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Swallowing the Hurt

Exploring the Links Between Anorexia, Bulimia and Violence Against Women and Girls

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Swallowing the Hurt: Exploring the Links between Anorexia, Bulimia and Violence Against Women and Girls was prepared by **Shelley Moore**, with the assistance of **Kelly D'Aoust**, **Donna Robertson**, **Christina Savage** and **Yasmin Jiwani**, of the FREDA Centre for Research on Violence against Women and Children, for the Family Violence Prevention Unit, Health Canada.

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"This report is dedicated to the memories of Pam and Carla. In their own struggles with food, these women taught me about strength, resistance, and survival. May their lives and deaths offer a call for more attention and more resources for help."

Shelley Moore

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Executive Summary

This report examines the links between eating disorders and violence against women and girls. It is based on information gathered from published literature as well as consultations with community workers, health practitioners, and mental health professionals. "Swallowing the Hurt" has been designed for use by frontline workers, health care and social service professionals, educators, and researchers who offer services directly for or who may interact with women and girls experiencing eating disorders or violence.

Over the last decade increasing attention has been turned to anorexia and bulimia as possible outcomes of abuse. Both the literature and most of the service providers contacted suggest that sexual, physical, verbal, and emotional types of abuse are contributing factors in a complex and multideterminant model of anorexia and bulimia. The research suggests that the connection between violence and eating disorders may be more pronounced under certain circumstances: food has been used as a weapon of abuse; a woman has been abused by more than one person; disclosure has been punished or disbelieved; multiple forms of abuse have been experienced; or the woman or girl feels a greater sense of powerlessness or shame.

It is estimated that at least 1 in 8 Canadian girls will be seriously sexually abused and 1 in 5 will be physically abused before the age of 18 years (Duffy, 1998). At least 10% to 25% of women will be battered by their husbands or common-law spouses (Benson, 1995; Statistics Canada, 1993). Abuse rates are 8 times higher among Aboriginal women (Duffy, 1998) and 4 times higher among women with disabilities (Razack, 1994). The psychological and health impacts of violence against women and girls can be serious and enduring. Eating disorders represent particularly life-threatening consequences for survivors of abuse. Across a 20-year period, 1 in 5 people with anorexia and at least 1 in 20 people with bulimia will die (Woodside, 1995). Girls and women constitute 90% of those fatalities (Gagnon, 1996). In addition, 56% of those with anorexia experience severe medical illnesses (Herzog et al., 1997). Both violence and eating disorders affect predominantly girls and women, and both appear to be rising in prevalence (American Psychiatric Association, 1994; Hsu and Zimmer, 1988).

Of those service providers who are aware of the links between eating disorders and abuse, not all are able to offer an integrated approach to treatment. Some refer the woman or girl to other agencies or to services outside the province; some only have resources to focus on a single issue. Both the service providers and the advisory panel for this project emphasized a greater need for "cross-training" between the fields of disordered eating and violence. From the

research and the consultations, 12 key components have been identified as optimal to an integrated approach: accessibility, assessment, safety, medical stability, validation, self-worth, re-framing, coping skills, control and empowerment, relationships and networks, education and awareness, and follow-up. A primary concern of service providers, however, is the effect of cutbacks on funding and facilities. Programs are suffering a loss of staff and services, a lack of follow-up care, increasing wait lists, and closures. In many cases the need for funding has become urgent. Integrated treatment approaches to family violence and eating disorders are likely to become increasingly scarce without the resources to ensure accessibility to services, appropriate medical care, sufficient staffing, shelters and transition houses, and counselling for underlying abuse issues.

Although this report specifically explores the links between violence and the development of disordered eating, the vast majority of participating service providers cautioned that abuse should not be considered as the only precursor to eating disorders.

Purpose and Background

Past research has demonstrated that women with more conflictive family backgrounds or childhood experiences are more likely to develop eating problems (Kinzl et al., 1994), particularly bulimia (Schmidt, Tiller and Treasure, 1993). There is an increasing amount of research being conducted to explore the role that abuse history might play in the development of eating disorders. Reviews examining this association have been published since 1992 (Wonderlich et al., 1997). Overall, the results of the research have been inconsistent (Connors and Morse, 1993; Mullen et al., 1993; Reto, Dalenberg and Coe, 1996), and controversy has emerged among theorists. In 1997, Brown observed that "over the last 5 years, the scientific literature has become polarized, with a heated, and sometimes vitriolic, debate played out between recognized experts, within and across countries." Whereas some researchers espouse a causal relationship between abuse and eating disorders (Everill and Waller, 1995a), others have characterized the link as neither special nor specific (Pope and Hudson, 1992) or as coincidental (Finn et al., 1986). Most theorists, however, have argued that the relationship is a complex one that should not be over-simplified (Brown, 1997; Welch and Fairburn, 1996; Wonderlich et al., 1997).

Much of the inconsistency in the literature has been attributed to methodological and interpretive difficulties. Widely varying definitions of abuse, and particularly child sexual abuse, have made comparisons among studies and conclusions difficult (Dansky et al., 1997; Miller, 1996). Whereas some researchers define child sexual abuse as both contact and noncontact experiences (Moyer et al., 1997), others measure only those experiences that include physical contact (Schmidt, Tiller and Treasure, 1993).

Diagnostic criteria of anorexia and bulimia have also been inconsistent across studies (Connors and Morse, 1993; Davis and Yager, 1992; Wiederman, 1996). The criteria for anorexia nervosa and bulimia nervosa within the Diagnostic and Statistical Manual-IV (DSM-IV)[1] of the American Psychiatric Association have been revised three times, making comparison across studies over time problematic (van't Hof and Nicolson, 1996). Moreover, there has been disagreement regarding which symptoms should be required for diagnosis. Amenorrhea (cessation of menstruation) has been contested as neither a necessary nor useful criterion in determining anorexia (Andersen and Holman, 1997; Cachelin and Maher, 1998; Garfinkel et al., 1995) and as one that excludes

1 The *Diagnostic and Statistical Manual-IV* is the most recent edition of the text published by the American Psychiatric Association for the purpose of categorizing and clinically describing psychiatric disorders. It is intended for use in research and professional diagnosis.

diagnosis of pre-adolescent girls (Woodside, 1995) and post-menopausal women (Cosford and Arnold, 1992). A number of researchers have critiqued fear of fatness as a necessary criterion for diagnosis, noting in particular that it may be a culturally specific symptom (Hsu and Lee, 1993; Lee, 1995; Lee, Chiu and Chen, 1989; Thompson, 1992) and a relatively recent addition to definitions of eating disorders (van't Hof and Nicolson, 1996; Palmer, 1993; Parry-Jones and Parry-Jones, 1995). Others have emphasized eating problems as a continuum, much of which may be missed through a strict adherence to diagnostic classifications (Hoek, 1995; Zerbe, 1992). Overall, DSM-IV criteria may fail to detect a large number of individuals in significant distress due to disordered eating.

The research on abuse and eating disorders has shifted from an earlier period of case studies to more recent reports of larger studies (Welch and Fairburn, 1996). Nonetheless, current research has continued to rely heavily on clinical (Moyer et al., 1997) and small (Wiederman, 1996) samples. Results have often reflected the type of sample and methodology used. Uncontrolled correlational studies of community samples have generally shown more support for a connection than have controlled examinations of abuse in women with eating disorders or of eating problems among abuse survivors (Connors and Morse, 1993; Wonderlich et al., 1997). Because both abuse rates and eating problems are higher in clinical samples, reviewers have questioned whether significant correlations are more artifactual than meaningful (Connors and Morse, 1993). Moreover, it is not clear whether abuse rates are higher among women with eating disorders than among women with other psychiatric or mental health difficulties (Everill and Waller, 1995b; Herzog et al., 1993; Wonderlich et al., 1997), particularly depression, anxiety disorders, somatization, and complex personality disorders (Welch and Fairburn, 1996). However, research has also suggested that eating disorders tend to be more enduring than many other psychiatric disorders and that repeated, severe abuse may lead to more chronic manifestations of mental health problems (Herzog et al., 1993; Welch and Fairburn, 1996).

Herzog et al. (1993) have noted that the co-occurrence of eating disorders and other mental health problems as well as the comparable rates of abuse among women with other mental health problems challenges the specificity of the relationship between abuse and troubled eating. Although the uniqueness of the relationship may be in question, however, it cannot be subsequently concluded that past abuse is a meaningless factor in clinical practice.

A second wave of studies with tightened methodology (Wonderlich et al., 1997) has led to greater agreement among researchers. Reviewers have acknowledged that a complete understanding of the relationship between abuse and disordered eating has not yet been attained (Brown, 1997; Everill and Waller, 1995b). As a result, current models emphasize the need for a multidimensional approach in

which abuse is not treated as a sole or exclusively causal factor of anorexia and bulimia (Connors and Morse, 1993; Dansky et al., 1997) and eating disorders are recognized as one possible outcome of abuse (Schaaf and McCanne, 1994). The impact of abuse will vary according to the context in which it occurs, the meaning for the individual survivor, and the resilience that may result from optimal family or other supporting relationships (Connors and Morse, 1993; Welch, Doll, and Fairburn, 1997). Overall, Brown (1997) has concluded that researchers do not generally dispute that history of abuse is neither necessary nor sufficient for the development of disordered eating. However, studies are examining the contributory factors that may determine the route from abuse to troubled eating (Everill and Waller, 1995b). This study was a part of that project.

The first purpose of this report was to further explore the existence, strength, and nature of a connection between abuse and eating disorders, as experienced by service providers across Canada through their work with clients. In particular, we asked service providers the extent to which they witnessed a link and their explanations for the presence or absence of a link. A second purpose was to integrate and compare the experiential data gathered from Canadian service providers with the clinical and empirical data published in the literature. A third purpose was to examine the connection across the life span, with particular attention to the unique developmental challenges of childhood, adulthood, and aging. Using such an inclusive framework, we also found the need for a broader definition of violence. The report therefore includes references to sexual abuse, physical abuse, emotional abuse, battering, sexual harassment, verbal harassment, sexual assault, neglect, family dynamics, systemic violence, and institutional violence. A fourth purpose was to use the feedback received from service providers to determine the need for and to develop an integrated treatment model for violence and disordered eating.

Producing the Report: The Advisory Panel and Service Providers

Method

This report is based on a review of published literature and on information gathered through consultations with practitioners. The authors would like to thank the many service providers and the advisory panel for their participation, willingness to share knowledge, and their contributions toward this project.

In producing this report, we contacted 143 service providers across Canada working in the areas of violence and eating disorders. Of these, 123 responded and agreed to participate in the study. Service providers were identified for contact through referrals, internet searches, community listings, published research in journals and reports, and telephone directories. The service providers who participated offer support through private practice (10%), family or mental health services (15%), public education or outreach programs (6%), hospitals or health units (25%), treatment and support organizations (32%), community services (6%), general child and youth programs (4%), and university or college services (2%). We gathered information through informal telephone consultations and discussions with informants in British Columbia (39), Northwest Territories/Nunavut (2), Alberta (12), Saskatchewan (16), Manitoba (4), Ontario (34), Quebec (9), New Brunswick (4), Prince Edward Island (3), Nova Scotia (15), and Newfoundland and Labrador (3).

The service providers were informally interviewed about possible connections between family violence and eating disorders, appropriate treatment approaches in addressing these connections, and their particular services and clientele. Six standard questions were used as a departure point for the interviews (see Appendix B). Participants were encouraged to elaborate on information that they felt was important to convey. Responses were accepted by telephone, fax, or e-mail in order to maximize response rate. The resulting data were analyzed for dominant themes, compared with the published literature, and used to develop an integrated treatment model. In order to protect the anonymity of the service providers, names, geographical locations, and affiliations have been omitted in citing comments and data.

For the final production of this report, a panel of 11 Canadian advisors was assembled to participate in a 1-day teleconference held in November 1999 to further explore links between violence against women and girls, anorexia, and bulimia. The suggestions generated during this consultation were integrated into the text of the report. Additionally, comments were elicited individually from treatment providers who were unable to participate in the teleconference. Advisory panel members were selected on the basis of both their being recommended by other service providers as Canadian experts in the fields of disordered eating and violence against women, and of their geographic location.

Approach

We took the following approach in undertaking and presenting this research:

- This report is a qualitative analysis that provides the reader with both (a) direct quotes from participants that contribute insight, precision, or substantiation, and (b) frequencies with which responses were given, to help the reader differentiate the perspective of a single service provider from those of multiple service providers. The inclusion of frequencies within qualitative analysis is common within social science publications (see Pope and Vetter, 1992; Jiwani, 1998).

- This document reports the direct responses of service providers to questions regarding the presence and strength of a link between abuse and disordered eating. In addition, it provides a thematic analysis of the experiences, explanations, theorizing, and treatment suggestions of participants.

- In light of the lack of evidence for a causal relationship within the literature and the controversies that exist among researchers, we have tried not to pre-suppose a link between violence and eating disorders. Rather, our conclusions are based on the published literature and on data gathered from the service providers. We have placed the perspectives of the service providers at the centre of the paper in offering an explanatory framework for the links observed.

- We recognize that the diversity of opinion within the research is echoed among both the service providers and the advisory panel members who participated in this project. We have attempted to strike a balance in negotiating between those who cautioned us not to overstate the connection between violence and disordered eating and those who feared that we would understate the link. We have attempted to best represent the overall input of our sample.

- We have placed a high emphasis on the confidentiality of our participants, recognizing that many of the service providers consulted may know each other. Because this report is intended for distribution in a wide variety of contexts, we have not highlighted or analyzed responses by location, type of service provided, or other potentially identifying information. We acknowledge, however, that this would be another set of informative variables in understanding an abuse–eating disorder connection and in understanding the service provider relationship to that connection.

- Following the tradition of other published qualitative studies (e.g. Websdale, 1995a; 1995b; 1998), findings in the literature and the responses of the service providers have been integrated throughout the report rather than separated. This approach was selected in order to allow the reader a more direct comparison between the research and our "field data". The literature was also used to provide context and to develop points raised by participants.

- This study was based on data collected from professionals and frontline workers in community, clinical, and private practice settings. We recognize that our participants use a wide scope of definitions and diagnostic criteria. We expect that this sampling represents the variety of perspectives and services being offered across Canada.

- One outcome of this review was a call by service providers for the integrated treatment of eating disorders and violence. This report therefore ends with a proposed integrated treatment model, emerging out of those factors identified as critical by Canadian service providers. Members of the advisory panel reviewed the model at the November 1999 teleconference.

The Nature of Violence Against Women and Girls and of Eating Disorders in Canada

Prevalence

Both survivors of family violence and those experiencing eating disorders in Canada are predominantly girls and women. Over 90% of individuals with anorexia and bulimia are female (Kuba and Hanchey, 1991; Prince, 1985; Siever, 1996). "Few disorders in general medicine or psychiatry are as skewed in gender distribution as eating disorders" (Andersen and Holman, 1997). Canadian service providers working in the area of violence and/or eating disorders reported that the overwhelming majority of clients, callers, and workshop participants are girls and women. In fact, the proportion of female service users is generally over 90%. In addition, between 80% and 99% of those who experience *both* violence and eating disorders are female. Evidence suggests that the prevalence rates for eating disorders among girls and women (American Psychiatric Association, 1994; Hsu and Zimmer, 1988),[2] domestic violence against women (BC Institute Against Family Violence, 2001), and spousal killings of women (Duffy, 1998) are currently rising.

Violence Against Women and Girls

Approximately 80% of First Nations women have experienced physical, sexual, or emotional abuse (Duffy, 1998; Frank, 1992). Aboriginal women face eight times the risk of battering as do non-Aboriginal women in Canada (Duffy, 1998). A third of First Nations women, on average, are abused by their partners (Frank, 1992), and between 75% and 90% of women living in some northern Aboriginal communities are battered (Dumont-Smith and Sioui Labelle, 1991). "Aboriginal people emphasize that family violence is not a tradition. Rather, family violence has become a problem following impacts of colonization" (Frank, 1992: 7).

Another form of post-colonization violence experienced by First Nations families has been the application of child apprehension and adoption policies that have disproportionately placed children into non-First Nations families (Jiwani, 1998). Over 52% of all apprehended children in British Columbia are Aboriginal, and 78% of Aboriginal children in permanent care in B.C. are placed in non-Aboriginal homes or facilities (Fournier and Crey, 1997). Through this process many children have experienced racism, dislocation, the erasure of cultural identities, and the severance of kinship, community, and ancestral ties

2 Note that van't Hof and Nicolson (1996) have argued that the apparent increase in eating disorders may both reflect changing norms of thinness and increased psychiatric labeling of women who defy feminine script.

(McDonald, 1985). This is compounded by findings that 43% of Aboriginal and non-Aboriginal foster children are subjected to violence within the foster home setting (Kufeldt et al., 1998). Within foster homes, 72% of girls report strong feelings of sadness, and 18% of girls participate in deliberate self-injury (Kufeldt et al., 1998).

Over 40% of women with disabilities have been or are in abusive relationships (DisAbled Women's Network, 1989). Abuse experienced by women with disabilities is four times the national average (Razack, 1994) and is mostly inflicted by family members or caretakers. Of women with disabilities surveyed by the DisAbled Women's Network (DAWN) in 1989, 37% reported abuse by parents and 17% reported abuse by spouses. Two-thirds of able-bodied and disabled older adults who face abuse are women (Senior Women Against Abuse Collective, 1989). Nearly 80% of this violence occurs at the hands of family members (Grandmaison, 1988).

Between 10% and 25% of non-Aboriginal, able-bodied Canadian women have experienced violence from their husbands or common-law spouses (Benson, 1995; Duffy, 1998; Statistics Canada, 1993). Reported rates are highest in B.C., where one in three women is assaulted by her spouse (BC Ministry of Health and Ministry Responsible for Seniors, 1995a; Statistics Canada, 1993; 1995). About 8% of adult women in Canada have been sexually assaulted by past or current spouses (Duffy, 1998). Approximately 20% of lesbians in Toronto report being battered by a previous or current partner (Ristock, 1991). Children witness abuse between spouses or partners in 40% to 100% of violent relationships (Alliance of Five Research Centres on Violence, 1999; Statistics Canada, 1993).

Among non-Aboriginal, able-bodied girls, 12.5% (1 in 8) are seriously sexually abused and 20% (1 in 5) are physically abused (Duffy, 1998). In addition, a quarter of girls attending secondary school experience sexual or physical assault by a boyfriend (Duffy, 1998).

Eating Disorders

Overall Prevalence of Eating Disorders

The Canadian Paediatric Society (1998) has reported that eating disorders are the third most common chronic illness among adolescent females. In Quebec, over 65,000 young women between 14 and 25 years old are affected by eating disorders each year (Clinique St-Amour, 2001). Over 70,000 women meet the clinical criteria in Ontario, for a prevalence rate of 1% to 2% of the general population (Kraft, 1998). The American Psychiatric Association documents the prevalence rate of eating disorders as 1% to 4% (Joiner and Kashubeck, 1996). People(s) of colour(s) represent 1.8% to 5% of referrals for anorexia and bulimia in the U.S. (Davis and Yager, 1992).

Prevalence Rates for Bulimia

Epidemiological data from the Mental Health Supplement of the Ontario Health Survey suggest that the prevalence rate of bulimia for Ontarians over 15 years of age is 0.5% (Offord et al., 1996). In a review by Woodside (1995), bulimia nervosa was estimated to affect 1% to 1.5% of women. This same clinician reported that binge eating in the absence of purging is much more common. In interview-based studies with rigorous diagnostic criteria, Garfinkel et al. (1995) found lifetime prevalence rates of 1.6% to 2.8% among Canadian women. The Anorexia and Bulimia Nervosa Foundation of Victoria (2000) estimates that the prevalence of bulimia in post-secondary students, however, may be as high as one in six.

Epidemiological data from U.S. prevalence studies suggest that approximately 1.0% of girls (1,000 per 100,000) demonstrate bulimia nervosa (Hoek, 1995). This estimate is consistent with findings of other researchers, who report that 1% to 3% (le Grange, Telch and Agras, 1997) and 1% to 2% (Pike and Walsh, 1996) of Western women are affected.

Prevalence Rates for Anorexia

Garfinkel et al. (1995), of the Clarke Institute of Psychiatry in Toronto, observe that full-syndrome anorexia nervosa affects 0.56% of the population and that partial-syndrome anorexia nervosa is present in 1.4%. The Canadian Paediatric Society has documented an increase in eating disorders over the past 30 years and reports that they now affect up to 5% of adolescent women. Clinique St-Amour (2001) reports that about 1% to 2% of young adolescents will develop anorexia. Hoek (1995) has reviewed epidemiological data and reported average prevalence rates of anorexia nervosa of 280 per 100,000 (0.28%) among U.S. girls.

Breaking Prevalence Rates Down

According to the Anorexia and Bulimia Nervosa Foundation of Victoria (2000), "recent findings indicate that both disorders affect all sections of the community and any type of family." Anorexia and bulimia affect women across race and culture (Bryant-Waugh and Lask, 1991; Daniels, 2001; Davis and Yager, 1992; DeAngelis, 1997; Field, Colditz and Peterson, 1997; Ford, 1992; Joiner and Kashubeck, 1996; le Grange, Telch and Tibbs, 1998; Pike and Walsh, 1996; Prince, 1985; Root, 1990), class (Gard and Freeman, 1996), *and* sexuality (Heffernan, 1996).

No significant differences have been found between women of colour and white women in reports of eating patterns or in the prevalence of eating disorder diagnoses (le Grange, Telch and Agras, 1997). The largest comprehensive study to date comparing black and white women, conducted by the National Institute of Health, has demonstrated roughly equivalent rates of bulimia and binge-eating (DeAngelis, 1997). In another study, African American women were more likely than white, Asian, and Latina women to have induced vomiting during the previous month (Field, Colditz and Peterson, 1997). High levels of disordered eating attitudes and behaviours have also been reported among adolescent Mexican-American women (Joiner and Kashubeck, 1996).

Within U.S. samples, 11% of Pueblo and Latina/o high school students (86% female) met the DSM-III criteria for bulimia (Smith and Krejci, 1991). Higher rates of eating disorder symptoms have been found for Aboriginal girls and women (Crago, Shisslak and Estes, 1996; Rosen et al., 1988; Smith and Krejci, 1991; Snow and Harris, 1989). In particular, Aboriginal adolescents have demonstrated higher rates of self-induced vomiting and binge eating (Smith and Krejci, 1991), depression after binge eating (Snow and Harris, 1989), and high levels of body dissatisfaction and fear of weight gain (Smith and Krejci, 1991; Snow and Harris, 1989).

Research in the U.S. has shown that 0.49% of lesbians currently meet diagnostic criteria for anorexia, and 4.9% of lesbians have had anorexia in the past (Heffernan, 1996). This same research has demonstrated that 0.98% of U.S. lesbians meet diagnostic standards for bulimia nervosa.

Diagnostic Criteria

A substantially larger proportion of women demonstrate bulimic symptomatology but do not meet the criteria required for a diagnosis of bulimia nervosa. Both service providers and members of the advisory panel cautioned that prevalence rates of anorexia and bulimia are unable to capture the broader continuum of "troubled eating" that girls and women experience. One advisor noted that diagnostic rates "certainly tend to ignore the concerns of individuals with food and weight issues that fall outside the very rigorous criteria for DSM classifications." Another indicated that "there's ample evidence to suggest that even amongst junior high and high school girls, many . . . have sub-clinical eating disorders [and] may never reach the statistical threshold for falling into this group." Estimates from the literature suggest that up to 19% of female students report bulimic symptoms in the absence of full clinical bulimia nervosa (Hoek, 1995; Zerbe, 1992). Approximately 5% of lesbians demonstrate binge eating disorder without meeting the full diagnostic criteria for bulimia nervosa (Heffernan, 1996). One of our advisory committee members speculated:

> *. . . that you see a number of women who are victims of violence and they may have eating disorders, but they may not have any disorders that put them at medical risk. And if they don't have eating disorders that compromise them medically, however you frame it, there just isn't anything out there for them . . .*

While a woman may be experiencing disordered eating, she may not be clinically diagnosable as having an eating disorder. Another reported:

> *As a frontline worker, I work in an organization where I'm required to go by the DSM IV criteria, and if my client hasn't missed her periods for a sufficient amount of time, then supposedly she's not anorexic, which is kind of ridiculous with regard to providing service, given you want to do it in as timely a manner as possible.*

Garfinkel et al. (1996b) have concluded that prevalence statistics based on diagnostic criteria are informative in a clinical setting but do not take into account the continuum of vulnerability to disordered eating. To work effectively with individuals experiencing high risk for disordered eating, all concerns regarding weight and shape issues and troubled relationships to food must be considered. Such difficulties may develop into more serious eating disorders or may still affect the psychological and physical functioning of the individual.

Impact

Both family violence and eating disorders are associated with serious physical and psychological health impacts. Many of these outcomes are common to both a history of abuse and to disordered eating. In fact, this similarity has been one factor that has led researchers to investigate the possibility of a connection. Anorexia, bulimia, and a history of abuse have all been linked to the following:

- feelings of shame and guilt, low self-esteem, a sense of inadequacy, and negative attitudes toward the body (Brown, 1997; DeGroot et al., 1992; Herzog et al., 1993; Schaaf and McCanne, 1994; Welch and Fairburn, 1996)
- problems with intimacy and trust (Brown, 1997; Herzog et al., 1993)
- negative feelings about sex (Brown, 1997)
- a sense of powerlessness in relationships (Schaaf and McCanne, 1994)
- a greater risk for alcoholism and substance abuse (Everill and Waller, 1995b; Schaaf and McCanne, 1994)

- depression and post-traumatic stress disorder (Everill and Waller, 1995b)
- self-harm through cutting, burning, scratching, and bruising (Brown, 1997; DeGroot et al., 1992; Everill and Waller, 1995b).

Within both eating disorders and family violence, the body is the physical site where issues of power and control are expressed. Through abuse, this power is stripped; through anorexia and bulimia, control is re-asserted. However, both disordered eating and abuse are often shrouded in secrecy and stigma. As a result, many girls and women remain at risk of serious medical complications, injury, and psychological ill-effects.

Girls and Women Dying

Between 1974 and 1993, approximately 75 women each year were killed by their spouses in Canada (Duffy, 1998). Aboriginal women are six times more likely to be killed by a spouse than are non-Aboriginal women (Duffy, 1998). About 43% of all wife assaults result in medical attention, and a third of women living in violent relationships fear for their lives because of the severity of the violence (Statistics Canada, 1993). In fact, fear of injury or death is as high for women who are raped by their husbands and their dates as it is for survivors of stranger rapes (Koss, 1989). In addition to the threat posed during abuse, women who have endured childhood sexual abuse, adult sexual assault, or battering are more likely to attempt suicide (DeGroot et al., 1992; Schaaf and McCanne, 1994; Yoder, 1999). Suicide is an even greater concern for high-risk groups, such as Aboriginal and/or lesbian, bisexual, or Two-Spirited[3] youth and women.

Approximately 90% of individuals who die from anorexia and bulimia are girls and women (Gagnon, 1996). Eating disorders are the most life-threatening of all psychiatric conditions (Zerbe, 1992). About 5% of girls and women with anorexia die from complications or starvation within the first 5 to 8 years (Woodside, 1995). Risk of mortality increases each year. Over a 20-year period, 13% to 20% of women with anorexia will have died (Woodside, 1995). Over a 3 to 5 year period, there is a 5% fatality rate for bulimia (Woodside, 1995). Adolescent women constitute 20% of the deaths from anorexia (Gagnon, 1996). Severe medical illnesses accompany chronic anorexia in 56% of cases (Herzog et al., 1997). Many health effects can be irreversible, even after recovery (Canadian Paediatric Society, 1998). Health outcomes for older women with eating disorders are particularly poor (Cosford and Arnold, 1992) and overwhelmingly lead to death in women who are 70 years of age or older (Gagnon, 1996).

3 "The term 'Two-Spirited' originates from the First Nations recognition of the traditions and sacredness of people who maintain a balance by housing both the male and female spirit" (Deschamps and Wahsquonaikezhik, 1998: 10).

Although many outcomes associated with family violence are serious, anorexia and bulimia are health and life threatening. Both abuse and disordered eating can be debilitating to the woman and potentially result in her death. Although the shared serious nature of family violence and eating disorders does not indicate their correlation, it does suggest that their co-occurrence may have critical consequences. Moreover, the impact of eating disorders and of violence extends beyond the individual woman and girl within whom they have been embodied. These issues also have an impact on the health and the social and economic fabric of the broader community in which they are embedded.

Links Between Violence Against Women and Girls, Anorexia, and Bulimia

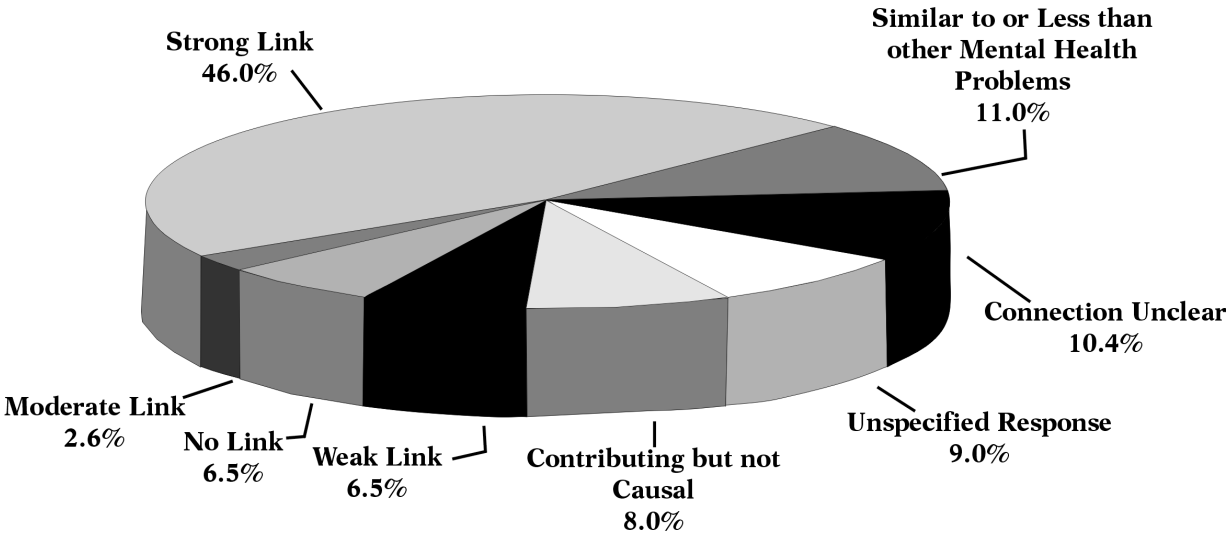
Nearly two-thirds (63%) of the 123 service providers who responded reported seeing a link in their clients between family violence and disordered eating. Only 6.5% said that there is no link. Estimates from Canadian service providers regarding the number of women and girls with anorexia and bulimia who have experienced family violence varied widely. The average estimate across service providers was that 50% of the women they treat for disordered eating have a history of abuse of some form – sexual, physical, emotional, or psychological.[4] The average estimates were lower (30%) for Quebec and Newfoundland and higher (60%) for Saskatchewan and Nunavut/Northwest Territories.

About 9% of those who identified a link indicated that it was a moderate or weak one. Approximately 8% of informants emphasized that violence was a contributing factor but not the only cause. Nearly half (46%) of service providers contacted, however, characterized the connection between violence and eating disorders as "definite," "strong," "absolute," "always," "usually," or "almost always."

As with the published literature, there was a high variability in the responses from service providers, reflecting differing definitions of abuse, diagnostic criteria for eating disorders, the type of population served, and the type of treatment provided. The subsequent sections of this report explore further our respondents' experiences with varying forms of abuse, different age groups, observations about mediating factors between abuse and disordered eating, explanations for their experiences, and approaches to treatment.

4 The average estimation figure of 50% represents the mean, median, and the mode of the responses provided to us by the 123 service providers across Canada. Standard deviation of the responses was 25.14%.

Figure 1: Responses by Canadian Service Providers to a Possible Link between Family Violence and Eating Disorders



Abuse of Children and the Development of Eating Disorders

Childhood Sexual Abuse

Sexual abuse has been a topic of research and interest since the mid 1980s (Thompson, 1992). With this growing interest has come an exploration of childhood sexual abuse as a possible contributing factor to anorexia and bulimia. Although estimates range widely, published research indicates that, overall, about 30% of women with eating disorders have been sexually abused (Connors and Morse, 1993). Data collected on 25,838 British Columbian adolescents indicated that 28% of young women reporting problem weight control practices also reported sexual abuse (McCreary Centre Society, 1998). Nearly a quarter (23%) of Canadian service providers that we contacted reported a clear link between sexual abuse during childhood and the development of anorexia or bulimia.

The connection between sexual abuse and eating disorders may be influenced by a number of factors. Women are at greater risk for eating disorders if they have had more unwanted sexual experiences (Mullen et al., 1993) or more abusers (Davenport, Browne and Palmer, 1994), or if physical abuse has accompanied sexual abuse (Miller, 1996; Wonderlich et al., 1997).

Women who have experienced past extrafamilial child sexual abuse (i.e., abuse by someone outside the family) have reported binge eating, vomiting, fasting, and using diet pills more frequently than those who have not (Hernandez, 1995). Intrafamilial (abuse by a family member) sexual abuse (Baldo and Baldo, 1996; Baldo, Wallace and O'Halloran, 1996; Waller, Halek and Crisp, 1993), particularly by a close male relative (Mullen et al., 1993), has been linked to greater likelihood and more serious manifestations of eating disorders. Canadian researchers have also observed a difference in the type of eating disorder that develops. For example, women with bulimia who purge may be more likely to have experienced sexual abuse than women with bulimia who do not purge (Garfinkel et al., 1996a). High rates of sexual abuse have been found in Canadian women for both types of anorexia (Garfinkel et al., 1996b).

> *"It is a chilling reality for a staggering number of girls that sexual activity is equated with violence and violation long before they are introduced to life-affirming sexual activity based on mutual consent."*
>
> *- Thompson, B.W. (1994)*

Childhood Physical Abuse

The role of childhood physical abuse in the development of disordered eating has received much less attention than has childhood sexual abuse (Reto, Dalenberg and Coe, 1996; Rorty and Yager, 1996). There is, however, some evidence to support a connection. Over a third of British Columbian adolescent women surveyed who reported frequent binge eating or vomiting, frequent use of diet pills or frequent weight loss efforts, reported physical abuse histories (McCreary Centre Society, 1998). Aboriginal, African-American, Latina, and white U.S. children, adolescents, and women who have been physically abused have reported higher incidences of eating disorders and more severe cases of bulimia (Hernandez, 1995; Reto, Dalenberg and Coe, 1996). Women with bulimia are more likely to have experienced repeated and severe physical abuse and to have been abused within the year preceding the onset of symptoms (Welch, Doll and Fairburn, 1997; Welch and Fairburn, 1996). Moreover, physically abused women may have more difficulty identifying hunger and fullness than sexually abused women (Schaaf and McCanne, 1994).

Bodily shame (Andrews, 1997) and an emotionally disturbed family environment (Schmidt, Humfress and Treasure, 1997) have been found to further strengthen the links between physical abuse and bulimia. In particular, research has suggested that bulimia may offer a dissociative response to physical abuse and the feelings of shame that derive from it (Nagata et al., 1999; Reto, 1998).

Of the Canadian service providers we contacted, one in seven (14%) said that there was a link between physical abuse experienced during childhood and the development of eating disorders. One B.C. informant estimated that about 60% of eating disorders are directly tied to physical abuse. Taken together, the published research and the experience of service providers indicate that a history of physical abuse may play a contributory role in the development of eating disorders, particularly bulimia.

Family Interactions During Childhood

Seven of the service providers (5.7%) emphasized family dysfunction and poor family relations as factors in the development of anorexia and bulimia. In particular, they identified poor communication, lack of conflict resolution, higher levels of conflict, perfectionist expectations, and witnessing of woman or child abuse. One service provider defined what she termed "intellectual abuse" as a form of verbal abuse by middle class and affluent parents in which sarcasm, perfectionism, rigid control, and high expectations undermine the child's self-esteem. Factors that have been highlighted in the published literature include parental indifference, excessive parental control, family discord, and parental disapproval (Schmidt, Tiller and Treasure, 1993). Leighton (1989) also notes that children's witnessing of woman abuse is linked to the development of eating disorders.

An additional 14% of the service providers said that *emotional or verbal abuse* during childhood was connected to the emergence of anorexia and bulimia. One informant observed that a background of verbal abuse was very common, and another suggested that most clients experienced emotional rather than physical abuse. Thompson (1994) has observed that many eating disorders begin as a "search for refuge" from physical abuse or such forms of emotional abuse as verbal insults, accusations, refusals to give reassurance of love, neglect of basic needs, and lack of physical touch. Rorty and Yager (1996) have pointed out that a continuum of maltreatment must be considered that includes parental/caretaker intrusiveness (e.g., opening mail, eavesdropping, reading diaries), and sexualized relationships (e.g., genital exposure, sharing pornography, etc.).

Service providers also pointed to damaging messages about food that children receive within the family, including verbal abuse about size and fatness, withholding of food, forcing children to eat food, and social stigma attached to

types and quantities of food. Mealtimes may be stressful and may become an area in which parental authority, control, and abuse are exerted (Miller, McCluskey-Fawcett and Irving, 1993a). Women with bulimia have commented that "it was a relief when my father wasn't at dinner"; "my father commented about my mother's weight when I was young"; "when I was hurt or upset my mother would offer me food as a special treat"; "both my father and mother made me eat food I didn't like" (Miller, McCluskey-Fawcett and Irving, 1993a). If mealtime control is combined with patterns of sexual and physical abuse, the food itself may become a symbol of conflict, intrusion, and pain.

Women with bulimia have reported more negative mealtime and food-related experiences, high levels of stress and conflict during meals, parental use of food as a tool for punishment or manipulation, and a family emphasis on dieting and weight (Miller, McCluskey-Fawcett and Irving, 1993b). Family interactions during meals and around food can be especially pertinent to the maturing girl if access to food varies according to gender. In some homes, boys may be given more food and encouraged to eat whereas girls entering adolescence are increasingly pressured to reduce food consumption in order to attract a male partner (Thompson, 1992).

Youth and Adolescent Experiences of Violence, Anorexia, and Bulimia

The connection between family sexual, physical, and emotional violence and the development of disordered eating in adolescents is often included in research addressing childhood experiences, but there are also types of abuse that are unique to adolescents.

In an epidemiological study examining adult abuse and DSM-III-R disorders, Danielson et al. (1998) reported that between 35% and 50% of young adults were involved in some level of physical partner abuse. Mercer (1987)[5] found that among the Toronto secondary school women he surveyed, 20% reported experiencing abuse in their romantic relationships. The Nova Scotia Advisory Council on the Status of Women found that among young women in dating relationships, 11% experienced sexual abuse, 32% reported emotional abuse, and 18% faced physical abuse (Day, 1990). Moreover, adolescent wives (ages 15 to 19) are murdered three times more often than adult wives (Canadian Centre for Justice Statistics, 1994).

Unfortunately, there has been virtually no research to examine the role of battering in adolescent girls' romantic relationships and their pre-existing manifestation or subsequent development of eating problems. One of the service

5 Research by Mercer (1987), Canadian Centre for Justice Statistics (1994), and Leighton (1989) was integrated and reported by Battered Women's Support Services (1997).

providers, however, informed us that girls with bulimia and anorexia talk a lot during group sessions about violence in schools, with friends, or in dating relationships. In addition, whereas boys under the age of 13 are more likely to be physically abused in the parental home, girls are more likely to be physically abused when older (Gadd, 1997).

Lesbian and gay youth are confronted with homophobia both within the family and from peers. Adolescence is a time when they face pressures to date the opposite sex and to engage in heterosexual discourses as well as to make decisions about "coming out". Between 20% and 50% of all street youth in Canada are lesbian or gay (Deschamps, 1998), many having left to escape homophobia within the family and within peer environments. In his thesis research, Samis (1995) found that 5% of lesbians and 11% of gay men in the Vancouver region reported having been gay-bashed by family members. Thompson (1994) has highlighted the role of homophobia as a form of "psychic violence" in the development of eating disorders. Lesbians she interviewed reported binge eating in response to the isolation of coming out (Thompson, 1992). Research in British Columbia has indicated that 15% of non-heterosexual youth report purging at least once in a while compared with 6% of heterosexual youth (McCreary Centre Society, 1999). One service provider noted in "many instances" of eating disorders the women consulting her "have questioned their sexuality." The connection between homophobia and eating disorders is further supported by the greater prevalence of anorexia among young gay men than among young heterosexual men (French et al., 1996; this point was also raised by one of the service providers we consulted).

Adolescence is accompanied by a number of lifestyle changes: assertion of independence, part-time jobs, occupational options, spending more time away from home, driving, increased body fat, increased importance of peers, and social pressure regarding appearance (Chapman, 1994). The adolescent woman may encounter prohibitions on freedom and exertion of parental control as she seeks her adulthood (Hill and Holmbeck, 1987). She receives messages that her sexuality must be protected and experiences the gender-specific nature of this standard if her brothers have later curfews, less surveillance, and fewer restrictions (Atwood, 2001; Peters, 1994; Zani, 1991). In this way, she increasingly becomes the body that cannot be trusted (Gremillion, 1992). This situation can be compounded when family members or peers make sexual remarks and jokes about her body, when her developing secondary sexual characteristics become the object of harassment, or if she has experienced or is experiencing sexual abuse (LaBarbera, 1984; Larkin and Popaleni, 1994; Smith, 1997).

Families may encourage young women to develop goals and body images that are conducive to upward class mobility. In fact, some researchers have hypothesized that upward mobility is a contributing factor to eating disorders.

Weight loss has become a symbol of interpersonal and financial success (Striegel-Moore, 1995). Thinness in North America represents competence, intelligence, assertiveness, and self-control (Smith, Waldorf and Trembath, 1990). Women are often required to modify their bodies to obtain access to employment, education, and economic resources (Littlewood, 1995). Young women often face pressures from parents about thinness, dieting, and lighter or restricted eating (Tsiantis and King, 2001; Vincent and McCabe, 2000). The degree of family pressure to control weight has been found to moderate the relationships among thinness norms, body dissatisfaction, and disordered eating (Twamley and Davis, 1999). More serious manifestations of eating disorders have been linked to more critical maternal attitudes toward weight during adolescence (Ritter, 1998). Strong family relationships, in contrast, have been found to decrease the risk for eating disorders among abused youth (Neumark-Sztainer et al., 2000). Consistent with this finding, research suggests that youth who have spent more time in foster or group homes (Garfinkel et al., 1995) and homeless youth (Freeman and Gard, 1994) are at greater risk of bulimia.

Both race and class assimilations are tied to thinness and dieting (Root, 1990). In interviews conducted by Thompson (1992), both African-American and Puerto-Rican women highlighted their experiences of family pressure to emulate white, middle class standards of thinness. For example, one woman explained that as her family class shifted from a working class to an executive, upper class level, her family moved from big meals, chubby children and keeping plenty of food in the house to an insistence on elegance and thinness and to pressure for her to take diet pills.

Root (1990) further discusses how the devaluation of non-European cultures causes adolescent women of colour to move toward European values of beauty and reject their cultures of origin. She warns that this process converges with the developmental point at which women are most vulnerable to eating disorders. One African-American woman, for example, related her eating disorder to statements by her white grandmother that she would never be as pretty as her cousins because of their lighter skin (Thompson, 1992). Racialized identity is further affected by the presence of abuse. “Sexual violence shakes up what ‘home’ means. Since racial and cultural identity is primarily taught in the home, this socialization process is inevitably disrupted when the home is no longer a refuge, but rather a place of stress and fear” (Thompson, 1994). One service provider added that the negotiation for young, first generation Canadian women between the dominating culture and the struggle of their parents to preserve cultural identity is one precipitating factor for eating disorders.

Family dynamics may have a specific impact for adolescents with chronic illness and disability. Youth with chronic illness have been found to be at greater risk of disordered eating than those without (Neumark-Sztainer et al., 1998). This same sample of youth also experienced lower levels of family communication, parental caring, and parental expectations. In addition, adolescents with chronic illnesses have reported more sexual and physical abuse (Neumark-Sztainer et al., 1998). Such research suggests that an interaction of non-supportive family dynamics, family violence, and the presence of chronic illness may put youth at greater risk of developing anorexia or bulimia. Women with disabilities indicate confronting similar pressures as able-bodied women to conform to standards of body shape, size, and weight (McCarthy, 1998; Watson, 1999). However, research on samples of women with arthritis, visible blood vessel conditions, skin conditions, diabetes (Ben-Tovim and Walker, 1995), spinal cord injury (Beatus, 1997), learning disabilities (McCarthy, 1998), and other visible physical disabilities (Watson, 1999) has generally reported that women with disabilities do not necessarily disparage their bodies more or demonstrate a more negative body image than able-bodied women. Rather, disabled women have indicated that, as a result of discrimination, they experience a stronger pressure to "dress for success" (Watson, 1999).

In addition to the above, informants who were consulted for this study noted the impact of harassment as experienced by young women in high school. Violence within the school environment was also emphasized. One service provider observed that 80% of girls with eating disorders in her practice experience some form of violence at school, and that experiences of harassment are more prevalent than are verbal, sexual, or physical abuse.[6] Another informant mentioned an "increasing amount of emotional violence exchanged between the girls, which takes the form of verbal 'put downs' or undermining with malicious intent". Teasing by peers has been found to predict both body esteem and eating behaviour among adolescent girls (Lieberman et al., 2001). Indeed, recent research into the role of peers in disordered eating has suggested that members of the same friendship cliques tend to share similar body image concerns and dieting behaviours (Paxton et al., 1999). Those girls whose friends participate in extreme weight loss behaviours are more likely to engage in these same behaviours (Paxton et al., 1999). Even in third and fifth grades, children's eating and body concerns have been found to correlate with being liked by peers (Oliver and Thelen, 1996).

6 This observation is supported by the statistical profile of youth violence, which demonstrates low levels of physical violence between girls or where girls are the perpetrators (Reitsma-Street, 1999).

Violence and Eating Disorders in Adulthood and Aging

Battering

There have been few studies examining the relationship between eating disorders and physical abuse experienced during adulthood (Kaner, Bulik and Sullivan, 1993). Some information has come from research done in the U.S. In a study conducted about a decade ago, 45% of women with bulimia reported being physically victimized at least once during an adult relationship (Root and Fallon, 1988). Of these, 23% had been raped, 23% had been battered, and 6% had been both raped and battered. In a more recent U.S. study, almost two-thirds of women interviewed who experienced severe spousal abuse met the criteria for one or more psychiatric diagnostic categories and had elevated rates of mood, anorexic/bulimic, and substance use problems (Danielson et al., 1998).

Perhaps the most informative study is that by Kaner, Bulik and Sullivan (1993). These researchers found that 40% of women with bulimia as compared with 5.9% of women without bulimia had been battered one to three times per week during an adult relationship. The risk of battering was 6.8 times higher for women with bulimia. Moreover, women with bulimia were more likely to blame themselves for the abuse and to feel that it was deserved than were those women without bulimia. An additional factor is present if the woman leaves her batterer and is confronted with initial or greater poverty, in which food becomes one of the least expensive substances available as a method for coping (Thompson, 1992).

The findings of these studies suggest that battering and other forms of abuse in women's heterosexual and lesbian romantic relationships may be factors in the development and manifestation of eating disorders.

Four of the service providers contacted for the present report linked anorexia and bulimia with the experience of physical assault. One informant reported that "the most common scenario is the married bulimic woman with a history of domestic violence", noting in addition that children who come from violent homes are also at risk. A second service provider similarly observed that eating disorders tended to be manifest among women in their 30s and 40s who have a history of child abuse and more recent experiences of domestic violence. Of facilities and practitioners that received referrals, some noted that many of these came from women's shelters. Others reported that they sometimes found it necessary to refer women with eating disorders to women's shelters because of the immediacy of the experience of abuse or because of their own lack of knowledge in the area of abuse. Our advisory committee noted that people tend to

. . . talk a lot about integrating treatment in terms of when women come to seek treatment for their eating disorder. What about when women come to seek support, emotional support or advocacy for the fact that they're in an abusive relationship and eating disorders come up in the course of the counselling session or in the course of our work with her? Our focus seems to be the other way: when women go and get treatment for their eating disorder and then how do we integrate issues of violence into that?

Sexual Trauma in Adulthood

Numerous researchers have found evidence for an association between past sexual trauma and bulimia (Baldo and Baldo, 1996; Connors and Morse, 1993; Dansky et al., 1997; Everill and Waller, 1995a; 1995b; Lanzi et al., 1997). In her study of African-American, Latina, Jewish, and white North American women, Thompson (1992) found that sexual abuse history was the trauma that participants most frequently related to the development of their eating problems. In a national U.S.-based study of 3,006 women, participants with bulimia had experienced higher rates of rape, sexual molestation, aggravated assault, direct victimization, and current and lifetime post-traumatic stress syndrome (Dansky et al., 1997). In a college sample of women, just over twice as many women with bulimia (56.8%) as women without bulimia (26%) reported having narrowly missed being sexually assaulted (Beckman and Burns, 1990). Both rape and oral sexual abuse have been found to be related to bulimia (Welch and Fairburn, 1996). Canadian research has also shown that 82% of federally incarcerated women and 72% of provincially incarcerated women have experienced either sexual or physical abuse or both. Within this same population, 59% disclosed self-injurious behaviour, and disordered eating was common (National Crime Prevention Council of Canada, 1995).

Six service providers (5%) in this study reported that sexual assault and rape were linked to disordered eating in Canadian women. One informant further emphasized the role of sexual harassment.

Aging

Between 1986 and 1988, abuse of older adults in Canada increased by almost 20% (National Aging Resource Centre on Elder Abuse, 1990). Overall, this type of abuse has been estimated to affect 1% to 10% of the senior population, with incidences as high as 36% for physical abuse and 81% for psychological abuse within some institutions (Patterson, 1994). Approximately 4% of older Canadians living in private dwellings have reported being abused, and a fifth of these have reported more than one type of abuse (Swanson, 1999). Older women are roughly one and a half times as likely to be abused as older men (5:3) (Podnieks

et al., 1990). In 1992, approximately 1.4 million women between 45 and 64 years of age were physically abused by spouses (Mother's Report Call to Action, 1994). In an Ontario survey, 20% of nurses and nursing assistants indicated that they had witnessed abuse of patients within nursing homes: 10% reported that other staff had hit or shoved patients, and 28% observed yelling, swearing, and embarrassing comments (Ens, 1998).

Elder abuse may include beatings, sexual assault, physical restraint, failure to provide care or necessities, humiliation, isolation, intimidation, abandonment, and financial control. Moreover, seniors face increasing isolation through the death and loss of friends, siblings, and spouses or lovers. They may not have a network to seek help or shelter from abusive environments. Aging women are at particular risk of food deprivation and control if they are dependent on others to shop for them, prepare, plan, and/or feed them meals. They may also face infantilization in their changing relationships with adults younger than them, which is often highlighted in interactions around feeding.

For the older woman who is experiencing physical or sexual abuse, restraint, condescension, or neglect, it is the aging body that is the site of trauma. She may decide that it is simply "her time" and engage in reduced food consumption. She may alternatively seek control of her body again through food refusal or binge-purge cycles. Eating may be one of the few avenues through which the aging woman feels she may exert control. Wiederman (1996), for example, discusses an 86-year-old woman who, upon being institutionalized, developed an eating disorder. Her own description of her environment highlighted noise and intrusion, a lack of control over food selection and preparation, frustration over a loss of independence, and poor quality of food. For another 80-year-old white widowed woman, dieting and purging represented weight loss and relief that had been denied to her by her husband when he forbade her to seek a breast reduction (Beck, Casper and Andersen, 1996). She had continued to live with social and physical discomfort until the age of 73, when her husband died.

Eating disorders among post-menopausal women are under-diagnosed, not recognized as legitimate diagnoses, or met with skepticism (Cosford and Arnold, 1992). In one study of five patients aged over 55 with eating disorders, it was found that all had been under the care of a physician, two were seeing a psychiatrist, and none had been diagnosed (Hsu and Zimmer, 1988). Yet, eating disorders are overwhelmingly fatal for seniors. Just over 78% of deaths from anorexia occur in individuals over 45 years of age (Gagnon, 1996). When older adults depend on family or institutions for finances, transportation, housing, or the provision of basic necessities, then they are at risk of abuse. If food is used as a weapon in abuse or is provided in an atmosphere of dependence by the abusing individual, then eating may become an aversive experience that the older adult resists.

The Role of Disclosure

Eighteen of the service providers (15%) consulted raised the issue of disclosure in assessing the link between violence against women or girls and eating disorders. Girls or women who are hospitalized or who seek treatment for anorexia or bulimia may be reluctant to disclose current or past abuse. Violence may be difficult to address because of the secrecy that surrounds abuse, the ongoing threat of the situation, and denial by girls, siblings, or parents that violence exists in their families. Secrecy may be exacerbated in rural or small town settings where lack of anonymity and stigmatization are concerns (Jiwani, Moore and Kachuk, 1998). One service provider also noted that "families with secrets like a history of violence are not likely to seek out this program."

Women and girls living with violence may be less apt or less able to pursue treatment for anorexia and bulimia. Moreover, because both the history of abuse or sexual trauma and having an eating disorder are stigmatized, the girl or woman who experiences both may be less likely to seek help or may seek help for one but be hesitant to disclose the other. As one advisory committee member commented, "This whole issue of accessibility and the fact that whether it's a history of violence, abuse, or an eating disorder, people are often very reluctant to disclose that. And the younger they are, the more reluctant they tend to be sometimes."

It is important to note, however, that women and girls are more likely to reveal abuse if they are directly asked (Ferris, Nurani and Silver, 1999). Both the American College of Obstetricians and Gynecologists and the American Medical Association have recommended routine screening of women and girls for abuse. Nonetheless, across Canadian and U.S. studies, health care practitioners indicate that they do not routinely or directly ask about abuse (Ferris, Nurani and Silver, 1999).

One service provider suggested that the setting may be important to whether the woman or girl discloses abuse as a factor in her eating disorder. Several variables related to setting were discussed by informants. Some dieticians and nutritionists indicated that women were more likely to disclose to other types of mental health workers than themselves. In particular, one therapist suggested that an examination of family systems and structures tended to encourage greater disclosures of violence. Three service providers indicated that group settings often led to higher disclosures and more discussion of abuse as a factor in eating disorders than did individual sessions. Abuse is then subsequently addressed in individual therapy, where at least one informant felt it was most appropriately addressed. On the other hand, one service provider emphasized

that family violence was not usually raised in group sessions. It was also noted that when the connection between violence and disordered eating was directly addressed during the initial assessment, the frequency of disclosure was higher.

Higher levels of disordered eating have been found in women who have previously disclosed their abuse and received an adverse reaction (Everill and Waller, 1995a). Responses such as disbelief, blaming the girl or woman, ignoring the disclosure, and punishment can further increase the woman's feelings of general worthlessness, inferiority, and stigmatization (Brown, 1997; Everill and Waller, 1995a). The woman may feel betrayed, distrust the experiences of her own body, or distrust her ability to communicate her experiences (Everill and Waller, 1995b). For the girl, disclosure may be followed by the removal of her father from the home and subsequent loss of income, or she may become the scapegoat for "breaking up the family" (Friedrich, Urquiza and Beilke, 1986). In the context of ongoing discrimination in child apprehension, the Aboriginal woman may fear losing her children if she discloses eating disorders, alcoholism, or battering.

Like the service providers we interviewed, some researchers have suggested that the mixed research findings about the links between violence and eating disorders may be, in part, attributable to under-disclosure of abusive experiences due to denial, repression, and dissociation (Connors and Morse, 1993; Miller, 1996). This may particularly affect girls and women who have experienced more severe forms of abuse (Miller, 1996). Moreover, girls and women may not always label their experiences as abuse even when asked directly. For example, in one study, 42% of children who described multiple experiences of burning, biting, kicking, and beating with an object by their parents did not label it as abuse (Reto, Dalenberg and Coe, 1996).

Miller (1996) has highlighted some strategies for assessment that tend to elicit greater disclosure. These include more inclusive definitions of abuse, the use of "inverted funnel questioning" (i.e., specific and overlapping questions about the experience), and interviewing. Detailed questionnaires combined with interview formats generate the most information (Connors and Morse, 1993). The use of interviewing is particularly important in light of one study in which a third (33%) of women who did not disclose child sexual abuse on an intake questionnaire later disclosed it in a research interview (Miller, 1996). The validity of such interviewing is supported, as reports of childhood abuse by women generally demonstrate high rates of corroboration, exceeding 75% (Weiner and Stephens, 1996). Ferris, Nurani and Silver (1999) have recommended that women be asked about specific acts (e.g., slapping) rather than global problems (e.g., domestic violence), using either screening instruments (e.g., checklists) or private patient interviews.

Age

Service providers presented a relatively consistent picture regarding the ages at which women experience abuse, disclose abuse, and seek or require help. Overall, they indicated that the connection between violence and eating disorders affects women across the life span. Although many women with eating disorders have experienced abuse at an early age (for example, 9 to 10 years old), most of these women disclose the abuse and develop their eating problems when they are in late adolescence or early adulthood. Fewer women disclose current experiences of violence than discuss a history of past violence. One service provider observed that incest and sexual abuse are not always revealed by young women or adolescent girls but are discussed by older women who are more ready and who are no longer dependent on their families.

Service providers identified women in their 60s and 70s as an age group also suffering from eating disorders that are linked to abuse or violence. Research has suggested that childhood sexual abuse remains an important issue for later onset cases of eating disorders (Beck, Casper and Andersen, 1996). Memories and associated emotions still persist as women age. Attaining closure on past experiences of abuse has been identified as an important part of recovery for older women with anorexia and bulimia (Beck, Casper and Andersen, 1996).

Research studies examining violence against girls or women, anorexia, and bulimia are almost exclusively retrospective. Both adult women and adolescent girls are asked to recall abuse history and childhood environments (e.g., DeGroot et al., 1992; Miller, 1996; Moyer et al., 1997; Schmidt, Tiller and Treasure, 1993). Unfortunately, this approach tends to focus on adult samples remembering childhood through an adult perspective, rather than on adolescent samples at a time when many eating disorders develop (Herzog et al., 1991). The opportunity for youth to disclose both eating disorders and ongoing family or other forms of violence is critical to an integrated therapeutic approach as well as to a better understanding of abuse as a contributing factor in the development of an eating disorder.

Understanding the Links

The explanations that service providers offered for a connection between abuse and disordered eating demonstrated five themes: causality, coping, control and power, self-esteem, and sociocultural context.

Causality: Do Experiences of Violence Lead to Eating Disorders?

Many researchers and clinicians have observed high abuse rates among girls and women with anorexia and bulimia. However, some have questioned whether this connection simply reflects that both abuse and eating disorders occur predominantly among women and girls (Connors and Morse, 1993). If sexual abuse is a contributing factor to the development of eating disorders, then child sexual abuse must precede the onset of symptoms. Some evidence exists that, at least for some women, sexual abuse does precede and contribute to their anorexia or bulimia. For over 90% of girls who have survived sexual abuse, the age of onset for eating disorders is *after* their first experiences of abuse (Herzog et al., 1993; Miller, 1996). Both research and one of the service providers have estimated the average age of first abuse for women with eating disorders to be about 9 to 10 years old (Miller, 1996). Approximately 10% of women who develop bulimia are known to have been sexually abused within a year preceding the onset of their symptoms (Welch, Doll and Fairburn, 1997).

Researchers (Welch and Fairburn, 1996) and some of the service providers have cautioned against "oversimplifying" the relationship between family violence and eating disorders. "An approach insisting on a one-to-one or straightforward causal relation is also likely to miss many of the more individual and experiential aspects trauma plays for this particular population" (Brown, 1997). Overall, reviewers and many of the service providers have concluded that although child sexual abuse is neither necessary nor sufficient for the development of eating problems, it does act as a contributory factor (Connors and Morse, 1993; Dansky et al., 1997; Reto, Dalenberg and Coe, 1996; Rorty and Yager, 1996). As one of our advisory committee members noted, "It's not necessary or sufficient that people have violence in their background to develop anorexia or bulimia, but there is a considerable link in considerable numbers of the cases." A history of abuse was characterized as one contributor in a complex multideterminant model that includes both risk factors and resiliency factors.

Coping with Violence

Nine service providers told us that eating disorders are one type of coping mechanism for women and girls who have experienced violence. In particular, food is used to deal with stress and with more serious underlying family problems. Anorexia and bulimia may emerge as ways of coping with the pain or trauma of living with ongoing or past abuse.

Binge eating serves different, and potentially multiple, purposes for different individuals. For some women, eating is used as sedation, to alleviate anxiety, and to combat loneliness (Thompson, 1992). For adolescent women surviving sexual abuse, food may be the most accessible and socially acceptable drug available to them (Thompson, 1992). Dissociation may provide a connection between a history of sexual or physical abuse and subsequent eating disorders. Dissociation allows escape from trauma when physical escape is not possible (Everill and Waller, 1995a). In particular, binge eating can serve to block emotions, self-degradation, continued memories of the abuse, fear, self-blame, and anger from awareness (Everill and Waller, 1995b; Miller, McCluskey-Fawcett and Irving, 1993a; Wonderlich et al., 1997). Binge eating draws the girl's or woman's attention to the immediate present, thereby blocking depression, anxiety, and thoughts (Wonderlich et al., 1997). In addition, it induces a physiological alteration that is similar to the lasting chemical changes in the body that ensue following trauma (Wonderlich et al., 1997). In this way, it "anesthetizes" the woman, allowing her to numb feelings and attain relief (Brown, 1997; Thompson, 1992). Psychologically "leaving the body" during binge eating parallels "leaving the body" during sexual and physical abuse (Thompson, 1992). Moreover, the act of eating large amounts of food can encourage sleep and provide another way to block pain (Thompson, 1992). As the woman or girl blocks her feelings, memories, and experiences through binge eating, she may follow this with attempts to "cleanse" herself of violation through purging (Brown, 1997; Waller, Ruddock and Cureton, 1995). Thompson (1994) has described bulimia as a mechanism for "throwing up" abuse.

Childhood abuse can include starvation, force-feeding, forced ingestion, emotional abuse around eating and weight, forced eating of vomitus or spoiled foods, physical abuse during meals, use of food as rewards or bribes following abuse, and use of food in sexual acts (Brown, 1997). Within Canadian residential schools, food was often used as a weapon of abuse. Aboriginal children endured starvation (as punishment and as a cost-saving measure), food unfit for human consumption, the forced ingestion of vomit, inadequate nutrition for growth and subsistence, forced feeding, bread and water as punishment, and severe beatings for trying to acquire extra food or water (Chrisjohn, Young and Maraun, 1997). These food deprivations and punishments occurred in conjunction with extensive physical and sexual abuse.

Research has suggested that young men are more likely to express pain resulting from abuse outward, and young women are more likely to direct pain inward into self-injury and eating disorders (Totten, 1997). Moreover, when inflicted as abuse, food itself may become unappetizing, an aversion, or a provision over which the abused girl or woman is not accustomed to having control or access. Certain foods may trigger memories of ejaculation through their appearance or consistency, leading to their avoidance or purging (Brown, 1997). For girls and women who have histories of family or institutional violence, we are reminded that "their eating strategies began as logical solutions to problems rather than problems themselves as they tried to cope with a variety of traumas" (Thompson, 1992).

Control and Power

Increasingly, there is a shifting focus in the theoretical model used to understand disordered eating from a model in which a desire for thinness is regarded as the central factor in disordered eating to one that emphasizes control and powerlessness (Thompson, 1992; 1994). This shift has provided more clarity in understanding the connection between violence against girls and women, anorexia, and bulimia.

Work by Sandy Friedman (1994; 1999) suggests that the experience of violence results in a loss of voice and a loss of connection to others. In particular, she notes that connection to others is fundamental to girls' self-esteem. In looking outward for definition, in trying to please others, in being silenced, and in undergoing related life changes, girls can experience a "complete collapse on the inside". Friedman observes, in addition, that "if you've been abused, one of the things that happens is your connections are severed – the trust, the connections with others." It is this severance of connection and loss of self that Friedman views as a fundamental cause of eating disorders.

Nine service providers told us that eating disorders are one way in which girls and women who have been abused seek to gain control over their lives. For example, one informant explained that "eating disorders are really about control and feeling powerless in a violent family." Indeed, research has demonstrated that sexual abuse history is linked to a lower level of perceived control (Waller, 1998). The service providers indicated that a lack of safety and security in the home may lead young women to search for an area of life that they can control. As one informant noted, "the one thing they can control is their food intake." One frontline worker providing services to battered women noted that she frequently encounters "how food is regulated or denied or deprived or other forms of using food as a weapon to control" and the internalization of this control by women.

> *"The genius of oppression is that it denies us any control over our own lives except the power to destroy ourselves. Particularly, we are denied control over our own bodies."*
>
> *- service provider and survivor of anorexia*

The binge-purge cycle provides a means of "expressing of anger, relieving stress and tension, regaining a sense of self, establishing control, ensuring predictability and personal space, and 'cleansing' oneself of the abusive experience" (Everill and Waller, 1995b). For both the girl still living in the home and the woman who has left the parental home, food refusal may be one way of expressing hostility or punishment toward the abusing parent or caregiver and/or the parent who was unable to protect her (Brown, 1997; Lee and Lee, 1996; Williams, Wagner and Calam, 1992).

The repeated violation of personal body boundaries can lead to a sense of powerlessness in the woman (Everill and Waller, 1995a). She may feel that she has lost control of her body (Miller, McCluskey-Fawcett and Irving, 1993a) or that her body betrayed her by being weak, vulnerable, sexual, or small (Brown, 1997). "Both abuse and eating problems significantly disrupt a woman's ability to see her body as her own" (Thompson, 1994). Levels of perceived control have been shown to be lower in women who report abuse and to be especially lower when attempts to regain control through disclosure have failed (Everill and Waller, 1995a). Ritualized eating behaviour is one way in which the survivor may impose a sense of control in her life and on her body (Brown, 1997). Whereas past psychodynamic theories have characterized this exertion of control as immaturity and teenage rebellion, more current models propose that the search for control is a creative and powerful act of resistance in an environment in which escape is impossible (Thompson, 1992; 1994).

Root (1990) has suggested that for groups who have been denied food through war or discrimination, eating symptomatology may manifest as food hoarding or compulsive eating. Prisoners who survived the last stage of starvation disease in Auschwitz-Birkenau, for instance, reported a continued preoccupation with food (Ryn, 1990). Focus group discussions have suggested a relationship between African-American eating patterns and the legacy of slavery (Airhihenbuwa et al., 1996). The generational effects of these experiences on eating should be considered as a factor in assessment and treatment. The relationship to food may be more than just a healing process of the individual patient. The girl or woman's relationship to her community and her community's own healing processes around food and violence may be important to her recovery. One

theorist in Prince George, B.C., for example, has argued that the restoration of the potlatch is central to Tsimshian identity, kinship, and heritage as well as to recovery from the impact of colonialism (McDonald, 1995).

Self-Esteem

Four service providers pointed to low self-esteem as a shared connection between eating disorders and a history of family violence. Three of these informants observed that abuse often leaves children with lower self-esteem, and eating disorders are one way of coping with these feelings. Indeed, women with eating disorders who report unwanted sexual experience are more likely to see themselves as contaminated by the experience and to have lower sexual self-esteem (Waller, Ruddock and Cureton, 1995). The shame that a woman feels about unwanted sexual experience has been connected to the development of anorexia (Schmidt et al., 1997).

Sexual abuse can result in the woman feeling disgusted with her own body, femaleness, and sexuality (Brown, 1997). Girls who are surviving or have survived childhood sexual abuse are more likely to see themselves as fat, ugly, and unworthy during adolescence (Schaaf and McCanne, 1994). Negative feelings are most directed toward those areas of the body associated with sexuality such as the breasts, stomach, and buttocks (Miller, McCluskey-Fawcett and Irving, 1993a) and can lead to dieting and purging in an effort to change these body parts (Thompson, 1992). Indeed, in research by Griffiths and McCabe (2000), adolescent girls scoring higher on body dissatisfaction showed higher levels of disordered eating behaviours, and one of the most important predictors of body dissatisfaction was self-esteem.

One service provider noted that criticism of appearance can further undermine the self-confidence of girls and women. Thompson (1992) has observed that "exposure to trauma did much more than distort the women's visual image of themselves. These traumas often jeopardized their capacity to consider themselves as having bodies at all." Thompson now uses the term "body consciousness" rather than "body image" to describe the woman's ability to reside comfortably in her own body and to consider her body connected to herself. It is this body consciousness that is disrupted by abuse and that is, in turn, linked to the development of eating disorders.

Bulimia has been linked to self-degradation among girls and women who are survivors of family violence (Everill and Waller, 1995b). Feelings of inadequacy, guilt, anxiety, inferiority, worthlessness, self-blame, and shame may provide the "psychic link" between abuse and the development of eating disorders (Brown,

1997; Hernandez, 1995). The guilt and self-blame that survivors experience is often further exploited by the abuser in an effort to maintain secrecy (Everill and Waller, 1995b).

The Sociocultural Context

The intersection of violence and eating disorders must be understood within the sociocultural context of women's experiences. The diet and beauty industry achieves gross earnings of approximately $30 billion each year (Pike and Walsh, 1996). In an examination of 222 studies over the last 50 years, it was found that the number of women who have a poor body image compared with men has risen dramatically since the 1970s (DeAngelis, 1997). It has been argued that "comparing one's own body to cultural ideals, and knowing one's body will be subject to such comparisons by others, is fundamental to women's experience" (Frederickson and Roberts, 1997: 192). In fact, eating practices and disordered eating in young and middle-aged women have been shown to be related to the extent to which they feel negatively about themselves when cultural body standards are not achieved (McKinley and Hyde, 1996).

Stereotypes regarding fatness have been repeatedly documented to begin early in childhood. Lawson (1980) found that 2nd, 4th, and 6th grade children had strong negative stereotypes about fat body figures and positive ones about average-sized figures. This trend worsened with increasing age. Similar responses were found in kindergarten through 4th grade by Brylinsky and Moore (1994). Research on adolescent girls has indicated that fat models in photographs were evaluated less positively and were less liked, unless they were ascribed an "excuse" for their fatness (DeJong, 1980). In other words, there is an onus on the fat girl or woman to prove that her size is a medical problem and not an external symptom of a lazy, undisciplined, or disordered character. Indeed, Chrisler (1991) has observed that "image has become a central part of identity and is now used to convey invisible aspects of identity such as personality traits." Both fat and non-fat children have been found to generate more negative stereotypes of fat people (Counts and Jones, 1986). Degradation of fatness also exists among Canadian children and adolescents (LeBow, 1988; LeBow et al., 1989).

Research has shown that women's exposure to thinness-depicting media (magazines and television) predicts eating disorder symptomatology, a drive for thinness, body dissatisfaction, and a feeling of ineffectiveness (Harrison and Cantor, 1997). Young women are exposed to 10 times as many thinness-promoting advertisements as young men (Andersen and Holman, 1997). Media representations promote stereotypes that "women of colour are either fat and powerless (African American and Latina women); fat, bossy, and asexual; corrupt and/or evil (Asian/Pacific Americans, Island and African Americans); exotic (Asian American, mixed race); or hysterical and stupid. American Indian

and Alaskan Native women are virtually nonexistent" (Root, 1990). By grade 3, 40% of girls think that they should be thinner (Kraft, 1998). In Canada, more than 50% of girls under 18 years of age see themselves as too fat, even though 80% report a "normal" weight (McCreary Centre Society, 1993). Twice as many girls as boys see themselves as fat, and as early as grades 3-6 twice as many girls as boys are dieting (Andersen and Holman, 1997). Of those who diet, 70% to 80% are dissatisfied with their bodies (Andersen and Holman, 1997). It is for this reason that some researchers have called for caution in speaking about the woman with anorexia or bulimia. To focus predominantly on biomedical explanations, cognitive deficits and biases, maladaptive attitudes and beliefs, and physiological dysfunctions is to risk treating the woman solely as the source of the problem without a consideration of her social context (Malson and Ussher, 1996).

While the girl or woman receives messages about her appropriate body size and presentation, she is also exposed to portrayals of the violence that she may be experiencing in her life. Popular women's magazines, for example, predominantly characterize woman battering as a private problem and, specifically, the woman's problem (Berns, 1999). Similarly, reality-based television crime programs tend to ascribe blame to the abused woman or represent her as uncooperative (Carmody, 1998). It is therefore not surprising that exposure to media aggression leads to more intense feelings of disempowerment for women (Pryor, Everett, and Ridener, 1999; Reid and Finchilescu, 1995). Moreover, written news reports about the rape and murder of women are most frequently described in the passive voice, which has been shown to result in a greater acceptance of violence among both women and men (Henley, Miller and Beazley, 1995). The impact of these media representations is further compounded when they are projected into the woman's home, where she may be surviving abuse. For the girl who is being sexually abused, she is confronted with a rising skepticism in the media reporting of child abuse (Benatar, 1995).

The girl or woman living with abuse is faced with a complex interaction of violence, verbal degradations, beauty standards, dieting and thinness norms, and media images that stigmatize her or discredit her abuse. In this context, her body becomes a shameful, sexualized, and "not-good-enough" body. It is blamed for the violence inflicted on it, as well as the way in which it grows and develops. The messages the individual receives from the media may be reinforcing the very messages she is being given by her abuser. Eating disorders may be one way in which the girl or woman seeks to gain control in relation to both her violated body and her discursive body.

Issues in Treating Violence and Eating Disorders

Eight themes emerged from service providers' responses to questions regarding their current treatment approaches and recommendations for treatment: integration of treatment; self-esteem; individualizing treatment; barriers of marginality; geographic isolation; safety; developmental treatment issues; lack of funding and services.

Integration of Treatment

Three of the service providers told us that the connection between family violence and eating disorders must be recognized and treated directly. An additional fourteen (11%) reported addressing this link as a central part of their approach. About 27% said that they address the connection if it arises. A further 5% provide an integrated treatment if the woman or girl herself puts a high priority on exploring the connection as her therapeutic goal. Two programs are developing information resources and treatment toward an integrated approach.

On the other hand, seven service providers commented that they do not alter their treatment approaches to either violence or to eating disorders if the two occur together. These providers indicated that abuse, for example, would be another issue to be addressed in healing self-esteem, but that it was not a central focus. Ten of the service providers reported approaching the treatment of abuse and eating disorders separately or sequentially. In some cases, the woman is transferred after the completion of one program into another or is temporarily transferred for immediate help and then returned to the original program. In other cases, she may first receive counselling for abuse and then receive counselling for eating disorders. Many women and girls who seek treatment for eating disorders and subsequently disclose abuse are transferred or referred. They are sent to other programs, psychiatrists, abuse-related individual counselling, women's shelters, and/or the facilities of larger cities or provinces. In other cases, the advisory panel informed us, eating disorder programs will not accept individuals who demonstrate co-morbidity, such as depression. This can further fragment care since, as one of our advisory committee members indicated, "it divvies the person up and sends their various symptoms to different clinics housed in the same individual." Yet, as another advisory committee member noted, this policy does not aptly reflect the circumstances of the woman: "What doesn't make sense is if a woman with an eating disorder and who is perhaps also experiencing violence in her intimate relationship, is not depressed."

Overall, there are relatively few resources that are established to directly assess, treat, and support girls and women who experience both abuse and eating disorders. Service providers indicated that they were eager for information, discussion, and resources addressing the links between abuse, anorexia, and bulimia. In the published literature, reviewers have emphasized that suggestions for an integrated treatment approach are sorely needed (Brown, 1997).

Self-Esteem

Service providers and members of the advisory committee drew attention to the power relationship that exists between professionals and patients. One participant noted that "going to the hospital is the most powerless experience a girl can have", cautioning that this loss of power can risk heightening the girl's need for her eating disorder. Another participant observed:

> *I've seen that things have been done wrong in hospitals where physicians and nurses have been in the position of control and power over very ill eating disordered people and have, in my considerable experience, frequently treated these women quite poorly.*

Eleven service providers identified self-esteem as a core focus in treatment. As one informant explained, a program for the woman or girl who has experienced both abuse and disordered eating must help build confidence, trust, and hope. It is important that the therapist–client relationship be warm and supportive and not recapitulate the controlling dynamics of past abusive relationships.

Service providers emphasized that clients need to be provided with new, positive coping skills for dealing with family violence and stress, which can then replace the use of anorexia and bulimia. For example, the use of positive affirmation techniques and positive self-criticisms was suggested. A primary focus of informants was alternative ways in which the woman or girl could take control of her life or situation. One particularly critical point was made by two informants who noted the importance of identifying abusive relationships by naming the abuse and condemning the actions of the abuser. Re-framing an understanding of the violence away from self-blame is central to the woman's reappraisal of her own self-worth and bodily integrity. In addition, women might be taught how to find resources for dealing with abuse and encouraged in assertiveness to overcome the fear of violence. Fourteen service providers addressed body image as a part of treatment, and 21 provided the woman with education and awareness about violence, eating, nutrition, and/or body image.

Individualizing Treatment

Consistent with the research (Fichter, 1995), 10 of the service providers highlighted an approach to treatment that is individually based. Recovery was described as "a very individual process", and emphasis was placed on the girl or woman's ability to choose the most important issues she would like addressed. In this way, each woman is invited to "make her own connection with her experiences." Several informants noted that an integrated approach to treating abuse and eating disorders was used only when the client identified this as her goal. Some service providers encouraged women to take action, in a way that was individually appropriate, in order to aid healing. Suggestions for action included role playing, letter writing, and possible confrontation of the abuser, where safety was not an issue. For some, the focus of counselling is on personal growth. Women are taught to "listen to their bodies" and to examine disordered eating as "a vehicle for learning about the self."

Barriers of Marginality

According to the information we received from the service providers, available Canadian treatment and resources are offered predominantly in English only, with limited access to other languages. Fourteen of the service providers consulted offered services in either French only or in both French and English. Eight were able to provide help in languages other than French and English, and eight had access to interpreters if required. One informant found the use of interpreters difficult when confidentiality or disclosure was a critical issue. As concluded by one service provider, those women who are not able to explore, in English, the issues of abuse and eating disorders "do not have much access and are generally restricted to treatment within their own communities."

Although service providers had seen a variety of ethnic groups overall, many informed us that they served a rather homogeneous European-based clientele. Ten percent characterized their clients as "diverse." Some service providers specifically noted cultural barriers to receiving treatment, a reluctance to seek help by non-European women, and difficulty confiding in professionals who are unfamiliar with issues that these women face. Eurocentrism in the health care system, for example, has resulted in a lack of information about health issues affecting women of colour and has discouraged women from seeking help for fear of reinforcing racial stereotypes of themselves as "nurturing, well-nurtured, and overweight" (Bowen, Tmoyasu and Cauce, 1991; Dolan, 1991). Moreover, anorexia and bulimia have been mistakenly considered "the Golden Girl's Disease" (Root, 1990), and women of colour have been assumed to be immune or "buffered by cultural differences" (DeAngelis, 1997; le Grange, Telch and Tibbs, 1998; Williamson, 1998). As a result, women of colour are often disbelieved, undiagnosed, misdiagnosed, and diagnosed late as having eating disorders,

leading to greater severity prior to diagnosis (Pike and Walsh, 1996; Thompson, 1992). This is especially problematic given that the severity upon presentation for treatment appears to be the best indicator of eating disorder prognosis (Casper and Jabine, 1996).

Many women of colour have also been confronted with stereotypes of their communities as more prone to family violence, more patriarchal, and backwards or regressive in gender relations. As a result, women of colour may hesitate to disclose past or ongoing abuse to European service providers for fear of exacerbating racial stereotypes, losing community, or betraying community solidarity (Flynn and Crawford, 1998).

Service providers also expressed concerns that they were not equipped to address the needs of Aboriginal women and girls. One informant noted that racism was a frequent part of the experiences of First Peoples who consulted her for eating disorders. The definition of "family violence" itself must be examined within a context of colonialism to include, for example, the history of residential schooling or apprehension from families and communities. "As adults or elders, individuals may feel that they do not have an avenue for voicing concerns or that what they experience is labelled as family violence, particularly in areas of emotional and mental abuse" (Frank, 1992). It is important for service providers to recognize that "family violence" may include institutional violence, violence imposed upon the family, and forms of systemic or oppressive violence within which the family must live.

Research has shown that lesbians also tend to avoid mainstream avenues to health care and turn more often to alternative health because of past discriminatory experiences (Simkin, 1991; 1998). Lesbians who do seek help may avoid identifying their sexuality for fear of homophobia (BC Ministry of Health and Ministry Responsible for Seniors, 1995b). Most lesbians report wanting to disclose their sexuality to family physicians, but need to feel safe and secure to do so (Geddes, 1994; Simkin, 1998).

In addition, lesbians who report current or past battering by a partner or sexual assault by a woman need to be believed. Practitioners require an understanding of the issues specific to lesbian battering that differ from heterosexual women's experiences – lack of resources and safe shelter, community loyalties, lack of anonymity within the community, disbelief by authorities and by community, and internalized lesbophobia. The disbelief of violence within lesbian relationships may be compounded by assumptions that lesbians have a "protective buffer" against societal standards of female beauty and against disordered eating (DeAngelis, 1997). Lesbians are not immune to the cultural standards in which

they live (Heffernan, 1996). The belief that they are not generally at risk for anorexia, bulimia, battering, or woman-on-woman sexual assault can lead to under-recognition of problems and to alienation of the woman within treatment.

One service provider noted inaccessibility and lack of informed services for women with disabilities or chronic illnesses. Yet, women and girls with disabilities face higher rates of physical abuse, sexual abuse, and battering (Hay, 1997). Moreover, hearing impaired women do not differ from hearing women in attitudes toward food or dieting behaviour (Fletcher, 1993). Women with disabilities or chronic illnesses are already stigmatized as the "abnormal body" (Davis, 1995) and risk further labelling as pathological in disclosing disordered eating. Medical approaches to anorexia and bulimia in the absence of therapeutic support may further impose procedures on an already over-medicalized body, thereby discouraging some women with disabilities or chronic illnesses from seeking treatment. Such women who present with eating disorders need to be asked about the presence and role of past or current abuse. In addition, if they seek help for abuse and display signs of disordered eating they should not be assumed to be displaying a simple "medical complication" and have their symptoms dismissed.

Clinicians and researchers must recognize that eating disorders affect heterosexual, bisexual and lesbian women and girls of all racial, ethnic, and class backgrounds. Primary care providers, social service providers, and other professionals must challenge the myth that disordered eating affects only or mostly white, middle class and/or heterosexual girls and women. Both research and treatment projects need to be proactive in including girls and women of colour (Root, 1990), lesbians, and women or girls living in poverty. Clinicians must take the initiative to become culturally literate and the time to build community relationships (Root, 1990). Culturally specific treatment will consider the impact of historical and current racism, immigration experiences, institutionalization, and colonialism on communities and individuals. In particular, the impact of food deprivation across generations and for those currently living in poverty must be further investigated and factored into individual treatment where applicable. Moreover, service providers must be sensitive to both disability and to abuse. Physically accessible services are necessary, as well as sensitivity to the needs of girls and women with hearing, visual, cognitive, and developmental disabilities.

"The core psychological themes reflected in disordered eating are the pursuit of identity, power, specialness, validation, self-esteem, and respect – themes significant in the lives of all oppressed persons."

- Root, 1990: 526

Geographic Isolation

Women living in isolated, rural, or small communities who are experiencing violence face unique barriers to accessing treatment: a lack of anonymity within their home areas, the threat of firearms, lack of public or personal transportation, lack of protective services such as police within their areas, and an inability to physically leave the area or an incident of battering (Jiwani, Moore and Kachuk, 1998). Such factors may compound the sense of powerlessness and lack of control that these women feel. Control over eating may become one way in which to manifest a sense of self. There may be few services for girls and women seeking help for abuse and eating disorders. For example, some regions reported no publicly funded programs or limited access to psychologists and nutritionists. Women are referred to services in the closest large city, which can be an hour or more away. Small urban centres reported that women and girls requiring more intensive treatment or hospitalization must be moved to larger cities. For smaller provinces and for northern areas, women and girls must often be sent out of province, away from community support and family, to receive appropriate help. Service providers noted that this is especially true in acquiring services that address the connections between family violence and disordered eating. Counsellors are also more likely to have to travel in order to meet the needs of the community and surrounding area.

Safety

A few service providers reported that they do not address violence for women and girls with anorexia and bulimia unless their client is in danger from her abuser. Those service providers who used an integrated approach, however, stressed that the individual's safety is a prime concern during therapy and in considering programmatic changes. Suicide checks and assessments of risk to ensure the safety of the girl or woman from violence were recommended. One informant noted that, upon disclosure of abuse history in women with eating disorders, he avoided doing physical examinations beyond routine requirements in order to avoid further traumatization. Similarly, another service provider

noted that a history of abuse affected her approach to body work in treatment. Safety issues are emphasized more "in an attempt to have clients feel safe inside their bodies".

Developmental Treatment Issues

Approximately 5% of all cases of anorexia develop among children younger than 12 years old (Nielsen, Lausch and Thomsen, 1997). The child's accessibility to treatment is a particularly pertinent issue when she is presenting with both disordered eating and a history of family violence. As one service provider indicated, abuse must be reported, and the presence of abuse determines whether state child welfare agencies will become involved. Often parents will try to withdraw children from treatment as a consequence. Similarly, another informant explained that some parents or guardians may not cooperate with treatment because one parent/caregiver is the perpetrator of abuse or because divorce affects relationship dynamics. However, researchers have noted that many children who are abused show difficulties with eating in the short term, and early intervention may be critical in preventing the development of eating disorders (Williams, Wagner and Calam, 1992).

The Canadian Paediatric Society (1998) has highlighted some of the barriers to effective care for adolescent girls. Provincial health care plans often place limits on access to private care resources such as mental health or nutrition counselling. In addition, as the adolescent ages, she may no longer be eligible for coverage under provincial medical insurance rules. She therefore finds her treatment ending at a time when she is faced with such developmental challenges as leaving home, unemployment, or temporary employment. Moreover, she may be forced into transition from pediatric to adult care by the age limit policies of some treatment programs. One service provider noted a lack of services for those individuals who are in transition from youth to adult programs. For some, such disruption in care may hinder or endanger recovery. Youth health centres were suggested as important locations for early identification and prevention programs (advisory panel). Important to this provision, however, is the need for confidentiality and accessibility, as many youth may be unwilling to disclose violence or eating disorders to family or meet with service providers if it requires transportation arrangements (advisory panel).

For some older women, anorexia may replace previous forms of self-harm, such as wrist cutting (Nicholson and Ballance, 1998). For some, it may be a relapse to earlier eating disorders. "No former sufferer should be considered immune from relapse at any age, especially following a bereavement or other significant loss" (Cosford and Arnold, 1992). Clinicians should be alert to previous histories of eating disorders, depression, battering, sexual abuse, and post-traumatic stress.

Some older women who enter treatment for eating disorders may be reluctant to discuss childhood sexual abuse and sexuality issues (Beck, Casper and Andersen, 1996). Recurrence or late onset of eating disorders may be triggered by the death of somebody close (e.g., a spouse), institutionalization, loss of independent living, or moving in with family. For older women, limited financial resources may determine poor diet and inability to access services. It is important that services addressing the intersections of violence and disordered eating be available to aging women. Such services must include consistent and appropriate screening.

Lack of Funding and Services

A consistent problem that service providers identified was the impact of increasing funding cutbacks and of lack of funding. Treatment facilities are facing numerous difficulties in continuing to meet the needs of individuals who have experienced abuse and who are at risk from anorexia and bulimia. Service providers across Canada told us that they were struggling to survive staff shortages, decreased program lengths, free and frequent staff overtime, expanded geographic areas to serve, re-allocation of treatment time to fundraising, and increasing reliance on volunteers. Underlying issues of family violence, abuse, powerlessness, family dynamics, and control are left unaddressed. It is crucial to the eating disordered girl or woman who has experienced abuse that she be approached as a *whole* person in order for treatment outcomes to be lasting and effective.

Key Components Identified for the Treatment of Violence and Eating Disorders

Approximately two-thirds of the service providers reported a connection between abuse and disordered eating. Almost half of the total sample characterized this link as strong. Of these, all except one attempted to use an integrated approach to treatment, either as a central component or as a priority identified by the client. Many of our participants, however, emphasized the need for more information and resources. In addition, they offered suggestions for treatment.

Based on a review of research and on the input of Canadian service providers, 12 therapeutic concerns across four stages of treatment have been identified as necessary to an integrated treatment approach to disordered eating and violence against women and girls.

Stages of Treatment	Therapeutic Concerns
Presentation	Accessibility Assessment
Immediate Needs	Safety Medical Stability
Therapeutic Support	Validation Self-worth Re-framing Coping Skills Control and Empowerment Relationships and Networks Education and Awareness
Continuity	Follow-up

Presentation

1. Accessibility

Individuals must have access to adequate services, appropriate services, and to already existing services. The provision of access means that

- issues pertinent to marginalized women are understood and addressed in treatment;
- facilities are physically accessible to and specialized for girls and women with disabilities or chronic illnesses;
- both abuse and eating disorders are properly identified across race, language, ancestry, and developmental lines;
- services are affordable and sufficiently funded;
- sufficient community-based programs exist within small and rural areas.

Maria Root (1990) has called on health professionals to take the initiative in being culturally literate, to actively participate in organizations that are multiracial and multicultural, and to be aware of cultural understandings of causation, help-seeking, and cure. She has highlighted the importance of building relationships within various communities and learning from key community members. Practitioners have not, for example, expected, looked for, or treated anorexia or bulimia among homeless people, despite higher rates of both a history of abuse and of eating disorders in this population (Gard and Freeman, 1996).

Members of the advisory panel emphasized that transition houses are important sites for intervention, noting that "it's a residential setting so there are lots of ways to make things accessible whether it's education about body image, body size, body consciousness, or just the food that's available. For lots of women who go to transition houses, it's the first time that they can actually eat freely and eat what they want."

2. Assessment

Several recommendations emerged for assessment:

- Service providers who are working with girls and women experiencing sexual, physical, and emotional family or institutional (e.g., foster homes, residential schools) violence should inquire carefully about eating patterns (Williams, Wagner and Calam, 1992).

- Girls and women presenting with eating disorders should be asked directly about past and present experiences of violence, emotional abuse, and abusive interactions surrounding food. Either interviewing or a combined use of admission forms and interviewing may be used, structured with overlapping, open-ended questions.

- The presence of eating disorders, childhood abuse, and partner abuse should be assessed across age and sexual identity (e.g., battering in lesbian and/or older couples, adolescent battering, the impact of child abuse for older women).

- The messages that the girl or woman has received about her body from family should also be explored, including the impact of family changes in class positioning, "coming out," dieting, and cultural assimilation.

- Assessors should also check for possible accompanying or co-morbid risks, such as depression, post-traumatic stress disorder, self-harm, and suicidal ideation or attempts.

Immediate Needs

3. Safety

The girl or woman who is living with abuse should have a safety plan. This includes protection from reprisals, punishment, or being withdrawn from treatment by the family or abuser. The abused adult should be assured consistent support and appropriate safety measures if she makes the decision to confront, escape, or report the violence. Safety also includes resources for meeting basic needs. Individuals who are homeless or living in poverty will need appropriate and sufficient food, food storage facilities, and shelter to facilitate recovery. Women and girls with disabilities will require accessibility to both services and to safe houses/transition houses as well as attentiveness to higher levels of poverty. Joan Meister (1990), of the DisAbled Women's Network (DAWN), has noted that: "Often the only cushion between a disabled woman and poverty on social assistance or poverty on minimum wage is the financial support of the family. Yet dependence on family is a demeaning and even dangerous place for many women with disabilities…Battering, incest, and other forms of abuse are endemic and unrecognized by the support services which are largely inaccessible." (p. 42).

4. Medical Stability

In conjunction with therapeutic support, medical stabilization of the body may be necessary. This includes access to medical treatment, monitoring, advice, and emergency hospitalization. In addition, support for addiction recovery may be required. Attention to the woman's health needs should occur within a supportive, caring atmosphere that encourages her sense of wholeness or "body consciousness" (Thompson, 1992; 1994). Health practitioners need to be particularly aware of possible abuse histories among eating disordered women and be respectful in approaching the woman's body. Body boundaries and issues of consent must be carefully considered in providing medical treatment.

Therapeutic Support

5. Validation

Service providers must be aware of their own reactions to revelations of abuse by women or girls with eating disorders. Responses should be appropriately warm and empathetic. Expressions of horror, shock, disbelief, disgust, or complete neutrality may exacerbate shame, self-doubt, and self-blame (Everill and Waller, 1995b). It is important that the strength and survival of the woman be acknowledged, that the abuse be named, and that the woman's experiences be believed.

6. Self-worth

Counselling should be aimed at the restoration or promotion of a sense of the self as worthy, capable, and trustworthy. Self-affirmations, a more holistic "body consciousness", and more constructive forms of self-criticism should be developed to displace forms of self-denigration or internalized messages of oppression. One service provider suggested that the girl or woman be actively engaged in prioritizing issues and establishing individualized goals within treatment.

7. Re-framing

The woman's beliefs about the abuse, about herself, and about her body should be openly discussed. In particular, self-blame should be identified and re-framed through the clear condemnation of the abuser's actions. Reactions to previous attempts she has made at disclosing should be discussed and inappropriate responses by caregivers, professionals, or family should be acknowledged.

8. Coping Skills

A number of service providers suggested teaching coping skills during counselling. For example, discussion might address alternative ways to reassert personal control, methods of establishing and enforcing new body boundaries, strategies for seeking resources or help when needed, the power to recognize and name abuse, and the creation of a political or social voice.

9. Control and Empowerment

It is critical to support the girl or woman in gaining the sense of control that she may be seeking. This might develop through re-defining her role, rights, and status within the family or helping her to leave the family. It may come through establishing a sense of herself as a strong individual. In addition, one service provider has observed that some women find "calling their abuser to account an important step toward healing." In particular, this informant noted that some women have found phoning their abusers, writing them letters, confronting them in person, or lodging a complaint with police a "powerful form of self-validation."

In research by Roush (1999), most of the incest survivors who confronted their abusers characterized the action as empowering and important to their healing. These same women also noted a mixture of family reactions from improvement to terminated relationships and a mixture of personal reactions, including shock, fear, anger, and regret. As noted by one advisory panel member and by Cameron (1994), the woman's safety must be paramount. Moreover, the advisory panel noted that eating disorder symptoms may flare up in response to the increased risks in which the woman or girl sees herself engaging during the recovery process.

10. Relationships and Networks

The establishment of healthy relationships, support networks, and community membership/relations should be a part of the therapeutic goal. This may be variously accomplished through

- family therapy
- support groups
- building of relationship skills
- helping the woman to define her own goals for a healthy relationship
- establishing a network of community advocates and resources that the girl or woman can contact or join

- ensuring that the therapist–client relationship is supportive and does not re-create the power dynamics that the woman has experienced during abuse

- supporting the woman in her relationships with peers defined by her race, ethnicity, sexuality, disability/chronic illness, reserve, or community, and understanding the role that she wishes her peers to play in her healing.

11. Education and Awareness

Service providers recommended that the recovery process include consciousness raising about media, family, peer, and other sociocultural influences on body image and issues of violence. The provision of libraries, videos, workshops, and peer discussion groups can challenge the stigmatization of fatness, disordered eating, sexuality, addiction of self or family, sexual abuse, and physical abuse that creates shame and silence.

Continuity

12. Follow-up

It is critical that the recovering girl or woman be able to retain a sense of connection, receive counselling subsequent to medical stabilization, and receive follow-up checks for health complications or relapse. Provisions might include check-in calls, letters, or cards, drop-in access, available telephone support, continued access to support groups, gradual release, and the opportunity to become involved in educational or peer counselling programs. Funding cutbacks, however, have made treatment programs themselves difficult to sustain and have eliminated the necessary follow-up from many programs.

Conclusion

The literature and the data obtained from interviews with 123 service providers identified a relationship between eating disorders and violence against women and girls. This finding was affirmed by feedback from our national advisory committee. However, both the literature and the interview data caution us that the connection is not a simplistic or an inevitable one. Rather, the particular experiences of the individual girl or woman will shape the likelihood, nature, and personal meaning of eating disorders in her life. For some women, eating disorders may represent resistance against past and further violation of the body. For others, they may represent a way to destroy the body and purge feelings of shame and guilt.

Exploring the specific importance of anorexia or bulimia as a response to abuse for the individual is central to recovery. It is a focus on the unique needs of the girl or woman in assessment and treatment that characterizes an *integrated approach*. Specific components of an integrated approach suggested here include an emphasis on accessibility; assessment; safety; medical stability; self-worth; re-framing; coping skills; control and empowerment; relationships and networks; education and awareness; and adequate follow-up.

Although research is increasingly examining the manner in which abuse may contribute to the development of disordered eating, there has been relatively little focus on resiliency factors within this relationship. A direction for future research posed by the advisory committee of this project is the investigation of the variables or circumstances that "inoculate people or provide them with supports and coping strategies" in averting the development of eating disorders.

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Appendix A:
A List of Programs

This appendix lists programs providing services for disordered eating. No individual program listed is necessarily recommended or endorsed by FREDA or by Health Canada. An extensive directory of transition houses, emergency shelters, second stage housing and safe networks across Canada has been published in *Transition Houses and Shelters for Abused Women in Canada* (2002), available through the National Clearinghouse on Family Violence, Health Canada.

British Columbia

Chilliwack Mental Health
274-45470 Menholm Road
Chilliwack, BC V2P 1M2
Tel: 604-795-8375

Eating Disorder Outreach Program
St. Joseph's Hospital
2137 Comox Avenue
Comox, BC V9M 1P2
Tel: 250-339-1576
Fax: 250-339-1439

Tri-Cities Mental Health BC
Coquitlam, BC
Tel: 604-941-3471
Fax: 604-660-9805

Ministry of Children and Family Development
Tri-Cities BC
Coquitlam, Port Moody, New West, Maple Ridge, Pitt Meadows, Port Coquitlam
Tel: 604-469-7600

East Kootenay Eating Disorder Clinic
Cranbrook Regional Hospital
13-24th Avenue North
Cranbrook, BC V1C 3H9
Tel: 250-489-6416
Fax: 250-426-5285

HUGS, Cranbrook Regional Hospital
13-24th Avenue North
Cranbrook, BC V1C 3H9
Tel: 250-426-5281
Fax: 250-426-6262

Child & Youth Team
Canadian Mental Health Association
205-149 Ingram Street
Duncan, BC V9L 1N8
Tel: 250-746-5521
Fax: 250-748-2606

Mental Health
PO Box 2126
Invermere, BC V0A 1K0
Tel: 250-342-4295
Fax: 250-342-4322

Kamloops Community Eating
Disorder Program
Thompson Health Region
519 Columbia Street
Kamloops, BC V2C 2T8
Tel: 250-828-4438
or 250-828-4143
Fax: 250-828-4990

Langley Memorial Hospital
22051 Fraser Highway
Langley, BC V3A 4H4
Tel: 604-533-6493

Nanaimo Family Life Association
1070 Townsite Road
Nanaimo, BC V9S 1M6
Tel: 250-754-3331
Fax: 250-753-0268

Associated Family and Community
Support Services, Ltd.
2033 Sanders Road
Nanoose Bay, BC V9P 9C2
Tel: 250-248-0076
Fax: 250-468-9182

Eating Disorders Self Help Group
Kootenay Lake Regional Hospital
333 Victoria Street
Nelson, BC V1L 4K3
Tel: 250-354-6321
Fax: 250-354-6320

North Shore Mental Health BC
Suite 209, 267 West Esplanade
North Vancouver, BC V7M 1A5
Tel: 604-660-1273
Fax: 604-660-3108

ANAD North Vancouver Support Group
North Vancouver City Library
Activity Room
122 West 14 Street
North Vancouver, BC V7M 1N9

Tri-Cities Mental Health
Eating Disorders Program
Adult Short-term Assistance
2232 Elgin Avenue
Port Coquitlam, BC V3C 3B2
Tel: 604-941-3471
Fax: 604-660-9805

Child & Youth Mental Health Services
300-3003 St. John's Street
Port Moody, BC V3H 2C4
Tel: 604-469-7600
Fax: 604-469-7601

HUGS, c/o Heart & Stroke Foundation
106-490 Quebec Street
Prince George, BC V2L 5N5
Tel: 250-562-8611
Fax: 250-562-8614

Prince George Eating Disorder Clinic
Northern Interior Health Unit
1444 Edmonton Street
Prince George, BC V2M 6W5
Tel: 250-565-7479
Fax: 250-565-7416

Eating Disorder Project North
Prince George, BC
Tel: 250-997-3367

Shuswap Lake General Hospital
PO Box 520
Salmon Arm, BC V1E 4N6
Tel: 250-833-3636 Ext. 259
Fax: 250-833-3602

Sunshine Coast Mental Health Services
St. Mary's Hospital
PO Box 949
5544 Highway 101
Sechelt, BC V0N 3A0
Tel: 604-885-6101
Fax: 604-885-5842

Bulkley Valley District Hospital
PO Box 370
Smithers, BC V0J 2N0
Tel: 604-847-2611 Ext. 255

National Institute for Compulsive Eaters (NICE)
2467-127B Street
Surrey, BC V4A 8N8
Tel: 604-873-6423
Fax: 604-536-6423

Surrey Central Mental Health
110-7525 King George Highway
Surrey, BC V3W 5A8
Tel: 604-543-5660
Fax: 604-543-5699

FAIR Family & Individual Resources
860 Eldorado Street
PO Box 153
Trail, BC V1R 4L5
Tel: 250-364-2326
or 250-368-3311

Association for Awareness and Networking Around Disordered Eating (ANAD)
109-2040 West 12 Avenue
Vancouver, BC V6J 2G2
Tel: 604-739-2070
Fax: 604-730-2843

ANAD East Vancouver Support Group
Mount Pleasant Neighborhood House
Room 4, 800 East Broadway
Vancouver, BC V5T 1Y1

ANAD Kitsilano Support Group
West Side Family Place
2819 West 11 Avenue
Vancouver, BC V6K 2M2

Healthy Attitudes Program
South Health Unit
Vancouver/Richmond Health Board
6405 Knight Street
Vancouver, BC V5P 2V9
Tel: 604-321-6151
Fax: 604-321-2947

Supporting the Struggle Against Anorexia Nervosa (SUSTAAN)
PO Box 29105 Delamont, RPO
Vancouver, BC V6J 5C2
Tel: 604-734-0006
Web: http://www.direct.ca/sustaan

BC Coalition to End Disordered Eating

Eating Disorders Program for Children & Adolescents
B.C. Children's Hospital
4480 Oak Street
Vancouver, BC V6H 3V4
Tel: 604-875-2200
Fax: 604-875-2271

Nutrition Clinic at the Children's Centre
Mount St. Joseph's Hospital
3080 Prince Edward Street
Vancouver, BC V5T 3N4
Tel: 604-877-8551

Eating Disorder Service
University Hospital - UBC Site
2211 Wesbrook Mall
Vancouver, BC V6T 2B5
Tel: 604-822-2415

Eating Disorder Resource Centre of BC
St. Paul's Hospital
1081 Burrard Street
Vancouver, BC V6Z 1Y6
Tel: 604-631-5313
or 1-800-665-1822
Fax: 604-631-5461

Vancouver Anti-Anorexia/Anti-Bulimia League (VAAABL)
306-1212 West Broadway
Vancouver, BC V6H 3V1
Tel: 604-731-7304
Fax: 604-730-1015

Eating Disorders Program for Children and Adolescents
4480 Oak Street D4
Vancouver, BC V6H 3V4
Tel: 604-875-2200
Fax: 604-875-2271

Deliciosa! Nutrition Counselling
3675 West 16th Avenue
Vancouver, BC V6R 3C3
Tel: 604-225-0505
Fax: 604-225-0555

What Are You Hungry For?
3675 West 16th Avenue
Vancouver, BC V6R 3C3
Tel: 604-225-0505
Fax: 604-225-0555

Vernon Eating Disorder Program for Youth and Adults/The People Place
3402-27th Avenue, Room 303
Vernon, BC V1T 1S1
Tel: 250-542-7111
Fax: 250-542-7111

Vernon & Area Eating Disorders Association
Vernon, BC
Tel: 250-542-1388

BC Eating Disorders Association
526 Michigan Street
Victoria, BC V8V 1S2
Tel: 250-383-2755
Fax: 250-383-5518

Eros House for Creative Recovery
628 Bryden Court
Victoria, BC V9A 4Y5
Tel: 250-361-4848

Ministry of Children and Family Development
302-2955 Jutland Road
Victoria, BC V8T 5J9
Tel: 250-387-0000
Fax: 250-387-0002

Ministry of Children and Family Development, North Shore
230-1425 Marine Drive
West Vancouver, BC V7T 1B9
Tel: 604-981-0165
Fax: 604-926-5835

Outpatient Eating Disorders Program
Williams Lake Mental Health Centre
487 Borland Street
Williams Lake, BC V2G 1R9
Tel: 250-398-4465

Yukon

Yukon Mental Health Services
PO Box 2703
4 Hospital Road
Whitehorse, YT Y1A 3H8
Tel: 867-667-8346
Fax: 867-667-8372

Northwest Territories and Nunavut

HUGS, H.H. Williams Memorial Hospital
3 Gaetz Drive
Hay River, NT X0E 0R8
Tel: 867-874-6512 Ext. 140
Fax: 867-874-3377

Baffin Region Health and Social Services Board
Community Services
Bag 200
Iqaluit, NU X0A 0H0
Tel: 867-979-7680

Alberta

Eating Disorders Co-ordinator
Calgary Regional Health Authority
1509 Centre Street South, 4th Floor
Calgary, AB T2G 2G6
Tel: 403-303-6002
Fax: 403-232-6153

Eating Disorders Program
Outpatient Services
Calgary Counselling Centre
200-940 6 Avenue Southwest
Calgary, AB T2P 3T1
Tel: 403-265-4980
Fax: 403-256-8886

HUGS, Coronation Health Centre
PO Box 250, Mailbag 500
Coronation, AB T0C 1C0
Tel: 403-578-3803
Fax: 403-578-3474

Still Waters Counselling Service
PO Box 1126
Crossfield, AB T0M 0S0
Tel: 403-703-3743
Fax: 403-337-2136

HUGS
Drumheller District Health Services
625 Riverside Drive East
Drumheller, AB T0J 0Y0
Tel: 403-820-7213
Fax: 403-823-5076

HUGS, Wellness Consulting
PO Box 36048
Edmonton, AB T5Z 2L5
Tel: 780-456-1182
Fax: 780-473-0352

University of Alberta Hospital Site
Sub unit 4F4
8440-112 Street
Edmonton, AB T6G 2B7
Tel: 780-492-6114
Fax: 780-492-1310

Elizabeth Seton Community Partners
c/o Community Services –
Clairview Site
600A Hermitage Road
Edmonton, AB T5A 4N2
Tel: 780-496-5868
Fax: 780-496-5881

HUGS c/o Kinsmen Sports Centre
Edmonton, AB
Tel: 780-988-3026
Fax: 780-922-4220

HUGS
Stetsko Mayne Nutrition Consulting
7802 Mission Heights Drive
Grande Prairie, AB T8W 1Y2
Tel: 780-538-1275
Fax: 780-532-7034

HUGS, Harry Collinge High School
158 Sunwapta Drive
Hinton, AB T7V 1T7
Tel: 780-865-3714
Fax: 780-865-5011

The Centre for Recovering Anorexic:
bulimic Disordered Lives Entrust
(CRADLE)
50 Ryerson Bay West
Lethbridge, AB T1K 4P4
Tel: 403-381-8544

Quanah Mercredi Society
Ponoka, AB
Tel: 403-783-8737

Saskatchewan

HUGS
Pipestone Health District
Mental Health Services
PO Box 970
Grenfell, SK S0G 2B0
Tel: 306-697-3577
Fax: 306-697-2686

Girls in the 90's, Pasquia Health Unit
PO Box 1075
Hudson Bay, SK S0E 0Y0
Tel: 306-865-3277
Fax: 306-865-2660

North Central Health District
Mental Health Services
Melfort Hospital
PO Box 1480
Melfort, SK S0E 1A0
Tel: 306-752-8767
Fax: 306-752-8711

BridgePoint Centre for Eating Disorders
PO Box 190
Milden, SK S0L 2L0
Tel: 306-935-2240
Fax: 306-935-2241

Moose Jaw Mental Health Clinic
455 Fairford Street East
Moose Jaw, SK S6H 1H3
Tel: 306-691-6464
Fax: 306-691-6461

HUGS
1071 River Street East
Prince Albert, SK S6V 7N6
Tel: 306-764-5820

Saskatchewan Provincial Consultant for Eating Disorders
Saskatchewan Ministry of Health
3475 Albert Street
Regina, SK S4S 6X6
Tel: 306-655-6673

Inter-Agency Committee for the Prevention and Management of Eating Disorders
350 Cheadle Street West
Swift Current, SK S9H 4G3
Tel: 306-778-5250
Fax: 306-778-5408
Contact: Krista Olson, Social Worker; Cathy Knox, Public Health Nutritionist

Manitoba

Westwind Eating Disorder
Recovery Centre
458-14 Street
Brandon, MB R7A 4T3
Tel: 204-728-2499

HUGS
PO Box 102A, RR # 3
Portage La Prairie, MB R1N 3A3
Tel: 204-428-3432
Fax: 204-428-5072

Women's Health Clinic
3rd Floor, 419 Graham Avenue
Winnipeg, MB R3C 0M3
Tel: 204-947-1517
Fax: 204-943-3844

HUGS
518-1281 Grant Avenue
Winnipeg, MB R3M 1Z6
Tel: 204-478-4847
Fax: 204-488-2169

Winnipeg Eating Disorder
Clinic/Health Sciences Centre
771 Bannatyne Avenue
Winnipeg, MB R3E 3N4
Tel: 204-787-3345
or 204-787-3482

Ontario

Body Image Coalition of Peel
180 B Sandalwood Parkway East
Brampton, ON L6Z 4N1
Tel: 905-791-7800 Ext. 7694

HUGS
22 Westgate Walk
Brampton, ON L64 3H4
Tel: 905-453-5590

New Attitudes and New Directions
135 McHardy Court
Brampton, ON L6Y 1H7
Tel: 905-796-3474

Pediatric Program
Peel Memorial Hospital
20 Lynch Street
Brampton, ON L6W 2Z8
Tel: 905-796-4066 Ext. 4010

Brant Community Mental Health Centre
408-760 Brant Street, Level 2
Burlington, ON L7R 4B7
Tel: 905-631-1939
Fax: 905-631-0513

Eating Disorders Program
Joseph Brant Memorial Hospital
1230 North Shore Boulevard East
Burlington, ON L7R 4C4
Tel: 905-632-3730

The Wellness Centre, Inc.
PO Box 364
Campbellville, ON L0P 1B0
Tel: 905-854-2390

HUGS, 287 Campus Parkway
Chatham, ON N7L 4V7
Tel: 519-351-4292

HUGS Nutrition Counselling
4 Erinwood Drive
Erin, ON N0B 1T0
Tel: 519-833-0843
Fax: 519-824-9233

Inpatient Eating Disorders Program
Homewood Health Centre
150 Delhi Street
Guelph, ON N1E 6K9
Tel: 519-824-1762

Childrens Exercise and Nutrition Centre
Chedoke McMaster Hospital
Sanatorium Road, PO Box 2000
Hamilton, ON L8N 3Z5
Tel: 905-521-7967
Fax: 905-385-5033

North Kingston Community Health
400 Elliot Avenue
Kingston, ON K7K 6M9
Tel: 613-542-2813
Fax: 613-542-5486

Kingston Psychiatric Hospital (KPH)
752 King Street West
Kingston, ON K7L 4X3

Beechgrove Children's Centre
Kingston, ON
Tel: 613-549-5600

Youth Crisis Service
Kingston, ON
Tel: 613-548-1155

Hotel Dieu Hospital Eating Disorders Program, Hotel Dieu Hospital
166 Brock Street
Kingston, ON K7L 5G2
Tel: 613-544-3310
or 613-548-6121

KGH Outpatient Eating Disorders Clinic
72 Barrie Street
Kingston, ON K7I 3J7
Tel: 613-548-6121

Kingston Community Counselling Centre
417 Bagot Street
Kingston, ON K7K 9Z9
Tel: 613-549-7850
Fax: 613-544-8138

Anorexia Nervosa and Bulimia Association (ANAB)
767 Bayridge Drive
PO Box 20058
Kingston, ON K7P 1C0
Tel: 613-547-3684
Web: http://www.phe.queensu.ca/anab/

Student Health Services
Queen's University
St. Lawrence Building
Kingston, ON K7L 3N6
Tel: 613-533-2893
Fax: 613-533-6740

HUGS
PO Box 670
Lindsay, ON K9V 4W9
Tel: 705-454-9818
Fax: 705-454-9837

HUGS
507 Eastern Avenue, PO Box 1046
Lively, ON P3Y 1M8
Tel: 705-692-0720

Eating Disorders Association of London
Victoria Family Medical Centre
60 Chesley Avenue
London, ON N5Z 2C1
Tel: 519-433-8424
Fax: 519-433-2244

HUGS, Long Life-Style Consulting
PO Box 532, 15 Marlborough Street
Maxville, ON K0C 1T0
Tel: 613-527-3377
Fax: 613-527-3377

HUGS
1703 Kelsey Court
Mississauga, ON L5L 3J8
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Fax: 905-607-5420

HUGS, Health Source Associates
2550 Argentia Road
Mississauga, ON L5N 5R1
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Mississauga Community Health Nursing
Peel Health
3038 Hurontario
Mississauga ON L5B 3B9
Tel: 905-791-7800 Ext. 7401

Trillium Health Centre
Mississauga Hospital
100 Queensway West
Mississauga, ON L5B 1B8
Tel: 905-848-7100
Fax: 905-848-7592

HUGS
185 Napier Street
Mitchell, ON N0K 1N0
Tel: 519-348-4293
Fax: 519-348-4293

Eating Disorders Recovery Group
4 Bruno Street
Naughton, ON P0M 2M0
Tel: 705-692-0442

HUGS, Nutrition Consultants Ottawa
91 Beaver Ridge
Nepean, ON K2E 6E5
Tel: 613-224-5685
Fax: 613-723-9173

Jack Knight, Private Practice
PO Box 156
1100 Gorham Street
Suite 11B
Newmarket, ON L3Y 7V1
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or 905-476-2880
Fax: 905-476-2880

HUGS, Perfect Balance Canada
2006-7 Bishop Avenue
North York, ON M2M 4J4
Tel: 416-250-6658
Fax: 416-733-4719

Child & Adolescent Psychiatry Program
Oakville Trafalgar Memorial Hospital
327 Reynolds Street
Oakville, ON L6L 3L7
Tel: 905-338-4134

Youth Services Bureau/Bureau des services à la jeunesse
1338- ½ Wellington Street
Ottawa, ON K1Y 3B7
Tel: 613-729-1000
Fax: 613-729-1918
Web: http://www.ysb.on.ca/

Department of Psychiatry
Ottawa General Hospital
501 Smyth Road, Box 400
Ottawa, ON K1H 8L6
Tel: 613-737-8010
Fax: 613-739-9980

HUGS, OASIS Institute
RR # 3-1803
Prescott, ON K0E 1T0
Tel: 613-657-4688
Fax: 613-925-4537

Eating Disorders Recovery Group
206-111 Elm Street
Sudbury, ON P3C 1T3
Tel: 705-692-0442
Web: http://www.mirror-mirror.org/eatdis.htm

HUGS, Diet Enders
23 Oriah Court
Thornhill, ON L4J 8B3
Tel: 905-764-5935

Hospital for Sick Children
555 University Avenue
Toronto, ON M5G 1X8
Tel: 416-813-7195
Fax: 416-813-7867
Web: http://www.sickkids.on.ca

Ontario Centre for Adolescent Eating Disorders
2 Gloucester Street, Suite 210
Toronto, ON M4Y 1L5
Tel: 416-944-2693
Fax: 416-813-5560

Bellwood Health Services, Inc.
1020 McNicoll Avenue
Toronto, ON M1W 2J6
Tel: 416-495-0926
1-800-387-6198
Fax: 416-495-7943
Web: http://www.bellwood.ca

Anorexia Bulimia Family Support Group
783 Windermere Avenue
Toronto, ON M6S 3M5
Tel: 416-766-8134
Fax: 416-762-5642

Nutritional Eating Disorder Clinic
1206-4950 Yonge Street
Toronto, ON M2W 6K1
Tel: 416-229-6656
or 416-498-4921

Brief Psychotherapy Centre for Women
2 Carlton Street, Suite 1806
Toronto, ON M5B 1J3
Tel: 416-591-2000

National Eating Disorders Information Centre (NEDIC)
CW 1-211, 200 Elizabeth Street
Toronto, ON M5G 2C4
Tel: 416-340-4156
Fax: 416-340-4736
Web: http://www.nedic.ca/

Toronto Hospital
Program for Eating Disorders
EN 8-231, 200 Elizabeth Street
Toronto, ON M5G 2C4
Tel: 416-340-3041
Fax: 416-340-4198

Ontario Community Outreach Program for Eating Disorders
Toronto General Hospital
CCRW 2-828, 101 College Street
Toronto, ON M5G 1L7
Tel: 416-340-4051

New Realities Eating Disorder Recovery
103-62 Charles Street East
Toronto, ON M4Y 1T1
Tel: 416-921-9670
or 905-763-0660
Web: http://www.newrealitiescan.com

Sheena's Place
87 Spadina Road
Toronto, ON M5R 2T1
Tel: 416-927-8900
Fax: 416-927-8844

HUGS, The Wellington Club
Toronto, ON
Tel: 416-362-2582
Fax: 416-362-1373

Sandra Edwards, Private Practice
308-10 Unionville Gate
Unionville, ON L3R 0W7
Tel: 905-479-0869 (office)
Fax: 905-946-1431

Body Balance Total Nutrition Care
105 University Avenue East
Waterloo, ON N2J 2W1
Tel: 519-747-1848
Fax: 519-747-1848

HUGS
371 Prince of Wales Drive
Whitby, ON L1N 6M8
Tel: 905-668-6831 Ext. 1336
Fax: 905-668-8279

Bulimia Anorexia Nervosa Association (BANA)
300 Cabana Road East
Windsor, ON N9G 1A3
Tel: 519-969-2112
Fax: 519-969-0227
Web: http://www.bana.ca

Vitanova Foundation
6299 Rutherford Road
Woodbridge, ON L4L 1A7
Tel: 905-850-3690

Québec

Centre de traitement des désordres alimentaires du Québec
8149 du Mistral Street, Suite 201
Charny, QC G6X 1G5
Tel: 418-832-0574

Groupe de soutien et d'entraide anorexie et boulimie de Granby
315 Cartier Street
Granby, QC J2G 5A9
Tel: 450-372-2098
Fax: 450-372-0406

Le centre de thérapie du comportement
L'hôpital général de Montréal
1650 Cedar Avenue
Montréal, QC H3G 1A4
Tel: 514-934-8034

Le collectif action alternative en obésité
7378 Lajeunesse Street, Suite 210
Montréal, QC H2R 2H8
Tel: 514-270-3779
Web: http://www.multimania.com/caao/

Outremangeurs anonymes
434, de l'Église Street
Montréal, QC H4G 2M4
Tel: 514-490-1939

Service de médecine à l'adolescence
Hôpital Sainte-Justine
3175 Côte Ste-Catherine Road
Montréal, QC H3T 1C5
Tel: 514-345-4721

Service de santé aux étudiants
McGill University
3600 McTavish
Montréal, QC H3A 2T5
Tel: 514-392-5119

Anorexia Nervosa and Bulimia Quebec (ANAB)
114 Donegani Boulevard
Pointe Claire, QC H9R 2W3
Tel: 514-630-0907
Fax: 514-630-1225
Web: http://www.generation.net/~anebque

Clinique St-Amour
1100 Rive-sud Boulevard, Suite 120
St. Romuald, QC G6W 5M6
Tel: 418-834-9825

Douglas Hospital, Eating Disorder Unit
6605 LaSalle Boulevard
Verdun, QC H4H 1R3
Tel: 514-761-6131 Ext. 22894
Fax: 514-761-8885

New Brunswick

HUGS
PO Box 3365, Station B
Fredericton, NB E3A 5N4
Tel: 506-458-9285

HUGS
158 Burpee Street
Fredericton, NB E3A 1M5
Tel: 506-455-8256
Fax: 506-459-2829

Charles Emmrys, Private Practice
115 Connaught Avenue
Moncton, NB E1C 3P4
Tel: 506-856-3262
Fax: 506-856-2238

The Daycentre
George Dumont Hospital
185 Church Street
Moncton, NB E1C 5A1
Tel: 506-862-4144
Fax: 506-862-4322

Eating Disorder Resource Centre
New Brunswick YWCA
35 Highfield Street
Moncton, NB E1C 5N1
Tel: 506-855-4349
Fax: 506-855-3320

Health & Community Services
77 Vaughn Harvey Boulevard
Moncton, NB E1C 8R3
Tel: 506-856-2401

Service de Psychologie
Université de Moncton
C-101, Centre étudiant
Moncton, NB E1A 3E9
Tel: 506-858-4007
Fax: 506-858-4492

Prince Edward Island

Richmond Centre
PO Box 2000
Charlottetown, PE C1A 7N8
Tel: 902-368-4430
Fax: 902-368-4427

HUGS, Royal Trust Tower
119 Kent Street, Suite LL100
Charlottetown, PE C1A 1N3
Tel: 902-566-4847
Fax: 902-892-4433
Contact: Cheryl Turnbull

Self-Help Clearinghouse
PO Box 785, 181 Kent Street
Charlottetown, PE C1A 7L9
Tel: 902-628-1648

Souris Teen Group
Child and Family Division
Souris Regional Service Centre
PO Box 550
Souris, PE C0A 2B0
Tel: 902-687-7060
Fax: 902-687-7091

HUGS
153 Spring Street
Summerside, PE C1N 3G2
Tel: 902-436-2438
Fax: 902-436-0124

Nova Scotia

HUGS
Annapolis Community Health Centre
PO Box 426
Annapolis Royal, NS B0S 1A0
Tel: 902-532-2381
Fax: 902-532-2113

St. Martha's Regional Hospital
25 Bay Street
Antigonish, NS B2G 2G5
Tel: 902-863-4511
Fax: 902-863-4496

HUGS
Western Kings Memorial Health Centre
PO Box 490
Berwick, NS B0P 1E0
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Fax: 902-542-6333

HUGS
115 South Street
Bridgetown, NS B0S 1C0
Tel: 902-665-4131
Fax: 902-665-4133

Health Services Association of the South Shore
90 Glen Allan Drive
Bridgewater, NS B4V 3S6
Tel: 902-527-5228
Fax: 902-543-3120

HUGS, Sacred Heart Hospital
PO Box 129
Cheticamp, NS B0E 1H0
Tel: 902-224-2450
Fax: 902-224-2903

Eating Disorders Action Group
7-106 King Street
Dartmouth, NS B2Y 2S1
Tel: 902-469-0650
Fax: 902-469-9918

HUGS, Digby General Hospital
PO Box 820
Digby, NS B0V 1A0
Tel: 902-245-2501
Fax: 902-245-5517

HUGS, Eskasoni Health Centre, RR # 2
East Bay, NS B0A 1H0
Tel: 902-379-2666
Fax: 902-379-2172

Eating Disorder Resource Network
55-5222 Green Street
Halifax, NS B3H 1N7
Tel: 902-425-0345

Eating Disorder Clinic
Queen Elizabeth II Health Science Centre
Third Floor, Lane Building
Camp Hill Site
Halifax, NS B3H 2E2
Tel: 902-473-6288
Fax: 902-473-6282

Eating Disorder Program
Victoria General Hospital
1278 Tower Road
Halifax, NS B3H 2Y9
Tel: 902-473-6285
or 902-428-2110

Eating Disorder Resource Network
Self-Help Eating Disorder Awareness Group
6235 St. Mathais Street
Halifax, NS B3L 2S4
Tel: 902-423-0360

IWK-Grace Health Services Centre
Halifax, NS B3J 3G9
Tel: 902-428-8409
Fax: 902-428-8736

Psychological and Counselling Services
Fourth Floor, Student Union Building
Dalhousie University
6136 University Avenue
Halifax, NS B3H 4J2
Tel: 902-494-2081
Fax: 902-494-1984

Body Image and Eating Program for Women
Twin Oaks Continuing Care Centre
RR # 2
Musquodoboit Harbour, NS B0J 2L0
Tel: 902-889-2200
Fax: 902-889-2200

HUGS, Strait Richmond Hospital
RR # 1 Cleveland
Richmond County, NS B0E 1J0
Tel: 902-625-3100
Fax: 902-625-3804

Eating Disorder Program, Cape Breton
Cape Breton Healthcare Complex
1482 George Street
Sydney, NS B1P 1P3
Tel: 902-567-8000
Fax: 902-567-7905

HUGS, Colchester Regional Hospital
207 Willow Street
Truro, NS B2N 5A1
Tel: 902-893-4321 Ext. 129
Fax: 902-893-5533

HUGS
PO Box 146
Windsor, NS B0N 2T0
Tel: 902-798-2358
Fax: 902-798-4435

Mental Health Clinic
Hants Community Hospital
9 Payzant Drive
Windsor, NS B0N 2T0
Tel: 902-792-2042
Fax: 902-798-0709

Outpatient Nutrition Services
Hants Community Hospital
9 Payzant Drive
Windsor, NS B0N 2T0
Tel: 902-792-2000
or 902-792-2052
Fax: 902-798-4435

HUGS
E.K.M. Community Health Center
PO Box 1180
Wolfville, NS B0P 1X0
Tel: 902-542-2266
Fax: 902-542-4619

HUGS
Site 16, Comp A9, RR # 2
Wolfville, NS B0P 8B3
Tel: 902-542-4055

Girls in the 90's
Public Health Services
60 Vancouver Street
Yarmouth, NS B5A 2P5
Tel: 902-742-7141
Fax: 902-742-6062

Yarmouth Mental Health Centre
60 Vancouver Street
Yarmouth, NS B5A 2P5
Tel: 902-742-4222
Fax: 902-742-2320

Newfoundland and Labrador

Health Care Corporation of St. John's
c/o Leonard A. Miller Centre
100 Forest Road
St. John's, NL A1A 1E5
Tel: 709-737-3872
Fax: 709-737-3883

HUGS, Newfoundland
School for the Deaf
425 Topsail Road
St John's, NL A1E 5N7
Tel: 709-364-1234
Fax: 709-729-5848

St. Clare's Mercy Hospital
St. John's, NL A7C 5B8
Tel: 709-778-3398

Appendix B:
Interview Questions

1. Do you think that previous or current experiences of family violence are linked to eating disorders? Can you elaborate on this?

2. In your experience, have your patients/clients revealed past or present experiences of abuse?

3. In your estimation, how prevalent is this connection?

4. Can you provide an approximate range, in percentages, of the number of clients who have experienced abuse and have manifested this in the form of eating disorders? Are they predominantly male, female, or are they both? What age groups do they represent?

5. Do you factor past or present experiences of abuse into your treatment approach to eating disorders?

6. Can you elaborate on your treatment approach?

Appendix C: The Advisory Panel

Sheila Baxter
Author and Anti-Poverty Activist
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Girls in the 90's
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