European Eating Disorders Review
Eur. Eat. Disorders Rev. **14**, 43–53 (2006)

Understanding Intimacy for Women with Anorexia Nervosa: A Phenomenological Approach

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Intimacy is considered as an essential aspect of 'ideal' romantic relationships and Western culture, in particular, places a strong emphasis on its value. Despite this, intimacy has been largely unexamined for women with anorexia nervosa (AN). This phenomenological study sought to describe the subjective experiences of intimacy for this group of women; a purposive sample of 11 participated in in-depth, semi-structured interviews. Whereas previous research has drawn little attention to the contextual factors that support intimate and non-intimate experiences for women with AN, participants in this study were able to identify what intimacy meant to them, their experiences with intimacy and what they needed within their romantic relationships to be intimate. The women's meanings and experiences with intimacy were consistent with generalized conceptualizations of emotional and physical closeness, and companionship through parenting. These findings augment current research, and may better assist in tailoring specific interventions to foster intimacy and minimize impediments to intimacy. Copyright © 2006 John Wiley & Sons, Ltd and Eating Disorders Association.

Keywords: anorexia nervosa; eating disorders; intimacy; phenomenology; qualitative research

INTRODUCTION

Anorexia nervosa (AN) is estimated to occur in 0.5 to 4% of women in industrialized societies (Steiger & Séguin, 1999). It is an eating disorder that extends beyond its cardinal disturbances of self-starvation and the attainment of an idealized thin physique. Deeply rooted in this disorder is the egosyntonic nature of the women's acute and unrealistic distress over body shape and weight alongside an intrapsychic conflict over who they feel they are, who they feel they should be and what others in their relationships expect of them. This internal conflict raises questions about the nature and quality of intimacy in romantic relationships for women with AN, given that the achievement and sustainability of intimacy is related to a number of elements including authenticity and acceptance (Dahms, 1972; Hatfield, 1988). One essential question is how women with AN conceptualize and experience intimacy in light of the cognitive struggles related to their eating disorder. Current research, however, has yet to focus on how women with AN develop meanings of intimacy in their romantic relationships and to describe the nature of their experiences.

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Contract/grant sponsor: Ontario Ministry of Training, Colleges and Universities; contract/grant numbers: OGS 2001-2202, OGS 2002-2003.

LITERATURE REVIEW

Although the term 'intimacy' is used casually in everyday conversation, the scholarly literature has

Published online in Wiley InterScience (www.interscience.wiley.com). **DOI**: 10.1002/erv.669

explored the nature of intimacy and how intimacy is experienced in romantic relationships. Intimacy-related research, however, is limited for women with AN who are in marital relationships, and to date no known studies provide a conceptualization of intimacy described by these women.

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

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

The assignment of gender roles in intimacy through socially constructed gender expectations is also discussed in the literature. Philpot, Brooks, Lusterman, and Nutt (1997) assert that economic and social status have shaped intimacy, providing and maintaining gendered experiences. Men and women are raised to be differently expressive, with women typically encouraged to be more open and disclosing than men (Leary, 1996) and to primarily form their identity in intimate relationships through mothering and being a wife. Cancian (1986; cf. Heller & Wood, 1998) reinforces a gendered view of intimacy stating that women's intimate preferences include emotional closeness and emotional interdependence through disclosure (Heller & Wood, 1998).

Although the conceptualisation of intimacy varies greatly, the literature does not substantively reflect the meanings and experiences for women with AN. While scholars have proposed that the achievement of intimacy is related to one feeling and being authentic (Dahms, 1972; Hatfield, 1988), it remains unknown if women with AN will conceptualize and experience intimacy according to these definitions in light of their cognitive struggles.

Intimacy in romantic relationships as an area of inquiry has been limited for women with AN. Research on intimacy for women with AN has focused on relational characteristics; shown to be a significant source of relational dissatisfaction. Results include women with AN showing poor marital adjustment and global ratings of relationship satisfaction (Van den Broucke, Vandereycken, & Vertommen, 1989), poor marital communication (Van den Broucke, Vandereycken, & Vertommen, 1995a), and limited and unsatisfactory sexual experiences (Beumont, Abraham, & Simson, 1981; Heavey, Parker, Bhat, Crisp, & Gowers, 1989; Morgan et al. 1999; Raboch & Faltus, 1991; Rothschild, Fagan, Woodall, & Andersen, 1991; Wiederman, Pryor, & Morgan, 1996). Van den Broucke et al. (1995b) reported that women with AN and their partners have significantly low levels of intimacy; concluding that deficiencies resulted from a particular lack of openness within the marital relationship.

While the aforementioned studies do provide a beginning in terms of intimacy related research for women with AN, research has only begun to explore this construct. Much is to be learnt about how women with AN negotiate meanings of intimacy in their relationships and what constitutes their intimate experiences. Studies on these topics will allow the research in this area to move beyond correlations between treatment and relational deficits, which is the current focus in the literature. This new direction of research can explore specific meanings of intimacy for women with AN. This research reflects a secondary objective of a larger study with the purpose to explore the experiences of romantic relationships from the perspective of women with clinical and subclinical AN. The intent of the secondary objective was to explore conceptualisations and experiences of intimacy. With meaning as the *sine qua non* of qualitative study, a phenomenologically-based approach was used to provide the most descriptive representations and experiences.

METHODOLOGICAL APPROACH

Research Design

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

Husserlian phenomenology gave parameters that directed the nature of reality and ways of knowing for the principal researcher (M. Newton). This included adopting a presuppositionless position, known as Epoche, during inquiry to promote objectivity. Epoche involved the principal researcher setting aside previously known values and knowledge about the experience (Moustakas, 1994). Through Epoche, reality for the participants was *identified* rather than *verified* (Tesch, 1990). This ensured that the description remained truthful, based on the participants' experiences and unclouded by research assumptions.

Setting and Recruitment

A purposive sample of 11 women participated in this study. Inclusion criteria were women at least 18 years of age; diagnosis of AN or eating disorder (not otherwise specified) [ED (NOS)] (American Psychiatric Association, 1994); and receipt of treatment at a recognised eating disorders programme that required medical (physical) stability. Given that phenomenology aims to realise a unified vision of the essences of an experience, sampling continued until 'crystallization' was achieved. This relates to the re-emergence of essences for the participants, to reflect a shared experience (Crabtree & Miller, 1999).

Women who met the inclusion criteria were recruited from two outpatient-oriented eating disorder programmes in Southeastern Ontario following ethics approval from the programmes' Institutional Review Boards. Programme psychologists identified eligible participants, and the principal researcher (M. Newton) obtained informed consent from participants. Participant demographics, including illness duration and medical stability, were comparable at both sites.

Method

Husserlian descriptive phenomenology elucidates the importance of using data collection procedures that capture the structural ('what' is appearing) and textural ('how' it is appearing) elements of an individual's experiences (Moustakas, 1994). Thus, data collection involved in-depth, one-on-one interviews between each participant and the principal researcher (M. Newton) (Creswell, 1998; Moustakas, 1994). Each interview lasted approximately 45 minutes to 1 hour and was audiotaped, and transcribed verbatim for analysis. During interviews, participants were asked to describe what intimacy meant to them and their experiences with it in their romantic relationships. Women who did not identify having been intimate were asked to explore this experience. Subsequent interviews were conducted alongside data analysis, highlighting the cyclical nature of the research method. Succeeding interviews served two purposes: (1) to provide the participant with an opportunity to give feedback concerning the first interview; and (2) to allow the researcher to expand and verify descriptions of the studied phenomenon, thus ensuring a proper reflection of the structural and textural descriptions.

Data collection, analysis and interpretation occurred cyclically, until crystallization of the essential essences of the experience occurred. Thus, a comprehensive 'descriptive' (the final product) of the investigated experience was ensured (Crabtree & Miller, 1999; Creswell, 1998). Audiotaped interviews and transcribed data were reviewed concurrently to capture the nuances of verbal communication. Data analysis for the researchers was based on the work of Moustakas (1994). During this process:

- Transcripts were re-read several times by the researchers, while same statements were identified and extracted into key meaning units (the structural elements of the women's experiences).
- Descriptions of the meaning units were extracted to highlight experiences (the textural elements of the women's experiences).
- The textural and structural essences were synthesized by the principal researcher (M. Newton), marking the last step in data analysis.
- Textural and structural essences were reviewed by the researchers.

Interpretation of the structural and textural essences was supported by the principal researcher's return to the literature.

PARTICIPANTS' CONTEXTS

Of the 11 women participating in the study, five were diagnosed with AN, and six diagnosed with subclinical AN; all women were in a treatment programme and deemed medically (physical) stable. The average age of participants was 26 years (range 19–42). The average age at diagnosis was 20 years (range 15–26), with the average duration of illness 7.5 years (range 1–22). Comorbidity was seldom present: one woman was concurrently diagnosed with depression, and two women were diagnosed with personality disorders. One woman disclosed a history of childhood abuse.

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

RESULTS: PARTICIPANT EXPERIENCES AND MEANINGS OF INTIMACY

The intimate experiences of the participants were diverse. Participants, who currently or formerly were in a romantic relationship, described varying forms of intimacy. Intimacy was described as the women feeling that they were on the 'same wavelength' or 'connected' with their partner. For many women, their desired level of intimacy exceeded what was actually present in their relationship. During data analysis and interpretation, both ideal or actual intimacy levels were individualized and not reflective of the participants' type or length of romantic relationship. They were also not reflective of the participants' illness severity. That is, despite varying body weights and disordered thoughts/behaviours, what emerged in their descriptions was a crystallization of shared essences; their subjective reality. The structural essences of intimacy that emerged were emotional and physical closeness and companionship. Each of these structural elements was supported by textural essences, including barriers to intimacy, which will be presented now.

Emotional Closeness

All participants currently in romantic relationships described desiring the structural essence of emotional closeness, which was most strongly felt when they were able to disclose their feelings, thoughts and behaviours in their relationship. When participants discussed emotional closeness, they felt it was best attained through the textural essence of disclosure, which required trust and acceptance, feeling known and partner congruence. Textural essences of emotional closeness also included

Table 1. Analytical procedure

Structural essences	Textural essences	Descriptive example
Emotional closeness	Disclosure	
	Trust and accpetance	'. . . I didn't have to pretend who I was'.
	Feeling known	'. . . he listens to me, and tries to understand'.
	Being congruent	'. . . It won't work if he's not the same'.
	Barriers	
	Fear and non-acceptance	'. . . I worry all the time that he won't accept me for who I am'.
	Feeling unknown	'[He] tells me he can't handle that stuff. So I don't talk about it'.
	Partner incongruence	'. . . when I'm the only one that's sharing, I definitely feel less close to him'.
Physical closeness	Sexual/non-sexual expression	'When the physical part is there, our relationship's better . . . I'm happier, he's happier'.
	Being congruent	'He's okay' . . . that sometimes I just need my personal space'.
	Barriers	
	The impact of AN	'. . . I cry 'cause I just feel so unattractive . . . when it comes to sex and that sort of thing, it's all gone'.
Companionship	Congruence	
	Recreational activity	'socializing with friends'
	Parenting	'. . . we have a family together. We'll always be connected'.
	Barriers	
	Incongruence	'It's so hard on the relationship that we don't spend time together . . . I feel like we lead parallel lives. It's so disconnecting'.

barriers, which were described as fear and non-acceptance, feeling unknown and incongruence.

Trust and Acceptance

The participants emphasized emotional closeness through disclosure; inherent in this was their need for acceptance in their relationships in order to disclose. The women described the importance of acceptance for developing trust with their partners to be able to talk about their eating disorders with them. This was consistently reinforced for many participants who felt that because acceptance and trust were present in their relationships; they felt comfort in sharing who they were: '. . . I didn't have to pretend who I was' and '. . . if you felt close enough to someone you could tell anything to that person, and they would still love you no matter who you are, or what you did, or didn't do'.

Feeling Known

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

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

Several other participants, on the other hand, felt that emotional closeness meant that they felt heard by their partner, but did not necessarily require their partner's understanding of their eating disorder experiences. This was grounded in the women feeling that their partners could simply not understand such experiences, as those were not something the partners too were experiencing. As one participant explained, '. . . don't expect them to understand . . . don't expect them to be able to help you at all. Just use them as an outlet, but you can't expect too much of them, 'cause they're not trained . . . ' For participants who shared these beliefs, emotional closeness was attained in the relationship by their partner understanding issues that could be 'realistically' shared (e.g. general relationship desires).

Being Congruent

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

Barriers to Emotional Closeness

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

Fear and Non-Acceptance

For women who described relational avoidance, both a desire for and fear of emotional closeness were present. Fear was related to judgment and rejection: 'I try not to get too close to guys because I just don't want to get hurt in the end'. Desire, on the other hand, was reflected when the women questioned if their fears would be warranted with a partner with whom they developed trust: '. . . I know that when I'm with someone I really trust and feel that, that I'm sure I won't worry all the time about being rejected. It's just so hard to think that will happen though . . . I hope it does'.

Feeling Unknown

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

Partner Incongruence

For women in relationships, incongruent disclosure between themselves and their partners was

often cited as contributing to deficits in emotional closeness. In addition to the previous example where the partner expressed disinterest in the participant's disclosure, many participants described feelings of frustration with their partners' own lack of disclosure. These women believed that mutual accessibility in the relationship to each other's thoughts and feelings would heighten emotional closeness, 'I need to have that communication both way . . . I don't want to feel like I'm the only one that is talking about how I feel'.

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

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

Physical Closeness

The second structural essence of intimacy for the participants was physical closeness. This was described as a facet of intimacy for all participants, but with less emphasis than emotional closeness and, as a result, was less delineated than emotional closeness. Thus, the presence of physical closeness varied in the participants' relationships. Textural descriptions of physical closeness included sexual (e.g., sexual intercourse, sexual play) and non-sexual expression (e.g., hugging, cuddling with their partner). Being congruent with their partners was also important to the women. The women's eating disorders were consistently cited as barriers to physical closeness.

Sexual and Non-Sexual Expression

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

Being Congruent

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

Barriers to Physical Closeness

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

The Impact of AN

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

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

Although many of the women expressed hopes that sexual activity would regain importance once their weight stabilized, two women who experienced past

personal violations (e.g., abuse) cited that the return of sexual activity as inconsequential to their experiencing physical closeness and thus intimacy.

Companionship

The women did not find that their eating disorder affected companionship. As a structural essence, companionship was texturally defined by congruence in recreational activity and parenting. The barrier cited for companionship was incongruence.

Shared Recreational Activity and Parenting

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

Barriers to Companionship

Incongruence

Two women in marital relationships, on the other hand, described leading 'parallel lives' to their partners, with little time together to facilitate companionship. As one of the women described, 'It's so hard on the relationship that we don't spend time together . . . It's so disconnecting'. Women whose decision-making and parenting norms were incongruent with their partners' also felt a similar decrease in their degree of companionship.

DISCUSSION

This research fills a gap in what is known about intimacy for women with AN. In this study, all participants desired some form of intimacy in their romantic relationships, and data analysis showed the multiplicity of their intimate experiences. The elements of intimacy that emerged from the participants' descriptions included emotional and physical closeness, as well as companionship. The participants felt emotional closeness to be achieved predominantly through mutual disclosure; their feeling of acceptance by their partner allowed them to be authentic and fostered their own disclosure in the relationship. Physical closeness included both sexual and non-sexual experiences, while companionship through recreational activity and parenting was also seen as an important element to intimacy. Congruence (or similarity) between the participant and her partner was described as underlying all elements of intimacy.

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

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

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

It is interesting to highlight those participants who preferred to edit what they disclosed to their partners in order to foster emotional closeness, and thus, intimacy. This approach to relating is supported by

Hall and Taylor (1976) and Schaefer and Olsen (1981). These authors state that romantic relationships may function more optimally with some degree of idealization where certain matters are withheld to maintain a focus on matters that can elicit positive relating. Hall and Taylor (1976) conclude that marital relationships need to involve validation and a joint construct of reality, with both partners seen as a source for feeling known.

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

The participants' experiences with physical closeness bring us nearer to understanding their experiences with the physical aspects of intimacy. Many study participants perceived that their eating disorder was directly related to their sexuality, which is consistent with the literature (Beumont et al., 1981). In keeping with this influence, the women attributed absent sexual expression to poor libido and body image, which may explain several findings of the literature: sexual disturbances for both women with AN who are in relationships and those who are not (Heavey et al., 1989), and sexual dissatisfaction and discomfort as a sexual person (Rothschild et al., 1991). Many of the women in this study, however, expressed interest in the return of physical intimacy in their romantic relationships, which is a new addition to the pre-existing literature. Experiences with physical closeness among the study's participants varied, however, to include regular sexual and/or non-sexual expressions. Several women described themselves as engaging in sexual activity for their partner's benefit, despite absent desire and a lack of emotional closeness associated with this experience. This may be grounded in a gendered perspective of how women are socialized to relate in romantic relationships, which warrants further exploration within a feminist paradigm. Additionally, two participants described pleasure from sexual activity. These women may have been at a desired body weight, reflecting less internal conflict related to who they feel they should be (ideal self) and a greater self-esteem. Moreover, there may be a point in the illness, before moderate/extreme starvation and marked hormone diminution, when women experience heightened self-esteem and physical interrelatedness with their partners due to their reaching the desired body ideal.

Companionship was the final theme described by the study's participants as contributing to intimacy in their romantic relationships. Essential essences related to this theme consisted of sharing recreational and parenting activities with their partner. Such experiences are supported in the psychological literature on marriage and parenthood. Fitzpatrick (1987) remarks that marriage drives the couple into a more exclusive and intimate way of relating (cf. Eshel, Sharabany, & Friedman, 1998). Reis senchack, and Solomon (1985) state that parenthood involves an even greater investment in the relationship but requires a shift in focus from the dyadic unit to the family unit. Indeed, the participants in this study described how shared experiences with their children and mutual decision-making fostered emotional closeness.

While this study's findings lend new insight into intimate experiences for women with AN, no research is without limitations. Those specific to this study mirror those of many qualitative approaches. First, gaining access to participants for interviewing depended on a number of variables, including the participants' interest in the issue. Waring et al. (1981) have noted that participants with inadequate or maladjusted relationships are reluctant to volunteer. Thus, the descriptions of experiences with intimacy for women with AN may warrant further exploration to include individuals less likely to seek out research participation. Additionally, the limited timeframe of the data collection and analysis may have failed to capture the ongoing and temporal nature of intimacy as described by the participants, and that the experiences of the participants may have occurred only with the selected group; new essences may or may not emerge with a different group of

participants due to the context-specific information elicited in phenomenological studies (Morse, 1989). Finally, although the descriptions in this phenomenological study may prove invaluable for informing the scientific and clinical communities, it still remains unclear whether the deficiencies in intimacy experienced by women with AN are antecedents to, or consequences of, their eating disorder. (It may also be both.) At the same time, the strategies used to ensure the rigour of this work, the connections made with existing literature and the implications that the findings have for development in theory, research and clinical practice, support the usefulness and generalizability of this research.

IMPLICATIONS

This study presents opportunities for development in theory, research and clinical practice. The enhancement of theoretical development lies in the gendered perspective described by the study's participants. This suggests that understanding relationships for women with AN should not be limited to a disease framework, but should be explored within a normative relational framework. Within this framework, women with AN can be considered first as women, who experience intimate experiences comparable to other women, but in the context of *having* an eating disorder. In this sense, perceptions shift from viewing experiences with intimacy solely as disorder sequelae.

Specific areas of future research are many. To begin with, the exploration of individual contexts should include the impact of affect and mood on the relationship because disordered eating has been linked to negative mood states (Bulik, Beidel, Duchmann, Weltzin, & Kaye, 1991), depression (Steiger, Fraenkel, & Leichner, 1989), and anxiety (Hesse-Biber & Marino, 1991). Thus, future qualitative and quantitative studies should examine intimacy for women with AN from a longitudinal perspective to further account for the temporal nature of relationships and the progression of women's eating disorders (including following the effects of starvation on relating).

The interpersonal literature suggests that individuals select partners who allow them to sustain their ways of relating (Sullivan, 1953), and who may also have complementary ways of relating (Hazan & Shaver, 1987). Thus, the inclusion of partners in future research should be seen as a salient ingredient in exploring intimacy in romantic relationships for women with AN. Although this has already been recognized in eating disorder literature on intimacy, research should expand to include the partner's individual experiences with intimacy and how both partners interrelate. Additionally, research that emphasizes gendered differences in perceptions of intimacy, marital satisfaction and ways of relating should be further addressed (Heller & Wood, 1998; Merves-Okin, Amidon, & Bernt, 1991). Given that research asserts men use sexual interaction to increase emotional intimacy, while women need emotional intimacy to increase sexual intimacy (Talmadge & Dabbs, 1990), this research focus is particularly important to further understand the decreased sexual closeness described in this study and emphasized elsewhere (Beumont et al., 1981; Heavey et al., 1989; Morgan et al., 1999; Raboch & Faltus, 1991; Rothschild et al., 1991; Wiederman et al., 1996).

Due to the increasing awareness and prevalence of eating disorders in our society, health care practitioners in the field of mental health may be particularly interested in incorporating the phenomenological description into their practice to tailor interventions specific to patient need. This study can both guide the practitioners' assessments and provide considerations for the development of therapeutic interventions. Clinicians are likely to confront intimacy difficulties with couples or single women who have trouble forming or maintaining intimate relationships. The difficulties can be due in part to intimate relationships requiring individuals to open themselves to vulnerability through disclosure and trust. An essential approach to therapy, whether it is marital or individual, is to facilitate the recognition of individual context (e.g., the presence of an eating disorder, a history of childhood abuse), immediate context (e.g., non-verbal behaviours, environment or setting), relationship context (e.g., type of relationship) and sociocultural context (e.g., culture and gender norms). Such an approach can provide a 'launching pad' for therapeutic discussion. It can assist, in particular, with the delivery of strategies to transform patterns of relating that result in a lack of intimacy, and support/enhance those that lead to intimate experiences.

CONCLUSION

Intimacy is thought to be one of the most salient and rewarding features of romantic relationships. With this in mind, this study sought to describe the meaning of intimacy for women with AN and their intimate experiences through phenomenological

inquiry. Meaning gave content to the women's relationships, clarifying what intimacy meant to them and showing a multiplicity of intimate experiences. Although the available literature suggests that women with AN have difficulty forming intimate relationships, the participants in this research were able to identify what intimacy meant to them and what they needed, within their romantic relationships, to be intimate.

ACKNOWLEDGEMENT

The authors would like to thank Angela Eady for her editorial review of the manuscript.

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