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PERCEPTIONS OF CHILDREN WITH EATING DISORDERS AND THEIR PARENTS PARTICIPATING IN SUPPORT GROUPS: AN ETHNOGRAPHIC APPROACH

By

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ABSTRACT

PERCEPTIONS OF CHILDREN WITH EATING DISORDERS AND THEIR PARENTS PARTICIPATING IN SUPPORT GROUPS: AN ETHNOGRAPHIC APPROACH

By

Diane L. Budres

This study utilizes ethnographic techniques to explore multi-dimensionally the perceptions of children with eating disorders and their families. Data were available for four families.

Research questions examined: 1) perceptions of the eating disorder among the afflicted children and their parents; 2) perceptions of attending support groups among afflicted children and their parents; and, 3) familial relationships possibly affecting perceptions of the eating disorder.

Kantor and Lehr's (1980) "player parts" concept was used to categorize familial interactional patterns. Participants' choice of words was also examined; word association questionnaires were administered.

Results suggest that: 1) daughters' relationships to the eating disorder were more personalized than their parents'; 2) parents view support groups as primarily educative meetings, whereas daughters see them as mainly social; and, 3) opposition between fathers and daughters is marked; mothers generally play supporting roles.

This study raises questions for future research into eating disorders and support groups. For practitioners and researchers, it provides useful insights about families who have a child with an eating disorder.

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CHAPTER I

INTRODUCTION

Anorexia Nervosa

While it was once considered a rare disorder, anorexia nervosa is becoming a common problem among families with adolescent females. Based on previous studies, it can be concluded that the disorder occurs predominantly in females (the female:male ratio is 9:1) and affects an estimated one in 250 girls aged 16 or younger (Crisp, 1980). It is not clear whether this estimation reflects an increase in cases or an increase in the reporting of cases as public education has made the disorder more easily recognized by professionals and lay people.

The term anorexia nervosa has led to some confusion. The literal etymology is "lack of appetite" (anorexia) "due to nerves" (nervosa). Usually, however, this is not the case: the victim does have an appetite, but learns how to control response to it in the pursuit of a slimmer body (Levekron, 1982).

The classification of anorexia nervosa has added to the confusion. In some texts, anorexia is referred to as a disease; in others, as an illness; and in still others, as a disorder. The term preferred in this thesis is disorder: a derangement of physical and mental health.

This thesis examines the individual anorectic child and her parents, together referred to in the clinical setting as the family. The "typical" anorectic female and "typical" family are described in general terms. Although it is recognized that such typification may be a simplistic representation of a complex disorder, the descriptions are based on a composite of clinical case studies.

The "Typical" Anorectic Female

The "typical" anorectic female has a distorted body image; she feels overweight or "fat" even if she is emaciated. Often, the person is preoccupied with her body size, and she frequently gazes at herself in the mirror, obsessed by her appearance. In efforts to lose weight, she may reduce her food intake to one-fifth of her previous consumption level, eating foods low in carbohydrates and fat.

Although the genesis of the disorder is not certain, researchers with various clinical perspectives have noted that, for the most part, the symptoms of obsessive dieting and weight loss become apparent after a stressful life event or situational conflict in the family (Minuchin, 1978).

The "Typical" Anorectic Family

The "typical" anorectic family is generally described as upper-middle class and achievement oriented. Externally, the members present themselves as an exceedingly healthy family unit. However, internally, the dynamics which regulate the system are in conflict; certain unaddressed conflicts between parents, or between parents and child (or children) lurk below the surface. The parents are often overdirective, closely monitoring the anorectic child's development, yet paradoxically maintaining the position that the development of the child's autonomy is important. Double messages and communication patterns are notable characteristics of the verbal exchanges between parents and their anorectic children (Minuchin, 1978).

Usually the anorectic child is sensitive to the parents' verbal cues regarding autonomy, but because of the child's failure to develop a sense of self-reliance, she relies on parental approval for guidance. This often results in a perfectionistic quality in the anorectic child, arising from an exaggerated need to please the parents.

When the symptoms of anorexia become apparent, the parents are at a loss. They typically make such remarks about the child as, "But she used to be such a good girl."

The parents in an anorectic family tend to feel isolated. A common reaction: "If she were like some of the other kids, getting into drugs or drinking, we'd have someone to turn to for support. But this isn't normal, is it? Where do we turn?"

Treatment

Although many forms of therapy are available for the anorectic child and/or her parents to consider, none has emerged as the definitive form of treatment. Often, families in therapy express a need to interact in a supportive atmosphere with other families dealing with similar experiences. To alleviate the families' feelings of isolation while facilitating understanding of the disorder on many levels, support groups have been suggested as an adjunct to therapy (Levekron, 1982).

Support groups have the ability to allow members to explore themselves and their relationships in a neutral, non-clinical environment. People are able to educate themselves while educating each other through discussion on planned and unplanned topics.

Currently, there is quite an array of support groups for people with various concerns. Some such as Alcoholics Anonymous (AA), Overeaters Anonymous (OA), and Weight Watchers (WW), have been established for a long period of time. A few others are relatively new and have not yet reached a national or international level, such as Parents Without Partners (PWP).

Although there are many types of support groups to choose from, there have been few reports of the use of groups for parents of children with illnesses, and even fewer reports of support groups which include the participation of both the parent and the afflicted child in the same group. However, those support groups for just parents of ill children have been described as "successful arenas" for verbalizing residual feelings of anger, fear, and guilt (Rosman et al., 1976).

Purpose of the Study

When this study was proposed, the researcher was not aware of any literature on the use of support groups in which both anorectic children and their parents participated simultaneously. Although there is a general belief that benefits can be achieved for parents and children through the use of support groups, there appears to be no evidence to back up this view.

This gap in the literature needs to be addressed. Therefore, the present study will examine the role of support groups for anorectic children and their parents, utilizing an ethnographic approach to explore these research questions:

1. What perceptions of the eating disorders do children with eating disorders and their parents share and not share?
2. What perceptions of attending support groups do children with eating disorders and their parents share and not share?
3. What relationship is there between the afflicted child and the parents which may shape the perception of the eating disorder?

It is anticipated that this study will be of interest to a variety of readers. Clinical and lay personnel dealing with families who have anorectic members may find this study useful as a guide for the future examination of support groups in the management of anorexia nervosa. At the same time, this study may serve as a reference for the future examination of support groups for other types of disorders where both the afflicted child and the parents participate together.

Other individuals who may find this study useful include educators, school guidance counselors, and social workers, as well as volunteers who interact with female adolescents and their parents on a regular basis. Because the number of anorectics continues to rise in families with adolescent females, school systems may consider providing support groups in order to alleviate the symptoms of anorexia nervosa.

Finally, this study will be of interest to people studying families who would like to explore ethnographic techniques in order to collect data. The techniques used to obtain data for this study are methods associated with anthropology. Students of anthropology are often stereotypically depicted as learning from exotic cultures by cohabitating with them. Because this study concerns anorexia nervosa, a Western disorder, and the researcher shares the same culture with the participants, the methodological stereotype is removed. What is left is the underlying characteristic of the ethnographic method: learning about the culture from the inside, or in this case, from the families involved with the study. In this respect, the study illustrates the adaptation of research techniques from one discipline to another.

Conceptual Framework

The concept of family systems underlying this study is based on the work of Minuchin (1978) with psychosomatic families who have an anorectic member. This model emphasizes the interdependence of forces and the circular interactions which regulate and affect the processes of the family. Under the systems paradigm, every part of the system is seen as organizing and being organized by other parts. An individual's behavior is simultaneously caused and causative. A beginning or an end is defined only by arbitrary framing and punctuating (Minuchin, 1978). (See Figure 1.)

The system can be activated at any number of points, and feedback mechanisms are operative at many points. The activation and regulation of the system can be achieved by a system member or by forces outside the system.

The systems model postulates that certain types of family organization are closely related to the development and maintenance of psychosomatic syndromes in children, and that the child's psychosomatic symptoms in turn play an important role in maintaining the family. Anorexia nervosa, in this light, is defined not only by the behavior of one family member, but also by the interrelationships of all members. Under this model, then, the anorectic's failure to eat is controlled by the interactional processes among family members.

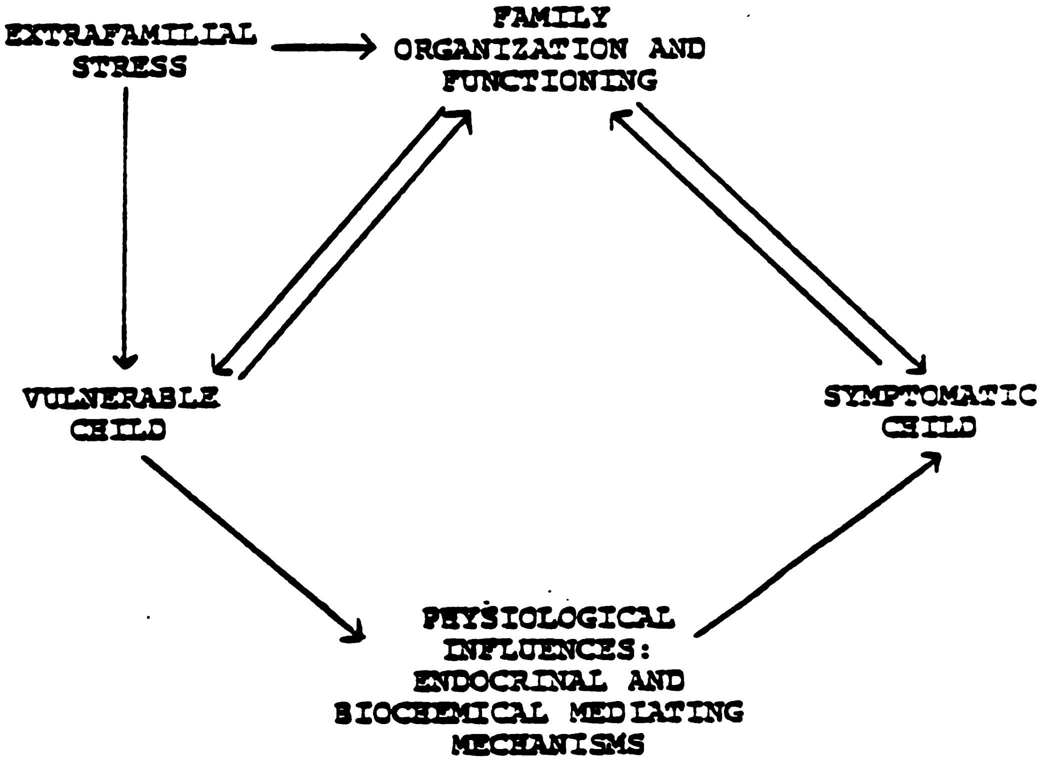


Figure 1. Family systems model, showing interactional forces. (Arrows indicate direction of influence. Adapted from Minuchin, 1978.)

The systems framework challenges linear approaches which are also used to study eating disorders. In a linear approach, the behavior of the individual is seen as sparked directly by others' behavior. This approach assumes an action and a reaction, a stimulus and a response, or a cause and an effect. Thus, in the individual who is labeled as having an eating disorder, the disorder is seen to be internalized.

For the purposes of this study, Minuchin's work needs to be modified, because of the researcher's interest in presenting the family as a system interacting with a support agency by attending meetings of a support group. Certain characteristics presented by Minuchin (see Figure 1) are accepted as givens, and the researcher adds to the conceptual framework. (See Figure 2.)

The model in Figure 2 represents the family as it interacts as participants in the support group. This study takes place within the boundaries represented by the dashed line. Family functioning and organization and the symptomatic child are the family elements included. The other attributes of Minuchin's model are accepted as givens because they are outside of the arena with which the present study is concerned.

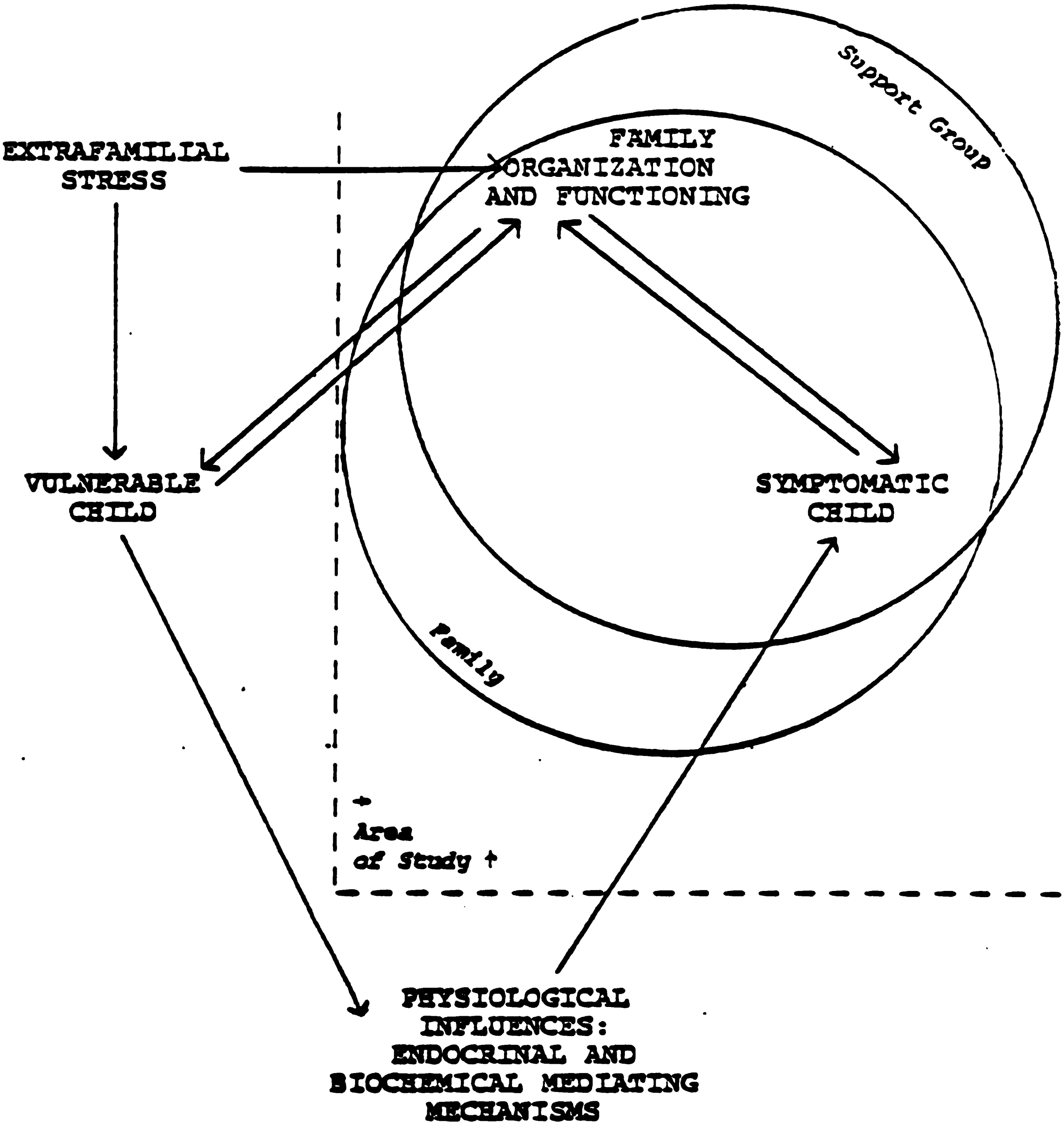


Figure 2. Minuchin's (1978) model, as modified for the present study. (The upper right quadrant represents the area of study. The overlapping circles represent the boundaries of the support group (upper rightmost circle) and the family (lower leftmost circle). Arrows indicate direction of influence.)

CHAPTER II

REVIEW OF THE LITERATURE

Anorexia Nervosa Defined

The term anorexia nervosa is something of a misnomer. Its literal etymology is "lack of appetite" (anorexia) "due to nerves" (nervosa), however, usually the person with anorexia nervosa does have an appetite but learns how to control her response to it in pursuit of a slimmer body (Levekron, 1982). Although this is a simplified description of the disorder, it does indicate one of the key issues: control. The issue of control over one's tissues as a coping mechanism has appeared in several schools of thought on the subject. The Freudian psychoanalytical point of view sees anorexia nervosa as a means to control one's psychosexual development (Bruch, 1977). Many anorectic females are, or appear to be, pre-pubescent. Lack of nutrition can delay onset of sexual maturity, so anorexia can serve as a protective device, obviating the need of the individual to face the pressures of sexual maturity. Behaviorists see the regulation of food intake as a comforting buffer zone, with the individual turning to food (or lack of it) for the expression of feelings until this conduct becomes part of the behavioral pattern. Systems and family systems people view anorexia as a means to regulate the individual's internal environment (seeking a homeostatic pattern) when the person feels unable to control the external environment (i.e., the family) (Minuchin, 1978).

Incidence Rates

It appears that anorexia nervosa is becoming more common. The increase in reported cases may be attributable to causal factors or to an increase in the rate of reporting cases as a result of greater medical and public awareness over the past twenty years. Case-registry studies have demonstrated an increase in patients presenting the illness to psychiatrists. For example, Jones et al. (1980) used psychiatric case studies and hospital records from a major general hospital to estimate the incidence of anorexia in Monroe County, NY over two time periods: 1960-1969 and 1970-1979. The number of diagnosed cases nearly doubled from the first time period (0.35 per 100,000) to the second (0.64 per 100,000). The increase was most prominent in the 15-24 year old group. Further Garfinkel and Garner (1982) indicated that the incidence rate is probably much higher, as the case-registry method has severe limitations. It requires the individual's identification as a psychiatric or medical patient, but many anorectics receive treatment by non-medical personnel (dietitians, psychologists, counselors and clergy, among others) and thus are not adequately represented in psychiatric case records.

Prevalence

In an attempt to develop a picture of the prevalence of anorexia nervosa in a non-clinical setting, Crisp et al. (1976) conducted a detailed survey of nine schools in London. They discovered one severe case for every 100 girls over the age of 16 in private schools. The disorder was less common in public schools, evidencing the preponderance of cases among the upper classes. Overall, Crisp estimated that one serious case was present in every 250 females between the ages of 12 and 16 years (Crisp, 1980). Moreover, Crisp included only very severe cases in the count, so the results may be considered to be conservative. Garfinkel and Garner (1982) suggest that the disorder has reached epidemic proportions.

Mortality and Morbidity

The mortality rate of anorectic children ranges in the literature from two percent to ten percent, with an average of nine percent (Garfinkel and Garner, 1977). When death occurs, it is usually due to starvation and its complications (e.g., bronchiopneumonia or other infections, renal and cardiac failure), to electrolyte disturbances (secondary to purging and vomiting), or to complications of somatic therapies (gastric dialition). Suicide has also been a cause of death among anorectic patients, particularly those who have been suffering from a chronic case (Garfinkel and Garner, 1982).

Morbidity statistics are sparse. The definition of morbidity ranges from recurrent episodes of weight loss to interpersonal difficulties experienced by an individual and her family, so it is difficult to compare various studies.

Treatments

Although many treatments are available, ranging from nutritional support to family therapy, none has emerged as the definitive therapy. Garfinkel and Garner (1982) found that 25 to 50 percent of the patients studied remained unchanged at follow-up one year later. Crisp (1980) found a similar range in Great Britain. The data suggest that the resolution of intrapsychic and interpersonal conflicts is germane to recovery. These conflicts can include (a) problems with peer and parental relationships, (b) social isolation, (c) feelings of powerlessness, and (d) internal stress.

To attempt to alleviate these feelings, support groups may be used as an adjunct to therapy, as suggested by Levekron (1982). Support groups are seen as fulfilling a specific purpose in the treatment of eating disorders (ANAD, 1983). They may provide an arena for people to explore themselves, their problems with peer and parental relationships, and their feelings of powerlessness in a neutral territory where the sharing of experiences is facilitated. Facts can be produced and examined with the knowledge that the group is a non-intervening activity. At the same time, the element of friendship is present, enabling the person to feel relief from isolation (Macleod, 1982).

Following the completion of data gathering for the present study, a preliminary report of a related study appeared in the literature. Huerta (1983) reported possible benefits of support groups as an adjunct to therapy based on clinical observations of group therapy for anorectics. More than 100 anorectic individuals had participated in 1-1/2 hour weekly group therapy sessions which were observed during a two-year period. The members of the group were mainly females who ranged in age from 12 to 37 years. Additional demographic, symptomatic, and treatment variables were still being analyzed when the report was published.

The benefits, or curative factors, of support groups which Huerta derived from the observations and analyses were reported. They include the following:

1. There is an opportunity for group members to express themselves in a non-threatening environment.

2. Hope and fear can be instilled as patients are confronted directly by both healthier and less healthy people. Patients see and hear about other group members who have already improved, and may be particularly impressed by those who have improved without having to be hospitalized.

3. The anorectic's sense of uniqueness is often heightened by social isolation. From very early sessions, the discomfirmation of feelings of uniqueness is a powerful source of relief.

4. Patients want to help each other. They derive self-esteem from their ability to be useful to other group members. They no longer need to fight the world; instead, they fight anorexia.

5. Corrective recapitulation of the primary family group can take place. As the group resembles a family, with male and female therapists as parental figures, maladaptive, growth-inhibiting relationships are not permitted to become rigid, and the closed, structured system that characterizes many families does not develop. Rigid behavior is constantly challenged by exploration of relationships and suggestion of new ways of behaving by the therapist.

It has been suggested by Levekron (1982) that support groups for younger anorectics (16 years or under) are more effective if the parents are involved. This may be due to many factors. The parents and the child can together acknowledge a problem; the family is voluntarily seeking help; the family wishes to understand and overcome the condition (Levekron, 1982).

Summary

The review of the literature reveals that anorexia nervosa is increasingly becoming a problem among families with adolescent females. Although many treatment modalities are available, none has emerged as the definitive form of therapy. Very little research has been published on the use of support groups as therapy for anorexia nevosa, and even less has appeared that covers support groups in which parents and afflicted child participate together. Several writers have suggested that such support groups offer promise as an adjunct to other forms of therapy.

CHAPTER III

PROCEDURE

At the beginning of this project, the researcher designed a research proposal which was examined and approved by the thesis committee members and the University Committees for Research in Human Subjects (UCRIHS). In the research proposal, the following were described: (a) the research design, (b) questions, (c) objectives, (d) the usefulness of the study, (e) criteria for the selection of participants, (f) techniques of data collection, and (g) the time sequence. This process took approximately three months, and the research proposal was formally approved by UCRIHS on April 1, 1983.

Selection of the Agency

A number of agencies have been established for the purpose of providing support to eating-disorder sufferers. These agencies include Anorexia Nervosa and Associated Disorders (ANAD), the American Anorexia-Bulimia Association (ABBA), the Maryland Anorexia Nervosa Associates (MANA), and Anorexia Nervosa and Related Eating Disorders (ANRED). The agency's usual role is to act as a clearinghouse, providing information on therapists, treatments, and support groups affiliated with the agency. Several of the organizations have central offices staffed by professionals, lay personnel, and volunteers, some of whom may be involved with people exhibiting eating disorders or may themselves be afflicted.

The agency selected for the present study was expected to meet these criteria:

1. Professional in status.
2. National in scope.
3. Established for a period of at least five years.
4. Operates support groups in which both parents and children participate simultaneously.
5. Permits researchers to have access to an ongoing support group composed of children with eating disorders and their parents.

ANAD was selected because it met all five of the selection criteria. Also, its location, near Chicago, allowed the researcher easier access when compared to the other agencies considered for the selection process.

Selection for Participants

Once the agency had been chosen, participants were to be selected from among anorectic children and their parents who had attended support group meetings for the calendar year (1982) prior to the planned observation of support group meetings. These attendees were to be identified through the files of the organization sponsoring the support group meetings. This is in contrast to selecting information from a hospital register or clinical office files, which may or may not yield an adequate representation of people attending support group meetings.

Based on a profile analysis of demographic characteristics, 10 to 15 families were to be considered for initial observation at support group meetings. From these, five families were to be selected for indepth in-home interviews, based on similarity of characteristics such as age of parents and of the symptomatic child, age at onset of symptoms, chronicity, and clinical data (Appendix A).

Ethnography: Qualitative Research

Ethnography is a research orientation toward learning from people, as opposed to studying people (Spradley, 1980). The ethnographic method was selected for this study because it allows for the study of perceptions of children with eating disorders and their parents in support groups through the eyes of the participants. This is desirable for an exploratory study in which the researcher seeks questions to ask throughout the course of the research. Furthermore, this approach is necessitated by the limited amount of documented information and evidence on the topic.

The ethnographic research cycle includes the following steps: (a) selecting a topic/theme; (b) asking questions; (c) collecting data; (d) making a record; (e) analyzing the data for reoccurring themes; and (f) either writing an ethnography, or pursuing more data by asking more questions (returning to step b).

The flexibility of this method allows the researcher to pursue new but related areas of research as they arise. This is viewed by the researcher as being essential when documented materials on the subject are limited. The sparcity of precedent studies to which the researcher can turn for guidance increases the likelihood that the researcher will need to modify study procedures as the project progresses. This was, in fact, the case for the present study, and is the reason why the Procedure section is divided into Procedure As Proposed and Procedure As Enacted subsections.

Procedure as Proposed

Data Collection

The original proposal called for the use of observation and participant observation in collecting data, as well as ethnographic interviews. In order to provide an understanding of these three techniques, brief descriptions are provided.

Description of Data Collection Techniques

Observations can fall into three categories: broad, descriptive observations; focused observations, and selective observations (Spradley, 1980). The three differ in regard to specificity. Broad, descriptive observations are first at hand. As time progresses, the observer begins to categorize materials in order to make focused observations. When the researcher begins to notice similarities and differences within and between categories, the observation becomes selective.

Participant observation, a special type of observation, is when the researcher becomes actively involved with the people under study. It might be argued that the researcher as an observer is always a participant, because the observer's presence unavoidably affects the people. Participant observation, under this view, would be observation <u>consciously</u> <u>intended</u> to involve the researcher in the situation under study.

Ethnographic interviews may be formal or informal. For the purposes of this study, formal ethnographic interviews were planned. A formal interview usually takes place at an appointed time and results from a specific request to hold the interview. Formal ethnographic interviews generally begin with explorative questions which build rapport with the participant (Spradley, 1980). This is accomplished by the researcher requesting repeated explanations and restating what the participant has said over the course of the interview. Usually the researcher is asking for the participant to describe meanings attributed to the participant's daily ways of life, as opposed to analyzing why the person is behaving in a certain fashion. The flow of the ethnographic interview may shift as the researcher reformulates the questions being asked, using words or phrases that are meaningful to the participant.

Description of Proposed Application of Data-Collection Techniques

It was proposed that data be collected via several ethnographic methods.

Observations

Observations of the family members selected for the study as they attended support group meetings were to be conducted. It was proposed that three family support group meetings and six separate support group meetings for the symptomatic children be attended and observed.

Participant Observation

Participant observation was proposed as a further method to collect data. One participant observation of each of the five families at mealtime was to be conducted.

Ethnographic Interviews

Three separate interviews of five families were proposed. The first was to include all family members involved in the study, that is, the parents as a dyad and the labeled anorectic child. This interview was to be conducted at the home of the selected family. (Appendix B.) For the second and third interviews, the parents and symptomatic child were to be considered separately. Incomplete sentences were to be used as a projective technique to obtain respondents' spontaneous answers. The incomplete- sentence stems were created based on the Eating Aptitude Test (EAT), a questionnaire used by Garfinkel and Garner (1982) to test perceptions of eating attitudes in clinical and non-clinical populations, and a guide information sheet supplied by ANAD which examines respondents' perceptions of treatment. Eight stems were created addressing each category. (Table 1.) In addition, the researcher included two other areas, with two stems each, addressing aging and perceptions of people in general. These additional items were put at the beginning of the incomplete sentences as "icebreakers," with no other purpose related specifically to the disorder in mind.

Table 1

Items in the Incomplete Sentences and Their Purposes

Items	Purposes
1-2	Perceptions of Aging--"icebreaker" function only
3-4	Perceptions of People in General--"icebreaker" function only
5-12	Characteristics of Illness/Disorder as Related by EAT[a] Criteria
13-20	Characteristics of Illness/Disorder as Related by Treatment Questions

[a] EAT = Eating Aptitude Test (Garfinkel & Garner, 1982).

Enacted Procedures

Modifications in procedure became necessary after the first observation. These modifications are described below.

Modification of Terminology and Definition

The participants labeled themselves as a support group for children with eating disorders and their parents (March 30, 1983), rather than as an anorexia nervosa support group. Because of the participants' choice of vocabulary, the term anorexia nervosa was replaced by eating disorders for this study. It became evident that the support group included a variety of people with problematic eating behaviors other than those of the classic anorectic person. This situation represents a broadening of the spectrum of eating disorders present in the group.

Many different disorders result from variations of eating symptoms. (Figure 3.) The psychological and social factors which may be related include: (a) a desire to achieve "bodily perfection" as depicted in the culture's mass media; (b) a feeling of lack of control over one's life; (c) a drive to attain perfection or superior achievement because of fear of rejection or the pursuit of praise and approval instead of personal satisfaction and accomplishment; (d) loss of a loved one through death or separation; and (e) inability to cope with stress or tension. The disorders manifest themselves as particular coping techniques, such as binging or starvation (ANAD, 1983).

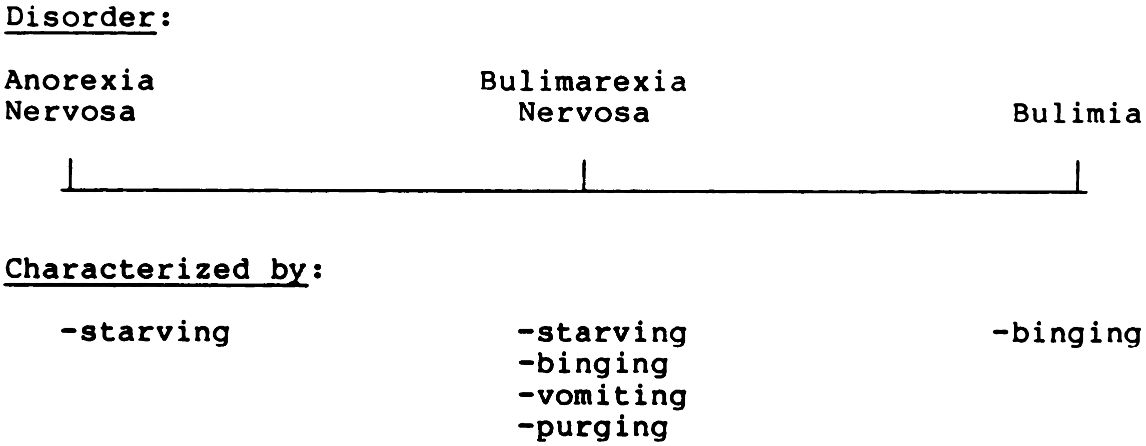


Figure 3. The continuum of eating disorders.

Modification of Data-Collection Procedures

Modifications of the data-collection procedures were necessary.

Observations

The number of observations of family support group meetings was changed from three meetings (proposed) to five enacted Wednesday evening sessions. (Table 2.)

Table 2

Dates and Times of Observed Family Support Group Meetings

Dates Observed	Time Periods
March 30, 1983	7:30-10:30 p.m.
April 6, 1983	7:40-10:20 p.m.
April 13, 1983	7:45-10:30 p.m.
April 20, 1983	7:40-10:30 p.m.
April 27, 1983	7:30-10:40 p.m.

The researcher had anticipated the separation of participants into two subgroups because an agency representative had informed the researcher that this was the format. Actually, the sponsor organized special Saturday sessions for the children exhibiting eating disorders. Three of these were incorporated into the study in order to allow observation of these children's views as expressed without the presence of their parents. (Table 3.) The Saturday meetings were held every other week for 90 minutes.

Both sets of meetings took place in the education rooms of the large city hospital utilized by the sponsoring organization.

Table 3

Dates and Times of Observed Children's Support Group Meetings

Dates Observed	Time Periods
April 30, 1983	10:30 a.m.-Noon
May 7, 1983	10:00 a.m.-Noon
May 28, 1983	10:30 a.m.-Noon

Ethnographic Interviews

The ethnographic interviews were arranged to take place after three observations of the participants in family support groups had been made (i.e., after April 13, 1983). The researcher felt that this plan allowed participants and the researcher to familiarize themselves with one another, facilitating more open communication in the interviews. To arrange the interviews, the researcher approached the families either before or after a support group meeting to ask for an interview. The researcher presented herself as being interested in any support groups in which the families had participated over the past year. The researcher believed that presenting the purpose of the interview broadly would allow greater flexibility during the interview.

After a few days, the researcher contacted the families again, in all cases by telephoning the mother, to set up a time and place for the interview. To maintain consistency in the interviews, the researcher proposed that at-home interviews take place at 8:00 p.m. The proposed schedule is shown in Table 4.

Table 4

Proposed Schedule for Ethnographic Interviews

Family	Members Expected[a]	Date	Time	Place
#1	F, M, D	May 14, 1983	8:00 p.m.	Home
#2	F, M, D	May 6, 1983	8:00 p.m.	Home
#3	F, M, D	May 13, 1983	8:00 p.m.	Home
#4	F, M, D	May 12, 1983	8:00 p.m.	Home
#5	F, M, D	May 7, 1983	8:00 p.m.	Home

[a] F=Father; M=Mother; D=Daughter

The researcher had anticipated executing all ethnographic interviews during a two-week period. However, not all of the families found the proposed schedule convenient. The schedule was therefore modified, and was carried out as shown in Table 5.

Table 5

Ethnographic Interview Schedule, As Modified

Family	Members Expected[a]	Date	Time	Place
#1	F, M, D	May 14, 1983	10:30 a.m.	Home
#2	F, M, D	May 6, 1983	8:00 p.m.	Home
#3	F, M, D	May 13, 1983	8:00 p.m.	Home
#4	F, M, D	May 27, 1983	8:00 p.m.	Home
#5	F, M, D	June 4, 1983	11:00 a.m.	Home

[a] F=Father; M=Mother; D=Daughter

Although five families were selected and contacted, only four sets of completed data are available. This was due to a robbery involving the researcher's file case which contained a portion of her raw data. Because of time constraints, she was unable to complete another interview with Family #5. In addition, a second interview would not necessarily have been comparable to first interviews.

After the first two interviews, the researcher became aware of many unanticipated boundaries or barriers to interviewing. Therefore, modifications were made in the questions asked. Instead of requiring families to address the five ethnographic interview questions initially proposed (Appendix B), the researcher decided to propose one general framework question. This core question was intended to present the researcher as being interested in support groups. The question, "Could you describe what you see as being the role of support groups?" was asked directly of all participants. From the responses to this central question, the researcher generated other follow-up questions, which focused attention on attendance, importance of attendance, and reason for attendance.

Although the researcher waited until the third group meeting before proposing the interviews to the family members in order to build rapport for better access to the families, relations with the subjects were not as comfortable as had been expected. Therefore, the researcher collapsed the proposed three interview contact times into one meeting. The researcher also modified the incomplete-sentence exercise into word associations, distributing the papers at the end of the interview as a means to end the series of questioning and exit promptly. She also decided to eliminate the proposed task of doing participant observations during mealtimes.

Assumptions and Limitations

Assumptions

For the present study, the following assumptions are made regarding the participants in the study: 1) that they responded as honestly as possible to the question, 2) that they reacted as they would normally during support group meetings, and 3) it is assumed that the researcher recorded the observations and the responses to the ethnographic interview questions as objectively as possible.

Limitations

This study is limited by a number of factors:

1. The number of participating families is four.

2. The study is concerned with only the family members participating in the support group and does not consider other individuals who may influence the family members' responses.

3. Only one in-house ethnographic interview per family took place.

4. The use of only one support group does not allow comparisons between different types of support groups and their functioning.

5. The use of only one agency does not permit comparisons among different types of agencies.

6. The inclusion of a variety of eating disorders rather than all anorectics as participants in support groups may have diluted information on anorexia nervosa.

7. The researcher's over-ambitious nature coupled with the lack of experience and skill in interviewing led to many modifications in the research plan.

CHAPTER IV

DESCRIPTIONS

Introduction

The purpose of this chapter is to describe and present the families as participants in both the support groups and during the ethnographic interviews. In order to accomplish this task, a brief presentation of the families will be provided, followed by a description of the support groups and interviews illustrating where the data were collected, thus, resulting in a multi-dimensional description of the participating family members.

Presentation of Families

Identification

For the present study, families are identified as Family #1, Family #2, Family #3, and Family #4. Family members are identified correspondingly (e.g., Mother #1, Father #1, Daughter #1). The selection criteria used in this study were based on factors related to prognosis. Parents ranged in age from 45 to 55 years; their afflicted children, from 14 to 15 years. The chronicity of the disorder was less than eighteen months prior to involvement in the support group which ensured that the families shared some basic characteristics. After the initial observation, additional and more particularizing information was gathered from support group meetings and ethnographic interviews.

Other information was supplied by the participants themselves in an indirect manner. Thus, for example, one of the men stated: "I'm the one who pays for all the food she flushes down the toilet--she doesn't work and my wife doesn't work" (6 April 1983). This comment indicated that the man assigned to himself the role of "Father-as-Breadwinner."

This method of obtaining information--from the participants' comments about themselves and others--differs significantly from the method of direct question-asking and answering, for it allows the individual to define himself or herself based on self-perception.

Table 6 lists some of the informal statements made by the participants during support group meetings which were used as information in describing the participants. Table 7 supplies additional information on the families participating in the study. Together, both tables provide details of additional similarities beyond those ensured by the selection criteria, and they also provide a picture of the families' differences, thus creating a composite description of the participants. This description is further augmented by the researcher's observations of the physical characteristics and mannerisms of each participant, as presented below.

Table 6

Examples of Informal Statement and Corresponding Role Assignments

Informal Statement	Role Assignment
"I'm her mother."	Mother
"I'm her father."	Father
"I'm their daughter."	Daughter
"I'm his wife."	Wife
"I'm her husband."	Husband
"She doesn't work"; "I work, so she doesn't"; "They both don't work, but I do."	Husband as Breadwinner
"She had to start working"; "We both have careers, but hers . . ."	Wife also works, provides secondary income
"I work to support my habit."	Daughter is employed
". . . high-school counselor" "I'm in . . . high school.	Daughter in High School

Table 7

Family Composites Based on Information Supplied by the Families

Family	Member	Characteristics
#1	Father	College degree, professional level; employment associated with university
	Mother	Homemaker; does not work outside the home
	Daughter	First year high school student; age 14 years
#2	Father	College degree, executive vice president of a bank
	Mother	Homemaker; does not work outside the home
	Daughter	First year high school student; age 14 years
#3	Father	College degree, professional level; key management position
	Mother	Homemaker; does not work outside the home
	Daughter	First year high school student; age 14 years
#4	Father	Foreman, some mechanical training
	Mother	Homemaker; during course of this study, became employed
	Daughter	Second year high school student; age 15 years

Family #1

Father #1 was balding and paunchy. He often sat quietly in the corner of the room during the support group meetings, an elbow resting on his crossed knee, and his chin resting in the palm of his hand. However, when he spoke he straightened his posture and uncrossed his legs, putting both feet firmly on the floor. His voice, strong and clear, seemed equally "upright." From the researcher's point of view, Father #1 seemed to generate a great deal of force when he wanted to be heard. In the support group, this energy was often useful in shifting the direction of the conversation.

Mother #1 usually sat close to her husband, periodically touching his shoulder during the course of the evening. Slightly graying around the temples, her hair surrounded a small, plump face. Round glasses accentuated her round features.

Daughter #1 characteristically sat with her long, bony arms wrapped around her body. From the researcher's point of view her arms seemed out of proportion to the rest of her body, probably due to their extreme thinness. Rocking back and forth in her chair, Daughter #1 seemed to be hugging herself throughout the meetings. Often this rocking caused wisps of straggly brown hair to fall over her sunken gray cheeks. To the researcher she appeared to be in her own self-enclosed world, yet whenever she participated in the meetings her rocking stopped and her arms unfolded. She gestured when she spoke, her long, bony fingers fluttering in the air. These gestures brought her much attention (16 April 1983).

Family #2

Like Father #1, Father #2 had a paunch, or what he termed a "well developed middle" (6 April 1983). He wore his bluish-black hair slicked back. In the researcher's view the hair was either dyed or false. On occasion, Father #2 wore glasses, which periodically slid down his nose as he talked. His wife, Mother #2, also wore glasses that caused her similar difficulties. To the researcher, they made a rhythmic pair in the support group; first one pushing up the wandering glasses, then the other. In essence, the "push-ups" seemed to be calculated, as was the parents' habit of finishing each other's sentences.

Daughter #2 often sat with her skeletal legs drawn up on the chair. Sometimes she grasped her ankles and rocked back and forth, like Daughter #1. However, the way Daughter #2 sat distinctly reminded the researcher of a bird perched on a ledge, teetering in the wind. Her bird-like appearance was further enhanced by her long, beak-like nose. Daughter #2 seemed acutely aware of, and sensitive about, her avian likeness. She often sat with her head down, her black, shoulder-length hair falling about her face, as if to hide it. Once she even referred to her nose as "a problem bigger than anorexia nervosa!" (6 April 1983).

Family #3

Father #3 was short with round features. His baldness seemed to accentuate this roundness, which was further emphasized by his brightly-colored attire. During a support group meeting, his daughter hyperbolically alluded to his looks by saying, "Well, at least your father doesn't look like a beach ball when he comes to school, like my dad does . . . It's embarrassing . . ." (28 May 1983).

Mother #3 was also short and stout. Her graying brown hair, pulled away from her face, seemed to emphasize her rotundity.

Daughter #3 was small in stature like her parents, yet very thin. Her height, her thinness, and her close-cropped hair made her appear elf-like.

Father #4

In this family, the parents often dressed alike, in casual his-and-hers outfits. Both had blonde hair, with the father's hair combed down over his balding forehead. Like Fathers #1, #2, and #3, Father #4 was stout. He characteristically sat with his arms folded across his middle. Mother #4 usually sat next to him, her arms similarly folded. Yet unlike the father, she was quite slim.

Daughter #4 had frizzy blonde hair that fell around her shoulders. Sometimes she twisted one section of hair around her fingers until her mother tapped her on the shoulders to stop. When this happened Daughter #4 would often place a stick of sugarless bubble gum in her mouth, constantly cracking it until her mother again interceded.

The external characteristics described above were all readily apparent. In essence they are similar to the features of the "typical" anorectic family presented in Chapter I. Yet these characteristics are only one dimension of the families involved in the study. In pursuing the system's perspective, families must be further examined for interactional processes in contexts.

Family Members in Context: The Support Group

Characteristics of the Support Group

The observed working characteristics of both the support group for the families and the meetings for the identified patients were classified on the basis of leadership, topics, and seating arrangements.

The support group members labeled their group an ongoing support group, meaning that it met on a regular basis without a predetermined date of cessation. The meetings ran, on the average, from two to two and a half hours. Coffee and tea were available during the meetings.

Leaders

Each meeting had two co-leaders, each of whom had specific tasks based on his or her relationship to the group and to the disorder. The leaders were designated:

1. Sponsor--a person who had an advanced degree. In this group the sponsor had a Master of Arts in Counseling Psychology.

2. Facilitator--a person recovered or recovering from an eating disorder. In this group the person was a recovering anorectic.

Ideally the two worked together to affect positively the dynamics of the group, though they operated from different contexts: the sponsor from "outside," as a person not afflicted with the disorder; and the facilitator from "inside," as a person being or having been afflicted with the disorder.

Topics

Meetings usually began with the sponsor asking members to introduce themselves and share what they would like to get out of the meeting. Topics for discussion generally fell into two categories: spontaneous or planned.

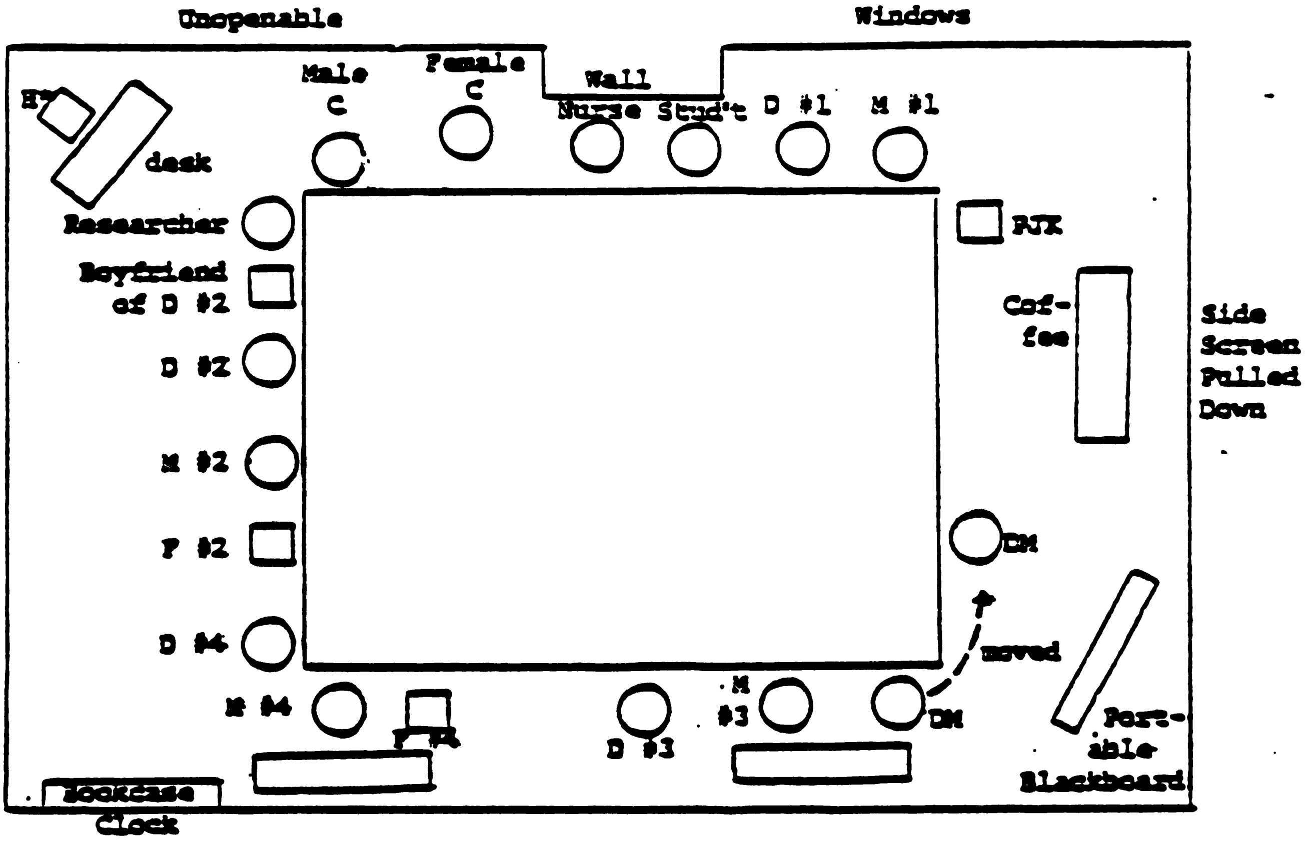
Spontaneous topics usually emerged as a result of a crisis experienced by a member since the last meeting, with the member feeling a need to talk and share with the group. Some of the crises brought up by afflicted children in the group included: incidents of overeating, uncontrollable urges to eat (lack of control), vomiting, growing up, manipulating parents by not eating, inability to react to human contact, inability to feel, and fear. Parents' issues often centered around feelings of frustration with the disorder, and the child's inability to grow up, understanding the child's fear, and wanting to cope with the child.

Planned topics, on the other hand, were selected by the sponsor and the facilitator prior to the meeting. Some of the planned topics were: control of the eating disorder, release of stress, inability to grow up, inability to express feelings, and fear. Fear, in fact, was an element in many topics--the fear of change, the fear of loss, and the like.

On some days spontaneous topics led to planned topics for the next meeting. For example, on one occasion a parent brought up the subject of the children's inability to grow up (13 April 1983), and the following week the facilitator presented a related exercise in which the participants were asked to close their eyes and to imagine at what age they saw themselves. Parents often saw themselves as young adults, even though their biological ages were 45 to 55 years. Similarly, children experienced themselves as ages 8 to 10, although their biological ages were 14 to 15. The group then explored what was learned through the exercises. Parents acknowledged that they did not realize that their children experienced themselves as so young. The facilitator pointed out that the 8 to 10 age range is the period prior to the onset of the disorder.

Seating Arrangements

Chairs were arranged in the rectangle, a triangle, or a circle, depending on whether or not tables were present. Figures 4 and 5 illustrate typical seating arrangements of the support group meetings. The number of members in attendance varied from meeting to meeting, and because of the group's ongoing nature, new members and an occasional



M = Mother; F = Father, D = Daughter; C = Visiting Counselor

○ female

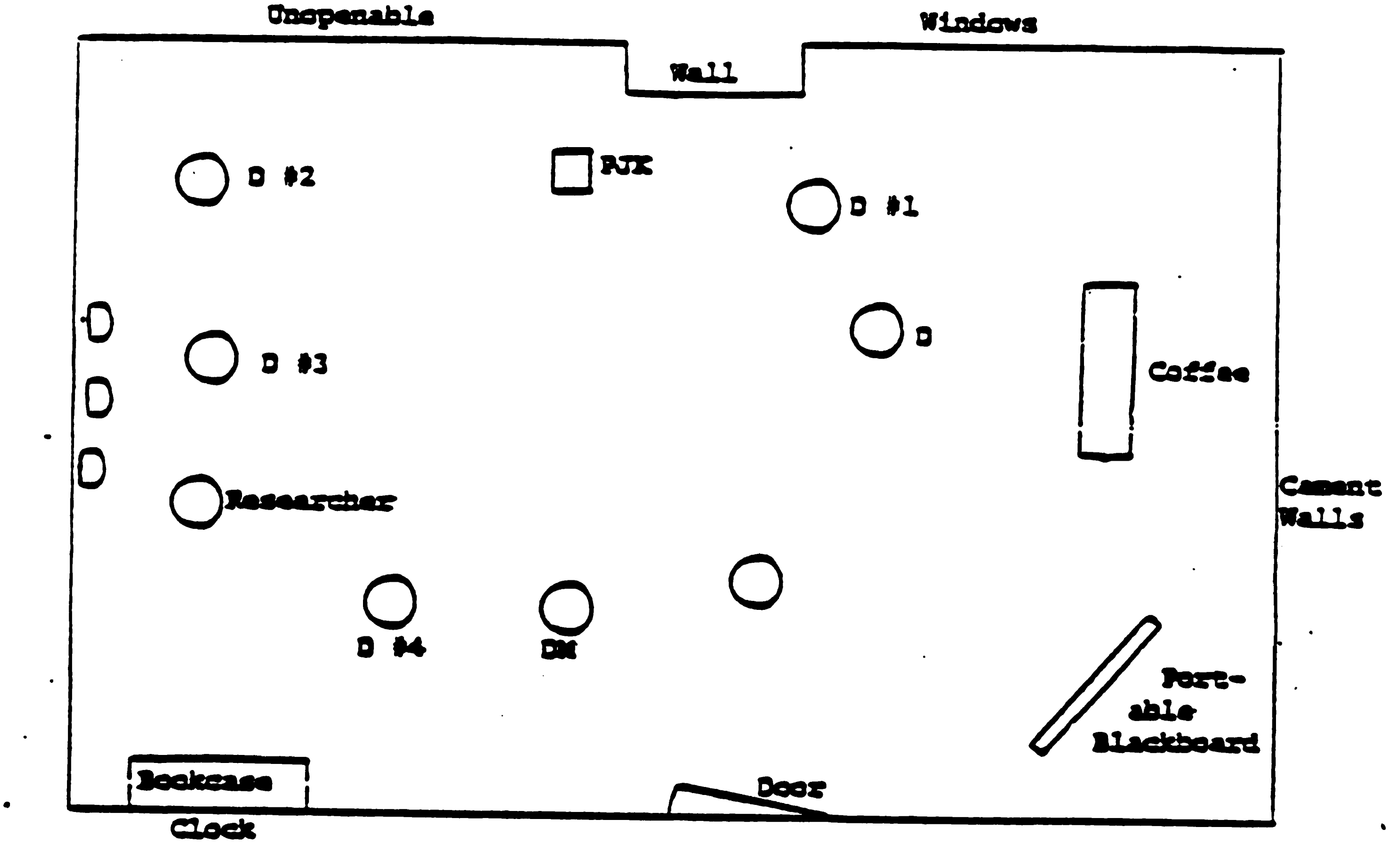
□ male

*H = Husband of woman who has eating disorder, representing openness of group

DM = Leader

PJK = Leader

Figure 4. "Typical" family support group seating arrangements. Also note not every family member attended.



female ○ PJK = Leader

male □ DM = Leader

empty chair ◗ D = Daughter

(Mother and Father not present in this setting)

<u>Figure 5</u>. Typical seating arrangements of meetings for children with eating-disorder symptoms.

visitor sometimes were present. The representations in Figures 4 and 5, then, should be understood as composites of typical meetings rather than any information about any specific meeting.

Family Members in Context: The Ethnographic Interviews

The Interviews

The ethnographic interview provided not only additional information about how family members interacted with each other, but also insight into the home environment. Therefore, these interviews contribute to the composite picture of the family by describing their homes.

Family #1

Upon arrival at the home of Family #1, the researcher was greeted at the door by the mother, who, smiling, asked, "Did you have any trouble finding the house? (pause) I wasn't sure if I confused you about turning at the traffic light. My husband was concerned because I'm always mixing up directions." She shrugged her shoulders and continued, "So I usually have him do the honors. You know, I could never get things right--north, south, east, west all confused me . . . and I didn't want you to end up in Gary!" The researcher reassured her that she had no problems finding the home, emphasizing that the directions were clear and precise.

As they entered the home, the mother suggested that the researcher take off her coat and allow her, the mother, to hang it in the closet. "We never get to use this closet much for what it was designed for," the mother added, as she opened a closet full of toys. "This closet was built so when we had company I'd have a place to hang the coats. You know," she gestured toward the living room, "guests could go straight into the living room without having to be concerned with leaving their coats all over."

Entering the living room area, the researcher was immediately struck by the clash of styles--by the pronounced contrast between the sombre panelling of the walls, the dark wooden beams and, the bold white carpet and glaring contemporary lighting fixtures. The effect of the mix was disconcerting.

Meanwhile, the mother continued her discourse on the closet, comparing it to a messy drawer, remarking, "Some people have a catch-all drawer. I guess we're different, we've got a catch-all closet."

At this point the father appeared, dressed only in pants and a T-shirt. He stretched, mumbled something, then turned and left the room. "I wonder what that was all about," the mother mused. Then she pulled open the draperies, remarking, "It's always so dreary in here, please sit down. I'm sure my husband will be right back."

The phone rang, and the mother excused herself, as the researcher sat down on the sofa to wait. Shortly the father reappeared, this time in a button-down shirt, pants, and loafers. "I didn't realize you were coming so early," he offered. His wife called out from the other room, "I guess I forgot to tell you we changed the time because of the bake sale this afternoon. You know Martha and the kids are coming at 1:00 and . . ." "Oh," the father mumbled, as he dropped down onto one of the pillow-laden easy chairs across from the couch.

The mother reappeared, apologizing for having left the room. There was a slight pause. In an attempt to break the ice, the researcher commented on the home and its furnishings. She also inquired as to the daughter's whereabouts, stating that she wanted the daughter to participate in the interview.

"Yes, where is she?" the father asked, turning to his wife. "I'd like to get this show on the road." "I think she's upstairs," the mother began. "Well, I don't think it's right to make people wait," the father growled. "I'd better go and get her."

As he stood up the daughter strolled through the doorway, head down, arms wrapped around her thin frame. She was wearing a bright purple warm-up suit, with bulky purple and gray legwarmers extending from her calves to her thighs. Her self-enfolding stance and her bulky attire created a cocoon-like appearance. Her hair was pulled back in a braid, further accentuating her gaunt face and neck.

"I'm sorry, I didn't realize what time it was. I haven't had time to go jogging yet, but I didn't want to be late," she said. Brushing past the father, she seated herself on the chair he had just vacated. "That's your father's chair," the mother cautioned, reaching over to stroke the daughter's arm. The daughter shook off the mother's hand and slid over to the couch. Pulling one leg up under the other, in a position familiar to the researcher from the support group meetings, the daughter began rocking back and forth, teetering on the edge of the couch. At the same time the father sat down, pushing himself far into the chair cushions. He crossed his legs and cupped his chin in one hand.

The researcher began: "Since you have been attending many of the support groups over the past year, and I've only attended a few, would you tell me if the meetings I go to are typical? Maybe you could describe what you see as a typical family support group meeting, and this will help me to understand more about the group."

"Well," the father noted, removing his hand from his chin and straightening his back. "We go, some people arrive early and others arrive late, sit down and discuss the girls' problems, and go home . . . that's about it."

A silence ensued. Turning to the mother, the researcher probed, "that sounds like a concise statement if I've ever heard one and basically that's what I've observed. But maybe you could give me a bigger picture. Add some more descriptions.

"Well, I don't know, what do you want to hear?" the mother asked.

"What she wants," the father interrupted, "is for you to fill in the details. Tell her who comes to the meetings." Turning to the researcher, he explained, "She's good at that, I'm not"; then to his wife, "So tell her."

"Well," the mother began again, "I'm not sure, but usually most parents bring their daughters, but sometimes one will come on her own." The father broke in, "Usually they're older." "Why do you say that?" the researcher probed. "Well, (pause) some can drive and I guess I just associate being older with driving."

"I don't know about that," said the mother. "What I was thinking about was the ones who are in the hospital." "Oh," the father replied.

In an attempt to involve the daughter in the conversation, the researcher asked, "What about you? Maybe you can give me an additional point of view, a clearer picture."

The daughter ceased rocking and looked up. "Dad's right," she replied. "We do sit in circles and talk, sometimes people are late or early. Mom's right, sometimes people are older. So I'm not sure of what you want." The father broke in, "For you to tell her. Describe the support group, that's all."

"Well, do people sit in circles or squares more often?" the researcher probed. "I don't know what I think . . .," the daughter trailed off.

"Okay," said the researcher. "Maybe you can help me understand why people attend support groups." Looking toward the mother, the researcher continued, "Maybe you can describe for me why you attend the support group meetings?"

"That's simple enough," the father interrupted. Yet perhaps he had noticed that the question had been directed to the mother, for he changed his course. "Tell her why you think people attend support groups," he said to his wife.

"Well, I'm not sure, but a number of reasons." The mother looked up at the ceiling, concentrating. "I remember some say it helps them understand themselves, they aren't alone, learn, or . . ." "You have described for me many reasons and have given me a great deal of insight," the researcher remarked. "Now could you personalize this and maybe tell me why <u>you</u> attend?"

"Oh, that's easy," the father answered. "To help our daughter." "That's right," the mother stated matter-of-factly.

The researcher turned to the daughter: "Your parents have helped me understand why many people attend support group meetings, but could you add to their statements?" Tilting her head from side to side, the daughter declared, "I meet people who are like me. I'm not afraid now that I know there are others like me." She paused.

"I bet it's scary when you feel all alone," the researcher said. "What about us!" the father interrupted. "How do you think we feel? Having a beautiful child go from a happy-go-lucky girl to a bag of bones isn't easy."

The phone rang again, and the mother rose to answer it. The ring startled the researcher, who caught her thumb on her paper and drew a few drops of blood. While she searched in her briefcase for a tissue, the daughter whispered to her, "Don't bleed on the carpet or my mother'll kill you!" The father warned, "No telling secrets in this family . . ." The researcher interrupted, saying, "Oh, I just cut myself and your daughter was giving me a suggestion." "Oh," the father replied. "Do you need a band-aid or something? We have cotton." The researcher reassured him that she was fine. At this point the mother reappeared, announcing, "Martha's just called, and I've got to get over to the bake sale as soon as possible."

The researcher asked the family members to fill out a word association form to aid her in understanding why people attend support group meetings. Then she thanked the family and left.

Although she had originally purposed future visits, she realized that the family's boundaries were not as permeable as she had expected. She also realized that she was running into time constraints, and felt the pressure of completing at least one visit with each of the families. Therefore, after much consideration and deliberation, she condensed the home visits to one per family. The rationale was that she desired at least one home visit with all of the participating families as opposed to many visits with one family and zero with others.

Family #2

The researcher arrived in the family's neighborhood 30 minutes earlier than expected. To avoid inconveniencing the family by such an early arrival, the researcher decided to use the extra time to walk around the area. Although she had not previously set out to incorporate an external picture of the families' neighborhoods into her study, she discovered that her stroll provided her with some valuable insights into the family's context.

The researcher was particularly intrigued to note that one could walk around Family #2's entire block without seeing anything of the houses in it except their very tops; tall fences blocked off any other view. The fences suggested to the researcher that in this neighborhood privacy was very highly valued. The family's house itself, dimly lit by a front-lawn lamp, seemed, like its neighbors, self-contained and intimidating. Entering through the gate, the researcher faced an imposing mock-Tudor house front having three "front doors." Walking to a door lit by a yellow beam, the researcher rang the doorbell.

Mother #2 greeted her at the door with the comment, "I just put the front light on. I was afraid you'd get confused by the three doors. Two don't work." Opening the door even wider, the mother continued, "Please, come in. Here, let me take your coat. Isn't it miserable out?"

"Yes, it is," the researcher replied. "I guess I'm not accustomed to all the wind you have here."

The mother led the researcher through a closet-sized foyer, which opened into a sunken living room. There the Tudor theme was repeated, in rustic wooden ceiling beams, plaster walls, and furniture in deep browns, golds and oranges. The whole had an almost regal atmosphere.

"Well, where do you want us," the mother began, the father continued, "--in the living room or in the kitchen, which is really the room we live in." The mother laughed and suggested the living room. . Then, pausing, she asked if the researcher would be more comfortable at the table and chairs.

The researcher responded, "Wherever you feel comfortable." "Well then," the father said, sitting down heavily on the couch, "How about here?" He paused. "Jeez," he said to his wife, "this isn't as comfortable as our old one." Turning to the researcher, the mother explained, "We just received new furniture, and he's still not used to it." She laughed and then sat down next to him on the couch.

"Well, what do you want to know?" the father asked. The mother interrupted, "I didn't tell him much, except you were coming out tonight, and after we talked on the phone this morning, well, I thought I'd wait until you arrived." The father commented, "I knew it was for a project."

The researcher explained that she was interested in support groups and wanted to talk with families who had been attending meetings over the past year. Then, noticing the daughter was absent, stated, "I'd like to include your daughter in on this." "Why, we're all here," the father replied, pushing his glasses up off the tip of his nose. The researcher glanced around the room again. As if sensing her confusion, the mother explained that her daughter was "in the kitchen making fudge for the Thompsons."

"I'll be right out!" came a voice from the other room. "She can hear us," the father stated, "if you'd like to continue telling us about your project."

The researcher continued describing her interest in support groups. She then asked the family to describe a "typical" support group meeting, based on their attendance over the past year.

"Oh, I don't know," the mother began. She was instantly cut off by the father, who continued, "Well, we go on Wednesday evenings, usually at 7:00, but they have been later now, 7:30 I believe, and run until 9:00, but now later; until 10:00." The mother added, "Sometimes we sit in a circle, square, or I guess it usually depends on who's there. If we're a large group the tables are better . . ." The father interjected, "Oh, I don't know, we crowd around better if the tables aren't in our way."

The researcher remarked, "This is very informative and helpful, but will you describe what you usually talk about?"

"It all depends," the mother began, shrugging her shoulders, "we learn a lot about others who have problems and how they deal with it . . . (pause). It becomes important for me to attend so I become aware of the situation." The mother then added, saying, "For the sake of my own knowledge, they have become important. I'm concerned with her health and I want to make things right. I guess I find I'm not as hard on her. By going to the meetings, I see other parents who aren't so accepting of the illness as we are. Some only tolerate it. We try to understand it. We try to understand why it happens, but usually it's about the girls' problems."

"She knows that," the father interrupted. "She wants to know what the topics are."

"Oh, control, fear of becoming fat, losing control, and not eating are common," the mother elaborated. "Well, so are not eating and insecurity, not being able to grow up," the father added, as the mother concluded, "or not wanting to."

The researcher inquired why the mother thought the girls did not want to grow up. The mother responded, "I think it's why they starve themselves, to appear helpless and child-like."

"I'm not sure about that," the father objected.

"Why do you say that?" the researcher asked.

"Well," he answered, "I sit there and look at all these kids and their parents. (pause) You can't tell me that they are all afraid of growing up or won't grow up. (pause) Yet I get confused because they do look helpless and child-like. Being confused isn't one of my better qualities," he grinned.

"You have given me a great deal of insight about support groups," the researcher commented. "But I'd like to hear what your daughter has to say."

"I'll go get her," said the mother.

Just then a voice from the kitchen called out, "I'll be right there. I don't want it to lump."

The father shrugged: "She spends more time cooking than anybody I know." He laughed. "But she never eats a morsel. We used to kid her about poisoning the neighborhood because she wouldn't eat a bite and now it's no longer a joking matter."

"No," the mother agreed, "it's frightening. But we're told it's normal for starving anorectics. (pause) It's so hard. You don't know what it's like to live with a person like that . . ." The mother's words trailed off, as she shook her head and stared vacantly. "I would give anything for a normal day with my daughter," she continued at last, now regarding the researcher. "Sometimes I feel so helpless and if I could only reach out and hug her, make it all go away, I would." The father added, "She scares us."

A loud crash resounded from the kitchen. The mother winced and closed her eyes. "I'm okay, you don't have to run checking on me, an angry voice called out. The father crossed his arms and sighed, while the mother pushed up her glasses and touched the father's knee.

"Maybe you'd like to talk with her. I think she likes you," the father said to the researcher.

The researcher consented. Leaving the living room, she entered the kitchen where she encountered a substantial baking operation in process. Three large pans of chocolate fudge were laid out on the kitchen table, among cookie sheets spotted with dough and assorted boxes already packed and tied. More chocolate bubbled on the stove, as the daughter, standing over the pots, stirred constantly. The oven exuded the odor of chocolate chip cookies.

Remarkably, though, the kitchen was neat and tidy, showing little evidence of the considerable preparation that must have gone on earlier. The kitchen was also extremely hot, yet the heat did not appear to affect the daughter. The researcher was impressed by the industry and composure evidenced by one so small and seemingly frail.

"Hi," the researcher began, moving slowly into the kitchen, taking care not to get in the way of the daughter's activities.

"Oh, yeah, hi," the daughter remarked. "Sorry I didn't get out there yet. My folks sent you in here, didn't they?"

"Well, they suggested I could come in here and talk to you," the researcher answered. Then, to shift the discussion, she added, "I didn't realize what a baker you were."

"Oh, I make cookies for people and sell them," the daughter said enthusiastically. "My dad thought of the idea when he saw that I enjoyed cooking more than they could eat. (pause) Besides, I don't eat it."

"Why is that?" the researcher probed.

Looking directly at the researcher, the daughter replied, "You know. You've been to enough meetings."

"Do you enjoy the meetings?" the researcher asked casually.

Gesticulating, the daughter answered, "Sometimes I do, sometimes I don't. It depends who's there. I like some of the people and not others."

"How often do you attend?" the researcher asked.

"Every Wednesday evening with my folks. But I like going to the Saturday ones better."

"Why do you say that?" the researcher queried.

"Because they are for eating disorder people only! (pause) There I can be myself."

"Don't you feel that you can be yourself at the other meetings--" the researcher began. But before she could finish the daughter answered with a flat "no." Turning away from the researcher, she stirred the chocolate on the stove.

At this point, the researcher was uncertain about whether to press the daughter for more information, change the subject, or do nothing. The researcher wondered if in interrupting the daughter's task she had, as it were, invaded the daughter's territory, broken into her privacy. The researcher decided to do nothing, to wait for the daughter's next move.

The room became quiet, except for the ticking of the timer on the stove. When the timer bell rang, the daughter brought a hot batch of cookies from the oven. She offered one of the cookies to the researcher, who accepted, then asked if the researcher would like to take some cookies home. As the researcher ate some cookies, the daughter poured herself a diet soda over crushed ice and offered the researcher a diet soda also. As she moved the chocolate chip cookies off the cookie sheet and onto a wire rack, the daughter crunched the ice cubes in her drink. From the researcher's point of view, it seemed as if the daughter were crunching the ice to avoid eating the cookies.

While chomping on the ice and shuffling the cookies, the daughter began to talk about her relationship to her parents. "I guess I don't feel like I have any privacy here," she said, then paused. "I guess, no, maybe umm . . ." She searched for a word, then resumed, "I think the Saturday meetings give me privacy."

"It sounds to me like privacy is important to you," the researcher suggested.

"Yeah, it is," the daughter replied. "You know, we don't have any locks on the doors here and it's always _we_ do this or _we_ do that. I'm getting sick of it. I feel like a baby!" She tilted her head and continued, "Sometimes my eating disorder separates me from my folks. Maybe I get privacy by being alone in my disorder. I never thought of that before! Yet I do wish they could understand me."

"Do you think any of the parents understand their kids in the group?" the researcher asked.

"Are you crazy?" said the daughter. "How can they unless they feel from the inside? You don't know what it's like," she shrugged. "You've got to have it to understand."

"Maybe, if you explain more of your feelings about having an eating disorder to me, I can understand it," the researcher prompted.

"I don't think so," the daughter answered. "I mean, I tried to tell my therapist and he has a Ph.D. and all that, and he still doesn't understand. (pause) Did you know he looks like Woody Allen?"

"No," the researcher responded.

"I laugh at him when I see him it's so funny."

Since no other comments were forthcoming immediately, the researcher returned to the living room and asked the family to fill out a word association sheet. The family members regrouped with the father and mother sitting down next to each other on the couch. The daughter plopped down in the chair announcing, "I don't want my cookies to burn," sat up and began to reply to the word association sheet. The father sighed and the mother asked the researcher, "Are you doing this with everyone?" With that the father sighed again, answering, "Of course she is." The researcher smiled and allowed the participating family members to answer in silence.

Family #3

As the researcher made her way along the stone walkway of Family #3's house, a tiny white poodle appeared and yelped at her in staccato barks. Immediately, the front door opened and Mother #3 called out to the dog to come inside. The dog continued growling. "You protect the house, don't you?" the mother laughed. Then, motioning to the researcher to enter, she continued, "He won't hurt you."

Entering the house, the researcher was next greeted by an enormous gray gat, which rubbed itself against the researcher's legs. The mother pushed the cat away with her foot, saying, "Dickens, leave the girl alone. She doesn't need your fur." Turning to the researcher, the mother added, "I do wish my daughter would brush that cat. She promised she would, oh but that's a kid for you, and mothers are the ones who get stuck. I've never liked a long-haired animal because they shed. I guess that's why I like poodles so well."

The mother continued chatting about poodles while she ushered the researcher into the living room, past a large wooden stairway. The living room was decorated in rose and blue pastels, which seemed to flow together in an oriental motif. The vases, glassware, and art around the room echoed the oriental theme.

The father and the daughter were seated facing one another in matching chairs at right angles from the sofa. The daughter was curled up in her chair, filing her nails. The father, for his part, was buried behind the sporting section of the newspaper. A summer Sears catalog lay open on the sofa. The nail file, the newspaper, and the catalog were oddly a variance with the "showpiece" atmosphere of the living room, which was clearly not a place where the family usually gathered. The researcher guessed that the family members had been waiting for her arrival, an "event."

The mother motioned for the researcher to sit on the couch. The daughter sighed, placing her nail file in the pocket of her enormous, plum-colored sweatshirt. Then she coiled herself up in the chair again, wrapping her arms around her body. The mother asked the father to put his newspaper away, which he did--under the chair.

Uncertain of where to place her coat, the researcher finally draped it over the arm of the sofa. As she did so the cat reappeared and jumped onto her lap. The father remarked, "It looks like you've got a new friend."

The mother was apologetic. Turning to her daughter, she complained, "I've just about had it with that cat." "Aw Mom," the daughter began, picking up the cat and hugging it. "Now!" the mother said firmly. The father added, "You listen to your mother."

Rocking the cat like a baby, the daughter kissed it and walked out of the room. The mother shook her head: "I wish she wouldn't put her mouth on that animal. You can never be too sure where a cat has been." "Oh, but she loves that cat. Dickens means a lot to her," the father said. Then he turned to the researcher and asked, "Would you like some coffee? My wife can get you some."

"Yes, I'd be happy to," the mother joined in. The daughter reentered the room, announcing that the cat had been "exiled to the basement." Then she dropped down on a chair, folding her arms across her chest.

In an attempt to commence the interview, the researcher explained her interest in support groups. Before she could finish, though, the father interrupted, "Are you sure you wouldn't like some coffee? I'd like some." Turning to the mother, he asked her to prepare coffee.

The researcher agreed to have a cup of coffee in the hope of stopping the discussion about it and steering the focus of the comments back to support groups. Yet on second thought she realized the potential the coffee discussion presented to explore family dynamics, and she decided to let the conversation continue as directed by the family's concerns.

The father continued: "How about a few cookies? (pause) I'd like some." He turned to his daughter: "How about you?" The daughter sighed and glared at the researcher.

By now the researcher was feeling somewhat bewildered. On the one hand, she was confronted by the parents, who insisted on showing their hospitality by offering foods; on the other, she was confronted by the daughter, who was getting increasingly annoyed and seemed to want to take out her hostilities on the researcher.

"Please don't go to any extra trouble on my behalf," the researcher began, only to be interrupted by the father. "It's no extra trouble," he cut in. "My wife enjoys fixing food when she can."

"Okay, I'd appreciate it," the researcher responded. With that, the mother seemed to spring out of her chair to head for the kitchen. The father turned to the researcher and noted the wife's enthusiasm.

While the mother was out of the room, the researcher and the father exchanged small talk about the weather. Because the daughter was not joining in, the researcher sought to involve her by redirecting the interview to the subject of support groups. But again the father interrupted. "Why are you so interested in support groups for people who have eating disorders?" he asked, then paused. "You know, you're awfully thin. You don't have an eating disorder, do you?" The mother returned while the researcher answered in the negative. "Well then why don't you have some good food?" the father said, turning to the mother. "We have some of that corned beef for a sandwich . . ." He suggested she prepare a sandwich for the researcher.

The researcher was feeling beset. The parents seemed fixated on presenting her with food, while the daughter remained aloof, curled up in her chair. The researcher tried to resume a line of questioning that explored attending support groups for people with eating disorders. As she did so, however, the daughter exclaimed, "Look!

They've pushed food on you, and food isn't the issue." The father responded, "Yeah, that's what they say, but I still have a hard time. (pause) You tell me--a kid doesn't eat and that's not an issue? But you raise this beautiful girl and . . ." The mother interrupted, addressing her husband: "Why do you think they call it the 'golden-girl disease'?" Without pausing, she turned to the researcher and asked, "Would you like some more coffee?"

The mother's ability to shift the focus of the discussion surprised the researcher. Acknowledging this surprise, the researcher turned to the mother saying, "You've surprised me on how quickly you are able to change the focal point, from what I'd call an information response to a daily living response."

The mother shrugged, "I guess we feel [the eating disorder] all the time so our thoughts about eating and eating disorders are one." "I'd say," the father began, shaking his head and continued. "They say it's lack of control, but she's really controlling us. It scares me." The daughter sighed loudly, catching the researcher's attention. "I don't control anybody, they control, no, it controls me . . . Oh, it's so confusing . . . you wouldn't understand."

With a lull in the conversation, the researcher presented the family with the word association sheet. The father, taking his sheet, examined it and declared, "You expect me to be able to think up something for each one of these?" The mother groaned, "I'm never any good at these."

In an attempt to include the daughter, the researcher asked her what she thought of word associations. "Oh," she replied matter-of-factly, "they're kind of fun. (pause) My therapist and I do them all the time!"

Family #4

When the researcher arrived at the home of Family #4, she was greeted at the front door by the mother, who ushered her into the living room. Immediately the researcher noticed the daughter, who was seated in a swivel chair, with her back to the researcher. Her feet were propped up on a window sill, and she was apparently staring out the window into the darkness. The father was also in the living room; he was seated on the tweed sofa, reading a newspaper and chewing on the butt of a cigar. A television set was on, yet neither the father nor the daughter was watching it.

The mother suggested that the researcher sit on a particular chair she designated as "a lady's chair." She then turned off the television set. The father looked up from his newspaper and muttered something the researcher could not hear as he folded up the paper.

The mother suggested that the daughter "come over and join us." At this the daughter sighed heavily, swung around, and stamped her feet on the floor. The parents exchanged glances. The father began rolling his cigar butt around with his lips. "Okay I'm here," the daughter announced, as she threw herself down on a chair next to the researcher's.

The researcher felt threatened and wondered if she had arrived at a bad time. However, because she wanted to observe the family's dynamics, she decided to continue the interview.

Commencing with the statement of her interest in support groups, the researcher asked the family members to describe the support group meetings. As she spoke the researcher noticed that the daughter placed both feet on the coffee table. Then, she noticed, the daughter began to unwrap a piece of sugarless bubble gum.

The mother, who had seated herself next to her husband and across from her daughter, shook her head in admonition. The daughter shrugged and removed her feet from the coffee table.

The researcher, as in the earlier interviews, asked this family to describe a support group meeting. The father responded, "Well, I'm not sure if it's typical or not, but I can give it a try." He then offered a brief description of the location, time, and set-up of a meeting.

When asked why people go to such meetings, the mother said, "Well, I think most people go to understand their kid's problems. I know I've learned so much by hearing what other mothers are doing." "Yeah, that's about right," the father added. "I'm not much for this self-help business, but I'm willing to go."

To include the daughter in the discussion, the researcher asked her directly why she thought people attended meetings. "Because they have problems," the daughter answered laconically, then added sarcastically, "Why else?"

The father sighed. The researcher was persistent. "I realize people attend support groups in order to help them understand their problems--or someone else's problems," she began. "I also realize that some people attend to learn some more about a topic. But I'm hoping you can personalize the information and tell me why you attend."

The parents looked at each other. Then the father declared, "Well, ummm, I've learned a lot about how other people are handling the situation. We didn't know at first what we had here. I mean, starvation to get attention was all I saw happening." The mother continued, "We see things are much deeper than that, but I'm so confused . . . it's my last hope."

The researcher was hesitant about including the obviously hostile daughter in the conversation. Yet she also wanted to hear the teenager's response to the question; she asked the daughter whether she found support groups valuable.

"I don't," the daughter declared. "I'm not sick." With that she placed both feet on the coffee table again, in an out-and-out act of defiance.

On reflection the researcher began to feel that the daughter might be putting on a show for her benefit. She recalled that during the earliest recorded meetings of the support group the daughter sat quietly, head down, unless prodded by her mother's "She has something to tell you (the other participants). Now say what you wanted to say" (6 April 1983). Later, the researcher remembered, the daughter's demeanor often became sarcastic; when asked on one occasion by the facilitator to describe how she felt, for example, the daughter glanced at her mother and exclaimed, "She's already told you!" (13 April 1983). Then finally, the researcher recalled, the daughter decided (or so her parents said) not to attend the support group meetings any longer (20 April 1983).

Remembering this sequence of events, the researcher was even more interested in pursuing the interview with the daughter than she had been at the start of the discussion. The young woman, though, appeared unwilling to cooperate. In a final attempt to gather information, then, the researcher asked the family members to fill out the word association sheets. On receiving her form, the daughter rolled it up and waved it in the air. "Look, I'm not sick!" she exclaimed, and left the room. The father countered, "This is the last straw!" and left after her. The mother remained to apologize for both of them and to explain that the father and the daughter had had an argument just prior to the researcher's arrival. The family members thus did not complete the word associations.

Summary

The home visit afforded the researcher the unique opportunity to observe and interview the family members in another context. By doing this, the researcher obtained additional information about the families which may not have been obtainable elsewhere. To illustrate, each family is briefly highlighted. In Family #1, the observation of toys hidden in the closet contrasted with the neat and tidy living room, suggesting the family's desire to present themselves as organized. Even the father's shirtless parade added to the effect when he returned in a button-down shirt. In Family #2, the daughter's constant cooking led the researcher to ask if this was a typical evening. In Family #3 the interactions among the animals and the presentation of the sandwich left the researcher feeling overwhelmed, leading her to wonder if the family members experience similar feelings. And in Family #4, the hostile response by the daughter seemed to influence the atmosphere of the room. This in turn, led to the researcher to question if the parents' responses to the questions presented in the interview were influenced by the daughter.

Although the home visits added to the multi-dimensional picture of the family members, the researcher feels that she must remind the reader that description is specific only to family members participating in the support groups. Therefore in the following chapter, the results of this study will be presented as they relate to the family members participating in support groups.

CHAPTER V

RESULTS

Introduction

Chapter IV, Descriptions, presented and described the families by means of data that had been collected in two different contexts: the support group and the home. In this way, a multi-dimensional portrait emerged of the family members as participants in the study. The researcher might logically be expected in this chapter to use the data presented in Chapter IV to answer directly the research questions initially proposed:

1. What perceptions of the eating disorder do children with eating disorders and their parents share and not share?
2. What perceptions of attending support groups do children with eating disorders and their parents share and not share?
3. What relationship is there between the afflicted child and the parents which may shape perception of the eating disorder?

However, during the course of the interviews themselves and while analyzing the data, the researcher realized that these questions, while appropriate for an experimental design project, were too limiting for, and even tangential to, the experience of the actual ethnographic interviews.

For instance, often the researcher found herself trying to force responses, as an experimenter might, during the in-home interviews. In some instances she was probably too insistent--or at least other participants in the interview seemed to feel this way. "Well, what do you want to know?" Father #2 demanded at one point during the home interview, as the researcher pressed him on why he attended support group meetings. Having a participant ask a researcher what she wants to know, of course, goes against the ethnographic method, which asks the participants to tell what _they_ know (Spradley, 1980). In this case, as in others, the researcher found that she could pursue her line of questioning only at the expense of jeopardizing the ethnographic method.

Not wanting to do this, the researcher decided to modify her use of the research questions. Instead of seeking answers to them, she used them as "thought organizers," vehicles to propel her through her notes, while she allowed participants to frame and articulate their own concerns from their own perspectives.

In pursuing this process, the researcher became aware of four recurring topics emerging from the interviews: fear, lack of control, growing up, and feelings. These topics confirm the analysis of issues involved in the pathogenesis of eating disorders, as these issues are presented in the literature review in Chapter II. In that chapter, the reader will recall, anorexia nervosa emerges as a disorder in which control of one's appetite becomes a coping mechanism and points to one of the key issues in the dynamic of the disorder: control. Related to the issue of control are fear, inability to grow up, and feelings (Levekron, 1982).

The researcher observed that, true to this formulation, family members often heatedly addressed these issues. In addition, in confronting these difficult topics families and individuals seemed to repeat certain interactional patterns. These phenomena, the researcher felt, were worth exploring. However, the researcher also realized that to do this with maximum clarity she would need some way in which to categorize interactional patterns. The concept of player parts within the family system that is present by Kantor and Lehr (1975) seemed applicable to the interactions of the families observed.

Kantor and Lehr's player parts are as follows: Mover, Opposer, Follower, and Bystander. Each of these player parts has distinct characteristics, which are, briefly:

The Mover -- one who initiates the action;

The Opposer -- one who interferes with the Mover's action;

The Follower -- one who supports either the Mover or the Opposer;

The Bystander -- one who remains neutral in the situation.

These terms allow us to analyze how family members participated within the support group and in-home contexts whenever the four topics mentioned above arose.

Another dimension of interaction that the researcher realized merited close attention is choice of words. It will be suggested that word choice is an important strategy of family opposition. In what follows both player parts and choice of words will be examined closely in order to present the results of this study; Figure 6 gives a brief synopsis of how the discussion of player parts will be organized. Following this analysis, the researcher will return to the initial research questions and propose answers.

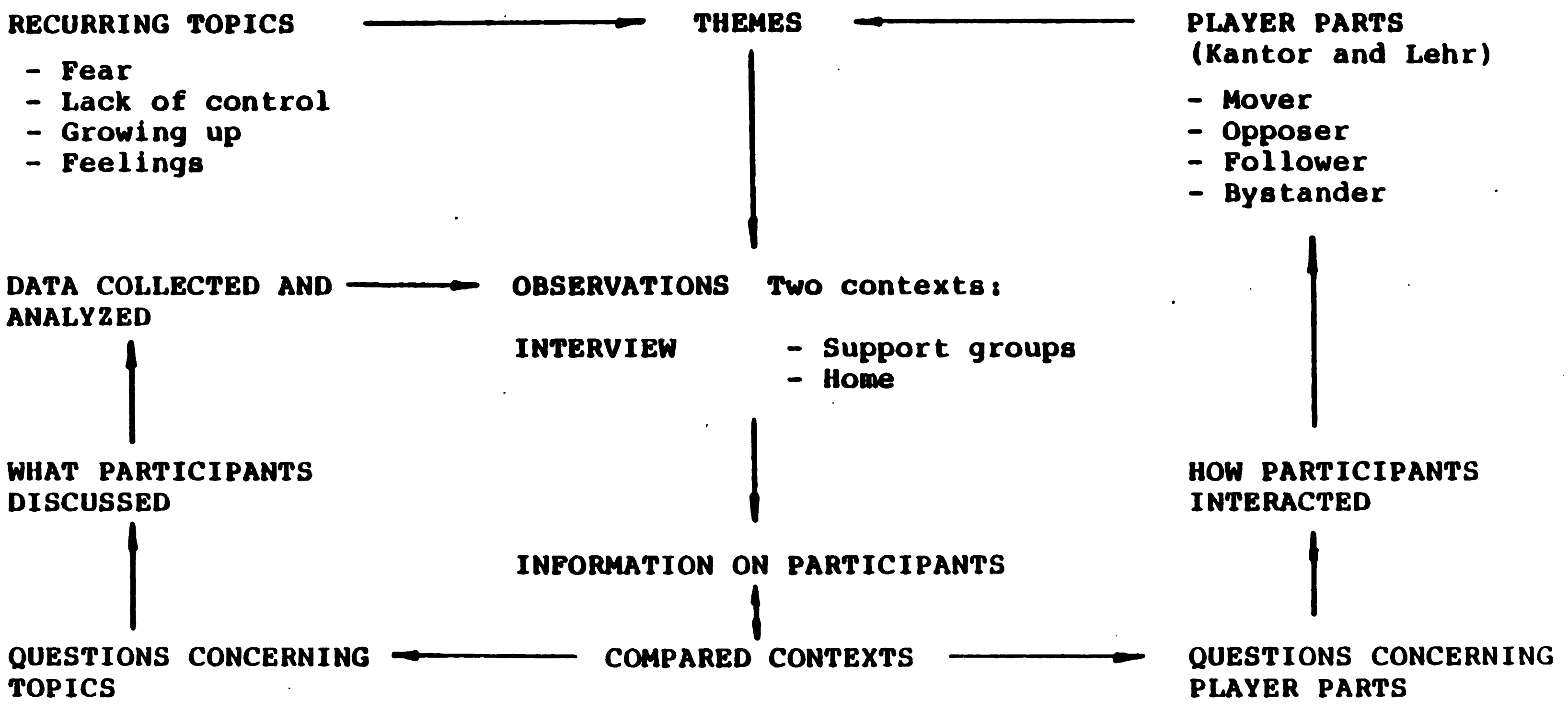
Exploring The Themes

An Overview

Throughout the study the researcher observed that the parents and the children generally assumed opposing player parts around the topics of fear, lack of control, growing up, and feelings. To illustrate: whenever one of the parents, usually the father, initiated action, thereby taking on the part of Mover, the daughter of the family would usually oppose him--that is, she would assume the player part of Opposer. The mother would then often assume the player part of Follower, supporting either the father or the daughter or both simultaneously. This last was illustrated by one of the mothers verbally supporting the father and non-verbally supporting the daughter through stroking her arm. This type of interaction was common in

Figure 6

Flow Chart Presenting Findings



Note that arrows all lead to information on participants.

both support groups and the homes. In the support groups, however, the daughters tended to reassure each other by offering mutual support, and the parents did the same among themselves.

As might be expected, the participants' choice of words often seemed to establish and sharpen the opposition between Mover and Opposer. Daughters usually addressed the themes with personal pronouns and offered internalized responses, as demonstrated by some characteristic phrases: "my fear," "my feelings," "my ability to control myself." In addition, the ways in which the daughters identified themselves with the disorder and separated themselves from their parents suggested a sense of a common bond among the afflicted children. Hence the daughters often repeated such phrases as, "You don't understand it [the disorder] unless you have it"; or, "We are different than you...can't you understand what it is like to have an eating disorder?" The "we" in the latter phrase, especially, highlights the daughters' sense of comraderie and illustrates a commonality.

The parents, on the other hand, referred to the themes indirectly and related to them through their daughters: "her fear," "she scares us," "she feels this," "she tries to control herself." In each of these responses, the parents identify the daughter, not themselves, as involved in the issues.

In essence, both the parents and the children identified the <u>daughter</u> as related to the themes, suggesting that they viewed the disorder more as the child's than as the rest of the family's. However, it is clear that both sides experienced the disorder from different perspectives: the daughters internalized and identified directly with the themes surrounding eating disorders whereas the parents were involved more indirectly. This difference in perspectives probably intensified opposition between parents and children, and this greater opposition seemed to emerge most clearly in the multi-family context of the support groups. In part, this greater opposition is due to the daughters' attempts to reassure each other by offering mutual support, and the parents behaving similarly among themselves.

To understand more completely the importance of the data presented in Chapter IV, we must now take a closer look at, first, the player parts of the families, and second, the choice of words of family members--as both of these phenomena are developed in the contexts of the support group and the home. Discussion will be organized around the four themes.

Fear

In both contexts, the topic of fear provoked sharp opposition between parent and child. A typical instance from the support groups is the following: The sponsor announced a group exercise to explore "words we use to associate ourselves with fear." Before she could continue, Father #1 unfolded himself from his huddled position and interjected: "I just can't understand how this exercise around fear is going to help me understand my daughter's problems with food." Mother #1 touched her husband's arm in a supportive manner, adding: "I think it's nice we do all these things for the girls, but my husband is right. I don't see how we are going to help these girls with their problems by doing these exercises." While this exchange took place, Daughter #1 rocked back and forth in her chair. She then paused, turned to her father, and challenged: "How can you when you don't listen to what we are saying? Fear is an important part of my disorder, and it's the food that's the symptom." She turned to the facilitator, who nodded. Father #2 chimed in: "You tell me, you see your daughter starving and she's afraid to eat and food isn't a problem?" Daughter #2 sighed loudly: "But we don't even know what the exercise is about and we're talking about something else...." Shrugging, she pulled one leg up under her body, grumbling, "We always do this!" Just then the sponsor waved a hand in the air and turned to Father #1. "You remind me of my father," she remarked, "jumping the gun, trying to get things rolling along."

In this typical exchange, Father #1 clearly took on the role of the Mover, not only for the family but also for the entire support group. By shifting the exercise topic's perspective from a general issue (fear) to a specific one (the relationship of fear to eating), he changed the proposed direction of the discussion. Daughter #1, on the other hand, shifted the flow of action, first by challenging her father ("How can you when you don't listen to what we are saying?") and then by shifting the focus of the disorder ("...it's the food that's the symptom"). In this exchange, in other words, Daughter #1 took on the role of the Opposer to the Mover.

Father #2 played a dual role; he opposed Daughter #1 and supported Father #1 ("You tell me...food isn't a problem?"). Daughter #2 supported Daughter #1 by interjecting, "But we don't even know what the exercise is and we're talking about something else...." In sum, in this incident Father #1 played the role of Mover, being supported by Mother #1 and Father #2. Daughter #1 took on the role of Opposer, with Daughter #2 acting as Follower by offering support. Parents and children chose player parts that aligned themselves in distinctly opposite camps.

A prime medium for delineating and intensifying the oppositions is, of course, words. In the above exchange, Daughter #1 used personal pronouns to identify herself with fear, calling fear an important part of "my disorder." This identification was not a one-time event but occurred spontaneously at other meetings whenever fear was mentioned: "I'm afraid to let go of my disorder, so I don't eat"; "My eating disorder used to make me feel superior at school. I'd go to the cafeteria and not eat [pause] just look at the other kids." On such occasions, too, her highly personalized perspective contrasted with her father's distanced comments: e.g., "She's some kind of a kook. I used to think with her fears of eating she was some kind of nut. Now I realize she has an eating disorder and accept it, but I still have a difficult time understanding it." In this case, Father #1 acknowledged his inability to understand the fear, whereas Daughter #1 affirmed that she achieves a sense of superiority through fear.

Other fathers and daughters often acknowledged similar perceptions. Father #1 may have evinced a striking tendency to cast the eating disorder in terms of something remote, something "out there" and having not much to do with himself: "I used to think she was some kind of a kook"; "I still have a difficult time understanding it." Yet his responses represent a clear example of a rhetorical pattern common to all parents in the support group. Likewise, his daughter's remarks are typical of the personalized responses of all the daughters.

In the home setting, similar choices of words and of player parts were observed. Again, Father #1 provides a useful example. If anything, in the home setting he became even more aggressive as a Mover, and more verbally intrusive, than he had been in the support group meetings. Indeed, sometimes he became overwhelming, as when he overrode the researcher's attempt to prod the daughter into exploring her feelings with the remark, "I'll bet it's scary when you feel alone." "What about us?" Father #1 jumped in. "How do you think we feel? Having a beautiful child go from a happy-go-lucky girl to a bag of bones...." It should be noted here that while Father #1 seems to be expressing his fear, he does so with characteristic indirection--in this case using the plural pronoun "we," a question rather than a declarative sentence and metaphor ("a bag of bones").

Lack of Control

Whenever the topic of lack of control was sounded, it was usually in conjunction with fear, as in this typical statement from one of the daughters: "I'm afraid I'll lose control." This kind of phrase often elicited confusion in the parents, as illustrated by this exchange in Family #3:

During a planned support group exercise exploring the sense of control, Daughter #3 began: "I'm afraid to eat. If I eat too much I lose control. It's as if I know each day will be the same if I don't eat." Father #3, turning to her, asked, "How does that work?" Daughter #3 replied, "It...I don't [pause] know." She shrugged her shoulders as her voice trailed off. With prompting from the facilitator, she once more attempted to answer: "I guess that's it... yeah, I feel better, better than anyone if I don't eat...I know it's stupid."

Father #3 sighed loudly, folding his arms across his chest: "Now wait a minute, you do this to make yourself feel special? Can't you do anything else to get your kicks?" Mother #3 patted her daughter's arm and stroked her daughter's hair. "I don't think she means that," she interceded. Father #3 countered: "But that's what she just said. Jeez, I can't understand these kids! I mean, you have this girl who won't eat--" "Or can't," Daughter #1 put in. Father #3 turned to her and grumbled, "What do you mean, <u>can't</u>?" Daughter #3 stared down at the floor and shrugged, diverting her eyes from her parents. A moment later Daughter #2 mumbled, "You don't understand unless you have it--the disorder." Daughter #3 glanced toward Daughter #2 and then toward her parents: "No one understands it unless they have it."

In this exchange, Daughter #3 began the action and is the Mover, expressing her fear of losing control. By questioning her, Father #3 initiated his role of Opposer. The question, of course, was not of itself an opposing challenge, but the manner in which it was asked and the gestures and movements observed and recorded were clearly threatening to the daughter's initial action. Her role as Mover was resumed when she was supported by Daughter #2's remark, "You don't understand unless you have it--the disorder."

Father #3 resumed his role as Opposer after Daughter #3 expressed feeling superior for not eating. Mother #3 played a dual role as Follower--first supporting the daughter (by patting her on the arm) and then supporting the husband (by telling him his daughter did not mean what she had said). In supporting both child and spouse, Mother #3 seemed to be trying to avoid conflict. Yet the clash between father and daughter continued--until the daughter finally gave up. Her role as Opposer diminished, though briefly sparked again by

Daughter #2's comment, "You don't understand unless you have it--the disorder."

When the discussion is viewed from the perspective of the participants' choice of words, we gain additional insight into the interaction between parents and child. The two units seemed to view the disorder from different contexts. The parents, for instance, lamented that their daughter <u>won't</u> eat, whereas the daughter claims she <u>can't</u> eat. The parents, by using "won't," imply active defiance on the part of the daughter. The daughter's "can't" suggests a more passive role: She becomes the victim of a force that prevents her from executing the task of eating.

During the home interviews, Family #3 also, and characteristically of all the families, grappled with the issues of control. The father began: "They say it's lack of control, but she's really controlling us. It scares me." The daughter sighed loudly, catching the researcher's attention. "I don't control anybody," the daughter exclaimed. "They control--no, <u>it</u> controls me...it's so confusing [pause] you wouldn't understand." Here again both parties seemed to acknowledge that the issue of control is related to the eating disorder. Yet just as before, the daughter seemed to see herself as powerless to assume control, to see her eating disorder as a force greater than herself. Conversely, the parents seemed to attribute lack of control to the daughter's willful act of defiance. Thus, differences in perspective, as evidenced by choice of words, set parents and children apart in opposing polarities on the issue of control.

Growing Up

The researcher noted that growing up was a confusing subject for both parents and children. The support group sponsor apparently felt the same and, in an attempt to alleviate the group's confusion, brought in an exercise exploring people's perceptions of age. The sponsor asked the participants to close their eyes and use their "mind's eye view" to consider at what age they currently saw themselves. For the majority of the parents, the age responses ranged from 27 to 35 years. As Mother #2 stated: "I saw myself at age 30, pregnant, which was probably one of the happiest times of my life. I couldn't wait to have a baby." Mother #3 followed, announcing that she saw herself at around the same age, "probably when I was at peace with myself." Father #3 claimed to see himself at 27, the age when he was slim, vital and moving up the business ladder.

For their part, daughters' age responses were around 8 to 10 years. Mother #2 looked surprised when her daughter said, "I saw myself at [age] 8." "Why 8?" Mother #2 asked. "I don't know," her daughter responded, twirling her hair nervously around her fingers. "Surely you must see yourself as older than that?" Mother #2 began, pausing to place her hand on Daughter #2's hair in an effort to stop the young woman's nervous movements. Then she continued: "Why was age 8 so much better than now? I thought surely you'd see yourself at 14 or 15. I know I must have at your age." The daughter had put a piece of sugarless bubble gum in her mouth and was now cracking the gum wildly and tapping her left foot. Shrugging, she replied, "Why'd you see yourself at age 30 and not at 16?" "Because 30 was an appropriate age for me," the mother responded.

The facilitator then noted that adolescents who have eating disorders often see themselves at an earlier age," possibly at an age prior to the onset of the disorder which was a comfortable time." Father #1 then asked, "Does this starving mean the girls want to look 8 or 10 again?" Before the facilitator could respond, however, Father #2 intoned, folding his arms across his chest, "Then it sounds to me that these girls don't want to grow up." "Or can't," Daughter #2 added. "Look," Father #2 continued, "we've given you every opportunity to grow up. Now you have to learn how." "That's right," Mother #2 agreed, stroking her daughter's hair. Daughter #2 looked down at the floor again, twirling her hair and snapping her bubble gum.

In this exchange, Mother #2 and Daughter #2 opposed each other on the age at which each thought the other should perceive herself. Acting as Mover, Father #2 then attempted to shift the focus of the discussion from perceived age to not wanting to grow up. At this point, with her comment, "Or can't," Daughter #2 became the Opposer to the Mover, her father. In turn, he opposed her ("Look, we've given you every opportunity...."), with his wife supporting him as

Follower. Daughter #2 opposed her parents again, this time through her gestures.

The words used by the family members to express themselves establish opposing views towards the ability to grow up. In this example, Father #2 seemed to think that his daughter had been given every opportunity to grow up and had stubbornly refused the responsibility ("We've given you every opportunity to grow up. Now you have to learn how."). The daughter, on the other hand, described a phenomenon in the face of which she felt helpless ("Or can't.").

A similar expression was noted during a spontaneous discussion by Family #4 that erupted during another support group meeting. Father #4, turning to his daughter, asked, "Why don't you grow up and out of this mess?" "Because it's not that easy," his daughter replied. "My eating disorder makes me comfortable because I know what to expect each day. [pause] And I can't right now." Again we see the daughter's sense of incapacity and the parent's frankly accusatory judgment that the child is just being stubborn. We see too that the daughter viewed the dilemma as hers, whereas the parents were not willing to take responsibility for the eating disorder of a member of the family.

During the home interviews, a similar confusion surrounded the theme of growing up, and so did a similar choice of player parts and of words.

Feelings

Feelings, of course, were often discussed in conjunction with many topics. However, they became a specific focus in the support group one evening when one of the mothers announced that she had read that many eating disorders resulted because the afflicted person did not know how to respond to others and so used food, an inanimate object, for emotional gratification. With that, Father #3 replied: "How does that explain not eating? You lose me." Mother #3 added, "I could see that resulting in obesity by the person abusing eating, doing it all the time." Daughter #3 exclaimed: "That's it! The abuse of food! I've read that a person can abuse food in many ways--too much, too little. It's easier to be able to control intake than people." Father #3 replied, "That's so confusing...." Daughter #1 added: "Yet alcoholics do the same thing. Food's just another substance to abuse." Mother #3 asked: "So you're saying to me, like an alcoholic, you've a lack of food? You're obsessed about not eating?" "Ah, Ma," Daughter #3 answered. "You know what it's like, you've been living with me for the last few years." "Yeah," her mother responded, "but I still don't understand you."

In this exchange, Father #3 began the action by asking a question, taking on the role of Mover. Mother #3 supported the father, establishing her role as Follower. Daughter #3 assumed a Bystander's role by offering information she had read. Daughter #1 provided additional support for Daughter #3, thereby taking on the role of Follower. As in discussions on the other three themes, parents and children thus assumed opposing roles. What is unusual is that in the discussion around feelings, both parents and children spoke in rather abstract terms throughout most of the exchange. But toward the end, with Mother #3's challenge ("You're obsessed about food?") and Daughter #3's response ("You know what it's like, you've been living with me for the past few years."), the verbal polarizing observed in other conversations surfaced once again: the mother's language is distancing ("you") while the daughter's is more personal and in fact implied that she is the sole focus of the disorder ("you've been living with me for the past few years.").

Summary of Themes

Thus far, this chapter has focused on how family members have interacted both by choice of player parts and by choice of words in discussions around the four themes during the support group and at home. The four themes are: fear, lack of control, growing up, and feelings. To briefly summarize:

In both contexts, parents and children used words and gestures to set themselves in opposition. Opposition between father and daughter seemed particularly marked. The opposition that showed itself in gestures and in attempts to change or control the direction of discussion also appeared in the substance of the discussions themselves. Daughters characterisically identified themselves closely with the themes through, among other things, a heavy use of personal pronouns: "my feelings," "my fear," and the like, and they often expressed feelings of helplessness in the face of fear. For their part, the parents often used the language of distance: "She's some kind of a kook"; "she's controlling us." By this means, the parents implied that they saw the themes as unrelated to their personal concerns, or at any rate that they did not personalize the themes to the extent that their daughters did. An analysis of player parts and of the participants' choice of words, in short, reveals the opposition between parents' and children's perceptions of the eating disorder and the themes associated with the disorder.

It is interesting to note, though, that in all families, and during discussions of all four themes in both contexts, language and gesture sometimes betrayed conflicting self-perceptions. For instance, the mothers, however much they may have supported the fathers' sense of a daughter's willfulness, often touched their daughters in reassuring, but nonetheless patronizing, ways. A pat on the head, a stroking of the hair--these gestures seemed to speak of a mother's sense of her daughter's fragility and even helplessness. The daughters, on the other hand, however much they spoke of themselves as hopeless victims, often resented their mothers' gestures as infantilizing. Hence Daughter #2's remark during a support group meeting for afflicted members: "If she [her mother] touches my head one more time I think I'll puke! She seems to think I'm a baby or something and want her reassurance." A great deal of ambivalence thus seems to surround a family's perception of a member with an eating disorder, though this ambivalence is not overtly acknowledged.

Indeed, despite the ambivalences that were betrayed by fleeting remarks and gestures, both "camps" seemed eager to align themselves on clearly opposite sides. Whether this exaggeration of opposition is present in all families with eating disorders or peculiar to the four families in this study has not been determined.

As noted above, the results were obtained by using two methods: observation and interviews. At this point, it should be mentioned that the indirect method of data gathering was also employed in this study: a word association exercise was administered to participants. No strong trend was observable in the word association results. However, the word associations do show a division between parent and child that supports other results reported in this chapter. To cite only one telling example: in Item #14, an item dealing with anorexia nervosa, daughters personalized their responses ("my" disorder) while fathers were more apt to answer in a detached fashion ("a" disorder). Indeed, such different rhetorical stances were evident in every family that completed the word association exercise. Mothers who answered were inclined to take a verbal middle road, answering alternately in personal and general terms, just as in the support groups and during the in-home interviews the mothers would generally support either the husband or the daughter. In sum, information collected by means of indirect methods seemed to support the data from the interviews and observations (see Appendix C for further information).

Research Questions

Having examined closely the patterns of familial interaction disclosed in both the support group and the home contexts, we can now return to the research questions presented at the beginning of the chapter.

Question 1: What perceptions of the eating disorder do children with eating disorders and their parents share and not share?

Both parents and children evinced the same perceptions of who had the disorder, actively labeling the daughter as the affected family member. However, a difference in perception of the disorder was discovered through the participants' choice of words used to identify themselves and their relationship to the disorder. Daughters tended to use personal pronounds, such as "my fear," "my feelings"; these suggested an ownership of the themes. Because the themes relate to the disorder, the researcher can hypothesize that the daughters characteristically perceived themselves as unique by virtue of the disorder, over which they also felt ownership. Supporting data for this position are found in many of the daughters' stock phrases, for example: "My disorder is different, you know. [pause] You wouldn't understand it unless you had it"; "I am unique when I starve."

Question 2: What perceptions of attending support groups do children with eating disorders and their parents share and not share?

A finding similar to that of Question 1 was discovered when the researcher examined the data for the participants' perceptions of attending support group meetings. Throughout the study the researcher observed that support group meetings were necessary for the daughter. Parents acknowledged that they attended to help their daughters "get well." Daughters voiced similar statements about attending in order to "get well." However, over the course of the study the researcher realized that the parents and the children did not share similar perceptions of how the support group would help the daughters "get well."

Generally, the parents emphasized that they attended the support group in order to learn about the disorder. The daughters, conversely, seemed to use the support group as a social outlet. Hence the following statements from the daughters: "I've never missed one of my meetings"; "I like going to our meetings because I learn about others who have it [the disorder]...we are unique." The daughters' use of a possessive vocabulary suggested to the researcher that the daughters shared a perception of ownership over the support group. Other statements suggested belongingness and membership. Indeed, as the study continued the daughters' sense of membership and their developing comraderie became more pronounced. This was particularly apparent during the group exercises: whenever a daughter was in opposition to a parent (usually the father), other daughters offered her support.

Question 3: What relationship is there between the afflicted child and the parents which may shape perception of the eating disorder?

The researcher observed opposition between fathers and daughters both in the support group and during the in-home visits; during the latter, the daughters' opposition was generally less verbal. At home the daughters also seemed to back down on and avoid argument; perhaps they lacked the reassuring support of their peers. Mothers generally tried to support both spouse and child, and rarely assumed a directly assertive role. However, daughters were often hostile to their mothers' show of support, which seemed to the daughters to be infantilizing. As one of the daughters remarked: "She seems to think I'm a baby or something and want her reassurance."

All three family members displayed gestures and used language that would suggest that their relationships to each other were less clear-cut, more ambivalent, than they were willing to acknowledge overtly.

Other Considerations

The answers to the research questions raise questions for future research and point to implications for future work on children with eating disorders and their families. Both matters will be discussed in Chapter VI.

CHAPTER VI

SUMMARY AND IMPLICATIONS

The purpose of this chapter is to provide a summary of the preceding chapters and discuss implications for future studies.

Summary

This study utilized ethnographic techniques that included observation at support group meetings and family homes, interviews during home visits and word association questionnaires to explore multi-dimensionally the perceptions of children with eating disorders and their families. Five families who attended support group meetings during 1982 were selected for intensive attention from March to June 1983; however, data for only four families are available.

Three research questions were proposed at the onset of the study:

1. What perceptions of the eating disorder do children with eating disorders and their parents share and not share?
2. What perceptions of attending support groups do children with eating disorders and their parents share and not share?

3. What relationship(s) between the afflicted children and the parents may shape the individual's perception of the eating disorder?

However, while analyzing her data, the researcher realized that the questions were more appropriate for an experimental design than for her own study, and that if she tried to use the information obtained by this study to answer the questions directly, she might be forcing the results and hence jeopardizing the ethnographic method.

To alleviate this dilemma, the researcher decided to use the questions as thought organizers while pursuing her data analysis. During this analysis, she became aware of four recurring topics: fear, lack of control, growing up, and feelings. These topics coincide with the review of literature as issues involved in eating disorders (Levekron, 1982).

Although the researcher had not originally anticipated presenting a discussion of fear, lack of control, growing up, and feelings, she became intrigued with how family members interacted around these topics and decided to explore this interaction. However, the researcher also realized that in order to do this with maximum clarity she needed some way to categorize interactional patterns. The concept of player parts within the family system that is presented by Kantor and Lehr (1975) seemed applicable to the interactions of the families observed.

Kantor and Lehr's player parts are as follows: Mover, Opposer, Follower and Bystander. Each of these player parts has distinct characteristics, which are, briefly:

The Mover -- one who initiates the action;

The Opposer -- one who interferes with the Mover's action;

The Follower -- one who supports either the Mover or the Opposer;

The Bystander -- one who remains neutral in the situation.

Using the player parts to categorize the family members' interactional styles, the researcher observed that the parents and the children generally assumed opposing player parts around the four topics. If a father, for instance, initiated an action, thereby assuming the role of the Mover, his daughter usually would oppose him--that is, she would assume the player part of the Opposer. The mother, often, would then assume the player part of the Follower, supporting either the father or the daughter or both simultaneously. This type of interaction was common in both the support groups and the homes. In the support groups, however, the daughters tended to reassure each other by offering mutual support, and the parents did the same among themselves. At home, the daughters' opposition was more muted.

The choice of words by which the participants expressed themselves often seemed to establish and intensify the relationship between Mover and Opposer. Daughters usually addressed the themes with personal pronouns and offered internalized responses, as demonstrated in some characteristic phrases: "my fear," "my feelings," "my ability to control myself." Additionally, the daughters often seemed to express a sense of a common bond among themselves by identifying themselves with the disorder and further distancing their identities from those of their parents. This view was expressed in some of the daughters' characteristic phrases: "You don't understand it [the disorder] unless you have it"; or, "We are different than you."

The parents, on the other hand, referred to the themes indirectly and related to them through their daughters: "her fear," "she scares us," "she feels this," "she tries to control herself." In each of these responses, the parents identify the daughter, rather than themselves, as being involved in the issues.

In essence, both the parents and the children identified the daughter as related to the themes, suggesting that they viewed the disorder more as the child's than as the entire family's. The contrast, however, is one of degree and not kind, with the daughters internalizing and identifying directly with the themes surrounding eating disorders and the parents being involved more indirectly. From this information, it is clear that both sides experienced the disorder from different perspectives. This difference in perspectives probably intensified opposition between parents and child, and this greater opposition seemed to emerge most clearly in the multi-family context of the support groups. Whether this verbal intensification for opposition is present in all families with eating disorders or peculiar to the four families in this study has not been determined.

The researcher used the information provided by the discussion of interactional styles around the themes to answer the research questions. She found that:

1. While both parents and children evinced the same perceptions of the eating disorder, actively labeling the daughter as the affected family member, the daughters tended to personalize their relationship to the disorder while the parents characteristically assumed a more distanced approach.
2. While both parents and children agreed that attendance at support group meetings was necessary for the daughter, the parents saw the support groups as primarily educative in function, whereas the daughters considered the main purpose of the support groups to be a social one.
3. While their words and gestures displayed some ambivalence, parents and daughters seemed to align themselves in opposition. Opposition between fathers and daughters was the most

marked, whereas mothers tended to support either spouse or child or both simultaneously.

At this point the researcher again reviewed her notes, trying to assess more fully the relationship between the afflicted child and the parents that might have helped to shape the perception of the eating disorder and could therefore explain why so much opposition occurred. The task eventually took her beyond her notes and back through the literature on the disorder.

From this process, new questions emerged:

1. Were there certain unaddressed conflicts between fathers and daughters that caused them to oppose each other?
2. Was the child reacting to overdirection on the father's part?

The observation of player parts, that is, led the researcher to wonder whether perceptions facilitate the enactment of those player parts both within and between family members. For example, may the fact that parents and children did not share the same perception of the eating disorder but felt that attendance at the support group was necessary for the afflicted member explain why the roles of Mover and Opposer erupted during many of the support group meetings and during the in-home interviews? May perceptions of the relationship to the afflicted member facilitate the role of Follower within the family setting?

Questions for Future Research

The following questions for future research emerged from this study; they concern both disorders and support groups.

Disorders

1. To what extent do perceptions of a disorder shape the enactment of a role within a family?

2. To what extent do other types of families that include a labeled disordered member show similar commonalities and differences of perceptions of that disorder, or is the pattern identified in this study peculiar to eating-disordered families?

3. To what extent to other families that include adolescent females share similar patterns of familial and societal interaction?

4. To what extent does being labeled as the person with the eating disorder shape a person's role within the family?

5. To what extent does such labeling shape other family members' perceptions of the role of the labeled disordered member in the family?

Specific Support Groups

1. Do people who use support groups to deal with a disorder in the family have a different perception of the role of the groups that those who do not use such groups?

2. What are the roles of support groups for families with problems?

3. How do support groups meet the needs of families with problems?

4. Once families become accustomed to using support groups, does participation in such groups become integrated into their lifestyle?

Other Considerations

This study not only generated questions for future research but also provides implications for future work.

Implications

This study provides useful insights about families who have a child with an eating disorder. Its implications will be of interest to a variety of readers, among them practitioners and researchers especially those who utilize field techniques for studying families.

Practitioners

Clinical and lay personnel working with families who have members with an eating disorder will find this study informative, as it provides a multi-dimensional picture of four families dealing with an eating disorder. Clinicians who see afflicted families only in one context--that is, in an office or clinic--will find the home visits particularly enlightening, as the home space usually is "off limits" to therapists and clinical professionals. Both clinical and lay personnel will find it useful to examine ways that families in this study seemed to present themselves in "treatment" (as illustrated by the support group meetings) and at home when discussing the eating disorder.

Researchers

This study demonstrates the feasibility of utilizing ethnographic research methods to study families with eating disorders. The observations during the support group and home visits offered a "felt sense" of the disorder unattainable by use of questionnaires and table constructions alone. As a corollary, the study also suggests that there are gaps in studies of eating disorders that rely solely on tabulated, as opposed to observed, data.

APPENDIX A

APPENDIX A

FACTORS RELATED TO PROGNOSIS

Demographic Factors

1. Age of onset: The earlier the age of onset the better the prognosis.

2. Marriage: Being married while ill with anorexia nervosa is associated with a worse prognosis.

3. Chronicity: Patients who have been chronically ill when first seen (longer than 18 months in treatments elsewhere) have been noted to do poorly.

Clinical Factors

1. Bulimia, vomiting and laxative abuse are associated with a less-favorable prognosis.

2. Lowest body weight upon admission: If less than 60 percent of average body weight, this factor is associated with a less-favorable prognosis.

3. Past history of obesity: Patients who have been obese premorbidly tend to share certain features which may predispose them to a poor outcome.

APPENDIX B

APPENDIX B

ETHNOGRAPHIC INTERVIEW QUESTIONS

The following are questions to be asked of anorectic families. Unspecified probe-type questions may have been used to facilitate discussion and are recorded in the interviewer's notes.

1. Could you describe a typical ANAD family support group meeting based on your attendance over the past year?

2. Would you describe how you feel attending ANAD's family support group meetings?

3. Would you tell me how important you feel your attendance is at these meetings?

4. Could you describe what you see as being the role of support groups in dealing with anorexia nervosa?

5. Would you describe your feelings about dealing with anorexia nervosa in your family over the past year?

APPENDIX C

APPENDIX C

WORD ASSOCIATIONS

Family #1

	Participants		
Items	Father	Mother	Daughter
1. Growing up	a fun time	memories	time to grow
2. Growing older	retirement	years	getting older
3. People are	generous	enjoyable	problems
4. Overweight people	fat	people	not my friends
5. Losing weight	pounds off	my daughter	less calories
6. Exercise	jogging	lazy to do	calories burned
7. Sleep	tired	until noon	waste of time
8. Eating	a way to get nourishment	cooking	control it
9. Eating alone	at lunch time	home alone	in my room
10. Over-eating	good food	entertaining	cookies
11. Family meals	a dinner	dinner time	don't like
12. My favorite food is	a steak	cream puffs	mustard and green beans
13. Forced feedings	hospital	treatment	hospitalization
14. Anorexia Nervosa	an eating disorder	starvation by choice	my eating disorder
15. Support groups	ANAD	ANAD, Weight Watchers	Wednesday
16. Health of children	doctor bills	healthy kids	exercise and diet
17. Health of parents	medical care	bills	exercise and diet
18. Starvation	a disease	hungry children	my control
19. Self-control	internal	control of self	I don't know
20. Pressure	a stressful event	cooker	stress

APPENDIX C

WORD ASSOCIATIONS

Family #2

	Participants		
Items	Father	Mother	Daughter
1. Growing up	age process	happy times	getting older
2. Growing older	process goes on	gray hairs	time
3. People are	out for themselves	trustworthy and kind	lonely, tired
4. Overweight people	how over?	are fat	can't control themselves
5. Losing weight	dieting	Weight Watchers	healthy for people
6. Exercise	playing golf, tennis	is boring	healthy for people
7. Sleep	8 hours at night	napping	is for rest
8. Eating	a way to get food in body	is fun	awful
9. Eating alone	no big deal	I don't like	enjoyable for me
10. Over-eating	stuffing one's self	Christmas	too much awful food
11. Family meals	eating at 6:00 pm	as mother, my responsibility	hassle
12. My favorite food is	mashed potatoes	cheese	spinach
13. Forced feedings	treatment	hospitalization	not necessary as treatment
14. Anorexia Nervosa	a disease	hassle	a way to control myself
15. Support groups	ANAD	ANAD	ANAD
16. Health of children	parents' responsibility	as mother, my responsibility	who cares
17. Health of parents	their responsibility	medical work	doctor bills
18. Starvation	a severe loss of weight	disease of health	loss of weight
19. Self-control	a way to control anger	control inside	inside control
20. Pressure	work stress	tension	nervousness

APPENDIX C

WORD ASSOCIATIONS

Family #3

Items	Participants Father	Mother	Daughter
1. Growing up	aging process	getting older	scary times
2. Growing older	gray hair	'Miss Clairol'	growing up
3. People are	out to get you	supportive, gentle	inconsiderate
4. Overweight people	have no control	lazy	are awful
5. Losing weight	going on a diet	curbing food intake	makes me happy
6. Exercise	helps to lose weight	rather read a book	makes me thinner
7. Sleep	a way to relax	until noon	a waste of time
8. Eating	enjoyable event	time to cook	avoidable
9. Eating alone	unenjoyable	read a book	okay if don't eat
10. Over-eating	business lunch	celebration	my family
11. Family meals	all sit together	lots of dishes	hassle
12. My favorite food is	corned beef	corn-bread stuffing	bean sprouts
13. Forced feedings	may be necessary	cure anorexia	a way to make me fat
14. Anorexia Nervosa	a disorder	problems	my problem I can't control
15. Support groups	Wednesday meetings	ANAD	help me
16. Health of children	parent's responsibility	take to doctor	overprotective
17. Health of parents	their responsibility	medical bills	go to doctor
18. Starvation	weight loss	disease	lose weight
19. Self-control	internal	anger	self-control body
20. Pressure	stress	tension	pressure

APPENDIX C

Word Association Responses Showing Perceptions Shared and Not Shared: Families #1, #2, and #3

	Shared (+) and Different (-) Perceptions								
Items	Mother-Daughter Dyad In Family:			Father-Daughter Dyad In Family:			Father-Mother Dyad In Family:		
	#1	#2	#3	#1	#2	#3	#1	#2	#3
1. Growing up	+	-	-	+	+	-	-	-	+
2. Growing older	+	+	+	+	+	-	+	+	+
3. People are	-	-	-	-	+	+	+	-	-
4. Overweight people	-	-	+	-	-	+	-	+	+
5. Losing weight	-	-	-	+	-	-	-	+	+
6. Exercise	-	-	-	+	+	+	-	-	-
7. Sleep	-	+	-	-	+	-	+	+	+
8. Eating	-	-	-	-	-	-	-	-	-
9. Eating alone	-	-	-	-	+	-	-	-	-
10. Overeating	-	-	-	-	-	-	+	+	+
11. Family	-	-	-	-	-	-	+	+	-
12. My favorite food is	-	-	-	-	-	-	+	+	+
13. Forced feedings	+	-	-	+	-	-	+	+	+
14. Anorexia Nervosa	-	-	-	-	-	-	+	-	-
15. Support groups	-	+	-	-	+	-	+	+	+
16. Health of children	-	-	-	-	-	-	+	+	+
17. Health of parents	-	+	+	-	+	-	+	-	-
18. Starvation	-	+	-	-	+	+	+	+	-
19. Self-control	-	+	-	-	+	+	+	+	-
20. Pressure	-	+	+	+	+	+	-	+	+

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