A Journey Into Narrative Inquiry:
One Teacher's Lived Experience
With Eating Disorders

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Abstract

In “A Journey Into Narrative Inquiry: One Teacher’s Lived Experience With Eating Disorders,” an elementary teacher searches for answers regarding how education can help prevent eating disorders by journeying into her own experience of having had such a disorder. This qualitative study is a personal narrative based on an individual’s experience, a method appropriate to the sharing of personal voices and stories told in education research. It is an attempt to address the gap found in the research on this topic by offering a subjective and unique perspective of what it is like to live within the nightmare of an eating disorder and by sharing the wisdom gained from having survived such an experience.

This narrative inquiry explains how a teacher found herself at a stage where she was willing and ready to share her experience for the sake of research. The story of having had an eating disorder, consisting of both anorexia and bulimia, for over a decade is shared in a genuine, reflective manner. The researcher then shares the analysis of her own story, unpacking the themes of journeying toward voice, self-esteem, self-acceptance, and self and the completion of an M.Ed. degree. Bridges are made which connect these themes to the personal and professional life of the researcher, to the schools in terms of both curriculum and climate, to research directions, and to the larger culture. Suggestions are made for possible changes in educational settings that may help teachers in providing students with some tools and strategies to prevent turning to eating disorders as coping mechanisms. A literature review of eating disorders is included as well, as a guide for others to use when undertaking such qualitative studies.
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INTRODUCTION

Women will starve in silence until new stories are created which confer on them the power of naming themselves.

Sandra Gilbert and Susan Gubar
(Heilbrun, 1988, p. 33)

My story. With this tentative yet powerful phrase I started my research journey. I wish to begin with how I ended up here at this place. At this time, I am ready to share my education journey. The study I undertook as part of completing my Master’s of Education degree at Brock University was a qualitative one, a narrative inquiry about my own experiences, both professionally and personally. Professionally, I am a teacher and personally, I am someone who has experienced first hand what it is like to live within the nightmare of eating disorders. I was unable to separate these strands of who I was in order to complete a research project, nor did I want to. Although my voice is an exploratory one, throughout this thesis I stress the journey over the final destination (always an important facet in my real life travels) and hope to offer you, as a reader, the opportunity for further conversations rather than undebatable conclusions.

My personal experiences provided the incentive for me to begin researching the topic of eating disorders and how they related to education. I had already read a plethora of literature on both anorexia and bulimia but wanted to substantiate my understanding with knowledge from studies conducted by ‘experts’ on the subject. A complete Definition of Terms is included in Appendix A. I had the desire to answer many personal questions such as: What causes eating disorders and what in particular caused mine?
What programs existed in terms of possible prevention, and intervention and could I develop such a program? What role does education play in helping to either perpetuate or lessen the extent of the problems? How could I help as a teacher? and How could I share my story so that others could learn from my experience? What I most wanted to discover was how I could make a difference for my students who might be at risk and prevent them from living through the horror of an eating disorder.

What occurred as I progressed through my Master’s journey was that I felt myself becoming more and more distanced from the topic. Although I could not have verbalized the problem at the time, I found myself quantifying what interested me and of course, as I quantified the experience (Conle, 2000), the richness of personal expression was stripped away. My writing during the first attempt at a proposal was mechanical, objectivist, impersonal, and clinical. This writing was entirely at odds with the way in which I needed to write. My shift in both thinking and understanding began after a meeting about that first proposal. I found myself turning toward a different perspective about the possibilities I could explore. I discovered that it was not necessary to reiterate what the expert/scientific/authoritative community wrote about the topic of eating disorders that interested me. Rather, I began embracing the method of narrative inquiry as it gave me the scope to write using a personal/insider account. I became present in my own research and the process started to feel right, that it fit who I was.

It was the respected John Dewey (1938) that coined lived experience as a personal passage that connects others through time and space. This simple statement underlies the reason why I chose a narrative inquiry for my research and came to embrace a qualitative method that was best suited to my research needs. I wished to write about
what is entailed in experiencing the experience. Clandinin and Connelly (1994) wrote about how people learn about education from thinking about lives and vice versa. It is impossible to separate the personal and professional strands. In further writing by these two pioneers in narrative inquiry (1995), they outlined how to reconstruct one’s history as a way of understanding and how I would relive and retell my own stories, leading to personal practical knowledge. In this way, I felt I would best be able educate both myself and others. This quest, a balance between living and analyzing (Conle, 2000), became important as my lived road and my academic road merged to become one path of learning. It was both challenging and rewarding to travel down this new path. Like an archaeologist, I needed to put together past experiences that lay nestled within me alongside my understanding of all that I had read. This type of research is highly unique since only I could tell my story, only I that could choose the thread to connect all the pieces and only I can invite you as a reader to come along on the journey.
POSITIONING

I was looking outside myself for strength and confidence but it comes from within. It was there all the time.
Anna Freud
(Anderson, 1997, p. 81)

It is important in the sharing of my story that I help others understand where I am now situated in both my professional research and my personal life. I am a person who has recovered from an eating disorder, and because of this life experience I found myself interested in any research that could relate to the prevention of such struggles in others. I am also a teacher, currently of grade 8, and due to my professional involvement I was naturally drawn toward research that focused on an educational role in the possible prevention of eating disorders. One focus of my studies in the completion of Master's courses at Brock had been such a role. I have worked on projects involving curriculum development in the area of eating disorders, conducted literature reviews on the subject of eating disorders, researched grade three girls' knowledge and understanding of body image and eating disorders and completed an independent course on the sociocultural determent relating to the development of eating disorders. Personally, I have been involved in our local teachers' federation's Status of Women committee and have been responsible for helping to bring speakers to our area who dealt with topics such as body image, media awareness, and eating disorders. I am presently on a Provincial Federation committee that has a mandate to develop a program to address the problem of eating disorders in public classrooms in Ontario.
I explain these areas of professional and personal interest because it is an important facet in who I am as a Master’s student embarking on thesis writing. I came to the topic of eating disorders with a different perspective than other researchers because of my personal experience. I have a personal story to tell, and that story helps to explain my biases and beliefs toward the topic that I am investigating. My narrative inquiry is unique because it is my own narrative I am sharing. Up until I began this journey, my internal conditions of experience (Clandinin and Connelly, 1994) tended not to play an important role in my research. As Clandinin and Connelly point out, I had often been consciously silenced through more conventional research. "Personal experience methods recognize both voice and signature" (Clandinin & Connelly, 2000, p. 147). This statement resonated with me as who I am made a huge difference in all levels of my research and it was of fundamental importance that my voice come out of my work.

After researching the subject of eating disorders for both personal gain and educational advancement, I often found myself overwhelmed with new questions. After any thorough examination of the literature available on any given topic, it is critical to reflect upon the knowledge presented to generate and identify such questions and possible gaps in the knowledge available. From my information gathering, it certainly appeared that over the last twenty-five years there had been an extensive amount of literature generated about the topic of eating disorders. This literature encompassed many topics such as: What behaviour constitutes eating disorders, who develops eating disorders, why individuals develop such conditions and how to possible prevent and intervene with such disorders. More recently, I would speculate in the last 15 years, there had been an increase in literature that examined how schools could specifically have a
role in both prevention and intervention, as well as some studies that had tested specific programs that were developed for such a purpose.

This literature had played a tremendously powerful role in shaping my own understanding about why I had developed an eating disorder, my behaviour in coping with the problems associated with such a disorder, and my understanding of how prevention could be possible for others, specifically students. However, I did believe that there was a significant gap in the research on eating disorders. So many of our young people, particularly females, seemed to be experiencing eating disorders or developing behaviours that could possible lead to such difficulties. I questioned why the literature seldom included their voices, their ideas, or their experiences. Much of the research I had read was written by experts who, at best, could be classified as outsiders as opposed to insiders sharing their own experiences. I believed that the research community would be better served through a balance of both perspectives. There needed to be some subjectivity to lend authenticity and further insight to such stories. I also wondered why it was so difficult to find any research about teachers as they struggled in their classrooms with students who were experiencing such difficulties first hand. I began to recognize how crucial it was to have access to more qualitative, narrative studies on the subject of eating disorders, especially in light of the fact that each case is unique and individual. Missing from the multitude of self-report measures and educational studies was examinations of how young students experienced, understood and articulated their weight reduction practices, as well as how their educators assisted or hindered them with their daily struggles and recovery processes.
Mired in such quandaries, I began my thesis journey. I found myself frustrated by the lack of answers and the objective nature of analysis that did not directly relate to my own experiences, needs and inquiries. As an intermediate level classroom teacher, I wanted research that could best help me deal with the realities in my classroom. As a person recovered from eating disorders, I needed research that reflected who I was and validated what I had experienced. I wanted to understand the logistics for truly assisting my students who might be at risk or who could already be exhibiting disordered behaviour. I needed to understand the barriers and the limitations to the amount of help I could offer. I often wondered if it was even possible to prevent such problems effectively. As I pondered these many thoughts and questions, I started to think about what path my own personal research might take. What I really wanted to do was make a difference in the lives of others.

The beginning of my thesis journey began at a time when my previously overwhelming personal difficulties had started to heal. This healing process had allowed for deeper meaning and wider issues to become illuminated as I worked towards developing a topic for my thesis. I had hope because of my own healing process and I wished to pass on this hope to others by building something useful. Simply put, I wanted to make a difference while studying and researching the topic of eating disorders. I wanted to prevent others from developing eating disorders. I realized it was an impossible goal for one research paper, but it was a dream. Nevertheless, I found myself at the stage of writing a research proposal with quite a broad topic. The dilemma quickly reared its evil head as I attempted to narrow down such a broad topic.
It was during this time of questioning and planning around my thesis that I was changing both schools and grade levels. After having taught for 7 years in the primary and junior divisions at a school in a large town, I had transferred to a rural school and a grade 7 classroom was excited about the challenge and rewards of such a change. I believed that students in grade 7 and 8 are often misunderstood, and I felt I was at the crossroads in my career where I was challenged to impact my students’ lives through the development of a positive community and relationship building. I was eagerly trying out my beliefs about interacting with intermediate students that were supported by literature written by researchers such as Carol Gilligan (1982) and Andy Hargraves (1994). Such authors stressed community building, the importance of a positive classroom climate, and the need for strong relationships between students and teachers.

In the fall of 1999, I was to begin teaching for my second year at the “new” school. I had been procrastinating with my thesis proposal for almost a year due to my inability to find a real focus that felt suitable. In August of that year, I learned that I had a young woman named “Alicia” on my class list who would be unable to start school as usual on the first day in September due to the fact that she had recently been hospitalized with anorexia nervosa. Of course, I was quite concerned and offered to do anything that I could to help her and her family through this situation. I had taught the younger brother in this family at my previous school and had a solid relationship with the family. I remember I was shocked that I actually had a student with an eating disorder in my own classroom. I had suspected others over the course of my teaching career but had not had any verified. Even with the knowledge of the statistics that it was likely I would have at
least two of three girls with eating disorders in my class, I was still surprised by the fact that this student was in my room.

The first couple of months in the school year passed in the usual whirlwind. I was communicating with Alicia’s mother on a regular basis and had been putting together packages of work to send to Sick Children’s Hospital where Alicia was a patient. She had sent a couple of letters to the class that had been quite emotional for me to read as they took me on a disturbing trip down memory lane to the time when my own difficulties had arisen. Although I had never been hospitalized, there were thoughts in those letters that I remembered thinking, such as ‘I will be better in no time’ and ‘the doctors don’t know what they are talking about’. Our grade 7 class had had several in-depth conversations about the topic of eating disorders as well as the physical and emotional problems that Alicia was experiencing. I found myself quite upset by the whole experience as memories of my own ordeal came flooding back and I struggled to come to terms with having my first student with an officially diagnosed eating disorder. I also felt like a fraud as I was not sharing my own intimate knowledge about eating disorders with my students.

Around this time, I met with my thesis advisor, Dr. Sharon Abbey, to discuss the direction of my slow moving proposal. The idea of using Alicia as a case study was raised as we brainstormed possibilities. This thought was certainly a new one and fortunately (or unfortunately really) a real case study had landed in my lap, so to speak. I decided that this case had the possibility of giving me a real opportunity to share a genuine insider experience within the research field. At this point, I had yet to discover any literature that a teacher had written in a qualitative manner about such an experience
and I strongly felt that such writing had an important place alongside the very worthy quantitative literature that I was more familiar with.

Thus, I embarked on this new proposal idea. I submitted the necessary research proposal ethic forms, both to Brock University and to our local Board of Education. I obtained permission from both Alicia’s family and Alicia herself. I began to keep copious journal notes about the experience of having this student in my classroom with her eating disorder. The reading of many articles and books in the areas of both eating disorders and qualitative methodology around case studies helped broaden my perspective and aided me in starting to feel that my proposal was coming together.

However, I was experiencing a great deal of questioning and stress relating to the entire project. I was concerned about the ethical issue of using Alicia. I wondered if I was exploiting her primarily for my own academic gain. I found myself thinking that perhaps I was, but justifying this selfishness with my intrinsic interest in her as an individual as well as my paramount concern for her well being. I also found that I was not feeling involved enough in the whole writing process. I eventually came to recognize that I was feeling distanced from the topic. My intent originally had been to share Alicia’s story, but I was experiencing difficulty because I was not sure it was fair to allow my voice to speak for her voice. I was finding it a challenge to keep my own story and feelings separate from her story but felt it was necessary to do so for the sake of “unbiased” research. Because most of my previous academic experience had been more traditional (void of subjective input), I started to oversimplify how learning happens and what knowledge consists of (Hanrahan, Cooper & Burroughs-Large, 1999) because I forgot to include myself as part of the learning equation. I did not realize I could
intertwine the two voices and stories as valid research and attempted to keep Alicia’s story separate from my own thoughts, ideas and memories, even though I still wrote about myself personally but on different pages in my journal. I had assumed a linear, impersonal and individualistic process that started to result in my detachment toward my research. As Hanrahan et al. (1999) point out, the personal, cultural and historical context of the researcher needs to be accepted and reported as a legitimate part of the learning process and presented as part. The first person who had to accept such subjectivity was me.

As I had no prior experience interweaving the personal into my research, procrastination became a huge obstacle in the writing of my proposal. I had no motivation or desire to work on my writing. Being involved with many other professional and personal commitments allowed for me to continually push the proposal writing aside. As I fast-forward to the fall of 2000, I had transferred schools again, to a team teaching situation in grade 8 in a large town. I saw Alicia occasionally, but essentially my data gathering time with her had ended. She was well enough to avoid hospitalization but was still exhibiting disordered eating. I finally got down to the business of writing my proposal but was quite disturbed by my lack of connectedness with the whole writing process. I found myself following the guide that Brock University provided for the thesis proposal like a formula and, truthfully, my sole motivation was completion. I was extremely perturbed about the fact that I did not care about what I was writing because I was beginning to believe that my thesis would not be an endeavour that would make a difference to my life. What I wanted was what Clandinin and Connelly (1995) explain as a more meaningful way to navigate through the complex professional landscape.
Not until my meeting with my advisory team at Brock University, early in 2001, did I start to catch a glimpse of the reason for my disengagement with my own research. My proposal did not satisfy me, and I began to understand the contradictions that were contained in my writing. I was attempting to complete qualitative research using quantitative language and methods. It was like trying to open a bottle of wine with a screwdriver; I lacked the necessary tools. In fact, even the proposal guide I had been using was itself structured in a manner that better suited quantitative proposals. I had written my proposal in the only way I knew how to and was unable to make education or personal meaning of the project. Essentially, it did not work.

The discussion at the meeting itself was quite intriguing, and I found myself fascinated by the professors’ views about both the processes involved and the products constructed through various types of research. It seemed as if my project came at a time when Brock itself was dealing with some of the difficulties surrounding qualitative research and the changes necessary to support such alternate research models. It also seemed to me that the professors themselves all had different understandings about the possibilities and merits of qualitative research, and it was reassuring to recognize that they too, being much more educated than myself, still had quandaries about the issues surrounding qualitative research, such as how to verify that field research was authentic and what it was necessary to include in a proposal. They were still at a questioning stage themselves. There was much discussion around the specific methodology of narrative inquiry, and listening to each person’s perspective and comments made me question the entire intent of my proposal as well as wonder about the best process to use. I was filled with tension about both the positive and negative outcomes of this meeting.
I came away from this meeting feeling excited and infuriated. I spent a long time crying in my car at the disappointment at knowing I had to begin again if I was to feel happy with what I was to propose. I was thrilled that I was starting to see the possibility of breaking away from what I viewed as the stilted guideline that I had been using poorly and beginning to write in a more personal way. It felt empowering to think that I could share my own story as part of my research. I think this feeling came from what Clandinin and Connelly (1994) refer to as the “voice after silence”, a veil of silence is lifted and researchers, particularly women, find a way to speak and to acknowledge that you have something valuable to say.

This notion at first seemed at odds with the ideas of knowledge that I grew up with and had been practising over the last few years as a student. However, it was not at all at odds with what my common sense told me about how I experience life and teach my own students. Intuitively, I had realized that I needed to put myself in the story for it to have meaning. As a teacher, I practice this type of education by always assisting students to see the value of what they are learning as it relates to their everyday lives. Unfortunately, I had not been doing this for myself. After the meeting, I started to feel that I could care about writing my proposal if I no longer had to deny my subjectivity. However, my enthusiasm for my new thesis possibilities coincided with a great deal of anger. I felt anger at myself, at my professor, and at the M.Ed. program as a system. I felt I should have taken more opportunities in my course work to learn about alternative methodologies and been encouraged to take courses that would have better prepared me to complete a thesis that I would find valuable and important. It was as if I was sent out rock climbing without the necessary equipment. I felt robbed of educational experiences
that might have made a difference to me as a student. This anger was productive in a way, for it marked a new stage on my learning curve.

Along my path toward thesis completion, I came to understand that part of the process is the valuable time that I, as a student, take as a break from working on anything specific to concentrate on thinking and reflecting about what it is that I actually wish to accomplish, to incubate ideas. I needed to allow my instincts to guide me in the direction that I needed to travel. Connolly and Clandinin (1988) describe this process as an opportunity to see unity, continuities, images and rhythms of the whole in order to refigure the past and create a purpose for the future. I had to spend a certain amount of time cocooning. By this, I mean really evaluating what I felt able to do in terms of telling my own story as part of my research. I spent a few months reading and thinking. I had a chance to explore more of the methodology around narrative inquiry and certainly found it more intriguing than the case study I had originally been proposing. I had to feel in my heart that this new direction was the right way to head, even as it meant that in many ways I had to start from scratch. The original proposal had just felt wrong; I neither cared about it nor felt it was valuable. What I learned over this period of inactivity was that I needed to embrace my anxiety in order to learn from it and not, as Ellis and Bochner (1997) outline, ignore the emotional and personal aspects of my research.

I read some of the Ph. D. theses that Dr. Carmen Shields had recommended at our meeting and pieces of ideas that had been busily floating around in my head started to fit themselves together. I realized that I did not wish to leave my story out and that I should not be ashamed if my work had both therapeutic and personal values. Ellis and Bochner (1997) state that researchers will sometimes hide behind analysis instead of learning how
to express vulnerability. I had certainly been doing just that, but as I absorbed information about the methodology and methods associated with narrative inquiry, I realized that exposing vulnerability can bring about growth and transformation, that learning can be enhanced when we pay critical attention to everyday thoughts and feelings about such learning. Such meaning in educational jargon is meta cognition (Hanrahan et al., 1999) and I use this philosophy in my teaching every day as I question students about their learning and provide opportunities for them to think about their thinking.

One of the major issues I had to come to terms with while making the decision to use narrative inquiry was whether I was truly ready to share my story. Although I termed myself someone who had “recovered” from my eating disorder, there were certain aspects of the disease that I was still dealing with, mostly in the areas of expressing emotions and honouring self-esteem. Writing a thesis draws on a great deal of emotion and self-esteem, and I was aware that old feelings could come back to sabotage me. I was frightened about actually starting to write my story but had difficulty actually naming the cause of the fear. I suppose it was really a combination of reasons. Although I had dealt with many of the aspects involved in my struggles, I was sure that there was bound to be some baggage that I had not yet unpacked. I recognized the likelihood that writing and reflecting about my own experience would uncover facets of myself that I was unaware of. I was particularly wary of this possibility. I am sure this is a reason most people do not have the courage to write their own stories and why I had been unable to find any in the literature. Another aspect of my fear lay in the fact that although I had shared my experiences with others, including family and close friends, my history was not
something that was public knowledge. Committing my story to paper would certainly make it public. Once I went public, I would no longer have complete control over my own story. Hence, there was uncertainty about doing so. I was unsure if I really wanted people who are close to me, particularly my family, to read all the details I would feel it necessary to include. My lack of self esteem was the last factor involved in my trepidation of sharing my story. Although my confidence had certainly grown immensely as I had recovered in the past few years, there were still underlying doubts that somehow my story would not be valuable enough to be considered research at such a high academic level.

Despite these fears, I started to feel a personal urgency to listen to the silent whisperings of my own inner life. I entered what Clandinin and Connelly (1995) term a period of awakening and transformation. I instinctually recognized that telling my story was something I felt the need to do. I no longer wanted to share Alicia’s story...that would be for her to do when she felt ready. However, I spectacled that having Alicia in my class had happened for a reason. Without having had that particular experience, I may have chosen a completely different route for thesis completion and would never have had this new door open. I strongly felt that I was destined to come to that point in my life. I began to feel that the next step toward my complete recovery would be to use a narrative inquiry process to write my thesis. I envisioned myself growing and discovering in ways that would not have otherwise been possible. I knew it was right because of so many overpowering feelings I had just thinking about the possibilities. It felt extremely challenging and overwhelming but I believed in the phrase, “What doesn’t kill you makes you stronger”.

This positioning section of the thesis has attempted to reconstruct where I was in the understanding process as I embarked on my second attempt at thesis writing. It offers the lens to the reader in which to best view my space, place and time in the educational landscape (Clandinin and Connolly, 1995). It describes the exact spot of my journey where I felt I was supposed to be. I had given myself permission to be part of the story. Having had an eating disorder for such a long period meant that my inner voice had been suppressed and numbed for far too long. In many ways, I had overcome this silence in my personal life, and I needed to learn how to do so in my academic and professional lives in order to feel completely genuine. I had stayed within the security of theory, never disclosing my voice or myself in many of the papers I had completed on eating disorders or sharing my story as a teacher.

I was not a qualified ‘expert’ on the topic of eating disorders as I started this journey but I did have the knowledge that came from having lived the experience. I wanted my readers to have the opportunity to be inside my experience, to understand how it felt to be someone who has lived through the nightmare of eating disorders and who wanted to help those who might find themselves in similar circumstances. My story deserved to be part of my own inquiry and I started to strive to live within my own text.
PHENOMENON

*If there is a book you really want to read but it hasn't been written yet, then you must write it.*

Toni Morrison

(Anderson, 1997, p.26)

The phenomenon that I wish to explore through the context of this thesis is the essence of lived experience in the realm of eating disorders. I approach this inquiry in a holistic manner, in an attempt to weave together rational and intuitive thinking, intellect and emotion, thoughts, and feelings. Throughout this section, I also weave the necessary theory and my own story together, because doing so seemed to make the most sense, both for my readers and for me. I no longer see the need to separate my story from the ideas in professional literature that I have become familiar with. A separate literature review and some specific definitions contained in Appendixes A and B are included for readers who may seek further information and clarification on the topic of eating disorders.

I fully expected to struggle with "inquiry tension" (Clandinin & Connelly, 2000) as I pursued this narrative inquiry. I came to this research full of views, attitudes, and ways of thinking which were necessary to recognize, explore, and, it is hoped, resolve. I had to keep in mind that my inquiry might not answer any of my questions and remind myself that it was the process that was of utmost importance. I believed that as my narrative unfolded I would discover new layers to my story that had never been exposed, and my reflections about these new insights would be what would lead to greater understanding for both my readers and me.
The phenomenon of eating disorders (as defined in Appendix A) is a pervasive one in our culture. We live in a society where weight obsession has become a significant health issue (Connolly & Corbett-Dick, 1990). Disordered eating covers a wide spectrum of eating behaviours. Perhaps it is most helpful to view eating on a continuum, with all eating disorders at one extreme and normal eating at the other. All eating patterns exhibited by people fall somewhere along such a continuum. It is estimated (Milne, 1998) that up to 5% of teenage girls will develop an eating disorder and up to 20% will dabble in unsafe weight control practices. While eating disorders are increasing in males (Romeo, 1994), it is generally the female population that suffers from such disorders. 90% of people with diagnosed eating disorders are female (National Eating Disorder Information Centre (NEDIC), 2001), not to mention the many individuals whose eating habits would most likely place them more toward the extreme end of the continuum. In Canada, reports by NEDIC, 2001, found that more than 350 000 Canadians or 8% of women are affected by eating disorders. With a mortality rate estimated at approximately 15%, it is argued (Poulton, 1996) that this health issue should be a priority in our country. Frightening as that information alone may seem, the statistics become even more grave when considering that younger and younger children are being affected (NEDIC, 2001). Girls as young as 8 years of age are being admitted to hospital programs with fully developed, diagnosable eating disorders (Bear, 1996).

Such statistics are personally relevant to me. I am a part of the percentage of those individuals who have been clinically diagnosed with an eating disorder. Luckily, I also constitute part of the 85% who survived. I am a person who has “recovered” from my eating disorder. This fact is one strand of who I am. My experience, when I choose to
reveal it in such a way, could be reduced to the simple statement of, "I used to have an eating disorder." However, an eating disorder is not something one gets over. It is not an experience captured in a snapshot to store in a photo album or a memento one sets on a shelf to be dusted off and remembered from time to time. It is an experience that becomes part of you, an experience you are always conscious of, one that is never forgotten.

A question constantly plaguing me was, "Why me?" Why did I, from a period in my early teens to my mid-20s, end up with a full-blown eating disorder? Through my reading, I have discovered that much research has been conducted in an attempt to determine what underlying determinants of eating disorders may be (Attie & Brooks-Gunn, 1989; Graber, Brooks-Gunn, Paikoff, & Warren, 1996; Levine, Smolac, & Hayden, 1994). Many different factors appear to be related to the development of these disturbances including: genetic, sociocultural, psychological, physical, and familial characteristics. What I have often found in the literature is that these factors frequently overlap and cannot be easily separated into isolated categories. It seems impossible to determine cause and effect. Medical and scientific literature (Collins, 1998; Connolly & Corbett-Dick, 1990; Kater, 1998) confirms the need for and stresses the value of early identification of those most at risk, as well as intervention with those individuals who have already developed difficulties. Yet, in my opinion, the interwoven nature of the aforementioned factors makes it difficult to ascertain true links or to determine the actual causation. For a long time, I have thought that what is needed for recovery is a more holistic approach, where all possible factors are examined and understood in order to best comprehend the complex nature of the disorders.
I have attempted to reflect on my own experiences with eating disorders in such a holistic, all-encompassing manner. The question was how did my living incubus of having an eating disorder originate? I found myself thinking that if I could just understand how my eating disorder began in the first place, then I could truly be able to assist others in never starting, somehow preventing them from boarding the hellish roller coaster that becomes your life and, in some sad cases, destroys your life.

It was difficult to pinpoint when my issues around food began. I grew up in a farming community in southern Ontario as the oldest daughter in a family of five girls. I grew up in a house with a scale, but this is not to say that I lived in a household fixated on weight or food, at least not overtly. Yet, food was an essential part of our lives. Being a farm family, we ate hearty food and plenty of it. Growing up, we ate three meals as a family, with dessert at two of those meals. Much of our social life included events revolving around food: church dinners, family gatherings, and having friends over for meals. Thinking back, I am unable to recall a time when I was too young to assist with food preparation or was unable to cook, although my cooking skills became greatly enhanced through 4-H homemaking courses that required me to expose my family on a weekly basis to some new concoction. Upon reflection, the important aspect was that I equated food with love and family connections. I felt that because my “stay-at-home” mother loved our family so much, she spent an exorbitant amount of time involved with food preparation and cleanup. Whether I baked cookies or prepared a meal, I was rewarded with gratitude and attention. I do not remember my childhood as being unhappy. It is only because I have the knowledge of what experiences followed this
segment of my life that I started to question whether my early upbringing made up part of the underlying problems that led to my eating disorder.

My status as the oldest child in a white, middle-class family placed me in the category of individuals identified most at risk for developing eating disorders, particularly anorexia (Bruch, 1979; Brumberg, 1997). However, as western culture has started to pervade all cultures, statistics are becoming more representative of all gender, socioeconomic, and cultural backgrounds (O’Dea & Maloney, 2000). I find it curious, although not entirely surprising, that a great deal of blame is placed on the family of the individual with an eating disorder. Literature relating to the familial factor often includes the individual’s family structure and dynamics. The theory relating to this factor (Hesse-Beber, 1996) emphasizes relations between people rather than conflict within a person and frustratingly places little importance on wider factors outside a family unit. I have no doubt that family structure plays a role, but I do not believe it is the singular cause. Studies (Attie & Brooks-Gunn, 1989) indicate that those with existing disorders generally report low family cohesion, recent family crisis, chaotic family systems, and/or high expectations. My own family fits the “perfectionist family model” (Bradshaw, 1994) in which there is a covert message that appearance, or how things appear to others, is important and that the self must be sacrificed for the good of the family. In such a family, the father tends to have the power, there is a concern over how others might view the family, and a general “no feelings” rule. It is often typically the oldest daughter who is most susceptible to developing an eating disorder. As such, I was the classic case.

Although the message was never expressed in words, there exists in my family a subtle pressure to be an overachiever. Even though I excelled at many activities as a child and
teenager, I never once felt good enough. I thought, and still think, that I had to achieve more and be better than my best. I think that my parents were so wary of their children, thinking too highly of themselves that they seldom praised us, perhaps thinking that no feedback was good feedback. However, for me, no words telling me I was worthy meant that I wasn't. My family did not, and to a great extent still do not, express feelings in the family setting. This lack of communication has been one of the hardest parts of dealing with the many issues related to my eating disorder. I had to learn how to let myself feel the whole gamut of emotions and to recognize that all emotions should be welcomed and validated.

I think that when people who have experienced eating disorders look back to examine how their family may have influenced the development of such problems, there is a tendency to place blame. Such finger-pointing is not productive. One has to consider the family's role as part of the complex interplay with the other factors, including physical, psychological, biological, and sociocultural, that combine to contribute to the genesis and perpetuation of the problems. There are many elements in the complex dynamic, and all must be considered as interwoven strands. For me, I now recognize that my family did not provide me with what I needed in order to feel valued, but I do not believe they were aware of the subtle pressures they placed on me. I also reflect on and wonder how families are supposed to know what they are to provide to each and every member.

Research outlining the physical factors related to the development of eating disorders involved two key issues, pubertal growth (Gabel & Kearney, 1998) and metabolic reactions to dieting (Keys, Brojel, Henshell, Nickelson, & Taylor, 1950;
Thelen, Powell, Lawrence, & Kuhner, 1992). My personal experience indicates that such issues certainly played a role in my progression toward anorexia. My difficulties began when I hit the tender years of puberty and I began dieting at this time, starting a cycle that would eventually endanger my life.

Attie and Brooks-Gunn (1989) found eating problems might relate to physical changes occurring in middle school when body shape becomes a primary focus and weight-controlling techniques intensify. I, having taught at all grade levels and currently in the intermediate division, would agree that this age is when the problems begin, as I certainly see ample evidence of dieting and concern about body size and shape among my students. What seems pathetic to me is that there exists a considerable discrepancy between actual healthy weights of adolescents and the weights they would like to achieve. In an 8-year study, Graber et al. (1996) found that the onset of abnormal eating patterns suggests that early puberty is the crucial time for those attempting to help prevent such problems with weight and eating from developing. This time period is a problematic period for young students. They want to fit in but stick out at the same time, in that they need to blend in with their peer groups but wish to also be noticed individually. They begin to develop, changing body shape and gaining normal amounts of weight, but struggle to maintain a prepubescent body in an attempt to meet societal images. It is no wonder that what results are depression and the lowering of self-esteem (Gilligan, 1982). It is paradoxical that normal development associated with girls’ puberty typically results in both weight gain and an associated dissatisfaction with one’s physical appearance.
The way in which many young women deal with such a paradox is to start dieting. Dieting itself may be a sufficient condition for the development of eating disorders (Bradshaw, 1994; Correia, 1995). Efforts to lose weight and change one’s body shape are largely ineffective, resulting in the failure of most diets over long-term periods. It seems ironic to me, when counting the number of diet books, programs, or methods that are in existence, that we would need so many different types. Dieting may lead to binging and actually precipitate weight gain due to the lowering of the metabolism (Bradshaw, 1994; NEDIC, 1988) during decreased caloric intake. The body reacts as if it is in starvation mode. When one begins to eat normally again, the body attempts to store that food in anticipation of another starvation period. Severe dieting also has many physiological effects that include anxiety, depression, food preoccupation, irritability, lethargy, isolation, and impaired concentration (Keys et al., 1950). These physical and physiological consequences of dieting can predispose an individual to develop an eating disorder, although it can be hard to see which comes first, the chicken or the egg, the diet or the eating disorder.

I believe many people would agree that adolescence is a time in life that they would not wish to experience again. It is a period of development where nothing about one’s body and mind seem to match and unanswered questions abound. I entered the adolescent period of my life with blinders on. I had no idea what to expect. Of course, at school we had undergone the routine visits by the school nurse, at home I had received the token What Happens to Girls? book to read at my leisure, and in my social circle we had giggled our way through many conversations about boys and sex. However, no one had really talked to me about what it meant in be in adolescence, and I certainly was not
prepared for the changes that were happening to me. I suppose I started this stage of my life quite similarly to many other adolescent girls. I anxiously awaited my first period, experimented with make-up far away from the disapproving eyes of my parents, shopped around for a personality, and developed a crush on a different boy each day.

I have tried to examine where my life started to go so wrong. This examination allowed me to understand how the physical factors related to the etiology of eating disorders in my own experience. As much as I can recall, my problems officially began with my first diet. I had just turned 14. It was January 1, 1983, D for Diet Day, the day I was going to start on the path to a new me “fit and skinny” (at the time I believed the two were synonymous) and of course, happy. I am able to remember the actual date because my birthday was the day before and I recollect being quietly upset when I had received sunflower seeds (previously one of my favourite snacks) from my friend as part of her gift. I remember thinking that she obviously had no idea how many calories they contained, but I certainly did. I had recently purchased a calorie-counting guide (the type that is available for 99 cents at every grocery store) to assist me in my dieting pursuits, and my almost photographic memory was proving to be a real bonus in categorizing food into good (low calorie) and bad foods. Having an excellent recall of facts is usually deemed a positive intellectual trait, but for a young woman about to move toward the starvation end of the eating continuum, such an ability becomes frightening as every solitary food item could be broken down into calorie and fat content.

Thus, my diet began. I threw out the sunflower seeds. Although I was certainly an abstract thinker at the time, my eating habits were very black and white. I created eating rules such as “no high calorie food,” “no desserts,” “no butter”, and “no meat products.”
and they were not allowed to be broken. I soon began arguing with my mother over what she presented our family to eat on a daily basis. Did she actually want us to get fat? Why did we not have any salad ingredients? Why did we have to drink whole, "fatty" milk? My new diet consisted of eating a tiny bit of what the rest of the family was consuming along with a giant salad (my mother eventually gave in and bought the ingredients). I began to lose weight. I was taking healthy eating practices to the extreme.

By the time I started grade 10 in the fall of that year, I had lost a significant amount of weight, about 15 pounds. Writing my story, I was able to look back and say that I had not been overweight in the first place, but at the time I had gained the normal amount of pubescent weight through grades 7 and 8 and felt like I was overweight (over what weight exactly I am unsure). Everything about me seemed awkward and wrong at that time. I had already reached my adult height of five feet eight inches, I had what I termed "mousy brown" hair, and I thought I was big boned. I liked school and was teased for being a "browner." These characteristics did not fit the socially accepted adolescent image of popular. I vividly remember wishing I looked like many of my friends who were petite, blond, and blue eyed. I wanted to be socially adept, not book smart. I felt at odds with who I was and who I thought I wanted to be. I needed my outward appearance to be valued, since it appeared my inner strengths were not.

This stage is a juncture in the story of my life where I unfortunately chose the wrong path. It was also the moment at which the sociocultural component relating to the development of eating disorders fits into the puzzle. I was at a vulnerable point in my life, and I unsuspectingly fell right into the eating disorder trap.
Almost all of the research I have reviewed leads to the generalization that eating disorders affect predominantly females, indicating a strong gender factor. Indeed, 90% of those clinically diagnosed are female (Neumark-Sztanier, 1996). I personally believe that this sociocultural factor has the greatest impact on both the development and the perpetuation of eating disorders. This factor explains the reason why females are primarily affected with such disorders. It is the female’s body type that has narrower criteria for acceptance in our western culture, and it is our social stereotyping that makes some girls and women more susceptible to developing such problems. Feminist research (Brown & Jasper, 1993; Wolf, 1991) in particular focuses on the sociocultural factor as one of the most overwhelming pressures that lead females to feel poorly about their bodies and thus attempt to change them through whatever methods are possible. Culture, specifically media and popular culture, focuses little on inner qualities and strengths and strongly influences attitudes toward acceptable body weight and eating habits (Wolf).

The biological changes and social pressures that adolescents experience during puberty overlap and are exacerbated by the tension that young women have about their bodies. Puberty results in a natural and normal increase in body fat that is necessary for development. Eating disorders can develop at any time, but an individual is more vulnerable to sociocultural messages when facing several changes at once, as is true at the beginning of adolescence. Russell and Rice (1997) point out that some young girls learn to scrutinize and judge every possible physical attribute and that they start to engender feelings of worthlessness, powerlessness, shame, and self-loathing. These feelings were certainly what I was facing at the time of my first diet. Quantitative studies (Bear, 1996; Collins, 1998; Graber & Gunn, 1996) reveal that a significant number of
adolescent girls are dissatisfied with their body size. This pressure puts young women at a great risk for developing self-harming behaviour, such as eating issues, alcohol and drug misuse, smoking, and depression. Long term, such pressure can lead to ongoing body and self-image problems. A Psychology Today survey (Garner, 1997) determined that a significant number of women representing all ages would resort to frightening extremes to fit society’s image, with 24% stating that they would willingly give up 3 years of their lives to achieve their weight goals. Such statistics seem ridiculous to me now, and yet I was almost willing to give up my entire life to achieve the same goal.

Dieting is such a pervasive practice among women in our culture that it could be considered normative. Listening to women’s conversations, the topics of weight, dieting, and appearance seem to be almost an obsession, as common as discussing the weather. Being of average weight is the eighth deadly sin (Poulton, 1996). Adolescent girls are particularly at risk of internalizing dieting myths and misinformation due to their impressionable nature. Studies (Roblin, 1997; Russell & Rice, 1997) indicate that dieting is beginning as early as grade 4, at 9 years of age. To me, it is of no surprise that those diagnosed with eating disorders are becoming younger and younger. There exists an ad for Special K cereal in which a baby has a cartoon bubble filled with the words, “Am I fat?” People laugh at the irony, but it is also quite a sad message.

For myself, about to enter grade 10, having lost weight through eating less and having firmed up through exercise, I was about to be strongly affected by this cultural factor. Apparently, my new appearance made me more attractive to others, and I gained new-found popularity. I had always had friends, but then people whom I barely socialized with were complimenting me. Comments like, “Wow, You look terrific,” “You are so
lucky to be so skinny, how do you do it?”, “You should try modeling,” or “The boys are going to love you” were uttered to me on a daily basis. I ate up these comments in every sense of the word. Sadly, the twisted validation and feedback contained in these statements began to sustain me during a period when I was not allowing myself any other kind of sustenance. Even more pathetically, such comments continued even when I reached my lowest anorexic weight of 105 pounds and looked sickeningly thin, as well as when I was in the full grip of bulimia and throwing up several times a day.

So what does a young girl of 14 do when she suddenly discovers she has the right look? Unfortunately, in my case, she didn’t say, “Terrific, I look great right now so I can stop dieting and maintain this weight.” I could not do this because I had already started to be addicted to dieting, and my perfectionism caused fear that if I stopped my diet I would gain all the weight back. If I had the capability to return to any crucial turning point in my own life and change the direction of my own story, this dieting stage would be the time. One of the most gripping autobiographical books on eating disorders that I have read is entitled Wasted by Mayra Hornbacher (2000). “Wasted” is exactly what I feel in many ways I did with the next 14 years of my life. I wasted so much of the experience of the rest of my high school, university, and beginning teaching years because I continued my obsession with dieting. Of course, how could I have known at that point that I would go on to develop anorexia and then bulimia or that my eating disorders would grow to consume every aspect of my life, start eroding both my body and mind, as well as doing permanent damage to me physically and emotionally. I can only speculate as to why I just did not stop dieting.
In all probability, this stage is where the **genetic or biological factors** relating to the development of eating disorders emerged. This biological component could be further subdivided into four factors: personality characteristics, biochemical makeup, mother-daughter relationships, and inherited body type. All of these factors are related, and I clearly see how they played a part in my own story.

One factor suggests that certain individuals may have a predetermined vulnerability for the evolvement of eating disorders. It is suggested (Johnson, 1996) that there are inherited characteristics of individuals who have eating disorders including: extreme perfectionism, obsessiveness, inflexibility, persistent self-doubt, and a high degree of need for control. I would describe myself using all of these aforementioned terms, although it is hard to know if I have always been so or if some of these characteristics developed due to my eating disorder. It is the chicken-and-egg dilemma again. I do know that these characteristics remain part of my personality even as I no longer exhibit disordered eating. I have just developed different mechanisms with which to cope with my traits.

The question can be raised as to why, when so many females engage in restricted eating, does only an isolated group of individuals actually become anorexic or bulimic? One argument that attempts to deal with the quandary is that such women have abnormal levels of serotonin (Johnson, 1996), a chemical in the brain, and that some of these individuals, when given antidepressants, such as the “happy pill”, Prozac, are able to better move toward recovery. Apparently, the drug assists in the regulation of the levels of this chemical, which in turn helps the person moderate their eating habits. This is not to say that all people with eating disorders are clinically depressed, but there is certainly
enough evidence to indicate that many people can be assisted through therapy combined with some medication. I, myself, although quite apprehensive at first, found the use of Prozac helpful in my own recovery. It could be argued that I am unable to compare my experience to one where I would have tried managing without such drug use.

Other research into the relationship between genetic construction and eating-disordered behaviour (Milne, 1998) suggests that mothers who are food and weight preoccupied tend to have daughters who exhibit similar behaviour. I do not find this research particularly surprising, given that modeling is a way in which many behaviours are learned, but it is hard to differentiate between nature and nurture. Is such research indicative of an inherited gene or simply more evidence of the weight-conscious world that we grow up in, with an unnatural value being placed on thinness within many families? As well, our society tends to blame mothers for everything (Caplan, 2000). In my case, I have no recollections of my mother dieting or even the mention of her wanting to lose weight. However, I did think my mother was overweight, and I feared growing into a similar body size and shape. Of course, my teenage mind did not take into account the fact that my mother had given birth to five children and I certainly at the time had no knowledge of predetermined set points. I believe I thought my mother probably knew she was overweight and wished to lose weight but did not put any effort into doing so. I reflect that because I was more successful at losing weight than my mother, it enhanced my feelings of self-empowerment.

Such set points are part of another factor that is considered as a possible contributor to the development of eating disorders. These set points may influence the development of a certain body type and weight. There is scientific evidence (Bear, 1996)
that weight, like height, is largely inherited and tends to fall across a wide range instead of being solely determined, as many women in our culture believe, through food and exercise. Such genetically influenced sizes and shapes may result in most women being unable to mold their own bodies and thus beginning to take more drastic measures to change their body size. To me, it seems terribly sad that women are not allowed to accept their natural weights and be happy with our diversity of sizes and shapes.

At 14, I was not even content with my new body, whittled down by the all-too-popular “not eating much at all” diet. Whether it was my genetic makeup, the sociocultural pressures, the onset of puberty, my family structure, or, most likely, a combination of all of these factors, I continued to choose the wrong pages in my “choose your own adventure” life. I continued to diet, stupidly figuring that since I had already lost weight, I might as well lose more. The addiction began. I lost more than 25 pounds in all. My lowest weight was never life threatening, meaning I never had to endure being hospitalized and force-fed, but I was certainly unhealthy and underweight for my height. People today still tell me I am thin, and I weigh 35 pounds more than I did then.

Grade 10 was around the time I first started purchasing women’s fashion magazines. This form of the media captured my attention, and my consumption of magazines such as *Cosmopolitan, Seventeen, Flare,* and *Young Miss* played what I believe to be a crucial role in shaping my personal views around the ideal image of beauty and the body. These magazines helped me define “perfection.” Magazines were far removed from the perception of my own appearance and, to a great degree, the reality of my own existence. No girl or woman in those magazines ever grew up on a farm in “north nowhere,” had four pesky younger sisters, or was a wholesome-looking, albeit
skinny, adolescent. It wasn’t just the pictures I felt distanced from but the lack of information about the people portrayed that made me feel like an outsider. Unfortunately, I did not at the time possess the ability to assess this media critically. Today, I still enjoy reading magazines, but through a completely altered lens. Now, I can laugh at the paradoxes and contradictions found in such “literature”, but I am also reminded that there is nothing really funny about the psychological and physiological suffering that eating disorders entail and that I believe are contributed to by such magazines. In adolescence, I read magazines in order to learn what I was supposed to be like, inside and out. Up until this point, my appearance, weight, and diet had never been issues of great concern, but during one of the milestones of my personal development I became exposed to the world of fashion and subculture in which looks and appearance became the fundamental components of my self-worth. I realize now that I allowed these magazines to exploit my insecurities. I was dieting. I was experiencing social rewards at school for my new appearance. Due to my developmental level, I was experiencing a great deal of emotional upheaval in the process of developing my own identity, but in my family such discussion of feeling was not encouraged. It is of no surprise that I became preoccupied by such an ideal of beauty. I foolishly believed what those pages propagated. If I lost 10 pounds, I would feel better about myself. If I followed the “10 easy steps to getting a guy,” I would get one. The frightening thing about such silly headlines is that they were being reinforced in my school setting. Initially, I did feel better about myself when I first began losing weight because I measured my self-worth through what others thought about me. Positive feedback about my appearance equaled my feeling more positively about myself. My body had become a tool through which I was gaining popularity, and magazines were
the operating manuals for that tool. I exerted control over something I was in complete
control of with my weight, and this sense of control really served to boost my faltering
self-image. Magazines did not validate me; they only served to reinforce the idea of all I
would lose if I gained back that weight.

Magazines, along with television, movies, and music videos, form the cultural
media that seem to promote impossible standards for most females to achieve. Recently,
there was a Body Shop T-shirt printed with the clever slogan, "There are three billion
women who don’t look like a super model and only eight who actually do." If I had seen
this ad when I started my dieting, it would have backfired. I set such high standards for
myself that I wanted to be one of those who did. Levine et al. (1994) state that 60% of
girls aged 10 to 14 read magazines. Judging from what I see the grade 8 girls in our
classroom browsing through, I would hazard a guess that today’s figure would only be
higher. This period of a girl’s life is also the age at which she is at the greatest risk for
developing an eating disorder, prepuberty. The majority of magazines replay a tiresome
focus, with articles on making up, losing weight, wearing the right fashion, and attracting
the right male. They seldom challenge women intellectually, because their purpose is to
give training in “lookism” (Kater, 1998). I think most magazines, with the exception of
excellent publications such as Ms., fail to deal with the variety of important women’s
issues or portray a variety of realistic-looking women. As Wolf (1991) points out, female
magazines have to ensure that their readers don’t liberate themselves out of the interest in
such trivial, appearance-related material. Educate the masses and they will surely revolt.
There is also anything but a coincidental juxtaposition of advertisements and articles
containing identical messages that illustrate the state of the union between magazines and
marketers that has been present since the early 1960s (Poulton, 1996). The mixed messages found between photos featuring high-calorie recipes located near advertisements that feature anorexic-looking models would be considered an oxymoron if such messages did not become so ingrained in our psyches. We strive to look like the women these magazines tell us are the ideals, without taking into account that the unrealistic images we aspire to are more than likely a product of technology or seductive camera angles (Brumberg, 1997). We try to achieve the impossible, and it is no surprise we fail.

Young people often believe they are invincible. At 14 years of age, failure was not a word in my vocabulary. I was incredibly hard on myself. In my mind, if I just tried hard enough I would be able to continue losing weight. It becomes a game in which a female competes with herself and thus no winner can be declared. As I look back, it is amazing to me that I survived on so little food. I was surrounding myself with people and things that reinforced the proposition that women should be thin. I now realize that it really had nothing to do with what I looked like and everything to do with what I felt like. I was starving myself by not ingesting any food, but what I was really starving for was some self-esteem. The irony is that eating disorders are not about food. Food issues are only the tip of an enormous iceberg. The submerged part of the problem lies in the emotions, values, and structure of the personality.

So I started to go head to head with the nature of my body in a campaign to defeat my own biology. There were many days when I existed on half a grapefruit for breakfast, a can of diet coke for lunch (many of my friends enjoyed the same nourishing meal, so I was not entirely alone in the game, there was reinforcement from my peers), and a salad
for dinner. I remember babysitting and eating only two Mr. Freezies during the entire day. I always woke up early in order to exercise (running or biking) to deal with the calories I had consumed the day before. I was addicted to denial. Unfortunately, although I counted it as a blessing at the time, my parents were occupied with my newest sibling and did not pay much attention to my dieting and exercising ritual. Being the oldest daughter, I expect they thought that the behaviour I was exhibiting was normal and more than likely there was some hidden jealousy of my younger siblings. I often wonder at what point my family actually did start to worry. I wonder if they really thought that what I was doing was typical for my age, or did they suspect early on that there were issues? In my present life, my parents and I have an unspoken pact not to discuss my past or current difficulties with food. If I circle around the issue, I sense their uncomfortableness, and so I avoid the topic. I desire our relationship to be more open and honest but am unable to make it so. Maybe in the future, I will feel it is more under my control. Right now, it remains an issue.

I do recall being “busted” when I was 15. The confrontation occurred just a few days after returning home from a 5-day canoe trip to Algonquin Park with our high school. I had eaten normally on that trip in order to physically manage paddling, portaging, and hiking each day, and I remember my father commenting that I looked healthy when I walked in the door. I had felt guilty for eating so much on the trip, but also surprisingly good. I suppose that comment indicated my father’s awareness of how unhealthy I had looked prior to this time. That trip was probably the healthiest I was for the next 14 years. However, I soon resumed my dieting regime and dropped the 5 pounds the scale told me I had gained. My parents noticed the difference. It was time for a rare
family meeting. Of course, I denied there was a problem. I ranted that it was my family that was the problem, that they were too controlling, that they should just leave me alone as I was fine, thank-you. and that everyone my age ate the same amount. I had what would be termed an adolescent temper tantrum. My parents did not give up. I was going to be forced to see our doctor.

I was dragged off to see our family doctor, a man I had never really felt comfortable with. What I can recall of that appointment is that I stubbornly refused to talk, my mother embarrassingly stumbled through what she thought were my problems, the doctor confirmed that I most likely had an eating disorder, and that he would schedule a visit to Sick Children’s Hospital in Toronto. I remember sitting in the car on the way home, silently raging and plotting how to get around this new problem. I believe now that I desperately needed my mother to talk to me about how she was feeling, but instead we settled on not communicating. I could not say what I needed, and she did not know how to help.

I became an outpatient at “Sick Kids” Hospital for a period of approximately one year. I was diagnosed with anorexia nervosa, that is an eating disorder characterized by an “obsession” with thinness, drastic weight loss resulting from dieting and/or intense exercise, a poor or distorted body image, an intense drive for thinness, and a heightened fear of weight gain. Although I continued to adamantly deny I had problems (certainly a barrier to treatment), I fit the criteria to a tee. This period in which I underwent treatment is quite hazy in my memory, and many specific details escape me. I think that perhaps they are repressed due to my denial at that time. I know I felt like I was in control of my eating and my life and that it was other people who just thought I had problems. Such
people posed a threat to my control. I believed I could start eating normally anytime I wanted to, but that I just did not choose to. I thought I looked just fine, even when one of the doctors said, “You would be such a pretty girl if you just gained some weight.” It seems ironic that even the doctor focused on my appearance. I believed my family and my doctors were wasting their time with all this worrying.

**Intervention** with eating disorders refers to early identification of those who have difficulties, followed by referral and prompt treatment. The longer such problems are left untreated, the more deeply rooted the behaviours become. Intervention is certainly more effective when started early (Connolly & Corbett-Dick, 1990), and a more complete and timely recovery is likely with early intervention (Natenshon, 1996). I was undergoing intervention a year and a half after my first diet had begun. It might have worked, but it came too late and I refused to admit that I needed help.

Different treatment formats work for different people, and in my own reading regarding the topic of intervention it appears that there seems to be a relationship between techniques and factors associated with causation. The familial factor is often dealt with using a psycho-dynamic approach with focuses on early relationships and experiences and the impact they have on the eating disorder. The individual, through therapy, will learn to make and deal with such connections. The biological factor may be dealt with through the use of medication, as previously outlined in this paper. The physical factor is frequently handled with the support of a nutritionist or dietitian who assists by reviewing food intake and designing an appropriate food plan for the individual to follow. The goal for this type of treatment is to get the person back on the track of normalized eating. A cognitive behavioural approach is tried when the psychological
factor seems most prevalent. Through support groups or writing in a journal, the person engaged in this type of therapy is encouraged to become more aware of thoughts and feelings, and how they relate to behaviour.

There are numerous options for intervention, and they seem to differ in terms of intensity. However, each is about providing attention. This attention can be hard when it comes at a time when it is too late for the individual who wants it, when the disorder becomes more important than the attention. To me, it appears that none of the traditional intervention suggestions target what I feel is the most crucial factor, the sociocultural one. This is an ironic fact, since this factor represents such a powerful influence. I also believe that each individual’s case is unique and that the people involved in each intervention need to assess how the factors weave together to influence that case and intervene using that knowledge.

In 1984, Sick Children’s Hospital treated my case using a combination of intervention strategies. I met regularly with a dietitian, who confirmed that I did not eat enough and instructed me to eat what seemed like enormous quantities of food. I sat in a psychiatrist’s office where he attempted to get me to talk about my problems. He did not seem to understand that I did not have any problems, and if I did, I certainly was not going to discuss it with a man who was sure not to “get it.” I had weekly weigh-in sessions, where my doctors were disappointed that the numbers did not continually increase to reflect weight gained. I felt I was in control. I was not a cooperative patient. Of course, everyone tried to scare me by telling me that if I did not stop such dangerous dieting I would do permanent damage to myself. I was not scared, for I had my belief in my invincibility and did not care how sick I became. I was highly unpleasant,
disagreeable, resistant, and defiant. My parents and two of my sisters came for a family therapy session that I vaguely remember, during which I vacillated between stony silences and angry outbursts. No one seemed to understand what I was experiencing, certainly not my family, and especially not the “experts” at the hospital. I felt trapped and betrayed.

I often wonder how I actually avoided being hospitalized. I know I was threatened with such an unhappy outcome if I lost any more weight. It became a game; I did not lose any weight, but I certainly did not gain any either. I maintained my weight of 110 pounds. Many anorexics dip far below such a weight. I wasn’t about to become “fat” again and lose all the social rewards I was enjoying at school, but I believe I was clever enough to realize I would lose the control game if I was admitted as an inpatient. I became quite deceitful and manipulative, as many people with eating disorders do. My reasoning, which today makes little sense to me, was that if everyone thought I had a problem, then I just had to make it appear that I did not. The hospital staff wanted me to maintain my weight, so I did, but certainly not in the desired manner. I had to travel to Toronto on a biweekly basis. What I employed was a dangerous cycle of losing weight in the 12 days after the appointment followed by eating a great deal the night before the next one. This strategy, combined with the downing of about 3 litres of water right before I weighed in, worked. I maintained my low weight. The doctors seemed content with my efforts to at least maintain my weight. I believed I was fooling everyone, and I was, even myself.

Sadly, I actually came to enjoy the visits to the hospital. After the first few appointments that my mother had accompanied me on, it was decided that I could travel by bus to the “big smoke,” go to the appointment, amuse myself in the city and then
catch the coach home later the same day. What resulted was my looking forward to these
exciting solo ventures. They became a further reward for my negative behaviour. I
believed I was a city mouse at heart, born into the wrong country mouse family. I loved
the vibrancy of the city. I was allowed to miss an entire day of school. Having eight
different teachers on rotary each day meant that no school personnel bothered to find out
about my regular absences. Even though I believe the school should have been notified
about my problems, they were left in the dark. After suffering through the one-hour
appointment, I was free to spend the rest of the day wandering and shopping. I felt
independent and grown up.

These excursions came to a halt at the end of grade 11, although it is a bit unclear
in my mind how or why this period of intervention actually ended. My recollection is that
the hospital staff told my parents that they had done everything they could do and that,
while I was not getting better, I did not “appear” to be getting worse, so there was no
point in continuing. I was told that I had to accept that I had a problem before I would be
able to recover. It would be another decade before such acceptance occurred. At the time,
I pretended I was fine. My denial and my deceitfulness intensified. It seemed that if I
maintained my weight and made it look like I was eating normally, then I would get what
I thought I wanted: everyone would leave me alone. What I really needed was for
someone to be emotionally honest with me and to help me see what I was really starving
for, love and self-worth. Of course, this would have looked like open communication. No
one, including my family, friends, or teachers, communicated with me in this way, and to
my warped way of thinking it meant that I was not worth caring about.
On some subconscious level, I must have realized that I was sick, but I could not bring myself to admit it. I shut down many parts of myself emotionally at this time. I was operating under the supremely stupid delusion that I was in control, when in reality I was spiraling further and further out of control. It was easier to rid my body of unwanted pounds than to exorcise my mind of ugly thoughts. The following poem is one I wrote during this period of my life and which was published in our high school yearbook.

Unfortunately, no one, including myself, recognized how much I was writing about my own situation.

**MASKS**

Masks
Are they only once a year?
Or do we hide behind them
at other times?
Pretending everything is fine,
when it isn’t.
Pretending to be like everyone else
when we aren’t.
Pretending not to care
when we really do.
We long to be the best we can possibly be
without pretense or evasion.
Yet we tailor ourselves to meet other’s expectations of us.
Change our principles so as
not to offend those around us,
so that we will be well liked.
We have to take away the masks
and false images
that block us from others.
We have to learn
to laugh and cry together,
sharing happiness and sadness,
become real human beings.
We have to be ourselves.
My mask was seldom removed, not even when I tried to look at myself. In fact, over the next decade, I wore my mask so often that I lost my own identity. I had started flirting dangerously with bulimia just prior to my parents confronting me about my anorexia, by throwing up on a couple of occasions. Bulimia nervosa is an eating disorder characterized by repeated bouts of binge eating followed by purging to prevent weight gain. The purging may be accomplished by self-induced vomiting, excessive exercise, laxatives, or diuretics. It is not surprising that many people with eating disorders vacillate between anorexia and bulimia. Although in many ways the two disorders seem at opposite ends of the continuum, they are actually two sisters in the same family. I used both of these illnesses as crutches for many years. When people starve themselves on a daily basis, they start to crave large amounts of food in order to satisfy the incessant hunger. People with anorexia do not hate food; they are, in fact, obsessed with food. This fixation is why many anorexics adore preparing food for others and love to pore over magazines and recipe books. During the period when I was existing on little more than grapefruit, diet cola, and lettuce leaves, I thought about food every waking moment, constantly clipped recipes for my personal cookbook, and often relaxed myself into slumber by imagining myself eating huge portions of the very food I denied myself in my waking life.

I distinctly recall the first time I purposely threw up. I was in grade 11, it was following dinner, and it was because I had “foolishly” eaten two potatoes instead of one with my usual meal of salad accompanied by an unbuttered piece of bread. I know that I went upstairs to our bathroom and tentatively stepped on the scale. It did not matter to me that it was the end of the day, that I had just eaten a meal along with three glasses of
water. All I knew was that I weighed more than I had when I had stepped on that same scale earlier that day. I felt a panic over that extra weight, and my highly critical, anorexic reasoning told me that it was the extra potato that was responsible. A voice inside me was telling me that I was such a bad dieter that I could not even resist a potato. My inner critic (Stone & Stone, 1993) was constantly destroying my self-esteem, inflicting penance and punishment. I was pathetic. I knew it meant an extra half hour of exercise, at least! Then a thought popped into my already illogical mind, and before I could weigh the pros and cons about such a stupid move, I was hunched over the toilet and using two fingers in order to relieve myself of both the guilt of overindulgence and the extra calories. It was a form of self-punishment. I did the deed, I flushed, stood up, rinsed out my mouth, and realized I felt better. I felt control, and control was my motivation. I had solved the “problem.” What I did not realize was that the problems were just beginning and that I would ride that emotional roller coaster for the next 10 years.

Dieting had initially succeeded in getting me what I thought I wanted. I was thin. I was popular. I thought I liked myself. However, losing all of the weight had resulted in far too much attention from my family and the medical profession. Such attention did play a factor in how my eating disorder developed. Bulimia became the natural solution. It is a disorder that is much more difficult to detect than anorexia, because those suffering appear to eat more normally and generally maintain weight that is closer to the norm. However, it is equally dangerous. Of course, I did not think about the dangers; I only realized that I could now eat my cake and maintain my weight too. To others, it seemed as if I was on the road to recovery from anorexia since I was now actually eating.
At first, I did not throw up that frequently, perhaps two to three times per week and only when I felt I had consumed too much. As I developed my bulimic tendencies, I would characterize myself as anorexic for most of the day while purging on occasion. Food was an obsession either way. As a high school “model student” who also worked part time and was extremely busy with extracurricular activities (including sports, students’ council, and band), I had no difficulty around breakfast and lunch. I had total control over these two meals, and I would eat little to nothing. It would surprise no one that by the time the evening meal rolled around I was completely famished (a word that tends to get distorted). I would eat a normal meal and then relieve myself of it. Purging was something I dreaded but enjoyed. For a short while, I may have even been a tad healthier, as I absorbed some of the vitamins and nutrients before I relieved myself of the food. However, the temporary health vanished as I found a friend in bingeing and purging. What seemed like a perfect solution became a flirtation with death. I also distinctly recall the first time I actually ate food outside of a normal mealtime with the specific intent of throwing it up afterwards. In our high school, we had a small store that sold mostly the junk food that teenagers seem to subsist on. My friends and I frequently bought snacks there. This particular afternoon, I was by myself on the way to catch the school bus home. I bought a small bag of cheese popcorn, knowing that I would make myself throw it up after I consumed it. This incident was another turning point in my life that I wish I had never chosen. Why did I feel this need to purge after eating a normal snack? I know that I took that bag of popcorn home and rewarded myself with it while I was in my room “doing homework.” It probably took me over an hour to eat the whole bag, picking up one piece at a time and savoring it completely. Conversely, it probably
took me less than one minute to punish myself in the way I felt I deserved, one minute to puke up the whole orange mess of saturated fat and kernels. What seems odd, even to me, is that I also found solace in such behaviour.

Like a drug addict, or perhaps an addict to any substance, my comfort in bingeing and purging grew to require a larger and larger amount of food. People who have luckily never lived through the pain and contradictions of an eating disorder are understandably shocked when they hear or read about the unbelievable amounts of food that a person with bulimia can eat during a typical binge. Even as I write my story, I feel ashamed recalling such binges. How could I, when so many people in this world die from starvation, eat more at one sitting than an average person could consume in an entire week? Currently, I have not binged in over a year, and as the time passes, even I find myself amazed at the quantities of food I went through.

What is important for anyone to understand about bulimia is that, at some point, it stops becoming about food and becomes an addiction to food and the associated behaviour. It becomes a compulsive behaviour disorder. The paradox is that although this behaviour is a form of slow suicide, one starts to feel that life could not continue if it were given up. I was addicted to bingeing and purging through the latter part of high school, throughout university, and during the first 5 years of my teaching career. On one hand, it was a way in which I controlled my weight. For the most part, my weight remained a stable 125 pounds over this period. More important, bingeing and purging was my way of handling life and the emotions I was not expressing. I threw up to avoid having emotions. Having bulimia meant that no one nagged me to eat as they had when I was more anorexic. In front of most people, I ate normally, sometimes too little and
sometimes too much. People often commented on my amazing metabolism. Foolishly, I took this as a compliment.

It was not long before bingeing and purging became a daily process. In the beginning, I threw up only my evening meal, but gradually the incidences increased until, during my most severe periods, I would throw up several times per day. This process swiftly took over my entire life until every aspect of my day involved figuring out how, when, and where I was going to engage in my secret, shameful behaviour. It was terribly unfortunate that I never took the time to figure out the why. Now, looking back to that period, I realize that the process of eating, throwing up, eating, throwing up, was in its own way quite orderly. It was a vicious cycle with no way out. I controlled every facet, or so I believed; I thought I could restrain myself or stop if I chose to. It was the times when I was unable to partake in my rituals that I would feel most out of control. Even now, as I write this, I can recognize that when my life feels overwhelming in some way, I have the urge to make it all go away by resorting to old behaviour. However, this difficulty is something I am working on, although it is good to admit that I must still be cautious. What stops me from still bingeing and purging? Fear mostly; the fear that the doctors from Sick Kids had tried to induce in me but had failed. I am paranoid about the damage that I have already inflicted upon my body that would only be exacerbated if I threw up again. I am scared that it might just be the one next time that I resorted to throwing up that would be the one where my heart would revolt and give up, or my stomach would give in and rupture. Now, I am also able to recognize that if I binge and purge even once as a way to handle stress, there is a real possibility I could go down that path again, and it is not a route I ever care to travel along again. I am afraid that the
binge and purging would take over my life again and force me back into a dance with this awful ritual. I attempt to comfort myself with more pleasant behaviours.

Throughout the entire period when I could have been clinically diagnosed as bulimic, food became my solace. The frightening aspect of this disease is that very few people knew. I was highly deceptive and manipulative. My family eventually realized through observation that I had successfully replaced anorexia with an equally dangerous problem, but it is doubtful that even they recognized the severity of my disease. They tried at times to discuss my problems with me but, as communication was not their strong point, were justly afraid that they might lose me completely if they pushed treatment on me. My sisters, in recent years, have admitted such fear to me. On two separate occasions, I was confronted by a friend who was also a roommate at the time. Adamantly, I denied the problem and just became even more careful at hiding the extent of my disease. Amazingly, I was quite adept at concealing my problems. Many people who were close to me during this period, including another friend who lived with me during university and a boyfriend of 3 years, were extremely shocked when I shared my story with them during my stages of recovery. I successfully pulled the wool over others’ eyes, and this fact is not something I am proud of.

What actually astonishes me the most when writing my story is that I am still alive. I do not really understand how I managed to binge and purge so often while simultaneously being successful in other areas of my life. I do everything to the extreme. In high school, I maintained good marks, handled a part time job, and balanced many extracurricular endeavors. In university, I again maintained high grades, worked part time, and managed an extremely active social life, going out at least four times per week.
I believe that there is a relationship between malnutrition and mania (slightly over the line from extreme involvement), that I had some sort of bizarre “high” brought on by the ingestion of too few calories. I continued this rapid pace through my first few years of teaching, and I am sure this hectic schedule is the reason I experienced so much stress. It was a vicious cycle. As if adapting to a new career was not enough, I also took part in many extracurricular activities and was busy with social engagements many evenings and weekends. In retrospect, it is amazing that I found the time to binge and purge. Needless to say, I did not sleep much. I have never been a good sleeper, but during my eating-disordered period I had difficulty falling asleep, awoke many times during the night, and often awakened very early in the morning. I am sure I was tired, but my mind was so revved up that I could not relax and let go. The voice in my head kept driving me and criticizing me. Also, the electrolytes in my body were probably so out of balance that I was incapable of deep sleep.

Much of this bulimic period of my life is a blur. My mind is empty of many memories that should be there. My eating disorder consumed my life. The memories I am able to recall involve food. Some of my part-time jobs were food related. I worked as a waitress on two occasions, and I worked in a bulk food and convenience store. It used to give me great pleasure to serve food all day without giving in to the urge myself. It was a form of self punishment. When I left work, I would eat and then get rid of what I had “weakly” swallowed. This ritual really became the way in which I coped with my life. I could always manage any events during the day as long as I was able to look forward to rewarding myself with a binge and purge session in the evening.
As someone who threw up anything I ate, I have an uncanny memory of every bathroom in every house or establishment I have been in. It is embarrassing to think of all the places where I have actually made myself sick. I was a professional puker. After the first few months of forcing myself to throw up, my body and brain learned to do it consciously. Even today, I could make myself throw up just by willing my stomach to do so. As unnatural as this reflex sounds, it was a prettier picture than using two fingers and having the identifiable teeth marks that give away the secret.

I spent an incredible amount of money during this period of my life. Having anorexia is certainly the more economical of the two disorders. I estimate that I spent a minimum of $100 a week on food; since I worked part time, no one knew I was spending such an exorbitant amount. These food purchases were extremely wasteful; I purchased food with the specific intent of throwing it up. Such spending also meant that I denied myself the pleasure of spending money on something I would have enjoyed. I also ingested more than my fair share of food from my parents’ house, but with five daughters it was most likely difficult for my family to actually figure out who was eating what. I would hoard food, saving it until I had enough for a binge. The needed amount grew proportionately larger as my disease worsened. At my worst, I could engage in a binge and purge session that would last for several hours. Part of the difficulty in planning such a bout was ensuring that I would be alone, not an easy task when you are part of a large family or living with three other university students. I think my conniving behaviour was part of the game in some way. Similar to people who enjoy sex in public places, I sought some sort of thrill in almost being caught. Perhaps I actually did want to be exposed. Maybe the thing I needed most was for someone to actually care enough to confront me
about how sick I actually was and persuade me to seek treatment. My parents had done this once but did not take that risk again.

Planning and looking forward to each binge was part of the solace I needed. I would buy reams of food. I would often start with some salty snacks such as chips or crackers, then proceed to more meal-type food such as pasta or rice (with huge amounts of butter, sauce, and cheese). Often I would throw up and then proceed with round two that might involve more of the same food, or move on to sweeter choices such as chocolate, ice cream, cookies etc. It was common for me to purge more than five times during the serious binges that often occurred daily. It was no wonder that the grocery bill added up. When I was finally finished, I would drink several glasses of water and throw up again and again in a vain attempt to purge myself of every little possible calorie. There was no way I could avoid absorbing some calories, which in retrospect were probably responsible for keeping me alive.

This activity did begin to take a serious toll on my body. After rising from my "porcelain friend" I would often be so dizzy that I was unable to stand, and I recall more than a few times lying on the bathroom floor, my cheek pressed against the coolness, until the room stopped spinning and my heart rate slowed. My hands would shake as I pressed a cold washcloth to my face until the blotches disappeared. I would attempt to cover up the smell of vomit by rinsing my mouth with toothpaste and water or by brushing my teeth, not realizing that I was actually making the enamel disintegrate off my teeth by grinding the acid in with that brush. To this day, I detest how my teeth look. They are almost transparent at the edges, and my dentist appointments fill me with shame. I suppose that I could consider myself lucky for actually having my teeth, but I
live in constant fear that some hard piece of food will chip off part of a tooth. In many ways, shame and fear are still part of my present story, although I am attempting to conquer these.

I am not going to pretend that I did not know what I was doing to myself. I was well informed about my disorder, including its symptoms and health risks. I was probably as informed as many eating disorder specialists are about such problems. I have always been a voracious reader, and I read most of the time while I binged; it was a way in which I did not have to actually think about what I was doing as I occupied my brain in another way. I knew that I was endangering my life. I knew I fit all the diagnostic criteria for a full-blown eating disorder. I had identified many of the reasons I clung so desperately to the disorder. Yet I continued to fool myself into thinking that I could have stopped any time I wanted to. I stupidly believed that I was in control, when in reality I had absolutely lost any degree of control. Perhaps I was getting a “high” from such dangerous living.

During this time, I stopped thinking in many ways. I also stopped feeling. I had managed to construct the perfect moat around myself, much like a castle, safe from any invaders. Bingeing and purging served as my emotional release and had the ability to calm me down, to quiet that inner critical voice. I remember when I was much younger that I would unsuccessfully try to stop my brain from thinking, not about anything in particular, just from all the random thoughts. I also grew up in a household where emotions were not, and are not, discussed. Bulimia allowed me to avoid thinking and feeling; bingeing and purging was a self-medicated way of numbing the pain of how I thought and felt about myself. I thought only critical thoughts about myself, and I felt
unlovable. Not only was I damaging my physical self, but I was also wreaking terrible havoc on myself in emotional and intellectual ways. One of the more difficult aspects of my recovery process was relearning, through practice, how to honestly express emotions and allow myself to think positive thoughts.

It is actually quite frightening how warped my thinking became. Controlling my food intake became my religion. I could not deal with any spare time in my life; I could not risk the time to think about what I was actually doing. I filled up every single second with activity. Presently, I still have to resist doing this. I now schedule times for relaxation. I craved control over these activities, and it became cataclysmic if anything changed at the last minute. I was horribly inflexible as I wanted my life to be ordered and sequential. To a great degree, I still seek such order in my life. I like to know what I will be doing and when. I am terrible at relaxing, although I am working on changing this orientation. This difficulty became a huge mountain in therapy. As my bingeing/purging episodes decreased, I found myself with spare time on my hands, and I was incapable of dealing with it. I felt out of control. I did not know with what to replace the frenzy of activity. I did not know how to be with myself and not be busy. Therapy helped me with this.

No one was ever allowed past the fortress to observe my real self. As my problems intensified, not even I had the key for the box that I placed myself in. I felt that people would not like me if they discovered who I really was. I did not even know who I was. So I wore a mask that showed the world a person that everyone liked. I tried to make my appearance perfect. I tried to always be outgoing, happy, and confident. I became involved in everything in order to make others like me. For the most part, I
succeeded. People liked me; what was there not to like? I was fun to be around and I was a good listener. I believed others just liked the character I portrayed; I could not risk exposing any of the real Tracy Armstrong. What ended up occurring is that I played this two-dimensional character for so long that by the time I started teaching I really could not tell anyone who I was. I only knew that I harbored intense hatred for the person I felt I was hiding inside. I had to learn how to become friends with myself and realize that no one is perfect.

There were people who tried to tear down my walls and cross over the moat. I went through a series of relationships that always lasted until I felt that the person was getting too close and might discover how terribly screwed up I actually was. At that point, I would find some flaw in the person to use in order to distance myself from the relationship. I was effectively sabotaging any relationship potential. I feel guilty about this behaviour now, as I am sure I hurt and confused many of these people. One boyfriend called me “hot and cold water taps” because I would be unpredictable from moment to moment as I attempted to deflect any attempts at honesty, even though I craved such openness from my family. I did have many friends, but no one with whom I allowed myself to share my problems. I was not as veneered as the person others saw, and yet I could not bring myself to scratch the surface and allow my dark self to flow out. I hated my life and myself. I knew every facet of my life was a farce, and I did not know who I was without my eating disorder. I had to figure out with what to replace such behaviour.

People with eating disorders often have a particular tendency to self-destruct, and this characteristic is certainly true for me. Even now, I have a hard time trusting my
relationships. I feel uncertainty about whether people really love me for who I am, including my imperfections. What actually arises from this problem is that I do not completely love myself and often feel doubt creeping in. It is like I have a tiny, critical voice inside of me that continually questions and probes, provoking anxiety. I constantly fight against this hypercritical voice and work at changing what it says by answering back with positive thoughts. It is as if I had an inner mirror that became terribly distorted as my eating disorders progressed and I have had to reconstruct the mirror. This mirror distorts how I see myself physically, emotionally, intellectually, and socially. One of my greatest fears is that in the future I may find myself resorting to old, dangerous habits or finding new and equally harmful ways to deal with my illusions. I can understand why some people mutilate themselves. I can sympathize, as feeling pain is sometimes preferable to not feeling at all.

I had an inaccurate view of myself. My thoughts about how others viewed me also became warped. I had a heightened sensitivity to others and a very critical imagination—constantly aware of them and what they must be thinking. Other people seemed to be everything I was not, and I felt that they could easily see through my shiny surface to the disturbed depths beneath. I was terribly self-centered even though ironically I had no sense of self. My obsession became my imperfections and how I could change them into perfection. I strove to be perfect for 15 years, and in the process of doing so I almost succeeded in being perfectly dead.

I am not dead. As mentioned previously, people with eating disorders who receive help early on have a better chance of recovering. I had struggled with both anorexia and bulimia for the better part of 14 years before I finally admitted I was not in control. I
admitted this only when I thought that if I did not I would actually die. Statistics were not on my side. What was working in my favor was that I finally said the words, “I need help” to myself. That statement is a short phrase with deep meaning. I did not utter these words until I was 25 years old. It remains one of the hardest things I have ever had to say.

What changed so that I finally sought assistance with my problems? I had tried to stop binging and purging by myself. For a period of several months I had been trying to decrease the amount of times I was engaging in such behaviour and having little success. I was completely miserable. I had not talked to any of my friends or family about what I was attempting to do. As the realization grew that I was unable to stop on my own and that I was a loser in my own game, the panic about how out of control I was began to rise. I was becoming increasingly frightened that there was a strong possibility that I could just drop dead. My heart had started doing weird palpitations on a regular basis, and I was knowledgeable enough to recognize that I had most likely done serious and irreversible damage to this major organ. I had reached rock bottom and was no longer believing in my invincibility. Although I hated myself, I knew I did not want to die, and it gradually dawned on me that I was committing suicide in one of the slowest manners possible. I made and canceled three doctor’s appointments before finally admitting to my female family doctor what was wrong. It was such a huge relief to actually admit to another human the extent of my problems. Luckily, my doctor was extremely sensitive and recommended a therapist who specialized in treating eating disorders in Guelph.

I was eager to get my treatment started. Unfortunately, the lengthy waiting list meant that I would not start therapy for several months. Apparently, the waiting time presently is more than a year, that is pretty frightening considering these diseases are life
threatening. As I waited, I entered a period of limbo. My eating disorder actually intensified during this time as I realized I might soon give it up. I desperately tried to hold on to it as much as I could.

I did not know what to expect with the new therapist. I had great apprehensions due to my unsuccessful experience at Sick Kids over a decade before. I was aware that the psychiatrist was a male, and I was wary that he might not be able to truly understand my perspective. I was petrified of becoming better, but equally fearful of perhaps not being able to be helped at all. Luckily, the first meeting with my psychiatrist, “Dr. Rodlum” put me at ease. He did not weigh me and did not force me to talk about issues I was not ready to. He did a lot of the talking and sent me away with homework, a series of tests to fill in which would help him treat me. While I remained fearful, I also saw the light at the end of the recovery tunnel for the first time.

It is important to realize that treatment often takes time and that recovery does not happen overnight. It is also crucial to recognize that overcoming an eating disorder is possible. Treatment of eating disorders sometimes requires a multifaceted approach and a respect for the many factors that may have led to the development of the problem in the first place. I know now that no one could have forced me to get better. I had to choose recovery for myself. I had to ultimately save myself and ask for the necessary support to do so.

What I came to realize in therapy is that no amount of avoiding or bingeing/purging food could allow me to get rid of the roots of my problem. Stopping the nonsensical behaviour with food was only peeling away the outer layer of the problem. I
had been covering up the real problems since I had embarked on my diet at 14 and they lurked far beneath the surface.

One of the first important parts of treatment was to start back on the track of **normalized eating.** Only when I started eating again could my mind cope with the challenge of dealing with the precipitating or underlying issues. The first thing I had to deal with in my therapy was to get my eating back in control. My bizarre consumption patterns were affecting my brain and the way I thought. My therapist suggested I take Prozac, commonly referred to as the “happy pill,” which had proven successful in helping other bulimic patients with resisting the urge to binge and purge, to relax my thoughts, and perhaps aid in stopping my self-hatred. I was extremely uneasy about taking any drugs; I was ironically concerned with the side effects. After much personal debate, I decided I had nothing to lose. At the same time as I started taking the drug, I was meeting on a weekly basis with Dr. Rodlum and was attempting to keep a journal to record what I ate each day as well as the corresponding feelings and thoughts, in order to reflect on the possible relationships between food and emotion.

This therapeutic approach is known as “**cognitive behavioural**” and deals with the thinking behind disordered eating. It is the thinking that often leads to self-defeating behaviours such as dieting. The goal in such an approach is to become aware of and develop healthier thinking patterns, which in turn will lead to healthier eating behaviours. It is the meta cognitive process of thinking about thinking that aids in the recovery process.

My male doctor turned out to be my savior by combining drug and cognitive behavioural therapy. It is frightening to think where I might have ended up if for some
reason I had mistrusted him. Most likely I would not have survived. I do not wish to convey that therapy was a piece of cake or that I enjoyed every session. In fact, many times I felt intense hatred toward this man as he forced me to delve deeper into myself and pull out my most hidden thoughts and feelings. He was a very intelligent and sensitive person who was an “expert” on eating disorders. He treated many other women and girls with similar problems. He understood what I was going through. I trusted him with my life. For me, just knowing that I was not the only person with such shameful secrets made me feel better. I had known, of course, that others suffered from similar eating disorders, but now I saw evidence of these other sufferers each time I arrived and departed from the doctor’s office as our session times overlapped. I found myself intensely curious about these other patients, but we seldom made eye contact let alone spoke. It was not until I was at the end of my therapy sessions that I began to have the courage to look directly at them, to smile, and perhaps offer some hope if they had just begun the recovery path I was on.

After about 6 weeks on Prozac, the “happy pills” started working their magic and the number of bingeing and purging incidents started to decrease. One strategy that worked effectively for me was to schedule a binge/purge while gradually increasing the time between each one. As long as I knew I had one scheduled in the future, I was able to manage during the times I was not engaging in such self-destructive behaviour. One of the hardest things about having a food addiction is that, unlike drugs or alcohol, a person requires a certain amount of food to live. There is no going cold turkey or staying on the wagon. I had to figure out a way to eat and to do so normally. Most food scared me. Luckily, Dr. Rodlum recognized this fear, and I was allowed to stick with safe (non
fattening in my mind) food until I felt comfortable enough to introduce others into my diet. I was petrified of gaining weight. I felt sure that if I started eating normally, I would balloon up and become overweight. That fear was never substantiated. I do not weigh much more now that I did when I started therapy, and am able to now eat most foods in a balanced way. I was often weighed by Dr. Rodlum, but only for the purpose of putting this fear to rest. It turns out I had a pretty good metabolism after all. I now recognize that a perfect body is a healthy one.

Recovering from an eating disorder is complex and in many ways is never over. Once my eating patterns became more stabilized, I was able to discover why I had developed an eating disorder in the first place. This understanding involved examining my family dynamics and the role that my family played in the development of my problems. I had to come to terms with the fact that my family does not match my ideal and that the lack of emotional support is something I will always have to deal with in my life. I can not change my family, but I can change my ideal and myself. Examining my personal characteristics and how they contributed in the etiology of my problems was also crucial in my recovery. Again, I can not change who I am, but I have learned to deal with my high degree of anxiety, my perfectionist tendencies, and my need to please others. I can now anticipate how my personality sets me up for failure and have developed new coping strategies. Giving myself permission to both experience and express a wide variety of feelings allows me to act out in a healthy manner rather than act in using destructive methods. I have also learned how much the culture I live in affects how I may feel about myself, and I am better able to deal with the constant messages regarding appearance. I have had to deal with the negative thoughts that fill my mind if I
allow them to, and I continually work on trying to think positively about my life and myself. It is over 6 years since I first asked for help, and realizing that I do, in fact, require help from others was an important step for me. I am still, in many ways, recovering, but I no longer consider myself as eating disordered.

A few years ago, I decided to write another poem to reflect how I was thinking and feeling about hiding behind masks. This piece of writing symbolizes to me the stage at which I felt I was leaving eating disorders behind and allowing my true self to be revealed.

EMERGENCE

Once upon a time
not that long ago,
I thought that many people
covered up who they truly were.
By donning a mask,
adopting a disguise,
playing a part.

I didn’t really like it,
often questioned, “Why?”
knew it was unhealthy.
Yet, I fell into the act,
just the same.
Easier...safer...
the lines weren’t that hard,
the audience seemed convinced.

And I...I forgot who I was,
when not playing the part.

But now, I feel differently.
They aren’t really masks,
easily removed with one gesture,
in order to reveal the true identity behind.
We hide beneath layers,
of carefully constructed protection, 
So cleverly placed, 
like a suit of armor, 
to protect against enemies unknown 
or imagined. 
Honesty? 
Feelings? 
Risk? 
Love? 
The layers so completely cover 
the real person within. 
All that remains 
is a tiny voice, 
which pleads, “Let me be me.”

Peeling the layers off is a painful process, 
full of fear, doubt, anger and sadness. 
For what if...  
after all the layers are removed, 
Nothing remains of who was once inside.

But hiding within, 
is not really living, 
but a sad, slow 
journey toward death. 
As layers are peeled, 
examined, 
held up to the light, 
understood, 
discarded, 
the healing begins, 
new life occurs. 
As a butterfly emerges from a cocoon, 
as a reptile sheds its worthless skin, 
as the trees drop their summer sheltering, 
so the seasons turn, 
a new phase is entered. 

Change can be beautiful, 
and is, of course, continual. 
Layers, cast aside, 
the costume no longer needed. 
We shall step forward, 
vulnerable and exposed, 
yet happy and free.
Light as a feather,
"I've decided to play me."
UNPACKING THE THEMES:

DISCOVERING THE JOURNEYS OF MY STORY

*Time is not a line but a dimension, like the dimension of space... You don't look back along time but down through it, like water. Sometimes this comes to the surface, sometimes that, sometimes nothing. Nothing goes away.*

Margaret Atwood in *Cat's Eye* (1981, p.173)

Telling my story was not enough. Although I believe that sharing my experiences on paper was a positive action and a courageous act, I had to delve deeper by stepping back further and peeling off more layers. I needed to search for my "invisible glass walls" (Zerubavel in Connelly & Clandinin, 1988) in order to examine the stories that were so much a part of me that they remained unnoticed, to view my story through different lenses, and to recognize the themes that were found within my life up to a point in time.

The themes that I wish to share and reflect on are the emerging themes that I believe to be important at this point in my life. I have little doubt that others reading my story may recognize different themes. It is likely that in a future stage of my life, I too will look back at my history told in this thesis and pull out different issues and journeys than I see now. Such is the value of hindsight, further experiences, and greater maturity. I could share in this analysis only what I felt to be the case at this particular point in time.

As Mary Catherine Bateson (1989) points out, not only is it impossible to predict what
the future holds, but it is also difficult to know what the memories of the past will be the next time they are brought forward.

Telling my story thus far has not been done without some selective interpretation. I believe it is impossible to tell any past experience without some present-day influence that shapes comments and reflections. Connelly and Clandinin (1988) term this interpretation a "reconstruction of meaning." As McAdams (1993) states, history is not simply a chronicle, but a narrative interpretation of what we believe to have happened in the past, based on what we know in the present. However, the themes that I wish to reconstruct from many perspectives and share in this section of my thesis involve another layer of interpretation, pulled out (painfully at times) of the story I have narrated about my experience with eating disorders. As Peters and Fallon (in Fallon, Katzman, & Wolley, 1994) point out, few research studies have documented the recovery process involved with eating disorders, leaving little place for women to instruct about the process of change and allow for the possible discovery of curative factors. These authors outline important dimensions of the change process involving psychological and social development. Although the themes I examined are somewhat different in nature, I found it valuable to use their concept of growth occurring along continuums. The next section explains the overall themes of journey I discovered in my story and then I go on to explore the continuums of voice, self-image, self-acceptance and self and M.Ed. as they relate to my analysis of my own story.
Tools and Philosophy Needed for the Journey

One of the most prevalent metaphors found in my story was that of the journey of life. Perhaps it is due to the fact that I love to travel that I found myself writing with so much travel terminology, such as suitcases, journey, and crossroads. I love to plan out my next destination, reading travel books to gain insight into the places I wish to journey to as well as to ensure that I have all the necessary requirements for being able to travel there. As I write this paper, I am already looking forward to next year when I will be on an extended leave from my school board and will embark on a journey to three continents for a period of several months. Growing up, travel in my family meant day trips to nearby locations, but as an adult, I seek out destinations that are far removed from Orangeville, Ontario, both in distance and in culture. A few years ago, I had the opportunity to teach for a year in Australia as a participant in a teachers’ exchange, which fulfilled a dream I had had for several years. To me, traveling is a way in which to learn more about the world I live in, but equally important to discover more about myself. Traveling consists of both outward and inward journeys.

Looking back to the years leading up to when I first used eating disorders as a way to manage my life, I wish I had known then what I do now about life being such a journey. I was in such a hurry to get everything right and become the perfect person that I had no chance to enjoy the process of traveling through my teenage and early adult years. I did not disembark to enjoy or explore each port-of-call. I had such a focus on the final destination that I allowed myself no opportunity to explore the side journeys on the way there. I think that perhaps in adolescence I viewed life as more of a maze and believed I
just needed to navigate my way through in order to make it out to the other side to the paradise I craved.

What I possess now that I did not then is the knowledge that I am on a journey through life and that there is no final, ultimate destination. I have gathered some necessary tools and philosophies along the way that will help me with this journey but will not ensure its perfection. There is no map to follow. I am able to look back to observe the lived route I had traveled on so far (memory lane), but will undoubtedly face many crossroads and possible doors that are difficult to open in the future. What is valued is the process of exploration and navigation. I am now aware that life involves crises and that I do not need to deny them or make them all go away by eating and bingeing. What a smart traveler does is learn from past experience in order to travel with less trepidation and more instinctual choices in future unfamiliar territory. The past empowers the present, making a pathway to the future (Bateson, 1989). Mistakes will be made as wrong paths are selected, dead-end routes will be uncovered and force backtracking, and mountains will have to be climbed. However, there are views to be appreciated, breathtaking landscapes to be photographed, and people to be loved along the way that make the journey worthwhile. All trips, including life, come with positive and negative experiences. I understand now that it is what I choose to do with these experiences that becomes important. I wonder how this knowledge can best be shared with others.

The journey themes that I have unpacked in order to further this exploration can be viewed as small trips on my overall life journey. They chart the development or growth along continuums from negative or little knowledge and understanding to positive
or deeper understanding and insight. In no way do I imply that I have reached the end of any of these journeys, as they are all ones, with perhaps the exception of the M.Ed. journey, that I see continuing throughout my life. The important thing is that I use my new insight to recommend changes and action in education so that others can gain from my experience.

### Journey To Voice

One of the themes that came into focus through writing my story was the journey of voice. Prior to developing anorexia and eventually bulimia, I had started lowering a veil of silence. I suppressed both my emotions and my voice as I attempted to be the perfect person for everyone else but myself. Having an eating disorder is all about denial, disconnection, and disempowerment. I numbed my feelings and silenced my thoughts. I attempted to express my confusion about who I was and what was happening to me by not eating or by eating and throwing up. What I really needed was for someone to help me express the feelings I was experiencing and to allow me to try to voice the frustrations of my life at that time. I also needed to understand that these were acceptable feelings that others my age also experienced. The longer I hid within my disease, the deeper my voice became hidden, but at the same time my internal critical voice became louder. The denial grew greater as I stopped being able to even think about what I was feeling. Occasionally, I would hear whisperings of my true self, but I did not allow her to ever come to the surface, out of fear. If I did allow that voice to speak, I was afraid of dealing with the reality of my sickness, and that was certainly something that, for a long period of time, I neither wanted nor was able to do.
I first started to journey toward finding my voice and embracing my inner, critical voice (Stone & Stone, 1993) when I admitted to myself that I could not stop my bulimic behaviour without some intervention. Revealing this fact meant that it was finally out there in the open. Once I talked first to my doctor and second to my therapist, I could no longer hide. I had spoken out loud about what I needed, and I could no longer deny the fact.

Finding my voice and allowing myself to share it has been an extremely difficult process. I had been deceitful and dishonest for so long that I had fooled even myself about what I really thought and wanted to express. Often, I was not sure what I really thought or felt, and even when I was, I seemed unsure about expressing my ideas to others for fear of their disliking me. Socially, I was reinforced by the magazines I read and the friends I hung around with. What became important for me was further dialogue, at first in therapy and then gradually with friends, family, and even acquaintances. I started to realize that by denying my voice and keeping it underground I was making myself sick and risking death. I needed to embrace personal expression in order to be a healthy individual.

As I learned to express my voice, both orally and in written form, I gradually came to trust that it was safe for me to share what I thought and felt. Luckily, my friends and some family members allowed me to feel secure when working through the process of trying out my voice, and I grew to trust that people might actually want to hear what I thought and felt. I started to feel that my voice had value, and I awakened to the fact that who I am has to be expressed through my personal words and actions. Saying sentences that start with, “I am...,” “I feel...,” and “I think...” have been tremendously empowering.
Although I have made great progress along the journey to finding my voice, I by no means have completed this trip. I still find it much easier to express myself through written words rather than spoken, particularly when I am upset or angry. Certain emotions, such as rage or frustration, are difficult for me, as I feel that having such negative feelings reflect a weakness in me. These emotions often stemmed from unrealistic expectations. Some individuals can render me voiceless again when they appear to be poor listeners or act in uncaring manners. However, I have begun to recognize when and why I resort to such silences and have developed ways to cope with the desire to do so. I recognize the situations and people that diminish my self-esteem, and I try to avoid them if possible. I still think about many things that I have not voiced outside of myself...yet! That journey continues.

Journey To Self-Image

Another theme that became apparent as I reconstructed my story is that of the journey to self-image, or how I view myself. It is certainly a journey that has moved me from a negative to a more positive view. Unfortunately, for a long period of my life, I looked to others as the mirror in which to see myself, and the self who I saw reflected was always distorted and disturbing.

It was difficult for me to recall, even in childhood, a time when I viewed myself in a positive light. I think that I had a neutral view of myself because nobody in my family viewed it as important or found the time to help me feel worthy, loved, or proud of my accomplishments. My assumptions were probably unfounded, with my inner critical voice already at work when I was young. I did not know what my parents thought
or felt about me. I believe this problem intensified in early adolescence when my eating
difficulties began, and I latched onto a fixation with my physical appearance and the self-
loathing began. I started to be hypercritical of how I looked, and I fell for the
all-too-common belief that if I could just achieve the right look, I would be happy and
achieve success. Feedback about my “appearance” was better than no feedback at all. I
think that I learned that ‘appearance’ was important from my family first, not in looks but
in that others keep up the appearance of a normal family at all costs.

What I never stopped to examine was what would actually make me happy or
would qualify as success. Probably nothing would satisfy the inner critic, for it does not
recognize when enough is enough (Stone & Stone, 1993). In shallow ways, I believed
that if I just weighed the right amount and attained the proper shiny surface, then others
would like me and I would like myself. I desperately longed for others to like me, but
even when they did I could not like myself. There is a certain irony in the fact that the
more popular I became, the more distorted my view of myself became. My outside
appearance did not match my inner turmoil. No amount of positive comments regarding
my physical appearance could fill up the hole that I felt inside of me. I needed feedback
on all aspects of who I was, but it was never enough.

The more I became immersed in my eating disorder, the more mixed up I started
to realize my life was becoming on a subconscious level. I thought I was so unworthy that
I would go to any measure to ensure others did not see the real me. I started to hate and
hide myself. Why? It is an enormously difficult question, as I do not remember ever truly
examining who I was. I knew only that I didn’t measure up. I think I felt that
intellectually I was too smart, that others thought I was a “browner,” but I did not have
one area of particular strength academically, just a general aptitude for many subjects. I felt invisible. Emotionally, I felt I had way too many feelings, and that other people were better able to control and handle their emotions. Although socially, it appeared that I had many friends, and invitations, I was unsure if they liked the real me or just the person I pretended to be. I mistrusted their attention. In reality, I certainly did not give them a chance to see the real me. I was unable to take the risk. In fact, it appears that I did not allow myself any depth or real identity, being scared of what might happen if I did not measure up in others’ eyes, the way I thought I did not in the eyes of my own family. I wanted to be perfect in every aspect of my character, and such perfectionism can only lead to perceived failure. I pretended to be perfect; I was seemingly happy, well adjusted, and balanced in my life. However, all the while, I was afraid to truly examine who I was, or might become if I allowed myself to be less than perfect.

Undergoing therapy for the second time, in Guelph at 25 years of age, I took the first step to developing a more positive self image. I took off my mask for the first time in many years. I could not really say I did not like myself for I did not really know myself. That is what I hated, the not knowing. I had been too busy having no self and being what I thought others might like me to be. I needed to have someone look at me, with me. I started to see myself through someone else’s eyes, and although it was quite tempting to allow my inner critic to have the loudest voice, I started to learn how to honestly appraise my own character. I had to accept that, physically, I was becoming healthier the more I got my eating under real control, and that I had a positive physical appearance. I needed to embrace my intellect, and learn to use it in a positive manner instead of constantly worrying and criticizing. I began to allow myself to experience the
whole gamut of emotions and realized that doing so is part of being a human. Socially, I was faced with examining my friendships and determining which ones I was lucky enough to have as well as to deal with accepting the family I was born into.

I began to view my personal characteristics as threads that had to be woven together. Accepting each strand of who I am was important and unique. Only I could choose what pattern to weave. By trying to hide threads, I had achieved no pattern at all, and I no longer wanted to be an invisible self. What resulted from the intertwining of each facet of my character is a more holistic fabric of myself...not solely the physical surface.

My self-image has developed in a process that is best viewed as a spiral. There has been continual progress, but I often circled back because of negative thoughts. It was not easy, after allowing my inner critic centre stage for so long, to allow positive thoughts to become players. Part of coming to terms with how I looked at myself was realizing that the most important mirror to look in is your own. I had to learn to trust what I saw instead of what I thought others saw, particularly as my critical imagination made their views distorted in my mind. I needed to turn and show the world all the views that make up how best to see the whole me.

Once I began to stop the self-destructive behaviour of constantly viewing myself in a negative way, I had a hard time not being ashamed and embarrassed of my eating disorder, dysfunctional beliefs, and styles of thinking. My critical voice (the real culprit) tried to win favour by attempting to convince me that there was obviously something quite wrong with me if I had developed such problems. This view became hard to overcome, and the only way I finally reconciled it was to view my eating disorder as one
piece of the puzzle. I was like an archaeologist digging out pieces from the past, each one needing to be viewed, not in isolation, but as a part of forming the story of my past.

Currently, I have a much deeper, wider, and far more realistic self-image than I once did. It has been a difficult but important journey. My self-image is far more positive than the one I possessed the entire time I struggled with eating disorders. I have learned to trust and have the courage to turn my image in different lights to see the many facets that make up who I really am. This turning has been hard to practise in a culture where there is an omnipresent reminder that appearance is all that matters, but I have learned to struggle with such dichotomy. It has been a truly healing process as I have found so many characteristics I had hidden, lying nestled inside of me to be discovered during my searches, characteristics such as empathy and compassion. I have allowed myself to show vulnerabilities and recognize both strengths and weaknesses as well as some qualities that could be considered either. Although I would not yet say I am self-confident, my growth and transformation along this continuum are moving me in that direction.

Journey of Self-Acceptance

Associated with my journey of self-image was my journey towards self-acceptance. Learning to view myself as a whole person has allowed me to see my worth, and I have begun to accept all the strengths and weaknesses of who I am, instead of being alienated from myself.

My self-doubt and fear of others disliking me caused me to hide behind the mask of eating disorders. I was highly self-critical and judgmental. My inner critic was always telling me that I was not good enough and comparing myself to others in a negative
manner. Developing anorexia and bulimia became my way of exerting total control over my life. Although I was quite intelligent, in some ways I was thinking in a linear way, for I believed that if I just controlled my physical appearance and weight, then I could control my whole life. My inner critic could be seen as a manifestation of my intelligence or my intellect turned against myself. In reality, of course, I was moving farther and farther away from anything that resembled actual control. I hid within the security of my disorder.

I lived in constant fear of being found out, of people discovering that I was a phony. I developed a wariness of people becoming too close to me, being afraid that they would be able to see beneath the shallow surface to the inside truth of who I really was. If I felt someone was becoming too close for comfort or appearing to be able to strip away my layers of denial, I would use my critical voice to find any little thing that might be wrong with them and which would enable me to push them away, making it impossible for them to be a real friend or an intimate partner. Social contact was too risky. Although I had many relationships and friendships over the course of my illness, I remained distant and impersonal in many ways. I was like a talented goalie, deflecting any attempt that others made to try to get close to the real me.

My parents have told me that from an early age I would utter the statement, “I can do it myself,”, when they attempted to offer support or assistance. I inherited a strong will and independence from both my maternal and paternal grandmothers. Such characteristics can often be viewed as strengths. During my period of struggling with eating disorders, I used them in a negative manner to close the drawbridge. I wished for
complete control over my life and devised rules and rituals that allowed me to exert such control. I told myself I did not need help from anyone. I thought I could do it myself.

I would describe myself as a driven person. In my life story, it was apparent that I was constantly setting goals such as, “I will lose weight,” or “I will become a teacher.” However, no matter how many goals I managed to attain, I was never satisfied. Instead of reflecting on my success and allowing myself the satisfaction of how my skills and talents allowed me to be successful, I would immediately set another goal. I would not allow myself to admit that I was meeting my goals, and I certainly did not allow myself any pride or happiness about the hard work of getting there. I did not accept compliments from others, however genuine, and had little means of praising myself. I filled my life with constant activity: academic pursuits, social engagements, and extracurricular endeavors. I planned every single second of my life, a frenzy of activities. It was as if I was on some campaign to prove to anyone who might actually be noticing how much I was able to handle, although in reality I was not handling my life successfully at all. My enemy was spare time, for I did not want any time for reflection. Such behaviour, the burning of the candle at both ends, was a strategy that allowed me to both cope with my life and continue my self-destruction.

I craved order and routine and feared anything that looked like change. I was quite inflexible and could not accept any altering of my plans. I would reward myself with bingeing and purging if I could make it through my ultraplanned day. These episodes of bulimia were the way I managed the rest of my life. I felt I could cope with everything I tried to do if I could have the relief of eating until I burst and then the
punishment of throwing up. In many ways, this was how I expressed my need for acceptance and then wallowed in the guilt that followed.

Having an eating disorder becomes very much like playing a game after a certain amount of time. It is a game where the winner succeeds if everyone leaves her alone; it is a game where if you are declared the winner, you have actually lost. Subconsciously, I wanted people to care about me and even help me, but consciously I told myself that only weak people admit needing others, and I wanted to be strong. I could not accept that as a person I actually wanted and needed others to be happy and successful.

Many phrases emerge in my story alluding to such a game. My behaviour became quite conniving and deceitful as I secretly planned my binges and purges. I cheated others from the experience of knowing the real me. I lied in order to preserve the eating disorder that became my only friend. I fooled others (although this could be argued), and in the process became a fool myself. During recovery, it was extremely difficult to quit playing the eating disorder game and become a player in my own life. I had lived according to my own rules for so long that I clung to them quite tenaciously. It was hard to learn that in real life there often are no rules. There are just strategies that I can employ, not always successfully. I had to learn how to accept that if I wanted to live I had to give up the game.

Accepting that life is a journey and not just a painful game has involved having many conversations, embracing honest communication, and allowing myself to feel connected with a number of meaningful communities. I had to give myself permission to say that I cannot always do things by myself, nor should I want to. I had to say to others, "Don’t leave me alone." I had to allow myself to admit and begin to believe that I have
strengths and weaknesses and that it is what I do with them that is important. Expressing my feelings and developing trust in relationships has been part of this acceptance. I had been starving for attention and praise for almost my entire life, and I had to allow myself to accept both from my family and friends as well as myself. Moving from the game of denial to a life of reality has made such acceptance worthwhile.

Journey to Self

Although it became somewhat challenging to separate the intertwined themes that emerged from my personal narrative, the journey to self can be lifted out, examined, and discussed as a singular thread. In a sense, this journey can be viewed as one that moves from being self-less (not in a positive sense) to possessing a sense of self. I could not have moved toward this journey to self without the other journeys of claiming a voice, a positive self-image, and acceptance of who I am.

I wore a mask and played a role in the game for such a long time that in the process I lost whatever sense of self I had been developing in childhood. During the time I had an eating disorder, the set of rules I had imposed on my life, my inflexibility, and my practiced denial had combined to result in an inability to develop as a whole person.

Part of the underlying problem that led to the lack of self was that during my adolescence I began to measure myself in shallow, nonproductive ways...using physical appearance, weight, and size. My perfectionism ensured that no matter what tool I selected, I never measured up to the standard I envisioned. I was never thin enough. I was never pretty enough. I was too tall. My hair was too thin. I also measured my success through examining how much I could accomplish in a period of time or by how busy I
could make my life without falling apart. Again, I guaranteed failure by devising impossible standards. My warped way of thinking meant that when I compared myself to others I always came out the loser. No matter what I weighed, what marks I achieved, what jobs I held down, what activities I participated in, or how many parties I was invited to...it was never, ever enough. Having recovered, my reasoning and behaviour at that time make little sense now. I reflect that if I had actually admitted to myself that I was succeeding in many ways or that I was a worthwhile person, then I would have had to examine why I needed my eating disorder and why I could not be happy. My inner critic was too powerful at the time and denied me such an opportunity of reflection.

I sought feedback from others and began the vicious cycle that can perpetuate eating disorders. I had originally started dieting in order to feel better about myself. As I lost weight, I started to get feedback from others that provided me with the validation I so needed in order to feel positive about myself. As I stopped eating, starvation began, and it was not solely hunger for food. I needed a different kind of validation, and when I could not get it, I attempted to make myself better by eating less and less in order to receive the only feedback I could get. Eventually, no amount of weight loss or compliments from others regarding my appearance could possibly provide me with what I really needed, a sense of who I was.

It is tempting to look back at the past and easily point out what I needed at age 14, 20, or 25. Unfortunately, it is impossible for a person in the midst of an eating disorder to say what she needs. If I could have told someone what I needed, I most likely would not have developed such a serious eating disorder. Having written my story, I can now say that I needed a sense of who I was as well as the validation that who I was mattered. I
needed self-esteem, self-acceptance and a positive self-image. I needed to accept who I was as well as receive acceptance from others.

My recovery process allowed me to start developing that sense of who I was, who I am, and why such self-knowledge matters. I have had to close the gap between my own perception and others' perceptions of me. Part of this process has involved listening to what others say about me and accepting their opinions as genuine...both the compliments and the criticisms. I have had to examine facets of my personality and ask myself if they are truly who I am or what I had adopted in order to please others. I have had to let go, with extreme difficulty, of some of the pretense I had operated under. I no longer pretend to be happy all the time or do what others want if it is something that would not please me, and these are changes that are hard for others close to me to adjust to. I am working towards developing myself into a person I feel comfortable with, and although this process is far from over, I now possess a far greater sense of self than I ever have. I see and accept all the colours within my kaleidoscope.

Journey Of My M.Ed. Degree

Better to write for yourself and have no public,
Than to write for the public and have no self.
Cyril Connolly

Without having embarked on the journey towards achieving a Master's degree, it is doubtful that I would have been examining the themes of my life in such depth. As such, this journey was also one that was important to both reconstruct and deconstruct along with my other journeys toward voice, self-acceptance, self-image, and self.
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In some ways, the journey towards completing my M.Ed. parallels my own life story. I started out rather tentatively and unsure, gradually coming to the realization of what was important and valuable: that I needed to do this. I have gone through periods of great stress as well as those of great accomplishment. Writing my own story for academic purposes has caused me to reflect on my past experience, similar to looking at trip pictures in a photo album. This viewing has been a positive and negative experience. It has been positive in that it has allowed me to put all of the story pictures in perspective and see the big picture that is my life, but it has been negative at times to look back at some of my pictures that are filled with pain, shame, and self-destruction.

At the beginning of this M.Ed. journey, I found myself using words and performing actions that were mechanical, objective, and impersonal. I worked under the only model I was familiar with, one that was quantifying and clinical. This work parallels my early visits to Sick Children’s Hospital. I had no voice and certainly no sense of self in my writing. I was thinking negatively, about myself as a student as well as my work. I was not accepting what I needed or wanted to do. I found myself resorting to the familiar behaviour of listening to my critical voice and telling myself I could not possibly complete this degree.

Gradually, through working through the process of completing the necessary steps, I found that I recovered my sense of self as a student. It was therapeutic in that I had to express that I required assistance, that the strategies I was employing were not working, and that I required a certain type of treatment. I had to learn how to accept both help and criticism. The process was very experience based, and I eventually started to validate myself.
I moved along the continuum to a more personal, qualitative method of completing my work. I found my voice by starting to tell my own story, something I had seldom given myself permission to do. It was my understanding and my story that became important, and realizing that what I had to share was valuable and extremely positive was also crucial. I had to accept that my experience mattered, and that only I could pass on the personal knowledge through reliving, retelling, and reflecting on my story. It has certainly been a journey with many hills and valleys, but one that it was necessary for me to travel along.

Conclusion: Connecting the Themes

Putting my experiences into perspective has been a difficult process. It was extremely challenging to step back far enough from my own story to be able to actually see it for what it is and to recognize the themes that bind it together. Using the metaphor of a series of journeys has simplified the process for me, as I have been able to parallel them with other journeys I have made in my life. The other aspect that made writing this analysis section difficult was that I had seldom had the opportunity to write about myself to such a great degree, and putting myself under the spotlight was often uncomfortable. I proceeded with the knowledge that transformation was occurring during this journey as well, and it was just one further step towards complete recovery.

What became important at the end of examining the themes was that I would go on to use my new knowledge and understanding for action beyond my own healing process. Interpreting meaning was of crucial importance, but for me such meaning might be extended if it were applied to action that can make a difference, in both my personal
and professional life as well as the world in which I live. Having been on the journeys, I now have the opportunity to share my new understandings about myself and my experiences with eating disorders.

At this point in my thesis journey, I found myself referring back to my original questions of how I might possibly help my students avoid falling into the trap of developing eating disorders and how to guide teachers in examining their own practices in school settings. Based on what I have gleaned from my own story, I want to share my themes with teachers about how their classroom stories might develop. The next section of my thesis attempts to build such bridges between my story and the outside world, including curriculum development, school climate considerations, and research implications. Each reader will take away her own ideas and interpretations.
CONCLUSION: BUILDING BRIDGES
CONNECTING TO THE GRAND LANDSCAPE

Experience is not what happens to you:
it's what you do with what happens to you.
Aldous Huxley

Introduction

I am a teacher, and one of the first considerations I teach my students to make when they are engaged in the writing process is to reflect about the purpose of their written work. I instruct them to think about the following questions: What audience are you writing for; what do you view as the purpose for your writing; what do you hope to communicate to your readers? Similarly, it was necessary for me to consider such questions as I embarked on my most ambitious piece of writing to date, my thesis.

For me, the purpose of writing this thesis has been threefold. First and foremost, my writing is for myself. It was a personal journey of educational transformation. I am making a link between my own experiences with eating disorders, my experiences as a teacher and my experiences as a researcher. The narrative plays a role in the formation of self (Witherall & Noddings, 1991), and as I examined the phenomena of eating disorders from an insider’s perspective, I was writing as a journey of personal inquiry. As Fallon et al. (1994) point out, it is the concept of self-improvement that reminds us to learn about the past, build on it, and bequeath wisdom to future generations. Inquiry is primarily about the self, both personally and professionally.
Second, I aimed to share this qualitative research study with others, both in the education field and in the research community. I hoped to influence teaching practices and make suggestions for fundamental changes in climate and curriculum in schools. By providing a personal, insider account, I wished to inform and persuade others through the use of rich description with an emphasis on experiences, feeling, and interpretations. I wanted to influence direction in the field of qualitative research, particularly at Brock University, so that others may choose to embark on such a journey as well as provide a deeper and wider understanding of the eating disorder phenomenon within the research.

Last, I wrote this thesis in order to have an impact on our culture. Witherall and Noddings (1991) state that narrative plays a role in the transformation of our culture. By breaking away from quantitative studies and writing on newer ground, I hoped to further illuminate the problems of eating disorders for individuals who may choose to become familiar with my work. I wanted to influence how people view the society in which we live by providing a unique perspective regarding our culture for consideration, the perspective from inside an eating disorder.

The challenging part when working on this thesis was to keep the three aspects of my purpose simultaneously in the forefront of my mind. As Ritchie and Wilson (2000) suggest, I had to turn my stories over, inspect them, and understand them in the light of who I have become. I also had to recast meaning by theorizing my stories into my personal, professional, practical, and political lives. As Clandinin and Connelly (1994) describe, I had to look inwards, outwards, forwards, and backwards in order to see all possible perspectives. Most important, I had to begin with myself.
The search for meaning in our lives and stories is an integral part of being human. As such, I had to provide unity, purpose and connections in my work. The purposes of my writing were entwined; the more I attempted to separate the strands, the more tangled they became. I had to stop trying to separate them, instead viewing my narrative as the study of the whole, as a flexible, woven landscape (Connelly & Clandinin, 1988). As I completed this educational requirement, I was developing personally and professionally, consciously trying to make my audience gain insight. Keeping these purposes and potential audience in view on my landscape enabled me to better approach each section of my thesis. Attempting to answer my own writing questions led to further enlightenment for me. Sharing my perspective with my readers invites them along as part of my journey.

Bridge to the Inside

Personal Growth and Professional Development

My past experience provided me with a unique perspective. Because I have lived through the experience of having an eating disorder, I feel I have a meaningful story to share about what it actually feels like to struggle within that particular experience. I ended up arriving at this place in my research and writing a narrative inquiry because it became impossible for me to remain objective about issues I had personally experienced. Attempting to write in such an objective and distanced way caused me to feel like a hypocrite. I questioned how I could suggest ways to help people recover when I had not recovered enough to share my own experience. In no way could I claim to be solely an observer or an all-knowing expert, for I was still in the process of being known to myself.
I needed not only to understand what I was writing about, but also to be able to express my personal thoughts, feelings, and opinions. I needed to share my particular and personal point of view.

In this section of my conclusion, I have examined how I myself have changed by traveling on this personal journey. My identity and professional practice are inextricably linked, and so I investigated changes in both of these landscapes. As Witherall and Noddings (1991) describe, I had to bridge my inner “mindscape” to my outer landscape. I had to answer the questions of how I had been transformed and how this process had been worthwhile.

I have come to believe that I arrived at this spot in my educational journey because it was where I personally needed to be. Having an eating disorder was branded on my identity, and I could no longer comfortably pack away my experiences. I had always had a difficult time understanding how researchers seldom write about their personal connections to their own studies. I wondered how they resolved this dilemma in their own minds.

Quantitative tools could not measure what I wanted or needed to know. I had recognized that problem for a long time. However, because of my own education experiences, I found myself possessing only quantitative tools and language. I needed to gain a new set of tools in order to complete research that I would personally find valuable. I was mentally exhausted from quieting my own inner voice. The pieces of my research refused to come together in that first proposal because I was missing the largest piece: myself. When I legitimized my own story enough for it to be immersed in my
phenomenon of study, I started to feel the sufficient interest needed to sustain my commitment to the project.

It was only then that the door to the qualitative world opened and allowed me to find an inner strength I did not know I possessed and likely would not have been able to discover on that other landscape. It was as if I was on my own journey in the Land of Oz, only to realize I had a voice all along. The recovery of my voice not only changed what I said but served to increase my own depth of meaning. True dialogue is possible only with voices that are honest and reflective. I no longer chose to be silent or use a compliant voice, but to communicate in an articulate and personal manner.

Up until the point of writing my thesis, I had not been forthcoming with many people about the fact that I have suffered through an eating disorder. I have now learned to feel comfortable enough with my story to let the drawbridge down and share personal information with others. Being able to share my experience was indicative of real personal growth on my part. There had been many incidents in the past where I had questioned the value of sharing my story and often chose not to due to fear of what others might think as well as feelings of shame at my weaknesses. Now I realize that sharing my story may impact others’ ways of thinking about eating disorders and may help in the grand scheme of things. I may help others to think differently about food and eating disorders, to be more conscious of the images they seek to be like, and to set different goals in their lives.

By writing using “I,” I was drawn back into a kind of knowing that had too often been silenced through the institutions that I had been educated in. Buttignol (1999) points out that as individuals progress into higher learning, they are forced to stop writing with
"Is" and the self is lost. The disappearance of these "Is" marks the rift between the personal and professional. Our voices help us examine who we are and assist us in identifying our unique needs. I needed to find myself in my research. The overlapping theme of personal silence in quantitative studies, eating disorders, and my own story was one that particularly resonated with me. Publicly writing my story has helped to move me from isolation and emotional absence to the genuine sharing of self. Self-narration produced a sense of continuity (Ellis & Buchner, 1997) and has allowed me to hold a mirror to my past in order to figure out who I was, who I am, and what the possibilities for the future may be.

Writing this narrative has in some ways served as a further stage of recovery, the peeling of one more layer. What is apparent to me presently is that I had to heal myself inside before I could hope to impact the outside community. Recovery is multidimensional and involves a progression of changes in relationship to the body, self, family, and culture. I needed to feel a connection to my writing in order to lay the foundation for personal growth and further recovery. The process has affirmed who I am. Witherall and Noddings (1991) rightly describe such a process as both cathartic and introspective. It gave me the right to intelligently examine my own life, use my experiences as a lens to see in new ways, and wrestle with the angst of the past in order to make meaning in the present. Even as I was deeply embedded in my own context, I had to learn to understand more deeply my investment in the continuation of my project (James, 1999), which became considerably more personally important once I allowed my voice to become part of it.
Writing my own story was personally therapeutic. Although critics of qualitative research may view such a claim as a weakness, as “soft research,” I believe that such personal growth should be seen as a strength of such writing. Subjectivity should be stated, instead of attempting to hide it away as is the case with quantitative data. The therapeutic value of narrative inquiry should be embraced for as Connelly and Clandinin (1988) point out, narrative is therapy. I grew to realize that the more I understand myself, the better teacher I have the chance of becoming. Such personal writing allows people to let go of emotional baggage (Ritchie & Wilson, 2000) and move into a higher level of thinking. Maturity demands acceptance of internal barriers and obstacles within the self, as well as the meaningful organization of the past. Writing my story has only enhanced my understanding of the phenomenon of eating disorders. I feel a sense of contentment after sharing my story, for although I would not say I am completely peaceful with who I am, I am happy about who I am becoming.

Freedman and Conks (1996) describe lived experience as being stored inside of people, and that experience is coloured and shaped by the meaning people make of it as well as how that meaning is relevant to personal lives. Writing stories help people unpack their lives and see them from unique perspectives. What ought to be interesting in research, according to Conle (2000), is the unfolding of a life, the peeling back of layers in such a lived life, rather than the confirmation such a chronicle provides for some theory. Not only did I find myself more fully present in my work, more engaged, and more honest, but I recognized that only narrative inquiry could provide the necessary catalyst I required for the change (Jalongo & Isenburg, 1995) that I was subconsciously
seeking. Writing my narrative inquiry allowed for personal awakening that served to make me a stronger person.

I believe that personal growth allows for professional development to occur. Our stories are who we are (Buttignol, 1999). Education is about the building of a person, whether it is a child enrolled in kindergarten or an adult engaged in postsecondary courses. My Master of Education degree has allowed for enough individualized selection that I could identify both my personal and learning needs. Only through the development of personal knowledge could the basis be laid for the development of my professional knowledge. Having reached the next stage of recovery, I was able to hold out my practice to the light of this new understanding, and I found myself positioned at a new location on my educational landscape.

In my work, I see that educators frequently question the significance of their own experiences in shaping their attitudes about teaching and learning. Professional philosophies of education are developed because of personal beliefs. Narrative, according to Jalongo and Isenburg (1995) prompts us to recall, rethink, and reconnect personal and professional events in holistic, synthetical ways rather than compartmentalized and linear ways. Such research, metaphorically described as a kaleidoscope, is able to shift to meet each particular view rather than remain a stationary lens. It can provide a view from many vantage points rather than just one. To me, narrative became the vital choice to forge the needed connections, linking my personal experience to what kind of teacher I have been and am becoming.

Personalizing my own experiences surrounding eating disorders has in many ways helped substantiate what I believe as a teacher. I became a teacher in order to help make
a difference in the lives of the children whom I have the opportunity to teach. The metaphor that best suits my beliefs about how children learn is that of a garden. As a teacher, I have many types of children, or plants, that have arrived in my garden from many different nurseries. All are capable of growing into beautiful and unique beings. It is my job to nurture these children, to provide exactly the right conditions for each in order for them to grow to their full potential. Outside factors certainly influence our garden, but it is I, the main gardener, who must decide how the garden will look and the requirements of each child. Even though as a student, I had appeared to be a healthy and beautiful plant on the outside, I was wilting on the inside because I was missing any internal substance. A good gardener needs to recognize such problems and help to change them. I believe such a metaphor is applicable from preschool education right through graduate work. University professors have to nurture their students and provide the necessary nutrients.

As a teacher, I am aware of the vital role personal experiences play in learning and teaching. Children can not grow intellectually if they are starving physically, emotionally, or socially. With a classroom full of adolescents, I recognize how crucial social interactions and connections are to these young learners. It should have been no surprise that I had to deal with my own personal problems surrounding eating disorders before I could finish my thesis, as each day in my classroom I assist my students in resolving problems before we go on to learning opportunities.

Writing my story has helped reinforce my belief that teaching intermediate grades is where I am most needed as a teacher at this stage in my life. The M.Ed. program has highlighted this understanding for me. Due to my own experiences and how I have
learned to cope with them, I am extremely sensitive to the children trusted to my care. I intuitively recognize when students are upset and do everything in my power to support individuals so they might rectify such situations. I attempt to make every single child in my room feel valued and important, both to myself and to our classroom community. I refuse to let the latest pendulum swing in curriculum or testing to prove accountability stand in the way of the classroom climate or a child’s self-esteem, which I feel is the most important aspect of teaching. I take the necessary time to communicate, to ask questions of my students, and to be there for them when and if they need me. Writing and reflecting about my personal experiences helped illuminate for me why I believe in team teaching at the intermediate grades, with minimal rotary. I recognize the value in knowing as much as possible about each individual child, and that explains why I choose to teach the students and not the subjects.

There is a similarity in what I have experienced through writing this thesis and the experiences I try to replicate for my students. I help them to get to know who they are, to recognize their strengths and weaknesses, and to feel good about their personal growth throughout the year through writing and communicating activities. I try to cultivate deep reflection in the processes they are personally engaged in as well as about how they fit into the big world out there. I try to provide some of the tools they will require to develop into good people and productive citizens. Who I am personally explains how I operate professionally. The choices I make each day in my teaching practice are made in part because of my past experiences.

Using narrative inquiry is not always the easiest choice for the researcher to make. It is risky, as it makes the writer vulnerable and thus requires courage. For me, it
was like diving into unfamiliar and often quite turbulent waters (Carter, 1993) or embarking on a journey to new and unmapped territory. Frequently, I found myself having to resurface for air or going down dead-end paths. However, with perseverance and growing confidence in the method I was engaged in, I was rewarded with beautiful views of the inner landscape I was exploring. I now have a clearer vision of who I am, personally and professionally.

I am proud that my research has a personal significance. Contributing to personal growth and professional development should be of primary emphasis in any higher education program, particularly one about education. The onus has been on me to demonstrate initiative with the project, and perhaps it should be on me to measure its success. My being part of the research story meant that I was fully able to participate in the construction of my new knowledge and attitudes and to build myself as a person so that I can better provide the opportunities for my students to build themselves.

I am now a different teacher than I was when I began this research project. Although I would not say that my beliefs about education have changed, I do believe that they are more strongly ingrained in my philosophy of teaching. I used to just do what I thought was best for my students in my own little part of the world, my classroom. Now, I strongly voice my beliefs and my practices to other professionals, advocating for what I think my students need. Also, I now have a much clearer vision about why I aim to become a school administrator, in order to impact direction and make possible changes on a broader landscape. The writing of this thesis has made me see myself more clearly.
Bridge to the School

Curriculum Possibilities and Research Directions

The original purpose of my research has always remained close to the surface of my writing: the question of how educators can help in the prevention of eating disorders. The interest in the phenomenon of eating disorders had been of personal interest to me, but that reason alone was not enough to warrant such an inquiry. I had a need to connect my unique story, written in a narrative way, with larger questions of significance. These questions included what implications my story has for possible curriculum developments and what direction research may take. In this section of my conclusion, it was necessary for me to articulate such links.

In order to make these necessary links, it was crucial to look at how my story may have suggestions for classroom and school settings. Based on my story, there are many things that teachers might see the need to do. They may choose to be on the alert for “perfectionist” tendencies, to be aware that “model students” may be harbouring such disorders. They might seek further knowledge about eating disorders, including characteristics, symptoms, and etiology. They might wish to be sensitive to how girls tend to compare themselves and how such comparisons affect their self-esteem. They could role-model acceptance for all body shapes and help young women accept that pubescent weight gain is healthy and normal. Thinking skills could be emphasized in many areas, including media literacy. Students could be taught and given opportunity to practise effective ways of expressing a whole gamut of emotions as well as be encouraged to find and use their voices. Teachers could build stronger communication
bridges with parents so that trust can be established and information about students can be shared.

The possibilities I have just explored are by no means a list of what I think every teacher needs to and should be told to do. In a narrative, I cannot interpret and then give the answers. I do not want to tell other professionals what to do, but rather suggest, for my story is only one story and others should interpret it in a way they view as best. The following section explores some possibilities that educators could consider that I feel might have helped me as I travelled through my schooling and that I believe might help other students avoid the world of eating disorders.

**Curriculum Implications**

It is often suggested that developing and implementing educational curricula that address eating disorders would aid in the prevention of such disorders. As a result, several such curricula have been designed and utilized, mainly at the junior high and high school level (Body Image Coalition of Peel, 1997; Kater, 1998; Levine, 1983; NEDIC, 1988). Some of these programs include topics such as: the negative consequences of dieting, emotional factors related to eating, media influence on body image, risk factors and symptoms of eating disorders. Few of these programs have been systematically evaluated (Fallon et al., 1994), and those that have generally do not meet the objectives set out, of changing long-term attitudes and future behaviour. As my story suggests, victims of eating disorders are in denial, and the basic issue is self-esteem. Such denial or issues are seldom addressed. However, some researchers (Fallon et al., 1994) caution that
such negative results should not be viewed with discouragement for it simply means we need to continue to evolve such programs. In my opinion, that need still exists.

What I hoped to offer through the completion of my thesis were some implications for such curricular evolvement. As I found myself working through the research process and gaining new understanding of how a narrative worked, I discovered that theory and practice are best integrated through the narrative unity of experience (Connelly & Clandinin, 1988). To me, this means that what I learn through research about the nature of eating disorders needs to be entwined with what I suggest for practice in schools. As Connelly and Clandinin point out, theory and practice make up part of personal knowledge, and the learning of new theory becomes practical when it actually becomes part of the self and one acts in ways that reflect the novel ideas. Connelly and Clandinin, pioneers in the area of narrative inquiry, define personal practical knowledge as a person’s past experience in a person’s present mind and body and in the person’s future plan and action. Thus, I needed to link what I had learned about myself through narrative inquiry with what might make a difference to others and to make practical suggestions for such inclusion, links that I referred to in the last section. By no means do I have all the answers, but I do have personal knowledge that should be shared.

In my mind, there is little doubt that prevention programs can be effectively run through school programs and initiatives. However, I think the curriculum needs to be viewed in two different ways. Our local school board often defines the curriculum as “big C” and “little c” programs. The “big C” curriculum encompasses everything that occurs within a school, whereas the “little c” curriculum covers the teaching and learning program, curriculum in the more traditional sense of the word. Based on my personal
experience, I believe my story has implications for both the broader and narrower curriculum.

In regard to the “little c” or teaching and learning curriculum, I believe that student and teacher knowledge about eating disorders is nowhere near enough. Knowledge is certainly power. However, simply learning about eating disorders, their causes, risk factors, symptoms, and dangers is not sufficient enough to actually prevent such disorders from occurring. Covering the topic through one unit within the health component will do little to affect attitudes or change behaviour. If anything, it may make the incidence rate higher as young women learn about the disordered behaviour and give it a try (Boskind-White & White, 2000). I believe that changes across the curriculum are needed in terms of how eating disorder prevention is addressed and taught.

As my story indicates, eating disorders are not simply about food or about not eating enough or about eating in a disordered manner. They are about the loss of self and the need to feel valued. What students require is certainly not a quick unit to cover the topic of eating disorders and then to move on to the next learning expectation. What students require are opportunities to learn about the value of their own individuality. I believe that students need ongoing positive confirmation in whatever subject they are engaged in. Further, I think that we as educators should be assisting our students in learning about themselves as much as possible. Students need to learn about and how to cope with peer pressure, self-criticism, perfectionism, the need for control, obsessive-compulsive behaviour, and using food for the wrong reasons; they need to be able to explore, validate, and appreciate their skills, abilities, and possibilities in each of the quadrants: physical, intellectual, emotional, and social. Like society, our schools are
often far too competitive and judgmental. Students need to discover their inner strengths and beauty and how to love themselves. They need opportunities within the school day to learn the language that surrounds feelings as well as a safe place in which to express such feelings through practice and role modeling. We need to provide students with the chance to acquire tools that will serve them in the future in order for them to be their own best resources and their own best supporters through opportunities to dialogue, peer coach, and learn about the self. In this way, they may become empowered enough to nourish themselves and to learn how to be the best that they can be. Such personal strengths and sense of selves would help prevent any high-risk behaviour, not solely eating disorders.

The ideal age at which prevention programs should occur is often debated within the literature surrounding eating disorders. The tricky part of such a decision is that prevention programs can look quite different from one another, ranging from a specific unit to integrated philosophies. Some research suggests implementation at the average age of onset, which is early to mid adolescence (Collins, 1998); others suggest earlier, as they feel the age of onset is too late (Boskind-White & White, 2000). The question becomes, when do girls decide how they look is more important and deserves more of their efforts than who they are? I certainly agree that adolescence is too late to begin prevention, and I would argue that, as educators, we should be aiming to prevent all high-risk behaviour from the earliest age possible. Prevention of various difficulties, whether it is eating disorders or teenage pregnancy, can not be a one-shot deal. I believe that any prevention requires long-term commitment and cross-curriculum strategies.

I would also suggest that students need to be as involved as possible in such prevention initiatives. There could be the opportunity for peer-led discussions so that the
students learn the value of their own voices as well as have the chance for reflection through listening to others. Students could be encouraged to talk to each other about what they are going through in order to learn how worthwhile honest, genuine communication can be. They need to feel heard by those they consider important in their lives.

Media studies are another important area that must be stressed along with possible prevention strategies. I believe our students must learn how media operates, who controls media and how media has the possibility of manipulating them. They could be taught how to think critically to understand how to make their own decisions. Such teaching might occur in every grade across subject areas. Prevention programs will be ineffective unless young people learn how to confront and alter the culture they live in. Only genuine discussion about the development of such skill will equip students with the necessary tools to make informed choices and to be aware of how they are influenced.

I am the first to admit that none of my curriculum suggestions are simple to implement. They require that we, as educators, explore prevention as a cross-curriculum possibility in a much broader sense. They also require that each professional make decisions about how to use the ideas I suggest to best fit their students and their school environment. Such changes require consistency and hard work. They require examining what it is that the children in our classes actually require beyond the “little c” curriculum. Most important, my suggestions require us to view students as whole people. They do not leave their emotions at home. For most teachers, such considerations may not be a new concept, while for others they may be a timely reminder to examine the possibility for change. In current times, when the government has mandated increased accountability and the emphasis is on a curriculum that is much more intense and has to be presented at
a faster pace than ever before, teachers may feel that they just can not do it all. However, I would suggest that if we do not provide our students with the opportunities they require to develop, understand, and appreciate themselves, then we are doing our students and our society a huge disservice. Many of my suggestions involve teacher attitude rather than additional time away from the already huge curriculum.

There are also many suggestions that I would make for the “big C” or the broader idea of curriculum. Such implications could affect the culture, or the climate, in schools and might require fundamental changes in both philosophy and action.

There has been much researched and written about the difference between females and males regarding their needs related to education (Gilligan, 1982). I think it is important to realize that our students often require different things from our education system in terms of both learning and social needs. Adolescence becomes a crucial time to address such discrepancies. In adolescence, girls need encouragement to stay connected to their bodies as well as connection with others to feel value (Gilligan). They may start to go underground, presenting to the world who they think they should be while hiding the person who does not fit the cultural criteria. This secrecy is certainly what I encountered at that age. As Gilligan aptly describes, girls turn to other women for guidance, requiring examples, critical perspectives, and company. She suggests that as adult women we must listen to our girl students. We owe them dialogue and careful listening. We need to listen to the stories that lie beneath the language of feeling fat and help female students to feel the connections between how they feel about their bodies and how they feel about themselves. My story suggests that students need control and authentic confirmation. As Friedman (1994) suggests, we need to attempt to diffuse any
incipient preoccupation with food and weight before it becomes entrenched in behaviour by looking at such connections. What is difficult for teachers at this level is that girls will be seeking independence while simultaneously needing connection. It is part of the school’s role to help nurture what our young women require, providing a sense of community, and offering alternate ways of self-expression besides obsession with food and weight. Teachers need to make conscious decisions to offer such opportunities and be attuned to such needs.

I focus on the intermediate age level in this section for good reasons. Although I believe we can do as much as possible in helping prepare children for this often difficult and confusing period of their lives, it is equally important to help them through this period. It is of no surprise that students of this age often engage in high-risk behaviour as they shop for personalities and test all limits. In many ways, the traditional manner of handling the intermediate learner may add fuel to the fire. I think that throughout the transition years of grades 7, 8 and 9, students should not be rotated through the subjects with many different teachers. I developed an eating disorder at a time when I was on complete rotary and felt a sense of distance from my teachers. Our students most need connection and stability at the time when schools often start teaching the subjects and not the students. How can teachers help each student feel valued as a whole, individual person if they have each child only for a period of 70 minutes each day? How can adolescents feel a sense of community if they must change locations up to eight times per day? I believe that we should reshape the existing role of the teacher at this age level and provide continuity, consistency, and community for our young people. School boards need to ensure the careful selection of intermediate teachers by keeping the learning process
student centered. Teachers need to have the time to listen to children’s stories, to get to know them outside of school, and to allow for communication, empathy, and attention. We must make changes that provide students with what they really need holistically, not just intellectually. I believe school boards should evaluate the purpose of rotary at the grades 7 and 8 level and take the whole student into consideration when deciding what approach is the best. Research indicates (Hargreaves, 1994) that students involved in rotary have a sense that their teachers do not care very much for them as people in the school. For some students, a sense of belonging may far outweigh subject knowledge.

Another way in which schools might help prevent eating disorders more effectively is through teacher education. Most teachers are not knowledgeable about eating disorders and may not be sensitive to the signs of potential problems. There needs to be a broader and wider program of in-service for all teachers, not just those that teach intermediate-aged students. Teachers must learn about the underlying factors that may influence the development of eating disorders. They must examine their own attitudes and behaviour surrounding food and body image. They need to be aware that female students experiencing difficulties may wear masks or be in denial, that the “good girl” mold is not really desirable, and that intervention must occur as promptly as possible for those students who may require it. Intermediate level teachers in particular need to be instructed how to have a heightened awareness of what their students most need from them, however subtly they express such needs. These needs may include self-esteem, acceptance, and encouragement. I watch my sister with her newborn baby and I cannot help thinking that, as an intermediate teacher, I need to be as sensitive to my students’ needs as she is to that little girl’s. I also believe that teachers need encouragement to be
more honest and genuine with their students, to share stories and experiences, and to learn how to be both guides and mentors for our young people.

That bridge is one I hope to cross more often in my future time as a teacher. I have tried to be more honest and genuine with my students, to share stories instead of always moving on to the next academic task. Being honest with students involves walking a fine line. Being too open may present as many obstacles as not being honest enough. Parents, federation, and administration may not support such honesty through story telling in the classroom, and a teacher must respect the professional boundaries between being a student’s teacher and a student’s friend.

The curricula within both the classroom and the school as a whole are important in regard to their roles in preventing eating disorders. I believe that many of the prevention programs that have been developed and implemented thus far reflect positive beginnings but do not reach deeply or widely enough. In some ways, prevention needs to happen throughout the education system in order to change the entire climate in which our students are educated. I think that only through such broad changes may a real difference be made. Writing my own story helped me understand what I was lacking in my school environment and identify what might have made a difference for me.

**Research Directions**

One of the main ways I believe my study will contribute to the field of research surrounding eating disorders is through providing a personal, insider account. I want my readers, whether they be teachers, students, parents, or other researchers, to feel up close, not out there (Carter, 1993). As evidenced in the research available on eating disorders,
the voices of those individual, actually experiencing the disorders are largely silent. As Fallen et al. (1994) point out, there is a need to amplify the voices of eating-disordered women and to allow them to teach others what is involved in the process of recovery and the important dimensions of the change process. I believe women who have recovered can act as essential sources of information to researchers in their quest to understand, treat, and prevent eating disorders.

I also hope that my writing about eating disorders in this manner may encourage other women who have recovered from such difficulties to come forward and share their experiences about similar challenges. Only we, the recovering and the recovered, can provide to others a keyhole through which to view eating disorders. One of the frustrations I experienced when researching the large amount of literature on eating disorders was that most studies were of the quantitative nature, and I did not feel connected to such research. They provided snapshots of the disorders, but never the holistic stories behind the pictures. As Squires (2000) points out, stories invite the reader to connect with events and issues in ways quite different from statistics, figures, and graphs. Narrative is a powerful research tool that provides the audience with a picture of people in real situations, struggling with real problems (Witherall & Noddings, 1991). Clandinin and Connelly (2000) further point out that stories lived and told educate the self and others, including the young and those, such as researchers, who are new to their communities. Narrative is a form of public inquiry, to be shared with others.

Another reason that I believe my study contributes to the research field is that narrative inquiry is often viewed as feminist in nature, in that it is designed to validate the subjective experiences of the participant. My story is not generalizable; my story is
different from anyone else’s story. There may be similarities to other stories, but it is my unique and intimate journey. Connelly and Clandinin (1990) suggest that there is an aligning of the narrative with feminist studies. All humans are natural storytellers who lead storied lives, and K. Carter (1993) deems narratives as the most appropriate form of women’s knowing and expressing, especially for people like me, who had previously felt excluded by traditional researchers’ language. By writing my narrative, others may see the value of such feminist research.

Through the sharing of my experience of having an eating disorder as well as my experience of completing a narrative inquiry, I will possibly enable others to overcome their silences by thinking and speaking in terms of story. My story also highlights several topics and issues that teachers could address in their classrooms. In writing this account, I may resonate with others, providing a source of insight and assistance in telling stories that can shape the meaning and texture of a life at every stage and juncture. If other readers could be assisted in believing in the value of their own narrative authority, they might also start believing in the significance of their abilities to learn more about their own personal, practical experience by inquiring into such stories (Peshkin, 1999). Reading my story may help others realize that they too could share their personal experience in such a manner, and I offer a guide for others to follow.

When I first began this research inquiry, I found myself easily justifying it due to personal reasons, but often questioned the broader value it would have to research on eating disorders. What Connelly and Clandinin (1990) term the “tentacles of traditional research” made me feel that narrative, subjective and personal experience, was somehow less than acceptable in the higher levels of academia, that narrative was weak, soft, and
ineffective, lacking in rigor, precision, or certainty. I no longer feel this way and can recognize the value of my own study in terms of research direction. By reading others’ stories and writing my own, I now understand that stories best capture the richness and indeterminacy of experiences as well as the complexity of our understanding and individuality. Narrative attempts to make events more comprehensible, memorable, and sharable through the use of words as opposed to numbers, emphasizing description and discovery rather than hypothesis testing and verification, and contributing a piece of the research puzzle rather than answers of cool and shining certainty. My study has value in that it offers others an alternative to the snapshot view of eating disorders and directions for research to be written in the future.

Bridge to the Society

Cultural Connections and Social Suggestions

_We do not need to change our bodies, we need to change the rules._

Naomi Wolf

(1991, p. 78)

When I first began my research journey, I found myself continually faced with the larger “so what” questions regarding my narrative inquiry possibilities. As Richardson (1994) points out, it seems foolish at best and narcissistic and selfish at worst to spend a great deal of time doing research that ends up not being read or of making a difference to anyone but the autho. I experienced trepidation in this respect, for I was familiar with many individuals who had completed research only to have their writing sit on a shelf, collecting dust. I found myself thinking that surely that scenario is not what higher
learning is supposed to be about. I needed to feel that my research endeavor might result in shifting the perspective about the culture in which we live. Out of the method options I had to choose from, narrative inquiry seemed to have the best possibility in this regard.

I have long believed that the sociocultural factors influencing eating disorders are the ones that have the most impact. The prevailing culture perpetuates the problem by not providing alternatives for the way it seems acceptable to look. If people could be more aware of the ways in which we are influenced by culture and were to think more critically about such powerful persuasion, then perhaps we could learn more resistance to this factor. As a society, we have many groups that are concerned with saving the rain forests, the endangered species, the ozone layer, but who is working to save the female population? We need to become outraged at these highly controlled cultural standards and promote more acceptance of variety among people.

I often question whether it is possible to make a difference in society in order to change the culture. A further question may be: Does change come from outside in, or do we change individuals in order to change society? Connelly and Clandinin (1990) state that it is the particular and not the general that moves people. To me, this statement means that I need to help others understand my individual story and in that way influence their perspective on their outside world, their culture.

K. Carter (1993) outlines how people can be seen as composing lives that shape and are shaped by social and cultural narratives and that stories can be judged as important when they are read by others for the vicarious testing of life possibilities that they permit to the reader. Sharing stories in a personal way can influence the thinking of others in a way that disembodied facts and issues cannot. I believe that people seek texts
that allow them to enter into the world of others and relate what they read to their own experiences. The contribution of my story, told in an honest and reflective way, can offer the opportunity to the reader to share my journey and relate it to their own personal and professional lives and then to the broader society in which they live, which may in turn influence the culture.

Stories can invite us to speculate about what might be changed and with what effect (Witherall & Noddings, 1991). To me, this speculation ultimately means that we teach, learn, and research in an attempt to improve the human condition. Witherall and Noddings further point out that stories have the ability to instruct and transform society (a myriad of voices) to add to the collective voice we call culture. This statement is a hopeful one about all research, but particularly, I feel, with narrative inquiry.

Squires (2000) expands on this idea of helpfulness by outlining that stories are told for a purpose and impose meaning and structure to events that exist within a social context. It is important for the storyteller, me in this case, to situation the narrative within larger systems and through time; it is necessary to broaden the scope of the lens through which the story is being told in order to depict the entire landscape. Only through this technique can the domain of understanding be broadened (Freedman & Conks, 1996) to show the impact of a problem and its real effects. These writers suggest highlighting the “sparkling events” from different vantage points to provide an original and substantial contribution to society. It is a productive idea to stand back to see how a series of stories compares and to build theories through such learning.

My story of struggling with eating disorders is just one of many in our culture. What I want readers to understand is that many young women turn to such disorders as a
way of handling the society in which they live, one that emphasizes physical perfection while failing to nurture self-esteem, a sense of self, or the value of a voice. I want people to sense what a great loss this is, not just for the individuals but for our society collectively. We, as citizens, need to recognize the long-term consequences of eating disorders and make conscious attempts to help alleviate the factors that influence them. By placing such an emphasis on physical appearance at the expense of inner validation, we deny our young women a chance to develop their unique characteristics and fully contribute to society.

With regard to eating disorders, it is an enormous challenge to work against the popular culture and society's entrenched and dominant ideas about body shapes and self-worth. In fact, some of the most sobering comments about preventing eating disorders (Graber & Gunn, 1996) refer to the impossibility of altering the sociocultural context that promotes the ubiquitous concern among young women about their body weights and shapes. A great deal of money is made by businesses and media moguls through perpetuation of the myth that physical appearance is all that matters. As mentioned, I myself have often questioned whether it is even possible to overcome such a huge obstacle. Even with all the knowledge about the danger of eating disorders that exist currently, as well as the programs aimed at preventing and intervening in such problems, the incidence rate continues to climb (NEDIC, 2001).

However, the role that the sociocultural factors play must be confronted if even a small dent is to be made in female weight preoccupation. As Correia (1995) suggests, what is needed is a fundamental change in social institutions and attitudes that endorse women's subordinate status, that legitimize a hatred of body fat, that promote chronic
appearance anxiety and that idealize certain standards of beauty. The question remains how best to do this. I think that such change must come from individuals. Adult women, along with adolescent girls, are too often silenced, afraid to speak up, to “rock the boat”, to be seen as too political or too feminist. Many young girls may think that feminists have already highlighted this issue enough, and that such problems are solved. These women do not recognize how such problems are systemic in our culture. We must take responsibility for changing ourselves, for only through individual transformation can collective change occur.

To influence culture, I begin with myself, using my newly acquired voice. I cannot hope to alter society if I don’t speak up and speak out. I must challenge myself to change the way people think and influence others through joining in discussion and by consciously bringing issues to the forefront. This personal change means that I speak to others when the opportunity presents itself, that I challenge media and advertising that helps perpetuate the problem by writing to express my views, and I share my voice every day in my classroom.

I have often found myself having a conversation in my own mind while others are conversing around me. It is astonishing to me how many of women’s discussions revolve around food and weight. There is so much guilt associated with the necessary intake of food. When I hear comments such as, “Oh, I shouldn’t eat this.” “I’m not eating lunch because I am going out for dinner later,” or “I’m on a new diet...all protein for the first week,” I have a desire to scream at these women for perpetuating their own as well as society’s problems. Do women not wonder why we can’t just eat and enjoy food as the life-sustaining substance it is? They can not see what they are doing to themselves, just as
I could not during a period in my life. It saddens me that so many women base their worth on what enters their mouths instead of what comes out. So many women struggle with their self-worth and it has nothing to do with food. I want such women to be validated.

When comments are specifically directed at me, the anxiety I feel is heightened. Such remarks as, “You are so lucky you don’t have to worry about your weight,” “You make me sick because you are such a healthy eater,” or “You look good in any clothing because you are so thin,”, make me extremely uncomfortable. What I have learned to do upon hearing such comments or receiving such remarks is to answer or question honestly and tell people how they make me feel. I avoid making comments regarding a person’s weight or appearance. I try to compliment internal qualities instead. I make every attempt to be genuine and promote discussion. Sharing my story through this thesis has further highlighted for me why I need to continue all of these actions and encourage conversation and discussion around these issues we face.

My idealistic self at times believes that perhaps I shared my story in order to stop other individuals from traveling down the same path toward a full blown eating disorder. If telling about my painful experience could prevent even one person from developing similar problems, I would consider my sharing worthwhile. So many people know about eating disorders only through the popular media where the disorders are, in my opinion, glamourized and trivialized. I wanted to help people really understand what it feels like to live inside a frightening, possibly deadly, psychological illness. In terms of this thesis, it is up to my readers to change their perspectives through whatever meaning they may take away from my story. I believe that only through such individual changes can
sociocultural factors be influenced and the problems surrounding eating disorders possibly be reduced. We may still live in the same society, but we will have changed ourselves. Unfortunately, the question remains how best to enhance the self-worth of women.

**Possibilities for the Future: My New Position on the Landscape**

Heilbrun (1988, p. 130) states that "when the hope for closure is abandoned, new adventure will begin". Similarly, Bloom (1998) outlines that while a novelist resolves the loose ends of characters' lives and writes "the end" on the last page, ethnographers and life historians can (and should) provide only tentative endings to the research, for participants do grow emotionally and intellectually and continue to make important choices about their lives after the researcher has ceased to document these choices and changes. As a teacher, I have helped young students learn that all stories have a beginning, middle, and end, but as a more mature student, my understanding of story recognizes that narratives are too complex to summarize neatly. I began in the midst; I will end in the midst.

I have had the opportunity to write about my journey, to unfold, reexperience, and repack my stories in the present, and in some ways reach a sense of resolution. By interpreting my interconnected pieces, I was provided with a chance to complete a different thesis than the one I had originally anticipated, which resulted in a far more textured analysis. As my writing evolved and emerged, I was able to try different techniques at drawing out meaning. Connelly and Clandinin (1998) state that people are storytellers living out their past, reawakening that past in order to deal with current
situations. I had to go through such a process. I could no longer neglect my experience and risk missing what actually counted. My present picture or position on the landscape consists of where I have been along with where I am going. Both are now clearer and more colourful.

In many ways, I have resolved my past enough through the writing of this thesis that I can actually view my experience with eating disorders as a story. This story does not have a Hollywood ending where the main character, me, lives happily ever after. I think that completing this narrative inquiry allowed me to discover things about myself and eating disorders that I knew all along, more than having radically changed me. Writing my story has not resolved all issues I have around eating disorders; some, like learning to give myself praise, perhaps will never be resolved. However, I believe I will be a better person and a better teacher because of this experience. I am better able to take on the challenges encountered when helping to prevent eating disorders and will bring my new "expertise" to the provincial federation committee I am presently on by voicing my perspective and influencing changes in curriculum and school settings. It is true that guidebooks don't really guide people, they only point them in the right direction. That is what I aim to do.

Dewey (1938) wrote that stories are inquiries to which further inquiry takes place, through the telling and the response to the telling. Such reflexive practice seems to operate in a spiral as the story winds around again and again (Hole & McEntee, 1999). As we research, we often find more questions than answers and this is certainly true in my case. I still have many unanswered questions such as: Why do some young women turn to eating disorders and not other high-risk behaviours; how can other women who
have recovered from eating disorders be best encouraged to share their personal experiences; how can teachers be best educated in order to assist in the prevention of eating disorders; and how can activism change society so that unrealistic images are no longer idealized?

This thesis has allowed for me to experience growth in many ways. Growing as a person, a teacher, a student, and a citizen are all worthy pursuits of education. My new position on the landscape, however challenging it was to arrive here, affords broader views of my past and different perspectives for the future. My story has not yet ended...my narrative will continue.
THE RECIPE: MY METHODOLOGY AND METHOD

The thoughts that come often, and as it were, drop into the mind, are commonly the most valuable of any we have.
John Locke

It seems important to explain my reasoning for placing this section here, towards the end of my thesis. Typically, researchers will explain their method before they outline their actual data, findings, and conclusion. For me, in this narrative inquiry, putting the method earlier would have been like putting the cart before the horse. I could not feel comfortable explaining the "how" of my method until I actually completed the entire project. Doing so would have been like writing the travel guide for others before embarking on or completing a journey myself. To me, explaining the recipe for my research could only occur after I baked the product, allowing others to see how I arrived at and carried out my research steps, to use as a possible guide for writing their own stories.

My work is qualitative in nature. More specifically, this research is a narrative inquiry that emphasized voice, subjectivity, and an insider's perspective. As Clandinin and Connelly (1994) outline, narrative is both phenomenon and method; this is similar to the metaphor used in Richardson (1994) of "theory is story." I tend to think of method as both a process and a product; it is important for me to share both the steps in the recipe as well as the finished product. The difference between narrative and other methodology is not what I actually know but how I chose to tell it and for what purpose. I sought a method that would allow me to write subjectively, in my own voice. Telling my story has
given me permission to alter my work and research practices as I developed strategies for putting myself into my text and my text into research. I gave myself permission to be part of the story.

My underlying beliefs surrounding narrative inquiry were partially outlined in my positioning section, for I had to come to terms with the reasons I believed that this particular type of research was the best choice for my personal thesis. Although I had always been drawn to qualitative research, I began to understand how narrative inquiry was an important facet of feminist research as it foregrounded the female subjective and allowed for feeling and emotions to become a valued part of the educative experience. It was this research voice that started to feel like the most natural and appropriate one as my need to reencounter and retell my own story became more powerful. I had to learn how to integrate myself into the research in a rich, compelling, and honest way.

In order to begin this process, I had to "get my head around" my understanding of narrative inquiry. Instead of writing a case study on my student, I would instead be writing an autobiographical account of myself. This change required a huge shift in my thinking and perspective. How was I to imagine forms of research and qualitative language I had never even heard of? How are any women supposed to create narrative, personal stories if they have mainly scientific, Cartesian language to do so? I felt that as a woman researcher, I had been silenced by my positivist experiences in higher education. I felt angry about this repression, but simultaneously recognized that as I learned new language and forms, I would be helping myself and possibly others break away from the more traditional type of research.
The more absorbed I became in narrative inquiry, the more the idea of writing my own story seemed eminently suitable. As Peshkin (1999) aptly points out, no research paradigm has a monopoly on quality. Why did I choose narrative? It best suited my experience (Clandinin & Connelly, 2000). Here was a research method that was more congruent with my intellectual and ethical beliefs; it particularly matched the philosophy of the humanistic teaching that I employ in my classroom. I read texts outlining various approaches to narrative inquiry as well as research proposals and theses that utilized this method. Writing by Clandinin and Connelly (1994, 1995, 2000) as well as that of Conle (2000), Buttignol (1999), Ellis and Bochner (1997), and Witherall and Noddings (1991) served to broaden my perspective of what research could include and deepen my understanding of narrative inquiry. Through these authors, I learned the history and merits of narrative inquiry as well as possible avenues for developing my own unique product. By reading the “lived experience” of other researchers within their own texts, I realized the advantages of writing using “I.” What I was reading was for me more satisfying as a reader of research. I felt that using narrative inquiry would have the potential of providing me with a far more accessible and compelling research text to work within, which in turn would be far more relevant and meaningful to my readers. I started to feel freed from traditional constraints as I began to see the relationship between theory and practice, research and story; to see how I could use my story as research and use what I learned from narrative inquiry for personal practice and professional implications.

At the beginning stages of my thesis development, I was filled with more questions than answers. I did not really know or even have predictions about the
direction my thesis might take. I did not know if I could write well enough, if I was sufficiently introspective, if I was observant enough, or if I possessed the courage to put my story on paper. However, the literature I had become familiar with in preparation for this stage in my journey provided some comfort in dealing with these incessant questions. Bassey (1999) suggested that narrative inquiry is quite eclectic and that it is permissible to use methods such as journal writing, story telling or conversations that seemed appropriate and practical at the time. I appreciated such flexibility for it meant my research could be shaped to meet my individual needs. Clandinin and Connelly (1995) reinforced the belief that my exploratory voice would have value and that I would learn the methodology best by being involved in the method. It was the old adage, “learn to do by doing.” I would not be attempting to replicate anyone else’s study, nor would I be providing a formula that someone in the future could duplicate. I would give my best attempt at writing a compelling and experientially vivid (Freedman & Conks, 1996) story as well as sharing the map of how I completed this journey.

After I became more comfortable with the idea of breaching the conventional separation of text and self (Ellis & Buchner, 1997) and had delayed, temporarily at least, the vulnerability and fear I was feeling about revealing myself in my text, it was necessary for me to start using some of the personal experience methods (Clandinin & Connelly, 1995) that I had been learning about. In order to integrate my personal story into my research text, I had to start by writing my personal story. At first glance, such writing may seem like an easy, straightforward task, but it is anything but. I had to show trustworthiness and credibility to my audience through my writing. I had to avoid what Dewey (1938) terms a miseducative experience by providing a more-than-adequate story.
It was quite a daunting task that lay before me, to write a story that had long been hidden, even from myself.

However, even though I was filled with a lot of fear and self-doubt, I intuitively knew I had to start somewhere. In preparation for the actual task of writing my story, I began to explore many avenues to help me remember my past. I poured through all of my photo albums in an attempt to capture in my mind what I was like in each of my younger years. I read through letters, yearbooks and journals from my childhood, teenage, and adult years. I plotted out a time line of my life on which I attempted to highlight all the major memories and experiences I felt might be important to my story. Such methods are specifically narrative methods. This raw data formed part of the “field texts” (Clandinin & Connelly, 1994) for my research; I used such “memory enhancers” in an attempt to start constructing the whole picture I wished to encapsulate, analyze and share with my readers. Clandinin and Connelly (2000) explain how these texts help fill in the richness, nuance, and complexity of the landscape. By using a variety of raw data forms, the researcher is better able to return to this skillfully woven landscape than memory alone would likely allow. Narrative is mult-layered and many stranded (Clandinin and Connelly, 2000), and thus necessitates using adequate detail and sufficient connections between fragments of story. At that stage of drawing my story to the surface, I was not concerned with making meaning. I was focused on recovering details and remembering my past.

Throughout this time of gathering my field research, I was also engaged in a process of thinking about how these pieces were going to fit together into my final product. Although I was reminding myself not to fixate on the meaning aspect of my
story at that point, my brain continued to swirl with questions and pondering of possible connections. Even when I tried not to, I found myself repeatedly asking questions concerning meaning and significance. What resulted was a period of about 6 weeks, following my gathering of remembrances during which I was unable to complete any written work on my personal story. I felt paralyzed with a type of writer’s block; I could not fathom how my work was going to progress. I was fearful of the aspects in my story I would feel necessary to include if it was to be authentic, memorable, and compelling. I felt frustrated because I thought I was at a standstill. I needed incubation time. I needed to find a structure. Due to my own personality, I needed to know where everything fit. As a perfectionist, this stage was very frustrating for me to work through.

What I have come to realize by working through the method of narrative inquiry, is such periods of dormancy, internal incubation, or cocooning are very important to the process. A piece of writing that is as important as a thesis takes time to grow, change, and develop. The steps can not be rushed in order to finish at a certain time. For me, this new experience of intertwining the aspects of my story with my understanding of theory was strikingly different from my experience writing the first three chapters in my initial attempt at a thesis proposal. That writing had been a very sequential process in which I found myself mechanically checking off sections as I completed them, with very little sense of accomplishment. With narrative writing, I discovered that I traveled between ideas, articles, and questions in a more cyclical route. I had all of these little fragments and giant possibilities that I had to trust would come together into a satisfactory, finished product. It was not surprising to me that many researchers working with narratives use a quilt metaphor; the beauty of the finished product is that the pieces can be stitched
together in an infinite number of ways. During this period of "inactivity," I viewed my work as more of a puzzle metaphor, one that did not come with a picture to use as a guide for fitting the pieces together. I would not really know what picture would start to become apparent until I determined the links between the pieces, an emerging design. What I did not realize at that time was that I required a **reflective period** in order to prepare for what awaited in the next steps.

Eventually, I felt able to move into the second stage of developing my field texts. I believe I entered a period referred to by Clandinin and Connelly (1995) as "**pulling out**". I began to write my story using all of the raw data I had gathered during my first stage as well as parts I was still finding within myself. Sometimes, memories and feelings would come pouring out as if experiences stored in my memory during years of lived experience had been waiting to be released and shared. At other times, however, each word had to be pulled out slowly and painfully, with many tears. Writing about my experiences with anorexia and bulimia was both a terrifying process and a tremendous relief. Occasionally, I would feel tempted to skip over certain aspects of my story because they were too embarrassing or painful, but I forced myself to confront my fear and shame and continually probe at the layers I had built up over the years. I had to remind myself that there was no point in continuing to hide my feelings and experiences and that I could not alter the past. Instead, I needed to expose and illuminate my story in order to enhance my future.

The next stage in my research journey was to start to **shape a research text** from the enormous amount of raw data and the field notes I had collected. At first, this task seemed impossible, as there were many different directions I could travel along and each
seemed an equally significant way of understanding my human experience. I found myself needing to reread what the “experts” on narrative inquiry suggested, and this reading proved helpful in my attempts to piece my story together with the literature I had read. Clandinin and Connelly (2000) suggested weaving the literature together throughout in order to create a seamless line, and to think of the literature review as a kind of conversation between theory and life. Similarly, James (1999) recommended interrupting my tale with reflexive commentary in order to illustrate how I constituted both the data and the theory. Personally, I had to determine the best way for my research text to link my own story with all that I read, in order for my writing to make sense for my reader. I felt an enormous intellectual struggle as I attempted to write in this manner; I felt myself trying to join the worlds of thinking and feeling (Witherall & Noddings, 1991) while simultaneously attempting to make meaning out of all I was writing.

Qualitative research is not always perfectly sequenced and organized. It is far more like writing a poem than reporting on a scientific experiment.

There were many considerations to reflect on and challenges I encountered while writing this research text. Many times I felt overwhelmed with what I was attempting to do. Luckily, all that I had read about narrative inquiry outlined how difficult such a process can be. Clandinin and Connelly (1994) discuss the four different directions a researcher must travel in: backward (into the past), forward (into the future), inward (into yourself), and outward (into the society), all at the same time. What is challenging is to remain alert, prepared to follow the leads in many directions, and to hold them all in inquiry context as the work proceeds. These researchers (Clandinin & Connelly, 2000) further outline how the researcher's space can be viewed as three dimensional, with
interaction (personal and social), continuity (past, present and future), and situation (place), all being dimensions in that space. I found it helpful to view my thinking as a camera; I required many different lenses through which to examine my work and capture my story. Sometimes I needed to zoom in on one little aspect of my story, and at other times I needed the widest angle possible to keep the big picture in mind. I then had to put all of these pictures together in one photo album in a way that my readers, along with myself, could discover views that had not been known or substantiated before.

It became important for me to recognize that because of my lived experiences I saw my story through more than one lens at a time. I had to use the lenses of myself as an adolescent, as a daughter, as a recovered anorexic and bulimic, as a teacher, as a student, as a perfectionist, as an inner critic, and as a successful achiever. I had to really examine what I saw and learn how to interpret my various views. The views inform each other, as they make up who I am. I had to keep these lenses in my consciousness while struggling with the issues of meaning and significance, a state termed “wakefulness” by Clandinin and Connelly (2000).

As James (1999) points out, any researcher’s story is written from a privileged point of view and can be distorted and limited. I wanted my writing to be as authentic and genuine as possible. One of the difficulties I encountered in writing my own story is that it is both natural and tempting to remember the past in a more sentimentalist, positive light as both time and distance separate us from it; it is tempting to reinvent the past to give more meaning to the future (Ritchie & Wilson, 2000). I had to struggle to be as honest and truthful as possible. I also had to make agonizing decisions about what to include and what to omit. I had to admit that my study is limited in this regard.
As McAdams (1993) states, memory is highly selective and involves substantial reconstruction. A story is not just related in an objective manner like a secretary scribing the facts but subjectively with meaning, highlighting certain events and disregarding others. It is not an accurate past but a story about it (Ellis & Bochner, 1997). For me, I preferred to think of my selective remembering as the skill of photography. My stories, or pictures, could not possibly hope to capture every detail or view, but I had to explain the “why” of having chosen to capture some images and not others, selecting certain angles while blocking out others. As McEwan and Egan (1995) outline, our rhetorical choices function to conceal or reveal, magnify or minimize, simplify or complicate, link or divide, elevate or degrade, sharpen images or blur them. What remained important, for me, was to explain how those choices were made.

While trying to be as honest as possible when remembering in order to write my narrative inquiry, there were times when I recognized I was avoiding certain topics. I felt uncomfortable writing about my relationship with my parents, mostly due to the desire not to upset my family should they choose to read my thesis. There remains a layer, difficult to peel away, over my shame at having pushed away people who genuinely cared about me in my past, and so it was not something I cared to describe in detail. Keeping my purposes in mind no doubt helped determine what I remembered as I tried to keep my story relevant to myself as an educator. At times, there was too much to capture in a picture, so I had to make a choice about what seemed like the best photo. At other times, I would try desperately to recall a snapshot of my past, only to realize that my eating disorder had caused it to be too blurry to be of use. For my readers, I could only ensure that I tried to illustrate the essential truths and allow them to give birth to the meaning.
As Ellis and Bochner (1997) suggest, I had entered an autobiographical genre of writing and research that displays multiple layers of consciousness while connecting the personal to the cultural. The process is like being inside and outside of yourself at the same time. I had to learn how to weave together the layers of story fragments and research theories, through practice, in an organized fashion so that my readers would find it useful and engaging.

A narrative inquiry is not simply an autobiography. It was not enough for me to stop at the first step and simply tell my story, nor was it enough to link my story together with the research about eating disorders. Narratives are descriptive by nature, but after the narrator tells what happens, it is necessary to take a step outside of the experience in order to interpret and analyze, to make sense of what the story means and the impact this meaning has on life. Connelly and Clandinin (1988) would view this step as looking both inward and outward. This analysis was quite possibly the most difficult aspect of the method involved in narrative inquiry. The task was to discover themes and construct meaning, to look for patterns, narrative threads, and tensions within and across personal experience (Clandinin & Connelly, 1994). The task became to answer the “so what” question that continually nagged at me through the process. This analysis stage could not be rushed and required me to put some distance between my words and myself before I could go back to my story with a fresh and objective eye. I also chose to have a close friend read my story and offer her much needed reflections.

One of the interesting aspects of narrative inquiry, for me, was that my topic changed as I wrote, and I started to relate to my writing differently as I progressed, gradually embracing the process. Being a perfectionist, I found it was challenging to
work on a piece of writing that I often did not have a clear picture of. I often felt as if I were in a mild state of panic because I did not have “control” over the steps in the process. I felt the desire to know where I was headed and what the finished product would look like. I could not know either in narrative inquiry. I had to have confidence that the connections would become more apparent as I continued on my journey of growth and transformation. I took comfort in Heilbruns’s (1988) assertion that women transform themselves only after an awakening and it is only identifiable in hindsight. I had to continue, knowing that, as Conle (2000) states, it seemed right at the level of feeling as I worked toward an unspecified, abstract goal.

The final analysis and conclusion stages required that I delve beneath the surface of my writing to examine motives, implications, and connections. I had to reflect, discuss, interpret, and reinterpret. Clandinin and Connelly (2000) suggest that I had to position my work relative to the stream of thought, research, and ideologies, which to me meant that I had to determine the importance of my work: for myself, professionally and personally, for the educational and research community, and for the culture within which we live. I had to take a “reflexive position” (Freedman & Conks, 1996) from which I could regard different aspects of my story, my various relationships, and myself in order to experience the implications and the significance of my story. This process can be described as looking at the internal and existential whole. I had expectations that my purpose would be inevitably redefined as new, unexpected, and interesting connections and reflections were made.

The research project is a story in itself, and it was important for me to highlight the process of personal and social changes that occurred through the engagement. It was
hard to know when I was actually finished, and I finally resolved that I was as finished as I could be at that time. Each researcher's journey is unique, and in the end it was my voice that had to come through to the reader. I had to tell my story. I had to decide how best to integrate the story into the research text, and I had to decide the meaning this process had for me as well as envision what it might have for others. My story helped me identify new directions for schools and teachers in order to help support adolescents as they struggle with self-esteem. Each reader of my work will bring to the text her/his own context and will have to make meaning is her/his own way. My story will be turned in many different ways, viewed with many different perspectives by many different readers. My interpretation is not intended to present a generalizable construction, but a personal account of my own understanding and transformation. What should remain central is my lived experience.
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Appendix A

Definition of Terms

For the purpose of this thesis, the following terms and concepts are defined:

ANOREXIA NERVOSA: an eating disorder characterized by an “obsession” with thinness. It involves drastic weight loss resulting from dieting and/or intense exercise. The individual has a poor or distorted body image, an intense drive for thinness, and a heightened fear of weight gain.

BULIMIA NERVOSA: an eating disorder characterized by repeated bouts of binge eating, followed by purging to prevent weight gain. Purging may be accomplished by self-induced vomiting, excessive exercise, laxatives, or diuretics.

BODY IMAGE: is made up of three components: the messages we receive about our bodies from other people, networks, systems and institutions, our perceptions and experiences of our bodies as they filter through a developing sense of self and become increasingly shaped by surrounding systemic forces, and our resulting feelings about and behaviours towards our bodies/selves. (Russell & Rice, 1997).

CONTINUUM: what eating disorders exist along, ranging from normal eating to clinically diagnosed eating disorders such as anorexia and bulimia. Skipping meals, excessive exercise, dieting, and fixation on eating only “low-cal” foods are all behaviours that fall along the continuum. (Brown & Jasper, 1993).
EATING DISORDERS: expression of a range of food and weight issues many individuals, particularly women, experience, characterized by an intense fear of weight gain, feelings of ineffectiveness, and low self-esteem. An eating disorder exists when the preoccupation with food and weight becomes an obsession and when the behaviours around food are driven primarily by psychological need.(Friedman, 2000)

FEMINIST APPROACH: an approach to eating disorders and weight preoccupation which recognizes how the conditions of women’s lives shape their experience with weight and eating.(Brown & Jasper, 1993). This approach differs from the traditional medical model in which the individual is separated from her social and cultural influences.

SELF-ESTEEM: is made up of two aspects: a sense of personal efficiency which is termed self-confidence and a sense of personal worth which is termed self-respect. (Canadian Teachers’ Federation, 1990).

SELF-CONCEPT: relates to the total description an individual provides about herself.

SELF-IMAGE: a mental picture of the body which develops and changes over time.
Appendix B

Literature Review

This review focuses on related literature to the topic of eating disorders. It is meant to stand alone from the rest of my thesis, as it reads in a separate voice, not as a continuation of my story. The purpose of this appendix is to help readers who may seek additional information about research surrounding eating disorders.

1. Historical Background

Behaviour associated with disordered eating first began centuries ago when it was first documented that women engaged in fasting and purging as a way to lose weight. However, it was not until 100 years ago that anorexia nervosa first became a clinical entity with the reports of Gull in England and Laseque in France (Brumberg, 1987). Both of these doctors identified several similar symptoms of the disorder including emaciation, lack of appetite, and amenorrhoea (loss of the menstrual cycle). However, there is a lack of consensus within the past literature regarding both the definition and the etiology of the disorders. Some “experts” believed the symptoms were caused by psychological factors, while others thought it had to do with physical imbalances. Attention seemed to be placed on two variables: the symbolic significance of the oral component of the disorder and the personality/interpersonal relations of the patient (Bruch, 1973). Based on Freudian assumptions, it was viewed that anorexia was an expression of an internalized sexual conflict, while other factors that may have contributed to the development and continuation of the disordered eating were neglected. Eventually, there was a move away from such a singular view of the disease to a more all encompassing view that included relationships with others and life experiences. More attention at this time was given to
identifying subgroups within the disorder itself (Bruch, 1973). Eating disorders began to be classified into different categories, such as anorexia and bulimia, with specific behaviours being linked to each.

In today’s society, anorexia nervosa and bulimia have become all too common, especially in developed Western societies. Neumark-Sztanier (1996) reports that eating disorders now rank as the third most chronic illness among adolescent girls. Correspondingly, the research on the topic has become increasingly extensive. Research is conducted in both medical and psychiatric fields, and there is literature available on the etiology, the intervention in, and the possible prevention of eating disorders. The issue of treatment in particular has evolved so that there has been a general move away from the behaviourist model of intervention, which may include force-feeding and removal of privileges, to a more progressive, feminist model of treatment that includes investigating the underlying issues that have contributed to the development of the eating disorder, as problems with food are seldom the cause (Brown & Jasper, 1993). This treatment is viewed as a feminist model (as opposed to a behaviourist model) because it investigates the root of the problem rather than the symptoms. The feminist approach might deal with low self esteem and/or peer pressure that many sufferers experience. There is also a growing body of research that addresses the biological componen, (Johnson, 1996). Generally, it is presently accepted that struggles with weight and the development of disordered eating are embedded in complex dilemmas and contradictions. However, historically, few researchers have looked at eating disorders using a holistic approach.
2. **Factors Contributing to the Development of Eating Disorders**

2.1 **Introduction**

Disordered eating covers a wide spectrum of eating behaviours. If one can picture eating as a continuum, with eating disorders at one end and normal eating at the other, it is evident that all eating patterns exhibited by people would fall somewhere along that continuum. It is estimated (Milne, 1998) that up to 5% of teenage girls will develop an eating disorder and up to 20% will dabble in unsafe weight control practices. While eating disorders are increasing in males (Romeo, 1994), it is generally the female population that suffers from such disorders. 90% of people with diagnosed eating disorders are female. In Canada, reports by the National Eating Disorder Information Centren find that more than 350,000 Canadian or 8% of women are affected by this problem. With a mortality rate estimated at around 15%, it could be argued that this is one of the priority health issues concerning the female population in this country (Poulton, 1996). Frightening as that may seem, the statistics become even more grave when considering that younger and younger children are being affected. Girls younger than 10 years of age are being admitted to hospital programs with fully developed, diagnosable eating disorders (Bear, 1996), and several clinics are now offering eating disorder programs for girls as young as 5 (Boskind-White & White, 2000).

2.2 **Etiology**

Much research has been conducted in an attempt to determine what the underlying determinants of eating disorders may be. Many different factors appear to be related to the development of these disturbances, including genetic, sociocultural,
psychological, physical and familial characteristics (Fairburn, Cooper, Doll & Welch, 1999; Graber et al. 1996). Medical and scientific literature (Attie & Brooks-Gunn, 1989; Neumark-Sztanier, 1996) confirms the need for and stresses the value of early identification of those at most risk, as well as intervention with those who have developed difficulties. Due to the nature of these factors and the way that they are interwoven, it is difficult to ascertain true links or to determine an actual causation. However, all must be examined as possible contributors, and all must be understood in order to best comprehend the complexities of these disorders.

2.3 Physical

Physical development and maturation have been associated with the onset of weight preoccupation and/or eating disturbances. Attie and Brooks-Gunn (1989) found eating problems might relate to physical changes occurring in middle school when body shape becomes a primary focus and weight-controlling techniques intensify. The intermediate grades seem to be the ones requiring more teacher vigilance. There exists a considerable discrepancy between actual weights of adolescents and the weights they would like to achieve. In an 8 year study, Graber et al. (1996) found that eating patterns suggest early puberty is the time for the greatest onset of eating disorders, as this is a problematic time for young students that often results in depression and lowering of self-esteem. Normal development associated with puberty typically results in both weight gain and the associated dissatisfaction with one’s physical appearance.

Dieting itself may even be a sufficient condition for the development of eating disorders (Correia, 1995). Efforts to lose weight and change one’s body shape are largely ineffective, with most diets failing over long-term periods. Dieting may lead to bingeing
and may precipitate weight gain due to the lowering of the metabolism during periods of decreased calorie intake. Severe dieting has many psychological effects that include anxiety, depression, food preoccupation, irritability, lethargy, isolation, and impaired concentration (Keys et al., 1950). The physical and psychological effects of dieting can predispose an individual to developing an eating disorder.

2.4 Genetic

The genetic, or biological, factor related to the development of eating disorders suggests that some individuals may have a predetermined vulnerability for developing an eating disorder. It is suggested (Johnson, 1996) that there are certain personality characteristics of individuals who have eating disorders. These characteristics include extreme perfectionism, obsessiveness, inflexibility, persistent self-doubt, and a high desire for control. These may be inherited traits. These traits would also be fairly obvious to a classroom teacher and thus could signal warning signs that could lead to prevention or intervention. A distorted body image and poor self-esteem (Nassar, Hodges, & Ollendick, 1992) have been examined as possible personality factors that may lead to the development of eating disorders. However, such behaviours may develop once the individual has engaged in eating disorders. It is difficult to ascertain which behaviour comes first. The argument for the impact of genetic make-up questions why many women diet, engage in food restriction or binge, on occasion, while only an isolated group of individuals actually become anorexic or bulimic. There is some evidence that some women with eating disorders have abnormal levels of serotonin (Johnson, 1996) and that some individuals who are given antidepressants such as Prozac, which helps to
regulate the levels of this chemical, are able to move towards recovery and away from the depressed states that may have acted as a catalyst for harmful behaviour in the first place. This research does not suggest that depression causes eating disorders, but merely outlines some intervention strategies that seem to have been successful in some cases.

Other research into the relationship between genetic construction and eating disordered behaviour (Milne, 1998) suggests that mothers who are food and weight preoccupied tend to have daughters who exhibit similar behaviour. It can be counter argued, however, that such behaviour is simply modeled and thus nurtured, as mothers of today’s teenagers grew up in a weight conscious world and the value placed on thinness by parents may be reflected in the community (Paxton, 1996).

Genetic factors may also contribute to the development of eating disorders because they may influence the development of a certain body type and weight. There is scientific evidence (Paxton, 1996) that weight, like height, is largely inherited and tends to fall across a wide range instead of being determined solely through weight control and exercise. Such genetically influenced sizes may result in some women being unable to mold their own shape, and thus they begin to take more drastic measures to change their body size.

2.5 Psychological

An individual who has had a traumatic life experience such as sexual abuse, family disturbances, or the loss of a loved one, may also experience an increased risk for developing an eating disorder. Exploring the psychological trauma can help individuals understand how eating problems might have arisen in the first place, but this approach often amounts to “blaming the victim”. The individual feels that there is something
wrong with her or his life and that is why these problems surfaced. There are other possible causes in the psychological realm as well, as outlined by Pipher (1995). Women who experience some kind of failure might attribute that failure to their weight. They think that if they can control their weight, they will be able to get what they want. This may be partly true, as such thoughts may stem from a lack of self-esteem.

Cognitive psychologists focus on such disordered thinking. Many eating-disordered individuals (particularly anorexics) need to feel a sense of control and predictability about their lives. Continuing to drop in weight means that they are safe and in control (Pipher, 1995). Unfortunately, this way of thinking is too simplistic. When some of these women can not make sense of the world, they may start to avoid participating in it, instead concentrating on not eating or bingeing and purging.

2.6 Familial

Another factor relating to the development of eating disorders may be the individual's family structure and dynamics. The theory relating to this factor (Hesse-Beber, 1996) emphasizes relations between people rather than conflict within a person and places little importance on wider factors outside a family unit. Studies (Attie & Brooks-Gunn, 1989) indicate that those with existing disorders generally report low family cohesion, a recent family crisis, chaotic family systems, poor communication, and/or high expectations. The history of family abuse, particularly sexual, has also been a link in many cases (Brown & Jasper, 1993). Helen Bruch (1979), who was a pioneer in the treatment of anorexic girls, found that such girls generally came from families where the parents had imposed a predetermined identity on the daughter. The daughters were unable to show independence and had to fit within a rigid framework of expectations.
Ongoing depression or the use of alcohol or drugs by either parent can also contribute to the risk (Friedman, 1997). Family dynamics certainly play their part if there is ineffective communication, expectation of perfection (whether real or imagined), and boundaries that are either too loose or too inflexible.

There is also some evidence (Fairburn et al., 1999) that there are raised rates of parental eating disorders, family dieting, and adverse comments from family members about eating, appearance, or weight for individuals who have developed eating disorders. Many individuals who have developed eating disorders can recall the pressure from the family to “slim down a little” or rewards from family members for losing that first little bit of weight.

Like many other factors relating to the development of eating disorders, no studies offer substantial proof that a direct relationship exists between family structure and eating disorders. Many individuals who are eating disordered come from a “healthy” family, and many others who have families that fit the profile do not develop such problems. Each case is unique. Often, subtle pressures and complex relationships may exist which are hard to determine through quantitative data.

2.7 Socio-Cultural

Almost all of the research reviewed leads to the generalization that eating disorders affect predominantly females, indicating a definite gender difference. Indeed, 95% of those clinically diagnosed are female (Neumark-Sztanier, 1996). One of the factors continually examined in the literature is the sociocultural one, and many researchers (Berg, 1997; Boskind-White & White, 2000; Brown & Jasper, 1993; Nagel & Jones, 1992) believe that this sociocultural factor has the greatest impact on the
development and perpetuation of eating disorders. This factor also explains the reason why it is primarily females that are affected with such disorders. It is our body types that are more narrowly defined in the culture and our social conditioning that make us more susceptible to developing such problems. Feminist research in particular focuses on the sociocultural factor as one of the most overwhelming pressures that lead girls and women to feel poorly about their bodies and thus attempt to change them through whatever methods possible. Culture, specifically popular culture, strongly influences attitudes towards acceptable body weight and eating habits.

One cultural media form that seems to promote impossible standards for most girls and women to achieve is magazines, and not only due to their heavy advertising content. Magazines were invented to become the means of communication by which women could be taught what was expected of them beauty wise, a virtual operator’s manual (Poulton, 1996). However, the majority of women’s magazines replay a tiresome focus, with articles on making up, losing weight, wearing the right fashions, and attracting boys or men. The magazines’ content seldom really challenges women intellectually because their purpose is to give training in “lookism” (Kater, 1998). As Wolf (1991) points out, female magazines have to ensure that their readers don’t liberate themselves out of the interest in such trivial, appearance related material. There is also anything but a coincidental juxtaposition of advertisements, and articles containing identical messages that illustrate the state of the union between magazines, and marketers that has been present since the early 1960’s (Poulton, 1996). The mixed messages found in ads continue in magazines as spreads for sugary dessert recipes are found between advertisements that feature anorexic looking models. Often, the age when girls start
attempt to diminish themselves in order to become as slim as their ideals. The culture is not viewed as wrong. Females attempt to change themselves only to meet the culture.

We live in a cultural climate where the benefits of weight reduction are extolled. The prepubertal body (thin and undeveloped) is the one that is at present more culturally valued (Correia, 1995) and one that is socially reinforced and validated. Think of Ally McBeal from the same-named show or the female stars from Friends. Unfortunately, this cultural ideal is often impossible to achieve if eating normally is for good health. It is interesting to note that eating disorders are rare in nonwestern cultures unless they have been exposed to or started to adopt Western cultural values of appearance (Parnell et al., 1996). As other cultures start to become increasingly involved in the global economy (hence Americanized), there will be an associated negative impact on body image for their female citizens.

Our ideals about the “perfect body” depend on our cultural background. When food is scarce, it is more fashionable to be larger (showing plenty). In our Western world, ideas about the culturally acceptable body have changed over time. In the Renaissance, the “reproductive” body was fashionable. In Victorian time, corsets were necessary to show the proper hourglass figure. In the 1920s, the slender, boyish flapper style was all the rage. The 1940s brought more well-endowed bodies, with models such as Lana Turner gaining in popularity. During the 1950s, Marilyn Monroe was at her peak, and so women aspired to have a shapely (overweight by our standards today) body. A drastic change, started by the model Twiggy, brought back the slender, waifish body. Through the 1980s, physically fit bodies were the fashion. Today, as during the 1990s, the slender adolescent body is what women strive for as the cultural ideal. From womanly to waif
and back again. The notion of beauty and the ideal body has continually shifted. Culture sets the standards, and women strive to meet the unattainable demands. The underlying point, however, is, during all these eras it is women that are expected to conform to these narrow standards. Certainly, men are affected also, but not to the same degree.

The media images that infiltrate our culture have an enormous influence on the sociocultural factor in developing eating disorders. Advertisements, movies, fashion, and television use deep societal pressure to be thin in order to sell products for self-improvement (Shollhorn, Simpson & Smellie, 1990). The multimedia and the advertising world wield a great deal of power in our culture as evidenced by the extraordinary amount of money that is spent on it by corporations. As Milne (1998) points out, young women are being initiated into feelings of body dissatisfaction at a young age and this programming becomes difficult to undo. It is all about image. So many children and adults absorb the media messages, learning that this distorted image of thin is the one to achieve. “Thinner is better” is the message we come to believe, and thus many females embark on the diet roller coaster, often ending up with eating disorders. Society’s present standard of beauty is an image that is practically just short of starvation for most women (Pipher, 1994).

Part of considering the sociocultural factor is to realize that society’s obsession with thinness is often justified due to health. Scientific studies frequently promote the slender ideal as desirable and important to achieve in order to prevent health problems (Poulton, 1996). As Poulton points out, there is a billion dollar food and exercise product market that reinforces this stereotype. Antifat attitudes start early, with toys such as Barbie and her 36-inch bust, her 18-inch waist, and her “itty bitty” feet that make it
impossible for her to even stand up (Canadian Teachers’ Federation, 1990), and the stigmatization continues in all areas of the media.

The biological and social changes that adolescents experience are exacerbated by the tension that young women have about their bodies. Puberty results in a natural increase in body fat that is necessary for development. Eating disorders can develop at any time, but an individual is more vulnerable when facing several changes at once, as is true at the beginning of adolescence. Russell and Rice (1997) point out that young girls learn to scrutinize and judge every possible physical attribute and that they start to engender feelings of worthlessness, powerlessness, shame, and self-loathing. Their normal, developing bodies are at total odds with the thin ideal that they equate with intelligence, success, achievement, and desirability. Quantitative data consistently reveal that a significant number of adolescent girls are unsatisfied with their body size (Paxton, 1996). It is during this time that adults, particularly teachers and parents, must be especially vigilant in noticing any changes in eating habits. The pressure puts young women at a great risk for developing self-harming behaviour, such as eating issues, alcohol and drug misuse, smoking, and depression. Long term, it can lead to ongoing body and self image problems. A Psychology Today survey (Garner, 1997) determined that women of all ages will go to frightening extremes to fit society’s image, with 24% stating that they would give up 3 years of their life to achieve their weight goal.

Dieting is such a pervasive practice among adolescent girls and women that it could be considered normative. Unfortunately, such efforts are largely ineffective. Weight is women’s normative obsession. Being of average weight is the eighth deadly sin. Adolescent girls are particularly at risk of internalizing dieting myths and
misinformation. Studies indicate that dieting is beginning as early as grade 4 or at 9 years of age (Roblin, 1997; Russell & Rice, 1997). Dieting alone may be a sufficient condition for the development of an eating disorder, as dieting may cause bingeing due to psychological and physiological grounds (Correia, 1995). There are adverse effects experienced during dieting including depression, anxiety, and bingeing, all of which are normal physiological responses to starvation but serve to compound feelings of failure (Correia). Sadly, because dieting often does not allow women to meet their unrealistic body size goals, many will turn to more drastic methods of “forcing the fit”.

While no cause can be the sole determinant in developing an eating disorder, it does appear that while sociocultural factors may not directly cause eating disorders to develop, they certainly play a role in contributing to generate and perpetuate the problem. Our culture tends to normalize what is abnormal in relation to body size, with the media omitting any representation of the wide spectrum of possible body sizes and shapes. Culture continues to lend truth to the myths and thus encourages an atmosphere where weight preoccupation is normal for women.

2.8 Conclusion

As outlined in the previous sections, there are a multitude of causal elements in the proliferation of eating disorders. A complex interplay of factors, including physical, genetic, psychological, familial, and sociocultural, may contribute to predisposing certain individuals towards eating pathology. This complexity is why eating disorders are so difficult to prevent and treat. Rather than interpret these factors as distinct causes, it is useful to see them as interconnected and interwoven. It is important to recognize that each case and its underlying causes are as complicated and varied as the women
themselves. The factors in each individual case combine in unique ways to cause women to develop issues around food and weight.

Often, the research findings about the causes of eating disorders are difficult to interpret. Most studies have focused on a restricted range of putative etiologic factors; most samples have been recruited from specialist centres, and few studies have included general psychiatric control groups or control groups without eating disorders. Thus, although many risk factors have been implicated in the development of eating disorders, not enough is known about their relative contributions. It is safe to say that a person is predisposed, or vulnerable to the risk of developing an eating disorder as a result of the factors.

It is generally agreed upon by feminists writing about this subject (Brown & Jasper, 1993; Chernin, 1981; Pipher, 1995; Wolf, 1991) that the sociocultural influences play the most important role in the development of eating disorders by interacting dangerously with the individual’s personal factors. Such individuals internalize the sociocultural values emphasizing thinness that are so prevalent in Western culture. However, eating disorders are far from simplistic and most certainly not primarily about food. Food issues are only the tip on an enormous iceberg. The hidden portion of the disease lies in emotions, values, and structure of the personality.

3. Prevention and Intervention

3.1 Introduction

When a problem such as disordered eating is displayed by such a large population of people, it is only natural to try to find a way to help those affected, through either prevention or intervention. It is interesting and in many ways cause for worry, that
although the alarm about eating disorders has been sounded for many years, the incidence rate continues to climb (NEDIC, 2001). The following sections outline what literature is available about prevention and intervention and what direction present research is taking. Education's role, including available curriculum, is also examined.

3.2 Prevention

Prevention of eating disorders is a topic that has traditionally received little attention in the literature (NEDIC, 1988). A great deal of research exists about intervention or what to do after eating disorders have been detected, but not what to do in order to stop these difficulties from their inception in the first place. Prevention can refer to either the elimination of predisposing factors (primary prevention) or early detection and treatment of perpetuating factors (secondary prevention). Either way, the goal is to reduce the incidence of eating disorders.

Developing and implementing ways to prevent eating disorders is problematic since the varying causal and multidimensional factors are not completely understood. Prevention is an enormous challenge, particularly for schools. Many factors can come into play in developing an eating disorder or issues around food, so it is important to examine ways to minimize each factor.

One factor that is often viewed as part of the cause in developing eating disorders is the family's role. In order for the family to lessen its potential impact, there are several issues that can be addressed. Family members and parents in particular can guard against transmitting harmful attitudes. Lines of more open and honest communication can be encouraged. There should be education provided by schools, doctors, and the community health department about eating disorders and an understanding of the early symptoms for
all family members. Each person in the family needs to examine their own attitudes towards food and weight and realize they may be exerting subtle pressures or sending messages to the female members in their family.

Although individual factors often result from other influences and therefore might be difficult to alter, there are suggested ways to counterbalance such impacts (Brown & Jasper, 1993). Counseling may be sought about issues around negative self-esteem or poor body image, feelings of ineffectiveness or other personal issues. Again, early identification seems to be crucial.

It is an enormous challenge to work against the popular culture and society's deeply entrenched dominant ideas about desired body shapes. In fact, some of the most sobering comments about preventing eating disorders (Graber & Gunn, 1996) refer to the impossibility of altering the sociocultural context that promotes the ubiquitous concern among young women about their body weights and shapes. The role that the sociocultural factor plays must be confronted if even a small dent is to be made in females' weight preoccupations. As Correia (1995) suggests, what is needed is a fundamental change in social institutions and attitudes that endorse women's subordinate status that legitimizes a hatred of body fat, promotes chronic appearance anxiety, and idealizes certain ideals of beauty.

Working on changing the images presented in the media is one way to help prevent the issues that surround disordered eating. Media literacy and awareness education in schools can assist with this change. Several studies have documented the role of the media in setting up models for emulation ("Guidelines for schools", 1997). Parnell et al. (1996) suggest that the media should be influenced to become more
sensitive about how body shapes and sizes are extolled and admired at the expense of other qualities, and that the media also needs to refrain from suggesting that problems can be solved through controlling the diet and maintaining an unrealistic weight (Collins, 1998). Since the media is such a powerful instrument, it could be used for positive change and possible prevention. If images are made, then they can be unmade (Cavallaro, 1998). That way, cultural attitudes could be shifted and more awareness of detrimental cultural stereotypes and practices could be raised.

Some writers on this topic suggest that, to reverse society’s misguided idealization of thinness and its destructive effects, a larger scale effort needs to occur. Wolf (1991) argues that women need to put together a personal counterculture, a third wave of feminism to fight the beauty and thinness myths. Changing the cultural icons may be virtually impossible since they exist in the interest of capitalist marketing. Trying to change this popular culture may not be effective. Feminist approaches such as the one taken by Brown and Jasper (1993) suggest that the only way off the dieting treadmill is for women themselves to reject thinness and rebel against its tyranny, in essence rebelling against the predominant social values. Females need to stop taking for granted the ideal images of the body that are presented to them and start to view such images as myths. The “ideal” comes naturally only for a small percentage of women.

Promoting acceptance seems to be a key ingredient in overcoming the belief that attractiveness fits only within small parameters. Acceptance of all body shapes and sizes, similar to acceptance about height and eye colour, needs to occur before pressure to fit the mold can lessen and stop interacting with other factors that work together to create eating disorders. The present Healthy Living Curriculum in Ontario attempts to address
this issue with its expectations of “outlining the factors that influence body shape and size” and “describing the influence of the media on body image” (Ministry of Education and Training, 1998). People need to see and hear strong, talented, intelligent women of diverse sizes, ages, ethnicity, and body shapes. Healthy role models for females need to exist, both in real life and in the media. Teachers need to advocate to promote such inclusion.

Critical thinking and coping skills need to be nurtured so that conflicting sociocultural messages can be questioned and painful periods of poor self-image, especially in the transition years, can be avoided (Kater, 1998). The development of such skills should be an emphasis for schools. Students of both sexes should be taught to nurture their own self-esteem through specific activities and be encouraged to respect others for their differences. The attention given to a female needs to be shifted to include the body and the brain (Brumberg, 1987), as reliance on beauty as power is a dangerous form of dependency. The unhealthy images that women see in the popular media and that are reinforced by society must be recognized, deciphered, and criticized in order not to be endorsed. Only in these ways can the impact of sociocultural pressure be minimized.

There is some literature suggesting that some preventive methods may be detrimental, doing more harm than good (J.C. Carter, Stewart, Dunn & Fairburn, 1997). Prevention may inadvertently increase student knowledge, glamorize eating disorders and teach about good and bad foods. O’Dea and Malony (2000) express that some preventative programs may exaggerate the shape and weight of vulnerable individuals, who may start dieting, and dieting in itself is sometimes a predictor of developing an eating disorder. Points made by such literature need to be taken into consideration but as
they contain short-term research they may not be predictive of long-term effects. It could be as inaccurate as the argument that teaching children about birth control will increase sexual activity and pregnancy rates. Knowledge is power, and providing students with all available information will only enhance their decision-making capabilities. There is a present shift towards preventing eating disorders by incorporating more comprehensive elements, such as health promotion and personal skill development. This is a positive development, as such prevention is all encompassing and will assist is all areas of difficulties, not just eating disorders.

Statistics about eating disorders clearly indicate why prevention of this continually increasing epidemic is necessary, and research has provided the basis for determining the contributing factors that need to be taken into consideration when attempting to play a preventive role. The questions arise about when such prevention would be most effective, and at what ages should young girls be targeted? Experience with female students leads to the conclusion that such prevention needs to occur quite early, as children who are in primary grades already express ideas and opinions that indicate they are being influenced by the culture in which we live. Younger populations need to be reached before attitudes and behaviours become firmly entrenched.

Neumark-Sztanier (1996) suggests prevention should occur right from preschool age through university, but recognizes it may be most advantageous for adolescents of middle-school age. Primary prevention should include all students, male and female. Although girls are more apt to develop eating disorders, boys are becoming more at risk and may also play a contributing part in maintaining pressure in relation to sociocultural influences (Romeo, 1994). It is important that all children be taught, through example,
role playing and dialogue, to respect and accept each other. They should learn how to nurture others rather than insult, isolate and criticize. Data (Phelps, Andrea & Rizzo, 1994; Thelen et al., 1992) show that girls as young as the 4th grade are expressing a desire to be thinner. Nassar et al. (1992) suggest that by age 10 children are very aware of others’ opinions and may start dieting as a response to a negative perception of their own appearances. These studies would suggest that prevention needs to target young populations before attitudes and behaviours are firmly established.

Gabel and Kearney (1998) stress the prevention of dieting at an early age, stating that it may be a significant factor in sustaining permanent healthy eating behaviour. Dieting is a risk factor for developing eating disorders, as many physiological changes occur while dieting which can create ideal conditions for an eating disorder to take root. Preventing children from dieting, or in fact feeling the pressure to diet in the first place should be an important consideration.

The general age of onset for eating disorders is a fact to consider when deciding at what age prevention would have the most preventative impact (Graber and Gunn, 1996). Early-maturing girls are particularly at risk due to increased body weight and size changes, which they view as negative in relation to societal images. It is important to inject critical thinking and other preventive strategies before this time in order to help free them from this debilitating obsession. There is some suggestion in the literature that there may be a special need to target high-risk individuals, perhaps those that fit the individual criteria or who have experienced some sort of personal trauma, for particular or more intensive prevention programs (Neumark-Sztanier, 1996).
3.3 Intervention

Intervention refers to early identification of those who are developing or who already have eating disorders, followed by referral and prompt treatment. The longer such problems are left untreated, the more deeply rooted the behaviours become. Intervention is certainly most effective when started early (Connolly & Corbett-Dick, 1990), and a more complete, timely recovery is more likely with early intervention (Natenshon, 1996). It is crucial for educators to understand different types of intervention as it will assist them in understanding the experiences their students may be having.

It is important to realize that treatment often takes time and won’t happen overnight, but that overcoming an eating disorder is possible. Treatment of eating disorders sometimes requires a multifaceted approach with different professionals contributing their own expertise at various points in the therapy process (NEDIC, 1988). If medical complications are apparent, it is vitally important for a physician to be involved, and the individual may have to be hospitalized. Mental health professionals such as psychologists may provide individual, group, or family therapy.

One of the first important parts of treatment is to start the individual back on the track of normalized eating (NEDIC, 1988). This stage of treatment requires the support of a nutritionist or dietitian who can assist by reviewing food intake and designing an appropriate food plan for the individual to follow. A health professional connected with the school may take on this role, and the classroom teacher may be of assistance in helping to implement the plan. The person must be out of physical danger and be back on the track with “norma” eating before she can deal with any precipitating or underlying issues.
Different treatment formats work for different people, and researchers are trying to determine how to best identify who would benefit from what type of treatment. The options for intervention are numerous and differ in terms of the intensity of the therapeutic efforts and the numbers of people who ultimately assist in the person’s care. The following approaches are summarized from several texts (Boskind-White & White, 2000, Friedman, 1997, NEDIC, 1988).

One therapeutic approach is the cognitive behavioural. This approach deals with the thinking behind the eating behaviour. The thinking often leads to self-defeating behaviours such as dieting. The goal of this approach is to become aware of and develop healthier thinking, which in turn leads to healthier behaviours. An individual engaged in this kind of therapy may be asked to keep a reflective journal about food intake and related feelings and thoughts. A classroom teacher can certainly assist with such an intervention as she deals with cognitive processes across the curriculum.

A psychodynamic approach can also be taken. The focus in this approach is on early relationships and experiences and the impact these have on the current situation. In-depth psychotherapy may be undertaken in order to deal with these traumatic or abusive experiences. The individual learns to make the connections between the experiences or relationships and the eating problems.

The behavioural approach is often a component of hospitalization or outpatient programs. The individual gradually increases activities and privileges through eating and gaining weight. This approach works with an emphasis on control and rationalizes that if the individual can control the weight loss then she can conversely control the weight
gain. Some of the privileges gained may be related to school, so it is important for the educator to be aware of and in support of such a plan.

Support groups are another route that may work therapeutically for an individual with an eating disorder. Such groups allow the woman to share experiences with others who share similar problems and provide support that the individual may not receive from family and friends. A school nurse may set up such a group in a school if the need requires, and school personnel might participate in discussions.

3.4 Education’s Role

It is often suggested that school health programs could become one of the most efficient means that nations could employ as a means of prevention. Berg (1997) advocates for a unified health approach where children receive consistent messages that encourage normal eating, active living, self-respect, and appreciation of size diversity. The idea is to inoculate with education, as awareness would be heightened and images would be thought about critically.

The adolescent population that is most affected is in our schools, but the programs to prevent eating disorders are virtually nonexistent (Natenshon, 1996) and often have to be purchased by the classroom teachers themselves. The National Eating Disorder Information Centre has published guides (1988) for the classroom teacher but has not published an updated version that might better reflect current trends in the research and report on up to date statistics. Sandra Susan Friedman (1994 & 2000) has written facilitators’ manuals entitled Girls in the 90’s and Nurturing Girlpower. Both of these manuals are excellent resources for teachers who are attempting to integrate prevention and intervention strategies in their classrooms and in their schools.
Everybody is a Somebody, published by the Body Image Coalition of Peel (1997), is an active learning program which helps to promote a healthy body image, positive self-esteem, healthy eating, and an active lifestyle in each student. This program was written with a team of experts, including Dr. Gail McVey, in regard to eating disorders, adolescents, and education, and is one that is used with success in classrooms as it corresponds to the health curriculum. Getting There is Half the Fun (1995) is another well-written resource put out by the Department of Public Health in Hamilton/Wentworth. It is an active learning program that helps develop a positive self-image, healthy eating habits, and active living strategies. It is specifically designed to be implemented at the grade 6 level.

For teachers, there is certainly an availability of preventive curriculum for use in the classroom. However, as professionals, teachers want to select the one that is most appropriate for the level they are teaching as well as one that has the greatest impact. There is not a lot of literature comparing the different resources available or measuring their effectiveness at preventing eating disorders or promoting a positive body image and self-esteem. It is also important to recognize that prevention of eating disorders fits within the parameters of only one third of the current Ontario Health and Physical Education curriculum, and thus makes time another important consideration. To justly deliver such curriculum would generally mean leaving out another, probably equally worthwhile, endeavor.

Education’s role in prevention and early intervention is crucial. Most available literature outlines the guidelines for an education program that include educating teachers and staff members, utilizing community resources, educating students, and
including parents. It is suggested by Natenshon (1996) that the greatest potential for eradicating eating disorders lies in recognizing the disease in its early stages before pathological behaviour becomes entrenched.

If schools are not part of the solution, then they are part of the problem. Prevention needs to be a prime goal (Levine, 1983), and it must be understood that culture plays a significant role in the formation of and prevention of eating disorders. It is crucial that staff be made more aware about the eating disorders: their causes, issues, prevention and intervention. Through workshops led by knowledgeable, trained personnel, staff must examine their own beliefs and biases, as many school personnel don’t see anything inherently wrong with dieting or the prevailing attitudes regarding weight (Shollhorn et al., 1990). Staff attitudes are important, as teachers play an important role in transmitting cultural attitudes and shaping student beliefs (Bear, 1996). Educators need to be aware that they have a powerful impact as both teachers and advisors. If curriculum and staff development happened in the area of preventing eating disorders (Russell & Rice, 1997), then there would be more support, education, and consciousness raising for girls and women.

Concern about the population most at risk for developing eating disorders is the primary reason for including prevention as a facet of the school curriculum, but all students would benefit from heightened awareness. Connolly and Corbett-Dick (1996) suggest that such curriculum should address concepts of nutrition, the link between food and emotion, appearance values, biological changes in adolescence, and the psychological and social components of maturation. Such curriculum needs to start being addressed at the elementary level. The Ontario Healthy Living Curriculum (Ministry of
Education and Training, 1998) does not mention specific expectations about eating disorders until grade 8 although, to its credit, it does address influences on eating and changes in appetites due to growth spurts in the junior grades. Many eating disorder specialists (Berg, 1997) now believe eating disorder prevention programs aimed at adolescents come too late. By the intermediate grades, negative eating attitudes and behaviours are strongly ingrained, almost a part of female teenage culture. However, Connolly and Corbett-Dick (1996) point out that teachers should not glamorize eating disorders by teaching that they are problems that happen only to smart, attractive, and popular students or linking them too closely with famous celebrities such as Princess Diana or Ally McBeal.

Like most alcohol- and drug- prevention programs, there could be a large-scale education effort to prevent this cultural disease (Pipher, 1995). In fact, Graber and Gunn (1996) argue that prevention should target the gamut of transitional risk behaviours among adolescents: dieting, cigarette smoking, alcohol use, drug use, and unsafe sex. This prevention should be sustained by comprehensive effort within the broader context of societal and systemic changes. It is schools that have the power and the means to offset such destructive behaviour.

However, schools can not achieve this goal on their own when a cultural milieu has a large influence in food-related beliefs, values, and practices. The Journal of School Health’s “Guidelines for Schools” (1997) suggests that such programs need to be quite comprehensive and reach students of all levels. Levine (1983) also suggests that coordinated effort within the school system and the communities take place, as well as a greater emphasis on prevention/detection and referrals. Staff and students should be
provided with a list of community resources. In many local boards of education this occurs as the public health personnel make resources (both people and paper) available to the schools. However, too few schools take full advantage of such a partnership. These programs also need to be long-term (Neumark-Sztanier, 1996) and reach beyond the classroom to larger school and community environments, becoming a catalyst for broader societal changes. Only then can girls and women hope to free themselves from this debilitating obsession.

Of course, it could be argued that it may not even be realistic for schools to hope to overcome such societal problems. Many researchers involved with eating disorders wrestle with this dilemma. At times, preventing eating disorders may seem as futile as preventing students from experimenting with cigarettes, drugs, and alcohol. However, students must be provided with the necessary tools and as educators, we must be optimistic about the long-term effects such preventive measures may have on our students.

There is some literature available on what the role of the educator is after intervention has started to take place. Levine (1983) stresses that school personnel are not therapists and therefore should not become involved in diagnosis or counseling that need considerable training and experience. Teachers are on the “front line” of detecting eating disorders (NEDIC, 1988), which means they are in an excellent position to notice developing eating disorders. They spend considerable time with students and may more objectively notice their behaviour and attitude changes than the students’ parents might. It is also important when students are being treated for eating disorders that school personnel respect the treatment plan throughout its duration. However, it is difficult to
draw the line between teaching the student and helping them with their personal difficulties that affect the teaching.

If the school setting is viewed as such an effective place for the implementation of prevention programs and educators are thought to be in such an enormously powerful position, then it is important to examine the effects of studies that have attempted to do so. Results from preliminary programs already suggest (Neumark-Sztanier, 1996) that for school based programs to be effective, they need to be more intensive, be long-term, and need to reach beyond the classroom to the larger school and community environments. The Ministry of Education, school boards, and classroom teachers need to be persuaded to do so by health officials, advocacy groups, and individuals.

Some studies have shown effectiveness with prevention techniques, while others have not. O'Dea and Maloney (2000) write about trials that have examined whether school based programs could prevent disturbed and unhealthy eating and body dissatisfaction among adolescents. Some studies reported no improvement in body image and no reduction in disturbed eating, weight loss behaviour, or body dissatisfaction. Others demonstrated statistically significant improvement in knowledge of nutrition, growth and development, and dangers of fad weight-loss methods and eating disorders. Certain studies reported encouraging long-term findings (12-month follow-up) with improvement in body satisfactions as well as reductions in concern about how others' viewed them. Dieting and weight losses were prevented among females. Part of the varying results found in such studies may be due to methodological weaknesses. These weaknesses include those associated with self-reported data. Subjects' perceptions of
their behaviour may not be entirely accurate, and those with existing problems may not indicate them in quantitative or qualitative studies.

Conflicting results that on one hand indicate prevention programs in schools could be effective in preventing eating disorders, while on the other hand indicating that such programs have the potential to be harmful and may actually increase the incidence of eating disorders, need to be examined together in order to further question what is the best route to take with prevention in schools. To develop programs that have a positive and lasting impact on body image, eating behaviours, attitudes, and self-image, professional, must first exclude approaches and practices proven ineffective or harmful. A suitable approach encompassing a range of influences internal and external to the school environment must be undertaken in order to provide a safe, effective, and long-term solution to these pernicious problems. Schools need to confront the challenges to become one of the most efficient means to prevent the major health problems that confront our young women (Berg, 1997).

3.5 Conclusion

Prevention of and intervention with eating disorders are both important when examining the issues surrounding eating disorders. Society in general and education in particular must work together to eliminate and reduce the risk factors for disordered eating. Prevention needs to be seen as the ultimate goal, as it is more humane and less costly than treatment. When prevention has not worked, early identification of those who are either developing eating problems or those who are already experiencing eating disorders is crucial. Prompt, individualized, and effective treatment must take place.
Upon reflecting about the literature available on prevention and intervention, it can be stated that a great deal of quantitative data is in existence. This information gives reasons why this problem needs to be addressed in the education system, due to the high prevalence and the increasing pressure on both genders to attain the “perfect” body. The numbers of those diagnosed with eating disorders are not diminishing. Research has started to move beyond the why and what to select who, and at what specific age prevention would be most beneficial. It is clear that more qualitative data are required in order to give a voice to those individuals who make up the “who” in research and to make such studies more subjective. Research is starting to test what programs need to be developed, reimplemented, evaluated, reworked, and implemented again until successful results are obtained. Such research is also helping to develop responses to the question of whether prevention is even a realistic goal for schools and teachers. Researchers and educators together must put the results to use in an attempt to alleviate the seriousness of this problem. The school setting is a natural forum, but ideally such prevention needs to be far reaching, including community awareness and changes in social attitudes. Research needs to incorporate and evaluate strategies into the existing, comprehensive school health programs in order to deter disordered eating and encourage healthy eating habits in our youth.

4 Summary of Literature Reviewed

This review has examined the literature related to eating disorders. Exploring this issue in a historical context allows the understanding of how eating disorders were first labeled and how the views of such disorders have changed to the present views held today; that the development of eating disorders are complex and multifaceted. The
factors contributing to the development of eating disorders include physical, genetic, psychological, familial, and sociocultural. While all of these factors may interact together to predispose an individual to developing such problems, it appears that the sociocultural factor has the greatest negative impact and thus needs to be examined most closely. The prevention of and intervention with eating disorders has started to receive more attention in the literature. There are many theories of how best to prevent such problems from occurring in the first place and helping with such difficulties after they have occurred. The role of education and teachers in assisting with both prevention and intervention remains unclear, but certainly has the potential to have a positive impact on students receiving such education. For the problem of eating disorders to be alleviated and for the young women in our society to be most benefited, further research in all areas must be continue, including qualitative work to add voices to the discussion.