

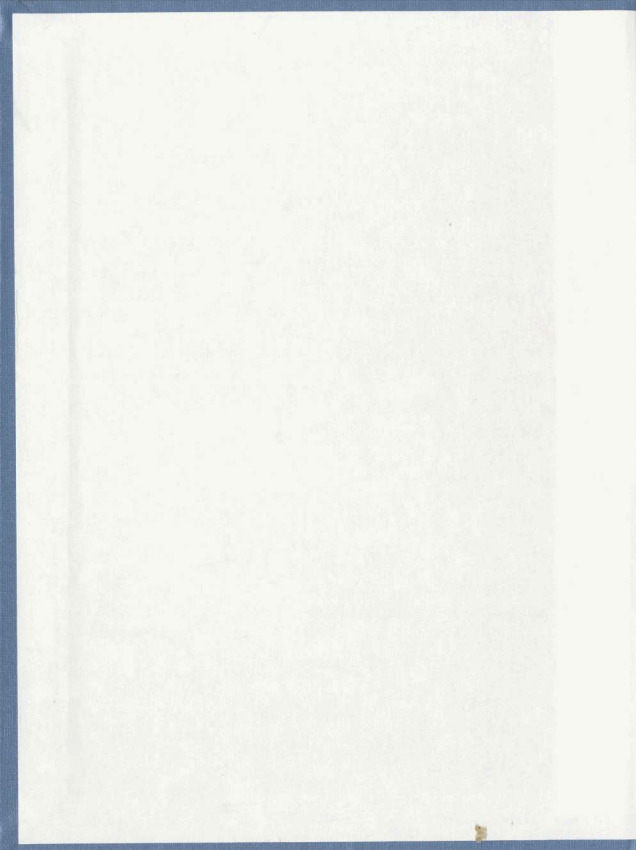
THE LIVED EXPERIENCE OF BULIMIA NERVOSA
A PHENOMENOLOGICAL STUDY

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The Lived Experience of Bulimia Nervosa

A Phenomenological Study

by

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A Thesis submitted to the

School of Graduate Studies

in partial fulfilment of the

requirements for the degree of

Master of Nursing

School of Nursing

Memorial University of Newfoundland

St. John's, Newfoundland

June 25, 2001

St. John's

Newfoundland

Abstract

Bulimia nervosa is an emotional disorder that impacts the lives of individuals, families, and society as a whole. It is estimated that up to 80% of North American women suffer from sub-clinical eating disorders, with 20% ultimately manifesting full-blown anorexia or bulimia nervosa (Farrell, 1999).

In this study, a phenomenological method of inquiry was selected to explore the lived experience of bulimia nervosa. Seven females, nineteen years of age and older, each participated in two audiotaped interviews. During the interviews participants were encouraged to speak openly and freely about their experience with bulimia nervosa. Data analysis was conducted in line with van Manen's method of hermeneutic phenomenology.

From the writing and rewriting of the text, five themes emerged: feelings of inadequacy, struggling for control, concealment, consumed by the illness, and the elusive road to recovery. The interrelationships between the five themes guided the essence of the lived experience of bulimia nervosa: searching for acceptance and a meaningful existence. Study's findings and new insights into the lived experience of bulimia nervosa are discussed, as well as the implications for nursing, health care providers and the health care system. Nursing as well as other health care professionals are challenged to develop effective treatment modalities to help alleviate the suffering of individuals and families.

Dedicated to

My parents, Michael and Gertrude O'Leary, who had been very supportive of me when my journey began. Even though my dad has since entered his own eternal journey, he has never left my side.

My loving husband Gary, and two beautiful daughters, Lisa and Allison. I would never have achieved this goal had it not been for you giving up many hours of important and valuable family times. *Thank-you from the bottom of my heart.*

Acknowledgments

Many thanks to my thesis supervisor, Dr. Christine Way, whose strong work ethic and persistent drive for perfection for detail, served as motivation for me to continue with my goal and overcome all obstacles.

Special thanks to my thesis committee members, Lorna Bennett and Lorraine King. Your guidance and insight were invaluable. Your constructive feedback made this thesis possible.

True friendships are built on love and respect for each other as individuals. I have yet to cut the umbilical cord to two very close friends, Lorraine and Barb. Lorraine your many years of support, guidance and encouragement have made my thesis a reality. Barb your constant support and guidance did not go unappreciated. I thank-you both for helping me achieve what I thought many times was unattainable.

My sisters, Mary and Brenda, I thank-you for the secretarial expertise especially with the workings of the computer and printer. Your time and knowledge was greatly appreciated.

To my mother and mother-in-law for believing in me and encouraging me to continue when I thought I could do no more.

To Scott and Patricia for their long distance dedication and Scott's ability to articulate my thoughts and feelings.

To my past and present co-workers who have listened to my struggles and have been there throughout this process, providing ongoing support and encouragement.

To the psychiatrists who supported and assisted me by contacting the seven women who participated.

Of most importance, a very special thank-you to the seven women who gave their time to share their life experiences with me. Without your willingness and co-operation this thesis would not have been possible. Thank-you.

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CHAPTER 1

Introduction

It is estimated that up to 80% of North American women suffer from sub-clinical eating disorders, with 20% ultimately manifesting full-blown anorexia nervosa or bulimia nervosa (Farrell, 1999). Anorexia nervosa and bulimia nervosa are the most prevalent types of eating disorders. Restrictions on food intake is more characteristic of anorexia nervosa. In contrast, bulimia nervosa is characterized by uncontrolled binge eating episodes in combination with drastic measures of weight control, including self-induced vomiting, use of diet pills and laxatives, rigorous exercise and periodic fasts (Boumann & Yates, 1994).

There is considerable controversy over the exact prevalence of bulimia nervosa in the population. While some authors believe there has been a decrease in the rates (Heatherton, Nichols, Mahamedi, & Keel, 1995), others assert that there has been an increase (Halmi, 1994; Jarman & Walsh, 1999). Fairburn and Beglin (1990) estimated the prevalence rate of bulimia nervosa to be 1% to 2% of the population of young women.

Using data from the Mental Health Supplement of the Ontario Health Survey, Garfinkel, Lin, et al. (1995) examined the prevalence of bulimia nervosa and associated co-morbidity in a nonclinical community sample. Of the total number of survey participants ($N = 8,116$), 124 and 22 subjects, most of whom were women, met the criteria for full and partial syndrome bulimia nervosa,

respectively. Lifetime prevalence for the entire sample was 1.1% for females and 0.1% for males. In addition, the mean age of onset was 21.4, with those born before 1950 depicting a significantly later age of onset (i.e., 32.6 years) than those born between 1950 and 1959 (i.e., 18.2 years) or after 1960 (i.e., 17.5 years). Similar findings were reported by Fairburn, Welch, Doll, Davies, and O'Connor (1997) who estimated the age of illness onset at 19 ± 4 years and the age of initial symptoms at 15.5 ± 3.9 years.

The Diagnostic and Statistical Manual of Mental Disorders (DSM - IV) has incorporated recent research findings to facilitate health providers' access to reliable diagnostic tools. It is still debatable whether or not existing diagnostic criteria are capable of capturing the full spectrum of lifetime behaviors. Increases in the incidence and prevalence rates of bulimia nervosa, especially in younger children, are believed to be only a fraction of the actual number with many individuals delaying medical attention until physical symptoms reach a high level of severity (Brewerton, 1995; Fredenberg, Berglund, & Dieken, 1996; Huon, 1994; Kreipe, Golden, Katzman, & Fisher, 1995; Strauss, 1995). As well, the shame and secrecy that characterize the disorder precludes the accuracy of statistics (Fairburn, Cowen, & Harrison, 1999).

Bulimia nervosa impacts not only the individuals with the eating disorder but also has the potential to affect the emotional, physical and financial well being of families. Unfortunately, early warning signs are not readily discernible

by others and often become firmly entrenched in behavior patterns by early adulthood. With the scarcity of health care dollars and the escalation of human suffering, the inevitable long term care of these persons may be dramatically reduced with early detection, diagnosis and treatment (Hay, Gilchrist, Ben-Tovim, Kalucy, & Walker, 1998; Keel, Mitchell, Miller, Davis, & Crow, 1999). Although many dollars have been spent on research and treatment, most authors agree that past and current treatment modalities have failed to abate the escalating rate of bulimia nervosa (Fisher et al., 1995; Walsh & Devlin, 1998).

Background and Rationale

There has been quite a bit of controversy concerning the etiology and treatment of the disorder. With the precise etiology unknown, research continues to unravel the enigma surrounding bulimia nervosa (Boumann & Yates, 1994; Hay et al., 1998; McGilley & Pryor, 1998; Rodin, 1999; Walsh & Devlin, 1998; Yager, 1994). Today, clinicians agree that bulimia nervosa is a multi-dimensional disease (Irwin, 1993; Rorty, Yager, & Rossotto, 1994) which requires a multidisciplinary approach to treatment (Fisher et al., 1995; Fredenberg et al., 1996; Halmi, 1994; Irwin, 1993; Schachtel & Wilborn, 1990; Strauss, 1995).

A few decades ago bulimia nervosa was believed to be confined to Western society and more pronounced in white, upper class females between

the ages of 18 and 25 years. Current research findings indicate that males and females as young as 12 years from all ethnic and socioeconomic classes are being diagnosed with eating disorders (Hay et al., 1998; Strauss, 1995; Wilfley & Grilo, 1994). Bulimia nervosa has a chronic, sometimes episodic course, which involves periods of remissions alternating with binge/purge cycles (McGilley & Pryor, 1998). The longer the duration of symptoms before treatment, the more negative the outcome. Thus, the importance of early diagnosis and treatment for improving prognosis is important (Keel et al., 1999).

There is a plethora of literature on the treatment of eating disorders. Despite increased knowledge and awareness about eating disorders, health care providers are still struggling to identify effective treatment modalities (Fredenberg et al., 1996; Jarman & Walsh, 1999). The efficacy of any one treatment modality has yet to be established, with clinical studies reporting recovery rates ranging from 13% to 69% two years or more after treatment (Herzog et al., 1993). Longitudinal studies into effective treatment modalities have found cognitive-behavioral therapy to be superior to other regimes (e.g., pharmacological, cognitive therapy and interpersonal therapy) (Fairburn et al., 1991; Garner et al., 1993; Goldbloom et al., 1997; Wilson, 1996).

Based on the assumption that prognosis may improve with early diagnosis and treatment (Fisher et al., 1995; Wilfley & Grilo, 1994), prevention and health promotion strategies have become the focus of recent research (Childress,

Brewerton, Hodges, & Jarrell, 1993; Crisp, 1988; Kennedy & Garfinkel, 1992). However, conflicting findings also exist on the timeliness, appropriateness, and effectiveness of prevention strategies (Crisp, 1988; Paxton, 1993; Shisslak, Crago, & Neal, 1990; Walsh & Devlin, 1998; Wilson, 1993).

A critical impediment to early detection, diagnosis, and treatment is the surreptitious and complex nature of the disease. One significant confounding factor is the presence of co-morbid illnesses, which often obscure and complicate diagnosis and treatment. Comorbidity coupled with the secretive nature of bulimia nervosa (Hay et al., 1998; McGilley & Pryor, 1998; McGown & Whitbread, 1996) prevents detection until the stage of chronicity exposes the physical manifestations of this emotional disorder. Zaider, Johnson, and Cockell (2000) identified major depression, anxiety, obsessive compulsive disorders, as well as drug and alcohol abuse, as illnesses which often precede or accompany bulimia nervosa.

Problem Statement

For many years researchers have been working toward developing diagnostic tools that will help diagnose bulimia nervosa. Considerable research efforts have also been focused on refining therapeutic approaches that will assist in eradicating the disorder. Despite improvements in treatment modalities and a slight decrease in the number of long-term chronic illness cases, there is still a

high percentage of women living with bulimia nervosa. The chronicity of the illness is associated with a dismal trajectory, higher rates of recidivism, and a poorer prognosis.

As a clinician having worked with individuals living with bulimia nervosa, the problems associated with early detection, diagnoses and treatment of eating disorder were very real and alarming. This researcher noted that many of the women encountered in clinical practice spoke about how the illness had progressed to the point where negative effects were eventually felt in all aspects of their lives. The first and most important step of the treatment process is to have a good understanding of the illness. Because limited information was available describing what it is like to live with bulimia nervosa, the researcher decided to pursue a phenomenological line of inquiry in the current study.

A phenomenological inquiry allows one to gain entrance into the lived experience of bulimia nervosa and to develop a greater understanding of and appreciation for what it is like to live with this illness. This information can only be gathered through an in-depth, thematic analysis of narrative descriptions of those living with bulimia nervosa. The purpose of the current study was to develop a greater understanding of what it is like to live with bulimia nervosa on a daily basis. It was anticipated that the resulting information gleaned from in-depth interviews with study participants would help facilitate clinicians' understanding of the unique, personal side of the experience.

Research Question

The current study was designed to address the following research question:

What is the meaning of the lived experience of bulimia nervosa for the individual?

CHAPTER 2

Literature Review

A greater understanding of eating disorders, like bulimia nervosa, requires insight into the risk factors for this illness as well as the difficulties encountered in identifying effective treatment modalities. Most of the published research has been quantitative in nature, with few studies focusing on the individual's perception of living with an eating disorder. Increasing prevalence rates and high resistance to treatment once the disease is established, suggest that greater research efforts should be directed toward gaining insight into the meaning of the illness for the individual. This type of database is needed to ensure greater availability of appropriate health care services for individuals with bulimia nervosa.

This chapter provides a discussion of relevant literature on bulimia nervosa as an eating disorder, the risk factors involved in illness onset and perpetuation, the factors shaping prognostic potential, and the meaning of the illness and treatment for affected individuals. The first section presents an overview of bulimia nervosa as a disorder, with particular emphasis on diagnostic criteria and associated comorbidity. The second section discusses the risk factors involved in the onset and perpetuation of the disorder, as well as prognosis potential. The final section reviews qualitative studies on individuals' experiences with the illness and the subsequent treatment.

Bulimia Nervosa as an Eating Disorder

The term bulimia was derived from the Greek words "bous limos" meaning ox hunger. Prior to 1979, the absence of a standardized classification system made it difficult to determine the exact prevalence of eating disorders in the population. Russell (1979) identified bulimia nervosa as a separate entity from anorexia nervosa and it subsequently received its own diagnostic classification in the DSM - III. With additional research, further changes were made resulting in the DSM - IV.

Although still a secretive disorder, bulimia nervosa has received much media attention over the past decade. Greater public awareness has been linked to the increase in the number of people with this disorder entering the health care system. The discussion that follows is organized according to the diagnostic criteria for bulimia nervosa and concomitant illnesses that often obscure the presence of this disorder.

Diagnostic Criteria and Empirical Measures

It has been conjectured that changes in the characterization and classification of bulimia nervosa have contributed to the increases observed in prevalence rates. In 1980 when anorexia nervosa was sub-classified based on the presence or absence of bulimia, Bruch, a clinician-researcher, noted a dramatic shift in referrals. Following a review of her clinical files, Bruch noted

that 25% of anorexic patients seen at the Toronto group consultation practice in 1973 were bulimic. This proportion had increased to 50% by 1980 and 70% by 1990 (cited in Dorian & Garfinkel, 1999). Garfinkel, Kennedy and Kaplan (1995) noted that the overlap among the eating disorder categories prevents clinicians *from reaching a definitive diagnosis*.

The medical model and the DSM - IV continue to be an important mainstay in the identification of risk factors and treatment for eating disorders. The DSM - IV outlines the criteria for bulimia nervosa as: (a) recurrent episodes of binge eating, (b) recurrent inappropriate compensatory behavior in order to prevent weight gain, (c) binge eating and compensatory behaviors occurring at least twice a week for three months, (d) self-evaluation unduly influenced by body shape and weight, and (e) disturbances not occurring exclusively during episodes of bulimia nervosa (American Psychiatric Association, 1994). There are two subtypes of bulimia nervosa; purging and non-purging forms. Individuals with purging engage in the use of laxatives, enemas, diuretics, and self-induced vomiting. Non-purging subtypes use weight reduction methods such as excessive exercising, diet pills, fasting and dieting to lose weight (American Psychiatric Association, 1994).

Numerous diagnostic tools have been developed over the past decades based on the DSM - IV classification system. While some diagnostic tools are designed to measure both the behavioral and attitudinal components of eating

disorders, other tools are restricted to assessing one component. Some of the more well-established self-report scales noted in the literature include the Eating Attitudes Test (EAT), the Eating Disorder Inventory (EDI), the Binge Eating Scale (BES), the Body Shape Questionnaire (BSQ), among others. The EAT and BES assess both attitudes and behaviors. The EAT is designed to measure eating patterns along three dimensions (i.e., restrictive attitudes and dieting behaviours, bulimic attitudes and behaviours, and personal/social control over intake), whereas the BES assesses binge eating and feelings and cognitions related to binge-eating episodes. Conversely, the EDI is restricted to measuring psychological aspects (i.e., drive for thinness, bulimia, body dissatisfaction, ineffectiveness, perfectionism, interpersonal distrust, and recognition of emotions and sensations of hunger or satiety). As well, the BSQ is restricted to measuring over-concern or preoccupation with shape and weight.

In a review of scales designed to assess eating disorders, Heffernan (1995) noted that the usefulness of most self-report scales is restricted to providing global estimates of the severity of symptoms and attitudes. As such, these scales do not measure the specifics about and frequency of certain behaviors which are needed to monitor treatment outcomes. Jarman and Walsh (1999) and Wilfley and Grilo (1994) also argued that many of the self-report diagnostic tools may be less reliable than interview methods in detecting early symptoms of an eating disorder. Heffernan (1995) argued that the most effective

diagnostic tool based on the DSM - III - R and DSM - IV is the semi-structured, interviewer-based Eating Disorder Examination (EDE).

Despite some notable differences in bulimic symptoms present in males and females, the same standardized instruments are used for both genders (Ricciardelli, Williams, & Kiernan, 1999). Researchers have commented on the inappropriateness and limitations of such practices without adequate psychometric data to justify the use of these instruments with men (Carlat & Camargo, 1991; Dolan & Ford, 1991). Furthermore, it has been suggested that the traditional eating disorders categories used for adults are not sensitive enough to diagnose these disorders in children. Children do not present with the same symptoms. Eating disorders not included in the classification system go unrecognized which can result in potentially serious consequences for this age group (Nicholls, Chater, & Lask, 2000).

The limitations referenced in the preceding paragraphs have led many clinicians and researchers to question the sensitivity and specificity of existing diagnostic and screening tools for eating disorders. Additional confounding variables to early detection and diagnosis are the presence of co-morbid and concomitant illnesses. The aspect is discussed in-depth in the next section.

Associated Conditions

The high incidence of co-morbidity with eating disorders makes it difficult

to isolate the defining characteristics or pathology of any one specific disorder (Zaider et al., 2000). Research findings suggest that mood disorders, anxiety disorders and substance abuse are the most common co-morbid conditions associated with bulimia nervosa (Braun, Sunday, & Halmi, 1994; Bulik, Sullivan, Carter, & Joyce, 1996; Bulik, Sullivan, Carter & Joyce, 1997; Kendler et al., 1991). There is also some support for the presence of other co-morbid conditions, such as personality disorders and suicide attempts (Braun et al., 1994; Halmi, 1994).

Using data from the Mental Health Supplement of the Ontario Health Survey, Garfinkel, Lin, et al. (1995) compared the presence of associated co-morbidity in female subjects with full - and partial-syndrome bulimia nervosa ($n = 77$) with the total female sample ($n = 4,208$). The findings indicated that women with bulimia nervosa had a threefold increase in lifetime occurrence of major depression and a double rate of anxiety disorders than women in the comparison group. In addition, the bulimic subjects had a significantly higher rate of phobias (i. e., social, simple, agoraphobia), panic disorders, generalized anxiety disorders, and lifetime alcohol dependence than the comparison group. As the authors noted, the lower rates of co-morbidity (i.e., affective disorders, anxiety disorders and alcoholism) observed in the study sample may be a function of using a community-based, as opposed to a clinical population.

In another epidemiological study, Lilienfeld et al. (1998) investigated the

prevalence rates of co-morbidity for eating disorders in a sample of females with anorexia nervosa ($n = 26$), bulimia nervosa ($n = 47$), and normal controls ($n = 44$). Participants completed a modified version of the Schedule for Affective Disorders and Schizophrenia-Lifetime Version (i.e., assesses lifetime DSM-III-R Axis 1 disorders), Schedule for Affective Disorders and Schizophrenia-for School-Age Children-Epidemiologic Version (i.e., assesses lifetime psychopathological disorders in subjects younger than 18 years), the Structured Clinical Interview for DSM -III - R Personality Disorders, and the Personality Disorders Examination (i.e., assesses cluster B disorders). The anorexic and bulimic groups had similar rates of major depressive disorder (MDD) which were significantly higher than those found in the control group. The anorexic group had a significantly higher rate of obsessive-compulsive disorder (OCD) and obsessive-compulsive personality disorder than either the bulimic or control group. As well, the anorexic group exhibited higher rates of generalized anxiety disorder and social and simple phobias than the control group. The bulimic group had significantly greater rates of alcohol and drug dependency than the anorexic and control groups, as well as significantly higher rates of post-traumatic stress disorder, OCD and cluster B personality disorders than the control group.

Zaider et al. (2000) examined the prevalence of psychiatric co-morbidity associated with eating disorders in a sample of adolescents ($N = 403$) between

15 and 18 years of age who attended medical clinics or the school nurse's office. Standardized instruments - the Primary Care Evaluation of Mental Disorders and the Structured Clinical Interview for the DSM - IV's Personality Disorder - were used to identify mental health problems (i.e., alcohol, anxiety, eating, mood and personality disorders). The findings indicated that only a small percent of the sample, mostly females, had eating disorder symptoms (5.2%) or an eating disorder diagnosis (3%). Significantly, adolescents with a depressive disorder, anxiety disorder or dysthymia were more likely to have an eating disorder and eating disorder symptoms than those without such disorders. However, only a very few personality disorder types (i.e., antisocial, borderline and dependent) were significantly associated with the presence of eating disorders and eating disorder symptoms.

Several clinicians and researchers have noted that MDDs occur frequently in individuals diagnosed with bulimia nervosa (Braun et al., 1994; Brewerton et al., 1995; Bulik et al., 1996; Fornari et al., 1999; Garfinkel, Lin, et al., 1995; Lilenfeld et al., 1998; Walsh & Devlin, 1998). It has been estimated that the prevalence rate for depression in individuals with this disorder may vary from 36% to 70% (Halmi, 1994). Garfinkel, Lin, et al. (1995) found that the lifetime occurrence rate for major depression was 37.7% in their community-based sample of female subjects with bulimia nervosa. In contrast, Fornari et al. (1999) reported a 70.7% lifetime occurrence rate for major depression in a clinical

sample of individuals with bulimia nervosa. Besides the uncertainty over the exact prevalence, there is conflicting empirical evidence on the sequencing of MDDs and bulimia nervosa. Some researchers have found stronger support for MDD preceding bulimia (Brewerton et al., 1995; Kendler et al., 1991), while others reported mixed results (Braun et al., 1994; Bulik et al., 1996).

Probably the most convincing evidence for the concomitant role of depression is reported by Kendler et al. (1991). In an epidemiological study, Kendler et al. investigated the presence of major psychiatric illnesses in a sample of female twins ($n = 2,163$) obtained from a population-based register. The Structured Clinical Interview for the DSM - III - R (SCID) was used to assess psychiatric illness. The findings indicated that MDD occurred in 63 of the 123 subjects diagnosed with broadly defined bulimia.

Other studies have documented the presence of anxiety disorders in individuals with bulimia nervosa (Braun et al. 1994; Brewerton et al., 1995; Bulik, et al., 1996; Garfinkel, Lin, et al., 1995; Kendler et al., 1991; Lilenfeld et al., 1998). Estimates of the prevalence rates for anxiety vary across studies. In a study of women with bulimia nervosa ($n = 114$) participating in a clinical trial, Bulik et al. (1996) found that 64% of the sample had some type of anxiety disorder. A comparable rate of 62.3% was reported by Garfinkel, Lin, et al. (1995). These findings are considerably higher than the 36% and 38% reported by Brewerton et al. (1995) and Braun et al. (1994), respectively. Significantly, a

few studies found support for anxiety disorders preceding the onset of bulimia (Brewerton et al., 1995; Bulik et al., 1996).

It has also been noted that a significant number of bulimic individuals are substance abusers (Brewerton, 1995; Dansky, Brewerton, & Kilpatrick, 2000; Garfinkel, Lin, et al., 1995; Grilo, Levy, Becker, Edell, & McGlashan, 1995; Holderness, Brooks-Gunn, & Warren, 1994; Kendler et al., 1991; Lilienfeld et al., 1998; Muscari, 1996; Schachtel & Wilborn, 1990; Wiederman & Pryor, 2000; Wilfley & Grilo, 1994). Substance abuse has been estimated to range from 18% to 32% in individuals with bulimia nervosa (Braun et al., 1994; Brewerton et al., 1995; Halmi, 1994). Bulik et al. (1996) reported that 47% of their sample of women with bulimia had alcohol dependence. In contrast, Garfinkel, Lin, et al. (1995) reported a lifetime rate of 24.7%. Welch and Fairburn (1996) failed to find any significant differences in the alcohol consumption of individuals with bulimia nervosa ($n = 102$) versus comparison groups consisting of individuals with other psychiatric disorders ($n = 102$) or normal controls ($n = 204$). This finding contrasts with those of Garfinkel, Lin, et al. (1995) who found a significant difference between bulimic subjects and normal controls.

Personality disorders have also been identified as co-morbid illness for eating disorders. Matsunaga et al. (2000) and Zaidar et al. (2000) noted that it is difficult to determine the exact prevalence rate of personality disorders due to the methodological inconsistencies across studies. Braun et al. (1994) and Halmi

(1994) estimated prevalence rates to range from 28% to 77%. Despite discrepant findings, there is sufficient evidence that personality disorders are relatively common among adults with eating disorders. In a sample of 105 eating disorder patients, Braun et al. (1994) reported that 31% of the bulimic subgroups had cluster B disorders (antisocial, borderline, histrionic and narcissistic) and 30% had cluster C disorders (avoidant, dependent, obsessive compulsive and passive aggressive). Bulik et al. (1996) found that 63% of their sample had at least one personality disorder.

Suicide and deliberate self-harm have also been investigated in individuals with bulimia nervosa. In a study of patients ($n = 125$) with bulimia nervosa attending an eating disorder out-patient clinic, Favaro and Santonastaso (1998) investigated the presence of impulsive and compulsive self-injurious behavior (i.e., impulsive self-injury, suicide attempts, substance abuse, hair pulling, severe nail biting, vomiting, and laxative diuretic abuse). Ninety subjects reported at least one form of self-injurious behavior, with suicide attempts (18.4%) or self-cutting episodes (21.6%) the most common. In a comparative study, Welch and Fairburn (1996) found that individuals with bulimia nervosa had higher overdose rates and deliberate self-harm attempts than normal controls and psychiatric controls. In another study comparing patients with bulimia nervosa ($n = 152$), anorexia nervosa ($n = 68$) or major depression with no history of an eating disorder ($n = 59$), Bulik, Sullivan, and Joyce (1999) found that the

percentage of suicide attempts was equal across all groups.

Summary

The general conclusion is that the diagnostic criteria differentiating one eating disorder from another continues to evolve in response to clinical and research findings. Part of the problem in reaching a definitive diagnosis with individuals suspected of having eating disorders is attributed to the absence of reliable and valid measures which are both sensitive and discriminatory. The difficulties in reaching a definitive diagnosis are compounded by the symptom variations in males and females, as well as adults versus children. This situation is further complicated by the presence of one or more co-morbid psychiatric conditions.

Risk Factors for Bulimia Nervosa and Predictors of Outcome

The theoretical, clinical, and research literature abounds with conjectures about, and empirical support for, risk factors believed to be associated with the development of bulimia nervosa. Most research studies since 1979, both quantitative and qualitative in nature, have tended to focus on the risk factors and the effectiveness of various treatment modalities. Despite the expanding research on individual-related risk factors (e.g., age, psychological disposition, individual and family risk for psychiatric disorders, heritable factors, etc.) (Walsh

& Devlin, 1998), the etiology of bulimia nervosa remains a mystery. The complex interactive relationship among several risk factors has been highlighted as the most important barrier to full recovery from the illness.

The discussion in this section is organized into three major sections. The first section presents a summary of research studies that focused on the early warning signs for bulimia nervosa. The second section broadens the discussion to include studies that have investigated different risk factors believed to be involved in the development and perpetuation of bulimia nervosa in clinical populations. The final section discusses some of the most important predictors of recovery.

Early Warning Signs

Bulimia nervosa, once thought to develop in female college age students is now being diagnosed in pre-adolescent and adolescent females and in males, although to a lesser degree. Prior to the 1990s, no studies were identified that investigated the risks posed by early childhood eating disturbances for the development of eating disorders. Recent research findings suggest that eating disturbances which place individuals at greater risk for eating disorders are often present in very young children and pre-adolescents (e.g., Button, Sonuga-Barke, Davies, & Thompson, 1996; Calam & Waller, 1998; Franko & Omori, 1999; Killen et al., 1994; Schur, Sanders, & Steiner, 2000; Stice, Agras, & Hammer,

1999).

A number of antecedents and correlates of disturbed eating behaviors have been investigated in young children, pre-adolescence, and early and late adolescence. Some of the more common individual characteristics identified as significant markers for bulimia nervosa include weight concerns, body mass index (BMI), self-esteem, body dissatisfaction, physical and sexual abuse, and substance use. Empirical support for the influence of weight concerns and fluctuations, dieting concerns, and body dissatisfaction on early disturbed eating behaviours is stronger than the influence of overweight status and dieting behaviours (French, Perry, Leon, & Fulkerson, 1995; Hill & Pallin, 1998; Killen et al., 1994; Neumark-Sztainer, Butler, & Palti, 1995; Schur et al., 2000). Other researchers have found support for the important role played by self-esteem, physical and sexual abuse and substance use (French, Story, Downes, Resnick, & Blum, 1995; Hill & Pallin, 1998; Neumark-Sztainer et al., 1995).

Killen et al. (1994) examined potential risk factors for the development of eating disorders in females ($N = 839$) attending grades 6 and 7. Data were collected with the EDI, revised Dietary Restraint scale (i.e., concern for dieting and weight fluctuations), Center for Epidemiologic Studies depression (CED-D), Depression Self-Rating Scale (DSRS), Family Adaptability and Cohesion Evaluation Scale (FACES), Pubertal Development, and Structured Clinical Interview (SCID). Based on the SCID findings, participants were assigned to

either the symptomatic ($n = 36$) or asymptomatic group ($n = 803$). The symptomatic group were significantly more developmentally advanced, had more depressive symptoms, were heavier, evidenced greater maladaptive eating attitudes (i.e., drive for thinness, bulimia, body dissatisfaction, ineffectiveness, and interoceptive awareness), and demonstrated greater restraint (i.e., weight fluctuations and dieting concerns) than the asymptomatic group. Besides the strong link observed between disturbed eating and psychological and behavioral dysfunctions at a young age, the authors highlighted the significance of the presence of most of the diagnostic criteria for bulimia in the symptomatic group.

French, Perry, et al. (1995) examined weight reduction strategies in a sample of female students ($N = 1,015$) in grades 9 to 12. A researcher-developed instrument was used to measure dieting behaviors and the Restrained Eating Scale (RES) assessed weight concerns and fluctuations and emotional reactions to weight and dieting. A number of single items were used to assess binge eating, history of eating disorders, and frequency of intentional weight loss. The results indicated that 1.9% and 1.6% of the sample reported having a history of anorexia nervosa or bulimia nervosa, respectively. While the majority of students (63%) reported not using weight loss methods during the past year, those who did so were significantly more likely to use healthy methods (e.g., increased exercise and fruit and vegetable consumption, decreased fat intake, elimination of snacks, etc.) as opposed to unhealthy ones (e.g. diet pills,

vomiting, appetite suppressants, liquid diets, etc.). Participants who were overweight and had higher RES scores were significantly more likely to report greater weight fluctuations and intentional weight loss, and to use both healthy and unhealthy dieting behaviors than participants who were of normal weight or had low RES scores. Significantly, restrained eating and over concern with body weight surfaced as a much better predictor of future eating problems than overweight status or dieting behaviors.

Using a comprehensive health behavior school-based survey, French, Story, et al. (1995) investigated correlates (i.e., psychological, social and health behaviors) of frequent dieting in adolescent males ($n = 16, 258$) and females ($n = 17, 135$) in grades 7 to 12. The findings revealed that 12% of females and 2.2% of males had dieted 10 or more times and 15% of females and 6.5% of males used some type of purging behavior over the past year. An increased frequency of dieting and purging behaviors was independently associated with greater psycho-social and health behavior risk factors. Dieters and purgers were significantly more likely than non-dieters and non-purgers to be binge eaters, to have fears of not being able to stop eating, to have a negative body image, to be at greater risk for suicide, to engage in sexual activity, to use tobacco and alcohol, and to have experienced physical or sexual abuse.

In a study of a non-clinical sample of girls in grade 10 ($N = 341$), Neumark-Sztainer et al. (1995) examined the influence of self-esteem, body

dissatisfaction, unhealthy weight loss methods and the drive for thinness on the bingeing behaviors of dieters. The EDI (i.e., body dissatisfaction and drive for thinness subscales), the Rosenberg Self-Esteem Scale (SES), and several researcher-developed items on bingeing and dieting behaviors were used during data collection. Study findings revealed that a significant proportion of the sample were currently dieting (53.7%), had used unhealthy or dangerous weight loss methods (27.9% and 7.9%, respectively), had engaged in binge eating (20%), and depicted high-risk psychological profiles (16.4%). During logistic regression analysis, weight loss method and psychological profile were found to exert a significant effect on the bingeing behaviors of dieters. Specifically, adolescent dieters who used dangerous weight loss methods and had low self-esteem, high body dissatisfaction, and a drive for thinness were more likely to engage in bingeing behaviors than other dieters.

In a descriptive, correlational study of students ($M = 8.67$ years) attending four state Junior schools, Hill and Pallin (1998) examined predictors of early dieting awareness in boys ($n = 90$) and girls ($n = 86$). Data were collected on dieting awareness, BMI, body shape preference, body esteem, and self esteem (i.e., social acceptance, behavioral conduct, scholastic and athletic competence and physical appearance). Although there were no gender differences in height or weight, both groups weighed more than age-standardized norms. With regard to body shape preferences, girls desired to have a thinner shape and boys a

broader shape. There were also significant differences on self-esteem measures, with girls scoring lower on social competence, athletic competence and physical appearance but higher on behavioral conduct than boys. With regard to dieting awareness, both groups were more likely to advise others to diet and exercise than themselves, and to believe that their mothers would resort to dieting more so than their fathers. During regression analysis, the mother's tendency to diet if she felt fat and lower self-esteem levels and higher BMIs emerged as significant predictors of dieting awareness in girls. For boys, perceptions of mothers' dieting behaviours and personal dissatisfaction with physical appearance surfaced as significant predictors of dieting awareness.

Using triangulated methods, Schur et al. (2000) investigated third and sixth graders ($N = 62$) knowledge and beliefs about dieting and body dissatisfaction. The ChEAT, a standardized measure, was used to assess eating disturbances, and a modified version of the Body Figure Rating scale was used to assess body dissatisfaction. The BMI for each participant was computed and researcher-developed open-ended questions assessed knowledge and beliefs about dieting and desired body weight. Study findings indicated that approximately half of the girls and the boys (i.e., 51.7% vs 48.3%, respectively) wanted to weigh less and more than one-third desired a thinner body shape (i.e., 41.9% of the girls versus 35.5% of the boys). Significantly, higher BMIs were associated with a greater desire to lose weight and have a thinner body, as well

as a higher incidence of eating disturbances. A significant percent of the sample (i.e., 41.9% of the boys versus 12.9% of the girls) had actually engaged in weight altering behaviours, by changing food choices and exercise habits as well as eating less, the most common meaning of dieting. The authors concluded that boys and girls who have high BMIs, report body dissatisfaction, and want to lose weight at a young age are at risk for later developing disturbed eating attitudes and behaviours.

It has also been hypothesized that individuals who develop eating disorders progress sequentially on a continuum from early disturbed eating behaviors to later pathological eating behaviors. Several articles were identified from the research literature that tested the continuity theory. Study findings by Button et al. (1996), Calam and Waller (1998), Stice et al. (1999), Franko and Omori (1999) and Kaltiala-Heino, Rissanen, Rimpela, and Rantanen (1999) support the progression from sub-clinical eating disturbances in early childhood, to later clinical symptoms, and finally to a confirmed diagnosis of an eating disorder.

In a four-year prospective study, Button et al. (1996) examined the role played by self-esteem and other psychological factors in the development of eating disorders in a sample of school girls ($N = 397$) from early (i.e., 11 to 12 years) to mid-adolescence (i.e., 15 to 16 years). Participants completed a modified version of the Rosenberg SES (i.e., items were added concerning

school, family, fatness, health, and worry) at times 1 and 2. During the second phase, students also completed the EAT and the Hospital Anxiety and Depression Scale. The findings revealed that there was a significant increase in students with scores indicative of low self-esteem from times 1 to times 2, (i.e., 26% versus 40.5%, respectively). In addition, 12.1% of the scores were indicative of an eating disorder, and 1.3% and 31.8% of the scores were in the range for depression and anxiety, respectively. Participants also reported several weight control strategies, with dieting to lose weight (46%) and exercise (37.7%) the most common, and concerns with fatness. A higher eating disorder score was significantly associated with lower self-esteem and greater anxiety, depression, and total number of problems. As well, greater anxiety and depression were significantly related to lower self-esteem levels. During multiple regression analysis, different combinations of independent variables were used to predict outcome. Low levels of self-esteem at ages 11 to 12 were significant predictors of self-esteem problems, as well as eating problems, at ages 15 to 16 years. With regard to eating behaviors and concerns, fatness concern at ages 11 to 12 was predictive of feeling too fat, having a dieting history, greater weight, greater weight range, and a greater difference between present and ideal weight (i.e., weight dissatisfaction) at 15 to 16 years of age.

In a seven-year longitudinal study of young women ($N = 63$), Calam and Waller (1998) investigated the predictive role of psycho-social and eating

characteristics in the early teenage years (i.e., $M = 12.8$ years) on eating attitudes and behaviors in early adulthood (i.e., $M = 19.8$ years). Eating psychopathology was measured with the EAT and the Bulimic Investigatory Test (i.e., subscales assess the frequency of bulimic behaviors and attitudes and severity of bingeing and purging behaviors). As well, the Conditions for Anorexia Nervosa Scale assessed self-esteem and perfectionism. In addition to the young women's ratings, their mothers assessed various aspects of family function (e.g., general functioning, communication, problem-solving, roles and responsibilities, etc.) with the Family Assessment Device (FAD). The findings indicated that there was an overall increase in eating psychopathology levels over time. While early restrictive behaviors were more predictive of later purging behaviors, early bulimic attitudes were more predictive of later bingeing behaviors. In contrast to expectations, early levels of self-esteem and perfectionism were not good predictors of later eating psychopathology.

In a five-year perspective study, Stice et al. (1999) investigated the timing and predictors of disturbed eating behaviors in a sample of newborns and their parents ($N = 216$). Several factors were assessed during the study (i.e., infant body mass at baseline, infant sucking behavior and duration, parental BMI, maternal eating behaviors and eating pathology, and child eating disturbances). The results indicated that there was a greater tendency for children to exhibit overeating and secretive eating than inhibited eating and overeating-induced

vomiting from infancy to five years of age. The majority of the sample had only one of these behaviors present at a time, with the risk for disturbed eating behaviors increasing annually and peaking at five years of age. Using Cox's proportional hazards regression analysis, the findings revealed that the best predictors of secretive eating in children were elevated maternal BMI, disinhibition toward eating and hunger, body dissatisfaction and bulmic symptoms, as well as a paternal history of being overweight. The best predictors of overeating were maternal dieting and the drive for thinness, as well as the child's BMI during infancy. Finally, elevated maternal BMI was the sole predictor of inhibited eating, whereas infant sucking duration was the only predictor of vomiting.

In a descriptive-correlational study, Franko and Omori (1999) examined the continuity of eating disorders hypothesis in a sample of adolescents ($N = 207$) in their first-year of college. Data were collected with the Eating Pathology Scale (EPS), BDI, Bulimic Automatic Thoughts Test (BATT), Impulsivity Inventory (IMP), and EDI. According to the EPS criteria, the sample was divided as follows: probable bulimics (2.5%), at-risk dieters (6.7%), intensive dieters (23%), casual dieters (17%), and non-dieters (51%). Using multivariate analysis techniques, the probable bulimics and at-risk dieters failed to differ on any study measures and were subsequently combined during further analysis. The findings indicated there was a steady downward progression of scores on the

BATT and most sub-scales of the EDI, with probable bulimia nervosa demonstrating the highest scores and non-dieters the lowest scores. Furthermore, the combined high risk groups demonstrated significantly higher scores for depression, bulimic thoughts, and several eating attitude variables (i.e., drive for thinness, bulimia, ineffectiveness, and interpersonal distrust) than all other groups. That is, female adolescents with greater evidence of eating pathology were also more likely to have more depressive symptoms, more dysfunctional cognition, and greater disordered eating attitudes.

In a survey of 14 to 16 year old adolescents attending secondary schools, Kaltiala-Heino et al. (1999) investigated the prevalence of bulimic symptoms, bulimic behaviors, and bulimia in a large sample of males ($n = 4,181$) and females ($n = 4,347$). All questions concerning bulimic eating disorder were based on the DSM - III - R diagnostic criteria. Information was also collected on select biological, sociodemographic and social variables. The findings indicated that the lifetime prevalence of bulimia nervosa was 1.8% for girls and 0.3% for boys, and bulimic symptoms was 16.5% for girls and 12.3% for boys. The mean BMI for both girls and boys with bulimia symptoms was significantly higher than those without bulimic symptoms. Although the mean age for girls with bulimia symptoms was significantly higher than those without bulimic symptoms, age was not a differentiating factor for males. Furthermore, girls who had experienced the onset of menstruation and boys the onset of ejaculation were

significantly more likely to have bulimic symptoms or to meet the criteria for bulimia than those who had not achieved this level of physical maturation. With regard to peer group adjustment, bulimic symptoms and bulimia were significantly more common in girls and boys who were bullied at least once a week.

The role played by family dynamics and the peer group in the early onset of disturbed eating behaviors and the later onset of eating disorders has been examined by a number of researchers. While most study findings support both the positive and negative influence of family dynamics, there is some contradictory evidence. The empirical support for peer influence is much more consistent, with greater use of high risk behaviors representing attempts to make connection and gain approval.

In an examination of family factors associated with disturbed eating behaviors of girls in grades 6 and 7, Killen et al. (1994) failed to document significant differences between the symptomatic and asymptomatic groups on family cohesiveness and adaptability. Contrasting findings were reported by French, Story, et al. (1995) and Calam and Waller (1998). French, Story, et al. (1995) found that adolescent dieters and purgers were significantly more likely to report emotional and family stress, voice concerns about peer acceptance, have low feelings of family and other connectedness, and be involved in delinquent behaviors than non-dieters and non-purgers. While Calam and Waller (1998)

failed to find a predictive role for early family dynamics in the later development of purging behaviors. They did find that poorer perceived role differentiation was associated with later bulimic attitudes and behaviors, and poorer intrafamilial communication with more restrictive attitudes.

In a study of adolescent dieting behaviors, Huon and Walton (2000) investigated differences in parental and peer pressure, conformity disposition, assertiveness and parental supportiveness in two matched samples of females aged 12 to 16 years - one group ($n = 62$) had initiated dieting and the second group ($n = 62$) had never dieted. Dieting was measured with a modified version of the Dieting Status Measure, perceived parental care and control by the Parental Bonding Instrument (PBI), peer competitiveness with the Dieting Peer Competitiveness Scale, and level of assertiveness with the College Self-Expression Scale. Additional researcher-developed/modified scales were used to assess peer and parental influence (i.e., modeling, conformity and compliance pressure to diet) and conformity. The findings indicated that greater parental and peer influence, as well as less supportive fathers, were more prevalent in the dieting initiator group than in the never dieter group. With regard to the specific components of parental and peer influence with the most predictive power, discriminant analysis revealed that parental conformity and compliance and peer competitiveness most clearly differentiated initiating dieters from non-dieters.

In a study of third and sixth graders, Schur et al. (2000) also found that

family and peers influenced concerns about weight and provided information about dieting. Peer teasing and pressures from family members and the media were the most common reasons identified for wanting to lose weight. *Furthermore, the family, especially parents, was identified as the most frequent information source for dieting.*

In a statewide survey of adolescent health, Neumark-Sztainer, Story, Hannan, Beuhring, and Resnick (2000) reported on factors (i.e., abuse, family functioning, psycho-social, and depressive symptoms) associated with disordered eating behaviors in a sample of grade 7, 9, and 11 students ($n = 9,943$). Questionnaire items assessed sexual and physical abuse, family communications, parental caring, parental monitoring, peer support, family structure, parental expectations, and presence of depressive symptoms. The findings indicated that adolescents who had disordered eating were significantly more likely to report higher rates of sexual and physical abuse, more depressive symptoms, lower levels of parental expectations and caring, and lower family communications than their peers with normal eating behaviors. Furthermore, when family, physical abuse and other psycho-social factors were controlled for in the analysis, sexual and physical abuse continued to be associated with disordered eating but to a much lesser degree. The authors concluded that positive family relationships may buffer the impact of abusive experiences.

It is apparent from the preceding review of studies that the seeds for the

development of eating disorders are planted at a very early age. There is fairly strong support for the influence of personality traits, co-morbid psychiatric illnesses, critical events, and the social and family environments. The empirical evidence suggests that eating disturbances observed in childhood and adolescence are due to the interaction of a number of factors rather than one single factor. While there is some support for gender differences, the findings suggest more similarities than differences.

Risks Factors in Clinical Populations

A number of antecedents and correlates of eating behaviors have been investigated in clinical populations. While the correlates or co-morbidities were addressed in an earlier section, the discussion that follows focuses on the antecedent factors involved in the development of bulimia nervosa. The discussion places particular emphasis on those studies that dealt with some of the more prominent risk factors (i.e., psychological predispositions, family and genetic factors, sexual abuse, and gender and sociocultural factors).

Psychological factors. Psychological traits have been postulated to influence the development of eating disorders since the pioneer work by Hilde Bruch (i.e., *The Importance of Overweight*, 1957; and *The Golden Cage*, 1977). Although clinicians assert that the pre-morbid psychological trait of low self-esteem is a significant risk factor for bulimia nervosa, limited attention has been

placed on empirically investigating the role that it plays in the onset of this disorder (Fairburn et al., 1997; Fairburn et al., 1999; Griffiths et al. 1999; Hay et al., 1998; Jensen, 1994; Kendler et al., 1991; Muscari, 1996; Strauss, 1995; Wilfley & Grilo, 1994). Besides the questionable role played by self-esteem in the onset of eating disorders, there is considerable debate concerning the importance of distorted body image concerns, body dissatisfaction, drive for thinness, locus of control, and other personality traits (e.g., mood/affect, hostility, anger, etc.).

Using epidemiological data, Kendler et al. (1991) investigated the personality profiles of broadly defined bulimia cases ($n = 123$) derived from a sample of female twins ($n = 2,163$). The SCID was used to assess psychiatric illness, the Eysenck Personality Profile assessed personality traits, Rosenberg SES assessed self-esteem, and the modified Attributional Styles Questionnaire assessed locus of control. The findings indicated that low self-esteem, external locus of control, and high levels of neuroticism were significant risk factors for broadly defined bulimia nervosa.

Williams et al. (1993) investigated perceived control, assertiveness, self-esteem, self-directed hostility, and risk for mental health problems in five groups of participants: anorexia nervosa ($n = 32$), bulimia nervosa ($n = 30$), obese dieters ($n = 31$), non-obese dieters ($n = 29$), and normal controls ($n = 35$). A number of standardized scales were completed by all participants: the EAT- 40,

Bulimia Test (BT), Internal, Powerful Others, and Chance (I.P.C.) Scales (i.e., perceived control), Rathus Assertiveness Schedule, Hostility and Direction of Hostility Questionnaire (i.e., guilt and self-criticism), RES, General Health Questionnaire (GHQ), and Rosenberg SES. The findings indicated that both eating disorder groups scored significantly higher than the comparison groups on the EAT and BT, with anorexics scoring higher on the EAT and bulimics scoring higher on the BT. Furthermore, the eating disorder groups had significantly higher external control and self-directed hostility and lower assertiveness and self-esteem than the comparison groups. Finally, the eating disorder groups had more dysfunctional scores on the GHQ than the comparison groups.

In a case-controlled study, Fairburn et al. (1997) compared the role played by psychological factors in samples of women with bulimia nervosa ($n = 102$), psychiatric illness ($n = 102$), and normal controls ($n = 204$) selected from the same community. *Psychological traits constituted one aspect of the personal vulnerability category.* The findings indicated that the bulimic group had significantly greater exposure to personal risk factors than healthy subjects in the control group. Specifically, women in the bulimic group were more likely to report greater negative self-evaluation than their counterparts in the psychiatric illness and normal control groups.

In another study comparing women who binge ($n = 37$) with normal controls ($n = 41$), Sanftner and Crowther (1998) examined variability in self-

esteem, moods, shame and guilt. The Bulimia Test-Revised (BUILT-R) was used to determine binge status. Participants also completed the BES, Eating/Dieting Questionnaire, Revised Restraint Scale (RRS), State Self-Esteem Scale (i.e., levels of performance, appearance, social and total self-esteem), Positive and Negative Affect Schedule, and the State Shame and Guilt Scale. Women who binged reported significantly lower levels of state self-esteem and positive affect and significantly higher levels of shame and guilt than the control group. Contrary to expectations, a significant increase occurred in state self-esteem and positive affect between binges and no increase occurred in negative affect prior to a binge.

Griffiths et al. (1999) examined the interrelationships among self-esteem, depression and body dissatisfaction in a sample of women and men ($N = 117$) diagnosed with either anorexia nervosa, bulimia nervosa, or eating disorders not otherwise specified (EDNOS). Self-esteem was measured with the Rosenberg SES and the Coppersmith Self-Esteem Inventory (SEI). Maladaptive eating attitudes and behaviors was assessed with the EDI and depression with the Beck Depression Inventory (BDI). The findings revealed that all study participants were low on self-esteem, with no significant differences detected among the eating disordered groups. As well, for the combined groups, low self-esteem was significantly associated with abnormal eating attitudes, body dissatisfaction and depression. Finally, during regression analyses, the

Rosenberg SES emerged as a significant predictor of all dieting disorder psychopathology but not the SI. The authors concluded that the Rosenberg SES may be a more valid measure of self-esteem for individuals with dieting disorders.

Wiederman and Pryor (2000) investigated the impact of the drive for thinness on body dissatisfaction in a clinical sample of women with anorexia nervosa ($n = 91$) or bulimia nervosa ($n = 142$) and depressive symptoms attending an eating disorders clinic. The clinical samples were compared to female college students ($n = 228$). While all of the groups completed the EDI, the clinical sample completed the BMI and the control group the Well-Being scale from the Multidimensional Personality Questionnaire (MPQ). The findings indicated that increased bulimia, depression and drive for thinness was significantly associated with greater body dissatisfaction in the three groups. During regression analysis, depression and the drive for thinness emerged as the most significant predictors of body dissatisfaction in both clinical groups. In contrast, the drive for thinness was the only significant predictor of body dissatisfaction in the college sample. The authors concluded that study results demonstrated the importance of drive for thinness as an important mediating variable between negative body image and disordered eating.

Using a clinical sample of women with anorexia and bulimia ($n = 53$) and a randomly selected control group ($n = 73$), Gupta and Johnson (2000) examined

the prevalence of non-weight related concerns and body image disturbances. The EDI assessed body dissatisfaction and the drive for thinness, whereas researcher-developed items measured non-weight related concerns. The findings indicated that body dissatisfaction, the drive for thinness and the average BMI were significantly greater in the clinical versus the normal control group. Furthermore, dissatisfaction with select facial features (i.e., skin, teeth, jaw, nose, and ears) and body height was significantly more common in the clinical sample versus the non-clinical sample.

Familial and genetic factors. There have been several research studies published on the role played by family and by genetic factors in the development of eating disorders. Recently, researchers have examined the genetic link, environmental factors, and the interaction between the two. The strongest support for the influence of genetic and environmental factors in the development of bulimia nervosa is provided by twin studies. Kendler et al. (1991), Kendler et al. (1995), Bulik, Sullivan and Kendler (1998), and Wade et al. (1999) confirmed the significant contributions made by genetic factors over shared environmental factors.

Kendler et al. (1991) investigated the role played by genetics in the onset of bulimia. The SCID was used during data collection. The findings indicated that the life time prevalence rates was 2.8% and 2.9% for definite and probable cases of bulimia and possible cases of bulimia, respectively. In addition, the

concordance rates for bulimia in monozygotic twins were substantially higher than those in dizygotic twins, and the concordance rates for both sets of twins substantially exceeded the general population risk. In addition, the correlation for liability for bulimia in monozygotic twins (50%) was substantially higher than those in dizygotic twins (30%). In a subsequent re-analysis of the same data with multivariate techniques, Kendler et al. (1995) continued to find strong support for the etiological role of genetics in bulimia nervosa.

In a five-year follow-up study of the same cohort of twins, Bulik et al. (1998) re-interviewed 1,897 female twins (including both members of 854 twin pairs). Using structural equation modeling, the genetic liability for developing bulimia and binge eating were estimated to be around 83% and 82%, respectively. The role played by several environmental factors (i.e., similar childhood treatment, cosocialization behavior as twins, emphasis placed on similitude, physical similarity, degree of twin contacts as adults, and parental rearing attitudes) were also assessed. However, only cosocialization was identified to exert an independent effect on twin concordance for bulimia. That is, a higher tendency for twins to socialize together during childhood and adolescence was associated with an higher concordance for bulimia. The researchers concluded that broadly defined bulimia nervosa and binge eating are highly heritable conditions, with some environmental influence.

In a prospective, 7-year longitudinal study, Wade et al. (1999) examined

the eating behaviors and attitudes towards eating, weight, and shape in a sample of female twins ($n = 1,682$). Survey participants completed the General Health and Lifestyle Questionnaire during the first assessment and the general psychiatric interview during the second assessment. A semi-structured interview with the EDE was conducted during the third assessment with 325 women (i.e., a random sample of 225 and 100 with distorted eating). The findings revealed stronger correlations (i.e., more than twice the size) for distorted eating among the monozygotic twins than among the dizygotic twins over the study period. The multivariate analysis results also suggested that the additive genetic factor (60%) accounted for more of the explained variance in the development of distorted eating than the non-shared (i.e., individual-specific) environment factor (40%). While the genetics link indicated the presence of a latent liability or stable vulnerability for disordered eating, the environment factor was also a key interactive factor.

It has been argued that individuals born within families with a strong history of psychopathology are more susceptible to developing distorted eating behaviors. There is some support for the increased prevalence of eating disorders within the immediate and extended family (Lilenfeld et al., 1998; Woodside, Field, Garfinkel, & Heinmaa, 1998), as well as parental psychiatric illness (Boumann & Yates, 1994; Garfinkel, Lin, et al., 1995).

Using a case-controlled study design, Boumann and Yates (1994)

investigated the prevalence of psychiatric illness in females with normal-weight bulimia nervosa ($n = 25$) and female controls ($n = 25$). A battery of standardized instruments related to mental health problems, and the family psychiatric history interview (i.e., Family History Research Diagnostic Criteria) were completed by women with bulimia (case proband group) and women in the control group. As well, one family member of both groups completed the family psychiatric history interview and select self-report scales which assessed personality disorders, alcohol abuse, dieting and eating behaviors, and depression. The findings revealed a significantly higher incidence of parental psychiatric illness for the case proband group (64%) than the control group (24%). Specifically, MDDs and personality disorders were significantly more common in parents of case probands than normal controls.

Using data from the Mental Health Supplement of the Ontario Health Survey, Garfinkel, Lin, et al. (1995) compared the family psychiatric histories of female subjects with full - and partial-syndrome bulimia nervosa ($n = 77$) with the total female sample ($n = 4, 208$). The findings indicated that women with full - and partial-syndrome bulimia reported a significantly higher proportion of psychopathology (i.e., alcohol problems, depression, suicide attempts, treatment for an emotional disorder, and antisocial behaviors) in both parents than their counterparts in the comparison group.

Using a sequential cohort design, Woodside et al. (1998) investigated the

prevalence of eating disorders in family members ($n = 2,125$) of females diagnosed with anorexia nervosa and/or bulimia nervosa ($n = 93$). The findings indicated that 9.4% of relatives of probands had either anorexia nervosa (5.1%) or bulimia nervosa (4.3%). Significantly, first and third degree relatives (cousins) had higher rates of bulimia than second degree relatives (i.e., 10.9 %, 4.4 % and 2.2 %, respectively). There was also evidence of a tendency for the relatives of probands to have the same eating disorder. The prevalence rates for all relatives were higher than those in the community. Similar results on the higher incidence in first degree relatives were reported by Strober, Lampert, Morrell, Burroughs, and Jacobs (1990) and Hudson, Pope, Yurgelun -Todd, Jonas, and Frankenberg (1987).

Using epidemiological data, Lilienfeld et al. (1998) also investigated the familial aggregation of psychiatric disorders in the first-degree relatives of women with anorexia nervosa or bulimia nervosa, as well as normal controls. Family members completed the modified Eating Disorders Family History Interview and the updated Family History Research Diagnostic Criteria (i.e., psychiatric-related history). Relatives of women with anorexia nervosa and bulimia nervosa were found to be at greater risk for eating disorders not otherwise specified (i.e., 7 to 12 times more likely) than relatives of women in the control group. Furthermore, relatives of women with bulimia nervosa had significant higher rates of MDD, post-traumatic stress disorder and cluster B personality disorders, generalized

anxiety disorder, alcohol and drug abuse, and panic disorders than the relatives of women in the control group.

It has been postulated that family dynamics and functioning play a significant role in the development of eating disorders. Several studies have found support for such a relationship (Fornari et al., 1999; Garfinkel, Lin, et al., 1995; Kendler et al., 1991; Kendler et al., 1995; Kinzl, Traweger, Guenther, & Biebl, 1994).

Kendler et al. (1991) also investigated the risk status of the family environment for broadly defined bulimia nervosa. The Parental Bonding Instrument was used to measure maternal and paternal care, and overprotectiveness. The findings indicated that only low levels of paternal care was a significant risk for broadly defined bulimia. In a subsequent re-analysis using multivariate techniques, Kendler et al. (1995) found additional support for the substantive role played by the family environment in bulimia nervosa.

In a stratified random survey of female undergraduate university students ($N = 202$), Kinzl et al. (1994) examined the relationship between early family experiences and adult eating disorders. Participants completed the EDI, two subscales of the Biographic Inventory for Diagnosis of Behavioral Disturbances (i.e., parental relationship and parent-child relationship), and a modified version of the Child Sexual Abuse History Questionnaire. The findings revealed that higher eating disorder scores were significantly associated with greater

dysfunctional family dynamics (i.e., more disturbed parental and parent-child relationships).

Garfinkel, Lin, et al. (1995) also compared the family backgrounds of female subjects with full- and partial-syndrome bulimia nervosa with the total female sample. The findings indicated that women with full-syndrome bulimia reported significantly greater parental disharmony than those with partial-syndrome bulimia or normal controls (i.e., 54.5%, 45.5% and 27.1%, respectively).

In a study of individuals with eating disorders participating in an outpatient program, Fornari et al. (1999) examined the role played by family functioning. Participants completed the BMI, the Structured Diagnostic Research Interview and the McMaster Family Assessment Device, which assesses family functioning along six dimensions (i.e., problem solving style, clarity of information transmission, role differentiation, affective responsiveness, affective involvement, and behavior control). Family functioning was not found to be a significant factor differentiating the eating disorder groups. However, when depression was a comorbid condition with eating disorders, individuals diagnosed with bulimia nervosa demonstrated significantly more unhealthy problem-solving styles and role differentiation than their counterparts in other eating disorder diagnostic groups.

Significant life events have also been implicated in the onset of eating

disorders. Limited support has been found for the effects of changes in family structures (Boumann & Yates, 1994; Welch, Doll, & Fairburn, 1997) and other significant changes or events (e.g., relocation, major illness, abuse, etc.) (Garfinkel, Lin, et al., 1995; Fairburn et al., 1997; Rorty et al., 1994; Welch et al., 1997).

Rorty et al. (1994) compared a sample of women diagnosed with bulimia nervosa ($N = 80$) to control female subjects ($N = 40$) with no history of an eating disorder or related difficulties. Participants completed the SCID, EAT version of the Schedule for Affective Disorders and Schizophrenia, the EDI, Sexual Abuse Exposure Questionnaire, Assessing Environments - III (i.e., physical abuse), and the PSY (i.e., maternal and paternal psychological abuse). The findings indicated that women with bulimia nervosa reported significantly more physical abuse, maternal and paternal psychological maltreatment, psychological abuse by at least one parent, and multiple abuse than women in the control group.

Garfinkel, Lin, et al. (1995) investigated the impact of family disruptions on women with full- and partial-syndrome bulimia nervosa and female normal controls in the larger sample. The findings indicated that a significantly greater percent of women from the full-syndrome bulimia group reported having to spend time in foster or group homes than their counterparts in the comparison groups.

Using a case-controlled design, Welch et al. (1997) investigated the role played by significant life events in precipitating the onset of bulimia nervosa.

Two samples were used in the study - 102 females with bulimia nervosa recruited from 23 general practices clinics and a control group of 204 females without bulimia (i.e., matched for age and parental social class) selected from the same community. The standardized EDE interview and a semi-structured interview designed to assess life events were completed with both groups.

Women with bulimia nervosa reported several critical life events more often than those in the control group, including: a major house move, a major episode of illness (close relative, friend or partner), pregnancy, a change in family structure (member leaving or joining), sexual abuse, and physical abuse. During logistic regression analysis, the greater the number of abuse events, the greater the likelihood that participants had bulimia nervosa. Boumann and Yates (1994) also found support for the impact of a changing family structure, with parental divorce rates significantly higher for females with bulimia nervosa (28%) than their counterparts without bulimia (5%).

In a subsequent report to the Welch et al. (1997) article, Fairburn et al. (1997) compared the sample of women with bulimia and controls to a sample of women with psychiatric disorders. Significant life events were collapsed into three categories - personal vulnerability (i.e., psychological traits, premorbid psychiatric disorders, behavioral problems, and parental psychiatric disorder), environmental factors (i.e., parental problems with communication, affection and control; disruptive events; parental psychiatric disorder; teasing and bullying;

sexual and physical abuse), and *dietary vulnerability* (i.e., *dieting risk, obesity risk, and parental eating disorder*). During conditional logistic regression, the bulimic group was found to have significantly greater exposure to almost all of the personal, environmental, and dietary risk factors than healthy subjects in the control group. Overall, the greater the degree of exposure, the greater the risk for developing bulimia. Significantly, parental problems, obesity risk, parental psychiatric disorder, sexual or physical abuse, and premorbid psychiatric disorder were identified as posing the greatest risks for bulimia nervosa. There were fewer significant differences noted between subjects with bulimia nervosa and those with a psychiatric illness. Specifically, subjects with bulimia nervosa were more likely than those with a psychiatric illness to report parental alcoholism, high parental expectations, and childhood and parental obesity. As well, the bulimia subjects were more likely to have low parental contact and critical comments made to them by family members about their shape, weight, or eating habits.

Sexual abuse. Early sexual abuse is believed to increase a person's risk for both anorexia nervosa and bulimia nervosa (Everill & Waller, 1995). Connors and Morse (1993) reported that sexual abuse occurs in 30% to 65% of women with eating disorders. Other authors have reported that 12% to 75% of women with bulimia nervosa have experienced sexual abuse (Fairburn et al., 1997; Waller, 1991; Welch et al., 1997). In their community-based sample, Garfinkel,

Lin, et al. (1995) found that the childhood sexual abuse rate for women with full- and partial- syndrome bulimia nervosa (32.7% and 36.4%, respectively) was significantly higher than the rate (13.9%) in the female comparison group.

Kinzl et al. (1994) also investigated the role played by childhood sexual abuse in the development of eating disorders in a representative sample of female undergraduate university students. Participants completed the EDI and a modified version of the Child Sexual Abuse History Questionnaire. Study findings failed to support a significant relationship between victims of sexual abuse and participants at increased risk for eating disorders. Comparable findings were reported by Rorty et al. (1994) who failed to find significant differences between the sexual abuse experiences of women with and without a diagnosis of bulimia nervosa.

In contrast to Kinzl et al. (1994) and Rorty et al. (1994), Deep, Lilenfeld, Plotnicov, Pollice, and Kaye (1999) found support for a greater prevalence of sexual abuse in women diagnosed with eating disorders ($n = 73$) than normal controls ($n = 44$). Data were collected with a modified version of the Schedule for Affective Disorders and Schizophrenia - Lifetime and items related to sexual abuse. The findings revealed significantly higher rates of sexual abuse in the bulimic group with substance dependence than either the bulimic group without substance dependence, the anorexic, or the control groups. The researchers noted that the wide variations in the percentage of sexual abuse reported in the

literature on eating disorders are due to the absence of a universal definition for sexual abuse, reliable and comprehensive instruments for its assessment, and study inconsistencies in how eating disorder subtypes are defined.

Gender and socio-cultural factors. Recent research findings are showing that immunity to bulimia nervosa is not restricted to gender, race or social class. Study findings have highlighted the commonalities and differences in male and female risk factors for the emergence of disturbed eating behaviors and later development of eating disorders (Carlat & Camargo, 1991; Keel, Klump, Leon, & Filkerson, 1998; Olivardia, Pope, Mangweth, & Hudson, 1995). The role of socio-cultural factors in the onset of eating disorders has also, been discussed in the literature (French, Story, et al., 1995; Kaltiala-Heino et al., 1999; Neumark-Sztainer, Story, et al., 2000).

In a review of all English language published works with original data related to bulimia in males, Carlat and Camargo (1991) found that males with bulimia nervosa varied from 10% to 15% of all community-based bulimic individuals. In addition, the findings suggested that bulimia nervosa only affects about 0.2% of adolescent males and young men. Males were also found to have a later age of onset, to have a higher prevalence of premorbid obesity, to be more satisfied with their body weight, to be less inclined to diet, to be more realistic about ideal body weight, and to have less body image distortions than females. Furthermore, males with bulimia nervosa had a higher rate of

homosexuality and asexuality than their female counterparts. In addition, males, more so than females, were less concerned with strict weight control methods, less troubled by their binge eating, less depressed after bingeing, and less likely to believe that bingeing was not socially sanctioned. Both genders had similar clinical symptoms, as well as a higher than average prevalence of affective, anxiety, and personality disorders than non-bulimics.

Using data obtained from a community survey, Olivardia et al. (1995) compared a sample of college men ($n = 25$), between the ages of 18 to 25 years, with compulsive dieting and uncontrolled eating binges to a sample of women ($n = 33$) with bulimia nervosa. Data were collected with the revised Diagnostic Survey for Eating Disorders, the SCID, the EAT and EDI, and researcher-developed items measuring sexual abuse and psychiatric conditions in first degree relatives. The findings indicated that the men with eating disorders closely resembled the comparison group of women with respect to age of onset, types of weight control measures, attitudes toward the eating disorder, rates of comorbid psychiatric illnesses, and dissatisfaction with their bodies. However, the men were less likely to have sought treatment for their eating disorder than the women. Keel et al. (1998) also found that eating disorder symptoms in males was quite similar to those observed in females.

Besides the gender factor, consideration has been given to the variant effects of sociocultural factors in eating disorders. Studies by Story, French,

Resnick and Blum (1995) and Neumark-Sztainer, Story, et al. (2000) investigated ethnic/racial and socio-economic status differences with regard to body weight concerns, dieting, unhealthy eating behaviors, weight control measures, and psychosocial factors in adolescent populations.

Story et al. (1995) reported on study findings from a comprehensive health behavior survey of female ($N = 17,135$) and male ($N = 16,258$) students in grades 7 to 12. The sample was comprised of 86% white, 8% blacks, 1% Hispanic, and 2% Native American. The findings revealed significant cultural difference in the eating disorder behaviors. Dieting was highest among Hispanic females and lowest among Black females, whereas it was highest among Asian males and lowest among White males. Intentional vomiting was highest in Hispanic and American Indian females and Black and American Indian males, and lowest in White females and males. Laxative and diuretic use was reported by twice as many Hispanic females as their female counterparts in other groups. Binge eating and out-of-control eating were most frequent in Asian females and males and lowest in Black females and males. Black females reported the most body weight satisfaction, with Blacks and Asians least likely to view themselves as overweight than Whites. Another significant finding was that unhealthy weight control behaviors were not confined to upper socioeconomic levels, White females or males.

Neumark-Sztainer and Hannan (2000) assessed dieting and disordered

eating behaviors in a national, representative sample of male ($n = 2,139$) and female ($n = 2,498$) adolescents in grades 7 to 12. The sample represented various ethnic groups - White (53.7%), Black (14.1%), Hispanic (9.2%), Asian (4.2%) and other (2.7%). Data were collected with researcher-developed items for weight-related attitudes and behaviors, the RES, the modified Children's Depression Inventory, the Stressful Life Events Scale, and select characteristics (i.e., grade, BMI, and socioeconomic status). A similar percent of severely overweight girls and boys were in the sample (8.7% and 7.8%, respectively). The girls were significantly more likely than boys to perceive themselves as overweight, to be distressed by excessive weight, to have dieted, and to engage in the binge/purge cycle than the boys. Furthermore, girls of higher socioeconomic status had lower rates of dieting and disordered eating. A similar trend was noted for boys with disordered eating behaviors. With respect to race, dieting was highest among White females (51.3%) and lowest for Black females (37.6%). No significant differences were observed in the dieting behaviors of males across ethnic groups. Disordered eating was highest among Hispanic females (19.1%) and lowest among Black females (11.4%). Finally, Black, Hispanic and other ethnic groups were at greater risk for disordered eating behaviors than White males.

The review of study findings dealing with clinical populations reinforces the complex interaction of a number of diverse and similar risk factors leading to

the onset and perpetuation of eating disorders. There is empirical support for the role played by self-esteem, external locus of control, mood/affect, body dissatisfaction, the drive for thinness, and comorbid psychiatric illnesses. Importantly, it is apparent that genetic and environmental factors (i.e., especially family dynamics, functioning and stability) constitute a strong precipitating force in both the emergence of psychological liabilities and eating disorders. Finally, gender and sociocultural factors have also been identified as playing a role in the development of eating disorders.

Prognosis: Long-and-Short-Term Outcomes

Wilfrey and Gilo (1994) noted that the consequences and long term impact for those afflicted with eating disorders can be devastating and even life - threatening. Although chronicity is associated with higher mortality and morbidity rates, research data on the long-term outcomes of bulimia nervosa is quite limited (Keel et al., 1999).

Researchers have noted that the predictors of recovery and relapse rates vary across studies, with relapse rates ranging from 30% to 63%. Keel and Mitchell (1997) noted that the absence of a uniform operational definition for recovery from bulimia nervosa makes it difficult to isolate important predictors. For example, recovery has been measured in terms of the absence of abnormal eating behavioral symptoms, but no uniform time frame has been agreed upon to

date. Other authors (Collings & King, 1994; Keel et al., 1999; Olmsted, Kaplan, & Rockert, 1994) have also noted that the use of different predictors of recovery has resulted in the reporting of variable relapse and recovery rates.

In a 10-year longitudinal study, Collings and King (1994) investigated predictors of recovery, defined as the absence of abnormal eating attitudes and behaviors, in a clinical sample of ($n = 44$) women with bulimia nervosa. Additional risk factors used to predict outcomes included age of onset, length of illness, BMI, social and relationship factors, familial factors, and comorbidity. Instruments used during data collection included the EAT, the Hamilton Rating Scale, the SCID, the Eating Interview, and Social Problem Questionnaire. The findings revealed that 50% of the sample had fully recovered at the end of the ten year period. Younger age of onset, higher social class and a family history of alcoholism were significant predictors of full-recovery. The authors suggested that possibly when these individuals observed family members participating in programs for alcoholism, they were motivated to seek treatment for bulimia nervosa.

In an intervention study of 10.5 weeks duration, Olmsted et al. (1994) explored the predictors of recovery from bulimia nervosa in 48 patients over a 2-year period. Recovery was defined in terms of the absence of binge eating and purging episodes. Instruments used during data collection included the EDI, EAT, RES, BMI, Hamilton Depression Rating Scale, Social Adjustment Scale

Self - Report, and EDE. Pre and post test scores were taken one week prior to program initiation, the last week of the program, and two years following program completion. A 31% relapse rate was observed during follow-up. The findings indicated that the strongest predictors of relapse were younger age, higher vomiting frequency, and higher scores on the bulimia subscale of the EAT before treatment. During regression analysis, these three factors accounted for 25% of the variance between the relapse and no-relapse groups. Furthermore, higher vomiting frequency and greater interpersonal distrust at the end of treatment were strong predictors of relapse, accounting for 29% of the variance between the two groups.

In a review of several longitudinal studies focusing on the long-term outcomes of women with bulimia nervosa, Keel and Mitchell (1997) found it difficult to compare findings due to methodological differences. In general, the findings suggested that the long-term outcome for women with bulimia nervosa was somewhat discouraging, with approximately 50% fully recovered and 20% continuing to meet the full criteria. The authors also noted that personality characteristics, like impulsivity, seem to enhance the chronicity of the disorder.

In a follow-up study of 177 women with eating disorders, Keel et al. (1999) found that 11% of the women met the full criteria for bulimia nervosa, 18.5% had eating disorders not otherwise specified, 28.3% were in partial remission, and 41.6% were in full remission. The findings also identified that a longer duration

of the disorder at presentation coupled with the presence of a history of substance abuse were highly predictive of worse outcomes.

Study findings suggest a number of factors may intervene to prevent full recovery from eating disorders. While there is no universal agreement on what constitutes recovery, the findings suggest that a younger age of onset, longer illness duration prior to treatment, greater bulimic attitudes and behaviors, and greater vomiting frequency are strong predictors of relapse. However, conflicting findings exist on the predictive accuracy of age of onset.

Summary

From a review of the literature it is clear that there is no single factor involved in either the development or perpetuation of bulimia nervosa. Significantly, the risk factors involved in the development of eating disorders, such as bulimia nervosa, have been found to be present in young children and adolescents. While personality traits and co-morbid psychiatric conditions are important risk factors, genetics and environmental factors have been shown to exert a powerful influence in the development of these disorders.

Individual's Experiences with Bulimia Nervosa

Few qualitative research studies have looked at the experience of living with bulimia. Two studies identified from the literature search discussed the

importance of understanding the deeper meanings of living with this illness. It was argued that this type of approach is needed to effectively deal with the complex interaction of numerous factors that lead to the onset and perpetuation of bulimia nervosa.

In a phenomenological study, Schachtel and Wilborn (1990) explored five women's experience with bulimia nervosa. Over the course of three interview sessions, participants talked about past, present, and future concerns. The findings revealed an obsession with one's physical image (i.e., over concern with appearance, weight, and shape) and impeded development of self-identity with food being used to protect the self from feelings and relationships. Food was also used to block emotional expressions (i.e., feelings of anger, sadness, or fear of loss), while releasing built-up tension and anxiety through bingeing and purging at the same time. Locus of control was located outside the self, with a strong dependence upon others for approval. In addition, there was evidence of dichotomous thinking (i.e., inability to appreciate the finer shades of meaning), obsessive-compulsive behavior (i.e., preoccupation with the body, weight, and food, as well as the need to binge and purge), excitement and thrill seeking behaviors (i.e., concealing the amount/type of food consumption), drive to succeed and be noticed in different realms (i.e., academia, social world, and physical appearances), and the paradoxical nature of control (i.e., the control sought through bingeing and purging in the early stages became the "controller"

as the illness progressed). The researchers concluded that the behavior and personality of each person with bulimia nervosa should be considered separately during treatment in order to achieve the best possible prognostic results.

Using a phenomenological design, Lyons (1998) examined the experience of binge eating in a sample of professional women ($N = 6$). An open-ended approach was used during the interview sessions and Giorgi's (1985) approach was used during data analysis. Seven thematic categories were identified from the data. The childhood experiences category reflected perceptions of feeling overweight, commencing dieting in late adolescence, viewing food as something special, and modeling parents or grandparents behavior. The adult food types category highlighted the high calorie, fat and salt content of items consumed. The eating behaviors category reflected the secrecy surrounding eating, especially the drive to conceal the amount eaten from significant others. The perceived lack of control category reflected the unconscious activity of eating until a sense of discomfort was reached and disgust with the self. The reasons for overeating highlighted multiple factors (e.g., stress, loneliness, boredom, etc.). The emotional consequences of overeating were described as guilt, shame, rationalization, and blaming. The final category, compensatory behaviors consisted of exercising, dieting, and participating in self-help groups, among others. The essence or unifying theme was identified as the struggle to maintain an acceptable weight and gain control of binge eating.

Summary

With the emphasis on obtaining quantitative data, researchers have ignored the phenomenology of individuals' experience with the illness. As a consequence, there is limited information on the process of change which occurs as the illness spirals downward and then slowly recedes after treatment. It is this subjective experience that, if captured, can provide invaluable information on effective treatment modalities.

Discussion

The majority of research studies published in the literature used an epidemiological design to identify the risk factors associated with the onset of bulimia nervosa. Study findings suggest that the separate and interactive effects of individual traits, family dynamics, genetics, and sociocultural and environmental factors exert a significant influence on the development of bulimia nervosa. Given the multidimensional nature of this disorder, it is not difficult to understand the complexity and challenges involved in the diagnosis and treatment of bulimia nervosa. Although clinicians and researchers agree that bulimia nervosa is a multidimensional disorder which requires a multidimensional approach to treatment, the prevalence of the disorder in vulnerable populations is basically unchanged.

The current research surrounding bulimia nervosa is scarred by

methodological issues which are partially responsible for the inconsistent findings observed across studies (Dorain & Garfinkel, 1999). Current diagnostic and screening tools for eating disorders have been criticized for their lack of sensitivity in detecting individual variations in clinical manifestations, especially with respect to gender, age, and cultural differences. From an extensive review of relevant literature, it also became apparent that there is a dearth of qualitative studies investigating the human elements of the disease. That is, little is known about the convoluted course of the illness or how individuals struggle with bulimia nervosa on a day-to-day basis. Consequently, the significant predictors of short- and long-term outcomes have yet to be delineated.

Early identification of individuals at greatest risk for this disorder is sorely needed if appropriate intervention and prevention programs are to be developed and implemented in a timely fashion. What is needed is greater interdisciplinary research efforts to help shed new light on the risk factors involved in eating disorders. Of crucial importance to this approach is the inclusion of the client and his/her perspective of living with bulimia nervosa. Qualitative research methodologies that explore the "lived experience" of bulimia nervosa will furnish useful data to help clinicians and researchers understand the meaning of being bulimic. By understanding the structural and communication patterns within the family unit, researchers may glean a greater insight to earlier identifiable childhood risk factors.

CHAPTER 3

Methodology and Methods

This qualitative study was designed to explore and discover what it means to live with bulimia nervosa. A qualitative inquiry allows researchers to approach the inherent complexity of social interaction and to do justice to that complexity by respecting it in its own right. In assuming the complexity of human interactions, qualitative researchers avoid simplifying social phenomena, explore the range of behaviors associated with the phenomena and examine variant understandings of interactions. A qualitative research approach was chosen for this research study in order to develop greater insight into the essence of the lived experience of bulimia nervosa.

This chapter discusses the methods used for data collection and analysis. The first section presents an overview of the methodological approach, hermeneutic phenomenology, used in this study. The remaining sections of the chapter describe how this approach was used to explore the lived experience of bulimia nervosa.

Hermeneutic Phenomenology as a Research Method

Over the past few decades, the phenomenological approach to data collection and analysis has gained increasing acceptance as a useful mode of inquiry into nursing phenomena (Streubert & Carpenter, 1995). The goal of

phenomenology is to develop a greater understanding of the meaning of everyday life experiences. Phenomenology provides the researcher with an opportunity to gain insightful descriptions of the way we "experience the world pre-reflectively" (van Manen, 1990, p. 9).

While phenomenology describes the lived experience, hermeneutics makes sense of this description. Semiotics is used to develop a practical writing or linguistic approach to the data and insights gleaned from using phenomenology and hermeneutics. In hermeneutic phenomenology, the goal is the discovery of meanings, which are not immediately obvious to our intuiting, analyzing and describing. Hence, the researcher is an interpreter who has to go beyond what is directly given. This approach to data collection and analysis provides the researcher with a means to grasp "a deeper understanding of human existence through attention to the nature of language and meaning" (Allen & Jensen, 1990, p. 241). It is through semiotics, or the writing and rewriting, that a researcher is able to make external what is internal to the research participants. The hermeneutic phenomenological approach was chosen for this study since it seeks to question and understand what a particular experience is like from the perspective of the person experiencing it (living with bulimia nervosa).

Properly combining the phenomenology, hermeneutic, and semiotic components is the key to obtaining good data. van Manen's (1990) research

method has had an impact on all the human sciences as it clearly articulates the interrelationships of phenomenology, hermeneutics and semiotics. In addition the process of textual reflection contributes to understanding practical action. The van Manen approach was selected for this study because it encompasses the interplay among the following key research activities:

- ▶ Turning to the phenomena of interest and developing a sense of commitment to the research. This step involves orientating oneself to the phenomenon of interest (bulimia nervosa), formulating a phenomenological question (What is the lived experience of bulimia nervosa?) and explicating (making clear) assumptions and pre-understandings about the phenomena being studied. van Manen identifies the "practise of thoughtfulness" as essential to the investigation. One is able to concentrate on the whole, which then renders fullness or wholeness to a life event.
- ▶ Investigating the experience as it is lived as opposed to how it is conceptualized. Phenomenology studies the original experience as it occurred in the past - a reflective perspective. Information is gathered through various methods such as taped interviews, written journals, and experiential descriptions from others (women who have lived with bulimia nervosa). These methods assist the researcher in reaching deeper meanings and greater understandings of the phenomena.

- ▶ Reflecting on essential themes inherent in the phenomenon. Reflecting on the written text enables the researcher to uncover, through a line-by-line examination, themes that bring meaning to the lived experience.
- ▶ Describing the phenomenon through the art of writing and rewriting. The writing and re-writing of the text culminates into a sensitively crafted document that gives voice to the lived experience. This kind of product allows the reader "to see" the lived world of another.
- ▶ Maintaining a strong and oriented relation to the phenomena. One has to remain completely focused on the research question in order to avoid outside distractions that can prevent one from becoming completely engrossed in the lived experience.
- ▶ Balancing the research content by considering part and whole. This step allows the researcher to identify the significance of the parts and how they contribute to the whole.

Population and Sample

The target population was all women in Newfoundland who were living with bulimia nervosa. The accessible population was women in the St. John's area who lived within 100 kilometers of the city. Study participants had to meet the following inclusion criteria: 1) a confirmed diagnosis of bulimia nervosa and attending group or individual counseling for at least one year, 2) physically and

mentally competent (clinical competency was determined by the attending psychiatrist), 3) nineteen years of age or older, and 4) fluent in the English language.

A purposive sample of seven women from the accessible population participated in the study. Phenomenological research lends itself to fewer participants, as person-to-person interviews provide extremely large amounts of narrative data for analysis (Sandelowski, 1995). Although it was anticipated that eight to ten participants would be required, a sample size of seven women was deemed adequate with the observed consistency in the themes emerging during the data analysis of each transcript.

Procedure

Potential participants were identified through consultation with psychiatrists working in St. John's, Newfoundland. Letters of support were received from two psychiatrists who were currently providing care to individuals with bulimia nervosa (see Appendix A). Psychiatrists applied the inclusion criteria to the accessible population and contacted potential participants by telephone or during a clinic visit. The intermediaries informed potential participants about the study, ascertained their willingness to participate, and sought permission for the researcher to contact them. Those women who expressed an initial willingness to participate in the study received a telephone

call from the researcher who explained the study more fully and addressed any questions or concerns. Once agreement for study participation was obtained, a time and place was scheduled for the initial interview.

Five of the interviews were conducted in the researcher's home, as these participants felt more comfortable telling their stories outside of their own home. The other two women preferred to be interviewed in their own homes. The time of the interviews was chosen by individual participants to maximize comfort and minimize inconvenience for them.

At the onset of the initial interview, each participant was presented with a detailed overview of the study. The researcher reviewed key aspects of the study (i.e., purpose, data collection methods such as audio taping and note taking), answered questions, and ascertained whether the participant wished to continue with the study. Informed and witnessed consent for participation and audio taping were obtained prior to the interview (see Appendix B). With participants permission, the interview was audio taped, and ranged from 60 to 90 minutes.

A second interview was arranged with all seven participants following transcription of the first interviews and initial thematic analysis. Four of the interviews were conducted in the researcher's home, and the remaining three interviews took place in participants' homes. During the follow-up interview, each participant was given personal time to read the interpretive summary prepared by

the researcher from the first interview and then asked to confirm its accuracy. Any misconceptions or omissions were clarified and, where necessary, revisions were made to the interpretive summaries. All of the participants confirmed that the summary accurately described their experience with bulimia nervosa.

Interview Approach

Data were collected using an unstructured interview format (see Appendix C). Each interview was interactive and focused on issues of importance to the participant. Participants were encouraged to begin where they felt most comfortable in describing their lived experience. Due to the researcher's familiarity with the area and professional contact with other clients diagnosed with bulimia nervosa, every effort was made to avoid using a non-leading and non-threatening approach with participants.

Participants were asked to describe to the best of their ability their experiences in living with bulimia nervosa. Open-ended questions were used to clarify statements or prompt information from the participant. During each interview the researcher took notes periodically which were later used to assist with the thematic analysis. Once participants had exhausted their description of the phenomena, interviews were brought to a closure.

Ethical Considerations

Approval to conduct the study was sought and granted from the Human Investigation Committee, Memorial University of Newfoundland (see Appendix D). Psychiatrists, persons known to all potential participants and not involved in the research study, acted as intermediaries.

Once initial contact was made through the intermediaries, each participant was contacted by the researcher, the study was fully explained, and an interview was scheduled. During the initial interview, the researcher outlined the purpose of the study, the possible risks and benefits to the participants, the voluntary nature of participation, and the time commitments. Questions or concerns were addressed and the participants were also informed that they could withdraw from the study at any time and refuse to answer any questions posed by the researcher. After the researcher was assured that each participant wanted to become involved in the study, informed written consent was obtained prior to the commencement of the interview in the presence of the researcher and a witness. Participants were given a copy of the consent which included the researcher's name and phone number.

It was anticipated that risk from participating in this study would be minimal. In order to avoid any potential negative effects, the researcher used a non-leading approach and made every effort to be sensitive to participants' discomfort while they discussed their experiences. All participants were

encouraged to call if any concerns or questions arose as a result of the information shared during the interviews.

Appropriate measures were taken to ensure that confidentiality of all data was maintained. The researcher transcribed audiotapes verbatim and assigned a numerical code to each transcript and audiotape. A master sheet with a list of participant names and corresponding code numbers was secured in a locked filing cabinet separate from transcripts and audiotapes and was accessible only to the researcher. All identifying information together with the audiotapes will be destroyed following study completion.

Participants were assured that the information provided would be held in strict confidence and reports of findings would include only grouped data or anonymous quotes. Members of the thesis committee were asked to review and discuss the initial three to four interviews to provide feedback on the researcher's interview technique and to assist with identifying underlying themes. Consent to share information with the researcher's committee was obtained from the participants. Each participant was informed that the final draft would be available to them following the completion of the study completion.

Data Analysis

The audiotaped interviews were coded and transcribed verbatim by the researcher immediately following each interview. The researcher's notes

addressing non-verbal communication were also reviewed and coded. The researcher read the transcripts and listened to the participants' personal accounts of living with bulimia nervosa. Analysis of the data through reading and re-reading focused on uncovering the essence of each lived experience and extracting themes. This approach enabled the researcher to reflect upon and to become more deeply involved with the data in order to grasp the deeper meaning of each participant's experience of living with bulimia nervosa.

The researcher made every effort to bracket all thoughts, feelings, preconceptions, and beliefs. Bracketing is viewed as the key component of phenomenological reduction because it helps the researcher separate his/her previous knowledge or personal beliefs from that being conveyed in participants' descriptions (Streubert & Carpenter, 1995). As van Manen (1990) noted, bracketing is required in order to accurately "study the essential structures of the world" (p. 175).

While re-reading the text, notes were made in the margins, emerging themes were addressed and questions that needed further clarification during the second interview were written down. The selective or highlighting approach as outlined by van Manen (1990) was used to reveal the thematic experiences. In using this process, the researcher listened to each tape, read the text several times, and underlined specific statements or phrases which captured key aspects of living with bulimia nervosa. During this process the researcher asked,

"What does this sentence or sentence cluster reveal about the phenomena or experience being described" (van Manen, 1990, p. 91).

Reflection on the meanings that came from the text, assisted the researcher in teasing out the multiple layers of information obtained from each participant, separating the minor themes from the more crucial ones. Layer by layer, more explicit themes began to arise. As each interview was completed, cross-comparing began so that the researcher was able to see the themes that were common for all participants, as well as the unique themes for individual participants. To ensure that there were no procedural errors, the researcher consulted with the thesis supervisor for feedback on the approach taken to develop the content of the interpretive summaries. Only after approval was given did the researcher arrange the second interviews.

Once the relevant themes were identified and interpretive summaries confirmed by participants, the researcher started the process of constructing a report on the findings. To facilitate this process, the researcher reflected upon her personal experiences in working with individuals with eating disorders, and reviewed the notes taken during data collection and analysis which provided meaningful insight into the lived experiences of participants. Through the process of writing and rewriting, the researcher, with guidance and input from the thesis supervisor and committee members, developed a clearer understanding of the emergent themes. Eventually, the themes began to assume an unique, but

interrelated form, with the written accounts culminating into a hermeneutical interpretation of the text. van Manen (1990) described this phase of the analysis as: "The inscribing, the writing of the text *is* the research; it is a relic of embodied reflections" (p. 129).

The final step in the analysis is what van Manen (1990) refers to as "balancing the research context". As the researcher assessed the overall text in terms of the significance of the themes for the whole, the essence of the lived experience began to emerge and assume a meaningful form.

Credibility of Findings

van Manen (1990) noted that phenomenology does not lend itself to empirical generalizations. Qualitative research should be evaluated by examination of credibility, fittingness, audit ability, and confirmability of findings. The researcher used bracketing (i.e., setting aside one's preconceived notions and beliefs concerning the phenomenon under study) throughout the study. A deliberate effort was made to suspend all perceived thoughts and ideas before the study commenced, during data collection, and while writing a report on the findings.

Credibility, the extent to which an individual can recognize the written experience as his or her own, was established when the researcher asked each participant to review an interpretive summary of her transcript and verify its

accuracy (i.e., validate the researcher's transformation of the interview text and be able to recognize it as their own experience). Each participant readily identified the information as reflecting the lived experience as told by her. This was evident when a participant remarked: "That's me, I can't believe my life was as difficult as it was until I can reflect back on it now that I am recovering".

Credibility and auditability (consistency) of the findings was enhanced further by having two nurse researchers with expertise in phenomenological research, independently analyze the transcripts for themes. Following thematic analysis at each stage of data collection, the researcher and thesis committee members aimed to achieve intersubjective agreement concerning the dominant themes. This discussion facilitated clarification of the meanings explicated from the text, and provided greater insight into the meaning of the lived experience of bulimia nervosa.

Fittingness of the findings (applicability, similar meaning to others in the same situation), was ensured when the researcher sought the assistance of participants who were able to articulate their lived experience. Each participant was able to provide rich data as is evident from the direct quotes used throughout the discussion of the findings.

Confirmability was achieved by ensuring that credibility, auditability and fittingness were demonstrated. The researcher, aware of her present knowledge on bulimia nervosa through literature readings and clinical

experience, practiced bracketing to assist in maintaining objectivity throughout the study.

CHAPTER 4

Findings

What is it like for an individual to live with bulimia nervosa? What is it about a person's emotional and psychological make-up that leads to self-destructive behaviors? Why do individuals continue to engage in binge/purge activities when they have such a negative impact on the emotional and physical aspects of the self? This chapter will explore these questions from the perspective of seven women who shared their experiences about living with bulimia nervosa.

This chapter is divided into three sections. The first section presents a brief introduction to the seven individuals who lived with bulimia nervosa for more than one year. The second section describes the themes that surfaced during the phenomenological analysis of the text. The third section explores the essence of the lived experience of bulimia nervosa.

Introduction to Participants

The seven individuals who participated in the research study were diagnosed by a psychiatrist as having bulimia nervosa. Three of the women were married or living common-law, one was divorced, and three were single, two of whom were living on their own. Most of the women were working full time, with one attending a post-secondary institution.

Participants were at different phases on the continuum to recovery, but all had been receiving individual and/or group counseling for a number of years. Although three of the women were still actively bingeing and purging, they reported a decrease in the frequency of these behaviors. The remaining four were in the recovery phase (i.e., not actively bingeing/purging for at least six months prior to the study).

Study participants identified a range of markers to describe the onset and progression of their eating disorders. Almost all of the women perceived themselves to be overweight and initiated dieting during their pre-adolescent or adolescent years. While battling real or imagined weight problems, these women grew tired of the dieting regime and eventually progressed to the more destructive behaviors typifying the binge/purge cycle. There was a wide variation in the duration of bingeing and purging activities, ranging from 3 ½ years to 16 ½ years.

In addition to having bulimia nervosa, most of the women were diagnosed with co-morbid psychiatric illnesses. Without exception all of the women had either a primary or secondary diagnosis of an affective illness (i.e., depression or bipolar illnesses). A few of the participants also had other concomitant diagnoses, such as obsessive-compulsive disorder or substance abuse. While three of the women required hospitalization at some point for their eating disorder and/or co-morbid illness, the others received treatment on an outpatient

basis. The majority of the women had suicidal ideations, with two actually attempting suicide.

Thematic Analysis

Through the candor of the seven women who gave their time and shared their private thoughts and feelings, this researcher began to appreciate "the true experience of living with bulimia nervosa". By reflecting upon the descriptive commentary provided by these women, themes were identified from similar and different aspects of their lived experiences. Although the themes are interrelated they will be presented separately to enhance clarity. The themes which emerged from the participants' text were: a) feelings of inadequacy, b) struggling for control, c) concealment, d) consumed by the illness and, e) the elusive road to recovery.

Feelings of Inadequacy

Webster's Dictionary (1999) defines inadequacy as "a lack of what is needed or the amount needed; deficiency" (p. 666). The Oxford Thesaurus (2000) uses such phrases as unmet needs, or feeling inept, deficient, or flawed as synonyms for inadequacy. Feelings of inadequacy encompass a broad range of negative emotions. The message to the self is that you have much less than "what is required" to become a worthy person. The stories of several study

participants contained words and phrases which conveyed the impression that they were "feeling inept", "different", "flawed", or "not good enough".

For most of the women, initial feelings of inadequacy began in early childhood and continued into the teen years. All participants talked about how early feelings of low self-esteem and self-worth dampened their ability to like and trust themselves. One woman described how she felt about herself at a younger age: "I didn't like myself". In later years it progressed to "I hated myself" and "I was dirty, hated myself". She experienced feelings of low self-worth: "I had no idea I was a worthwhile human being, no clue, no clue". Another woman talked about how her feelings of inadequacy persisted from childhood through adolescence: "I always felt inadequate, not good enough". Still another woman felt that "something was wrong" with her from the age of seven.

I always felt like there are people a lot better than me and why couldn't I be like them. There must be something wrong with me that I couldn't be like them. So that is the earliest memory I have of me comparing myself to other children, when I was 7.

Other comments used by participants to describe how they felt about themselves were: "I never liked myself"; "Wasn't used to that [*being accepted*]"; "It [*self-esteem*] was very low, really, really, really low"; "Growing up, I didn't feel good enough. I never felt like I could do anything right. No matter what I did, I was gonna upset somebody".

As the women shared their stories about bulimia nervosa, it was apparent that they viewed their bodies with dissatisfaction. One woman's comments

reflected an intense dislike for her body: "By the age of 14 years I hated who I was when I looked through the mirror. I actually hated what I saw, I was revolted, I was disgusted". Other participants echoed similar body image concerns: "I was always pudgy. . . . I was healthy but pudgy"; "I was always fat as a child"; "I was a really big girl all my life". The descriptive narratives of other participants conveyed a stronger message about how they viewed their bodies. One woman's comments hinted at the presence of a distorted body image: "I looked disproportionally huge. . . . I was always chubby".

From early in life these women did not trust their ability to do "anything right", and they also did not "like" who they were or how they looked. Feeling unable to trust themselves or rely on their own judgement, these women began looking to others for acceptance. One woman talked about how her life long feelings of inadequacy affected her interactions with others: "You feel like a failure if like you're not living up to someone else's expectations". Feelings of low self-esteem also prevented these women from accepting compliments from others. One woman commented thus: "When they told me I looked good, I figured I had to lose weight, I had weight on". Another woman talked about how she could not bring herself to accept positive comments from others: "Even though people were saying, you're a pretty girl, or you're talented, or you're smart, it was kind of like, 'Yes, whatever'. You hear it but I would never believe it". She elaborated further on how insecure feelings prevented her from not

being able to trust herself or others:

My insecurities, I always felt like I wasn't good enough. If I felt I wasn't good enough, there was no way that I was going to believe that I was. Just because other people said it, didn't mean that it was true. Like, I always felt differently. It didn't matter what other people said to me, I didn't believe it.

Still another woman described how she felt in the presence of strangers: "[I had] really, really low *[self-esteem]*. . . people who saw me on that bus, what did they think".

By reflecting on their lived experiences, all of the women talked about critical events in their early childhood that impacted and reshaped how they saw themselves. Without exception, each woman talked about the difficulties family members experienced in trying to express their feelings. One woman felt somehow deprived because her parents never said, "I love you". A second woman echoed a similar sentiment: "At the age of 36, it was the first time I heard my mother say, 'I love you'. And then only one time". A third woman felt slighted because her parents seemed to care more for her brother than her: "I knew they loved me, but I always felt like. . . I always felt like they loved him *[younger brother]* more". Another woman talked about how she felt scrutinized by her mother who constantly compared her to her friends' children: "I always felt judged". Still another woman described how she struggled with her parents inability to provide her with the encouragement that she needed to help her feel good about herself: "So like nobody ever thought to sit down and say you are a

brilliant child; you could be anything you want to be. I never heard that, although they are wonderful parents".

The absence of a nurturing home environment was identified by several participants as having a significant impact on how they felt about themselves. Whether it was an emotional distancing or a combination of physical and emotional separation from their parents, the outcome was the same – the difficulty in forming meaningful bonds with others deprived the self of a sense of safety and security. One woman talked about the limited availability of her parents because of their work commitments outside the home: "I suppose they worked a lot and didn't show it [*love*]". Another young woman talked about how the emotional and physical separation from her parents at an early age deprived her of their love and attention: "I had to go and live with my grandparents when I was 3, and I didn't know why". The most poignant story was heard from two women who described how the callous thief of their childhood innocence was lost at the hands of an abusive family member: "I didn't really know that it was wrong what he was doing, but just that I didn't feel very good. . . . [*Abuser*] really had a hold on me"; "He [*abuser*] controlled my life".

In summary, the perception that an individual has of one's self is crucial to healthy growth and development. Many of these women, for one reason or another, were left questioning their self-worth: "My self-esteem was almost non-existent"; "It [*self-esteem*] is terrible, terrible. I didn't like myself at all". Feelings

of worthlessness and inadequacies made them vulnerable and subject to the influence of others. All of the women identified early life experiences, especially problematic communication within families and a breach of trust from an authority figure, as the main culprits responsible for these feelings. Unable to deal with inner conflict in a healthy manner, these women began to rely on negative coping mechanisms in their struggle for self-control.

Struggling for Control

Webster's Dictionary (1999) defines control as regulating or "a means of holding steady or in check" (p. 291). When applied to a person, the concept of control suggests that individuals who are in control of their lives possess the power to "hold things together" in their "lived worlds". Control is not intrinsic, but is acquired (i.e., a learned response to events experienced at each stage of growth and development). Control implies that a person feels in charge of his/her life. Conversely, out-of-control suggests that a person feels unable to meaningfully assimilate or regulate the stimuli encountered in his/her world.

As the participants talked about living with bulimia nervosa, all either directly or indirectly spoke about early childhood events that left them feeling like they had limited or no control over their own lives. Whether voluntarily or by force, these women relinquished control of themselves to significant others, starting with family members.

Some of the study participants talked about growing up in a controlling environment. One woman commented on the early years thus: "My mother controlled my life". Another woman spoke about how her parents' expectations controlled her life: "We always had to have good grades in school. Mom and dad wouldn't accept anything below a 75. . . . So I learned really quick not to get below 75". For other participants, parental attempts at control continued into their adult lives. As one woman talked about the duration and intensity of her parents controlling tactics, her body language and voice tone indicated that she was both amazed and dismayed: "You have to come home early!" *[Pause]* "Im - ag - ine, I was out working and I had to come home early!". The presence of strong controls in the home environment led these women to believe that they had very little control over events in their world.

The inability to develop a strong sense of self-control left these women more open and vulnerable to influences from events and situations present in their social worlds. Without exception, all of the women talked about early exposure to weight control measures and how these measures, instituted by others, led them to embark on the life long journey of seeking control through bulimia nervosa. Quite often they were introduced to dieting and weight control by family members or friends. One woman described how her mother's obsession with weight influenced her dieting behaviors:

Mom was really concerned about her weight, especially after her pregnancy. . . . Mom would haul me into the bathroom and get on the

scales you know, like she wanted to know what I weighed and stuff. Don't eat that or else you'll gain weight. Mom was really concerned about her weight. She was always on a diet and she had a calorie counter out all the time. She would have her weight on the calendar every day.

Other women echoed similar sentiments: "Mom was always on a diet"; "Mom was always in weight watchers"; "Mom started dieting with me when I was 12, just to help me, so I wouldn't have to do it by myself". Another woman received her first instruction on dieting from a neighbour, "Who was always dieting".

For most of these women, the eating disorder started as a normal diet that eventually became something else that they found difficult to control. One participant commented on how something that was at first easy to manage became unmanageable: "It started out as a diet. Then it got out of control". Another participant talked about how her career path influenced the development of the eating disorder: "When I joined modelling school, weight became a big issue for me. . . . They would make comments like, 'Your thighs are a little big'. Then I would feel horrible. I would have to fix that right away, work out".

All of the women talked about how initially, their pursuit of weight loss, through dieting, helped bring some joy into their lives. The feeling of being connected to something in their world made them feel good about themselves. As their stories unfolded these women clearly articulated that dieting and exercise was feeding their need to be loved and accepted: "I started going out

with my friends"; "I started to lose weight and the compliments came". Several participants commented on the positive reinforcement received from dieting: "I felt wonderful"; "I felt really good when I lost the 12 pounds"; "When I lost my weight I felt good about myself"; "When I first lost my weight *[82 pounds in 8 months]*, I felt like a million dollars".

For the first time in their lives, some of the women felt they had found the key to happiness. As one woman so proudly stated: "I could finally do something right". The positive feedback from others became a powerful tool in communicating the message that self-worth could be measured by weight loss and physical appearances. By controlling their body size, they had found a way to please themselves and gain approval from others: "Everybody was amazed and astonished"; "The coach was all of a sudden a real womanizer". For the first time they perceived themselves as being judged positively by others. By engaging in weight reduction and succeeding, the possibility of gaining control over some aspect of their lives was the driving force that propelled them to pursue restrictive behaviors with a vengeance.

The message conveyed by most of the participants' stories was that the happiness derived from dieting was short-lived. Eventually, their inability to keep the weight down resulted in negative vibes from those around them. It was not what was said, but more importantly: "What was not said, the positive comments had stopped". A couple of women commented on how they became frustrated

with the challenge of trying to control their weight: "Oh, my god, I'm getting fat, I'm getting fat"; "I just could not keep it up". Feelings of satisfaction with the self were quickly replaced by anger at the self for being a failure and losing control yet again. A couple of participants described feeling inept because they could not sustain the self-discipline required to maintain a desired weight: "Gees, I can't even keep 12 pounds off"; "I was feeling really angry".

With the boost to the self-esteem from the positive reinforcement related to weight loss no longer present, many of these women began the search for control through more restrictive behaviors, such as laxative, diuretics, purging and exercising. Participants alluded to the progression from normal dieting to more atypical measures as the anxiety, perceived rejection from others and disappointment in themselves increased with weight gain. Many of the women described their weight control efforts in the following manner: "When you go back on a diet you do so with a vengeance!"; "I started off slowly with laxatives. I didn't do that [*throw up*] right away, but I did after a while and that was amazing because I hate to throw up"; "I started taking laxatives big time, taking them everyday, six a night I would take"; "I'd exercise and exercise, eat and throw up".

On a daily basis, these women were always searching to hold on to something that would give them a sense of control. The drive for thinness through the restrictive behaviors became their method of dealing with life's stressors: "I felt absolutely nothing in my life was in control, but I could control

where I threw up, when I threw up, how I did it. . . the only thing I could control was the bathroom". In times of increased stress and anxiety these restrictive behaviors would escalate: "I wouldn't be eating at work. . . when I'm working *constantly I never think about food. . . .When I'm home day and night, day and night, I think I eat more and just get rid of it*"; "My husband had no control over if I threw up, because he didn't know anything about it. So I had control over my weight always. . . forever and always".

During increased periods of stress, the women resorted to familiar coping strategies. They had learned that the bingeing would numb their emotions and provide an escape from the pain that was associated with high degrees of anxiety: "I was anxious before I ate a lot of food to numb emotions". After eating, they would feel guilty and want to get rid of the food, so they purged. After the purging, some described feelings of relaxation, while the others described increased feelings of guilt, which then reinforced their feelings of inadequacy.

The narratives indicated that many of these women moved from one controlling situation to another. It was only upon reflection that they came to truly appreciate how much control others had over them. For some, the tendency to relinquish self-control permeated their entire existence. One woman's commentary vividly captured how out-of-control feelings dominated her life: "I had no control in my life, everything was always, like it was planned out for me".

For others, the familiar patterns and feelings of not being in control were most evident in close relationships. One woman commented thus:

I was going with this guy. . . I went with him for two years. . . he was very controlling and possessive. . . . Then I became involved with another person who was possessive and when that relationship ended I met and married my husband who was very controlling.

The extent to which significant others were permitted to exert control was also captured in another woman's description of how her boyfriend manipulated her into passively complying with his wishes:

He would have issues if I wanted to go out with my friends. I wasn't allowed. Not that I wasn't allowed, he would never say that, but he would guilt me into not going out. . . . Okay, the easiest way to deal with this was not to go out with my friends.

She elaborated further on how his intense jealousy and possessive behaviors generated feelings of guilt and shame: "My clothing, he didn't like it if I wore anything the least bit clingy because the boys would be looking at my chest. Then it was my fault that they had wandering eyes". A poignant statement made by another woman captured her inner turmoil while striving for more control in her life: "Why are you going here and why are you going there, and he [*husband*] was gone all the time. . . . If he didn't agree with what I had to do, it was like, 'You're stupid, you're stunned [*Pause*]'. As these women became bombarded with negative messages from significant others, they began to believe what they were told: "And I believed him".

In summary, all of the study participants felt they had limited control over

events in their world from an early age. Whether real or imagined, out-of-control feeling states left these women in emotional turmoil, continuously searching for ways to enhance their sense of feeling in control of their lives. Their stories reflect a lifetime of moving from one controlling situation to another. Although different circumstances led them to embark on a path to bulimia nervosa, the end result was the same - progression to being controlled by the illness.

Concealment

Webster's Dictionary (1999) defines conceal as "to cover and hide, to keep secret, avoid disclosing or divulging" (p. 275). From listening to all seven women, concealment was a part of their everyday existence. The need to "cover up" and "hide" the true self from others was a very real and pervasive part of their lives: "I used to take food, like eat food to cover up my pain". From a very early stage in their lives, these women talked about how they learned to hide their true self from others.

For several woman, early fears of abandonment led them to silence themselves in the home and to hide or suppress their emotions and feelings: "Like I always covered up my feelings. . . many times behind closed doors I really cried". These women had learned that what they had to say was not perceived to be important by others: "You couldn't voice your opinions". Another participant who had been abused found it difficult to trust herself and others.

Hiding the secret of the abuse was essential to her own survival: "I kept quiet, I did what I had to do". Still another participant who experienced a temporary separation from her family home at an early age, talked about how this influenced her sense of safety and security: "In order to stay with mom and dad, because I wanted to stay with mom and dad, I had to prove myself all the time". She also spoke of how she had learned through her parents to hide her feelings and emotions:

Myself and my brother modelled ourselves *[after our parents]*, you just kind of kept things to yourself, you didn't want to rock the boat. . . . There was never any kind of communication among the four of us. We always held our opinions inside. . . it seemed like a normal family life, but we just didn't talk. . . you were not allowed to talk.

Many of these women had learned socially acceptable ways to hide themselves: "I always put a smile on my face, just to keep. . . not to let my family know what was really wrong"; and "I always played the game. I did what I had to do, it was all an act". Other women talked about how the "cover up" efforts affected them:

I don't know what I could do to myself, like I was so knotted up inside but yet I was always this calm and collected, always in control. I felt like I'd lose it, and I felt like I'm not allowed to lose it, because I didn't know what I was capable of and I was afraid I was going to hurt somebody else besides myself.

Still another woman described how her outside persona hid her inner securities and intense longing for acceptance from others:

I always wanted to please others and I still do to this day. . . . I was always in a group. I always tended to be the group leader, class clown. . . I think

to compensate for everything else, I just acted funny. . . . at the expense of whatever, I just acted funny. . . . maybe for love who knows. . . . It was a need for me to be accepted and to belong.

For these women, the process of hiding their true self from others became increasingly more challenging. Unable to cope with life stressors the restrictive behaviors became a mechanism, which allowed them to hide themselves and avoid life's demands: "I wonder what did they all think of me [*gorging on the chocolate bars*]?". Hiding unacceptable restrictive behaviors was critical to maintaining acceptance from others: "My mother would be horrified"; "I was afraid to tell"; "I think if they found out [*pause*]".

Study participants also talked about how comments about their weight led them to conceal their eating habits from others. This hiding or concealing of behaviors from others is captured in the following illustrative quotations:

So then I started hiding my food. I started hiding, I would never eat when he was around.

I was hiding my food in my room or hiding the empty bags of the food. If I had eaten a bag of chips or something at night while I was watching TV, I didn't want people to know I had eaten that bag of chips, so I would hide the garbage in my room.

As their stories unfolded, some talked about how they had learned to equate the consumption of food and eating with failure. Eating and food became a sign of weakness, a trait that they all struggled to hide. One women commented thus:

I didn't want them to think I was this b-l-g p-l-g eating! So I would always hide food or garbage of food in my room and I'd think of it with ever bite, every little ounce of food. But I would always hide, wouldn't eat a lot in front of mom. I thought they might know or something.

Others talked about the need to eat alone so that they could 'hide' their binge/purge activities: "When I would go to a restaurant by myself, I would eat, throw up and eat again. If someone came in the washroom I would stop and wait and then start again". Another participant was able to manage her bulimic behaviors because she had her own office at work: "I worked in an office by myself so I could do this really well. No one knew how much I ate, and I would go to different places to buy my food".

For others the ordeal of hiding their restrictive behaviors became a preoccupation: "I'd run the bathtub. That was the only thing loud enough that would drown out when I was urging"; "If I was in the bathroom, I'd turn on the tap or turn the shower so that they wouldn't hear me do it [*purging*]"; "I would run the bathtub or I would take a radio in"; "I frequently flushed the toilet"; "I'd go out in the laundry room with a bag and do it that way. Throw it in a couple of bags so it would not smell". Those individuals who were bulimic during their high-school years would purge in the school bathrooms and were able to hide it because of the loud flush of the toilets. One woman commented thus: "I would wait until I heard no more feet, that people were gone and I would stay in the stall, there was no getting me out of there". At times the purging became very uncontrollable and often resulted in emesis on the floor: "So I began the clean up before the family got home. . . I swear I did Shopper's Drug Mart good with air fresheners".

Over time, the progressive nature of the restrictive behaviors made the concealment more of a challenge: "My head was always racing to see what I could do to hide this [*throwing up*]. All participants commented on spending laborious hours concealing their true behaviors from others: "I remember 2 months before my graduation talking to my therapist saying, "How am I going to get rid of this food? There are going to be tons of people around; tons of people in the bathroom". Several of the women found that their eyes would water during the purging activities and confined themselves to the washroom for extended periods: "I'd make sure my eyes were not watery, I'd stay in the bathroom for a few minutes because of my eyes".

As the self became secondary to the illness, participants hid their true persona from others for fear of rejection or having to justify their actions to others: "I never talked about it [*bulimia nervosa*], it was not something I felt comfortable talking about. I guess I was ashamed of it". Because the risk of others finding out about their restrictive behaviors was too great, these women put a lot of time and energy into creating a facade. One woman, who was able to hide her illness from her best friend and husband, became consumed with her illness:

Not one of them knew I was bulimic . . . I was so secretive, and I got so good at being secretive about it that nobody knew. . . .They never knew. They never went through any of that [*the bulimia*] with me because you keep that secret. That is your innermost secret.

For these women the need to engage in behaviors that assisted in physically

hiding the self from others became a part of their everyday life:

When I was out to a restaurant, me and mom went out to eat, and I was so big, I would always have to have my hand over my face, on the side of my face so you couldn't see me eating. I was big, I didn't want anyone to know what I was putting in my mouth.

As the illness progressed, the physical manifestation of the disease made it more challenging for these women to "hide" or "conceal" their behaviors from others. Even when hospitalized one participant continued to use purging activities to assist with weight control:

I'd go home on passes and I snuck them [*laxatives*] in and I was taking them, and they didn't know. . . . I got to the point where I was hiding stuff when I got weighed, so I had to get weighed in a johnny coat. . . . You get trade secrets and everything [*from fellow patients*].

For some of the participants, concealment of their restrictive behaviors became less and less of an issue as the obsession with the need to rid the body of food contents escalated. One woman commented on how the desire to purge became so intense that purging in public washrooms became more acceptable as long as she was with someone she knew well:

It depended on who I was with. If I was with one of my girlfriends, I wouldn't, If I was with my boyfriend or someone like that I would because they would expect it from me. My girlfriends were not around me so much when I would throw up.

Eventually all participants developed physical symptoms as a result of the long-term effects of the restrictive behaviors. Often their bodies became so weakened that they physically collapsed, but this did not deter them from continuing with these behaviors. One woman recounted several episodes of

fainting as she tried to continue on with her facade:

Several times I passed out at work from the bulimia. I think if they [co-workers] found out, well they would probably want to know why and I was afraid to tell what was going on with my life. . . . I was always carrying on, they didn't think there was anything wrong. . . . I was always smiling. . . the smile was to hide and to kill the pain, not to let them know what was really going on, I did my crying behind closed doors.

This particular participant felt pressured to continue the abusive relationship, while hiding her emotional pain, because the risk of losing her family was so great. All of the participants had a strong need to conceal restrictive behaviors so that others would not think negatively of them. One woman explained the teeth scratches on her knuckles as eczema: "I just said I had eczema, I'd try to hide my hands, and I had to work the cream in".

What drives these women to continue with these destructive behaviors, especially when the body is sending signals indicating it is wearing down. After purging for several months, five times a day, one study participant collapsed: "I remember I fainted, I had school the next day, mom and dad took me to the hospital". Another study participant spoke of purging for several years, and on the day she presented to the hospital she had purged eight times: "I was up to the point of throwing up eight times a day and my body went into shock". When told by the hospital staff that she had a psychological problem and needed to see a psychiatrist, she experienced disbelief and shock. Similar sentiments were conveyed by the comments of other participants: "I rapidly cut back food, ran harder. . . . I was running until I collapsed", "I have so many cavities, the dentist

said it is from the purging", "I threw up blood once", "I have problems with my stomach and I will have to take medication for that forever".

In summary, by concealing aberrant behaviors, all of the participants were struggling to maintain some semblance of self-control. Denial of the disparity between the actual and projected selves provided these women with a temporary coping mechanism. The false sense of security about the self, that accompanied the restrictive behaviors, allowed them to feel in control of their lives. While concealment of restrictive and purging behaviors fed the illness, it also weakened the self. As concealment of aberrant behaviors became a number one priority, the balance was eventually tipped in favour of the illness and the "true self" became hidden or obliterated: "There's two percent of me left". It was not until physical symptoms became so pronounced that it became impossible to hide and eventually they confided in someone that they were suffering from bulimia nervosa.

Consumed by the Illness

Webster's Dictionary defines consumed as "to spend, exhaust, to absorb or overwhelm" (p. 287). All of the participants, talked about the intensity of the bulimia nervosa escalating to a point where they became engrossed with and overwhelmed by the restrictive behaviors. Initially, the women talked about feeling in control of the eating disorder, which then progressed to the point where

the illness invaded their everyday thinking, and consumed their being.

At the juncture where these women were unable to maintain their chaotic self-inflicted schedules of dieting and restrictive behaviors, weight gain became a visible sign of failure. The overpowering need to have their lived world 'in check' or 'steady' led them down a destructive path. In many instances these women were forcing their bodies to endure or reach beyond their physical capabilities. A couple of women commented on the intensity of their restrictive behaviours: "I was swimming harder and faster, and harder and faster kept going through my head. . . .You gotta do it faster, you gotta do it harder, you gotta keep going"; "I had to get it all out . . . I had to do it". As the power of the restrictive behaviors weakened, these women became even more vulnerable and less able to maintain a semblance of normalcy.

The intensity of the restrictive behaviors became more and more demanding, driving these women to fight harder and harder to gain control: "I rapidly cut back, ran harder, did extra laps. I was swimming 3 times a day, I was running, I was running until I collapsed, I wouldn't stop running until my knees gave out. I was just running around and around and around until literally I couldn't stand up". Another participant followed exercise videos: "I put in my video and work out for at least an hour or two straight. I would be thinking as I'm working out, 'Okay, how many calories is that gone'".

The drive to maintain control through the restrictive behaviors escalated to the point where all waking hours were consumed with thoughts of food: "I think of it *[throwing up]* every bit, every little ounce of food". For others it was their first thoughts as they entered every new day: "I was so pre-occupied with food. . . .I *would get up in the morning my first thought was food, not to see if it was sunny*"; "That's all I concentrated on, you don't know what's wrong to a degree, because it becomes part of your everyday lifestyle". For all these women, even spending time with their families and/or socializing with friends became increasingly stressful. Social and family commitments invaded the time that the restrictive behaviors demanded: "I can remember being out in places and worrying about what I was going to eat and that being an issue". One woman described her family gatherings:

When we go to dinner, I'm not comfortable after dinner because I have to think, "When is a good time for me to go to the bathroom?" That's when conversation goes on, its after dinner and I'm absorbed in, "When is a good time for me to go to the bathroom".

All the participants spoke about reaching a point where all their thoughts, perceptions and activities were dictated by their restrictive behaviors. Several participants described how their preoccupation with restrictive behaviors progressed to the point of becoming an obsession. The following quotes convey this sentiment:

I was consumed, everything was, "Think thin, you got to be thin, you got to lose weight."

All I talked about was my weight. . . I don't think I've gone a day yet in 13 years without talking about my weight.

You think you are ugly and you think you're fat and you think you're insane.

On a fat day I would probably check in the mirror about 10 times. I'm always worried about the way I look. When I try on my jeans and they don't fit, I would just as soon go to bed and stay there. I don't want to go through this day. . . . *My whole life revolves around my weight and its never ever changed.*

I was so absorbed in my weight and self-image.

Participants' obsession with restrictive behaviors imposed extreme demands on their time. The time-consuming nature of the illness is conveyed in the following comments:

Very time consuming. . . this [*bulimia nervosa*] consumed my life for too long. . . it consumed my life so much. . my head was always racing to see what I could do to hide this.

I was consumed. . . . I just did what I had to do in order to be able to throw up.

It would always be in my head if I ate. It would always be in the back of my head to throw it up and I'd just do it and come back out as if everything was normal.

One participant spoke about how bulimia nervosa consumed her life from an early age: "It consumed my life from the time I started throwing up". Another participant was feeling so consumed that she could not detect a difference in her eating behaviors during good or bad days. All emotions and feelings were a reason for celebration/over-eating:

Now I think celebration and I think food. I overindulge. During a bad day [pause] go into work in the morning, order breakfast, bacon and hash browns, get rid of it. At coffee time, I would have 2 muffins and I would get rid of that. Lunchtime I would probably have fries, dressing and gravy, get rid of that. . . in the evening maybe a salad and a sandwich and that I would keep because it was good. A snack at night and I would get rid of that.

As participants became immersed in their restrictive behaviors, there was no time for the self. As one participant indicated she lost who she was as an individual: "I had no time for me"; "All I have left is my bulimia". Another participant remarked on how circumstances in her life prevented her from being the person that she was prior to becoming bulimic. She spoke about her efforts to raise her own daughter differently: "I encourage her [daughter] to be the kind of person I was before Mom had the accident. I guess the type of person that I am now, but let her be her own person". Another participant commented on how daily living had improved considerably for her:

I am obsessed with bulimia at times. . . there was a time when at work, people would be talking to me and all I would be thinking about is, "When am I going to get my next food. When am I going to get my next food". Now I can carry one full time job and manage my bulimia at the same time without being all absorbed.

One participant described the intensity of feeling absorbed and overwhelmed by bulimia nervosa: "There's that chunk of time, where I was my eating disorder, my eating disorder was 98 % of me and there's 2% of me left".

For these young women, the emotional pain took a toll on their psychological well being. With only one exception, all participants reached a point in their lives where they felt suicidal and would rather not exist. One

woman commented thus: "It was an existence, not a life". Another woman remarked on how she felt so distraught that she wanted to end her life:

I was a very negative, unhappy, stressed out, anxious person who really wished I didn't have to be alive. I wouldn't kill myself because that would have hurt my family. I did do that thing when I was driving down the highway, tried to put my car over. I did that a couple of times, more than a couple, but I kinda thought if it looked like an accident and if I really didn't make that turn, it really would be an accident and then I would be absolved. But I certainly didn't want to be here. I was very angry. Angry, very angry, frustrated, screaming at God, "There are so many people who want to live and you're killing them. I want to die and I can't, what's wrong with you". I'd be screaming this in the car.

Another study participant described how she reached the point where she contemplated ending her life at the wheel of her car:

I was really depressed, I would be driving down the road and just want to smack into a pole. I don't know what kept me back. I think I love my family too much to do that to them. . . .Enough was enough, I've been through enough of this crap. I've thrown up too much, I'm just sick of everything kind of feeling. . . I could never, never do it, but I can't count the number of times driving that I would want to do that.

One study participant went from one addiction to another searching for a way that would end her life, but she felt she could not take her own life:

There were times I didn't want to live. . . I used to always think about it, how I would do it. Driving my car over the cliff, cutting my wrist, but I just wouldn't do it. I used to fight it.

Even during counseling the suicidal thoughts were still present: "I was looking for a way out. I really wanted to end my life". For another participant the suicidal ideations continue to this day, and sometimes she feels that there is nothing that can cure her of this disorder:

I got really depressed, I used to cry, I just wanted to commit suicide. It was just all these feelings I had of weight, it was like 'Oh god, I'm getting fat, I'm getting fat. Like I could not deal with the thought of getting fat again.

One participant became suicidal prior to her first admission to hospital. A victim of sexual abuse, she became suicidal and made explicit plans about what to do and when to do it:

I wanted to shrink away. I didn't want anything to be left of me. I wanted to become invisible. . . . when I was admitted to the hospital I was a high suicide risk. . . . My plan was to, when I got home, because dad and step-mom always got home later and I had letters written to everybody, and I had a bottle of, I had 6 bottles of tylenol extra strength and that was gonna do. Just crawl into bed and go to sleep and let that be it, because I was tired of living, I just didn't want to a part of this thing called life anymore.

While most of the women talked about having suicidal ideations, only one participant made an attempt to take her own life: "I have tried suicide before, three years ago. . . I overdosed on my pills". Once admitted to hospital she began to receive the therapy necessary to help her with her recovery. It was also during this hospitalization that she broke her secret about being bulimic.

In summary, these women talked about how the progressive nature of the restrictive behaviors was associated with their struggle to gain and maintain control in their lives. Their relentless pursuit of finding happiness through restrictive behaviors became a way of dealing with the world. Eventually, they became consumed by the disorder, with all of their daily thoughts and behaviors revolving around planning and executing restrictive behaviors. Control through

the restrictive behaviors became a paradox as the false sense of security and happiness, gained from using restrictive behaviors in the earlier stages of the illness, eventually took control of their lives and consumed their being.

The Elusive Road to Recovery

According to Webster's Dictionary recovery means "the regaining of something lost or taken away; restoration or return to any former and better condition, especially to health from sickness, injury, and addiction" (p. 1104). All study participants spoke of their struggle to regain some sense of normalcy in their lives. Recovery became, for all of the women, a struggle.

Bulimia nervosa consumed so much of their time, there was none left for the self. These women had lost who they were as human beings, and no longer felt connected to another person. Several participants reached a point where they no longer concealed their purging behaviors from others. The need to feel the inner peace that bingeing/purging permitted, if even for just a "few" seconds, was stronger than the need to conceal: "I didn't care who saw me". Unknown to them, others were on to their secret: "We knew you had an eating disorder, so it was no secret to anybody". Fortunately many of these women reached the point of "breaking the concealment" and surrendered themselves to professionals in the hope of being rescued from the bingeing and purging cycle.

In order to accept help each person had to be ready to make changes in her life. Readiness according to Webster's Dictionary means: "the condition of being ready; willingness, inclination" (p. 1098). Initially this was possible, but as *stressors increased, these women quickly relapsed into previous restrictive behaviors*. Despite seeking help, they continued to struggle with regaining control of their lives and for long periods of time continued the binge/purge cycle. Being faced with the possibility of more stringent controls, these women resorted to concealing aberrant behaviors: "I told them lies. I couldn't keep going on"; "I actually lied to my doctors. I never told anybody, I didn't even tell my friends that I was taking laxatives big time".

For many of these women disclosing that they had bulimia nervosa came as a result of years of suffering from the disorder and reaching a point where they no longer had the energy to conceal their actions. Several participants began to purge in public washrooms when the need to purge became stronger than the need to maintain secrecy. One woman's comment conveys this sentiment: "I got to the point with eating and throwing up, that I didn't care who I told after". For another participant, her young child began to make innocent comments to her husband: "Mommy's sick, mommy's sick. . . I was standing up and I was fine". Around the same time her family doctor began noticing weight variations: "Your weight is too erratic. You are going up, you are coming down, you are coming in and you're pudgy, you're coming back and you're skinny. . . .

So there was a whole lot of people getting in on my secret then". Another woman recalled having a doctor's appointment and how out-of-control she became because of how she felt in her clothes:

I had a short set on, and I just felt F-A-T! in it. I took my shorts and just Rip- -ped, ripped it off my back! At that point I said, "Oh my God, this is not normal, there's something wrong, I've been back and forth to the doctor ever since.

At this point she talked about how it was slowly dawning on her that she was losing the battle for control of her life. Her body weight controlled how she felt about herself. Another participant also was aware that she should seek the assistance of a health care professional but was afraid of relinquishing what control she had left in her life:

I did not want help from a doctor. I wouldn't have wanted a doctor to say to me, "You have to stop this". Because I knew perfectly well he would say you have to stop this so I wasn't going to tell.

For others the realization that they needed and were willing to accept help was a milestone on their road to recovery. For several of the women, accepting help changed their lives. Over time and through consultation with a psychiatrist one woman was able to confront her family regarding bulimia nervosa:

I was able to, over a period of time, make myself a number one priority without feeling greedy or guilt . . . I was able to go to my family and say: "Look, I suffer from bulimia, I'm not throwing up anymore, but I suffer from it".

Another participant also acknowledged how her psychiatrist was able to help her come to terms with her bulimia nervosa: "My psychiatrist, who was absolutely

wonderful, who made me feel like there was something worthwhile going on and I was intelligent and a good person". Yet, all health care providers did not receive equal ratings as one woman described nurses as, "being guards. . . . The nurse just stood there watching us".

In addition to seeking counseling, one woman found solace in her spirituality. She commented on how her strong faith helped her cope with bulimia nervosa: "It was terrifying [*disclosing bulimia*] but it was almost like a relief. Here God this is what's wrong with me, please fix me. I am just so sick and I am sick of being sick". This insight came only after a suicide attempt:

I overdosed on my pills, was hospitalized and that's when I came clean with everything. I kind of felt good actually. It was like therapeutic, not while I was doing it but afterwards I felt good. Its like somebody knows my secret.

Today she acknowledges that: "I'm not out of the closet with it yet. I'm not that comfortable. My husband knows about it, my immediate family and his immediate family know about it". For another woman, the breaking of her secret came as a result of an encounter with the law:

I'd put a bottle of vodka in my closet and drank it straight and this is how it all came out. I had a doctor's appointment and I think I took too many pills and had too much to drink that morning and I drove my car to the doctor's office and I hit her.

Many of the participants were not sure how their loved ones would respond to disclosing their eating disorder to them. One woman who was sexually abused initially felt that her family would not believe her and had made

arrangements to live elsewhere: "I told them all what I was doing and mom filled up". Another participant she disclosed to her boyfriend early in her illness: "When I first got sick, I told him, he got really angry with the throwing up and stuff. What are you doing to yourself, and you're going to kill yourself and then what about me?"

As the breaking of the cycle unfolds, individuals are left with a void in their lives. Their past coping strategies and ways of dealing with the world and its issues are changing, they are left feeling vulnerable to everyone and everything around them. Several of the women have yet to reach this stage in the life cycle of the disorder. For others it was and continues to be, at times, an inner struggle. Several participants used self-talk as a positive coping strategy to help them through minute by minute.

Recovery has been a long time coming for one participant. However, after going through counseling, she is now able to say, "The way I look at it, I don't care anymore. If I gain weight fine and dandy, if I lose it fine and dandy". She is beginning to feel more comfortable about who she is as a person and is trying to move on with her life. Reflecting back on her life she is now able to realize that self-esteem was a major issue for her. Only after seeking counseling did her self-esteem gradually improve. Another woman continues to struggle with her body image. She has made some positive improvements in how she feels about herself, as she developed greater insight into her problem:

Self-esteem improvements is what you need. That is where all of my weight and image problems started. Like I said I was 124 pounds. I really thought I was ugly because I was 5 to 10 pounds heavier than the chart said I should be.

Seeing a psychiatrist and being diagnosed with obsessive-compulsive disorder has had a positive influence on turning her life around. When she entered university, she began to feel more hopeful about the future. "I get excellent positive feedback from professors and you know people. . . they say a lot of really nice positive things to me about my work, about myself, and that keeps me going".

For another woman, the help received from counseling sessions motivated her to try and regain control of her life. She commented on the progress made: "I'm not eating as much as I used to be doing, I used to eat a lot". Since entering counseling, she realized that recovery is a slow process: "Its hard, there are temptations. They are still there. . .but then when I get upset or anything, there's temptations there to go to the bathroom but I make myself busy or go out, get in the car and go".

Another study participant reached a point in her illness where she sought medical attention to help her recover. Today she is able to reflect on her past and identify how far she has come in her recovery: "So between my psychiatrist and my family. . . I guess like my self-esteem started to pick up. . . I felt okay being who I was and I was at my desired weight". With time, she was able to communicate to her husband, "You're going to have to accept me for me".

Although in remission for a number of years, she continues to struggle with self-esteem issues:

People say to me, "You know what you want, you have a lot of self-control" . . . But sometimes its like too much pressure, because you feel *like a failure if you're not living up to everyone else's expectation*. . . .am I expecting too much of myself trying to please everyone else. . . .then you kind of haul yourself back into perspective.

Still another participant commented on how she felt better about herself after turning her life around.

I'm a lot happier with myself. I don't feel that I have to prove anything to, especially to my family, because I think I've already done that. I made the Dean's list, I did get my job, I have my own car and my apartment and I feel like I have done it now. So I feel I don't have to prove to them anymore . . . I finally realized that is the best that I can do, so I'm a lot happier.

However, there are also times in her life when she doubts herself:

I don't think it [*self-esteem*] will ever be normal. I come down on myself really hard if anything at all goes wrong. Automatically I blame myself right away, that it was my fault or I should have foreseen something, that kind of thing, but it is better. I don't always, I can go out of the house now without make-up on. I don't have to look perfect all the time. I try the best I can, if its not good enough well, I come down on myself.

Several women commented on the positive effects of counseling. After several years of therapy, one participant is able to feel more positive about herself and in so doing, is moving on with her life: "I'm starting to feel good about myself, self-esteem is still low. . .but better". Other women also commented on the benefits of having both counseling and family support. One woman talked about how her feelings about herself improved: "So between my psychiatrist, and

my family, my self-esteem started to pick up and I felt okay being who I was". Another woman stated: "When I started to see a psychiatrist my self-esteem started to improve". For another woman, the separation from her mother caused unforgettable memories. Only after years of reflection is she able to focus on the whole picture, accept the situation and put it in perspective. Resolution for this participant began during a period in her life when she was feeling more confident about who she was as an individual:

I was feeling a little more confident. At this point [third year university], I knew why I was kind of alone when I was 3 years old. So that made me feel a bit better. I knew there was a reason why I was with my grandparents and my brother was with my parents. . . . I didn't know the things that had been kind of happening behind the scenes.

In summary, all of these women reached the point in their lives where they could no longer battle or fight the disorder alone. Realization of the devastating effects of their restrictive behaviors was spurred by a critical incident in their lives. Out of control behaviors lead these women to embrace the support of health care workers. All of them talked about their readiness to change as being critical to the recovery process. Their road to recovery began at the juncture of breaking the concealment. However, these women continued to struggle with the disorder long after their secret was revealed. For all these women, periods of increased stress created oscillations in their aberrant restrictive behaviors and tarnished their road to recovery.

Essence of the Lived Experience of Bulimia Nervosa

Through formal, unstructured interviews, the participants reflected upon and described their lived experiences with bulimia nervosa. The themes that emerged from the reports of study participants were: feelings of inadequacy, struggling for control, concealment, consumed by the illness, and the elusive road to recovery. Phenomenological themes may be understood as "the structures of experience. . . the experiential structure that make up the experience" (van Manen, 1990, p. 79). What made participants' experiences with bulimia nervosa what they were, rather than being something else, was the constant search for acceptance and a meaningful living.

For all of the study participants, the onset of the illness was marked by early feelings of inadequacy. With memories of childhood scarred by unhealthy interactions and communication patterns within the family, participants described how they felt vulnerable and sensitive to the needs of others. Lacking a sense of inner control and peace, all looked outside themselves to find a way to gain acceptance and control. Ultimately, the self and self-worth were constantly being judged in terms of one's ability to measure up to others' expectations and beliefs - an unattainable goal. Feelings of inadequacy (i.e., not liking or trusting themselves or the way they looked) were enhanced as they struggled to meet self-imposed, unrealistic expectations. The end result was a further plummeting in the sense of self (i.e., self-esteem, self-concept, and body

image).

Peer pressure also influences how one views the self. Some of the women were left feeling vulnerable, unloved, less valued as a person and not accepted as individuals. Such comments as "I always tended to be the group leader, class clown. . .It was a need to be accepted and belong". Another woman stated, "I always felt like I wasn't good enough". These were poignant reminders to themselves that they were not as worthy as others.

The struggle for internal and external control became a daily battle in all of these women's lives. Controlled by others and out-of-control behavior were strongly associated with participants' eating disorders. Both types of control also influenced how they felt as individuals and related with others. Control of their illness allowed them to maintain a balance, albeit unhealthy, in their lives. In reality the illness was controlling them and caused a disruption in "normal" lifestyles. This out-of-control behavior can be equated to one who appears to lack the abilities to respond to stress in a healthy manner. When controlled by others they often became enraged internally and tried to rebel, often resulting in an increase in the binge/purge cycle .

Not feeling a strong sense of internal control, they quickly learned how to gain a sense of control by responding to societal pressures to be thin. One of the most basic fundamental needs of man, food, was something within their reach and something that they could and would use as a means of self-control.

Positive comments from others about their weight loss and dieting became a critical factor in determining their sense of self and self worth.

The concept of control is paradoxical. The person with bulimia nervosa, who attempts to gain control through restrictive behaviors (i.e., dieting, exercise, and laxatives), is also using them to deal with the stressors of daily living. Restrictive behaviors became a way of coping with life because participants lacked the emotional developmental skills and self-esteem to deal with stress. The daily stressors that accompanied adolescence and young adulthood appeared insurmountable - "It [*restrictive behavior*] was always worse when I had a bad day at work". As restrictive behaviors began to dominate the lived world, *feelings of inadequacy increased and relief from the pain of confronting the self* was no longer attainable. Paradoxically, bulimia nervosa was gaining control as these women desperately sought to have control over their lives.

The progressive nature of the illness led these women to the point where their total existence revolved around planning and executing restrictive behaviors. While these women were initially subject to control by others' expectations, they later became controlled by a force chosen to help the self gain acceptance and approval from others. All of the women eventually became overwhelmed with the stress of adhering to self-imposed demands. When the intensity of restrictive behaviors became all encompassing, the true self was almost completely lost to the illness: "There was 2% of me left". Personal

identities could only be defined in terms of the eating disorder - the true self, who they wanted to conceal from others, now became an elusive entity.

As participants became consumed with the illness, they struggled to conceal their aberrant behaviors from others. Revealing insecurities and vulnerabilities would be a sign of weakness that would leave them more open to rejection and criticism. Fears of rejection, guilt, shame, as well as the need to be loved and cared for, were high stakes in the "concealment" game. Intuitively, these women knew that restrictive behaviors were not helping them but were, in fact, destructive. But feelings of insecurity and ineptness prevented them from working to regain self-control. The juncture at which cracks appeared in their ability to appear normal surfaced with the emergence of medical problems and the external physical signs of the illness.

The elusive road to recovery unfolded as these women talked about how their entire existence revolved around weight reduction measures. They believed that the "self" could only be strengthened by obtaining an ideal body weight. This is an unattainable goal, as the bulimic's altered body image precludes one's ability to see an accurate reflection of the self. When the body is seen as reflecting the strength of the mind and soul, the projected image is often grossly distorted. The self is perceived as weak and the person is constantly searching for some means to stabilize the emotional turmoil associated with these feelings of ineptness. The relentless pursuit of thinness

through the binge/purge cycle gives control to the weakened bulimic.

Individuals with bulimia nervosa are bursting with insecurities, uncertainties and fears, as they try to deal with daily stressors. Perceived weaknesses negate their ability to control life events and they feel powerless to shape or regulate their future; a future that appears bleak when personal growth is impeded. The essence of the lived experience of Bulimia Nervosa: Bulimia nervosa is a searching for acceptance and a meaningful existence.

CHAPTER 5

Discussion

This chapter discusses this study's findings in relation to relevant literature dealing with bulimia nervosa. The first section deals with the five identified themes and the essence of the lived experience of bulimia nervosa. The second section offers new insights into what it is like for an individual to live with bulimia nervosa on daily basis.

Living with Bulimia Nervosa

Study participants described the difficult challenges that they had to endure in their search for peace, tranquillity, meaning, and acceptance. While the themes that emerged from the phenomenological analysis reinforce some of the clinical and research findings in the literature, they also provide new insights into living with bulimia nervosa. The discussion that follows focuses on each of the themes and the essence separately.

Feelings of Inadequacy

This theme describes how participants developed feelings of inadequacy at an earlier age due to a number of personal, familial and environmental factors. The core concepts used by the women to describe how they felt about themselves were low-self esteem and self-worth, and strong dislike for their

bodies. Several authors have documented the risks posed by low self-esteem and/or self-worth (e.g., Button et al., 1996; Fairburn et al., 1997; Fairburn et al., 1999; Griffiths et al., 1999; Hill & Pallin, 1998; Kendler et al., 1991; Neumark-Sztainer et al., 1995) and strong dislike for one's body or body dissatisfaction (e.g., Button et al., 1996; French, Story, et al., 1995; Hill & Pallin, 1998; Killen et al., 1994; Neumark-Sztainer et al., 1995; Schur et al., 2000; Wiederman & Pryor, 2000).

Participants dislike for the self emerged from perceptions of not feeling valued, loved, or accepted by significant others. The void or emptiness within left these women unable to trust themselves or others. These study results are supported in the literature as low self-esteem and poor self-worth (Calam & Waller, 1998; Fairburn et al., 1997; Griffiths et al., 1999; Hill & Pallin, 1998; Neumark-Sztainer et al., 1995; Pryor & Wiederman, 1998; Williams et al., 1993) and/or negative body image (Akan & Grilo, 1995; French, Story, et al., 1995; Goldfein, Walsh, & Midlarsky, 2000; Neumark-Sztainer et al., 1995; Schur et al., 2000).

The women in this study described how their beliefs and attitudes about eating, thinness, and coping were shaped by their family's beliefs and practices. Although none of their family members were diagnosed with an eating disorder several participants were exposed to unhealthy eating and coping patterns within their family. Numerous authors have noted that a familial history of eating and

affective disorders increases a person's vulnerability to develop bulimia nervosa (Bulik et al., 1998; Fairburn et al., 1997; Huon & Walton, 2000; Kendler et al., 1991; Wade et al., 1999). In addition, to the influences of family members some participants described the role their "slimmer" and "dieting" peers played in shaping their drive to gain acceptance through dieting and restrictive behaviors. The impact of peer relationships in the development of eating disorders is noted in the literature (French, Story, et al., 1995; Huon & Walton, 2000; Schur et al., 2000; Thompson, Coover, Richards, Johnson, & Catterin, 1995).

This theme also addressed how a critical life event triggered the onset of bulimia nervosa (i.e., death, divorce, and parental separation). There were similar findings in the literature on the impact of life events (Schmidt, Troop, & Treasure, 1999); parental loss (Boumann & Yates, 1994); and parental problems (Dolan, Lieberman, Evans, & Lacey, 1990; Fairburn et al., 1997; Kendler et al., 1995).

Study's findings revealed the role that family relationships and dynamics play in the development of bulimia nervosa. Whether real or perceived all these women experienced a lack of open, honest, and direct family communication patterns which impeded their ability to develop their expressive self. Halmi (1994) noted that family characteristics of individuals with bulimia nervosa include greater hostility, chaos, feelings of isolation, and substantial deficits in nurturing and empathy. Other authors have documented the important role

played by family dynamics and family functioning in the onset and perpetuation of bulimia nervosa (Fornari et al., 1999; Garfinkel, Lin, et al., 1995; Kendler et al., 1991; Kendler et al., 1995; Kinzi et al., 1994).

Unable to label and articulate their feelings, these women were driven to find a means of expression and acceptance from outside of the self. All entered into a relentless journey of seeking acceptance of the self by pleasing others. Numerous authors concur with these study findings (Bruch, 1969; Calam & Waller, 1998; French, Story, et al., 1995; Leon, Fulkerson, Perry, & Cudeck, 1993; Zborowski, 1998).

Struggling for Control

This theme captured participants' descriptions of living with feelings of not being in control. Without exception, all of the women spoke openly about moving from one controlling situation to another from childhood, through adolescence, and into adulthood. This tendency to relinquish control to others was a result of perceiving the self as weak and unable to make independent judgments. These women looked outside of the self to find external measures to gauge self-worth and identity, while seeking approval and acceptance. Similarly, Schachtel and Wilborn (1990) reported that the bulimic women in their study relied heavily on others for approval. Numerous authors have described how the bulimic's struggle for control results in compliance with the expectations and

demands of others to gain acceptance (Calam & Waller, 1998; French, Story, et al., 1995; Garfinkel, Kennedy, & Kaplin, 1995; Huon & Walton, 2000; Neumark-Sztainer, Story, et al., 2000; Rodin, 1999).

The drive for self-control led these women to embark on a path of restrictive behaviors. Subject to the influence of others in their lived worlds participants' comments captured the movement from the innocence of early dieting measures to the relentless struggle to find control through weight reduction measures. Several authors have noted that individuals with bulimia nervosa enter this illness trajectory via the innocent diet route (Childress et al., 1993; Muscari, 1996; Sasson, Lewin, & Roth, 1995; Walsh & Devlin, 1998).

All of the participants talked about how the rewards of dieting (i.e., weight loss and positive comments from others) provided them with an initial boost to their self-esteem. While food provided them with a means of control in the early stages, it eventually became something else that they found difficult to control. Unable to maintain the strict self-imposed dieting regime, the visual signs of weight gain and the perceived rejection by others confirmed their self doubts, enhanced their anxiety, and their self-esteem plummeted. In an effort to regain control, refuge was sought by intensifying restrictive behaviors. Clinicians and researchers have described this struggle to maintain control as progressing from healthy dieting to unhealthy restrictive behaviors (Friedman, Wilfley, Welch, & Kuncze, 1997; Pipher, 1995).

Concealment

The theme of concealment captured the participants drive to hide their "true" insecure and inadequate self from others. Concealment of the true self and use of aberrant behaviors was perceived as essential to maintaining acceptance from others. While serving as a protective mechanism in the early years to hide the self, it later became a strong force for blocking feelings and hiding personal failures, especially the shame and guilt associated with bingeing and purging behaviors. Lyons (1998) also reported on how the women in her sample were driven to conceal how much they had eaten from significant others. Numerous authors have noted that the secrecy surrounding the eating disorders perpetuates the illness and precludes early diagnosis and treatment (Brewerton, 1995; Fredenberg et al., 1996; Herzog, 1982; Huon, 1994).

This theme also elucidates the emotions and feelings that engulf the binge/purge cycle. All of the participants in this study talked about the feelings surrounding this cycle. Bingeing was described as a brief period of "numbness" or "escape" from reality. The use of food as a form of emotional blocking is also reported by Schachtel and Wilborn (1990). In a somewhat similar vein, Lyons (1998) reported that the women in her sample described bingeing as an unconscious activity that continued until they felt discomfort.

Upon realizing how much food had been consumed during the binge, the resulting high levels of anxiety drove these women to purge and rid their bodies

of the food. Lyons (1998) noted that the women in her study reported feeling disgusted with themselves following a binge and experienced guilt, shame, rationalizing, and blaming. In contrast, Sanftner and Crowther (1998) reported that the women in their sample experienced a significant increase in self-esteem and positive affect between binges. Schachtel and Wilborn (1990) also found that the women in their study used purging to release tension and anxiety in the aftermath of a bingeing episode.

For some study participants, the purging activity was followed by a wave of guilt and shame that invaded their minds and reaffirmed their feelings of failure. Other researchers have reported similar findings (Johnson-Sabine, Wood & Wakeling, 1984; MacDonald, 1996; Wilfrey & Grilo, 1994).

All these participants described how the binge/purge cycle escalated to the point where much time and energy was directed towards planning and executing restrictive behaviors. The lived world of bulimia nervosa was characterized by a preoccupation with food and restrictive behaviors. Similar findings are reported by Schachtel and Wilborn (1990) who found that the women in their sample became preoccupied with food and the need to binge and purge.

The strong reliance on restrictive behaviors as a coping mechanism for dealing with stress eventually began to weaken the body and feelings of being in control. Although these women were slowly becoming cognizant of the negative

effects and the increased challenge of adhering to a strict restrictive regime, they felt powerless to change their behavior and actually began to intensify their efforts. Numerous authors concur that bulimia nervosa is a self-perpetuating disorder because its inherent nature is typified by strong resistance to change aberrant behaviors due to the high reliance on restrictive behaviors as a coping mechanism (Hay et al., 1998; Lowe, Gleaves, & Murphy-Eberenz, 1998).

Consumed by the Illness

This theme elucidates the paradox of control. While initially these women found control and refuge in restrictive behaviors, the illness eventually gained control of them. As feelings of inner control dissipated, participants intensified their use of restrictive behaviors to try and regain earlier feelings of being in control. In so doing, the illness eventually moved to permeate their entire existence and the self, which they had sought to conceal from others, and became elusive even to themselves in the ensuing struggle for control. A number of authors have described how bulimia nervosa escalates to the point where an individual's total identity is lost to the illness (Claude-Pierre, 1997; Herzog, 1982; MacDonald, 1996; Pipher, 1995). Schachtel and Wilborn (1990) also identified the paradoxical nature of control in their sample of women with bulimia nervosa as they described moving from experiencing the control brought by the binge/purge cycle to eventually being controlled by the illness.

This theme also describes the internal turmoil experienced by these women as they began to realize that restrictive behaviors were not providing them with the safety and security that they so desperately sought. As restrictive behaviors escalated to the point where they were no longer productive, they found it much more difficult to maintain a semblance of normalcy. Ultimately, their lives became so distraught with the obsession to maintain the bingeing/purging cycle and other restrictive behaviors that they contemplated suicide. A number of researchers have reported on the use of self-destructive behaviors in individuals with bulimia nervosa (Bulik et al., 1999; Favaro & Santonastaso, 1998; Welch & Fairburn, 1996).

The Elusive Road to Recovery

This theme captures the difficulties experienced by these women in the struggle to overcome the holding powers of the eating disorder. For many, the road to recovery started as they became aware of the adverse effects the illness was having on their physical and emotional health. Although the critical turning point was unique for each woman, all participants, through force or choice, eventually sought professional help. A number of authors note that people suffering from bulimia nervosa usually do not seek professional attention until they reach a crisis state (Hay et al., 1998; Keel et al., 1999).

All of the participants had received various types of treatments (i.e.,

individual therapy from a psychiatrist or psychologist, and all attended group therapy). For the most part, participants described their encounters with health care professionals as having a positive influence and helped them "turn their lives around". However, nurses were not identified as playing an active role in their treatment or recovery. The importance of having helpful and understanding family members was also highlighted by these women as playing an important role in their recovery. Collings and King (1994) found in their study that the partners' friends and the psychotherapist were the most helpful contact persons.

The participants described the challenges and barriers that they encountered on the road to recovery. Stress became the most difficult challenge, with frequent relapses to comfortable and familiar coping behaviors and restrictive behaviors. This was a common behavioral response in the early stages of treatment for all of the participants. For many, the perceived benefits of treatment were continuously balanced against the need to maintain control over their lives through weight reduction measures. The bulimic's struggle with recovery and relapses is well documented in the literature (Collings & King, 1994; Correia, 1995; Keel & Mitchell, 1997; Keel et al., 1999; Olmsted, Kaplan, & Rockert, 1994; Wilfrey & Grilo, 1994).

Today, recovery remains a daily struggle for these women and continues to oscillate in response to stressors encountered in their worlds. One important factor that clouds their ability to achieve full recovery is the interactive effects of

comorbid and concomitant illnesses (e.g., major depression, anxiety disorder, obsessive-compulsive disorder, substance abuse, sexual abuse, etc.).

Researchers have documented the high rates of associated mental health problems in women with bulimia nervosa (e.g., Brewerton, 1995; Dansky, Brewerton, & Kilpatrick, 2000; Fornari et al., 1999; Garfinkel, Lin, et al., 1995; Kendler et al., 1991; Lilenfeld et al., 1998; Zaider et al., 2000; Zborowski, 1998).

Essence

The essence of the lived experience of bulimia nervosa was identified as a search for acceptance and meaningful existence. There is some support in the literature for the theme of searching for acceptance (French, Story, et al., 1995; Fornari et al., 1999; Kendler et al., 1991; Schachtel & Wilborn, 1990). Schachtel and Wilborn (1990) noted that women with bulimia nervosa were constantly searching for approval and acceptance from others encountered in their lived worlds.

What became obvious to the women in this study, when they eventually embarked on the road to recovery, was that they had to first accept and believe in themselves. Engaging in meaningful relations with others was contingent upon giving the self first priority. While this meant undoing and reshaping the ways in which they had lived their lives, all of the women realized that this was the only means of achieving a meaningful existence.

New Insights into the Lived Experience of Bulimia Nervosa

Most clinicians and researcher agree that the multidimensional nature of bulimia nervosa lends itself to a multidimensional approach. Clinicians recognize that the interrelationship of a multiplicities of factors play a role in the onset and trajectory of bulimia nervosa. There is also an agreement between and among professionals that early detection and treatment facilitate more positive outcomes. Yet, this study elucidates the findings that health care providers fail on two accounts. First, clinicians do not readily assess for eating disorders. Second, a unified approach or treatment modality for these devastating eating disorders remains elusive. The need exists for a unified approach in dealing with eating disorders and until this goal is realized the prevalence and incidence will continue to escalate.

Collings and King (1994) noted that the people who provide the most support to clients with bulimia nervosa were family, friends, and psychiatrist. These findings were replicated in this current study. These women talked about the support they received after their disclosure and breaking their silence. The women related their initial fears and anguish with having to trust and share their true weakened self with another person. For most of these women the turning point culminated with a critical event which manifested as either a physical or an emotional collapse. These women's stories describe the clues, traces, signals, and indicators of their internal conflict and the presence of the eating disorder.

Yet, the signals were never perceived to be heard or acknowledged by another. Clinicians, nursing, and society as a whole need to be educated about the risk factors and the warning signs of bulimia nervosa.

In the theme concealment, the hiding of the true self is aligned with personal failure. These women as very young children shared feelings of being less valued or less loved than other family members. They viewed themselves as never seeming to measure up to the expectations of others. They perceived their best as never being good enough. The unconditional love and acceptance they needed and longed for was always an elusive dream. These women feared rejection and spent a lifetime struggling to find a way to please others and avoid further rejection.

Although the literature describes societal messages about thinness and a slim physique as a predisposing factor to the development of eating disorders, the participants in this study did not directly relate the onset of the disorder with societal values on thinness. The emphasis on thinness was talked about in terms of the importance that family and friends placed on food, eating, weight, shape and sizes. Numerous authors (Childress et al. 1993; Garner & Garfinkel, 1980; Normandi & Roark, 1998; Pipher, 1995; Wilfrey & Grilo, 1994) note that cultural factors (i.e., societal emphasis on thinness) are now considered essential in understanding, diagnosing, and treating individuals with bulimia nervosa. However, Lee, Ho, and Hsu (1993) argue that the onset of bulimia

nervosa cannot be independently attributed to societal emphasis on thinness, as bulimia nervosa is also evident in non-western countries.

CHAPTER 6

Limitations, Nursing Implications, and Conclusion

The findings in this study have limitations, as well as implications for nursing in terms of education, practice, and research.

Limitations

The nature of qualitative inquiry precludes the generalizability of the findings. Phenomenological research requires the selection of participants who can clearly articulate their lived experience. A possible consequence of this requirement is the issue of "elite bias" which occurs when study participants are the most articulate, accessible, or high-status members of their group. Additionally, all participants were diagnosed and receiving treatment which could be a key differentiating feature from their counterparts who have not been diagnosed or receiving treatment.

All of the participants in this study were Caucasian who were successfully employed or attending post secondary education. Therefore, it is conceivable that others diagnosed with bulimia nervosa, especially males and women with varying cultural and socioeconomic backgrounds, may describe the lived experience a little differently.

The participants were all females. Since the issues were social in nature and there are different pressures on men, it is very likely that a similar study with

males might reveal different issues. All participants had a secondary diagnosis of either an affective or an anxiety disorder, which makes it difficult at times to separate the pure characteristics of bulimia nervosa from other DSM - IV diagnoses.

Implications

The findings from this study have provided insight into the lived world of those with bulimia nervosa and their day-to-day experiences. While there were some commonalities within the women's experiences, there was an element of uniqueness that helped shape each woman's experience and made it her own personal struggle. Although the implications discussed below are presented in a broad context, clinicians must be forever mindful of individual differences when dealing with those women or men living with bulimia nervosa.

Nursing Education

Nursing educators have the responsibility to heighten nursing students' awareness about their own cultural beliefs and biases about "fatness" and "thinness". Self-awareness is essential in the delivery of nursing care. Before nurses can care for others, they must be aware of their own thoughts, feelings, and beliefs. An individual's thoughts and beliefs shapes their behavior and interactions with others. Nurses have the responsibility of providing optimal care

to their clients. Self-awareness is a prerequisite to meeting this ethical and professional responsibility. Nurse educators and students must be given the opportunity to examine and explore their roles and responsibilities in the identification and delivery of care to individuals with eating disorders. Particular attention to the lived experience is important in understanding the illness from the perspective of the person experiencing it.

Nursing Practice

Hospitalized patients typically interact more with nurses than with other health care professionals, yet this study reveals that people with bulimia nervosa confide in physicians and view the nursing staff as "the guards". Nursing staff were not presented in a positive light nor identified as a source of support.

Most of the study participants talked about other disciplines (i.e., psychiatrist, psychologist, social worker) as providing them with the guidance and treatment they needed to get themselves on the road to recovery. Nurses were only visible in the hospital setting and were viewed as the "law enforcers" who ensured that treatment protocols were being followed. The participants also described nurses as the ones who took away their control and caused them more anxiety. It was the other health care members who were helping them to learn about themselves and facilitated the replacement of old coping strategies with healthy ones. To more effectively care for individuals with this disorder,

better and more effective use of high contact time provided by hospital nursing staff with these patients is sorely needed. The health care of people with eating disorders needs to be reviewed and the nursing profession is being challenged to play a role in the development of critical clinical pathways for eating disorders.

King-Murphy (1997) noted that numerous authors (Cahill, 1994; Childress et al., 1993; Conrad, Sloan, Jedwabny, 1992; Deering & Niziolek, 1988; Halmi, 1997; Irwin, 1993; Lilly, Brown-Sanders, 1987; Meades, 1993) have addressed the role of nursing (primary, secondary, and tertiary) in the provision and management of health care for clients with bulimia nervosa. Despite these directions and resources, most practicing nurses in mental health remain restricted to in-patient units. This study confirms the need for nursing to expand its roles in the areas of primary and secondary care.

A good example of the direction that nursing efforts need to go in is the recent inception in the province of Newfoundland and Labrador of the Body Image and Youth Network Program. This network is an interdisciplinary approach to develop a unified health promotion approach to abate the escalating prevalence of eating disorders. Nurses involved in this network are mentors and endeavor to make inroads in the development of primary and secondary treatments of eating disorders.

The community health nurse is in an ideal position in the community to provide primary interventions. The community health nurse can help educate

teachers, school counselors and peer counselors on the signs and symptoms of eating disorders, including their similarities and differences. Information sessions on how to approach students thought to demonstrate signs and symptoms as well as professional contact persons in the community would be beneficial to school staff. For students with the diagnoses of an eating disorder, further education for the teachers on medical complications may assist in early treatment and improved prognosis. A cultural environment that promotes the accepting of oneself in the primary school years may help to avoid the development of eating disorders for some individuals.

Nursing Research

To date, epidemiological studies have not been conducted to determine the prevalence and incidence of eating disorders among Newfoundland adolescents and young adults. One pilot study conducted at a rural high school in Newfoundland revealed that the prevalence of eating disorders was comparable to national statistics (King-Murphy & Dale, 1995). Until professionals know more about the etiology of bulimia nervosa, further research is necessary to profile prevalence rates and identify the risk factors that increase the likelihood for an individual to develop bulimia nervosa. This data base will be useful for developing more effective treatment plans and health prevention strategies to meet the needs of those at risk or suffering from the disorder.

More research is needed to explore the lived experience of bulimia nervosa. Further qualitative studies need to be conducted to determine the commonalities and differences, within and between, all cultural and socioeconomic groups. Men should also be studied to determine whether the uniqueness of their lived experiences differs from those of women. Participants without a co-morbid diagnosis will be invaluable in helping isolate the true nature of bulimia nervosa.

The sensitivity of the current diagnostic tools (e.g., DSM-IV) has been questioned by researchers and clinicians. Further research is warranted to assess the sensitivity of current tools in early detection, diagnosis, and treatment. Lastly, research is required to design evaluation measures to evaluate efficacious treatments for bulimia nervosa.

Study Summary

This study has provided an understanding of the lived experience of bulimia nervosa. The researcher hopes that the findings from this study will assist in the development of primary, secondary, and tertiary levels of health care that will assist in the early detection, diagnosis and treatment of bulimia nervosa suffers. As primary caregivers, nurses must take a lead role in the development of health promotion and prevention programs for the school system, which will hopefully decrease, and some day eradicate, the diagnosis of

bulimia nervosa.

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APPENDIX A
Letters of Support



HealthCare

Corporation of St. John's

158

Dr. D. A. MacLaughlin, FRCPC

208 LeMarchant Rd.

St. John's, NF

A1C 2E6

Tel: (709) 778-3278 Fax: (709) 778-3490

June 29, 199

To Whom It May Concern

I have reviewed information from Shellagh Dale regarding a summary of a planned nursing research study titled, *The Lived Experience of Bulimia Nervosa: A Phenomenological Study*. I am in support of this study and I am willing to review my patient list to recruit clients who may be suitable to participate in the study.

Yours sincerely,

Dr. Deirdre MacLaughlin, F.R.C.P.C.

St. Clare's Mercy Hospital

LeMarchant Road, St. John's, Newfoundland, Canada A1C 5B8 Tel. (709) 778-3111 Fax (709) 738-0080

SITES: General Hospital • Lunenburg Child Health Centre/Children's Rehabilitation Centre • Leonard A. Miller Centre
St. Clare's Mercy Hospital • The Salvation Army Grace General Hospital • Dr. Walter Templeman Health Centre • Waterford Hospital

June 30, 1999

Confidential

Ms. Sheilagh Dale
Community Support Program
Waterford Hospital

Dear Ms. Dale:

This is confirmation that I agree to help recruit patients for your study.

Thank you.

Sincerely,

Gordon Noseworthy, MD, MHSc, FRCPC

GN/kb

Terrace Clinic

Terrace on the Square, 8-10 Rowan Street (Box 15), St. John's, Newfoundland, Canada A1B 2X3 Tel. (709)758-3450 Fax (709)758-3461

APPENDIX B
Informed Consent

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FACULTY OF MEDICINE - MEMORIAL UNIVERSITY OF NEWFOUNDLAND
AND HEALTH CARE CORPORATION OF ST. JOHN'S

Consent To Participate In Health Care Research

TITLE: The Lived Experience of Bulimia Nervosa:
A Phenomenological Study

SHORT TITLE: Living with Bulimia Nervosa

INVESTIGATOR: Sheilagh Dale
Telephone: 745-6816

SUPERVISOR: Dr. Christine Way

You have been asked to participate in a research study. Participation in this study is entirely voluntary. You may decide not to participate or may withdraw from the study at any time without affecting your normal treatment.

Information obtained from you or about you during this study, which could identify you, will be kept confidential by the investigator(s). The investigator will be available during the study at all times should you have any problems or questions about the study.

Purpose of study: The purpose of this study is to gain a greater understanding of what it means to live with bulimia nervosa. A related purpose is to increase health care professionals understanding of bulimia nervosa.

Description of procedures and tests: You are being asked to participate in two interviews which will be conducted at a time and place that is convenient for you. Interviews will be audiotaped (with your permission). The tape will be transcribed word for word, and will be used to help the interviewer remember the details of the conversation and construct summaries for you to reflect upon at a later date. During the first interview you will be asked to reflect upon and describe your experiences with bulimia nervosa. During the second interview, you will be asked to read a written summary of the first interview and confirm whether or not it accurately reflects your experience with bulimia nervosa. You will also be given an opportunity to provide any additional information at this time. All

identifying data will be destroyed following completion of the study.

Duration of participation: The first interview will take approximately 60 to 90 minutes of your time. The second interview will be scheduled within two months and will last about 30 minutes.

Possible risks, discomforts, or inconveniences: There are no expected risks from participating in this study. You may refuse to answer any questions that make you feel uncomfortable, and terminate the interview at any time. All information that you provide will be kept strictly confidential, secured in a locked file, and accessible only to the investigator and thesis committee members. If you become emotionally upset during the interview, support will be offered and the investigator may refer you back to your psychiatrist for additional counselling.

Benefits: You may not derive any direct benefits from participating in this study. However, the information that you provide may help nurses and physicians develop a better understanding of the needs of persons with bulimia nervosa.

Liability statement: Your signature indicates your consent and that you have understood the information regarding the research study. In no way does this waive your legal rights nor release the investigators or involved agencies from their legal and professional responsibilities

Other information: Findings of this study will be available to you and health care professionals upon request. Findings may be published but you will not be identified.

Signature Page

Title of Project: **Living with Bulimia Nervosa**

Name of Principal Investigator: Sheilagh Dale

To be signed by participant

I, _____, the undersigned, agree to my participation in the research study described above.

Any questions have been answered and I understand what is involved in the study. I realize that participation is voluntary and that there is no guarantee that I will benefit from my involvement.

I acknowledge that a copy of this form has been given to me.

(Signature of Participant)

(Date)

(Signature of Witness)

(Date)

To be signed by investigator

To the best of my ability I have fully explained the nature of this research study. I have invited questions and provided answers. I believe that the participant fully understands the implications and voluntary nature of the study.

(Signature of Investigator)

(Date)

Phone Number _____

Consent for audiotaping during interviews

(Signature of Participant) _____ (Date) _____

(Signature of Witness) _____ (Date) _____

APPENDIX C
Interview Schedule

Interview Script

Thank-you for agreeing to participate in this study. I am interested in your experience with bulimia nervosa. I would like for you to take some time to reflect upon your experience and tell me in your own words what it is like to live with bulimia nervosa. You may share any thoughts and feelings about your illness. Feel free to talk about whatever comes to your mind.

Examples of probes/questions to guide the interview

1. When did you first realize that you may have bulimia nervosa?
2. Tell me about your average day living with bulimia nervosa. What makes the difference between a good day and a bad day for you?
3. What do you find most aggravating about the situation? What are some of your biggest concerns/worries?
4. How has your illness affected your interactions/relationship with your family, significant others, and/or friends?
5. Reflecting back, can you remember anything that would have triggered the onset of your illness?
6. Can you remember any particular thing and/or person that led you to seek help? How do you see people who try to help you?
7. What aspects of your treatment have you found most/least helpful in coping with your illness?
8. How do you cope with bulimia nervosa? What helps? What does not help?
9. Are there any thoughts or comments that you would like to share with me about your experience with bulimia nervosa?

APPENDIX D**Human Investigative Committee Approval**



Memorial

University of Newfoundland

Office of Research and Graduate Studies (Medicine)
Faculty of Medicine
The Health Sciences Centre

the copy
Sent 17 Aug '99
jr

167

1999-08-17

TO: Ms. S. Dale

FROM: Dr. Richard Neuman, Acting Assistant Dean
Research & Graduate Studies (Medicine)

SUBJECT: Application to the Human Investigation Committee - #99.78

KEYED

jr

////////////////////////////////////
The Human Investigation Committee of the Faculty of Medicine has reviewed your proposal for the study entitled "The Lived Experience of Bulimia Nervosa: A Phenomenological Study".

Full approval has been granted for one year, from point of view of ethics as defined in the terms of reference of this Faculty-Committee.

For a hospital-based study, it is your responsibility to seek necessary approval from the Health Care Corporation of St. John's.

Notwithstanding the approval of the HIC, the primary responsibility for the ethical conduct of the investigation remains with you.

Richard Neuman, FRCPC
Acting Assistant Dean
Research & Graduate Studies (Medicine)

cc: Dr. K.M.W. Keough, Vice-President (Research)
Dr. R. Williams, Vice-President, Medical Services, HCC
Dr. C. Way, Supervisor





Memorial

University of Newfoundland

Human Investigation Committee
Research and Graduate Studies
Faculty of Medicine
The Health Sciences Centre

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1999 08 13

Reference #99.78

Ms. S. Dale
C/o Ms. Christine Way
School of Nursing

KEYED

Dear Ms. Dale:

This will acknowledge receipt of your correspondence wherein you provide a revised consent form for the research application entitled "The Lived Experience of Bulimia Nervosa: A Phenomenological Study".

At a meeting held on August 12, 1999, the Human Investigation Committee granted full approval of your research study.

Sincerely,

~~H.B. Younghusband~~/PhD
Chairman
Human Investigation Committee

HB Yjgic

C Dr. M.W. Keough, Vice-President (Research)
Dr. R. Williams, Vice-President, Medical Services, HCC
Dr. C. Way, Supervisor



