THERE IS MORE TO IT THAN JUST BEING THIN: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF PATIENTS' PERCEPTIONS OF ANOREXIA NERVOSA

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ABSTRACT

THERE IS MORE TO IT THAN JUST BEING THIN: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF PATIENTS' PERCEPTIONS OF ANOREXIA NERVOSA

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Anorexia nervosa has become an increasing health concern in the society since it is not only affecting individuals but also their families. It results in a significant impairment in the individual's health and psychosocial functioning in life. The primary purpose of this study was to examine anorexia nervosa experiences of Turkish women with the diagnosis. The focus of the study is to understand the meaning and function that the individuals' attributed to their experiences. Therefore, a qualitative research was conducted in order to explore both the subjective experiences of individauls and culture-spesific dynamics related to the symptoms. Purposive sampling consisted of six females diagnosed with restricted subtype of anorexia nervosa. Semi-structured interviews were conducted once with each of the participants and these interviews were analyzed through Interpretative Phenomenological Analysis. As a result of the analysis, six super-ordinate themes were emerged. These were "food deprivation as a substitute for privation of love and care; food deprivation to compensate for the feelings of loss of control and freedom; receiving love and care from the family: repairing the broken relationship; others as a

reference point: the importance of others' thoughts and acceptance; is anorexia nervosa the only way out?: expressing resentment and anger through punishing others; distracting attention away from relational problems: "I was dealing with what I ate to keep my mind occupied." The results of the presenting study were discussed in light of the relevant literature, and clinical implications stemmed from these results were explained in detail.

Keywords: Eating Disorder, Anorexia Nervosa, Qualitative Methodology, Interpretative Phenomenological Analysis, Function

ÖZ

SADECE ZAYIF OLMANIN ÖTESİNDE: ANOREKSİYA NERVOZA ALGISININ YORUMLAYICI FENOMENOLOJİK ANALİZİ

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Anoreksiya nervoza sadece bireyi değil aynı zamanda aileleri de etkileyen ve toplumda sıklığı yıllar içerisinde artan bir sağlık sorunu haline gelmiştir. Semptomlar bireyin fiziksel sağlığı ve psikososyal yaşamı üzerinde önemli bir bozulmaya yol açmaktadır. Bu sebeple, mevcut çalışmanın temel amacı, tanı almış genç Türk kadınlarının anoreksiya nervosa deneyimlerini incelemek ve deneyimlerine atfettikleri anlam ve işlevi anlamak olarak belirlenmiştir. Hem bireylerin öznel deneyimlerini hem de semptomlarla ilgili kültüre özgü dinamikleri araştırmak için nitel bir araştırma yapılmıştır. Amaca yönelik oluşturulan örneklem sonucunda kısıtlı tip anoreksiya nervosa tanısı almış altı kadın çalışmaya katılmıştır. Katılımcıların her biri ile yarı yapılandırılmış görüşmeler gerçekleştirilmiş ve bu görüşmeler Yorumlayıcı Fenomenolojik Analiz yöntemi ile analiz edilmiştir. Analiz sonuçlarına göre, ‘besin yoksunluğunun sevgi ve ilgi yoksunluğunun yerine geçmesi’, ‘kontrol ve özgürlük kaybı duygularının telafisi için besin yoksunluğu’, ‘aileden sevgi ve ilgi almak: parçalanmış ilişkinin onarılması’, ‘referans noktası olarak başkaları: başkalarının düşünce ve kabullerinin önemi’, ‘anoreksiya nervoza tek çıkış yolu mu?: başkalarını cezalandırarak kızgınlığı ve öfkeyi ifade etmek’, ve ‘dikkatin ilişkisel sorunlardan uzaklaştırılması: kendimi meşgul tutmak için ne yediğimle

uğraşıyordum’ olmak üzere altı tema oluşturulmuştur. Çalışmanın sonuçları ilgili alanyazın ışığında tartışılmış ve mevcut bulgular doğrultusunda klinik uygulamalara dair yapılan çıkarımlar belirtilmiştir.

Anahtar Kelimeler: Yeme Bozukluğu, Anoreksiya Nervoza, Nitel Metodoloji, Yorumlayıcı Fenomenolojik Analiz, İşlev

To my family…

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CHAPTER 1

GENERAL INTRODUCTION

1.1. Overview

This presenting study is an Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2003; Smith, Flowers, & Larkin, 2009) of the meaning and function of anorexia nervosa (AN) symptoms among Turkish young females with the diagnosis. In this chapter, a general introduction about anorexia nervosa in light of the existing literature will be briefly given. Also, the rationale and aims of the study will be explained.

1.2. Historical Evolution of the Concept of Self-Starvation

The symptomatology of AN is acknowledged as a relatively contemporary disease; however, several studies have presented examples of voluntary self-starvation across history (Davis & Nguyen, 2014; Dell'Osso et al., 2016). In Ancient Greek and Egyptian cultures, there had been records that evidenced ritual fasting for short time periods (i.e., one to three days), but there was not any prolonged fasting (Bemporad, 1996). During the middle ages, particularly from the 13th to the 16th century, there were cases of extreme, self-induced fasting, which often caused premature deaths (i.e., Catherina from Siena). Fasting or self-starvation through food deprivation, except for the ritual of Eucharist, at the time, was a peculiar trait of women and female sainthood idealization. It was described in different terms, such as 'holy anorexia', 'ascetism', or 'anorexia mirabilis' (Behar & Arancibia, 2015; Dell'Osso et al., 2016).

Throughout ages, fasting and extreme self-punishment were practiced for the purification of the soul and the glorification of God in Gnostic philosophy and Christianity. For instance, Saint Jerome presented the benefits of self-starvation for purification to Roman women, to the extent that a Roman girl died of ascetic diet following those dogmas (Dell'Osso et al., 2016). Thus, in early times of Christianity, restraining from food became a usual everyday practice. The needs of the human body and sexuality were accepted as secondary to the will and spirit. For instance, Saint Catherine de Siena, was born in Italy and lived her life virtuously. She was controlling her bodily needs to show her devotion to God. When she reached 16, she started to eat very little and cut her hair. Then, she began to vomit after eating. She also flagellated herself in imitation of Christ' s passion. However, she died at the age of 32 from malnutrition (Davis & Nguyen, 2014; Behar & Arancibia, 2015). Furthermore, between the 13th and 17th centuries, there were 181 cases of holy fasting identified in southern Europe, and there were several cases of women fasting to the point of death. Those women believed they had direct communication with God, and this was also a way of avoiding arranged marriage and childbirth (Bell, 1985; as cited in Davis & Nguyen, 2014). Two hundred years later, Santa Rosa de Lima thought of spirituality as an oath to poverty and advocated fasting and extreme forms of asceticism. She fasted three times a week starting from the age of 11. When she was 15, she stopped eating meat and ate only bread. She dedicated her life to prayer and helping poor and sick people before succumbing to AN (Behar & Arancibia, 2015).

Lastly, it is also essential to look at the evolution of the meaning of self-starvation in the last three centuries. Restriction of food has become more related to body image and self-representation than religious purposes. Since the mid-18th century, the ideal female figure has changed from a rounded figure to a slender shape and thin appearance (Dell'Osso et al., 2016). For example, in the case of the Empress Elizabeth of Austria, also known as Sissy, she practiced a remarkably strict diet and followed excessive exercise. With her tall and very slim body, she was the representative of the modern ideal of beauty during the second half of the 19th

century; this ideal of thinness has progressively received more popularity until the 21th century (Dell'Osso et al., 2016).

As it is seen from the information above, 'holy anorexia' is different from the anorexia nervosa of this century. Even though 'holy anorexia' and contemporary AN share common features, they have served different purposes. 'Holy anorexia' is about focusing on spiritual purity or divine encounter with God. In other words, it is a way to achieve holy communication with God and to practice self-discipline. However, AN is associated with a defective sense of self and obsession with thinness, as well as an excessive valuation of body shape and weight in order to meet the sociocultural aesthetic ideals (Behar & Arancibia, 2015; Dell'Osso et al., 2016).

1.3. Clinical Definitions and Features of Anorexia Nervosa

The word anorexia is of Latin origin. It is comprised of the words 'an- (without)' and 'orexis (appetite, desire)'; thus, it means a lack or loss of appetite. However, the term AN has been criticized as a misnomer (misleading term) because the syndrome actually does not involve a lack of appetite (Habermas, 2015). The patients with the diagnosis do not suffer from lack of appetite, in fact, they deliberately and willfully restrict their food consumption (Bruch, 1982a).

One of the first known clinical definitions of the syndrome was proposed by Gull in 1874; he coined the phrase 'anorexia nervosa' and distinguished it from 'hysteria.' According to his description, young women were defined as experiencing a "delirious conviction that they cannot or ought not to eat." The women also presented features of oppositional behaviors and an obsession with food. In addition to the refusal of eating, he specified an early onset during young adulthood or adolescence, restlessness, amenorrhea, and lack of worry about the worsening health condition (Davis & Nguyen, 2014). Over time, anorexia nervosa was acknowledged as a psychogenic disorder and listed in the Diagnostic and Statistical Manual of Mental Disorder (DSM; American Psychiatric Association (APA), 1952), DSM-I, for

the first time. In DSM-II (1968), AN was placed in the section of special symptoms under the name of feeding disturbances. The symptoms were first described in DSM-III (1980) as separate disorders under disorders of childhood or adolescence because of the different clinical pictures of the symptoms. In the DSM-IV-TR (2000), eating disorders moved into a separate section. Lastly, in the latest version of DSM, DSM-V (2013), eating disorders were categorized under the section named *Feeding and Eating Disorders*.

Feeding and eating disorders are described as a persistent overconcern in eating behavior that causes a negative change in the consumption of food (i.e., inadequate or excessive food intake), which ultimately result in significant impairment in the individual's physical health and psychosocial functioning in life. Diagnostic criteria are specified for pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder (APA, 2013). The most common forms of eating disorders include anorexia nervosa, bulimia nervosa, and binge eating disorder. These disorders affect both males and females. In this study, the focus will be specifically on anorexia nervosa. Details of the diagnostic criteria of AN based on DSM-V were given below.

Anorexia nervosa is defined as a disorder in which the fundamental features are a persistent refusal of eating (restricted food intake) because of the extreme fear of becoming fat, persistent behaviors to prevent weight gain, maintaining a lower body weight than what is minimally normal, and disturbance of self-perceived body image. Diagnostic criteria for anorexia nervosa are specified in DSM-V (2013) as the following:

> Restriction of energy intake relative to requirements, leading to significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected. Intense fear of gaining weight, or persistent behavior that interferes with weight gain, even though at a significantly low weight. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent

> lack of recognition of the seriousness of the current low body weight (pp. 338-339).

Also, in the DSM-V (2013), two subtypes of anorexia nervosa are described, which are the restricting type and the binge-eating/purging type. In the restricting type of anorexia nervosa, individuals have not had repeated episodes of binging and purging behavior (i.e., self-induced vomiting or misusing of laxatives, diuretics, or enemas) in the last three months. The weight loss is achieved mainly through dieting, fasting, and/or exercising. On the other hand, in the binge-eating/purging type anorexia nervosa, individuals primarily have had repeated episodes of binging and purging behavior in the last three months (APA, 2013). Considering the strong emphasis on having a normal weight in the diagnostic criteria, it becomes a challenging situation to assess an individual's weight because the definition for normal weight range differs among individuals based on their age, sex, developmental path, and physical health. Therefore, it is considered useful to employ body mass index (BMI) as a measure to evaluate body weight in accordance with height. According to the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO), for adults, a BMI of 18.5 kg/m^2 has been accepted to be the lower limit of normal body weight. Additionally, a BMI less than 17.0 kg/m^2 is taken as significantly lower weight.

However, in the case of children and adolescents, it is beneficial to employ a BMI-for-age percentile which is a percentile calculator specific to children and teenagers in the CDC standards. For instance, the CDC suggests to use a BMI-for-age below the 5^{th} percentile as being underweight; however, children or adolescents with a BMI above this percentile could still be considered as significantly underweight due to their failure to maintain the expected growth trajectory. Thus, while deciding whether an individual meets the diagnostic criteria for anorexia nervosa, the clinician should take into consideration both available numerical guidelines and the individual's weight history, body build, and physiological difficulties together (APA, 2013).

In addition, the individuals with anorexia nervosa express an excessive fear of putting on weight or becoming fat and this fear of becoming fat is often not lessened by losing weight; on the contrary, it sometimes increases even when the individual's weight decreases. Also, the individuals' perceptions of their body weight or shape are distorted. They feel either extremely overweight or they think that they are thin, but are convinced that certain parts of their body, such as abdomen, buttocks, and thighs, are too fat. They are occupied with evaluating their body size or weight by using a variety of techniques, including frequent weighing, repeatedly measuring of body parts, and using a mirror regularly to control the areas considered as fat (APA, 2013). Additionally, their self-esteem depends on their perceptions of body shape and weight. In their point of view, while weight loss is seen as self-discipline and control, weight gain is taken as a disappointing failure of self-control. They are often brought to professionals by family members, and it is unusual for them to complain about their weight loss. They either have a lack of insight or deny their disturbance (APA, 2013). For instance, in Espíndola and Blay (2009), it was reported that the patients with the disorder considered the disturbance as part of their own identity, and they believed that living without the disorder was a threat; they perceived it as a loss of their identity. Therefore, for those individuals, who see the disturbance as an integrating part of their personalities, accepting the treatment could be a difficult and distressing decision to make.

1.3.1. Accompanying Medical Conditions of Anorexia Nervosa

The anorexic behaviors can affect major organ systems and might cause significant life-threatening medical disturbances, including amenorrhea, vital sign abnormalities, cardiovascular/gastrointestinal/renal problems, bone mineral density, hypotension, hypothermia, bradycardia, and so on. While the impacts of most of these physiological conditions are reversible with nutritional rehabilitation, some of them are not completely reversible, for instance, bone mineral density (APA, 2013; Mehler, Krantz, & Sachs, 2015; Walsh, 1998). Therefore, the symptoms may result in serious health problems. In addition to the physiological findings, there are some

psychological symptoms associated with anorexia nervosa. For example, when individuals are significantly underweight, they also experience depressive signs and symptoms, including depressed mood, social isolation, irritability, insomnia, and a reduced interest in sex (APA, 2013). Food related or not, obsessive-compulsive behaviors are also noticeable in those individuals. Most of them are preoccupied with thoughts of food. Some other features accompanying anorexia nervosa are concerns about eating in public, a powerful desire to control one's environment, rigid thinking, limited socially spontaneous behavior, and restricted emotional expression (APA, 2013). However, the course of those psychological symptoms might not be severe enough to meet any additional diagnostic criteria.

1.3.2. Comorbidity of Anorexia Nervosa

AN is a mental health disorder with significantly great comorbidity, chronic course, and mortality among other psychiatric illnesses. It occurs simultaneously with a variety of psychiatric diagnosis (Bühren et al., 2014; Pompili et al., 2004). Many individuals with the diagnosis disclose the presence of anxiety disorder or symptoms prior to the beginning of their eating disorder symptoms. Obsessive-compulsive disorder is another illness reported by the individuals, especially those who have a restricting type of anorexia nervosa. Alcohol or other substance use disorders are common among those with the binge eating and purging type (APA, 2013). For example, in the study of Bühren et al. (2014), they investigated the rates of comorbid psychiatric disorders in anorexic individuals (N=148). Seventy patients (47.3%) fit into the criteria for at least one comorbid psychiatric disorder. The most frequently observed comorbid disorders were affective disorders and anxiety disorders, specifically social phobia and obsessive-compulsive disorder.

There were other clinical and community-based studies confirming these results. In Godart et al. (2015), around 64% of individuals with anorexia nervosa disclosed having at least one episode of major depressive disorders during their life. Also, AN carried a high risk of developing other psychiatric disorders during the individuals'

lifetimes, even after the recovery (Jagielska & Kacperska, 2017). Follow-up studies showed that a large percentage of patients with AN suffered from additional psychiatric disorders, such as anxiety disorders and phobias, mood disorders, substance use disorders, obsessive-compulsive disorder, unspecified personality disorders (Steinhausen, 2002). In another follow-up study, affect disorders were reported to be the most common comorbid psychiatric disorders, with 17.5% of the sample having met the criteria for depression. Also, anxiety disorder was identified in 15.9%, obsessive-compulsive disorder in 6.4%, substance related disorders in 11.1%, and personality disorder was diagnosed in 6.4% of the participants (Löwe et al., 2001).

1.3.3. Estimates of Incidence and Prevalence of Anorexia Nervosa

Epidemiological studies have specifically addressed the incidence and prevalence rates of AN over time and in different populations (Wakeling, 1996). However, conducting epidemiological studies in AN population is difficult and requires access to large samples due to low prevalence rates and patients' reluctance to disclose their condition (Hoek & van Hoeken, 2003; Polivy & Herman, 2002). Those with the AN symptoms generally deny that they have an illness and frequently seek treatment only because of the concern of those close to them (Polivy & Herman, 2002).

It has been seen from the history that eating disorders have been identified since ancient times; however, their incidence and prevalence rates have increased significantly in the last few decades (Miller & Pumeriega, 2001; Wakeling, 1996). Starting from the late 1960s, AN has become much more prevalent in Western societies. Young women from middle- and upper-class families are in highly restricted eating patterns and starved themselves (Polivy & Herman, 2002). According to DSM-V recordings, the prevalence of anorexia nervosa among young women is about 0.4%. Although limited information is known about prevalence among men, anorexia nervosa is considerably less prevalent in men than in women; the research results reflect approximately a 10:1 women-men ratio (APA, 2013).

The US National Comorbidity Survey Replication estimated the lifetime prevalence of AN, according to DSM-IV diagnostic criteria, as 0.9% in females and 0.3% in males (Hudson, Hiripi, Pope Jr., & Kessler, 2007). In another study conducted in the United States, the lifetime prevalence estimates of AN was reported to be 0.3% among a nationally representative sample of 10,123 adolescents aged 13 to 18 years (Swanson, Crow, Le Grange, Swendsen, & Merikangas, 2011). Also, Stice, Marti, and Rohde (2013) reported that lifetime prevalence by age 20 was 0.8% for AN in a large US sample. Additionally, considering the studies conducted in UK, Turnbull, Ward, Treasure, Jick, and Derby (1996) reported that the age and sex-adjusted incidence rate of AN was 4.2 per 100,000 population in the UK. The relative risks of women to men was 40:1. In addition, in a recent study employing a UK sample, the prevalence of AN was reported as 3.2% in 14-year-old females while 1.6% in males (Micali et al., 2015).

Furthermore, in a review presented by Keski-Rahkonen and Mustelin (2016), epidemiology of eating disorders in Europe was reported. The authors summarized European studies, published in 2015 and the first half of 2016, on their prevalence. They reported that the prevalence of anorexia nervosa was in the range of 1-4% among women in Europe. Accordingly, in Denmark, the incidence rate of AN almost doubled from 9.9 to 19.3 per 100,000 people among females and from 0.9 to 2.4 per 100,000 people among males in the years between 1995 and 2010 (Steinhausen & Jensen, 2015). In Germany, the cumulative incidence of anorexia nervosa, based on DSM-IV diagnostic criteria, was reported to be 1.7% among young community-based women (Nagl et al., 2016). Also, in Finland, the lifetime prevalence of anorexia nervosa among community-based young adult women aged between 22 and 27 years, based on DSM-V diagnostic criteria, was 3.6% (Mustelin et al., 2016). Moreover, the prevalence of AN in adult Australian twin cohort was reported to be 1.9%, with an additional 2.4% who met the diagnostic criteria partially (absence of amenorrhea) (Wade, Bergin, Tiggemann, Bulik, & Fairburn, 2006). In a Swedish population-based sample, Bulik et al. (2006) found that the prevalence of AN, based on the DSM-IV diagnostic criteria, in women was 1.2%, and in men 0.29%. In Smink, van Hoeken,

Oldehinkel, and Hoek (2014), the lifetime prevalence of AN among women in a Dutch sample, according to DSM-V diagnostic criteria, was 1.7%.

What's more, eating disorders have been identified worldwide to a varying extent in non-Western countries as well. Thus, a number of studies investigated the increase in the prevalence of AN and its appearance in those cultures, and confirmed that the illness is not only limited to Western culture anymore (Lucas, Crowson, O'Fallon, & Melton, 1999; Wakeling, 1996). For instance, Yasuhara et al. (2002) investigated the prevalence of eating disorders in Japan. The incidence rates of AN in the survey presented as 10 cases per 100,000 of the general population. This incidence rate was four times higher than those reported in 1993. Similarly, the results of a nationwide epidemiologic study, conducted in Japanese adolescents, showed that AN was predominant among girls and the prevalence of AN for girls was in the range of 0.05-0.56%. The results also pointed out a noticeable sex difference; the prevalence of young males was one-third that of young females (Hotta et al., 2015). These two studies showed that the prevalence rates of eating disorders in Japan might soon reach those in the west. This increase was explained by the rapid changes in family structure and increasing industrialization in recent years in Japan. Those changes also might result in a vulnerable family structure, insufficient social support systems, and changes in the moral values among Japanese young populations (Yasuhara et al., 2002). However, in a meta-analytic review consisting of the existing studies conducted in Latin America, the researchers investigated the epidemiology of eating disorders in Argentina, Brazil, Chile, Colombia, Mexico, and Venezuela. A mean point-prevalence rate of 0.1% for AN was found in the general population in this review while the point-prevalence for anorexia nervosa in Western Europe and North America ranged from 0 to 0.9% in the high-risk population of young females. In other words, AN had lower prevalence in Latin America when compared to Western Europe or the United States (Kolar, Rodriguez, Chams, & Hoek, 2016). This difference in the prevalence rates might be due to the different body ideals of Latin culture which favors a curvier shape and higher weight of the body than western cultures. The culture in those countries might be a protective factor for adolescents to develop the symptoms.

1.3.4. Development and Course of Anorexia Nervosa

Anorexia nervosa prevalently begins during adolescence or young adulthood. It is infrequent that it begins before puberty or after the age of 40. The onset of anorexia nervosa is generally associated with a stressful life event (i.e., leaving home for college). The course and outcome of the disorder are greatly diverse across individuals (APA, 2013). Identity development is one of the most important and core developmental stages of the adolescence phase and it has increasingly been linked to eating disorder development (Verschueren et al., 2018). The primary need of adolescents in this stage is to discover themselves: discovering their identities and their developing bodies and relationships. The lack of identity integration in adolescents in this path causes serious impairments in the functioning of the adolescent's life and results in a disturbance in psychological health (Erikson, 1968). For instance, Bruch (1981) stated that adolescents with high scores for AN tend to have a disrupted identity development process. Therefore, they try to use their bodies as an improper source of self-definition because, according to them, body weight is controllable and valued in contemporary society. For those individuals, the drive for thinness actually might represent the need for individualization (Bruch, 1981; Casper, Hedeker, & McLough, 1992).

By controlling food intake, patients with eating disorders are trying to regulate their bodies. This could also be considered as an attempt to regulate their own identity (Schupak-Neuberg & Nemeroff, 1993). The results of a recent study have confirmed this finding as well. Identity confusion appeared to increase vulnerability to body dissatisfaction and eating disorder symptoms while identity integrity appeared to be protective against the drive for thinness. It also seemed that body dissatisfaction and eating disorder symptoms positively predicted identity confusion and negatively predicted identity synthesis over time (Verschueren et al., 2018). It is concluded that anorexic eating is a way of attributing meaning to one's experience, defining their identity, and developing a new sense of self (Serpell, Treasure, Teasdale, & Sullivan, 1999; Weaver, Wuest, & Ciliska, 2005). The identity gained through AN functions

as a way to obtain self-esteem and social approval, in addition to compensating for concerns about handling interpersonal relationships (Bruch, 1981).

1.3.5. Risk Factors of Anorexia Nervosa

Today's mainstream culture is preoccupied with a new cultural obsession: the relentless pursuit of thinness. In this era, individuals have fixated on food consumption/diet and their body shape (Schwartz, Thompson, & Johnson, 1982). Some of the risk factors that have been specified for developing AN are being female, being an adolescent, and having an obsessional style (Walsh, 2013). Also, increased body mass index, self-perception of being overweight, low self-esteem, being neglected, depressive symptoms, suicide attempts, economic difficulties in the family are reported to be other potential risk factors in developing the syndrome (Stephen et al., 2014). In accordance with this, certain occupations or recreational activities, such as modeling, dancing, or athletics, might promote thinness and increase the risk for the disorder (APA, 2013; Nattiv, Agostini, Drinkwater, & Yeager, 1994). Furthermore, individuals with a history of anxiety disorder or obsessional tendency in childhood are at greater risk of developing anorexia nervosa (APA, 2013).

There are several studies addressing the relationship between AN and personality factors. For instance, Wonderlich, Lilenfeld, Riso, Engel, and Mitchell (2005) specified that the restricting-type of AN was characterized by high degrees of obsessionality, restraint, and perfectionism. Similarly, in Cassin and von Ranson (2005), both AN and BN were characterized by perfectionism, obsessive-compulsiveness, neuroticism, negative emotionality, harm avoidance, low self-directedness, low cooperativeness, and traits associated with avoidant personality disorder. Also, in Vitousek and Manke (1994), it was reported that the patients with AN were reported to be mostly shy, perfectionist, and compatible. In the study of Westen and Harnden-Fisher (2001), they observed that patients with purging type anorexia nervosa tended to be more impulsive than the restrictive subtype of

anorexia, and restrictive type of anorexia was considered to be more perfectionist and obsessive. Also, they stated that the key psychological characteristics of these patients were low self-esteem, feelings of hopelessness, unsatisfactory development of identity, tendency to seek external approval, hypersensitivity to criticism, and conflicts referring to issues regarding autonomy and/or independence.

In addition, it was reported that individuals diagnosed with the restricted subtype usually had obsessive-compulsive and avoidant personality disorders (Herzog, Keller, Sacks, Yeh, & Lavori, 1992) while individuals with the binge eating-purging subtype presented the characteristics of borderline, avoidant, and dependent personality disorders (Sansone, Levitt, & Sansone, 2005). In a Danish study, anxiety disorders, namely obsessive-compulsive disorder, generalized anxiety disorder, panic disorder, social phobia, post-traumatic stress disorder, were found to increase the risk of subsequent anorexia nervosa (Meier et al., 2015). Similarly, in a study conducted in Sweden, females diagnosed with obsessive-compulsive disorder had a 16-fold and men with a 37-fold increased risk of anorexia nervosa (Cederlöf et al., 2015). Lastly, the research focusing on the genetic and physiological factors reported that among the first degree biological relatives of patients with the illness there is an increased risk of developing anorexia nervosa. In addition, concordance rates in monozygotic twins are considerably higher than those for dizygotic twins (APA, 2013).

1.3.6. Prognosis of Anorexia Nervosa

AN is a serious psychiatric condition in the young population and the outcome of the disorder is often poor (Arcelus, Mitchell, Wales, & Nielsen, 2011). In a meta-analysis, consisting of 119 studies including 5,590 patients, it was reported that among surviving patients less than half of them fully recovered (46.9%), one-third improved with only partial or residual features of the illness (33.5%), and 20% remained chronically ill (Steinhausen, 2002). Similarly, in a German study, 47% of adolescents with AN continued to experience symptoms at follow-up assessments over 10 years (Nagl et al., 2016). In addition, in a prospective 21-year follow up

study on the long term outcome of AN, Löwe et al. (2001) reported that 51% were found to be fully recovered at follow up, 21% were partially recovered, and 10% still met diagnostic criteria fully.

Furthermore, in a nationwide population based study conducted in Finland, the researchers aimed to define 5-year recovery rates of AN among women. Almost seventy-one percent of females with the diagnosis achieved clinical recovery by the time of the study (Keski-Rahkonen et al., 2007). In another study, regarding prognosis, Polivy and Herman (2002) stated that about one-third of individuals with diagnosis continued to meet the diagnostic criteria for five years and longer after initial treatment, and 50% of individuals manifested significant improvement more than five years after beginning treatment. These results showed that the syndrome was associated with a high risk of chronic course and poor prognosis in terms of treatment. Longer duration of illness, older age of onset, extreme loss of weight, bulimia, poor family relations, social isolation, low self-esteem, neurotic problems, obsessive-compulsive or personality disturbances, and alcohol abuse were related to poor outcome (Hsu, Crisp, & Harding, 1979; van der Ham, van Strien, & van Engeland, 1998).

Nevertheless, contradictory results were also identified, which were related with the onset-age of disorder, number and duration of earlier treatments, and the duration of illness at the admission (van der Ham et al.,1998). In a study conducted in France, the researchers disclosed five factors for a good prognosis, which were having middle socioeconomic class parents, no prior treatment, hospitalization for more than a month, a follow-up of less than 12 months, and no readmission to a hospital (Kermarrec, Kabuth, Rat, Vidailhet, & Vidailhet, 2014). Also, the onset of illness at a younger age, good parent-child relationship, and a short duration of symptoms before treatment resulted in a favorable outcome (Steinhausen, 2002). Finally, living with someone, having children, and being able to work were the factors associated with good outcome (Löwe et al., 2001).

1.3.7. Mortality and Suicide Risk of Anorexia Nervosa

As stated in DSM-V (2013), the crude mortality rate of the syndrome is around 5% per decade. Both Arcelus et al. (2011) and Smink, van Hoeken, and Hoek (2013) reported that AN was associated with increased mortality. In a literature review, consisting of 36 peer-reviewed articles published between 1966 and 2010, the estimated mortality rates for AN were 5.86 (Arcelus et al., 2011). According to Rudge and Fuks (2014), these rates have gotten worse depending on age: the age that the individual was diagnosed has a great influence on the risk of death. In proportion with the general population, the rate of death among individuals diagnosed before the age of 15 increases threefold, 10-fold between the 15-19 years old, and sixfold after the age of 30 (Rudge & Fuks, 2014). Also, in the study of Löwe et al. (2001), 16% of the participants passed away due to causes related to AN; the standardized mortality rate was 9.8.

Death is most generally caused by medical complications resulting from the disorder itself or by suicide (APA, 2013). Suicide risk increased with time, and the reported incidence rates were around 12 per 100,000. In the study of Arcelus et al. (2011), suicide was very common among those: one in five patients with AN had committed suicide. Bulik et al. (2008) also investigated the prevalence and patterns of suicidal attempts among people with AN (N=432). The results showed that around 16.9% of anorexic individuals attempted suicide. Individuals with the restricting subtype of AN reported a significantly less ratio of suicide attempt (7.4%) than those with the purging subtype of AN (26.1%), AN with binge eating (29.3%), and a mixed type of AN and bulimia nervosa (21.2%).

All in all, in Pompili et al. (2004), they stated that suicide is a major cause of death in individuals diagnosed with AN; however, the rate of suicide in this population is generally underestimated. In their meta-analysis, it was found that suicide among patients diagnosed with anorexia nervosa is more frequent in comparison to the general population. Suicide among this population carries a greater risk of death than

starvation. As it is seen, AN is associated with a high mortality rate as a psychiatric condition. Thus, during the evaluation, the clinician should include questions to assess suicide related ideas and behaviors, as well as whether there is a history of suicide attempts (APA, 2013). This fact also highlights the need for further studies to improve our understanding of AN to enhance prevention and treatment options (Nunn, 2009).

1.4. Changes in the Perception of Ideal Body Image in Time

Throughout history, the concept of feminine beauty or the prototype of ideal body shape for women has gradually changed based on the aesthetic standards, and the cultural and social norms of a particular period. In the past, for most societies, women with curvaceous, ample figures were considered to be attractive and in some cultures, obesity had even been admired and thought as a secondary sexual characteristic. However, over the years, particularly during the last decades, a significant shift has appeared in the idealized female shape. More positive attitudes attributed toward an angular, lean body shape, especially among Western adolescent females (Bemporad, 1997; Caparrotta & Ghaffari, 2006; Dell'Osso et al. 2016; Garner, Garfinkel, Schwartz, & Thompson, 1980).

For example, in the study of Garner et al. (1980), they investigated the shift toward a slender ideal shape for women over the last decades. Data from magazines and beauty pageants manifested a significant increase in thinner standards; also women's magazines documented significantly more diet articles, which as a result caused a change within the weight norms for young females. In a similar study conducted by Rubinstein and Caballero (2000), it was reported that in beauty pageants, the ideal of beauty, including body weight and shape, was determined for society. The authors brought together the data on the weight and height of winners of Miss America Pageant between 1922 and 1999. They found a significant decline in body mass index over the years. Some of them had a body mass index as low as 16.9; this value is categorized by the World Health Organization as in the range of undernutrition.

As it is seen above, the current cultural period glorifies thinness via mass media to all levels of the society. Additionally, the idealization of thinness is communicated by advertisements (Bemporad, 1997). The developing fitness industry has also advocated the prevalent misconception that being thin equals being healthy (Dell'Osso et al., 2016). The media has a pathogenic role in fostering attitudes about the ideal body shape, which ultimately increases the risk of developing an eating disorder (Garner et al., 1980; Miller & Pumeriega, 2001; Moore, 1993; Selvini-Palazzoli, 1985; Rubinstein & Caballero, 2000). In accordance with this, women present increasing evidence of dissatisfaction with their bodies and report feeling pressure to conform to this ideal (Miller & Pumeriega, 2001). The existing literature on the influence of the media (i.e., fashion magazine articles and photographs) on adolescent girls' weight concerns, weight control behaviors, and perceptions of body weight and shape has shown that almost 50% and 75% of adolescent females were not happy with their weight and their body image and wanted to lose weight. It was reported that the frequency of reading magazines was positively associated with the prevalence of dieting and exercising to lose weight. They reported that they were influenced by the idea of the perfect body shape presented in magazines and their behaviors were initiated by those pictures (Field et al., 1999). Similarly, Moore (1993) mentioned that almost two-thirds of adolescent girls were dissatisfied with their weight and more than half of the girls were dissatisfied with the shape of their bodies. The young females were mostly distressed about the excess size of their thighs, hips, waists, and buttocks, as well as the inadequate size of their breasts. They tended to perform potentially dangerous weight control behaviors, including dieting, fasting, self-induced vomiting, as well as using diuretic, laxative, and diet pills (Moore, 1993).

Furthermore, Bruch (1978) claimed that fashion's ideal indirectly impacts vulnerable adolescents who believe that weight control is equal to self-control and will lead to beauty and success (Garner et al., 1980). Young females with the diagnosis of AN try to meet desired psychological goals, such as desirability, popularity, or achievement through self starvation (Bemporad, 1997). Hence, due to the overvaluation of thinness and dietary restraint along with overexposure to thin role models in the

media, in a report entitled *Eating Disorders, Body Image and the Media*, broadcasters and magazine publishers are called to "portray a more realistic range of body images." (British Medical Association, 2000). In a similar vein, the British Medical Association criticized the cult of "bodily perfection" preserved by the mass media in contemporary society. Additionally, in the report of the British government, it was stated that "Young women are tired of feeling second rate because they cannot match the thin ideal that they see so often in the media. For many, poor body image can lead to low levels of self-esteem; for some it is far more dangerous, leading to eating disorders and other forms of self abuse" (Morant, 2000). Therefore, the association also recommended in the report that media commissions should review their policy on the use of thin women in advertisements and schools should include media literacy programs to support critical viewing skills, specifically in the area of food advertising (Morant, 2000).

1.5. Cultural Perspective of Anorexia Nervosa

AN had long been considered as a disorder observed mostly among upper socioeconomic groups in industrialized societies (Bruch, 1981) and often in Western cultures where relative affluence and better social opportunities for people are available (Bemporad, 1997). Initially, the clinical findings on the subject had been substantiated by cross-cultural studies, which documented few cases in rural areas of Africa, the middle east, or the Asian (except Japan). Therefore, it was suggested that AN is a "culture bound syndrome", which means that the signs and symptoms of a disorder represent psychosocial characteristics of a certain culture (Bemporad, 1997; Davis & Nguyen, 2014). However, recent studies have refuted this thesis and presented that AN has been identified as more common in a wide range of ethnic, cultural, and socioeconomic groups than previously observed (APA, 2013; Dolan, 1991; Miller & Pumeriega, 2001). For example, a literature review indicated that AN is not a cultural-bound syndrome; their review showed that AN has been observed in every non-Western region of the world. It was also presented that the prevalence of AN is almost similar to that in Western nations (Keel & Klump, 2003; Yasuhara,

2002). This view is also supported by Davis and Nguyen (2014) in that AN is seen in different forms across different cultures and historical contexts. In the review of Miller and Pumeriega (2001), cultural factors have been defined as powerful contributors to the development of eating disorders. Prevalence and incidence rates of these disorders have varied across different racial/ethnic and national groups, the rates also have changed in time as cultures evolve.

Miller and Pumeriega (2001) investigated the role of culture as an etiological factor in the development of eating disorders. Historical and cross-cultural factors showed that cultural change itself is related to increased vulnerability to eating disorders, specifically when values about physical appearance are involved. Acculturation can occur in many ways, such as across time within a society, or on an individual level, for example when an individual moves into a new culture. For instance, in the study of Miller and Pumariega (2001), they provided an explanation from a sociological perspective and attributed these changes to the growing globalized interconnected world. As such, more individuals are subjected to these societal pressures common in Western culture emphasizing a thinner female body image. For example, they stated that recent immigrants and students of foreign exchange programs were at risk of eating disorders since they experienced a clash between cultures. It might have been more striking for adolescents who were abruptly separated from the family origin and expected to adjust to new social and familial interaction patterns and were in the phase of establishing their psychological and cultural identity (Miller & Pumariega, 2001). Or, in some Asian and Arab countries, increasing industrialization, urbanization, modernization, and globalization were found to be related with an increase in eating disorders (Pike, Hoek, & Dunne, 2014).

On the other hand, ethnic identity was reported to have a protective function against the development of eating disorders. For instance in the study conducted by Schooler and Daniels (2014) ethnic identity acted as a protective factor for Latina girls from the negative effects of viewing sexualized, thin ideal images. Similarly, in Kolar et al. (2016), it was stated that only a few cases of anorexia nervosa were identified in

their meta-analytic review, which might indicate that the Latin American culture might be a protective factor for those individuals. In comparison to other ethnicities, different body ideals, a curvier shape, and higher body weight were idealized among Latinas and Latinos. In accordance with this finding, the intense fear of weight gain, or in other words fat phobia, is less common among Latino groups and Asians (APA, 2013).

Consequently, it is beyond the scope of this study to provide a complete review of research concerning the history, prevalence, cause, and prognosis of AN. The current study is mainly concerned with the meaning and function of AN symptoms; therefore, the following section proposes a selection of the relevant literature on the etiology of AN. More than one approach or theoretical model was adopted as a framework to prevent any excessive influence of a certain model or approach on the analysis. By using multiple approaches as a constructional baseline, causing a biased interpretation of the researcher's account and attempting to fit the participants' experiences in a certain perspective are also avoided.

1.6. Etiology - Theoretical Explanations and Contributions

The etiology of AN have remained poorly understood even though the present models stress its multifactorial origin, multiple determinants, and risk factors and their interactions within the individual's developmental framework (Fairburn & Harrison, 2003; Garner & Myerholtz, 1998; Steinhausen, 2002; Keski-Rahkonen et al., 2007). For instance, explanations for the etiology of AN have started with the early psychoanalytic theories focusing on unconscious conflicts about sexuality and wishes for oral impregnation in addition to adolescent rebellion and regression to the oral phase of development (Freud, 1905, 1954; Waller, Kaufman, & Deutsch, 1940). Later, the emergence of object relations theory focusing on the role of early infant-mother interaction on the individual's development lead to a reconsideration of the fundamental basis of eating disorders (Kohut, 1971; Winnicott, 1953). Also, genetic and socio-cultural factors have been found to be related so far, but how and to what

extent the factors interact is not yet completely known (Treasure, Claudino, & Zucker, 2010; van Son, van Hoeken, Bartelds, van Furth, & Hoek, 2006; Walsh, 2013). In this section, the theoretical orientations explaining the etiology of AN, in accordance with the research question will be presented.

1.6.1. Cognitive Behavioral Theory

Cognitive behavioral theory mainly proposes an explanation on the maintenance factors of eating disorders, including a powerful need to control eating, a tendency to evaluate self-worth in terms of body shape and weight, and dietary restraints (Fairburn, Cooper, & Shafran, 2003; Fairburn, Shafran, & Cooper, 1998; Murphy, Straebler, Cooper, & Fairburn, 2010). Individuals with eating disorders have strict cognitive structures on the issues of weight and its implications for the self, which impact their perceptions, thoughts, affect, and behaviors (Vitousek & Hollon, 1990). In the cognitive behavioral approach of AN, the importance of the thinking patterns of individuals with AN are highly stressed (Fairburn et al., 1998). These ideas were also reiterated and extended by Garner and Bemis (1982). In their research, they applied the principles of Beck's cognitive theory and therapy of depression to patients with AN, and their study still holds the leading role in the cognitive behavioral therapy of AN (Garner & Bemis, 1982). Their model focuses on the role of information processing, self-representation, personality variables, and motivation (Garner & Bemis, 1982). Cognitive-behavioral therapy aims to change distorted beliefs about the individuals' weight and body shape, as well as to investigate the function of the symptom in interpersonal terms to build healthy behavior (Halmi et al., 2005).

However, the model does not suggest a pathogenic explanation of the phenomenological and interpersonal aspects of the disease (Amianto, Northoff, Daga, Fassino, & Tasca, 2016). Individuals with AN report difficulty in understanding their own and others' internal experiences (Rothschild-Yakar, Waniel, & Stein, 2013; Tapajoz Pereira de Sampaio et al., 2013). They suffer from an inability to feel and describe their emotions and bodily sensations, such as hunger,

satiety, and fatigue (Bruch, 1975). They do not feel and act as if they have an identity of their own and describe that they "do not even own their own bodies" (Bruch, 1975). Therefore, AN symptoms might function as a way of managing internal experiences related to a deficit of the self (Tasca & Balfour, 2014; Williams, King, & Fox, 2015). For this reason, in the following part of the study, the syndrome is investigated from the divergent theories and treatment philosophies addressing the internal experiences of individuals, such as Drive-Conflict Model, Freud's Classic Psychoanalytical Model, Ego Psychology, Interpersonal Theory, Object Relations Theory, Self Psychology, Attachment Theory, Feminist Theory, and Lacan's Psychoanalytical Perspective.

1.6.2. Drive-Conflict Model

The earliest explanations of AN were mainly about the oral characteristic of the disorder and its symbolic significance (Chassler, 1994). The syndrome was referred to as a defensive adaptation to greatly instinctualized unconscious fantasies of oral impregnation (Freud, 1905; Waller et al., 1940). In Waller et al. (1940), they explained the fantasy as the following: the mouth as the receptive organ of food symbolizes conception, the gastrointestinal tract symbolizes the womb, and the cessation of menstruation symbolizes pregnancy. From a classical psychoanalytical view, it was also claimed in the study of Scott (1987) that individuals with AN are psychosexually immature and the symptoms are the results of a failure to handle the biological and social demands of puberty. AN is considered to be a refusal of adult femininity: a rejection to accept the inevitability of becoming a sexually mature woman, a failure to deal with the problems of puberty, namely conflicts of sexual feelings and behavior.

1.6.3. Freud's Classical Psychoanalytical Perspective

From the early years of the psychoanalytical work, psychoanalysts have studied eating disorders to determine the psychological influences and the specific characteristics related to unconscious conflicts and motivations (Caparrotta &

Ghaffari, 2006). They have employed different ways to understand the unconscious and the symbolic meaning of the disorders, particularly of anorexia nervosa. The remarkable emphasis on meaning has shifted from internal conflicts to object relations and even to the family dynamics depending on the predominant theories and concepts of the time (Caparrotta & Ghaffari, 2006).

Sigmund Freud is one of the most well known and leading figures in the psychoanalytical field. Even though there is no indication in Freud's monumental writings that he specifically treated patients suffering from eating disorders, there are several references to eating problems in his writings (Caparrotta & Ghaffari, 2006). For instance, in 1893, Freud diagnosed one of his hysteric patients, Frau Emmy von N, with mental anorexia and stated that the patient ate very little and had the habit of hiding and throwing away food. During the treatment process, it became clear that her refusal of eating was related to her early unpleasant memories of being forced to eat food under the threat of punishment. She was also forced to eat with sick family members with disgusting habits and disallowed to express an affect of repulsion. Based on these presenting symptoms and past memories, Freud concluded that her symptoms were the result of an unresolved expression of distressing emotions caused by traumatic events (Freud, 1893; Caparrotta & Ghaffari, 2006). He pointed out that "every neurosis in an adult is built upon a neurosis which has occurred in childhood but has not invariably been severe enough to strike the eye and be recognized as such" (Freud, 1918). In accordance with this argument, Freud later proposed that a disturbance in one's appetite, which might have been unnoticed during childhood, "laid down the predisposition" to neurotic break down (anorexic behavior) later in life (Freud, 1918; Caparrotta & Ghaffari, 2006).

In another study of Freud (1893), he linked the eating disturbance of anorexia nervosa to melancholia, explaining that the affect observed in melancholia is mourning, which is longing for something lost. For this reason, melancholia is a question of loss, a loss in instinctual life, a loss of libido. Also, in melancholia, sexuality was underdeveloped. Freud added that in most of the young girls with anorexia, sexuality is underdeveloped

as well (Freud, 1954; Scott, 1987). Therefore, according to Freud, in sexual terms, the loss of appetite in anorexia refers to the loss of libido as in the cases of melancholia (Caparrotta & Ghaffari, 2006; Ruangsri, 2009).

In his later writings, Freud viewed anorexia nervosa from the perspective of drive, pathology of orality (Cosenza, 2016). He mentioned in his case of Dora, an adolescent who lost her appetite after encountering Herr K (1905). Freud linked her self-starvation and psychogenic vomiting to the unconscious fantasy of oral pregnancy (Freud, 1954; Caparrotta & Ghaffari, 2006). He proposed that it is not a fixation at the oral stage, rather it is a defensive regression against sexual fantasies of oral impregnation (Farrell, 1995; Ruangsri, 2009). In other words, in Dora's situation, the avoidance of genital sexuality is an unconscious solution to conflicts stemmed from fantasies of oral and poisonous impregnation. Similarly, in his later writings on sexuality, Theories of Sexuality (1905), On Sexual Theories of Children (1908), and On the History of Infantile Neurosis (1918), Freud revealed the fact that there is a connection between anorexia and hysterical disgust in terms of the refusal of food. Anorexia in adolescent girls might be an expression of an aversion to sexuality, and he proposed that eating disorders are types of hysterical symptoms and closely related to unresolved Oedipal conflicts (Caparrotta & Ghaffari, 2006; Ruangsri, 2009).

1.6.4. Ego Psychological Model

The ego psychological model, different from the oral impregnation theory, pointed out the role of weakness in ego development in individuals with AN (Chassler, 1994). The model argues that AN is a result of an impaired child-mother relationship in the early years of a child's life (Schwartz et al., 1982). Meyer and Weinroth (1957) emphasized that the fundamental conflict in anorexia was preoedipal, and they changed the focus of interpretation of phantasies of oral impregnation to a purpose for the reestablishment of mother-child unity. They claimed, "an exceedingly early disordered relationship between the child and the mother which establishes the intensely oral stamp of these patients and their gradually unfolding symptomatology" (Meyer & Weinroth, 1957).

1.6.5. Interpersonal Theory

According to the interpersonal theory of Bruch (1982a), AN is mainly observed in adolescent girls and young females from educated and prosperous families; and it is associated with a problem in the development of identity, sense of self, and autonomy. The individuals with AN have major ego deficiencies due to the chronically disturbed mother-child interactions. Bruch (1973) hypothesized that hunger is not innate, rather it is mostly learned; and the essential part of the feeding experience is whether the response to the infant's need was appropriate or was superimposed based on what the mother felt was needed, which was often incorrect (Chassler, 1994). When the mothers' responses to her infant's needs are inappropriate or contradictory, the infant will grow up without experiencing one's self in control of his/her own body and its functions; and s/he lacks the conviction of living one's own life. Such deficits in basic psychic orientation are the core issues underlying the psychological disturbances in the development of AN (Bruch, 1975).

Also, those individuals are perplexed when they try to differentiate between disturbances in the biological field and in emotional and interpersonal experiences. They lack awareness about their impulses, feelings, and needs (Bruch, 1981). They are impaired in their sense of separateness, with diffused ego boundaries, and they do not feel self-directed, but feel helpless under the influence of external forces; they even experience internal stimuli as externally induced (Bruch, 1975). They report a paralyzing sense of ineffectiveness, camouflaged by negativism and defiance, and is related to the perception of the self as behaving only in response to the demands of others (Bruch, 1981). The characteristics of individuals with the diagnosis were often reported as good, successful, obedient, and gratifying as children (Bruch, 1981, 1982a; Strober, 1980). However, with the onset of the illness, significant changes occur in behaviors, meaning that previously compliant children become negativistic, angry, and distrustful (Bruch, 1982a).

Furthermore, Bruch (1981) argued that the highly controlling and perfectionist parenting style limits an adolescent's opportunities for autonomous functioning and

the development of a clear and elaborated sense of self. When they encounter challenges in life, this lack of self-definition results in feelings of incompetence, self-doubt, and fear of losing control. Thus, in order to compensate the lack of a decent identity and associated feelings of powerless, the young individual focuses on the personally controllable, significantly prominent, and culturally appreciated domain of body weight for their self-definition (Bruch, 1981; Nunn, 2009; Stein & Corte, 2003). The extreme focus on body image is viewed as an attempt to deal with the lack of a stable and authentic sense of self (Bruch, 1982b). Bruch also suggested that the dissatisfaction with and obsession of body image presents a maladaptive 'search for selfhood and a self-respecting identity' (Stein & Corte, 2003).

Similarly, Selvini-Palazzoli (1974) proposed that anorexia derived from the mother's failure to meet and validate her child's need for autonomy and independence. The mother instead substitutes her own needs. In these cases, the mothers 'abuse and seduce' their daughters to comply with their needs; as a result, the daughters become obsessed with sensing out what others want and ultimately lose the sense of what they want. Accordingly, this lack of sense of self is exaggerated during the adolescence phase because this phase requires the individuals to develop an identity separate from their parents.

All in all, anorexia stems from parents' attitudes of imposing their needs on to their children (Sayers, 1988). If the parents do not encourage independence during the individuation and separation phase, the child will remain tied to the parents; he/she might be deprived of autonomy and decision making ability. Expressions of emotions are not encouraged and the individuals experience only a small range of emotional reactions. It is observed that they have a primitive helpless rage and anger that they kept in until the disease developed or even they were brought into treatment.

1.6.6. Object Relations Theory

The object relations theory highlights the distortions of the self and object representational structures. Several researchers elaborated the symbiotic attachments

that anorexic individuals have with their mothers and the incompleteness of the separation-individuation process (Chassler, 1994). Johnson and Conners (1987) wrote that some of the individuals with AN might experience parental overinvolvement as maliciously intrusive. They feel that their attempts to separate would have a consequence of active punishment. As a result, they establish a paranoid defense in which fat becomes the symbolic focus protecting them from intrusiveness that is perceived as malignant. In other words, fat becomes a concrete appearance of the parental intrusiveness; and fat becomes something that she could gain control over. Thinness is not for feeling aesthetically pleasing rather it provides a sense of safety. The misconception of body image provides a psychological organization to exist that gives the individual autonomy, control, and a sense of purpose and motivation (as cited in Chassler, 1994).

1.6.7. Self Psychological Perspective

According to self-psychology theory, the internalization of certain mental functions (i.e., capacity to provide one's own sense of security and comfort, self-esteem, and tension regulation…etc.) is important for the individual to develop the capacity to tolerate separation without psychic fragmentation (Chassler, 1994). The term self-object is an essential concept in self psychology (Kohut, 1971). It refers to an object experienced as part of the self, but at the same time, it is cognitively perceived as external to the self, similar to Winnicott's (1953) transitional object. Kohut (1971) emphasized the critical role of self-object parenting. It refers to emphatically mirroring the child's grandiosity and allowing for the idealization of the parental self-object features. In this way, the child's primitive grandiosity and idealization are altered into a cohesive self with positive self-esteem with healthy goals and ideals (Goodsitt, 1985; as cited in Chassler, 1994). In other words, a secure and genuine sense of self stems from the parents' acts as self-objects, reflecting and mirroring back to the child its initial grandiose sense of self. However, the lack of emphatic responsiveness might damage the internalization process, and as a result, a disorder of the self can occur. This approach is similar to Winnicott's work, advocating that

the child's integrated self-development depends on her mother's recognizing, reflecting, and meeting the infant's needs rather than forcing their own needs to their infants. When they behave that way, the infants comply with their mothers' needs and develop a "false self" (Winnicott, 2005). Considering these failures in mothers' holding behavior, especially emphatic mirroring, this might lead to the development of AN symptoms in the child's life (as cited in Sayers, 1988). From this perspective, AN is considered as a disorder of the self in relation to the separation and individuation issues. Individuals with the diagnosis have reported experiencing a lack of adequate and responsive self-object parenting; therefore, their internalization process has been distorted. Due to the deficits in self-regulatory structure, they become inadequate to separate. They have troubles in reliable self-soothing, mood, and tension regulation so they stay dependent upon self-objects for their well being (Goodsitt, 1977; as cited in Chassler, 1994). Also, individuals with the habits of self-starvation devote themselves to the care and feeding of others to deny their own self-object needs (Chassler, 1994).

1.6.8. Attachment Theory

The idea of attachment was proposed by John Bowlby; he created the theory on the origins of the infant's first bound to his or her mother (Bowlby, 1958). The essential point, according to Bowlby's theory, was the powerful relationship between the child's experiences and the parents, which impact the capacity to make affectional bonds later in life (Chassler, 1994). The availability and responsiveness of the attachment figure (Chassler, 1994; McMillen, 1992) are very important in helping the child to establish the sense of security that is required to begin developing the capacity to trust others (Bowlby, 1979). Bowlby (1979) concluded a relationship between the defected affectional bonding during childhood and the psychological troubles that people develop (as cited in Chassler, 1994).

Based on this point of view, AN is considered as a syndrome of impaired early childhood attachments. Individuals with the diagnosis of AN have lacked the sense

of security, trust, and confidence which is required to separate from their primary caregivers and explore the world (Chassler, 1994, 1997). The overcontrolling or undernurturing mothers caused the individuals with the diagnosis to give prime importance to proximity in interpersonal contacts (Minuchin, 1978). As stated above, those mothers strengthen symbiotic-like attachments and dissuade the separation-individuation process between themselves and their children. Mothers support dependency and fail to improve autonomy due to their inability to provide an adequate and secure home base from which the child could separate (Minuchin, 1978).

In addition, these ideas were supported by Henderson (1974). He categorized AN as a care-eliciting syndrome in families where food and eating are much stressed items. He stated that the refusal of food and emaciation are two strong signals that provoke anxiety and concern in their parents, and it brings the others closer. Expressing those emotions too much reinforces the symptoms. Therefore, it could be said that the symptoms of AN might be explained as a way of obtaining attachment and care.

Furthermore, in the study of Chassler (1997), it was reported that the onset of AN is related with the early attachment problems with caregivers; and it was found that the individuals with the diagnosis described their early attachment figures as significantly more unresponsive, unavailable, and untrustworthy. They recalled their mothers as discouraging the separation-individuation. They encountered repeated threats of separation in their early development, feeling responsible for their parents' happiness, and of being abandoned. Lastly, they reported feelings of being unwanted, alone, helpless, and of shame and guilt. This resulted in uncertainty concerning their sense of security, constant feelings of abandonment, depression, and helplessness (Chassler, 1997). All in all, the various theories consider AN as a protective adaptation to early childhood developmental failures. According to Chassler (1994), through the refusal of food, anorectics express not only their childhood conflicts and developmental failures but also hope to repair their unfulfilled needs with important early attachment figures in order to experience security, comfort, trust, and confidence.

1.6.9. Feminist Theory

Feminist theories pointed out that even though male psychosocial development is characterized by acknowledging the differences between the self and the caregiver, female development is associated with ongoing identification with the caregiver; thus, the distinction between the self and others is less obvious for women. As a result of this, greater internalization of cultural values and ideals regarding women's role in society, femininity, and weight are observed (Stein & Corte, 2003). As stated in Miller an Pumeriega (2001), the change in the role of women in society may impact the development of eating disorders among women. Therefore, it is not a coincidence that the increase in the prevalence of eating disorders has been parallel to noticeable changes in the role of women in Western culture and increasingly in other cultures around the world.

The emphasis in society on achievement and performance in females might increase the vulnerability to eating disorders. These contemporary emphases are in contrast with the traditional emphases of compliance, deference, and unassertiveness (Miller & Pumeriega, 2001). Furthermore, contradictory role demands in contemporary culture push women to be high achievers while maintaining their nurturance, femininity, and attractiveness, which may be a potential risk factor for developing AN (Gilbert, 1993).

1.6.10. Lacan's Psychoanalytical Perspective

Looking into the theory of Jacques Lacan, who is one of the most controversial and well-known psychoanalysts of the 20th century, his diagnostic criteria are based predominantly on Freud's work (Fink, 1997). However, while Freud highlights the importance of the dynamic aspect, Lacan redefines the Freudian concepts of drives and develops his theory from a structural point of view (Gessert, 2014; Romanowicz & Moncayo, 2014). He also keeps his differentiation among the fundamental clinical structures quite simple and employs only three main categories which are neurosis,

psychosis, and perversion to diagnose mental structures (Fink, 1997). All the remaining can be evaluated as symptoms rather than separate distinctive categories although the nature and function of symptoms change depending on which structure they appear. The differences among the structures can be distinguished on the level of the unconscious and Oedipal family structure, as well as on the individual's way to relate to language and the Other (Romanowicz & Moncayo, 2014). Therefore, according to Lacan, the best way to understand an individual is to describe the person in his or her complexity (Romanowicz & Moncayo, 2014).

Lacan, towards the end of his lessons, changed the focus of the analysis from truth to jouissance[1] and described the psychoanalysis of the 21st century as an era of *parlêtre*. "Parlêtre" is a concept and also a neologism; it is a combination of the word "parle" means "to speak" and "être" means "being" in French (Evans, 2006). It was invented and introduced by Lacan to explain that being is constituted in and through language. A human being is above all a speaking being, and the status of the speaking body is considered as a substitution for the Freudian unconscious. The shift from the centrality of the unconscious to the centrality of the parlêtre means that there is a movement from the concept of the symptom as a metaphor (representing a meaning) to the concept of the sinthome (representing jouissance without meaning). In that sense, the jouissance is condensed and/or centered in the speaking body. With this knowledge in mind, it is proposed that eating disorders are not symptoms of the unconscious in the classical Freudian sense, in fact, they are the symptoms of parlêtre (Miller, 2015; Cosenza, 2016).

In the Freudian perspective, symptoms are thought to belong to the unconscious, representatives of the unconscious. They convey a message beyond the conscious intention of the speaker. They have a meaning for the speaker and transmit some

[1] The French word *jouissance* basically means "enjoyment" in English, but there is also a part in the meaning that refers to sexual connotation (orgasm); therefore, the word is left untranslated in most English editions. Jouissance is defined as an enjoyment beyond the pleasure principle to a point where the pleasure becomes painful for the subject since there is only a certain amount of pleasure that the subject can bear. Therefore, the concept of jouissance expresses a paradoxical satisfaction that the subject gets out of his/her symptom (Evans, 2006).

unconscious and enigmatic signification, and the subjects seek to identify what this is in the analytical treatment. However, the symptoms in eating disorders are surely symptoms disconnected from the unconscious, or in other words, they are "unsubscribed from the unconscious." The symptoms do not express any meaning or unconscious messages for the subject who experiences them. They actually function as condensations of jouissance established in the body; therefore, the subject does not resist the symptoms and has an ego-syntonic relationship with them. The subjects do not experience and express the symptoms as an illness, but "as a style of living; not as a problem, but as a solution." Since the symptoms are associated with weak demand, they are resistant to medical or psychotherapeutic treatment; for this reason, they are considered as a "substantial refusal of the Other" (Cosenza, 2016). This relationship established with the Other is observed in different forms in the Lacanian clinical structures. Thus, when an individual comes into the treatment with the symptoms of anorexia nervosa, it is important to figure out the subject's unusual relationship with food because it represents the relationship with the Other.

For example, there are cases of anorexia developing in a paranoiac subject, as in the form of the classic delusion of being poisoned or of contaminated. The refusal of food intake, in this case, could be an example of persecutory defense characterized by an invasive, threatening jouissance coming from the Other (Cosenza, 2016). On the contrary, the explanation for the neurotic subject is a little bit different. The clinical scene of the neurotic subject is that s/he rarely questions their symptoms as something enigmatic, and they present a relation with their symptoms in which "they have neither any involvement nor any subjective responsibility" (Cosenza, 2016). In order to explain the disorder in the structure of neurosis, a case example of Freud, a hysteric patient, can be given. The case of the butcher's wife includes a short dream interpreted by Freud in *The Interpretation of Dreams* (1900) and later by Lacan in *The Direction of Treatment and the Principles of Its Power* (1958). The important point about the butcher's wife is that she keeps telling her husband for a long time; that she would love to have a caviar sandwich every morning. However, when her husband proposes to buy it, she rejects it determinedly and tells him not to spend

money on it. She, nevertheless, continues bothering him about it (Freud, 1900). What she does here is, from the Lacanian perspective, getting dissatisfaction; she deprives herself of jouissance; it is where she finds her satisfaction, in her sacrifice (Palomera, 2012).

Continuing with the same example, Freud states in his writing that one of butcher's wife's female friends likes salmon a lot, but she deprives herself of it too; she behaves in a similar way with the butcher's wife (Freud, 1900). When an individual desires something very much but deprives him/herself of that thing, the individual is simply continuing to desire that thing. In other words, once an individual rejects the thing wanted or desired, s/he keeps up the desire as unsatisfied (Soler, 1996). She could maintain her desire for it (Freud, 1900). Because she takes pleasure in being able to want it and in depriving herself of it. Strictly speaking, self-deprivation or self-restriction is itself pleasurable for her (Fink, 1997). Therefore, it can be concluded that there is a desire for deprivation in hysteria (Freud, 1900; Lacan, 1958; Soler, 1992). Accordingly, Lacan uses the idea of "the assumption of privation" as an expression to describe hysteria in his later teachings (Soler, 1992).

This case of hysteria presents the fact that the hysteric's relationship with food is ambivalent; they actually refuse the object of their desire to keep the desire alive. Also, they produce an affirmative jouissance condensed in their bodies through the refusal of food (Cosenza, 2016). Similarly, in the cases of AN, the subject's relationship with food is ambivalent as well; they essentially reject the object of their desire. The situation with food is the same as it is with sexuality: rejecting it. With this argument in mind, in the case of AN, food represents the desire of the subject, the subject keeps her desire alive by refusing food intake. In fact, the anorexic desire is the "desire of nothing." It is nothingness that manifests the inadequacy of every imaginary object which refers to the structurally metonymic inclination of human desire (Recalcati, 2013). The anorexic subject refuses the food precisely in order to maintain some space for her desire, some room for desire to subsist in. (Lacan, 1958). In other words, the anorexic subject's refusal of food is as a way of

controlling and resisting the demands of the Other because it is the only way that they can maintain themselves as desiring subjects (Silva, Pereira, & Celeri, 2010).

In the case of the obsessive anorexics, the individuals become stronger narcissistically when they get more capable of keeping the oral drive under control. The previously mentioned ego-syntonic relationship with the symptom supports the individual with adhering to their superego ideal of rigid control of the oral drive through the refusal of food, which results in an effect of jouissance in the body. It is seen in both of the structures that the jouissance acquired from refusing food is absolute and infinite; and for this reason, anorexics go close to death without realizing it since they pull along by this overdose of jouissance. By not taking food in, they refuse the inscription of the body by the symbolic and condense the jouissance in their own body (Cosenza, 2016).

Additionally, later in his teachings, Lacan introduced another concept for anorexia nervosa, the term "nothing", which corresponds to the enigma that covers the question of which object constitutes the cause in AN (Lacan, 1956/1957). This object of "nothing" is an invisible, unrepresentable object in the world. However, at the same time, it is all object at the root of the desire which Lacan calls "objet petit a/object little a" (Cosenza, 2016). The rationale of AN could not be reduced to an object because the object is never completely reachable in experience since it had been lost from the beginning, and settled at the very base of the life of desire (Cosenza, 2016). As Lacan proposed, 'nothing' as an object causes AN; and he disagrees with the belief that the anorexic subject does not eat, he states that the subject eats the object "nothing" (Lacan, 1958).

According to Lacan, this object of 'nothing' had a highly symbolic value in relation to the need for separation (Recalcati, 2014). The term refers to anorexic need for a lack of something, so as to reduce the omnipotence of his or her mother (Lacan, 1956/1957). Similarly, in Birksted-Breen (1989), it has been claimed that individuals with anorexia have a wish for and fear of fusion with their mother. The anorexic

individual is stuck in between the terror of aloneness and psychic annihilation. In a similar vein, Recalcati (2003; as cited in Rudge & Fuks, 2014) reiterated this idea and insisted that the individual's choice of eating nothing manages to turn this nothing into a barrier against the mother. The argument behind the hypothesis is that the paternal metaphor is very weakly engraved in individuals with anorexia, and the mother's wish is not sufficiently countered by the paternal function. The paternal function here represents the Other and the space between mother and the infant (Birksted-Breen, 1989). This is not a total foreclosure of the name-of-the-father; however, a weakness in the process of separation of the child from the mother. Eating nothing is a shield and a support to wishing. What it means is that the choosing of nothing means a subjective defense that is an attempt to separate from the mother (Birksted-Breen, 1989; Fortes, 2012; Rudge & Fuks, 2014). By opposing the requirements to eat, she builds a difference between the demand for food that the other has and the demand for love that is always directed to the void in the Other (Rudge & Fuks, 2014). Therefore, AN can be considered as a girl's attempt to have a body separate from her mother's body, and a sense of self which is separate from her mother. It can be concluded that AN is more than a disorder in relation to body weight, rather it is a state of relations that lie in the disturbance in the area of symbolization associated with a lack of a 'transitional space' with the primary object (Birksted-Breen, 1989).

Accordingly, as stated in Rudge and Fuks (2014), by highlighting the conceptual differences among need, demand, and desire, Lacan opened a new perspective to the understanding of AN and widened the scope of psychoanalytic practices in relation to their treatment. When looking at the life story of anorexic patients, the mother imposes herself with no room for the wish be created; she immediately responds to the demands of her child as if they were needs, without leaving the necessary space for the wish to emerge. In opposition to the mother's actions, the child rejects obeying her mother's command to eat, and the child demands of her a wish beyond itself because that is what the child needs to achieve his/her own wish (Rudge & Fuks, 2014). In other words, anorexia manifests the irreducibility of the field of the

need to the field of desire. Since the need is the need for something, but desire is desire for nothing, for the other thing, it is desire for the Other; therefore, it cannot be reduced to need (Recalcati, 2013).

Furthermore, it has been identified that there is a disturbed perception of the body image in individuals with the diagnosis of AN. Even though they think differently, others around them think that they have lost contact with reality. Encountering their image in the mirror is a painful experience for the subject, and it is repeated each time they come across. Here, what the anorexic subject encounters goes beyond the image in the mirror. She faces the judging gaze of the Other: in the judging gaze in the mirror, she sees the refusal of the Other. This refusal cannot be reduced to the typical judging gaze of an omnipotent mother, undivided by castration. Rather, this is the refusal of the Other as perceived between the subject and her own gaze that is not separated from that of the primordial Other (child's identification with his own image, narcissistic image in the mirror, ideal-I). In other words, the underlying process of AN belongs entirely to alienation, that is, identification with the image, as the Other desires it (Varhaeghe, 2004). The fact that this image is an object that is not lost in anorexia nervosa and is manifested by the gaze presents itself in the experience of the patient as a judgment without appeal. Therefore, what is seen in the anorexic subject is the subject's attempt to extinguish the desire from the body to destroy the disruptive, uncanny element from the body image, to kill it at its root. The subjects repeat it unconsciously, every time, there is something in excess to be eliminated in the body (Cosenza, 2016).

In summary, as it was stated above, according to Lacan, since the subject is constituted in the field of the Other, the process of constitution follows a different path of formation for each individual so that it can never be reduced to a pure and linear determination. Thus, it is important to apply a one by one, case by case approach to understand why a certain symptom takes hold in a subject's life. Also, while contemporary psychiatry considers eating disorders as a behavioral deviation in the subject's eating habits in comparison to statistically calculated norms, the

analytical approach accepts it as developing a solution for the subject, a solution that the subject cannot handle in any other way. They emphasize that the symptoms represent a symbolic meaning which is hidden in the singularity of the subject. In other words, exploring the level of subjective implication embedded in the symptom is essential because subjects do not develop symptoms via the same paths or for the same reasons (Cosenza, 2016). Hence, it is important to ask: "What function does this symptom have for the subject? or What purpose does the syndrome serve for the individuals?"

1.7. The Aim and Scope of the Study

In this thesis, it was intended to investigate the subjective experience of women living with anorexia nervosa in order to explore and understand the function of the symptom in their lives. Their perceptions of and reflections on their experiences with the meaning they attributed to the function of the symptom were examined. In other words, the researcher aimed to unfold and capture the diversity and similarity of participants' responses and describe the multifaceted function of the symptom. Also, how they expressed their thoughts and feelings about their symptoms were included in the scope of the study in order to facilitate a deeper understanding of the experiences of women diagnosed with anorexia nervosa. However, it is difficult to identify the meaning and function of a symptom when it is not acknowledged as a problem or when it is egosyntonic and valued. In individuals diagnosed with anorexia nervosa, the symptom is in an egosyntonic nature (Garner & Bemis, 1982; Gregertsen, Mandy, & Serpell, 2017; Nordbø, Espeset, Gulliksen, Skårderud, & Holte, 2006; Vitousek, Watson, & Wilson, 1998). It means that they are often not complaining about or uncomfortable with their condition and do not see it as a disease (Vitousek et al., 1998); therefore, the meaning that they attribute to the symptoms would be different from an outsiders' perspective. It would not be possible to get information about the meaning of the symptom on the person's life as in the way of quantitative scales, which are directed or evaluated from a certain predetermined point of view. In addition, the existing literature presents the prevalent

characteristics of women with AN as anxious, insecure, avoidant, dysregulated, inhibited, rigid, and inflexible, strict, and stubborn (Sjogren, 2017; Strober, 1980, 1981; Perkins, Klump, Lacono, & McGue, 2004). For this reason, considering all these studies and being aware of the characteristics of individuals with AN, studying the meaning and function of the symptom with such a unique group can be more effective and appropriate with a qualitative approach. Since the approach encourages the participants to express themselves freely so that it provides the researcher with a wide range of detailed knowledge on the respondents' experience with AN.

All in all, an interpretative phenomenological analysis (IPA), as a qualitative approach, was thought as the most suitable methodology for this research purpose. IPA is specifically practical and beneficial when the subject or the phenomenon examined is fundamentally "complex, ambiguous, and emotionally laden" (Smith & Osborn, 2015). In compliance with this knowledge, in a research conducted by Higbed and Fox (2010), it was reported that participants diagnosed with anorexia nervosa defined the disorder as "complex, uncertain, and often described as difficult to make sense of."

The reasons for preferring a qualitative approach, namely IPA, were explained below in detail, along with the information on the features of the general methodology. Also, the information on the research design and procedures applied were specifically provided.

CHAPTER 2

METHOD

2.1. General Methodology and Research Design

Qualitative methods are highly valued in clinical research because, compared to quantitative research, they render it possible for the researcher to deeply engage with the experience of the individuals while providing sensible detail and texture of the lived experience (Cromby, 2012). The approach provides the researcher with an opportunity to develop an idiographic understanding of the individual's subjective experience of living in a particular condition or being in a specific situation (Pietkiewicz & Smith, 2012). It specifically focuses on explaining the characteristics and features of experience or phenomenon in rich, comprehensive, and descriptive accounts (Pietkiewicz & Smith, 2012). In other words, qualitative research makes possible the ineffability of embodied experience that people are incapable of expressing or describing in predetermined words as in quantitative research (Cromby, 2012; Larkin, Watts, & Clifton, 2006; Smith, 2004). It aims to remain true to participants' perspectives as much as possible (Elliott, Fischer, & Rennie, 1999). Therefore, they have been considered as a reliable way to acquire knowledge that might not be reachable by quantitative methods (Espíndola & Blay, 2009). The central focus of the approach is to enrich understanding on certain phenomenon, rather than to test, verify the hypothesis, or place the phenomenon in a predetermined category or conceptual criteria, or to create causal explanation as in quantitative approach (Elliott et al., 1999; Pietkiewicz & Smith, 2012). Also, it leaves room for the researcher's own emotional responses aroused during the research process to interpret the emotions of respondents (Hubbard, Backett-Milburn, & Kemmer, 2001).

2.2. The Reason for Choosing IPA for This Study

In the last few decades, there has been a great increase in the use of the qualitative methodology in psychology (Reid, Flowers, & Larkin, 2005). IPA is one of those qualitative approaches (Smith, 2004). It represents an epistemological position and consists of a group of instructions for conducting research, and possesses characteristics and features of empirical research (Smith, 2004). As regards to its theoretical position, IPA provides detailed examination of personal lived experiences of individuals and how individuals make sense of and act upon their experience (Biggerstaff 2012; Eatough & Smith, 2008; Smith, Jarman, & Osborn, 1999; Smith, 2004; Smith & Osborn, 2015; Smith et al., 2009; Smith & Osborn 2003). Or in other words, it intends to understand the participants' world and to describe what it is like to experience that specific event, situation, or relationship and what meaning they attach to these feelings, claims, and concerns (Larkin et al., 2006). It is an "adaptable and accessible" approach; and it provides a complete and in-depth explanation that privileges the participant (Pringle, Drummond, McLafferty, & Hendry, 2011). Another aim of the IPA is to provide an understanding in relation to the social, cultural and theoretical context. This method presents the participants' lived experiences in their own terms rather than exhibiting them in predetermined theoretical conceptions (Smith & Osborn, 2015).

Additionally, the method allows the targeted phenomenon to speak for itself (Pietkiewicz & Smith, 2012; Willig, 2008), which increases the adequacy of data and interpretation (Elliott et al., 1999). Nevertheless, it is important to point out here that accessing the experience from the first-person (participant's) account is impossible, it is always built up by the participant and the researcher: It is the joint reflections of both the researcher and the respondent (Osborn & Smith, 1998; Smith, Flowers, & Osborn, 1997). Or in other words, understanding the participant's meaning attributed to the phenomenon is always dependent on the researcher's own interpretation of the participant's personal world (Smith et al., 2009). Thus, the approach is described as double hermeneutic (Smith, 2004). The researcher is deeply involved with the data as

much as possible (Pietkiewicz & Smith, 2012) and attempts to make sense of the individuals' experiences while those individuals try to make sense of their own experiences (Smith & Osborn, 2015). This could also be described as a two-stage interpretation process: the researcher decodes the meaning that the participant attributed (Smith & Osborn, 2008; Pietkiewicz & Smith, 2012; Pringle et al., 2011).

The fundamental objective here is to construct a "coherent, third-person, and psychologically informed description" to cover the participants' expressions as much as possible. Thus, IPA encourages the researcher to an active interaction with the participants (Jarman, Smith, & Walsh, 1997). As Willig (2001) stated, it leaves "room for creativity and freedom" for the researcher's subjectivity. What it means is that by allowing the researcher to deeply engage with the experiences of people, IPA gives the researcher a central role in understanding and interpreting the personal experience of participants, as well as forming rooted meanings and contextualized understanding in relation to their symptoms from a psychological perspective (Cromby, 2012; Larkin et al., 2006; Reid et al., 2005; Smith, 2004).

IPA is characterized as being "idiographic, inductive and interrogative" (Smith, 2004). Firstly, it is idiographic. It means that the main concern is to focus on one or a few individuals to generate a rich and detailed description and understanding of each participant's account (Morrow, 2005). Therefore, each case is investigated individually/in their unique contexts in great detail (Pietkiewicz & Smith, 2012; Smith & Osborn, 2007; Smith & Osborn, 2015). As recommended by Smith et al. (1999), themes are generated initially from the participants' own statements of their experiences and then these are used to formulate more interpretative themes before coming together to form clusters of related themes. This process occurs for each transcript before comparisons are made between them. Therefore, it has a constructivist stance (Morrow, 2005). Also, since case-by-case-analysis is intensive, detailed, and time-consuming, sample sizes are usually kept small (Larkin et al., 2006). For example, there have been studies published with one, four, nine, and fifteen participants. Additionally, there is no rule for the number of participants that

should be included; it usually depends on the research purposes, the depth and richness of analysis of an individual case, and the pragmatic restrictions (i.e., time constrains or accessibility of participants…etc) (Pietkiewicz & Smith, 2012).

Secondly, IPA is inductive (Reid et al., 2005); it is concerned with verifying or negating a hypothesis or any prior assumptions, yet it does formulate research questions. As stated above, it proposes to acquire knowledge on how the participants make meanings of their experiences. IPA provides a chance "to learn from the insights of the experts-research participants themselves"; and this lived experience is evaluated with a "subjective and reflective process of interpretation" (Reid et al., 2005). Also, the researchers using this methodology are expected to be flexible and open to any emerging new topics and questions/issues, and include them into the analysis (Smith, 2004), which corresponds to IPA's third characteristic, being interrogative. With respect to these characteristics of IPA, it could be concluded that IPA is beyond a simple descriptive analysis; rather, it places a great emphasis on the interpretative aspect of the analysis (Larkin et al., 2006).

2.3. Participants and the Sampling Method

For this study, the researcher formed a purposive and homogeneous sample consistent with IPA guidelines (Smith & Osborn, 2003). The aim for creating such a sample was to reach people sharing similar experiences of a certain situation or a phenomenon. Therefore, four inclusion criteria were determined. These were age range, education, city of residence, and gender. The participants were required to be women who resided in Ankara and had at least high school education (or higher) and aged between 15 and 30 years. Additionally, the primary inclusion criteria for participants was to be diagnosed with anorexia nervosa based on DSM-V criteria by a professional (either a psychiatrist or a clinical psychologist). Since eating disorders commonly coexist with other conditions, such as mood disorders, anxiety disorders, substance abuse, or depression (APA, 2013), the factor of comorbidity was ignored.

The reason for choosing this sample with these criteria was that anorexia nervosa prevalently begins during adolescence or young adulthood. It is not very common that the onset is before puberty or after the age of 40. The emergence of symptoms is generally associated with a stressful life event (i.e., leaving home for college, school stress, critical comments/criticisms related to physical shape, losses, traumas…etc). Also, it is known that anorexia nervosa is far less common among males than in females, with a female-to-male ratio of 10:1 (APA, 2013). Thus, it was believed that female participants of this age range would be the best representatives of the purpose of research.

Six female patients participated in the study. The age range of participants was between 16 and 27. All of the participants had suffered from the restrictive subtype of anorexia, the main symptom was a restriction on food intake/consumption (APA, 2013). All of them had their symptom debut. The participants had no prior history of diagnosis or any psychological intervention of anorexia nervosa symptoms/complaints. One participant was a high school student, two were graduated from high school, two participants were university students, and the last one was a college graduate, and all of them were unemployed. The marital status for all of them was single. The majority of participants had siblings and were residing with their families; their biological parents were together, and the mother was designated as the primary care-giver. All of the participants described their socio-economic status as moderate.

At the time of the data collection period, all the participants were in active treatment with psychiatrists and/or clinical psychologists for at least three months. The context for the treatment was public psychiatry service. In this study, treatment means individual psychotherapy with regular sessions every week or every other week. The psychotherapeutic approach was mainly based on cognitive behavioral therapy. Also, at the time of the interviews, four of the participants were outpatients, and two were inpatients. Lastly, participants' names, along with their identifying information, had been changed for confidentiality and to provide anonymity (Smith & Osborn, 2008).

Socio-demographic characteristics of the participants, including the ages of the participants and the length of time since diagnosis were listed in Table 1.

Table 1 *Descriptive Information about the Participants*

Name	Age	Type Of Treatment	Education	Time Since Diagnosis
Ela	16	Outpatient	Student enrolled in a high school	8 months
Yaren	18	Outpatient	Graduated from high school	6 months
Sinem	19	Inpatient	Graduated from high school	7 months
Busra	21	Outpatient	Student enrolled in a college	11 months
Selen	23	Outpatient	Student enrolled in a college	4 years[a]
Yeliz	27	Inpatient	Graduated from high school	6 months

[a]Her concerns have dramatically increased in the last month again

2.4. Procedure

Ethical committee approval for the procedures planned had been approved by the Human Subject Ethics Committee of METU (Appendices A). Since the data was planned to be collected from different sites, the study was also approved by AYNA Clinical Psychology Unit, Hacettepe University Hospital Non-Interventional Clinical Research Ethics Board, Gazi University Hospital Clinical Research Ethics Boards, and Dışkapı Yıldırım Beyazıt Training and Research Hospital Clinical Research Ethics Committee. Throughout the research design, the researcher followed the IPA guidelines (Smith & Osborn, 2003). The participants were reached through the collaboration with the clinical psychologists and psychiatrists working with the sample group either at a state hospital or at a private practice in Ankara, Turkey. The researcher didn't have any connection to the consulting institutions. The practitioners were informed about the study and asked to invite their female patients with the

diagnosis of anorexia nervosa who also fulfilled other research criteria to participate. In addition, an online announcement was made through social media and e-mail groups. Then, the researcher arranged a meeting (either via e-mail, telephone call, or face-to-face) with those who showed an interest and accepted to participate in the study. These initial meetings with the volunteer participants were short interviews and took around 10-15 minutes in order to determine if the participant met the inclusion criteria and to ensure the participant's own acceptance of the diagnosis, as well as to check if the participant was capable of expressing herself clearly. During these interviews, the volunteer participants were given detailed information both verbally and in written form about the aim, nature, and rationale of the study, including the content and research process, and were asked whether they would consider participating in the study under these circumstances. Also, the participants were informed about the terms of confidentiality and it was greatly emphasized, both verbally and in written form (Appendix B), that participation was voluntary and they could withdraw from participation anytime they wanted without any negative consequences on their treatments, which were totally independent from the research process. Afterwards, they were also asked whether they would agree with the audio recording of the interviews. All willingly accepted audio recordings, and written information and consent forms were obtained from the participants.

After the preliminary interview mentioned above, face to face, semi-structured, informant-centered, and in-depth interviews in accordance with the IPA requirements were conducted to explore the participants' self-understanding and articulation of their lived experiences (Smith, Flowers, & Larkin, 2009). There were a set of predetermined, but open-ended and non-directive research questions (Brocki & Wearden, 2006; Smith, Flowers, & Osborn, 1997). The questions prepared for the interview covered a wide range of topics relevant to the participant's life and the symptom (i.e., the history of their illness, turning points, their understanding of the illness, its possible functions, its impacts on their lives, as well as their feelings, attitudes or beliefs about themselves etc.) to obtain insight about the participants (Appendices C and D). Also, the researcher aimed to elaborate on the knowledge

provided. Therefore, during the interviews, the preestablished question list was not used strictly, the participants were encouraged to talk as freely and in a detailed manner as possible about their experiences (Brocki & Wearden, 2006; Smith & Osborn, 2008; Smith & Osborn, 2003; Smith & Osborn, 2007). Since, the interviews were designed to be less directive but more interactive, it was crucial to establish a good/strong therapeutic relationship/alliance. In order to attain this, participants' personal points of view were valued and any critical or questioning comments/judgments were avoided. Additionally, the researcher tried to obtain expressions as precise, comprehensive, and close to the participants' subjective experience as possible. Hence, she tried to confirm and clarify the participants' statements, for example, she investigated the exact or extended meaning of what they disclosed in order to strengthen the accuracy and validity of what was understood by the researcher.

The data collection took around eight months. The interviews took place at AYNA (METU Clinical Psychology Service), Hacettepe University Hospital Psychiatry Department, Gazi University Hospital Psychiatry Department, and Dışkapı Yıldırım Beyazıt Training and Research Hospital Psychiatry Department. Before giving the details of the sample, it is important to give information on the pilot study. Initially, a pilot study was conducted in order to guide the researcher to decide how best to carry out the interviews. Also, it was thought that using a pilot study would help the researcher to refine the questions and to figure out the proper ways to address the knowledge pursued. As a result of the interview, the participant of the pilot study mentioned no problem with the questions; she expressed that she could understand and answered the questions easily, and she did not feel uncomfortable with the content of the questions. Rather, she said the questions made her think deeply. Therefore, the researcher did not make any major modifications in the questions for the study. However, to ensure the quality of questions, the researcher added some sequential questions and partly rephrazed some of the questions to simplify their verbalizations based on the feedback received from the interview; since it was believed that such changes would lead to deeper response from the participants.

For this study, twelve participants were reached and first-interviewed by the researcher. Three of them were not included in the study since they have bulimia nervosa. Also, two of them were excluded from the study because they had binge-eating/purging type anorexia nervosa diagnosis. One of them is older than predetermined age range, she was 40 years old. Six of them met all the inclusion criteria and all of them accepted to participate in the study. Therefore, a total of six women formed the final sample of the study. Sample size and sampling method were consistent with the required conditions of IPA guidelines (Smith & Osborn, 2003). IPA requires an intensive and detailed analysis of each case; small sample sizes such as 2-10 people are preferred (Smith & Osborn, 2003; Smith, 2004; Smith & Osborn, 2007) because a small number of participants provides for a richer and in-depth analysis that may be hindered with a larger sample (Smith et al., 2009). Also, the sample size was determined based on the criteria of data saturation. Data saturation is achieved when no new themes emerge (Brocki & Wearden, 2006). Therefore, in this study, the sample size was kept small and this sample size was considered to be sufficient. Each participant was interviewed individually and only once (upon a single occasion) by the researcher and the interviews took around 93 to 103 minutes. Also, throughout the research design and evaluation/analysis process, notes were taken regularly by the researcher about the events, thoughts, and feelings that drew attention as interesting or significant about the participants' statements (Smith et al., 1999).

2.5. Data Analysis

Semi-structured interviews with open-ended and non-directive questions were conducted (Brocki & Wearden, 2006; Smith, 1996; Smith & Osborn, 2003) with six patients and all interviews were audio-recorded and transcribed verbatim by the researcher. The data was analyzed abiding by the guidelines of IPA (Smith et al., 1999; Smith & Osborn, 2003). Since IPA has an idiographic focus, the analysis of the data was done case by case, which requires focusing on a detailed examination of one case and then moving on to the analysis of the other one (Smith, 2004). Hence, the data analysis process began after the first interview was conducted. After the

transcripts were documented as raw data on a text, the researcher read the transcripts several times to become familiar with the nature of the data. This phase is important because each reading brings up new insights (Smith et al., 1999); the researcher can immerse him/herself in the data, recall the atmosphere of the interview and the setting in which the interview was conducted (Pietkiewicz & Smith, 2012). After that, a detailed and comprehensive idiographic case analysis started with a close interpretative reading of the transcript of the first case and explanatory notes (ie., initial thoughts, observations, reflections, and explanations) on the responses of the participants were noted in the left margin. Those comments could be summarizing, descriptive, or initial interpretations, associations, and connections of the researcher (Smith, 1999; Smith, Michie, Allonson, & Elwy, 2000; Smith et al., 1999). Additionally, in this study, the researcher used the traditional method of pen and paper (Pietkiewicz & Smith, 2012).

Afterward, the researcher moved on to search for and identify themes that best capture and fit the important features of the interview. Then, the themes were examined for connections between them to create a list of subordinate themes by clustering them together (Biggerstaff, 2012; Smith et al., 1999). The subordinate themes were gathered to identify super-ordinate themes for the first interview. Then, the subordinate and superordinate themes that occurred were listed for the first case; the final version of the theme table was completed for the first case. The noted remarks regarding the observations of the research process were included in the analysis. The same analysis procedure was followed out exactly the same way for the remaining case interviews. After analysis had been conducted on each case, as the final step, cross-case comparisons were performed in an attempt to specify patterns; and a master themes table was created for six recurrent and mutual themes across six cases (Smith & Osborn, 2007). This table includes the main features and concerns addressed by the research participants.

Lastly, the list of subordinate, superordinate, and also the master themes with the interview transcripts were reviewed and controlled collectively by both the research

team and the researcher to make sure that the conceptualization of the participants' statements was well represented and covered as accurate and comprehensive as possible by the themes created. The master table consisted of six themes. The first theme was "food deprivation as a substitute for privation of love and care." The second theme was "food deprivation to compensate for the feelings of loss of control and freedom." The third theme was "receiving love and care from the family: repairing the broken relationship." The fourth theme was "others as a reference point: the importance of others' thoughts and acceptance." The fifth theme was "is anorexia nervosa the only way out? expressing resentment and anger through punishing others." Finally, the last theme was "distracting attention away from relational problems: "I was dealing with what I ate to keep my mind occupied." The themes were written in a narrative account. They were explained and exemplified by the related quotations from the transcripts (Smith & Osborn, 2007). The extracts/excerpts were provided both in English and Turkish in the "Results" section.

2.6. Trustworthiness of the Study

The quantitative approach has a positivistic epistemology and is interested in observable and measurable phenomenon; hence, it uses reliability and validity as its tools (Creswell, 2003). However, the qualitative approach follows a constructivist epistemology, which takes into account the subjective perspective of the participant and the researcher as well as accepting the subjective nature of data and analytic processes rather than searching for "an objective reality" (Lythcott & Duschl, 1990; Morrow, 2005). Trustworthiness is one of the quality standards for conducting qualitative research, which includes reflexivity, subjectivity, adequacy of data, and adequacy of interpretation (Morrow, 2005).

The qualitative approach acknowledges that data collection and data analysis process are subjective in nature; therefore, subjectivity is not something controlled, limited, or managed, but instead, it is used as a source of data because it improves the quality of research (Morrow, 2005; Patton, 2002). The approach considers the researcher as

an integral part of the process (Biggerstaff, 2012). It is agreed that the researcher's perspective and the way that s/he understands the world inevitably influences the research process (Patton, 2002). For this reason, the researcher's reflexivity becomes a critical component in this approach in order to be aware of the impact of his/her own perspective on the research (Patton, 2002). However, since the approach acknowledges that the researcher is not neutral, it is impossible for the researcher to simply put aside his/her point of view (Elliott et al., 1999). Therefore, the researcher is suggested to use "bracketing" practice, which is a process of being aware of his/her own values, biases, assumptions, predispositions, and experiences about the subject matter and revealing them to the self and others throughout the research procedure, from the beginning of the research design up until the presentation of the data (Briggs, 2010; Fischer, 2009; Morrow, 2005; Willig, 2008).

Bracketing can be ensured by the researcher's disclosure of his/her theoretical and personal orientation and personal anticipations; description of personal experiences and training related to the subject matter; clarification of the social/cultural context of the study; explication of the subjective processes of the researchers, as well as close involvement with the data, and asking for descriptions and examples from the participants (Elliott et al., 1999). The theoretical framework of this study was established upon interpretative phenomenology as described by Heidegger (as cited in Gearing, 2004). There are six different types of bracketing. These are ideal (philosophic) bracketing, descriptive (eidetic) bracketing, existential bracketing, analytical bracketing, reflexive (cultural) bracketing, and pragmatic bracketing (Gearing, 2004). In this study, existential bracketing was employed (Gearing, 2004). In accordance with the requirements of existential bracketing, the researcher put aside/held in abeyance her assumptions and described/depicted her clinical interest as her research praxis for bracketing. Also, as for the reintegration phase, she unbracketed the bracketed data and interpreted the themes in compliance with her clinical and theoretical orientation.

I will describe my clinical interest and experience with anorexia nervosa as research praxis for bracketing. As the researcher of the study, I became interested in eating disorders when I began to work on Lacanian Psychoanalysis. I had a chance to examine and understand my own relationship with food while going through my personal psychoanalysis. I realized that eating behavior has had a symbolic meaning for me. I have never had an eating disorder, but since my adolescent years, I have always had a problem with binging. Therefore, I have been working on the meaning and function of binge eating for me during my time in psychoanalysis. I have come to an understanding that binge eating was my way of coping with my unpleasant emotions. The more I worked on my eating tendency and reading on this subject, the more I got curious about the underlying motives and urges, or in general terms, the etiology of the symptom. Additionally, I wondered what was behind the symptom that makes people maintain this symptom. During these times, I thought that eating habit (no matter if it was binging, purging, or restricting) was serving a purpose, it had a function somehow in people's lives.

Furthermore, my clinical orientation is psychoanalysis, specifically Lacanian psychoanalysis; and I am conducting psychoanalytically oriented psychotherapy. Therefore, I conceptualized that the eating behavior of individuals might have a symbolic meaning and function for them. Thus, they rigidly hold on to those symptoms. Also, during this research process, I tried to pay attention to the data related to personality traits, family relations/dynamics, traumatic memories/major life events, and defense mechanisms.

Moreover, I consider myself as an outsider within the scope of this study; however, I was a close observer of AN experience. My former relation to this experience, I believed, might have been an opportunity for me to conceptualize and understand the experiences of women living/diagnosed with AN. It may have been easier for me to isolate myself and deepen what they told me. At this point, I would like to be transparent and mention my personal experience with AN and explain how my clinical interest developed on AN, which gave me the motivation to conduct a

research on this subject. Throughout the time I spent in psychoanalysis, I talked about my sister's eating habit as well, which was just the opposite of what I tend to do. She was always thin and had never been diagnosed, but during her high school years and especially in the first year of college, she lost weight dramatically. At the time, we, as her family, felt worried and frightened for her health, because she was barely eating. However, her situation had never become an issue in the family, she was never taken to a doctor for this, it was thought by my parents that she was stressed because of school work. Besides my interest in eating tendency, this situation of my sister was very influential in my later decision to study eating disorders, especially anorexia nervosa. Because, over time, I believed that the emotional pain she was in back then was not realized/understood at all, and she got well/recovered on her own. This thought of how she might have been feeling in those days still makes me feel sad. Starting with this touching memory, I developed an interest in the mechanism behind that anorexic propensity. I aimed to explore its nature from the experiencer's perspective. As a result, being aware of my past experiences and clinical and theoretical orientations, the research topic stems from this context: the meaning and function of anorexia nervosa.

I adopted an inductive approach in order to be flexible and open to the emerging issues participants brought in. I asked open-ended and non-directive questions; and participants opened up new topics related to their understandings of the function of the symptom, such as developing a new and healthier relationship with their family. This formed one of the superordinate themes. In this study, I also tried to approach the process reflexively by revealing my emotions and using them in the analyses of the cases. In the literature, it was stated that keeping a reflexive diary on the thoughts and emotions arisen during the observations of and interviews with the participants was especially important. Since it helps the researcher to repeatedly examine what her assumptions and understandings were and how they might impact the analysis in order to avoid imposing meanings (Fischer, 2009). This attitude also provides her readiness to be open to anything that comes up rather than prejudging or predetermining of research findings (Finlay, 2008). The notes were used in the

analysis of the cases by revealing them in the results section in order to represent the research process reflexively.

In complying with this, from the beginning of the research design, I took notes on my thoughts and emotions evoked during the interviews, which formed a reflexive diary. The most significant/explicit emotion I felt was a worry for them because I felt that they were so into their gainings from the symptom that they were not realizing the irreversible damage they do to their psychological and physical health. I sometimes felt sad while listening to the emotional pain they are in, especially on the topics of how neglected/ignored or pressured their needs and emotions were by their closest ones. I felt the urge inside me to tell them they have a beautiful soul and they are precious as they are. I wanted to empower them to improve their self-esteem/self-confidence. Similar to these, another powerful feeling that I felt was anger towards their parents; I felt helpless. On the other hand, I was very surprised that the participants were willing to talk and did not show any resistance or any negative reactions during the interviews. They reported that they enjoyed talking, and in fact, one of them told me towards the middle of the interview that she would like to talk about her parents about whom she refused to talk at the beginning of the interview. Also, two of them reached out to me a few months after the interview and asked whether they could start individual therapy with me. I thought these were signs of a good therapeutic relationship established between us.

One other strategy suggested for reflexivity is to form a research team or peer debriefers or peer researchers (Elliott et al., 1999; Morrow, 2005). Forming a research team to consult at the different levels of analysis was thought to be essential because it enhances the credibility of the study. The research team for this study, apart from the researcher, was composed of two thesis advisors, and three Ph.D. candidate clinical psychologists who are experienced in qualitative research. The research team read the transcripts with noted themes, the quotations, and the reflexive diary; and then they discussed and updated the subordinate and superordinate themes. In the end, all themes were verified by the research team to make the analysis process clear and easy to understand. Also, the direct excerpts for the themes were presented to improve the

credibility. Furthermore, respondent's socio-cultural background, their surroundings, and the environment they live in were also taken into consideration to increase the trustworthiness of the study (Morrow, 2005).

In the following section, the meaning and function of the symptom of anorexia nervosa explored by in depth interviews were presented and main themes derived from IPA were revealed.

CHAPTER 3

RESULTS

In this part, the meaning and function of the symptoms of anorexia nervosa were presented in light of the themes derived from IPA. By condensing various text excerpts coded as the function of AN behavior, six themes were detected. These were "food deprivation as a substitute for privation of love and care; food deprivation to compensate for the feelings of loss of control and freedom; receiving love and care from the family: repairing the broken relationship; others as a reference point: the importance of others' thoughts and acceptance; is anorexia nervosa the only way out?: expressing resentment and anger through punishing others; distracting ttention away from relational problems: "I was dealing with what I ate to keep my mind occupied." The superordinate themes were also listed in Table 2. In this section, each superordinate theme was described, and extracts from the participants' accounts were also provided in the related sections.

Table 2 *Themes of interpretative phenomenological analysis of experiencing AN in women with the diagnosis*

1. Food deprivation as a substitute for privation of love and care
2. Food deprivation to compensate for the feelings of loss of control and freedom
3. Receiving love and care from the family: Repairing the broken relationship
4. Others as a reference point: The importance of others' thoughts and acceptance
5. Is anorexia nervosa the only way out? Expressing resentment and anger through punishing others
6. Distracting Attention away from Relational Problems: "I was dealing with what I ate to keep my mind occupied

3.1. Food Deprivation as a Substitute for the Privation of Love and Care

This first theme was reflecting that AN symptom was a substitution for the privation of (unconditional) love and care in the family. In this theme, participants were referring to deprivation of love, affection, support, and communication in their relations with their mothers. Their perceptions of mothers' characteristics were "dominant, authoritative, distant, and rigid" prior to the diagnosis. The mothers did not show much affection to their daughters. For example, Sinem expressed:

> "I think my mother is already a cold person even towards her other daughters. For example, if I got a beating from anyone, it's probably from my mother and those behaviors of her affected me a lot. Those days, I used to feel like I was adopted. I always felt like I was adopted when it came to my mother. As I said, I don't remember when she loved me, I mean, she was the one who said you work so hard and nothing happens. Or when I would go outside, I apologize but I must say this, she once called me a slut. I took that to heart so much that months later I went outside once. Then I stopped going out. She never showed me any love."
>
> *"Annem zaten soğuk biri öbür kızlarına karşı da soğuk biri bence. Mesela birinden dayak yediysem ben annemdendir ve onlar beni çok etkiledi. O zamanlarda kendimi evlatlık gibi düşünürdüm, annem tarafından hep evlatlık gibi düşündüm. Ne zaman dediğim gibi beni sevdiğini hatırlamıyorum, dediğim gibi bu kadar çalışıyorsun da olmuyor diyen de oydu veya dışarı çıktığımda kusura bakmayın bunu söyleyeceğim sürtük demişti bir kere. O kadar ağırıma gitmişti ki ben yani aylar sonra bir kere dışarı çıkıyordum sonra zaten çıkmadım da. Bana hiç sevgi göstermiyordu annem."*

Sinem continued and explained her feelings on her mother's love, which she described as conditional, and she defined their relations as distant.

> "I wasn't her daughter when I didn't help her out, I was her daughter when I removed dust. She would talk sweet. I was like an object, a used object. Yes, I would make people happy when useful, but tossed aside when not useful. Something like that. I mean, my mother and I were never close, not really. Bit by bit I felt this with my father as well. I felt it with my mother first."
>
> *"Yardım etmediğim zaman kızı değildim, toz aldığım zaman kızıydım. Tatlı konuşurdu. Ben bir obje gibiydim. Kullanılan bir obje, işe yaradığım zaman tamam, mutlu ediyordum insanları ama işe yaramadığım zaman at gitsin gibi bir şey. Yani annemle hiç yakın olamadık yani gerçekten olamadık. Bunu yavaş yavaş babamda da hissettim, ilk önce annemde hissediyordum"*

She also described the feeling of worthlessness and withdrawal of affection in her relation with her mother. She disclosed a wish to have a close relationship with her. She reported:

> "I really wanted to be close to my mother, I really wanted to spend time with her. I envied other mothers and daughters, for example, my aunt, but we could never be like that. I would go to her when she cried and such, I would be the only one to go, but it felt like she didn't love me. My mother would never show me any affection. None. My father was all right, but my mother wouldn't! She would show it to her mother, to her father, to my cousins, to someone else's child. There wasn't any left for me, it wasn't enough for me. There was even enough for my sister. When it came to my mother, I always felt worthless, like my birth was an accident."
>
> *"Annemle yakın olmayı çok istedim, annemle vakit geçirmeyi çok istedim öbür annelerle kızlarına çok özendim. Teyzeme mesela çok özendim ama olamadık yani. Annem sevmiyor gibiydi beni. Ben giderdim falan ağladığında bir tek ben giderdim yanına ama o sevmiyordu sanki beni öyle hissediyordum. Bana hiç sevgi göstermiyordu annem. Hiç. Babam neyse de annem hiç göstermiyordu ya. Annesine gösterirdi, babasına gösterirdi, kuzenlerime gösterirdi, başkasının çocuğuna gösterirdi, bana kalmıyordu, yetmiyordu bana. Ablama da yetiyordu. Ben hep değersiz hissettim annem konusunda, yanlışlıkla olmuş bir çocuk gibi hissettim."*

Similarly, Büşra described her mother as distant and dominant:

> "My mother was always distant, perhaps my doctor has told you, you know, my mother and I are very distant. For example, my mother really insists on having people do what she says. She is a very authoritative woman and a little dominant. You see, my father is dominant, but I can say she is a little more dominant than him, I mean, dominant over us. At home, she has more influence over us."
>
> *"Annem zaten hep mesafeliydi doktorum belki anlatmıştır, hani annemle çok mesafeliyiz biz. Mesela annem dediğini yaptırmaya gerçekten direten bir insan. Çok otoriter bir kadın, biraz baskın da bir kadın, yani babam baskın ama babamdan da biraz baskın diyebilirim, yani bizim üzerimizde baskın. Evde biraz daha böyle bize sözü geçer."*

Büşra further explained how her mother had an impact on her other relations in the family.

> "My mother fuels my father, I mean, she constantly says 'your daughter is doing this and that, treat her like this, treat her like that, she wants to go here don't let her go because she doesn't do what we say' and straight-up fuels

my father and my father gets roped in and, you know, we can be on bad terms with him too.

Researcher (R): so your mother influences him?

Participant (P): I mean, as I said, she influences everyone since she is in the center. As I said, my brother is very fond of my mother; he takes a stance depending on my mother's position. I mean, towards me, if my mother says 'a' it's a, if she says 'b' it's b for him."

"Annem babamı dolduruyor yani sürekli 'kızın şöyle yapıyor, kızın böyle yapıyor, kızına şöyle davran, kızına böyle davran, işte şuraya gitmek istiyor gitmesine izin verme çünkü o bizim dediğimizi yapmıyor' gibi direk babamı dolduruyor ve babam da tabi bu dolduruşa geliyor ve yani onunla da kötü olabiliyoruz

Araştırmacı (A): etkiliyor annen yani?

Katılımcı (K): yani dediğim gibi merkezde olduğu için herkesi de etkiliyor. Küçük kardeşim dediğim gibi çok düşkün anneme; o mesela annem ne cephe alırsa ona göre şekilleniyor. Yani bana karşı annem 'a' dese a oluyor 'b' dese b oluyor kardeşim için."

Büşra also talked about her difficult relationship with her mother and emphasized that she felt more pressure from her mother than her siblings because she thought that she was introverted and therefore, she could not oppose to her. She reported that her mother was criticizing and insulting to her. According to her, the humiliation and pressure from her mother might have affected her sense of self and led her to be introvert.

"Sometimes they have fights with my elder brother, sometimes with my younger brother as well, but she is more dominant towards me because I have a more silent nature, so she puts more pressure on me. My brother can oppose her but she can even make me do things that I don't want to do. When they say they won't do it, they can get away with it, but she is able to make me do them, I mean, whether I like it or not, even if she has a certain attitude towards them as well, I can't oppose. My weakness is her words like 'idiot' or, like, 'naive' and such. For example, she finds my smallest mistake and uses it. With a small mistake I made, she directly held it against me and tried to break me down, for instance. For example, 'you are not like this around people, you are naïve, you don't even express yourself in other environments, nothing will become of you' and so on. She tries to tear me down with these words or with violence. My mother already had a tendency towards violence ever since our childhood, maybe that's why I am introvert. That could have triggered me as well."

"Abimle de bazen kavgaları oluyor, kardeşimle de oluyor ara sıra ama bana çok daha fazla baskın çünkü benim biraz daha sessiz bir yapım olduğu için benim üzerime daha fazla geliyor. Onlar karşı gelebiliyor ama benim yapmak istemediğim şeyi bile bana yaptırabiliyor onlar yapmayacağım dediğin de yapmayabiliyor ama bana yaptırıyor, yani istemesem de, onlara da tavrı olsa da, ben karşı koyamıyorum. Benim zayıf noktam olan işte 'geri zekalı' işte 'saf' bu lafları falan da. Ya da benim küçücük bir hatamı buluyor mesela o hatamı da kullanıyor. Yakın bir zamanda yaptığım bir hata mesela o, onu direkt yüzüme vurarak beni oradan yıkmaya çalışıyor. Mesela 'sen ortam içinde hiç şöyle değilsin, sen safsın, sen ortamın içinde kendini bile belli edemiyorsun, senden ne olur ki' böyle mesela. Bu laflarla beni yıkmaya çalışıyor ya da şiddetle. Annemin zaten bizim çocukluğumuzdan beri böyle bir şiddet eğilimi vardır, belki bu yüzden de içime kapanık olabilirim, o da beni tetiklemiş olabilir."

Selen mentioned her mother as insensitive/emotionless and reported that they often had conflicts and misunderstandings in their relations.

"She was an emotionless woman. I admire her but that's probably it regarding personal characteristic. She was a little arrogant, I mean, it could be my arrogance as well. There were conflicts between us. Besides, she would misunderstand me a lot, as if she interpreted everything backward but to me, it was like my mother's natural state. Yet, she wasn't, you know, bad."

"Duygusuz bir kadındı. Onu takdir ediyordum ama o kadar heralde kişisel karakteristik özellik olarak. Biraz ukalaydı o, yani benim ukalalığımda olabilir. Çatışma oluşuyordu aramızda. Onun dışında beni çok yanlış anlardı sanki, tersten alabilirdi her şeyi ama bu doğal hali gibiydi benim için annemin ama öyle yani kötü değildi."

As it was seen that the participants described problematic relations with their mothers and criticized them; however, they usually idealized and valued their fathers and their relations with them. For instance, Sinem revealed:

"But I was really good with my father, I mean, I'm a real dad person, never been a mom person. We were always on good terms. I would get encouragement from my father, be spoiled by him, I would take everything from him. I always had good relations with him, I love my father a lot."

"Ama ben babamla çok iyiydim, yani tam bir babacıydım, anneci hiç olmadım. Aramız hep iyiydi babamdan yüz alır, babamdan şımarıklık alır, her şeyi babamdan alırdım. Ben onunla hep çok iyiydim, çok seviyordum babamı"

Or Selen expressed:

"We are really good and close with my father, my father is really loving, what people would call fatherly. He spoils me a little and is very fond of me. Throughout my life, he was never restricting towards me, always accepting, always approaches me saying "whatever makes you happy." Perhaps my mother was the more idealistic, more rule setting, more restricting side."

"Babamla baya iyidir, yakınızdır, babam sevecendir, babacan dediklerindendir. Biraz şımartır da beni düşkündür bana. Hiç kısıtlayıcı da olmadı bana hayatım boyunca, hep kabul edicidir, hep 'sen nasıl mutlu olacaksan' diye yaklaşır. Annem bir tık daha idealistti heralde hep daha fazla kural koyan, kısıtlayan taraf olmuştur."

In Büşra's statements, it was seen that she favored her father over her mother. She was blaming her mother for the same behavior she was tolerant towards her father.

"R: Do you think them leaving was like a punishment because you didn't eat?

P: Not my father, but my mother was a bit like that

R: Do you think he was influenced by your mother? Would he have not done it?

P: My father is really influenced by my mother because whenever something happens my mother immediately flames up. She does it out loud on purpose when she says 'why are you doing this, why are you doing it like that' and so on. She purposefully voices her thoughts. She does this so my father can hear, I mean, she wants someone to stand behind her and when my father sees this reaction he doesn't side with me but with my mother."

"A: Yemediğin için ceza gibi mi olmuş biraz bırakıp gitmeleri?

K: Yani babamın değil de annemin ki biraz öyle

A: Annenden mi etkilendiğini düşünüyorsun babanın o yapmaz mıydı?

K: Babam gerçekten annemden çok etkileniyor çünkü annem bir şey olduğunda direk parlıyor. Diyor ki bilerek sesli söylüyor yani 'şunu niye yapıyorsun, şunu niye böyle yapıyorsun' falan diye düşüncelerini sesli aktarıyor. Bunu da babamın duyması için yapıyor, yani birinin onun arkasında durmasını istiyor. Hani tek başıma kalmayayım, yalnız kalmayayım diye. Arkasında durmasını istiyor ve babam da bu tepkiyi görünce benim yanımda olmayacak annemin yanında oluyor."

Furthermore, participants expressed deep sadness and loneliness upon their distant and troubled relationships with their parents prior to the symptoms/diagnosis. For instance, Sinem expressed that "I couldn't be like 'mother and daughter' with my mom, I couldn't be like 'father and daughter' with my dad." [*"annemle anne kız gibi olamadım, babamla baba kız gibi olamadım"*] Or Yaren was complaining about her parents' restrictions and not being able to please them. She was describing a lack of support and communication going on in the family. She also reported that she felt suffocated and started to hurt herself, and she described her psychological health as bad during that time.

> "I wasn't already well, I came to the psychiatrist a lot. Two or three years ago I used to hurt myself, we used to have domestic problems. My parents are very oppressive. I was suffocating and began to hurt myself. They wouldn't let me go out, once in a blue moon I would sit in front of the door with my friends and they wouldn't allow it. For example, my mother would complain about me saying 'you are of no use, you come home and lie down and stuff, you play with your phone.' I'd do it but it wouldn't be enough. I would do housework, arrange the dishwasher, spread the sheets, do the ironing if there were any, but I could never ingratiate myself. It's also like this right now, for instance. It's very… you know how they say old-fashioned, they are like that because they haven't experienced it. In their time, there was no such thing as hanging out with friends, going outside. We would fight constantly, I would get fed up, I would react at these things, I would close myself in my room, lock myself in. I remember not seeing my parents' face for 2-3 days. Two or three times I took pills because I wasn't well, I mean, I was mentally depressed until two or three years ago. I feel a bit more recovered now. I don't have stupid thoughts like hurting myself. I don't even know why I did it at the time. I would razor myself, cut myself. For example, we would fight for no reason, constantly argue, you see, my mother would constantly complain saying 'gather that, pick this up, do this, do that, and I would do the work. Then I would want to go out but she wouldn't let me, I got fed up. I mean, it's possible to talk nicely, right? In the end, there is talking nicely and there is yelling and screaming and beating, threatening to take you from school and I was fed up with these. I would think of what to do, what to do. My psychology really wasn't well, at every turn I struggled to commit suicide."

> *"Zaten ben iyi değildim, çok geldim psikiyatriye. İki üç sene öncesinde falan kendime zarar veriyordum, ailevi sıkıntılarımız oluyordu. Annemgil çok baskıcıdırlar, bunalmıştım artık kendime zarar vermeye başlamıştım. Dışarı çıkmama izin vermezlerdi, arkadaşlarımla kırk yılın başında kapıda oturacak olurdum izin vermezlerdi. Mesela annem işte 'bir işe yaramıyorsun, işte geliyorsun eve yatıyorsun bilmem ne, telefonla oynuyorsun' falan derken çok şikayetçi idi benden. Yapıyordum ama*

yaranamıyorum. Ev işlerini yapıyordum, makineyi dizerdim, çamaşırları sererdim, ütü varsa ütü yapardım ama yaranamadım hiçbir şekilde. Şu anda da öyle mesela. Çok şey…derler ya eski kafalı öyleler hani onlar görmedikleri için. Onların zamanında yoktu arkadaşlarla gezmek, dışarı çıkmak falan. Kavga ediyorduk sürekli, çok bıkardım, böyle her şeylerden isyan ederdim, kendimi odaya kapatırdım, kilitlerdim kendimi. Annemgilin 2-3 gün yüzünü hiç görmediğimi bilirim. İki üç kere ilaç içmiştim çünkü çok iyi değildim yani gerçekten psikolojim çok bozuktu benim iki üç sene öncesine kadar. Yine biraz toparlamış hissediyorum kendimi. Öyle kendime zarar verme gibi aptal düşüncelerim yok. Zamanında niye yaptım onu da bilmiyorum, jiletlerdim kendimi, faça atardım. Sebepsiz yere biz kavga ederdik mesela, sürekli tartışırdık işte annem yakınırdı sürekli orayı topla, burayı topla şunu yap, bunu yap, yapardım işlerini tutardım. Bu sefer dışarı çıkmak isterdim izin vermezdi, çok bunalmıştım. Hani şöyle güzelce konuşulabilinir demi sonuçta bir güzelce konuşmak var bir bağırıp çağırıp dövmek var, seni okuldan alacağım diye tehdit etmek var bunlardan bunalıyordum ben işte. Ne yapsam ne yapsam aklıma bunlar geliyordu yani. Psikolojim gerçekten hiç iyi değildi, ben intihar etmeye çok çabaladım her seferinde."

Similarly, Ela described her family as prone to an argument: "frankly, it could be due to anything. There could be a fight even when we didn't tidy the shoe rack. I don't know why but we are a family that is particularly suitable to fighting, you know, everything can be a topic for argument." [*"açıkçası her şeyden olabilir yani. Ayakkabılığı toplamazsak bile kavga olabilirdi biz neden bilmiyorum ama özellikle kavga etmeye çok müsait bir aileyiz mesela hani her şey kavga konusu olabilir"*] In accordance with Ela and Yaren's statements on familial problems, Sinem expressed how she became distant to her family as a result of constant arguments between parents.

"For example, I didn't want to go anywhere with my family, be it the officer's club, dinner, they already don't like doing things with each other. We constantly fight, there are constant accusations. We go on vacation and we are always separate there as well.

R: When you say they, do you mean your mother and father or do you have conflicts as a family?

P: With each other, they have conflicts with each other but the topic gets thrown at us too. It comes at us as well. In this way I got really distant from them, my room was my living space. I would study and sleep, study and sleep.

R: How is your relationship with your siblings?

P: We weren't on good terms with my elder sister. Not good, not like sisters. Not bad, but not like sisters."

"Mesela ailemle bir yere gitmek istemiyordum, orduevi olsun, yemek olsun, zaten onlarda birlikte bir şey yapmaktan çok hoşlanmıyorlar. Sürekli bir kavga ediyoruz, sürekli suçlama. Tatile gidiyoruz orada sürekli ayrıyız.

A: Annenle baban için mi diyorsun onlar diye yoksa aile olarak mı çatışıyorsunuz?

K: Birbirleriyle. Birbirleriyle çatışıyorlar ama bize de atlıyor konusu. Bize de geliyor. Böyle böyle ben onlardan çok uzaklaştım, odam benim yaşam alanımdı. Ders çalışıp uyuyordum, ders çalışıp uyuyordum.

A: kardeşlerinle ilişkin nasıl?

K: Ablamla hiç iyi değildik. İyi değildik değil, ablamla abla kardeş değildik. Kötü değildik. Ama abla kardeş değildik."

As it was seen from the participants' accounts that they were talking about the deprivation of close and affectionate relations with parents and expressing a deep longing for such a relationship.

In accordance with the lack of love and care in their relations with their parents, the participants described experiencing withdrawal at different levels in various parts of their lives. Considering the triggering factors for some of the participants, the onset of the symptom seemed to be related to the loss of a relationship, which could also be defined as the withdrawal of love. For instance, for Büşra, her symptoms had started with school stress, but gotten worse when she separated from her parents due to moving to another city for college. She expressed that she felt being abandoned by her parents, and disclosed a feeling of loneliness.

"I was always a very stressful student. In those days, my eating habits changed. I would wake up early at 7 and skip breakfast. Then it would be noon, and I wouldn't eat anything until noon, sorry, until evening, then I would come home and dinner would be my only meal. I would quickly eat dinner less or much, I don't know, I mean I eat really fast and quickly leave in order to study. In that period my irregular eating pattern began, I had no breakfast, no lunch, but my real weight-loss period was during university. I dropped from 43 to 34 kilograms then, I lost a lot of weight.

R: So what do you think happened that turned your loss of appetite into something like this?

P: Like I said, when I went to university and became distanced from my family, as I see it. It was actually bad to be separate from my mother and father. Also, we separated on bad terms with my mother and father when I enrolled in the university. They dropped me off at the university, and even then there was a fight about food. We had gone to a restaurant. I didn't eat my serving there, I mean, didn't entirely finish it. It was my last meal with my parents on account me going to university. They said 'you will return in no more than two weeks' to me, 'we'll take you out of school then.' Then they left me there without kissing me goodbye. That affected me negatively. That is also when I started not eating, I mean, I really didn't feel like eating… I really felt very lonely"

"İlk önce ben çok stresli bir öğrenciydim. O dönemde yeme düzenim değişti. Sabah erken 7'de kalkıyordum kahvaltı yapmıyordum. Daha sonra öğlen geliyordu, öğlene kadar hiçbir şey hatta pardon akşama kadar hiçbir şey yemiyordum, daha sonra eve geliyordum sadece tek öğün akşam yemeği yiyordum. Akşam yemeğini de hemen hızlı bir şekilde az veya fazla hiç bilmiyorum hani hızlı bir şekilde yiyip hemen dersimin başına oturayım diye hemen kalkıyordum. O dönemde çok düzensiz yemelerim başladı, kahvaltım yoktu, öğlen yemeğim yoktu ama asıl benim zayıflama dönemim üniversite döneminde, 43'ten 34 kiloya düştüm o zaman, çok zayıfladım.

A: Peki sence ne oldu da bu iştahsızlık böyle bir şeye dönüştü?

K: Dediğim gibi üniversiteye gittiğimde bence ailemden uzak kaldığımda. Annemgilden babamgilden ayrı kalmak kötü oldu aslında. Bir de annemle babamla kötü ayrılmıştık üniversiteye yazıldığımda. Üniversiteye bıraktılar beni, yine o zaman yemek kavgası olmuştu. Bir restorana gitmiştik. Orada porsiyonumu yemedim yani tam bitirmedim. Annemgille beni üniversiteye bırakacakları için son yemeğimdi. 'Sen iki hafta sonra gelirsin' dediler bana, 'iki hafta sonra seni okuldan alırız' dediler. Sonra hiç öpmeden beni oraya bıraktılar. O beni çok olumsuz etkiledi yani öyle. O zaman da yememeye başladım yani yemek canım hiç istemiyordu… çok yalnız hissettim ben kendimi gerçekten"

In the extract above, the withdrawal of love can be seen clearly in her statement: "Then they left me there without kissing me goodbye." [*"Sonra hiç öpmeden beni oraya bıraktılar"*]

Additionally, Yeliz mentioned that her symptoms started with the break up with her fiancé. She reported that after the breakup, she felt as if "everything was taken away from me." She described that period of her life as a loss experience: loss of a loving relationship. With the breakup, she also withdrew from her social life.

> "Actually, I have had a belly since my childhood but this belly never really bothered me or got my attention. After I broke up with this boyfriend, I wondered if he left me because I got ugly, if something popped up here and there in my body because, for example, I had a beautiful social life. At that time, I was cut off from everything, everything I had was taken from me."
>
> "*Aslında çocukluğumdan beri de hep göbeğim vardı ama hiç bir zaman bu göbeğim aklıma gözüme bu kadar takılmamıştı. Bu erkek arkadaşımdan ayrıldıktan sonra ya dedim bu beni bırakıp gitti ben acaba çirkinleştim mi, hani sağım solum mu çıktı çünkü mesela çok güzel bir sosyal hayatım vardı. Her şeyim kesildi o dönem her şeyim elimden alındı."*

Similarly, Yaren disclosed that her restricted eating behavior had started after her friend's comment on her weight; however, it had gotten worse after her romantic relationship had ended:

> "We had a fight again and it was completely over. We had a one-and-a-half-year or maybe a two-year relationship and this was also a bit of the reason why I wasn't eating, the reason for this illness. Something like this happened: we had a fight, broke up, I was really upset; I stopped eating and drinking and so on, my appetite was lost like this. The thing that my friend said was also influent, but our break up was as well."
>
> *"biz kavga etmiştik yine artık bitmişti tamamen bir buçuk iki yıllık ilişkimiz vardı bizim biraz da yemek yememenin sebebi oydu bu hastalığa yakalanma sebebim. Şöyle bir şey olmuştu: biz kavga etmiştik, ayrıldık, çok üzülmüştüm; yemek falan yemeden içmeden kesilmiştim, iştahım bu şekilde kesildi. O arkadaşımın söylediği şey de tabii etkili oldu ama ayrılmamız da etkili oldu."*

Consequently, considering the triggering factors on the onset of the symptoms and the familial relations together, it was seen that the participants described experiencing different levels and forms of deprivation in their lives prior to the first appearance of the symptoms (i.e., lack of unconditional love, affection, care, support, acceptance, and freedom…etc.). Therefore, it could be concluded that AN symptoms arose/emerged as a substitution for the deprivation of love and care in their lives.

3.2. Food Deprivation to Compensate for the Feelings of Loss of Control and Freedom

This theme indicates that food deprivation was a way to compensate for the feelings of loss of control and freedom in the participants' lives. Many of the participants mentioned that they resisted their parents' demands on eating and behaved quite the opposite. For example, Sinem explained how she refused her parents' demands and escalated/exaggerated her restricted food intake as the following:

> "I would immediately stop when they told me to eat something. When they brought an apple to my room, I would throw it in the trash. If they told me to eat olives, I stopped eating olives. At the end of that year, I had really hated them both (mother and father) and told them to get lost, get out of my room. For example, they would bring me dried nuts and I would throw it. I did a lot of things similar to this. When we went to eat, for instance, they would say 'eat eat', whenever they told me to eat I would just put the spoon down, and tell them 'I'm not eating', you know, food started to become terrible. As if food was harmful. As if the act of eating, rather than not eating, was harmful. When they asked me to eat a slice of bread, I would eat half a slice or none at all. Molasses with tahini, for example, I would wonder in my head why they tried to feed me that, then I would decide not to eat it. For example, I would just eat oatmeal for a period because that was the only thing I enjoyed. I liked it a lot but they meddled with that as well so I stopped eating that too. In the end, I wasn't eating anything."

> *"Ben onlar bana bir şey ye dediğinde direk kesiyordum. Benim odama bir elma getirdiklerinde onu çöpe atıyordum, bana zeytin ye dediklerinde zeytin yemeyi bıraktım. Bu senenin sonunda ben ikisinden (anne ve babadan bahsediyor) de gerçekten nefret ediyordum ya 'defolun' diyordum, 'odamdan çıkın' diyordum. Bana mesela kuruyemiş getiriyorlardı fırlatıyordum. Bir sürü şey yaptım bunun benzeri. Yemeye gittiğimizde mesela 'ye ye' diyorlardı, onlar ye dediği anda hooop kaşıkları bırakıyordum, 'ben yemiyorum' diyordum ve hani yemek artık korkunç gelmeye başladı. Hani yemek zararlıymış gibi. Yememek değil de yemek zararlıymış gibi. Onlar bana bir dilim ekmek ye dediklerinde ben yarım dilim yiyordum ya da hiç yemiyordum. Tahin-pekmez mesela bana niye bunu yediriyorlar deyip kuruyordum kafamda o zaman yemeyeceksin diye kuruyordum kafamda. Böyle mesela yulaf yiyordum bir dönem tek hoşuma giden şey oydu. Çok hoşuma gidiyordu ama ona da karıştılar onu da yemedim. Onu da yemeyince hiçbir şey yemedim. En son hiçbir şey yemiyordum zaten."*

It seemed that the eating behavior built a barrier between her and her parents' demands; she was refusing her parents' expectations by restricting her food

consumption. In addition, continuing with Sinem's interview, it was seen from her statement that resistance to hunger signified the control and power in her life. According to her, restricting her food intake was the only way to feel powerful, superior, and in control:

> "They say antidepressants will make you hungry and you'll eat, but I'm not someone who eats when hungry. I'm already hungry and I'm someone who controls this… If I don't want to, I won't eat. If I say I won't eat right now, I won't eat anything and no one can make me eat... I only feel good like this. I mean, you know how you can't study when hungry? I can… It doesn't trouble me, it's not difficult for me. I don't struggle when I don't eat because my body has gotten used to it. I'm really used to it. Like I've been saying, there are 30 days of Ramadan and I can get by with just drinking water. I did it, I can pull it off."
>
> *"Antidepresan acıktırır yersin diyorlar ya ben acıktığımda yiyen birisi değilim ben zaten acıkıyorum bunu kontrol eden biriyim…ben istemezsem yemem ben şu an yemeyeceğim desem hiçbir şey yemem ve hiç kimse de bana yedirtemez...kendimi sadece böyle iyi hissediyorum yani açken ders çalışamıyorsunuz ya ben çalışabiliyorum…beni zorlamıyor zor gelmiyor. Hiç zorlanmıyorum yemediğim zaman çok alıştı vücudum çok alışkınım diyorum ya ben 30 gün ramazan var ya sadece su içerek durabilirim yaptım başarabiliyorum."*

Sinem was also defying the power/impact of others on her by saying "and no one can make me eat." [*"hiç kimse de bana yedirtemez"*] Additionally, in the case of Sinem, losing weight through her anorexic behavior was an accomplishment, something that she could be good at. Or in other words, she considered it as a compensation for her failure in the college entrance exam, which gave her some degree of satisfaction with herself.

> "To me, this feels like an achievement, as the numbers decrease I see success… I have strived to do this, I ate almost nothing, it's like I'm reaping the rewards of my effort. It feels like I have achieved something I couldn't in the university. This act of not eating feels like my own success."
>
> *"Bu bana başarıymış gibi geliyor sayı düştükçe ben başarı görüyorum...şu an bunu yapmak için çok çabaladım, neredeyse hiç yemedim, emeğimin karşılığını almış gibi bir şey oluyor. Üniversite için yapamadığımı burada yaptım onu yapabilmiş gibi hissediyorum. Bu yemek yememek benim başarım gibi geliyor."*

Similarly, Yeliz described how she became stubborn as her parents forced her to eat. She disclosed that she was doing it out of spite due to her parents' criticizing comments. The eating behavior turned into a power struggle between them:

> "Because things like 'you aren't eating, you look like a stick, what is this hideousness' are not nice. You become stubborn and ambitious. I would say 'I'm not eating, don't force me.' I would have reactions such as 'are you going to make me eat, I won't' and stubbornly wouldn't eat at all."
>
> *"Yemiyorsun çöp gibi oldun bu ne çirkinlik gibi şeyler hoş olmuyor çünkü. İnsanı inada bindiriyor hırs yapıyorsun. Yemiyorum ya zorla mı yicem derdim siz mi yedirceksiniz yemiyorum işte diye tepkiler verirdim daha çok yemezdim inat ederdim."*

Yeliz was challenging herself with the food offered and praising AN behavior because, through that, she was feeling in control and having strong willpower. She expressed that,

> "I used to say 'what strong willpower I have', it made me feel like I had strong willpower… I thought this was perfect, 'I have unbelievable willpower, if they put tons of food in front of me after a week of hunger, I wouldn't touch any of it' and such."
>
> *"Ne kadar güçlü bir iradedeyim diyordum, iradem ne kadar güçlü diye hissettiriyordu… ben bunu mükemmel bir şeymiş gibi düşünüyordum inanılmaz güçlü bir iradem var önüme bir sürü yemek koysalar bir haftadır aç olayım hiçbirine dokunmam falan."*

In a similar vein, Yaren expressed how she opposed her parents' demands. It was seen in her statement that she was not granted freedom by her parents and therefore, controlling eating behavior and opposing her parents' insistence on eating were her reactions to their restrictions on her life. She was also emphasizing the feeling of physical endurance and inner strength gained through restricted eating.

> "I would do the opposite of what my parents said, they would say eat and I deliberately wouldn't. Because they said so. Perhaps if they hadn't restricted me this much, if they hadn't persisted this much, perhaps things wouldn't have escalated this much, perhaps I would eat because I just sought to eat until satiated. All right, I was limiting myself and all, but at least something was going into my stomach until I was satiated. Yet, as they told me to eat, my blood would literally boil as they said eat I would get annoyed. Them

> telling me to eat, too overbearing, eat eat eat I get tired of it you know so that's why I don't eat. Also, I have gotten used to it, I mean, I feel like I can live without eating as if I can live like this until the end of my life."
>
> *"Annemgil ne derse tersini yapıyordum yemek ye diyorlardı yemiyordum inadına. Onlar diyor diye. Belki bu kadar kısıtlamasalardı, bu kadar üzerime düşmeselerdi, belki işler bu raddeye gelmeyecekti, belki ben yemek yiyecektim çünkü ben doyana kadar yemenin peşindeydim ben tamam kısıtlıyordum kendimi falan ama doyana kadar da yine mideme bir şeyler gidiyordu yani ama onlar ye dedikçe benim şöyle başımdan aşağı kaynar sular dökülüyordu resmen ye dedikçe sinirime gidiyordu ye demeleri çok baskı yapıyorlar ye ye ye sıkılıyorum yani o yüzden dolayı yemiyorum. Bir de alışmışım yani yemek yemeden yaşayabilecekmişim gibi hissediyorum sanki ömrümün sonuna kadar yemek yemeden yaşayabilirmişim gibi."*

In accordance with this, Yaren's understanding of the function of the symptom was related to receiving freedom or not being restricted anymore with the help of AN. AN behavior was protecting her from others' attempts to step into her life; it functions as a boundary between her and others.

> "Nobody but me can interfere with me. Right now, I don't allow it in my life because I really can't allow my freedom to be restricted at all, I can't, I mean, freedom and not being restricted is really important to me."
>
> *"Bana kendimden başka kimse müdahale edemiyor şu an hayatımda izin vermiyorum çünkü ben gerçekten özgürlüğümün kısıtlanmasına hiçbir şekilde izin vermem veremem yani benim için gerçekten çok önemli özgürlük, kısıtlanmamak."*

These excerpts showed that her need to control her life was fulfilled by anorexic behavior. In other words, AN provided her the desired control that she needed to have on herself and others. Taking into consideration the excerpts from the participants' accounts, AN behavior functions as a way to draw their own boundaries and take control of their lives as a reaction to the intrusive demands of others.

3.3. Receiving Love and Care from the Family: Repairing the Broken Relationship

This theme fundamentally referred to receiving care and love from the family, as well as repairing the broken relationship with them. The theme was fairly commonly

addressed by the participants. As it was given above, for some of the participants, care was not something that they received from their families before the diagnosis. However, a sickly appearance with problematic eating behaviors and increased health problems evoked health-related worries from people around them; especially their families started to express their concerns and worries.

As a result, the occurrence of the symptoms increased the care that they received from their families. They emphasized that their parents became more understanding, caring, and supportive due to the AN related symptoms and changes in their lives. In other words, participants took some relational benefits out of AN. For example, in Ela's situation, the disorder was helping her to receive attention from and feel looked after by her family. Ela expressed that she took advantage of AN by eliciting care from her family more than she used to get. She verbalized it as such:

> "I liked being the center of attention. For example, as I recovered, I stopped being the center of attention. I mean, this wasn't in my friends' eyes, but I was the center of attention in my family's eyes. They would care about me more, humor me more. They wouldn't be so angry with me. For instance, you know how you don't do anything to someone who is ill, have nothing bad said about them and such? I enjoyed that a little."
>
> *"Ben ilgi odağı olmayı da seviyordum mesela ben iyileştikçe de ilgi odağı olmaktan çıktım yani bu arkadaşlarımın gözünde değil ailemin gözünde biraz ilgi odağı oluyordum beni daha çok önemsiyorlardı biraz alttan alıyorlardı mesela bana çok kızamıyorlardı mesela hasta birine şey yapmazsınız ya laf dokundurmazsınız ya hani onun gibi biraz o hoşuma gidiyordu."*

Also, Yeliz emphasized that AN brought care and consideration in its wake; she described her situation as a child demanding constant care and attention from the family:

> "It's really like, you know, like you go back to your childhood, both physically and mentally. It's both like someone wants to make sure you eat, doesn't believe you, doesn't send you to the subway alone fearing something might happen, because that person doesn't trust your health. You physically shrink and weaken."

> *"Gerçekten böyle şey gibi insan böyle çocukluğa geri dönüyor gibi oluyor hem fiziksel olarak hem zihinsel olarak. Hem sürekli birisi sizin yediğinizden emin olmak istiyor, size inanmıyor, hani sizi tek başınıza metroya göndermiyor bir şey olur şeyiyle güvenmiyor çünkü sağlığınıza. Fiziksel olarak da küçülüyorsunuz güçsüzleşiyorsunuz yani."*

Furthermore, in conjunction with the theme mentioned above, AN had a repairing and unifying effect on the relations. As participants stated, the relationship between the parents and the participants changed in the course of AN. They expressed that they had not received care from their family before the symptoms had gotten worse. However, afterward, their relationship turned into a caring one. Even though participants expressed sadness, disappointment, or anger due to their parents' earlier attitudes, they were glad that they had such a positive new relationship, which was more affectionate, intimate, and fulfilling. They sounded happy and relieved with the fact that their parents started to exhibit affectionate behaviors more frequently, such as hugging and kissing.

For example, Sinem was feeling like she did not belong in her family ("I didn't feel like a part of the house." [*"Evin bir parçası gibi hissetmiyordum"*]). She emphasized that she was feeling pressure due to the high expectations she and her parents put on her performance for the college entrance exam, but suddenly her parents had an attitude that was more along the lines of "it is ok, it's not that important really." She interpreted this attitude as:

> "I think they want me to come back as if I've taught them a lesson. They were afraid of losing me and now they have realized it. Like I said, my mother kisses me, we hug, my father says come let's do lots of stuff together, my sister says come home and let's travel and have a vacation."
>
> *"Geri dönmemi istiyorlar diye düşünüyorum sanki onlara ders vermişim gibi beni kaybetmekten korktular ve şu an farkındalar dediğim gibi annem beni öpüyor annemle sarılıyoruz babam diyor ki gel senle bir sürü şey yapalım ablam diyor ki gezelim tatil yapalım."*

She expressed pleasure over her parents' overly caring behaviours such as "eating from her mother's hands (like spoon-feeding)" or "I tell my father that I'm going to be a garbage collector, he tells me to do it, I tell him I'm going to stay home

unmarried, he tells me to do that" [*"babama diyorum ki çöpçü olcam diyorum, ol diyor, evde kalcam diyorum kal diyor"*] The symptom also empowered their relations. Sinem exemplified it as:

> "And in my opinion until this time we weren't able to become a family, I mean, we were a very disconnected family. For example, I never hugged my mother until this illness, but after the illness, we hug. Does it hurt me? Yes, why do things have to happen when something bad occurs? Did I have to die for you to understand me or do I have to be ill for you to kiss me? Why now? I didn't feel like a part of the house. Whatever, but now we are fine. See, everyone is fine and I have missed them so much. This hurts me a little but it also makes me very happy. Like I said, did these have to happen in this situation, but, on the other hand, the situation is like everything happens for a reason. We are gaining benefit from my malice, you know, it's family."
>
> *"Ve bu zamana kadar bence biz aile olamadık, yani çok kopuk bir aileydik. Mesela ben annemle nerdeyse şu hasta olana kadar hiç sarılmadım ama hasta olduk sarılıyoruz. Zoruma gidiyor mu evet neden bir şeyler böyle olduğunda olmak zorunda. Ölmeli miydim beni anlamanız için veya böyle bir hastalığa mı yakalanmam lazımdı senin beni öpmen için? Neden şimdi? Evin bir parçası gibi hissetmiyordum. Her neyse ama şimdi iyiyiz bak şu an herkes çok iyi ve o kadar özlemişim ki onları. Bu biraz zoruma gidiyor ama çok da mutlu ediyor. Dediğim gibi bunlar bu durumda mı olmalıydı diyorum ama bir yandan da her şer'de bir hayır vardır gibi oldu durum. Benim şerr'imden hayır çıkarıyoruz işte aile yani."*

In her statements, there were both signs of guilt and triumph. She also stated that this disease had given them a chance to have a more affectionate and loving relationship with her mother. She could share more time with her mother and tried to seize the moment:

> "For example, the other day I took a leave of absence but didn't stay at home. What I wanted the most was to lie down on my mother's lap. I wanted to stay there for an hour and that's what we did. It really feels good. She doesn't realize it but for a daughter or for a child their mother is very important. I mean, she doesn't have to constantly show affection, but at least she should show that she is a mother. She needs to realize I am her daughter, not an object."
>
> *"Mesela geçen gün ev iznine çıktım ama kalmadım, en çok istediğim şey annemin bacağına uzanmaktı, bir saat öyle kalmak istedim ve öyle kaldık. Ya gerçekten çok iyi hissettiriyor, farkında değil ama bir kız için veya bir evlat için annesi çok önemli, yani illa böyle sürekli sevgisini göstermek zorunda*

değil evet ama en azından annesi olduğunu göstermesi lazım. Bir obje gibi değil kızı olduğumun bir farkında olması lazım."

3.4. Others as a Reference Point: The Importance of Others' Thoughts and Acceptance

Weight loss makes reference to getting compliments and positive feedback regarding appearance from others in participants' accounts. However, before getting into the details of this theme, it was beneficial to give brief information about the situations that initiated the symptoms for some of the participants. The triggering factors for the onset of their symptoms seemed to be related with an intolerance to criticism and comments related to their physical shape. For example, Ela explained the development of her symptoms as follows:

"R: How do you think anorexia developed?

P: My friends who are close to me, my inner circle, were always very thin. I was also never overweight actually, but in my opinion, I wasn't thin enough. They were also making these tiny suggestions, hints among themselves. They would jokingly tell me I was fat because they knew I would be annoyed, so this doesn't count as implying. Now, this is going to be a strange one, but I will give an example. We had a photo with a friend and me. My friend is heavier than me. I show this picture to another friend and both of our faces are obscured because we are in the shade, and she says 'oh, which one are you' but really it's plainly obvious which one I am. That is done intentionally. And also, for example, I used to exercise my abs and still do and I had abs in those days, really obvious abs and everyone would point it out. I would also do 700 or so sit-ups in one day. My friend once said 'I don't believe you have abs.' I said 'look, feel it.' Again, another friend felt it and said 'I only see a belly, but whatever.' Also, for instance, a friend that used to carry me on their back said 'I can't, you are too heavy' and stuff like this, these aren't actually bad things but, you know, they would affect me badly and I was already obsessed with myself."

"A: Anoreksiya nasıl gelişti dersin?

K: Benim yakınımdaki arkadaşlar yakın çevrem hep çok zayıftı. Ben de hiçbir zaman kilolu olmadım aslında ama bence yeterince zayıf değildim onlar da böyle minik minik imalar dokundurmalar yapıyorlardı kendi aralarında. Hani şakasına kilolusun diyorlardı benim gıcık olduğumu bildikleri için ki bu bir ima sayılmaz ama. Şimdi çok garip bir örnek olacak mesela ama bizim bir fotoğrafımız vardı bir arkadaşım ve ben arkadaşım daha kilolu bir kız mesela o fotoğrafı bir arkadaşıma gösteriyorum hani

ikimizin de yüzü kapalı ve gölgedeyiz şey diyor 'aaa hangisi sensin' ama yani gerçekten açık ara hangisinin ben olduğum çok belli hani o kasıtlı yapılmış bir şey. Bir de mesela ben baklava çalışıyordum hala da çalışıyorum ve baklavam vardı benim o zaman da gayet de net vardı belli oluyordu herkes de söylüyordu. Bir de günde 700 mekik falan çekiyordum yani arkadaşım şey dedi 'Senin baklavan olduğuna inanmıyorum' demişti. Ben de bak elle demiştim. Yine başka bir arkadaşım elleyip 'ben göbek görüyorum ama neyse' demişti. Bir de mesela eskiden beni sırtına alan bir arkadaşım 'alamıyorum çok ağırsın' falan bunlar aslında kötü şeyler değil ama hani beni biraz kötü etkiliyordu bir de ben zaten kendime takıntılıydım."

A similar intolerance was true for Sinem. She expressed how her aunt and mother's comments impacted her:

"I used to be very upset when my aunt made fun of me or when my mother said things like fatty. I was 58 or 59 kg. These affected me a lot, no one can say these things to me. I don't accept them."

"Halam dalga geçtiğinde çok bozuluyordum veya annem hani böyle lömbür lömbür falan diyordu. 58 mi 59 mu ne olmuştum. Bunlar beni çok etkiledi, kimse bana bunları diyemez. Ben bunları kabul etmiyorum."

Additionally, Yaren stated that the onset of her anorectic behaviors was influenced by humiliation from her friends about her weight.

"R: So, how did this begin? P: My friends, we were sitting down and the topic of weight came up. I was easily 50-55 kilograms. They asked me my weight and I said 45 and they said 'don't lie, you can't be 45, you're fat' and so on. This was actually how my obsession began. I felt bad, I mean, saying these in that way among all those people really hurt my pride, you know, you can say this when we are alone, no need to say it in front of all those people. They said 'you are probably more, you are probably heavier.' After that day, whatever happened, I started to restrict myself. 'Slowly slowly slowly slowly I need to lose weight' I thought and set a goal for myself. '45 kilograms, I need to be 45' I thought. I mean, this is what caused it, my friends. After that day I began to restrict myself, I have been like this for about a year, I wouldn't put anything in my mouth."

"A: Nasıl başladı peki? K: Arkadaş çevrem, oturuyorduk bana işte kilodan açıldı konu ben 50-55 kilo rahat vardım. Bana denildi işte kaç kilo olduğumu sordular 45 dedim işte 'yalan atma sen 45 olamazsın kilolusun' falan filan bu şekilde takıntım başladı aslında. Kötü oldum yani o kadar kişinin içinde bana öyle söylenmesi benim gerçekten gururumu incitti hani sonuçta yalnız başına da söyleyebilirsin bunu o kadar insan içinde söylemene gerek yok. 'Daha fazlasındır daha kilolusundur' dediler bana. O günden sonra zaten ne

olduysa oldu kısıtlamaya başladım kendimi yavaş yavaş yavaş yavaş zayıflamam lazım dedim kendime hedef koydum. 45 kilo, 45 olmam gerekiyor dedim. Yani bu sebep oldu arkadaşlarım. O günden sonra kendimi kısıtlamaya başladım yaklaşık bir yıldır böyleyim hiçbir şekilde ağzıma hiçbir şey sürmezdim."

It was seen from the extracts that there was social punishment (i.e., being humiliated in front of everyone) in the participants' accounts; also, they were sensitive and gave importance to others' thoughts. They felt that others did not find them beautiful. They did not feel approved by others. Therefore, by staying slim through restricting their food consumption, they tried to meet friends' imposed standards. As a result, they felt they were worthy of compliments and recognition, and receiving social rewards from others. In the statements below, the importance of others' thoughts on themselves, as well as the participants' pursuit of compliment/positive feedback can be seen clearly.

"Actually, it had a very negative effect on my life, but, on the other hand, I liked the situation because being thin, appearing pretty to people was important for me. You know, things like clothes were looking good on me, people around me saying I look thin, I look beautiful and such… They should think I'm pretty and thin, appearance is important to me… health wasn't important, looking beautiful to people, people saying good things about me, receiving good comments, these were more important, more than health -YAREN-"

"hayatımı çok olumsuz yönde etkiledi aslında ama bu durum bir yandan da hoşuma gidiyordu çünkü zayıf olmak, insanlara güzel görünmek benim için önemliydi, işte giydiğinin yakışması, çevrendekiler sana diyor ne kadar zayıfsın çok güzel olmuşsun falan… güzel olduğumu zayıf olduğumu düşünsünler dış görünüş önemli benim için…benim için sağlık önemli değildi insanlara güzel görünmek insanların hakkımda güzel şeyler söylemesi güzel yorumlar almak bunlar benim için daha önemliydi sağlıktan daha çok -YAREN-"

Similarly, Sinem reported that these praises were more often when she first started to lose weight. Sinem's view of herself was based on or depended on the views of others. Thinness was also comforting for her because it ceased the comments of others.

> "at first, I took pleasure in those who realized I lost weight, they would say 'you have become very beautiful…' I really liked this… for someone for others… it wasn't important how I saw myself… so I said 'Sinem, you are going to eat carefully…' thinness is a comfort, you know, no one will say anything."
>
> *"ilk başta zayıfladığımı fark edenler de hoşuma gitti, çok güzel olmuşsun demişlerdi… bu benim hoşuma gidiyordu…birileri için başkaları için…kendimi nasıl gördüğüm önemli değildi…ben de dedim ki Sinem dikkatli beslenecеksin…zayıflık rahatlıktır ya hani kimse bir şey demez."*

The second part of this theme illustrated that AN behavior was related to receiving acceptance from others. The interviews revealed an outstandingly negative self-image, and the participants reported that they were diffident/unconfident. For example, Ela thought that she had low self-confidence, "I have low self-confidence, I mean, it's not very high, it's low." [*"benim özgüvenim düşük yani çok yüksek değil düşük"*] She attributed meaning to body shape or weight as if it was the determinant of her self-worth; and therefore, for her, the AN behavior functioned as a way to receive acceptance and value from others.

> "It could be self-confidence; you know, for example, like the desire to make people accept you with your beautiful body and appearance. Or, for instance, like if people see me as overweight, maybe they won't value me or like not valuing yourself when thinking you are overweight. That's how it was for me; when I gained weight I would see myself as the most worthless, least successful person in the world, who shouldn't even exist. I mean, weight could be the measure that determines my value in my own eyes, for example, the lower it is on the scale, the more important I become."
>
> *"Özgüven olabilir; hani mesela insanlara kendini güzel bedenle, güzel dış görünüşle kabul ettirme isteği gibi. Ya da mesela insanlar kilolu görürse belki beni değerli görmezler gibi ya da direkt kendini kilolu olunca değerli görmemek gibi. Benim öyleydi; ben mesela kilo aldığımda kendimi dünyanın en değersiz, en başarısız, dünya üzerinde bile olmaması gereken bir kişi gibi görüyordum. Yani kilo biraz belki kendi gözümdeki değerimin belirleyicisi ölçeği olabilir mesela ne kadar düşükse tartı olarak o kadar önemli birisi oluyorum."*

Additionally, thinness was considered as a synonym of beauty, a way of feeling more attractive. Here they also talked about the "fact" that they considered putting on weight as becoming not attractive. For instance, Yeliz was afraid she would never

have a boyfriend if she gained weight. Also, it was thought, based on her expressions, that weight gain was imposing a threat of being alone.

> "I felt my beauty was fading; like I said, my break up with my boyfriend, him looking at others, the women at the gym being heavy but looking slim, they are more beautiful than me, they look more beautiful. Due to the perception of beauty, I associated this to weight; I don't know how I connected them but I associated it to my weight. In fact, I thought I would never have a boyfriend again if I gained weight. I thought I would become ugly, that no one would look at me, I always associated this to beauty… It (weight) was ruining my concept of beauty. That's why I chose not to eat food, I didn't want to be ugly, it felt like I would be alone, that I couldn't marry, that even my friends wouldn't talk to me."
>
> *"güzelliğimin bozulduğunu hissettim ben; dediğim gibi erkek arkadaşımdan ayrılmam, onun başkalarına bakıyor olması, spor salonundaki kadınların kilosunun fazla ama zayıf görünüyor olmaları, benden daha güzel bunlar daha güzel görünüyorlar. Güzellik algısı yüzünden bunu da kiloyla ilişkilendirdim; nasıl bağdaştırdım bilmiyorum ama kilomla ilişkilendirdim. Hatta kilo alırsam bir daha hiç erkek arkadaşımın olmayacağını falan düşündüm. Kilo alırsam çirkinleşeceğimi, bana kimsenin bakmayacağını düşündüm hep güzellikle ilişkilendirdim…Benim güzellik kavramımı bozuyordu (kilo), ben o yüzden yemek yememeyi seçtim, çirkin olmak istemiyordum, yalnız başıma kalırım gibi geliyordu, evde kalıcam, arkadaşlarım bile benimle konuşmaz diyordum."*

Similarly, Sinem associated weight with being attractive. She thought that putting on weight was an obstacle to be liked by others.

> "This is a really bad thing and it feels like people won't like me if I'm overweight, like I won't have a lover or anything else."
>
> *"Bu çok kötü bir şey ve insanlar ben kilolu olunca beni beğenmezlermiş gibi geliyor ne sevgilim olurmuş ne başka bir şeyim olurmuş."*

Both Yeliz and Sinem associated weight gain with the potential threat of refusal from others; hence, they valued thinness in order to secure acceptance from others. It was protecting them from rejection.

In compliance with Yeliz and Sinem's argument on increasing in weight, Selen referred thinness as a guarantee for or as insurance of her acceptance.

> "I'm really ashamed of eating anything outside, in public. At home, for example, I eat with my friends, I'm not ashamed when I eat with them, but I feel ashamed to eat outside, among other people. It felt like they would have thoughts about me: it felt as if they would have thoughts like 'she looks like a cow and she's still eating', it still feels like that. I think it was a little due to: since we are a skinny family, as a child I usually, it's not nice of course but when we sat somewhere with my mother, you know, if someone at a table was eating, she would say 'they look like a cow but are still eating' or when she saw a chubby child she would turn to me and say 'thankfully you aren't like this.' That's why whenever I eat something, it feels like people are doing the same to me."
>
> *"Dışarda bir şeyler yemeye de çok utanırım ben insan içinde. Evde mesela arkadaşlarımla yerim, arkadaşlarımdan utanmıyorum ama dışarıda başka insanların yanında bir şeyler yemeye çok utanıyorum. Benimle ilgili şey diye düşünecekler gibi geliyordu: 'dana gibi olmuş hala yiyor ya' falan gibi düşünecekler gibi geliyordu, geliyor hala. Biraz şeyden sanırım: biraz sıska bir aile olduğumuz için ben küçükken falan genelde hoş bir şey değil tabi de annemle bir yerde oturduğumuzda hani masada şişko birileri yemek yiyorsa falan dana gibiler hala yiyorlar derdi ya da işte şişko bir çocuk gördüğünde falan sen iyiki böyle değilsin falan derdi. O yüzden de işte insanlarda bana öyle yapıyorlar gibi geliyor ben bir şey yediğimde."*

On the other hand, Büşra interpreted that the function of AN was seeking acceptance from others by standing against their expectations in order to make them accept her for who she was. Or to put into words differently, she described AN as a way to prove herself to others. She verbalized that,

> "She needs to accept me being thin (talking about her mother), that's how I am. If I am healthy, she needs to accept this because, for example, in the results (bloodwork results) nothing shows up. It's like my mother is disappointed as if she expects something to go wrong or there to be some kind of problem. I mean, she wants my thinness to be connected to something. It's like only then will she find comfort, but it's just me being thin and she doesn't want to understand this. She presents me as flawed but I'm not. I really think anorexia nervosa is an attempt to prove oneself. They really need to understand me a little, they should stop bearing down on me, you know, 'you should do this, you should do that. They need to let me be for a while."
>
> *"Benim zayıf olduğumu kabullenmesi gerekiyor (anneden bahsediyor) ben böyleyim eğer sağlıklı isem bunu kabullenmesi gerekiyor çünkü mesela sonuçlarda (tahlil/tetkik sonuçları) bir şey çıkmıyor sanki annemin morali bozuluyor gibi bir sorun çıkmasını bekliyor bir pürüz çıkmasını bekliyor gibi yani bu zayıflığımın bir şeye bağlanmasını istiyor. O zaman rahatlayacak gibi yoksa sadece zayıf olmam bunu anlamak istemiyor. Böyle beni kusurlu gibi gösteriyor ama öyle değilim ben. Gerçekten de biraz kendini ispatlama*

çabası olduğunu düşünüyorum anoreksiya nervozanın. Beni biraz anlamaları gerekiyor gerçekten biraz üzerime çok fazla düşmemeleri gerekiyor işte şunu yapacaksın bunu yapacaksın biraz kendi halime bırakmaları gerekiyor aslında."

Taking into consideration all of these quotations, it could be seen that the participants considered others as a reference point for their view of self or self-worth by either refusing or accepting the expectations of others.

3.5. Is Anorexia Nervosa the Only Way Out?: Expressing Resentment and Anger through Punishing Others

This theme presented that eating difficulties also appeared to serve a functional purpose for participants in terms of expressing their feelings. Participants' disclosures showed that AN behavior was a way to communicate emotional difficulties to their parents. Some of the participants showed their feelings through punishing their parents and/or themselves to show how much emotional pain they were in. For example, as it was seen below, in Sinem's case, the AN behavior was a way to express her anger to her parents and became a punishment for both herself and her family.

"They inflicted all this debt to me, I would tell them I hated them. As punishment to them and to myself. I caught this illness under the criteria of both punishment and reward. I mean, maybe this (eating food) is how I showed my boiling point. That is, for example, when I buy clothes and when they said 'was it necessary' I wouldn't buy any more clothes. This is what I did with everything, I photocopied my books, I got worse. As I got worse, let me put it this way, you know how a person fills up and up then bursts, I couldn't go off at them and couldn't say anything. I just exploded, punishing myself or them."

"Bu kadar borcu yüklediler ya bana nefret ediyorum sizden diyordum hem onlara hem kendime ceza olarak hem ceza hem başarı kıstasıyla bu hastalığa yakalandım. Yani belki patlama noktamı bu şekilde (yemek yemeyerek) göstermişim. Yani mesela kıyafet aldığımda böyle ne gerek vardı dediklerinde bir daha kıyafet mıyafet almıyordum her şeyde böyle yaptım kitaplarımı fotokopi çektirdim iyice bozdum. Bozdukça da ya şöyle söyleyim insan dolar dolar da patlar ya ben onlara patlayamadım hiçbir şeyimi de söyleyemedim böyle patladım kendime ceza vererek veya onlara ceza vererek"

Additionally, The AN behavior seemed her only way to stop or get rid of the burden she had on herself.

> "I don't think they gave me any chance to choose my profession, but I don't know how they did this, intentionally or not. I just have a burden that doesn't show on the scale, that's how I really feel. That invisible burden feels very heavy. I know I'm upsetting them more right now, to upset them, until this time, I wanted not to upset them, but enough is enough."
>
> *"Bana meslek seçme şansı bırakmadıklarını düşünüyorum ama bunu bilerek veya bilmeyerek nasıl yaptıklarını bilmiyorum, sadece tartıda gözükmeyen kadar yüküm var benim gerçekten de böyle hissediyorum. O gözükmeyen yük bana çok ağır geliyor. Biliyorum şu an onları daha çok üzüyorum onları üzmek hani bu zamana kadar onları üzmemek istedim ama yetti gayri yani."*

Continuing with Sinem, she also felt resentment against her parents' conditional love. She felt that her parents took advantage of her motivation to make them happy. Her statements showed that she was accusing her parents:

> "My sister made her own choices. I mean, my sister said 'I'm going to university' and she went. I was a bit indecisive to make them happy. I wanted whatever they wanted, they misused this. That's what happened. I have this idea that my mother will love me if I study law or if I study medicine. Because my mother loved me when I was cleaning, that's how I associated it. For her to love me. For her to talk about me, to keep me at the tip of her tongue. I needed to do these. She doesn't even have to say my daughter is perfect."
>
> *"Ablam kendi yaptı tercihlerini. Yani ablam 'ben üniversiteye gidicem' dedi gitti. Ben biraz kararsızdım onları mutlu etmek için, onlar ne istiyorsa onu istiyordum, bunu kullandılar. Böyle oldu. Annem beni hukuk kazanırsam sever gibi bir düşüncem var, annem beni tıp okursam sever. Çünkü annem beni temizlik yapınca seviyordu, böyle bağdaştırdım. Beni sevmesi için. Beni konuşması için, beni dilinde gezdirmesi için. Bunları yapmam gerekiyordu. Onun dışında kızım mükemmel benim bunu demesine bile gerek yok."*

Yaren mentioned that anorexic behavior was an attempt to convey a message to her parents, that they were wrong in what they were doing to her, and to make them regret their attitudes toward her.

> "I actually didn't want it to turn out like this, I wish they hadn't pressured me so much, restricted my freedom, and I wouldn't have had to do these. They should see their mistakes and understand. It's kind of like punishing

> them. While striving to punish them, I also punished myself. I wish they had gotten better until now. It's actually making them regret what they did because my freedom was restricted and constantly apply pressure. There were things I did with the purpose of punishing them a bit. Had they listened to me, had it been as I asked, perhaps everything would have been better, perhaps I would never have gotten this illness."
>
> *"Ya aslında istemezdim böyle olmasını keşke üstüme bu kadar düşmeselerdi özgürlüğümü kısıtlamasalardı da ben bunları yapmak zorunda kalmasaydım. Görsünler hatalarını anlasınlar bir nevi onları cezalandırmak aslında. Onları cezalandırmak için çalışırken kendimi de cezalandırdım keşke düzelmiş olsalardı bu zamana kadar. Aslında onları pişman etmek yaptıklarına çünkü kısıtlanan şey özgürlüğüm ve baskı yapıyorlar sürekli. Biraz onları cezalandırmak amaçlı yaptığım şeylerdi. Beni dinleselerdi benim dediğim gibi olsaydı her şey belki daha güzel olacaktı belkide bu hastalığa hiç yakalanmayacaktım."*

At another part of the interview, Yaren opened up again and told that,

> "Maybe they'll realize my value, maybe they won't restrict me, pressure me so much. This is actually a little of how I'm thinking right now, or I think they'll be sad when they do this, they'll think 'this girl is going to do something to herself or worse, she is going to kill herself' and give up on pressuring me. That's why I would always do it."
>
> *"Belki değerimi anlarlar belki biraz daha sıkmazlar hani belki üstüme düşmezler bu şekilde düşünüyordum aslında biraz veya bunları yapınca üzülürler bu kız kendine bir şey yapacak daha kötüsü olacak kendini öldürecek diye düşünürler üstüme düşmekten vazgeçerler gibisinden düşünüyordum hep o yüzden yapıyordum."*

This statement might have meant that punishing her parents implicitly was a call for support and understanding from them. In addition, Büşra disclosed a similar purpose for her anorexic behavior:

> "It was something I did to make them regret what they did, to punish them a little bit, to explain to them what they did."
>
> *"biraz aslında onları pişman etmek yaptıklarına biraz onları cezalandırmak yaptıklarını anlatmak amaçlı yaptığım bir şey."*

Also, at the end of the interview, Büşra asked for the audio recording. She expressed that she was not able to talk to her mother easily; therefore, she wanted her to listen to the recording and take a lesson from it. She wished for her mother to understand

and support her. However, her asking for the records might also be thought of as a sign of anger and revenge. Since throughout the interview, she prominently criticized her mother.

> "P: She sort of stood by me, but she just looked like it. She never really supported me. She always tried to tear me down with a beating or words. I mean, how should I say this, I wish she hadn't done it with beatings and such, I mean, I wish she hadn't confronted me with these… Umm, do you mind giving me the audio recording?
>
> R: Why do you want it? What will you do with the recording?
>
> P: I don't know what I'll do. I am, in fact, a very forgetful person and my mother will ask what we talked about. I'll make her listen to it and also keep track of what we discussed.
>
> R: How will making your mother listen to it make you feel?
>
> P: I don't know. I kind of also want her to hear the things we spoke about. I don't want it to remain unresolved. I want her to learn a lesson from this conversation.
>
> R: You want to show her something.
>
> P: Yes, I want to show her something.
>
> R: What will she hear, or what do you want to say to her?
>
> P: I want her to understand me a little, to believe the things I say. I mean, I want her to support me, to know what I think about her because I can't stand in front of her and explain it the way I explained it to you. I really want her to hear the things I told you about.
>
> R: Why don't you tell her then?
>
> P: I mean, when I confront her, she doesn't listen to me. That's why. I mean, for example, she doesn't look at my face."
>
> *"K: Aslında benim yanımda oldu gibi ama oldu gibi görünüyor ama gerçekten hiç olmadı hep böyle dayakla ya da sözle beni yıkmaya çalıştı yani nasıl diyeyim dayakla falan keşke yapmasaydı yani bunlarla karşıma çıkmasaydı keşke…Şey siz bana kaydı atabilir misiniz?*
>
> *A: Neden istedin ki? Ne yapacaksın kaydı?*
>
> *K: Ne yapacağım bilmiyorum. Aslında ben çok fazla unutkan bir insanım da annem yine soracak neler konuştunuz diye ona dinletirim hem de neler konuştuğumuzu aklımda tutarım*

A: Annene dinletmek nasıl gelecek sana?

K: Ya bilmiyorum biraz da aslında konuştuklarımızı onun da duymasını istiyorum böyle boş kalmasın istiyorum onun da biraz ders amaçlı ders alsın konuşmadan

A: Ona bir şey göstermek istiyorsun?

K: Evet, bir şey göstermek istiyorum?

A: Neyi duyacak ya da ne söylemek istiyorsun ona?

K: Beni biraz anlasın dediklerime biraz inansın yani bana biraz destek olsun onun hakkında ne düşündüğümü bilsin istiyorum çünkü ben onun karşısına geçip böyle size anlattığım gibi anlatamıyorum size anlattığım şeyleri onun da duymasını çok istiyorum

A: Ona niye anlatamıyorsun peki?

K: Yani karşısına geçip de dinlemiyor beni o yüzden yani yüzüme bakmıyor mesela."

3.6. Distracting Attention away from Relational Problems: "I was dealing with what I ate to keep my mind occupied"

The avoidance theme was identified as a strategy used to help distract attention away from unpleasant experiences and feelings. The participants reported avoidance of negative feelings and relational problems. They described that it helped them escape from their problems. The type of problems mentioned varied. It seemed that by focusing on food, eating, and exercising, participants were able to distract themselves from other troubling/unpleasant experiences even though they knew it was not a functional way of dealing with situations/emotions. They thought eating problems were useful tools to get away from stressors/ to cope with or to distract from the difficulties in life, and this was in some way comforting for them due to the preoccupation it caused.

"Maybe I was obsessing about not having an occupation because I wasn't dancing, I wasn't doing anything, just sitting idly at home. Or with my friendships, for example, there was a period I didn't have any boyfriends for quite a while, that would upset me, not to let that get to me. When my friendships were turbulent I was focusing on that a lot because, otherwise, I'll think about that, you know, if I think about this, it's something I'm more

accustomed to. For example, if I fight with a friend I would start to not eat. It's not a normal thing and also something I shouldn't do because running from things is not right, but it feels easy. You know, when some people give themselves to sports when they are angry, I would obsess with what I eat to keep my mind occupied. If I didn't eat for one day, for example, I am not a durable person in that regard, if I didn't eat for one day, I would enter such a state of mind that, nevermind thinking about friendships, you know, I feel I should go somewhere and lie down or I'll faint… I mean, it kept me busy, you know from other responsibilities I didn't want to face, or it's such a busying thing, you know, you don't have time to think about anything else. Maybe it kept me busy, it was some kind of occupation. -ELA-"

"Belki bir uğraşımın olmamasını dert ediyordum çünkü dansa gitmiyordum bir şey yapmıyordum boş boş oturuyordum evde. Ya da arkadaşlık ilişkilerimde mesela bir dönem hiç sevgilim olmadı baya uzun bir süre o beni baya üzüyordu, onu kafama takmamak için. Arkadaşlık ilişkilerimde çalkantı olduğunda da ona çok odaklanıyordum direk çünkü öbür türlü onu düşüneceğim hani bunu düşünürsem daha alışık olduğum bir şey. Mesela bir arkadaşımla kavga edersem hiç yememeye başlıyordum kendi kendime hani biraz pek normal bir şey değil ama yapmamam da gereken bir şey çünkü bir şeylerden böyle kaçmak doğru bir şey değil ama kolay geliyor hani bazı insanlar sinirlenince kendini spora verir ya ben sinirlenince aklımı meşgul etmek için yediklerime takıyordum. Zaten hani bir gün yemek yemezsem mesela ben çok dayanıksız bir insanım o konuda bir gün hiç yemek yemezsem öyle bir ruh halinde oluyordum ki bırakın hani arkadaşlık ilişkilerini falan düşünmeyi böyle şey zaten ben gideyim bir yere yatayım yoksa bayılacağım modunda oluyordum…yani beni meşgul tutuyordu hani yüzleşmek istemediğim başka sorunları veya aslında o kadar meşgul edici bir şey ki hani sürekli kafanızda başka hiçbir şey düşünmeye vaktiniz kalmıyor. Belki beni öyle meşgul tutuyordu bir çeşit bir uğraştı galiba -ELA-"

Yeliz's understanding of AN was that it was a way of handling psychological pain. She became focused on body, weight, and food in order not to think of/concentrate on her real-life difficulties and problems.

"My whole focus was food, the only thing I talked about was food, my whole connection to life revolved around food. I was thinking as, you know while I'm speaking to you, for example, I would think this; 'I wonder if she ate today, what will she eat tonight, does she eat a lot, do I eat a lot, does she eat less?' That's how I was. This is what I say about my condition, I told this to doctor as well, when I couldn't find something to keep myself occupied, I struggled with myself and fell into emptiness back then. With my work or boyfriend, etc., I say, I couldn't find something to keep busy with and struggled with myself or maybe it's to avoid dealing with them. People eat when they are stressed, and I chose not to eat because it was ruining my concept of beauty. That's why I chose not to eat. I didn't want to be ugly. It felt like I would be all alone at home, and even my friends wouldn't talk to me."

“Bütün odak noktam yemekti benim, konuştuğum tek konu yemekti, hayatla tüm bağlantım yemek üzerineydi. Şey diye düşünüyordum sizle konuşuyorum ya mesela şunları düşünüyor olurdum acaba bugün yemek yemiş midir, akşam ne yiyecektir, çok mu yiyordur, ben mi çok yiyorumdur, az mı yiyordur böyleydim ben. Ben şöyle diyorum bu durumum için doktoruma da dedim ben uğraşacak bir şey bulamayınca kendimle uğraştım boşluğa düştüm o esnada işim erkek arkadaşım vs uğraşacak bir şey bulamadım kendimle uğraştım diyorum ya da onlarla uğraşmamak için de olabilir insanlar strese girince yiyorlar bende yememeyi seçtim benim güzellik kavramımı bozuyordu ben o yüzden yemek yememeyi seçtim çirkin olmak *istemiyordum yalnız başıma kalırım gibi geliyordu evde kalıcam arkadaşlarım bile benimle konuşmaz diyordum.”*

CHAPTER 4

DISCUSSION

In this study, six young women diagnosed with AN were interviewed in order to explore the meaning that they attributed to their symptoms. Interpretative Phenomenological Analysis, a qualitative design, was employed. The participants' statements showed that they tend to place a positive value on their symptoms. Therefore, the themes in this presenting study gathered around the function of anorexia nervosa symptoms. The psychological meaning and function of the symptoms derived from the participants' accounts were summarized in six constructs: food deprivation as a substitute for privation of love and care; food deprivation to compensate for the feelings of loss of control and freedom; receiving love and care from the family: repairing the broken relationship; others as a reference point: the importance of others' thoughts and acceptance; is anorexia nervosa the only way out?: expressing resentment and anger through punishing others; distracting attention away from relational problems: "I was dealing with what I ate to keep my mind occupied."

To the best of our knowledge, few qualitative studies have examined the function of or positive attributions to the symptoms in individuals with anorexia nervosa; and it is, therefore, our hope that the presenting study will improve and develop the existing knowledge in the area. In the following section, the key findings of the current study were discussed in light of the existing literature on the subject matter. The significance or importance of the study, clinical implications of the results, limitations of the study, and suggestions for future research were then provided.

4.1. Food Deprivation as a Substitute for the Privation of Love and Care

The first theme of this study was food deprivation as a substitute for the privation of love and care. The findings of this study showed that AN symptoms were substitutions for the privation of (unconditional) love and care in the family environment. Starting from the earliest descriptions of AN in the literature, the interaction between the individuals with AN and their parents have been ascribed a crucial role. This interaction is reported to be influential in the development, maintenance, and outcome of AN (Le Grange, 1999). Selvini-Palazzoli (1970) discovered that there were some dysfunctional family characteristics directly and specifically related to anorexia nervosa symptoms (as cited in Minuchin, 1975). The findings of disturbed family relationships and interaction patterns in anorexic families have been greatly supported by the existing literature (Humphrey, 1986; Lilenfeld et al., 1998; Logue, Crowe, & Bean, 1989; Morgan & Russell, 1975; Strober & Humprey, 1987; Strober, Lampert, Morrell, Burroughs, & Jacobs, 1990; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003).

Several theories pointed out that symptoms of eating disorders are reflections of a deeper and more pervasive problem in the family's structure, affective expression, and style of interaction. For example, the findings of Garfinkel et al. (1983) showed that anorexics defined their families as having greater difficulty with task accomplishment, role performance, communication, and affective expression. Similarly, in the study of Dare, Le Grange, Eisler, and Rutherford (1994) and Le Grange, Eisler, Dare, and Hodes (1992), it was shown that the families in the study were critical, hostile towards their children, and had a low level of affective expression; they were only moderately warm. Humphrey (1989) presented that both anorexic and bulimic subjects rated their parents as blaming, rejecting, and neglectful toward their children. Mothers and fathers of restricting anorexics were more ignoring and neglecting toward their daughters than parents of normal controls or bulimics. However, in contrast, anorexic daughters were the most submissive toward their parents (Humprey, 1989). This personality trait of anorexics might increase

their vulnerability to developing the symptoms of AN. In addition, current theories present that anorexics have difficulties in individuation (separating from their families) and developing a separate, individuated identity (Bruch, 1973; Humphrey, 1986; Minuchin et al., 1978). Such problems are thought as the result of impaired patterns of interaction, affective expression, and role structure within their families (Humphrey, 1988). For example, in the study of Humphrey (1988), the researchers perpetuated the idea that families of anorexics all experienced considerable distress and dissatisfaction in their relationships with one another.

Additionally, in Beumont, Abraham, Argall, George, and Glaun (1978), participants reported unusual patterns of family interaction, such as a hostile and ambivalent relationship with parents observed in one-third of the cases. Also, other studies of family interaction in the laboratory environment showed that bulimic and anorexic families were enmeshed, intrusive, hostile, and negating of the child's emotional needs (Strober & Humprey, 1987). Thus, it could be concluded from these data that particularly long-standing and adverse family problems (i.e., chronic discord, poor parental care/childhood deprivation, pervasive family tension/fights, extreme alienation of affection, extreme restriction of autonomy, parental overcontrol) increase the risk of a more chronic course of illness (Bolattin, Mannarini, Rossi, Rossi, & Balottin, 2017; Lacoste, 2016; Strober & Humprey, 1987; Tozzi et al., 2003). The rivalry and hostility occurring in the family and outside relationships, as a result, are channeled into an overt conflict centering around food (Waller et al., 1940).

These findings were supported in our study as well. Participants reported deprivation of love, affection, support, and communication in their relations with their parents, especially with mothers. They described their mothers as “dominant, authoritative, distant, and rigid.” Mothers were defined as dominating figures in the family; they dominated/impacted the relationships and interactions among family members. They were critical towards their daughters. Therefore, participants felt a pressure to conform to their mothers’ expectations or otherwise they felt they would be (or were)

punished by their mothers (i.e., Büşra's mother constantly says 'your daughter is doing this and that, treat her like this, treat her like that, she wants to go here don't let her go because she doesn't do what we say').

Consistent with study findings, the relevant literature presented that parental characteristics are of critical importance in the development of the symptoms. For instance, in the study of Sours (1969), the participants described their mothers as controlling, domineering, and as primarily interested in their daughters as instruments of their own needs, wishes, and aspirations. Participants considered their mothers as punishing, withholding, and ignoring. In accordance with this definition, they disclosed defiant and aggressive, as well as guilty and fearful feelings toward their mothers (Sours, 1969). Also, in Bolattin et al. (2017), mothers were apprehensive and authoritarian, but not particularly affectionate and empathetic; and Bemis (1978) exemplified that the mothers of anorexic individuals were commonly defined as dominant and intrusive. Similarly, Beresin, Gordon, and Herzog (1989) conducted a study with 13 recovered women with AN. Results showed that all of the subjects perceived harmful family conflicts; and they depicted their mothers as intrusive, unable to tolerate their child's growth and development, and excessively concerned with physical appearances. In accordance with this, Bruch and Selvini-Palazzoli described a mother-child relationship in which the child's needs were converted into what the mother's sense found appropriate. As a result, the child did not develop any conception of herself as an individual and displayed maladaptive symptoms, such as anorexic behaviors, in a desperate struggle to find a self-respecting identity (as cited in Bemis, 1978).

There have been several studies evidencing that the mother's characteristics and mother-daughter relationships are significant predictors of developing AN symptoms (Bruch, 1973; Granek, 2007; Salzman, 1997; Scourfield, 1995; Woodside et al., 2002). Salzman's study (1997) stated that daughters with the ambivalent attachment style reported that they found themselves trapped in the paradox of longing for their mothers and also wanting to reject them. They used a 'push-pull' analogy to describe

their relationships. The participants stated that the only time they did what they wanted without being subverted or manipulated by their mothers was with their symptoms. They were starving for nurturance that they could not get from their mothers. They were unable to stop longing for it; therefore, they were angry at their mothers for not supplying it. The findings of the study suggested that, in AN, a daughter might be hoping to secure love, nurturance, and attention from her mother who proved that she was unable to offer these in a consistent fashion. To conclude, the results showed that the daughters felt intense longing and anger towards their mothers since they perceived them as inconsistent, volatile, and preoccupied with their own emotional needs rather than their daughters'. The daughters said that they felt looked down on by their mothers on their self-esteem; however, they continued to hope for unconditional love and acceptance (Salzman, 1997).

Accordingly, in our study, participants expressed a deep sadness and loneliness regarding their distant and troubled relationships with their parents prior to the symptoms/diagnosis. They were describing a lack of support and communication. Due to the familial problems, they became distant to their family; they expressed a feeling of isolation within the family. They mentioned their parents' restrictions and not being able to please them. All these parental attitudes made them feel suffocated and they started to hurt themselves through actions such as cutting or starving, or both. They reported that their mothers did not show much affection to them and their love was defined as conditional. They perceived their families as much less cohesive and they disclosed a wish to have closer relationships. They also had a longing for love. They emphasized feelings of worthlessness and withdrawal of affection in their relations with their mothers. In addition, the humiliation and pressure of their mothers might have affected their sense of self and led them being introvert.

Furthermore, Selvini-Palazzoli (1974) stated that in comparison to mothers, the role of the father has remained unclear and been less studied. For example, in the study of Dare et al. (1994), it was reported that mothers were significantly more overinvolved than fathers in their daughters' lives. Fathers were usually characterized as lacking

affection, sulky, withdrawn, and at times avoidant toward their daughters (Bemis, 1978; Bolattin et al., 2017; Humphrey, 1988; Kalucy, Crisp, & Harding, 1977; Waller et al.,1940). In Beresin et al. (1989), participants described their fathers as distant, overinvolved with work, and often prone to alcohol abuse. However, the findings of this presenting study were contradictory. Participants described problematic relations with their mothers and criticized their motherhood; however, they idealized and valued their fathers and their relations with them. They described the parents as polar opposites. They presented their fathers as accepting and loving paternal figures while mothers were more restrictive and ruling. For the same behavior, they were criticizing their mothers while being tolerant towards their fathers. They thought their mothers' attitudes influenced their fathers' behaviors towards them, which affected their daughter-father relations as a result. They believed their fathers would not behave as such if it were not for their mothers. As it is seen, these statements contradict with the general findings of the literature in which several researchers often reported negative father images in their studies.

In addition, the findings of this study also have some culture-specific features. The general understanding of traditional family characteristics of Turkish parents is described in several studies. However, the traditional features presented in the literature are quite different from our findings. For example, contrary to our findings about family dynamics, in Turkish families, emotional bonding and social contact among family members are found to be very strong; ties between parents and children, between siblings, and between the children of siblings are extremely close. Much emotional closeness in the family is indicated, especially between mothers and children, and to a lesser extent, between fathers and daughters. Similarly, Kagitcibasi and Ataca (2005) stated that psychological needs and values are very important among family members and there was emotional closeness between generations, and these tend to be fulfilled more by daughters. Even though parents are generally restrictive in discipline, expecting their children to obey them instead of deciding independently and carrying the responsibility of their decisions (as cited in Aydogdu & Yildiz, 2016), they are emotionally warm. They provide nurturing, protective, and

supportive environments (Mottram & Hortacsu, 2005). Also, in relation to mother-daughter relationships, in Ataca (2009), the author reported that the Turkish youth generally feel closer to their mothers than to their fathers; they also communicate more with their mothers than with their fathers. In urban families, youths share information about themselves and their decisions with their fathers while sharing their emotions with their mothers. Mothers are more expressive than fathers. Daughters are more expressive than sons. Additionally, mothers express their emotions overtly such as through hugging and kissing, or verbally (Sunar & Fisek, 2005). However, in our study, participants reported to be diffident/unconfident and mentioned that they do not share much about their emotions with their parents. Also, mothers did not express their emotions either verbally or behaviorally. Accordingly, as stated in Imamoglu, Karakitapoglu-Aygun (2006), in traditional Turkish culture, there is a strong emphasis on interpersonal relationships and close ties with family members, and higher levels of relatedness are promoted. In fact, when individuals are asked about their desired levels of relatedness, they often report preferring even more relatedness with family members. Individuals report even greater relatedness with their mothers compared to their fathers; they have closer and more intimate relationships and open communication with mothers compared to fathers (Imamoglu & Karakitapoglu-Aygun, 2006).

Considering the discrepancy between our findings and the relevant literature on family dynamics and parental characteristics, it could be concluded that the deficiency in our family dynamics and problematic relations among family members might be a factor for women to develop anorexic symptoms. The symptoms might have emerged as a result of the conflict between what they have been experiencing in their families and what they have been observing in their social environment. However, this hypothesis needs to be supported with further research conducted with anorexic individuals and should specifically focus on this matter.

Moreover, Lacan's concept of object "nothing" (Lacan, 1956/1957) was supported our findings as well. Lacan stated that anorexia isn't not eating, but in fact eating

nothing. This means eating the object of "nothing." Nothing is something that is on the symbolic register. Lacan described how, through the object of nothing, children invert their dependence to their mothers (Lacan, 1958; Legrand, 2013; Silva et al., 2010). According to Lacan, this object of 'nothing' had a symbolic meaning in relation to the need for separation (Recalcati, 2014). The term refers to the anorexic's need for a lack of something, so as to reduce the omnipotence of his or her mother (Lacan, 1956/1957). The individuals with anorexia have a wish for and fear of fusion with their mothers (Birksted-Breen, 1989). The anorexic individual is stuck in between the terror of loneliness and the psychic annihilation. This view was supported in our study as well since the participants mentioned a longing for a close relationship and at the same time a lack of freedom and sense of separate self. Therefore, the individuals' stance of eating nothing is an attempt to turn the "nothing" into a barrier against the mother (Birksted-Breen, 1989; Fortes, 2012; Rudge & Fuks, 2014). AN actually is an attempt to separate from the mother and have a sense of self which is separate from the mother. Also, related to this, even though the participants did not mention it directly, it was our observation that the fathers were not active in their parental roles. The daughters were mostly in crisis with their mothers, and there was no mention of their fathers' involvement as mediators. Therefore, even though the daughters idealized their fathers and their relations with them, the protective paternal role is very weak in their lives. This lack of paternal involvement in the individual's life is similar to the findings of the literature (Birksted-Breen, 1989).

What's more, Gilbert (2001) suggested that 'symptoms can be related to the activation of evolved defense mechanisms to respond to losses and threats.' Once the defenses are easily evoked or prolonged, they become pathological. In other words, if they are aroused, but not expressed, they become inaffective/maladaptive. For instance, in Beresin et al. (1989), some women associated the beginning of their symptoms with problematic life experiences (i.e., separation from family, work, or school and meaningful relationships). These were thought as essential in the development of the symptoms (Beresin et al., 1989). In accordance with this, in this

study, there were statements supporting this argument. Besides the lack of love and care in their relations with their parents, the participants also described experiencing withdrawal at different levels in various parts of their lives. Considering the triggering factors for some of the participants, the onset of the symptom seemed to be related to the loss of a relationship, which could also be defined as the withdrawal of love. For some of them, their symptoms had started with school stress, but gotten worse when they separated from their parents due to moving to another city for college. For example, Büşra expressed that she felt abandoned by her parents, and disclosed feelings of loneliness. Additionally, in a study, women associated the beginning of their symptoms with troubling romantic experiences (Beresin et al., 1989). In our study, two of the participants mentioned that their symptoms started with the breakup with their significant other. For example, Yeliz described that period of her life as a loss experience: loss of a loving relationship. With the breakup, she also withdrew from her social life. Similarly, Yaren disclosed that her restricted eating behavior had started after her friend's comment on her weight; however, it became worse after her romantic relationship had ended. As a consequence, taking into account the precipitating factors on the onset of the symptoms and the troubling family relations together, it could be said that the participants experienced different forms of deprivation in their lives prior to the beginning of their symptoms. Therefore, it might be thought that anorexia enters the scene as a substitution for the deprivation of love and care in their lives.

In a similar vein, Waller et al. (1940) stated that AN symptoms can appear at a somewhat later period in life when adjustments of immense psychological significance must be faced, such as leaving home for college or boarding school, or marriage. In addition, it was stated in Kalucy et al. (1977) and Beumont et al. (1978) that these psychopathologies may arise at any stage of adolescent development. For example, when pressures in the family environment suddenly change, become more repressive, less supportive due to emerging adolescent behaviors or long-buried intra- or inter-parental conflicts, and bereavement in the family, the possibility of developing such problematic behaviors increase.

However, contrary to these relationship characteristics, McWey and Davis (2002) proposed that parental support significantly modified the association between negative life events and disordered eating in young females. High levels of maternal support were reported to have a protective function against negative events in the family in relation to disordered eating. In another study, Swarr and Richards (1996), found that closeness with parents was a contributing factor in the prevention of eating problems in young females (McWey & Davis, 2002). All these research findings seem important in developing intervention models or treatment programs when working with such individuals.

4.2. Food Deprivation to Compensate for the Feelings of Loss of Control and Freedom

This theme explained that food deprivation was a way to compensate for the feelings of loss of control and freedom in the participants' lives. As stated above, one of the key issues in the development of AN is a strong sense of unhappiness and loss. Something had gone wrong in the lives of the patients or something has been missing in the life of the individuals with AN (Dignon, Beardsmore, Spain, & Kuan, 2006). This might have been the result of trauma, bereavement, or might have stemmed from a more generalized experience of neglect or failure (Dignon et al., 2006; Kalucy et al., 1977; van der Broucke & Vandereycken, 1986). For instance, in Dignon et al. (2006) some patients reported feeling 'passed over' by their parents or peers. One of the patients disclosed that she felt a sense of loss because she felt she had never really been important in the life of her parents, and she had felt she had never developed a proper relationship with them. Or another patient reported that she experienced a generalized sense of dissatisfaction and loss in her performance at school. Several of the patients stated a failure to fit expectations. In general, they presented feelings of great pain and loss. Lawrence (1979) proposed that women feel unable to deal with the problems in life at the environmental level and turn it into an entirely internal problem. Therefore, it might be thought that to compensate for the sense of loss and failure, the individual focuses on food as a source of control and

discipline. The examples of loss and failure for the participants in this study were presented in detail in the Results section and discussed in the first theme above.

In terms of the theme of control, rigid desire to control food intake and weight is the essential feature of anorexia. They are used as a substitute for controlling real issues in their lives over which they feel they have no control at all (Granek, 2007; Lawrence, 1979; Surgenor, Horn, Plumridge, & Hudson, 2002; Thompson & Sherman, 1989). Hilde Bruch (1978) pointed out that behind the perfectly-controlled surface, there is a terrifying feeling of lack of control. She defined it as a 'paralyzing sense of ineffectiveness.' Thus, this sense of total inability to control their environment is compromised by an attempt to control the self with self-starvation (Lawrence, 1979). For example, in Dignon et al. (2006), the patients overcame all the problems in their lives by controlling their food intake. They were redressing the shortfalls in different areas of their lives, where their needs were unmet, through gaining control over food. By doing that, they somehow were able to keep at bay the pile of pain which was threatening and overwhelming them. Therefore, control over food can be considered as a coping mechanism that helps patients compensate for the lack of control in other areas of their lives.

When looking at the results of our study, many of the participants expressed that they resisted their parents' demands on eating and behaved contrarily. As a matter of fact, the participants reported that their food restrictions escalated/were exaggerated even more when the parents' kept pressuring them on eating. While explaining the development and course of the disease, they talked about feeling anger, hatred, and threatened. Therefore, considering all the statements together, it was thought their emotions/feelings towards their parents have been geared towards food; and food has become threatening. This was clearly observable in Sinem's expression, "at the end of that year I had really hated them both (mother and father)… Food started to become terrible. As if food was harmful. As if the act of eating, rather than not eating, was harmful…I would wonder in my head why they tried to feed me that, then I would decide not to eat it." Such eating behaviors also built a barrier between

them and the parents' demands; refusing food intake symbolized refusing the parents' expectations and created a power struggle between them. For example, Sinem stated "I would just eat oatmeal for a period because that was the only thing I enjoyed. I liked it a lot but they meddled with that as well so I stopped eating that too" or Yeliz disclosed "are you going to make me eat, I won't."

Additionally, through anorexic behavior, they were able to defy the power/impact of others on them. For example, Yaren expressed how she opposed her parents' demands. It was seen in her statement that she was not granted freedom by her parents and therefore, controlling eating behavior and opposing her parents' insistence on eating were her reactions to their restrictions on her life. Her understanding of the function of the symptom was related to receiving freedom or not being restricted anymore with the help of AN. AN behavior was protecting her from others' attempts to step into her life; it functions as a boundary between her and others. She stated "nobody but me can interfere with me. Right now, I don't allow it in my life because I really can't allow my freedom to be restricted at all, I can't". The participants' expressions showed that their need to control their life was fulfilled by anorexic behavior. In other words, AN provided them the desired control that they needed to have on themselves and others. Taking into consideration the participants' accounts, AN behavior functions as a way to draw their own boundaries, gain freedom, and take control of their lives.

In regard to the participants' attempts to set boundaries between them and their families, this finding was supported by several studies in detail. Studies have often evidenced rigid and enmeshed family dynamics as a causal factor for anorexia and bulimia nervosa (Minuchin et al., 1978). For instance, Sugarman, Quinlan, and Devenis (1981) reported that familial disharmony and blurred boundaries between family members were related to the development of AN. Most of the women in the study of Lamoreux and Bottorf (2005) described being overshadowed by their parents, which made it hard for them to distinguish where their boundaries end and others' boundaries begin. Lawrence (1979) also supported this finding stating that

patients could only define their own limits and set boundaries around themselves through their anorexic behaviors.

As it is seen, the findings of the literature and our study have common features in terms of autonomy, individuality, and separation. There is also some culture-specific features supporting those findings. For example, in the traditional Turkish cultural context, there seem to be 'fused and undifferentiated systems of relationships' and self-other boundaries appear to be fuzzier (Imamoglu & Karakitapoglu-Aygun, 2006). This was also supported in Akyil (2012) that Turkish families value interdependence, fluid boundaries, and cooperation. Similarly, as stated in Sunar (2002) (as cited in Kayrakli, 2008) that families place a high emphasis on conformity, obedience, and dependence while characteristics such as autonomy and assertiveness are not encouraged. Parent are restrictive and controlling toward their children, particularly on their daughters. Daughters are expected to be more obedient and dependent on their parents compared to boys (Ataca, 2006; as cited in Kayrakli, 2008). Accordingly, in our study, almost all of the participants mentioned that, compared to their siblings, they are more hesitant, dependent, and obedient to their parents and their decisions. Before the onset of the symptoms, they tended to do what their parents asked them. In other words, they used to place the family's needs/expectations before theirs.

Another sociocultural factor worth mentioning here is the potential effect of religion in the family context. Even though in our study, none of the participants referred to religion-related factors, religion is a highly valued element in child-rearing practices. In Turkey, the population is mostly Muslim, and it is inevitable that the parental values and desired child traits are influenced by Islamic content (Acevedo, Ellison, & Yılmaz, 2013). The Muslim parent-child socialization process is described within the framework of collective and interdependent cultures. Individualism is partly neglected and disregarded; and autonomy and individualism are not much encouraged due to the collective values of society (Acevedo et al., 2013). Child's obedience is more preferred than independence. Even though the influence of

religion differs across the country, from urban to rural areas, it is still there due to on-going cultural traditions. Taking into account this argument, the religion of the families might be a factor in not encouraging individualism and separation in our families. However, in order to make any interpretation or to come to a conclusion, the impact of Islamic restrictions on individuals should also be examined in future studies.

To continue, in a similar vein, Sours (1974) stated that the anorexic patient was unable to separate; she disclosed that she had no will of her own and so must have followed her mother's suggestions and shared her thoughts or feelings (as cited in Sugarman, 1981). However, due to the mother's characteristics of being cold, distant and so on, she was never able to meet her mother's expectations/needs, etc; therefore, she might have felt frustrated and established boundaries through AN behavior. Maladaptive AN behaviors might symbolize erected defenses and setting boundaries. Also, according to Bruch (1973), the pursuit of thinness in individuals with anorexia nervosa was initiated by an attempt to deal with the feelings of ineffectiveness and to stop their parents' efforts to control them. Parents did not encourage separateness and autonomy during their child's development. Hence, the control of food intake is an attempt to achieve autonomy and separation from parents (Schwartz, Thompson, & Johnson, 1982). In Sugarman's study (1991), several females used their eating disorders to express their rejection of authority and rules and to regain control over their lives (as cited in Gilbert & Thompson, 1996).

Accordingly, from the Lacanian perspective, this control and power applied to their relationships with their bodies and the feeling of mastery on their most basic need, hunger, seems to guarantee a way to relate to the Other. The anorexic subject's refusal of food is as a way of controlling and resisting the demands of the Other because it is the only way that they can affirm and maintain themselves as desiring subjects. Anorexic behavior guaranteed her the possibility of a lack and of a separation that allowed her to situate her own desire. Also, the aim of the treatment is to sustain their unconscious desire: the lack that the individuals need to establish

their own desire. The lack which is not threatened by the intrusive presence of the Other (Silva et al., 2010).

Moreover, as stated in Sugarman et al. (1981), anorexic symptoms are defenses against the threatened boundary loss related to the anorectic's anaclitic depression and accompanying symbiotic wishes. These features actually overlap the first theme of this study, which indicates a deprivation of love from the mother and a wish for a closer relationship with her. To continue, the extreme focus on food intake and the reaction to the feeding object function to avoid the anaclitic needs. In other words, by restricting or reducing their food intake they, in fact, attempt to reduce their feelings of dependency. The extremely thin shape represents their own body image, which is significantly and concretely different from others. Such a noticeable accentuation is important and necessary to maintain their differentiation of self at its most concrete and basic level, the body. Consequently, their attempts to be thin help to emphasize their body ego boundaries.

Lastly, anorexic behavior is depicted as a 'disorder of control' (Fairburn et al., 1999) and it functions as a 'successful behavior' when an individual perceives failure in all other areas of life (Lamoreux & Bottorff, 2005). The women feel they are not in charge of even ordinary everyday matters in their lives and that their relationships are often directed by others. Therefore, in their anorexic symptoms, they find the sense of control, power, success, and satisfaction as well as the feeling of specialness, superiority, and sense of mastery (Dignon et al., 2006; Fairburn et al., 1999; Fox, Larkin, & Leung, 2010; Granek, 2007; Higbed & Fox, 2010; Nordbø et al., 2006; Serpell et al., 1999; Slade, 1982; Weaver et al., 2005; Williams & Reid, 2010). Therefore, they expressed increased positive emotions and appreciated their symptoms. It was seen from their statements that they considered accomplishment in food restriction was a compensation for the failure in different areas of life (i.e., poor performance in college entrance exam, broken relationship, adjustment problems when leaving home, failing attempts of dieting, and so on).

4.3. Receiving Love and Care from the Family: Repairing the Broken Relationship

This theme indicated receiving care and love from the family, as well as repairing the broken relationship with them. The establishment of boundaries around the self that was stated in the theme above is actually a difficult problem for women because while setting boundaries they might also limit their relationships with others, which is what they strive for as stated in the first theme (Lawrence, 1979). However, paradoxically, the participants reported eliciting care through their symptoms. Their pursuit of emaciation might serve to reach their desire for eliciting care. The thinner they are, the more care they receive from their parents (Sugarman et al., 1981).

One of the most distinctive features of AN is being highly visible, it is probably the only psychiatric 'spot diagnosis', which evokes intense emotional reactions from others, especially from those closest to the person (Schmidt & Treasure, 2006). Whether intentional or not intended, the anorexic body conveys a hard-to-ignore message to others (Schmidt & Treasure, 2006). This powerful way of communicating their difficulties, without needing to communicate directly, brings about eliciting care and attention. Parents are horrified due to seeing their daughter systematically starving herself and becoming more and more ill (Lawrence, 1979). They expressed strong emotions, such as fear, despair, and pity to disapproval, horror, and disgust caused by their child's frail physical appearance (Schmidt & Treasure, 2006). Therefore, family, friends, and professionals try to persuade them to seek treatment and change their pattern of eating (Lawrence, 1979; Selvini-Palazzoli, 1985; Schmidt & Treasure, 2006).

Similarly, participants in this study expressed that care was not something that they received from their families before they were diagnosed with the syndrome. However, their disease, with increased health problems, stimulated health-related worries of their families, and therefore, their families started to express their concerns and worries. Consequently, AN symptoms resulted in the care and special

attention that they received from their families. They mentioned taking some relational benefits out of AN, which meant that their parents became more understanding, caring, and supportive. Additionally, in terms of eliciting care, Nordbø et al. (2006) mentioned that since the patients lost a significant amount of weight, people around them disclosed their concern. Similar to the findings of our study, participants of the study expressed that they had missed the manifestation of care and attention from their family and friends. However, after AN, they felt that others were concerned about their health. This showed that worrying about worsening health condition due to loss of weight became a sign of care. They thought that AN provided them the feelings of love that they had not experienced before in their relationships with their close ones.

Similar statements about receiving love and attention from others were found in Schmidt and Treasure (2006) and Higbed and Fox (2010), as well. One of their participants stated 'I think, in a way, when I am showing that there's something wrong, mum and dad pay a bit more attention to me. They understand that I am finding it hard and they try and talk to me and everything like that.' Considering participants' statements on receiving care, it was observed that the illness allowed them to obtain affection, to be the center of the family. Thus, it would be safe to conclude that AN symptoms have resulted in a secondary gain for the individuals. The secondary gains are frequently accepted at a conscious level that the individual with the diagnosis admits the desire for attention and sympathy.

To continue, Granek (2007) pointed out that even though the importance of thinness differed among individuals with the diagnosis, the common theme is that all of the women had a desire for feeling worthy and loved. As Bruch (1973) mentioned, in her book called *The Golden Cage: The Enigma of Anorexia Nervosa*, that anorexia nervosa has some exhibitionistic features in its nature even though only few women will confess it at first. In the process of psychotherapy, they admit that this cruel dieting is a way of drawing attention to themselves because they feel that nobody really cares for them. Additionally, the theme was also supported with the findings of

Serpell et al. (1999) and Garner and Bemis (1982) stating that they felt looked after, protected, and gained attention and concern through food rejection.

Furthermore, when looking at the second part of this superordinate theme, repairing broken relationships, participants stated that AN had a repairing and unifying effect on their interactions. Their relationship with the parents has changed in the course of AN. It turned into a caring one over time, and they were glad with this change. For example, in Sinem's situation, she was feeling pressure due to the high expectations regarding her performance for the college entrance exam. However, with the onset of her symptoms, her parents had an attitude which was more understanding and tolerating. She interpreted this change as her parents being afraid of losing her and starting to show affection. She expressed pleasure over her parents' overly caring behaviors and thought that the symptom also empowered their relations, and made them a family. This alteration in family dynamics could be considered as a secondary gain as well.

There are studies that enhance the understanding of the repairing function of AN symptoms in the literature. For example, Lacoste (2016) stated that AN behavior preserves the family circle or unity. The symptoms create a reason to be helpful and to be together. Minuchin et al. (1975) proposed a model that is formed of their observations of the families of psychosomatically ill individuals, the psychosomatic families. The model presents that the sick child plays an important role in the family's pattern of conflict avoidance; and this role is an important source of reinforcement for the child's symptoms (Minuchin, 1975). Additionally, Minuchin et al. (1978) said that the anorexic daughter tries to create harmony and closeness within her family by sacrificing her developmental need for a separate identity (as cited in Humphrey, 1988). Her such attempts divert the focus away from her parents' inadequacies and problems toward her symptoms. This changing of focus in the family enables the family to unite in helping their child in need. Similarly, in the study of Chassler (1997), the researchers reported that the participants felt more responsible for their parents' happiness than the control group. This feeling of the

children was thought to be an attempt to preserve or acquire a harmony, cohesion, and emotional stability within the family. These examples are thought to be highly related to the findings of our study. Since, as stated above, almost all of the participants mentioned family conflicts and how after their symptoms the family members gathered around to help the anorexic individual. There is a touching/moving saying of one of the participants in our study explaining very well the function of the symptom for her: "We are gaining benefit from my malice, you know, it's family."

4.4. Others as a Reference Point: The Importance of Others' Thoughts and Acceptance

According to a model based on Gilbert's evolutionary approach to psychopathology, mentioned in Schmidt and Treasure (2006), "symptoms are often related to the activation of defense mechanisms." The symptoms emerge in response to social threats to biosocial goals of evolutionary relevance, such as 'eliciting care from others' or 'gaining and maintaining social rank' (Gilbert, 2001, 2001a). With this model in mind, Schmidt and Treasure (2006) stated that self-starvation in AN is a maneuver with complex defensive functions to reduce the impact of the social threat that the individual faces. Hence, the symptoms of AN can be defined as an adaptive function.

In Granek's study (2007), all of the female participants defined their social circles as having a powerful impact on their desire and ability to maintain their anorexic behaviors. They stated that many of their peers were restricting their food intake and that their symptoms were spurred on by comments from their friends or family members. Thus, preoccupation with their bodies became a norm among them, rather than an exception. In relation with this, it was reported, in Mussell, Binford, and Fulkerson (2000), that women influence each other in developing and maintaining AN symptoms. Peer teasing was reported to have a significant impact on the onset of body self-consciousness and dieting. Similarly, findings in another study showed that there was a significant social pressure and interaction which contributed to maintaining

disorder. When the patients questioned the stress preceding the onset of their symptoms, they mentioned having being advised to diet or being teased about their weight.

In conformity with literature in our study, when looking at the situations that initiated the symptoms for some of the participants, it was seen that the triggering factor for the onset of their symptoms was related with an intolerance to criticism and comments related to their physical shape. Participants specified the onset of their anorectic behaviors as an influence of humiliation by their friends about their weight (i.e., Yaren and Ela's statements given above in the Results section). As it was seen from the statements of participants that there was social punishment perceived from others about their body shape/weight; also, it was very clear that they were sensitive and gave importance to others' thoughts. They were afraid that others would not find them beautiful and would not approve of them. Therefore, they thought by staying slim, they could meet their standards of beauty. As a consequence, they would feel they are worthy of compliments and recognition, and receiving social rewards (i.e., the pursuit of compliment/positive feedback) from others. Their self-worth was dependant on the views of others.

Furthermore, eating disorders are considered a result of societal obsessions with thinness (Collier & Treasure, 2004; Garner & Bemis, 1982). Recent research has evidenced the glorification of thinness in contemporary culture, and mass media's contributing impact on the development and maintenance of eating disorders by advocating slenderness (Garner & Garfinkel, 1982). Studies have presented a trend of increased thinness (Garner et al., 1980). For instance, research exploring the role of the media in eating disorders highlighted the decreasing weight of models, actresses, and beauty pageant contestants over time. These individuals are considered as ideal representations of beauty in the community (Spettigue & Henderson, 2004). In addition, magazine articles, tv shows, and advertisements have created a social perception that contributed to body dissatisfaction and disordered eating patterns in girls and women (Spettigue & Henderson, 2004). The strong focus on the importance of appearances and thinness for females have a significant negative influence on

body satisfaction, weight preoccupation, eating patterns, and the emotional well-being of women in contemporary cultures (Spettigue & Henderson, 2004). However, on the contrary, in our study, participants did not emphasize the adverse impact of media or contemporary cultural standards about thinness on their anorexic symptoms.

Moreover, as stated, there has been an increased emphasis on weight control and thinness in affluent contemporary societies; and when those cultural validations overlap with the emotional conflicts of the individuals, such as self-esteem regulation, autonomy, or control over separation, they might turn into symptoms. For instance, the individual, with her relentless pursuit of thinness, tries to satisfy social demands while denying or temporizing one's powerful internal needs (Schwartz et al., 1982). In a similar vein, women estimate their personal worth by comparing themselves to external standards, such as comparing their physical appearance, academic success, popularity, or work performance with others (Weaver et al., 2005). For example, in our study both Ela and Yeliz specifically mentioned how they compared their body shape with others and perceived their bodies as not beautiful enough. Additionally, individuals with the diagnosis do not know how to differentiate their own needs and wants from what they perceive others expect of them; therefore, they design their interactions to seek approval from others. In other words, the results of their AN behavior provide recognition from others (Weaver et al., 2005). For example, in our study, Selen stated that her mother showed her thinness to associate her sense of self-worth with her weight or body size and therefore, she believed that if she stayed slim, her mother would keep loving her or she would be loved. Similar to the findings of our study, Granek (2007) reported that anorexics want to feel worthy, valued, and loved; and they believed that this would be guaranteed by thinness. The participants of our study displayed a significantly negative self-image, and they disclosed being diffident/unconfident and having low self-confidence. Their body shape or weight seemed like the determinant of self-worth; and thus, the anorexic behavior functioned as a way to receive acceptance and value from others. Sinem and Yeliz thought that if they gained weight, they would

never have a boyfriend, which meant weight gain was imposing a threat of being alone. They associated weight gain with the potential threat of refusal from others; hence, they valued thinness in order to secure acceptance from others. It was protecting them from rejection. To put into words differently, participants referred to thinness as a guarantee or insurance of their acceptance.

In accordance with this argument, literature findings presented that women defined themselves by their anorexic behavior, and equated self-worth with weight loss. They feel good when they meet their expectations for food intake and exercise (Weaver et al., 2005). Susan Orbach (1978) discussed in her book called *Fat is a Feminist Issue* that the general image of womanhood is almost synonymous with thinness. If a woman is thin, she feels healthier, lighter, and less restricted, she also gains approval, love, and admiration from others and lives a good life with her athletic, sexy, and elegant body. Similarly, in Nordbø et al. (2006), the researchers explained that AN behavior, for participants, was referring to a way of getting compliments about their looks from other people and feeling worthy of compliments and acknowledgment. Through losing weight, the participants felt better about themselves. For example, they reported feeling smart, pretty, and successful, which they believed was supported or confirmed by their surroundings. As seen, there was an external positive affirmation felt by informants. Similarly, in Serpell et al. (1999), looking slim and looking more attractive was described as providing the benefits of getting more attention from the opposite sex; and putting on weight was reported to have the negative consequences of not being attractive. People around them, particularly their friends, initially, complimented the individuals' weight loss, which reinforced efforts to restrict food intake and created thoughts about being more attractive or generated feelings that they were special and confident (Branch & Eurman, 1980; Schmidt & Treasure, 2006; Serpell et al., 1999). In compliance with findings in the literature, in this study, weight loss was associated with getting compliments and positive feedback regarding appearance from others in participants' accounts. Additionally, thinness was considered as a synonym of beauty, a way of feeling more attractive.

Here they also talked about the fact that they considered putting on weight as becoming not attractive.

Thinness was also comforting for them because it ceased the comments of others. This finding is also important because it overlaps with the control theme in terms of setting boundaries to others. On the other hand, Büşra interpreted that the function of AN was seeking acceptance from others by standing against their expectations in order to make them accept her for who she was. Or, she described AN as a way to prove herself to others. She verbalized that it created a sense of self. In accordance with this, in Lacanian point of view, it is believed that the anorexic seeks for the "gaze of others." The individual with her body and behaviors calls for others' recognition, be it conformism or in conflict (as cited in Legrand & Briend, 2014). Taking into consideration all of these quotations, it could be seen that the participants considered others as a reference point for their view of self or self-worth by either refusing or accepting the expectations of others.

4.5. Is Anorexia Nervosa the Only Way Out?: Expressing Resentment and Anger through Punishing Others

This theme illustrated that eating problems seem to function as a way to express feelings. In the findings of our study, there were several feelings that the participants disclosed. Anger and resentment for the conditional love that they felt because of their families' attitudes were some of them. Additionally, The AN behavior was their way to stop or get rid of the burden they had on themselves. The burden was their attempts to make their families happy and proud. It was also an attempt to convey a message to their parents to make them regret their parenting attitudes toward them. Accordingly, when reviewing the literature, studies evidenced that anorexia nervosa symptoms are used as a means of communication when it is difficult to express true emotions (Jenkins & Ogden, 2011; Williams & Reid, 2010). The symptoms are patients' way of talking to the world about how they feel: communicating distress or emotions to the outside world (Nordbø et al., 2006; Serpell et al., 1999) because the

informants said that they did not know how else they could express their problems. AN helped them make others realize their feelings so that they could feel understood by the people around them. Anorexic behaviors help patients to express what they cannot say with words through their bodies; AN became a bodily expression of their stressful feelings (Jenkins & Ogden, 2011; Weaver et al., 2005). Lacoste (2016) supported these arguments and stated that AN symptoms are used as the element of language, as a way to communicate with others. Participants symptoms were interpreted as materialization of hunger in the body, which was a transformation addressed to parents. Also, similar to those findings, in the study of Tiller, Schmidt, and Treasure (1993) on alexithymia, they used their body instead to communicate feelings of distress.

In a similar vein, in the study of Williams and Reid (2010), it was stated that the symptoms are used as a means to punish themselves and others. An extreme emotional dependence accompanying resentment and hostility was commonly reported in the study conducted by Hsu et al. (1979). Also, it was observed that this dependency was reinforced by families. Participants mentioned a disturbed relationship, but excessive dependence on their mothers, with their parents before the onset of the symptoms. They felt hostile towards their fathers whom they described as remote and inaccessible (Hsu et al., 1979). Similarly, in Berlin, Boatman, Sheimo, and Szurek (1951), it was stated that the mothers of children with AN are overly concerned with food and seem to be very domineering, unable to give much love to their children, and often quite hostile to them. The fathers are defined as passive men who have little to say in family affairs. Therefore, the intake or refusal of food represents a significance in the reaction and expression of various emotional factors related particularly with the familial problems and conflicts with the environment. Through their symptoms, individuals were able to work out hostilities and to evoke the environment to certain acts of punishment. The symptoms help to reduce the internalized frustration and hostility towards parental figures (Waller et al., 1940). Food refusal is an acting out; a symbolization of aggressiveness. It is both a punishment for having such desires and is actually punishing the parents with threats

of death through self-starvation (Berlin et al., 1951). In accordance with these literature findings, participants'statements in our study also evidenced that anorexic behavior was a way to communicate emotional difficulties to their parents. Some of the participants expressed that their AN behaviors were their way of punishing their parents and themselves to display how much emotional pain they were in.

Adolescents are experiencing strong and often painful emotions (Barth, 2003), and it seems that refusing food is the patients' only rebellion. They were simply ignoring to do what is asked of them. This attitude is actually quite healthy in some ways because it is a way to prove that they are separate and independent individuals. It is their reaction to their "controlling, demanding, and needy" parents (Barth, 2003). These findings overlap with our second theme. Controlling the demands or expectations of the parents through food refusal is related both with gaining control over the parents and expressing their feelings towards their parental attitudes.

Furthermore, from the Lacanian perspective, hunger is not only a bodily need but is communicated as a demand which is addressed to others with the expectation of a response. Therefore, food cannot be reduced to a set of nutriments but is a way of communication with others, a communicative tool which the subject manipulates in the hope of controlling others. The eating behavior of the subject with the diagnosis of anorexia is modulated according to whom it is addressed, and according to the responsiveness of this person. The subjects body shape exposes to one's self and others the reality of the subjects hunger, that is, the reality of the desire for a response to one's demand. As it is seen, the key point in AN is not the food, it is the demand of the subject and response of the Other. The anorexic subject is demanding the bare responsiveness of others. The subject wants to see the Other's sensitivity to the subjects that are brought up. In accordance with this, in Lacanian psychoanalysis, it is specified that a demand is never only a 'demand of', but always a 'demand to', addressed to the Other with the expectation of his/her response (Legrand & Briend, 2014).

In the case of hunger, hunger elicits a demand, the other responds to it in a way that either satisfies this hunger or does not. However, the importance here is that in addition to manifesting a need to be fed, the demand always presented a desire to be heard, but to be heard for nothing. Since it is simply a desire, a desire for nothing, a desire of what is impossible to satisfy via the regulation of needs. In anorexia, the subject demands the others' response to her desire but excludes others' answer to her need. The subject needs no thing, no food, no answer, but only the bare responsiveness of others. Therefore, it could be concluded that anorexic symptoms are bodily manifestations addressed to others via the manipulation of food and eating behavior. The subject's body is transformed in the aim of addressing others with a desire purified from needs. And once the anorexic does not receive response from the other, she then radically rejects the other, isolates herself. Her rejection is frank and massive (as cited in Legrand & Briend, 2014).

However, as it is stated in Barth (2003) that since neither they nor their parents can tolerate the feelings, adolescents with eating disorders often have difficulty expressing anger. Once they express such feelings, their parents get angry and become self-critical to their child's aggression. This is similar to a Turkish family characteristic in which children are not allowed to communicate their anger toward parents (Ataca et al., 2005; as cited in Kayrakli, 2008). In our study, in the cases of Yaren and Büşra, we observed that they even become punishing. It is therefore often important to explore the adolescent's aggressive feelings toward their parents and reflect that the adolescent is angry at them and that her self-destructive behavior may be a result of her feelings of being hurt, neglected, and so on. Some of the participants in this study were struggling with neglecting, disconnected, uninvolved parents while others were looking for ways to separate from overly involved, controlling, and intrusive parents, who did not let their daughter manage their life. They attempted to regain control from their parents. However, all in all, anorexic behaviors were a call for support and understanding from them.

4.6. Distracting Attention away from Relational Problems: "I was dealing with what I ate to keep my mind occupied"

This theme referred that AN symptoms function as a way of avoiding negative emotions and experiences. In our study, participants reported that they used anorexic behaviors to distract their attention away from unpleasant experiences and feelings, as well as relational problems. They disclosed that those behaviors (i.e., restriction of food intake, calculating calories, and exercising) helped them escape from their problems and deal with the psychological pain they are in. AN behaviors were somewhat comforting for them due to the preoccupation they caused.

Similar to these findings, in the study of Nordbø et al. (2006), participants reported avoidance of hurtful feelings, relational problems, and high expectations for their own performance through AN behaviors. In addition, some of them described AN as a way of eluding problems. The type of problems that they disclosed varied. They expressed that they felt significant pressure on how to live their lives, how to make the 'right' decisions in many areas. Also, the participants' expectations from themselves were reported to be high, and this pressure was escalated by their friends and family members as well. Thus, they expressed feelings of sadness, loneliness, and anger. Through AN, they were able to avoid those negative emotions. When they focused on their body shape, weight, and food, they had almost no energy to concentrate on other difficulties or problems in their lives.

Similarly, as stated in Weaver et al. (2005), anorexia symptoms interrupt developmental and situational crisis and distract the individuals' attention from stresses of their lives, such as academic studies, child rearing problems, abuse, harassment, neglect, or loss. Anorexic behaviors function as a coping mechanism in order to deal with emotional problems and stress (Mulveen & Hepworth, 2006). It was discussed that AN allows the individuals to avoid emotions, responsibilities, and close relationships; it was also described as 'anorexia nervosa helps stifle emotions' (Serpell et al., 1999; Serpell, Teasdale, Troop, & Treasure, 2004). Due to the

exclusive mental preoccupation with food and eating, emotions become less salient; therefore, many patients reported that they feel somewhat numb. This feeling of numbness is favored by individuals because many of them have already had difficulty in tolerating negative emotions; and through AN behavior, they were able to manage those emotions (Higbed & Fox, 2010; Schmidt & Treasure, 2006; Serpell et al., 1999; Williams & Reid, 2010).

There were other studies that perpetuated these findings. For instance, in Fox et al. (2010), it was mentioned that focusing on food and eating distracts the participants from other troubling experiences. They thought that the eating issues served as a 'back up plan' or 'safety net' when life got out of control. In the study of Jenkins and Ogden (2011), most women expressed that AN became a tool of control for coping with stress and frustrations of everyday life, or with the transitional challenges or early traumas of life.

In the following section, a general conclusion with the implications, strengths, and limitations of the study, as well as suggestions for future research will be presented.

CHAPTER 5

CONCLUSION

5.1. Conclusions and Implications of the Current Study

The particular contribution of this study is to provide an in-depth interpretative exploration of the meaning and function of AN in Turkish young females experiencing AN. The use of interpretative phenomenological analysis provided a comprehensive and idiographic investigation of participants' lived experiences. The analysis resulted in six superordinate themes. These were "food deprivation as a substitute for privation of love and care; food deprivation to compensate for the feelings of loss of control and freedom; receiving love and care from the family: repairing the broken relationship; others as a reference point: the importance of others' thoughts and acceptance; is anorexia nervosa the only way out?: expressing resentment and anger through punishing others; distracting attention away from relational Problems: "I was dealing with what I ate to keep my mind occupied."

The participants' story began with the idea of privation of love and care, and being neglected by those who are close to them. They felt they lost control and freedom in their lives. Therefore, in order to handle all the difficulties in their lives, they developed AN symptoms. They believed that the symptoms were providing them a sense of control, power, acceptance, love, and care, as well as helping them avoid unpleasant feelings and situations that they were facing. Thus, as a result, the relentless pursuit of thinness is not a primary concern, rather it is a final step in this effort to solve the problems of living.

Accordingly, in AN, eating is considered as a “byproduct” (Minuchin et al., 1978); and AN is considered as a “communication disorder”: a disease of one’s relation to others; the root of it is one’s relation to the original other, the mother (Legrand, 2010). As it is reported in the study’s findings, the symptoms of AN develop when the subject cannot express herself and communicate with others. Then, the body takes hold of the subject and expresses the meaning which cannot be put into words. The anorexic symptom is not about beauty, it is about body language when every other language fails (Legrand, 2013). According to Lacan (1958), the silenced speech lies in symptoms. Symptoms that we are talking about are not words, in fact, they emerge when speech is muzzled and the words are missing. Like slips of the tongue (parapraxes), lapsus of memory, and dreams, symptoms are the symbols created in language, they express something that is structured and organized like a language. Since they are meant to substitute words, they maintain the structure of language; this view shows that there is more to language than words. As Lacan (1958) stated, what is not repressed but expressed is tailored based on what can be communicated to, accepted by, the Other. Therefore, as bodily language, the symptom involves others, and are inter-subjective. In this study, the symptoms of the participants have several meanings related to their relations with others, especially with the closest ones.

Participants of our study try to become powerful and autonomous; however, all they achieve is ‘‘pseudo-independence’’ (Andersson, 1995). It is a dilemma that is placed in between connectedness and dependence. At the same time, they mentioned an intense longing for being close to their mothers to feel connected and loved. Thus, their maladaptive eating patterns can be considered as coping mechanisms to manage the feelings of alienation and loneliness they experience in their family. Their experiences might have been so hurtful that they did not know how else they could survive.

Taken together, it might be thought that these young females were trying to fill a gap or fulfill an expectation of theirs. For them, thinness was a symbol compensating the

deprivation of love and loss of control and freedom. Hence, these women need to be supported in their meaning-making process to accept treatment. The relational effects of family, relatives, as well as socio-cultural atmosphere, in general, should be incorporated into psychotherapies or counseling processes. Also, health care providers should be more knowledgable about the nature of the disease and should embrace a careful approach to the patients suffering from the disease.

Furthermore, this study has several clinical implications. First of all, as seen in the findings, AN was a psychologically purposeful behavior for participants. Second, in accordance with the literature, participants' severity of their illness (i.e., level of acceptance or acknowledgment of their symptoms) were different; their maladaptive relationships with their anorexic behavior presented different intentions. Therefore, it would be a challenge to apply a standard treatment for those individuals. This study proved the importance of individualized treatment plans while working for those groups in order not to elicit resistance or dropout in the treatment process. At this point, it is also essential to mention that while applying such individualized treatments, it is critical to encourage patients to express their personal values and to explain how their anorexic behaviors fulfill and compromise their expectations from the symptoms. At this point, the six constructs of function uncovered in this study might be useful to clinicians and serve as a guide to help the patient verbalize the motives to maintain their symptoms. Third, conducting one-on-one face to face interviews, helped the researcher to establish a therapeutic alliance which led participants to open up more. Moreover, the findings have implications for prevention. For example, educative sessions should be conducted with parents and professionals who have a significant role in children's development. This may include emphasizing, praising, and promoting the qualities in young individuals so that they are not obsessed with their physical appearance and seek conformity on this. Also, the findings give some identifying hints that a child may be regulating their emotions through their food intake. Such hints would guide the parents or other close ones to respond sensitively to the individuals with the diagnosis.

5.2. Strengths and Limitations of the Study and Suggestions for Future Studies

The presenting study has several strengths. To the best of our knowledge, the present study is the first qualitative study investigating the meaning and function of AN among Turkish women with the diagnosis. This study also appears to have been one of the few qualitative studies using a sample of only a restricted subtype of AN. The findings are consistent with previous theories and researches, and therefore provide additional support for the following clinical practices.

The methodology utilized to investigate experiencing AN symptoms is Interpretative Phenomenological Analysis (IPA). It is useful to understand the experiences of participants in-depth and in detail from a socio-cultural perspective. Also, since it is a qualitative study, the issue of trustworthiness, subjectivity, and reflexivity was considered by the researcher carefully. In addition, a homogeneous sample was formed based on predetermined inclusion criteria to obtain an in-depth understanding of having AN from the participants' accounts. Additionally, the study focuses on the function, positive sides/aspects, of the symptoms. In the literature, there is a relatively small number of studies investigating only the positive side of the syndrome/gainings in both the world and Turkey. Therefore, it is our hope that our findings will enhance understanding of the ambivalence or reluctance to seek treatment and egosyntonic nature of the disease, and will lead further research and guide clinical interventions in the subject matter. Moreover, considering the increasing number of people with the diagnosis, it can be considered that AN has become a growing health care problem all around the world, including Turkey. This study proposes to investigate and understand this ever-increasing health problem, which may motivate health care professionals to generate a greater understanding of the experiences of these individuals.

Since it was beyond the scope of this study to provide a comprehensive investigation of AN experience; many other areas are left to examine. Therefore, there are some limitations to this study. The size and homogeneity of the research sample were

congruent with IPA guidelines requiring a detailed analysis of a specific group of people's response to a particular situation. Therefore, it is important to state that the findings of the study are rooted in time and culture and are not generalizable to population. It is likely that additional themes in terms of the functions of the symptoms would have been detected by using both a similar and a different sample. For example, probably, another homogeneous sample with regard to the other subtype of anorexia, namely binging-purging, might have different dynamics in its nature and would have yielded different conclusions. Thus, future studies might form a group with those individuals and conduct a study with them. Also, the sample included only young females. Even though AN is more prevalent among young women, studies with males and different age groups should be conducted as well. In addition, all the informants who took part in this study had been in treatment. They were getting treatment from different institutions and had experienced different theoretical traditions. This may have influenced their understanding and interpretation of AN and the informants' descriptions may reflect their therapist's understanding of AN rather than their own.

Furthermore, even though the participants mainly belong to a similar socioeconomic status, we could not meet homogeneity completely. Forming a homogeneous sample with similar family dynamics and cultural backgrounds would provide more accurate explanations. Additionally, the literature on this subject mainly focuses on the problematic maternal involvement in the development of the symptoms, and there is a relatively small number of studies on the paternal role. As stated above, in the discussion part, we found different father-daughter interactions. Hence, the paternal role requires more interest in order to make an interpretation and more research is needed on this issue.

Moreover, since the participants were comfortable with talking about the topic of the research and they provided in-depth information even in a single interview, it can be thought that this partially eliminated the disadvantages of having only one interview. However, it is still a limitation of the study. More than one interview with the same

participant may enrich the findings. Another limitation is the different years of the diagnosis of the participants; the meaning of the symptoms in the years of diagnosis, and later on, might be different. Thus, longitudinal studies looking at the meaning and function of AN symptoms in progress of time would provide more accurate results.

In terms of the suggestions for future studies, the current study has highlighted the need for more qualitative research into the phenomenology of AN. For example, as it is stated above, the syndrome has been found to be related with family dynamics; therefore, further research including family members, including mothers, fathers, and siblings, are much needed. Further research adding parents or other family members of those individuals might add another layer of understanding to the syndrome and the whole family system. Also, conducting further research with different cultural backgrounds is critically important in enriching the interpretations. These would be culture-specific studies conducted with different individualistic and collectivistic cultures, SES groups, and religious backgrounds.

Also, continuing with follow up studies with these patients might provide detailed information on the prognosis of the symptoms. Additionally, a way of addressing the thoughts of the individuals to their symptoms are retrospective, and, it may not accurately represent the nature of past experiences. Therefore, conducting longitudinal studies of the experience of the symptoms would be beneficial. Besides that, the participants of this study somehow agreed on getting treatment and psychological support; however, it might be beneficial to conduct studies with individuals who do not seek or refuse treatment, as well as who dropped out from treatment. This might give us some in-depth information on the egosyntonic nature of the syndrome. Lastly, as a final recommendation, since the meaning of the symptoms is unique to individuals, the best way to understand an individual is to describe the person in his or her complexity (Romanowicz & Moncayo, 2014). Thus, future research can focus on individualized, culture-sensitive treatment plans/strategies.

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APPENDICES

A: APPROVALS OF METU HUMAN SUBJECTS ETHICS COMMITTEE

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ
APPLIED ETHICS RESEARCH CENTER

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ORTA DOĞU TEKNİK ÜNİVERSİTESİ
MIDDLE EAST TECHNICAL UNIVERSITY

Sayı: 28620816 / 406

09 AĞUSTOS 2017

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Prof. Dr. Tülin GENÇÖZ ;

Danışmanlığını yaptığınız Derya ÖZBEK ŞİMŞEK'in ***"Yeme'yi Reddin Anlamı: Yeme Bozukluğu Algısının Yorumlayıcı Bir Fenomenolojik Analizi"*** başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülerek gerekli onay **2017-SOS-136** protokol numarası ile **01.09.2017 – 30.06.2018** tarihleri arasında geçerli olmak üzere verilmiştir.

Bilgilerinize saygılarımla sunarım.

Prof. Dr. Ş. Halil TURAN
Başkan V

Prof. Dr. Ayhan SOL
Üye

Prof. Dr. Ayhan Gürbüz DEMİR
Üye

Doç. Dr. Yaşar KONDAKÇI
Üye

Doç. Dr. Zana ÇITAK
Üye

Yrd. Doç. Dr. Pınar KAYGAN
Üye

Yrd. Doç. Dr. Emre SELÇUK
Üye

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Sayı: 28620816 / 425

08 AĞUSTOS 2018

Konu: Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi: İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Prof.Dr. Tülin GENÇÖZ

Danışmanlığını yaptığınız doktora öğrencisi Derya ÖZBEK ŞİMŞEK'in ***"Yeme'yi Reddin Anlamı: Yeme Bozukluğu Algısının Yorumlayıcı Bir Fenomenolojik Analizi "*** başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülerek gerekli onay **2017-SOS-136** protokol numarası ile **08.08.2018 - 30.08.2019** tarihleri arasında geçerli olmak üzere verilmiştir.

Bilgilerinize saygılarımla sunarım.

Prof. Dr. Ş. Halil TURAN
Başkan V

Prof. Dr. Ayhan SOL
Üye

Prof. Dr. Ayhan Gürbüz DEMİR
Üye

Doç. Dr. Yaşar KONDAKÇI
Üye

Doç. Dr. Zana ÇITAK
Üye

Doç. Dr. Emre SELÇUK
Üye

Dr. Öğr. Üyesi Pınar KAYGAN
Üye

B: INFORMED CONSENT FORM

Gönüllü Katılım Formu

Bu araştırma, ODTÜ Psikoloji Bölümü Klinik Psikoloji opsiyonu doktora öğrencisi Derya Özbek Şimşek'in doktora tez çalışması kapsamında olup Prof. Dr. Tülin Gençöz danışmanlığında yürütülmektedir. Bu form sizi araştırma koşulları hakkında bilgilendirmek için hazırlanmıştır. Araştırmanın amacı yeme bozukluğu örüntüsü gösteren bireylerin kişisel deneyimlerini ve bu deneyime verdikleri anlamı incelemektir. Ayrıca, bireylerin bu deneyimle ilgili duygu ve düşüncelerini nasıl ifade ettiklerini incelemek hedeflenmektedir. Çalışmanın yaklaşık olarak 60-90 dakika arasında sürmesi planlanmaktadır. Katılımcılardan araştırmacı tarafından sözel olarak sunulacak bir grup soruyu kendi deneyimleri çerçevesinde değerlendirerek cevaplandırmaları beklenmektedir. Görüşme süresince ses kaydı alınacaktır; ancak verilen bilgiler ve görüşler tamamen gizli tutulacak sadece araştırmacılar tarafından değerlendirilecektir. Katılımcılardan edinilen bilgiler kendi başına değil, diğer katılımcıların yanıtlarıyla beraber, bir bütün olarak ele alınıp değerlendirilecek ve yalnızca bilimsel amaçlarla kullanılacaktır. Bu çalışmanın sonuçları bilimsel dergi veya toplantılarda sunulabilir.

Katılım gönüllülük esasına bağlıdır. Araştırma genel olarak kişisel rahatsızlık verecek sorular veya uygulamalar içermemektedir; ancak görüşme esnasında sorulardan ya da herhangi başka bir sebepten dolayı rahatsız hissedildiği durumda katılımcı soruları cevaplama işini yarıda bırakabilir ve araştırmaya katılımdan vazgeçebilir. Böyle bir durumda çalışmayı uygulayan kişiye, çalışmadan çıkmak istediğinizi söylemeniz yeterli olacaktır.

Katıldığınız için şimdiden teşekkür ederiz. Çalışma hakkında daha fazla bilgi almak için Derya Özbek Şimşek ile iletişim kurabilirsiniz (e-posta: derya.ozbek@metu.edu.tr).

Mevcut çalışmanın kapsamı ve amacı araştırmacı tarafından görüşme öncesinde tarafıma sözel olarak yapıldı. Yukarıda yer alan bilgileri okudum, katılımcı olarak sorumluluklarımı anladım, ve çalışmaya katılmayı kabul ediyorum.

Katılımcının Adı-Soyadı:

İmzası:

Tarih (gün/ay/yıl):

C: SEMI-STRUCTURED INTERVIEW QUESTIONS

1) Can you tell me about yourself? How is your life? How is your relationship with your family and/or friends?
2) Can you tell me about history of your anorexia from the beginning to the present day?
    a. When did your complaints first appear? How did it start? How did it develop?
    b. What were your complaints?
    c. Are there any situations or people that you think is related to the onset of your complaints? What kind of impacts do you think they may have?
    d. What are the positive and negative impact/outcomes on/in your life?
3) Can you tell me about your diagnosis?
    a. When did you get the first diagnosis? Did you receive any treatment? What kind of treatments were they?
    b. How did the treatment process begin? What do you think about this?
    c. Do you think there are situations that affect the treatment process positively or negatively? What can these be?
    d. How do you think of your diagnosis/complaint? What do you think about it?
4) How do you evaluate your life when you think about your relationship with your family and friends before and after your complaints has started?
    a. Do you talk about your situation? Are there any people you want/received support from? Who?
    b. What would you say about the best and worst approaches of your close others?
5) Is there anything else you would like to add on? Or anything you thought I would ask but did not?

D: TURKISH VERSION OF THE QUESTIONS FOR INTERVIEWS

1. Kendinizi tanıtır mısınız? (Detaylı olarak hem kendi, hem de aile ve arkadaşlık ilişkileri hakkında, eğer ilgili bilgi gelmezse soru açılabilir)
2. Anoreksiya nervosa hikayenizden bahseder misiniz?

a. Şikâyetleriniz ilk ne zaman ortaya çıktı? Nasıl başladı? Nasıl gelişti?

b. Şikayetleriniz nelerdi?

c. Şikayetlerinizin başlamasıyla ilişkili olduğunu düşündüğünüz durumlar ya da kişiler oldu mu? Ne tür etkileri olduğunu düşünüyorsunuz?

d. Şikayetlerinizin hayatınızdaki negatif ve/veya pozitif etkileri neler olabilir?

3. Tanınızdan biraz bahsedebilir misiniz?

a. İlk tanıyı ne zaman almıştınız? Tedavi aldınız mı? Ne tür tedavilerdi?

b. Tedaviye süreci nasıl başladı? Sizin bu konuda görüşleriniz neler?

c. Tedavi sürecini olumlu ya da olumsuz etkileyen durumlar olduğunu düşünüyor musunuz? Bunlar neler olabilir?

d. Siz tanınızı/şikayetinizi nasıl değerlendiriyorsunuz? Bu konu hakkında ne düşünüyorsunuz?

4. Şikayetlerinizin öncesini ve sonrasını düşünerek yakınlarınızla ilişkilerinizi ve hayatınızı nasıl değerlendirirsiniz?

a. Şikayetiniz/hastalığınız hakkında konuşur musunuz? Kimlerle bu konu hakkında konuşursunuz? Destek istediğiniz/aldığınız kişiler var mı? Kimler?

b. Şikayetlerinizin başladığı zamandan itibaren düşünecek olursanız size en iyi ve en kötü gelen durumlarla/yaklaşımlar ilgili olarak ne söylersiniz?

5. Eklemek istediğiniz başka bir şey var mı? Ya da sormam gerektiğini düşündüğün bir kısım kaldı mı?

E: CURRICULUM VITAE

DERYA OZBEK SIMSEK

E-mail: deryaozbeksimsek@gmail.com

Education

Middle East Technical University, Faculty of Arts and Sciences, Ankara, Turkey

Doctor of Philosophy (PhD) in Clinical Psychology, October, 2019

Pennsylvania State University Harrisburg, School of Behavioral Sciences & Education Master of Arts (MA) in Applied Clinical Psychology, May 2014

(Sponsored by Ministry of Education, national scholarship program)

Indiana University, College of Arts & Sciences, Bloomington, IN

Intensive English Program, September 2010-May 2011

Hacettepe University, College of Arts & Sciences, Ankara, Turkey

Bachelors of Science in Psychology, June 2009

Work Experience

Middle East Technical University, Psychology Department

June 2015- present

Research and Teaching Assistant

Freud Lacan Psychoanalysis Association, Ankara, Turkey

(placed in the catalog of Association Lacanienne Internationale (A.L.I.)

June 2017-present

Board of Directors Member, Treasurer

Middle East Technical University, Psychology Department, AYNA Clinical Psychology Peer-Reviewed Journal (AYNA Klinik Psikoloji Dergisi)

December, 2016- present

Editorial Board Member

Middle East Technical University, Psychology Department, AYNA Klinik Psikoloji Dergisi (AYNA Clinical Psychology Peer-Reviewed Journal)

December, 2016- present

Journal Reviewer

Middle East Technical University, Psychology Department, AYNA Clinical Psychology Intervention Unit

October 2016 - present

Supervisor

Middle East Technical University, Psychology Department, AYNA Clinical Psychology Intervention Unit

June 2016 - present

Assistant Coordinator

Nevsehir Haci Bektas Veli University, Psychology Department

October, 2014- June 2015

Research Assistant

Ozdecan Special Education and Rehabilitation Center

August 2009-August 2010

Counselor

Internship Experiences

AYNA Clinical Psychology Intervention Unit, Middle East Technical University, Clinical Psychology Department

September 2015-Present

Outpatient Therapist

T.W. Ponessa & Associates Counseling Services

January 2013-August 2013

Outpatient Therapist Intern

Philhaven Behavioral Health

August 2012-December 2012

After School Program Intern

Diskapi Training and Research Hospital, Ankara

July 2008-August 2008

Intern at Adult & Child Psychiatry Service

Autism Association - Training Project for Volunteers, Ankara

September, 2007-January, 2008

Intern/Volunteer

Eskisehir State Hospital

July 2007-August 2007

Intern at Child & Adolescent Psychiatry Service

Teaching Experiences

Adult Psychopathology: Psychodynamic Approach, Prof. Dr. Tulin Gencoz (Spring 2017, 2018)- Teaching Assistant (METU)

Cognitive Behavioral Therapies, Prof. Dr. Nuray Karanci (Fall, 2015)- Teaching Assistant (METU)

Dynamic Psychotherapy, Prof. Dr. Faruk Gencoz (Fall, 2018)- Teaching Assistant (METU)

Emotions in Psychopathology, Prof. Dr. Faruk Gencoz (Spring, 2018)- Teaching Assistant (METU)

Psychotherapy Supervision, Prof. Dr. Faruk Gencoz (Spring, 2019)- Teaching Assistant (METU)

Research Methods in Clinical Psychology, Prof. Dr. Tülin Gencoz (Fall, 2018)- Teaching Assistant (METU)

Selected Topics in Psychology, Prof. Dr. Faruk Gencoz (Spring, 2018)- Teaching Assistant (METU)

Techniques of Psychotherapy, Prof. Dr. Faruk Gencoz (Spring, 2019)- Teaching Assistant (METU)

Research Experiences

Gulhane Training and Research Hospital & Gazi University & The Scientific and Technological Research Council of Turkey (TUBITAK)

January 2015- May 2016

Graduate Research Assistant, The association of reassurance seeking with obsessive compulsive symptoms and related emotions

Hacettepe University & The Scientific and Technological Research Council of Turkey (TUBITAK)

March 2008-April 2008

Undergraduate Research Assistant, The role of self determination in the development of healthy adolescent functioning and the effects of parental practices

January 2009-June 2009

Undergraduate Research Assistant, Stanford-Binet Intelligence Scale – Standardization Project

Undergraduate Research Assistant, Wechsler Intelligence Scale for Children IV-Standardization Project

Publications

Gencoz, T., **& Ozbek Simsek, D.** (in press). Psikanalitik Kuramlar. In M. Eskin (Ed.), *Klinik Psikoloji*. Ankara: TPD.

Ozbek Simsek, D., Bulut, B. P., Baltacı, S., & Gencoz, F. (under review). Klinikte Lacanyen Psikanaliz. *Türkiye Klinikleri Dergisi, Lacanyen Psikanaliz Özel Sayısı.*

Ozbek Simsek, D. (2017). Lacanyen Yaklasımda Histerigin Arzusu ve Arzunun Tatminsizligi (A Lacanian Approach to a Case of Hysteria: The Desire of the Hysteric). *AYNA Klinik Psikoloji Dergisi*, *4*(3), 24-42.

National Congresses, Symposiums & Seminars

Ozbek Simsek, D. (May, 2019). *Imgesel, Simgesel, ve Gercek*, Psikanalize Giris Seminerleri - I. METU CEC, Istanbul, Turkey.

Ozbek Simsek, D. (April, 2019). *Psikanalizin Gelisimi ve Freud'a Donus*, Psikanalize Giris Seminerleri - I. METU CEC, Istanbul, Turkey.

Ozkul, G., & **Ozbek Simsek, D.** (2019, April). *Dora Vakası & Histeri.* Lacanyen Psikanaliz Seminerleri - 2019 Spring, Ankara, Turkey.

Gagua, N., & **Ozbek Simsek, D.** (2019, April). *Arzu & Kasabın Karısı.* Lacanyen Psikanaliz Seminerleri - 2019 Spring, Ankara, Turkey.

Bulut, B. P. & **Ozbek Simsek, D.** (2018, October). *Psikanalizin Gelisimi ve Freud'a Donus*. Lacanyen Psikanaliz Seminerleri - 2018 Fall, Ankara, Turkey.

Bulut, B. P., & **Ozbek Simsek, D**. (2018). *Psikanalizde Klinik Yapılar.* Oral Presentation at *20. Ulusal Psikoloji Kongresi*, Ankara, Turkey.

Gursel, D., Gencoz, F., Gencoz, T., **Ozbek Simsek, D.**, Baltaci, S., & Bulut, B. P. (2018, April). *"Karnavalesk" Mizah ve Dil*. In D. Gürsel (Chair), *Lacanyen Psikanaliz Sempozyumu-III: Söylem ve Dil*. Symposium conducted by the Freud Lacan Psychoanalysis Association at Turkish-American Association, Ankara.

Ozbek Simsek, D. (2017, November). *Surcmeler ve Espriler*. Lacanyen Psikanaliz Seminerleri - 2017 Fall, Ankara, Turkey.

Baltaci, S., **Ozbek Simsek, D.**, Gokdemir- Bulut, B. P. (2017, May). *Histerinin Identifikasyonu (Identification in Hysteria)*. In F. Gencöz (Chair), *Lacanyen Psikanaliz Sempozyumu-1: Kimlik ve Kimliklesme.* Symposium conducted by the Freud Lacan Psychoanalysis Association at the Middle East Technical University, Ankara.

Ozbek, D., Kilic, M., Turkan, N. (July, 2007). *University Students' Attitudes about*

Premarital Sexual Intercourse. Oral Presentation *13th National Psychology Student Congress*, Cyprus.

Trainings

Psychodrama Workshop, XIII. National Psychology Student Congress July, 2008

Psychodrama Workshop, Hacettepe University March, 2009

A. Ozbek Psychodrama Institute Workshop May, 2009

Psychosocial Crisis, Suicidal Behavior, Intervention Techniques November-December, 2009

Traumatic Stress Reactions Workshop June, 2010

Prepare-Enrich Training/Certificate Program March-April, 2013

International Society for Schema Therapy-ISST Approved November, 2014-May, 2015

Istanbul International Zerka Moreno Psychodrama Institute November 2015- June, 2016

Schema Therapist for Children and Adolescents (Dr. Christof Loose) February, 2019

Languages

Turkish (Native), English (Advanced)**,** French (Elementary)

F: TURKISH SUMMARY / TÜRKÇE ÖZET

BÖLÜM 1

GENEL GİRİŞ

1.1. Genel Bakış

Bu araştırma, anoreksiya nervoza (AN) tanısına sahip Türk kadınlarının anoreksiya nervoza semptomlarının işlevine yükledikleri anlamı inceleyen bir Yorumlayıcı Fenomenolojik Analiz (YFA) çalışmasıdır (Smith ve Osborn, 2003; Smith, Flowers, ve Larkin, 2009).

Bu bölümde ilk olarak, mevcut literatür ışığında anoreksiya nervoza hakkında genel bir giriş sunulacaktır. Ayrıca, çalışmanın gerekçesi ve amaçları detaylı olarak açıklanacaktır.

1.2. Kendini Aç Bırakma (Self-Starvation) Kavramının Tarihsel Gelişimi

Anoreksiya nervoza göreceli olarak içinde bulunduğumuz çağa ait bir hastalık olarak kabul edilse de bazı çalışmalar istemli kendini aç bırakma örneklerinin tarih boyunca, antik Yunan ve Mısır kültürleri de dahil olmak üzere, birçok dönemde ve kişi de gözlemlendiğini ortaya koymuştur (Davis ve Nguyen, 2014; Dell'Osso ve ark., 2016). Orta çağlar boyunca, özellikle 13. yüzyıldan 16. yüzyıla kadar, genellikle erken yaşta ölümlere neden olan kişinin kendinin başlattığı, aşırı boyutlara ulaşan aç kalma davranışlarından (self-induced fasting) bahsedilmiştir (örn., Catherina from Siena). O dönemlerde kendini aç bırakma davranışı daha çok kadınların azizlik ideallerinin kendine özgü bir özelliği olarak düşünülmekte, ve çağlar boyunca ruhun

arındırılması ve Tanrı'nın yüceltilmesi amacıyla uygulanmaktadır. Bu durum "kutsal anoreksiya (holy anorexia)", "çilecilik (ascetism)" veya "anoreksiya yılı (anorexia mirabilis)" gibi farklı terimlerle tanımlanmıştır (Behar ve Arancibia, 2015; Dell'Osso ve ark., 2016).

Bu noktada ayrıca, kendini aç bırakma kavramının anlamının son üç yüzyıldaki değişimine bakmak da önemli olacaktır. Beslenme kısıtlaması son yüzyıllarda dini temsillerden çok beden imgesi ve kendilik temsili ile ilişkili hale gelmiştir. 18. yüzyılın ortalarından bu yana ideal kadın bedeni yuvarlak bir figürden ince bir şekle ve görünüme dönüşmüştür (Dell'Osso ve ark., 2016). Örneğin, Sissy olarak da bilinen Avusturya İmparatoriçesi Elizabeth, döneminde oldukça katı bir diyet uygulamış ve aşırı egzersiz yapmıştır. Uzun ve çok ince vücudu ile 19. yüzyılın ikinci yarısında modern güzellik idealinin temsilcisi olmuştur ve bu incelik ideali 21. yüzyıla kadar giderek daha fazla popülerlik kazanmıştır (Dell'Osso ve ark., 2016).

Yukarıda belirtildiği gibi, "kutsal anoreksiya" bu yüzyılın anoreksiya nervozasından oldukça farklıdır. Her ne kadar "kutsal anoreksiya" ve modern anoreksiya bazı ortak özellikleri paylaşsa da farklı amaçlara hizmet etmektedirler. "Kutsal anoreksiya" ruhsal saflığa ya da Tanrı ile ilahi bir karşılaşmaya odaklanmakla ilgilidir. Başka bir deyişle, Tanrı ile kutsal bir iletişim kurmanın ve öz disiplin pratiğinin bir yolu olarak kabul edilmektedir. Bununla birlikte, günümüzde anoreksiya nervoza, sosyokültürel estetik ideallerini karşılamak için beden şekli ve ağırlığının aşırı değerlendirilmesi ve kusurlu bir benlik algısı ve takıntılı bir incelik düşüncesi ile ilişkilidir (Behar ve Arancibia, 2015; Dell'Osso ve ark., 2016).

1.3. Anoreksiya Nervozanın Klinik Tanımı ve Özellikleri

Anoreksiya kelimesi Latince kökenlidir. "An-(olmayan)" ve "orexis-(iştah, arzu)" kelimelerinden oluşur. Bu nedenle, iştah kaybı anlamına gelmektedir. Ancak, anoreksiya nervoza terimi sonraki yıllarda yanıltıcı bir kullanım olmakla eleştirilmiştir çünkü sendrom aslında bir iştahsızlık içermemektedir (Habermas,

2015). Tanı alan hastalar iştahsızlıktan yakınmamaktadır, aksine kasıtlı ya da gönüllü bir biçimde yiyecek tüketimlerini kısıtlamaktadırlar (Bruch, 1982a).

Anoreksiya nervoza psikojenik bir bozukluk olarak ilk kez Mental Bozuklukların Tanısal ve Sayımsal El Kitabı- I'de listelenmiştir (DSM; Amerikan Psikiyatri Birliği (APA), 1952). DSM-II'de (1968), anoreksiya nervoza beslenme bozuklukları adı altında, özel belirtiler bölümüne yerleştirilmiştir. Farklı klinik tabloları nedeniyle semptomlar ilk önce DSM-III'de (1980) çocukluk ve ergenlik bozuklukları kategorisi altında ayrı bozukluklar olarak tanımlanmıştır. DSM-IV-TR'de (2000) yeme bozuklukları ayrı bir bölüme taşınmıştır. Son olarak, DSM'nin en son versiyonu olan DSM-V'de (2013), yeme bozuklukları Beslenme ve Yeme Bozuklukları adı altında sınıflandırılmıştır.

Beslenme ve yeme bozuklukları, yiyecek tüketiminde (yetersiz ya da aşırı yiyecek tüketimi) olumsuz bir değişikliğe neden olan ve sonucunda da bireyin fiziksel sağlığında ve psikososyal işlevlerinde önemli bir bozulmaya yol açan davranışlar olarak tanımlanmaktadır. Pika, ruminasyon bozukluğu, kısıtlı yiyecek alımı bozukluğu, anoreksiya nervoza, bulimia nervoza, ve tıkınırcasına yeme bozuklukları için tanı kriterleri belirlenmiştir (APA, 2013). En sık görülen yeme bozuklukları arasında anoreksiya nervoza, bulimia nervoza, ve tıkınırcasına yeme bozukluğu bulunmaktadır. Bahsi geçen durumlar hem erkekleri hem de kadınları etkilemektedir. Erkekler arasındaki yaygınlığı hakkında sınırlı bilgi olmasına rağmen, anoreksiya nervoza erkeklerde kadınlardan daha az yaygındır; araştırma sonuçlarına göre kadın erkek oranı yaklaşık olarak 10:1 olarak belirtilmiştir (APA, 2013). Bu çalışmada odak noktası özellikle anoreksiya nervoza üzerinde olacaktır. DSM-V'e göre anoreksiya nervoza tanı kriterleri detaylı olarak aşağıda verilmiştir.

Anoreksiya nervoza, kilo alma korkusu ile yeme kısıtlaması ya da reddi, kilo alımını engelleyen davranışlar, vücut ağırlığının minimal düzeyde normal olandan daha düşük tutulması, ve bozulmuş beden algısı ile karakterize edilmektedir. Ayrıca, DSM-V'de (2013), kısıtlayıcı tip ve tıkınırcasına yeme-çıkarma tipi olmak üzere iki

alt tip anoreksiya nervoza tanımlanmıştır. Kısıtlı tip anoreksiya nervozada, bireyler son üç ay içerisinde tekrarlayan yeme ve çıkarma davranışına sahip değildir ve kilo kaybı temel olarak diyet ve egzersizle gerçekleşmektedir. Öte yandan, tıkınırcasına yeme-çıkarma tip anoreksiya nervozada, bireyler son üç ay içinde tekrarlayan tıkınırcasına yeme ve sonrasında kusma örüntüsüne sahiplerdir (APA, 2013).

Anoreksiya nervoza yaygın olarak ergenlik döneminde veya genç erişkinlikte başlamaktadır. Ergenlikten önce veya 40 yaşından sonra başlaması nadirdir. Başlangıcı genellikle üniversite için evden ayrılmak gibi stresli bir yaşam olayıyla ilişkilidir ve hastalığın seyri ve sonucu bireyler arasında oldukça çeşitlilik göstermektedir (APA, 2013).

Tanı alan bireylerin özgüvenleri vücut şekli ve ağırlık algılarına oldukça bağlıdır. Onların bakış açısına göre, kilo kaybı öz disiplin ve kontrol olarak görülürken, kilo alımı kendini kontrol etmekte başarısızlık olarak kabul edilmektedir. Genellikle aile üyeleri tarafından tedaviye getirilirler ve kilo kaybından şikayet etmeleri alışıldık bir durum değildir. Bu durum içgörü eksikliği ya da hastalığın reddi olarak yorumlanabilmektedir (APA, 2013). Örneğin, Espíndola ve Blay (2009) çalışmalarında, tanı alan hastaların durumu kendi kimliklerinin bir parçası olarak gördüklerini ve anoreksiya nervoza semptomları olmadan yaşamayı kimliklerinin yitimine ilişkin bir tehdit olarak algıladıklarını belirtmişlerdir. Bu nedenle, anoreksiya nervozayı kişiliklerinin ayrılmaz bir parçası olarak gören bireyler için tedaviyi kabul etmek alması zor ve stres yaratıcı bir karar olabilmektedir.

Ayrıca, anoreksiya nervoza belirtileri ciddi sağlık sorunlarına neden olabilmektedir. Fiziksel sağlığı, özellikle organ sistemlerini, etkileyebilmekte ve hayati tehlike arz eden tıbbi rahatsızlıklara yol açabilmektedir. Ortaya çıkan rahatsızlıkların çoğunun etkileri beslenme rehabilitasyonu sonucunda tedavi edilebilirken bazıları, örneğin kemik mineral yoğunluğu, tamamen geri dönüşümlü bir şekilde tedavi edilebilir değildir (APA, 2013; Mehler, Krantz, ve Sachs, 2015; Walsh, 1998).

1.4. Etiyoloji - Teorik Açıklamalar ve Katkılar

Mevcut modeller anoreksiya nervozanın çok faktörlü kökenini, risk faktörlerini ve bunların birbiri ile ilişkisinin bireyin gelişim çerçevesi içindeki etkileşimlerini vurgulasa da hastalığın etiyolojisi hala yeterince anlaşılamamıştır (Fairburn ve Harrison, 2003; Garner ve Myerholtz, 1998; Steinhausen, 2002; Keski-Rahkonen ve ark., 2007). Anoreksiyanın etiyolojisine ilişkin açıklamalar cinselliğe ilişkin bilinçdışı çatışmalara odaklanan erken dönem psikanalitik teorilerle başlamıştır (Freud, 1905, 1954; Waller, Kaufman, ve Deutsch, 1940). Sonraki süreçte, erken dönem bebek-anne ilişkilerinin bireyin gelişimindeki rolüne odaklanan nesne ilişkileri teorisinin ortaya çıkması yeme bozukluklarının temelinin yeniden gözden geçirilmesine yol açmıştır (Kohut, 1971; Winnicott, 1953). Ayrıca, genetik ve sosyokültürel faktörlerin de hastalığın gelişimi ile ilişkili olduğu bulunmuştur, ancak bu faktörlerin nasıl ve ne ölçüde etkileşime girdiği henüz tam olarak bilinememektedir (Treasure, Claudino, ve Zucker, 2010; van Son, van Hoeken, Bartelds, van Furth, ve Hoek, 2006; Walsh, 2013).

Bu çalışmada belirli bir modelin veya yaklaşımın verilerin yorumlanması üzerinde aşırı etkisi olmasını önlemek için veriler birden fazla yaklaşım ve teorik model çerçevesinde ele alınmaya çalışılmıştır. Böylelikle, katılımcıların deneyimlerinin belirli bir perspektife sığdırılmasının ya da yanlı bir yorumlamanın önüne geçilmesi hedeflenmiştir. Metnin tam formunda değinilen başlıca yaklaşımlar şu şekildedir: Dürtü Kuramı, Freud'un Klasik Psikanalitik Modeli, Ego Psikolojisi, Kişilerarası Teori, Nesne İlişkileri Teorisi, Kendilik Psikolojisi, Bağlanma Teorisi, Feminist Teori, ve Lacan'ın Psikanalitik Perspektifi. Bu kısa özette bahsi geçen modellerin detaylarına kelime kısıtlılığından dolayı yer verilememiştir, ancak tezin giriş bölümünde araştırmanın sorusuna uygun olarak anoreksiya nervozanın etiyolojisine yönelik açıklamalarına genişçe yer verilmiştir.

1.5. The Aim and Scope of the Study

Bu tez çalışmasında, anoreksiya nervoza tanısına sahip olan kadınların öznel deneyimini araştırmak ve semptomun yaşamlarındaki işlevini anlamak amaçlanmıştır. Ayrıca, araştırmacı katılımcıların cevaplarının çeşitliliğini ve benzerliğini ortaya koymayı ve böylelikle semptomun çok yönlü işlevini tanımlamayı amaçlamıştır. Katılımcıların deneyimlerinin daha derinlemesine anlaşılmasını kolaylaştırmak için katılımcıların semptomları hakkındaki düşüncelerini ve duygularını nasıl ifade ettikleri de çalışma kapsamına dahil edilmiştir. Ancak, yukarıda belirtildiği üzere anoreksiya nervoza tanısı olan bireylerde semptom egoyla uyumlu (egosyntonic) bir doğaya sahiptir ve çoğunlukla bireyler tarafından bir hastalık olarak kabul edilmez (Garner ve Bemis, 1982; Gregertsen, Mandy, ve Serpell, 2017; Nordbø, Espeset, Gulliksen, Skårderud, ve Holte, 2006; Vitousek, Watson, ve Wilson, 1998). Bu sebeple nicel çalışmalardaki gibi önceden belirlenmiş belirgin bir bakış açısı ile yönlendirilen ve değerlendirilen bir yaklaşımla semptomun kişinin yaşamındaki anlamı hakkında bilgi edinmek pek mümkün olmayacaktır. Bütün bu noktaları göz önünde bulundurarak, böyle bir grupla semptomun anlamını ve işlevini incelemenin nitel bir yaklaşımla daha etkili ve uygun olacağı kanaatine varılmıştır.

Nitel yaklaşım, katılımcıları kendilerini özgürce ifade etmeleri için cesaretlendirdiğinden, araştırmacının katılımcıların anoreksiya nervoza konusundaki deneyimleri hakkında geniş bir bilgi yelpazesi sunmasını mümkün kılmaktadır. Sonuç olarak, nitel bir yaklaşım olan yorumlayıcı fenomenolojik analiz (YFA), bu araştırma için en uygun metodoloji olarak düşünülmüştür. YFA araştırmaya konu edilen fenomen temel olarak "karmaşık, belirsiz, ve duygusal olarak yüklü" olduğunda özellikle pratik ve faydalıdır (Smith ve Osborn, 2015). Bu bilgiye uygun olarak, Higbed ve Fox (2010) tarafından yapılan bir araştırmada, anoreksiya nervoza tanısı alan katılımcıların, hastalığı "karmaşık, belirsiz, ve sıklıkla anlaşılması zor olarak" tanımlamışlardır.

BÖLÜM 2

YÖNTEM

2.1. Genel Metodoloji and Araştırma Dizaynı

Nitel yöntemler, klinik araştırmalar açısından oldukça değerlidir çünkü araştırmacının katılımcının deneyiminin detaylarını derinlemesine anlamasını mümkün kılar (Cromby, 2012). Özellikle, deneyim ya da fenomenin özelliklerine ilişkin zengin, kapsamlı, ve betimleyici biçimde bilgi sunmaya odaklanır (Pietkiewicz ve Smith, 2012). Yaklaşımın ana odağı, hipotez test etmek, doğrulamak, araştırmaya konu olan fenomeni önceden belirlenmiş bir kategori veya kavramsal ölçütlere koymak veya nicel yaklaşımda olduğu gibi nedensel bir açıklama getirmek yerine, söz konusu fenomene ilişkin anlayışı zenginleştirmektir (Elliott ve ark., 1999; Pietkiewicz ve Smith, 2012).

2.2. Araştırma için YFA Seçilmesinin Nedeni

YFA, bireylerin kişisel yaşam deneyimlerini nasıl algıladıklarını, nasıl hareket ettiklerini ve bu deneyime nasıl bir anlam atfettiklerini ayrıntılı olarak incelemektedir (Biggerstaff 2012; Eatough ve Smith, 2008; Smith, Jarman, ve Osborn, 1999; Smith, 2004; Smith ve Osborn, 2015; Smith ve ark., 2009; Smith ve Osborn 2003). Katılımcının deneyimine ayrıcalıklı ve öncelikli bir önem atfetmektedir (Pringle, Drummond, McLafferty, ve Hendry, 2011). YFA'nın bir diğer amacı da sosyal,

kültürel ve teorik bağlamla ilgili bütünlüklü bir anlayış sağlamaktır (Smith ve Osborn, 2015). YFA'nın ayırıcı özellikleri şöyle sıralanabilir. Öncelikle, yöntem her bir katılımcının deneyiminin zengin ve ayrıntılı bir tanımını ve anlamını oluşturabilmek için bir veya birkaç kişiye odanlanmaktadır (Morrow, 2005). Bu nedenle, her bir vaka ayrı ayrı ve kendine özgü bağlamda ayrıntılı olarak incelenmektedir (Pietkiewicz ve Smith, 2012; Smith ve Osborn, 2007; Smith ve Osborn, 2015). Ayrıca tümevarımsal bir yaklaşıma sahiptir (Morrow, 2005; Reid ve ark., 2005). YFA kullanan araştırmacıların ortaya çıkan yeni konular, sorular, ve sorunlara ilişkin açık olmaları, bu durumları sorgulamaları ve analize dahil etmeleri beklenmektedir (Smith, 2004).

2.3. Katılımcılar ve Örnekleme Yöntemi

Bu çalışmada, YFA kurallarına uygun olarak amaçlı ve homojen örnekleme yöntemine başvurulmuştur (Smith ve Osborn, 2008). Kişilerin çalışmaya dahil edilebilmeleri için dört kriter belirlenmiştir. Bunlar, yaş aralığı, eğitim durumu, ikamet edilen şehir, ve cinsiyettir. Katılımcıların Ankara'da ikamet eden, en az lise öğrenimine sahip, 15-30 yaş aralığında kadınlar olması ve elbetteki öncül kriter olan bir psikiyatrist ya da klinik psikolog tarafından verilen DSM-V kriterlerine karşılamak suretiyle anoreksiya nervoza tanısına sahip olmaları beklenmektedir.

Altı kadın hasta çalışmaya dahil edilmiştir, katılımcıların yaş aralığı 16 ile 27 arasındadır. Katılımcıların tümü anoreksiyanın kısıtlayıcı alt tipinin ana belirtilerine sahiptir ve hepsinin ilk tanı ve tedavi sürecidir. Veri toplama dönemi sırasında tüm katılımcılar en az üç aydır psikiyatristler ve/veya klinik psikologlarla aktif bir tedavi süreci içerisindedir. Tedavi her hafta ya da iki haftada bir düzenli aralıklarla bireysel psikoterapiyi içermektedir, ve kullanılan psikoterapötik yaklaşım temel olarak bilişsel davranışçı terapiye dayanmaktadır.

2.4. Süreç

Çalışmada uygulanması planlanan prosedürler için etik onay Orta Doğu Teknik Üniversitesi Etik Kurulundan alınmıştır. Veriler farklı kurumlardan toplanacağı için çalışma aynı zamanda Ayna Klinik Psikoloji Destek Ünitesi, Hacettepe Üniversitesi Hastanesi Girişimsel Olmayan Klinik Araştırmalar Etik Kurulu, Gazi Üniversitesi Hastanesi Klinik Araştırmalar Etik Kurulu, ve Dışkapı Yıldırım Beyazıt Eğitim ve Araştırma Hastanesi Klinik Araştırmalar Etik Kurulu'ndan da etik izinler alınmıştır. Katılımcılarla yarı yapılandırılmış görüşmeler yapılmıştır (Smith, Flowers, ve Larkin, 2009). Bu görüşmelerin öncesinde katılımcılara araştırmanın doğası ve süreci hakkında bilgi verilmiştir. Ayrıca, kişisel bilgilerin gizlilik koşulları ve istedikleri zaman görüşmeyi sonlandırabilecekleri konusunda da bilgilendirilmişlerdir. Son olarak, görüşmelere başlanmadan önce araştırmaya gönüllü olarak katıldıklarını beyan eden sözlü ve yazılı onamları alınmıştır (Ek A'da verilmiştir). Görüşmeler süresince yine katılımcıların onayı ile ses kaydı alınmıştır.

2.5. Veri Analizi

Her katılımcı ile, araştırmacı tarafından, bireysel olarak ve sadece bir kez görüşülmüştür ve görüşmeler 93 dakika ile 103 dakika arasında sürmüştür. Görüşmelerin ses kayıtları araştırmacı tarafından dinlenilmiş ve kelime kelime deşifre edilmiştir. Katılımcıların isimleri gizlilik ilkesi gereği değiştirilmiştir. Verilerin analizinde YFA'nın kriterlerine bağlı kalınarak çalışılmıştır (Smith ve ark., 1999; Smith ve Osborn, 2003). YFA her bir vakanın ayrıntılı bir incelemesini gerektirdiği için her bir görüşmenin detaylı bir şekilde analizinin ardından bir diğerine geçilmiştir (Smith, 2004). Bu sebeple, ilk görüşmeden sonra veri analizi sürecine başlanmıştır. İlk adım olarak, birinci görüşmenin görüşme dökümü detaylıca defalarca okunmuş ve üzerine araştırma sorusuyla ilişkili olabilecek noktalarda notlar alınmıştır. Dökümün tekrarlı okunmasının ardından alınan notlar tema oluşturmak amacıyla değerlendirilmiş ve ilk görüşme için katılımcının deneyimini en iyi kapsayan ve anlatan temalardan oluşan bir liste meydana getirilmiştir. Detaylı olarak tezin orijinal versiyonunda anlatılan bu analiz süreci her katılımcı için birebir

tekrarlanmıştır. Tüm görüşme dökümlerinin analizinin yapılmasının ardından her katılımcı için oluşturulmuş olan tema listeleri bir araya getirilmiş ve karşılaştırılmış, ve altı katılımcıyı ortak olarak yansıtan alt ve üst temaları içere tema tablosu oluşturulmuştur.

2.6. Çalışmanın Güvenilirliği

Nitel çalışmaların güvenilirlik ölçütleri öznellik (subjectivity), yansıyabilirlik (reflexivity), verinin yeterliliği (adequacy of data) ve yorumlamanın yeterliliği (adequacy of interpretation) olarak sıralanmıştır (Morrow, 2005). Nitel yaklaşım, veri toplama ve analizi sürecinin doğasında öznellik olduğunu kabul etmektedir; bu nedenle, öznelliğin kontrol edilen, sınırlandırılan, ya da yönetilen bir şey olamayacağını, aksine araştırmanın kalitesini artıran bir bileşen ya da veri olarak araştırmaya dahil edilmesi gerektiğini savunmaktadır (Morrow, 2005; Patton, 2002). Araştırmacının kendi perspektifinin, tecrübesinin, ve dünya anlayışının kaçınılmaz bir biçimde araştırma sürecini etkileyeceği kabul edilmektedir (Patton, 2002). Bu sebeple, araştırmacının kendini yansıtması (researcher's reflexivity), araştırma sonuçlarının üzerindeki etkisinin anlaşılabilmesi için kritik önem arz etmektedir (Patton, 2002). Belirtildiği gibi araştırmacının öznelliğini doğrudan kenara koyabilmesi ya da tamamen nötr olması (Elliott ve ark., 1999) beklenemeyeceği için bu noktada araştırmacıların paranteze alma yöntemini kullanmaları önerilmektedir (Briggs, 2010; Fischer, 2009; Morrow, 2005; Willig, 2008). Bu çalışmada varoluşsal paranteze alma (existential bracketing) yöntemi kullanılmıştır (Gearing, 2004).

BÖLÜM 3

BULGULAR

Altı görüşmenin yorumlayıcı fenomenolojik analizi altı ana tema ortaya çıkarmıştır. Bunlar: ‘besin yoksunluğunun sevgi ve ilgi yoksunluğunun yerine geçmesi’, ‘kontrol ve özgürlük kaybı duygularının telafisi için besin yoksunluğu’, ‘aileden sevgi ve ilgi almak: parçalanmış ilişkinin onarılması’, ‘referans noktası olarak başkaları: başkalarının düşünce ve kabullerinin önemi’, ‘anoreksiya nervoza tek çıkış yolu mu?: başkalarını cezalandırarak kızgınlığı ve öfkeyi ifade etmek’, ve ‘dikkatin ilişkisel sorunlardan uzaklaştırılması: ‘zihnimi meşgul tutmak için ne yediğimle uğraşıyordum.’

3.1. Besin Yoksunluğunun Sevgi ve İlgi Yoksunluğunun Yerine Geçmesi

İlk tema anoreksiya nervoza semptomlarının ailedeki (koşulsuz) sevgi ve bakım eksikliğinin yerini almasını yansıtmaktadır. Bu temada katılımcılar anneleriyle ilişkilerindeki sevgi, şefkat, destek ve iletişimden mahrum kalışlarını anlatmaktadır. Katılımcıların tanı almadan önceki ilişkilerinde annelerinin özelliklerine ilişkin algıları “baskın, otoriter, uzak, ve katı”dır. Anneler kızlarına karşı çok sevgi ve şefkat göstermeyen ebeveynler olarak tanımlanmaktadır. Katılımcılar ayrıca anneleri ile ilişkilerinde hissettikleri değersizlik duygusundan bahsederken yakın bir ilişkiye yönelik özlemlerini de dile getirmektedirler.

Katılımcılar anneleri ile sorunlu ilişkiler tanımlayıp onların ebeveynliklerini eleştirirken öte yandan babalarını ve onlarla olan ilişkilerini genellikle idealize etmekte ve değer verdiklerini belirtmektedirler. Babalarını annelerine kıyasla imtiyazlı ya da ayrıcalıklı davranmakta ve aynı davranış için annelerini suçlarken babalarına karşı hoşgörülü/anlayışlı bir tutum benimsemektedirler. Ayrıca, katılımcılar semptomların ortaya çıkışından önceki dönemde ebeveynleriyle olan uzak ve sorunlu ilişkilerine dair derin üzüntü ve yalnızlık hislerini dile getirmektedirler. Ailelerindeki kısıtlamalardan şikayet ederek onları bir türlü memnun edemediklerini ve iletişim eksiklikleri olduğunu dile getirmektedirler.

Ebeveynleriyle olan ilişkilerinde sevgi ve bakım eksikliğine yapılan vurgunun dışında katılımcılar hayatlarının çeşitli noktalarında farklı seviyelerde yaşadıkları kayıp deneyimlerinden de bahsetmektedirler. Bazı katılımcılar için semptomları tetikleyici faktörler göz önüne alındığında, semptomun başlangıcıyla ilişkili görülebilecek sevginin kaybı olarak da tanımlanabilecek bir ilişki kaybının varlığı görülmektedir. Örneğin, üniversite için aileden ayrılma, romantik ilişkinin kaybı, ya da arkadaş ilişkilerinde dışlanma katılımcıların bahsettikleri faktörlerden bazılarıdır. Tüm bu faktörler göz önüne alındığında anoreksiya nervoza semptomlarının ortaya çıkışı katılımcıların yaşamlarında sevgi ve bakımdan yoksun kalmalarının yerine geçen bir ikame olarak düşünülebilmektedir.

3.2. Kontrol ve Özgürlük Kaybı Duygularının Telafisi için Besin Yoksunluğu

İkinci tema besin yoksunluğunun katılımcıların yaşamlarında kontrol ve özgürlük kaybı duygularını telafi etmenin bir yolu olarak işlev gösterdiğini ifade etmektedir. Katılımcıların çoğu, ebeveynlerinin yemek yedirme taleplerine karşı koyduklarını ve onların taleplerinin tam tersi şeklinde davrandıklarını belirtmişlerdir. Katılımcıların ifadesinden yeme davranışının bireyin kendisi ve ailesinin talepleri arasında bir bariyer oluşturduğu anlaşılmaktadır. Katılımcılar yiyecek tüketimini kısıtlayarak ailelerinin beklentilerini reddetmektedirler. Anoreksik davranışla başka insanların onların üzerindeki gücünü ya da etkisini reddedebilmektedirler. Bir başka deyişle,

özgürlüklerinin kısıtlandığını ya da tanınmadığını hisseden katılımcıların yeme davranışlarını kontrol ederek ve ailelerinin bu konudaki ısrarlarına karşı gelerek hayatlarındaki kısıtlamalara tepki verdikleri düşünülmektedir. Böylelikle, özgürlüklerine kavuştuklarını ve kimsenin hayatlarına karışıp kısıtlayamadığını ifade etmektedirler. Anoreksik davranış onları başkalarının hayatlarına karışmalarından korumakta bir nevi onlar ve başkaları arasında bir sınır işlevi görmektedir. Ek olarak, katılımcılar açlığa karşı direnmenin onlara kontrol ve güç duygusu verdiğinden de bahsetmektedir. Onlara göre, yiyecek tüketimini kısıtlamak, kendini güçlü, üstün ve kontrolde hissetmenin tek yoludur.

Katılımcıların beyanları göz önüne alındığında, hayatını kontrol etme ihtiyacının anoreksik davranışlarla yerine getirildiği söylenebilir. Başka bir deyişle, anoreksiya katılımcılara kendi ve başkaları üzerinde sahip olmayı istediği kontrol duygusunu sağlamaktadır. Tüm bunlar dikkate alındığında, anoreksik davranış kendi sınırlarını çizmenin ve başkalarının girici müdahalelerine karşı yaşamlarının kontrolünü ellerine almanın bir yolu olarak işlev görmektedir.

3.3. Aileden Sevgi ve İlgi Almak: Parçalanmış İlişkinin Onarılması

Üçüncü tema temel olarak aileden bakım ve sevgi almayı ve bunların yanı sıra parçalanmış ya da bozulmuş aile ilişkilerinin onarılmasını içermektedir. Bu temaya katılımcıların çoğunluğu tarafından oldukça yaygın olarak değinilmiştir. Birinci temada da belirtildiği gibi katılımcılar tanı almadan önceki ilişkilerinde ailelerinden bakım almadıklarına değinmektedirler. Bununla birlikte, problemli beslenme davranışları ve artan sağlık problemleriyle beraber gelen hastalıklı görünüm etraflarındaki insanlarda, özellikle aile bireylerinde, kaygı ve tedirginlik meydana getirmektedir. Sonuç olarak, semptomların ortaya çıkması ailelerinden aldıkları bakımı arttırmaktadır. Katılımcılar semptomları ve beraberinde ortaya çıkan yaşamlarındaki değişiklikler nedeniyle ebeveynlerinin daha anlayışlı, özenli, ve destekleyici olduklarını vurgulamaktadırlar. Başka bir deyişle, katılımcılar anoreksiya nervozadan bazı ilişkisel yararlar elde etmektedirler. Semptomlar

katılımcıların aile içinde daha fazla dikkat çekmelerine ve bakım almalarına neden olmakta ve böylelikle katılımcılar daha önce aldıklarını düşündüklerinden daha fazla özen ve bakım aldıklarını belirtmektedirler.

Ayrıca, aileden bakım almanın yanı sıra, semptomlar ilişkiler üzerinde onarıcı ve birleştirici bir etkiye sahiptir. Katılımcılar tarafından belirtildiği üzere, ebeveynleri ile ilişkileri hastalık sürecinde değişmektedir. Katılımcılar semptomları kötüleşmeden önce aileleri tarafından bakım verilmediklerini vurgulamışlardır, ancak, daha sonra, ilişkileri daha sevgi dolu bir hale dönüşmektedir. Katılımcılar, ebeveynlerinin önceki davranışlarından ötürü üzüntü, hayal kırıklığı, veya öfke dile getirmelerine rağmen, daha şefkatli, samimi ve tatmin edici yeni ilişkilerinden duydukları memnuniyeti de belirtmektedirler. Ebeveynlerinin onları öpmesi, kucaklaşmaları gibi şefkatli davranışlarından dolayı mutlu ve rahatlamış bir tablo çizmektedirler.

3.4. Referans Noktası Olarak Başkaları: Başkalarının Düşünce ve Kabullerinin Önemi

Kilo kaybı, katılımcılar için başkalarından övgü ve olumlu geri bildirim alma anlamına gelmektedir. Pek çok katılımcı için semptomları tetikleyici faktörler fiziksel görünümlerine, kilolarına ilişkin negatif yorumlara, eleştirilere, ve aşağılanma hislerine karşı tutumları ile ilişkili görülmüştür. Katılımcıların ifadelerinden anlaşıldığı üzere arkadaş çevrelerinde sosyal bir cezalandırmanın (herkesin önünde küçük düşürülme) olduğu görülmüştür. Ayrıca, katılımcılar başkalarının kendilerine ilişkin düşüncelerine önem vermektedirler. Katılımcıların kendilerine ilişkin görüşleri başkalarının onlarla ilgili ne söylediklerine oldukça bağlıdır. Başkalarının onları güzel bulmadığını düşünerek ve onaylanmamış hissetmektedirler. Bu nedenle, yiyecek tüketimlerini kısıtlayarak ince kalmaya ve böylelikle arkadaşlarının dayattığı standartları karşılamaya çalışmaktadırlar. Sonuç olarak, bu şekilde, iltifat ve takdir edilmeye değer olduklarını ve sosyal olarak ödüllendirildiklerini hissetmektedirler.

Bu temanın ikinci kısmı, anoreksiya nervoza davranışlarının diğerlerinden kabul almakla ilgili olduğunu göstermektedir. Görüşmelerde katılımcıların aşırı derecede olumsuz bir kendilik algıları ve düşük özgüvenleri olduğunu gözlenmiştir. Vücut şekillerini veya ağırlıklarını kendi değerlerinin belirleyicisiymişçesine düşünmektedirler, ve bu nedenle anoreksiya davranışı onlar için başkalarından kabul ve değer almanın bir yolu olarak işlev görmektedir. Ek olarak, zayıflık, daha çekici hissetmenin bir yolu ve güzelliğin eş anlamlısı olarak kabul edilmektedir.

Bu tema içeriğinde ayrıca, kilo alırlarsa erkek arkadaşlarının olmayacağından korktuklarından bahsetmektedirler. Kilo alma onlar için yalnızlık tehdidi ile eşdeğer bir durumdur. Kilo alma reddedilme tehlikesi ile eşdeğerdir ve bu nedenle ince kalmak başkalarının kabulünü garanti altına almakta, onları reddedilmekten korumaktadır. Öte yandan, bazı katılımcılar için ise anoreksiya davranışı başkalarının onları oldukları gibi kabul etmelerini sağlamanın ya da onların beklentilerine karşı durmanın böylelikle başkalarından kabul görmenin bir yoludur. Veya başka şekilde ifade etmek gerekirse, anoreksiya nervoza kendilerini başkalarına kanıtlamaın bir yolu olarak tanımlanabilir. Tüm bu ifadeler dikkate alındığında, katılımcılar başkalarının beklentilerini reddederek ya da kabul ederek yani bir şekilde başkalarının görüşlerini referans noktası olarak kendilerini ya da kendilik değerlerini belirlemektedirler.

3.5. Anoreksiya Nervoza Tek Çıkış Yolu Mu?: Başkalarını Cezalandırarak Kızgınlığı ve Öfkeyi ifade etmek

Beşinci tema yeme problemlerinin katılımcıların duygularını ifade etmelerinde işlevsel bir amaca hizmet ettiğini ortaya koymaktadır. Katılımcıların açıklamaları, anoreksiya davranışının ebeveynlerine duygusal zorluklarını iletebilmelerinde bir yol olduğunu göstermektedir. Katılımcıların bazıları, ne kadar duygusal acı çektiklerini göstermek için ebeveynlerini ve/veya kendilerini cezalandırmak suretiyle duygularını anoreksiya nervoza davranışı aracılığı ile göstermektedir. Bahsi geçen duygulardan bazıları öfke ve sitemdir ve katılımcılar ebeveynlerinin davranışlarından ötürü

pişman olmalarını istemektedirler. Bahsedilen öfke ve cezalandırmanın ardında aslında örtük bir destek ve anlayış çağrısınında olduğu düşünülmektedir.

3.6. Dikkatin İlişkisel Sorunlardan Uzaklaştırılması: 'Zihnimi meşgul tutmak için ne yediğimle uğraşıyordum'

Son tema olan kaçınma teması, dikkatin istenmeyen deneyimlerden ve duygulardan uzaklaşmasına yardımcı olmak için kullanılan bir baş etme yöntemi olarak belirlenmiştir. Katılımcılar anoreksiya nervoza davranışlarıyla beraber olumsuz duygularından ve ilişkisel problemlerinden uzaklaşabildiklerini belirtmektedirler. Yeme eylemine, yediklerine, ya da egzersize odaklanarak durumların ya da duyguların üstesinden gelmenin işlevsel bir yol olmadığını bilmelerine rağmen kendilerini rahatsız edici ve tatsız deneyimlerden uzaklaştırmanın bir yolu olarak bu davranışa başvurmaya devam ettiklerini söylemektedirler. Yemek yeme ile ilgili problemler stresten uzak durmanın, stresle başa çıkmanın ya da yaşamdaki zorluklardan uzaklaşmanın bir aracı olarak düşünülmektedir çünkü bu davranış bir şekilde kişiyi meşgul tuttuğu için bir çeşit rahatlama sağlamaktadır.

BÖLÜM 4

TARTIŞMA

Bu çalışmada, anoreksiya nervoza hastalarının semptomlarına atfettikleri anlamı ve semptomun işlevine yönelik deneyimleri incelenmiştir. Bu amaçla altı kadın hasta ile yapılan görüşmeler yorumlayıcı fenomenolojik analiz yöntemi kullanılarak analiz edilmiştir. Katılımcıların ifadelerinde semptomlarına olumlu bir değer atfetme eğiliminde oldukları gözlemlenmiştir. Bu nedenle, bu çalışmadaki temalar, anoreksiya nervoza semptomlarının işlevleri çerçevesinde toplanmıştır. Bulgular kısmında da belirtildiği üzere görüşmelerden elde edilen bilgiler ışığında semptomların psikolojik anlamı ve işlevi altı ana tema altında ele alınmıştır.

İlgili alandaki Türkçe ve İngilizce literatüre bakıldığında, az sayıda niteliksel çalışmanın anoreksiya nervoza semptomlarının işlevini ve pozitif atfını incelediği görülmüştür, ve bu nedenle, mevcut çalışmanın alandaki bilgiyi geliştirmesi hedeflenmektedir. Aşağıda bu bulgular ilgili literatür bilgisi eşliğinde tartışılacaktır. Çalışmanın ayırt edici özellikleri, önemi, klinik sonuçları, kısıtlılıkları ve gelecek çalışmalar için öneriler de yine bu bölüm içerisinde sunulmaktadır.

4.1. Besin Yoksunluğunun evgi ve İlgi oksunluğunun Yerine Geçmesi

İlk temada, anoreksiya nervoza semptomlarının ailedeki (koşulsuz) sevgi ve bakım ayrıcalıklarının yerini almasından bahsedilmektedir. Literatürde, semptomların aile

yapısındaki, duygusal ifadelerdeki, ve etkileşim tarzındaki daha derin ve yaygın bir sorunun yansıması olduğu belirtilmiştir (Humphrey, 1986; Lilenfeld ve ark., 1998; Logue, Crowe, ve Bean, 1989; Morgan ve Russell, 1975; Strober ve Humprey, 1987; Strober, Lampert, Morrell, Burroughs, ve Jacobs, 1990; Tozzi, Sullivan, Fear, McKenzie, ve Bulik, 2003). Örneğin, bazı çalışma bulgularında anoreksiya nervoza tanılı çocuklara sahip ailelerin çocuklarına karşı eleştirel ve düşmanca olduklarını ve düşük düzeyde duygusal ifade tarzına sahip oldukları belirtilmiştir (Dare, Le Grange, Eisler, ve Rutherford, 1994; Le Grange, Eisler, Dare, ve Hodes, 1992). Ayrıca, anoreksiya nervoza tanılı bireylerde ebeveynlerini suçlayan, reddeden, ve ihmal eden ebeveynler olarak tanımlamışlardır (Humprey, 1989). Özellikle uzun süredir devam eden olumsuz aile problemleri (örn., uzun süredir devam eden uyuşmazlık, kötü ebeveyn bakımı/çocuklukta deneyimlenen yetersiz bakım alma, yaygın aile içi gerginlikler/çatışmalar, aşırı derecede duygusal yabancılaşma, ebeveyn aşırı kontrolü) hastalığın kronik seyrini etkileyen faktörler olarak belirtilmiştir (Bolattin, Mannarini, Rossi, Rossi, ve Balottin, 2017; Lacoste, 2016; Strober ve Humprey, 1987; Tozzi ve ark., 2003). Aile içi ve dışı ilişkilerdeki ortaya çıkan bu rekabetçi ve düşmansı duygular sonuç olarak yiyeceklerin etrafında merkezileşen açık bir çatışmaya dönüşmektedir (Waller ve ark., 1940).

Bahsi geçen araştırma bulguları bu çalışmada da desteklenmiştir. Katılımcılar ebeveynleriyle, özellikle anneleriyle, olan ilişkilerinde sevgi, şefkat, destek, ve iletişimden mahrum olduklarını belirtmişlerdir. Bu çalışmanın bulgularıyla tutarlı olarak literatürde de ebeveyn özelliklerine ilişkin Sours (1969) annelerin kontrol edici, otoriter, ve kızlarını kendi ihtiyaçları ve isteklerinin bir aracı olarak kullandıklarını belirtmiştir. Katılımcılar da annelerini cezalandıran, mahrum bırakan, ve görmezden gelen ebeveynler olarak tanımlamışlardır. Bu görüşle uygun olacak şekilde, Bruch ve Selvini-Palazzoli, çocuğun ihtiyaçlarının annenin algısının uygun bulduğu şeye dönüştürüldüğü bir anne çocuk ilişkisi tanımlamışlardır ve sonuç olarak çocuk umutsuz bir kimlik bulma mücadele içerisine girmekte ve kendine özgü bir benlik algısı oluşturamayıp anoreksik davranışlar gibi uyumsuz semptomlar geliştirmektedir (aktaran Bemis, 1978).

Ayrıca, Selvini-Palazzoli (1974) annelere kıyasla babanın rolünün belirsiz kaldığını ve araştırmalarda daha az çalışıldığını belirtmiştir. Örneğin Dare ve arkadaşları (1994), annelerin kızlarının hayatlarında babalardan çok daha fazla aşırı katılım gösterdiğini belirtmiştir. Babalar genellikle şefkattan yoksun, somurtkan, içe çekilmiş, ve zaman zaman da kızlarına karşı kaçınmacı (avoidant) olarak nitelendirilmişlerdir (Bemis, 1978; Bolattin ve ark., 2017; Humphrey, 1988; Kalucy, Crisp, ve Harding, 1977; Waller ve ark., 1940). Beresin ve arkadaşları (1989), katılımcıların babalarını uzak, işleriyle fazla zaman geçiren, ve sıklıkla alkol bağımlılığına eğilimli olarak tanımlamışlardır. Ancak, bu çalışmanın bulguları literatürdekilerle farklılık göstermektedir. Bu çalışmanın katılımcıları anneleriyle sorunlu ilişki tanımlamakta ve annelerinin anneliklerini eleştirirken babalarını ve onlarla olan ilişkilerini idealleştirmektedirler. Ebeveynlerini iki karşı kutup olarak tanımlamaktadırlar. Annelerini daha kısıtlayıcı ve kuralcı olarak tanımlarken babalarını kabul edici ve sevecen olarak tanımlamışlardır. Aynı davranış için annelerini eleştirirken babalarına karşı sevecen ve hoşgörülü olmuşlardır. Annelerinin tutumlarının babalarının etkilediğini ve babalarıyla ilişkileri üzerinde bozucu bir etkisi olduğunu ve hatta eğer anneleri için olmasa babalarının o şekilde davranmayacağını belirtmişlerdir. Görüldüğü üzere, bu ifadeler literatürdeki birçok araştırmacının çalışmalarında sık sık rapor edilen olumsuz baba imajı bulgularıyla çelişmektedir.

4.2. Kontrol ve Özgürlük Kaybı Duygularının Telafisi için Besin Yoksunluğu

İkinci tema, besin yoksunluğunun katılımcıların yaşamlarındaki kontrol ve özgürlük yoksunluğunun telafisi olarak yer aldığını ifade etmektedir. Lawrance (1979), anoreksiya nervoza semptomu ile ilişkili olarak, kadınların çevresel düzeydeki yaşam sorunlarıyla başa çıkamadıklarında bunu tamamen içsel bir soruna dönüştürdüklerini ileri sürmüştür. Bu nedenle, kayıp ve başarısızlık gibi duyguları telafi etmek için bireylerin bir kontrol ve disiplin kaynağı olarak yemeye odaklandıklarını belirtmiştir. Bu çalışmada da katılımcılar için kayıp ve başarısızlık örnekleri bulunmaktadır ve detayları bulgular kısmında ve ilk temanın tartışmasında detaylı olarak verilmiştir.

Kontrol teması açısından bakıldığında besim tüketimini ve beden ağırlığını kontrol etme konusundaki katı arzu anoreksiya nervozanın temel özeliğidir. Semptomlar bireyler tarafından yaşamları üzerinde hiçbir kontrole sahip olmadıklarını düşündükleri noktada gerçek sorunları kontrol edebilmenin bir alternatifi olarak kullanılmaktadır (Granek, 2007; Lawrence, 1979; Surgenor, Horn, Plumridge, ve Hudson, 2002; Thompson ve Sherman, 1989). Hilde Bruch (1978), yüzeyde görülen mükemmel kontrolün arkasında kontrol eksikliğinin yarattığı korkunç yoğun bir duygunun olduğunu belirtmiştir. Bu durumu "felç edici bir etkisizlik hissi (paralyzing sense of ineffectiveness)" olarak tanımlamıştır. Bu nedenle, çevreyi kontrol edememekle ilgili bu duygu bedeni aç bırakarak kontrol etme çabasıyla telafi edilmeye çalışılmaktadır (Lawrence, 1979). Başka bir deyişle, yemek üzerindeki kontrol, bireylerin yaşamlarının diğer alanlarında hissettikleri kontrol eksikliğini telafi etmelerine yardımcı olan bir başa çıkma mekanizması olarak düşünülebilir. Bu çalışmada da katılımcıların ifadelerini göz önüne aldığımızda ebeveynlerine karşı olumsuz duygularının yemeğe yöneltildiği açıkça gözlenmektedir. Anoreksiya nervoza davranışları katılımcılarla ebeveynleri arasında bir tür engel, sınır oluşturmaktadır. Yemeyi reddetmek ebeveynlerin beklentilerini ya da taleplerini reddetmeyi sembolize etmektedir, ve aynı zamanda da ebeveynleriyle aralarında bir güç mücadelesi yaratmaktadır. Anoreksiya nervoza davranışlarıyla başkalarının kendileri üzerindeki gücüne ve etkisine karşı koyabilmektedirler. Katılımcılardan bazıları aileleri tarafından onlara özgürlük tanınmadığını dile getirmektedir ve onlar için yeme davranışını kontrol etmek ve ailenin yeme konusundaki ısrarına karşı çıkmaz yaşamlarındaki kısıtlılığa karşı verdikleri bir tepkidir. Semptomun aracılığı ile özgür hissetmekte ve başkaları tarafından kısıtlanamadıklarını düşünmektedirler. Semptom katılımcıları başkalarının onların hayatlarına karışma girişimlerinden korumakta ve onlarla başkaları arasında bir sınır işlevi görmektedir. Katılımcıların ifadesinden de görüldüğü üzere anoreksiya nervoza kendi sınırlarını çizme, özgürlük kazanma ve yaşamlarını kontrol altına almanın bir yolu olarak işlev görmektedir. Benzer şekilde, Lawrence (1979) da bu bulguları desteklemiştir. Bireylerin anoreksiya nervoza davranışı ile kendi sınırlarını tanımlayabildiklerini ve başkalarına sınır koyabildiklerini ifade etmiştir.

Ayrıca, anoreksiya tanılı bireylerin aileleri çocukların gelişimi sırasında ayrışma ve özerkliği teşvik etmemektedirler. Bu nedenle, yemenin kontrolü, özerklik ve ebeveynden ayrışma girişimi olarak da düşünülmektedir (Schwartz, Thompson, ve Johnson, 1982). Sugarman'ın (1991) çalışmasında, birçok kadın yeme davranışını otorite ve kuralları reddetmek ve yaşamları üzerinde kontrolü yeniden kazanmak için kullandığını belirtmişlerdir (aktaran Gilbert ve Thompson, 1996).

4.3. Aileden Sevgi ve İlgi Almak: Parçalanmış İlişkinin Onarılması

Üçüncü tema, semptom aracılığıyla aileden bakım ve sevgi alma ve bunların yanısıra kopmuş, parçalanmış ilişkilerin onarılmasını içermektedir. Sugarman'ın (1981) çalışmasında katılımcılar semptomları ile başkalarından ilgi aldıklarını belirtmişlerdir. Zayıflama istekleri bakım alma isteklerine ulaşmalarında yardımcı olmaktadır, ve bu nedenle, ne kadar ince olurlarsa ebeveynlerinden o kadar fazla bakım aldıklarından bahsetmişlerdir.

Anoreksiya nervozanın en belirgin özelliklerinden biri doğrudan gözlemlenebilir olmasıdır, psikiyatrik hastalıklar içerisinde belki de tek gözle görülebilir olandır. Bu durum etraftaki insanlarda, özellikle de aile üyelerinde, yoğun duygusal reaksiyonlar ortaya çıkarmaktadır (Schmidt ve Treasure, 2006). Kasıtlı olsun veya olmasın, anoreksik vücut başkalarına görmezden gelinmesi zor bir mesaj iletmektedir (Schmidt ve Treasure, 2006). Bireyler için doğrudan iletişim kurmaya gerek kalmadan içinde bulundukları duygusal zorlukları iletmenin güçlü bir yoludur anoreksiya nervoza davranışları ve kişinin dikkat, özen ve bakım almasını sağlamaktadırlar. Aile, arkadaşlar, ve profesyoneller bireyleri tedavi görmeye ve yeme alışkanlıklarını değiştirmeye ikna etmek için büyük çaba göstermektedirler (Lawrence, 1979; Selvini-Palazzoli, 1985; Schmidt ve Treasure, 2006).

Benzer şekilde bu çalışmanın katılımcıları da hastalıktan önce ailelerinden bakım almadıklarını, ancak hastalıkla ve artan sağlık problemleri ile beraber ailelerinin onların sağlığı hakkında endişelenmeye ve bunu ifade etmeye başladıklarını

belirtmişlerdir. Sonuç olarak, araştırmanın katılımcıları semptomların ortaya çıkması neticesinde özlem ve ihtiyaç duydukları bakımı, desteği ve özel ilgiyi ailelerinden alabilmektedirler. Anoreksiya nervoza semptomları bireyler için ikincil bir kazanıma yol açmaktadır. İlgi ve sempati almaya yönelik bu ikincil kazançlar bireyler tarafından sıklıkla bilinç düzeyinde kabul edilmektedir (Higbed and Fox, 2010; Schmidt and Treasure, 2006).

Ayrıca, bu üst temanın bir diğer alt temasına bakılacak olunursa, semptomlar kopuk ya da parçalanmış aile ilişkilerini onarıcı ve birleştirici bir işlev de göstermektedirler. Belirtildiği gibi aile ilişkileri tanı ile değişmiş zaman içinde daha yakın ve bakım veren hale gelmiştir. Katılımcılara göre ebeveynleri onları kaybetmekten korktukları için şefkat göstermeye başlamıştır. Bu durum katılımcılar tarafından semptomun aile ilişkilerini güçlendirdiği ve onları bir aile haline getirdiği şeklinde yorumlanmıştır. Aile dinamiğindeki bu değişim de katılımcılar tarafından elde edilen ikincil bir kazanç olarak düşünülebilir.

Literatürde de anoreksiya nervoza semptomlarının onarıcı işlevini destekleyen çalışmalar bulunmaktadır. Örneğin, Lacoste (2016) anoeksiya nervoza davranışının aile çevresini veya birliğini koruduğunu belirtmiştir. Semptomlar aile üyelerinin bir araya gelme ve birbirlerine yardımcı olmalarına bir sebep oluşturmaktadır. Benzer şekilde Minuchin ve arkadaşlarının (1975) çalışmalarında da hasta çocuğun aileyi çatışmadan koruyan bir rolü olduğunu ve bu rolün çocuğun semptomu için önemli bir pekiştirici olduğunu belirtmiştir (Minuchin, 1975). Semptom ailenin ilgisini problemlerden ve çatışmalardan çocuğa yönlendirmekte ve aile üyeleri de çocuğa yardım etmek için bir araya gelmektedirler (Humphrey, 1988).

4.4. Referans Noktası Olarak Başkaları: Başkalarının Düşünce ve Kabullerinin Önemi

Schmidt ve Treasure (2006), anoreksiya nervozadaki kendini aç bırakma davranışının bireyin karşılaştığı sosyal tehdidin etkisini azaltmanın bir yolu olduğunu

belirtmiştir. Bu nedenle, semptom aslında adaptif bir fonksiyona sahiptir. Kültürel değerler bireyin duygusal çatışmalarıyla (örn., benlik saygısı düzenleme, özerklik algısı, ayrışma üzerindeki kontrolü) bu durum semptomların ortaya çıkmasına sebep olabilmektedir (Schwartz ve ark., 1982). Örneğin, zayıf olma gayretinde olan bir birey kendi ihtiyaçlarını reddederken devamlı bir biçimde sosyal talepleri karşılamaya çalışabilmektedir (Schwartz ve ark, 1982). Bu çalışmada bazı katılımcılar da benzer şekilde vücut şekillerini başkalarıyla karşılaştırdıklarını ve vücutlarını yeterince güzel bulmadıklarını özellikle belirtmişlerdir ve semptomlarının başlaması ile ilişkili olarak arkadaş çevrelerinde maruz kaldıkları bedenlerine ilişkin küçük düşürülmeyi/aşağılanma hissini sebep göstermişlerdir.

Katılımcıların alıntılarından anlaşıldığı üzere arkadaş çevresinde sosyal anlamda cezalandırıldıklarını (küçük düşürülme) düşünmektedirler. Bu kişiler ayrıca başkalarının düşüncelerine önem de verdikleri için sosyal anlamda daha duyarlı bireylerdir. Güzel bulunmamak ya da onaylanmamakla ilgili korku duymaktadırlar. Bu nedenle de zayıf kalarak dayatılan stardartları karşılamaya çalışmaktadırlar. Sonuç olarak, iltifat almaya ve takdir edilmeye değer olduklarını sosyal olarak ödüllendirildiklerini düşünmektedirler. Bu düşünceyi destekleyecek şekilde, literatürde de kadınların değerlerini fiziksel görüntü, akademik başarı, popülarite, ve iş performansı gibi dışsal faktörlere atfettikleri görülmüştür (Weaver ve ark., 2005). Benzer şekilde, Granek (2007), bireylerin değerli ve sevilen hissetmek istediklerini ve bunun da zayıflıkla garanti edilebileceğini düşündüklerini ifade etmiştir. Bu çalışmanın katılımcıları içinde zayıflık kabul edilmenin, sevilmenin, ve terk edilmemenin garantörü olarak kabul edilmiştir.

4.5. Anoreksiya Nervoza Tek Çıkış Yolu mu?: Başkalarını Cezalandırarak Kızgınlığı ve Öfkeyi İfade Etmek

Beşinci tema yeme ile ilgili problemlerin duyguları ifade etmenin bir yolu olarak görüldüğünü anlatmaktadır. Çalışmanın bulgularında katılımcılar ailelerinin gösterdikleri koşullu sevgiye yönelik öfke ve kızgınlık duygularından

bahsetmektedir. Katılımcılar anoreksiya nervoza davranışları ile üzerlerinde hissettikleri yük ve sorumluluktan da kurtulabildiklerini ifade etmektedir. Ayrıca, anoreksik davranışlarını ebeveynlerini ebeveynlik tutumları ve davranışları ile ilgili olarak pişman etme istekleri için bir mesaj iletme çabası olarak da tanımlamaktadırlar.

Literatür bulgularına bakıldığında, çalışmalar anoreksiya nervoza semptomlarının gerçek duyguları ifade etmenin zor olduğu durumlarda bir iletişim aracı olarak kullanıldığını kanıtlamıştır (Jenkins ve Ogden, 2011; Williams ve Reid, 2010). Semptomlar, bireylerin dünyaya nasıl hissettikleri, stresleri, ve duyguları hakkında konuşma şekillerdir (Nordbø ve ark., 2006; Serpell ve ark., 1999) çünkü söz konusu bireyler için duygu ve düşüncelerini ifade etmenin başka yolu yoktur. Semptomlar aracılığı ile çevrelerindeki insanlar onların nasıl hissettiğini anlar ve böylelikle bireyler anlaşıldıklarını hissederler. Başka türlü ifade etmek gerekirse, anoreksik davranışlar bireylere kelimelerle söyleyemediklerini bedenleriyle ifade etmeleri için yardımı olmaktadır; anoreksiya nervoza stres veren olumsuz duyguların bedensel bir ifadesi haline gelmektedir (Jenkins ve Ogden, 2011; Weaver ve ark, 2005). Lacoste (2016) sözü edilen argümanları destekleyecek şekilde semptomların başkalarıyla iletişim kurmanın bir yolu, dilin bir unsuru olarak kullanıldığını belirtmiştir.

4.6. Dikkatin İlişkisel Sorunlardan Uzaklaştırılması: 'Zihnimi meşgul tutmak için ne yediğimle uğraşıyordum'

Altıncı tema anoreksiya nervoza semptomlarının olumsuz duygu ve deneyimlerden kaçınmanın bir yolu olarak işlev gördüğünü ifade etmektedir. Bu çalışmada, katılımcılar dikkatlerini olumsuz deneyimlerden ve ilişkisel problemlerden uzak tutmak için anoreksik davranışlar kullanabiliyor olduklarını bildirmektedir. Bu davranışların içinde bulundukları psikolojik acı ile baş etmelerinde yardımcı olduğunu ifade etmekte, ve sebep oldukları mental yoğunluk ve yorgunluktan dolayı da bir şekilde rahatlatıcı bir işlevi olabileceğini eklemektedirler. Çalışmanın bulgularına benzer şekilde, Nordbø ve arkadaşları (2006) da katılımcıların

anoreksiya nervoza davranışları ile kendileri için acı veren duygulardan, duygusal problemlerden, ilişkisel beklentilerden kaçındıklarını belirtmişlerdir. Anoreksik davranışlar kaçınmanın bir yolu olarak tanımlanmıştır; ek olarak, vücut şekillerine, ağırlıklarına, yiyeceklerine odaklandıklarında yaşamlarındaki diğer zorluklara ya da problemlere odaklanma konusunda neredeyse hiç enerjilerinin kalmadığından bahsetmişlerdir.

BÖLÜM 5

SONUÇ

5.1. Sonuçlar ve Klinik Uygulamalara Dair Öneriler

Bu çalışmanın birincil katkısı anoreksiya nervoza semptomlarına sahip genç Türk kadınları için semptomların anlamı ve işlevinin derinlemesine yorumlayıcı bir analizini sağlamış olmasıdır. YFA kullanılması, katılımcıların yaşadıkları deneyimlerin kapsamlı ve öznel bir incelemesini mümkün kılmıştır. Katılımcıların öyküsü, yakınlarından alamadıkları sevgi ve bakımın eksikliği ve ihmal edilmekle başlamıştır. Hayatlarında kontrol ve özgürlüklerini kaybettiklerini hissetmektedirler. Bu nedenle, yaşamlarındaki zorluklarla başa çıkmak için anoreksiya nervoza semptomlarını geliştirmiş olabilecekleri düşünülmektedir. Semptomlar onlara bir kontrol, güç, kabul edilme, sevgi ve bakım alma duygusu sağlamasının yanı sıra karşı karşıya kaldıkları hoş olmayan duygu ve durumlardan kaçınmaları için de yardımcı olmaktadır. Dolayısıyla, salt bir zayıflık peşinde olmak birincil mesele değildir, aksine yaşamlarındaki sorunları çözebilme çabaları içindeki son adım olarak düşünülebilir. Bu görüşe göre, anoreksiya nervozada bahsi geçen yeme problemi bir yan ürün olarak kabul edilebilir (Minuchin ve ark., 1978); ve anoreksiya nervoza bir iletişim bozukluğu olarak değerlendirilebilir (Legrand, 2010).

Ayrıca, bu çalışma birçok klinik sonuca sahiptir. Öncelikle bulgularda görüldüğü üzere, semptom her bir birey için faklı bir psikolojik amaca hizmet etmektedir. Bu

sebeple, standart bir tedavi uygulamanın bireyler için direnci ve tedaviyi bırakma oranını artırıcı bir etkisi olabileceği göz önünde bulundurularak bireyselleştirilmiş tedavi planlarının geliştirilmesi ve uygulanmasının önemini ortaya koymaktadır. Bu noktada, çalışmanın bulgularında sunulan altı temanın alanda çalışan klinisyenler için faydalı bir rehber olabileceği düşünülmektedir. Çalışma bulguları önleme çalışmalarının önemini de ön plana getirmiştir. Anoreksiya tanılı bireylerle çalışan ya da yakın temas içinde olan uzmanlar, aile üyeleri, ve arkadaşlar için eğitici toplantılar ya da seanslar oluşturabilir ve semptomlara ilişkin bilgiler verilebilir.

5.2. Çalışmanın Güçlü Yönleri, Sınırlılıkları ve Gelecek Çalışmalar için Öneriler

Çalışma güçlü yönleri arasında hem Türkçe hem de İngilizce literatürdeki sınırlı sayıda nitel çalışmadan biri olması bulunmaktadır. Bilindiği kadarıyla Türkçe literatürdeki anoreksiya nervozanın işlevini inceleyen ilk çalışmadır. Ayrıca, sadece kısıtlayıcı tip anoreksiya nervoza hastalarını dahil etmiş olası da yine çalışmanın güçlü yönlerinden birisidir. Bu anlamda mevcut çalışma, sağladığı bilgilerle semptomun egoya uyumlu doğası ve bireylerin tedaviye olan dirençleri veya kararsızlıkları konusunda bir perspektif sunmayı ve konu ile ilgili araştırmalara rehberlik edebilmeyi hedeflemektedir.

Çalışmanın sınırlılıkları arasında da katılımcılarla tek bir görüşmenin yapılmış olması, sadece kadın örneklem içeriyor olması, ve tedavi almayı bir şekilde kabul etmiş kadınları dahil etmesi sayılabilir. İleriki çalışmaların bu kısıtlılıkları gözeterek çalışmalarının kapsamını belirlemelerinin faydalı olacağı düşünülmektedir.

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