AN is gradual. However, when symptoms escalate to a state of crisis, defined as "a perception of an event or situation as an intolerable difficulty that exceeds the resources and coping mechanisms of the person" (Gilliland & James, 1993) help of a particular kind is needed. A crisis, characterized by an exacerbation in physical symptoms and, to a lesser extent, psychological disturbances and interpersonal distresses, could occur before, during, or subsequent to any kind of treatment (Garner & Friedman, 1994).

According to Garner & Friedman (1994), the aim of crisis intervention should be to stabilize the physical and mental condition of the individual. Crisis intervention for an AN sufferer includes normalizing eating and weight, redefining the problem(s) that lead to AN, confronting the reluctance to gain weight, helping the individual to identify beliefs that interfere with the problem and finally family intervention. Garner & Friedman advocate that most patients with AN have access to out-patient therapy where they meet two to three times per week with a therapist and enjoy telephone contact.
between sessions. To informants in this study, such accessibility was hardly adequate. Under ideal circumstances, they claimed that crisis intervention must be immediate, intense and focused. Informants maintained that they did not know where to turn for expert treatment when they needed to call off hours. Most agreed that they might go to a local emergency department in a serious crisis but that they would not expect specialized treatment there. Although some emergency rooms do have experts in AN available, which ones these are was not always known to informants. Thus, crisis interventions for those with AN both in the form of expert practitioners in emergency rooms and in the form of counselors on the telephone crisis lines are sadly limited yet absolutely required.

With all levels of government facing unprecedented debt levels, themes of initiatives for the 1990's include restructuring and downsizing the health care system. Organizational restructuring and downsizing has begun with a common objective of achieving organizational synergy: that is, getting more for less (Mara, 1993, Roch, 1992). Woodside (1995) writes "with ... such resource-intensive treatments, efforts to demonstrate long-term efficacy of treatment for eating disorders are no longer optional" (p. 75). But, in an atmosphere of downsizing, with all interest groups vying for the few dollars left, likely those with the weakest voices,
such as those with AN, will receive the least resources for treatment.

People Within The System

The second main obstacle diminishing the quality of the treatment experience and limiting recovery from AN is the lack of expertise among practitioners within the system. A concern extensively documented both in lay literature and feminist writings (Bordo, 1993; Lawrence, 1984; MacLeod, 1981; Wolf, 1990), and validated by the informants in this study, is that practitioners exercise both a rigid adherence to ideological perspectives often contrary to those held by informants and behavior apparently devoid of empathy. In the views of the women in this study, both of these characteristics of care served as obstacles which diminished the effectiveness of the treatment.

Ideological Perspectives of Practitioners

An overview of the literature in Chapter Two indicates that there are numerous well entrenched ideologies regarding the biological, psychological and sociological aspects of AN. While most of the literature written by conventional practitioners acknowledges the need to use a biopsychosocial approach to treating AN, findings reveal that, most commonly individuals are actually treated using medical, quantitative, and behavioral modification approaches. Many practitioners continue to adhere rigidly to one ideological perspective
when treating AN. As Lambley (1983) notes, practitioners attempt to mold the individual into a framework rather than to modify the framework to fit the individual's needs.

Of all the common approaches, findings showed that AN is treated most often within a medical framework; that is, people are often hospitalized, refed and medicated before they can be referred to a program within the community to receive psychotherapy. Under the medical approach, there is a strong following for the quantification of treatments. In his review of the literature from 1954 to 1978 evaluating the outcomes of AN after treatment, Hsu (1980) found that many studies neglected to discuss what he called "psychiatric outcome" (p.1042) meaning behavioral outcome of treatments. In fact, most studies based the success of the treatments on "nutritional outcome, menstrual outcome, and eating difficulties at follow-up" (p. 1042). Those that did evaluate psychiatric outcome found "only a small portion [of patients] who expressed no concern about their shape or weight .... Hardly any of the patients were free from neurotic fixations on body weight. This characteristic can persist despite the subject having maintained a normal weight" (p. 1043). Recent studies still focus on the importance of the quantity of weight gained by the individual and the duration that it is maintained rather than on whether the AN behavior persists (Woodside, 1995).
The obvious question is why do practitioners continue to place such importance on the quantifiable aspects of treatment when these so easily cover up the underlying problem(s). Obviously, psychiatric outcomes such as those derived through psychotherapy, experiential therapy and/or complimentary therapy are more subjective and harder to evaluate. Further, it is believed that a certain level of weight restoration is required before psychotherapy can be of benefit. However, this has been disputed in the lay literature, and informants themselves indicated that psychotherapy should begin concurrently with other treatments. As well, the economies of health care are such that it is less costly to refeed a person for three weeks in a hospital milieu and offer a limited amount of psychotherapy in the community, than it is to offer unlimited psychotherapy in conjunction with refeeding within the community. Still, longitudinal studies indicate that, because weight gained during rapid refeeding is transient and because psychotherapy is not always available in conjunction with refeeding, any strides forward are quickly lost and the individual becomes part of the revolving door syndrome, costing more dollars in the long run (Hsu, Crisp & Callender, 1992; Walford & McCune, 1991). Finally, as the gatekeepers to conventional treatments, many physicians support an empirical domain which treats AN by objective and quantifiable measures. This
ideology seems to be a difficult mold to break free of; thus much emphasis is placed on the biological aspects of the condition even though many physicians in the literature acknowledge that AN should be viewed from a biopsychosocial perspective. Many nurses, psychologists, and dietitians have also been educated within a empirical domain, preserving the trend toward quantifiable treatments. Perhaps the desire to actually see the results of treatment is too strong to resist.

According to the literature, the behavioral modification approach is still used by most practitioners in conventional treatment facilities in Canada (Canadian College of Health Record Administration, 1987; Woodside, 1995). A study by Glatter Nusbaum and Drever (1990) described in Chapter Two attests to the notion that many nurses are in favor of a behavioral modification approach to treatment. Some programs veer towards a more lenient approach as opposed to a strict approach to treatment. Most of the literature does indicate that a lenient approach is the more effective of the two (Touyz, Beumont, Glaum, Phillips & Cowie, 1984); most informants, however, regarded the approach as merely the better of two evils. Behavioral modification, after all, focuses on a system of rewards or incentives for weight gain and 'good eating habits'. Here again, one's success is defined by one's weight gain. Certainly, informants in this
study articulated that the more strict a particular treatment was the less effective it was in the long run. They explained that not only did a strict program fail to meet the needs of the individual, but anything that was learned or accomplished was not applicable to the informant's reality.

Silber, Delaney, & Samuels (1989) indicate that many insurance companies in the United States are reluctant to pay for medical care to people with AN, believing that psychiatric and psychological care is what is essential. While this may be true, medical intervention is unavoidable when an individual with AN is in crisis and needs a combination of medical and psychological supports. Whatever the intention(s), what must be avoided is the perspective that AN can be treated using only medical, quantifiable and behavioral approaches.

**Behaviors of Practitioners**

The informants in this study indicated that many vituperative behaviors are exhibited by practitioners which result in a less than satisfactory treatment experience and may even limit recovery. Findings indicate that among the behaviors exhibited by practitioners, the most destructive are a lack of empathy, a split in ideologies among practitioners, and a dichotomous approach to treatment.

As was explained in Chapter Four, a practitioner was viewed as an expert when she/he had achieved knowledge,
experience, and empathy. Lacks in any of these qualities proved to severely impede the establishment of a professional rapport with an informant. Most informants stated that it was a complete waste of their time to be with a practitioner who was not perceived as an expert.

Findings in this study indicated that informants found few so-called experts because they lacked empathy. Asked how they defined empathy, informants offered that real empathy, focused on inspiring confidence and trust in the informants themselves. As was revealed in this study, the consequences of a practitioner without empathy included: poor rapport with clients because of a lack of trust; an unpredictable and often tumultuous relationship with clients because of mistrust; a rejection of treatment by clients which leads to a rejection of the practitioner; diminished expectations of treatment by the client because of a negative perception attributed to the practitioner; client compliance with the short-term goals of treatment (such as refeeding) in order to escape treatment sooner; uncooperative or unruly behavior by the client in response to a perceived lack of understanding or foresight demonstrated by a practitioner; and a complete loss of hope for recovery by the client accompanied by frustration and disappointment regarding the skills of the practitioner. Unfortunately, double-blinded controlled studies do not exist that compare long-term outcomes of those
individuals who receive treatment from practitioners thought to be expert and empathetic with those perceived to be without empathy.

A second ineffective set of behaviors exhibited by practitioners surrounds the splitting that occurs across disciplines and within disciplines. Splitting, defined for the purpose of this study, is a destructive interaction that polarizes practitioners and leads to antagonistic encounters. Findings of this study exposed reports of countless negative feelings among practitioners that were witnessed by informants. Such behaviors left informants feeling mistrustful and suspicious of the entire health care team.

Splitting within and amongst disciplines is documented both in the medical and the nursing literature related to eating disorders. Within medicine, there is an obvious splitting that occurs between psychiatrists and other medical practitioners regarding the optimal treatment of AN (Bryant-Waugh, Lask, Shafran & Fosson, 1992). There is much debate within medicine about the value of forced tube feedings in a hospital setting; an internist may value the short-term benefits of tube feeds while a psychiatrist may recognize the long-term psychological complications of forced feedings. The patient being tube fed will not feel the full support of the psychiatrist if she is aware of his or her feelings. A study by Conrad, Sloan and Jedwabny (1992) showed that the main
reason why the splitting of care occurs in place of a united front appears to be that practitioners tend to avoid conflict while enjoying control over their patient's treatments. Some practitioners went so far as to create The Therapeutic Administrative Split Model (T/ASM) (discussed in Chapter Two) which divides care between nurses and physicians allowing both to function separately, even where contradictions might occur. Research has shown that practitioners of different disciplines usually agree on the goals of treatment for AN, restoring weight to a normal level in conjunction with renewing psychosocial well being — but, they often fail to agree on the approach to accomplish this end. Rather than practitioners of all disciplines functioning as a cohesive group with common plans for intervention, turf wars often resulted in divisions in the way treatments were conducted. The effects of such splitting on the patients involved has not yet been studied.

Davidson and Cosgrove (1991) discussed what they called the 'dualistic nature' exhibited by a woman with AN. That is, the woman experiences two separate realities, the reality of AN (death) and that of her daily lived reality (the denial of death). What is unclear is whether dualistic behavior within the individual is preceded by, or subsequent to, or independent of similar interactive splitting behaviors exhibited by practitioners. Further, the question remains as
to whether such dualism within an individual is intensified because of an increased severity of her AN or an increased exposure to split treatments. Regardless of the answer, it can be assumed that split treatments are counter-productive to an individual's recovery in that such experiences must parallel the dysfunction that often contributes to the AN behavior.

A third set of behaviors contributing to a diminished quality of care and limited recovery involve the dichotomous approach used by practitioners. Informants claimed that they were controlled by practitioners at some points in their treatment and abandoned at others. While the treatment of severe AN may necessitate taking control, the practice of taking control in all aspects of the treatment of those with AN is not supportable. Given that issues of control — rigid and compulsive behaviors — are linked to the condition of AN, it is small wonder that relinquishing control is perceived by many people with AN as an obstacle in recovery.

When admitted to the hospital, most of a client's activities are controlled — from eating to going to the bathroom. While they reported signing written contracts allowing such care and agreeing to certain incentives, the informants in this study felt this to be manipulation, poorly masking the control of practitioners in that their only alternative was not to be admitted, again, abandonment. The
use of restraints and seclusion, (optional in approaches to treatment of AN) represented a complete loss of control and a feeling of being abandoned. According to Tardiff (1989), restraints and seclusion are contraindicated unless used in a behavioral approach where the individual is suicidal and such interventions might prove necessary to preserve life.

Sanger and Cassino (1984) describe such power struggles between nurses and patients on an eating-disorder ward. Not surprisingly, power struggles over control issues often arose between practitioners and informants in this study. Ironically, controlling behaviors among practitioners seemed to mimic anorexic behaviors in their rigidity and compulsiveness. While practitioners may think themselves as consistent and offering a fair bargain (Garfinkel & Garner 1982; Glatter Nusbaum & Drever, 1990; Tardiff, 1989), the fact that they have all the power remains. Informants perceived that practitioners could not be truly empathetic without relinquishing some of their control, nor without diminishing some of the apparent abandonment.

It is astonishing, then, that many of the behaviors of practitioners dealing with the treatment of AN parallel the very behaviors that intensify AN. Certainly, those whose AN is connected to similar control issues within the family perceive the controlling elements of treatment ineffective and even detrimental to recovery (Conrad, Sloan & Jedwabny,
Whether the sense of abandonment (the product of professional control) that informants experienced occurred within treatment programs or following them, or both, they all stated their response to it was to exercise their own control by way of reincorporating AN behaviors, thus perpetuating a vicious cycle. Thus, it is not difficult to understand the dualistic nature of AN as described by Davidson & Cosgrove (1991) given the dichotomous circumstances of treatment.

Medicalization of a Social/Psychological Phenomenon

A third and final obstacle impeding the quality of care and influencing the level of recovery deduced from this study is the existence of entrenched norms within the system that allow the dominance of medicalizing what is possibly a social/psychological phenomenon. Many experts debate this point, citing numerous empirical and descriptive studies indicating that biological abnormalities (e.g., the role of genetics and various neuropsychiatric abnormalities) predispose certain individuals to AN (Kaplan, Sadock & Grebb, 1994). Still, others (Giles-Banks, 1992, for example) concur that such abnormalities are most likely secondary to the AN and not the cause of it. The implications for medicalizing AN rather than approaching it from a social/psychological perspective include a dependency on the medical modality
which excludes crucial aspects of treatment that would otherwise gain our attention.

**The Medical Modality**

For the purpose of this study, the medical modality refers to the entire conventional structure of the Canadian health care system in which nurses, occupational therapists, pharmacists, physicians, psychologists, physiotherapists and social workers all contribute to a rigid biological perspective of AN. Within the literature, there is a paucity of material suggesting that a 'multidimensional approach' to AN should be practiced (Woodside, 1995, p. 73). This approach entails viewing the individual from a biopsychosocial perspective. However, findings show that the biological perspective is the dominant approach to treatment. The predominant practices include medicating, refeeding and weighing practices, and/or isolating individuals with AN.

According to the informants in this study, the least controversial aspect of medicalizing AN is the practice of prescribing and administering medications. Psychotropic medications (for mental conditions) are commonly prescribed and administered to individuals with AN (Woodside, 1995), including those who participated in this study. Prescribed and administered by physicians and nurses respectively to alleviate depression, stimulate appetite, reduce anxiety, sedate during refeeding, alleviate insomnia, and reduce
obsessive-compulsive behaviors (Woodside), these drugs address long standing problems with short-term results. Certainly, none of the drugs approached a cure for the underlying condition, Anorexia Nervosa.

A great deal of literature in a variety of disciplines reflects the belief that the benefits of medicating those with AN are high (Goldbloom & Kennedy, 1993; Wolfe, 1995). But, the psychological dependency that is developed by many who take such medications is, at best, unclear. In some cases, medications are prescribed and administered because nothing else seems to work. For example, two informants in this study were taking Resperidone (an antipsychotic for those exhibiting psychotic behaviors) although they claimed that they were never psychotic.

Often an individual is hospitalized for refeeding accomplished through tube feeds, and sedated during refeeding to facilitate toleration of the infusion. However, while informants claimed that drugs did enable them to tolerate the food and weight gain while hospitalized, they also claimed they were unable to maintain the weight later because they never really learned how to eat or to deal with their psychosocial problems. Perhaps practitioners find sedation superficially an easier route to the desired goal, forgetting that the ultimate goal is to empower the individual with AN by teaching/reteaching her how to eat comfortably. This study
revealed that informants felt torn between receiving sedation and engaging in psychotherapy. The theory behind refeeding is that an individual must weigh an optimal amount before she can concentrate and focus on any type of psychotherapy. Before emotional support comes renourishment. Still the trauma of undergoing sedation, refeeding and both the loss of control and the abandonment associated with these may have a great effect on the success of psychotherapy. Much is yet unknown. It may be that experiential and complimentary therapies during refeeding, such as poetry therapy, hypnosis, therapeutic touch, music therapy and massage therapy could prove conducive to long-term weight gain. Informants in this study all indicated that some form of therapy that focuses on an individual's problems may indeed be of benefit at all stages of her treatments.

Another controversial aspect of medicalizing AN concerns the quantity of the tube feeding and the rapid rate at which an individual is refed. Many informants asserted that they were forced to take in a certain amount of nourishment within a three week to three month time frame or suffer consequences. Often, this regime entailed being tube fed at night accompanied by consuming three square meals per day. When one considers that, upon admission, many of the informants were consuming no more than coffee and a few cookies a day, it seems astonishing to expect individuals to
tolerate such extreme quantities of food immediately. There is ample literature to demonstrate the dangers and complications of rapid refeeding, such as bloating and cardiac irregularities (Woodside, 1995). However, there is little literature that explores the psychological trauma that informants all felt was induced by rapid refeeding and/or the mandatory consumption of three square meals per day. Though none wanted to experience the consequences of refusing treatment, the long-term consequences of such practices, whether they be frustration and disappointment regarding one's inability to maintain desired weight or a contrived fear of and dependency on the treatment, are indeed suffered.

The extent to which individuals become dependent on tube feedings or even dependent upon practitioners to 'supervise their eating' is not addressed in the literature. For one informant in the study, the only means she had of tolerating nourishment was through tube feeds. She would go to the hospital daily to receive tube feedings and commute daily from her home to the hospital with a naso-gastric tube in her nose. She described feeling humiliated yet dependent on this practice. Another informant was able to eat three square meals per day while she lived at a community transition home, under supervision, but she was unable to cope with regular eating practices on her own. Clearly, these informants were not learning how to improve their plight. Instead, they were
learning how to rely on practitioners and the medical modality to maintain their illness.

One of the most appalling ironies of this study was that, while AN is understood to be a psychological disorder, unlimited and systematic weight checks were available as an ongoing service at an eating-disorder facility to all informants and unlimited and/or systematic mental health checks were not available to any of the informants. One can only speculate that the reasons have to do with funding and priorities. Most of the literature indicates that weight gain is not a decisive factor in recovery (American Psychiatric Association, 1994; Bordo, 1993; Bruch, 1988). Still, funding schemes suggest that this is where the priority lies. Even though informants knew that their actual weight was not their main problem, and though all suffered great anguish before, during, and after weigh-ins, all felt responsible for showing up to be weighed — a measure of their willingness to comply with practitioners and an obsession with knowing their actual weight.

A debate exists in the literature as to how often one should be weighed during treatment and, indeed whether weighing an individual is detrimental to the progress of AN (Day, 1974; Gabereau, 1994; Garfinkel & Garner, 1982). Touyz, Lennerts, Freeman & Beumont (1990) wrote that weighing three times per week versus once per week had no bearing on the
course of treatment. This study only looked at the short-term outcome with respect to weight gain, not at whether the AN behaviors persisted. Also debated is the practice of weighing an individual backwards so that she is unable to know her weight, the rationale being that she can trust the practitioner and be removed from the constant source of stress regarding her weight. The research available on the effectiveness of this point is minimal. Still, Lawrence (1984) discusses how weighing practices alone actually contribute to the AN behavior rather than counter it. Clearly, one with AN can be assessed as needing nourishment without being weighed. Although it could be argued that calculating an adequate calorie intake is based on the weight of the individual, the practice of being weighed causes so much trauma that other more adaptable ways of determining needs should be developed.

In addition to the practices of medicating, refeeding and weighing individuals, a final approach used within the medical modality that affects the quality of care and impedes recovery is that of isolating individuals during treatment. The informants related the following examples of isolation: being admitted to wards that did not specialize in eating-disorders, being discharged from a program when the goal of weight gain was not accomplished, and being subjected to various types of seclusion.
Findings demonstrated that being admitted to a setting that did not specialize in eating disorders (such as general psychiatric wards and provincial psychiatric institutions) was ineffective and often detrimental to recovery. There, informants were left to their own devices and only received pharmacological and nutritional treatments. Further, because there were many unskilled practitioners in these areas, the informants perceived that they were not understood. They said that they felt they were not considered to be 'ill'. They perceived that they were simply occupying a bed. Ultimately, the informants felt little self-worth while in such settings. The literature exploring how isolating features of such settings affect the quality of treatment for AN is non-existent. However, the literature does indicate that a lack of resources exists forcing admissions of individuals into non-specialty areas (Tardiff, 1989).

Informants in this study were subjected to various types of seclusion which they perceived to be both overtly and covertly manipulated by practitioners and resulted in feelings of tremendous isolation. According to informants, covert seclusion, in which the primary goal was to create an incentive to comply with treatment, was achieved by being given limited bedroom privileges, being subjected to bedrest, having visitors restricted, and having restrictions placed upon telephone calls. Overt seclusion, in which the primary
goal was to isolate, was achieved through the use of restraints. As discussed in Chapter Four, one informant was restrained for overdosing on 10 aspirin and told this measure was imposed on her to teach her a lesson even while she denied being aggressive or suicidal. Her motive she had said, was simply to get help. Another informant was restrained in order to be sedated for life-saving tube feedings. She claimed to have been highly agitated and irritable. Restraints were employed for these informants in the place of any crisis intervention, in their views because practitioners were short staffed.

Being secluded caused feelings of great isolation in the informants. Isolating approaches only intensified the anxiety and helplessness that informants experienced as a result of their AN. When practitioners secluded informants who were already reclusive and reticent individuals, informants felt they were being punished. None felt there were any positive outcomes of seclusion and added that seclusionary tactics only accentuated the need for control to be regained through an exacerbation of symptoms. While therapeutic effectiveness and moral justification of seclusion have been topics of considerable controversy, raising issues of sensory deprivation, hallucinations, punishment and convenience, none of the literature touches on the specific effects on an individual who has AN or any type of eating disorder (Brown &
Tooke, 1992; Kennedy, Williams & Pesult, 1994). Still, seclusion, both overt and covert, is a practice used in the treatment of eating disorders even though the long-term effects are unclear. Certainly, such techniques show short-term weight gain; yet once again long-term recovery is questionable. Informants in this study claimed to feel cumulative feelings of 'just getting crazier' from such experiences. One wonders how much isolative techniques contributed to those feelings.

The medical modality is not without its short-term benefits and these must be acknowledged. However, in the long-term, medicating, refeeding and weighing practices, and isolating those with AN seem to offer only short-term intervention, leaving individuals with AN still severely troubled in the long-term. Whether medical approaches are helpful to the recovery from AN or whether they simply contribute to a vicious cycle worsening an individual's condition must be determined. Certainly, women being treated are telling us medical modalities are missing the mark, and allowing practitioners to ignore the roots of the matter, the psychosocial problems beneath the physical ones.

**Exclusionary Aspects of Treatment**

The implications of medicalizing a social/psychological phenomenon are that crucial aspects of treatment are excluded. Because great emphasis on medical approaches
eclipses attention to other aspects of an individual's welfare, the quality of the treatment experience is diminished and recovery is impeded. Three major exclusionary aspects of treatment that are identified in this study relate to family, peers and environment.

Possibly the most neglected aspect of treatment for AN is the inclusion of the family and significant others in conventional treatments. This is astounding given the amount of literature linking family dynamics to the cause of AN (Crisp, 1980; Minuchin, Rosmar & Baker, 1982). I spoke to a mother of one informant who felt so strongly about this issue that she asked me to research the extent to which families are included in the treatment for AN.

Some literature discusses the inclusion of the family, particularly with reference to pediatric and adolescent individuals with AN (Woodside, 1995). However, limited literature exists on the involvement of family when the individual in treatment is an adult. What is discussed in the lay literature is the limited role families are encouraged to play in the treatment programs of their loved ones (Ardell & Ardell, 1985; Dunbar, 1986; Tranquada, 1995). Only two of the informants claimed to have received family therapy as part of their treatment. These sessions were not formalized, and thus they were sporadic and without focus. Informants revealed that family therapies were never a comprehensive part of
their treatment, nor was marital therapy a part of the conventional treatment, even when families and/or partners were clearly thought to be contributing to the AN.

Families appear to be excluded both explicitly and implicitly from conventional treatments. Explicitly, they were often excluded from treatment in that visitor restrictions were often imposed on the informant supposedly to provide incentives to comply. For the same reasons, privileges such as day passes and telephone calls were denied. In the therapeutic milieu, treatment plans were devised that included only relations between the informant and the practitioners. Finally, therapy sessions for families were scheduled during daytime hours that were inconvenient to family members.

Implicitly, family members were constantly excluded from the assessment, planning, intervention and evaluation phases of conventional treatments. They were not given direction, guidance or suggestions as to how to cope with and/or aid their loved one prior, during, and upon termination of treatment. Husbands in particular were viewed as peripheral to treatment according to the informants who were married.

As well as being excluded from their loved one's treatments, family members were also without support or therapy in connection to living with one who has AN. Indeed, according to the literature, resources available for such
family support are almost non-existent (Kinoy, Miller & Atchley, 1984; Minuchin, Rosmar & Baker, 1982). Tranquada (1995) documents a mother's burden of caring for a daughter with AN:

The lowest point came one night in the fall of 1992, when mother and daughter actually discussed the suicide pact. 'We sat down and talked about how our lives had become such hell. Her disorder. My inability to cope. Sheena said, Maybe I should just end it Mom. And I said, Not without me, honey (p. 51).

Such desperation is often the case when families are overburdened with the responsibility of keeping their loved one alive. Indeed, as Bachrach notes (1994), families work hard with little return at keeping up with the ever changing policies and expectations as their loved ones are moved from program to program.

Families suffer along with their loved one as she battles AN. Often, they experience frustration with the complexities of AN, guilt in the belief they have caused the condition, anger and helplessness at not being able to rectify the situation, and terror at the prospect of their loved one's death (Garner & Friedman, 1994; Minuchin, Rosmar & Baker, 1982). Support groups such as ANAD exist in various parts of the world to reach out to family members (Kinoy, Miller & Atchley, 1984). Findings of a study by Woodside (1995) indicate that many families are not aware of the support groups available to them. Woodside endorses the
growing role of psycho-education for families but concedes that the growth of consumer — acceptable and appropriate education is slow. Among families who are aware of ANAD and other support groups, some people represent a generation that does not feel comfortable attending open forum discussions. Further, some family members perceive the meetings as inadequate to address the needs of the entire family unit. One informant's ex-husband (the informant denies that the marital breakdown was a result of the AN) attended ANAD meetings and felt he gained insight and understanding into his wife's condition. The informant believes that attending ANAD in particular gave him more patience in coping with her AN. While family support groups exist in the vicinities of all the families of the informants in this study, none actually attended regular support groups or family therapies affiliated with the centers at which they had received treatment. It is unclear in the literature whether most or even any institutions offer consistent support groups or family therapies for families as part of the continuing treatment for their loved ones.

Thus, the family appears to be excluded from conventional treatments of AN. What often happens is that individuals are treated for their AN, and then they return to an environment that was in some or many ways a significant contributing factor to the AN. Informants claimed to learn some adaptation
behaviors related to family dynamics; however, without other family members themselves gaining insight, direction, or guidance for coping with AN, many informants indicated that they would simply relapse into old patterns within the family structure rather than fight the status quo. One informant's older sister also had AN, yet her family did not receive family therapy. One wonders if interventions with the first daughter would have prevented the second daughter's more severe condition. Without interventions, the family may in fact have established even deeper patterns of dissension. According to a study by Russell, Szmukler, Dare & Eisler (1987), a clear benefit exists for all when family therapy is offered and the client is under 18 and has suffered from AN for less than two years. Addressing the social/psychological components related to the family may indeed be as valuable as addressing the biological needs.

A second exclusionary aspect of conventional treatment is related to peer support. The effects of peer support in the treatment of AN is not well documented in the literature. Informants indicated many benefits and only a few limitations related to peer support. A first benefit included establishing friendships. Three of the informants were reclusive and reticent women. As part of their AN development, they slowly isolated themselves from most of their friends and family members. Essentially, they were all
alone until treatment began, when these informants all established friendships with peers with AN. They claimed, then, to establish and benefit from a large repertoire of social activities. Another benefit from support from others with AN was the realization that one was not alone or crazy because others were afflicted with many of the same challenges. One informant spoke of the motivation that was provided by peers who were making progress in their treatment. She felt, 'if she can do it, then so can I'. Peer support also provided informants with information about who were good practitioners and who were not and which treatments were worthwhile and which should be avoided. Finally, peer support gave families a chance to get acquainted and in some cases establish their own network and support systems.

According to informants, a key limitation to peer support existed. They described a dichotomy between feeling motivated when a peer succeeded in gaining weight and feeling in competition with the peer who was thinner yet not making progress. Some informants viewed the thinner, less progressive peer as being better, stronger, more in control because she could continue to lose weight. Such dichotomies were stronger during initial stages of treatment and became less of a problem as recovery became more evident. Thus, peer support was felt to be beneficial to informants even though it could also be problematic.
Most informants indicated they were unable to establish lasting friendships or continuing peer support while hospitalized. Informants who spent time within hospital settings were often medicated and thus compromised in their ability to interact with peers. Conversely, the informants indicated that they had established lasting friendships and continuing peer support from day programs and community transition houses. In transition environments, informants were on fewer medications, and interaction amongst peers was encouraged. Perhaps one must be at an advanced stage of recovery to accept and provide peer support, but it is likely that peer support can be beneficial at any time in an individual's recovery. Research to substantiate these claims has not been conducted.

Curiously, informants were discouraged from sharing an apartment after establishing friendships and developing a peer support network. Two informants claimed that practitioners believed that two women with AN who shared an apartment would influence each other in destructive rather than constructive AN patterns. Informants who desperately wanted to live with a companion were apt to take this advice because they were terrified of slipping back into old AN behaviors. Sadly, they ended up living on their own and continuing the AN lifestyle. There is no literature to support whether people with AN who live together present any
danger to one another. Thus, it seems peer support, whether in hospital settings, community transition homes, day programs or continuing post treatment are not actively or consistently advocated by practitioners. No formal descriptive or empirical research exists to validate or dispute peer support. Views can only be deduced from the five informants in this study who valued peer support but were sometimes guarded and sometimes entered into competitive relationships. One wonders if the benefits of peer support are being consciously repressed or simply ignored because practitioners are not devising more active plans to use this resource. Again, within the medical modality, it appears that peer support is neglected as a form of treatment.

A third exclusionary aspect of treatment is the diminished emphasis on reality-based treatments as opposed to institution-based treatments. As the noted Canadian Pierre Berton (1987) mused, "we tend to build up institutions rather than individuals" (p. 48). Over and over again in this study, informants explained that the setting and context of treatment was pivotal in influencing quality of care and recovery.

Informants often considered hospital-based treatments transient: they were too safe, too controlled, or not comprehensive enough and they didn't consider the environment that the informant must return to when treatment was
terminated. The safety of eating-disorder wards was perceived as an environment that was too comfortable and difficult to leave. There, individuals were provided all their meals, were given a structured routine, and were surrounded by practitioners who appeared to be at their disposal. The extremes of safety there and danger at home presented such a dichotomy for one informant that she did not want to leave the hospital.

As well as feeling safe, however, informants who spent time on general psychiatric wards, provincial psychiatric institutions or medical wards also felt very controlled. In such places, they were subjected to rigid rules whereby compliance was rewarded and non-compliance was punished. Such rigidity often mimicked the very environments that predisposed the women to AN. Upon discharge from these settings, informants experienced an intensified need for the rigid environment offered by an exacerbation of AN behavior.

Although hospitalizations are validated in the literature as a short-term means of simply refeeding the individual so that she is able to concentrate and be well enough to receive community psychotherapy and be closer to her own environment (Hsu, 1986), longitudinal studies indicate that three week in-hospital refeedings do nothing for long-term outcomes of AN behaviors (Freeman & Newton, 1992). Findings from this study indicate that the hospital associated weight gain
within an artificial environment underlies the transient nature of the gain. Community programs and out-patient programs reflect a more realistic environment. Further, there is no literature to support why refeedings are not conducted in the community — a realistic setting — at a slower rate, with greater support. Such treatment is attempted at community transition homes, though many tread the fine line of molding themselves to the medical modality, thus risking repetition of the same mistakes made in hospital settings. Medicalizing the treatment of AN neglects the realistic aspects of day-to-day living. Many women with AN find themselves in 'institutionalized' environments that do not lend themselves to the reality of the individual's own world upon discharge. This short sighted thinking may cause intensified AN in the long run.

As a result of medicalizing what is likely a social/psychological phenomenon, many aspects of how the condition might be prevented or managed are overlooked. The result is that individuals with AN are treated within a paradigm that inadvertently fosters dependency on the system. Further, the quality of the treatment is diminished and long-term recovery is limited because of encountered obstacles such as the gaps in the system and the people within the system.
The Concerns of Consumers

All of the informants in this study are cognizant that most practitioners are trying to do the best that they can within a poorly analyzed system. Still, they experience more obstacles to recovery than successes. In addition, consumers and those advocating for better systems to deal with AN share a number of concerns. These include the disregard for individualized care provided to women with AN and a lack of support for unconventional therapies as a viable option by mainstream practitioners.

Research demonstrates that practitioners and consumers of mental health services have very different perspectives, challenging the belief that consumers are unable to define their own needs realistically (Goering, Paduchak & Durbin, 1990). A major concern expressed both in the literature and by informants in this study is the lack of acknowledgment of the contextual aspects of each individual's AN and an absence of treatment which would reflect such an acknowledgment.

When considering the context of an individual's experience of AN, one should include social and psychological in addition to physical aspects. The literature advocates obtaining an adequate history/assessment in order to design an appropriate treatment plan (Woodside, 1995), and this is always performed upon admission. Yet, informants claimed that once the history/assessment was taken, they received
treatment that was generalized for all patients with AN. They perceived that their own unique circumstances were rarely understood and their individual needs rarely met. Further, they felt that, often, topics of discussion were related to their weight and dietary habits rather than to their individual problems. According to the informants in this study, among the important aspects to be considered in making assessments are a history of sexual abuse, a history of being overweight in childhood, present age and stage in life, family genogram and family dynamics, marital or significant-other status, religion and type of AN behaviors.

Apparently, for treatments to strike a balance between maintaining the flexibility to adapt to individual perceptions and the structure that each individual needs to feel secure, assessments need to be ongoing. Lambley (1983) writes that the most effective practitioners are those that individualize care; they do not mold the person into a particular framework familiar to them, but work within the framework as it suits the needs of the individual. Bachrach (1994) offers by analogy that what is good for mentally ill people and what is good for a particular mentally ill person are two separate issues. Thus, the context in which each woman develops AN must be explicitly and consistently taken into account during all phases of treatment.
Another concern voiced by consumers and advocates of conventional treatments is the lack of encouragement for opting for unconventional treatments such as private clinics, experiential therapies or complimentary therapies. While conventional treatment centers exist in most parts of the country, most of which offer programs that treat AN as a mental illness accompanied by a medical condition, unconventional treatments are almost unheard of. Only in the last ten years has there been a suspicious acceptance of unconventional treatments (Chisholm, 1995). Most people in the mainstream have had limited exposure to unconventional treatments. Reasons include skepticism of the gatekeepers in their use, therefore lack of encouragement for consumers to explore additional avenues, and financial costs of accessing such services because most are not covered under the Canada Health Act (Chisholm). However, such treatments have begun to reach acceptance in the mainstream, amidst an economic crisis in which conditions perceived as more urgent, are funded and preserved. Given these circumstances, the medical modality of conventional health care persists.

Conventional eating-disorder centers exist at St Paul's Hospital in Vancouver, British Columbia as well as at the University of Alberta Hospital in Edmonton, Alberta, at The Toronto Hospital in Toronto, Ontario, and at the Douglas Hospital in Montreal, Quebec to name a few (Canadian College
of Health Records Administration, 1987; McCreary Centre Society, 1993; Woodside, 1995). Most treatments for AN within these facilities are covered under the Canada Health Act thus making them affordable to consumers. Not surprisingly, the Canadian health care system supports conventional health care treatments. Very little is given to programs that are unconventional, even though these, say informants, could help them to recover much more effectively than anything else. In 1990, 38% of the Canadian health care dollar went to the country's 1240 hospitals; 15% of the dollar went to physicians; 13% covered medications costs; and the rest went to capital spending and to other health practitioners (Freeman, 1994). Not even 1% of the country's allotment for health care went to research of unconventional methods of treatment.

Discussed in Chapter Two, unconventional treatments include private clinics such as the Montreux Centre in Victoria B.C (Gabereau, 1994) and Sheena's place in Toronto, Ontario (Tranquada, 1995). Experiential therapies include poetry therapy, dance therapy, art therapy, gestalt therapy and music therapy (Rice, Hardenbergh & Hornyak, 1989). And, complimentary therapies include acupuncture, therapeutic touch, homeopathy, herbal medicine, reflexology and aromatherapy (Chisholm, 1995). According to informants, practitioners never explicitly supported or encouraged
private clinics, experiential or complimentary therapies. Informants felt that there was little room for overlap of unconventional treatment ideologies with conventional treatments. They maintained that practitioners would not approve of jointly participating in both spheres of treatment. Practitioners went so far as to make disparaging comments about private clinics such as the Montreux Centre. Because informants depended on the respect of such practitioners, they did not contradict their opinions. Some finally believed that, if such treatments were of benefit, then practitioners would long ago have endorsed them.

For the most part, informants perceived that many practitioners were unaware of unconventional treatments. Indeed, most informants had themselves only heard of one private clinic, had experienced one experiential therapy (art therapy) and had never thought of seeking out a complimentary therapy as part of their treatment. For those consumers who are aware of alternatives to conventional health care treatments (most are not aware of their options) there has been a societal resistance to openly embracing unconventional treatments in the mainstream. Only a decade ago such alternatives were viewed as quackery (Chisholm, 1995). A possible explanation for such resistance is rooted in the antiquated beliefs that scientific, rational thought alone is valuable to us (Sauvage, 1995).
So how can we know whether unconventional treatments really have a place in improving the quality of the treatment experience and enhancing recovery of AN? According to consumers, informants and advocates alike, it is important to find out (Chisholm, 1995; Lawrence, 1984). However, issues such as accountability, outcome measurement and evaluation seem to be required before a practice can be accepted, funded and can prosper (Chisholm). Establishing the safety of such practices is the first step in making an argument for their use. Aside from the controversy that surrounds such practices, most unconventional treatments are not covered under the Canadian Health Act (Chisholm). Most unconventional treatments are thus out of financial reach for the informants in this study. Clearly, a bias toward the more expensive and very possibly less effective conventional treatments is draining our health care resources.

**Understanding The Demand For Conventional Treatment**

So why do individuals continue to depend on the system for conventional treatment? The answer is that the mere existence of treatment, regardless of its type, provides hope to individuals. The concept of hope was referred to in association with treatments of every kind by informants throughout the discussions that we shared. Hope from practitioners communicated a renewed sense of motivation to succeed and respond well to treatments. It seems that hope
was not a feeling that began with the informants: rather, it was a notion that was introduced externally, primarily from practitioners.

Informants described their interpretation of hope throughout this study. Hope was indirectly related to recovery and cure but never referred to as such. Instead, informants referred to hope for the possibility of leading a normal life with a career, partner and children. Informants believed that they may be hopeless cases but as long as practitioners still believed in them, then there was some small hope. Informants needed to believe that practitioners were earnestly willing to invest themselves in an informant's recovery. This was more important to them than the unconditional reassurance given to them by family, friends or partners. Hope was primarily conveyed through expert practitioners. An amazing finding in this study was that almost any type of treatment would be tried or endured if it was suggested and administered by an expert practitioner. Such trust or blind faith was instilled in an informant when a expert practitioner could genuinely convince the informant that the treatment would help them towards leading a normal life.

Informants reiterated the importance of being able to access the system for treatment. That is, as long as treatment was available to them, there was always hope for
them to lead a normal life. Perhaps that is why being discharged from a treatment program because the goal of weight gain was not obtained was so detrimental to them. In such a circumstance, hope would be obliterated.

An interesting finding was that, rather than criticize the treatment, the women in this study blamed themselves when a particular treatment was not effective. In blaming herself rather than the treatment, the informant was able to rationalize that, with hope provided by practitioners providing the treatments, she could try again in the same treatment and, thus, perhaps accomplish the goals of that treatment a second time around.

Finally, a great deal of confusion and conflict sprung forth from the informants who seemed to be open to trying any type of treatment to help them. While they would not abandon practitioners in the conventional milieu who they trusted and who had provided hope in the past, they would be open to treatments that were unconventional in nature.

Findings indicated that hope conjures up both inspirational and detrimental feelings: inspirational, because hope supports optimism, making a normal life seem imminent; detrimental, because a deep, dark vale of misery and disillusion awaits the individual who does not 'fit' the treatment. Thus, practitioners must come to realize the important role that they play in providing hope to
individuals with AN and the implications for those individuals that do not succeed in a particular treatment after believing that they would.

**Summary**

With the complicated, convoluted and intricate nature of AN treatment in our society, it is not surprising that the recovery for AN is limited. What comes into clarity with this study is a number of obstacles that present themselves to individuals attempting to recover from AN. Gaps in the system, such as a lack of continuity of services and lacking or limited resources contribute to a tumultuous recovery. In addition, the rigid ideological perspectives maintained by practitioners in the system tend to involve individuals with AN in destructive patterns of behavior. Finally, in medicalizing a social/psychological phenomenon, by focusing on medicating, refeeding and weighing practices, and excluding individuals with AN, the dominant perspective of treatment is the medical modality whose focus (and funding) eclipse attention to other important aspects of treatment. Specific aspects that are excluded include the family, peers and treatment geared toward coping with the informant's reality.

Situated within this ethos, women with AN continue to access conventional treatments in the face of such adversity, and with the prospect of a slow or no recovery because their
mere availability provides hope. In the following chapter, the implications of these findings for nursing research, practice, education and social policy will be discussed.
CHAPTER SIX: SUMMARY, CONCLUSIONS, IMPLICATIONS

Summary

This study was undertaken in order to describe and explore the conventional treatment experiences that women with AN undergo from the perspective of the women themselves. The impetus for the study grew from the literature indicating that there is a strong consumer critique of various aspects of conventional treatment approaches. Further, conventional treatments have almost entirely been guided by psychiatric and psychological clinical opinion rather than by research, and many approaches are having limited success rates in terms of long-term outcome. In addition, more nurses are caring for women with AN in all settings, and yet the nursing care is orchestrated in accordance with ineffective conventional treatment approaches. Finally, the opinions and perspectives of practitioners in the health care industry are often different from those of the consumers of health care services. Although more practitioners are understanding the importance of giving a voice to those consumers, the views of recipients of care need to be documented and their issues fully investigated before we can expect changes toward improved treatment approaches for AN.

A review of the literature revealed that conventional treatment approaches are generally based on a biopsychosocial perspective that is predominately made up of medical
treatment, psychotherapy and behavioral therapy. Studies evaluating the long-term outcomes of treatments based on these approaches indicate only minimal success. Unconventional treatment approaches such as private clinics, complimentary therapies and experiential therapies claim to have high success rates. Yet, these claims are inconclusive as they have not yet been empirically tested. As long as they are not covered under the Canada Health Act and remain unaffordable to many consumers, empirical testing will not likely be forthcoming. Support groups and self-help groups for both individuals and families are a welcome addition to treatment when available, but alone they cannot actually represent an individual's entire treatment plan.

Nurses play an integral role in an individual's experience of a conventional treatment approach as they spend more time with an individual than does anyone from any other health discipline. Yet, many nursing approaches are orchestrated by the ideologies and treatments devised by other disciplines. Further, research to evaluate the effectiveness of nursing interventions is virtually non-existent and governing ideologies go unchecked. All aspects of treatment are under scrutiny by consumers for it is they who suffer the lengthy process of undergoing ineffective conventional treatments.
Findings from this study revealed that there are many obstacles diminishing the quality of the treatment experience and limiting recovery of those suffering from AN. These include gaps in the system, perspectives and behaviors of practitioners within the system, and the medicalization of what perhaps should be considered a social/psychological phenomenon.

Gaps in the system led to a discontinuity of services and limited resources for treatment. The result was that informants had difficulty in accessing treatments especially those that specialized in eating disorders, were community-based, offered crisis intervention and were covered under the Canada Health Care Act. Sustaining treatments that were similar across treatment settings also proved to be difficult for informants.

Findings also indicated that the quality of the treatment experience was contingent upon the setting in which individuals were treated. Settings for treatment included emergency wards, eating-disorders wards, medical and general psychiatric wards, provincial psychiatric institutions, and community-based treatment programs. A number of limitations existed within each of these settings. Limitations of hospital-based settings included emergency services being ill-equipped to handle women with an AN crisis; medical and general psychiatric wards and provincial psychiatric
institutions lacking practitioners who had expertise in AN; and eating-disorder wards that maintained a quantifiable focus rather than one broader, more flexible with diversified alternatives. Overall, all settings within the hospital milieu were perceived as artificial and unrealistic.

Limitations of community-based services included programs that terminated before recovery was achieved; programs that were understaffed with mammoth waiting lists; a lack of emphasis placed on the inclusion of significant others within the treatments; and a lack of continuity from the hospital to the community.

Another obstacle diminishing the quality of the treatment experience and limiting recovery was the ideological perspectives and behaviors of practitioners within the conventional health care system. Practitioners were perceived as rigidly adhering to three ideological perspectives that focused on medical, quantifiable and behavioral approaches to treatment. Thus, recovery was judged in terms of weight gain. The result was short-term successes, repeat admissions, and resignation on the part of the informants.

Practitioners were categorized as expert or orthodox depending on the verbal and nonverbal behaviors that they displayed. Most practitioners providing treatment were orthodox in that they were either indifferent or authoritarian in their approach to treatment. They tended to
exhibit a split in ideological perspectives and utilize a dichotomous approach to treatment where informants were exposed to extremes, either being over-controlled or being abandoned. Conversely, expert practitioners were those who had knowledge and clinical experience with AN and above all else conveyed empathy to informants. Such practitioners were able to provide informants with the hope they needed to imagine a normal life.

According to the five informants, another obstacle diminishing the quality of the treatment experience and limiting recovery was medicalizing what may be a social/psychological phenomenon. This has resulted in the dependency of informants on a medical modality over one more comprehensive, while excluding crucial aspects of treatment. Being medicated, refed, weighed and isolated all resulted in dependency upon the system. Informants report not learning to cope with their AN. Because great emphasis on medical approaches eclipsed attention on other aspects of the informants' well-being, family and peers were often left out of the treatment regime.

The findings seem to support what consumers and advocates of AN have been saying for years. That is, conventional treatments are inadequate. With all the negativity surrounding conventional treatments it is a wonder that consumers continue to access and support conventional
treatments. Findings showed that the demand for conventional treatments exists because alternatives are limited if not unobtainable. Specifically, unconventional treatments such as experiential therapies, complimentary therapies and private clinics have not been empirically evaluated. As a result, they are shrouded in suspicion and viewed with skepticism. Further, they are generally not covered under the Canada Health Care Act and therefore not affordable to many informants. However, a major reason why consumers continue to access conventional treatments is that expert practitioners (though few) have relentlessly invested themselves in an informant's recovery and this has sustained the hope, faith and confidence that informants have in conventional treatments.

Conclusions

Findings in this study support the following conclusions:

1. Conventional treatments may not meet the needs of consumers.

2. Many treatments for AN tend to reflect a medical modality.

3. Conventional treatments include some elements that may be counter-productive to recovery from AN.

4. Conventional treatments may exclude some elements that facilitate recovery for some or all individuals.

5. The need to establish recovery within a quantifiable context may be contingent upon the severity of the AN.
6. Treatment philosophies may be inconsistent and poorly coordinated within and between settings.

7. Women with AN believe that the behaviors and ideologies practitioners possess are critical to the success of treatment programs.

8. This study reiterates claims made by consumers and advocates of AN that conventional treatments alone are ineffective.

9. The demand for conventional treatments persists possibly because of the eternal hope these treatments symbolize.

10. The views of recipients for treatment of AN are invaluable in understanding the implications of conventional treatments.

**Implications**

The ten conclusions gathered from the findings carry significant implications for nursing research, practice, education, and social policy.

**Nursing Research**

There are numerous fundamental areas in which nursing research in the treatment of AN must be conducted. First, qualitative research studies must be undertaken to enable consumers of care to have a voice. Second, studying the implications of medicalizing what perhaps is a social/psychological phenomenon is necessary. Third, establishing the implications of the settings within which
treatment takes place must be documented. Fourth, exploring the therapeutic benefits of certain ideologies and behaviors that practitioners possess must be studied. Finally, the debate concerning the criteria for recovery of AN must be resolved.

Most research continues to embody only measurable, objective, anecdotal or descriptive data from the researcher's prospective and to exclude the subjects' perspective. Recently, experts have been discovering the value of including the perspective of the subject(s) into research studies. Only when we begin to hear personal anecdotes regarding the experience of treatment for AN will we be able to effectively evaluate what facilitates recovery (revealed by population trends) and why certain approaches do not work.

The literature on how AN should best be treated reveals a tendency toward medical treatments for AN. Thus, the following implications of medicalizing treatment for AN must be researched: 1) determining the benefit of weighing practices to recovery and whether such practices are counter-productive to treatment in terms of increased preoccupation with weight gain; 2) examining the worth and consequences of using the threat of being discharged from a program and implementing such a threat as a means to securing compliance of weight gain; 3) ascertaining whether a certain amount of
weight should be obtained before psychotherapy is warranted; 4) determining whether cumulative hospitalizations increase the dependency on pharmacological therapy, tube feedings, and supervised compliance with treatment; 5) exploring the psychological trauma of rapid refeedings and the long-term efficacy; 6) exploring whether short-term admissions into hospital settings for rapid refeedings correlate with suicide rates or recidivism rates as Freeman & Newton (1992) speculate; 7) conducting a literature review of the benefits of pharmacological therapy for long-term efficacy; and 8) determining the long-term efficacy of isolating individuals with AN either covertly or overtly.

Determining whether such medicalization eclipses other less conventional treatments which may better contribute to the physical and psychological well-being of the individual with AN is warranted. For example, comparing the long-term efficacy of using unconventional treatments such as experiential therapies and complimentary therapies to pharmacological therapy, behavioral modification therapy and traditional psychotherapies.

Given that treatment philosophies may be inconsistent and poorly coordinated within and between settings, evaluation of patient outcomes is necessary to improve coordination and consistency among services. Further, as trends in health care continue towards deinstitutionalization, determining the long
term efficacy of deinstitutionalizing AN completely and providing treatment in community-based programs is necessary. In addition, exploring the long-term efficacy of being treated in settings that do not have expert practitioners including medical wards, general psychiatric wards, and provincial psychiatric institutions is warranted to determine the necessity for expertise in such settings.

Research must be conducted to evaluate the negative or positive influences of those practitioners who are perceived as experts from those practitioners who are not. Also, double-blind controlled studies of long-term outcomes of those individuals who receive treatment from expert practitioners with those individuals who do not should be conducted. An explanation is required for the discrepancy in the nursing literature with that found in this study that orthodox practitioners instigate power struggles while nurses claim that power struggles exist between nurses and patients because of the manipulative personalities of the patients. Further, double-blind controlled studies are needed to measure the efficacy of empathy versus the lack of empathy in treatment. Given that splitting behaviors do exist among and between disciplines, research should be undertaken to determine if such behaviors mimic the dysfunctional characteristics of so called anorectic families described in the literature as predisposing factors to AN. We also need to
establish the extent to which practitioners treat a patient within the context of their own needs as opposed to fitting the patients into their own frameworks.

The etiology of AN remains unknown. Practitioners of all disciplines are only able to hypothesize why more women than men are afflicted with the condition. Such hypotheses tend to influence the types of treatments. Conducting a secondary analysis solidifying the study conducted by Keys, Brozek, Henschel, Mickelsen & Taylor, (1950) revealing that physical and psychological symptoms of AN are secondary to AN may contribute to a greater understanding of the social/psychological basis of the phenomenon. Further, determining why more women than men have AN could provide direction for treatment that focuses on the specific needs of women. Before empirical evaluations of any treatments can begin, establishing criteria for recovery must be conclusive in order to have a basis for establishing effective and ineffective treatments.

Nursing Practice

A revisit to the nursing literature indicates that nurses are cognizant of many of the concerns voiced by informants in the study. Conversely, the consumer literature and findings in this study show that most nurses treating women with AN do not grasp the implications of nurses relying only on conventional approaches to treatment. This study provides
nurses with the ability to improve the direction of nursing care by increasing our knowledge about the treatment experience for AN. Further, perhaps findings from this study will encourage nurses to develop and articulate their own holistic stance toward the treatment of AN.

The findings of this study revealed that programs of limited duration were not effective especially when they focused too much on weight gain. As well, the waiting that resulted from a lack of continuity of services produced anxiety that was counter-productive to treatment. Further, the lack of avenues to seek help in times of crisis meant that informants either suffered in silence or accentuated the severity of their condition, therefore requiring emergency services.

For too long nurses have relied only on conventional approaches to the treatment of AN often without truly understanding the implications for informants. Nurses have been taught to maintain a firm yet supportive alliance with a client due to the reputation of clients being manipulative. They have relied on the administration of medications rather than relaxation techniques to promote compliance with refeeding resulting in the inability of women to learn to eat and cope for themselves. Nurses have added to the obsessions and compulsions of those with AN by obtaining daily weights, counting calories and supervising meals. Further, they have
restrained clients in emergency wards and medical wards without exploring the context within which the restraints were thought to be needed. In addition, nurses have provided treatment to clients on generalist wards without fulfilling their professional obligation to keep current and updated regarding eating disorders. They have threatened and discharged clients from programs because of insufficient weight gain without considering the hopelessness and futility that this brings to informants. Nurses have assumed that a client has chronic AN when she cannot be cured by conventional treatments, rather than considering that the specific treatments may not be right for the individual. Moreover, they have neglected to include in treatment the family, peers and significant others of clients. Finally, nurses have often only paid lip-service to the concepts of empathy and hope since according to findings they are often unable to truly understand the client with AN. Their actions do not reflect their empathetic philosophies. It can be argued that nurses are merely carrying out the physician's orders. However, a great deal of the nursing literature espouses most of the conventional treatments perceived to be ineffective by informants. Thus, although some nurse scholars and practitioners have articulated the need for a more comprehensive approach to AN, nurses are not actually
practicing or providing the quality of interventions espoused by the literature.

Nurse scholars have written about the contextual aspects of nursing care and described the importance of providing individualized care to patients and building a therapeutic alliance that includes knowledge of the condition, effective patient teaching, and establishing a nurse-patient rapport (Lyall, 1991; McNamara, 1982; Muscari, 1988). However, informants claimed that their individual needs were often not met and that few practitioners that they encountered provided expert or individualized treatment.

Nurses must become both knowledgeable about how to provide individualized care and experienced at practicing this way. Contributing factors such as age, past history of sexual abuse, being overweight as a child, and religious orientation need to be addressed, and areas of specific concern such as the needs of bingers versus the needs of restrictors must be explained. Those providing psychotherapeutic treatments must also provide adequate documentation, and a decision trail so that others can learn from the most successful of interventions and contribute to continuity for each client.

Findings suggest that therapeutic nursing interventions ought to include active, explicit and consistent guidance, direction, support, and explanations for family members and
significant others within the treatment approach. Moreover, a more active role must be described for significant others of adult clients. It appears that families are included in the treatments of their children and adolescents, but that husbands, partners, friends and relatives are not told how they might aid in the treatments of their loved ones who are adults. Further, nursing interventions must be extended to those involved with the AN sufferer in the forms of therapy, support groups and education. Nurses in practice must begin to explicitly include the family, significant others and friends within the treatment regime in order to provide holistic care. In addition, the value of peer support must be explicitly studied and then endorsed if it is found to have merit. Nurses must also work to foster an appropriate level of empathy. Finally, they must maintain competency in their practice and promote and facilitate the autonomy of their clients.

Nurses caring for women with AN must be sensitive to the importance of establishing and maintaining a collegial work environment. His or her behavior towards colleagues, other disciplines and especially clients is ascribed meaning by individuals with AN. All levels of nursing must devise a comprehensive, consistent plan of care that is endorsed by all other levels of the multidisciplinary team. Nurses cannot function as a cohesive unit if there are divisions amongst
disciplines. Findings indicate that practitioners undermine each other's approaches resulting in counter-productive care. Nurses in the hospital and the community must work jointly to ensure that consistency and continuity is achieved across environments. Ultimately, better coordination and consistency within and between disciplines, programs and settings will allow each member of the health care team to offer a woman with AN individualized care that is aimed at recovery, not just weight gain and basic survival.

Leadership in all areas of nursing ought to challenge existing programs and demand societal responses. In order for the goals of appropriate and effective care to be accomplished, the specific nursing leadership concerns should include hospital-based and community-based initiatives.

Hospital-based initiatives include the feasibility of increasing nurse-to-patient staffing ratios so that nurses can spend quality time with clients and assess for and provide therapeutic interventions. Findings of this study and others are that hospital nurses are too busy to spend quality time with patients who have AN and that nurses in the community settings alone offered uninterrupted and effective attention to individual problems although they are understaffed. In addition, the extensions of the length and duration of all treatment programs must be reviewed. A system to ensure the continuity of services is needed so that
counter-productive waiting periods are avoided. For the present time, it is inevitable that women with AN will continue to be admitted to 'generalist' wards. Nurses in medical wards, general psychiatric wards, and provincial psychiatric institutions are often not knowledgeable about the treatment of eating-disorders in these areas and as a result the quality of care is often impeded. Such nurses must be offered ongoing inservice education programs about the importance of conveying earnest, genuine and empathetic behaviors to patients with AN. Further, they must receive regular inservices that heighten their knowledge base about AN. Finally, only those nurses who are receptive to caring for individuals with AN on such generalist wards should be assigned to them as more harm can be done if orthodox or nurses lacking in knowledge, experience and empathy are assigned to individuals with AN.

Community-based initiatives for improved efficacy of treatments include increasing the availability of support groups for significant others as well as implementing crisis intervention services as part of all treatment centers. Further, little is written about formalized awareness campaigns for school children, adolescents or adults (Chitty, 1991). While school programs exist which are designed to prevent AN, they are rare and inadequate. It appears that less than 10% of all school children receive indepth
education about eating disorders and the prevention of them. Thus, more resources with enhanced coordination amongst disciplines and settings having greater variety of treatment available to individuals is required.

Practitioners should be receptive to exploring new avenues of treatments such as private clinics, experiential therapies and complimentary therapies as an adjunct to conventional treatments. An interest must be taken in evaluating them and determining which can be applied in more conventional settings. Nurses must find alternatives to pharmacological therapies as a means of aiding clients in coping with AN. Perhaps nursing interests in such modalities as therapeutic touch can be encouraged through leadership vis-à-vis exploring and developing holistic programs of AN. Attitudes receptive to unconventional treatments being proposed and offered will only prevail with the support of leaders who are committed to exploring and testing such avenues at all levels within organizations.

Walsh (1995) insists, "we need to make [AN] a public health issue so people are aware of the treatment. We also need to invest the resources in studying these eating disorders, which continue to plague the lives of too many people" (p. 8). But such statements are sadly only that — statements. Nurse must take a more active role in providing health promotion and prevention programs to all sectors of
society. Thus, practitioners and leaders alike will only become cognizant of the need for individuals with AN to receive new or revised alternatives when they appreciate problems associated with the more common conventional alternatives.

**Nursing Education**

If a dramatic change in treatment for AN is to become a reality, it must include nursing education at the forefront. The profession must begin to teach prospective nurses to be open to different approaches to interventions depending on the needs of consumers. Professors must focus on designing curricula that include threads of hope and empathy throughout, as well as specific content on these topics. Generally, nursing education is rife with examples of the importance of empathy (Benner, 1984; Bevis & Watson, 1989); scholars write about how important it is to model empathy as a professor (Diekelemann, 1990). Yet, these concepts are often not explicitly and implicitly taught within the curriculum. Nor are they often practiced, understood or evaluated — by teachers toward students, between nurses and clients, and between students and clients. It is no longer enough to pay lip-service to these concepts or simply role model them. Nurse educators ought to teach students to understand the implications of exploring the concepts of hope and empathy. Nurses must describe, explore and analyze the
concepts of hope and empathy in order to gain an understanding of what these concepts mean, what meaning they have to the woman with AN and what meaning is ascribed to them by significant others.

It is not enough to simply provide content on the importance of the inclusion of the family and significant others. Such areas ought to be included as threads in the curriculum so that prospective nurses are able to view the patient within the context of her world and design care based on this view. Given that few nurses as yet have the knowledge and skills necessary to provide care for families-as-clients, this requires on-going basic and continuing education and supervised practice. Likewise, health prevention and promotion foci must be included as threads so that prospective nurses are able to provide such care to family, friends and significant others while providing tertiary care to the individual with AN. Further, complimentary and experiential therapies should be part of the nursing content in order to increase the number of interventions at a nurse's disposal.

No discrete nursing models exist for AN. All are associated with or dependent on conventional treatment approaches. For new models to exist, new theories must be developed, perhaps a process which could be fostered at a graduate level. In 1988, Geary petitioned for a holistic
nursing model to caring for clients with AN. Today, there is still no discrete model for practice. Nursing education ought to facilitate and support students first to determine explicitly the value and function of nursing's role in the treatment of AN and then to undertake theory design, implementation and evaluation toward improving the quality of nursing interventions and enhancing recovery.

Finally, nursing education must focus on the importance of becoming active within nursing associations and at all levels of government. Only there will we obtain enough lobbying power to support changes and gain public support for AN programs. Again, it is not enough to simply teach such content; students must get acquainted with the process of lobbying through participation. Nurses must learn how to access and increase resources in the system and discover where they will be best used toward long-term recovery.

Social Policy

Huge expenditures in conventional health care treatments have prompted economists to state that additional expenditures would not necessarily result in improved health status but only additional expenditures (Decter, 1994). A lack of coordination among general psychiatric wards, provincial psychiatric institutions and community mental health programs has emerged as a major impediment to service planning and delivery in Canada (Wasylkeni, Goering &
Macnaughton, 1994). This is certainly reflected in the findings of this study.

The incidence of AN continues to climb despite present treatments. Unless treatments change and produce more effective results, additional expenses will indeed be wasted. Rather than expanding present conventional trends, additional resources should be sought for newer more appropriate treatments. Funding for research must be found to enable those in power to separate the treatments that are cost-effective but geared toward only short-term gains from those that are cost-effective and geared toward long-term recovery. Areas needing close examination for their relevance to quality of care and effectiveness of recovery include medical treatments, treatments at private clinics, complimentary therapies, and experiential therapies. Only when this is done can experts, consumers, and leaders make informed decisions about what should be available, what should be funded, and what should be covered under the Canada Health Act; only then can preventative, tertiary, and chronic care programs expect public support and government funding. There is no sense in opening up more beds in a medical ward or training more experts under a medical modality when medical measures do not work. Instead the priority must be to fund studies which demonstrate what does work in a cost-effective manner.

The emphasis on the design and implementation of
prevention programs must be considered in all areas of practice. Although many practitioners acknowledge the sociocultural factors predisposing women to AN, they do little to discover what might be done at this same level to reduce the prevalence of the condition (Freeman & Newton, 1992; Woodside, 1995).

It is difficult to cope with, heal and prevent AN in a society that values thinness. Still, little has been done to initiate a societal campaign to end AN. Unlike the awareness enjoyed by campaigns for cancer prevention and safe sex, issues regarding AN have yet to gain public attention. More and more articles are beginning to appear in magazines creating an awareness of AN but they are slow in coming (Brody, 1995). Their prevalence cannot compare to mainstream preventative programs like those for stopping smoking. Campaigns to stop AN do not exist; there are no ribbons representing those who have suffered and died from AN. Yet, the number of fatalities from this condition grows each year. Findings indicate that none of the informants knew what AN was until they had full-blown AN and were diagnosed by their general practitioners. None could remember receiving any type of preventative program in primary or secondary school. All believed that if programs had existed earlier in their lives, they might have prevented their AN or at least encouraged them to obtain help at an earlier stage of their condition.
Thus, the individual with AN, who has been exposed to the numerous treatments available may experience so much discouragement regarding her recovery that recovery will be beyond her expectations. Only with a health care system dedicated to her recovery will she support that dedication by her own efforts.

A Final Thought

The Canadian identity is strongly linked to Canada's health care system and the notion of a "universal entitlement" to medical attention (Bachrach, 1994, p. 4). With so much of our concern on the costs of such entitlement, the suitability of various types of medical approaches based on an exploration of their benefits should come into question with regard to the treatment of AN. Long-term gains can be made toward recovery from AN with increased research, heightened public awareness and administrative support. Thus, hope for those who have AN can be renewed.

The intent of this study then, was to describe the conventional treatment experience that women with AN undergo. The basis for this study included extensive consumer literature and scholarly literature that indicated that the present treatments were not working. The purpose of the study was to gain a greater understanding of the treatment experience for AN in order to improve the nursing care that women receive.
Findings from the study revealed that for too long nurses have relied on conventional treatments for AN without truly understanding the implications of such treatments. Women with AN are searching for expert practitioners in effectual treatment settings. Nurses can be those expert practitioners. Their unique role is caring — and more specifically caring for the whole person. Nurses are also in the unique position to listen to women with AN and understand the frustration, sense of futility and hopelessness that conventional treatments foster within these women. Given this knowledge base, it is the moral obligation of nurses to agitate for change in the treatment that women with AN currently receive.
REFERENCES


Vandereycken, W., & Van Deth, R. (1989). Who was the first to describe anorexia nervosa: Gull or Lasègue? *Psychological Medicine, 19*, 837-845.


APPENDIX A: DSM IV CRITERIA: 307.1 ANOREXIA NERVOSA

A. Refusal to maintain body weight over a minimal normal weight for age and height, e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected.

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

C. Disturbance in the way in which one's body shape is experienced; undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

D. In post-menarchal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen administration.)

Specify type:

Restricting type: During episode of Anorexia nervosa, the person does not regularly engage in binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives or diuretics)

Binge Eating/Purging type: During the episode of Anorexia Nervosa, the person regularly engages in binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives or diuretics)
APPENDIX B: OVER-EATERS ANONYMOUS (12 STEPS)

1. Admitted we were powerless over food—that our lives had become unmanageable.

2. Came to believe that a power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all the defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and, when we were wrong, promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to compulsive overeaters and to practice these principles in all our affairs.
April 25, 1995

Dear Informant:

My name is xxxxx xxxx. I am a Registered Nurse who is enrolled in the Graduate Program, Department of Nursing at the University of British Columbia. My Master's thesis is a study of how women describe their treatment experience for Anorexia Nervosa.

I became interested in this topic when I discovered that a good friend of mine had Anorexia Nervosa. I had many long conversations with her and gained new insight and understanding into the experiences that she had while treated for Anorexia Nervosa. My curiosity was heightened when I discussed with several nurses their opinions and beliefs in caring for women with Anorexia Nervosa. They expressed sadness and regret for not entirely understanding the experiences of women who are treated for Anorexia Nervosa. This lead me to the idea of learning from women with Anorexia Nervosa about their treatment experiences first hand. It is my hope that this knowledge will assist nurses to provide improved nursing care for women who are treated for Anorexia Nervosa.

This letter is to ask if you are willing to participate in this study. I would like to talk with approximately 5 women who presently have or have had Anorexia Nervosa, have been treated for Anorexia Nervosa at least once, and who are not hospitalized at the present time. Your involvement in this study will include meeting me in your home or a setting which is convenient to you. Our conversation will last approximately one hour. In addition, you will be asked to supply me with your telephone number so that I may contact you and possibly meet with you again in order to verify my interpretations of our conversation. With your permission, our conversation will be tape-recorded, but you will have the right at any point to request that the tape be turned off or that a portion of the tape be erased.
Confidentiality will be maintained by coding your name so that your identity is known only to myself. Your name and any other identifying information will not be used in the study or in any future publications of the findings. The tape recordings and transcripts will be destroyed upon completion of the study.

You are not obliged to participate in this study. Refusal to do so will not jeopardize any care, treatment or therapy that you may presently be receiving. Similarly, you may refuse to answer any questions during our conversation or withdraw from the study at any time. You can give only information that you wish me to know, or choose not to give any information at any time. There will be a $20.00 honorarium to show my appreciation, which you will receive before our tape-recorded conversation begins.

If you are interested in participating in this study, or would like more information prior to making your decision, please feel free to call me at 000-0000. My supervisor is xxxxx xxxx R.N., Ph.D. She can be reached at the School of Nursing, University of British Columbia, xxx-xxxx.

Sincerely,

xxxxx xxxx R.N., B.S.N.
Graduate Student
University of British Columbia
APPENDIX D: INFORMANT CONSENT FORM

How Do Women Describe The Conventional Treatment Experience for Anorexia Nervosa: A Thematic Descriptive Study.

THIS IS TO CERTIFY THAT I, ...........................................
(print name)

am giving my consent to meet and talk with xx xxxx, a graduate nursing student at the University of British Columbia. I understand that she is interested in studying my treatment experience for Anorexia Nervosa. I am aware that this study may provide increased understanding and awareness to nurses who care for women with Anorexia Nervosa.

I understand that agreeing to participate in this study involves meeting and talking with Janet Emes about my treatment experience for Anorexia Nervosa. I understand that our conversation will be tape-recorded in a setting which is convenient for me. The tape-recorded conversation will last approximately one hour in duration. The conversation will be transcribed into written form. I understand that at the completion of the study, the tapes will be destroyed and that my name will not be associated with any published or unpublished material. My identity will be known only to x x xxxx because she will numerically code the information that I provide when she transcribes the tape-recording.

I understand and agree that my involvement will require submitting my telephone number to x x xxxx and possibly meeting with her at a future date in order to validate her interpretations of the conversation that we have. I am informed and understand that I am under no obligation to participate in this study and that I am free to withdraw from the study at any time. I am informed and understand that I may refuse to answer any questions, remain silent, or leave the conversation at any time, and refuse any telephone calls or future meetings. I understand that refusal to participate in this study will not jeopardize any care, treatment or therapy that I may presently be receiving.
I understand that potential benefits directly to myself are limited to contributing nursing knowledge and to communicating my experience of being treated for Anorexia Nervosa. I understand that there are no risks involved in partaking in this study. I have been informed that I will receive a $20.00 honorarium before the tape-recorded interview begins in appreciation for participating in the study.

I understand that the results of this study will be made available to me if I request them from xxxx xxxx. I am informed that xxxx xxxx is the person to contact if I have any questions or concerns regarding my involvement in this study. xxxx xxxx can be reached at 000-0000. xxxx xxxx' supervisor to contact is xxxx xxxx R.N., Ph.D. at the School of Nursing, University of British Columbia at 000-0000.

I, the undersigned, understand the nature of xxxx xxxx' study. I give my written consent to participate as an informant in her study. I acknowledge receiving a copy of the consent form.

Date.......................................My Name..............................

My Telephone Number..................My Signature......................

Date.....................................Researcher Signature..........
APPENDIX E: INTERVIEW GUIDE

1. Could you please describe what life was like for you with Anorexia Nervosa before treatment?
2. Could you please describe the setting in which you received treatment?
3. I'm interested in what it is like to receive treatment for Anorexia Nervosa. Please describe what it is like for you to have been treated for Anorexia Nervosa?
4. Could you describe what sort of treatments you received?
5. How did you feel about the treatment(s)?

How is this interview going for you so far?

6. Did you feel that you were involved in the decision making of the treatment(s)? If yes, how? If no, why not?
7. Could you please describe your response to the treatment experience?
8. What sort of interactions did you have with the various nurses in the setting in which you received treatment?
9. Could you please describe what life was like for you with Anorexia Nervosa after treatment?
10. How do you think your experience with the treatment has affected you in general?
11. What aspect of your treatment experience would you have liked to change?
12. What aspects of the nursing care would you have liked to change?
13. What aspects of the nursing care did you find helpful?
14. What suggestions, if any, do you have for nurses or others who work with women who have Anorexia Nervosa?
15. What race, religion, type of Anorexia Nervosa (restrictor or binger/purger), educational level, sexual orientation and type of employment do you have?