

**EXPLORING THE EXPERIENCES OF
ROMANTIC RELATIONSHIPS AND INTIMACY
FOR WOMEN WITH ANOREXIA NERVOSA**

By

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A Thesis

Submitted to the School of Graduate Studies

in Partial Fulfillment of the Requirements

for the Degree

Doctorate of Philosophy

McMaster University

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RELATIONAL EXPERIENCES FOR WOMEN WITH ANOREXIA NERVOSA

DOCTORATE OF PHILOSOPHY (2003)
(Clinical Health Sciences – Nursing)

McMaster University
Hamilton, Ontario

TITLE: Exploring Experiences of Romantic Relationships and Intimacy for Women with
Anorexia Nervosa.

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NUMBER OF PAGES: xi, 189

ABSTRACT

Intimacy is considered an essential aspect of 'ideal' marriages and romantic relationships. Western culture in particular, encourages individuals to seek intimacy within their romantic relationships and maintain it through consistent effort. Intimacy as an area of inquiry in romantic relationships has remained largely unexamined for women with anorexia nervosa (AN) despite a growing body of quantitative research signifying deficiencies in their romantic relationships as compared to women without the disorder. With this in mind, this dissertation sought to describe experiences with romantic relationships and intimacy for women with AN through phenomenological inquiry. A purposive sample of 11 women participated through in-depth, semi-structured interviews. Analysis revealed that these women engaged in diverse relational experiences characterized by dialectical themes of engagement and distancing, which acted as basic drivers of relational change and maintenance. For many women, their desired level of intimacy exceeded what was present in their relationships, with intimacy precluded by incongruent disclosure with their partner and the women's lack of physical desire. Collectively, these findings demonstrate that the women's relational experiences did not contradict generalized theories. Rather, like other individuals in relationships, the participants' relationships involved behavioural patterns, motivational dynamics, and situational environments in the context of their lives, which in their situation happened to include an eating disorder. This study suggests that understanding relationships for women with AN should not be limited to a disease framework, but should be explored

within a normative relational framework. Within this perspective health care professionals can tailor interventions specific to patient ways of relating.

ACKNOWLEDGEMENTS

This Ph.D. dissertation represents not only my own ‘labor of love’, but also the contributions of my thesis committee and the women who participated in my research. I would like to express my sincere appreciation to my supervisor, Dr. Sheryl Boblin, and members of my thesis committee, Dr. Donna Ciliska and Professor Barbara Brown, for their unwavering support and expertise throughout the course of my graduate studies. Their knowledge and support has been invaluable. My academic achievements are truly reflective of my thesis committee’s dedication to advancing my learning, which has allowed me to gain experiences and knowledge that I never thought possible.

I would also like to express my gratitude to the women who shared their experiences for my research. My work with them has given me a better appreciation of the world in which they live, and it is my hope that my work will contribute to understanding the dynamic experiences of romantic relationships that women with eating disorders may experience. In addition, the eating disorder programs at St. Joseph’s Healthcare in Hamilton, Ontario, and Homewood Health Centre in Guelph, Ontario, deserve recognition for not only their participation in my thesis work, but also for the services they provide in supporting women with eating disorders to achieve wellness.

I would also like to extend my appreciation to McMaster University’s School of Graduate Studies and the funding programs of the Ontario government. My graduate work would not have been possible without their scholarship support. The transcription services provided by MLW, the editorial expertise of Angela Eady, and the qualitative

research expertise of Dr. Lynne Lohfeld were also instrumental in helping me address my workload, deadlines, and achieve academic rigour.

Finally, I would like to thank my friends and loved ones for reminding me how to maintain balance in my life and their faith in my abilities. My academic demands would often supersede these relationships, and their understanding and support is reflective of how fortunate I am to have such people in my world.

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Chapter 1

Introduction

This ‘sandwich’ thesis represents a collection of four papers prepared for publication based on my doctoral work with women with anorexia nervosa (AN). This introductory chapter will set the context for the body of work by describing my research interests, objectives, as well as outlining each chapter’s contribution.

The Researcher’s Context

My research interests originally stem from my baccalaureate studies at McMaster University. During a pre-graduate clinical placement with an in-patient eating disorders program, I developed meaningful relationships with several patients and was privy to their journey towards wellness. Several of the women I worked with were wives and mothers, which surprised me. Most of my learning before this placement came from reading the literature, and I had developed assumptions that women with eating disorders avoided intimate relationships and rejected sexual maturity. In listening to my patients’ stories and their difficulties in being separated from loved ones during treatment, I realized that these individuals were not ‘eating disordered women’, but women *living* with eating disorders. I began to appreciate their context beyond their eating disorder (the sick role) and recognized their roles as wives and mothers. Upon entry into graduate school, I chose to continue learning about these rich experiences.

Thesis Focus

Whereas the hallmark symptoms of AN, such as severe disturbances in eating behaviours and acute and unrealistic distress over body shape and weight (American Psychiatric Association (APA), 2000) are familiar in the literature, less known are the personal meanings and lived experiences for women with this disorder. The integrative research review in Chapter 2 provides a comprehensive account of key research on romantic relationships for women with AN, illustrating its strengths and limitations. In particular, although the literature draws attention to the varied experiences and marked dissatisfaction expressed by women with AN with their romantic relationships, the quality and dynamic nature of the women's relationships is little understood. Orthodox quantitative research methods have failed to reflect the dynamic nature of women's experiences, which I had seen in my own clinical work.

The failure of the literature to capture the women's rich, lived experiences shaped my doctoral work. I became interested in exploring romantic relationships and intimacy for women with AN, and given this, a qualitative design was used to best suit the objective. I felt that the findings from a qualitative study would illuminate how women with AN experience their illness in the context of their romantic relationships and vice versa, lend further support to the view that many factors interact to influence these women's experiences of romantic relationships, and inform relationally-related interventions for this clinical population.

Husserlian phenomenology (Husserl, 1960, 1977) and its methodological adaptation (Moustakas, 1994) were selected to guide this qualitative study. In developing

his theory of transcendental phenomenology, Edmund Husserl once wrote, “From what rests on the surface one is led into the depths” (1970, pp. 355). I felt this quote would serve as a good guide for exploring human experiences in my research, in that I wanted to illuminate meaning and give content to the women’s relationships. Thus, the second paper of this sandwich thesis (Chapter 3) makes explicit the philosophical and methodological literature that influenced my approach to the research question. The paper begins with a review of the history of phenomenology, followed by the concepts and qualities that embody Husserl’s philosophy of transcendental phenomenology. It then examines the methodologic adaptations of this philosophy, specifically developed for research inquiry, discusses the challenges of translating this philosophy into methodology for research inquiry, and provides approaches to specific interpretive issues. This paper is presented in an ‘extended’ format for comprehensiveness, with the intention of shortening it for journal submission.

Chapters 4 and 5 present and discuss the research itself. The findings described in these to-be-published papers are the features of the women’s relationships as offered by the women themselves. In Chapter 4, the women’s experiences with romantic relationships are presented. Analysis revealed two main, opposing themes to the women’s experiences with romantic relationships: engagement and distancing. For the women, engagement was emphasized as a state of emotional and physical connection attained in the relationship, which included feeling understood and supported by their partners. Engagement was predominantly described as being achieved through open dialogue in relationships that fostered trust and comfort. Distancing was described as a

state of emotional and physical disconnection. Elements that contributed to distancing in the women's romantic relationships were secrecy, fear of exposure to judgment and rejection, and an inward focus on their eating disorder. All of the participants experienced varying degrees of engagement and distancing, which required them to consistently address the tension between these two states in their romantic relationships. Intimacy, as described by the women in Chapter 5, meant feeling they were on the "same wavelength" as their partner or "connected" with their partner. The elements of intimacy that emerged from the women's descriptions included emotional and physical closeness, and companionship. Underlying these experiences were trust, acceptance, feeling known, and partner congruence. For many women, their desired level of intimacy exceeded what was actually present in their relationship, with intimacy felt to be precluded by incongruent disclosure within their relationship and a lack of sexual desire. Chapter 6 is reflective and conclusive. It provides a review of major findings from Chapters 4 and 5, a discussion of methodological rigour and the application of its concepts to my work, as well as a review of the implications my study's findings have for clinical practice, research, and theory.

The appendices in this sandwich thesis include the appraisal tool used in the integrative review (Appendix A), additional findings (Appendix B), and a detailed exploration of the logistics of my research (Appendices C to J). Additional findings emerged on the women's perceptions of the impact of their eating disorders on their partners and children, and their relational experiences with friends and family. These additional data provide another avenue for future exploration. Appendix K highlights the

general author guidelines from the journals the individual papers will be submitted to following the thesis defense; these guidelines provide clear boundaries regarding each journal's purpose and manuscript preparation. Appendix L provides a list of research questions generated from my research.

Chapter 2

**Rewarding relationships? An integrative review of the literature exploring
relationship quality for women with anorexia nervosa**

TO BE SUBMITTED TO

International Journal of Eating Disorders (refer to Appendix K for author guidelines)

ABSTRACT

Background. With anorexia nervosa (AN) now recognized as a mental health problem affecting women of all ages, a growing body of literature examines a wide range of romantic relationships for women with this disorder.

Purpose. The purpose of this integrative review was to critically appraise and discuss literature on the features and quality of romantic relationships for women with AN, and to gain perspective on future research directives.

Methods. Key electronic databases were searched from 1983 to 2003. Reference lists, key journals, and Internet-based journal sites were also searched. The search was limited to relationship quality and the relational aspects of communication, sexuality, and intimacy. Fourteen studies were retrieved, critiqued, and abstracted.

Results. All 14 studies used a quantitative design; no qualitative studies were retrieved. Methodological strengths of these studies included confounder control and appropriate statistical analyses for design. Weaknesses included a failure to declare study designs, address sources of bias, and justify sample sizes, which were often small in comparison to the number of examined variables and possible covariates.

Findings. The review drew attention to the varied relational experiences and marked relationship dissatisfaction expressed by women with AN. Although the literature highlighted several variables contributing to this dissatisfaction, the understanding of their quality and dynamic nature is still limited. Future research should focus on how meanings for women with AN are negotiated in their relationships and provide detailed descriptions of their experiences, which is best done with qualitative study. Well-

conducted longitudinal research should address questions that cannot be answered by cross-sectional designs, such as the temporal nature of the women's relationships.

Keywords: Anorexia nervosa, eating disorders, relationships, integrative review.

Introduction

Anorexia nervosa (AN) is an eating disorder characterized by severe disturbances in eating behaviours and acute distress over body shape and weight (American Psychiatric Association, 2000). Evidence to date highlights the complex interactions in the development and persistence of this disorder, which includes the influence of personal (developmental, cognitive/affective, and psychological factors), socioenvironmental (cultural and peer norms, familial factors), and behavioural (eating, weight management, and coping) features (Barr Taylor et al., 1998; Rosen & Neumark-Sztainer, 1998).

Although AN is well defined in young women between the ages of 14 and 24, the disorder is diagnosed in women well beyond this age group. This age consideration and the dynamic nature of the disorder contribute to the wide range of relational experiences documented in the literature. In particular, researchers have begun to explore the clinical characteristics of women with AN, the relationship between AN and the quality of dating/marital relationships, and the relational elements of communication, sexuality, and intimacy. This literature, however, has yet to be comprehensively reviewed and critiqued.

Integrative Review Methodology

The integrative research review provides a comprehensive account of specific phenomena found by inter-relating discrete research with a common objective (Cooper, 1989). In terms of relationship oriented literature for women with AN, the strength of this type of review is its ability to identify areas where existing knowledge may be underdeveloped or untrustworthy and discuss questions or issues requiring further

research. In addition, it can illustrate the strengths of this body of literature to allow clinicians to confidently integrate findings into their clinical practice and researchers to move forward to complementary areas of study (Beyea & Nicoll, 1998; Kirkevold, 1997).

Research Question and Aim

This review examines the question: What are the features and quality of romantic relationships for women with AN? In an endeavour to provide stakeholders in the eating disorder field with a comprehensive, up-to-date review of the research, this review aims to: (1) critically appraise discrete literature based on the research question, (2) discuss findings in the context of underlying theoretical constructs, and (3) gain perspective on future research directives for exploring romantic relationships for women with AN.

Inclusion Criteria and Search Strategy

The search was limited to research on the quality of romantic relationships for women with AN, including the specific aspects of communication, sexuality and intimacy, and investigations on the clinical characteristics of women with AN associated with these aspects. The search strategy allowed for both quantitatively and qualitatively designed research to be included in the review.

MEDLINE, CINAHL, PsycINFO, HealthStar, and Cochrane electronic databases were searched. Key terms included combining the terms *anorexia nervosa* and *eating disorders* with *intimacy*, *dating*, *relationships*, *marriage*, *sexuality*, and *communication*. Language restrictions (English) and date (1983 – 2003) were specified during retrieval. Key articles from reference lists in journal articles and Internet-based journal sites were also retrieved. In addition key journals in the field of eating disorders were hand-

searched: *International Journal of Eating Disorders*, *European Eating Disorders Review*, and the *Journal of Consulting and Clinical Psychology*. While such parameters were needed for the review to be both manageable and comprehensive, such an approach can limit the research retrieved and explored in the review.

Findings

Retrieval

The electronic database search, Internet-based journal search, and hand-searching yielded 14 relevant studies for review once duplicates were removed. Of these 14 studies, three explored clinical characteristics of married and unmarried women with AN, three studied relationship quality, one studied communication in marital relationships, five explored sexuality in relationships for women with AN, and two studied intimacy in the women's marital relationships.

No studies were removed from the review based on methodological rigour. This approach afforded a review of the range and quality of research available in this topic area. Given the research question, it was expected that both qualitative research (descriptive in design) and quantitative research (correlational, non-experimental in design) would be retrieved. The search, however, only yielded studies of quantitative design. Indeed, of the 14 critically appraised studies, two study designs were longitudinal cohort, nine were cross-sectional, and three were retrospective.

Review Procedure and Article Quality

Critical appraisal of the selected research augments Cooper's (1989) approach to the integrative review and included using specific criteria outlined by several notable authors (Levine, Walter, Lee, Haines, Holbrook & Moyer, 1994; Polit & Hungler, 1997; Streiner & Norman, 1996). Criteria for the quantitative study designs included assessing: study design, sample size justification, the description for replicability/generalizability, statistical analyses, outcomes and their interpretation, participant accountability (e.g. drop-outs), and control of potential sources of bias (see Appendix A). The synthesis of the review uses tables and text to describe the appraisal and review's integrative findings.

Methodological strengths of many of the studies included controlling for confounders and appropriate statistical analyses for study designs. Methodological weaknesses included a failure to declare study designs, address sources of bias, and justify sample sizes, which were often small in comparison to the number of examined variables and possible covariates. Although most studies used measures of known reliability and validity, they often failed to explicitly report the measures' psychometric properties.

Clinical Characteristics

Current research reflects diversity in the clinical presentation of women with AN. The literature review yielded one cross-sectional study and two retrospective studies that examined the differences in clinical characteristics between married and unmarried women with AN, and explored the association between the women's eating disorder and their relationship experience (refer to Table 1).

Wiederman and Pryor (1997) used a cross-sectional, descriptive survey approach to investigate whether symptom history and severity was associated with relational experience in ever-married ($n = 51$) and never-married ($n = 40$) women with AN. Data collection was achieved through participant recall on a questionnaire (psychometric properties not indicated). After controlling for age, no statistical difference was found between ever-married and never-married women with AN regarding symptom history or severity. However, never-married women with AN were found to have experienced menarche at an older age than the ever-married women ($p < 0.05$). Ever-married women with AN were more likely to have had sexual intercourse ($p < 0.01$) or to rate their satisfaction with sexual activity as lower ($p < 0.01$) than the never-married women. Author explanations for reported lower satisfaction with sexual activity include the ever-married women engaging in more opportunities to evaluate their experiences (Wiederman & Pryor, 1997).

In a similar vein, Heavey *et al.* (1989) in the UK conducted a retrospective, descriptive study that aimed to explore the role of weight and age, 'anorectic' symptoms, and sexual attitudes in the relationship between women's eating disorders and marital status. The study compared married ($n = 39$) and single ($n = 66$) women with AN and used hospital chart audit to collect data. The study showed statistical differences in eating disorder onset ($p < 0.01$), with the mean onset of AN for single and married women being 18 and 23 years of age, respectively. Findings also showed that a trend towards difference between the groups for food-restricting behaviours ($p < 0.067$), with single

women restricting more than the married women. The two groups did not differ significantly for weight at the onset of the illness and lowest achieved weights.

With regard to sexual attitudes and behaviours, statistical significance was only shown in most recent sexual intercourse ($p < 0.01$), with married women endorsing more recent relations. No statistical significance was found between the married and single women for interests in sexual matters: 10% of the married women with AN expressed interest compared to 13% of single women. Similarly, both groups exhibited comparable avoidance of sexual relations (70 - 80%) (Heavey, Parker, Bhat, Crisp & Gowers, 1989), which is highly suggestive of marked disturbances in sexuality for women irrespective of relationship status.

In keeping with this profiling focus, Japanese researchers led by Kiriike (1998) used a retrospective design (hospital chart audit) to elucidate the relationship between eating disorders and marriage. The study sample included married ($n = 40$) and never-married ($n = 22$) women with eating disorders. Married women were further differentiated by premarital and postmarital onsets of their disorder. The sample included women with AN ($n = 4$). However, results were presented using comparisons between the married (pre- and postmarital onset) and never-married groups. The study found no statistically significant differences between the three groups for illness duration or symptom severity, which suggested that marital distress was a significant trigger for approximately 70% of women with postmarital eating disorder onset (Kiriike, Nagata, Matsunaga, Tobitan & Nishura, 1998).

The aforementioned literature highlights the variety of clinical characteristics and the lack of consistent findings to differentiate women with AN in marital relationships from those who are not. What researchers have found, in fact, are more similarities than differences in the eating disorder histories of married and unmarried women. The dissatisfaction highlighted with current sexual activity, discomfort as a sexual person, and avoidance of sexual relations warrants further inspection. Although these findings are highly suggestive of marked disturbances in sexuality for both women with AN who are in relationships and those who are not, this body of research does not address the underlying motivators for certain women with AN to seek out sexually intimate relationships. Additionally, research should begin to ask what enables some women with AN to express interest in sexual relations and/or activity in sexual activity given the overwhelming evidence of cited avoidance and dissatisfaction. Finally, the elements that characterize the romantic relationships of women who cite marital distress as a factor for disorder onset remain unknown.

Relationship Quality

Research exploring the quality of relationships for women with AN focuses on the women's and their spouses' perceptions of relationship quality and the perceptions and values attributed to dating women with AN, which are all significantly important in relationship establishment and maintenance. The literature review yielded three cross-sectional studies of relationship quality for women with AN (refer to Table 2).

A cross-sectional study conducted in the UK by Tiller *et al.* (1997) examined correlations between self-esteem and perceived adequacy of social support networks

among women with AN and bulimia nervosa (BN) (AN, $n = 44$; BN, $n = 81$) as compared to a control group of women sampled from a general college population ($n = 86$). The eating disorder groups did not differ statistically from the control group for sociodemographic covariates, but statistically significant differences were noted between the three groups for age ($p < 0.001$) (mean ages: AN = 25, BN = 26, control = 22). A psychometrically sound questionnaire was used to measure actual levels of support the women received and desired levels of support. The discrepancy between the actual and ideal ratings served as a measure of satisfaction with the actual level of support. Statistically noteworthy findings included the women with AN and BN identifying significantly fewer support figures (spouse/partner) ($p < 0.001$) and more often describing inadequate established spousal or partner support systems ($p < 0.05$) when compared to the control group. Overall, however, no statistical significance was seen, even though the control group reported higher satisfaction with actual support than did the women with AN ($p < 0.07$). This may relate to women with AN reporting statistically significant lower ideal levels of support ($p < 0.05$) than the women in the control group (Tiller, Sloane, Schmidt, Troop, Power & Treasure, 1997).

Recognizing that the perceptions and values attributed to dating women with AN are also significant in relationship establishment and maintenance, Sobal and Bursztyn (1998) explored the attitudes and beliefs of dating individuals with eating disorders within a university student population. The cross-sectional study design relied on an author-constructed questionnaire (psychometric properties not published). Students were asked questions regarding perceived dating experiences for individuals with AN and their

own comfort dating someone with AN. The results indicated that although 95% of students reported knowledge of AN, most students had little personal experience with the eating disorder or dating individuals who had the disorder. Beliefs that individuals with AN would have difficulty dating were similar between male and female students, with frequencies of 35% and 30%, respectively. Additionally, 59% of female university students believed that this population would experience 'much conflict' during dating, while 45% of men believed that dating would result in 'some' conflictual issues. When the students were asked about personally dating someone with AN, 52% of men and 57% of women reported feeling 'not very', or 'not at all' comfortable with the idea. Complementary to these responses were the students' negative expectations of personally dating an individual with AN, including the anticipation of stress, difficulties, frustration, and dislike of the individual (Sobal & Bursztyn, 1998).

The idea that young people may expect dating relationships with individuals with AN to be unsatisfactory and negative is psychosocially grounded. Young people may perceive a significant dissimilarity in personal characteristics and hypothesize that the stigma they associate with eating disorders may also reflect on them, thus disrupting their social status or interactions. They may also use a cost-benefit ratio, or reward value to evaluate the potential relationship, with the perceived negative aspects and problems outweighing the positive (Maxwell, 1985). This may include young people finding the disorder's sought after thinness aesthetically displeasing and sexually unappealing. Finally, the stigmatization of dating relationships may be a measurement issue within the

study itself, resulting from the types of questions asked (e.g. “How much conflict would you expect?”) and the questionnaire’s focus on a mental health issue.

The negative expectations of dating individuals with AN follow the same vein of research that explores the evaluation of marital relationships in which one partner has an eating disorder. Belgian researchers, Van den Broucke and Vandereycken (1989), used a cross-sectional design to descriptively study marital dyads. They compared 12 married couples where the female spouse had an eating disorder (AN, $n = 5$; BN, $n = 7$) to a matched group of couples where one partner was being treated for a neurosis ($n = 13$), and to a large non-clinical, control group representing the general population (women, $n = 432$; men, $n = 577$). Although no statistical significance was seen between groups for relevant sociodemographic covariates, the authors did not state whether or not the control group comprised married couples (Van den Broucke & Vandereycken, 1989).

Using personal interviews and questionnaires (psychometric properties not published), the researchers explored couple satisfaction with sexual and social relations and examined the psychological profile of the spouses of the women with eating disorders. Although it is important to note that the small number of cases make meaningful statistical comparison difficult; statistical significance was found between spouses of the partners with eating disorders as compared to the control group when reporting symptoms of depression ($p < 0.01$) and feelings of insufficiency ($p < 0.001$). Women with eating disorders and their partners also reported statistically significant dissatisfaction with their sexual relationship ($p < 0.001$) as compared to the control group (Van den Broucke & Vandereycken, 1989).

The literature consistently shows expected or realized relationship dissatisfaction for both women with AN and their dating or marital partners. Dissatisfaction was related to the women's descriptions of inadequate partner support systems, both the women and her partner reporting displeasure with their sexual relationship, and young people's negative expectations of dating relationships with individuals with AN. Although this quantitative research is a starting point for understanding the nature and quality of relational experiences for women with AN, the limits to this approach include the failure of data collection to bring a voice to the women's experiences and the potential for premature interpretation. Qualitative research on this question would address these shortcomings by describing the lived experiences of romantic relationships for women with AN, allowing us to appreciate how their 'context' modifies and influences their relating and the quality of their relationships.

Dyadic Communication

Communication within marital relationships is a direct correlate of relationship quality and subsequent satisfaction. Current research postulates that communication within marital relationships for women with AN is unresponsive and blocked by the couple's communication strategies. The literature review yielded one cross-sectional study exploring marital communication for women with AN (refer to Table 3).

Belgian researchers, Van den Broucke, Vandereycken, and Vertommen (1995a), used a cross-sectional, matched group design to investigate the communication characteristics of women with eating disorders (AN and BN) and their partners (n = 21), as compared to clinically identified 'nondistressed' (n = 21) and 'distressed' (n = 21)

couples without eating disorders. Hypotheses were that the interactions of 'eating disordered' couples would reflect the communication deficiencies found in maritally distressed couples (more negative nonverbal communication), and the partners would have a lower degree of positive verbal reciprocity as compared to the nondistressed couples. Using questionnaires (psychometric properties not divulged), observed tasks, and prompted discussions between the couples, communication in eating disordered couples, in fact, had significantly less criticism ($p < 0.01$) and disagreement ($p < 0.01$) than that found in distressed couples, but did not differ significantly from nondistressed couples for positive verbal reciprocity. The eating disordered couples did, however, show significantly fewer responsive communication statements ($p < 0.05$), more demand for unilateral change as a problem-solving technique ($p < 0.05$), and higher rates of disclosure ($p < 0.01$) than the nondistressed couples. The authors asserted that the lack of responsiveness and maladaptive communication techniques in eating disordered couples could have contributed to their reported high levels of marital dissatisfaction (Van den Broucke, Vandereycken & Vertommen, 1995a).

Van den Broucke *et al.* (1995a) provide an excellent starting point for research on the communication styles and experience for women with AN and their partners. Their most interesting finding was the high level of disclosure between the women and their partners. Although disclosure reciprocity between partners has been cited as a source of marital satisfaction and intimacy (Hansen & Schuldt, 1984), the depth and relevance of the topic should be taken into account. Dissatisfied couples may disclose more negative thoughts and feelings and display a congruent affect, which may explain the lack of

responsiveness in communication and expressed marital dissatisfaction for women with AN and their partners. Future research should investigate the possible sources of relationship dissatisfaction in a qualitative exploration of contextual factors underlying the communication experience of women with AN and their partners.

Sexuality

The underpinnings of sexual expression within relationship quality and satisfaction are affective, cognitive, and biological in nature. Affectively, an individual identifies, accepts responsibility for, and manages sexual and non-sexual feelings appropriate to cultural, personal, and societal values. Cognitively, an individual attains positive self-esteem and self-acceptance for satisfying sexual expression and pleasure. Biologically, hormonal changes in women can affect libido (Fontaine, 1991).

Although studies have sought to investigate the affective and cognitive impact of AN on relationship quality, sexuality, and intimacy, the biological underpinning to sexuality has mainly been restricted to interests in reproductive functioning. Among researchers studying affect and cognition within a sexuality paradigm, postulations and results with multiple perspectives are common and continue to emerge in the literature. Five studies were identified in this literature review: three cross-sectional, one retrospective, and one longitudinal cohort design (refer to Table 4).

An American study led by Wiederman (1996) used a cross-sectional approach to compare the sexual experiences of 450 women with eating disorders (AN, $n = 131$; BN, $n = 319$). The mean age of the women with AN and BN was 24 and 23 years, respectively. The study used a diagnostic questionnaire to convey the women's

perceptions of sexual interest, changes in interest, and satisfaction with current sexual relations (psychometric properties not presented). Statistical analyses tested whether the severity of reported eating disorder symptoms predicted sexual experiences. After controlling for relevant covariates, a significant statistical difference was seen between women with AN and BN for reports of having sexual intercourse ($p < 0.0001$). A logistic regression showed that beyond diagnostic difference, however, symptom severity was not a significant predictor of sexual experience. Among those women who reported having had sexual intercourse, the groups' median age at the onset of sexual activity differed significantly (BN = 17, AN = 18; $p < 0.02$), and women who reported the most extensive food restrictions reported the lowest satisfaction with current sexual activity. The authors concluded that women with AN have fewer sexual relationships (Wiederman, Pryor & Morgan, 1996).

Wiederman *et al.*'s conclusion (1996) supports Fontaine's (1991) assertions that women with AN are more likely to fantasize about food than sexual relations and often experience feelings of self-disgust and guilt concerning their bodies. Thus, the eating disorder is thought to lead to both covert and overt sexual dysfunction and to provide secondary gains, such as the avoidance of maturation and development of overt sexual characteristics in younger woman, denial of sexual needs, and relationship and sexual experience avoidance.

Two questions remained from the previous study: (1) what are the sexual experiences of women with eating disorders as they progress through treatment, and (2) what is their level of sexual functioning post-treatment? Both questions were addressed

in a recent longitudinal cohort study led by Morgan (1999) in the UK which examined the changes in sexual drive, anxiety, and depression during weight restoration in women with AN (n = 11). Data were collected through questionnaires (psychometric properties presented) at several points in time during a weight restoration program. Given the small sample, the power to detect meaningful statistical differences between groups was limited. However, statistically significant findings were reported for (1) a positive relationship between weight restoration and sexual interest (measured through sexual daydreaming) ($p < 0.001$), and (2) a weak, positive relationship between weight restoration and decreased depression scores ($p < 0.046$). The relationship between weight restoration and reduced anxiety scores was not statistically significant (Morgan, Lacey & Reid, 1999).

Morgan *et al.*'s study (1999) highlights the biological perspective of sexuality for women with AN. That is, the extreme weight and body fat loss seen in AN can induce, among other manifestations, endocrinological dysfunction and subsequent libido loss due to hormonal changes. This is most overtly evident in menstrual irregularities (including amenorrhea) and covertly shown in decreased estrogen hormone levels (Gidwani & Rome, 1997; Pirke et al., 1985). Fontaine (1991) also asserts that decreased estrogen levels, resembling those seen in pre-pubescent girls, promote a more child-like interest in sexual relations rather than late adolescent and adult desires for sexual activity and intimate relationships, which are impacted by increasing body fat percentage and hormone levels.

Raboch and Faltus (1991) explored sexuality for women with AN using a cross-sectional design. The study compared women with AN ($n = 30$) to a control group of women representing the general female population ($n = 50$). The groups were matched for age and education. Of the women with AN, 24 were single, four married, and two divorced. In the control group, six women were single, 43 married, and one divorced. Through questionnaires, the study collected data on sexual development, function, and arousability. The psychometric properties of the questionnaire were not reported. The study's statistical analysis was also not discussed, nor was the control for potential confounding variables. When comparing the two groups on sexual development, no statistically significant differences were found in age at first romantic date, sexual touching, or coitus. The difference in age was statistically significant at the time of first marriage ($p < 0.001$), with women with AN significantly older than the control group. However, the sample size differed greatly: four women with AN compared to 43 women in the control group. An analysis of the women's sexual function scores showed a statistically significant difference ($p < 0.001$), with women with AN indicating more dysfunction (e.g. low sexual desire) than the control group. No statistical difference was found between the groups for the women's sexual arousability (Raboch and Faltus, 1991).

Rothschild *et al.* (1991) used a retrospective design to explore how maturation and experiences influence sexuality and current levels of sexual function in women with eating disorders (AN, $n = 29$; BN, $n = 13$). Data were collected through a questionnaire and structured interview. Consistent with the other literature presented in this review, the psychometric properties of the questionnaire were not published. No statistical

differences were noted between groups for relevant confounders. A comparison of maturational landmarks, including age at menarche and age at first masturbatory and coital experience, yielded statistically insignificant results. Overall, the sexual satisfaction findings were statistically insignificant, showing that all of the study's participants had similar levels of sexual dissatisfaction and restriction, romantic relationship dissatisfaction, and discomfort as a sexual person. Women with AN reported significantly less sexual fantasy than women with BN ($p < 0.001$). Although women with BN reported a higher sex drive, it was statistically insignificant ($p < 0.11$) in comparison to women with AN (Rothschild, Fagan, Woodall & Andersen, 1991).

An Australian cross-sectional study by Beumont *et al.* (1981) examined the psychosexual histories of a small group of 31 adolescent and young women with AN who were 15 to 33 years of age. Again, the psychometric properties of the administered questionnaire and control of potential confounders were not addressed. In this study, women with AN displayed a wide variation of sexual knowledge, attitudes, and experience. Many women were inhibited, and others were experienced and assertive with respect to sexuality. Responses to marital questions indicated that 73% of the unmarried women eventually wanted to marry. The five women married at the time of the study all expressed relational difficulties and dissatisfaction. Questions related to sexual experiences and activity yielded similar responses from all of the study's participants. The majority of women (64%) aged 18 and older had experienced sexual intercourse before the study. Of these experiences, 40% of the women evaluated them as negative, and 60% reflected positively on them (Beumont, Abraham & Simson, 1981).

In 14 of the 31 women, first sexual experience preceded the development of AN, and sexual problems were seen as precipitants of the disorder in 42% of both the sexually active and inactive women. In addition to this, interest in and pleasure from sexual activity decreased at the onset of the disorder. Women cited sexual problems, including marital conflict and guilt, as contributing to the maintenance of anorectic behaviours. Of the 14 women who experienced intercourse prior to the onset of the disorder, half continued to have regular sexual contact, and three reported being relatively 'promiscuous'. The other six women described a significant decrease in sexual activity resulting from 'tiredness' due to weight loss. One woman ceased sexual activity completely (reasons undisclosed) (Beumont, Abraham & Simson, 1981)

Beumont's (1981) conclusions are consistent with Fontaine's (1991) assertions in that healthy, sexually intimate relationships are affectively and cognitively driven. In contrast to previous ideas that women with AN avoided sexuality, the study's participants showed a wide range of sexual responses, with predominant affective and cognitive features including negative views about body concept, sexual feelings, and needs. Most women also perceived their disorder as directly impacting their sexual experiences (Beumont, Abraham & Simson, 1981).

Intimacy

Intimacy is an essential element to rewarding interpersonal relationships and is thus a common construct used to evaluate relationship quality. Fontaine (1991) asserts that individuals in healthy, rewarding relationships show affective and cognitive abilities to express feelings, share intimacy, and resolve conflict while respecting the boundaries

and well-being of others. She also states that an individual's ability to experience intimate relations is also directly related to self-acceptance, and that individuals with negative self-concept may have difficulty forming intimate relationships. Despite intimacy's importance for interpersonal relationships, there is a dearth of research measuring and exploring this concept for women with AN. The literature review yielded one cross-sectional and one longitudinal cohort design for review (refer to Table 5).

In addition to studying marital satisfaction and communication within relationships for women with AN, Van den Broucke *et al.* (1995b) have also explored marital intimacy in couples experiencing an eating disorder. They used a reported valid and reliable author-constructed questionnaire in a cross-sectional, matched group design. Twenty-one women with eating disorders (12 women diagnosed with AN) and their partners were compared to clinically identified 'nondistressed' ($n = 21$) and 'distressed' ($n = 21$) couples. The study proposed that marriages of the 'eating disordered' cohort would be characterized by lower levels of intimacy than couples without overt individual or relational issues. A between-group comparison supported this hypothesis with the maritally distressed group showing statistically significant lower levels of intimacy than the eating disordered group ($p < 0.001$) who, in turn, displayed statistically significant lower intimacy levels than the nondistressed group ($p < 0.001$). Analyses revealed a strong correlational relationship between relational dissatisfaction and low intimacy for women with AN and their partners (mean r for partners = 0.72, mean r for women = 0.78). Van den Broucke *et al.* (1995b) concluded that the data confirmed their previous

clinical impressions of intimacy deficiencies for eating disordered couples, which were characterized by a particular lack of openness within the marital relationship.

A recent Canadian longitudinal cohort study conducted by Woodside *et al.* (2000) examined intimacy by means of a self-administered questionnaire between 22 women with eating disorders (AN, n = 9; BN, n = 11; eating disorder not otherwise specified, n = 2) and their spouses throughout a course of day hospital treatment. The psychometric properties of the questionnaire were not presented. Statistical analyses showed that throughout the course of the women's treatment, the women's rating of marital intimacy continued to improve, with a statistically significant difference from treatment entry to program discharge ($p < 0.0246$). There was not, however, a statistically significant change in spouses' ratings of marital intimacy from partner program entry to discharge ($p < 0.1859$). Another important statistic to note is that although the women's pre- and post-treatment intimacy scores from the questionnaire (21.8 and 24.2 respectively) did indicate lower levels of intimacy, they did not fall out of the range seen in the general population (15 – 25; highest possible score = 40) (Woodside, Lackstrom & Shekter-Wolfson, 2000).

Research has only begun to explore intimacy for women with AN. It still remains unclear from the reviewed research whether the deficiencies in intimacy experienced by women with AN are antecedents to or consequences of their eating disorder.

Additionally, much is to be learned about how women with AN negotiate meanings of intimacy in their relationships and what constitutes their intimate experiences. Studies on these topics will allow the research in this area to move beyond correlations between

treatment and relational deficits, which is the current focus in the literature. This new direction of research can explore specific meanings of intimacy for women with AN.

Summary

This integrative review explored romantic relationship quality for women with AN, including the specific relational aspects of communication, sexuality, and intimacy, and as they related to the women's clinical characteristics. While the search strategy delineated specific parameters to allow for the review to be both manageable and comprehensive, such an approach can limit the research retrieved and explored in the review. The use of other electronic databases or key terms could yield similar results or supplementary research for review. In this sense, the integrative literature review is intended to be comprehensive, but not necessarily all-inclusive.

In the review of the selected research, women with AN reported dissatisfaction with current sexual activity and discomfort as a sexual person, and tended to describe relationships negatively (Raboch and Faltus, 1991; Rothschild, Fagan, Woodall & Andersen, 1991; Wiederman, Pryor & Morgan, 1996). Married and unmarried women with AN exhibited a comparable avoidance of sexual relations (Heavey, Parker, Bhat, Crisp & Gowers, 1989). For many married women with AN, marital distress was identified as a significant trigger for postmarital disorder onset (Kiriike, Nagata, Matsunaga, Tobitan & Nishura, 1998). Both women with eating disorders and their partners reported significant dissatisfaction with their sexual relationship. Spouses of the

partners with eating disorders reported significant symptoms of depression and feelings of insufficiency (Van den Broucke & Vandereycken, 1989).

Women with eating disorders and their partners experienced high rates of disclosure, a reduced quantity of responsive communication statements, and more demands of unilateral change as a problem-solving technique (Van den Broucke, Vandereycken & Vertommen, 1995a). However, communication between women with eating disorders and their partners remains unclear at this point. This lack of clarity is, in part, due to a poor understanding of the context of disclosure in relation to reported relationship dissatisfaction.

An examination of intimacy for women with AN and their partners illustrated deficiencies characterized predominantly by a lack of openness within the marital relationship (Van den Broucke, Vandereycken & Vertommen, 1995b). Furthermore, symptomatic treatment of the women's eating disorder was positively correlated to a reported improvement in perceived marital intimacy by women with AN, but not in their partners (Woodside, Lackstrom & Shekter-Wolfson, 2000).

Conclusions and Implications for Research

This integrative literature review draws attention to the varied relational experiences and marked dissatisfaction reported by women with AN with their romantic relationships. The literature critique has identified areas where existing knowledge is underdeveloped and has illustrated the strengths of the literature. As such, this paper has provided a forum for raising questions or issues requiring further research.

Although the literature highlights several contributing variables, more research is needed to enhance our understanding of the quality and dynamic nature of these women's experiences. Further exploration of relationship quality for women with AN should ideally include both quantitative and qualitative endeavours. Both can build on the identified gaps and limitations of the existing research and add a new perspective to understanding of the features and quality of romantic relationships for these women.

Future non-experimental investigations should take into account the methodological limitations of their predecessors. The reviewed research originated from a variety of research settings, with most studies coming from the US, the UK, and Belgium. Although these settings reflect industrialized societies in which AN is expected to occur, only eight studies described sample demographics in enough detail to allow readers to determine their clinical applicability or study reproducibility (Kiriike et al., 1998; Sobal & Bursztyn, 1998; Tiller et al., 1997; Rothschild et al., 1991; Wiederman & Pryor, 1997; Van den Broucke & Vandereycken, 1989; Van den Broucke, Vandereycken & Vertommen, 1995a/1995b). Additionally, all studies failed to justify their sample sizes, which were often small in comparison to the number of variables examined in the study and possible covariates. The small sample sizes decreased the study's power for detecting a statistically significant difference.

Surprisingly, only five reviewed studies explicitly stated their study design (Heavey et al., 1989; Kiriike et al., 1998; Sobal & Bursztyn, 1998; Tiller et al., 1997; Van den Broucke & Vandereycken, 1989). The validity and reliability (psychometric properties) of the data collection tools were also overwhelmingly absent and was found in

only three of the reviewed studies (Morgan, Lacey & Reid, 1999; Tiller et al., 1997; Van den Broucke, Vandereycken & Vertommen, 1995b). Although the studies used tools that had been previously published in the literature (e.g. Waring Intimacy Questionnaire; Waring, 1985), a brief description of their properties would increase the reader's confidence in their methodologies. The potential for other biases also merits discussion, with studies that used observed tasks, chart audits, and questionnaires susceptible to researcher (interpretation) and participant (attention and social desirability) bias.

The introduction of intervention studies would be ideal for evidence-based treatment of women with AN and, in particular, to discern the effectiveness of interventions for improving the relational aspects that women reported as being dissatisfactory. Additionally, well-conducted longitudinal studies that analyze changes in these women's relationships over time would be beneficial. Longitudinal studies can address important questions that cannot be answered by cross-sectional designs such as the how women's relationships are experienced over time.

The fact that the existing research is based on the positivist paradigm underpinning quantitative research is also a limitation for understanding the meaning and quality of the lives of women with AN. Such quantitative studies provide tacit depictions of outcomes of the women's experiences, which render their relationships as colourless, uniform end points and fail to reflect their rich, dynamic nature. The absence of qualitative research in this body of literature may be a reflection of the historical domination of quantitative research. As such, introducing qualitative research into this body of literature is important because it is more suited to describing the lived

experiences of romantic relationships for women with AN. It provides a better understanding of the importance of context in modifying and influencing the ways in which relating is carried out. The intent should be to foster an understanding of the women's interpersonal experiences through descriptions offered by the women themselves, to clarify hypotheses regarding the dynamic between illness and relationship, and to inform clinical interventions.

REFERENCES

- American Psychiatric Association (2000). American Psychiatric Association practice guidelines for the treatment of patients with eating disorders (revised). *American Journal of Psychiatry*, 157 (1), 1-39.
- Arrindell, W.A. & Ettema, J.M. (1986). *SCL-90: Manual for a multidimensional psychopathology-indicator*. Lisse, The Netherlands: Swets & Zeitlinger.
- Barr Taylor, C., Sharpe, T., Shisslak, C., Bryson, S., Estes, L.S., Gray, N., McKnight, K.M., Crago, M., Kraemer, H.C. & Killen, J.D. (1998). Factors associated with weight concerns in adolescent girls. *International Journal of Eating Disorders*, 24, 31-42.
- Beumont, P.J.V., Abraham, S.F. & Simson, K.G. (1981). The psychosexual histories of adolescent girls and women with anorexia nervosa. *Psychological Medicine*, 11, 131-140.
- Beyea, S.C. & Nicoll, L.H. (1998). Writing an integrative review. *AORN Journal*, 67(4), 877-880.
- Cooper, H.M. (1989). *Integrating research: A guide for literature reviews* (2nd ed.). Newbury Park, CA: Sage Publications.
- Fontaine, K.L. (1991). Unlocking sexual issues: Counseling strategies for nurses. *Nursing Clinics of North America*, 26 (3), 737-743.
- Gidwani, G.P. & Rome, E.S. (1997). Eating disorders. *Clinical Obstetrics and Gynecology*, 40 (3), 601-615.
- Hansen, J.E. & Schuldt, W.J. (1984). Marital self-disclosure and marital satisfaction. *Journal of Marital and Family Therapy*, 46, 923-926.
- Heavey, A., Parker, Y., Bhat, A., Crisp, A.H. & Gowers, S.G. (1989). Anorexia nervosa and marriage. *International Journal of Eating Disorders*, 8 (3), 275-284.
- Kiriike, N., Nagata, T., Matsunaga, H., Tobitan, W. & Nishiura, T. (1998). Single and married patients with eating disorders. *Psychiatry and Clinical Neurosciences*, 52 (Suppl), S306-S308.
- Kirkevold, M. (1997). Integrative nursing research: An important strategy to further the development of nursing science and nursing practice. *Journal of Advanced Nursing*, 25(5), 977-984.

- Levine, M., Walter, S., Lee, H., Haines, T., Holbrook, A. & Moyer, V. (1994). Users' guide to medical literature. IV. How to use an article about harm. *Journal of the American Medical Association*, 271(20), 1615-1619.
- Maxwell, G.M. (1985). Behaviour of lovers: Measuring the closeness of relationships. *Journal of Social and Personal Relationships*, 2, 215-237.
- Morgan, J.F., Lacey, J.H. & Reid, F. (1999). Anorexia nervosa: Changes in sexuality during weight restoration. *Psychosomatic Medicine*, 61, 541-545.
- Pirke, K.M., Schweiger, U., Lemmel, W., Krieg, J.C. & Berger, M. (1985). The influence of dieting on the menstrual cycle of healthy young women. *Journal of Clinical Endocrinology and Metabolism*, 60(6), 1174-1179.
- Polit, D.F. & Hungler, B.P. (1997). *Essentials of nursing research: Methods, appraisal, and utilization* (4th ed.). Philadelphia, PA: Lippincott.
- Raboch, J. & Faltus, F. (1991). Sexuality and women with anorexia nervosa. *Acta Psychiatrica Scandinavica*, 84, 9-11.
- Rosen, D.S. & Neumark-Sztainer, D. (1998). Review of options for primary prevention of eating disturbances among adolescents. *Journal of Adolescent Health*, 23 (6), 354-363.
- Rothschild, B.S., Fagan, P.J., Woodall, C. & Andersen, A.E. (1991). Sexual functioning of female eating-disordered patients. *International Journal of Eating Disorders*, 10 (4), 389-394.
- Sobal, J. & Burszty, M. (1998). Dating people with anorexia nervosa and bulimia nervosa: Attitudes and beliefs of university students. *Women & Health*, 27(3), 73-88.
- Streiner, D.L. & Norman, G.R. (1996). *PDQ epidemiology* (2nd ed.). St. Louis, MO: Mosby.
- Tiller, J.M., Sloane, G., Schmidt, U., Troop, N., Power, M. & Treasure, J.L. (1997). Social support in patients with anorexia nervosa and bulimia nervosa. *International Journal of Eating Disorders*, 21(1), 31-38.
- Van den Broucke, S. & Vandereycken, W. (1989). The marital relationship of patients with an eating disorder: A questionnaire study. *International Journal of Eating Disorders*, 8(5), 541-556.

- Van den Broucke, S., Vandereycken, W. & Vertommen, H. (1995a). Marital communication in eating disorder patients: A controlled observational study. *International Journal of Eating Disorders*, 17(1), 1-21.
- Van den Broucke, S., Vandereycken, W. & Vertommen, H. (1995b). Marital intimacy in patients with an eating disorder: A controlled self-report study. *International Journal of Eating Disorders*, 34, 67-78.
- Waring, E.M. (1985). Measurement of intimacy: Conceptual and methodological issues of studying close relationships. *Psychological Medicine*, 15(1), 9-14.
- Wiederman, M.W. & Pryor, T. (1997). A comparison of ever-married and never-married women with anorexia nervosa or bulimia nervosa. *International Journal of Eating Disorders*, 22, 395-401.
- Wiederman, M.W., Pryor, T. & Morgan, C.D. (1996). The sexual experience of women diagnosed with anorexia nervosa or bulimia nervosa. *International Journal of Eating Disorders*, 19(2), 109-118.
- Woodside, D.B., Lackstrom, J.B. & Shekter-Wolfson, L. (2000). Marriage in eating disorders: Comparisons between patients and spouses and changes over the course of treatment. *Journal of Psychosomatic Research*, 49, 165-168.

Table 1. A Summary of Research Concerning Clinical Characteristics for Women with Anorexia Nervosa (AN)

STUDY	DESIGN (LEGEND)	SAMPLING & SUBJECTS	INTERVENTION (LEGEND)	OUTCOMES/RESULTS
Wiederman & Pryor USA 1997	Cross-sectional, descriptive survey (a) Comparative analyses (frequencies, t-tests, Chi-squares)	Incidental sampling Never-married (n = 40) and ever-married (n = 51) women with AN (c)	Questionnaire (e)	1. No statistical difference between ever-married and never-married women regarding symptom history or severity. 2. Never-married women experienced menarche at an older age compared to ever-married women ($p < 0.05$). 3. Ever-married women more likely to have engaged in sexual intercourse ($p < 0.01$) and rated their satisfaction with sexual activity as lower ($p < 0.01$) than the never-married women.
Heavey <i>et al.</i> UK 1989	Retrospective, descriptive Comparative analyses (frequencies, t-tests, Chi-squares, Fisher's exact test)	Incidental sampling Married (n = 39) and single (n = 66) women with AN (c,d)	Chart audit (1979-1986) (b)	1. Statistically significant differences in eating disorder onset ($p < 0.01$) for single and married women. 2. Marginal statistical significance between the women's food restricting behaviours ($p < 0.067$). 3. No statistical significance between married and single women for interests in sexual matters, with both groups endorsing avoidance of sexual relations.

Legend to Methodological Weaknesses

- a) failure to specify study design or inappropriate study design;
b) methods do not control for biases;
c) failure to justify sample size;

- d) failure to describe sample size for replicability/generalizability;
e) measures lack validity/reliability testing, or are not mentioned;
f) inappropriate or missing statistical analyses for study design.

Table 1 Continued

STUDY	DESIGN (LEGEND)	SAMPLING & SUBJECTS	INTERVENTION (LEGEND)	OUTCOMES/RESULTS
Kiriike <i>et al.</i> JAPAN 1998	Retrospective, descriptive Comparative analyses (frequencies, Chi-squares, ANOVA)	Incidental sampling Never-married (n = 22) and ever-married (n = 40) women with eating disorders (c)	Chart audit (1983-1994) (b)	1. No statistical difference between the women regarding illness duration or symptom severity. 2. Marital distress was a significant trigger for approximately 70% of women with post marital disorder onset.

Legend to Methodological Weaknesses

- a) failure to specify study design or inappropriate study design;
- b) methods do not control for biases;
- c) failure to justify sample size;
- d) failure to describe sample size for replicability/generalizability;
- e) measures lack validity/reliability testing, or are not mentioned;
- f) inappropriate or missing statistical analyses for study design.

Table 2. A Summary of Research Concerning Overall Relationship Quality for Women with Anorexia Nervosa (AN)

STUDY	DESIGN (LEGEND)	SAMPLING & SUBJECTS	INTERVENTION (LEGEND)	OUTCOMES/RESULTS
Sobal & Bursztyn USA 1998	Cross-sectional, descriptive survey Comparative analyses (frequencies, Chi-squares)	Incidental sampling Male (n = 349) and female (n = 378) university students (c,d)	Author constructed questionnaire (e)	<ol style="list-style-type: none"> 1. Students (30% females, 35% males) believed individuals with AN would have difficulty dating. 2. Students (59% females, 45% males) believed that dating for individuals with AN would be 'moderately' to 'very' conflictual. 3. Students (57% females, 52% males) expressed discomfort in personally dating an individual with AN, anticipating the experience to be negative.
Tiller <i>et al.</i> UK 1997	Cross-sectional, correlational Comparative analyses (ANOVA, Pearson's correlation, Chi-squares)	Incidental sampling Women with AN (n = 44), BN (n = 81), and female college student control group (n = 86) (c)	Questionnaire	<ol style="list-style-type: none"> 1. Women with AN and BN identified significantly fewer support figures (spouse/partner) than the control group ($p < 0.001$). 2. Women with AN and BN described inadequate established spousal or partner support systems compared to the control group ($p < 0.05$) 3. Overall, marginal statistical significance was demonstrated between the control group's reported higher satisfaction with actual support and women with AN's reports ($p < 0.07$).

Legend to Methodological Weaknesses

- a) failure to specify study design or inappropriate study design;
- b) methods do not control for biases;
- c) failure to justify sample size;

- d) failure to describe sample size for replicability/generalizability;
- e) measures lack validity/reliability testing, or are not mentioned;
- f) inappropriate or missing statistical analyses for study design.

Table 2 Continued

STUDY	DESIGN (LEGEND)	SAMPLING & SUBJECTS	INTERVENTION (LEGEND)	OUTCOMES/RESULTS
Van den Broucke & Vandereycken BELGIUM 1989	Cross-sectional, descriptive Comparative analyses (Bonferroni correction for t-tests, MANOVA, ANOVA)	Incidental sampling 12 couples with one spouse having an eating disorder (AN, n = 5; BN, n = 7), 13 couples with one spouse having a neurosis (c) Additional, non-clinical, control group taken from another study (females, n = 432; males, n = 577) (Arrindell & Ettema, 1986 * †)	Structured personal interview (b), questionnaire (e)	1. Compared to the control group, spouses of the women with eating disorders and individuals with neuroses reported significantly more symptoms of depression ($p < 0.01$) and felt insufficiency ($p < 0.001$). 2. Compared to the control group, both women with eating disorders and spouses reported their sexual relationships as significantly less satisfactory ($p < 0.001$).

* as cited in Van den Broucke & Vandereycken, 1989 † does not state if control group consisted of married couples

Legend to Methodological Weaknesses

- a) failure to specify study design or inappropriate study design;
- b) methods do not control for biases;
- c) failure to justify sample size;
- d) failure to describe sample size for replicability/generalizability;
- e) measures lack validity/reliability testing, or are not mentioned;
- f) inappropriate or missing statistical analyses for study design.

Table 3. A Summary of Research Concerning Marital Communication for Women with Anorexia Nervosa (AN)

STUDY	DESIGN (LEGEND)	SAMPLING & SUBJECTS	INTERVENTION (LEGEND)	OUTCOMES/RESULTS
Van den Broucke, Vandereycken & Vertommen BELGIUM 1995a	Cross-sectional (a) Comparative analyses (t-tests, Chi-squares, ANOVA with Bonferroni correction)	Incidental sampling 21 couples with one having an eating disorder, 21 'maritally distressed' couples, 21 'nondistressed' couples (c)	Observed verbal and tactile tasks (b), questionnaire (e)	1. Couples with the eating disorder used significantly less criticism ($p < 0.01$) and disagreement ($p < 0.01$) during tasks, than 'maritally distressed' couples. 2. Couples with the eating disorder emitted significantly fewer responsive communication statements ($p < 0.05$), more demands for unilateral change as a problem-solving technique ($p < 0.05$), and higher self-disclosure rates ($p < 0.01$) than the nondistressed couples. 3. Couples with the eating disorder did not demonstrate a statistically significant difference in terms of positive verbal reciprocity as compared to the nondistressed couples.

Legend to Methodological Weaknesses

- a) failure to specify study design or inappropriate study design;
- b) methods do not control for biases;
- c) failure to justify sample size;

- d) failure to describe sample size for replicability/generalizability;
- e) measures lack validity/reliability testing, or are not mentioned;
- f) inappropriate or missing statistical analyses for study design.

Table 4. A Summary of Research Concerning Sexuality in Women with Anorexia Nervosa (AN)

STUDY	DESIGN (LEGEND)	SAMPLING & SUBJECTS	INTERVENTION (LEGEND)	OUTCOMES/RESULTS
Morgan, Lacey & Reid UK 1999	Longitudinal cohort (a) Comparative analyses (t-tests, ANOVA with ϵ correction, logistic regression)	Incidental sampling Women with AN (n = 11) (c,d)	Questionnaire	1. A statistically significant increase in sexual drive accompanies weight restoration in women with AN ($p < 0.001$). 2. A positive relationship demonstrated between weight restoration and decreased depression scores ($p < 0.046$). 3. Relationship between weight restoration and reduced anxiety scores was statistically insignificant.
Wiederman, Pryor & Morgan USA 1996	Cross-sectional (a) Comparative analyses (Chi-squares, multiple regression)	Incidental sampling Women with AN (n = 131) and BN (n = 319) (c,d)	Diagnostic questionnaire (e)	1. A significant statistical difference ($p < 0.0001$) between women with AN and BN regarding reports of having engaged in sexual intercourse. 2. Among those women having engaged in sexual intercourse, statistical significance was indicated between median age at the onset of sexual activity (BN = 17, AN = 18; $p < 0.02$). 3. A regression analysis demonstrated that beyond diagnostic difference, symptom severity was not a significant predictor of sexual experience.

Legend to Methodological Weaknesses

- a) failure to specify study design or inappropriate study design;
- b) methods do not control for biases;
- c) failure to justify sample size;
- d) failure to describe sample size for replicability/generalizability;
- e) measures lack validity/reliability testing, or are not mentioned;
- f) inappropriate or missing statistical analyses for study design.

Table 4 Continued

STUDY	DESIGN (LEGEND)	SAMPLING & SUBJECTS	INTERVENTION (LEGEND)	OUTCOMES/RESULTS
Raboch & Faltus CZECHOSLOVAKIA 1991	Cross-sectional (a) Comparative analyses (f)	Incidental sampling Women with AN (n = 30), women seeking gynaecological care (n = 50) acted as a control group (c,d)	Questionnaire (e)	<ol style="list-style-type: none"> 1. No statistically significant differences in age for first romantic date, sexual touching, or coitus. 2. Difference in age became statistically significant at the time of first marriage ($p < 0.001$), with women with AN significantly older than the control group. 3. No statistically significant differences between the two groups in terms of sexual arousability. 4. Women with AN indicated more sexual dysfunction and deterioration than controls ($p < 0.001$).
Rothschild <i>et al.</i> USA 1991	Retrospective (a) Comparative analyses (descriptive, Chi-squares, ANOVA)	Incidental sampling Women with AN (n = 29) and BN (n = 13) (c)	Questionnaire (e), structured personal interview (b)	<ol style="list-style-type: none"> 1. All study participants identified similar levels of sexual dissatisfaction and restriction, along with relationship dissatisfaction, and discomfort as a sexual person. 2. Women with AN reported less sexual fantasy than women with BN ($p < 0.001$). 3. Although women with BN reported a higher sex drive, comparisons to women with AN demonstrated statistical insignificance ($p < 0.11$).

Legend to Methodological Weaknesses

- a) failure to specify study design or inappropriate study design;
- b) methods do not control for biases;
- c) failure to justify sample size;

- d) failure to describe sample size for replicability/generalizability;
- e) measures lack validity/reliability testing, or are not mentioned;
- f) inappropriate or missing statistical analyses for study design.

Table 4 Continued

STUDY	DESIGN (LEGEND)	SAMPLING & SUBJECTS	INTERVENTION (LEGEND)	OUTCOMES/RESULTS
Beumont, Abraham & Simson AUSTRALIA 1981	Cross-sectional (a) Comparative analyses (descriptive statistics)	Incidental sampling 31 adolescent and young women with AN (c,d)	Chart audit (b), questionnaire (e)	1. 64% of women with AN had experienced intercourse by the time of the study, with 40% of this cohort evaluating the experience negatively. 2. 14 of the 31 women with AN experienced intercourse before the onset of the disorder, with 42% of this cohort citing sexual problems as precipitants of the disorder. 3. Interest, and pleasure from, sexual activity was reported to decrease at the onset of the disorder. 4. 7 of the 14 women with AN continued to engage in intercourse, with the other 6 reported a decrease in activity, and 1 woman reported cessation.

Legend to Methodological Weaknesses

- a) failure to specify study design or inappropriate study design;
- b) methods do not control for biases;
- c) failure to justify sample size;

- d) failure to describe sample size for replicability/generalizability;
- e) measures lack validity/reliability testing, or are not mentioned;
- f) inappropriate or missing statistical analyses for study design.

Table 5. A Summary of Research Concerning Intimacy in Marital Relationships for Women with Anorexia Nervosa (AN)

STUDY	DESIGN (LEGEND)	SAMPLING & SUBJECTS	INTERVENTION (LEGEND)	OUTCOMES/RESULTS
Woodside, Lackstrom & Shekter-Wolfson CANADA 2000	Longitudinal cohort (a) Comparative analyses (Chi-squares, MANOVA, ANOVA)	Incidental sampling Women with AN (n = 9), BN (n = 11), and eating disorder not otherwise specified (n = 2) (c,d)	Questionnaire (e)	1. Throughout the course of treatment, combined scores of all the women indicated an ongoing improvement in rating marital intimacy, with a statistically significant difference from treatment entry to program discharge ($p < 0.246$). 2. No statistically significant change in spouses' ratings of marital intimacy from partner program entry to discharge ($p < 0.1859$).
Van den Broucke, Vandereycken & Vertommen BELGIUM 1995b	Cross-sectional, correlational (a) Comparative analyses (Pearson's correlation, ANOVA, MANOVA, MANCOVA)	Incidental sampling 21 couples with one partner having an eating disorder (12 having AN), 21 'distressed' and 21 'nondistressed' couples (c)	Questionnaire	1. Couple's with the eating disorder had a significantly lower level of intimacy than 'nondistressed' couples ($p < 0.001$), but a statistically higher level of intimacy than 'maritally distressed' couples ($p < 0.001$). 2. Strong correlation between low intimacy and marital dissatisfaction for women with AN and their partners (partners, $r = 0.72$; women with AN, $r = 0.78$).

Legend to Methodological Weaknesses

- a) failure to specify study design or inappropriate study design;
b) methods do not control for biases;
c) failure to justify sample size;
d) failure to describe sample size for replicability/generalizability;
e) measures lack validity/reliability testing, or are not mentioned;
f) inappropriate or missing statistical analyses for study design.

Chapter 3

Debate or dogma? Addressing Husserlian phenomenology as a philosophy to guide nursing research

TO BE SUBMITTED TO

Advances in Nursing Science (refer to Appendix K for author guidelines)

ABSTRACT

Husserl's philosophy of transcendental phenomenology was first published more than 70 years ago (Husserl, 1931). Since that time, scholars have debated the differences between North American phenomenological research methodologies and Husserl's philosophy upon which they were based. Nursing research, in particular, has been criticized for its failure to take a Husserlian philosophical stance during research decision-making despite citing methodologies grounded in transcendental phenomenology. This paper explores the foundations of Husserlian phenomenological philosophy, and discusses the challenges of translating this philosophy into methodology for research inquiry. It is suggested that the lack of methodological direction provided by Husserl's original philosophical work and today's demands for rigorous research methods are a basis for asserting that the research methodologies used by nursing are a credible and valuable extension of the phenomenological project. Specific methodological issues are addressed to provide nurse researchers with an approach to future phenomenological inquiry grounded in the Husserlian philosophical position.

Key words: Husserl, phenomenology, qualitative research, nursing research

Introduction

Husserl is recognized as the founding father of the phenomenological movement in science. Many other phenomenological philosophers' tenets have been influenced by his works. Research methodologies derived from his writings are commonly cited in nursing research, which has been critiqued for its misuse of the underlying philosophy (Crotty, 1996; Paley, 1997). This paper will begin with a review of the origins of phenomenology, followed by the concepts and qualities that embody Husserl's philosophy of transcendental phenomenology. It will then examine the methodological guides often used in nursing research literature, discuss the challenges of translating this philosophy into methodology for research inquiry, and provide answers to specific interpretive issues. Finally, this paper will conclude with the suggestion that the lack of methodological direction provided by Husserl's original philosophy and today's demands for rigorous research methods are a basis for argument that the methodologies used by nursing are credible and valuable extensions of the Husserlian phenomenological project.

Phenomenological Beginnings: Husserl in Historical Context

Phenomenology was a term first used by Kant in 1786 to describe the scientific study of phenomena or the 'appearance of things' (Roche, 1973). This spirit of inquiry remained in effect over the century, even though the movement of European phenomenology is more widely accepted as having emerged in the 19th century. European phenomenology, which was based on a growing critique of using natural science to explain human concerns, was a contributor to the philosophy of science (Cohen, 1987; LeVasseur, 2003).

The diversity of phenomenology as a philosophical method of inquiry is well documented. Equally diverse are the phenomenological methodologies that guide research inquiry, which are grounded in these various philosophical stances. Annells (1999) recognized four distinct variants of European phenomenology, detailing their advancement within various scientific paradigms: positivism (e.g. Husserl, 1931, 1970), neopositivism (e.g. Merleau-Ponty, 1962), critical theorism (e.g. Habermas, 1987), and constructivism (e.g. Heidegger, 1962). Each of these philosophical traditions of phenomenology has different views on natures of reality and ways of knowing for the researcher. Spiegelberg (1982) adds to Annells' work, detailing the historical movement of European phenomenological philosophy in three distinct phases: the Viennese preparatory phase, the German phase, and lastly, the French phase.

The Viennese preparatory phase involved the works of Franz Brentano (1838-1917) and his student, Carl Stumpf (1848-1936). Both Brentano and Stumpf viewed phenomenology as a way to describe and clarify human experiences before assuming causal explanations, an innovative notion for its time. Brentano further offered that human consciousness is purposeful (the idea of Intentionality), while Stumpf conceptualized an experimental phenomenology that involved data analysis by empirical means and set forth to establish 'scientific rigour' in phenomenology (Cohen, 1987; Spiegelberg, 1982).

The German phase was dominated by the writings of Edmund Husserl (1859-1938) and Martin Heidegger (1889-1976). Husserl, who worked with both Brentano and Stumpf, considered phenomenology as a means through which to view universal

elements (phenomena) of human experience. For Husserl, phenomenology was viewed as the only rigorous science untainted by subjectivity, because phenomenologists set aside ('suspended') preconceptions of the world around them (a 'natural attitude') in order to achieve an objective discovery of the true meanings of human experience (Cohen, 1987; Welton, 1999). Given this suspension of preconceptions of the world, these true meanings were considered ahistorical and essential to the experience being studied. Heidegger, on the other hand, linked phenomenology to existentialism based on his interests in ontology (the nature of being) and temporality (Heidegger, 1962). Heidegger's views of phenomenology deviated from Husserl's in his adopting a more constructivist view. Heidegger, like Husserl, asserted that in order to study 'being-in-the-world', the phenomenologist must acknowledge also his or her own 'being-in-the-world'. Unlike Husserl, Heidegger felt that phenomenologists could not objectively remove themselves from discovery because their interpretation of meaning was also grounded in their own experience (Leonard, 1989; Spiegelberg, 1982).

The phenomenological movement shifted from Germany to France due to social and political changes brought about by World War II. A key philosopher who emerged during this time was Maurice Merleau-Ponty (1908-1961). He furthered Husserl's thinking along existential lines by viewing human existence as situated in a 'pre-given world' that included both historical and present conditions, rather than Husserl's focus on abstract phenomena. In this sense, Merleau-Ponty's phenomenology is on the periphery of philosophical hermeneutics, although it maintains Husserl's emphasis on the need to be objective during inquiry. Merleau-Ponty is thus credited with adopting a

neopositivistic position in phenomenological philosophy (Annells, 1999; Sadala & Adorno, 2002).

Recent extensions of the phenomenological movement not included in Spiegelberg's (1982) historical phases include Habermas' contribution to contemporary hermeneutics within a critical theorist paradigm (1987). In his appeal for an emancipatory approach to inquiry, Habermas added a critical hermeneutic stance to phenomenological philosophy with his critique of its failure to reflect the social, economic, and political factors that oppress people (Annells, 1999). Several American psychologists and social scientists have also extended the phenomenological project, citing Husserlian influence in the development of their own phenomenological methodologies (e.g. Colaizzi, 1973; Giorgi, 1985; Moustakas, 1994; van Kaam, 1966). These relatively recent developments, however, are a source of debate in terms of the degree to which they are heirs to Husserl's philosophical work, and have been labelled the North American phenomenological movement versus the European advancement presented by Spiegelberg (1982). We will return to this debate later in the paper.

Husserlian Philosophy

Husserl's body of work leads the reader through his journey with life and philosophical experiences. He is recognized as introducing 'novel' conceptions for his time, including the philosophical relationships between meaning and reference, subject and object, and language and description. The discourse these relationships offered was observed by Welton (1999) as providing a turning point in philosophical thought towards a philosophy of phenomenology. Early works of Husserl bridge his foundational studies

in mathematics and logic and his later interest in philosophy. In particular, Husserl became fascinated with the phenomenology of expressions, and the way in which their meaning could be connected to intentional acts, an influence from his earlier work with Brentano (*Logical Investigations*, published circa 1900-1). Husserl's 'recrystallization' of his theory of Intentionality was gradual; reaching fruition with his belief that phenomenology could only become a philosophy proper if it became 'transcendental'. He thus began to work on his well-known philosophy of transcendental phenomenology from that point forward (*Cartesian Meditations*, published in 1931). In the years following, Husserl focused his efforts on what would be his final body of work – a view of the crisis in science and phenomenology. This was driven, in particular, by his ongoing concern about naturalism's (natural science's) incapacity to recognize the life of the spirit in human experience (e.g. *The Crisis of European Science and Transcendental Phenomenology*, published circa 1934-37) (Welton, 1999).

Transcendental Phenomenology

Husserl's middle period of writing involving his philosophy of transcendental phenomenology is widely reflected in nursing research scholarship (Porter, 1998). Although naturalism viewed knowledge as separate from being, Husserlian transcendental phenomenology challenged these presuppositions. Husserl emphasized that such a division, for human experience, was not possible because knowledge formed around interests and intentions gave it meaning (Husserl, 1960, 1970). He then developed a philosophy that emphasized the achievement of pure consciousness and pure ego ('transcendence') in which true meanings and essences ('eidos') of human 'lived'

experience would surface in the phenomenological philosopher's consciousness and be known as 'truth' for that experience. This epistemological foundation highlights several important concepts that will be addressed: phenomena and Intentionality, Epoche, transcendental subjectivity, and eidetic reduction. These concepts also draw attention to the influences of positivism (Annells, 1999), as well as those of the philosophers Brentano, Kant, and Descartes (Moustakas, 1994).

Phenomena and Intentionality

Fundamental to transcendental phenomenology, and inextricably bound to consciousness, is Intentionality, a concept Husserl expanded from Brentano's original description. Both Brentano and Husserl regarded Intentionality as occurring when an individual reached out in a 'mindful way' towards an object and is thus conscious of it (Beech, 1999; Koch, 1995). Brentano, however, believed that a relationship always existed between perception and reference (object), whereas Husserl held the position that the object of interest may be real or not exist at all. Thus, perception for Husserl was regarded as the primary source of knowledge, a source that could not be doubted (Moustakas, 1994). In this sense, Husserl opposed the Cartesian stance of doubting the accuracy of perception, believing that perception itself, not the object of interest, was reality and asserting that there were no meaningless sense perceptions just as there were no 'unintentional' objects of consciousness (Husserl, 1977; LeVasseur, 2003).

It is important to note Husserl's meaning of the 'object perceived'. According to Paley (1997), this has been a major source of misinterpretation in the literature. 'Object', to Husserl, referred to anything in the external world, including abstract notions such as

feelings, which in today's language are not described as objects (Corben, 1999; Welton, 1999). The important distinction to make is that in Husserlian philosophy, phenomena (essences) were what entered the consciousness based on the intentional 'object' experience, and were thus not found in the external world. As such, the philosopher investigated their experience of the object to reveal phenomena.

Husserl's view of consciousness was oppositional to the Cartesian dualist perspective. Husserl critiqued Descartes' notion of consciousness stating that Descartes was unable to 'free himself' from naturalism, which led to his position of distinguishing the 'thinking substance' of his ego from the external world (LeVasseur, 2003). Husserl's concept of Intentionality, on the other hand, wedded the external world and consciousness. It highlighted the relationship between object and ego (individual) by emphasizing that the nature of human consciousness was directed towards something other than itself. As such, consciousness was indivisible from its object (Husserl, 1960, 1977; Koch, 1995; Moustakas, 1994).

Epoche

While he opposed many of the epistemological foundations of positivism, Husserl did emphasize objectivity in that the object should be explored untainted by the philosopher's preconceptions. Husserl reinforced his belief in objectivity with his assertion that all sciences were naïve in regard to their points of departure (Husserl, 1960, 1977; Paley, 1997). That is, all sciences (and individuals practicing within various scientific paradigms) declared a 'natural attitude' comprising unexamined assumptions about their respective domains and the world in general. These assumptions violated

Husserl's belief that philosophy, as the most fundamental science, should be free of presuppositions. Husserl believed that if phenomenological philosophers could set aside their theoretical assumptions and their implied dogmatic tenets, they could come closer to a philosophical way to approach the truth. Husserl's device to address this philosophical concern was to introduce 'Epoche'. This was the philosophical stance that aimed to redirect the philosopher's sight from a straightforward orientation toward objects, to a 'back-inwards' orientation toward consciousness (Moustakas, 1994; Welton, 1999).

To achieve Epoche, Husserl stated that the natural attitude must be brought into reflection and subsequently 'suspended' or 'bracketed' (in the mathematical sense) prior to investigation of human experience (Husserl, 1931; Paley, 1997). Thus, Epoche required a reductionistic approach to the attainment of a presuppositionless (objective) stance concerning preconceptions, biases, or judgments: "We put out of action the entire ontological commitment that belongs to the essence of the natural attitude, we place in brackets whatever it includes with respect to being" (Husserl, 1931; pp. 111). What remained following Epoche was a 'transcendent ego', a consciousness reduced to purity, free to discover the object's true meanings and essences (Lowes & Prowse, 2001; Moustakas, 1994). Through the achievement of Epoche, the philosopher could be confident that what was left to inspect must be the pure contents of introspection, that is, those contents in consciousness itself. Given the suspension of the 'natural attitude', these pure contents were considered ahistorical and essential to the studied experience.

Husserl's emphasis on pure consciousness and pure ego rejected the positivistic assertions (laws and facts) seen in natural science. Indeed, in a Husserlian philosophical

approach to phenomenology, no positivistic assertions were made and no truths were presupposed concerning natural realities (Husserl, 1931, 1960). However, Husserl did not reject the notion of truth. In congruence with positivism, he asserted notions of certainty and permanence of understanding the world through essential structures (essences) of objects (Annells, 1999; Johnson, 1999).

The philosophical stance of Epoche also drew from Cartesian doubt in the sense that the philosopher was seen as 'turning away from the world'. Husserl's intention, however, was not solipsism (the self is the only reality) (Beech, 1999; Welton, 1999). Although the philosopher did direct a presuppositionless stance toward the intended object to achieve a 'transcendent ego', the reality of the natural attitude and external world was neither confirmed nor denied; it was merely 'suspended' in an act of phenomenological reduction. On some level, however, Husserl retained tenets of Cartesian subject/object dualism in his belief that the aim of transcendental phenomenology was to describe a lived world from a detached or bracketed stance. The difference between Husserlian and Cartesian thought in this aim, however, was the temporality and self-imposed nature of Epoche versus an essential structure of the world (e.g. the Cartesian division between *res extensa* (matter) and *res cognitans* (mind)) (LeVasseur, 2003).

Husserl has been critiqued as being idealistic in his assertion of Epoche. Constructivists, including Heidegger (1962), have challenged the notion that the phenomenological philosopher can take a purely reflexive attitude toward the world and achieve a perspective (pure consciousness) from which ahistorical truth could be

ascertained. Contrary to Husserl, Heidegger (1962) proposed that truth was relative to time and being and that consciousness could not be separated from 'being-in-the-world'. That is, the philosopher could not extricate himself or herself from a world in which he or she already exists (Lowes & Prowse, 2001; Spiegelberg, 1982).

Transcendental Subjectivity and Eidetic Reduction

After performing Epoche, what remained was a 'field of primordial phenomena' of the experience, which was the beginning point for phenomenological description (Kockelmans, 1994; Paley, 1997). The aim of Husserlian phenomenology was to construct an exact description of the primordial phenomena from a pure consciousness, highlighting Husserl's famous maxim, 'back to the things themselves'. Husserl (1931) called this primordial consciousness the realm of 'transcendental subjectivity' and stated, "Every imaginable sense, every imaginable being... falls within the domain of transcendental subjectivity, as the subjectivity that constitutes sense and being" (pp. 84). The examination of the primordial phenomena involved the examination of the horizons (or layers) of the phenomena that appeared in consciousness for the philosopher. Each horizon as it entered consciousness gave a distinctive character to the experience and had equal value as the philosopher sought to disclose its nature and essence. Husserl introduced the concepts of noeses and noema within this examination (Husserl, 1931), which illuminated his notion of Intentionality. Noeses comprised the acts of perceiving, thinking, feeling, and remembering by the mind and spirit of the philosopher, enabling them to discover the meaning or sense of what was brought into consciousness, known as

noema. Thus, noeses were the way in which objects were experienced, and noema were what was experienced (Husserl, 1931; Moustakas, 1994).

In Husserlian phenomenology, ‘eidetic reduction’ was a philosophical device to render phenomena clear, explicit, and complete in textual language (Paley, 1997). Husserl wrote that both the realm of transcendental subjectivity and eidetic reduction were solitary, philosophical endeavours (Paley, 1997; Welton, 1999). Important to eidetic reduction and transcendental phenomenology was the commitment to descriptions of essences (eidos), not explanations or analyses (induction or deduction). Descriptions were meant to keep the phenomenon alive: illuminating its presence, accentuating its underlying meanings, and enabling the structural (‘what’ was appearing) and textual (‘how’ it was appearing) essences to linger as near to its actual nature as possible (Welton, 1999). In *Cartesian Meditations* (1960), Husserl described the process of Epoche and subsequent eidetic reduction,

I begin, therefore, by questioning that which is mine, under the heading “world”, the character of the conscious, the experienced, and the intended, and which is accepted by me as being; I ask what it looks like in its being accepted thus; I ask how I became conscious of it, how I may describe it, how I can designate it, in terms valid for every occasion; how what is subjective in this way manifests itself in different modes, what it looks like in itself, as experienced or as intended as this or that, or what this experiencing itself as experience of the mundane looks like, how it is to be described (pp. 209).

In this review of eidetic reduction, it is apparent that although it upholds several positivistic qualities – reductionism, objectivity, and truth (notions of certainty and permanence of understanding) – eidetic reduction as a philosophical device was an

imaginative one. Thus, when engaging in eidetic reduction, Husserl permitted neither induction nor deduction, but 'intuiting' (Moustakas, 1994; Paley, 1997; Welton, 1999). Like Descartes, Husserl believed that knowledge based on intuition and essence heralded empirical knowledge, and involved the philosopher 'returning to themselves' (Moustakas, 1994). Husserl's focus on using intuitive processes through pure consciousness also reflected Kantian thought. Kant established that to know an object, there must be an intuition through which the object is presented and a concept by which the object is thought to correspond to the intuition (Kant, 1966). Husserl built on the notion of intuition and incorporated imaginative variation within it, which was targeted toward meanings and dependent on intuition as a way of developing the essence (Moustakas, 1994). Through imaginative variation, the range of possible forms the experience could take was examined. Through logic and insight, what was and what was not essential came into consciousness. In engaging in both intuition and imaginative variation, the philosopher became aware of an essential structure of the experience – an ideal or essence (Paley, 1997).

Husserlian Phenomenology: A Philosophy and an Approach to Research

In recent years, a growing body of qualitative scholarship has become concerned about the discrepancy between traditional European phenomenology that emerged in the 19th century and North American phenomenology that surfaced in the 1960s and 1970s. The latter phenomenological movement was grounded in the critique of Husserl's original philosophical assertions on phenomenology, which were purported to fail to bridge the gap from theory to the contemporary practice of humanistic research. That is,

Husserl provided no 'practical methodological guide' for researchers to conduct their investigations (Porter, 1998). Several American humanistic psychologists and social scientists found his work influential in the development of their respective phenomenological methodologies (e.g. Colaizzi, 1973; Giorgi, 1985; Moustakas, 1994; van Kaam, 1966). It is these methodological protocols that have been predominantly reflected in nursing's phenomenological research.

Omery (1983) is considered by Porter (1998) to be a key resource in the nursing literature on phenomenological methods developed by humanistic psychologists. Porter (1998) states that the methods reviewed in Omery's article (Colaizzi, 1973; Giorgi, 1985; van Kaam, 1966) were the most frequently employed benchmarks for guiding published phenomenological studies in nursing between 1983 and 1993. Porter (1998) asserts that although the review's influence on nursing's preference for phenomenological methods was unintended, the impact on their use in nursing research is evident.

While nursing is not the only discipline to use phenomenological protocols, several critiques have surfaced in response to nursing's use (e.g. Crotty, 1996; Paley, 1997). Paley (1997), in particular, harshly censures nurse researchers and asserts that their interpretation of Husserlian phenomenology has not made consistent use of key concepts as Husserl intended. The exemplars offered by Paley are many and include Omery's (1983) "inaccurate" description of the phenomenological method as inductive (Husserl's philosophy permitted neither induction nor deduction (Moustakas, 1994; Paley, 1997)) and Jasper's (1994) assertion that description of the phenomenon involves offering it in the 'person's own words' – a task 'impossible' according to transcendental

phenomenological philosophy unless the person is the phenomenologist's transcendental self (Paley, 1997).

Paley (1997) attributes such misinterpretations to the tiered, or hierarchical, manner in which phenomenology has been imported into North American phenomenological scholarship; stating this has increased the possibility of philosophical and methodological misinterpretations of Husserl's original work. He describes Husserl (1960, 1970) as the first tier. Philosophical commentators such as Spiegelberg (1982) form the second tier, and philosophically minded American humanistic psychologists and social scientists, including Giorgi (1985), Colaizzi (1973), and Moustakas (1994), comprise the third tier. Paley (1997) further states that while the American phenomenological methods used by many nurse researchers may be in the spirit of Husserlian thought and may retain some legitimacy, their misappropriation of the central tenets of Husserl's philosophy leaves them unqualified to justify research using this philosophical underpinning.

Porter (1998) emphasizes less ardently than Paley (1997) the challenges to philosophical translation and the risks of philosophical misinterpretation in American phenomenology. She also highlights the cautionary statements from the interpreters themselves claiming only *philosophical inspiration* from Husserlian tradition for their methodologies. For example, Colaizzi (1978) described finding himself in, "the unenviable position of trying to spell out phenomenologic research methods and procedures while simultaneously maintaining that there is no single method or procedure, but only methods and procedures of description" (pp. 53). In the same vein, Giorgi

(1985) stated, “My experience suggests that there is great risk of misunderstanding in presenting the method in such a schematic fashion” (pp. 20).

Although Paley (1997) may have called for a more radical abandonment of Husserlian interpretation by nurse researchers, Porter (1998) offers a more realistic and conservative approach. She asserts that examining the philosophical grounds of the chosen phenomenological research methodology invites an account of inspiration versus unwavering interpretation. This position not only recognizes the limitations of the direct translation of philosophical tenets into methodological schemata but also allows for philosophical adaptation by a research community living after Husserl’s time. In this sense, methodological protocols grounded in Husserlian thought provide a credible and valuable extension for today’s phenomenological ventures.

Methodological Interpretations: Salient Approaches to Husserlian Phenomenology

In recognizing the need to advance Husserlian philosophy into a useful form for inquiry, psychology has moved Husserlian thought into salient methodological procedures for phenomenological research. Although this may be controversial for some authors (e.g. Crotty, 1996; Paley, 1997), such a direction was needed to uphold the rigour expected of today’s research. As such, Husserlian-inspired methodological protocols have offered phenomenologists standardized procedures for conducting research, including ways to develop templates from which to evaluate their quality and rigour.

With no clear directive to guide phenomenological research and multiple methodologies to select from, nurse researchers have to appraise how well the Husserlian referents fit within the structuralism of North American phenomenological

methodologies and what divergences are needed to suit today's research community. Regardless of which phenomenological methodological approach is used (e.g. Colaizzi, 1973; Giorgi, 1985; Moustakas, 1994; van Kaam, 1966), the chosen method, data collection, and analysis should be comprehensive and concise in its approach to all stages of the research endeavour. It should also be supported by an account of conscious, deliberate choices with corresponding congruent philosophical and/or methodological rationale.

In order to critically appraise phenomenological studies, nurse researchers must then ask themselves what this synthesis of Husserlian philosophy and methodology means for North American phenomenology. Particularly salient is a review of previously discussed Husserlian concepts of phenomena, Intentionality, Epoche, transcendental subjectivity, and eidetic reduction within the North American phenomenological concepts of research aim, methodological rigour, phenomenological sampling, data collection, and analysis.

Research Aim

Consistent with both Husserlian and North American phenomenology is the aim to discover essential meanings and essences of human lived experience. Although Husserlian philosophy asserted positivistic notions of certainty and permanence of understanding the world through essential structures (essences) of objects (Annells, 1999; Johnson, 1999), North American phenomenological methods recognize a more neopositivistic view in that the context of the individuals who contribute to the

examination of the experience may limit these notions. In this sense, the temporality of essences and experience is acknowledged as a possibility (Morse, 1991; Patton, 1990).

In the Husserlian sense, the notion of Intentionality states that individuals should reach out in a mindful way towards objects and be conscious of their experience with them. In North American phenomenology, this notion does not exclude the researcher. This can be seen explicitly in the selection of research endeavours and the decision-making process during a study, including data collection and analysis. Although remaining attuned to this Intentionality is necessary for making appropriate methodological decisions, the researcher must also guard against bias and judgments. This results in a finely tuned tension between Intentionality and Epoche in North American phenomenology.

For Husserl, the aim of philosophical phenomenology was to construct an exact description of the primordial (elemental) phenomena from a pure consciousness that is removed from self-conscious thinking processes (Kockelmans, 1994; Paley, 1997). As such, it required that descriptions of pre-reflective experience be sought as a means of obtaining real descriptions of objects' phenomena – that is, the experiences' descriptions are sought before the experience is thought about! Endeavours governed by North American phenomenological methodological protocols aim to uncover elemental phenomena of the experience as well. In contrast to Husserlian thought, however, today's researchers often aspire to explore the description, thoughts, and feelings of lived experience. In this sense, the exploration solicits participants' applied ways of understanding and explanation. Thus, North American phenomenology often seeks to

understand the reality of lived experiences, or of an individual interacting with object experience, rather than just the objective reality of the nature of the experience itself.

Methodological Rigour

Objectivity is essential to both Husserlian philosophy and its methodological proponents. This is embedded in Epoche. Although Husserl's Epoche did not demand solipsism, it did require a continued presuppositionless stance in order to be confident that the philosopher's consciousness was reduced to a state of purity, free to discover the object's true meanings and essences (Lowes & Prowse, 2001; Moustakas, 1994). North American phenomenology recognizes that by using Husserl's Epoche as originally intended, however, researchers would be asked to refrain from any judgments found in the 'natural attitude', barring them from making methodologically-related decisions. Thus, Epoche is essential for suspending preconceived notions regarding the explored experience, but it is modified in North American phenomenology to acknowledge the need for Intentionality in methodological decision-making. In this sense, Epoche is used as a way to defend the truthfulness and authenticity of research endeavours (e.g. Colaizzi, 1973; Giorgi, 1985; Moustakas, 1994; van Kaam, 1966).

The use of Epoche to guard against unexamined attitudes and assumptions in North American phenomenology reflects a practical guide for researchers that is not found in Husserl's philosophy. For researchers who conduct an extensive literature review before they establish a niche for their research question, Epoche can be particularly important for taking an objective approach to the research. Epoche includes a number of researcher actions throughout the phenomenological endeavour, including

engaging in reflexivity through ‘memoing’, journaling, peer reviewing, and member checking. Congruent with Husserlian Epoche, memoing and journaling are seen as reflexive processes that make Intentionality explicit for examination and subsequent ‘suspension’. In this sense, researchers consistently reflect, intuit, and write about their thoughts and feelings on the explored experience (Moustakas, 1994), decisions concerning the research process, and even questions raised within the research during the phenomenological venture. For Frank (1997), “The challenge is not to eliminate ‘bias’ to be more neutral, but to use it as a focus for more intense insight” (pp. 89). Peer reviewing and member checking involve turning to other experts and the individuals involved in the research to audit the clarity and accuracy of the explored experience. While the use of these measures illustrate a significant deviation from Husserl’s Epoche as a stance of the researcher alone, such actions are seen as assistive devices to achieve the objectivity Husserl claimed was needed to guard against unexamined research assumption and attitudes.

Sampling and Data Collection

Husserlian philosophy provides no guideline about how to explore a particular object as experienced by others. Indeed, Husserl presented transcendental subjectivity and eidetic reduction as a solitary philosophical reflection (Paley, 1997). This was a challenge for humanistic psychologists and social scientists who intended to reflect the nature of current phenomenological studies as researcher distinct from participant (e.g. Colaizzi, 1973; Giorgi, 1985; Moustakas, 1994; van Kaam, 1966).

In terms of sampling, although qualitative literature recommends that on average, a phenomenological sample size of 10 is adequate due to the detailed descriptions elicited from participants (Patton, 1990), North American phenomenology is concerned with achieving a unified vision of the essences of an experience. Thus, sampling continues until 'crystallization' of essences of the experience is believed to have been achieved. Therefore, 10 is used only as a benchmark or likely sample size. Following Crabtree and Miller's (1999) guidelines for crystallization, it is said to exist when themes or essences begin to resurface from the participants (redundancy). Again, the temporality of essences and experience is acknowledged as a possibility in North American phenomenology: crystallization may only be realized with the selected group of participants in the research endeavour. Furthermore, new essences of the experience may or may not emerge with an entirely different group of participants (Morse, 1991; Patton, 1990).

The participation of others in revealing a particular object experience raises questions about self-presentation during data collection (experience exploration), whereby the participant may intentionally or unintentionally present a false description. This may be a relevant issue for researchers exploring sensitive topics or if the participant and researcher have yet to establish a rapport for truthful disclosure. Qualitative literature reinforces the importance of researcher-participant rapport stating that in the absence of trust, participants are more likely to offer descriptions based on what they perceive the researcher wants to learn (Morse, 1991). At first glance, this may seem to be a point of vulnerability in North American phenomenology. However, an examination of its underlying Husserlian philosophy reintroduces the concept of Intentionality and

Husserl's position that the object of interest may be real, imaginary, or not exist at all. Thus, perception, whatever it may be, is considered reality for research endeavours with Husserlian provenance.

A Husserlian approach to phenomenological research clarifies the importance of using data collection procedures that capture the structural ('what' is appearing) and textural ('how' it is appearing) elements of an individual's object experience (Kvale, 1996; Moustakas, 1994). Based on this, the predominant method of data collection in North American phenomenological studies is in-depth interviews with research participants. This method is deemed the 'gold standard' in qualitative research (Silverman, 2000), with its emphasis on the ability of mental processes to reveal essential phenomena of lived experiences.

Data collection may occur at single or multiple points in time. As a general rule, for North American phenomenology, data collection and analysis occur cyclically to fill out structural and textural features of the experience. Collection continues until the researcher achieves crystallization of the essences of the experience (Crabtree & Miller, 1999). During data collection, the researcher should pay sharp attention during reflexivity to how questions are asked during interviews, along with the possibilities of why they were asked. By engaging in reflexivity, the researcher acknowledges him or herself as part of the data collection instrument and analyzes the influence of assumptions and values that need to be part of Epoche. Although certain questions may seem to successfully elicit participant description, they may, in fact, introduce new ideas on

behalf of the researcher and thus threaten the truthfulness of the participant's experience.

The following exemplar illustrates this concern:

Participant: We started fighting a lot about our relationship.
and ever since then I've drifted away...

Researcher: Has that had a negative effect on your relationship?

In this exchange, the researcher introduced the concept of negativity to the participant. While this may have been an issue later addressed by the participant, it may have only been in response to the researcher's assumption, which has potentially compromised the truthfulness of the participant's description. A better way for the researcher to respond to the participant's statement would have been, "Can you tell more about your drifting away?", "What does drifting away mean to you?", and/or "What has that been like?" In these examples, the researcher maintains an objective attitude during data collection.

Data Analysis

Husserl provided numerous concepts in transcendental phenomenology's approach to interpreting object experiences. Yet no organized approach for these expressions was offered. North American phenomenological research methods bring a structured and systematic approach to data analysis.

Important to Husserlian philosophy was the commitment to descriptions of essences (eidos), not explanations or analyses (induction or deduction), through intuiting, reflection, and imaginative variation (Moustakas, 1994; Paley, 1997; Welton, 1999). Although North American phenomenology endorses the use of these philosophical concepts in data analysis, they are conducted within a structured approach that requires

ongoing inductive and deductive decision-making (e.g. how to proceed throughout the project). To capture the essence of the experience through eidetic reduction, data analysis also requires the researcher to become immersed in the texture, tone, mood, range, and content of the descriptions generated by the participants (Patton, 1990). This process involves listening to the participants' audiotaped verbal descriptions, as well as reading and re-reading the compiled transcripts, which assist in imaginative variation, reflection, and intuition. In keeping with Husserlian philosophy, North American phenomenology endorses the use of Husserl's 'eidetic reduction', illuminated in several steps to analysis: (1) horizontalizing participant statements from transcripts; (2) creating meaning units; (3) advancing units to textural and structural descriptions; and (4) developing a composite description by merging textural and structural descriptions into an exhaustive descriptive of the experience.

Horizontalizing correctly details Husserl's intent for eidetic reduction through the examination of the horizons (or layers) of the phenomena that appear to the researcher in the participant's transcript descriptions. Each horizon is seen as giving a distinctive character to the experience, and has equal value as the phenomenologist seeks to disclose its nature and essence (Moustakas, 1994; Paley, 1997; Welton, 1999). Through this process, the researcher is led to a deeper understanding of the object experience's totality.

In the creation of meaning units, participant experiences are analysed through the Husserlian interpretive characteristics of imaginative variation, reflection, and intuition (Husserl, 1960, 1970). Imaginative variation entails reviewing the participants' descriptions, and varying the described object experience freely in all its possible forms.

Those that remain constant, or crystallized, through the different variations, are considered the structural and textural essences of the experience (Colaizzi, 1973; Moustakas, 1994; van Kaam, 1966).

For Husserl, textural and structural descriptions were thought to keep the phenomenon alive, illuminating its presence and accentuating its underlying meanings (Paley, 1997; Welton, 1999). In North American analytic method, textural and structural descriptions are created for each participant, and then combined to create a final 'descriptive' of the essences about the experience for the participants as a whole. In this final descriptive presented to the research community, extractions from the participants' interviews are used to highlight certain essences. In this way, North American phenomenology once again extends beyond the transcendentalism of Husserlian philosophy, augmenting the presentation of the descriptive and highlighting the rich nature of phenomenological inquiry.

Conclusion

On the position of Husserlian philosophical congruence with methodology, one hopes that scholarly debate will continue in the place of assertions of dogma. While nursing scholarship has been heavily criticized for its use of contemporary North American phenomenological methodologies in research (Crotty, 1996; Paley, 1997), critics should bear in mind that nurse researchers need a pragmatic and robust approach to phenomenological inquiry that also remains epistemologically sound. North American phenomenology represents a needed shift from philosophical tenets to methodological parameters.

In a return to the exemplars offered by Paley (1997), they accurately reflect the methodological guidelines put forth by North American phenomenology. Jasper's (1994) once inaccurate assertion that description of the phenomenon involves offering it in the 'person's own words' – a task considered impossible according to transcendental phenomenological philosophy unless the person is the phenomenologist's transcendental self (Paley, 1997) – is now seen as a credible method for extending Husserl's original work in a North American phenomenological approach to data analysis. Additionally, while Omery (1983) use of the word inductive to describe the phenomenological method may be contradictory to the Husserl's intent for Epoche (Paley, 1997), it is in keeping with North American phenomenology's recognition that decision-making is necessary to the research process.

Nurse researchers who undertake phenomenological endeavours must navigate the obfuscation in literature on phenomenological methodologies based on Husserlian philosophy. This task is perhaps one of the greatest challenges to nurse researchers wishing to follow a phenomenological pathway. It requires a clear understanding of the 'philosophy of science' that directs the nature of reality and ways of knowing for the Husserlian phenomenological researcher. Enabled with knowledge of Husserl's philosophy of transcendental phenomenology (1960, 1970), nurse researchers can evaluate their chosen methodology's ability to reflect Husserlian thought, thus adding to the overall quality, rigour, and understanding of their research endeavour.

REFERENCES

- Annells, M. (1999). Evaluating phenomenology: Usefulness, quality, and philosophical foundations. *Nurse Researcher*, 6 (3), 5-19.
- Beech, I. (1999). Bracketing in phenomenological research. *Nurse Researcher*, 6 (3), 35-51.
- Cohen, M.Z. (1987). A historical overview of the phenomenological movement. *IMAGE: Journal of Nursing Scholarship*, 19 (1), 31-34.
- Colaizzi, P.R. (1978). Psychological research as the phenomenologist views it. In R.S. Valle & M. King (Eds.), *Existential-phenomenological alternatives for psychology*. NY, NY: Oxford University Press.
- (1973). *Reflection and research in psychology*. Dubuque, IA: Kendall/Hunt.
- Corben, V. (1999). Misusing phenomenology in nursing research: Identifying the issues. *Nurse Researcher*, 6 (3), 52-66.
- Crabtree, B.F. & Miller, W.L. (Eds.). (1999). *Doing qualitative research* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Crotty, M. (1996). *Phenomenology and nursing research*. Melbourne, AUS: Churchhill Livingstone.
- Frank, G. (1997). Is there life after categories? Reflexivity in qualitative research. *The Occupational Therapy Journal of Research*, 17, 84-98.
- Giorgi, A. (1985). Sketch of a psychological phenomenological method. In A. Giorgi (Ed.), *Phenomenology and psychological research*. Pittsburgh, PA: Duquesne University Press.
- Habermas, J. (1987). *The philosophical discourse of modernity: Twelve lectures* (F. Lawrence, Trans.). Cambridge, MA: MIT Press.
- Heidegger, M. (1962). *Being and time* (J. Macquarrie & E. Robinson, Trans.). NY, NY: Harper.
- Husserl, E. (1977). *Cartesian meditations: An introduction to metaphysics*. (D. Cairns, Trans.). The Hague: Martinus-Nijhoff.

- (1970). *Logical investigations* (J.N. Findlay, Trans.) (Vol. 1). NY, NY: Humanities Press.
- (1960). *Cartesian meditations* (D. Cairns, Trans). The Hague: Martinus-Nijhoff.
- (1931). *Ideas: General introduction to pure phenomenology* (W.R. Boyce Gibson, Trans.). London, UK: George Allen & Unwin.
- Jasper, M.A. (1994). Issues in phenomenology for researchers in nursing. *Journal of Advanced Nursing*, 19, 309-314.
- Johnson, M. (1999). Observations on positivism and pseudoscience in qualitative nursing research. *Journal of Advanced Nursing*, 30 (1), 67-73.
- Kant, E. (1966). *Immanuel Kant's critique of pure reason* (N. Kemp Smith, Trans.). London, UK: Macmillan.
- Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advanced Nursing*, 21 (5), 827-836.
- Kockelmans, J.J. (1994). *Edmund Husserl's phenomenology*. West Lafayette, IN: Purdue University Press.
- Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage Publications.
- Leonard, V.W. (1989). A Heideggerian phenomenologic perspective on the concept of person. *Advances in Nursing Science*, 11 (4), 40-55.
- LeVasseur, J.J. (2003). The problem of bracketing in phenomenology. *Qualitative Health Research*, 13 (3), 408-420.
- Lowes, L. & Prowse, M.A. (2001). Standing outside the interview process? The illusion of objectivity in phenomenological data generation. *International Journal of Nursing Studies*, 38, 471-480.
- Merleau-Ponty, M. (1962). *Phenomenology of perception*. London, UK: Routledge and K. Paul.
- Morse, J.M. (Ed.). (1991). *Qualitative nursing research: A contemporary dialogue* (Rev. ed.). Newbury Park, CA: Sage Publications.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.

- Omery, A. (1983). Phenomenology: A method for nursing research. *Advances in Nursing Science*, 5 (2), 49-63.
- Paley, J. (1997). Husserl, phenomenology and nursing. *Journal of Advanced Nursing*, 26, 187-193.
- Patton, M.Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage Publications.
- Porter, E.J. (1998). On "being inspired" by Husserl's phenomenology: Reflections on Omery's exposition of phenomenology as a method of nursing research. *Advances in Nursing Science*, 21 (1), 16-28.
- Roche, M. (1973). *Phenomenology, language, and the social sciences*. London, UK: Routledge and K. Paul.
- Sadala, M.L.A. & Adorno, C.F. (2002). Phenomenology as a method to investigate the experience lived: A perspective from Husserl and Merleau Ponty's thought. *Journal of Advanced Nursing*, 37 (3), 282-293.
- Silverman, D. (2000). *Doing qualitative research: A practical handbook*. Thousand Oaks, CA: Sage Publications.
- Spiegelberg, H. (1982). *The phenomenological movement: A historical introduction* (3rd Ed.). The Hague: Martinus-Nijhoff.
- van Kaam, A. (1966). Application of the phenomenological method. In A. van Kaam (Ed.). *Existential foundations of psychology*. Lanham, MD: University Press of America.
- Welton, D. (Ed.) (1999). *The essential Husserl: Basic writings in transcendental phenomenology*. Indianapolis, IN: Indiana University Press.

Chapter 4

‘An Engagement-Distancing Flux’: Bringing a voice to experiences with romantic relationships for women with anorexia nervosa

TO BE SUBMITTED TO

European Eating Disorders Review (refer to Appendix K for author guidelines)

ABSTRACT

Over the past twenty years, clinicians and researchers have been exploring the dynamic interplay between eating disorders and relational experiences. This phenomenological study sought to describe the subjective experiences of romantic relationships for women with anorexia nervosa (AN). A purposive sample of 11 women participated in in-depth, semi-structured interviews. Analysis revealed that these women engaged in diverse relational experiences characterized by dialectical themes of engagement and distancing, which acted as basic drivers of relational change and maintenance. The dialectical perspective illustrated that the women's relational experiences did not contradict a generalized theory of relationships. Rather, the participants often addressed behavioural patterns, motivational dynamics, and situational environments in the context of their eating disorder. Understanding how women with AN experience romantic relationships may assist health care professionals to tailor interventions specific to patient ways of relating.

Key words: Anorexia nervosa, eating disorders, interpersonal relationships, phenomenology

Introduction

Anorexia nervosa (AN) is an eating disorder characterized by severe disturbances in eating behaviours and acute and unrealistic distress over body shape and weight (American Psychiatric Association (APA), 2000). It is currently estimated that approximately 0.5% to 4% of women in industrialized societies will develop AN in their lifetime (Steiger & Séguin, 1999). This incidence increases when the category is expanded to include subclinical syndromes that do not meet full diagnostic criteria for AN, which are estimated to occur two to five times more frequently in women (APA, 2000; Mussel, Binford & Fulkerson, 2000). Evidence to date highlights the complex interactions in the development and persistence of AN, which include the influence of developmental, psychological, socioenvironmental, and behavioural factors (Rosen & Neumark-Sztainer, 1998). Added to this dynamic clinical portrait is variation in illness duration. Some women recover after a distinct experience with AN, whereas other women continue to have a variable pattern of wellness and disorder relapse.

Literature Review

Although AN is well defined in young women, it is diagnosed in women of all ages. The varied ages at which women experience this eating disorder, coupled with its dynamic character, has prompted investigation into the nature and quality of the women's relational experiences. Research over recent decades has consisted primarily of quantitative research inquiry, clinician case review, and theoretical perspectives. In particular, the clinical characteristics of women with AN has been explored, and initial

steps to investigate the relationship between AN and relationship quality, communication, sexuality, and intimacy have also been taken in account.

Much of the early work published on clinical characteristics for women with AN was based on observations from treatment. Early descriptive case reports for example, described little difference in the physical and psychological symptoms of the disorder between married and unmarried women in terms of weight loss, disturbed body image, and amenorrhea (Van den Broucke & Vandereycken, 1988). Many theorists have reflected on the findings in these reports; in doing so, they conceptualized the young woman with AN within psychoanalytic frameworks to explore ego disturbances, internal psychic conflict, and self-regulation through eating disordered behaviours (Casper, 1998; Ewell, Smith, Karmel & Hart, 1992; Smolak & Levine, 1993; Selvini-Palazzoli, 1974). The shift to quantitative research and cross-sectional designs in particular, concerning clinical characteristics has been more recent. Clinical characteristics amongst married and unmarried women with AN reflect their earlier case review counterparts. Recent studies have reported no statistical differences between the two groups of women in terms of onset of their eating disorder, symptom history, and illness severity (Kiriike, Nagata, Matsunaga, Tobitan & Nishura, 1998; Wiederman & Pryor, 1997).

In terms of romantic experiences, quantitatively led research illustrated that interest in, and pleasure from, sexual activity decreased at the onset of the woman's eating disorder (Beumont, Abraham & Simson, 1981). Morgan *et al.* (1999) found that satisfaction with sexual activity increased with weight restoration. Women with AN reported discomfort as a sexual person; dissatisfaction with, or avoidance of, sexual

activity; and negative relational experiences (Raboch & Faltus, 1991; Rothschild, Fagan, Woodall & Andersen, 1991; Wiederman, Pryor & Morgan, 1996). Both married and single women with AN also exhibited comparable high percentages of sexual relations avoidance (Heavey, Parker, Bhat, Crisp & Gowers, 1989). Considering these results as a collective, positive relational experiences are considered to be a less frequent experience for women with AN.

In research exploring relationship quality for women with AN, both women and their partners reported significant dissatisfaction with their sexual relationship. In addition, partners reported significant symptoms of depression and feelings of insufficiency (Van den Broucke & Vandereycken, 1989). Women with eating disorders and their partners also demonstrated high rates of disclosure, a reduced quantity of responsive communication statements, and more demands of unilateral change as a problem-solving technique (Van den Broucke, Vandereycken & Vertommen, 1995a). Finally, an examination of intimacy for women with AN and their partners illustrated deficiencies characterized predominantly by a particular lack of openness within the relationship (Van den Broucke, Vandereycken & Vertommen, 1995b).

Results to date highlight the dynamic nature of romantic relationships, but do not completely depict the women's experiences. Descriptive case reports and limited quantitative research have failed to bring a voice to the dynamic nature of romantic relationships for women with AN. The need to reveal the rich, lived experiences is further reinforced by the lack of qualitative research studies. A qualitative approach to inquiry will elicit a description of romantic relationships from the women's perspective.

These experiences may reflect what is previously known for women with AN or may contribute a new relational perspective from which to regard these women.

This study explored the experiences of romantic relationships from the perspectives of women with subclinical and clinical AN. Phenomenological inquiry was used to focus on descriptions of relating within the relationship, appreciating the importance of the women's context in modifying and influencing their relating. A secondary objective of this study was to elicit descriptions of intimacy from the perspectives of these women, which are presented in a separate paper.

Method

Research Design

This study was guided by the philosophy of Husserlian phenomenology (Husserl, 1960, 1977) and its methodological adaptation (Moustakas, 1994). Like other approaches to phenomenological inquiry, Husserlian phenomenology gave parameters that directed the nature of reality and ways of knowing for the researcher. This included the researcher adopting a presuppositionless position, known as Epoche. Epoche involved the researcher setting aside ('bracketing' through written memos and journaling) previously known values and knowledge about the experience (Moustakas, 1994). This included knowledge of published literature in this area, her experiences with romantic relationships, and experiences of working as a nurse therapist with this clinical population. Through Epoche, the researcher *identified* rather than *verified* reality for the participants (Tesch, 1990). This ensured that the description remained truthful, based on the participants' experiences and unclouded by research assumptions.

Sampling Frame

A purposive sample of 11 women participated in this study. Inclusion criteria were women at least 18 years of age; diagnosis of anorexia nervosa (AN) or eating disorder (not otherwise specified) [ED (NOS)] (American Psychiatric Association, 1994); and receipt of treatment at a recognized eating disorders program in Ontario that required medical (physical) stability. Given that phenomenology is concerned with the achievement of a unified vision of the essences of an experience, sampling continued until 'crystallization' was achieved. Crystallization relates to the re-emergence of essences for the participants to reflect a shared experience (Crabtree & Miller, 1999). It is recognized that this may have occurred only with the selected group. New essences may or may not emerge with a different group of participants due to the context-specific information elicited in phenomenological studies (Morse, 1989).

Setting and Recruitment

Women who met inclusion criteria were recruited from two eating disorder programs in Southeastern Ontario following ethics approval from the programs' Institutional Review Boards. Participant demographics, including illness duration and medical stability, were comparable for both sites. The program psychologists facilitated site entry. Psychologists and nursing staff identified eligible participants, who were either contacted through a mailed recruitment letter or approached in person by the researcher. The researcher obtained informed consent from participants. Remuneration for travel (when applicable) and a summary of the study after its completion were offered to participants.

Demographic information was collected through a standardized form developed for the study, while most recent eating disorder diagnoses were accessed from chart reviews. Table A presents selected participant demographic and contextual information.

Procedure

Husserlian phenomenology elucidates the importance of using data collection procedures that capture the structural ('what' is appearing) and textural ('how' it is appearing) elements of an individual's experiences (Moustakas, 1994). Data collection thus involved in-depth, one-on-one interviews with each participant (Creswell, 1998; Moustakas, 1994). Each interview, which lasted approximately 45 minutes to one hour, was audiotaped and transcribed verbatim for data analysis. During interviews, participants were asked to describe past and present experiences with romantic relationships. Women who reported no experiences were asked to explore that context.

Subsequent interviews were conducted alongside data analysis, highlighting the cyclical nature of phenomenology. Succeeding interviews served two purposes: (1) to provide the participant with an opportunity to give feedback on the first interview; and (2) to allow the researcher to expand and verify descriptions of the studied phenomenon, thus ensuring a proper reflection of the structural and textural descriptions of the experience. Interview spacing was based on the availability of the women and the researcher and varied between three to seven weeks.

Data Analysis and Interpretation

Data collection, analysis, and interpretation occurred cyclically, until crystallization of the essential essences of the experience occurred. This ensured a

comprehensive 'descriptive' (the final product) of the investigated experience (Crabtree & Miller, 1999; Creswell, 1998). Moustakas' modification of van Kaam's (1966) method of data analysis guided the study and promoted a clear audit trail.

Audiotaped interviews and transcribed data were reviewed concurrently in recognition of the nuances of verbal communication. During this process, same statements were identified and extracted, and the essential textural and structural essences crystallized. Transcripts were re-read several times to facilitate the process. After several renditions, textural and structural essences were synthesized. A merger of these essences marked the last step in data analysis. Data interpretation was supported by a return to the literature. Throughout the analysis, members of the researcher's supervisory committee acted as external auditors, reviewing both process and outcome.

Participants' Contexts

As shown in Table A, two women identified themselves as not being in a romantic relationship, and having yet to experience a significant relationship; the length of dating relationships for two women ranged from weeks to several months. For the women in long-term relationships, relationship length averaged 3.5 years. For two of these women, their eating disorders began prior to their relationships, while for the remaining two women onset followed several years after their relationship began. One woman in a long-term relationship disclosed co-parenting a child with her fiancé. Finally, the length of marital relationships for three women ranged from 9 to 18 years. Of these women, two had experienced the onset of their disorder before their marriages.

All the women in marital relationships co-parented children with their partners, with the average number of children being two. (Ages ranged from 5 to 16 years).

Romantic Relationships: Participant Experiences and Meanings

Analysis revealed two main, opposing themes to these women's romantic relationships: engagement and distancing. For the women, engagement was emphasized as a state of emotional and physical connection attained in the relationship, which included feeling understood and supported by their partners. Engagement was predominantly described as being achieved through open dialogue in relationships that fostered trust and comfort. Distancing was described as a state of emotional and physical disconnection. The elements that contributed to distancing in the women's romantic relationships were secrecy, fear of exposure to judgment and rejection, and an inward focus on their eating disorder. All of the participants experienced varying degrees of engagement and distancing, which required them to consistently address the tension between the two in the establishment and/or maintenance of their romantic relationships.

Engagement

Engagement occurred in the various stages of the romantic relationship from initiation through maintenance. Engagement in romantic relationships for all the women was emotional and included seeking connection or gaining attention, trust, and disclosure. Partner support was seen as essential in maintaining engagement. All participants, whether in a romantic relationship or not, described engagement as best achieved through

an emotional connection with their partner and de-emphasized the importance of physicality for engagement.

Emotional Engagement

Relationship Initiation

Seeking Connection

The women described a desire for connection when seeking a relationship.

Women who were in dating or long-term relationships described seeking relationships based on “mutual attraction” and “a desire for commitment”. Women in marital relationships on the other hand, sought relationships based on several different motives: “desiring a connection”, “an escape [from family problems]”, “[to have] somebody that would be there for me”, and “I was truly looking for a better relationship with my father”.

Gaining Attention

For several participants irrespective of relationship status, engagement was sought via their eating disorder as a means to “gain attention”. As one participant explained, “It was just fun to be skinny again, and all this attention from all these guys... I just felt good about myself in that fact that like, I looked great, people were giving me attention”. Although many women stated that this attention was not the underlying precipitant to their eating disorder, it was a reinforcing factor to maintain a perceived female ideal.

Relationship Transition

Trust

All of the participants, whether in a romantic relationship or not, described engagement as best achieved through an emotional connection, a connection described as

primarily based on disclosure with their partner. Facilitating participant readiness to disclose was the presence of trust in the relationship. As one woman with dating relationship experience stated, "... I really have to trust them... or I won't tell them anything 'cause I think I'll get hurt". Another woman in a long-term marital relationship further emphasized the importance of trust when she shared, "... If you trust [your partner] you feel you can tell anything to them, and they will still love you no matter who you are, or what you did, or didn't do".

Although many women in long-term and marital relationships expressed that the transition from closure to disclosure occurred once they felt trust had been established, the experience was still filled with uncertainty because they did not know how their partner would react. Thus, partner support in the romantic relationship was key to fostering emotional connection through disclosure.

Disclosure

The transition to a romantic relationship where the women felt supported in their disclosure of their eating disorder allowed them to experience engagement through open dialogue with their partners. They no longer felt constricted to present an inauthentic self. Overwhelmingly, participants found their partners to be supportive of their disclosure, with many validating their feelings of authenticity: "For the first time I felt like I was my true self", and "I was able to say whatever I wanted, it just felt natural".

In this transitional relationship, engagement also allowed relational needs to be expressed. The women looked to partners to participate in their achievement. Many women described feeling most engaged with their partners when they felt able to freely

disclose their needs. Needs expressed included personal desires related to their eating disorder, such as “reassurance”, “validation”, “support”, “understanding”, and “interest in who I am ”, and desired relationship qualities, such as “trust”, “stability”, “compatibility”, and “honesty”.

Relationship Maintenance

Partner Support

There was a distinct, cyclical relationship in the maintenance of engagement. For many participants, having their relational needs met led to emotional engagement, which in turn led to feelings of being listened to, understood, and supported. As two of the participants explained:

I totally feel like he listens to me, and tries to understand. He wants to take time. He'll sit with me, and just ask me questions about it, how you do feel, do you want to talk about things.

I couldn't have asked I think for better support-wise... He says 'I don't love you for what you look like, I love you for you.'

Many participants also described their surprise at the support and connection maintained in their relationships after disclosure about their eating disorder; they had worried that this disclosure would terminate connection. As one woman clarified:

He's been 100% supportive. Like I've said, 'I don't know how many times you know, you're crazy to be with me. You know this isn't final, it's not fun.' And he just says 'you know I'm not going anywhere.' So, he's been amazing through the whole thing. I really thought he'd be like, 'oh my God, like I don't need this kind of stuff,' but he wasn't... he wanted to be a part of everything.

Discrete Disclosure

Although many women described being able to consistently voice relational needs in an engaging relationship, this was not necessarily so for disclosure about their eating disorder. Rather, disclosure of their eating disorder often occurred in discrete periods contingent on symptom severity. Women with more severe symptoms were less likely to disclose: “It depends what it is, and how bad things are for me... I worry that he’s going to worry, and that adds more stress to the situation”. Thus, discrete disclosure was felt to contribute to relationship maintenance.

In addition, ongoing disclosure was also based on how receptive the woman perceived her partner to be at that moment in time or in the past. Several women described ongoing receptive experiences with partners: “... He takes the time to listen to what I need,” “... He listened to me. Talked to me, not at me” and “... Sometimes I don’t even have to say anything. He notices that I not eating as much, and then asks if I want to talk to him about it”.

Physical Engagement

A physical connection was less affirmed by the women as contributing to engagement in their relationships. Women found partner support in the presence of sexual (e.g. sexual intercourse, sexual play) and non-sexual (e.g. hugging, cuddling with their partner) activities important for physical engagement. Several women experienced sexual engagement to address partner needs, and for women whose relationships were absent of sexual activity, several described the importance of its return.

Presence

The presence of physical closeness varied in the participants' relationships. Two women, who described their pleasure in the sexual and non-sexual elements of physical closeness, also conveyed their comfort in the sexual expression and emotional closeness of this experience. These women stated they felt comfortable with their bodies and their partners and valued the presence of physical closeness in their relating: "When the physical part is there, our relationship's better, the communication's better and I feel better. I'm happier, he's happier". For participants without sexual engagement, the importance of non-sexual activity was emphasized as a means of physically connecting.

Regaining Importance

Although many women reinforced the belief that engagement could provide an emotional connection in the absence of physical engagement, they expressed hopes that once their weight stabilized, sexual activity would regain importance: "It would be nice to get that back. It used to be such an important part to our relationship in terms of the two of us relating to each other". Two women who experienced past personal violations (e.g. abuse), however, cited the return of sexual activity was inconsequential to their experiencing physical closeness.

Partner's Benefit

In contrast to emotional engagement, many women looked to their partners to support their desired level of physical closeness, but found themselves supporting their partners' physical connection needs in the absence of their own. Despite the importance placed on achieving emotional closeness in their relationships, several women described

engaging in physical closeness through sexual activity in the absence of desire and felt emotional closeness in the experience. For these women, the focus was on their partner's experience rather than their own: "I mean I don't mind doing it, but I more do it because I know that's what he needs... I don't really think about it [negative thoughts], 'cause I'm more focused on what we're doing". These participants did, however, describe pleasure from, and interest in, non-sexual aspects to experience physical closeness with their partners including "hugging" and "cuddling".

Partner Support

As with emotional engagement, partner support was cited as important for achieving physical closeness. Overwhelmingly, all the participants described feeling their partners were supportive of the degree of physical closeness currently experienced in the relationship and the degree to which they desired it in their relationship. As one participant explained, "He understands my hang-ups about the physical stuff, and that sometimes I just need my personal space".

Distancing

Although the participants emphasized engagement to be an emotional and physical connection, distancing was the disconnection of these in the relationship. Central essences to emotional distancing were self- and relationship protection, secrecy, and the women's investment in their eating disorder, which followed the same relationship stages. Physical distancing included a lack of sexual desire.

Emotional Distancing

Relationship Initiation

Self-Preservation and Protection

For several women (including one married woman with a history of childhood trauma and another with a previous negative, marital relationship), distancing was used as a means of self-preservation and protection. Their eating disorder served to avoid emotional risks such as being hurt or negatively judged by another. Distancing themselves through a lack of relationships enabled them to preserve self-concept and self-esteem. Embedded in this distancing for one woman not in a relationship was fear that revealing her eating disordered behaviours would elicit rejection by potential partners. She expressed, “They [might] start to get like ‘oh my God this girl hasn’t eaten, so she must be crazy’”. Similarly, for another woman not in a relationship, distancing allowed her to avoid rejection by others. She described, “I decided it doesn’t matter how skinny I am, I’m not going to be liked enough”.

Relationship Transition and Maintenance

Relationship Preservation and Protection

For several women, distance in their relationship was an acceptable and desired approach for maintaining a successful relationship. As one participant expressed,

... don’t expect them to understand... don’t expect them to be able to help you at all. Just use them as an outlet, but you can’t expect too much of them, ’cause they’re not trained...

In this sense, the women recognized limitations in their partners’ support and sought engagement elsewhere in the presence of this distance (e.g. relationship norms). As

another participant explained, "... that's probably why the relationship does work out 'cause I don't tell him much".

Secrecy

Emotional distancing was felt to be related to the women's own desire for secrecy (lack of disclosure). For several women this meant not disclosing the eating disorder to their partner, while for other women whose partners knew of their eating disorder, secrecy was framed in the lack of ongoing disclosure. All of these participants, however, described wanting to maintain secrecy of their eating disorder, feeling that it was something they wanted to control on their own. Inherent to this belief was that disclosure to their partner would make them accountable to someone other than themselves, and depending upon their partners' reaction, might require them to relinquish their behaviour: "I want it to be mine. It's the thing that I control. I don't want him trying to fix it". In addition, all of the participants who distanced through secrecy described a need to present an ideal self related to either what they wanted their partners to see of them, or what they felt their partners wanted to see of them. Reasons for this presentation were often protective: "I didn't want to upset him", "I just like that feeling of being normal", "I was afraid it would end the relationship", "He can't accept that I have an eating disorder", and "He'll jump all over me...[asking] 'what's wrong with you'... So I try and pretend everything's good".

Partner's Role

At times, emotional distancing was felt to be a result of the women's partners' comments or actions. For one participant in a long-term relationship, emotional

distancing occurred following a negative reaction from her partner regarding her appearance, "... sometimes when he's touching me [he says] 'ew, look at you, you're so skinny, your bones are sticking out' ... It makes you feel like he's disgusted by you, and I'm frustrated and hurt". For other women, the emotional distance was due to a perceived lack of understanding from their partner regarding their struggle with their eating disorder. They described:

I've know I've said, 'I wish you could have an eating disorder for a day, and then you'd understand what it feels like'.

He tries to understand, but I think it's just too hard for someone who doesn't have trouble with eating at all you know, food is just food. He thinks just eat and you know it's not that, it's not just eat, it's more than that.

... he thinks that if he just says 'oh [participant's name] you're beautiful, you're skinny, you look fine,' he thinks that's it.

Physical Distancing

The impact of the women's eating disorders was particularly noticeable in their descriptions of physical distancing from their partners, a distance attributed to a lack of sexual desire and poor body image. Many of the women expressed hopes that once their weight stabilized and they achieved wellness, connecting physically would regain importance. As three women described:

Sometimes it's to the point where afterwards I cry 'cause I just feel so unattractive... when it comes to sex and that sort of thing, it's all gone.

Sometimes it's difficult... I just didn't want him to touch me... I just felt gross and lumpy and I just didn't want him to touch me.

I'd cry sometimes when I was kind of thinking realistically: I was just bone, just bone. I'd wake up in the morning with marks on my knees, and on my shoulders because of the pressure from lying.

Discussion

This research revealed two previously unknown opposing themes to the experiences of women with AN: engagement and distancing. For these women, engagement was emphasized as a state of emotional and physical connection attained in the relationship, which included feeling understood and supported by their partners. Engagement was predominantly described as being achieved through open dialogue in relationships that fostered trust and comfort. Distancing was described as a state of emotional and physical disconnection. Elements that contributed to distancing in the women's romantic relationships were secrecy, fear of exposure to judgment and rejection, and an inward focus on their eating disorder.

All of the participants experienced varying degrees of engagement and distancing, which required them to consistently address the tension between these two states in their romantic relationships. Engagement and distancing acted as basic drivers of relational change and maintenance for the women's romantic relationships. Although many of the women in established relationships stated that their reason for initiating their relationship was a sought-after connection, the distancing experienced in their relationship often fragmented this connection. The majority of women discussed this fragmentation in terms of the impact of their eating disorder. Noticed by the women was a shift to self-investment from relationship-investment with the presence of an eating disorder. The degree of shift often depended upon the woman's state of wellness. Women who saw themselves as suffering had more self-investment than women who saw themselves as

recovering or recovered. All participants, however, revealed an intertwined relationship between distancing, engagement, and their eating disorder (current or remitted).

The engagement-distancing flux has not been revealed in previous research. In an attempt to understand these findings, links were made with existing research and theory. In keeping with the recommendations of Firestone (1993) and Moustakas (1994), the study's findings were not reviewed alongside an exhaustive review and critique of existing literature. Rather, literature was selected with an eye to interpreting the results.

Contributions to Eating Disorder Research

Interpretation of the findings was based on what has been written about communication and sexuality for women with AN. Several researchers have documented difficulties with communication (Van den Broucke, Vandereycken & Vertommen, 1995a) and a lack of connection (intimacy) based on a lack of communicative responsiveness (Van den Broucke, Vandereycken & Vertommen, 1995b). In this phenomenological study, however, women with AN were aware of the distance their lack of disclosure created in their relationships. Some women desired this distance, whereas others cited dissatisfaction with its presence. In addition, the women's choices to disclose or not disclose were conscious and regularly made in relation to their partners (e.g. concern about rejection, lack of support, loss of autonomy/control) and degree of illness severity (e.g. concern about their partner's response when very ill). Another notable finding is the importance placed on disclosure by the participants to achieve emotional closeness. This may begin to explain Van den Broucke *et al.*'s (1995a)

findings of high disclosure rates amongst women with AN and their spouses. This high rate possibly reflects the women's attempts to establish emotional closeness.

To a lesser extent, the women in this study described a physical connection with their partner as important for engagement. Research supports that women with AN report dissatisfaction with current sexual activity and discomfort as a sexual person and describe relationships engendered in negativity (Raboch & Faltus, 1991; Rothschild, Fagan, Woodall & Andersen, 1991; Wiederman, Pryor & Morgan, 1996). In addition, married and unmarried women with AN report a comparable avoidance of sexual relations (Heavey, Parker, Bhat, Crisp & Gowers, 1989). This phenomenological study reflects the diversity in experience of romantic relationships similar to that seen in the quantitative research. Consistent with other research (Beaumont, Abraham & Simson, 1981; Raboch & Faltus, 1991), many women in this study described physical distancing from a lack of sexual desire, which they felt to be influenced by their low body weights and/or poor body image.

In contrast to the literature (Raboch & Faltus, 1991; Rothschild, Fagan, Woodall & Andersen, 1991; Wiederman, Pryor & Morgan, 1996), however, several women in this study expressed a desire that the physical connection in their romantic relationship regain importance as they achieved a healthy body weight. Additionally, several women described comfort with their bodies and their partners, and they valued this physical aspect of relating. This may be due to these women being at a desired weight at the time of the interviews, as compared to the other women who may possibly not be at their desired weights. This finding draws attention to Morgan *et al.*'s (1999) findings that

satisfaction with sexual activity increased with weight restoration. Although this may be true for some women due to libido being biologically driven, other women may not be able to accept cognitively the weight that their body is approaching as they achieve wellness, and they may continue to report dissatisfaction. Alternately, women at low body weights may report sexual satisfaction based on the pleasure derived from the achievement of their desired weight, which may at times override their biologically driven low libido.

Contributions to Theory

The findings of this research contribute to our understanding of relationship theory. In particular, they enhance our understanding of other dialectic contradictions found in romantic relationship literature: ideal/real, expressiveness/protectiveness, judgment/acceptance, and connection/autonomy (Baxter, 1990; Baxter & Montgomery, 1997). This perspective demonstrated that the women did not experience ways of relating contradictory to a generalized theory of relationships. Rather, like other individuals in relationships, the women's relationships included behavioural patterns, motivational dynamics, and situational environments in the context of their lives, which in their situation happened to include an eating disorder.

In adopting a dialectical perspective of romantic relationships, relational phenomena are embedded in a dynamic and ongoing course of interaction (Baxter & Montgomery, 1997). Dialectical tensions are never eliminated but are transformed and adapted to the context of the romantic relationship. Thus, relationships occur in the interaction of conflicting and interconnected forces evident in the partners' behavioural

patterns, motivational dynamics, and contextual (situational) environment (Montgomery, 1993). From this perspective, the course that romantic relationships take can be viewed as a process of sustaining quality, particularly the satisfaction levels of the partners, in the presence of ongoing dialectical flux (Baxter & Simon, 1993; Montgomery, 1993). The participants in this study were quite active in addressing the presence of dialectical tensions in their relationships. Although discrete examples are presented to draw attention to the varied patterns of adjustment and transformation, these relational phenomena should not be viewed solely as antecedent-consequent relations. Rather, they should be seen as embedded in an ongoing and dynamic process of patterned interplay (Baxter & Montgomery, 1997).

At times, the dialectic of ideal/real embodied engagement and distancing. This occurred for the women who grappled with what they were actually able to give of themselves in their romantic relationships versus what they actually desired in their romantic relationships. Indeed, many participants made a noticeable shift from relationship-investment to self-investment, and the degree of shift was often dependent upon the woman's state of wellness.

Several women, who viewed distancing as ideal, felt it served as a self-protective measure to avoid rejection and/or judgment, while several others felt it fostered a successful relationship. Alternately, women who viewed distancing as an unwanted state for their relationship desired engagement. Several women described desiring engaging, romantic relationships, but their achievement was a challenge. As one 20-year-old participant who had yet to experience a relationship stated, "I very often see couples

together and think, I would love to have... just that connection, but I know it's not possible right now with my being sick". Similarly, a woman who had experienced a dissolved, long-term marriage reflected, "... it [my eating disorder] just makes any relationship impossible". Thus, the wish for engagement often conflicted with the reality of eating disordered thoughts and behaviours that facilitated distancing:

... it really doesn't matter what it does to the relationship, it takes first importance. You just get caught up with trying to lose the weight, and nothing else matters... You don't even take the time to think about what it's doing to the people around you...

Well there are days like I knew, like I'm sick, I'm sick, this is crazy and then there's other days it's like you don't even think about what you are doing to yourself, what you are doing to your body, what you are doing to your relationship, you don't. That doesn't even phase you.

Several women described expressiveness/protectiveness, judgment/acceptance, and connection/autonomy dialectics as a choreographed interplay of engagement and distancing when initiating relationships with dating partners. Initially, the women sought engagement, selectively expressing neutral information to gauge the reaction of their dating partner. They remained in tune with their date's responses, searching for possible signs of rejection, judgment, or incompatibility. If they deemed their situation safe and accepting, more engagement would be sought, and they might possibly share that they have an eating disorder. However, if at any point their date exhibited behaviours or offered statements that were deemed threatening to the women's self-esteem or self-concept, distancing was used as a self-protective measure, and the dating relationship was ended. Indeed, Baxter (1990) notes that expressiveness (openness) between partners is necessary to develop relational intimacy, but that such openness also creates

vulnerabilities for the self, other, and relationship that necessitates protectiveness. In the case of this study's participants, however, expressiveness and protectiveness were not seen as an ongoing tension. Rather, the women in dating relationships polarized to the protectiveness end of the dialectic and ended the relationship.

When exploring relationship satisfaction, the participants did not report dissatisfaction due to predominant distancing or satisfaction due to predominant engagement. Rather, relationship satisfaction was related to the degree of engagement and distance that was desired by the women. Such findings correlate to the fundamental nature of connection/autonomy dialectic in relationships (Baxter, 1990). Without connection, Baxter (1988, 1990) states, relationships have no identity and thus cannot exist; but without autonomy, individuals have no identity and cannot exist within the relationship. Hence, individuals in relationships pursue both connection and separation, and relationship well-being is thought to be contingent upon meeting both the connection and autonomy needs (Baxter & Simon, 1993).

The connection/autonomy dialectic can be seen in the engagement and distancing described by the women in the study. The women often saw engagement and distancing as oppositional forces, which they consistently had to address in the course of their relationships. All of the participants revealed an intertwined relationship between distancing, engagement, and their eating disorder. From a dialectical perspective, the women regulated their personal boundaries using their eating disorders. At times they were dependent upon their partners for understanding and support related to their eating

disorder and relational needs, and they were accessible in terms of disclosure; but they were also independent, solitary, and inaccessible emotionally and physically.

Several women consistently favoured (selected) one opposing force over the other, describing ongoing secrecy about their eating disorder, which can be seen as favouring the selection of closedness (protectiveness) over openness (expressiveness). On the other hand, women who favoured connection over autonomy (e.g. through disclosure with their partner) experienced more engaged than distanced relationships. Women who described isolative patterns of varying polarities engaged in what Baxter (1990) calls 'segmentation'. For example, several women desired autonomy with their eating disorder but also desired connection with their partners in terms of their identified relational needs. Finally, women in the study who described a desire for emotional engagement and connection, but then made themselves unavailable through distancing behaviours (secrecy, false self presentation) engaged in self-contradiction. Baxter (1990) states that reframing occurs when dialectic forces are redefined so that they are no longer oppositional (Baxter, 1990). In this study, this was demonstrated by women who viewed distancing as needed to begin and maintain an engaging relationship. Distancing in this instance occurred from a lack of partner understanding of their eating disorder.

Women who used selection and reframing described the most satisfaction with their relationship, possibly due to their negotiation of both dialectic (engagement and distancing) forces. Women who engaged in the expressiveness-protectiveness dialectic – favouring distancing but desiring engagement – described the least satisfaction with their relationships. These women attempted to extinguish the dialectic by ignoring one polar

opposite or not addressing either, and they possibly grew dissatisfied with the unmet needs that correlated to the disregarded dialectic(s).

The findings also contribute to what we know about individuation in relationships. In contrast to literature that depicts eating disordered behaviours in relation to psychoanalytic themes (Casper, 1998; Ewell, Smith, Karmel & Hart, 1992; Smolak & Levine, 1993; Selvini-Palazzoli, 1974; Van den Broucke & Vandereycken, 1988), the women in this study did not reveal a pathological degree of engagement reflective of disturbances in ego development and individuation. On the contrary, the women described knowing who they were and were able to define their individual needs and what they brought to the relationship. All of the participants described their need to assert autonomy through distancing thoughts and behaviours. Most often this was in the context of maintaining secrecy regarding their eating disorder. While the women's struggle to find a desired balance between connection and disconnection reflects intrapsychic conflict, it does not necessarily reflect a disturbance in individuation. This struggle reflects a common conflict within many adult, romantic relationships – maintaining 'a me', while being 'an us' (Rusbult & Arriaga, 1997).

Thus, for the women in this study, varying degrees of engagement and distancing existed in their romantic relationships within behavioural patterns, motivational dynamics, and situational environments. The role of their eating disorder was particularly salient in shaping their experiences with both. Noticed was a shift to self-investment from relationship-investment with the presence of an eating disorder. The degree of shift was often dependent upon the woman's state of wellness. Women who

identified themselves as suffering experienced more self-investment than women who identified themselves as recovering or recovered. All participants however, revealed an intertwined relationship between distancing, engagement, and their eating disorder.

Implications

This study's findings have implications for theory, research and clinical practice.

Theory Development

This research revealed a previously unknown aspect of romantic relationships for women with AN: an engagement-distancing flux. It has been shown to be comparable to other dialectic tensions that describe romantic relationships (Baxter, 1990; Baxter & Montgomery, 1997); and thus, adds strength to this existing theory. At the same time however, these findings add something new to our understanding of the experience of romantic relationships for women with AN. Chinn and Kramer (1995) define theory as: "A creative and rigorous structuring of ideas that project a tentative, purposeful, and systematic view of a phenomenon" (pp. 72). The systematic view of a phenomenon provided by a theory encourages the validation of existing knowledge as well as the pursuit of new knowledge. With this definition and direction in mind, engagement and distancing as concepts can be explored in more depth. By understanding their characteristics, and exploring the relationships between them, a theory of engagement and distancing within romantic relationships can be developed.

Research

Future research on romantic relationships for women with AN should situate their experience within a socially constructed world. Inherent in this approach could be the

use of a qualitative feminist research philosophy and methodology. A feminist analysis would explore gendered ways of knowing in relationships and place the development and maintenance of eating disorders in an already well-researched societal context.

Additionally, a grounded theory approach could build on this phenomenological study to explore the pathways that enable and disable engagement and distancing in romantic relationships for women with AN. Prospective qualitative and quantitative studies should use a longitudinal perspective to account for the temporal nature of relationships.

Finally, quantitative studies are needed to assess evidence-based practice in the treatment of women with AN and to discern the effectiveness of interventions that aim to reduce relationship dissatisfaction resulting from undesired states of engagement or distancing.

Clinical Practice

This phenomenological study provides more insight into how women with AN experience their illness in the context of their romantic relationships and vice versa. It lends further support to the view that a multiplicity of factors interact to influence women's experiences of romantic relationships. These findings provide clinicians working with women with similar experiences with issues to address during therapeutic assessment and interventions to improve relational functioning and satisfaction.

The finding that women with AN were aware of the engagement and distance created in their relationships illustrates the dynamic and interactional nature of the women's romantic relationships. Additionally, it raises questions for clinicians regarding their approach to patient care. In particular, clinicians should be cognizant of their view of dialectical themes present in the women's relationships. Are they viewed as normal

tensions experienced in the context of the women's eating disorder, or are they viewed as disorder sequelae?

Firestone (1993) suggests that the mirroring of the literature supports the theoretical generalizability of the research. Within a dialectical perspective, should engagement and distancing in the women's relationships be identified by clinicians, this theory can be regarded as a potential framework within which to view the women's experiences. This study suggests that understanding the dialectical tensions that arise for women with AN should not be limited to a disease framework, but should be explored within a normative relational framework. Discussions should occur with the women on the engagement-distancing flux experienced in the relationship to collaboratively guide assessments and the subsequent course of therapeutic interventions. Detailed interpersonal histories can enhance assessments, which can ascertain the women's approaches to distancing and engagement and their negotiation of the reality of their romantic relationship status versus their desired ideal. Such an assessment can provide a launching pad for therapeutic discussion. It can assist, in particular, with the delivery of cognitive behavioural strategies to transform problematic emotional and physical patterns of relating (engaging or distancing) and enhance ones that lead to relationship intimacy and satisfaction.

Conclusion

"Few would deny that we all have stories in us which are a compelling part of our psychological and ideological make-up" (Coles, 1989; pp. 24). With this in mind, this study used phenomenological inquiry to explore the experiences of romantic relationships

grounded in the subjective perspective of women with AN. The study showed a multiplicity of relational experiences for the participants grounded in dialectical themes, engagement and distancing, which acted as basic drivers of relational change and maintenance.

All of the participants experienced varying degrees of engagement and distancing, which required them to consistently address the flux in their relationships. Thus, the dialectical perspective illustrated that the participants' ways of relating and a generalized theory of relationships were not mutually exclusive. Rather, the women often addressed behavioural patterns, motivational dynamics, and situational environments in the context of their eating disorders. This would not be different for couples, where eating disorders are not involved, who bring their own individualized contexts to their relationships.

Finally, no research is without limitations. Those specific to this study mirror those of many qualitative approaches. The purposive sampling strategy resulted in a one-sided view of the relationships, which limits our understanding of the dynamic and interrelated nature of the women's relationships. Also, the limited timeframe within which the data collection and analysis were carried out may have failed to capture the ongoing, temporal nature of relationships as described by the participants. At the same time, the strategies used to ensure the rigour of this work, the connections made with existing literature, and the implications that the findings have for theory development, research, and clinical practice, support the usefulness and generalizability of this research.

REFERENCES

- American Psychiatric Association (APA) (2000). Practice guidelines for the treatment of patients with eating disorders (revision). *American Journal of Psychiatry*, 157, 1-39.
- (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, DC: APA.
- Baxter, L.A. (1990). Dialectical contradictions in relationship development. *Journal of Social and Personal Relationships*, 7, 69-88.
- (1988). A dialectical perspective on communication strategies in relationship development. In S. Duck (Ed.), *Handbook of personal relationships: Theory, research and interventions* (1st ed.). NY, NY: John Wiley & Sons.
- Baxter, L.A. & Montgomery, B.M. (1997). Rethinking communication in personal relationships from a dialectical perspective. In S. Duck (Ed.), *Handbook of personal relationships: Theory, research and interventions* (2nd ed.). NY, NY: John Wiley & Sons.
- Baxter, L.A. & Simon, E.P. (1993). Relationship maintenance strategies and dialectical contradictions in personal relationships. *Journal of Social and Personal Relationships*, 10, 225-242.
- Beumont, P.J.V., Abraham, S.F. & Simson, K.G. (1981). The psychosexual histories of adolescent girls and women with anorexia nervosa. *Psychological Medicine*, 11, 131-140.
- Casper, R.C. (1998). Behavioral activation and lack of concern, core symptoms of anorexia nervosa? *International Journal of Eating Disorders*, 24 (4), 381-398.
- Chinn, P.L. & Kramer, M.K. (1995). *Theory and nursing: A systematic approach* (4th ed.). St. Louis, MO: Mosby.
- Coles, R. (1989). *The call of stories: Teaching and the moral imagination*. Boston, MA: Houghton Mifflin.
- Crabtree, B.F. & Miller, W.L. (Eds.). (1999). *Doing qualitative research* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications.

- Ewell, F., Smith, S., Karmel, M.P. & Hart, D. (1992). The sense of self and its development: A framework for understanding eating disorders. In C.P. Wilson, C.C. Hogan & I.L. Mintz (Eds.), *Psychodynamic techniques in the treatment of eating disorders*. Northvale, NJ: J. Aronson Inc.
- Firestone, W.A. (1993). Alternative arguments for generalizing from data as applied to qualitative research. *Educational Researcher*, 22(4), 16-23.
- Heavey, A., Parker, Y., Bhat, A., Crisp, A.H. & Gowers, S.G. (1989). Anorexia nervosa and marriage. *International Journal of Eating Disorders*, 8 (3), 275-284.
- Husserl, E. (1977). *Cartesian meditations: An introduction to metaphysics*. (D. Cairns, Trans.). The Hague: Martinus-Nijhoff.
- (1960). *Cartesian meditations* (D. Cairns, Trans). The Hague: Martinus-Nijhoff.
- Kiriike, N., Nagata, T., Matsunaga, H., Tobitan, W. & Nishiura, T. (1998). Single and married patients with eating disorders. *Psychiatry and Clinical Neurosciences*, 52 (Suppl), S306-S308.
- Montgomery, B.M. (1993). Relationship maintenance versus relationship change: A dialectical dilemma. *Journal of Social and Personal Relationships*, 10, 205-223.
- Morgan, J.F., Lacey, J.H. & Reid, F. (1999). Anorexia nervosa: Changes in sexuality during weight restoration. *Psychosomatic Medicine*, 61, 541-545.
- Morse, J.M. (Ed.). (1989). *Qualitative nursing research: A contemporary dialogue*. Newbury Park, CA: Sage Publications.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.
- Mussel M.P., Binford R.B. & Fulkerson J.A. (2000). Eating disorders: Summary of risk factors, prevention programming, and prevention research. *Counseling Psychologist*, 28, 764-796.
- Patton, M.Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage Publications.
- Raboch, J. & Faltus, F. (1991). Sexuality and women with anorexia nervosa. *Acta Psychiatrica Scandinavica*, 84, 9-11.

- Rosen D.S. & Neumark-Sztainer, D. (1998). Reviews for options for primary prevention of eating disturbances among adolescents. *Journal of Adolescent Health, 23*, 354-363.
- Rothschild, B.S., Fagan, P.J., Woodall, C. & Andersen, A.E. (1991). Sexual functioning of female eating-disordered patients. *International Journal of Eating Disorders, 10* (4), 389-394.
- Rusbult, C.E. & Arriaga, X.B. (1997). Interdependence theory. In S. Duck (Ed.), *Handbook of personal relationships: Theory, research and interventions* (2nd ed.). NY, NY: John Wiley & Sons.
- Selvini-Palazzoli, M. (1974). *Self starvation: From the intrapsychic to the transpersonal approach to anorexia nervosa*. London, UK: Human Context Books.
- Smolak, L. & Levine, M.P. (1993). Separation-individuation difficulties and the distinction between bulimia nervosa and anorexia nervosa in college women. *International Journal of Eating Disorders, 14* (1), 33-41.
- Steiger, H. & Séguin, J.R. (1999). Eating disorders: Anorexia nervosa and bulimia nervosa. In T. Million, P.H. Blaney & R. David (Eds.), *Oxford textbook of psychopathology*. NY, NY: Oxford University Press.
- Tesch, R. (1990). *Qualitative research: Analysis types and software tools*. NY, NY: The Falmer Press.
- Van den Broucke, S. & Vandereycken, W. (1988). Anorexia and bulimia nervosa in married patients: A review. *Comprehensive Psychiatry, 29* (2), 165-173.
- Van den Broucke, S. & Vandereycken, W. (1989). The marital relationship of patients with an eating disorder: A questionnaire study. *International Journal of Eating Disorders, 8*(5), 541-556.
- Van den Broucke, S., Vandereycken, W. & Vertommen, H. (1995a). Marital communication in eating disorder patients: A controlled observational study. *International Journal of Eating Disorders, 17*(1), 1-21.
- (1995b). Marital intimacy in patients with an eating disorder: A controlled self-report study. *International Journal of Eating Disorders, 34*, 67-78.
- van Kaam, A. (1966). Application of the phenomenological method. In A. van Kaam (Ed.). *Existential foundations of psychology*. Lanham, MD: University Press of America.

Wiederman, M.W. & Pryor, T. (1997). A comparison of ever-married and never-married women with anorexia nervosa or bulimia nervosa. *International Journal of Eating Disorders*, 22, 395-401.

Wiederman, M.W., Pryor, T. & Morgan, C.D. (1996). The sexual experience of women diagnosed with anorexia nervosa or bulimia nervosa. *International Journal of Eating Disorders*, 19(2), 109-118.

Table A

Selected Demographic Features of Study Participants. Demographics were obtained from both the participant's demographic form and a review of the participants' initial assessments by the eating disorders program.

Feature	Number of Participants
<i>Current Age (years)</i>	
19-24	5
25-30	4
31-36	1
37-42	1
<i>Eating Disorder Diagnosis</i>	
AN	5
ED (NOS)	6
<i>Comorbidity</i>	
Depression	1
Personality Disorder	2
Childhood abuse	1
<i>Treatment Status</i>	
Currently suffering, in treatment	5
Currently recovering, in treatment	5
Fully recovered, in treatment	1
<i>Relationship Status</i>	
Single, not dating	2
Single, dating	2
Long-term relationship	4
Marital relationship	3
<i>Number of Dependents (Children)</i>	
0	7
1	1
2	2
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Chapter 5

Understanding intimacy for women with anorexia nervosa:

A phenomenological approach

TO BE SUBMITTED TO

Qualitative Health Research (refer to Appendix K for author guidelines)

ABSTRACT

Intimacy is considered an essential aspect of 'ideal' romantic relationships, and Western culture places a strong emphasis on its value. Despite research reporting intimacy deficiencies for women with AN and their partners compared to women without the disorder, intimacy has been largely unexamined for women with anorexia nervosa (AN). Although the available literature suggests that women with AN experience difficulties with intimate relationships, the participants in this research were able to identify what intimacy meant to them and what they needed within their romantic relationships to be intimate. The women's meanings and experiences with intimacy were consistent with generalized conceptualizations: emotional and physical closeness, and companionship through parenting. For many women, however, their desired level of intimacy exceeded what was present in their relationships, with intimacy precluded by incongruent disclosure and a lack of physical desire. Results of the analysis may assist in tailoring specific interventions to help foster intimacy and to minimize impediments to intimacy.

Key words: Anorexia nervosa, eating disorders, intimacy, phenomenology, qualitative research

Introduction

Anorexia nervosa (AN), which is estimated to occur in 0.5 to 4% of women in industrialized societies (Steiger & Séguin, 1999), is an eating disorder that extends beyond its cardinal disturbances of self-starvation and the attainment of an idealized, thin physique. Deeply rooted in this disorder is the egosyntonic nature of the women's acute and unrealistic distress over body shape and weight alongside an intrapsychic conflict over who they feel they are, who they feel they should be, and what others in their relationships expect of them. This internal conflict raises questions about the nature and quality of intimacy in romantic relationships for women with AN, given that the achievement and sustainability of intimacy is related to a number of elements including authenticity and acceptance (Dahms, 1972; Hatfield, 1988). One essential remaining question is how women with AN conceptualize and experience intimacy in light of the cognitive struggles related to their eating disorder. With meaning as the *sine qua non* of qualitative study, a phenomenologically-based approach was used to provide the richest and most descriptive data (Moustakas, 1994; Streubert & Carpenter, 1999) of the women's representations and experiences.

Literature Review

Although the term intimacy is used casually in everyday conversation, it has also been studied by researchers. The scholarly literature discusses the nature of intimacy and how intimacy is experienced by both sexes in romantic relationships. In addition, interest in the quantification of intimacy has surfaced over the years, and the development of measurement tools has opened the door to examine intimacy's correlation to relationship

factors. Intimacy-related research is limited for women with AN who are in marital relationships, and to date no known studies provide a conceptualization of intimacy described by these women.

Conceptualization of Intimacy

Many theorists have described individuals' motivation to seek intimate experiences (Horney, 1952; Sullivan, 1953) and intimacy's importance in psychosocial development (Erikson, 1959). Others have regarded intimacy as a quality and a process. As a quality of a particular interaction, Weingarten (1991) regards intimacy as reflecting 'mutual meaning making'. As a process, intimacy involves one (or change 'oneself' to 'herself or himself') knowing oneself and disclosing in the presence of another (Schnarch, 1991). To add to the varied conceptualizations, Wynne (1984) is careful to avoid labeling relationships as intimate in an effort to avoid totalizing relationships and obscuring the understanding that relationships also include many non-intimate interactions.

Variations also exist in assumptions concerning the way in which intimacy develops and is sustained in relationships. Important elements have included disclosure (Jourard, 1971; Schaefer & Olsen, 1981), sexuality (Schnarch, 1991), autonomy (Lichtenberg, 1991), authenticity and acceptance (Dahms, 1972; Hatfield, 1988), trust (Buhrmester & Furman, 1987; Gilligan, 1982), and physical and emotional closeness (Dahms, 1972). Marital intimacy has also been described as a multidimensional concept (Waring, McElrath, Lefcoe & Weisz, 1981) that encompasses such concepts as mutuality (Dahms, 1972), understanding, and authenticity (Beck, 1988).

The assignment of gender roles in intimacy through socially constructed gender expectations is also discussed in the literature. Philpot *et al.* (1997) assert that economic and social statuses have shaped intimacy, providing and maintaining different parameters for men and women's experiences. Men and women are raised to be differently expressive, with women typically encouraged to be more open and disclosing than men (Leary, 1996). Men have been encouraged to secure autonomy through power and separation from others, whereas women have primarily formed their identity in intimate relationships through mothering and being a wife. Cancian (1986; cf Heller & Wood, 1998) reinforces a gendered view of intimacy consistent with socially constructed gender roles. Women's preferences in intimate expression include felt emotional closeness and verbal expression, along with the desire for emotional interdependence through disclosure. Men prefer to engage in action such as sexual activity and doing activities together to express intimacy. The adoption of women's affinity for emotional and verbal disclosure is embedded in the conceptualization of intimacy, which has led to a critique that it has been feminized and does not necessarily represent both genders' socialization with intimacy (Heller & Wood, 1998).

Although the conceptualization of intimacy varies greatly, the literature does not substantively reflect the meanings and experiences for women with AN. Scholars have proposed that the achievement of intimacy is related to one feeling and being authentic (Dahms, 1972; Hatfield, 1988). A remaining question, however, is how do women with AN conceptualize and experience intimacy in light of their cognitive struggles.

Measurement of Intimacy

The measurement of intimacy involves appraising the perceptions of the quality of the relationship by the individuals within the relationship. The measurement tools currently proposed to measure and evaluate intimacy are many, with the most well known showing construct validity among each other (e.g. Schaefer & Olsen, 1981; Waring, 1985). The limitations of using these tools for research with women with AN, however, may lie in the underpinnings of their development and in the structured way information is collected. Given what is known about the intrapsychic conflicts for women with AN, these measurement tools may not acknowledge their representations or reflect how they negotiate intimacy in their romantic relationships. Research is needed that truthfully reflects these women's conceptualizations of intimacy and experiences in their romantic relationships. This may reflect the scholarly definitions of intimacy and what is previously known about intimacy for women with AN, or contribute to a new perspective from which to regard these women.

Intimacy for Women with AN

Research has focused on relational characteristics, which are a significant source of relational dissatisfaction for women with AN. Results include women with AN showing poor marital adjustment and global ratings of relationship satisfaction (Van den Broucke, Vandereycken & Vertommen, 1989), poor marital communication (Van den Broucke, Vandereycken & Vertommen, 1995a), and limited and unsatisfactory sexual experiences (Beumont, Abraham & Simson, 1981; Heavey, Parker, Bhat, Crisp & Gowers, 1989; Morgan, Lacey & Reid, 1999; Raboch & Faltus, 1991; Rothschild, Fagan,

Woodall & Andersen, 1991; Wiederman, Pryor & Morgan, 1996). Intimacy in romantic relationships as an area of inquiry has been limited for women with AN. Van den Broucke *et al.* (1995b) reported that women with AN and their partners have statistically significant lower levels of intimacy than couples in a control group. They concluded that the intimacy deficiencies seen for these women resulted from a particular lack of openness within the marital relationship. Woodside *et al.* (2000) examined marital intimacy between women with eating disorders and their partners throughout a course of day hospital treatment. The women's rating of marital intimacy continued to improve from treatment entry to program discharge. Spouses' ratings along the same time continuum, however, did not change significantly.

Future research needs to focus on how women with AN develop meanings of intimacy in their romantic relationships and to describe the nature of their experiences with intimacy. This paper reflects a secondary objective of a larger phenomenological study whose purpose was to explore the experiences of romantic relationships from the perspective of women with subclinical and clinical AN. The intent of the secondary objective was to explore conceptualizations and experiences of intimacy from the perspective of these women.

Method

Research Design

This study was guided by the philosophy of Husserlian phenomenology (Husserl, 1960, 1977) and its methodological adaptation (Moustakas, 1994). Like other approaches to phenomenological inquiry, Husserlian phenomenology gave parameters that directed

the nature of reality and ways of knowing for the researcher. This included the researcher adopting a presuppositionless position, known as Epoche, during inquiry to promote objectivity. Epoche involved the researcher setting aside ('bracketing' through written memos and journaling) previously known values and knowledge about the experience (Moustakas, 1994). This included knowledge of published literature in this area, her experiences with romantic relationships, and experiences of working as a nurse therapist with this clinical population. Through Epoche, the researcher *identified* rather than *verified* reality for the participants (Tesch, 1990). This ensured that the description remained truthful, based on the participants' experiences and unclouded by research assumptions.

Sampling Frame

A purposive sample of 11 women participated in this study. Inclusion criteria were women at least 18 years of age; diagnosis of AN or eating disorder (not otherwise specified) [ED (NOS)] (American Psychiatric Association, 1994); and receipt of treatment in Ontario at a recognized eating disorders program that required medical (physical) stability. Given that phenomenology aims to realize a unified vision of the essences of an experience, sampling continued until 'crystallization' was achieved. Crystallization relates to the re-emergence of essences for the participants, to reflect a shared experience (Crabtree & Miller, 1999). It is recognized that this may have occurred only with the selected group, and that new essences may or may not emerge with a different group of participants due to the context-specific information elicited in phenomenological studies (Morse, 1989).

Setting and Recruitment

Women who met inclusion criteria were recruited from two eating disorder programs in Southeastern Ontario following ethics approval from the programs' Institutional Review Boards. Participant demographics, including illness duration and medical stability, were comparable at both sites. The program psychologists arranged for site entry. The psychologists and nursing staff identified eligible participants, who were either contacted through a mailed recruitment letter or approached in person by the researcher. The researcher obtained informed consent from participants. Demographic information was collected through a standardized form developed for the study, while most recent eating disorder diagnoses were accessed from chart reviews. Participants were offered remuneration for travel (when applicable) and a summary of the study following its completion.

Procedure

Husserlian phenomenology elucidates the importance of using data collection procedures that capture the structural ('what' is appearing) and textural ('how' it is appearing) elements of an individual's experiences (Moustakas, 1994). Data collection thus involved in-depth, one-on-one interviews with each participant (Creswell, 1998; Moustakas, 1994). Each interview lasted approximately 45 minutes to one hour and was audiotaped, and transcribed verbatim for analysis. During interviews, participants were asked to describe what intimacy meant to them and their experiences with it in their romantic relationships. Women who did not identify having been intimate were asked to explore this experience.

Subsequent interviews were conducted alongside data analysis, highlighting the cyclical nature of phenomenology. Succeeding interviews served two purposes: (1) to provide the participant with an opportunity to give feedback concerning the first interview; and (2) to allow the researcher to expand and verify descriptions of the studied phenomenon, thus ensuring a proper reflection of the structural and textural descriptions. Interview spacing was based on the availability of the women and the researcher, and varied from three to seven weeks.

Data Analysis and Interpretation

Data collection, analysis, and interpretation occurred cyclically, until crystallization of the essential essences of the experience occurred. Thus, a comprehensive 'descriptive' (the final product) of the investigated experience was ensured (Crabtree & Miller, 1999; Creswell, 1998). Moustakas' modification of van Kaam's (1966) method of data analysis guided the study and promoted a clear and comprehensive audit trail.

Audiotaped interviews and transcribed data were reviewed concurrently to capture the nuances of verbal communication. During this process, same statements were identified and extracted, and the essential textural and structural essences crystallized. Transcripts were re-read several times to facilitate the process. After several renditions, textural and structural essences were synthesized. A merger of these essences marked the last step in data analysis. Interpretation of the essences was supported by a return to the literature. Members of the researcher's supervisory committee acted as external auditors throughout, reviewing both process and outcome.

Participants' Contexts

Of the women participating in the study, five were diagnosed with AN, and six diagnosed with subclinical AN. The average age of participants was 26 years (range 19 - 42). The average age at diagnosis was 20 years (range 15 - 26), with the average duration of illness 7.5 years (range 1 - 22). Comorbidity was seldom present: one woman was concurrently diagnosed with depression, and two women were diagnosed with personality disorders. One woman disclosed a history of childhood abuse. All women in the study were in treatment programs that required medical (physical) stability. Five women identified themselves as currently suffering from their eating disorder, five endorsed current recovery, while one woman stated that she was fully recovered.

Two women identified themselves as not being in a romantic relationship and having yet to experience a significant relationship. Two women were in dating relationships with the length of their relationships ranging from weeks to several months. Four women were in long-term relationships; the length of their relationships averaged 3.5 years. For two of these women, their eating disorders began prior to their relationships, while for the remaining two women onset followed several years after their relationship began. One woman in a long-term relationship disclosed co-parenting a child with her fiancé. Finally, the length of marital relationships for three women ranged from 9 to 18 years. Of these women, two had experienced the onset of their disorder before their marriages. All the women in marital relationships co-parented children with their partners, with the average number of children being two.

Intimacy: Participant Experiences and Meanings

The intimate experiences of participants were diverse. Participants, who currently or formerly were in a romantic relationship, described varying forms of intimacy. Intimacy was described as the women feeling that they were on the “same wavelength” or “connected” with their partner. For many women, their desired level of intimacy exceeded what was actually present in their relationship. Both ideal or actual intimacy levels were individualized and not reflective of the participants’ type or length of romantic relationship. The elements of intimacy that emerged include emotional and physical closeness, and companionship. Barriers to intimacy included fear and non-acceptance, feeling unknown, partner incongruence, and the women’s eating disorders.

Emotional Closeness

All participants currently in romantic relationships described desiring emotional closeness, which was most strongly felt when they were able to disclose their feelings, thoughts, and behaviours in their relationship. When participants discussed emotional closeness, they felt it was best attained through disclosure, which required trust and acceptance, feeling known, and partner congruence. Barriers to emotional closeness included fear and non-acceptance, feeling unknown, and incongruence.

Emotional Closeness through Disclosure

Trust and Acceptance

All the participants emphasized emotional closeness through disclosure. Inherent in the participants’ expressiveness was their need for acceptance in their relationships in order to disclose. Women described the importance of acceptance for developing trust

with their partners to be able to talk about their eating disorders with them. This was consistently reinforced for many participants who felt that because acceptance and trust were present in their relationships, they felt comfort in sharing who they were and had limited fear of judgment or rejection: "... I didn't have to pretend who I was" and "... if you felt close enough to someone you could tell anything to that person, and they would still love you no matter who you are, or what you did, or didn't do".

Feeling Known

For many women, feeling known in terms of their partner understanding their eating disorder experiences was important for experiencing emotional closeness. Several women described an emotional closeness with their partner concerning their eating disorder. They felt that their partner was invested in listening to and trying to better understand their experience:

I totally feel like he listens to me, and tries to understand. He wants to take time. He'll sit with me, and just ask me questions about it, how you do feel, do you want to talk about things.

I couldn't have asked I think for better support-wise... He says 'I don't love you for what you look like, I love you for you'.

Several other participants, on the other hand, felt that emotional closeness meant that they felt heard by their partner, but did not necessarily require their partner's understanding of their eating disorder experiences. This was grounded in the women feeling that their partners could simply not understand such experiences, as they were not something the partners too, were experiencing. As one participant explained, "... don't expect them to understand... don't expect them to be able to help you at all. Just use

them as an outlet, but you can't expect too much of them, 'cause they're not trained..."

For participants who shared these beliefs, emotional closeness was attained in the relationship by their partner understanding issues that could be "realistically" shared (e.g. general relationship desires).

Being Congruent

As a facet of intimacy, emotional closeness was most felt when disclosure was congruent between the woman and her partner. One participant echoed the sentiment of many of the other participants when she expressed the need for congruence in her relationship: "You need to be open... you need to tell your significant other what you're feeling, how you're feeling... and at the same time, it won't work if he's not the same".

Barriers to Emotional Closeness

The women were also able to describe aspects that inhibited their feeling emotionally close in their romantic relationship. Barriers to emotional closeness included a fear of emotional closeness and non-acceptance by their partner, feeling unknown in their relationships, and incongruent disclosure with their partners.

Fear and Non-Acceptance

For women who described relationship avoidance, both a desire for and fear of emotional closeness were present. Fear was related to judgment and rejection: "I try not to get too close to guys because I just don't want to get hurt in the end". Desire, on the other hand, was reflected when the women questioned if their fears would be warranted with a partner with whom they developed trust: "...I know that when I'm with someone I

really trust and feel that, that I'm sure I won't worry all the time about being rejected. It's just so hard to think that will happen though... I hope it does".

Feeling Unknown

Disclosure was also not always described as being positively related to emotional closeness. For participants with this experience, a desire for more emotional closeness was expressed. Several participants described that their partners' knowledge of their eating disorder was ideal for fostering emotional intimacy, but in reality this sharing did not leave them feeling emotionally connected. This lack of connection for several participants who engaged in disclosure was related to the feeling that their partners did not know their experience. As one participant conveyed, "I know I've said, 'I wish you could have an eating disorder for a day, and then you'd understand what it feels like". Another participant described a different experience: "[He] tells me he can't handle that stuff. So I don't talk about it. I think I'd feel so much closer to him if it was something I could at least talk to him about". In this relationship, the woman expressed not feeling known by her partner in terms of differing interests in disclosure and described a lack of congruence with her partner.

Incongruence

For women in relationships, incongruent disclosure between themselves and their partners was often cited as contributing to deficits in emotional closeness. In addition to the previous example where the partner expressed disinterest in the participant's disclosure, many participants described feelings of frustration with their partners' own

lack of disclosure. These women believed that mutual accessibility in the relationship to each other's thoughts and feelings would heighten emotional closeness:

I need to have that communication both way... I don't want to feel like I'm the only one that is talking about how I feel.

Sometimes I just think we'd be closer if he would just open up like I do, but he's just not like that, and it gets so frustrating.

Many of the participants noted that their own lack of disclosure had affected their relationship. One woman stated that her partner eventually mirrored her way of relating in the relationship by limiting his disclosure in response. Another participant described her own difficulties with her partner: "He should be my best friend and I shouldn't be afraid to talk to him, but I am... once I do [share] I feel so much better and closer to him. I shouldn't be afraid. I don't know [why I am]".

Finally, two women in marital relationships described leading "parallel lives" to their partners, with little expressiveness to facilitate emotional closeness. This barrier to emotional closeness, however, was not restricted to needs surrounding their eating disorder. For one of the women with a history of childhood abuse, this emotional disconnection was desired and considered a relationship norm; for the other woman, the disconnection resulted from changing relational needs and a lack of felt congruence in her relationship.

Physical Closeness

The second component of intimacy for the participants was physical closeness. It was described as a facet of intimacy for all participants but with less emphasis than

emotional closeness and, as a result, was less delineated than emotional closeness. Thus, the presence of physical closeness varied in the participants' relationships. Descriptions of physical closeness included sexual (e.g. sexual intercourse, sexual play) and non-sexual expression (e.g. hugging, cuddling with their partner). Being congruent with their partners was also important to the women. The women's eating disorders were cited as barriers to physical closeness.

Sexual and Non-Sexual Expression

Many participants described lack of sexual expression, although all participants described desire for and pleasure in non-sexual expression, including "hugging" and "cuddling." This closeness was a particularly important way of physically connecting for the women who lacked sexual expression in their romantic relationships.

Two participants who described engagement in the sexual elements of physical closeness found comfort in sexual expression and emotional closeness in this experience. These women stated they felt comfortable with their bodies and their partners, and valued the presence of physical closeness in their relating: "When the physical part is there, our relationship's better, the communication's better and I feel better. I'm happier, he's happier". Despite the importance placed on achieving emotional closeness for intimacy in their relationships, several women described engaging in physical closeness through sexual activity in the absence of desire and emotional closeness in the experience. In such instances, engagement in sexual expression was seen by the women as for their partner's benefit: "I do it because I know that's what he needs".

Being Congruent

Overwhelmingly, the majority of participants described feeling their partners were supportive of and satisfied with the degree of physical closeness currently experienced in the relationship. As one participant explained, “He’s okay with my hang-ups about the physical stuff and that sometimes I just need my personal space”.

Barriers to Physical Closeness

Just as the women were able to discuss what they needed to experience intimacy in physical closeness, they were also able to convey their eating disorder as a barrier to its development and/or maintenance.

The Impact of AN

The impact of the women’s eating disorders was particularly noticeable in their described lack of sexual expression with their partners. The majority of women who did not engage in sexual intimacy attributed this to a lack of sexual desire and poor body image. Several women who described the absence of desire and poor body image and who engaged in sexual expression for their partner’s benefit did so at the cost of emotional closeness with their partner and emotional distress. Several experiences were common for the participants:

Sometimes it’s to the point where afterwards I cry ’cause I just feel so unattractive... when it comes to sex and that sort of thing, it’s all gone. Sometimes it’s difficult... I just didn’t want him to touch me... I just felt gross and lumpy and I just didn’t want him to touch me.

I’d cry sometimes when I was kind of thinking realistically: I was just bone, just bone. I’d wake up in the morning with marks on my knees, and on my shoulders because of the pressure from lying.

Although many of the women expressed hopes that sexual activity would regain importance once their weight stabilized, two women who experienced past personal violations (e.g. abuse) cited that the return of sexual activity as inconsequential to their experiencing physical closeness and thus intimacy.

Companionship

Companionship through recreational activity and parenting was also an important element to intimacy. As with emotional and physical closeness, congruence was important for companionship. Women did not find that their eating disorder affected companionship. The barrier cited for companionship was incongruence.

Companionship was defined as including the enjoyment of shared recreational activities. Several women described setting aside time to spend with their partners doing mutually enjoyed activities, such as “dancing” and “socializing with friends”. For these women, companionship was felt to heighten both the emotional and other forms of non-sexual closeness in their romantic relationship. For the four participants who were mothers, intimacy was experienced through the companionship in co-parenting with their partners; they described an intimate connection, or bond, through their children related to mutual decision-making, congruence in desired parenting norms, and spending time together as a family. As one participant stated, “... we have a family together. We’ll always be connected”. Women whose decision-making and parenting norms were incongruent with their partners felt a decrease in their degree of companionship.

Discussion

This research fills a gap in what is known about intimacy for women with AN. In this study, all participants desired intimacy in their romantic relationships, and data analysis showed the multiplicity of their intimate experiences. Women who described relationship avoidance had both a desire for and fear of intimacy. Participants in a romantic relationship at the time of the study, or who had had one in the past, experienced varying forms of intimacy. For many women, their desired level of intimacy exceeded what was actually present in their relationship. This included study participants who felt they had yet to experience a romantic relationship. They both feared and desired intimacy. Fear was grounded in a fear of exposure to judgment and rejection in the relationship, while desire reflected the women questioning whether their fears would be warranted with a partner with whom they developed trust.

The findings of this research contribute to our understanding of how women with AN develop meanings of intimacy in their romantic relationships, how they describe the nature of their experiences with intimacy, and how intimacy is conceptualized and measured. As is noted by Firestone (1993) and Moustakas (1994), the study's findings need not be reviewed alongside an exhaustive review and critique of existing literature. Rather, literature was selected with an eye to interpreting the results. The findings are addressed first in relation to their contribution to the conceptualization and measurement of intimacy, and second to the meanings and experiences of women with AN. Given the dearth in research exploring intimacy for women with AN, links were made to broader

relationship theories in an attempt to understand the meaning and experience for the study's participants.

Contributions to the Conceptualization and Measurement of Intimacy

The elements of intimacy that emerged from the participants' descriptions included emotional and physical closeness, as well as companionship. The participants felt emotional closeness to be achieved predominantly through mutual disclosure. Their feeling of acceptance by their partner allowed them to be authentic and fostered their own disclosure in the relationship. Physical closeness included both sexual and non-sexual experiences, while companionship through recreational activity and parenting was also seen as an important element to intimacy. Congruence (or similarity) between the participant and her partner was described as underlying all elements of intimacy.

These themes reflect the conceptual and measurement literature on intimacy (e.g. Jourard, 1971; Schaefer & Olsen, 1981; Dahms, 1972; Buhrmester & Furman, 1987; Gilligan, 1982). Given these similarities, the use of intimacy tools found in the literature can be used with more confidence in future research. The participants in this study also described in detail the importance of emotional closeness as a construct of intimacy; physical closeness was described as less important. Taking a gendered perspective, research suggests that women are more apt to describe a need for emotional intimacy as compared to men who are more likely to endorse sexual activity as a main contributor to intimacy (Gilligan, 1982; Talmadge & Dabbs, 1990).

Contributions to Meanings and Experiences of Intimacy for Women with AN

Although the meanings of intimacy may have been the same for the women in this study as for those in the general population and in gender-conscious literature, the women's intimate experiences were often mediated by their eating disorders. Examples include the majority of participants' lack of sexual desire and poor body image, which affected sexual expression in physical closeness, and decisions about disclosure of their eating disorder to achieve emotional closeness. This effect of context on intimate experiences has been noted in the literature (Prager, 2000).

The experiences described in this phenomenological study augment the dearth of eating disorder-related research. Van den Broucke *et al.* (1995b) concluded that women with AN experience intimacy deficiencies characterized by a lack of responsiveness in their relationships. This present study has enriched our understanding to why this is so. This includes the absence of trust or acceptance in the woman's relationship, and the woman's fears of judgment or rejection following disclosure. Additionally, not feeling known by their partners following disclosure can influence responsiveness and, ultimately, the woman's experience of emotional closeness.

It is interesting to highlight those participants who preferred to edit what they disclosed to their partners in order to foster emotional closeness and thus intimacy. This approach to relating is supported by Hall and Taylor (1976) and Schaefer and Olsen (1981). These authors state that romantic relationships may function more optimally with some degree of idealization where certain matters are withheld to maintain a focus on matters that can elicit positive relating. Hall and Taylor (1976) conclude that marital

relationships need to involve validation and a joint construct of reality, with each partner seeing the other as a source for feeling known.

Kenny and Acitelli (1994) reinforce the need for couples to have similar relational norms, behaviours, and desires to contribute to a successful and rewarding romantic relationship. Consistent with this perspective, the study's participants saw congruence as being important for intimacy. Women highlighted the feeling of congruence in their descriptions of actual and desired physical (sexual and non-sexual) and emotional closeness, and companionship. Intimacy was precluded by incongruent disclosure and companionship. Many scholarly discussions on congruent disclosure in marital relationships reflect what the study participants described, and discuss its importance in the development and maintenance of intimacy in romantic relationships (Chelune, Waring, Vosk, Sultan & Ogden, 1984; Delega & Chaikin, 1975). Poor responsiveness (congruence) between partners has been cited as a source of marital dissatisfaction and lack of intimacy (Hansen & Schuldt, 1984), including women with AN and their partners (Van den Broucke, Vandereycken & Vertommen, 1995a). Thus, the value placed on congruence for intimacy by the women in this study suggests why incongruent couples showed relationship dissatisfaction in Van den Broucke *et al.*'s study (1995a).

The participants' experiences with physical closeness bring us nearer to understanding their experiences with the physical aspects of intimacy. Many study participants perceived that their eating disorder was directly related to their sexuality, which is consistent with the literature (Beumont, Abraham & Simson, 1981). In keeping with this influence, the women attributed absent sexual expression to poor libido and

body image, which may explain several findings of the literature: sexual disturbances both for women with AN who are in relationships and those who are not (Heavey, Parker, Bhat, Crisp & Gowers, 1989), and sexual dissatisfaction and discomfort as a sexual person (Rothschild, Fagan, Woodall & Andersen, 1991). Many of the women in this study, however, expressed interest in the return of physical intimacy in their romantic relationships, which is a new addition to the pre-existing literature. Experiences with physical closeness among the study's participants varied, however, to include regular sexual and/or non-sexual expression. Several women described themselves as engaging in sexual activity for their partner's benefit, despite absent desire and a lack of emotional closeness associated with this experience. This may be grounded in a gendered perspective of how women are socialized to relate in romantic relationships, which warrants further exploration within a feminist paradigm. Additionally, two participants described pleasure from sexual activity. These women may have been at a desired body weight, reflecting less internal conflict related to who they feel they should be (ideal self) and a greater self-esteem. Moreover, there may be a point in the illness, before moderate/extreme starvation and marked hormone diminution, when women experience heightened self-esteem and physical interrelatedness with their partners due to their reaching their desired body ideal.

Companionship was the final theme described by the study's participants as contributing to intimacy in their romantic relationships. Essential essences related to this theme consisted of sharing recreational and parenting activities with their partner. Such experiences are supported in the literature on intimacy measurement (Schaefer & Olsen,

1981; Waring, McElrath, Lefcoe & Weisz, 1981) and in the psychological literature on marriage and parenthood. Fitzpatrick (1987) remarks that marriage thrusts the couple into a more exclusive and intimate way of relating (cf Eshel, Sharabany & Friedman, 1998). Reis *et al.* (1985) state that parenthood involves an even greater investment in the relationship, but requires a shift in focus from the dyadic unit to the family unit. Indeed, the participants in this study described how shared experiences with their children and mutual decision-making fostered emotional closeness.

Implications

Theory

The findings from this research reveal that current measurement tools used to measure intimacy reflect the experiences of women with AN. Given this, these tools can be used with more confidence to assess these women's levels of intimacy in their romantic relationships. The experiences described by the study's participants also support taking a gendered perspective to understanding intimacy for women with AN. This suggests that understanding relationships for women with AN should not be limited to a disease framework, but should be explored within a normative relational framework.

Research

Specific areas of future research are many. To begin with, disclosure warrants further attention, given the participants' descriptions of the importance of and difficulties with disclosure. This exploration could take numerous forms. Several studies reviewed by Prager (1995; cf Prager, 2000) showed a positive correlation between disclosure and self-esteem. This would be ideally explored in women with AN, who described having

low self-esteem related to discrepancies between actual and ideal selves. To achieve this, research could present a small cross-sectional snapshot and explore the correlation between self-esteem and disclosure. Alternatively, it could present a broader picture and explore interrelationships within intimacy using a grounded theory approach. Using this latter example, scholarship can focus on learning more about the mechanisms by which individual, immediate, relational, and sociocultural contexts interact in the intimate relationships of women with AN.

The exploration of individual contexts should include the impact of affect and mood on the relationship because disordered eating has been linked to negative mood states (Bulik, Beidel, Duchmann, Weltzin & Kaye, 1991), depression (Steiger, Fraenkel & Leichner, 1989), and anxiety (Hesse-Biber & Marino, 1991). Thus, future qualitative and quantitative studies should examine intimacy for women with AN from a longitudinal perspective to further account for the temporal nature of relationships and the progression of women's eating disorders (including following the effects of starvation on relating). This last point would build on Woodside *et al.*'s (2000) research by examining the correlation between levels of relational intimacy and illness severity.

The interpersonal literature suggests that individuals select partners who allow them to sustain their ways of relating (Sullivan, 1953) and who may also have complementary ways of relating (Hazan & Shaver, 1987). Thus, the inclusion of partners in future research should be seen as a salient ingredient in exploring intimacy in romantic relationships for women with AN. Although this has already been recognized in eating disorder-related literature on intimacy, research should expand to include the partner's

individual experiences with intimacy and how both partners interrelate. Additionally, research that emphasizes a difference between men and women's perceptions of intimacy, marital satisfaction, and ways of relating should be further addressed (Heller & Wood, 1998; Merves-Okin, Amidon & Bernt, 1991). Given that research asserts men use sexual interaction to increase emotional intimacy, while women need emotional intimacy to increase sexual intimacy (Talmadge & Dabbs, 1990), this research focus is particularly important to further understand the decreased sexual closeness described in this study and emphasized elsewhere (Beumont, Abraham & Simson, 1981; Heavey, Parker, Bhat, Crisp & Gowers, 1989; Morgan, Lacey & Reid, 1999; Raboch & Faltus, 1991; Rothschild, Fagan, Woodall & Andersen, 1991; Wiederman, Pryor & Morgan, 1996).

Clinical Practice

This phenomenological study has augmented the limited quantitative research on women with AN, thus providing further understanding of how these women describe and experience intimacy in their romantic relationships. It also supports the multiplicity of interacting factors that influence the women's descriptions and experiences reported in the literature.

Due to the increasing awareness and prevalence of eating disorders in our society, health care practitioners in the field of mental health may be particularly interested in incorporating the phenomenological description into their practice to tailor interventions specific to patient need. This study can both guide the practitioners' assessments and provide considerations for the development of therapeutic interventions. Detailed interpersonal histories can enhance assessments to ascertain the women's experiences

with intimacy in their relationships. Such assessments can provide a 'launching pad' for therapeutic discussion. It can assist, in particular, with the delivery of cognitive behavioural strategies to transform patterns of relating that result in a lack of intimacy, and support/enhance those that lead to intimate experiences.

Clinicians are likely to confront intimacy difficulties with couples or single women who have trouble forming or maintaining intimate relationships. The difficulties can be due in part to intimate relationships requiring individuals to open themselves to vulnerability through disclosure and trust. An essential approach to therapy, whether it is marital or individual, is to facilitate the recognition of individual context (e.g. the presence of an eating disorder, a history of childhood abuse, a failure of disclosure and closeness due to fears of rejection/judgment), immediate context (e.g. non-verbal behaviours, environment or setting), relationship context (e.g. type of relationship), and sociocultural context (e.g. culture and gender norms). Prager (2000) reinforces clinician need to ascertain partners' intimacy congruence through an exploration of these contexts. The clinician assists the couple to recognize their different needs and expectations and to negotiate what is desired for a rewarding relationship.

Conclusion

Intimacy is thought to be one of the most salient and rewarding features of romantic relationships. With this in mind, this study sought to describe the meaning of intimacy for women with AN and their intimate experiences through phenomenological inquiry. Meaning gave content to the women's relationships, clarifying what intimacy meant to them and showing a multiplicity of intimate experiences. Although the

available literature suggests that women with AN have difficulty forming intimate relationships, the participants in this research were able to identify what intimacy meant to them and what they needed within their romantic relationships to be intimate.

No research is without limitations. Those specific to this study mirror those of many qualitative approaches. Firstly, gaining access to participants for interviewing depended on a number of variables, including the participants' interest in the issue. Waring *et al.* (1981) have noted that participants with inadequate or maladjusted relationships are reluctant to volunteer. Thus, the descriptions of experiences with intimacy for women with AN may warrant further exploration to include individuals less likely to seek out research participation. Additionally, the limited timeframe of the data collection and analysis may have failed to capture the ongoing and temporal nature of intimacy as described by the participants. Finally, although the descriptions in this phenomenological study may prove invaluable for informing the scientific and clinical communities, it still remains unclear whether the deficiencies in intimacy experienced by women with AN are antecedents to, or consequences of, their eating disorder. (It may also be both.) At the same time, the strategies used to ensure the rigour of this work, the connections made with existing literature, and the implications that the findings have for theory development, research, and clinical practice, support the usefulness and generalizability of this research.

REFERENCES

- American Psychiatric Association (APA) (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, DC: Author.
- Beck, A. (1988). *Love is never enough: How couples can overcome misunderstanding, resolve conflicts, and solve relationship problems through cognitive therapy*. NY, NY: Harper & Row.
- Beumont, P.J.V., Abraham, S.F. & Simson, K.G. (1981). The psychosexual histories of adolescent girls and women with anorexia nervosa. *Psychological Medicine*, 11, 131-140.
- Buhrmester, D. & Furman, W. (1987). The development of companionship and intimacy. *Child Development*, 58, 1101-1113.
- Bulik, C.M., Beidel, D.C., Duchmann, E., Weltzin, T.E. & Kaye, W.H. (1991). Analysis of social anxiety in anorexic, bulimic, social phobic, and control women. *Journal of Psychological and Behavioural Assessment*, 13, 199-211.
- Cancian, F. (1986). Gender politics: Love and power in the private and public spheres. In A. Skolnick & J. Skolnick (Eds.), *Family in transition*. Boston, MA: Little Brown.
- Chelune, G.J., Waring, E.M., Vosk, B.N., Sultan, F.E. & Ogden, J.K. (1984). Self-disclosure and its relationship to marital intimacy. *Journal of Clinical Psychology*, 40(1), 216-219.
- Crabtree, B.F. & Miller, W.L. (Eds.). (1999). *Doing qualitative research* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications.
- Dahms, A. (1972). *Emotional intimacy*. Denver, CO: Pruett.
- Derlega, V.J. & Chaikin, A.L. (1975). *Sharing intimacy: What we reveal to others and why*. Englewood Cliffs, NJ: Prentice Hall.
- Erikson, E.H. (1959). *Identity and the life cycle*. NY, NY: W.W. Norton.
- Eshel, Y., Sharabany, R. & Friedman, U. (1998). Friends, lovers and spouses: Intimacy in young adults. *British Journal of Social Psychology*, 37, 41-57.

- Fitzpatrick, M.A. (1987). Marriage and verbal intimacy. In V.J. Derlega & J. Berg (Eds.), *Self-disclosure: Theory, research and therapy*. NY, NY: Plenum.
- Gilligan, C. (1982). *In a different voice*. Cambridge, MA: Harvard University Press.
- Hall, J.A. & Taylor, S.E. (1976). When love is blind and maintaining idealized images of one's spouse. *Human Relations*, 29, 751-762.
- Hansen, J.E. & Schuldt, W.J. (1984). Marital self-disclosure and marital satisfaction. *Journal of Marital and Family Therapy*, 46, 923-926.
- Hatfield, E. (1988). Passionate and companionate love. In R. Sternberg & M. Barnes (Eds.), *The psychology of love*. London, UK: Yale University Press.
- Hazan, C. & Shaver, P.R. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, 52, 511-524.
- Heavey, A., Parker, Y., Bhat, A., Crisp, A.H. & Gowers, S.G. (1989). Anorexia nervosa and marriage. *International Journal of Eating Disorders*, 8(3), 275-284.
- Heller, P.E. & Wood, B. (1998). The process of intimacy: Similarity, understanding and gender. *Journal of Marital and Family Therapy*, 24(3), 273-288.
- Hesse-Biber, S. & Marino, M. (1991). From high school to college: Changes in women's self-concept and its relationships to eating problems. *The Journal of Psychology*, 125, 199-216.
- Horney, K. (1952). *Neurosis and human growth: The struggle toward self-realization*. NY, NY: Norton.
- Husserl, E. (1977). *Cartesian meditations: An introduction to metaphysics*. (D. Cairns, Trans.). The Hague: Martinus-Nijhoff.
- (1960). *Cartesian meditations* (D. Cairns, Trans). The Hague: Martinus-Nijhoff.
- Jacobson, N.S. (1989). The politics of intimacy. *Behavior Therapist*, 12, 29-32.
- Jourard, S.M. (1971). *Self-disclosure: An experimental analysis of the transparent self*. NY, NY: Wiley-Interscience.
- Kenny, D.A. & Acitelli, L.K. (1994). Similarity in couples. *Journal of Family Psychology*, 8(4), 417-431.

- Lichtenberg, P. (1991). Intimacy as a function of autonomy and merging. *Gestalt Journal*, 15(1), 27-43.
- Merves-Okin, L., Amidon, E. & Bernt, F. (1991). Perceptions of intimacy in marriage: A study of married couples. *The American Journal of Family Therapy*, 19, 110-118.
- Morgan, J.F., Lacey, J.H. & Reid, F. (1999). Anorexia nervosa: Changes in sexuality during weight restoration. *Psychosomatic Medicine*, 61, 541-545.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.
- Patton, M.Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage Publications.
- Philpot, C., Brooks, G., Lusterman, D.D. & Nutt, R. (1997). *Bridging separate gender worlds: Why men and women clash and how therapists can bring them together*. Washington, DC: APA.
- Prager, K.J. (2000). Intimacy in personal relationships. In C. Hendrick & S.S. Hendrick (Eds.), *Close relationships: A sourcebook*. Thousand Oaks, CA: Sage Publications, Inc.
- (1995). *The psychology of intimacy*. NY, NY: Guilford Press.
- (1991). Intimacy status and couple conflict resolution. *Journal of Social and Personal Relationships*, 8, 503-508.
- Raboch, J. & Faltus, F. (1991). Sexuality and women with anorexia nervosa. *Acta Psychiatrica Scandinavica*, 84, 9-11.
- Reis, H.T., Senchack, M. & Solomon, B. (1985). Sex differences in the intimacy of social interaction: Further examination of potential examination. *Journal of Personality and Social Psychology*, 48, 1204-1277.
- Rothschild, B.S., Fagan, P.J., Woodall, C. & Andersen, A.E. (1991). Sexual functioning of female eating-disordered patients. *International Journal of Eating Disorders*, 10 (4), 389-394.
- Schaefer, M. & Olsen, D. (1981). Assessing intimacy: The PAIR inventory. *Journal of Marital and Family Therapy*, 7, 47-60.

- Schnarch, D.M. (1991). *Constructing the sexual crucible: An integration of sexual and marital therapy*. NY, NY: W.W. Norton.
- Steiger, H., Fraenkel, L. & Leichner, P.P. (1989). Relationship of body-image distortion to sex-role identifications, irrational cognitions, and body weight in eating-disordered females. *Journal of Clinical Psychology, 45*, 61-65.
- Steiger, H. & Séguin, J.R. (1999). Eating disorders: Anorexia nervosa and bulimia nervosa. In T. Million, P.H. Blaney & R. David (Eds.), *Oxford textbook of psychopathology*. NY, NY: Oxford University Press.
- Streubert, H.J. & Carpenter, D.R. (1995). *Qualitative research in nursing: Advancing the humanistic imperative*. Philadelphia, PA: J.B. Lippincott Company.
- Sullivan, H.S. (1953). *The interpersonal theory of psychiatry*. NY, NY: Norton.
- Talmadge, L.D. & Dabbs, J.M. (1990). Intimacy, conversational patterns and concomitant cognitive/emotional processes in couples. *Journal of Social and Clinical Psychology, 9*, 373-488.
- Tesch, R. (1990). *Qualitative research: Analysis types and software tools*. NY, NY: The Falmer Press.
- Van den Broucke, S. & Vandereycken, W. (1989). The marital relationship of patients with an eating disorder: A questionnaire study. *International Journal of Eating Disorders, 8*(5), 541-556.
- Van den Broucke, S., Vandereycken, W. & Vertommen, H. (1995a). Marital communication in eating disorder patients: A controlled observational study. *International Journal of Eating Disorders, 17*(1), 1-21.
- (1995b). Marital intimacy in patients with an eating disorder: A controlled self-report study. *International Journal of Eating Disorders, 34*, 67-78.
- van Kaam, A. (1966). Application of the phenomenological method. In A. van Kaam (Ed.). *Existential foundations of psychology*. Lanham, MD: University Press of America.
- Waring, E.M. (1985). Measurement of intimacy: Conceptual and methodological issues of studying close relationships. *Psychological Medicine, 15*(1), 9-14.
- Waring, E., McElrath, D., Lefcoe, D. & Weisz, G. (1981). Dimensions of intimacy in marriage. *Psychiatry, 44*, 169-175.

- Weingarten, K. (1991). The discourses of intimacy: Adding a social constructionist and feminist view. *Family Process*, 30, 285-305.
- Wiederman, M.W., Pryor, T. & Morgan, C.D. (1996). The sexual experience of women diagnosed with anorexia nervosa or bulimia nervosa. *International Journal of Eating Disorders*, 19(2), 109-118.
- Woodside, D.B., Lackstrom, J.B. & Shekter-Wolfson, L. (2000). Marriage in eating disorders: Comparisons between patients and spouses and changes over the course of treatment. *Journal of Psychosomatic Research*, 49, 165-168.
- Wynne, L.C. (1984). The epigenesis of relational systems: A model for understanding family development. *Family Process*, 23, 297-318.

Chapter 6

Conclusion

This 'sandwich' thesis presented a collection of four papers prepared for publication based on my doctoral work with women with anorexia nervosa (AN). The aim of this concluding chapter is to provide an overall discussion including a review of major findings, a discussion of methodological rigour, the application of these concepts to my work, as well as the implications for clinical practice, research, and theory.

Major Findings: Exploring Romantic Relationships for Women with AN

A review of the major findings includes an examination of the dialectic themes of engagement and distancing that emerged from the women's descriptions of their romantic relationships. It also includes their meanings and experiences with intimacy.

An Engagement-Distancing Flux

Whereas the hallmark symptoms of AN, such as severe disturbances in eating behaviours and acute and unrealistic distress over body shape and weight (APA, 2000) are familiar in the literature, less well known are the personal meanings and lived experiences for women with this disorder. In particular, although the literature draws attention to the varied experiences and marked dissatisfaction expressed by women with AN with their romantic relationships, the quality and dynamic nature of the women's relationships are little understood. This study addressed this limitation by exploring the experiences of romantic relationships from the perspectives of women with subclinical and clinical AN. Phenomenological inquiry was used to focus on descriptions of relating

within the relationship, appreciating the importance of the women's context in modifying and influencing their relating.

In terms of romantic relationships, analysis revealed two main, opposing themes to the women's experiences: engagement and distancing. For these women, engagement was emphasized as a state of emotional and physical connection attained in the relationship, which included feeling understood and supported by their partners. Engagement was predominantly described as being achieved through open dialogue in relationships that fostered trust and comfort. Distancing was described as a state of emotional and physical disconnection. Elements that contributed to distancing in the women's romantic relationships were secrecy, fear of exposure to judgment and rejection, and an inward focus on their eating disorder. All of the participants experienced varying degrees of engagement and distancing, which required them to consistently address the tension between these two states in their romantic relationships. Engagement and distancing acted as basic drivers of relational change and maintenance for the women's romantic relationships. Although many of the women in established relationships stated that their reason for initiating their relationship was a sought-after connection, the distancing experienced in their relationship often fragmented this connection. The majority of women discussed this fragmentation in terms of the impact of their eating disorder. Noticed was a shift to self-investment from relationship-investment with the presence of an eating disorder, with the degree of shift often dependent upon the woman's state of wellness. Women who identified themselves as suffering from AN experienced more self-investment than women who identified

themselves as recovering or recovered. All participants however, revealed an intertwined relationship between distancing, engagement, and their eating disorder (current or remitted).

In keeping with the recommendations of Firestone (1993) and Moustakas (1994), the study's findings were not reviewed alongside an exhaustive review and critique of existing literature. Rather, literature was selected with an eye to interpreting the results. Key search terms used in identifying theoretical literature included the themes revealed in analysis: *opposition and relationships, distancing, and engagement*. What was found was that engagement and distancing mirrored dialectical tensions found in romantic relationship literature: ideal/real, expressiveness/protectiveness, judgment/acceptance, and connection/autonomy (Baxter, 1990; Baxter & Montgomery, 1997). This perspective demonstrated that these women did not experience ways of relating contradictory to a generalized theory of relationships. Rather, like other individuals in relationships, the participants' relationships involved behavioural patterns, motivational dynamics, and situational environments in the context of their lives, which in their situation happened to include an eating disorder.

Meanings and Experiences with Intimacy

Intimacy is thought to be one of the most salient and rewarding features of romantic relationships. The available literature including that by Van den Broucke *et al.* (1995) reflects the notion that women with AN experience difficulties forming intimate relationships. The women's descriptions of their experiences provide expansion to Van den Broucke and colleagues' work. All participants described wanting intimacy in their

romantic relationships. For many women, their desired level of intimacy exceeded what was actually present in their relationship. Van den Broucke *et al.* (1995) concluded that women with AN experience intimacy deficiencies predicated by a lack of responsiveness in their relationships; this study however, provides possible descriptions of precursors to this occurrence. For example, several participants struggled with the sexual aspects of physical intimacy, and experienced conflicts in disclosure about their eating disorder when attempting to achieve emotional intimacy. These experiences were influenced in part by the absence of trust or acceptance in their relationships, as well as by fears of judgment or rejection following disclosure.

The participants' meanings of and experiences with intimacy were consistent with generalized conceptualizations: emotional and physical closeness, and companionship through parenting. Congruence (or similarity) between the participant and her partner was described as underlying all elements of intimacy. Given this, current intimacy tools found in the literature (e.g. Schaefer & Olsen, 1981; Waring, 1985) can be used with more confidence to assess intimacy for these women.

A new perspective has been added to our understanding of intimacy: the women who participated in this research identified what intimacy meant to them, and what they needed within their romantic relationships to be intimate. Within this, a connection was seen between their descriptions of intimacy and the distancing and engagement themes that were illuminated in their romantic relationships. Women who experienced intimacy described connections (engagement) through emotional and physical closeness. They also described connection through companionship. The participants felt emotional

closeness was achieved predominantly through mutual disclosure. Their feeling accepted by their partner allowed them to be authentic and facilitated their own disclosure in the relationship. Physical closeness was described as including both sexual and non-sexual experiences. Finally, companionship through recreational activity and parenting was also seen as an important element to experiencing intimacy for the participants.

Disconnections (distancing) occurred for those women with a lack of intimate experiences.

Methodological Rigour

Strategies to promote methodological rigour in this phenomenological inquiry were employed from the onset of study development, and were present throughout. Several qualitative authors and researchers offer various frameworks and techniques to determine the study's trustworthiness, or quality (Lincoln & Guba, 1985; Miles & Huberman, 1994). In keeping with this literature, the authenticity, auditability, and transferability (generalizability), in particular, were addressed during Epoche and the methodological process. Included in this process were data collection (the interview process) and analysis (immersion/crystallization), as well as transferability (generalizability).

Epoche

Important to ensuring and maintaining truthfulness (authenticity) during my research was the adoption of the presuppositionless, or objective, position known as Epoche. In this position, "The challenge [was] not to eliminate 'bias' to be more neutral, but to use it as a focus for more intense insight" (Frank, 1997; pp. 89). Thus, the

consistent use of bracketing previous knowledge about the studied experience both before and during the study assisted in facilitating an objective descriptive, that remained true to the participants' experiences.

To achieve Epoche, I set aside previously known values and knowledge to *identify with*, rather than *verify* notions of reality for the participants during data collection and analysis (Tesch, 1990). This ensured that the description remained truthful, based on the participants' experiences and unclouded by research assumptions. Epoche involved engaging in memoing, journaling, and peer reviews (Crabtree & Miller, 1999; Miles & Huberman, 1994; Lincoln & Guba, 1985). Through memoing and journaling, I explored my thoughts, feelings, and actions during the research process. This included my setting aside knowledge of the published literature that was used to inform my research question. It also included my bracketing my own experiences with romantic relationships and work as a therapist with this clinical population. Peer reviews were used as a forum for discourse. These reviews focused on what knowledge, values, and beliefs were being bracketed, and what was emerging in the analysis. For example, my supervisor and I discussed the importance of bracketing my knowledge of the preexisting literature that drew attention to the marked relationship dissatisfaction expressed by women with AN; the intent of the process was to avoid asking interview questions or engaging in analysis that was driven by this knowledge.

To ensure that I was not influencing the participant's descriptions during data collection and analysis, Epoche included my examining the types of questions that I asked during data collection, as well as how I asked them – important for ensuring that I

did not introduce new ideas to the participant interviews. During data analysis, Epoche involved ensuring that the final descriptive accurately represented the women's lived experiences through peer reviews. My supervisory committee acted as external auditors, also immersing themselves in the transcribed data and extracting themes, to ensure my analysis truthfully reflected the participants' experiences.

The Methodological Process

Auditability refers to whether the study process is consistent, or reasonably stable over time (Miles & Huberman, 1994). It is typically achieved through recording the study's methods and procedures (known as an 'audit trail'). The consistent memoing of thoughts and decisions for data collection and analysis provided clear and comprehensive documentation of study decisions.

Data Collection: The Interview Process

The Husserlian approach to phenomenological research elucidates the importance of using data collection procedures that capture the structural ('what' is appearing) and textural ('how' is it appearing) elements of an individual's experiences (Moustakas, 1994). Based on this, the primary method of data collection involved using in-depth, one-on-one interviewing techniques with each of the participants (Creswell, 1998; Moustakas, 1994). This method is deemed the 'gold standard' in qualitative research (Silverman, 2000) with its emphasis on revealing essential phenomena of lived experiences. Because the nature of each interview was largely dependent on the data elicited from the participants (Creswell, 1998; Patton, 1990), a semi-structured approach allowed me to obtain targeted information, while allowing for flexibility.

The importance of the interview process to the phenomenological research project is consistently reinforced in the literature (Crabtree & Miller, 1999; Creswell, 1998; Kvale, 1996). Considered essential to ensuring methodologic rigour in this process were the types of questions asked during the interviews. According to Colaizzi (1978), the credibility of the questions put forth to the participants relies on the extent to which these questions elicited participants' experiences. To promote credibility, experts in the field of eating disorders and my supervisory committee were consulted. They audited the interviews and provided areas of questioning for subsequent interviews. Discussions during these consultations included asking whether the questions effectively revealed the purpose of the study, and addressed ambiguity (Do I understand the participants' descriptions? What else do I want to know?). Member checking also occurred at the end of each interview. Participants were offered a verbal summary of the interview, and given the opportunity to clarify or expand on any salient essences of their experience. Each of these research strategies contributed to Epoche and were fundamental in promoting the truthfulness of the study's findings.

In keeping with Epoche, the literature review that was used to develop the research question did not inform the questions asked during participant interviews. This promoted authenticity of the participants' lived experiences. Each interview began with my introducing the study and reinforcing the participants' rights to confidentiality and to stop the interview at any time. Initial questions served as a starting point for identifying broad themes, experiences, and stories specific to romantic relationships. The sequencing of questions in the interview was flexible and responsive to the participant (Crabtree &

Miller, 1999; Patton, 1990). Open-ended questions ensured neutrality during the interview by not assuming experience. Key questions included my asking participants to discuss their past and present experiences with romantic relationships, as well as asking them to describe what it has been like to have an eating disorder while in a romantic relationship. For women who did not identify being in a romantic relationship, I asked them to explore reasons underlying this experience. Follow-up questions (probes) during the interviews were specific to the experiences described by the participants. They were used to deepen the response to a question, and to elicit a rich description of their experiences. Examples include, "Tell me more about that" and "What was that like for you?"

Interview discussions were led by the participants to capture their experience. Thus, the key questions moderated the semi-structured interviews, and ensured a level of continuity of exploration across interviews (Crabtree & Miller, 1999; Patton, 1990). Participant interviews were 45 minutes to one hour in order to establish an initial relationship between the participant and myself, and to collect a sufficient amount of data. The number of interviews was ascertained as collection and analysis occurred, and was dependent upon crystallization of the essences of the experience (Crabtree & Miller, 1999; Patton, 1990).

A second interview was sought with all participants several weeks after their first interview to further contribute to my understanding of their experiences, and to reconfirm my understanding of each participant's first interview. Interviews were conducted alongside data analysis, highlighting the intended cyclical nature of phenomenological

inquiry. Additional interviews served two purposes: (1) to provide the participant with an opportunity to give feedback concerning the first interview; and (2) to allow myself to expand and verify descriptions of the studied phenomenon, thus ensuring a proper reflection of the structural and textural descriptions of the experience.

Spacing between the interviews was determined based on the availability of the participants and myself. Patton (1990) discusses the importance of the timeframe following interviews as being critical to the methodological rigour of the study. For the purposes of this study, a three-week interval allowed for adequate data review, which included my examining the rigour (quality) of the interview protocol and questions.

Johnson and Clarke (2003) call attention to another area of difficulty for qualitative researchers, including researcher role conflict and concerns of the impact of the interview on participants. My memoing, journaling, and discussions with my supervisory committee provided support for me as I balanced my roles as a researcher and clinician. In keeping with this latter role, and in recognition of the potential impact of the research on the participants, I had made arrangements for support to be available for the participants within their respective eating disorder programs should it be needed. With this measure in place, I found that I did not experience the conflict of being a researcher versus health care provider. While participant interviews warranted empathic statements for validation of the participants' experiences, therapeutic, psychiatric interventions were not needed. In the same vein, there were no instances during the initial interviews that gave concern to a negative impact on the participants. Indeed, during the second interview when participants were asked to reflect on the interview

experience, negative viewpoints were not expressed. In recognizing that this may have been particularly difficult for the women to voice during our meeting, I would consider introducing an anonymous, follow-up evaluation in future interviews. This would ideally further my self-evaluation by providing constructive feedback from those interviewed.

Data Analysis: Immersion/Crystallization

Although there is no steadfast rule for data analysis and interpretation, there are several procedural interpretations of phenomenology that serve as guidelines. For the purposes of my research, and in keeping with Husserlian philosophy, perspectives from Moustakas (1994) were used. Within this approach, data collection, analysis, and interpretation occurred cyclically through the following steps: (1) horizontalizing; (2) the creation of meaning units; (3) the advancement of meaning units to textural and structural descriptions; and (4) the development of a composite description by merging textural and structural descriptions into an exhaustive descriptive of the experience. The edict to collect data until crystallization of the essential essences of the experience occurred is the underlying factor for this cyclical nature, and thus, ensured a comprehensive descriptive (the final product) of the investigated experience (Crabtree & Miller, 1999; Creswell, 1998; Patton, 1990).

Much of my learning as a researcher centered on crystallization during data analysis, and is reflected in my memoing. Crystallization is regarded as a fluid process, and thought by Borkan (1999) to be a difficult course to map out given the artistic expression involved. It began with my immersion in the participants' experiences (Crabtree & Miller, 1999; Moustakas, 1994). To capture the essences of the women's

experiences, I became immersed in the texture, tone, mood, range, and content of their descriptions. This process began by my reviewing the audiotaped interviews and transcribed data concurrently in recognition of the nuances of verbal communication. This assisted in imaginative variation, reflection, and intuition; and as I brought these techniques to the data, the recommended steps by Moustakas (1994) became apparent.

Using N-VIVO to assist in data management (Qualitative Solutions Research, 1997), I examined the horizons (or layers) of the phenomena that appeared in the participant's descriptions. Each horizon was seen as giving a distinctive character to the experience, and had equal value (Moustakas, 1994). Through this process, I was led to a deeper understanding of the object experience's totality. Data were grouped into meaningful clusters to identify essential themes for understanding the experience.

In the creation of meaning units, participant experiences were analysed through the interpretive characteristics of imaginative variation, reflection, and intuition. Imaginative variation entailed reviewing the participants' descriptions, and varying the women's experiences freely in all its possible forms. Those essences which remained constant, or crystallized, through the different variations, were considered the structural and textural essences (Borkan, 1999; Moustakas, 1994).

As statements were identified and extracted, the essential structure of the women's experience began to crystallize. Textural and structural descriptions were created for each participant. The structural description revealed the 'what is appearing' for the participants; while the textural description provided content and illustration to the experience, the 'how is it' appearing. Preparation of the final descriptive of the

experience involved merging both the structural and textural descriptions of all the participants into one final descriptive (Borkan, 1999; Moustakas, 1994).

In order to ensure that the final product was credible, I employed member checking. During this process, participants were given the written individual and final descriptives. The accuracy of the structural and textural elements of each was confirmed and any ambiguous experiences were clarified. Content added or deleted by participants was noted and incorporated into the revised final descriptive.

One of the challenges I faced was knowing when themes or essences began to surface and/or resurface from the participants. Johnson and Clarke (2003) highlight this difficulty as one experienced by novice qualitative researchers. One of the tactics offered by the authors is the need for supervision by sage researchers (primarily the student's thesis committee). Thus, throughout data analysis, members of my supervisory committee also acted as external auditors, reviewing both process and outcome. This strategy was essential in addressing my concerns and challenges, and gave confidence to my progression as a researcher. Member checking promoted the truthfulness and comprehensiveness of the final descriptive that was generated.

Transferability: Generalizability

A final challenge during my research was becoming familiar with the concept of generalizability in relation to qualitative research. From this perspective, generalizability is a criterion that assesses 'fittingness'. A qualitative study meets the criterion of fittingness when its findings 'fit' into contexts outside of the study conditions, and when the reader views its findings as evocative and applicable to their own experiences (Miles

& Huberman, 1994; Sandelowski, 1986). In other words, generalizability refers to the extent to which a study's research findings are transferable (Firestone, 1993).

It is recognized that the final descriptive elicited in this study may only be realized with its selected group of participants, and that new themes may or may not emerge with an entirely different group of participants. This occurrence is a result of the context-specific information elicited in phenomenological studies (Morse, 1989). However, the final, rich descriptive generated through phenomenological methods should promote the opportunity for other researchers to assess the potential transferability to their own clinical and research settings.

One of the critiques of qualitative research that has prominently surfaced from quantitative proponents is that it is difficult to generalize its findings to settings not studied. Firestone (1993) suggests that rather than using the sample to population generalizability that is appropriate for quantitative research, case-to-case reasoning and case-to-theory reasoning be considered for qualitative studies such as the one I conducted. Case-to-case reasoning involves transferring learning from a study to another environment (Firestone, 1993). In terms of my study's case-to-case transferability, I believe that clinicians, who identify themselves as working with women with similar experiences, are provided with areas to address during therapeutic assessment and interventions to possibly assist in enhancing relational functioning and satisfaction.

To generalize to a theory as in the case of case-to-theory reasoning, the findings should provide evidence that supports a broader and already accepted theory (Firestone, 1993). The findings from my phenomenological study have provided more insight into

how women with AN experience their illness in the context of their romantic relationships and vice versa, and lent further support to published literature that discusses the multiplicity of factors that interact to influence the women's experiences of relating in romantic relationships. The linking of my findings with other research and theoretical literature on intimacy and relationships increased my confidence in the truthfulness of my analysis. Firestone (1993) suggests that the mirroring of the literature supports both the theoretical transferability of the research and the literature's postulations. Within a dialectical perspective, should clinicians identify engagement and distancing in the women's relationships, dialectics theory can be regarded as a potential framework within which to view the women's experiences. Thus, while the assessment of generalizability occurs by the reader (Firestone, 1993), I believe that the strategies used in my study support the transferability of the results beyond the context of the women who participated.

Thesis Implications

My doctoral work raises several health care practice issues, provides direction for research, and implications for theory development.

Clinical Practice

This phenomenological study has provided more insight into how women with AN experience their illness in the context of their romantic relationships and vice versa. Previous work has suggested that women with AN have difficulty forming intimate relationships and experience marked relationship dissatisfaction. These findings lend

further support to the multiplicity of factors that interact to influence the women's experiences of relating in romantic relationships. The importance of these findings is that clinicians, including nurses, working with women with similar experiences are provided with areas to address during therapeutic assessment and interventions to possibly assist in enhancing relational functioning, intimacy, and satisfaction.

The dynamic and interactional nature of the women's romantic relationships is illustrated by the proposal that these women were aware of the engagement and distance created in their relationships due to their own disclosure/secretcy, type of physical needs, and their partners' responses/input. Additionally, it raises questions for clinicians regarding their approach to patient care. In particular, clinicians should be cognizant of their view of dialectical themes present in the women's relationships. Are they viewed as 'normal' tensions experienced in the context of the women's eating disorder, or are they viewed as disorder sequelae?

This study suggests that the dialectical tensions that arise for the women should be explored within a patient focus and not be limited to a disease focus. These findings support a holistic approach to care, which is particularly suited to nursing. In this sense, discussions should occur with the women regarding the nature of the engagement-distancing flux experienced in the relationship. Insights can collaboratively guide assessments and the subsequent course of therapeutic interventions. Assessments can be enhanced through the inclusion of detailed interpersonal histories to ascertain the women's approaches to distancing and engagement in relating, as well as their negotiation of the reality of their romantic relationship status versus their desired ideal.

Such assessments can provide a 'launching pad' for therapeutic discussion. They can assist in particular, the delivery of cognitive behavioural strategies to transform emotional and physical patterns of relating (engaging or distancing) that result in dissatisfying relationships, and enhance ones that lead to relationship intimacy and satisfaction.

Clinicians are likely to confront intimacy difficulties with couples or single women who have trouble forming or maintaining intimate relationships. The difficulties can be due in part to the need for individuals to open themselves to vulnerability through disclosure and trust. An essential approach to therapy, whether it is marital or individual, is to facilitate the recognition of context. This should include the individual context, which can address issues such as the presence of an eating disorder, a history of childhood abuse, and difficulties with disclosure and closeness due to fears of rejection/judgment. The immediate context refers to non-verbal behaviours of the individual or couple and the environment within which they relate. Exploring a relationship context refers to examining the individual's or couple's type of relationship, while exploring a sociocultural context involves looking at culture and gender norms. Prager (2000) reinforces clinician need to ascertain partners' intimacy congruence through an exploration of these contexts. In this sense, the clinician is assisting the couple to recognize their different needs and expectations to facilitate negotiation of what is desired to produce a rewarding romantic relationship.

Future Research

Specific areas of future research are many. A generated list of future research questions can be found in Appendix L. The interpersonal literature suggests that

individuals select partners who allow them to sustain their ways of relating (Sullivan, 1953), and who may also have complementary ways of relating (Hazan & Shaver, 1987). Thus, the inclusion of partners in future research should be seen as a salient ingredient in exploring romantic relationships for women with AN. While this has already been recognized in eating disorder related literature on intimacy, research should expand to include the partner's experiences with intimacy. This would support determining how both partners relate to each other in terms of emotional and physical intimacy.

Research that emphasizes a difference between men and women's perceptions of intimacy, marital satisfaction, and ways of relating should be further addressed (Heller & Wood, 1998; Merves-Okin, Amidon & Bernt, 1991). We know that from previous research that men use sexual interaction to increase emotional intimacy, while women need emotional intimacy to increase sexual intimacy (Talmadge & Dabbs, 1990). Thus, a feminist approach to research would be appropriate for further understanding the decreased sexual closeness described by the women in my research and emphasized elsewhere (Beumont, Abraham & Simson, 1981; Heavey, Parker, Bhat, Crisp & Gowers, 1989; Morgan, Lacey & Reid, 1999; Raboch & Faltus, 1991; Rothschild, Fagan, Woodall & Andersen, 1991; Wiederman, Pryor & Morgan, 1996).

In light of the importance and difficulties described by the participants with disclosure, the construct warrants further attention. This exploration could take a number of forms. Several studies reviewed by Prager (1995; cf Prager, 2000) demonstrated a positive correlation between disclosure and self-esteem. This would be ideal to explore for women with AN, given the described experience of low self-esteem related to

discrepancies with who they see themselves to be and who they want to be. To achieve this, research could present a 'small snapshot', taking a cross-sectional approach and exploring if there is a correlation between self-esteem and disclosure for these women, or it could present a 'broader picture' and explore interrelationships within intimacy using a grounded theory approach. Using this latter example, scholarship can focus on learning more about the mechanisms by which individual, immediate, relational, and sociocultural contexts interact to produce intimate interactions for women with AN.

Included in the exploration of individual contexts should be the impact of affect and mood in the relationship, in recognizing that disordered eating has been linked to negative mood states (Bulik, Beidel, Duchmann, Weltzin & Kaye, 1991), depression (Steiger, Fraenkel & Leichner, 1989), and anxiety (Hesse-Biber & Marino, 1991). Thus, future qualitative and quantitative studies should aim to examine romantic relationships and intimacy for women with AN and their partners from a longitudinal perspective, to further take into account the temporal nature of relationships as well as the progression of the woman's eating disorder (including following the effects of starvation on relating). This last point would build on Woodside and colleagues' (2000) research by examining the correlation between levels of intimacy and illness severity.

The additional findings presented in Appendix B draw attention to the need to explore the parent-child experiences for women with AN and their children. This type of research focus can confirm the need for practitioners in family therapy settings to include the whole family in health care access. It can also help determine if the provision of psychoeducation and cognitive strategies to enhance healthy eating and self-concept with

the women's children is needed as a preventative measure to potential mimicking of their mother's beliefs and behaviours.

Theory Development

This research revealed a previously unknown aspect of romantic relationships for women with AN: an engagement-distancing flux. It has been shown to be comparable to other dialectic tensions that describe romantic relationships (Baxter, 1990; Baxter & Montgomery, 1997); and thus, adds strength to this existing theory. At the same time however, these findings add something new to our understanding of the experience of romantic relationships for women with AN. Chinn and Kramer (1995) define theory as: "A creative and rigorous structuring of ideas that project a tentative, purposeful, and systematic view of phenomenon" (pp.72). The systematic view of a phenomenon provided by a theory encourages the validation of existing knowledge as well as the pursuit of new knowledge. With this definition and direction in mind, engagement and distancing as concepts can be explored in more depth. By understanding their characteristics, and the exploring the relationships between them, a theory of engagement and distancing within romantic relationships can be developed.

Additionally, the findings from this research reveal that current measurement tools used to measure intimacy reflect the experiences of women with AN. Given this, these tools can be used with more confidence to assess these women's levels of intimacy in their romantic relationships. The experiences described by the study's participants also support taking a gendered perspective to understanding intimacy for women with AN. This suggests that understanding relationships for women with AN should not be

limited to a disease framework, but should be explored within a normative relational framework.

Concluding Remarks

This thesis supplements findings from existing quantitative research and case study descriptions. The qualitative approach to inquiry illuminated the experiences of romantic relationships and intimacy for women with AN. Most notable of the findings includes a previously unknown relationship dynamic: an engagement-distancing flux. Congruent with previous work were the women's descriptions of intimacy. These findings demonstrated that the women's relational experiences did not contradict generalized theories. Rather, like other individuals in relationships, the participants' relationships involved behavioural patterns, motivational dynamics, and situational environments in the context of their lives, which in their situation happened to include an eating disorder. This suggests that understanding relationships for women with AN should not be limited to a disease framework, but should be explored within a normative relational framework. Within this perspective health care professionals can tailor interventions specific to patient ways of relating, future research endeavours can be carried out, and the development of theory can be initiated.

REFERENCES

- Baxter, L.A. (1990). Dialectical contradictions in relationship development. *Journal of Social and Personal Relationships*, 7, 69-88.
- Baxter, L.A. & Montgomery, B.M. (1997). Rethinking communication in personal relationships from a dialectical perspective. In S. Duck (Ed.), *Handbook of personal relationships: Theory, research and interventions* (2nd ed.). NY, NY: John Wiley & Sons.
- Beumont, P.J.V., Abraham, S.F. & Simson, K.G. (1981). The psychosexual histories of adolescent girls and women with anorexia nervosa. *Psychological Medicine*, 11, 131-140.
- Borkan, J. (1999). Immersion/Crystallization. In B.F. Crabtree & W.L. Miller (Eds.), *Doing qualitative research* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Bulik, C.M., Beidel, D.C., Duchmann, E., Weltzin, T.E. & Kaye, W.H. (1991). Analysis of social anxiety in anorexic, bulimic, social phobic, and control women. *Journal of Psychological and Behavioural Assessment*, 13, 199-211.
- Chinn, P.L. & Kramer, M.K. (1995). *Theory and nursing: A systematic approach* (4th ed.). St. Louis, MO: Mosby.
- Colaizzi, P.R. (1978). Psychological research as the phenomenologist views it. In R.S. Valle & M. King (Eds.), *Existential-phenomenological alternatives for psychology*. NY, NY: Oxford University Press.
- Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications.
- Firestone, W.A. (1993). Alternative arguments for generalizing from data as applied to qualitative research. *Educational Researcher*, 22(4), 16-23.
- Frank, G. (1997). Is there life after categories? Reflexivity in qualitative research. *The Occupational Therapy Journal of Research*, 17, 84-98.
- Hazan, C. & Shaver, P.R. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology*, 52, 511-524.
- Heavey, A., Parker, Y., Bhat, A., Crisp, A.H. & Gowers, S.G. (1989). Anorexia nervosa and marriage. *International Journal of Eating Disorders*, 8(3), 275-284.

- Heller, P.E. & Wood, B. (1998). The process of intimacy: Similarity, understanding and gender. *Journal of Marital and Family Therapy*, 24(3), 273-288.
- Hesse-Biber, S. & Marino, M. (1991). From high school to college: Changes in women's self-concept and its relationships to eating problems. *The Journal of Psychology*, 125, 199-216.
- Johnson, B. & Clarke, J.M. (2003). Collecting sensitive data: The impact on researchers. *Qualitative Health Research*, 13(3), 421-434.
- Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage Publications.
- Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications.
- Merves-Okin, L., Amidon, E. & Bernt, F. (1991). Perceptions of intimacy in marriage: A study of married couples. *The American Journal of Family Therapy*, 19, 110-118.
- Miles, M.B. & Huberman, A.M. (1994). *Qualitative data analysis. An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Morgan, J.F., Lacey, J.H. & Reid, F. (1999). Anorexia nervosa: Changes in sexuality during weight restoration. *Psychosomatic Medicine*, 61, 541-545.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.
- Patton, M.Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage Publications.
- Prager, K.J. (2000). Intimacy in personal relationships. In C. Hendrick & S.S. Hendrick (Eds.), *Close relationships: A sourcebook*. Thousand Oaks, CA: Sage Publications, Inc.
- (1995). *The psychology of intimacy*. NY, NY: Guilford Press.
- Qualitative Solutions Research (1997). *QSR NUD-IST rev. 4 user's guide*. Melbourne, AUS: Author.
- Raboch, J. & Faltus, F. (1991). Sexuality and women with anorexia nervosa. *Acta Psychiatrica Scandinavica*, 84, 9-11.

- Rothschild, B.S., Fagan, P.J., Woodall, C. & Andersen, A.E. (1991). Sexual functioning of female eating-disordered patients. *International Journal of Eating Disorders*, 10 (4), 389-394.
- Sandelowski, M. (1986). The problem of rigour in qualitative research. *Advances in Nursing Science*, 8 (3), 27-37.
- Silverman, D. (2000). *Doing qualitative research: A practical handbook*. Thousand Oaks, CA: Sage Publications.
- Steiger, H., Fraenkel, L. & Leichner, P.P. (1989). Relationship of body-image distortion to sex-role identifications, irrational cognitions, and body weight in eating-disordered females. *Journal of Clinical Psychology*, 45, 61-65.
- Sullivan, H.S. (1953). *The interpersonal theory of psychiatry*. NY, NY: Norton.
- Talmadge, L.D. & Dabbs, J.M. (1990). Intimacy, conversational patterns and concomitant cognitive/emotional processes in couples. *Journal of Social and Clinical Psychology*, 9, 373-488.
- Tesch, R. (1990). *Qualitative research: Analysis types and software tools*. NY, NY: The Falmer Press.
- Van den Broucke, S., Vandereycken, W. & Vertommen, H. (1995). Marital intimacy in patients with an eating disorder: A controlled self-report study. *International Journal of Eating Disorders*, 34, 67-78.
- Wiederman, M.W., Pryor, T. & Morgan, C.D. (1996). The sexual experience of women diagnosed with anorexia nervosa or bulimia nervosa. *International Journal of Eating Disorders*, 19(2), 109-118.
- Woodside, D.B., Lackstrom, J.B. & Shekter-Wolfson, L. (2000). Marriage in eating disorders: Comparisons between patients and spouses and changes over the course of treatment. *Journal of Psychosomatic Research*, 49, 165-168.

Appendix A

Critical Appraisal Tool. Criteria were consistent with the quantitative study designs of the reviewed literature (Adapted from Levine, Walter, Lee, Haines, Holbrook & Moyer, 1994; Polit & Hungler, 1997; Streiner & Norman, 1996).

A. SAMPLING

(Q1) Was the sample adequately described for replication?

No Yes

If NO, what was missing (e.g. specific demographic data)? _____

(Q2) Was the sampling method described?

No Yes

If YES, specify. _____

(Q3) Was the sample size justified?

No Yes

If YES, what was described? _____

B. STUDY DESIGN

(Q1) Was the study described?

No Yes

Indicate the study design. _____

(Q2) Was a research question stated or implied?

No Yes

If YES, specify. _____

(Q3) Is the study design the most rigorous for the research question being asked?

No Yes

If NO, specify the most appropriate. _____

C. CONFOUNDERS

(Q1) Were there important differences between groups prior to the study?

- 1 Yes
- 2 No
- 3 Can't tell

If YES, indicate the potential confounders:

- 1 Race
- 2 Sex
- 3 Marital status/Family
- 4 Age
- 5 Socioeconomic status (income or class)
- 6 Education
- 7 Health status

If NO, indicate the confounders that were controlled (either in the design (e.g. matching) or analysis):

- 1 Race
- 2 Sex
- 3 Marital status/Family
- 4 Age
- 5 Socioeconomic status (income or class)
- 6 Education
- 7 Health status

D. DATA COLLECTION METHODS

(Q1) Were the data collection tools shown to be valid?

- 1 Yes
- 2 No
- 3 Can't tell

(Q2) Were the data collection tools shown to be reliable?

- 1 Yes
- 2 No
- 3 Can't tell

(Q3) Were outcomes measured in the same way in the compared groups?

- No
- Yes

If NO, specify what occurred. _____

E. WITHDRAWALS AND DROP-OUTS

(Q1) Were withdrawals and drop-outs reported in terms of numbers and reasons per group?

- | | |
|---|------------|
| 1 | Yes |
| 2 | No |
| 3 | Can't tell |

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, report the lowest).

- | | |
|---|---------------|
| 1 | 80-100% |
| 2 | 60-79% |
| 3 | Less than 60% |

F. ANALYSES

(Q1) Are the statistical methods appropriate for the type of data analyzed and the research question?

- | | |
|----|-----|
| No | Yes |
|----|-----|

If NO, specify. _____

(Q2) What statistical methods were used?

(Q3) Were the results interpreted correctly?

- | | |
|----|-----|
| No | Yes |
|----|-----|

If NO, specify. _____

If YES, specify. _____

G. BIASES

(Q1) Were potential sources of bias addressed and discussed?

- | | |
|----|-----|
| No | Yes |
|----|-----|

Specify biases. _____

Appendix B

Additional Findings. Two additional themes that emerged during data analysis warrant presentation in this paper as a foundation for future study. These themes are: the participants' perceptions on how their illness has impacted their partner's relational experiences; and their descriptions of relational experiences with friends, family, and children.

The Partner's Experience

Many women offered initial perspectives on how their struggle with their eating disorder has affected their partners' relational experiences. Descriptions included instances of partners' frustration regarding the impact of the illness on their partner and on the relationship,

He got very angry. He was angry at the disease, angry at what the disease was doing to me, angry at what the disease was doing to him and the kids.

It's frustrating for him because he's like, 'you're stupid, why are you acting like this, we've been together three and a half years, I've seen you before, why are you so self conscious.'

Finally, the need for partner support was highlighted by one woman's description of her partner's fear of her dying and experiencing this fear alone, "He never told me at the time, but now he'll say 'you know, I was afraid that you would die in your sleep.'" As one of the participants concluded, "I truly don't think there's enough support for spouses. I really don't, because I think that he's like 'you're the one that's getting all the help and support, and I don't know how to deal with this.'

Experiences with Other Relationships

The participants' experiences with other relationships included family, friends and children, and often paralleled their experiences with romantic relationships. Disclosure of their eating disorder for many women was passive, and not an occasion that was actively sought out. In most instances, friends and family discovered through observation of eating disordered behaviours. Although most women felt supported by their friends and family, they described feeling more distanced emotionally and physically from them than engaged. This was based on their perceptions that friends and family became too vigilant once their eating disorder was disclosed. The decision to distance for these women was based on wanting to preserve a satisfying relationship, while maintaining their eating disorder. Secrecy and avoidance became predominant strategies to uphold their relationships, and there was a constant battle for women to negotiate the tension between distancing themselves, and maintaining engagement. Several women also described losing friends and family relationships not only because of their own distancing, but also due to friends and family's distancing framed in frustration over the participants' difficulties in working towards wellness.

Participants with children described poignant experiences when it was clear to them that their eating disorder was more than affecting their own lives.

But then my son said one day, he says, 'you're too skinny mommy and you need to see a doctor, and you're sick, and I don't want to see you die.' He's older, he sees. You don't think that they do, but he notices.

You know, they didn't understand why mommy couldn't be with them. You know, them not seeing mommy eat, and then the kids don't eat.

I know it affects her more. She'll make comments and I think, 'oh my God, like I can't believe I've made this impression on my daughter. She'll be like, 'oh my mommy thinks that she's fat all the time.' It's just an innocent comment to her, but that's what she hears me saying.

Many women used such moments as motivators; concerned about what long-term exposure their eating disordered thoughts and behaviours would have on their children's self-concept and self-esteem. It was important for these women to work towards wellness not only for themselves, but also for their children. As one participant stated, "I have to be a better person for her... I don't want her to grow up and have these kind of problems too."

Implications for Health Care Practice and Research

Not only do the additional themes that emerged during data analysis highlight the obvious interactional quality to relationships, they draw attention to the need to further examine the experience of relationships for the partners and children of women with AN. At this point in time, these additional themes do emphasize an impetus for practitioners in family therapy settings to include the whole family in health care access. At the very least, the delivery of supportive health care interventions for both partners and children should take place. In addition, future research can confirm if the provision of psychoeducation and cognitive strategies to enhance healthy eating and self-concept with the women's children is needed as a preventative measure to potential mimicking of their mother's beliefs and behaviours.

Appendix C

Terms and Operational Definitions. For the purposes of this study, the following definitions have been used.

TERM	OPERATIONAL DEFINITION
Anorexia Nervosa (AN)	<p>The principle diagnostic criteria for AN are defined by the American Psychiatric Association (1994), and include:</p> <ul style="list-style-type: none"> A. A refusal to maintain one's body weight at the recommended standards for height and weight; B. A pervasive and intense fear of weight gain; C. A distorted body image, despite the possibility of being underweight; D. Amenorrhea, the disruption or cessation in menstruation, for at least three consecutive months in postmenarchal women. <p>The minimal weight criterion for AN in women is modeled after standardized height and weight recommendations, and defined by weight at least 15% below the mean weight for height for a medium frame.</p>
Eating Disorder (not otherwise specified) [ED (NOS)]	<p>ED (NOS) is a category defined by the American Psychiatric Association (1994) for individuals that do not meet other eating disorder diagnoses. In this study, women meeting the following criteria were included:</p> <ul style="list-style-type: none"> 1. All of the criteria for AN are met except the woman is experiencing regular menses, 2. All of the criteria for AN are met except despite significant weight loss, the woman's current weight is within the recommended range.

Appendix D
Study Consent Form

**Consent to Participate in the Study of Romantic Relationships and Intimacy
for Women with Anorexia Nervosa**

I understand that this study is looking at the experience of romantic relationships and intimacy for women with anorexia nervosa. It will study past and present experiences in dating and/or marital relationships. I also understand that it is not necessary that I be currently in a romantic relationship. Information from my experiences will help health care providers understand romantic relationships for women with eating disorders more fully so they will be able to provide help that is needed at the right time, and can assist my friends and family in understanding my experiences.

I understand that my involvement is voluntary, and that there are no right or wrong answers. I understand that interviews will involve meeting with the researcher personally for up to one hour, and will be audiotaped to ensure all my experiences are best understood. Questions will include my being asked about my experiences with romantic relationships and what I believe intimacy to be.

I will have an opportunity to review my transcript with the researcher if I choose, and can make recommendations for additions and deletions of what I have said to best convey my experience. I will verbally let the researcher know if I would like to do this. I also have the right not to respond to any individual question if I do not wish, and that I have the right to stop my involvement at any time without question from the researcher. I can verbalize this wish to the researcher at any time.

I am also aware that there may be a need for a second interview so that my experiences are best understood and described. This would involve the researcher contacting myself at a specified telephone number or e-mail address. All the information I give will be kept confidential.

I also understand that my decision about involvement and/or my responses will in no way influence the care that I receive at the Eating Disorders Program, and that to the researcher's best knowledge there are low risks associated with participating in this study such as emotional responses to my discussing my experiences. I am aware that I can address these emotional responses with someone such as a friend, family member, my therapist, or with the researcher during my interview.

I understand that any forms that identify me will be kept in a locked file. These forms will be accessible during the study to the researcher, the researcher's supervisor, and Eating Disorder Program's Research Ethics Board, and will be destroyed once the study has been successfully completed in August 2003.

**Consent to Participate in the Study of Romantic Relationships and Intimacy
for Women with Anorexia Nervosa**

I am aware that results from this study will be reported in summary form only, so that there will be no way to identify me or my individual responses. I also understand that results from this study will be seen by other researchers at McMaster University and the Eating Disorders Program, and may be published in the future. I have been offered a one-page summary of the results of this study. I can request a summary by submitting my name and address to the researcher.

By signing this consent form I agree to participate in the above named study, and understand the information provided on this form. I have been given a copy of this form for my records.

Printed Name of Participant

Signature of Participant

Date

The information within this consent has been explained to the participant and to the best of my knowledge the participant understands the nature of the study.

Signature of Primary Investigator

Date

If you have any questions about this study or wish further information you may contact:

Mandi Newton, RN, BScN, PhD (candidate)

School of Nursing, McMaster University

Phone: (905)525-9140 Extension: 22407

E-mail: newtonms@mcmaster.ca

Thesis Supervisor: Dr. Sheryl Boblin, School of Nursing, McMaster University

Phone: (905)525-9140 extension 22257

Appendix E
Recruitment Letter

Date:

Dear

My name is Mandi Newton, and I am a nurse researcher at McMaster University in Hamilton, Ontario. I am very interested in speaking privately with women who are currently dealing with, or are recovering from, anorexia nervosa. These discussions are a part of my graduate work at McMaster University in learning about experiences in your romantic relationships. You do not have to be in a romantic relationship at this time, and can speak of relationships that you have experienced past or present. All information in our discussions would be confidential, and there would be no way to identify you or your responses.

I would be very interested in meeting with you to discuss your own experiences. We could meet at the Eating Disorders Program or a location of your preference at a time most convenient for you.

What I learn from our discussion will be presented in summary form during my final exam at McMaster University, and may possibly be published in a recognized health care journal, but again, there will be no way to identify you as a participant. I have also included with this letter, a more detailed description of the study and the process involved.

I would appreciate hearing back from you by either e-mail or a phone call. If you have any further questions, please feel free to contact myself, or my research supervisor: Dr. Sheryl Boblin. I can be contacted at (905) 525-9140 extension 22407, while my supervisor can be reached at extension 22257.

If you have any questions regarding the study or your rights as a research participant, you can also contact the Eating Disorders Program and they will direct you to the appropriate individual.

I look forward to hearing from you,

Mandi Newton, RN, BScN, PhD (candidate)
School of Nursing, McMaster University

Phone: (905)525-9140 Extension: 22407
E-mail: newtonms@mcmaster.ca

Appendix F

Study Advertisement

Experiences with Romantic Relationships and Intimacy: Request for Participation

What is this notice for?

You are invited to take part in a study called, “Experiences with Romantic Relationships and Intimacy”. Your involvement is voluntary. **You will receive the best care possible at the Eating Disorders Program whether or not you participate in this study.** All information you give will be kept confidential, and there will be no way to identify you.

What is this study about?

This study is being done to understand the experience of relationships for women with anorexia nervosa. Anorexia nervosa is an eating disorder that occurs in women, but personal experiences in terms of romantic relationships for women with this diagnosis is not well known. This study would like to learn from you what your experiences with romantic relationships have been like.

Who is conducting this study?

A researcher from McMaster University’s School of Nursing will be conducting this study. Your experience and what you learned from it will help health care providers understand romantic relationships for women with eating disorders more fully so they will be able to provide help that is needed at the right time.

What is meant by, “experiences with romantic relationships and intimacy”?

This study would like to learn more about experiences with dating and/or marriage for women with anorexia nervosa. You do not have to be in a romantic relationship at this time, but need to be willing to talk about either of these types of relationships that you have experienced past or present.

What would you have to do?

If you are a woman over 18 years of age currently dealing with, or recovering from anorexia nervosa, and would like to take part in this study, please call collect or e-mail. In doing this, you will be contacting Mandi Newton, a researcher from McMaster University’s School of Nursing. You will then be invited to talk with Ms. Newton in a personal interview at a private office in the Eating Disorders Program at your convenience, or at another preferred location.

If you are interested in the results after the study is over, a one-page summary of can be sent to you.

Please contact:

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E-mail: newtonms@mcmaster.ca

Thesis Supervisor: Dr. Sheryl Boblin, School of Nursing, McMaster University

Phone: (905)525-9140 Extension 22257

Appendix G
Study Summary Option

Experiences with Romantic Relationships and Intimacy: Request for Summary

Please indicate below if you would like to receive a one page summary of the results of this study.

_____ Yes

_____ No

If yes, please provide your name and address:

Name: _____

Address: _____

Postal Code: _____

Appendix H
Demographic Form

I would like to ask you a few questions about your background. This information will remain confidential. Name: _____

1. Sex: Female Male

2. Year of Birth: _____

3. What is your ethnic background? _____

4. What is your current relationship status?
 - Single, Not dating
 - Single, Dating
 - Separated
 - Common-law/Long-term Relationship
 - Married
 - Divorced
 - Widowed

Age(s) during dating relationship(s): _____

Length of dating relationship(s): _____

Age(s) at marriage: _____

Length of marital relationship(s): _____

5. How many dependents (e.g., children, parents, loved ones) do you have (if any)? _____

6. What is the highest level of education you have received?
 - Some elementary school (up to grade 8)
 - Completed elementary school
 - Some high school
 - Completed high school
 - Some college/trade school/university
 - Completed college/trade school/university
 - Some professional or graduate school
 - Completed professional or graduate school

7. What is your employment status at present?

- Not employed
- Homemaker
- Self-employed
- Employed occasionally
- Employed part-time
- Employed full-time
- Other (please specify): _____

8. At what age were you diagnosed with your eating disorder? _____

What was the diagnosis? _____

What has been your most recent diagnosis? _____

9. How many years have you been dealing with your eating disorder? _____

10. Right now, would you consider yourself:

- Currently suffering from your eating disorder, Not in treatment
- Currently suffering from your eating disorder, In treatment
- Currently recovering from your eating disorder, Not in treatment
- Currently recovering from your eating disorder, In treatment
- Fully recovered from your eating disorder, Not in treatment
- Fully recovered from your eating disorder, In treatment

11. Do you have someone to talk to should you find that talking in our discussions brings up certain emotions? _____ (yes/no)

Appendix I

Debriefing Letter. Participants were given verbal feedback following the interview(s) with a mailed letter re-emphasizing their contributions to the study's development.

Date:

Dear

Thank you for speaking with me regarding your personal experiences with romantic relationships and intimacy. Information from our discussions will help health care providers understand romantic relationships for women with eating disorders more fully so they will be able to provide help that is needed at the right time. The thoughts and feelings you provided during our interview can also assist your friends and family in understanding your experiences should you like to share the study's summary with them when it is available.

Again, what I learned from our discussion will be presented in summary form during my final exam at McMaster University, and may possibly be published in a recognized health care journal. Please keep in mind that there will be no way to identify you as a participant.

If you have any further questions regarding this study or your participation, please feel free to contact myself, or my research supervisor: Dr. Sheryl Boblin. I can be contacted at (905) 525-9140 extension 22407, while my supervisor can be reached at extension 22257. You may also wish to contact the Eating Disorders Program Director/Team Leader to discuss this study.

If you requested a study summary, it will be forwarded to you as soon as this study is completed.

Regards,

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Appendix J
Study Budget

Estimated Itemized Cost per Participant

	<u># Visits</u>	x	<u>Cost</u>	=	<u>Total</u>
Parking/Bus Fare	2		\$10.00	=	\$20.00
			Total Cost per Participant	=	\$20.00
			Number of Participants	=	11
			Total Participant Costs	=	\$220.00 (a)

Estimated Itemized Administration Costs

Transcription			\$750.00	=	\$750.00
Investigator Travel and Parking			\$150.00	=	\$150.00
			Total Administration Costs	=	\$900.00 (b)
			Total Study Budget (a + b)	=	\$1120.00

Appendix K

Publication Guidelines

1. Advances in Nursing Science (Peer Reviewed Journal)

Journal Purpose: Foci of the journal include application of research and theory, and investigation of the values and ethics that influence the practice and research endeavors of nursing sciences.

Manuscript Preparation:

- Manuscript length (including references, tables, figures) should range between 15 and 30 pages.
- The abstract should be 100 words or fewer. It should briefly summarize the major issue being addressed and the findings and/or conclusions of the article.
- The abstract should include up to 10 key words that describe the contents of the article for indexing purposes. They should be similar to those that appear in the Cumulative Index to Nursing and Allied Health Literature (CINAHL)

2. European Eating Disorders Review (Peer Reviewed Journal)

Journal Purpose: An aim of the journal is to offer a forum for new thinking regarding the nature of eating disorders.

Manuscript Preparation:

- The abstract should be 150 words or fewer. It should be a concise summary of the whole paper and should contain no citation to other published work.
- The abstract should include up to 5 key words that describe the contents of the article for indexing purposes.
- There is no specified word or page limit.

3. International Journal of Eating Disorders (Peer Reviewed Journal)

Journal Purpose: It is expected that papers submitted to this journal represent a significant addition to knowledge, or a significant review and synthesis of existing literature.

Manuscript Preparation:

- The abstract should be typed as a single paragraph on one page, and should not exceed 150 words. Reviews of the literature must include the following information in the form of a structured abstract, under the headings indicated: objective, method, results, discussion.
- There is no specified word or page limit.

4. Qualitative Health Research (Peer Reviewed Journal)

Journal Purpose: It is designed to further the development and understanding of qualitative research methods in health care settings.

Manuscript Preparation:

- The abstract should be typed as a single paragraph on one page, and should not exceed 160 words.
- There is no specified word or page limit.

Appendix L
Generated Future Research Questions

QUALITATIVE FOCUS

1. What are the relational experiences of partners of women with AN?
2. How do women with AN and their partners interrelate through emotional and physical intimacy?
3. What are the interrelationships within intimacy in romantic relationships for women with AN?
4. How do women with AN and their partners experience their romantic relationship over the course of the women's eating disorder?
5. What are the parent-child experiences for women with AN and their children?
6. How do women with AN experience romantic relationships? (feminist focus)

QUANTITATIVE FOCUS

1. Is there a relationship between disclosure in romantic relationships and self-esteem for women with AN?
2. How is intimacy impacted for women with AN and their partners over the course of the women's eating disorder?
3. How are children of women with AN impacted by their mother's eating disorder?