Drive to "Self-Starvation": Qualitative Exploration of Narratives Amongst Eating Disordered Immigrant Women to the U.S.

by

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by

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April 2008

Dedicated to

My parents, Richard and Rita Costantino

Friends, family, mentors, and supporters

Women who suffer from eating disorders

Acknowledgements

It has been said that, “the strength of the effort is the measure of the result”. If someone asked me ten years ago if I thought completing a dissertation was possible, I would have said, “anything is possible”. Certainly I believe that much in life is possible and those possibilities are endless. I can thank my parents for this sense of optimism, and living through example. My mother is a Dominican immigrant to the U.S., as were my Italian paternal grandparents. It is phenomenal that both of my parents simply began with possibilities, dreams, and most of all, integrity of character. Their hard work, successes, and dedication to our family and to society truly inspired me to follow my aspirations to make a difference in this world from a very young age. Certainly completing a dissertation is an arduous task, but no more arduous of task than my ancestors encountered when they manifested their own possibilities.

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Abstract

The emergence of both eating disorders and ethnic minority populations in the U.S. has created a convergence of diverse individuals suffering from the illness (National Eating

Disorders Association, 2006). However, stereotypes and myths that eating disorder symptoms solely plague White women of upper middle-class affiliation still prevail (Gordon, Perez, & Joiner, 2002). Researchers have more recently begun to explore eating disorder etiology amongst ethnic groups, and are learning that women from non-western origins including Latin and African cultures, and from such places as China, Japan, India, and Pakistan also suffer from eating disorders (Abdollahi & Mann, 2001; Nakamura, Yamamoto, Yamazaki, Kawashima, Muto, Someya, Sakurai, & Nozoe, 2000). Numerous theories about self-starvation ranging from psychological, medical, religious, family systems, socio-cultural, and feminist frameworks have been proposed by experts and theorists. Yet few studies have explored the perspectives of immigrant women, and their contextual experiences around their rationales for food refusal. This study evaluated numerous theories around drive to self-starvation, and then utilized a grounded theory qualitative research methodology to guide data collection and analysis with an emphasis on generating theory from the data. The research captured the voices and perspectives of 10 anorexic ethnic immigrant subjects living in the U.S. from India, Iran, Russia, Columbia, China, Puerto Rico, U.K, and Guyana. Several complex categories emerged from in-depth interviews. A theory of separation and connection revealed that participants appeared to struggle with their self-identity as it related to their new world transitional experiences, and their relationship to their cultural roots following their newfound anorexic identity. Results of this study will invite new research possibilities for areas of future study, and increase the efficacy of clinical practice with diverse eating disordered populations in the U.S.

Chapter I—Introduction

There is an empty space in many of us that gnaws at our ribs and cannot
be filled by any amount of food.
-Marya Hornbacher, *Wasted: A Memoir of Anorexia and Bulimia*

This study systematically explores how immigrant anorectic women of color in the U.S. perceive "self-starvation" and the meanings and contextual factors driving their desires to restrict food intake. Such research is important given the increased incidence of both immigration and eating disorders in Western society, and bold efforts to improve health care services for a growing and culturally diverse population.

Projections indicate that by the year 2025 racial and ethnic groups will comprise approximately 40% of all Americans (Bureau of the Census, 2001). At the same time, the prevalence of eating disorders amongst women is increasing. As many as 10 million females are battling anorexia or bulimia, and 25 million more people are struggling with binge eating disorder in the U.S. (National Eating Disorders Association, 2007). Eating disorders are considered to be complex conditions with the highest mortality rate of all mental illness (Eating Disorders Coalition, 2006). Sufferers typically use their relationship with food to compensate for feelings or emotions that can arise from behavioral, psychological, emotional, social, or interpersonal factors (National Eating Disorders Association, 2006).

It is without question that diversification amongst suffering individuals continues to change the cultural shape of therapeutic practice for treatment of eating disorders, and challenges myths that the illness is an affliction affecting only upper middle-class college-age White women driven toward American images of slenderness (Gordon, Perez, & Joiner, 2002). In fact, we are starting to learn that women of color can and do

suffer from a variety of eating disorder symptoms and body image disturbances (Striegel-Moore, Wilfley, Pike, Dohm, & Fairburn, 2000). Unfortunately, mental health services have not acclimated to these diverse needs, and many individuals have been underserved, leading to health care disparities (President's New Freedom Commission on Mental Health, 2003). In fact, women of ethnic minority groups bear the greatest burden from unmet mental health care (National Women's Law Center, 2001).

Increased attention is now geared toward helping mental health clinicians enhance multicultural competencies (Sue, Arredondo, & McDavis, 1992) so that services they provide are responsive to the cultural concerns of various ethnic groups (United States Public Health Service Office of the Surgeon General, 2001). One way to accomplish this task is to increase practitioner awareness of the experiences of diverse populations, and to better help them to establish therapeutic alliances with ethnic women that are consistent with the client's personal values and context, which is the aim of performing this research study.

Women of Color and Eating Disorders

At Risk and Undetected

Over the past several years, researchers have begun to explore behaviors related to the development and maintenance of eating disorders (e.g., dieting and body dissatisfaction) in females of ethnic diversity within the United States (Jacob, 2001). However, limited awareness of multiple and culturally diverse perspectives of eating disorder etiology continually plague clinicians' abilities to recognize and treat eating disorders in ethnic individuals. Central to this discussion is the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR; American Psychiatric Association, 2000),

which has been criticized for culturally inflexible diagnostic criteria, weaknesses in its tendency to be standardized, and for its failure to generalize to ethnic groups living in Western countries (Wildes, Emery, & Simons, 2001). It has been suggested that culturally inappropriate definitions of eating disorders are to blame for differences in reported eating disturbance among ethnic and cultural groups (Wildes et al., 2001). The problem is two-fold. Traditional and normative standards of eating disorder symptomatology may impact a clinician's ability to detect symptoms unique to the individual (Gordon, Perez, & Joiner, 2002), and ethnic women may not be treated until their symptoms are comparable to those of Caucasians (Cachelin & Striegel-Moore, 2006).

At the same time, we are learning that eating disorders are occurring amongst of non-western origin including China, Japan, India, Iran, and Pakistan, and are ever more common (Abdollahi & Mann, 2001; Nakamura, Yamamoto, Yamazaki, Kawashima, Muto, Someya, Sakurai, & Nozoe, 2000). Also, recent studies have reported Hispanic females may experience eating disorder symptomatology with greater severity than their White counterparts (Cachelin, Veisel, & Striegel-Moore, 2000). Such information sheds light on the presence of such pathology amongst ethnically diverse women. However, findings regarding prevalence rates amongst particular groups are still limited (Smolak & Striegel-Moore, 2001). This increases our attention to the lack of population-based studies that include representatives from ethnically diverse groups, as well as to common stereotypes that ethnic females are at decreased risk and therefore may hinder clinicians' abilities to detect eating disorders amongst diverse women (Cachelin et al., 2000).

For example, minorities participating in a recent study of access to health care for eating disorder symptoms were significantly less likely than White participants to have

been asked by a doctor about eating disorder symptoms (Becker, Franko, Speck, & Herzog, 2003). Similarly, a community-based study comparing Black and White women with binge eating disorder revealed that Black participants were significantly less likely than White women to have received treatment (Striegel-Moore, Wilfley, Pike, Dohm, & Fairburn, 2000). Certainly, the practice of stereotyping can deceive clinicians into thinking a woman of color may not have an eating disorder. This situation can arise when clinicians disregard that eating disorder symptomatology can vary according to the ethnicity and culture of the individual (Simpson, 2002).

Deconstructing Anorexia Nervosa: The Discourse of "Fat Phobia"

According to the Diagnostic Statistical Manual of the American Psychiatric Association (American Psychiatric Association, 2000), Anorexia Nervosa is characterized by several essential features that mainly surround issues of appearance including—refusal to maintain minimally normal body weight (body weight less than 85% of that expected), intense fear of weight gain or "becoming fat" (p. 589) despite being underweight, disturbance in the way one's body is experienced accompanied by denial of the seriousness of current low body weight, and absence of at least three consecutive menstrual cycles. Subtypes for Anorexia Nervosa vary and specify the presence or absence of other eating disorder behaviors. Subtypes can include—Restricting Type and Binge-Eating-Purging Type. Anorexia Nervosa Restricting Type connotes that weight loss was primarily achieved through dieting, fasting, or excessive exercise without regular engagement in binge eating or purging. Anorexia Nervosa Binge-Eating/Purging Type means that an individual with Anorexia Nervosa regularly engages in binge eating and/or purging through the misuse of laxatives, diuretics,

enemas, or self-induced vomiting. Individuals within this subtype may purge after consumption of small amounts of food (p. 589).

While DSM-IV-TR criteria highlight drive for thinness and "fat phobia" as key motivational variables in weight loss efforts (Rodin, Silberstein, & Striegel-Moore, 1985), those attuned to cross-cultural research on anorexia nervosa note that "fat phobia is consistent with the values of contemporary Western culture" (Rieger, Touyz, Swain, Beumont, 2001, p. 208), which may be an unfair assumption to make when working with culturally diverse individuals. In other words, "to conceptualise the disorder as a 'weight phobia', embodying a Western cultural preoccupation with thinness, risks being unnecessarily ethnocentric" (Steiger, 1995, pp. 64-65). In two separate reviews, Mumford (1993) and King (1993) cautioned against concluding that emphasis on slimness and dieting found predominantly in Western societies is necessary for an eating disorder to occur. Both researchers proposed that Western diagnostic tools, like the DSM-IV-TR (American Psychiatric Association, 2000), do not take into account religious, cultural, and beauty practices of non-Western groups (King; Mumford) that may influence eating behaviors.

Self-Starvation: More than "Fat Phobia"?

While food refusal is typically an essential feature of those who suffer with Anorexia Nervosa, interestingly it is not mentioned as a criterion in the DSM-IV-TR for diagnosing Anorexia (American Psychiatric Association, 2000). Failure to maintain body weight and body image issues tend to be the central focus, but such biomedical discourse of fat phobia has been criticized for discounting, "the manifold metaphorical meanings of

voluntary self-starvation and the variable subjectivities of anorexic individuals" (Lee, 2001, p. 42).

Voluntary food restriction, or "self-starvation" is at the heart of this research study since reasons for food refusal are typically overlooked. It is believed that such ignorance may create limitations in understanding how anorectic self-starvation may be psychologically meaningful for women of color, impacting a clinician's ability to detect symptoms and experiences unique to the ethnic individual (Gordon, et al., 2002). Furthermore, some researchers have argued that the regularly accepted discourse for "weight phobia" for anorexic self-starvation may, "bar patients' subjective expressions and hinder the understanding of their psychosocial problems" (Lee, 2001, p. 48). In other words, assuming that anorexia symptomatology in women of color is purely appearance-based can camouflage underlying emotional issues and relationships.

For instance, Simpson (2002) found that anorexic women from some cultures may not express a "fat-phobia" that is included in diagnostic criteria to evaluate anorectics. These findings are consistent with a study investigating 48 Chinese anorectics. In that study, 16 non-fat-phobics gave rationale other than fat-phobia for refusal to eat. Such reasons included stomach bloating and no appetite (Lee, Lee, Ngai, Lee, & Wing, 2001). Furthermore, there is evidence to suggest "….existence among cases of anorexia nervosa in historical and cultural contexts beyond contemporary Western society" (Rieger et al., 2001, p. 208). Additionally, motivation for self-starvation may exclude fear of fatness and include deeper meanings. An example of this is an anorexic who expresses a desire to reduce food intake for religious purposes instead of body image concerns (Simpson, 2002).

Clinicians who work with large numbers of anorectic sufferers know that anorexia nervosa is not uniformly about a desire to be thin, and it is frequently asserted within treatment settings that the eating disorder is "not about the food". So, if it is not about the food, what is the desire to restrict food intake about? A variety of causes of motivated eating restraint have been recognized that include—medical and genetically based, individual psychology, systemic and family issues, religious, and socio-cultural perspectives. In Chapter Two, I will offer a detailed review of such proposed meanings for the drive to self-starve.

Research Purpose

There is still much to learn about the etiology of anorexia nervosa and the way women experience it. There are especially significant gaps in the literature regarding ethnically diverse immigrant women and the meanings they attribute to their anorectic behavior. The discrepancies in available knowledge not only limit empirical understanding of unique experiences with self-starvation, but can also hinder a clinician's ability to provide effective and culturally competent treatment.

In order to enhance provider sensitivity to cultural diversity, identification of difference in symptomatology, and the articulation of distress across diverse populations (Franko, Becker, Thomas, & Herzog, 2006), the American Psychiatric Association (2000) recommends that researchers develop studies to address issues surrounding the "epidemiology, causes, and course of illness" (p. 30). Clinicians are also encouraged to "articulate respect and inclusiveness for the national heritage of all groups, recognition of cultural contexts as defining forces for the individuals' and groups' lived experiences, and the role of external forces such as historical, economic, and socio-political events"

(American Psychological Association, 2002, p. 15), to understand how individuals with eating disorders "function in the larger contexts of their families and society" (Murray, 2003, p. 279). Therefore, it is believed that an exploratory study investigating the meaning of "self-starvation" amongst eating disordered immigrant women will be useful in helping clinicians develop systematic and differentiated knowledge about the psychological meanings attributed to the eating disordered behavior in ethnic women. Qualitative methods will be utilized in order to provide analysis of the participants' experiences, which may pave the way for new theories leading to quantitative research to test such theories.

Definitions and Language

Racial References

Subjects for this study will include a variety of women from racial and ethnic minority populations with onset of anorexia nervosa following immigration to the U.S. I recognize that terms referring to such groups change often. For example, it is understood that some individuals of African ancestry prefer to be identified as *Black*, while others prefer *African American*. To reconcile this I will ask participants to specify their preferred designation and acknowledge them as such within my study. It should also be noted that racial and ethnic groups will be referred to by proper nouns and will be capitalized. An example of this is *Black* and *White* instead of *black* and *white*. According to the *Publication Manual of the American Psychological Association* (APA) (2001), "colors to refer to other human groups currently are considered pejorative and should not be used" (p. 68). Furthermore, in accordance with these standards, I will name a specific nation or region of origin when identifying participants. For example, the more specific

term *Cuban American* is desired over the term *Hispanic*. Asian subgroups such as Chinese, Vietnamese, Korean, Pakistani, will be favored over the more general term, *Asian* or *Asian American*, which is preferred over the term *Oriental* (p. 68). Finally, when referring to *White* Americans, I will use the terms *White*, *Caucasian*, or majority culture interchangeably to enhance readability.

Race, Ethnicity, Culture, and Related Terms

Several key terms will be used to classify subjects in the study according to group identification with particular attention to subtle differences and aspects of their experience. These terms include race, culture, ethnicity, ethnic minority, immigrants, migration, foreign-born, women of color, ethnic identity, and acculturation.

Race. This study will evaluate participants' race according to federal guidelines as outlined by the Bureau of the Census. The question of race for Bureau of the Census 2000 was very different from the 1990 census, and Census 2000 used guidelines to collect and present data on race. Respondents were also given "the option of selecting one of more race categories to indicate their racial identities" (p. 2). This study will evaluate race according to such guidelines, and participants in the study will therefore have an opportunity to select their own racial categories.

"White" refers to people having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicated their race or races as "White" or wrote in entries such as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish.

"Black or African American" refers to people having origins in any of the Black racial groups of Africa. It includes people who indicated their race or races as "Black,

African American, or Negro," or wrote in entries such as Afro American, Nigerian, or Haitian.

"American Indian and Alaska Native" refers to people having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment. It includes people who indicated their race or races by marking this category or writing in their principal or enrolled tribe, such as Rosebud Sioux, Chippewa, or Navajo.

"Asian" refers to people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. It includes people who indicated their race or races as "Asian Indian," "Chinese," "Filipino," "Korean," "Japanese," "Vietnamese," or "Other Asian," or wrote in entries such as Burmese, Hmong, Pakistani, or Thai.

"Native Hawaiian and Other Pacific Islander" refers to people having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicated their race or races as "Native Hawaiian," "Guamanian or Chamorro," "Samoan," or "Other Pacific Islander," or wrote in entries such as Tahitian, Mariana Islander, or Chuukese.

"Hispanic or Latino" is a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture of origin regardless of race.

"Some other race" category will be included for respondents who were unable to identify with specific race categories, or who are of mixed race. Respondents will be able to provide write-in their racial self-identification.

Culture. Culture is generally conceptualized and will be referred to in this study as the subject's "belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes (language, caretaking practices, media, educational systems) and organizations (media educational systems)" (American Psychological Association, 2001, p. 380). Thus, in this study culture is viewed as "environmental, historical, and social process taking on specific structures such as language, leadership, kinship and religion" (Shon & Ja, 1982, p. 208)

Ethnicity. There has been debate over the definition of ethnicity and the interchangeability between the terms ethnicity and culture. Researchers, Lee, (1997); Lee, (1999); and Locke (1998), viewed ethnicity as part of one's culture. Barr (1997), Helms (1985), and Marin (1992) argued that culture differs from ethnicity in that it refers to a group's norms, values, attitudes, and behaviors that may not necessarily be based on ethnic background. Other researchers, (Gasser & Tan, 1999) regarded ethnicity and culture as the same using the terms and concepts interchangeably. In this study, the term ethnicity will refer to a group of people having a common national or cultural tradition and a sense of commonality within generations of families and within the larger community.

Ethnic Minority. This term refers to a subgroup within a community that differs ethnically from the main or dominant population. In this study, an ethnic minority specifically refers to individuals who are of non-Western European originated groups, and therefore differs ethnically from the main population (Pearsall, 1999).

Immigration, Migration, and International Migration. According the Bureau of the Census (2000), "Immigration (migration *to* a country) is one component of

international migration; the other component is emigration (migration *from* a country). In its simplest form, international migration is defined as any movement across a national border." To determine immigration rates, the U.S. Census Bureau makes estimates of net international migration for the nation, states, and counties in the United States, which are based on estimates from data collected in censuses and surveys.

Foreign-Born and Women of Color. In this study the terms foreign-born and women of color will specifically refer to women of non-Western European originated groups and who were not U.S. citizens at birth (Bureau of the Census, 2003). Such individuals may include those of Latina, Asian/Pacific Islander, and African American descent. On the other hand, natives are "those who were in one of the following areas—the United States, Puerto Rico, Guam, American Samoa, the U.S. Virgin Islands, or the Northern Mariana Islands—or were born abroad of at least one parent who was a U.S. Citizen" (Bureau of the Census, 2003, p.1).

Ethnic Identity. Ethnic identity is part of an individual's self-concept that develops from knowledge of membership in a cultural group and the value or emotional significance attached to that membership (Phinney, 1990). It's an enduring, fundamental aspect of self that includes both a sense of connection in a social group (Tajfel, 1978) or ethnic group, and the attitudes and feelings associated with that membership (Bernal & Knight, 1993; Keefe, 1992). The term ethnic identity will be used in this study to refer to an individual's sense of belonging and identification with a cultural group, specifically their culture of origin.

Acculturation. The term acculturation is defined as assimilation of a different culture to one's own culture which often means giving up most cultural traits of the

culture of origin and assuming traits of the dominant culture (Barry, Trimble, & Olmedo, 1986) and the degree to which an individual identifies with or conforms to the attitudes, lifestyles, and values of the dominant culture (Lee, 1997). In this study, the term acculturation will be used interchangeably with the word assimilation to refer to this process and the "psychosocial change that occurs when a group or individual acquires the cultural values, language, norms, and behaviors of a dominant society" (Wildes, et al., 2001), which may also involve modifying the relationship to one's existing culture of origin.

Overview of Chapters

In summary, Albert Einstein once stated that, "The important thing is to not stop questioning. Curiosity has its own reason for existing…" (QuoteWorld.org, 2007). The essence of that quote is at the core of this research study. It is not to seek generalized truths regarding how immigrant women of color to the U.S. perceive and experience the desire to self-starve or restrict food intake, but rather to extract further explanations for such motivations. It is believed that learning from a variety of participants may challenge or confirm commonly accepted ideas about ethnic women with eating disorders and open a dialogue for the inclusion of relational factors driving acts of self-starvation amongst ethnic women in the U.S. that may currently be overlooked.

Chapter Two will present a historical overview of the meanings of "self-starvation" through a variety of lenses, and include an in-depth literature review of "self-starvation" to rationalize how unknowns regarding desire for food restriction amongst diverse women support the need for qualitative inquiry.

Chapter Three will describe in detail the methodology for the study. The reader will be introduced to the grounded theory research design, sampling, data collection, review, and analysis procedures. Finally, I will discuss the importance of the researcher within qualitative research, rationale for selecting grounded theory methods, usefulness and limitations of the methodology, and ethics and verification procedures.

Chapter II—Review of the Literature

> Dear Father, I have no intention of making a peace pact between my body and my soul, and neither do I intend to hold back. Therefore, allow me to tame my body by not altering my diet: I will not stop for the rest of my life, until there is no more life left. You should not think that my body is so mortified and weak as it seems; it acts this way so that I should not demand the debt it contracted in the world, when it liked pleasure…Oh my body, why do you not help me to serve my creator and redeemer? Why are you not as quick to obey as you were to disobey His commands? Do not lament, do not cry; do not pretend to be half dead. You will bear the weight that I place on your shoulders, all of it…I not only wish to abstain from bodily food but I wish to die a thousand times a day if it were possible, in this mortal life of mine.
>
> –Saint Margret of Cortona, In a Letter to her Confessor ordering her to eat. D. February, 22, 1297, of Starvation. (Hornbacher, 1999, p. 126)

The Mystery of Self-Starvation: Theories, Definitions, and Inconclusive Causes

Current understandings of anorexia nervosa are often limited to criterion outlined in the DSM-IV. As we have previously discussed, narrow definitions of how the disorder manifests in individuals can contribute to medical and treatment errors. This issue is of special concern when it comes to properly diagnosing, treating, and understanding the experiences of "atypical" populations with anorexia who may not present with the same symptoms or rational for food refusal as Caucasian women, who have mostly been included in eating disorder studies. Thus, it is important for clinicians and researchers to begin the process of expanding their awareness of possible rationales for food refusal that may be based on the ethnicity, culture, and race of the individual, especially those who may have entirely different ways of thinking about the disorder itself. Of specific relevance to this study are socially constructed notions of self-starvation that may have roots in past understandings of the disorder, but may permeate the fabric of current conceptualizations of immigrant women who participate in this study. Therefore, this

chapter will review such common and uncommon theories of self-starvation and the drive for food refusal from a variety of perspectives.

Anorexia nervosa: Basic definitions and critiques

The term *anorexia* means an absence of eating. *Nervosa* refers to the psychological source of the condition that comes from the Latin word meaning nervous. Combined these terms describe a destructive pattern of starvation derived from irrational thoughts (Gilbert & Commerford, 2000). Some argue that the Latin term anorexia nervosa is misleading because it denotes a "lack or absence of appetite for nervous origin" (Vandereycken & Van Deth, 1994, p. 1) when anorexics do not necessarily suffer from lack of appetite but a "desired or deliberate suppression of appetite and hunger" (p. 1). Therefore, self-starvation is a more appropriate term to define the condition, and thus a core subject of inquiry for this research exploration.

Anorexia Nervosa as we commonly know it today is understood to be a serious mental disorder which "predominantly affects women in approximately 90 percent of the cases" (Leone, 2001, p. 14), and has a long-term mortality rate of over 10 percent (Leone, 2001). Today our perceptions of what anorexia nervosa is and looks like are frequently guided by criteria outlined in the *Diagnostic and Statistics Manual IV* (DSM-IV TR; American Psychiatric Association, 2000), that includes—refusal to maintain body weight at or above a minimally normal weight for age and height (body weight less than 85 percent of that expected); intense fear of gaining weight or becoming fat, even though underweight; a significant disturbance in the perception of the shape or size of his or her body, or denial of seriousness of the current low body weight; postmenarcheal females with this disorder are amenorrhoea (absence of at least three consecutive menstrual

cycles); usually weight loss is accompanied primarily through reduction in total food intake; and increased or excessive exercise.

As discussed in Chapter One, there has been criticism of the diagnostic criteria for its emphasis on "fat phobia" as a necessary component of anorexia nervosa diagnosis, when studies have shown that "fat phobia" may not be present for all individuals suffering from anorexia (Lee, et al., 2001). Kam and Lee (1998) described the case of a 16-year old anorexic female from Hong Kong for whom, throughout the course of treatment, "the fear of fatness…never constituted an issue" (p. 229). Additionally, more recent studies surveying the experiences of diverse groups of women have shown that a variety of contextual factors may in fact influence eating disorder symptoms and can be unrelated to a desire for thinness for aesthetic purposes of perfection (Shuriquie, 1999). Therefore, it is imperative that researchers begin the process of peeling away the onion to understand the variety of meanings women suffering from anorexia attribute to drive for self-starvation and rationale for food refusal. It is my belief that if professionals and clinicians can broaden their perspectives regarding multiple experiences attributed to self-starvation and restriction of food intake, more individuals, especially ethnically diverse women, may be able to receive proper treatment and referrals (Cachelin, Viesel, Striegel-Moore, & Barzegarnazari, 2000).

While there are many unknowns about anorexia nervosa including exactly what causes it (Brumberg, 2000), those looking for a specific "cause" may stumble over current explanations for its occurrence that typically fit under current and historical biomedical, systemic theory, psychological, or cultural understandings. There has been no single paradigm established for the "real" origin of the disease, nor has one model

explained the place of anorexia nervosa in the long history of female food refusal (Vandereycken & Van Deth, 1994). Those interested in the biological view of anorexia nervosa are particularly interested in the metabolic and hormonal disturbances, however, it is unclear whether or not such physiological disturbances are causes or consequences of the disorder (Treasure, Schmidt, & van Furth, 2003; Vandereycken & Van Deth, 1994). The psychodynamic perspective of anorexia nervosa is oriented to individual fears of sexual maturation and growth, and asserts that individuals with anorexia use emancipation of growth and development to physically and mentally lead a childish, asexual life. Vandereycken and Van Deth (1994) further assert that:

> Learning theory perspectives hold that anorexia is a weight phobia that is rewarded in two ways: losing weight enables individuals to avoid fear of weight gain, and also weight loss can invite a great deal of attention to the anorexic, particularly by her parents. The latter view is linked with systems theory that frequently regards symptoms of anorexia nervosa as a sign of disturbed structures and interactions within the family. Finally, the increase of anorexia nervosa in Western women has led to sociocultural views often inspired by feminist ideas: anorexia nervosa is a sign of (male) society submitting women amidst abundance to an ever more emphatic ideal of slenderness. (p. 3)

These modern day explanations of anorexia nervosa only skim the surface of possible meanings for self-starvation and food refusal amongst immigrant women with anorexia. Rather, the inclination of our everyday culture is to compartmentalize "symptoms" of anorexia nervosa into diagnosis that emphasize extreme desire for weight loss and "fat phobia", as opposed to considering other factors such as the individual's

psychological explanations, family and relational issues, and social and cultural contexts (Brumberg, 2000; Kam & Lee, 1998). However, more than a century of scientific interest in anorexia nervosa has given rise to a host of hypotheses and speculation on the cause of anorexia and its meanings. Qualitative studies have revealed multiple themes of the illness experience. At the same time, patients' experiences with anorexia were most often subjugated for professional definitions or rationales for food refusal (Deth & Vandereycken, 2000; Lee et al., 2001). In response, this study focuses on the participants themselves as the experts of their own experiences.

It is important to note that societal meanings of anorexic symptoms of self-starvation have also shifted from a past explanation based on religious intent to a more medical explanation of rationale for food restriction (Farrell, 2000). For example, "Psychotherapists may view these thoughts as being psychotic delusions, while for the 'holy women' they were the source of prestige and power they had in their society" (p. 16). Another modern concept is the physical fanaticism of women addicted to exercise and control over their body for aesthetic purposes (Lee, et al., 2001).

However, questions are being raised as to whether or not such rationale for the desire for weight loss is an adequate explanation for the presence of self-starvation amongst diverse women, or merely an oversimplification of current concepts applied to such populations that may have little relevance. For example, a study on Chinese women who refuse food noted that some patients gave reasons other than non-fat rationales for the desire to restrict food intake. Some other rationales included stomach bloating, loss of appetite, and feelings of no hunger (Lee, et al., 2001). Interestingly, similar to that of Victorian times, there was no mention of preoccupation with appearance, shape, or self-control

(Van Deth & Vandereycken, 2000), which is a more current hypothesis for the refusal of food in order to proclaim needs of self-control (Lee et al., 2001; Katzman & Lee, 1997). These studies defend the assertion that women in this study may experience self-starvation in a variety of ways, especially as immigrant women. Furthermore, such diverse explanations are relevant to broadening the rationale for how participants in this study may be differently motivated towards self-starvation behaviors.

Early History of Anorexia Nervosa: Rationales for Food Refusal

Given Western tendencies to focus on the here and now, as well as the future orientation, some individuals may be surprised to learn that evidence for conceptualizing anorexia symptoms can be found as early back as the eleventh century. Anorexia nervosa was first named and identified in the 1870s by professional medical men, and the "birth" of the disease was related to the new authority of medicine and changes in the larger society that had consequences for women (Brumberg, 2000). While the term anorexia nervosa is relatively new, self-starvation has historically occurred throughout various points in history throughout the world, leading to the death of countless women (Vandereycken & Van Deth, 1994). For example, *fushkubyo*, or 'non-eating illness', was described by Kagawa in the 17th and 18th century Japan (Soh, Touyz, & Surgenore, 2006). Most of the patients were women and the condition was thought to have a psychological origin. It is important to note that such ideas may have relevance to some immigrant anorexic women who participate in this study today, since it is not uncommon for ancient or cultural ideas or customs to maintain importance through time.

Social and cultural historians have sought to investigate and understand the experiences of food refusal amongst these women documented as early as the sixteenth

century, which represent a variety of themes and changing ideas about food and its meaning, including how food-refusing behavior evolved in response to developments in religion and secularization and medicine and medicalization. However, it has been well asserted that to "examine the responsiveness of the disease to cultural settings, we must look beyond doctors, diagnosis, and therapies to the patients themselves" (Brumberg, 2000, p. 8). In other words, even if an illness has organic components, sickness itself is a social act, and people can and do present physical pain and discomfort in a variety of ways depending on their gender, age, class, ethnic origin, worldview, and a host of other cultural variables (Brumberg, 2000, p. 8). Just as fashion and styles change with the changing times, it is believed that anorexia nervosa can "'present' differently, in terms of both predisposing psychological factors and actual physical symptoms" (p. 8). Historians have also noted variations in anorexia nervosa symptoms in response to different social and cultural environments (Vandereycken & Van Deth, 1994), although the modern anorexic's claims of "I am full" or "I am not hungry" are not markedly different from Victorian claims of "I have no appetite".

What *has* changed over time is how eating disorders are understood and conceptualized. This has specific relevance to this study, which concentrates on how immigrant women themselves understand their own desires for self-starvation. It is important to consider the similar and differing ways experts such as physicians and psychotherapists have conceptualized anorexic symptoms of self-starvation; societal and cultural ideas of the disorder; and the patient's perspectives themselves. Furthermore, an eco-systemic view of the drive for self-starvation may consider how such multiple perspectives of self-starvation may interact to influence the thinking of the participants.

Therefore, it is essential to this study to review meanings, which may seem outdated, but may still apply for those individuals who come from different and diverse cultural contexts.

Early Interpretations of Self-Starvation: Social, Medical, and Religious Discourses

Early interpretations of anorexia are important because they provide very different explanations of the relationship between women and food refusal than current hypothesis; show how the dominant ideas of culture impacted how symptoms of anorexia and self-starvation were perceived and interpreted in the past (Hepworth, 1999); and demonstrate how these ideas may impact present understandings of those from varying cultures.

The two discoverers of anorexia in the late nineteenth century were Ernest Charles Lasegue and English physician Sir William Gull, who coined the term 'anorexia nervosa' (Macsween, 1993). They specifically believed the syndrome was due to a morbid mental state (Van Deth & Vandereycken, 2000). In extreme cases of food refusal without an organic cause, clinicians often advised forced feeding (Van Deth & Vandereycken, 2000), and anorexia nervosa was frequently seen as a form of "hysteria" in women. Campbell (1878) observed, "considerable numbers of girls in the hysteric state, who had refused food at home" (Van Deth & Vandereycken, 2000, p. 392). It is not uncommon to hear such assertions today from those who do not fully understand anorexia and reasons for food refusal. These ideas may be relevant to the way participants in the study view their drive for food restriction.

Furthermore, the secrecy that the patients had around rationale for food refusal also confused clinicians then as it does now. From a psychological perspective, numerous reasons were expressed that included imitation, intention to commit suicide through

fasting, hunger strikes for revenge or to exact release; loss of fortune, parents, or friends because of isolation from family (Van Deth & Vandereycken, 2000, p. 393). The food refusing patients were frequently seen as delusional or hallucinatory. Some patients were said to think that food had been poisoned or was indigestible. Other patients refused food because of "hypochondriacal ideas" (Van Deth & Vandereycken, 2000, p. 394), such as the patient's mouth being too small, the throat shut off, or the stomach unable to digest food. Some patients had delusions of unclean animals gnawing at them in their intestines (p. 394). Such assertions continue to have relevance today, as evidenced by my own clinical work with numerous anorexic women who have expressed similar complaints, including one woman who noted that spaghetti reminded her of "worms moving around on her plate".

It is also not uncommon to hear clinicians describe food refusal behavior as "attention seeking". Such notions were also evidenced early on. Some clinicians noticed "that in some lunatics, the pathological wish to be interesting by refusing food, to be conspicuous, or to irritate the social environment and the physicians may give rise to fasting" (Van Deth & Vandereycken, 2000, p. 397). Others such as Chipley (as cited in Van Deth and Vandereycken, 1994) asserted that women who refuse food might be craving attention from those around them. One example of this is a woman who was amicable and delicate who:

> was not slow in perceiving that wonder and amazement grew inversely to the amount of food taken, and she did not fail to make herself the object of lively solicitude to all her numerous friends. The amount of food was diminished until finally she would pass whole days together without tasting a single morsel. After

> a long struggle, in spite of every effort to restrain her friends, and to wean her from her folly, she died…The autopsy revealed no material lesion except an extraordinary diminution in the capacity of the stomach—an effect, doubtless of the vicious habit that finally resulted in the death. (Van Deth, & Vandereycken, 2000, p. 398, 399)

It was not uncommon for professionals to believe that women used refusal of food as method of opposition to others or treatment. Physicians or clinicians today often describe such behavior as resistant. It has been suggested that physical starvation was "a way of drawing attention to the starvation of [the individual's] mental and moral faculties" (Van Deth, & Vandereycken, 2000, p. 399). Interestingly enough, doctors in asylums did not report "pursuit of thinness" or weight phobia in their patients (Van Deth & Vandereycken, 2000). Some say that early writers failed to mention the existence of weight concern in women simply because they overlooked it (Habermas, 1992), since the focus of anorectic patients at the time was more in the context of medicine and religion rather than weight. This information sheds light on how popular views of anorexia today as primarily a weight concern may cause clinicians to overlook what may be a serious dilemma in contributing to desire for food refusal. What is not so different between then and now is the minimization or lack of understanding surrounding the individual sufferers' experiences themselves with anorexia, especially in women of color (Nordbo, Psychol, Espeset, Gulliksen, Skarderud, & Holte, 2006).

In regard to religious rationale for self-starvation, such themes have been thought to arise more frequently in patients with eating disorders (Baxter, 2001). Some women self-starved due to delusions of being bewitched, while others believed that they could

reach the highest stage of eternal salvation by fasting. Others thought that by taking food, relatives, children, or the whole world would starve, and that ingesting food was a sinful act (Van Deth & Vandereycken, 2000; Vandereycken & Van Deth, 1994). Some women believed fasting was a kind act of penance, and heard God's voice directing them to restrict food intake (Van Deth & Vandereycken, 2000). Numerous Italian nuns from the twelfth to the seventeenth centuries starved themselves, sometimes to death, and it was in this century that 'holy anorexia' peaked. The best known of these women was Catherine Benincasa, later coined St. Catherine of Siena (1347-80), who claimed she could not moderate her behavior. She ate when she was ordered to do so, but restricted foods and vomited**.** It was suggested that Catherine's anorexia had domestic causes, which then caused her to take on 'radical holiness' and self-starve as part of her life of asceticism (Bell, 1985). As Bell (1985) points out, bodily urges were for Catherine "base obstructions in her path of holiness" (p. 15).

Writers such as Huline-Dickens (2000) have more recently described the relationships between asceticism, denial and anorexia nervosa, religious practices and ideas, such as that of the Catholic Church, which names gluttony as on the seven deadly sins. Such ideas of "holy" starvation are not included in the DSM-IV-TR (American Psychiatric Association, 2000) and frequently overlooked as reasons for food refusal amongst modern day clinicians who tend to believe that food refusal is entirely due to a desire to achieve thinness. However, some researchers such as Banks (1997) are considering the impact of varying belief systems on rationale for food refusal amongst modern day women. Banks (1997) described two cases of anorexia nervosa in which the patients perceived themselves as moral and religious, which she believed suggested a

persistence of association between religious belief systems and self-starvation. This information is consistent with earlier evidence when Bank (1992) noted a patient who "believed the soul or spirit to be heavy when the body is fat and overweight" (p. 874), and Morgan, Marsden, and Lacey (2000) who described four patients whose eating disorders were complicated by their religious faith.

While historical perspectives are interesting, they are also important in increasing our understandings of possible rationales for food refusal in modern day women of various races, cultures, and ethnicities who may present with atypical rationales for food refusal. Such perspectives are relevant to the nature of this research topic since religious and cultural rationales can be critical components of the ways individuals conceptualize the world around them and their personal experiences. This assertion is evidenced by experiences of some anorexic Orthodox Jewish women in my clinical practice, who have often cited religious reasons for refusal of food intake.

Self-Starvation: A Review of Relevant Research and Theories

Systemic empirical studies on how anorexic patients themselves perceive their behavior as meaningful are relatively scarce, particularly in regards to rationales for self-starvation. For years, researchers and clinicians have discussed ways to understand anorectic behavior, but personal values and patient meanings have frequently been overlooked in favor of professional theories. However, some therapy models and qualitative research studies have sought to understand the patient's perspectives. Social constructivist approaches, such as narrative therapy, have been used to help eating disordered family systems locate the problem in larger cultural contexts (Nylund, 2002). Based on constructivist ideas, problems people experience are stories they have agreed to

act out (Hoffman, 1990). The narrative model looks to deconstruct problem-saturated stories and enable clients to re-author more helpful narratives of experience. Specifically, narrative therapists are interested in helping people rewrite descriptions of their own lives to help them develop successful life stories as problem solvers. (Piercy, Sprenkle, & Wetchler, 1996, pp. 133-134). An example of this is offering opportunities for women to share knowledge and challenge social contexts that support troubled eating. David Epston and Steven Madigan founded Anti-Anorexia/Ant-Bulimia leagues to promote the sharing of experiences among women and challenge dominant cultural ideas about women (Epston, Morris, Maisel, 1995; Freedman & Combs, 1996). Serpell, Treasure, Teasdale, and Sullivan (1999) who asked patients to write a letter to anorexia as a friend and anorexia as an enemy and found that important benefits of anorexia to the study subjects included feeling protected, and gaining a sense of confidence. Drawbacks included constant thoughts of food, suffocation of emotions, and loss of social life. However, the methodology of their study has been criticized for its directness of inquiry. It has also been suggested that a more interactive method of inquiry may have provided more data and strengthened the validity of the study (Nordbo, Psychol, Espeset, Gulliksen, Skarderud, & Holte, 2006). In another qualitative study of 18 women aged 20-34 years old investigating the meaning of self-starvation among them, informants described anorexia as being far more than a medical disorder. They attributed varying psychological meanings to their anorectic behavior of self-starvation. The authors asserted that the findings were "clinically meaningful constructs" (Nordbo et al., 2006, p. 558) that included themes of using anorexia as a way of obtaining a sense of stability and security that provided routines and structure for everyday life; avoiding negative

emotions and difficult experiences by concentrating on body, weight, and food difficulties; using anorexia to get inner strength, drive, and power through weight loss and self-control; feeling better about oneself and worthy of compliments that is based on external affirmation; creating a different identity or personality, ridding oneself of their old identity to become a better and more likable person; a way of eliciting care and concern from other people; using anorexia as a means of communicating difficulties to other people, such as problems they did not know how to express to their friends or family; and starving oneself to death, and concrete wishes to disappear and not live anymore. The informants considered death by starvation as "a less brutal way of dying" because "the people around wouldn't notice" (Nordbo et al., p. 561). While the strength of the study was the interactive exploration of participants' experiences with anorexia, there were limitations. The sample was restricted to young ethnically Norwegian women.

There appear to be numerous explanations for the drive for self-starvation, but few studies have sought to understand the experiences of intentional food restriction from participants themselves. Theories abound as to the cause and maintenance of self-starvation symptoms and include a plethora of possible explanations from psychological, cultural, and familial perspectives. Many of the explanations for restrictive eating behaviors have become mainstream ideas in our society penetrating the fabric of our thinking. However, sufferers appear to be educated about the disease based on their own experiences, societal narratives, and what they have learned from professionals throughout the course of their illness. Therefore, it is imperative to understand the relevance of multiple perspectives of eating disorder restriction. It is essential to consider the impact that both present and historical views of self-starvation may have on suffering

individuals who come from a variety of socioeconomic, religious, educational, cultural, and ethnic backgrounds.

Psychological Explanations of Anorexia and Self-Starvation

Psychoanalysts have mostly stressed the symbolic meanings of self-starvation in unconscious fantasy (Farrell, 2000) with a particular focus on "unconscious conflicts about sexuality and wishes for oral impregnation (in the context of then prevailing cultural mores about sexuality), as well as adolescent rebellion and regression to the oral stage of development" (Miller & Pumariega, 2001, p. 95). In particular, anorexia has been construed as "defensive regression from adolescent sexuality, or from mature femininity" (Malson, 1998, p. 86). For example, Banks (1992) reported extreme emaciation in a patient who "kept boys at a far and 'safe' distance and allowed her to remain virginal" (p. 875). Additionally, Crisp describes anorexia as "a retreat into childhood from both the physical and social/psychological consequences of adolesence" (as cited in MacSween, 1993, p. 25). However, Crisp concurs that food is avoided, hated, and feared because of its association with an anorexic's desire to regress into childhood (MacSween, 1993). Therefore, individuals may find self-starvation purposeful in helping them to achieve a child-like appearance.

In regard to the relationship between food refusal and sexuality, classical Freudian ideas of anorexia aetiology recognize the "displacement of genital wishes to the mouth and the unconscious existence of the mouth-vagina equation" (Farrell, 2000, p. 23), or in other words

> The transformation of a conflict on the genital level to a conflict on an oral basis part of the ego's effort to gain mastery over a genital conflict by a change of

> venue, so to speak, by shifting the struggle to a safer, more familiar and more controllable ground. (Ritvo, 1984, p. 454)

These explanations are relevant to the study participants' desires for food refusal, and have been witnessed in my own practice, evidenced by women who claimed that they wanted to be small and asexual both in their appearance and physiologically through acquiring pre-pubescent characteristics, such as amenorrhoea, as a result of food refusal.

Post-Freudian ideas about self-starvation included the nature of oral fantasy. Waller, Kaufman, and Deutsch (1940) elaborated on this and asserted "anorexics have psychological factors that have a specific constellation centering around the symbolization of pregnancy fantasies involving the gastrointestinal tract" (Farrell, 2000, p. 23). Furthering these theories of self-starvation is the focus on the mother-child relationship itself where the locus of problems is thought to center around issues of control, power, immobility, and differentiation between self and mother (Farrell, 2000). According to Farrell (2000), "for many anorexics food still concretely equals mother. Food is the substitute for a longing for fusion, a longing for mother" (p. 30). Object relations theory later focused on the role of early parent infant interactions on personality development and eating disorders (Miller & Pumariega, 2001). Finally, Mara Selvini Palazzoli, an Italian psychiatrist who later moved onto family therapy, gave an early analysis of anorexia that focused on "the bodily experience of the anorexic woman" (MacSween, 1993, p. 25). Before converting to family therapy, she analyzed anorexia as a disturbance of body cognition. Palazzoli argued that the anorexic individual experienced the body as a phobic object that is alien, persecuting, and representative of feminine receptiveness. For Palazzoli, the root cause of anorexia, or the bad object, is the

mother, for several reasons but mainly because the mother failed to teach her daughter that she is separate and autonomous. Therefore, "starvation was for [the anorexic] a way of attempting to avoid, deny and control the bad mother" (Farrell, 2000, p. 32). Both Bruch and Palazzoli locate the origins of the anorexic's 'ego-deficits' in disturbances in the earliest mother-daughter relationships (Bruch, 1973). Malson (1998) asserts:

> The refusal of the mother to confirm the child's perceptions of her own needs results in the child doubting the legitimacy of her self-perceptions. She becomes confused about appetite and satiety, focusing on what others want rather than what she wants, so that her desires become indistinguishable from those of others. And her resulting lack of sense of self, her diffuse ego-boundaries', is later compounded by the imposition on the child of a role of submissive, high-achieving, perfect child. (p. 87)

In regards to father-daughter issues, Lawrence (1984) argued that "very few anorexics were attached to their fathers, while the majority were interested in him, defined by feelings of fear, adoration, loathing and wanting to please. Overwhelmingly, the father-daughter relationship involved issues that related to the daughter's sexual role as an adult" (Hepworth, 1999, p. 63).

It has also been asserted that the anorexic may have ideas of female penile desires, identifies with the father, and wishes to "compete phallically with him for the possession and sexual control of the mother" (Farrell, 2000, p. 24). It is also suggested that thin bodies created by starving anorexics become "identified with a penis" (Farrell, 2000).

Enriching theories of food refusal is the common assertion that food control is a way of imposing "in one area the personal control that the anorexic girl feels she lacks in her life as a whole" (MacSween, 1993, p. 25). Bruch (1974) discussed denial of food intake and hunger as a secondary struggle for identity and selfhood for which thinness becomes a supreme achievement. She argues that disturbed psychological functioning is at the heart of anorexic behavior. This is coupled with delusional body image and difficulty identifying hunger because of ego-deficiencies due to dysfunctional family patterns. Thus, anorexia, from this perspective, is a disorder of self for which the anorexic attempts to struggle for selfhood by achieving mastery over her body and refusal of food intake (Bruch, 1974). Along similar lines of thought, Moulding (2003) suggests that:

> Self-mastery is presented as the key feature of identity for the anorexic young woman, gained through mastery of 'starving' practices and 'control of one's eating' that are valued in the peer group. 'Control' is portrayed as synonymous with agency for the individual because it signifies 'owning one's own starving behaviour' and being 'able to make one do what one wants', thereby projecting a sense of 'self-possession' to the outside world. (p. 60)

Thus, as Malson (1998) describes, the eating disorder becomes an identity to deal with a lack of identity. Hepworth (1999) identifies such themes of self-control and agency in UK health workers' explanations of identity in anorexia nervosa.

It has also been emphasized that anorexics lack a clear or enduring sense of self which reinforces acts of food control as a method of self-assertion. This form of control over food is reliable, and does not involve other people (Slade, 1984). Slade hypothesizes that the psychological consequences of starvation morph from a deliberate act, to an act

or trap that escapes the individual's control (Slade, 1984). He proposes a medical understanding that starvation changes the way people think, which then results in a decline of the individual's intellectual capacity and reasoning. In turn, the individual is thought to see the world in simple sets of categories such as good and bad, black and white, and such thinking exacerbates the individual's preoccupation with food control. Slade argues:

> By severely reducing the amount of food she eats, the anorexic simplifies her thinking. As her style of thinking changes, her decision not to eat is reinforced. As a consequence of this she grows even thinner and the cycle continues. The more emaciated she becomes the easier it is for her to make the decision not to eat. So she spirals downward. (as cited in Macsween, 1993, p. 36)

Psychological frameworks to explain the drive for self-starvation provide relevant information that will be central to the data analysis of this study. However, it is important to note that while these theories are being incorporated into the review, it is not out of an acceptance of the theories themselves, but due to the likelihood that such meanings of anorexia are prevalent in society at large and within the mindset of participants who may present for this study.

Self-Starvation: Systemic and Familial Perspectives

Treatment for eating disorders has been strengthened by family therapists including the work of Minuchin (1978), Selvini-Palazzoli (1978), Maudsley (Dare et al., 1995; Rhodes, Gosbee, Madden, & Brown, 2005), who focused on understanding the familial and relational contexts surrounding eating disorder symptoms, as well as utilizing curious and respectful avenues to learn about and to work within the individual's

presenting culture and worldview. Unlike intrapsychic perspectives, family systems theorists emphasize circularity of relationships, and assert that specific events do not directly cause the eating disorder to occur. Instead, problems are viewed as created and reinforced by cycles of actions and reactions between people who are interconnected parts of the larger whole (Becvar & Becvar, 1996). In other words, the pathology of eating disorder symptoms, such as self-starvation, does not reside in the mind of the individual, but in the interactions between members of the relational system. For example, some researchers have asserted the following interpretations—that the chronic nature of the eating disorder itself can have an impact on the family. This can impact the family structure and caus[e] bias in the person's perception of her parents. Furthermore, the absence of parental care may impact the chronicity of the eating disorder condition (Bulik, Sullivan, Fear, & Pickering, 2000). Thus, systemic frameworks suggest that the family member suffering with an eating disorder may not be the only family member suffering (Costin, 1999; Levitt, 2001), and that the sufferer may be coping with current issues related to her environment.

It is important to note family behavior and symptoms of anorexia nervosa (Schmidt, Humfress, & Treasure, 1997). Several studies have found that anorexics showed more family problems. This information is reflected in recent findings investigating patient's perspectives of causes of anorexia nervosa, for which 'dysfunctional family' environments were a commonly cited factor. For example, increased conflict and disorganization (Schmidt, Humfress, & Treasure, 1997), high paternal over-protectiveness (Calam, Waller, Slade, & Newton, 1990), and increased conflict (Shisslak, McKeon, & Crago, 1990), have all been cited as family pathologies of

eating disordered individuals. These eating disordered families have been shown to display lower adaptability and cohesion (Waller, Slade, & Calam, 1990), lower maternal and paternal care (Palmer, Oppenheimer, & Marshall, 1988), as well as less cohesion, expressiveness, emotional support (Shisslak et al., 1990), and orientation towards recreational activities (Schmidt, Humfress, & Treasure, 1997). These family dynamics may be relevant for rationales for food refusal amongst anorexic participants in the study.

Family therapists in Western societies have identified several components of the family context that may contribute to the development of anorexia, including patterns of family interaction (Minuchin et al., 1978), family beliefs (Stierlin & Weber, 1989; White, 1983), family culture (Selvini Palazzoli, 1974) and family sexual abuse or incest (Luepnitz, 1988). Selvini Palazzoli and the Milan team focused particularly on tending to circular processes between the families' contribution to the disorder, and the behavior of the individual that perpetuates that role (Boscolo, Cecchin, Hoffman, & Penn, 1987; Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980). The Maudsley model placed emphasis on how individual, family, and sociocultural influences interact to maintain the disorder (Dare & Eisler, 1997). Specifically, Minuchin and colleagues (1978) hypothesized about a specific family context and structural characteristics in families within which eating disorders such as anorexia develop, such as enmeshment, overprotection, conflict-avoidance, rigidity, and involvement of the child in parental conflict. In *Psychosomatic Families* (1978) Baker, Rossman, and Minuchin observed that anorexic families all possessed similar characteristics, which consisted of interactional patterns that prohibited members, particularly the anorexic, from developing a stable sense of individuality or autonomy. For example, some researchers have suggested that

eating disordered individuals may experience parental pressure that is inappropriate for their age, gender, or abilities (Horesh et al., 1996). Other researchers have suggested that eating disordered individuals may also be more likely to receive low parental contact, and criticism from their families about weight, shape, and eating behaviors (Fairburn, Welch, Doll, Davies, & O'Connor, 1997). Furthermore, belief systems within anorexic families are thought to be rigid with high regard for loyalty to the family and specific role prescriptions for the anorectic family member (Palazzoli, 1978; White 1983). For example, families with an anorexic child may place emphasis on achievement, success, appearance and weight (Bruch, 1973; Hall & Brown, 1983). In regard to the egosyntonic nature of the state of emaciation, Russell (1995) acknowledges a variety of contributing psychosocial factors and asserts, "the patient avoids food and induces weight loss by virtue of a range of psychosocial conflicts whose resolution she perceives to be within her reach through the achievement of thinness and/or the avoidance of fatness" (p. 10). Banks (1992) says that extreme emaciation in one such patient was "a means of attracting attention from her peers and family" (p. 875).

Selvini-Palazzoli and Viaro (1988) and Selvini-Palazzoli, Cirillo, Selvini, and Sorrentino (1989) proposed a six-stage model for anorectic family process that emphasized the enmeshed quality of the eating disordered family as the primary clinical issue. The stages include a covert game in which members of the family disguise their feelings, goals, and intentions where first the parents reach an impasse demanding that the other change. Second, the future anorectic becomes involved in the relationship and may be totally devoted to her mother and confidant. Third, the daughter turns to her father after her mother turns attention away from her and usually onto another sibling.

The future anorectic and father share contempt for the mother. Fourth, the daughter differentiates by changing her food intake. The mother's attempts to control the daughter's food intake reinforce the problem. Fifth, the daughter becomes disappointed by the father's choice to not openly side with her against his wife. Finally, the daughter realizes that anorexia gives her power, and other family members become aware of ways they can influence one another vis-à-vis the daughter's illness.

Family disturbances in roles, communication, regulation of emotion and inappropriate boundaries are also thought to hinder developmental tasks of the anorexic that may include separating from the family and creating an individual identity (Humphry & Ricciardelli, 2004). Two family patterns have been identified in families of anorexia classified as 'centripetal' or 'centrifugal' processes. Centripetal processes were dominated by themes of excessive cohesion, reduced emotionally expressiveness, and lack of permissiveness. Centrifugal families were characterized by lacking cohesion and attachment with high conflict before the onset of the anorectic symptoms (Schmidt, Humfress, & Treasure, 1997). Several issues can also increase the likelihood of eating disorder development such as coercive parental control (Haworth-Hoeppner, 2000), including a view of their fathers, but not their mothers, as overprotective (Calam, Waller, Slade, & Newton, 1990; Pole, Waller, Stewart, & Parkin-Feigenbaum, 1988); separation-individuation between mothers and daughters (Zerbe, 1995); and a distant father-daughter relationship (Zerbe, 1995). For example, a study by Hodges, Cochrane, and Brewerton (1998) revealed that anorexic subjects in the study perceived their family environment as being less cohesive and supportive than normal population subjects. Furukawa (1994) confirmed the family factor of excessive parental control for Japanese students in cultural

exchange programs. Finally, Robinson and Anderson (1985) recognized family loss of a primary parent as a potential factor in a review of clinically documented cases of anorexia in African Americans.

Undoubtedly, it is impossible to grasp a comprehensive picture of the eating disordered individual without considering the relational context of that individual and precipitating factors contributing to the development of symptomatology of food refusal**.** Minuchin, whose views are widely quoted, stated that certain transactional patterns seem to be characteristic of all anorexic families, including over-protectiveness, conflict avoidance, rigidity and enmeshment (Minuchin, Rosman, & Baker, 1978). Stierlin and Weber (1989) reported the clinical impression that mothers would "on the one hand, anxiously hover over the anorexic daughter, enlist her as a source of concerns…and, on the other hand, treat her as an adult (i.e., parentified) confidante and ally in coalition directed against father" (p. 28). Additionally, eating disordered families were found to demonstrate less openness to discussing disagreements between parents and children than control families. Waller, Calam, and Slade (1989) asserted that anorectic women perceived their families as more rigid than the controls.

A considerable amount of research has also focused on family-of-origin history prior to the onset of eating disorders, leading to a variety of theories (Treasure, Schmidt, & van Furth, 2003). Interestingly, issues pertaining to boundaries, sexuality, perfectionism, or impulse control can extend back several generations (Costin, 1999; Pelch, 1999). As an example, Bowen (1992) discussed anorexia in the context of "family projection process" (p. 13), viewing anorexia as "a projection of fear of weight originating in the anorexic's same-sex parent" (Young, 1998, p. 64). Research studies

also indicate a higher incidence of eating disorders in families of sufferers (Strober & Humphrey, 1987).

Feminist Critiques and Theories of Self-Starvation

Systemic perspectives focus on the individual's relationship to dominant societal discourses (Gushue, Greenan, & Brazaitis, 2005), such as culture and gender issues; the individual's relationship to the family context. Social constructivist approaches, such as narrative therapy, have been used to help eating disordered family systems locate the problem in larger cultural contexts (Nylund, 2002). Based on constructivist ideas, problems people experience are stories they have agreed to act out (Hoffman, 1990). Since the experiences of the individual occur in relationship to variety of factors, a contextual understanding of the main symptom of anorexia—self-starvation—in relation to the family and society is particularly important in order to "shed light on the psychological struggles of modern women in a modern society in transition" (Ma, Chow, Lee, & Lai, 2002, p. 58), and to "point the way to new options and possibilities for treatment and prevention" (Ma et al., 2002, p. 58).

During the late 1970s and early 1980s feminist writers drew attention to the social, familial, and political aspects of women's lives that contrasted with medical and psychiatric explanations of anorexia nervosa. These writers criticized the pathologizing of women that referred to their behavior as hysterical (Hepworth, 1999). They also focused less on "historical and patriarchal definitions of women" (Hepworth, 1999, p. 54), and concentrated more on the voices of women themselves. Additionally, they proposed several explanations for why women do not allow themselves to act on their natural desire to eat and instead count calories and live in a constant state of hunger and

deprivation. Ultimately, such explorations lead to more diversification and range of alternative theories and ideas about women and food, which surround issues of power and control, sexuality, sexism, cultural ideals, and gender relations.

Fat prejudice: Historical overview of obsession with slimming in the U.S.

Feminists have often blamed fashion for oppressing and subordinating women, but it is also important to note how the trend with fat phobia evolved, since fat phobia is not only a criteria of anorexia, but typically considered to be a necessary requirement of the diagnosis. The culture of slimming came into fashion post-World War II. "Fashion continued to value a slender form, and the health industry, finally convinced by insurance companies, launched massive campaigns to persuade Americans to lose weight" (Seid, 1994, p. 6). "Fat phobia" arose spawning the conviction that "animal fat of any kind—on the body, in the blood, on the plate—was dangerous" (p. 6) and that perceptions of being fat somehow reflected on one's moral character. It is important to note that such fat phobic explanations are commonly witnessed utterances from the lips of those suffering from anorexia and who refuse food.

In subsequent decades the cult of thinness intensified as well as ideas of fat phobia. Weight loss and fitness ethics were seen as "life-prolonging" and a way to minimize body fat. The popularity of "Health food" also played on the same dynamic fueling diet obsessions leading to standards of thinness, such as the 1960s model Twiggy who was 5 feet 7 inches tall and 98 pounds. The health industry then embraced concepts of "ideal weight" decreeing that everyone of the same height and bone structure should meet this ideal. Criticisms of that injunction include that "body weight and ratios of fat to lean tissue were direct functions of eating and exercise habits" (Seid, 1994, p. 6) that

could be controlled through an individual's willpower. "In short, these decrees blamed the victim: if you were fat, it was your fault" (Seid, 1994, p. 6). Feminist critics assert that unreasonable expectations placed upon women perpetuated prejudices against fat. "Sadly, efforts to squeeze into the ideal size are often useless and destructive—not only because they can exacerbate the problem they are designed to cure, but because they trigger psychological, physiological, and behavioral consequences, including binge eating, food obsessions, and, in susceptible individuals, eating disorders" (p. 7).

Gender inequality and eating disorders. Some feminists have argued that eating disorders are a response to oppression or unequal status of women in our society (Orbach, 1978; Wolf, 1991). Specifically, these writers describe how images of unattainable ideals are used against women to perpetuate self-loathing, negative body image, and feelings of inferiority, anxiety, depression, and insecurity (Wolf, 1991). It has been asserted that the ideal body type today is unattainable by most women even if they starve themselves (Fallon, Katzman, & Wooley, 1994), and that "more than half of the adult women in the United States are currently dieting, and over three-fourths of normal-weight American women think they are 'too fat'" (Fallon, Katzman, & Wooley, 1994, p. 396). Feminists argue that these stereotypes mask women's real concerns and minimize meanings of eating disorders such as anorexia, as merely a "self-inflicted problem developed by young women lost in their world of fashion and calorie restricting" (Katzman & Lee, 1997, p. 389). Some argue that such over-reliance on weight preoccupation in anorexia nervosa "misses the universal power of food refusal as an attempt to free oneself from the control of others" (p. 389), particularly in regard to power imbalances (Katzman & Lee, 1997). For example, Katzman and Lee (1997) suggest an alternative view of eating

disorders as a "problem of disconnection, transition, and oppression, rather than dieting, weight, and fat phobia" (p. 392), particularly present in individuals who experience 'societal-identity confusion'. They note "Transition, as women's attempt to move between two worlds, and oppression, as efforts to adapt to a new culture, whether it be a different country, socioeconomic or subcultural group, or a work force historically dominated by men, may result in women attempting to perfect their physical selves as a method of coping with the prejudices and isolation that ensue" (p. 392).

Orbach's (1978) *Fat is a Feminist Issue* has become an influential figure in feminist literature on the topic of eating disorders. Co-founder of the Women's Therapy Centre in London, she published the book *Hunger Strike* in 1986. A feminist psychotherapist, Orbach began forums for sufferers exploring their relationships with food and their social position, and argued that Western societies encourage women to attach unconscious meanings to food, which include guilt and self-denial of nutritional needs. Ultimately, she suggests that eating disorders become expressions of women's oppression in a culture that is patriarchal (Orbach, 1986). Building on such ideas, feminists studying the interplay of pathology and culture have hypothesized about the ways women's roles in society may result in "abhorrent eating and body image distortions" (Katzman & Lee, 1997). Naomi Wolf (1991) further asserts in her bestseller *The Beauty Myth* that "a cultural fixation on female thinness is not an obsession about female beauty but an obsession about female obedience" (p. 187). In order words, imposing thinness on women is another way a patriarchal society can assert power. Wolf says, "if women cannot eat the same food as men, we cannot experience equal status in the community" (Wolf, p. 189). In regard to self-starvation, Susan Bordo (1993) says

that, "female hunger—for public power, for independence, for sexual gratification—[must] be contained, and the public space that women be allowed to take up be circumscribed, limited…On the body of the anorexic woman such rules are grimly and deeply etched" (p. 171). It follows that the rationales of being smaller and taking up less space are commonly asserted explanations amongst anorexic women echoed in my own professional encounters.

Additionally, it is thought that feminine gender role stress places unequal burden on women to maintain feminine appearance that can lead to eating disordered symptoms. Bruch (1978) argues that anorexia is "in part a personal response to the confusion and contradictions of female maturation. Women are expected to have successful careers, to be intelligent, competent and ambitious. Yet they are simultaneously expected to be desirable and alluringly feminine" (Malson, 1998, p. 94). Chernin (1983) argues that the discourse of the female body as slim reflects gender power relations. Swartz (1985) discusses the obstruction of women's natural needs by cultural prescriptions that value passive femininity. Thus, thinness is related to decreased fertility and sexuality in women (Fallon, Katzman, & Wooley, 1994). Connected to these ideas are issues of sexuality, which are thought to plague some eating disordered women. Wolf suggests that anorexic women deny their bodies of a natural body that is sexual. She says, "fat is sexual in women…to ask women to become unnaturally thin is to ask them to relinquish their sexuality" (p. 193). Bordo (1993) acknowledges that, "disindentification with the maternal body, far from symbolizing reduced power, may symbolize freedom from a reproductive destiny and a construction of femininity seen as constraining and suffocating" (p. 209). In regard to issues of feminine sexuality, compulsory

heterosexuality on a woman's experience of appetite and size should be considered in this research. Neither the traditional or feminist conceptualization of starvation considers how symptoms of self-starvation "may be a response to growing up as a lesbian amid heterosexist domination. Compulsory heterosexuality is a largely invisible, but enormously powerful force that dictates what is considered acceptable female sexuality" (Fallon, Katzman, & Wooley, 1994, p. 359).

Overview of meanings of food itself. Themes in advertising of "power and freedom" through weight loss are also relevant to this research, since they have been critiqued for propagating ideas that women must constantly be perfect and change themselves. "In a 1985 commercial for Weight Watchers, three young women danced and sang about the 'taste of freedom'" (Fallon, Katzman, & Wooley, 1994, p. 405), thanks to Weight-Watchers low calorie food plan. Such messages have been critiqued for aiding women establishing a fear of and need to control their bodies in order to achieve perfection. Feminist writers have scrutinized the portrayals of food itself. Such messages are worth noting since discourses and discursive practices, as Michel Foucault suggests are "where actual and possible forms of social organization and their likely social and political consequences are defined and contested…it is also the place where our sense of ourselves, our subjectivity, is constructed" (Weedon, 1987, p. 21). These discourses may impact how women perceive food and its intake. Advertising regarding food and fitness typically include the following themes "temptation and salvation", "altering one's mood", "food as a drug", "fear of fat", and "the good girl" (Fallon et al., 1994). In regard to "temptation and salvation", Kilbourne (1994) asserts that "dieting is the modern self-purification ritual, today's mortification of the flesh" (p. 409), and that many ads for food

play on "a kind of self-indulgence and sensuality that is almost sexual" (p. 409). Some examples include, an ad for frozen yogurt featuring a close-up of a woman's face "in what looks like sexual ecstasy and the copy 'Vanilla so pure it sends chills down your spine and up again'" (p. 409). Another version of the ad says "Your tastebuds cry out yes, yes, oh, yes" (p. 409). In another example, "a Cool Whip ad shows a manicured hand plunging a strawberry into whipped cream and the caption 'Go skinny dippin'" (p. 409). Thus, if these ads are sexual in nature, it makes sense that those wanting to deny their sexuality may be lured into denying themselves of such 'sexual pleasures' in the food itself. A study regarding women's self-reported eating behaviours and their responses to food and non-food television advertisements showed that advertisements featuring food aroused more negative emotions versus non-food advertisements, but only for women suffering from eating problems and disturbed attitudes about body and weight (Dittmar & Blayney, 1996). Additionally, following prolonged exposure to Western media images, ethnic Fijian girls showed changed attitudes about diet, weight loss and aesthetic ideals (Becker, Burwell, Gilman, Herzog, & Hamburg, 2002). Given this information, it may be reasonable to consider that participants' relationship to media exposure may have relevance in this study, and their participation in food refusal behavior.

Self-Starvation: Sociocultural Perspectives

More research is needed to provide understanding regarding the relationship between "Westernization" and eating disorder symptoms (Wildes, Emery, & Simons, 2001). Several studies suggest that exposure to Western weight preoccupations is implicated in the onset of anorexia nervosa (Rieger, Touyz, Swain, & Beaumont, 2001), and emerging realities indicate that Western beauty ideals may be uniquely oppressive

and confusing for women of color (Poran, 2002). Cross-cultural issues may make such women especially vulnerable to the development of eating disorder symptoms (Poran, 2002).

According to the sociocultural theory, eating and body-related disturbances are developed according to the cultural meanings placed on thinness and eating associated with Westernized orientation (Gordon, 2001). Vulnerability to this development may be increased by familial and psychological risk factors (Nasser, Katzman, & Gordon, 2001). The struggle to advance in a new country can place women of color at risk for developing an eating disorder. Katzman and Lee (1997) propose that food denial may be a way to cope with transitional process and oppression they may experience trying to reconcile conflicting worldviews. For example, Kempa and Thomas (2000) postulate that some women may be highly sensitive to societal oppression and develop eating disorders to manage. Thompson (1996) found that in interviews amongst eighteen women of various socio-economic status and race, eating disorders were frequently a response to environmental stress, such as abuse, racism and poverty. This hypothesis regarding the relationship between the impact of cultural context and eating disorder development is consistent with findings reporting increased rates of the impacts of cultural change on eating disorders reported among acculturating immigrant and minority groups (Miller, Veriegge, Miller, & Pumariega, 1999).

Bulik (1987) asserts that the psychological reactions to immigration may contribute to eating disorder symptamatology. These include a number of losses such as people left behind, “loss of self as it was in the culture of origin” (p. 134), and of things of value left behind (Grinberg and Grinberg, 1984). In case studies with anorexic

Hispanics, Silber (1986) also found that the theme of loss was pervasive and that women in the study were "suffering all the subtle, yet painful experiences involved in the loss of country" (p. 126).

Culture Change versus Culture Bound Syndrome. Specifically, it has been suggested that a "clash between traditional and adopted culture may heighten the risk for eating and body image disturbance" (Soh et al., 2006, p. 58) in susceptible individuals (Bhugra, Bhui, & Gupta, 2000; Thomas, James, & Bachmann, 2002; Tsai, Curbow, & Heinberg). DiNicola (1990) noted that change in culture may lead individuals from immigrant families living in Western societies to initiate anorexic behavior, thus describing anorexia as a 'culture-change syndrome' as opposed to a 'Western culture bound syndrome' that suggested individuals from non-Western societies had immunity to eating disorder pathology (Gordon, Perez, & Joiner, 2002; Lai, 2000). Rather, 'culture change', emphasizes the 'difference between two cultures, rather than a particular culture itself' (Soh et al., 2006, p. 58) which may contribute to eating disorder disturbances amongst immigrants.

While sociocultural theories have typically focused on the American emphasis of slimness as a vehicle to success and happiness leading to an increase of eating disorders, it has been argued that immigrants to the U.S. are faced with additional pressures to conform to physical ideals of the dominant standard. This can be especially conflictual for the immigrant women if her culture of origin does not emphasize slimness to the extent of American culture, increasing her sense of alienation and not belonging to the new society. An example of this is research with Asian women that suggested those living in Western countries are a high risk group for the development of eating disorder

pathology (Wildes, Emery, & Simons, 2001), since they may feel "additional pressure to be thin due to their inability to meet other white beauty standards" (Wildes et al., 2001, p. 540) like blonde hair, fair skin, and delicate bone structure (Hall, 1995). Some researchers argue that ethnic identity and acculturation are important to consider since higher levels of identification with the mainstream culture or Western culture are associated with adoption of the predominant ideals for dieting and thinness (Harris & Kuba, 1997; Root, 1990). For example, Abrams, Allen, and Gray (1993), Pumariega (1986), and Silber (1986) showed that women of color with less identification with their culture or higher levels of acculturation had significantly higher levels of eating and body disturbances (e.g., restrained eating, drive for thinness). Stieger (1993) also maintained "that when anorexia nervosa develops in non-Western families, it may often be in those with strong Western affiliations" (p. 350). In one study, researchers examined experiences of 9th through 12th grade adolescents of color, including 132 Hispanics, 221 Asians, and 420 European Americans. They assessed acculturation using two questions about length of time in the U.S. and language most often used, and found that the more acculturated Hispanic girls were more likely to be identified as having subclinical eating disorders (Gowen, Hayward, Killen, Robinson, & Taylor, 1999). In another study, Chamorro and Flores-Ortiz (2000) identified second-generation Mexican American women as a vulnerable group to developing eating problems with a tendency to experience high levels of disturbed eating and acculturation. Additionally, among all generations, they found a positive relationship between acculturation and the interpersonal experience of perceived pressure from others to gain weight.

"Culture change" may also impact the individual on a deeper contextual and relational level. Individuals who migrate to a new country may experience pressure to adapt to a new culture, and grapple with conflicted external and internal messages. Ethnic identity has been an important point in this. Harris and Kuba (1997) attempted to clarify the role of ethnic identity in the individual by explaining eating disturbances as symptoms of experiences with internalized oppression that may occur during the course of one's ethnocultural identity formation. That is, women of color may experience oppression when the values, ideals, and self-image resulting from their culture of origin clash with those of the mainstream and lead to confusion that is internalized. As these women struggle to fit into their environment, they may fluctuate between accepting and rejecting the mainstream values regarding beauty and achievement. Along the development of self-concept and identity, this fluctuation may be expressed through cycling between restricting intake (accepting the mainstream) and overeating or bingeing (rejecting the mainstream). The authors report increasing rates of eating pathology in other ethnic groups and recent immigrants or exchange students as evidence of this type of oppression (Harris & Kuba, 1997). Thus, researchers stress the influence of acculturation to mainstream culture or Western culture on the adoption of the predominant ideals for dieting and thinness (e.g., Harris & Kuba, 1997; Root, 1990). This cultural assimilation argument suggests that, "the incidence of eating disorders increases in women from non-Western cultures when they move to a Western society and assimilate to the host society norms and values, including those relating to the ideal female body shape" (Lake, Staiger, & Glowinski, 2000, p. 84).

Alternate literature on the subject emphasizes that females with a "stronger identity to their country of origin are at higher risk for the development of an eating disorder to the difficulties experienced growing up with two sets of cultural values" (Lake et al., 2000, p. 84). For example, in a study investigating the influence of culturally mediated factors on eating attitudes and perception of body shape amongst Hong Kong women, it was found that effects of cultural conflict elevated scores in Hong Kong born subjects, highlighting "the need for more cross culturally sensitive definitions of eating disorders" (Lake et al., 2000, p. 88).

It has been argued that women confronted with pressures to "conform to conflicting ideals may employ self-starvation as an instrument to achieve autonomy" (Humphry & Ricciardelli, 2004, p. 580). Cross-cultural theorists have also asserted that experiences of marginalization may contribute to eating disorder pathology and self-starvation may be used as a way to achieve "a greater sense of self-determination and perception" (Humphry & Ricciardelli, 2004, p. 580). Katzman and Lee (1997) suggest that food denial or control among immigrant women may offer a means to "negotiate transitions in values, expectations, and the conflicts they feel in absorption into a new society" (Greenberg, Cwikel, & Mirsky, 2007. p. 56). Simpson (2002) further asserts that eating disorders may be associated with different norms such as that of religion, and "culturally acceptable, psychosomatic expressions of distress" (Greenberg et al., 2007. p. 56).

Culture Change and the Family. Cross-cultural theorists have proposed that the experience of belonging to two different social worlds can result in a clash of culture, relating to the increase in eating disorders, and can have a greater impact if women have

a more traditional family background (Humphry & Ricciardelli, 2004; Lake et al., 2000). For instance, high levels of conflict with parents over social choices such as going out, contact with the opposite sex, arranged marriage, and dress norms has been associated with greater eating disorder pathology among Asian females (Humphry & Ricciardelli, 2004; Furnham & Husain, 1999; Shuriquie, 1999). In Kam and Lee's (1998) study describing a case of a 16-year old anorexic female from Hong Kong who denied fear of fatness as an issue, they discussed her goal of not wanting "to 'give in' to her family, especially her mother, who forced her to eat even when she was not in the mood to" (p. 229). Furthermore, internal conflicts, sense of disconnectedness, poor self-perceptions, lack of autonomy and sense of control over one's life have all been posed as a means by which culture clash may lead to eating pathology (Humphry & Ricciardelli, 2004; Shuriquie, 1999). Additionally, a variety of content analyses of family therapy sessions with five Chinese anorexic patients identified several themes of self-starvation in contemporary Hong Kong families that related to self-sacrifice for family well-being, filial piety over individuation, bridging of parental conflict, expression of love or control, and camouflage of family conflicts (Ma, Chow, Lee, & Lai, 2000).

The culture and tradition of the family is thought to be of importance in how women experience the new culture and whether or not they develop eating disorder pathology as a way to cope. For example, Lake et al. (2000) found that Hong Kong born women who identified more with their traditional culture scored higher EAT-26 scores than those who were more acculturated to Western society. Parental overprotection has also been proposed as an important factor in the experience of culture clash. Furhnam and Husain (1999) discovered that high levels of conflict with parents over such issues as

choice of friends were associated with greater eating pathology among Asian females in their study. In Bulik's (1987) case study of eating disorders in immigrants, she learned that "emphasis on exercise, diet, and slenderness, was a means to acceptance in American society" (p. 138), and the women "began to evaluate their self-worth on the basis of their body and the ability to control their appetites" (p. 138). At the same time, these women expressed guilt over wanting to separate from their families, such that "family structures that emerged subsequent to immigration were not unlike the enmeshed and overprotective families described by Minuchin (1970) and Minuchin, Baker, Rosman, Leibman, Milman, and Todd (1975) in which personal autonomy of the child is subjugated to family loyalty" (Bulik, p. 138).

Food itself has also been thought to take on special familial significance to immigrants, and can be a symbol fraught with guilt since "abundance of food can serve as a reminder of the fortune of the immigrant relative to the deprivation faced by those left behind" (Bulik, p. 139). Bulik (1987) asserted that both women in her study, "responded to guilty feelings with extreme deprivation" and "the smallest indulgence led to disproportionate guilt and increasingly strict dieting" (p. 139). Coupled with this were experiences of depression and isolation following immigration and changes in social status, which made the identity associated with abstinence and dieting attractive.

Women of Color: Research with Anorexic Immigrants to U.S

Information regarding aetiology of eating disorders amongst anorexic immigrant women of color to the U.S. is scarce, as is knowledge of prevalence rates. However, researchers are becoming more aware of the multiplicity of socio-cultural concerns, which may impact these populations. We do know that awareness of eating disorders

amongst women of color themselves is increasing as evidenced by articles regarding the globalization of eating disorders in women. In December 2006, the deaths of four Brazilian anorexic women appeared across the front pages of papers nationwide. It has also been noted that self-starvation syndrome "has spread to women of all socioeconomic and ethnic backgrounds as Japan, Hong Kong, China, Taiwan, Singapore, and India (Lee and Lock, 2007). In European countries, rates of eating disorders appear to be increasing (Miller and Pumariega, 2001). Eating disorders have been reported in Italy (Ruggiero, Prandin, & Mantero, 2001), as well as Hungary (Tury & Szabo, 1996). In the Middle East, Neumark-Sztainer, Palti, and Butler (1997) found higher rates of past dieting (74%) and current dieting (47%), amongst 334 Israeli adolescent girls. Blacks in Africa may also be trending towards unhealthy attitudes and behaviors. A study of anorexia in Johannesburg, South Africa, found a prevalence rate of 2.9% (Ballot, Delaney, Erskine, Langridge, Smit, van Niekerk, Winters, & Wright, 1981). Additionally, a recent study of females 18-25 years conducted at the University of Buenos Aires, in Argentina, showed that "13% presented with some type of eating disorder. Another study of 600 adolescent male and female student age 13-18 years in Mar de Plata, Argentina, indicated that 47% of females feared weight gain, 37% were not satisfied with their body image, and 37% were concerned about gaining weight" (Pan American Health Organization, 2002, p. 176).

Table 1.1 Countries reporting eating disorders

Argentina*	Hungry	Singapore*
Australia+	India	South Africa (blacks)*
Belgium	Iran	South Africa (whites)+
Brazil*	Israel+	South Korea*
Canada	Italy	former Soviet Union
Chile	Japan	Sweden+
China*	Mexico*	Switzerland+
Czech Republic	The Netherlands	Turkey*
Denmark+	New Zealand+	United Arab Emirates*
Egypt	Nigeria	United Kingdom+
France	Norway	United States*
Germany	Poland	
Hong Kong*	Portugal*	

+Formal epidemiological studies carried out *First reports since 1990
(Gordon, 2001)

The World Health Organization reports that multiple risk factors in women living in deprived socioeconomic circumstances, such as exposure to intimate partner violence and living with men who have substance abuse issues, can contribute to poor mental health and psychiatric co-morbidity (Patel, 2005, p. 12). Additionally, "eating disorders represent a growing mental health issue in developing countries" (Patel, 2005, p. 12) and may be influenced by sexual and gender issues such as intimate partner violence, that which influence rates of psychiatric issues and eating disorders (Vos et al., 2006). It has been noted that "recent immigrants may be particularly at risk for the development of eating disorders" (Miller & Pumariega, 2001), as evidenced by Kope and Sack (1989) who studied three Southeast Asian refugees who developed anorexia after arriving to the U.S, and 14 European exchange students who developed eating disorders following immigration (Van Den Broucke & Vandereycken, 1986). As previously discussed in this chapter, may be numerous influences for the development of eating disorders in immigrant populations. However, research, thus far, has failed to capture the reasons or

drive for self-starvation amongst immigrant populations to the U.S., and research available on prevalence rates amongst immigrant populations with eating disorders is scarce. Few researchers have explored meanings of self-starvation (Nordbo et al., 2006), and fewer researchers have investigated rationales for food refusal amongst ethnic women (Katzman & Lee, 1997; Lee, Lee, Ngai, Lee, & Wing, 2001; Ma, Chow, Lee, & Lai, 2000).

Since we do not know how ethnic women experience desires for food refusal, qualitative analytic tools can provide "a mechanism by which to examine the deeper meanings of self-starvation…" (Katzman & Lee, 1997, p. 391). This researcher believes that qualitative research measures can and will empower immigrant research participants in this study to describe their experiences with drive to self-starvation through in-depth interviews as they understand it, from their personal expertise, as opposed to forcing understandings imposed by professional authorities. It is hoped that new and relevant information can emerge from the study participants themselves to fill gaps of research amongst such suffering populations to the U.S. Such knowledge can pave pathways to further research explorations of eating disorder issues concerning immigrant women of color.

Qualitative inquiry will aid in this process of expanding the knowledge base of the eating disorder field. This study provides a forum for immigrant women of color to the U. S. to express their experiences of self-starvation so that researchers and clinicians enhance their knowledge of experiences of restrictive eating amongst these populations, invite new research possibilities for areas of future study, and increase the efficacy of clinical practice with these populations. The following chapters will discuss the

methodology and design of this research study; present evidence of the participants' accounts of their experiences of self-starvation, which will include themes noted in the analysis; and finally include a discussion of implications of the research for future inquiry.

Chapter III—Methodology

Overview of Qualitative Methodology

Qualitative inquiry is my chosen research method to inquire and examine collected data for this study regarding the unique perspectives of "self-starvation" in immigrant participants. This method was selected due to several factors. The absence of qualitative methodologies in mainstream eating disorder research is a weakness in developing theory and clinical practice. Similar to how women of color have been marginalized in eating disorder research, qualitative research methods have also been marginalized in favor of subjugated quantitative methodological approaches. Secondly, the need to implement and integrate qualitative research methods in the eating disorder field is necessary to generate more comprehensive descriptive data (Taylor & Bogdan, 1984). As part of evidence-based practice, the American Psychological Association (2002) recommends that researchers in medicine advocate the use of qualitative methodologies that "strive to recognize and incorporate research methods that most effectively complement the worldview and lifestyles of persons who come from a specific cultural and linguistic population" (p. 45). Thus, instead of focusing on empirical events with an eye for causality in relationships that disregard individual or cultural differences and social context (Rubin & Rubin, 1995), qualitative methods can identify rich descriptions of the social world, lived experiences of participants, and a focus on capturing the participants' varying realities (Lincoln & Guba, 1985).

The review of literature in Chapter Two reveals the absence of information regarding the perspectives of "self-starvation" amongst immigrant women of color. The chapter also justifies the need to explore research participants' views so that treatment

professionals can work with marginalized populations according to their realities of restricted food intake and the meanings behind the behavior. It is believed that openness, flexibility, and the aim of qualitative research toward interpretive understandings of subjects' meanings will contribute to the emerging literature, and celebrate diverse perspectives on the meaning of "self-starvation" in the field.

Methods

Grounded theory was used to guide data collection and analysis in this study. It emphasizes systematic generation of theory from data (Charmaz, 2000), and stresses "emergent, constructivist elements" and "flexible, heuristic strategies rather than as formulaic procedures" (Charmaz, 2000, p. 510). In grounded theory, the researcher does not approach the study with a formulated hypothesis in advance since preformed hypotheses are prohibited (Glaser & Strauss, 1967). Marshall and Rossman (1995) state that the foundation of grounded theory is instead "the process of bringing, order, structure, and meaning to the mass of collected data" (p. 111). Thus, the basic tenet of the approach is that a theory must emerge inductively from the data.

Therefore, grounded theory emphasizes "development, refinement, and interrelation of concepts" (Charmaz, 2000, p. 510) through several strategies including—"(a) simultaneous collection and analysis of data, (b) a two-step data coding process, (c) comparative methods, (d) memo writing aimed at the construction of conceptual analyses, (e) sampling to refine the researcher's emerging theoretical ideas, and (f) integration of the theoretical framework" (Charmaz, 2000, p. 510). Grounded theory assumes that researchers can discover an external reality, and Glaser assumes it can

happen through "discovering data, coding it, and using constant comparative methods" (Charmaz, 2000, p. 513). Thus, theory can emerge as the study progresses.

There are different views of grounded theory methodology spawning debate between Glaser and Strauss. Glaser's epistemology places emphasis on "the "emergent" process of theory development" (Rafuls & Moon, 1996, p. 67). However, the clear-cut "how to" guidelines in Strauss's approach are attractive. At the same time, "the expansiveness and creativity that are a part of Glaser's view can lead to ambiguity that may limit [the researcher] procedurally" (p. 67). Therefore, as Rafuls and Moon (1996) suggest for family therapy researchers, I will integrate Glaser and Strauss's approaches "in a way that is congruent with [the] data and [my] own style" (p. 67).

Researcher as Participant: Inclusion of "Self"

As with all qualitative research, the relationship between researcher and respondent is significant and based upon collaboration of data that is marked by "a transitivity, a continuous unfolding, [and] a series of iterations" (Lincoln & Guba, 1985, p. 100). My worldview will be an important factor to note in the emerging process of grounded theory data collection and analysis, since my belief systems and values may contextualize the research process and shape or influence the research design, interview, analysis, and final written text. I recognize that constructivist research is reflexive in nature, and I was aware of biases and beliefs that informed the research. Thus, I considered my own history, preconceived ideas about immigrant women of color with eating disorders, and their experiences and interpretations of self-starvation.

Being a Dominican-Italian American raised by an immigrant mother from Dominican Republic and a first generation Italian-American father, I always wondered

what kinds of meanings immigrant women may attribute to the desire for "self-starvation", and if there may be unique experiences, relational issues, or cultural stressors that may factor into those perceptions. While the stories of the women interviewed are not necessarily my story, I believed there were aspects of their narratives about "self-starvation" that I may have been able to relate to. For example, based on my own personal encounters with Hispanic women, I believed that an immigrant's desire for "self-starvation" may also symbolize or represent specific issues of politics, ethnicity, race, familial, socioeconomic, and other contextual factors perhaps related to acculturation and ethnic identity experiences. Having stated those worldviews, my main objective in the interview process was to ensure high standards of trustworthiness to deliver a quality report. I intended to be open and curious about the participants' experiences and allow the subjects' biographical data unfold and speak for themselves. While I understood that my own tacit knowledge could influence findings (Lincoln & Guba, 1985), as a qualitative researcher I did not presume to be more knowledgeable about the participants' experiences than the participants themselves. Thus, I encountered the interviews with openness, flexibility and without a formulated hypothesis (Denzin & Lincoln, 2000). To ensure I stayed aware of my biases, I included such procedures as keeping a journal, member checking, and peer debriefing.

Selection and Sampling Procedures

Women were recruited for this study via postings in community newspapers, university bulletins, online eating disorder web resources, eating disorder organization newsletters, and referrals from physicians. These advertisements provided a brief explanation of the study, and contact information for obtaining further details about the

study. It is important to note that language used in the advertisements for the study were slightly modified during recruitment in order to attract a diverse sample of ethnic immigrant women. For instance, the word "ethnic" was used in exchange for the term "women of color". Such rationales for differing word choices are further explained in the strengths and limitations section of this research.

Women were able to respond by telephone or e-mail and were screened for specific inclusion criteria including: (a) Participants must be/or have been less than 85 percent of ideal body weight with a desire to restrict food intake; (b) onset of weight loss must have occurred one year prior to or sometime following immigration to U.S.; (c) English-speaking U.S. first-generation immigrants qualified and could include those of Latina, Asian/Pacific Islander, and African American or other ethnicity; and (d) willingness to participate in one or more audio recorded interviews in person or by phone and share their history of anorexia and drive for "self-starvation". It is important to note that recruitment advertisements specifically did not request women with eating disorders to participate in the study, since some ethnic women may not identify with that diagnosis label to describe their symptoms of food restriction.

Women who met the inclusion criteria were invited to partake in the study and provided informed consent. Participants understood their role in the research, the risks involved, their privacy, and confidentiality. Confidentiality was rigorously protected, and anonymity maintained. Pseudonyms were used as proper names when necessary, and the consenting participant's name only appeared on the consent form (Appendix B). All transcripts and audio digital recordings were kept in a secure location to be destroyed at the completion of the dissertation. Subjects received a signed copy of the informed

consent. For telephone interviews, participants were given access to download an informed consent PDF online, or were able to receive it via direct e-mail. Participation in research was then arranged following signed receipt of form.

Subjects understood issues pertaining to compensation and how it would be affected should they decide to withdraw from the study. It was understood that there was no penalty should the participant choose to not participate in assigned tasks, and suggestions for psychological counseling and medical treatment were given if participants became distressed during the study. All participants received referral and reference materials for eating disorders, support options, and treatment.

Anorexic immigrant women 18-years of age and older with onset following immigration to U.S. were be recruited for this study since cultural assimilation arguments suggest that incidence of eating disorders increases in immigrant women from non-western cultures when they assimilate to Western norms and values, including those relating to body shape (Akan & Grilo, 1995). Literature also points to influences such as a clash of familial, societal, and individual forces relating to an increase in eating disorders, especially if women come from a more traditional family background (Humphry & Ricciardelli, 2004; Lake et al., 2000).

Women who met the inclusion criteria were be provided with information about the study and invited to participate with informed consent (Appendix B). In the first phase of the study, an initial interview and assessment was conducted to obtain the participant's demographic information. The participants then partook in an interview for at least an hour or until saturation of the interview topic (Appendix C).

Numerous sources of data were used to increase the "trustworthiness" of the study and develop the grounded theory. These included in-depth interviewing, audio digital recording, field notes, journals, theoretical, and analytical memos (Rafuls & Moon, 1996). Such materials were used to develop the theory, and begin the coding process and constant comparative methods. Such procedures are intended to "make the researchers' emerging theories denser, more complex, and more precise" (Charmaz, 2000, p. 515). Theoretical sampling was then used to select participants from the remaining women who responded to the advertisements, and involved using questions generated during the analysis to select sampling for further comparisons (Rafuls & Moon, 1996). This method of sampling also helped if, for example, as we refined our categories we recognized that our theory was limited due to "conceptual gaps and holes" (Charmaz, 2000, p. 519). We then chose to sample specific issues only or look for "precise information to shed light on the emerging theory" (p. 519) The aim of this sampling is to, "refine ideas, not to increase the size of the original sample," (Charmaz, 2000, p. 519), and help to "identify conceptual boundaries and pinpoint the fit and relevance of [the] categories" (p. 519). In other words, complete the work of "comparing data with data and [develop] a provisional set of relevant categories for explaining [the] data" (p. 519).

Participant Characteristics

The immigrant women who participated in this study were anorexic and originated from various parts of the world. There were numerous inquiries for participation for the study from a variety of ethnicities, but only a few of the women followed through with completing consent forms and interviews. Since the research was open to immigrant ethnic women, and not women of one particular ethnicity, recruitment

included all women who fulfilled the criteria of being an ethnic woman who immigrated to the U.S; 18 years of age or older; and must have had onset of anorexia sometime after immigration or one year prior to immigration. It was noted early on that many of the inquiries for participation came from women originating from Russia, U.K, Philippines, Puerto Rico, Pakistan, South America, China, Iran, and India, Mexico, Africa, Dominican Republic, and Puerto Rico.

The characteristics of 10 participants who completed the study included ethnic women mostly in 20's and 30's. Many of the participants completed college and were working in various fields including modeling/acting, fitness industry, college students, nursing, administrative, web design, and telemarketing. One subject was working from home due to her illness, and another was a stay-at-home mom. Most of the women in the research were single and had not been married. Only three participants were married and two had at least one child.

Of the women who participated in the research, two were from Russia, and two were from Columbia. There was one subject each representing China, Iran, India, Puerto Rico, Guyana, and the U.K. The participants resided in several areas of the U.S. including New York, Pennsylvania, Florida, Illinois and Ohio. Most of the women in the study had already resided in the U.S for a minimum of 4 years and up to 32 years. On average participants resided in the U.S. for 13.40 years, and their food restriction began 3.66 years following immigration. For some participants, food restriction began immediately following their move, and for others, food restriction began several years later. The average height of women participating in the study was 5'3 1/4" and the average lowest weight was 91.7 pounds, which is less than 80% of ideal body weight.

It is important to note that individual profiles are not included in the research to further protect the identity of the subjects involved. Additionally, each participant in the study selected a pseudonym. These pseudonyms are used to differentiate between participants, and are represented in the data and research analysis sections of this dissertation. The names include—Amy, Claire, Cindy, Eugenia, Kate, Madeline, Nancy, Sonia, Sophie, and Vicki.

Data Collection and Interview Process

As mentioned, data collection for this study involved the perspectives and voices of the subjects who were being studied, keeping in mind that such data was to be interpreted conceptually by the researcher who is informed by and follows the methodology. Rafuls and Moon observe that "in grounded theory, the researcher becomes the primary instrument of data collection and analysis, and it is the researcher's theoretical sensitivity that allows him or her to develop theory that is grounded in the data" (p. 68).

I began all interviews introducing myself, explaining the purpose of the study, and reviewing the informed consent for participation. Participants then choose the interview location, and interviews were scheduled to last at least one hour or until they have achieved saturation. I planned semi-structured interview sessions guided by in-depth interviewing qualitative research methods to understand "the experience of other people and the meaning they make of that experience" (Seidman, 1998, p. 3). Specifically, my interview guide organized around understanding the meaning of "self-starvation" for immigrants included in the study. Broad, open-ended questions guided the interview. The main questions followed: (a) What associations do make when you hear the word "thin";

(b) What does "self-starvation" mean to you?; (c) How did you come to value "self-starvation" as a part of your life; and (d) What factors do you feel play a role in your desire for/or to maintain "self-starvation". As data gathering progresses, subsequent interviews may become more focused, using more structured questions. Theoretical questions such as, "What did you do when that happened?" or "How is that related to what you said before?" will be used throughout to help move the analysis beyond mere descriptions to conceptualizations (Strauss & Corbin, 1998).

My hope was to learn from the respondents and their experiences. Marshall and Rossman (1995) describe the fundamentals of this approach asserting that, "the participant's perspective on the phenomenon of interest should unfold as the participant views it, not as the researcher views it" (p. 80). Thus, I intended to "ask questions that will elucidate and illuminate that particular subject" (Patton, 1990, p. 283), while using an interview guide to build conversation on the particular subject area, incorporating open-ended, discovery-oriented questions, without directing the subjects toward predetermined conclusions about the phenomenon (Morse & Field, 1995). I believe my systemic family therapy training skills helped me to conduct the interviews in a respectful and curious manner to elicit detailed information from the participants regarding the subject.

Since a fundamental property of grounded theory data collection is the notion that all data is important that helps the researcher generate concepts and emerging theory (Denzin, 2000), any field notes, interviews, or conversations were considered for the study's emerging theory. Extensive amounts of rich data with "thick description"

(Charmaz, 1995; Geertz, 1973) were collected to achieve theoretical saturation of categories. Glaser and Strauss (1967) describe saturation as a time when:

> …no additional data are being found whereby the (researcher) can develop properties of the category. As he sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated…when one category is saturated, nothing remains but to go on to new groups of data on other categories, and attempt to saturate these categories also. (p. 65)

Interviews were reviewed thoroughly and transcribed verbatim, so that I could maintain a sense of closeness with the data throughout the research study. Establishing an intimate connection with the data allowed me to continuously make "systematic comparisons" (Charmaz, 2000, p. 512) throughout the process. According to Glaser (1992) "categories emerge upon comparison and properties emerge upon more comparison…" (p. 43).

Data collection and data analysis are connected processes in grounded theory methods and "go hand in hard to promote the emergence of substantive theory grounded in empirical data" (Marshall & Rossman, 1995, p. 112). Lincoln and Guba (1985) state that, "the investigator must engage in continuous data analysis, so that every new act of investigation takes into account everything that has been learned so far" (p. 209). Thus, the process of constant comparison is an important feature to grounded theory (Glaser & Strauss, 1967) and I utilized "a constant process of categorization, sorting and resorting, and coding and recoding of the data for emergent categories of meaning" (Rafuls & Moon, 1996. p. 70). These methods enabled me to shape and refine developed categories that emerge from the data with a set of specific procedures. In other words, I incorporated

such processes such as coding and memoing, while the comparative process is "constant" throughout my data collection and analysis, until "categories, concepts, and theoretical level of an analysis emerge[d] from [my] interactions within the field and questions about the data" (Charmaz, 2000, p. 522). Furthermore, theoretical memos generated during such procedures as open coding were reviewed for developing hypothesis and questions that were addressed in subsequent interviews. Theoretical sampling was beneficial as Charmaz (2000) suggests to, "fill conceptual gaps and holes" (p. 519), and "look for precise information to shed light on emerging theory" (p. 519) so that, "relevant data and analytic directions emerge without being forced" (p. 519).

Data Analysis and Procedures

Analysis began with the open coding process, which initiated the theory development process for the study. In order to synthesize and reduce the massive amount of information I expected to compile, I used a variation of Strauss and Corbin's (1990) paradigm for coding and analyzing data.

I first conceptualized my field notes and transcripts line by line through "open coding". This will involve a line-by-line examination of the data to identify words and phrases that may reflect important ideas, actions and events. In other words, I fractured the data into bits to be examined, compared, conceptualized, and categorized (Strauss & Corbin, 1990). To accomplish this, I noted recurring concepts and phenomena in the transcripts, cut up the transcripts, and organized the phenomena into categories that reoccur or are unique. Taking an analytical position was important in this task, and I asked such questions as, "what is this about?" and paid close attention to the properties of these categories such as nouns, adverbs, and adjectives. I maintained an inventory of

codes and descriptions, and wrote memos or code notes that discuss the codes. “In vivo” codes are those codes taken from language in the text. Such codes were represented in quotation marks. Constant comparative methods were employed throughout the coding process.

The next step was to relate main categories of phenomena to each other, in other words, identify concepts that hold bits of information together. Strauss and Corbin refer to this as “axial coding”. This process focused on identifying and proposing relationships between the categories and subcategories, and “clustering the open codes around specific “axes” or points of intersection” (Harry, Sturges, & Klingner, 2005, p. 5). Such conditions giving rise to categories included noting “context, the social interactions through which it is handled, and its consequences” (Charmaz, 2000). Through the process of “axial coding”, I continued to abstract meaning from the data through my own interpretive lens as evidenced by Table 1.

Finally, the “selective coding” process began following identification of a core variable. Strauss and Corbin (1994) conceptualize the core category through the metaphor, “the sun, standing in orderly systemic relationships to its planets” (p. 124). The first step in selective coding was to integrate information developed in each of the categories by writing theoretical memos to describe the data and conceptual connections between categories. Writing theoretical memos was central in the process of generating theory, and will be ongoing throughout the research process. The memos aimed to explain, “properties, dimensions, and associated paradigmatic relationships” (Rafuls & Moon, 1996, p. 73), and helped me to sort through ideas during the coding process, and locate emerging theory or a central category that logically and consistently relates to all

the categories. Once theoretical saturation of categories was achieved, I reviewed, sorted, and integrated the memos related to the core category and its related categories. The sorted memos helped me to generate a conceptual framework to articulate a theory that is "grounded" in the data. Finally, concepts were mixed with description in words, tables, or figures to enhance readability of the theory in the final scholarly text.

Verification Procedures

Scholarly qualitative research methodology is represented by trustworthiness and authenticity of the study (Lincoln & Guba, 2000). Qualitative methods do not limit the researcher to deductive standards unlike positivist quantitative methods that contend that truths are "driven by natural laws and arrived at only by controlled experimentation" (Rafuls & Moon, 1996, p. 66). Thus, while positivist methods emphasize measurement and generalizations, the inductive logic of qualitative inquiry proposes that generalizations are "not found in nature; they are active creations of the mind" (Lincoln & Guba, 1985, p. 113). Therefore, the premise that "there are no absolutes; [and] all "truth" is relative"… (Lincoln & Guba, p. 114) suggests that "there exists multiple possible generalizations to account for" (p. 114). Thus, the goal of qualitative inquiry is not abstract or empirical generalization (Denzin & Lincoln, 2000). Rather, it is "concerned with providing analyses that meet the criteria of unique adequacy" (Psathas, 1995, p. 50) and "must be studied to provide an analysis uniquely adequate for that particular phenomenon" (p.51), so that readers of qualitative research will be able to "generalize subjectively from the case in question to their own personal experience" (Denzin & Lincoln, 2000, p. 370).

Essentially, grounded theory has been described as “an inductive strategy for generating and confirming theory that emerges from close involvement and direct contact with the empirical world” (Patton, 1990, p. 153). Therefore, there are numerous steps I took to ensure quality, rigor, and effectiveness of this methodology. The theory was “generated initially from the data”, and then “elaborated and modified as incoming data [were] meticulously played against them” (Strauss & Corbin, 1998, p. 159). Verification of resulting hypothesis was built into the course of the research. The aim was to develop a theory of great “conceptual density” (Strauss & Corbin, 1998, p. 161), which “refers to the richness of the concept development and relationships—which rest on great familiarity with associated date and are checked out systematically with these data” (Strauss & Corbin, 1998, p. 161). Therefore, multiple perspectives were sought during the research inquiry, and coding procedures were also included. This involved the “important procedures of constant comparison, theoretical questioning, theoretical sampling, concept development, and their relationships—to help protect the researcher from accepting any of those voices on their own terms…” (Strauss & Corbin, 1998, p. 173). These procedures also forced the researcher to question her own voice to be “questioning, questioned, and provisional” (p. 173). The subjectivity of my voice as a researcher is acknowledged such that “[my] values not only implicitly affect selected aspects of the inquiry process but may in fact be the central driving force in the work” (p. 175). This may include the choices I made in selecting the problem for study, methods of data collection and analysis implemented, as well as interpretations that were made from the findings (Lincoln & Guba, 1985). For instance, it was important to acknowledge that this qualitative research “can be influenced by an overidentification of the inquirer with

the cultural values that characterize a group or situation being studied, an error often referred to by anthropologists as 'going native'" (Lincoln & Guba, 1985, p. 177), and that "either under-identification or over-identification with contextual values leads to errors" (p. 177). To remedy this dilemma Patton (1990) recommends that the researcher "keep his or her assumptions explicit at all times" (p. 392). Therefore, I "examine[d] [my] values as well as the values of the context or situation" (p. 177) by journaling, peer debriefing, and member checking throughout the study.

Theoretical sensitivity also allowed for effective theoretical coding. "The procedures of theoretical sampling and constant comparison are allied with theoretical sensitivity" (p. 173). Therefore, attentiveness to issues of class, gender, race, and power is essential. Additionally, to ensure internal reliability of the study, the researcher utilized peer debriefing and provided readers with the researcher's personal and professional information, which "could have affected data collection, analysis, and interpretation" (Rafuls & Moon, 1996, p. 78). Internal validity was assured through use of multiple data sources or triangulation, and an explanation of the researcher's biases and assumptions. Finally, it was "important to let one's audience know about the researcher as a way of ensuring trustworthiness of findings and methods" (p. 78). Some of the techniques to establish trustworthiness in my study included—explanation of the nature of the research project to participants; development of rapport; member checking; and confirmability accomplished by peer debriefing, development of an audit trail, and triangulation (Lincoln & Guba, 1985).

Triangulation

Specifically in regard to triangulation, such methods were incorporated into my methodology to check out "insights gleaned from different informants or different sources of data" (Taylor & Bogdan, 1998, p. 80). I accomplished triangulation by seeking out multiple sources throughout my study. In addition to the data derived from interview subjects, I kept a reflexive journal and detailed audit trail to document the entire research process.

Peer Debriefing

A non-involved professional colleague served as a peer debriefer (Lincoln and Guba, 1985) as a third way to establish trustworthiness. I selected a trusted colleague from my doctoral program. Lincoln and Guba (1985) describes this as a "process of exposing oneself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer's mind." (p. 308). The peer served as sounding board to review my interview question and subquestions, and to talk about possible analytic categories during the analysis stage. The peer debriefer also helped to keep me honest, raise questions, and sort through ideas that surface throughout the research process. I shared tentative hypothesis, and emerging ideas with my peer in addition to journaling my thoughts and experiences.

Member Checking

Member checking (Lincoln & Guba, 1985) with interview participants was utilized continuously during and following completion of interviews. This method served several purposes in establishing credibility and refining interpretations (Guba & Lincoln,

1989; Lincoln & Guba, 1985; Taylor & Bogdan, 1998). Member checking is mostly the technique of playing back my interpretations of the data, and checking the accuracy of my emerging findings and ideas with the interview participants. It also served as an opportunity for participants to correct, argue, or give further information for interpretations and analysis. According to Lincoln and Guba (1985) member checking is a crucial technique for establishing credibility that can be accomplished in several ways, but are aimed to put "the respondent on record as having said certain things and having agreed to the correctness of the investigator's recording of them thereby making it more difficult later for the respondent to claim misunderstanding or investigator error" (p. 314). Taylor and Bogdan (1998) note that, "any interpretation of a social scene will be richer if you have induced members of that scene to comment and react to it. Even if people reject the interpretations, this can enhance your understanding" (p. 159). Lincoln and Guba (1985) describe these concepts as "negotiated outcomes" and assert that research subjects "have right to provide input on the subject of what are proper outcomes, and the inquirer has an obligation to attend to those inputs and honor then as far as possible" (p. 211).

External validity, that is the generalizability of findings across groups, was achieved by "maximizing comparisons across different groups of participants in differing contexts and situations through theoretical selection and saturation" (p. 78). In regard to level of generality, it is the responsibility of the researcher to provide "sufficiently descriptive data, or in the case of grounded theory, explanatory data, that will allow readers to make their assessment of the validity of the analysis and transferability to their own situation" (p. 79).

Theoretical sampling also aided in the process of testing emerging theory, and I continuously member checked with participants throughout the interviews, contacted participants following draft of data analysis, and gave them an opportunity to comment and "critique the draft of the case report prior to its finalization" (Lincoln & Guba, 1985, p. 213). This method of collaboration with the participants was central to the research gathering process and analysis, and held me accountable to participants throughout the study by privileging their voices and engaging them in the process.

Designation of Categories

Categories surfaced during the constant comparative and data collection process, which occurred throughout the course of the research study. "Categorization is a major component of qualitative data analysis by which investigators attempt to group patterns observed in the data into meaningful units or categories" (Chenail, in press). Specific procedures for category designation and analysis outlined in chapter three provided the researcher with a practical and manageable way to describe complexities of the data collected from the interviews. Additionally, these procedures ensured internal and external validity of the emerging categories. Category formation was based particularly on similarities and differences and separations and connections noted by the researcher who coded bits of information.

To further explore the emergence of categories in this study, Constas (1992) describes three specific components of categorization. They include the specific "locus of category construction" (p. 257) or origination of the category; justification of a category or verification which can improve credibility of the study; and nomination. Verification procedures included verification of categories by a peer-reviewer and member checking.

Nomination was the process of assigning a name to a particular category. Names for all subcategories categories were taken from the words within the transcripts; however, names for final categories reflect umbrella themes that had to do with the common thematic timeline of the participants' told stories and unfolding experiences before and following immigration.

Categories were carefully examined and designated at various points in time during the study, and they evolved a posteriori, or after the data was collected (Constas, 1992). Coding was used as a first step in the analytical process to make meaning of the data generated in the interviews. I then evaluated connections and patterns between the coded data, which resulted in the creation of themes. As a result of this coding and categorization process, homogeneity, or similarities appeared vertically within subcategories of each constructed category, and heterogeneity or differences appeared horizontally across the emergent categories. Thus, "an exhaustive system of categories [were created as indicated in Figure 1] so that no meaningful feature of the phenomenon under the study falls outside of the array of categories" (Chenail, in press). Furthermore, the credibility of the categories was continually utilizing the following questions as a tool, as recommended by Chenail (in press):

> (a) How well do the categories capture the richness of the data; (b) how coherent is the internal constitution of the categories; (c) How distinct is each category from the other categories; and (d) How were the categories created and tested?

Finally, research findings for this study is presented in Chapter Four and includes characteristics of the participants and a demographic overview of subjects involved in the study. Pseudonyms are used in the final text, and participant demographics are included.

Additionally, Chapter Four consists of a presentation of data analysis; and discussion of categories and grounded theory that emerged from the research.

Chapter IV—Research Findings and Discussion

This research explores the meanings of self-starvation/food restriction for immigrant women currently residing in the U.S. The data is based on in-depth interviews with 10 women from all over the world. They come from such countries as India, Iran, Russia, Columbia, China, Puerto Rico, U.K., and Guyana, and live in the following U.S. states—New York, Pennsylvania, Florida, Ohio, and Illinois. In order to protect confidentiality of the participants and focus more intently on the interview data and grounded theory, extensive profiles are not included in this discussion. However, aspects of the participants' lives will be sprinkled throughout this chapter to provide the reader with increased context surrounding the participants' life experiences. Data was collected via telephone interviews, and I utilized a semi-structured interview guide for the interview process. The guide was organized around the participants' unfolding responses and descriptions of their experiences with their drive for self-starvation and food restriction.

The interviews were recorded on audiotape, transcribed, and repeatedly reviewed over several months. The analysis process utilized a grounded theory approach and a theory began to emerge from the data. Theoretical sampling was then used to sample specific issues only and look for "precise information to shed light on the emerging theory" (Charmaz, 2000, p. 519). The aim of this method of sampling was to help to refine ideas and "identify conceptual boundaries and pinpoint the fit and relevance of [the] categories" (p. 519). Thus, I assessed the degree to which I identified saturation of data, and then evaluated variables potentially affecting the emerging theory. At this stage of the research, I began to further refine my sampling criteria to only include women in

their 20's and 30's whose onset of food restriction occurred following immigration. Furthermore, I requested that interested participants briefly describe what they felt caused and contributed to their drive to self-starvation following immigration to the U.S. as part of the screening process. Participants discussing similar themes as noted in the emerging theory were then included in the study for further refinement of the categories. An extensive review of the transcripts revealed numerous categories and themes, which were repeatedly reviewed before final theory emerged. Such categories will be discussed in this chapter, as well as verification and nomination.

Analysis and Discussion of Categories

The findings of this study are grouped into four heterogeneous categories with numerous subcategories. The themes relate to the participant's relationship to a period of time in their life and course of their experience. Specifically, the past life category has to do with the participant's reported experience of self and others while residing in their country of origin. The major categories or themes following that represent the broader themes of their unfolding experiences in a variety of areas of their life following immigration to the U.S., and how food restriction participated in that experience. The themes emerging from the research include:

1. Past Life in My Country—Protected from Anorexia

   Subcategories: Different Lifestyle/Non-Diet Culture

   Different Beauty Ideals

   Family Influence

2. Transition to U.S.—Free and Unprotected

   Subcategories: Culture Change and Adjustment to New World

New Beauty Standards and Trying to Fit In

Freedom from Roots

3. The Pursuit of Thinness—Becoming a New Me

   Subcategories: Breaking into the New Culture

4. Life With Anorexia—Positive and Negative Reinforcers

   Subcategories: Positive Reinforcers and Benefits of Being Thin

   Negative Reinforcers

   Physical Instability and Mood Changes

   Lacking Hunger and Controlling Calories

   Difficult to Stop Cycle

   Feeling Like an Outsider

Designation of Themes

The above categories surfaced during the constant comparative and data collection process, which occurred throughout the course of the research study. "Categorization is a major component of qualitative data analysis by which investigators attempt to group patterns observed in the data into meaningful units or categories" (Chenail, in press). Specific procedures for category designation and analysis outlined in chapter three provided the researcher with a practical and manageable way to describe complexities of the data collected from the interviews. Additionally, these procedures ensured internal and external validity of the emerging categories. Category formation was based particularly on similarities and differences and separations and connections noted by the researcher who coded bits of information.

To further explore the emergence of categories in this study, Constas (1992) describes three specific components of categorization. They include the specific "locus of category construction" (p. 257) or origination of the category; justification of a category or verification which can improve credibility of the study; and nomination. Verification procedures included verification of categories by a peer-reviewer and member checking. Nomination was the process of assigning a name to a particular category. Names for all subcategories categories were taken from the words within the transcripts; however, names for final categories reflect umbrella themes that had to do with the common thematic timeline of the participants' told stories and unfolding experiences before and following immigration.

Categories were carefully examined and designated at various points in time during the study, and they evolved a posteriori, or after the data was collected (Constas, 1992). Coding was used as a first step in the analytical process to make meaning of the data generated in the interviews. I then evaluated connections and patterns between the coded data, which resulted in the creation of themes. As a result of this coding and categorization process, homogeneity, or similarities appeared vertically within subcategories of each constructed category, and heterogeneity or differences appeared horizontally across the emergent categories. Thus, "an exhaustive system of categories [were created] so that no meaningful feature of the phenomenon under the study falls outside of the array of categories" (Chenail, in press).

Research Categories

After a number of reviews and revisions four final categories emerged from the research data. The remainder of this chapter will be devoted to exploring those emerging

categories in greater depth. Data excerpts and exemplars from the research will be unveiled to shed light on the specific categories they represent. A data analysis map similar to that utilized by Harry, Sturges, and Klingner (2005) will present the subcategories, themes, and theory that emerged from this research.

Data Analysis Map

6. Theory: Interview participants noted being exposed to Western media culture throughout the course of their experiences, however at different saturation levels. Many women noted being unaffected or acting upon desires for thinness until coming to the U.S. Theme of separation/connection emerged from the interview data. Participants appeared to struggle with their self-identity as it related to their new world transitional experiences, and their relationship to their cultural roots following their newfound anorexic identity. Participants noted benefits of thinness as it pertained to belonging in U.S. culture, but described various experiences of feeling connected to and separated from their bodies and other aspects of their lives and relationships to their roots once the life of anorexic thoughts and actions took over. They discussed various positive and negative aspects of their lives that encouraged anorexia to progress out of control to a level of high connection to their anorexic identity, but a separation from meaningful relationships with others and their cultural roots.

5. Interrelating explanations: Self ---------->Self as Separate/Other -----> Connecting to New Culture--->New Self as Belonging, Different, and out of control

<----------Influence of Western Media/Culture---------->

4. Testing themes (interviews, observations, documents)

Experience of Self and Life in Past	Experiences in U.S after immigration	Creating New Self via Anorexia	Anorexia out of control

3. Themes /Categories:

Past Life in My Country / Protected from Anorexia	Transition to U.S. / Free and Unprotected	Pursuit of Thinness / Becoming a New Me	Present Life Reinforcers / Positive and Negative

2. Subcategories:

Different Lifestyle and Non-Diet Culture	Culture Change and Adjustment to New World	Breaking into New Culture	Positive Reinforcers and Benefits
Different Beauty Ideals	New Beauty Standards and Trying to Fit In		Negative Reinforcers
Family Influence	Freedom from Roots		

1. Open Codes: Based on initial interviews.

FIGURE 1. *Data Analysis Map. The numbers at the far left represent the six levels of analysis, moving upward from the bottom of the figure. Two-directional arrows indicate nonlinear connections among items. One-directional arrows represent the linear timetable of unfolding experiences.*

Table 1
Categories and Codes

Category: Past Life in My Country—Protected from Anorexia
- Different Lifestyle/Non-Diet Culture
  - "Stay active everyday"
  - "Not much nutrition labels"
  - "How they cook and prepare the food is different"
  - Limited food choices and availability
  - "Healthy moderation" of food intake
- Different Beauty Ideals
  - "Influences from the West"
  - "Media images weren't real life"
  - "Expected weight or body type [in U.S] is different from what I was used to"
  - Women were more diverse or similar looking where I am from
  - People were "just naturally thin" where I am from
  - People were bigger and don't diet
- Family Influence
  - "Tight knight culture"
  - "Food major part of family gatherings"
  - "You're under a microscope"
  - I wanted to get thin back then but I didn't
  - "[Family] kept control" over me and the food

Category: Transition to U.S.—Free and Unprotected
- Culture Change and Adjustment to New World
  - "I got worse when I came to America"
  - "I don't do well with change"
  - "In a time of transition"
  - Different lifestyle here
  - Had to learn a lot of new things
- New Beauty Standards and Trying to Fit In
  - I gained weight when I came here
  - I saw the skinny American girls
  - Compared myself to others
  - "I had problems fitting in"
  - "I started to try to look like all the American girls"
- Freedom from Roots
  - "I had a lot more freedom"
  - "I didn't have [family] strain"
  - "You try to break away from your family"
  - "No one keeping me accountable"

Category: The Pursuit of Thinness—Becoming a New Me
- Breaking into New Culture
  - Beauty ideal in native culture versus my idea of beauty (U.S)
  - "The thinner you [are in U.S] the more accepted you [are]"
  - "I want to be my own person"
  - "I wanted to be opposite" of what I saw growing up
  - If I am thin "people will like me more"

Category: Life With Anorexia—Positive and Negative Reinforcers
- Positive Reinforcers and Benefits of Being Thin
  - "When you get incentives" you want to stay skinnier"
  - "I felt more self-confident"
  - People "encourage me to keep up the good work"
  - "People treat me different"
  - "I got more attention"
  - "You get treated better" by men and women
- Negative Reinforcers
  - Physical instability and less depressed
  - "Difficult to stop"
  - "I don't feel hunger"
  - "Found ways to trick my hunger"
  - Controlling calories
  - "I will never think I am thin"
  - "I am an outsider to [my family]"

Note: Italicized expressions are categories; each category is followed by the code or codes that it contains. Expressions enclosed in quotations marks represent the word choice of the interviewee.

Revisiting the Categories and Literature

Past Life in My Country—Protected from Anorexia

This category relates to the participants' expression of their experience of themselves and their culture while living and interacting in their country of origin. Many of the women in the study appeared to have a relatively distant relationship to life in their native culture and only briefly discussed glimpses of times past as it related to their present lives and relationships in the U.S.

Numerous participants in the study described being exposed to impressionable thin western media images while residing in their culture of origin due to the globalization of media images in magazines and television to other parts of the world. Interestingly, however, they described several differing factors they believed sheltered or kept them from pursuing food restriction while residing in their native land. The cultural and relational climate of their experiences in their cultures appeared to have particular relevance in protecting or shielding the participants from either feeling an increased sense of self-consciousness or acting out on thoughts generated from such media influences that promote thinness and food restriction. Many participants discussed the protective influence of their "different lifestyle and non-diet culture" and the impact of "normal looking different" in their culture of origin, which curbed self-starvation behaviors.

Subcategory: Different Lifestyle and Non-Diet Culture

The women often described how higher activity levels which naturally came with living in their culture of origin helped them to feel better about themselves and their weight. Madeline, an immigrant from Colombia, shared "In South America you can pretty much stay active everyday…" (5, 40, 5). Some of the women also discussed how

the differing focuses pertaining to eating, food, exercise and ideal body types in their cultures of origin protected them from an increased desire to restrict food. These factors included—the perception that their cultural meals were safer foods to consume in that they were healthier and less fatty. Nancy, an immigrant from China, and Sonia, an immigrant from Guyana, compared the differences in lifestyle:

> Nancy: Here [in the U.S.] they use butter and fat. You know, over there we don't really do that. That's why Chinese people are skinnier. Then um…more exercise, because you have to walk everywhere rather than drive. So, after I come here…You know hamburgers, pizza, and French fries…definitely make me gain a lot of weight, so I became like fat and that's definitely a factor after coming to America that caused a problem. (2, 26, 3)
>
> Sonia: When we were in Guyana we were actually a very poor family until we moved here and we were able to go to school and make a life for ourselves. My mother had a little garden in the back and she grew her own vegetables. So, I mean, food was an issue. We didn't always have food, you know. My brother would go fishing and catch fish. I guess our diet was restricted because we had no choice. We couldn't open our refrigerator and have it full. It didn't work like that for us there…We just didn't have the money to buy a lot of food. (10, 16, 2)

and the absence of nutrition labels as noted by Amy, an immigrant from Iran, "There was not much nutrition labels [in Iran], like they do here. You weren't able to get the fat free no sugar added products like you get here. You can get anything in the grocery store here…" (4, 9, 2). Participants, such as Claire from the U.K., noted decreased emphasis on

diet products, which were cited as protecting them from efforts to self-starve while residing in their native countries:

> Claire: [I saw Western media messages in my country], but they were not at all what you see here. There were no commercials on TV about Nutri Slim or Weight Watchers. There was nothing like that. There were always slim girls when you walk past the clothing store. But, you walk into a grocery store in [my country] and there was like one kind of peanut butter. It wasn't like you have 30% less fat, or you have "I Can't Believe It's Not Peanut Butter". It's not even fat at all. It's not even peanut butter. It's some sort of replacement. Here there are way too many choices and there's people telling you that if you eat this you are not going to get fat, here in America versus in England. It was like one thing. People just ate it. They had a healthy sort of moderation. (9, 22, 3)

Subcategory: Different Beauty Ideals

In some cases, the subjects' experiences of the beauty ideals of their native culture also appeared to aid in protecting them prior to immigration. For instance, Cindy an immigrant from Puerto Rico, noted that images of women were different in her country, "…[This weight loss didn't happen in Puerto Rico] because that is what was on TV and print, you didn't see that in real life" (7, 15, 2). Cindy, as did other participants, frequently compared their experiences of beauty in the U.S. to that in their country, "I just thought that there was an expected weight or body type here, which was different from what I was used to" (7, 3, 1). In describing these differences, many women noted an increased ability to blend in or fit in with those in their native culture without much effort, such as Amy who said, "I was covered in Iran…everybody kind of looked the

same," (4, 11, 2). Contrarily, Madeline, who currently works as a runway model, noted the diversity of women living in South America as opposed to in the U.S., "Down in South America you see women that you don't see anywhere in the world. You'll see like me, I am the only uh…African red head I've ever met, or my mom is blonde with green eyes and she's six foot tall. But she has darker skin. She is the color of honey. Like you see all kinds of women down there, and then when you come here…in America I always see the same girl over and over again"…(5, 26, 3). Madeline explained during her interview that her ethnic background includes a blend of Latino, African, Native American, and Irish. Another participant, Amy, whose food restriction began shortly before her arrival to the U.S. and exacerbated within a few months following her move, described the lack of emphasis her Iranian culture placed on thinness. She noted that women dressed similar or with clothes that did not place emphasis on body shape, which in that case, did not serve to reinforce Western media messages they received glorifying thinness, "Back in Iran there is a lot of restrictions, like what you wear, and in the Iranian culture" (4, 1, 1). Amy, like other subjects in the study, compared the culture of beauty in their country to Western media images. Sonia, who often ridiculed her culture's focus on food said, "In Guyana women look like that [bigger] and it's disgusting. (10, 18, 2)… A Guynese person doesn't really understand the concept of diet. They don't diet" (10,15, 1).

Subcategory: Family Influence

As a part of the particpants' different culture and lifestyle from the U.S., participants frequently mentioned the influence of their families. Vicki, an immigrant from Russia, whose food restriction began just two months following immigration noted, "my mom kept control over my food consumption in Russia" (3, 1, 1). Interestingly, the

impacts of the participants' families on their lives and experiences appeared to cross ethnic and cultural variations presented in the research. Specifically, the research data indicated that in most cases the structure of the participants' families was self-corrective in nature due to the strength of their family structure as Amy who moved to the U.S. six years ago and currently lives with her sister noted, "You know you are with your family a lot of the time, um. You're scrutinized, you're under a microscope, so you kind of are apprehensive to do anything that would create question or bring on attention to yourself and there wasn't as much a focus on the body within the family as there is in America" (4, 18, 3). The "tight-knit" (4, 11, 2) family culture as Amy and other participants noted appeared to aid in counteracting or diminishing their restriction of food intake. This was supported when some participants also described the family as a factor prohibiting them from acting out on desires to restrict food intake while living in their country. Vicki, whose food restriction began just two months following immigration said:

> Vicki: I had an idea that I need to get skinnier back when I lived in Russia, since I was 15 maybe, 16, but I wasn't that strong and um…when I was 18 I really wanted to get skinnier um…but my mom cooked food for me, and so she would keep control over that...and I decided my desire wasn't that strong that I would just comprise food for going out, so I ate food. (3, 1, 1)

Eugenia, an immigrant from Russia who said she only speaks to "American friends" about the anorexia because she is "too embarrassed", recalled the desire to be anorexic while residing in Russia.

> Eugenia: Even though I wanted to do something like this earlier in life (restrict food), I knew I couldn't get away with it. I couldn't do it with my family around.

But, being in college I was able to because I was a little bit more freer, and I just felt more comfortable doing it." (1, 10, 2)

Participants such as Claire, who left the U.K. in order to attend college in the U.S., noted that she would be less susceptible to illness due to restrictive food behaviors if she were living in her country, "[I don't think this food restriction would have gone awry if I was living in my country] because there were people who would have called me out on it well before I would have gotten to that point. (9, 28, 3)

Transition to U.S.—Free and Unprotected

This category describes the participants' personal experiences with transitional and adjustment experiences following their move to the U.S. The word "transition" in this research specifically relates to the "process of changing from one state or condition to another" (Pearsall, 1999). All participants interviewed in the study discussed and shared this experience of transition and culture change since they once lived in their native country and then immigrated to the U.S. It is important to note that the participants in the study moved to the U.S. at different times in their life, which may have had an impact on their specific experiences of transition. For example, if subjects immigrated to the U.S. at an early age, they may have not experienced stresses related to language barriers that participants arriving later in life frequently mentioned. Nevertheless, all subjects despite when they moved to the U.S. contrasted life in their culture of origin to their present life, and discussed their adjustment processes. As previously mentioned, many of the participants were educated there. However, such awareness about what to expect from life in the U.S. did not appear to prepare them for numerous personal

tribulations and adaptive experiences that became a difficult and necessary part of their transition to the new world.

Subcategory: Culture Change and Adjustment to New World

All participants in the study experienced culture change on some level by the nature of their move to the U.S. For many participants, immigrating to the U.S. represented the pursuit of freedom and opportunity to create a new existence, attain a higher education, make more money, achieve their dreams, or leave a country of violence and turmoil for greater peace and prosperity. In the literal sense, they moved from one culture into a different culture from the one they were accustomed to. Many participants noted struggling with the adjustment, such as Amy who currently works as a telemarketer from home due to her eating disorder and mental health condition. She said, "I think that I got worse when I came to America because again I don't do well with change" (4, 2, 1). Claire, a university student, who stopped eating "anything that was not a vegetable" (9, 9, 1) recalled being "in a time of transition" (9, 8, 1) when she moved to the U.S, and she recognized how this change impacted her relationships with others. She said, "I didn't really have any stable relationships that were present during that time" (9, 8, 1). Madeline, whose daily intake consists of eating nothing or a handful of peanuts or granola, stated a feeling of being alone, "When I got here you are surrounded by people that don't understand you and you need to talk to them. Like you are kind of in this box where you can't talk to anybody around you" (5, 23, 3).

The freedom many of the participants came to pursue appeared to be a double-edged sword. Without the comforts of home and life as they knew it, some women expressed feeling jolted by the day-to-day lifestyle adjustments that came with their new

world transitions, such a difference in the activity level. Cindy, who is single and works in the travel industry said, "I had been kind of sheltered in a lot of ways and it was just like learning everything and stuff that I had no idea about. Then not having anyone here, any family here was difficult" (7, 10, 2). Amy, who currently lives with her sister who is married, recalled the difference in lifestyle, "I come here and you know, just the different environment…You have to get a car. You have to drive everywhere" (4, 11, 2).

Having increased responsibilities also appeared to be an issue for some participants. "I wasn't ready to be on my own, I needed extra support at that point," said Claire (9, 30, 3), and Kate, an immigrant from India, recalled, "I did not know much of cooking also, so I start restricting. I would have only bread or bagel. So, that went on for about a month until I learned to cook...(6, 1, 1). She explained that a typical day of food restriction included a small amount of cereal in the morning, and bread in the afternoon. She said in India she was used to eating rice for lunch and dinner, and did not have access to Indian food in the states. "When I came to this country I couldn't get used to the food here. I was more used to Indian food, and I couldn't get much of Indian food here. So…ummm…I started restricting," said Kate (6, 1, 1). Amy who noted her own daily challenges, "Going to the grocery store…Major change here versus there. You have all these options, it's overwhelming. When I get overwhelmed I tend to just pull, pull away" (4, 11, 2). She explained that she eats protein but only if it lacks a high fat content, which limits her to eating tuna, turkey, and chicken tenders. Additionally, she discussed limiting her vegetable intake to green vegetables. She said she does eat some fruits.

On the other hand, some subjects discussed initially eating too much American food which caused weight gain after their arrival to the U.S, such as with Nancy who said

she developed anorexia and restrictive eating two years after immigration, following a time of weight gain. She said, “So, after I come here…You know hamburgers, pizza, and French fries…definitely make me gain a lot of weight, so I became like fat and that’s definitely a factor after coming to America that caused a problem” (2, 26, 3). Nancy said she now watches what she eats and eliminates greasy food, carbohydrates, sodas, candy, and sugars.

Additionally, participants frequently noted the difficulties of language barriers and being misunderstood after moving to the U.S, “The language is different. I mean I speak the language, but I don’t understand the spoken language the same way someone who is born and raised here understands it,” said Amy (4, 11, 2). “I couldn’t communicate with anybody, and it was kind of like feeling very trapped until I learned how to speak English…” said Madeline (5, 23, 3). One subject said she went to great lengths to sound more American. Eugenia stated, “I even took voice lessons to work on my accent. I really wanted to become an American and wanted to leave that old Russian thing behind me” (1, 19, 3).

Subcategory: New Beauty Standards and Trying to Fit In

As part of the culture change experience, participants specifically discussed difficulties fitting in and being impressionable to what they saw as new beauty ideals and standards in the U.S. as compared to beauty in their country of origin. Sonia, who now works successfully in the fitness industry stated, “When you look at magazines they keep track of the models and actresses and how many pounds they lose, who is getting fat, who’s got cellulite. When you watch TV all you see is people keeping track of how much women weigh. (5, 14, 2) Participants frequently emphasized the differences between

their experiences of self in their native countries versus how they judged themselves against American ideals while living in the U.S. For instance, Amy, whose lowest weight has been between 78-80 lbs, noted, "You see the body more than you see the body there. When you leave your home, the female, it's not that she has to but it's good for the female to beautify herself, whereas over there, everybody kind of looked the same" (4, 11, 2). These experiences coupled with other transitional experiences appeared to bring about feelings of outsider awareness and a decreased sense of group belonging in U.S culture. Numerous participants recalled the sense of not fitting in. Eugenia, who said she has restricted food intake on and off for the last ten years said:

> Eugenia: [The feeling of being an outsider] was definitely much more heightened here [in the U.S] because it was just….I was just not fitting in….I just didn't fit in, you know, in a fun way…. (1, 9, 2).

Madeline, whose lowest weight was 97 lbs., explained the experiences of feeling like an outsider:

> Madeline: I had a lot of problems fitting in with other kids, I had an accent, I had red hair. It got to the point that I never had a date. After awhile I started to try look like all the American girls. I tried to starve myself off and on.
> (5, 1, 1)…When I got to America I had a funny accent. I was definitely an ugly duckling, like I was the fat girl in the back of the room that you paid to do your homework. I didn't know English. I had red hair and dark features…I'm caramel colored with red hair, I have big curly hair, so when I tried to fit in in America people say you're not black. Latinos say we're doing our own thing, and White people were definitely sure that I wasn't White. So, when I got to America no

groups wanted to accept me. Black people were just like, why do you look like that, why does your hair look like that? White people were like well, you're Black. There was never really a group to be in. (5, 7, 1)

It was common that participants compared themselves to American women and slender figures, and saw themselves as other. Nancy, who recalled that a typical restrictive food day included eating just one egg and two apples per day stated, "You know, I couldn't fit…every time we'd go clothes shopping…looking at all the skinny American girls in the pretty clothes I just…my red light came on and I started worrying, become depressed" (2, 28, 3). In many cases, the women linked being skinnier with fitting into society, and conceptualized thinness as an avenue to being a part of the new culture:

Nancy: I started feel depressed and um and I [knew] if I lose weight and then become skinnier and prettier people would like me. (2, 16, 2)

Cindy: I guess [I wanted to] fit in to the standard and with the norm here or what I thought was the norm. (7, 2, 1)

Sonia: I had a hard time fitting in, that's why I think I started with the dance and yoga. It gave me a sense of belonging, because I really didn't fit in anywhere… (10, 24, 2)

Sophie, who immigrated from Columbia, noted the difference between how she is now versus then in her country, "I was hoping that if I looked more quote unquote "American" then I would be able to fit in better" (8, 5, 1)…She discussed how different she looks now, "When I was 19 I looked more… my body was a little rounder, and I hadn't plucked my eyebrows and I had very very long hair…Now I look more like, my

eyebrows are like perfect and my hair is shorter, and so I look more assimilated than I did back then" (8, 29, 3).

Subcategory: Freedom from Roots

All participants in the study tended to be increasingly impressionable to Western media images while residing in their countries of origin and when they moved to the U.S. But, in coming to the U.S. many women were bombarded with such diet messages, which are saturated in the American culture. Vicki, whose food restriction began just two months after immigration, stated, "When I get here and I saw all the diet pills available, TV commercials, over the counter…" (3, 3, 1). The combination of freedoms from one's family as Eugenia noted, "You try to break from your family, you know your connections…" (1, 19, 3) "I had a lot more freedom…(1, 10, 2), and feelings of not fitting in, appeared to make many of the women impressionable and vulnerable to restricting food intake. Claire's food restriction began just one year following immigration. She stated, "Having freedom enabled me. With no one keeping you accountable for anything you are doing, you can do whatever you want, and no one would hold me accountable. So, I did whatever I wanted" (9, 29, 3). Vicki also noted how lack of parental control influenced her food restriction following her move to the U.S., "I decided it's time for me and I can do it, and I don't have my mom's strain [about my food consumption] that I have back in Russia…So, that's how I started" (3, 3, 1). Amy and Eugenia, whose anorexia flourished following their move to the U.S, described their experiences with freedom:

> Amy: That sick, that mentality that I had that was just brewing [in Iran]…like what was brewing there for those years was able to then come out. I could carry

> out the thoughts," (4, 12, 2). So, I was able to carry out the thoughts that I had into action once I got to America, because I had that freedom and it was more acceptable and it was easier. (4, 19, 3)…It's easier to restrict when you are on your own than when you are around family. (4, 12, 2).

Eugenia emphasized wanting to restrict food earlier on while she lived in Russia, but resisted acting upon her desire:

> Eugenia: Even though I wanted to do something like this earlier in life (restrict food), I knew I couldn't get away with it. I couldn't do it with my family around. But, being in college I was able to because I was a little bit more freer, and I just felt more comfortable doing it. (1, 10, 2)

The Pursuit of Thinness—Becoming a New Me

This category represents rationales fueling the immigrant participants' desires to restrict food intake following their transition to the U.S. Cindy, whose onset of food restriction began soon after her arrival to the U.S., recalled in her interview, "I wouldn't have been exposed to what the thin ideal was if I stayed over there, so I wouldn't have had the desire to lose weight. So, it was totally related to moving over here" (7, 11, 1). Most research participants appeared to view the pursuit of a slim ideal as a vehicle to achieving a sense of empowerment in their lives while residing in the new world. As previously mentioned, many women in the study began their active pursuit of thinness following immigration, however some participants recalled being influenced but not affected by U.S. beauty ideals while living in their native country.

Subcategory: Breaking into the New Culture

For many participants, the pursuit of thinness represented breaking away from stereotypes or mores connected to their culture of origin and breaking into the new culture with a focus on being their own person. Amy recalled not resembling someone from Iran:

> Amy: When I tell people that I am from Iran, they say, "You don't look it". I say, "Why?" They say, "Because you don't have the curves, the big nose, the dark hair, the olive skin, the big brows, and the dark eyes". You know it's just, I don't want to be that person. I don't want to be in a little box. I want to be my own person. (4, 32, 5)

Sophie, who discussed being hospitalized for several months for eating disorder treatment, recalled her disgust with "the patriarchal family system" (8, 28, 3) that she was raised in:

> Sophie: …I almost wanted to be the opposite of what I saw my mother being, and the rest of the women in my family being. (8, 33, 4)

Sonia, who described that she is always on a diet, said that she disagrees with many Guynese values. She noted that Guynese people are "very rude and family [oriented]. They tell you to get married, have children, and you don't stray from that" (10, 20, 2). She described getting her own apartment and living alone for many years. Additionally, she discussed her weight loss as a symbolic breaking away from Guyenese culture.

> Sonia: Guynese women don't mind being overweight because the men respond to that (10, 21, 2)…I think that the typical person from Guyana, especially the

> female body, they need to be a little bit chunky. They like chunky women. That's not my idea of beauty. Beauty is a thin person, especially today, you look in the magazines…all the actors and actresses, they are in great shape. (10, 11, 1)…

Some subjects stated the thoughts that being thin would make them more accepted while living in the U.S., such as Madeline who said, "For awhile I thought it would make me more popular [being thin]… (5, 10, 1) So, when I got here I saw girls that wanted to be thin, that was all they ever wanted, and the thinner you were the more you were accepted… (5, 13, 2). Several other women in the study shared these sentiments that being thin might help with fitting into society. Eugenia, who makes a living managing a photography website and works with models, recalled not fitting in initially:

> Eugenia: I think a lot of it is just people I saw in school that were popular and having a good time were all thin, and they looked good. And I kind of wanted to get away from the books. I read all those magazines, and they looked…you know…they just didn't have the body shape that I had, and um…I just wanted to I guess, be more feminine. (1, 6, 1)

Nancy, who works as a mortgage loan officer and does marketing and promotions, said that she feels more comfortable as a thin person:

> Nancy: A lot of things go through my mind, and thinking uh…if I am skinnier, I'll become prettier, and I'll get more attention and people will like me more. Things like that. (2, 8, 1)

The interview data noted that the process of food restriction among the women was unquestionably reinforced by a Western society plastered with thin media images, and a diet-based emphasis. Sonia described being very diet and health driven:

> Sonia: All these shows they have…what do they do to get into shape. When I watch that it makes me ever more obsessive, then I realize there is so much I need to do to get into better shape. (10, 38, 4)

Life with Anorexia—Positive and Negative Reinforcers

Once the process of food denial was initiated it frequently evolved into a mind of its own. Participants described several positive and negative reinforcers that perpetuated the cycle. These factors included a variety of physical, psychological, relationship and sociocultural reinforcements. The term reinforcer refers to an environmental change, whether it is the subject's internal environment (mind, health) or external environment (society, relationships), where such change is contingent upon the response. Reinforcers are confirmed retrospectively, as objects, thoughts, reactions from others, physical health responses, or other potential 'reinforcers' that can only be called such as evidenced by increases in self-starvation behavior following their exposure. In other words, the strength of the response is reinforced. In this research "positive reinforcers" refer to an increase in the frequency of restrictive food behavior due to the addition of a stimulus viewed as positively encouraging from the participants' perspectives. For example, positive encouragement for looking thin is an example of a positive reinforcer in this study (only if the participant recognizes this as a positive response, and such a statement involved an increase in their self-starvation behavior). "Negative reinforcers" in this study specifically refer to an increase in the frequency or maintainence of self-starvation behavior perpetuated by what the participant viewed as a negative or neutral response from internal or external factors. These factors were typically seen as being uncomfortable experiences or physcial consequences perpetuating food restriction that

were out of the participants'control. Examples of negative reinforcers include such issues as difficult relationships; physical consequences; and mood instability that led them to use self-starvation as a way to cope, which we will explore in more detail. In many cases, turning off (or *removing*) these negative reinforcers were often difficult or next to impossible for participants, and appeared to be out of their direct control.

It is important to note that reinforcers, whether positive or negative, appeared to encourage the cycle of self-starvation to take on a life of its own once it was initiated. Madeline, who has experienced several health consequences as a result of her eating disorder, summed up the nature of this process when she stated, "When you get incentives you want to stay skinnier, even if it means making yourself sick…" (5, 21, 3).

Reinforcers indicated in the study were as diverse and varied as the participants themselves. At the same time, there was a level of homogeneity amongst participants regarding particular reinforcers such as feelings of no longer being hungry; resisting hunger; self-starvation as a habit and way of life; and difficulty ceasing food restriction behaviors.

Subcategory: Positive Reinforcers and Benefits of Being Thin

There were several positive reinforcers that emerged in the study representing the participants' experiences of their life after weight loss, which continued to drive the desire to restrict food intake. In many cases, the subjects described the benefits of thinness and how it correlates to increased feelings of self-confidence. Cindy came to the U.S. to attend college and described her experiences as a thin person, "I just feel better, and I guess I developed more self-confidence" (7, 5, 1). Vicki, whose food restriction led to episodes of amenorrhoea, stated, "I have confidence about the body. You don't care

about the clothes. You don't care about being naked some places. You don't care. You know that your body is toned, skinny, you perfect" (3, 14, 2).

Many of the women also appeared to link being thinner with getting better treatment from others, which ultimately gave them an increased sense of belonging:

> Sonia: I definitely think [people treat me different as a thin person]. Career wise I think I've benefited a lot from being thin and being in good shape. (10, 34, 3)

Madeline, who has struggled with health complications due to her eating disorder, compared the ways she is treated when she is thin versus when she gains weight:

> Madeline: I was more accepted when I lost weight, when I wasn't so curvy or umm…It's easier to be more accepted (5, 13, 2)…The second I gain weight people treatment me different (5, 16, 2). People slowly start to treat you differently. Being treated differently still makes you want to lose weight (5, 17, 2)

Eugenia, whose lowest weight was 90 lbs, described feeling better about herself and her relationships as a thin person:

> Eugenia: I think a lot of it is really just confidence. I get treated equally, um…You know, I don't get looked down upon. So, it's more just getting treated equally. (1, 17, 3)

Subjects frequently noted receiving compliments for their thinness, which perpetuated the cycle of food restriction. Cindy recalled better treatment from her college roommate, "My roommate said that I looked much better, and that uhhhh…That I look more healthy and she was just impressed and encouraged me to keep up the good work or to keep the lifestyle that she felt I had admired" (7, 7, 1). Kate, who sought help from a

medical doctor with the encouragement of her family, noted her friends' reactions to her weight loss, "Then my friends said, "you are looking good when you lose weight". It just made me feel good, and then even I started making Indian food, I started restricting foods with high carbs and fat. Then that's how it started…" (6, 2, 1).

Other participants, described how being thin changed their relationships with men, specifically in regard to receiving more attention from them. Cindy related this to feeling more confidence on her part:

> Cindy: I felt more confident. I tried dating. I really wasn't dating or meeting much people when I first started, so I guess because I felt more confident I met new people and started dating…(7, 6, 1)

Madeline, who works as a model and actress, frequently described the responses from men throughout the course of her interview:

> Madeline: I dated guys who wanted to treat me like a Barbie doll. I dated one guy who wouldn't see me unless I was dressed in my modeling gear, wearing makeup, and my heels. That's the only time he'd come over and see me. He would always talk about how he wasn't attracted to fat women… (5, 36, 5)

Sophie, also worked as an actress, profoundly remembered how one man treated her differently following her weight loss:

> Sophie: After I lost weight that same person [guy] complimented me and he said, "Have you been dieting? You look great". And it was just the fact that he was the one to give me that little dig before, and now I got his validation…But, that was enough to make that strong of an impact on me. Here was this man, teasing me

about my weight, and then suddenly now I have his approval…On some level it ran very deep within me, his approval. (8, 7, 1)

The combination of media messages previously noted by the participants coupled with positive reinforcements, appeared to further any vulnerability for food restriction that the subjects may have experienced, and encouraged the ongoing cycle of self-starvation behaviors. Sonia affirmed this, "Americans love my body type. They think it's great. I did so well working in the fitness industry because everyone wanted to be as thin as I am. "What's your diet?" "What do you do?" "What's your workout routine?" (10, 30, 3)…I get very positive feedback from Americans. (10, 31, 3)

Subcategory: Negative Reinforcers

Once the process of self-starvation began, a range and variation of other consequences then participated in the cycle of furthering food restriction as a way to cope. These consequences ranged and varied amongst the participants. They primarily included the impact of physical and health consequences due to low body weight. Participants discussed feeling a lack of hunger, which also contributed to the cycle of food restriction. Additionally, subjects described a variety of aspects of the life of anorexia itself, which further complicated their ability to stop the process of restricting food and, instead, maintained the cycle.

Physical instability and mood changes. The women described experiencing several consequences of food restriction behaviors, one being the reality of physical health concerns, such as infertility, on their mental health and eating disorder. Madeline suffered severe health complications during pregnancy with her son. She painfully recounted the birth and death of her son that immediately followed, and blamed her

eating disorder for this consequence. She said, "In the end I know that I am ruining my body…because of the food restriction and all the things I did to my body uh…basically for 9 months I was in the hospital under strict supervision and then when I had my son, he opened his eyes for a little bit, then he died…" (5, 27, 3). Vicki, who says she really wants to have a child, noted having an ectopic pregnancy due to her eating disorder and extreme weight loss:

> Vicki: One more thing that may contribute to that [food restriction]…When I got here I was diagnosed with fertility problem and my husband and I knew that we would not be able to have a child, but it happened and I was pregnant. But at that point I was anorexic. Later on we figured out that it was an ectopic pregnancy. It means I am losing the pregnancy, and I losing the hope on the first place I had, and for woman that is a big issue, and I always wanted to have a child, and it took for me years to get used to the idea that I am not going to get pregnant. (3, 6, 1)

Some women also described their mental vulnerabilities, which exacerbated experiences of depression or stress, and ultimately use of denying of food as a way to cope. Claire noted experiencing a variety of physical symptoms that have impacted her emotionally:

> Claire: …I was depressed because I think my brain started shutting down because I wasn't getting the nutrition I needed. (9, 10, 1) I still am having menstrual problems. I haven't had a period in a year, and bladder control issues, which I know is a result of something happening to my bladder…And there are still lasting mental things, like I'll still get feelings of sadness. (9, 19, 2)

In some cases the women described using the denial of food to cope with difficult emotions, such as depression or stress:

> Madeline: The [loss of my son] actually probably triggers me more because my food restriction is a stress reaction. I might get upset about something, and then I stop eating for weeks. (5, 30, 4)
>
> Nancy: Before I restrict food I am depressed and then after about two weeks or a month I see you know…I see results [of being thin]. I'm really happy. I am not depressed anymore. (2, 18, 2)
>
> Sophie: The sort of high that you get from not eating, that was helpful. It affected me mostly positive, mood wise. (8, 20, 2)

Contrarily, one participant described her fear of not being able to have a baby as a result of food restriction, and therefore taking action to attempt to change her behaviors. Interestingly, in that case she appeared to have strong ties to her family of origin, and they were directly involved with her life, which was uncharacteristic of most other participants in the study, with the exception of one other participant whose family intervened. It appeared in this case that the family intervention was effective in helping the subject to cease her food restriction behaviors in order to live a healthier lifestyle.

> Kate: I had sudden weight loss in a month and a half and [my family] was worried that it was due to something else. So, I had to go to a doctor and have a check-up to see I am okay, and uhhh also I told you we were planning to have a baby, so they were worried about that too. So, if I kept starving myself it would not be good for the baby and me. (6, 8, 1)

Kate says that she now enjoys life as a mother of a baby boy, and she may like to have another child.

Lacking hunger and controlling calories. Participants in the study also described the physical consequence of lacking hunger, such as Vicki said at one point she ate no food at all, just water, "At this point I don't feel hunger anymore (3, 9, 1). This absence of hunger was frequently noted to occur following prolonged periods food restriction. Subjects often attributed their lack of hunger to changes in their physiology, such as Amy:

> Amy: No, I don't feel hunger. I think that is what happens to you, you lose that visceral function so to speak. You don't have a sex drive. I never feel thirsty. I don't drink water. I don't get hungry, and I think it's because when you starve your hypothalmus doesn't work properly. (4, 26, 5)
>
> Nancy: After awhile your stomach just shrinks and you are not really hungry all the time. (2, 10, 2)

On the other hand, some participants expressed feeling hunger but resisting the urge to eat through a variety of techniques and strategies to counter the desire. Such as Madeline who stated, "…There was period of years and months where I couldn't really bring myself to eat but when I got really desperate to eat I would kind of force myself to have a protein shake or maybe a cup of black coffee. I would force myself to eat nothing (5, 9, 1). Madeline explained that she has never sought therapy due to denial, and because her career as a model reinforces her food restriction behaviors.

Additionally, several participants stated that they count calories as a method of limiting the amounts of food they intake, and in some cases they feel full, without the caloric intake. Sophie said that she found alternative ways to control her hunger:

> Sophie: In the beginning I really felt hungry and I didn't eat. It got easier to find ways to trick my hunger…For me it was like the three C's coffee, cigarettes, and carrots. Umm…So, it was those things. Because I had no energy I would just drink coffee. Then I was also smoking at the time, so if I was hungry I would have a cigarette, and then I would eat carrots, because it had no calories and fiber fills you up. Also, I would drink tons of water, just constantly drinking water. (8, 11, 2)

Amy, who expressed desire to become a dentist, stated that limiting calories was also important to her, and that living in the U.S. culture helped to enforce this:

> Amy: [When I came to the U.S.] I had access to the no sugar added foods, so you could basically eat a lot less calories. (4, 10, 2)

Some participants, such as Sonia and Claire, discussed utilizing alternative techniques to expend and reduce calories in order to aid their weight loss and compensate for any calories consumed:

> Sonia: I'm always on a diet…I keep my calories very low. I exercise everyday. (10, 2, 1)

> Claire: Sometimes those [anorexic] thoughts will still come up, and I have to just push them back. Some of the thoughts at that point were things like, "Oh that is a bad food, you cannot eat that under any circumstances". To the point where if I

were to eat something and then realized halfway chewing the food I would actually spit it out and wash my mouth. (9, 20, 2)

Claire said that she later sought treatment for her eating disorder, after her mother noticed her weight loss and affirmed that she was losing weight.

Difficult to stop cycle. Participants described a number of automatic thought responses that became part of their life with anorexia and food restriction. Vicki said she sought treatment for her eating disorder, but did not find the treatment useful. She expressed a difficulty halting the process of food restriction once it began, "Once I started [to restrict food] I started to get some results, and it was very difficult for me to stop. Consequently I wanted to get more, and more, and more weight removed and when I got my weight off I wanted to build my body, so that was another step in my life" (3, 4, 1). In some cases, such as with Kate, food restriction did not begin on purpose, but once it was initiated it was hard to stop:

Kate: …When I started losing weight I felt good because I lost about eight pounds. I looked good. So, after about a month I started to do it purposely, sometimes because I wanted to lose a few more pounds. (6, 11, 2)

Some women described difficulty in ceasing the behaviors of self-starvation due to seeing evidence of weight loss results and a mindset telling them to lose more weight. Kate said, "There was something that kept telling me I need to lose more weight and that I was looking fat" (6, 5, 1). Such thoughts appeared to be obsessive in nature and manage and control the women as Claire stated, "I had nothing in control at all…" (9, 27, 3). This anorexia mindset appeared to restrict the participants' abilities to cease the cycle of food

denial, and instead reinforced the continuation of restricting food. For instance, Amy and Sonia, noted being consumed with thoughts of losing weight:

> Amy: I think I will never think I am thin. I think that there has got to be something in the brain of people who have eating disorders…I never see myself thin. (4, 21, 4)
>
> Sonia: I obsess about my weight. I talk about it. I take my weight everyday. Everything I put in my mouth I think about. I plan ahead. I stay away from rice, carbs, cookies, stuff like that. I don't drink soda. (10, 8, 1)

Many of the restrictive behaviors were reported to be responses to concerns about weight, but ranged and varied. In some cases, participants appeared to obsess about weight loss or desire for weight loss (wanting more of it), such as Claire who expressed her obsession, "Once I started to lose weight I decided to up the anti" (9, 12, 2), and Sonia who noted her desire for weight reduction, "I like to have a flat stomach" (10, 6, 1). In order cases, women focused their attention on their own weight gain, such as Cindy who said, "If I see that I've gained weight than I typically restrict what I eat that day" (7, 14, 2), and Nancy who noted, "Every time I realize the weight problem…If I watch what I eat for like a week, um…and exercise right, you can see I lose weight easily" (2, 31, 3).

In many cases the behavior of food restriction and weight loss became a way of life, which further decreased the women's abilities to stop limiting their food intake. This sentiment was echoed by Cindy who noted, "After almost 13 years it's ingrained in me and I am comfortable at this weight" (7, 12, 2). In some cases the women did get help mostly per intervention from their family of origin. Only four women in the study sought

professional help to break the cycle. Others stated their issues regarding treatment, such as Amy who said:

> Amy: I did try two years ago to seek therapy ummm and treatment, but it's very hard when there is that culture difference. I just found that they didn't understand what I was coming from, my culture. I didn't like that they were trying to give me medication. I don't like medication very much… (4, 6, 1) I'm not the same as the person who is coming right after me for an appointment. We're all different, and although there are those fundamental things that are the same…We're all going to have our own stories and our own reasons for being the way we are. (4, 37, 6)

Feeling like an outsider. Not only did the participants appear to be affected by internal negative reinforcers (such as physical or mental), they were also affected by negative occurrences in their relationships. This was particularly evident in their experiences of outsider awareness. Sophie described feeling "more like an immigrant to them [my family] than to myself" (8, 25, 3). She said, "I am an outsider them [my family]" (8, 37, 4). Several participants, such as Sonia, noted feeling like an outsider for looking too thin. "Every time I go back home everybody always says, "My goodness she's so thin, she looks terrible, she looks ugly"…(10, 26, 3). Nancy described how her thinness and food restriction behaviors are perceived those in her culture:

> Nancy: My parents yell at me [for restricting food] and I know some of my friends…every time I go back to visit they are the same, like their parents are not happy and they complain. Even we go shopping to buy clothes, and the older generation sales people they ask, and they say "do you starve yourself?" "you are skinny". And there is all kinds of comments that people make. (2, 19, 2)

Several participants, such as Cindy and Vicki, noted how their food restriction and weight loss impacts their mothers:

> Cindy: My mom tells me I'm too thin, that I need to gain a couple of pounds… (7, 9, 2)

> Vicki: My mom says that I am taking her life away from her. That whatever phone call she has with me she phrase that if something happens to me she feels very powerless because there is nothing she can do and she prays and begging me to do something. She will do anything possible for me to get better. (3, 13, 2)

In some cases, participants discussed how denying food is in direct conflict with how their cultures of origin view food. For instance, Sonia noted that some people in Guyana cannot afford to buy food:

> Sonia: In Guyana if you are thin, if you are skinny, it's probably because you can't afford to buy meat. You have no choice, but to buy vegetables. I think the typical person in Guyana thinks that behavior [restricting food] is very strange and will turn their nose up to someone who is very conscientious of what they eat. (10, 13, 1)…

Sonia, said that her restrictive food behaviors set her apart from how others think in her culture of origin:

> Sonia: I felt like an outsider to Guyenese culture then and I still do. I don't quite fit in with Guynese people. But I feel less of an outsider in American culture. (10, 26, 3)

While many participants in the research expressed that the pursuit and achievement of thinness served as a vehicle to fitting in and generating a sense of

belonging in American culture, several women discussed experiencing a sense of outsider awareness with their own families of origin that came with their newfound lifestyle. In some instances, the participants' extensive weight loss represented breaking away from cultural standards and values. This was the case with Sophie:

> Sophie: I'm an outsider to them [my family]. I feel like an outsider. It's not the culture itself because I listen to Latin music everyday, and I speak Spanish perfectly, and umm, and I like the food and all that. It's the dysfunction inherent in the cultural ideas that make me feel like an outsider, not the real culture itself. But, with people who aren't Latino I feel more at home. So, I've had to like, find a new family. (8, 37, 4)

Amy described being a disappointment to the family since her anorexia would not allow her to comply with familial expectations, such as arranged marriage:

> Amy: 85% of my family members were married through arranged marriages, but I've been told that I am not expected to do that. Although I have had arrangements made, but because of my eating disorder I wasn't able to pursue them. I think that I am getting to the point that I realize that maybe I am not going to get married because…there is the expectation that you need to get married to reproduce, you need to provide kids. So, I am struggling with not wanting that right now, and not wanting to be disappointing either to the family because that's a big thing. It's a major struggle for me too because in the culture that I've raised in you always try to please the family. Everything is about keeping the family name and living up to the family standards and expectations and values. And so…when you are the only one who is not moving ahead and maturing the same

> way as everyone else, you feel like you are disappointing. It almost like makes you want to go back into that eating disorder like mind, because it's like "I'm already screwed. I am not doing what they want, so I might as well continue doing what I am doing, and try to at least master that". (4, 30, 5)

Other participants, such as Eugenia, discussed how their new lifestyle of food restriction changed their relationship to family of origin rituals, such as their lack of participation in traditional family meals:

> Eugenia: I've definitely have stopped going to Brooklyn and having dinner with my family, because I knew I couldn't you know…it wasn't a situation that I could stop eating. Ummm…You know…What's on your plate you have to finish. I'm a lot more comfortable here in Manhattan. You know, I can eat what I want, I can do what I want. When I go back home I don't have that choice, that luxury. (1, 13, 2)

Ultimately, experiences of outsider awareness appeared to have an impact on some participants more than others, but several women in the study were aware of themselves as being different from their family of origin and experienced a sense of separation from aspects of their cultural roots. Eugenia described this feeling of not belonging with Russians when she said, "I feel more comfortable with my American friends than I do with my Russian friends or family. I don't talk about this [anorexia] with family" (1, 5, 1).

Grounded Substantive Theory

This discovery-oriented research revealed several insights and a central finding on the theme of separations/connections that emerged from the interview data. First, the

diverse women suffering from anorexia who were eager to participate in this study dispelled myths that ethnic women may be immune from the development of anorexia. Additionally, the detailed descriptions of the immigrant participants' lives of food restriction revealed numerous complex factors, which participated in their drive for self-starvation and the maintenance of those behaviors once the process began. Such factors for initiating food restriction particularly related to their unique experiences of life in their country of origin versus life in America as noted by Amy who stated, "There was not much labeling [in Iran], like they do here…(4, 11, 2); transitional processes, such as Claire who expressed being "in a time of transition" (9, 8, 1) and Madeline who stated, "I couldn't communicate with anybody, and it was kind of like feeling very trapped until I learned how to speak English…" (5, 23, 3); experiences of feeling like an outsider, such as Eugenia who said, "[The feeling of being an outsider] was definitely much more heightened here [in the U.S. because it was just….I was just not fitting in (1, 9, 2); and the quest for belonging which was expressed by numerous participants who shared similar sentiments as Cindy, "I guess [I wanted to] fit in to the standard and with the norm here or what I thought was the norm" (7, 2, 1). For many participants, thinness and the pursuit of it appeared to be a vehicle to achieve something more in their lives and relationships with others in the new world. Nancy stated, "A lot of things go through my mind, and thinking uh…if I am skinnier, I'll become prettier, and I'll get more attention and people will like me more…" (2, 8, 1). For other subjects thinness represented breaking away from old cultural values and traditions and into who the participants wanted to be for themselves. Amy echoed this value when she said, "I don't want to be in a little box. I want to be my own person" (4, 32, 5). Once the process began, participants

noted it was difficult to stop restricting food, and few subjects mentioned seeking treatment for their anorexia due to a number of reasons.

The opposing experiences of separations and connections emerged as a central theme reflected throughout the interview data as indicated in Figure 1. The participants' primary connection to their past lives in their countries of origin mostly included their experiences of separation or feeling less connected to their native cultures. It is important to note that the notions of separations and connections emerged from the data interviews themselves, but appears to be related to assertions by Flemons (1991). Flemons referred to the mutual influence of connections and separations on human existence, "connection and separation cannot be considered apart from each other, but must be considered a part of the distinction which, in separating them, connects them" (p. 32). Flemons (1991) specifically describes separation as being "a boundary which distinguishes *this* from *that* which is it not" (p. 25). The participants' comments regarding their distant relationship to their country of origin appeared to indicate their unique experiences of feeling separated to their connection with aspects of their native culture. For example, several participants noted experiences of feeling like an outsider to their family or origin, such as Sophie who said, "I am an outsider to them [my family]" (8, 37, 4). Several participants also identified feeling a sense of separateness or outsider awareness with others in their culture of origin (including family members) following extensive weight loss which often occurred following their move to the U.S. Subjects frequently noted feeling different than others in their native culture and breaking away from the beauty norms and/or traditional female values of their culture of origin. Sophie spoke of this in her interview, "I am an outsider to them [my family. I feel like an outsider. It's not the culture itself…It's the

dysfunction inherent in the cultural ideals that make me feel like an outsider…So, I've had to like, find a new family" (8, 37, 4).

It appeared that participants began to struggle with their self-identity following their move to the U.S. As previously stated, their experiences of life after immigration were frequently a stark contrast to life in their native countries. The new world culture was presented as a difference from the daily lifestyle and family involvement they were accustomed to, and such differences appeared to heighten their sense of outsider awareness in the U.S., as well as the awareness of differences between U.S. culture and their culture of origin. Experiences of transition and integration commonly challenged the identity of the participants on many levels. In most cases, the respondents did not feel they fit in with the beauty standards of U.S. culture emphasizing celebrity thinness. Cindy indicated this in her interview, "I just thought there was an expected weight or body type here, which was different from what I was used to" (7, 3, 1). Additionally, the culture change they experienced separated participants from the daily lives they once knew, which required adjustment on many levels. These experiences of difference may have been exacerbated by such issues as—language barriers, differences in U.S. food choices, and differing relationships and responsibilities from what the participants were used to in their country of origin. Claire summed up this period of time in her life when she said she was "in a time of transition" (9, 8, 1). Many respondents also discussed the difficulty with trying to find their way following their transition to the U.S., such as Madeline who stated, "When I got here you are surrounded by people that don't understand you and you need to talk to them. Like you are kind of in this box where you can't talk to anybody around you" (5, 23, 3). In conclusion, at this level of integration into the U.S., the

participants appeared to experience both a sense of separation from life as they knew it and from the new life they were aiming to become a part of.

Participants then took measures towards increasing their sense of integration and assimilation to U.S. society through the vehicle of thinness. Madeline recalled, "For awhile I thought it would make me more popular [being thin]"… (5, 10, 1). At this stage, participants appeared to actively utilize the pursuit of weight loss in order to achieve something more for themselves in their new world life. For many subjects the process of denying food appeared to concretize their separation from the life and values they knew in order to further connect or assimilate them to Western cultural standards. In regard to the benefits of thinness, Eugenia stated, "I think a lot of it is really just confidence. I get treated equally, um…You know, I don't get looked down upon. So, it's more just getting treated equally" (1, 17, 3). Some subjects also described breaking away from their roots and creating a new identity for themselves through thinness. The practice of achieving thinness was facilitated by the freedom they experienced from being separated from the structure of their family of origin and the expectations of their cultural roots. Vicki discussed the impact of freedom from her roots, "I decided it's time for me and I can do it [lose weight], and I don't have my mom's strain [about my food consumption] that I have back in Russia…" (3, 3, 1). Separating from one's past identity and connecting to the new culture appeared to be reinforced by Western media messages that promoted ideals of thinness. As Sonia noted, "All these shows they have, what do they do to get into shape. When I watch that it makes me ever more obsessive, then I realize there is so much I need to do to get into better shape" (10, 38, 4).

Finally, respondents discussed their life experience following their self-transformations into a thin person. They noted a variety of positive and negative reinforcers encouraging this new and anorexic self, which in many cases fostered a variety of both connections and separations in their lives. In regard to experiences symbolizing connections, respondents primarily noted feeling a sense of belonging and fitting in with others that they attributed to their thin physique. Madeline stated, "I was more accepted when I lost weight, when I wasn't so curvy or umm…It's easier to be accepted" (5, 13, 2). Being thin frequently set off a series of empowering feelings and positive responses from others that allowed them to generate connections to American society. Subjects in the study appeared to indicate becoming connected to an increasing sense of self-confidence, which enabled them to foster relationships with others and achieving results. Cindy stated, "…because I felt more confident I met new people and stared dating" (7, 6, 1).

As respondents discussed their experience with anorexia, they also described their increasing connection to the maintenance of a lifestyle of anorexia and use of it as a way to cope, as well as separation from a healthy relationship with food. Madeline stated, "I might get upset about something, and then I stop eating for weeks" (5, 30, 4). However, participants also discussed how their connection with anorexia led them to separations in other areas of their lives. For instance, some respondents described their separation from their physical wellness including loss of fertility. Vicki expressed issues with fertility and the impact on her, "…I was diagnosed with a fertility problem…I always wanted to have a child, and it took years to get used to the idea that I am not going to get pregnant" (3, 6, 1). Additionally, participants noted an increasing separation from feelings of hunger, such

as Amy, “I don’t get hungry, and I think it’s because when you starve your hypothalamus doesn’t work properly” (4, 26, 5). Some subjects also described feeling an accelerated connection to specific thoughts and activities geared towards curbing their appetites and compensating for calories consumed. For instance, Sophie noted tricking her hunger utilizing “the three C’s coffee, cigarettes, and carrots” (8, 11, 2). Along these lines, participants discussed feeling an escalated connection to their experience of their physical bodies, particularly in regard to obsession with weight loss. They described an increasing desire to separate from potentially gaining weight in order to achieve or maintain weight loss. Claire stated, “Once I started to lose weight I decided to up the anti” (9, 12, 2). Such concerns regarding initiating or maintaining weight loss appeared to exacerbate connections to recognizably anorexic behaviors of obsession with weight loss. Sonia indicated this when she stated, “I obsess about my weight” (10, 8, 1). Interestingly, participants in the research did not refer to themselves as feeling fat, but focused more on wanting to be thin to avoid or reduce weight gain. Nancy noted, “Every time I realize the weight problem…If I watch what I eat for like a week, um…and exercise right, you can see I lose weight easily” (2, 31, 3). Participants frequently emphasized a strong connection with their food denial. They also expressed an inability to stop the cycles of food restriction, especially since in some cases, the denial of food was utilized as a coping mechanism to elevate mood or cope with negative life experiences. Nancy noted, “Before I restrict food I am depressed and then after about two weeks or a month I see you know…I see results [of being thin]. I am really happy. I am not depressed anymore” (2, 18, 2).

Despite feeling an increased sense of connection and belonging with those in U.S. culture as a result of weight loss, many participants discussed experiencing outsider awareness on a different level than before. In some cases, they described a dual sense of connection and separation. While they discussed feeling accepted by those in U.S. culture and being successful as a thin person, they described still feeling different than others because of their weight loss. Sonia noted, "I definitely think [people treat me different as a thin person]. Career wise I think I've benefited a lot from being thin and being in good shape" (10, 34, 3). Additionally, some subjects discussed experiencing an increased feeling of separation from their families of origin as a result of their new lifestyle of thinness. Sonia recalls, "I felt like an outsider to Guynese culture then and I still do. I don't quite fit in with Guynese people. But I feel less of an outsider in American culture (10, 26, 3). Thus, at this level of the participants' identity, they appeared to develop greater connection and assimilation to life in the new world, along with some sense of outsider awareness in both their native culture and in U.S. society.

In Chapter Five, we will reflect back upon the research question; evaluate how the conducted research addressed the question; and engage in a discussion regarding strengths and limitations of the research, as well as explore directions for future research inquiry and clinical practice.

Chapter V—Implications of the Research

The goal of this research was not to discover or generate generalizable results, but rather to broaden existing information regarding perspectives of the drive to restrict food intake amongst immigrant ethnic women to the U.S. suffering from anorexia. Through the implementation of a grounded theory methodology, this research explored the rich descriptions of a sample of anorexic immigrant participants who identified themselves as initiating food restriction one year prior to or following immigration to the U.S. This chapter will explore the emergent theory resulting from the constant comparative analysis of the interview data and discuss research implications including: a comparative review of the research data versus previously known and unknown information; strengths and limitations of the study; future research directions; and practical applications of the research.

Comparative Data Review

This section will thoroughly review and compare and contrast the interview findings with previously known and unknown information cited in Chapter Two. To accomplish this task, each research category in Chapter Four will be reviewed accordingly by section.

Past Life in My Country—Protected from Anorexia

The research findings of this study challenged and dispelled myths that ethnic women are protected from eating disorders such as anorexia, and noted that they do in fact suffer. The results of the research pertained specifically to immigrant ethnic women following their move to the U.S., which may have influenced the findings. However, rationales cited in the literature review of this research stating that women of color are

protected from a desire to lose weight was unfounded as evidenced by the level of inquiry from anorexic immigrant participants in the study. Additionally, previously speculated mainstream notions were challenged by this research that—ethnic women are thought to be reluctant to accept, identify, and internalize ideals of dieting and thinness in mainstream Western culture (Gilbert, 2003; Palmer, 2008); they may experience less social pressure to conform to thin ideals than White women (Childress, Brewerton, Hodges, & Jarrell, 1993; Powell & Kahn, 1995; Striegel-Moore, Schriber, Pike, Wilfley, & Rodin, 1995); they have more role models and kinship networks protecting them from looking to media for self-other comparison (Greene, 1994); and they are more likely to describe beauty in terms of personality traits as opposed to physical characteristics (Landrine, Klonoff, & Brown-Collins, 1992; Parker, Nichter, Vuckovic, Sims, & Rittenbaugh, 1995).

Additionally, the results of this research emphasizing the individual's relationship to their self, family, and culture support notions focusing on the importance of familial and relational contexts surrounding eating disorder symptoms. This includes the emphasis the Maudsley model places on how individual, family, and sociocultural influences interact to maintain the disorder (Dare & Eisler, 1997).

The following sections will explore and discuss the above comparisons and their implications in greater detail.

Different Lifestyle/Non-Diet Culture

The research findings point to the different focuses regarding food, exercise and ideal body types that participants experienced in their culture of origin. They appeared to make comparisons between their lifestyle in the U.S. versus in their native cultures. The

participants described how the different lifestyle of their culture of origin protected them from an increased desire to restrict food, which supports notions regarding the protectiveness of their ethnicity and culture. However, such information was applicable to the participants only when they were residing in their country of origin. This often had to do with the fact that participants in the study believed that they lead a healthier lifestyle while living in their countries, which was mainly due to lack of nutrition labels, decreased emphasis on diet products, healthier and less fatty foods to consume, and increased exercise which was a natural part of daily life. Specific information regarding how ethnic immigrant individuals view their lives in their country of origin as different is worth further exploration.

Different Beauty Ideals

The notion that ethnic women may experience less social pressure to conform to thin ideals than White women (Childress, Brewerton, Hodges, & Jarrell, 1993; Powell & Kahn, 1995; Striegel-Moore, Schriber, Pike, Wilfley, & Rodin, 1995) applied to participants in the study, but only when they resided in their countries of origin. Many of the women described women in the native culture as looking more realistic and not similar to media images of "skinny" American women that they were exposed to even while residing in their countries. Unlike research with Fijian girls exposed to media images that showed changed attitudes about diet, weight loss and aesthetic ideals (Becker, Burwell, Gilman, Herzog, & Hamburg, 2002), women in this study appeared to more easily resist these messages while living in their countries. Some women indicated that they were impressionable to western media images, but were not inclined to act out food restriction behaviors while residing in their native land. This information supports

ideas of globalization of western media images and its potential impacts on ethnic women living in foreign countries. It also indicates that women may not necessarily be impressionable to such images or inclined to act out on the Western messages they are exposed to while residing in their countries of origin. Future research may therefore further investigate the strengths and resources of ethnic cultures, which may serve as counter-influences of Western media images promoting thinness.

Family Influence

The impact of the family system appeared to be a strong component in counteracting or diminishing the participants' desires to restrict food intake while residing in their countries. While several family therapists have noted that enmeshed family contexts characterized by overprotection and rigidity can influence the development of anorexia (Minuchin, 1978; Selvini-Palazzoli &Viaro, 1988), the exact opposite was noted in this research with immigrant women while they resided in their countries of origin. In fact, in many cases, participants noted that their tight-knit family structure overpowered their own ability to deny food prior to moving to the U.S. Some participants discussed how food restriction behaviors were unlikely to occur in their native countries due to the impact of the family involvement there. Therefore, family involvement appeared to be an important factor in protecting individuals from anorexia. Future research may seek to explore the specific qualities of tight-knit families in foreign countries which may serve as a protection instead of in the development of anorexia, as suggested by Minuchin (1978) and Selvini-Palazzoli and Viaro (1988), and/or explore how the structure of the family may interact with the larger cultural contexts in order to perturb the influence of thin media messages.

Transition to U.S.—Free and Unprotected

Systemic perspectives have focused on the individual's relationship to dominant societal discourses and have located problems in larger cultural contexts. Some researchers have emphasized the importance of a contextual understanding of self-starvation as it relates to the family and society as being particularly relevant in order to "shed light on the psychological struggles of modern women in a modern society in transition" (Ma, Chow, Lee, & Lai, 2002, p. 58). The concept of transition has been somewhat focused on in the literature, and food denial has been related to such experiences of transition. Thompson (1996) found that in interviews amongst eighteen women of various socio-economic status and race, eating disorders were frequently a response to environmental stress, such as abuse, racism and poverty. Bulik (1987) asserted that eating disorder symptomatology may be a response to psychological reactions related to immigration. The work of Katzman and Lee (1997) also suggested that eating disorders are a "problem of disconnection, transition, and oppression, rather than dieting, weight, and fat phobia" (p. 392), and pointed to the influence the transitional process can have on individuals. They noted, "transition, as women's attempt to move between two worlds and oppression, as efforts to adapt to a new culture, whether it be a different country, socioeconomic or subcultural group, or a work force historically dominated by men, may result in women attempting to perfect their physical selves as a method of coping with the prejudices and isolation that ensue" (p. 392). The findings of this research unveiled similar themes of transition in the immigrants' lives and the experience involved as they transitioned from one culture to another. One difference, however, was that symptoms of self-starvation were not simply indicated as "a problem

of disconnection, transition, and oppression, rather than dieting, weight, and fat phobia" (Katzman & Lee, 1997), but *both* a problem of transition and dieting and weight consciousness. This section will further explore specific themes regarding transitional arising from the research data, and compare and contrast learned information to what was previously known.

Culture Change and Adjustment to New World

Participants in the study frequently contrasted life in their culture of origin to their present experiences in the U.S and described their adjustment processes. All the subjects experienced culture change by the nature of their move from one culture to another, which influenced their self-starvation on some level. This information was in accordance to what Greenberg, Cwikel, and Mirsky (2007) suggested, that food denial may offer immigrant women a means to "negotiate transitions in values, expectations, and the conflicts they feel in absorption into a new society" (p. 56). Culture change is a concept that has been discussed by some researchers. It emphasizes, "the difference between two cultures, rather than a particular culture itself" (Soh et al., 2006, p. 58). Such experiences have been thought to contribute to eating disorder disturbances amongst immigrants. This research revealed specific aspects of culture change thought to have contributed to an increased sense of vulnerability amongst the participants themselves at a time when such change required increased independence and responsibilities for themselves. Participants frequently mentioned difficulty adjusting to the new lifestyle in America, new food and exercise, language barriers, differing responsibilities, the process of breaking free from family connections, and lacking healthy role models in their daily lives. At this stage of their transitional process, participants appeared to note and try to reconcile the difference

between the cultures they were from and the culture they are now living in. This information appears to support the assertion that the development of eating disorders in some immigrants may be the effect of "culture change syndrome" as opposed to "Western culture bound syndrome," which suggested that individuals from non-Western societies had immunity to eating disorder pathology (Gordon, Perez, & Joiner, 2002; Lai, 2000). It also supports the notion that a "clash between traditional and adopted culture may heighten the risk for eating and body image disturbance" (Soh et al., 2006, p. 58) in susceptible individuals (Bhugra, Bhui, & Gupta, 2000; Thomas, James, & Bachmann, 2002; Tsai, Curbow, & Heinberg). Specifically, several women in this study described their freedom as both friend and foe in that they came to America in the pursuit of their dreams, but became imprisoned by the lack of supports and comforts of the lives in which they knew. Future research may further investigate the high versus low levels of culture change. For instance, research may explore the differences between perceived aspects of American culture compared to aspects of other specific cultures, so that clinicians can be aware of these dissimilarities which may impact adjustment experiences for those immigrating to the U.S. Additionally, it may be worth investigating the concepts of high level versus low level differences between aspects of the participants' culture versus American cultural standards, which may heighten risk for increased vulnerability to eating disorder symptoms related to culture change.

New Beauty Standards and Trying to Fit In

Sociocultural theories of food restriction have argued that American emphasis placed on slimness can be especially conflictual for immigrant women especially if native beauty standards are different. For instance, Wildes, Emery, and Simons (2001) noted

that Asian women living in Western countries are at high risk for the development of eating disorders since they may feel "additional pressure to be thin due to their inability to meet other white beauty standards" (p. 540). Similar sentiments were indicated by participants who noted feeling an increased sense of outsider awareness following their transition to the U.S. In many cases, the subjects expressed feeling different and not fitting in. It appeared that most women interviewed in the study sought to assimilate to American culture, which resulted in breaking away or disconnecting from their cultural roots. This was similar to what Abrams, Allen, and Gray (1993), Pumariega (1986), and Silber (1986) suggested that women of color with increased levels of acculturation had significantly higher levels of eating and body disturbances (e.g., restrained eating, drive for thinness). Glowinski (2000) also maintained, "the incidence of eating disorders increases in women from non-Western cultures when they move to a Western society and assimilate to the host society norms and values, including those relating to the ideal female body shape" (p. 84). It is important to note that acculturation levels of individuals who participated in this study were not known. However, the impact of acculturation levels before, during, and following immigration to the U.S. may be explored in future research. Additionally, it may be worth investigating the correlation between acculturation and one's sense of connection to the new culture, since such themes were frequently expressed throughout the course of the interviews. A significant aspect to consider may be the extent of the family's involvement in the individual's life, during the individual's attempt to assimilate to the new culture, as well as the participants' relationships to their culture of origin.

Freedom from Roots

Immigrants in this study did not express factors associated with greater eating disorder pathology amongst some ethnic women. For instance, they did not discuss feeling guilty for having access to an "abundance of food" (Bulik, 1987, p. 139) compared to their relatives left behind. They also did not typically discuss conflicts with their family of origin regarding going out, contact with the opposite sex, and dress norms (Furnham & Husain, 1999; Humphry & Ricciardelli, 2004; Shuriquie, 1999). Interestingly, women in this study expressed that having freedom from their roots and culture enabled them to restrict food intake. In some cases, subjects discussed having the desire to restrict food prior to moving to the U.S., but not acting out on this desire while living in their country. They often cited their family participation as protecting them from pursuing food restriction. This information was different from what Minuchin and colleagues (1978) hypothesized that enmeshment and overprotection are characteristic of anorexic families. One rationale for this difference may have been the unique experiences and cultural differences in perceptions of immigrant women themselves who frequently reported separating from their culture of origin and integrating into the new culture. Additionally, it appeared that increased autonomy or freedom from one's roots and culture, not "lack of autonomy" as noted by Humphry and Ricciardelli (2004) and Shurique (1999) encouraged eating disorder pathology amongst the interview participants. Future research may further investigate the nature of one's ethnic identity experiences on food restriction. Some researchers have already argued that ethnic identity and acculturation are important to consider since higher levels of identification with the mainstream culture or Western culture are associated with adoption of the predominant

ideals for dieting and thinness (Harris & Kuba, 1997; Root, 1990). For instance, Abrams, Allen, and Gray (1993); Pumariega (1986); and Silber (1986) showed that women of color with less identification with their culture or higher levels of acculturation had significantly higher levels of eating and body disturbances (e.g., restrained eating, drive for thinness). Stieger (1993) also maintained "that when anorexia nervosa develops in non-Western families, it may often be in those with strong Western affiliations" (p. 350). Therefore, future research may also be concerned with further assessing the impact of autonomy from family of origin on acculturation.

The Pursuit of Thinness—Becoming a New Me

The findings of this research uncovered that participants sought the pursuit of thinness as a vehicle to achieving some sense of empowerment in their lives in the U.S. As one participant stated, "I don't want to be in a little box. I want to be my own person" (4, 32, 5). This thinking is in concordance with what Nordbo et al. (2006) cited in a qualitative study of 18 women aged 20-34 years old investigating the meaning of self-starvation among them. The authors asserted that "clinically meaningful constructs" (Nordbo et al., 2006, p. 558) emerged from their research which included utilizing thinness to create a different identity or personality, and ridding oneself of their old identity to become a better and more likable person; and a way of eliciting care and concern from other people. The information revealed in this study was in accordance with what several previous authors and researchers have suggested. For instance, Bruch (1974) asserted that denial of food intake and hunger as a secondary struggle for identity and selfhood for which thinness becomes a supreme achievement. Additionally, Malson (1998) described that the eating disorder becomes an identity to deal with a lack of

identity. Hepworth (1999) identified such themes of self-control and agency in UK health workers' explanations of identity in anorexia nervosa. This section will further explore the findings of this research that addresses how participants in this study utilized their connection to thinness to break away from their culture of origin and further establish their identity and their connection to U.S. culture.

Breaking into the New Culture

The results of this research appeared to support the cultural assimilation argument that Lake, Staiger, and Glowinski (2000) suggested stating that, "the incidence of eating disorders increases in women from non-Western cultures when they move to a Western society and assimilate to the host society norms and values, including those relating to the ideal female body shape" (p. 84). Most women in the study did not have their family of origin living with them in the U.S. This may have been a significant factor in the participants' assimilation process, since most subjects noted that the behaviors of food restriction would have not been possible in their native countries due to the over-protectiveness of their families. Many women in the study stated the desire to fit in and be liked by those living in the U.S. Participants frequently described the need to be their own person, a thin person, which was facilitated by the beauty ideals of U.S. culture. It appeared as though thinness was seen as a vehicle to connect and link into American culture. This concept seems to align with what Katzman and Lee (1997) proposed that eating disorders are a "problem of disconnection, transition, and oppression, rather than dieting, weight, and fat phobia" (p. 392), and particularly present in individuals who experience 'societal-identity confusion'. They noted "Transition, as women's attempt to move between two worlds, and oppression, as efforts to adapt to a new culture, whether it

be a different country, socioeconomic or subcultural group…[which] may result in women attempting to perfect their physical selves as a method of coping with the prejudices and isolation that ensue" (p. 392). Such information was evidenced in this study, but one difference was that participants' talk appeared to concentrate more on what they felt they could gain in their relationships and connections in the U.S. as a result of thinness. Future studies may be inclined to further research ethnic immigrant women with high levels of assimilation to the U.S., and the differences between those who developed eating disorders and those who have not. Such research may reveal other possible factors contributing to the development of eating disorders in some immigrant women, and potentially uncover resources, strengths, or interventions that allow some immigrants to assimilate and develop connections to U.S. culture without hurting themselves or harming their bodies.

Life with Anorexia—Positive and Negative Reinforcers

There are several areas of the literature that describe the power of reinforcements in maintaining problem cycles in relationships. From the systemic perspective, problems are viewed as created and reinforced by cycles of actions and reactions between people who are interconnected parts of the larger whole (Becvar & Becvar, 1996). This concept has been relevant to what Slade (1984) argued that in limiting food intake, the anorexic simplifies her thinking. As her style of thinking changes, her decision not to eat is reinforced. As a consequence of this she grows even thinner and the cycle continues. It has been noted in this research that the pathology of eating disorder symptoms in participants did not reside simply in the mind of the individual, or in the individual's relationships with outside factors such as family or culture. The locus of problems

appeared in *both* the mind of the anorexic, in regard to how they interact with and connect to their anorexic thoughts, as well as in their relationships with others and the culture around them. Both positive and negative reinforcers noted in this study seemed to encourage the cycle of anorexia in the participants' lives, further connecting them to the drive to self-starvation. However, while positive reinforcers were typically noted in the benefits of being thin and in connecting subjects to the new world around them, negative reinforcers were often internal factors such as the mind of anorexia itself, driving participants to carry through with particular restrictive behaviors and rituals in their daily lives. Ultimately, the combination of reinforcers often cycled into destructive sets of patterns connecting the participants to an existence of extreme weight loss, which will be furthered explored in this section.

Positive Reinforcers and Benefits of Being Thin

The research participants frequently noted increased experiences of self-confidence as a result of being thinner. Many participants linked their thinness to improved treatment from others, and social and career benefits. Several participants noted feeling positive encouragement from others, which perpetuated the cycles of food restriction. These findings are in concordance with several previous theories including learning theory which suggested that weight loss can invite a great deal of attention to the anorexic (Vandereycken & Van Deth, 1994). Others such as Banks (1992) stated that extreme emaciation in one such patient was "a means of attracting attention from her peers and family" (p. 875). However, it appeared in this research that there was a particular kind of attention and acknowledgement that immigrant women appeared attracted to which was more positively oriented towards their weight loss. Many

participants noted improved dating life and approval from men; getting positive feedback from Americans about their weight loss; and greater ability to blend in with what was perceived as U.S. cultural standards of beauty. Such influences seemed to be important to the women interviewed in this study, which appeared to make the loss of weight worthwhile for them in many instances. Future research can explore the relationship between self-confidence in immigrant women who restrict food and positive feedback from others. Specifically, researchers may consider further investigating the impact of particular kinds of positive feedback from others on self-confidence levels of the anorexic immigrant.

Negative Reinforcers

The findings of this research revealed a range of reported internal consequences of food restriction, which appeared to then perpetuate the process of denial of food from the inside the mind of the anorexic to their outside behaviors. For instance, Amy said, "No, I don't feel hunger. I think that is what happens to you, you lose that visceral function so to speak. You don't have a sex drive, I never feel thirsty. I don't drink water. I don't get hungry…" (4, 26, 5). This process was in concordance with assertions by Slade (1984) and Macsween (1993) that through the process of food restriction the anorexic's thinking changes and this way of thinking reinforces her desire not to eat. The following section will explore in more detail specific factors identified by the participants as being connected to their life with anorexia, and contributing to the maintenance of the problem itself.

Physical instability and mood changes. It is a well-known fact that eating disorders, such as anorexia, can have physical health consequences for women. However,

in this study the emotional impacts of fertility issues resulting from food restriction appeared to be especially relevant to the lives of several immigrant women who identified wanting to have children, but not being able to. Use of food restriction as a way to cope with underlying emotional issues was a particularly relevant issue for several women in the study, whether those issues related to transitional processes, experiences with the dominant culture, their family of origin concerns, or their relationship to self. Katzman and Lee (1997) proposed that food denial may be a way to cope with transitional process and oppression they immigrants may experience in trying to reconcile conflicting worldviews, however, it appeared that in some cases the denial of food was often reported as a method or attempt to attain some higher level of mood stability in the women interviewed. Such methods of attaining heightened mood through the denial of food are similar to feminist perspectives of the meaning of food in advertising. Specifically in regard to food portrayed as a method of "altering one's mood" (Fallon et al., 1994). Except in this research, the denial of food appeared to be used as a way of altering mood. Future researchers may explore medical and chemical aspects of food denial on heightened mood, and further investigate psychological links between hunger and happiness in immigrant women.

Lacking hunger and controlling calories. Participants in this study frequently noted lacking hunger, which contributed to furthering restrictive food behaviors. This information was in concordance with that unveiled by Lee et al. (2001) who found that Chinese women who refused food noted that some patients gave reasons other than non-fat rationales for the desire to restrict food intake. Some rationales included loss of

appetite, and feelings of no hunger. In some other cases, women stated experiencing hunger but resisting the urge to eat and controlling calories through a variety of methods.

Some theorists have argued that the Latin term anorexia nervosa is misleading because it denotes a "lack or absence of appetite for nervous origin" (Vandereycken & Van Deth, 1994, p. 1) when anorexics do not necessarily suffer from lack of appetite but a "desired or deliberate suppression of appetite and hunger" (p. 1). However, the data in this study revealed that in many cases, participants suffered from *both* a lack of appetite and suppression of appetite. They described their increased connection to controlling calories and resisting hunger in an effort to attain thinness. Future research may explore the relationship immigrant anorexics have to experiences of hunger, and if and how these experiences escalate their connection to anorexia and the behaviors involved in maintaining a life of anorexia.

Difficult to stop cycle. The research interviews revealed cycles of food restriction that became difficult to stop once the process began. In some sense, the anorexia appeared to be an identity that took on a life of its own in the subjects' lives. While there was no direct evidence that the participants' lacked a clear and enduring self that Slade (1984) asserted reinforces acts of food control, it did appear that the psychological consequences of starvation morphed from a deliberate act, to a trap that escaped the individual's control, as Slade (1984) suggested. This lack of control was evidenced by a subject who stated, "Once I started [to restrict food] I started to get some results, and it was very difficult to stop. Consequently, I wanted to get more, and more, and more weight removed and when I got my weight off I wanted to build my body, so that was another step in my life" (3, 4, 1). Slade argued:

> By severely reducing the amount of food she eats, the anorexic simplifies her thinking. As her style of thinking changes, her decision not to eat is reinforced. As a consequence of this she grows even thinner and the cycle continues. The more emaciated she becomes the easier it is for her to make the decision not to eat. So she spirals downward. (as cited in Macsween, 1993, p. 36)

Slade proposed a medical understanding that starvation changes the way people think, which then results in a decline of the individual's intellectual capacity and reasoning. In turn, Slade says that the individual is thought to see the world in simple sets of categories such as good and bad, black and white, and such thinking exacerbates the individual's preoccupation with food control. This way of thinking was indicated by numerous participants following the onset of their food refusal behaviors.

It was undetermined in this study if the anorexia mindset discussed above and evidenced in the interviews was a response to medical consequences of anorexia nervosa, a response to reactions from others, or whether there was a specific kind of relationship that was generated with anorexia itself that encouraged the life of it. Future research may be interested in exploring stages of anorexia and correlating the individual's relationship to the anorexia mindset at those stages. Qualitative research can also explore the dialogues between ethnic women and their anorexic voices to uncover the internal communication dynamics, which may perpetuate one's connection and relationship to food restriction. It would be interesting to learn which kinds of internal communications are more likely to perpetuate a closer connection to anorexia. This recommendation is closely related to a study by Serpell, Treasure, Teasdale, and Sullivan (1999) who asked patients to write a letter to anorexia as a friend and anorexia as an enemy and found that

important benefits of anorexia to the study subjects included feeling protected, and gaining a sense of confidence. Drawbacks to their study included constant thoughts of food, suffocation of emotions, and loss of social life. It was also suggested that a more interactive method of inquiry may have provided more data and strengthened the validity of that study (Nordbo, Psychol, Espeset, Gulliksen, Skarderud, & Holte, 2006).

Feeling Like an Outsider. While participants in the study did report experiencing an increased connection and assimilation to others in the U.S. following attaining thinness, they also reported the experience of feeling like an outsider on many levels. Some subjects discussed being an outsider to their family of origin as a result of their new lifestyle. It has been noted in previous research that more acculturated women may be more likely to have eating disorders (Chamorro & Flores-Ortiz, 2000; Gowen, Hayward, Killen, Robinson, & Taylor, 1999). However, outsider experiences to one's family and culture of origin are less cited in the literature, and the impacts on immigrant women are worth further research exploration. Several researchers have identified factors relevant to experiences of culture clash, including internal conflicts, sense of disconnectedness, poor self-perceptions, lack of autonomy and sense of control over one's life which have all been posed as a means by which culture clash may lead to eating pathology (Humphry & Ricciardelli, 2004; Shuriquie, 1999). In this study, some participants did not feel their small size was acceptable by their families and cultures of origin. In other cases, participants discussed how their food restriction was in direct conflict with how their cultures view food. Some participants also described being a disappointment in complying with familial expectations, such as arranged marriage or having a family, which was not possible due to their condition. In many cases, participants perceived their

new appearance of thinness as a breaking away from their culture of origin. Further exploring the nature of outsider awareness as a result of thinness may be relevant to future research with anorexic immigrant women. Specifically, it may be useful to investigate the impacts of outsider awareness with one's culture of origin on the individual's level of desire to maintain anorexia. Additionally, researchers can also explore the differences in norms regarding food, exercise, beauty, and family orientation between specific cultures versus that in the U.S. to determine levels of culture clash that may exist between them. Such knowledge may reveal how differences in cultures in anorexic immigrant women may impact outsider awareness, and encourage self-starvation behaviors.

Strengths and Limitations of the Research

This research explored the experiences of ethnic immigrant women who restrict food intake with hopes of generating new meaning and insights regarding the rationales behind food refusal. The qualitative research methodology driving this study emphasizes the multiple realities of individual experiences as outlined in Chapter Three. As a part of all conducted research, there were numerous limitations in the study worth exploring in greater detail. Such insights may influence the generated theory and future research inquiries.

Participant Sample

The study attracted a broad spectrum of ethnic immigrant women from numerous cultures and backgrounds. This was believed to be of value in the study since such a diverse sample of ethnic women challenges notions that eating disorders primarily affect White women, and instead supports ideas that ethnic women from a variety of

backgrounds do in fact suffer from anorexia. Such information is deemed important in raising awareness amongst researchers and clinicians that ethnic immigrant women are not necessarily protected from the development of eating disorders, as is reinforced by common myths regarding their immunity from such issues. At the same time, the diverse participant sample in the study may have also proved to be a limitation since the values, beliefs, and ideas regarding food restriction might have varied significantly amongst participants themselves given their varying contexts of origin and ethnicity. Nevertheless, the study discovered that despite potential differences or variations amongst the participants, there were interlocking themes that were consistent throughout the data interviews despite the participant's country of origin given similar baselines informing sample selection for research.

While the study sample did reflect a broad diversity amongst the participants in terms of their ethnicity, culture, and country of origin, there were differences amongst them, which may have also impacted the information gathered and ultimately the generated theory. Despite attempts to enlist participants through contacts at a variety of organizations, the majority of participants following through with interviews tended to reflect women of younger age in their twenties and thirties. It is important to note that the research was initially open to women eighteen years of age or older, prior to the onset of theoretical sampling, which then later limited the participants in the study to women solely in their twenties and thirties. Theoretical sampling was useful in this since was discovered that age of participants may influence the perspective of participants, regarding their political, economic, and life experiences. Women were not screened for their socioeconomic background, and this information was not factored into the study

aside from the participants' discussion of their work and career situation. Such information may be relevant to screening participants in future research, given that the participants' socioeconomic levels could potentially influence their experiences of such issues as assimilation, as well as their points of view on particular immigration experiences. It is important to note that many of the participants in the study appeared to be college educated, or currently studying and working from home. Participants did reflect a broad spectrum of careers. However, learning solely from participants who are not employed or college educated may have also yielded a different dimension to the research, and ultimately different results.

Recruitment

Recruitment proved to be challenging for this study for numerous reasons that came to my awareness prior to and throughout the course of the research. First, since the researcher was not native to the native cultures of potential participants for the study, recruitment strategies were limited due to logistical factors, such as lack of knowledge regarding how to reach potential ethnic candidates; inability to attract participants with study advertisements written in their native language, as well as an inability to conduct study interviews with participants in their native language; and difficulties attracting immigrant women who may experience eating disorder symptoms, such as food restriction, but do not identify with the label of anorexia or having an eating disorder. In order to compensate for these discrepancies, I attempted to make the recruitment advertisements simply written and easy to understand. Instead of requesting participants to identify whether or not they had an eating disorder, I asked them to identify demographic information including their height, lowest weight at the time of food

restriction, year when they immigrated to the U.S, and when they began food restriction. When theoretical sampling began, participants were also asked to briefly describe the reasons behind their food refusal. Women interested in the study were encouraged to contact the researcher to ask any questions they might have about the study participation. Those whose body weight were below ideal body weight for their age and height, and at less or greater than 85% of ideal body weight but below ideal body weight, were included in the research interviews. In future research, it may be useful to screen women who are at a specific level below ideal body weight, since variations in low body weight may potentially impact how the participants view themselves, their relationships, and their experience with food restriction.

I learned throughout the course of the study that several words utilized in my study may be useful for researchers and clinicians in identifying participants, but were problematic for recruitment. For instance, it is believed that the words "women of color" initially used in advertisements to recruit participants were a hindrance. Such wording was primarily selected to attract a diverse set of women to the study without attracting any one group of women. However, it became a slight limitation during recruitment due to stereotypes surrounding the term "women of color" and what it means to be a woman of color in America. As defined by the study, "ethnic women" indicates a broad spectrum of women, not necessarily related to black women. I discovered that utilizing this term tended to attract black women from the U.S. and that the word "ethnic" appeared to attract immigrant women who fit the study criteria. Additionally, the word "immigrant" also appeared to be a problematic term for recruiting participants, even though the focus of the study was to attract ethnic immigrant women to the U.S. I learned that many

women who immigrate to the U.S. may not necessarily define themselves as immigrants once they have moved to the U.S. Therefore, instead of referring to the need for "ethnic immigrant women to the U.S.", I requested the need for "ethnic women who have immigrated to the U.S." The use of language appeared to be very important in the recruitment process, possibility due to cultural differences and language differences of the potential applicants. Minor details in the wording of recruitment advertisements appeared to make a significant difference in the levels of interested ethnic participants. This detail should not be overlooked in future research, since it may impact research recruitment of ethnic participants, and therefore generate skewed notions that ethnic women do not in fact suffer from disordered eating.

Clinical and Academic Implications

The information provided by this research was informative, insightful, and further emphasized the importance for practitioners to enhance cultural competency practices when working with immigrant women and families. This includes encouraging clinicians to develop heightened awareness of the complexities of the immigrant's unique experiences so that they can be better served in treatment settings.

As indicated in the research, there are numerous and complex experiences of immigrant women who have become anorexic following their move to the U.S. Such rationales for food refusal revealed in this study appeared to focus more dominantly on relational and sociocultural, as opposed to intrapsychic perspectives of food restriction. Interestingly, the research interviews pointed to numerous theories for rationales for food refusal cited in Chapter Two, which depended on the participants' stage of connection and separation to their culture of origin, the new world, and to their anorexia mindset.

This research unveiled a new theory that systemically unites various rationales of food refusal to contextualize the experiences of ethnic immigrants. In essence, the theory emerging from this research connects the complexities of multiple aspects of the life of individuals who are both anorexic and immigrant to capture their experience in a global sense.

It is imperative that future research, clinical, and academic inquiries aim to further discover the anorexic immigrant women's connectedness and separateness of experience in relation to her self, family of origin, culture of origin, the new culture, and her anorexic mind and physical experiences. It is important for clinicians and researchers to be receptive to understanding and deeply listening to hear all of the complexities of the relational experiences that may be revealed in the stories of immigrant women to the U.S. This process can be facilitated through methods utilized in this study, which included listening deeply aided by open-ended curious questions and member checking throughout the interviews. Through this process, women from a diversity of cultures were able to discuss numerous sensitive topics surrounding their relationships and their eating disorder in great depth. In many cases, several participants said they had not spoken about their eating disorder openly before. Thus, it is believed that deeply listening to the participants' experiences aided the subjects to connect to the interviewer in a way that allowed them to discuss such sensitive topics. In many cases, the participants noted feeling good about the interview process and discussed coming to new realizations about themselves, their lives, and their eating disorder in the research space that set up an open and safe context for their personal and intimate stories with anorexia to emerge.

This research also makes the case that while studies with immigrant women have been lacking in eating disorder research, there is clearly more inquiry necessary and far more research needed to explore and understand the complexities of the immigrant experience. Such factors including time of immigration to the U.S, number of years residing in the U.S., and level of contact with family members of origin (e.g., …whether the family lives with anorexic following immigration) may be important considerations in future studies due to their influence on connection and separation experiences of the immigrant individual to various aspects of their lives.

In conclusion, it is my hope that this research will inform and inspire future academics and clinicians to connect instead of separate from notions that individuals from multiple cultures may be impacted by eating disorders both similarly and differently from upper middle class Caucasian women in the U.S. Participation in this study has broadened my own understanding of the transitional experiences of immigrant women, to reveal a new theory involving connections and separations in the lives of ethnic anorexic women. The emergent theory of separations and connections in this study appears to be universal in the sense that as human beings we can experience numerous connections and separations on a variety of levels throughout the course of our lives. Ultimately, through this research, new connections have been formed, unveiling awareness, and revealing greater possibilities for the future of both clinical and research practices with immigrant anorexic women. Such discoveries will hopefully transform the way we think of and practice with ethnic individuals, and enable practitioners to embrace the unique and complex experiences of immigrant women.

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Appendix A

Letter of Introduction

Dear

I am currently a Ph.D. Candidate in Marriage and Family Therapy at Nova Southeastern University conducting research in the area of eating disorders and related issues. My dissertation is entitled "Drive to "Self-Starvation": Narratives of Eating Disordered Immigrant Women to the U.S.". The purpose of this research is to explore the multiple meanings immigrant women to the U.S attribute to self-starvation symptoms. I am hoping that you or someone you know will agree to participate in the study.

The research data will be collected from interviews with participants over the age of 18 years old. Time involvement will include approximately one interview that should take approximately an hour and a half to two hours. The interviews will be conducted at a mutually agreed upon location. The study may also require an autobiography component of the evolution of the eating disorder and related factors. Information gained from this study may serve to help clinicians broaden their awareness of factors influencing eating disordered behavior amongst immigrant women so that women of color can be better served in treatment settings.

The interviews will take place during September, October, and November of this year. If you would agree to participate in my research study, please contact me as soon as possible. Thank you for your consideration.

Sincerely,

Lisa C. Palmer, Ph.D. Candidate
School of Humanities and Social Sciences
Nova Southeastern University
(954) 907-3446

Appendix B

Informed Consent Form

NOVA SOUTHEASTERN UNIVERSITY
Graduate School of Humanities and Social Sciences

NSU

Nova Southeastern Univ.
Institutional Review Board
APPROVED
Date Approved: 11/30/07
Valid Until: 11/29/08

Consent Form for Participation in the Research Study Entitled
Drive to "Self-Starvation: Narrative of Eating Disordered Immigrant Women to the U.S.

Funding Source: None.

IRB approval # GSHSS11210709Exp.

Principal investigator
Lisa C. Palmer, M.S.
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Institutional Review Board
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Office of Grants and Contracts
(954) 262-5369/IRB@nsu.nova.edu

Site Information
Nova Southeastern University
Graduate School of Humanities and Social Sciences
3301 College Avenue
Fort Lauderdale, FL 33314

What is the study about?

You are invited to participate in a research study. The goal of this study is to understand and learn what motivates immigrant women to the U.S. to restrict food intake.

Why are you asking me?

We are inviting you to participate because you fit the criterion of being a first-generation immigrant to the U.S. You are English speaking and 18 years of age and older. You also report a desire to restrict food intake. You also attest that your food restriction behaviors occurred one year before or sometime after immigration to the U.S.

What will I be doing if I agree to be in the study?

You will partake in one to three interviews, each consisting of one to 1.5 hours. You can stop the interview at any time, and you understand that this interview is not therapy. You will be interviewed by the researcher, Lisa C. Palmer, M.S. Ms. Palmer will ask you questions about your experience with and drive for self-starvation and food restriction.

Initials: _____ **Date:** _____

3301 College Avenue • Fort Lauderdale-Davie, Florida 33314-7796 • (954) 262-3000 • 800-262-7978
Fax: (954) 262-3968 • Email: shss@nsu.nova.edu • http://shss.nova.edu

NOVA SOUTHEASTERN UNIVERSITY
Graduate School of Humanities and Social Sciences

Is there any audio recording?

Yes. The interviews will be audio taped. This audio tape will be available to be heard by the researcher, Ms Lisa C. Palmer, personnel from the university's human research oversight board (the Institutional Review Board or IRB), and the dissertation chair, Dr Ron Chenail, PhD. The tape will be transcribed by Ms. Lisa C. Palmer. Ms Palmer will use earphones while transcribing the interviews to guard your privacy. The tape will be kept securely in Ms. Palmer's home office in a locked cabinet. The tape will be kept for 3 years following completion of data analysis for the study. The tape will be destroyed after that time by cutting it up. Since your voice will be potentially known by anyone who hears the tape, your privacy for things you say on the tape cannot be promised, although Lisa C. Palmer will limit access to the tape as discussed in this paragraph. Additionally, your confidentiality will be protected with use of pseudonyms throughout the study and in the final text, with the exception of this consent form.

What are the dangers to me?

Risks to you are moderate, meaning they are not thought to be greater than other risks you experience everyday. Being recorded means that confidentiality cannot be promised. Sharing your opinions about your experiences with self-starvation may make you anxious or bring back unhappy memories. If this happens Ms. Palmer will try to help you, and you will be allowed to take breaks during the interview if needed. If you need further help, she will suggest referrals for help and safety plan for you, but you will have to pay for any treatment yourself. You can withdraw from the study at anytime if you are uncomfortable. Some risks for participating in the study include:

- Inadvertent disclosure of sensitive personal information.
- Discussion of sensitive topics during the study interview that may increase mood instability or trigger eating disorder symptoms.
- Physical pain or discomfort in addition to psychological or emotional harm, possible invasion of privacy, and loss of time or pay.

Are there any benefits to me for taking part in this research study?

There are no direct benefits to you for participating, however you may find it useful to talk about your experiences.

If you have any concerns about the risks or benefits of participating in this study, you can Ms. Lisa C. Palmer or the IRB office at the numbers indicated above.

Initials: _____ **Date:** _____

NOVA SOUTHEASTERN UNIVERSITY
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Will I get paid for being in the study? Will it cost me anything?

You will have to pay for gas and transportation to the interview. If you are doing a telephone interview the Principal Investigator will call you in order to eliminate costs of the phone call to you. The Principal Investigator will call you at the scheduled time of the interview in order to protect your confidentiality and minimize risks. Additionally, all participants will receive a psycho-educational packet.

Upon completion of the study you will receive a $25 gift certificate of your choice for gas, a department store, or bookstore.

How will you keep my information private?

The transcripts of the tapes will not have any information that could be linked to you. Pseudonyms will be used in place of your name throughout the study with the exception of the consent form. As mentioned, the tapes will be destroyed three years after completion of data analysis for the study. All information obtained in this study is strictly confidential unless disclosure is required by law. The signed consent forms will be kept separately from the tapes in a locked cabinet. The IRB and regulatory agencies may review research records.

What if I want to leave the study?

You have the right to leave this study at any time. If you do decide to leave you will not experience any penalty, however you will not be eligible to receive the $25 gift certificate. If you decide to leave the study, your data will be retained for three years following data analysis for the study. If you choose not to have your information included in the study, you must inform the researcher.

Other Considerations:

If the researchers learn anything, which might change your mind about being involved, you will be told of this information.

Voluntary Consent by Participant:

I have read the preceding consent form, or it has been read to me, and I fully understand the contents of this document and voluntarily consent to participate in the research study entitled "Drive to "Self-Starvation: Narratives of eating Disordered Immigrant Women to the U.S." All of my questions concerning the research have been answered. I hereby agree to participate in this research study. If I have any questions in the future about this study they will be answered by Ms. Lisa C. Palmer. A copy of this form has been given to me. This consent ends at the conclusion of this study.

Participant's Signature: _____ Date: _____

Witness's Signature: _____ Date: _____

Appendix C

Research Curiosity

- In your own words, describe how self-starvation evolved as a part of your life, and what does it mean to you?
- From your perspective, what happened in your life that led you into self-starvation and restrictive food behaviors, and what does that behavior mean to you today?
- What is the drive behind restricting food intake?
- Please describe your relationship to food restriction and intake and the meaning it has in your life and relationships…
- What were precipitating factors that led you to restrict food intake?
- What is your opinion of your self-starvation behaviors, and what are the costs and benefits to you?
- How did you get into self-starvation behavior and what keeps that behavior going?
- Please describe the precipitating factors that you believe contributed to the eating disorder, your current relationship to the act of self-starvation, what factors, if any, keep it going, and the meaning it has for you in your daily life and relationships…
- History of your eating disorder…When it began, what forms it has taken, what attempts you've made, if any, to control it, and what you see as contributing factors to the desire to self-starve and maintenance of that behavior in your life
- How have engaged in food refusal behaviors in the present and past?
- What does a typical day of food refusal look like and what is typically happening for you before and during the food refusal process?
- What kinds of physical, emotional, relational, or psychological "triggers" may induce the desire to restrict food intake?

Appendix D

Negotiated Outcome Letter

Dear Research Participant,

Thank you very much for participating in the research study. As part of completing the dissertation on exploring the drives to self-starvation amongst immigrant women to the U.S., I would like to invite you to review the draft to Chapter 4. This portion of the dissertation centers around analysis of the research findings.

It would be helpful if you would review the characteristics of participants and the descriptions of the categories derived from the data. I would appreciate your feedback and corrections of there are any inaccuracies.

Please note that I have changed your names to protect your identities as promised, and replaced them with pseudonyms you selected during your interviews. Note that there are three numbers at the end of each interview exemplar that refer to the participant number in the order of interview participation, the line in the transcription, and the page number of the transcribed interview.

I understand that your schedules may be too busy to review the material, but it would be appreciated and helpful to the research if are able to. I welcome your comments, revisions, retractions, and additions to your statements.

You can contact via telephone or e-mail with your comments.

Lisa C. Palmer
499 East Palmetto Park Road
Suite 222
Boca Raton, Florida 33432
lisacpalmer@yahoo.com
(ph) 954-907-3446

Sincerely,

Lisa C. Palmer

Biographical Information

Lisa Costantino Palmer is an optimist who believes that much in life is possible and those possibilities are endless. She was born and raised in Rhode Island and is the daughter of an immigrant mother from Dominican Republic and an Italian-American father whose parents immigrated from Italy. Following a diverse education in her youth, and graduation from the Wheeler School in Providence, Rhode Island, she attended the University of Vermont in Burlington where she pursued a bachelor's degree in pre-medicine and philosophy. Having numerous interests in science, philosophy and the arts, Palmer soon found herself on a very different path. In 1997 she became the first member of her family to become a state delegate at the Miss USA competition. New doors opened making a career in media attractive. She later attended and graduated with a Bachelor of Arts degree from New York University in both journalism and sociology. Numerous adventures followed. She was selected for a position at the White House during a tumultuous time in national politics. She was told that while she would be a good fit, only politicians' relatives, Ivy League students, or those who had "ins", were admitted. Out of 2500 applicants, only 200 were accepted. Palmer was one of them, and she worked closely with the President and Vice President covering press conferences for the radio division of The White House. Palmer later became a journalist and enjoyed stints working at several major networks behind the scenes including ABC and CNN. She then served on-air for several local television stations for CBS and NBC as a television news reporter.

Following a breakthrough to lead a more purposeful life, Palmer decided to pursue a Master of Science degree in Family Therapy and then a Doctorate at Nova

Southeastern University. Today Palmer is a Licensed Marriage and Family Therapist; Certified in Hypnotherapy; Trained in Mediation; and focuses her research on the experiences of eating disordered immigrant women to the U.S. She is a AAMFT Clinical member and a AAMFT Supervisory Candidate with extensive experience working in the field of eating disorders, and in a variety of mental health settings including at several inpatient, residential and outpatient facilities. In the realm of eating disorders, Palmer is known for establishing the first ethnicity, culture and identity group in the U.S. at a renowned treatment facility, which received national recognition. Her work in the eating disorder field and beyond has been attractive to numerous magazine, television, and radio publications. She writes professional articles, and focuses her interests on topics involving immigrant women who suffer from eating disorders. Additionally, Palmer founded the popular www.MyEDHelp.com, a network offering resources and referrals for eating disorder recovery. Palmer currently has a private practice in Boca Raton. She also serves as the Clinical Director of The Eating Disorder Program at Hollywood Pavilion, an intensive outpatient eating disorders treatment program in Hollywood, Florida. It is one of the few programs in the U.S. to accept Medicare coverage for the treatment of eating disorders.

Despite Palmer's numerous clinical, academic, and research interests, she prides herself on leading a balanced and fulfilling life. She is married to Dr. Kevin Palmer, and they reside happily near Boca Raton, Florida with their two loving and charismatic dogs.