BULIMIA: A PHENOMENOLOGICAL APPROACH

DISSERTATION

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By

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This study used a qualitative/phenomenological research methodology to examine the perspective of five bulimic subjects about their lives in order to understand the bulimic individual's point of view and develop a clearer picture of the world of the bulimic.

This approach involved three interviews for each of the five subjects totalling 22 1/2 hours. The three interviews dealt with the subjects' past and present experiences and their ideas about the future. The qualitative/phenomenological methodology created an in-depth view of each subject's relationship to the beginning of her bulimia and its subsequent development.

During the period when the interviews were being transcribed, patterns and concepts emerged and were examined. Nine categories were developed from this data reflecting some of the characteristics of a bulimic's personality. Six research questions were formulated and then answered by evaluating them in the light of the nine categories as well as data and descriptions from the interviews.

No one single category was found to be uniquely dominant, but rather the categories tended to appear in a cluster-like fashion depending on the individual personality of the bulimic. The data of this study revealed a distinction between the personality and the behavior of the bulimic.
A form with a Likert-like response was developed by the researcher and given out to 11 raters in order to evaluate the presence or non-presence of the categories in selected passages.

On the basis of the findings of this study, with its limited subject pool, certain recommendations are presented for the reader that might perhaps be of some use in understanding bulimia.
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CHAPTER 1

INTRODUCTION

Relatively little definitive knowledge exists about bulimia. Swift, Ritholz, Kalin and Kaslow (1987) noted that not until the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM III, 1980) was the syndrome of bulimia classified as a diagnostic entity. "Knowledge of various aspects of this disorder is rudimentary" (p. 145). Pope and Hudson (1984) suggested that "the DSM III criteria for bulimia are quite broad; technically, one could have only a few major binges a year and still meet the definition of bulimia" (p. 36); however, the DSM III R (revised edition, 1987) diagnostic criteria of bulimia was modified by defining a bulimic episode as "a minimum average of two binge eating episodes a week for at least three months" (p. 69). Swift (1985) observed, "Our knowledge of predisposing factors, etiology, the complexity of interplay between disturbed physiology and disturbed psychology, natural course and treatment is still scant" (p. 384). Moreover, Swift, Andrews and Barklage (1986) noted that the field of eating disorders "is fraught with terminological confusion" (p. 290).

The current and rapid escalation of research into bulimia during the last two decades has added to the confusion regarding the subject.
Garner, Olmstead and Polivy (1983), Lenihan and Sanders (1984), and Frey (1984) have all suggested that the disorder of bulimia is still on the frontier of new knowledge in the area of eating disorders.

The literature indicates that bulimia is not only "episodes of excessive, uncontrolled binge eating often followed by vomiting, purging" (Ordman & Kirschenbaum, 1985, p. 305), but also involves suffering at a level deeper than the behavioral manifestations. Both "psychological and social factors have been hypothesized to play a role in the development of bulimia" (Katzman & Wolchik, 1984, p. 423). Bulimia "is thought to be a manifestation of underlying psychological problems" (Robinson-Smith, 1985, p. 147). Various psychological factors have been suggested as a part of the essence of this illness. For example, Boskind-Lodahl (1976) and Hawkins and Clement (1984) hypothesized that psychological factors such as depression, poor self-esteem, and social incompetence may play a crucial role in the onset of bulimia. Bell (1985) noted that, "there is more here than illness, suggesting the need for further thought rather than quick diagnosis" (p. 183). Swift (1986) noted that neither anorexia nervosa nor bulimia possesses a single pathogenesis; rather there are a multiplicity of forces that lead to them. Smith and Thelen (1984) summed up a critical dimension in the study of bulimia with the following observation: "Of particular importance is the finding that a subject's feelings about herself following a binge are as essential to the bulimia syndrome as the actual binging behavior" (p. 869).

Given the observation that bulimia transcends the purely behavioral aspect of the disease, this study explored bulimics'
phenomenological perspective of their world. Qualitative research methods provided the procedure and process for examining and understanding the subjective reality of the bulimic.

Qualitative research methodology is one type of research activity that can be used to "help people translate their personal troubles" (Taylor & Bogdan, 1984, p. 244). Bogdan and Biklen (1982) observed that the phenomenological qualitative approach is experiential and descriptive. This method as a process of understanding the internal world of the bulimic is reinforced by Weber who observed that, "man is an animal suspended in webs of significance he himself has spun" (cited in Magoon, 1977, p. 654).

Related Literature

This literature section discusses the relationship between bulimia and emotions, qualitative/phenomenological research method, qualitative versus quantitative research, conventional approaches to a qualitative/phenomenological inquiry, and statement of the problem.

Bulimia and Emotions

A question that has been much debated in the study of bulimia is its relationship, if any, to affective disorder. Kennedy, Piran and Garfinkel (1986) reported a double-blind placebo-controlled crossover trial with isocarboxazid in 29 bulimic patients. Binge episodes were reduced after six weeks and depression scores on a number of inventories (e.g., the Beck Depression Inventory) were significantly reduced. Benefit from anti-depressant medication such as
desipramine, phenelzine, and imipramine in bulimic patients has
been demonstrated. Hughes, Wells, Cunningham, and Ilstrup (1986)
treated 29 bulimic women of college age with desipramine and
successfully decreased binge frequency by 87%. Walsh, Stewart, Roose,
Gladis, and Glassman (1984) completed a double-blind placebo-
controlled study of phenelzine in treatment of 20 bulimic women and
found phenelzine treated patients reported fewer binges per week.
Using the same medication to examine its effect on bulimic symptoms
and depression, Hardy, Waller, and Orulak (1985) treated eight
bulimics and Johnson and Larson (1982) treated 15 bulimic women
with phenelzine; both studies reported success in reducing binging and
depressive symptomatology. Pope, Hudson, and Jonas (1983)
successfully treated 22 outpatients with imipramine (n =11) and
placebo (n =11) and found that binging decreased and depressive
symptoms were reduced. A follow-up study confirming the findings of
Pope et al. (1983) concerning bulimics and imipramine was conducted
by Agras, Dorian, Kirkley, Arnow and Bachman (1987). "Overall, the
results of this study confirm that imipramine is useful in the
treatment of patients suffering from chronic bulimia" (p. 36). Agras et
al. go on to say that "the medication is likely to be of some benefit to the
majority of patients and of great benefit to a few" (p. 37).
While some of the literature on bulimia indicates a strong relationship
between affective disorder and bulimia, there is no agreement
regarding the relationship (Muuss, 1986). Russell (1979) observed that
"antidepressant therapy should be tried when depressive symptoms
are severe along with a course of electro-convulsive therapy; however,
the treatments for depression usually do not influence the eating disorder itself" (p. 447). Halmi (1985) stated that with all the studies on affective disorders and eating disorders, it still "does not allow one to conclude that the eating disorders are a form of affective disorder even though there are some signs and symptoms and physiological changes in common in those disorders" (p. 678). Herzog (1984) stated that although studies in bulimia "have demonstrated that antidepressants may be effective in the short term, the long term efficacy of these drugs has not been clearly demonstrated in this disorder" (p. 1595).

Some authorities argue that along with affective disorder, there are "several personality deficits" (Katzman & Wolchik, 1984, p. 426) that appear to be another facet of the abnormal pattern of eating behavior. To evaluate the relationship between psychological impairment and the bulimic experience, 45 women (15 bulimic, 15 obese, and 15 normal) matched on age (mean ages, 20.8 years bulimic, 21.4 obese, and 21.6 normal) and height (approximately 65 inches for each group) were studied. Each subject completed the Minnesota Multiphasic Personality Inventory, the Beck Depression Inventory, and a body image assessment. Results showed that "a majority of the bulimics (87%) evidenced some signs of clinical psychopathology . . . . distorted cognition, mood disturbance and impulsivity" (Williamson, Kelley, Davis, Ruggiero, & Blouin, 1985, p. 166). The findings of Williamson et al. supported the findings of Katzman and Wolchik (1984) that areas of the client's functioning, such as depression, high self-expectations, and poor body attitude, are part of the bulimic characteristics and that bulimia does coexist with personality and
behavioral weaknesses. Garner and Davis (1986) noted that bulimia involves the task of "modifying misconceptions reflected in self-concept deficiencies, perfectionism, poor impulse regulation, depression" (p. 187). Agras and Raeburn (1986) observed that cognitive behavioral treatment is an alternative treatment since they view bulimia as a phobia of becoming fat. "Vomiting is viewed as anxiety reducing in much the same way that compulsive behavior reduces phobic anxiety" (p. 194). A study of 105 hospitalized female patients also found that bulimia is not simply a disorder of appetite, but a complex symptom of individuals who do not overeat to alleviate hunger feelings, but use binging to relieve distressing emotions such as feelings of depression, guilt and anxiety (Casper, Eckert, Halmi, Goldberg & Davis, 1980). Caffary (1987) noted that there are persons with eating disorders who are "unable to develop emotionally to risk change, which promotes an imbalance in their adjustment of self-protection. These individuals may have been described earlier in life as compliant by their parents, and becoming angry and distrusting" (p. 45).

Bulimia has also been determined to be related to high levels of anxiety and to be interrelated with syndromes, such as panic disorder, agoraphobia, kleptomania, and obsessive-compulsive disorders (Pope & Hudson, 1984). Davis and Marsh (1986) observed that "certain aspects of narcissistic pathology are similar to those of bulimic pathology. These specific areas of difficulties are control, self-esteem and feeling states" (p. 230). Brenner-Liss (1986) targeted the bulimic problem with regard to a weakness in ego development of "body boundaries and self-esteem" (p. 212). Furthermore, Davis and Marsh noted that the
narcissistic investment in the bulimic and narcissistic patients' bodies appears to be "a defense against lifelong feelings of incompleteness, i.e., against their impaired sense of self" (p. 230). Vomiting in bulimia has been found to be an anxiety reducing function (Rosen & Leitenberg, 1982). Purging "is similar to compulsive handwashing and checking rituals in obsessive-compulsive neuroses" (Leitenberg, Gross, Peterson & Rosen, 1984, p. 4), and "vomiting rather than binge-eating may be the primary mechanism for tension regulation in bulimia" (p. 18). At the other end of the spectrum from characteristics of psychological disorders, there are some who believe that bulimia needs to be perceived as an entity based on environmental influence. It has been suggested, for example, that sports in our society has contributed to the development of eating disorders (Borgen & Corbin, 1987).

The depth and intricacy of these psychological components of bulimia appear to be related to individual differences and multiple realities. The individual perceptions and formulations of these bulimics seem to have contributed to the confusion surrounding another problem in the study of eating disorders, labeling and defining. A climate of indecisiveness exists in regard to bulimia due to the lack of cohesion in diagnosis, assessment and treatment. Leitenberg et al. (1984) noted that bulimia is an independent disorder distinct from anorexia nervosa. Holmgren, Humble, Norring, Roos, Rosmark, and Sohlberg (1983), on the other hand, have stated that anorexia and bulimia are variants of the same syndrome. Frost (1985) further confused the situation when he concluded from his research "that vomiting and nonvomiting bulimics represented two different subtypes
of bulimia" (p. 115). Garfinkel, Moldofsky, and Garner (1980) stated that bulimic patients are a distinct subgroup within the primary anorexia nervosa syndrome. Squire (1983) in her book *The Slender Balance* discussed at least seven different categories of eating disorders. Cesari (1986) outlined differences between two types of bulimia, fad and clinical bulimia. Halmi (1983) noted, however, that "we need . . . a far more sensible and practical classification of eating disorders" (p. 25).

The literature on bulimia does seem to be in agreement on one aspect of the problem, the predominance of female bulimic patients (Hardy et al., 1985). Research indicates that only 10% to 15% of bulimic patients are male (Andersen, 1985). Although there are no conclusive reasons to explain this phenomenon, Andersen stated that "men are much less subject to social pressure to be overly thin, and male adolescents often receive praise for muscle development" (p. 191). Hotelling (1986) observed that "because of the importance of connection and relationships for women, many cultural norms seem to affect women more than they affect men, who learn to separate from their mother at an early age" (p. 203). Jones (1985) stated that there is a predominance of female bulimic patients because it is easier "for females to express emotional problems through the nutritional function than it is for males because food and eating symbolize a primordial attachment to the mother" (p. 315).
Qualitative/Phenomenological Research Method

The phenomenological research method is embedded within the philosophical tradition that emphasizes the interpretive understanding of human interaction (Bogdan & Biklen, 1982). The phenomenologists stress the subjective aspects of people's behavior. "They attempt to gain entry to the conceptual world of their subjects in order to understand how and what meaning they construct around events in their daily lives" (p. 31). The basic goal of qualitative/phenomenological research is to understand the subject from the subject's own point of view.

Taylor and Bogdan (1984) noted that central to the phenomenological perspective, and hence qualitative methodology, "is experiencing reality as others experience it" (p. 6) and, in addition, they observed the importance of realizing that in the phenomenological method instead of rules there are guidelines to be followed.

Bogdan and Biklen (1982) noted that synonymous with qualitative research is a major theoretical approach called symbolic interaction, which is part of the total methodology and philosophical stance. People act towards things, including other people, on the basis of the meanings these things have for them. People attach meanings to situations, others, things, and themselves through a process of interpretation (Blumer, 1969). The concept of symbolic interaction merges into the task awaiting the phenomenologist which is to capture this process of interpretation, namely to see things from the perception of others (Taylor & Bogdan, 1984).

Glaser and Strauss (1967) called the dynamic of qualitative research grounded theory. Bogdan and Biklen (1982) described
grounded theory as a picture that takes shape as one collects and examines the parts. "The process of data analysis is like a funnel, things are open at the beginning (on top) and more directed and specific at the bottom" (p. 129). Researchers in the qualitative/phenomenological method assert that the social scientist "cannot understand human behavior without understanding the framework within which the subjects interpret their thoughts, feelings and actions" (Wilson, 1977, p. 249). To make a comprehensive investigation of the disease of bulimia and to be sensitive to the uniqueness of each situation, it is necessary to consider reality as constructed by the bulimic. Such an understanding of individual reality is described by Emery (1978):

Our individual personal reality—the way we think life is and the part we are to play in it—is self-creative. We put together our own personal reality. It is made up of our interpretation of our perceptions of the way things are and what has happened to us. (p. 125)

Cronbach (1975) similarly observed that as the researcher "goes from situation to situation, his first task is to describe and interpret the effect anew" (p. 124-125). Through the qualitative method of research the enquirer becomes epistemologically in harmony with the experience of the bulimic. There is little a priori knowledge in this process (Taylor & Bogdan, 1984), rather the process elicits from the subject themes and patterns as the research evolves.

In regard to the research related to eating disorders, and specifically bulimia, Viesselman and Roig (1985) observed that "to date there is no universally accepted approach to treatment. . . . we should
continue to be open-minded in our approach to these difficult disorders" (p. 123). Even advocates of the quantitative approach to research who work clinically with bulimic women have observed that "it is often the phenomenological experience of being out of control, rather than the amount of food eaten that defines a binge. This aspect of the disordered eating pattern of the bulimic clearly requires further investigation" (Johnson, Lewis & Hagman, 1984, p. 254). Although such an approach seems indicated in order to capture the affective dimensions of the bulimic, no qualitative/phenomenological studies of eating disorders were found to be reported in the literature.

**Qualitative versus Quantitative Research**

To understand the difference between qualitative and quantitative research, it is important to return to their philosophical antecedents. Qualitative research emerged out of the phenomenological perspective (Husserl, 1913; Bruyn, 1966) which is committed to understanding the individual's own perspective (Taylor & Bogdan, 1984). Quantitative or normative grew from the positivist perspective (Comte, 1896; Durkheim, 1938). The positivist approach seeks causes and facts and is concerned with prediction, determinism and control. On the other hand, the qualitative/phenomenological approach requires description and speculation (Lincoln & Guba, 1985). With this approach there is no forcing of data for substantive concepts; symbols and meanings emerge from the interview themselves (Wilson, 1977). Taylor and Bogdan (1984) observed, "Qualitative study is systematic research conducted with demanding though not necessarily standardized procedures"
(p. 7). Qualitative methods are not as refined and standardized as other research approaches. Qualitative methodology "has guidelines but never rules" (p. 8). The qualitative approach encourages the researcher to be the methodologist. Development of a research design within the qualitative paradigm must be emergent rather than preordinant because meaning is determined by context and interaction which in themselves are not fully predictable (Lincoln & Guba, 1985). The qualitative design cannot be given totally in advance; it must be allowed to emerge, develop and unfold.

The qualitative study is an idiographic one, based on the individual, while the quantitative approach is nomothetic, based on law (Lincoln & Guba, 1985). The qualitative or naturalist study, as it has sometimes been referred to, finds the concept of population foreign to its total perspective. While normative research desires to generalize, and therefore is concerned with population and proper sampling, qualitative research is not concerned with a representative sample, but rather tries to maximize the depth and range of information gathered (Lincoln & Guba, 1985). Idiographic interpretation implies understanding in a very profound and holistic way (Lincoln & Guba, 1985). The case study method employed in this research provides "thick description" (p. 359). Unlike quantitative research, where instrumentation is external (objective), instrumentation for the naturalist or qualitative approach is internal (subjective). Another point of contrast is that "data analysis is open-ended and inductive for the naturalist, which is in contrast to the focused and deductive analysis common in conventional inquiry" (p. 224). The qualitative
inquiry moves towards transferability in the form of conceptualizations. On the other hand, quantitative research focuses on external validity, for example, in the form of statistical confidence limits. The worth of a qualitative study depends on the degree to which "it generates theory, description or understanding" (Bogdan & Biklen, 1982, p. 42).

**Conventional Approaches to a Qualitative/Phenomenological Inquiry**

Assessment of qualitative/phenomenological studies may appear to be difficult because of the inherent diversity in design. Goetz and LeCompte (1984) pointed out that "qualitative inquiry resists simplistic recipes for evaluation" (p. 244). However, conventional qualitative approaches do have guidelines related to in-depth interviewing which were the basic data-gathering device of this study:

1. It is important that the researcher learn and understand the idiom of their subjects (Goetz & LeCompte, 1984). In order to interview the participants, the researcher should achieve some kind of ease and familiarity with the vocabulary in the interaction. "Language fluency is critical" (p. 96).

2. With in-depth interviewing, the researcher must know the subjects well enough to understand what they mean and create an atmosphere in which they will talk freely (Taylor & Bogdan, 1984).

3. As subjects mention specific experiences or events, the interviewer should be aware of the times when there is a need to probe for greater detail. "It is also a good idea to take note of topics to return to at a later time" (p. 90).
4. Some researchers use an "interview guide" to make sure that key topics are explored with the subjects. In an interview situation, the researcher decides how to phrase questions with proper time to explore them (Taylor & Bogdan, 1984). "The interview guide can also be expanded or revised as the researcher conducts additional interviews" (p. 92).

5. In qualitative interviewing the researcher attempts to construct a situation that resembles those in which people naturally talk to each other about important things. The interview is relaxed and conversational (Taylor & Bogdan, 1984).

6. An important part of in-depth interviewing is to be non judgmental nor obviously opinionated (Taylor & Bogdan, 1984).

7. "Qualitative interviewers have to force themselves to constantly ask informants to qualify and elaborate on what they have said" (Taylor & Bogdan, 1984, p. 96).

8. Each recording must be clearly labeled and tape-recording equipment must be functioning properly before each interview takes place (Taylor & Bogdan, 1984).

9. It is helpful for the researcher to maintain a journal (Taylor & Bogdan, 1984). Here the interviewer takes note of emerging themes, interpretations, hunches and any non-verbal expressions. It is important to record any ideas or reflections of the interviewer as he or she reads and listens to the material.

10. The researcher must be someone familiar with the inquiry as well as with background material on the subject. According to Lincoln
and Guba (1985) this knowledge strengthens the researcher’s tacit knowledge (own feelings and thoughts).

11. Confidentiality and anonymity must be upheld (Lincoln & Guba, 1985).

12. A basic goal in a qualitative inquiry is to reconstruct from the interview "categories used by subjects to conceptualize their own experiences and world view" (Lincoln & Guba, p. 334). Bogdan and Biklen (1982) mentioned that "the coding categories can be modified, new categories can be developed and old ones discarded . . . It is important to realize that you are not attempting to come up with the right coding system, or even the best. What is right or best differs according to your aims. You might look at the data again after you complete more research projects and code it differently" (p. 165).

13. Steps should be taken to validate information as the study unfolds. Validation can be accomplished by the interviewer comparing data and concepts with more than one interview. This process is called triangulating (Lincoln & Guba, 1985).

14. The process of confirmability can be accomplished by an auditor, an individual or group who might confirm some of the findings and categorical development (Lincoln & Guba, 1985).

15. Goetz and LeCompte (1984) suggested evaluating a qualitative/phenomenological design by including the following as a guide to the overall merit of the study: (a) the goals of the effort and its questions should be identified, (b) an overall conceptualization of the study and design is needed, (c) an explanation about the subjects should be given, (d) the experience of the investigator should be given,
(e) data collection methods and analysis strategies and conclusions, interpretations and applications should be generated.

The qualitative approach would appear to be especially useful in the study of bulimia. Prestructured instruments are not able to reveal an individual's affect or external perceptions at any depth. By admitting into the research frame the subjective experiences of participants, qualitative methodology "may provide a depth of understanding lacking in other approaches" (Goetz & LeCompte, 1984, p. 32). The emotional complexity which is basic to bulimia warrants a study through the qualitative/phenomenological method.

Statement of the Problem

Because pre-structured assessment instrumentation has not led to an adequate understanding of the various intrapsychic and interpersonal stresses of bulimia, many questions about these important dimensions still exist. This study used a phenomenological approach to examine bulimics' own perspectives and meanings related to the condition of their lives in an attempt to help develop a clearer and more comprehensive understanding of the dynamics of the illness so that more effective interventions can be planned.
CHAPTER II

PROCEDURES

This chapter presents the research questions and a discussion of the subjects who participated in this project, collection of data, transcriptions of interviews, codification of data and the seven framing codes and definitions of the nine categories contained within these codes.

Research Questions

Due to the qualitative/phenomenological nature of this study, the following research questions were posed:

1. What are some possible explanations for the occurrence of bulimia in the subjects in this study?

2. What is the process and understanding with regard to the bulimic and herself? (a) How does she see herself? (b) How does she construct reality?

3. What is the process and understanding with regard to the bulimic and her interpersonal relationships? (a) How does she handle conflict and tension? (b) How does she handle success and failure? (c) What does she hear and feel from her peers? (d) Is she assertive?

4. What are some thoughts and feelings that have been continuous for the bulimic? (a) Are there any basic themes? (b) What
are feelings that are present during and after binging and purging?  
(c) What are feelings that are camouflaged during binging and purging?  

5. How much influence does the social-cultural variable affect her bulimia?  (a) What effect does the environment have?  (b) What are her relationships with males like?  (c) What are her relationships with females like?  

6. If the bulimic patient is improving, what are some of the elements that have contributed to the change?  (a) What internal changes have taken place?  (b) Are there any specific modifications that have altered her perception about herself and the world?  

Subjects  

Five female bulimics, Subject 1 (S1), Subject 2 (S2), Subject 3 (S3), Subject 4 (S4), and Subject 5 (S5), from ongoing counseling groups for bulimic women were the subjects for this study. They were selected by the researcher based upon the investigator's perception of their capacity to disclose, reflect and be willing to examine their own lives with relationship to bulimia. Each subject was interviewed to determine her willingness to cooperate in this study and the purpose of this study was thoroughly explained to each subject. At the conclusion of the interview a notice of consent (Appendix A) was signed by each individual subject.  

All five subjects were high school graduates. Subject 2 and S3 were college graduates. Subject 1 and S5 were college juniors in the fall of 1987, while S4 was a college senior. All the subjects were from
families with comfortable income levels. There were no divorces in the families of the five subjects. At the time of this study, S1 and S3 were 22 years of age, S5 was 21, S2 was 25, and S4 was 20. Each subject had at least one sibling in the family unit. Subject 1 and S5 had completed a five-week program as patients in a hospital eating disorder unit before becoming members of the counseling group which was co-led by this counselor. As of fall 1987, S1 was continuing in individual counseling with a female counselor. She left the group to attend school. Subject 5 continued in individual counseling with a male counselor. She returned to college after taking a year's absence. Subject 2, S3 and S4 were not enrolled in a hospitalized eating disorder program. Subject 2 was in ongoing individual and group counseling. Subject 4 occasionally saw a counselor on her college campus. Subject 3 was not undergoing counseling. The subjects in this study had been bulimic (binging and purging) for a minimum of three years before entering a clinic or a group or individual counseling setting.

At the time of the interviews, the researcher had worked as a co-counselor of counseling groups for these bulimic women for more than six months. In order to use a phenomenological methodology, it was important to develop a bond of trust and feeling of security between the researcher and the subjects. This kind of setting had an obvious impact on the quality and depth of the interview. Taylor and Bogdan (1984) considered it critical for "creating an atmosphere in which they are likely to talk freely" (p. 83) for qualitative research to be successful.
Collection of Data

Each subject was interviewed on three separate occasions for a total of 22 1/2 hours. The interviewing took place during a period of 11 weeks. Ten interviews took place in the researcher's office on a university campus, while four others took place in a counseling clinic on campus. One interview took place in the conference room of a local library.

Each of the sessions was audio taped using a micro tape recorder and a separate micro cassette for each of the 15 interviews. Lincoln and Guba (1985) observed that some of the advantages of a tape recorder include, "providing an unimpeachable data source; assuring completeness, providing the opportunity to review as often as necessary to assure that full understanding has been achieved" (p. 271).

Furthermore, Lincoln and Guba (1985) made the point that a tape recorder provides the opportunity to better comprehend the transcriptions through non verbal cues, such as "significant pauses, raised voices or emotional outbursts" (p. 272).

Within each separate interview, the transcription was broken down into three sections of 30 minutes each. Each 30 minute segment was then divided into subsections of three minutes creating 10 divisions. As a three-minute section was completed, the interviewer verbally indicated the time that had passed (3, 6, 9, 12, 15, 18, 21, 24, 27, 30). This time notation enabled the researcher to find particular categories or thematic units with greater speed.
The three interviews for each subject were organized into a time frame. During each interview, and following each interview, the researcher noted in writing observer’s comments and interviewer’s impressions from each interview. By the time of the third interview, the first and second interview tapes had been analyzed in their entirety. The third tape was also listened to after its completion. The first interview dealt with the past, junior and senior high school experiences and the subject’s life during that time. Perceptions of elementary school were included where relevant. The subject was asked to think of her past and her feelings at that stage. In the second interview, emphasis was given to the subject’s present situation and events leading up to her bulimic condition and discussion of the condition itself. At the conclusion of the second interview, an open-ended questionnaire (see Appendix B) was given to the subject to complete during her own free time and to return to the researcher at the time of the third interview. This questionnaire was developed by the researcher to compare the subjects’ responses to the transcriptions. The third and final interview focused on the subject’s perceptions, expectations for the future and goals.

Interviewer’s questions as well as comments by the interviewer (OC = observer’s comments) and any particular ideas, patterns or themes that emerged from the subject herself were noted as the interview proceeded and were also written down immediately following the interview. Observer’s comments included "a record of the observer’s feelings, interpretations, hunches, preconceptions and future areas of inquiry" (Taylor & Bogdan, 1984, p. 60). Observer’s
comments also included what Lincoln and Guba (1985) called tacit knowledge, "that which is gained from tacitly absorbed experience on a continual basis (intuitive, felt) knowledge" (p. 40). This spontaneity of process is viable precisely because the qualitative/phenomenological design is emergent rather than preordinate (Lincoln & Guba, 1985). It is precisely this spontaneity superimposed upon a flexible structure that allowed the subject and interviewer to proceed where the thematic material evolved.

Approximately the first 12 to 15 minutes of the first section of each of the initial interviews included some general guidelines regarding the subject's experiences in the past, present and future; for example, what was it like to be in junior high school, high school or college, or what did you hear people telling you, or what did you tell yourself. By the end of the first interview and progressing into the second and third interviews, an absorption effect took place where previous material was absorbed into the present interview. Each interview was listened to before the following interview took place. Themes, categories, rephrasing of questions, and direction of the interview emerged out of the current data which, in turn, was a product of the past interview creating new directions for the interviewer to follow. Inherent spontaneity in this phenomenological approach made it possible for the data collection process to absorb the different perceptions and feelings of the five subjects. In fact, this methodology made it possible for the researcher to be exposed to various levels of themes and ideas; for example, subjects' responses about their perception of reality. In the first example, the question, "What is reality" was not asked directly by
the interviewer, but rather evolved out of S2's discussion of her parents who, she believed, did not instill in her the fact that failure was O.K.

In all following typescripts in this study, S represents the subject and I represents the interviewer.

S: I don't think they instilled the fact that failure was O.K., that failure and unhappiness are a part of life. I think that's something I've only realized through this therapy in the last, you know, through talking with other people that I was very aware of that, but I really didn't realize that other people that were bulimic and anorexic had therapy and were similar that really tried to hide, to raise their children in such a happy environment that their children wouldn't have to experience failure or pain or negative feelings, but maybe those parents wanted to save their children from, when in reality that's a part of life and they should experience those feelings and realize they're not that bad.

I: Sadness and happiness are together really. It's part of life.

S: Right, except not in my reality.

I: Not in your reality.

S: And I'm still learning to deal with that now. I think I'm just going through some of the things that maybe someone goes through when they're 15 and they're first breaking away from their parents and experiencing failure and, you know, I think I'm still going through some of the trial runs with some of that stuff.

In another example, S4 is asked directly by the interviewer:

I: What's really real for you?

S: I don't know how to answer it.

After some caution and avoidance, S4 tackles the question again:

S: I mean reality is where I live.

I: Mm hm.
S: I guess reality is just being out in the world.

Subject 3 responds to the question with greater spontaneity, even though the interviewer's question is direct:

I: What was reality for you? What was really real?

S: Mm, (pause) it's hard to say. There was so much wishful thinking and fantasy stuff in my mind mm, wanting to be one of the pretty girls on campus, wanting, I mean that was still even in the back of my mind after, you know, going through that all in high school, mm, you know, it seems so foggy to me, Bard, I don't know why, but maybe because I wasn't experiencing things, you know, real, real, real.

Later on, in the final interview, S3 is asked again about reality. Here the question is asked with greater definition:

I: What's real for you now as compared to when you were bulimic?

S: What's real for me now is mm, open-minded personal satisfaction, and I think I've found that there's just not one single way to be satisfied and I'm finding out how many different ways I satisfy myself, through my family, through my friends, through hobbies, I'm, you know, that I enjoy doing . . . I'm finding out there's just an amazing number of things I can do if I want to change my mood.

The potential for the emergence of themes is an ongoing possibility depending on many different variables. The very nature of the phenomenological approach sets up an internal flexibility. The interviewer is not obligated to follow exactly some specific line of questioning if in the interview itself other areas become uncovered and emphasized by the subject.
Transcription

Transcribing of the audio tapes of each subject's interviews with the researcher was completed over a period of nine months. For purposes of analysis and organization of transcription data, an abbreviation system was set up as follows: subjects were identified by Roman numerals (I, II, III, IV, V). The following number indicated the interview (1, 2, 3) and the final digit indicated the section of the interview; for example, V, 3, 1 translated as Subject V, Interview 3, Section 1. In the final stages of analysis, as transcriptions were coded, page numbers were used to locate key materials together with the particular three-minute segment within any section.

Preparation, note taking and listening to each interview were necessary because of the lag time that sometimes occurred between the actual interview and its transcription. The lag time illustrates an important reason for using a tape recorder to keep the data exactly the way it was at the time of the interview (Lincoln & Guba, 1985). The lag time also gave the researcher time to examine each interview with a renewed freshness in his approach to the material.

As transcribing took place, ideas and thoughts were written down when they occurred. As the first, second and third transcriptions were completed, there was a constant comparison of themes and patterns across subjects, and a process in qualitative/phenomenological analysis referred to by Lincoln and Guba (1985) as "triangulating" took place. "As the study unfolds and particular pieces of information come to light, steps should be taken to validate each against at least one other source" (p. 283). Categories (characteristics of the bulimic personality)
were established through this triangulating process. The process of generating thoughts and ideas from data rather than preceding them, as in a conventional inquiry, was based on Glaser and Strauss' grounded theory (Lincoln & Guba, 1985).

Codification Organization

In this research project, codification organization of the transcribed data was divided into six basic sections:

1. Observer's comments and thoughts during and following the interviews were written in a notebook.

2. During the transcription itself, someone else typed while the researcher concentrated on listening to the tape while seeing the transcription appear on the computer screen. Categories and concepts were noted.

3. Copies were made from the original transcripts and each interview was analyzed for ideas, patterns, themes and categories. The researcher's thoughts were written down in the margin. After this stage, thoughts from the notebook and information from the questionnaire were integrated into the analysis.

4. Internal reliability, which "refers to the degree to which other researchers, given a set of previously generated constructs, would match them with data in the same way as did the original researcher" (Goetz & LeCompte, 1984, p. 210), was checked on the nine categories generated from the transcriptions. These evaluation forms and an evaluator's information sheet are in Appendix C. The nine categories
and their definitions were given to the evaluators plus a photocopy of the passages to be evaluated.

5. Framing codes used to develop the coding and category system for this study were based on Bogdan and Biklen's (1982) framing codes and adapted to fit this study: (a) internal perception—how the subject sees herself, (b) subject's orientation towards the world—how she sees the world, (c) strategy code—how the bulimic behaves—planning, executing techniques e.g., how the bulimic dynamic is accomplished; (d) process code—how the bulimic changes and grows, (e) relationship code—how the bulimic relates to people, (f) research and theory—how the researcher's theory develops from the transcription and how it does/does not relate to current theory, (g) literature/findings—special concepts and thoughts and their connection to the literature.

Within these seven framing codes, nine categories emerged from the transcriptions. The nine categories were sometimes more dominant in one code than another and some overlapping occurred. Some of the framing codes have under them the phrase, "depends on context", indicating that the particular code took on any of the nine categories depending on the context of the dialogue. Below is a list of the seven framing codes containing the nine categories and their definitions.
Framing Codes and Categories

Internal Perception:

1. Physical Image—The bulimic is obsessed with her body image. Her appearance, height, weight, thinness or fatness are central to her existence. Her value as a person can depend on her physical image.

2. Self Identity—This category is distinguished from the physical image in that Self Identity includes the individual's own identity and her perception of her internal self. Self Identity asks the questions: who am I; am I O.K.; how do I see myself.

3. Emotional Blocking—Emotional Blocking is the result of the bulimic act of binging and purging. Food becomes the substitute for the emotions which are camouflaged from expression and the possibility of feeling is blocked. Tension and anxiety become suffocating and are released through binging and purging. Although there is a release of tension through binging and purging, the true and underlying emotions are not dealt with, but rather blocked and stuffed.

Orientation Towards the World

4. External Locus of Control—The bulimic is controlled by her environment. What others say, do, wear, feel—whatever the external world does—the bulimic is influenced by it.

5. Dichotomous Thinking—The bulimic has the tendency to go overboard with her needs, actions and wants. Everything is either black or white. The bulimic is unable to perceive shades instead of extremes.
Strategy Code, Behavioral Tendencies

6. Obsessive Compulsive—The bulimic is compulsive in her behavior. There is a recurring need to binge and purge whenever tension, fear and other strong emotions intrude into her world. The bulimic tends to obsess about concerns she has such as her weight.

7. Excitement/Thrill—The bulimic subjects are attracted to bulimia because it represents a way of getting away with something. There is a certain thrill that entices them into lying and deceiving people around them.

8. Achievement/Recognition—The bulimic sees achievement and recognition as essential to her world. There is ambition to accomplish things and be noticed.

9. Control—The bulimic needs to control the world through the pursuit of perfection. The quest for perfection for the bulimic brings power and power brings Control.

Process Codes
Depends on context of category.

Relationship Codes
Depends on context of category.

Research and Theory
Depends on context of category.

Literature/Findings
Depends on context of category.

Bogdan and Biklen (1982) set up several guidelines for the development of a coding process:
1. Data are reviewed by researcher for patterns, topics, phrases and concepts.

2. Numbers are assigned to the various coding categories.

3. Coding categories numbers are then assigned to specific units of data that deal with a particular category.

4. Specific units of data are divided up, each labeled with one code.

They also noted that "some coding categories will come while one is collecting data" (p. 156) and such categories were developed by the researcher as indicated.

A method of using what Bogdan and Biklen (1982) called "the cut-up-and-put-in-folders-approach" was used for this study. A portable expanding file was set up. The seven framing codes were labelled on the outside of the divider and next to the appropriate categories as outlined above.

The cut-up method proved to be time consuming but comprehensive enough to handle the remarkable amount of units of data. Each subject was assigned a different colored dot that was adhesively placed on a section of transcript where the appropriate categories were found. Subject 1 was orange, S2 was blue, S3 was green, S4 was yellow and S5 was red.

The cutting and coding began by finding one of the nine categories in the photocopy of the transcript. If the passages could not stand alone without the surrounding dialogue, then the entire page was torn out and placed in the expanding file. On this selection the interview number was noted as well as the section of the interview from which it
came. If the passage could stand alone without the surrounding context, then that particular selection was cut out, a colored dot indicating the subject was placed on the margin and, where needed, the original page number from the transcript was placed on the margin. The passage was then placed in the file in the appropriately labelled section. In order to facilitate referencing of the various observations, perspectives and comments, the selection that was placed in the expanding file was also noted in a notebook under the appropriate category and framing code together with an observer's comment, if needed.
CHAPTER III

RESULTS AND DISCUSSION

This chapter presents case descriptions of the five subjects, an analysis of categories establishing internal reliability of the categories, an analysis of research questions, and a discussion of the findings.

Case Descriptions

Subject 1

In the opening minutes of S1's first interview, a basic tone, attitude and feeling were established by the subject that permeated all her interviews. Referring to junior high school, the interviewer asked her what it was like for her at that time.

S: I just have really bad memories. But, I mean all my whole family, they said now all they saw was me laughing, people always over, people always calling, and I was involved in things but it was like I wasn't involved in anything. So, like I didn't fit in or I really didn't have, you know, any one person I identified with, maybe it's because I didn't really identify with myself.

The interview continued:

S: Yeah, well, I didn't feel good about things but, I guess, everyone, like my whole family says, I, I was always laughing and mm, I was going to say something, I forgot.

I: Take your time.
S: Mm (pause), I always felt so different from everyone else, I mean even from when I was like real young, I mean I don't really feel that way any more, but it's like always, I always felt that I was different from most people my age.

I: Can you, can you get, can you flush that out at all? What do you mean, different?

S: Well, I felt like I saw things differently that mm, not that I was more intelligent, but I was either more sensitive or I looked at things, I always felt that I looked at things a little differently than most people. It made me feel kind of isolated.

A few minutes later the subject continued:

S: I always looked at myself as just being so ordinary. Yeah, not really less ordinary but just, I mean everything, I just thought I was so ordinary, but yet at the other extreme I felt so different, so, I guess, I wasn't really clear, you know.

This confusion of Self Identity and inability to develop a strong sense of self was also documented by Davis and Marsh (1986) in their two case studies of bulimic adolescents. This confusion alone would not necessarily be the cause of bulimia, but it represents a "constellation of symptoms" (p. 232) that contribute to the proclivity of an individual developing bulimia. Subject 1 gave the impression that her Self Identity was vulnerable and very unstable. She usually smiled, dressed stylishly and told jokes, but underneath this outwardly confident behavior was a sense of searching for self. In the open-ended questionnaire she responded to the phrase, *When I was growing up...* by writing, "I never felt a true sense of direction". Another problem for S1 was her inability to let her true feelings be known. She had difficulty distinguishing between what was real and what was false. Not only did her feelings become confused but her behavior was incongruent in
that it did not reflect the way she felt. The inability to feel and to show the true self, but rather to mask it with an untrue self and the tension that this creates parallels the thinking of Jones (1985) who noted the chronic tension between "the true self and false self" (p. 311).

S: Yes, as long as I appeared, appeared happy, then everything would be O.K. As long as everyone else thought I was happy, then I could live with not feeling that great as long as everyone else thought I was, you know,

I: Keep the appearance.

S: Right. (pause)

In experiencing the tension between the true self and false self, S1 managed to avoid feeling her true feelings and the fragility of her identity became that much greater. She talked about doing things that were foreign to her true self, which was also a problem for S3.

Cheating in college was an example for S1 as shown below:

I: You saw that, I'm sure, all around you. People are, people are always cheating on something.

S: Oh yeah, but I was right along with them, you know, not, not to the extreme, I don't think, but I was right there. The feeling, gah, that is so unlike me, I mean I am so conscientious, and then having all those feelings on top of feeling guilty about what I was doing. I was just always overwhelmed with feelings.

Subject 1 gave the impression that she was walking through her life on eggshells worrying about other people's opinions. Subject 1 showed a lack of spontaneity which could be attributed to her need to do things correctly. As S1 said:

S: I mean I didn't have the spontaneity that a lot of people my age had.
S: Yes, that it seemed like I was always so overly cautious.

A major issue for S1, as it was for S2, S3 and S5, was changing her view of life. She possessed an idealized view of the world and her relationship to it. She believed she should always be happy. She couldn't conceive of the possibility that there might be times of failure and sadness. In the following excerpt, S1 came to the realization that the individual cannot be happy all the time:

S: I think now, I kind of, when I think of towards myself feeling happy or content, it scares me because I know I won't feel it all the time, you know, there's always, you're always questioning yourself and always and everything is so extreme to me, I mean I feel like that once I feel good about myself it's going to be continuous. I'm going to be continuously moving forward. I'm going to always feel great about myself. I'm going to have it together, and I'm going to be, I'm going, you know, just be dynamic.

I: On a constant high.

S: I mean, yeah.

I: Life's not a constant high is it?

S: Uh uh, and that shocks me.

I: That shocks you?

S: Like when everyone says, you know, do you think you'll ever feel great about yourself and, you know, it like makes me mad that some day I won't feel that great about myself all the time.

I: Hm.

S: I guess it's just accepting things on life's terms.

Subject 1 spent six weeks in the eating disorder unit of a hospital and, after being dismissed, had several relapses. As of fall 1987, she
re-enrolled in college as a junior and was both scared and excited. At present, she is continuing with individual and group counseling, still finding it difficult to deal with the ambiguities of life, which is also true for S5. This was especially apparent in S1's relationships. She didn't like things hanging over or misplaced, but preferred a world of neat packages and 90 degree angles:

S: I always felt like I couldn't be caught up, you know, I couldn't be, I was never caught up or cleaned up with, in my relationships.

I: Yeah, that's another phrase you like to use is cleaned up. The ambiguity and loose ends

S: Mm hm.

An issue for S1 was her inability to handle the inconsistencies of life. She demonstrated occasional inappropriate impulsivity, also a problem for S5. Under such circumstances, S1 was unable to express her feelings. An example of this was seen in her relationship with her father with whom she had a tenuous relationship.

S: Mm, it was the spring semester of my sophomore year and this was when I was living in the dorm with ----, I mean I cannot, this is so weird, I think, but mm, it was like a month or so into the semester and I hadn't even talked to my dad like since school started and then he, so he finally called me one day and said uh, and the first thing he asked me was, you know, how my grades were, and I got so pissed and was like what, and he goes, "Well, how are your classes going?" you know.

I: What did you get pissed, what did you get pissed about?

S: That was the first thing he asked me, I mean I hadn't talked to him in a month. I was like pissed, oh I was. I, I don't think I'd get that mad now, I mean that's what I was supposed to be doing was school.
I: You sound kind of mad when you talk about it.

S: God, I mean ah, I got so mad, I mean it was like how are your grades. I was so, I mean I go, I go well, "I'm doing just fine. Thanks a lot." Hung up. Didn't go back to class, I mean I got a full time job, didn't go back. Can you believe that is so, that's like rebellious, I like made up for everything in one sweep. That was weird, I mean here I'm supposed to be getting an education for myself and totally blow it off because my dad doesn't phrase a sentence right.

Subject 1 did not feel comfortable when she was with her father.

The segment above described the culmination of what had been a strained relationship as well as providing an illustration of S1's inability to express her emotions appropriately. Another example of the distancing between S1 and her father was:

S: My dad said to me about that, he goes, "You know, uh, I always assume you're doing good unless I hear otherwise," he goes, "and don't waste your time calling me if you're feeling good," he goes, "I," well, he didn't mean it like that but it was like, you know, I assumed everything was O.K. unless you say otherwise, you know, I can't do anything if you don't call me when you're upset, but, you know, I was like what are you talking about, you know, we never talked about being upset and stuff before. All of a sudden you're telling me to turn to you and confide in you. (pause)

Subject 2

Subject 1 was able to camouflage her feelings of distress and pain and still present a good superficial image for the moment; however, S2 revealed her feelings in a more obvious way. Her high degree of sensitivity contained depression and an innate sadness which were manifested throughout her interviews. Her voice and deliberate speech patterns often emphasized this feeling of sadness. In S2's responses to the open-ended questionnaire, some of these feelings were revealed. In
response to *When I was growing up* ... S2 said, "I felt different and awkward. For *I always felt I had to* ... she replied, "Try and make people like me," and in answering *My body* ... the response was that it "has never looked right to me." Subject 1 was able to smile more while S2 appeared rather strained and tense. Subject 2's negative feelings about herself, especially in junior high school, were as follows:

S: I was pretty much a social outcast at that time in my life. I was mm, very, a very big tomboy, mm I didn't care about looking pretty. I didn't care about guys. I mm, didn't feel I was very pretty. I felt I was very homely.

Subject 2 had not been hospitalized but had been in individual and group therapy for three years. Although Russell (1979) pointed out that it is difficult to investigate the premorbid personality of a bulimic as it merges with the symptoms and disturbance caused by the eating disorder, in the case of S2 her personality, as observed during the interviews and later the transcriptions, had serious depressive qualities both before and during the bulimia.

S: I'm just saying that sometimes I would get an overwhelming sense of dread. Maybe that was when I was really depressed, when things were really down mm, sometimes I think it was just being scared of living, being terrified of, of feeling like I wasn't successful in life, I wasn't successful in just living the life like everyone does.

I: Uh huh.

S: I mean I couldn't seem to do it, I couldn't seem to do what I was supposed to do and I saw myself as somebody who didn't fit into this world.

Subject 2 continued by saying:

S: I think, I guess I would say part of the dread is just the feeling of sometimes, oh things would cave in and I would just have this overwhelming sense that I would
never be able to climb out of this hole, I would never be able to be happy, I would never be able to fit in with other people. It was just a, I think, an extreme sense of mm, doom, of just not, not being able to make it work.

Subject 2's self image was so integrated into her depression and so vulnerable that her struggle with bulimia seemed lengthy. It appeared that it was S2's *bulimic personality* that needed to be addressed which should be distinguished from her *bulimic behavior* which had been in abeyance for over a year at the time of the interviews. It is important to differentiate between the bulimic personality and bulimic behavior. The latter is usually the first to manifest itself but the former is the more deeply ingrained and can often linger long after the behavior has ceased.

Like S1, S2 had a fragile Self Identity. Both these subjects also shared a distorted orientation to life. In the words of S2:

S: I did not feel it was O.K. to fail. I did not feel it was O.K. to make bad grades. I didn't feel that failing and making bad grades were a part of life or, you know, just I didn't feel that, that failure was a part of life and that failure was sometimes the path of succeeding, that sometimes you had to fail to succeed. I saw failure as totally bad and totally scary and so rather than even try to succeed at all, failure would over-intimidate me.

Another characteristic of S2 was her inability to make decisions. It was easier to give someone else the burden of making choices.

S: I mean I would not, couldn't go to the mall and make a decision on a dress without my mom. I'd go to the mall by myself and I'd look at clothes and then I'd take my mother back and, if I was really in love with something, I'd go show it to her and if she thought it was ugly I wouldn't buy it. So I didn't have any confidence in making decisions on my own.
This lack of self confidence spilled into S2's decision-making process, a characteristic which was observed in all five subjects.

Of all the subjects, none had as strained a relationship with her mother as S2. Subject 5 showed some conflict with her mother but it did not appear to be nearly as deep-rooted as with S2. Subject 2 showed both resentment and anger toward her mother and blamed her for not presenting S2 with the image of an attractive, confident, feminine woman that she could follow.

S: I needed a role model. I needed a mother who had confidence in herself. I needed a mother who was outgoing, who liked herself, who thought she was O.K., whether she was pretty or not, who made the most of herself and wasn't, wasn't a quitter, and my mom was a quitter. My mom basically said I'm ugly, I'm not that pretty, so therefore I quit. I won't try to make myself look pretty, I'll walk around like I'm ugly, I'll mm, tell people I'm ugly so I'll beat them to the punch. And I think I grew up feeling like I was doomed. It was a doomed situation.

Subject 2's low Self Identity was so deeply entrenched that she gave all the power for her own value as a person to other people. She did not have the inner strength to take this responsibility upon herself.

Subject 2 had a strained relationship with her father because she felt uneasy around men, though this did not apply to her relationship with her two younger brothers:

S: I grew up being uncomfortable with men or males in general, and mm, didn't want really anybody male to deal with me.

She continued:

S: I went through a stage in my life, and I still even mm, wouldn't, where I didn't want my dad to hug me,
didn't want him to get near me and I would just cringe when he would come to give me a hug.

When S2 was asked if she would react differently with a female interviewer, the following dialogue ensued:

I: Do you feel uncomfortable with us talking? Let's see, if I were a lady doing the interview

S: No, but I'll be real honest with you, when you first were, when you were first in the group it made me uncomfortable.

I: Mm hm.

S: And I don't know why. And I, it had nothing to do with feeling threatened by you, feeling awkward, maybe I felt weird opening up and telling my feelings with an, an older man maybe that I saw in the light similar to my father.

Subject 2 appeared to be completely forthright in her responses. She had an excellent ability to articulate feelings and concepts and seemed to share deep thoughts with the interviewer. Of the five subjects, S2 was the only one that brought up the topic of religion; however, she still did not seem confident about her own belief system. Her validity of belief had been determined by others. Her lack of confidence in this area seemed to be tied to aspects of her bulimic personality. Subject 2's confrontation between her beliefs and those of her friend was as follows:

S: I'm just now coming to the idea that was always a big battle, an emotional battle for me, from being a little kid

I: O.K.

S: And it always has bothered me and I've always tried to adopt whatever principles, whatever religious beliefs friends have had.
I: Oh, I see.

S: And in college especially when I lived at the sorority house and I went to chapter church every weekend and my roommate in college was extremely devout, and a couple of guys I dated were strong Catholics, and so I just got to see a little bit of everything and I'm just saying it always made me feel worse about myself. When I was going to church I was more bulimic than I was before.

I: That's interesting.

S: I felt like I didn't fit in. I couldn't do it. I didn't feel what they were feeling. I tried and I tried and I tried but I didn't have the same feelings they had and the same, so I think now as I gain my confidence and I let go of the bulimia, I'm able to start thinking now for myself.

I: Thinking for yourself.

S: For the first time in my life and I'm able to start deciding that maybe whatever I think is just as good as what they think and maybe it's O.K. to think what I think and maybe it's O.K. to not even think what anybody else thinks.

I: Hm.

S: Maybe it's O.K. if my view of religion is totally and completely a personal view that no one else has to relate to. Nobody else has to believe it and

I: It's just yours.

S: But I can, but until I can have the confidence in that belief, it's not going to do me very much good.

Subject 3

Subject 3 appeared to display a more positive view of life than S2. The difference between S2 and S3 emphasizes the findings of Swift et al. (1987) who observed that bulimia "has a heterogeneous outcome pattern, with some patients doing well and others remaining severely afflicted" (p. 52). Not all bulimics are the same. There are differences
and nuances among them. The first two responses of S3 and S2 to the
open-ended questionnaire show their different perceptions of life. In
response to When I was growing up . . . S3 wrote, "I remember always
striving to challenge myself by taking on one new activity after another.
I didn't ever believe in limitations; I felt I could do it all." Her answer
to the question I always felt I had to . . . was "Be the best, no matter
what. For example, I wanted to be the 'best-liked,' the best 'best
friend,' the 'best of the class in grades,' and the 'best student leader.'"

Subject 2's relationship to her family was strong. She felt they
were supportive of her and she felt people around her had high
expectations of her.

I: What do you think you heard from people?

S: It was always encouragement. I had a lot of praise
and encouragement for the things I was doing. I don't
remember getting in trouble mm, I remember that was
the time even my grandparents, my grandparents would
uh, give my brother and I like a dollar for every A we'd
bring home on our report card, and so that was when I
started saying let's see how many A's we can get, and it
wasn't necessarily for the monetary, but to just be able to
say, "--- (subject) got started. She brought home five A's."

From an early age, therefore, S3 was goal and success oriented.
Achievement and Recognition were important to her. Her
environment had a great influence on her thoughts and behavior.
Hotelling (1986) stated that sociocultural messages about being a
woman in society have become "a powerful predisposing factor in the
development of bulimia" (p. 202). All the subjects were concerned to
some extent about their figures. At some point during her junior high
school years, S3 became preoccupied with her physical appearance, and particularly her weight, which was changing much to her regret.

S: It was, I mean I, I was so much more critical on myself about how I looked now, and I was more, I was confident and sure in junior high, and everyone, I think, starts opening their eyes about mm, a shower every day, curl your hair, but now it's like I'm not good enough if I don't, you know, I won't be good enough, I won't be liked any more

I: Unless what?

S: If I stay this size, if I'm fat. (pause) And I can remember lying on my driver's license saying I was, I had the same driver's license. It says like I was 100, 105 pounds. It says I'm 100 pounds on my driver's license or 95 pounds, and I was like 105 plus two, but yet, it says I'm 95 pounds and I was 105 pounds. This was when I started lying about my weight. I wanted to be back at 95.

I: Come hell or high water.

S: Mm hm. And I wasn't getting down there, that's the thing is I wasn't with this bulimia, actually I wasn't getting down there. And so, I guess, I started realizing there's no way I'll go back to that, you know, now I'm changing but I gotta stay here. I can't get any more, I just can't get any more. But I was eating more, I was purging more.

Subject 3 seemed to be self-motivated which did not appear to be the case with either S1 or S2, but was true of S4 and S5. Subject 3 received encouragement from the adults around her, parents, teachers and friends, but peer pressure increased dramatically in junior high school. Subject 3 felt she had to maintain a certain physical image of herself, yet this image had been determined by others.

S: I wanted a boyfriend who was popular too. (pause) So anything that was, that didn't seem right or didn't look right and oh, I'd add a, I'd put on four or five different outfits before going to school because the first three would
look like I was fat, the fourth I couldn't decide and I just agonized in going to class every day what to wear, you know, everyone was looking at what I wore . . . I kept seeing myself as fat, fat, fat. And that's not what I should look like. I need to look better, I need to look good all the time.

Subject 3's feelings of needing to be right and appearing to be right contributed to her inclination towards bulimia. She was able to control her success in school and athletic activities, but she needed something extra to help her with her weight problem.

S: The way I viewed myself then was I could do anything I wanted to do, except I couldn't be the weight I wanted to be, that I had to use something to help me there, but everything else I felt that I really had very few limitations

Subject 3 had a problem during her bulimia trying to understand how she could be doing something against her true nature. The bulimia assumed characteristics which she considered to be outside of herself.

S: The bulimia became almost like this other side of me, that I felt was like someone, you know, that this bulimia was like a spirit or something . . . it was something that was, I couldn't shake it off and it, it started becoming really scary when I realized, you know, every time I had a free moment I was running around either trying to get food or get rid of food.

Subject 3 drew an analogy between the bulimic and the cigarette smoker or someone that uses drugs:

S: Mm hm, I mean I use it as a fix like a cigarette or some people that have a fix on drugs, and I think a lot of times when I know people that don't, that have a cigarette kind of like they want to be able to have something that kind of calms them down, something that they can kind of not feel the real feelings that are, you know, the panic feeling or scared or crying, whatever it may be. And that was kind of what mine, you know, bulimia was like.
In the following excerpt of an incident that happened when S3 was in the kitchen with her mother, who then knew that S3 had bulimia, S3 revealed clearly what bulimia is not:

S: My mom was going, "Now, --- (subject), should I take these kind of foods out of the cupboard? Will these bother you?" And, "Mom, you don't understand. It's not the foods. It's how I deal with situations now."

Subject 3 verbalized very sharply the bulimic's inability to perceive boundaries. This feeling seemed to permeate S3's world while in high school and in college:

S: One side of me is saying I really like food, and the other side is saying I like it so well I don't want to stop eating it. It's controlling me mm, I never knew proportions or limitations when I was bulimic and so I kept, and because maybe my, I kept saying to myself, I have no boundaries, I have, you know, no limitations. I can do it all. I can achieve it all. That was an attitude of mine. I think I felt the same way maybe about food. I can eat anything I want and not ever gain weight.

As well as perceiving no boundaries, S3 was also looking for an instant solution to everything.

S: I used to think that there would be this quick way that I could be everything, you know, just like a quick way to get rid of the food, everything was real instant, like instant gratification, instant relief, mm, instant anything.

The compulsive nature of binging and purging was very powerful for S3. In the following excerpt, she explained the grip the disease had upon her and its almost magnetic force that pulled her into the bulimic mode:

S: I feel so disgusted when I'm full. You're ignoring the feeling of maybe why I went and overate. You're ignoring that. I've just got to get rid of that, and that was, I mean it didn't matter what was going on at the time, you could just pretty much bypass what any person was
saying to you, didn't even hear it. You could go through any situation to get where you wanted to be—at the bathroom.

Subject 3 recovered from the bulimic behavior while in college and she also made significant changes within herself enabling her to change her bulimic personality. She was helped in this by her determination. Her realization that she must change is revealed in her statement:

S: Even when I was little mm, there were a lot of examples of just how I'm a self-starter in things I do mm, whether that started with bulimia, whether it was starting as the first girl on a male soccer team . . . I still start up projects; sometimes I don't finish them but the majority of things I start up, I usually do finish, and like maybe by starting with the bulimia, I felt a responsibility to finish, you know, to end it mm, I came to the realization if no one else does it, I have to do it for myself or no one else can do it but me.

Subject 3 continued:

S: I thought it was one of those things where you got to a certain point, you had to decide what to do, sink or swim, and so, I guess, that it was a big inner strength. It was one of those feelings. I was just fed up and I think I can't even, I'd pushed myself to such an extreme that I realized something just was bound to break if I didn't do something.

Subject 3 achieved an important substantive change in her life which was not the case with S1, S4 and S5 who needed to learn personal responsibility to overcome the bulimic behavior and bulimic personality. Subject 2 needed a strengthening of her own Self Identity to transcend her bulimic personality.
Subject 4

The lowest moments with bulimia for S4 were not as severe as the experience had been for S1, S2, S3 and S5. Subject 4 maintained that her bulimia began due to environmental influence, specifically her boyfriend:

S: I don’t think it would have started in the first place because, I’m not blaming it on my ex boyfriend but he’s the one who made me aware of it, and I hadn’t been until then. I didn’t have a problem before then because I wasn’t worried about it and I think, you know, men do push stereotypes, but then again, not every man likes a real skinny woman, but somehow society has dictated that, and I think if I had been around a different kind of person, I wouldn’t have had that problem.

Throughout her interviews it became apparent that for S4 bulimia didn’t demand as much of her attention as it did for the other subjects. At the time of the interview, however, S4 had not stopped bulimic behavior although it was occurring at a low frequency rate. Subject 4’s main concern was with her thinness and a fear of being fat.

I: Do you have a fear, I mean a real fear, not just sort of casual, of being fat?

S: Oh yeah.

I: That’s something that really gets to you.

S: Mm hm.

I: Fear of being fat.

S: Definitely.

For some bulimics there is a part of bulimia that is attractive as has been shown by S3 and is especially true of S5. In the case of S4, she was able to maintain her physical image with what she considered to be a quick solution.
S: It turned out it was a perfect solution. You can eat whenever you want and, you know, it’s, you get it down to a science. It’s so quick and easy and painless, you know, it just gets more and more attractive and it’s a vicious cycle.

With regard to achievement, S5 and S3 were both filled with intensity about getting the A. Subject 4 did not have this all-consuming purpose.

I: What was important at that time? (pause)

S: Probably just doing what I do well.

I: Yeah.

S: Not perfectly, but just well, I would say, you know, mm, I tried to get straight A’s and did a couple of times but, you know, when I didn’t that was fine.

Subject 4’s responses to the open-ended questionnaire revealed what appears to be a basically happy individual who sees herself and life in a favorable light. Her views of life are pragmatic. In response to the question When I was growing up . . ., S4 wrote “I was a very happy child. No worries.” She wrote that I always felt I had to . . . “live up to people’s expectations, especially mine. (But without comprising my values.)” She noted For me to believe in myself . . . is essential. I do, and it has made all the difference.” She wrote that Failure is . . . something to avoid, but it will happen occasionally.

While it appeared that S4’s condition was not as critical as that of S1, S2 or S5, there seemed to be some degree of denial ingrained in her relationship to her bulimia and, at some point, this will have to be dealt with. She still clung to bulimia.
S: I think, I mean someday it'll just click and I won't have a problem any more because I really think my thinking is pretty much straight. It's just breaking that habit.

Subject 4 believed that she did not have any denial.

I: Where do you think denial comes in on that?

S: Well, it's like I don't think I deny anything.

I: You don't think you deny yourself anything. What about your emotions though? What about your, you know, you deny like I'm really not, I'm not angry about anything, I'm fine, when really you're very angry about something.

S: I think I'm pretty honest with myself.

I: You're pretty honest with yourself. (pause)

S: I can't think of anything I really deny.

I: You can't think of anything.

And yet, in the final interview with S4, the dialogue indicated that denial was present in her thinking.

S: So, it obviously didn't bother me. That's good but I have to watch it that I shouldn't gain too much weight and get back into that again. I don't think I will, but it just won't help, you know, especially with spring coming up and we'll be in bathing suits and

I: Mm hm.

S: It's just not, you know, a bathing suit is, I've always enjoyed it and

I: You really enjoyed what?

S: I like, you know, I like summer clothes and bathing suits.

I: Sure.
S: Because I've always looked better than most people when I was younger and I mean, you know, even now, but

I: You said live better?

S: Look better.

I: Look better, O.K.

S: And I have to watch that so I don't, you know, worry about it any more because I don't need to, I mean I'm O.K. now but you know what I mean.

I: Big deal.

S: Yeah, so I'm just trying to kind of keep a check on that.

I: It seems to me that one of the issues you have, you need to deal with for yourself is the fact that you say one thing but you really almost do another, in other words, you really are denying yourself a lot. There's a lot of denial going on with you. That's what it sounds like. I'm not sure.

S: Mm hm. There is and there's certain contradictions in me that I can see.

It was noted that S4 was a little reserved and on her guard. At moments during the first interview and part of the second she was reticent. As the interview progressed, she became more relaxed and comfortable, but, for the most part, she lacked spontaneity.

Subject 5

Subject 5 was quite different from S4 who spoke succinctly and to the point. Subject 5 was involved with the interview almost immediately and would almost always speak about any subject at great length and with intensity and enthusiasm. Subject 5's desire to accomplish and be the best at whatever she tried was evident from the outset:
S: I started seeing that I was capable of accomplishing these things, like I'd just take tests in, in class with all my friends and I'd always score the highest, and it wasn't like I tried any harder. I didn't study any harder, and I was a better cheerleader than my school friends because of my gymnastic background, like I was the best gymnast. I wasn't the most popular by all means, but I could tumble better than anybody else.

Throughout her interviews, S5 displayed a strong desire for achievement in any task she undertook. This desire ultimately affected her perception of having just the right body, weight and image. In pursuit of these goals S5 soon became trapped in eating disorders, first with anorexia and then with bulimia. Subject 5's concern with weight became an all-encompassing obsession, even involving her aptitude with numbers:

S: Oh, completely obsessed, like I'm to the point where I'm trying to get out of that right now. I still find myself counting calories, like I know how many calories I've eaten today, like a list. I don't think about it, but still, after that many years, it's just a habit. So I started losing weight and I was so excited. It was the first time that I had ever really lost weight and kept it off, and after I got down to like 102, like 12, 13 pounds, I was so excited. O.K., this is good weight. But I didn't want to gain it back, so I kept my calorie intake real low, and I got down to 100 pounds and I thought, oh God, I started feeling kind of weird. It was like this is just too weird. I can't believe I can do this, and then I read all the statistics of, you know, anybody can lose weight, you know, only 2% can keep it off; that's the hardest part. So I thought, O.K., I'm gonna be one of those 2% who keep it off.

I: So you thought, so again this idea of having a challenge

S: Ohhh

I: So you
S: I could get high off of getting on the scale and it was low.

With all her energy and enthusiasm, S5 still had bad feelings about herself. In this she was similar to S2:

S: I kind of always felt weird my whole life. I felt I was just different from everybody else and I've always been paranoid that they think that, that they see the difference as weird. Different doesn't bother me. I just don't, I never want people to think that I was weird because there's nothing weird about me. I just felt weird.

Subject 5, like S2, also blamed her mother, but in the case of S5 it was because her mother kept telling her that life was wonderful and that everything would turn out all right:

S: She thought that if she told me everything was O.K., then I would believe that, so, I mean that's, that's the reason for all those lessons when I was little and having all those things that she didn't have, so she could show me that everything was wonderful and life was going to be great. And that's why I just can't believe it. Here I am, 21 years old, and I'm finding out that life isn't wonderful. Life, every day you wake up, you don't just love the world to death, and that you're not happy and you don't, I mean live happily ever after like a little princess. I really felt that's how life was supposed to be. And then when I would be depressed it would just kill me because I just, you know, then,

I: I'm not feeling right, I'm not feeling the right way.

S: It's just like what's wrong with me. Why am I, I mean I always thought there was something wrong with me if I was depressed. Everybody gets depressed. It's a part of life and life isn't always wonderful.

Subject 5, like S2, was often depressed. She attributed this to being a serious person:

S: Yes, I've always been depressed. I just have a tendency towards that because I'm more serious than other people are, like it was so much easier for other people just to let down and go out on Friday night and have
fun and don't worry about it, don't worry about the test on Monday. I wasn't like that.

With all her external achievements, S5 was unable to find a strong Self Identity. Her worth became determined by how she felt she looked and how much she weighed:

S: I was so affected that how much I weighed determined how much... how much other people accepted me. That was what I did it for, but it turned into the fact, it turned into how much I weigh determines what I think of myself.

I: It determines your happiness almost.

S: It determines my, my worth.

I: It determines your worth.

S: If I woke up and gained two pounds next morning, I wasn't worth anything that day. I hated myself for it.

The bulimia, which began as something external, developed into a profound obsession for S5. The bulimia had become internalized and her relationship to it assumed the qualities of a relationship with another person. In the words of S5:

S: I wasn't about to give that up. That was the most important thing in my life. It was my privilege my mm, reward, my obsession, my fascination, my, all those things.

I: Your love.

S: Yeah.

I: Almost.

S: It can be compared to that in a lot of ways. It's like, I mean you see these soap operas where the girl loves the guy so much and she knows that he's bad for her and she's not about to go with him and da-da-da-da, she says these irrational things because she's so in love. Love just makes you so irrational, and it's just, bulimia is like the
same thing. I found that the first time I made that analogy I just started crying. I was so scared that I was in love with this.

From S5's open-ended questionnaire, she wrote *I sense within myself . . . "such strong emotions—anger, fear, fright, love, sadness, hopefulness, hopelessness, wonder, awe, understanding, sympathy, empathy, passion, . . . that it scares me, intrigues me and excites me."* She responded that *My body . . . is "unbelievably healthy as far as I know considering all the hell I've put it through is important to me. It seems funny that I never thought of all the bulimia as harmful. It just seemed to be the price I had to pay to be skinny."* She wrote that *For me food is . . . "anywhere from nourishment to reward, to friend to enemy to 'controller' to magical to disgusting to private."*

Subject 5 seemed to be a turbulent individual who felt intensely about most aspects of life. After six weeks of hospitalization in an eating disorder unit and over a year of individual counseling following her hospitalization, S5 was still not free of bulimic behavior nor of the bulimic personality. As of fall 1987, she was back in school but still struggling to free herself of bulimia.

**Analysis of Categories**

Nine categories emerged from the transcriptions as a basis for characterizing the bulimic individual. The categories fluctuated in their emphasis and frequency depending upon the subject. The categories cannot be thought of as completely separate from each other because they often interact and build within each other. The internal reliability questionnaire given to the evaluators indicated the
possibility of more than one category being found in any passage. The data of this study do not support the concept that one category alone can make someone a bulimic nor even that two or three categories can, but rather it is a combination of all these categories superimposed upon the individual's premorbid personality that may make one a possible candidate for bulimia. Davis and Marsh (1986) noted that "Bulimia appears to be part of a constellation of symptoms" (p. 224). Even when all these categories are found in a certain person, this still does not give us an indication of the severity of the bulimia; for example, S3 and S5 had the characteristics of all nine categories. Subject 3 was able to overcome the bulimia whereas S5 was still struggling to be free of it. Subject 5 lacked a strong Self Identity and had to battle constantly her inclination towards depression. Individual differences among the subjects must be kept in mind (Love, Ollendick, Johnson & Schlesinger, 1985).

In the coding and category system as outlined in Chapter II, there were seven framing codes under which the nine categories were placed. Below, the framing code is mentioned first, then the appropriate category with examples from the transcriptions, followed by a commentary.

**Internal Perception**

**Physical Image**

**Subject 2**

S: I can remember getting home from a football game and mother said that I needed to go on a diet, that she couldn't believe it but she saw me down there on the
football field and I looked like a little pear, my rear and my legs were so large, and that she was going to help me go on a diet, so we started doing, going to the diet center, doing the diet, the Scarsdale Diet or something. I lost some weight, looked a lot better and that was right before I started dating --- (boyfriend) is when I lost the weight.

Subject 3

S: I was real self conscious about I like being a size one and three, well now I'm going into like a size five, and my two other girlfriends --- and --- are still back in size one and threes, and now I'm going to a size five, and all I could think about is I didn't want to be like those other girls in cheerleading squad. I wanted to still be the cute little --- (subject).

Subject 4

S: I remember looking down and, you know, it was actually just something almost bulging out a little bit and it was just like wow, you know, 'cos whereas before, you know, when I put my leg down on the ground it didn't spread out or anything, you know, and I got, I probably gained about ten pounds and mm, when I gain weight it's right here, and so that's where I noticed it, you know. Things started getting a little tight and it was just basically kind of scary.

Subject 5

S: And my legs were, I thought, proportionately much bigger to my body than they should have been because they used to be real nice and slim. Then, when I quit gymnastics, I thought all that muscle turned to fat. It didn't but

I: It didn't but you thought that

S: Yeah, I thought that. I would look in the mirror and think how big my legs were. So, I decided I have to lose some weight and I started using, I mean full force, will power all the way, O.K. . .

One of the characteristics quite common to bulimia is the extra attention placed on Physical Image. What invariably happens with the
A bulimic is that concern for body image is translated into one's worth as a human being. Most young women between 15 and 20 years of age are concerned with their bodies; however, the bulimic takes this concern to an extreme. Body image becomes an all-consuming quest. Davis and Marsh (1986) pointed out that this stress on the Physical Image is actually a narcissistic investment in the bulimic's body and "appears to be a defense against lifelong feelings of incompleteness, i.e. against their impaired sense of self" (p. 230). The data from this study indicate that some bulimics connect the Physical Image, self-worth and identity.

**Self Identity**

**Subject 1**

S: O.K., but in all those things that I did, I mean that there was never, I was never like great at one thing, you know. If (pause), I don't know, I really don't remember what people told me, I don't think I really, I don't know, I think I just tried to identify myself as how I achieved in certain things.

**Subject 2**

S: Gosh, I think in the last six months I've just made major steps and bounds in figuring out what's going on with me. I used to be so confused. I still feel I'm fairly confused but I'm, I'm now feeling like I've really broke through some deep, you know, I don't know what you want to call them, some deep walls I've had up and I, you know, I'm really starting to feel that I am gaining some perspective on who I am.

**Subject 3**

S: I kept thinking, if I go to college I know there's going to be a lot of pretty girls down at --(college) in -- (town) and uh, I started just worrying and fretting over that and couldn't accept myself for even, I didn't even know myself.
Subject 4

S: Mm hm, but I never, you know, he (boyfriend) humbled me which I didn't need, you know, I mean I wasn't overly confident by any means but, you know, he made me feel like I had a whole lot of work to do and mm, he put pressure on me, you know, that I didn't need at the time, and mm, I think that had a lot to do with, you know, when I started bulimia

Subject 5

S: That's what I think I'm trying to find and what I'm in the process of finding even mm, a sense of constant or permanent permanency within myself because that's really the only thing that is going to be permanent with me. There's going to be, I mean my attitudes, my views, my opinions, my values, they might change in depth but the --- (subject), just the plain --- (subject), that's really the only thing that I've got to keep that real permanent with it, like I've got to figure out who that is so I can trust that person and know me,

This category is an important characteristic in studies of bulimia (Slade, 1982; Jones, 1985; Davis & Marsh, 1986; Caffary, 1987). At the center of Self Identity is the perception of reality (Hooker & Convisser, 1983). Instead of reality and Self Identity being linked in the individual's experience, "food and the eating experience become reality" (p. 237). The social cultural perspective also influences Self Identity since the environment exerts pressures on the bulimic with "the cultural equation between thinness and attractiveness" (Hotelling, 1986, p. 204). The amount of effect that the environment has on the bulimic depends on her inner strength and the clarity of how she defines herself.
Emotional Blocking

Subject 2

S: You start dealing with the issues that brought about that personality so, if anything, the intensity that I used to feel when I binged and purged is now worse, or has been worse, than it was when I was actively binging and purging because that seemed to relax or calm it or get, disrupt it for a while.

Subject 3

S: And I just had up so much pent-up energy and internalization that uh,

I: When you say internalization, what does that mean to you?

S: Just bottled-up emotions.

I: Bottled-up emotions.

S: And uh, bottled-up frustration and criticism. I was just really hard on myself.

I: And so as we look at it, which is interesting, is the binging and purging was at this point sort of an outlet.

S: Mm hm, that was, you know, a release for me. I thought, I mean that was, I thought it was a purging emotion. These emotions I had, well, I never went through the process of telling people how I felt,

Subject 4

S: Everything was planned and when I broke up with him that just threw everything up into the air which is very good, but, you know, at first it was, I guess it was, you know, a lot harder than I thought. I seemed really happy. In looking back I think it was a kind of false happiness but mm, you know, like I said, I did really bad in school and I just, you know, I wanted to forget the whole semester.

I: So when, so it was emotionally related, so when that really happened did the bulimic dynamic.
S: That's when I think it, you know, evolved.

I: Increase.

S: Into something more.

I: Uh huh.

S: Because I didn't have time for it all and it started taking up time, you know, a lot of time.

I: Oh sure.

S: And mm, it moves from just maybe getting rid of a meal to binging to get rid of a meal

Subject 5

S: I mean, like I just got through saying obsession and what were the other things I said bulimia was for me, a reward, a kind of privilege, an anxiety reliever, and let me escape from confusion. When I couldn't, didn't know what to, how to deal with myself or how to deal with a situation, I don't really have to deal with it if my mind is completely concentrated on food or where am I going to get more food or how am I going to get rid of this food.

In this category it becomes evident that bulimia has the power to suffocate emotional expression and distort affect. Dealing with Emotional Blocking needs particular emphasis after binging and purging has decreased since the real issues which have been buried must now be dealt with (Hooker & Convisser, 1983) as well as an emotional passivity which occurs (Caffary, 1987). In the researcher's work during the past year and a half as a co-counselor in a bulimic after-care group, it was observed that dealing with Emotional Blocking is at the core of dealing with the bulimic personality. The bulimic patient is encouraged to feel again and be able to deal with real emotional issues.
Orientation Towards the World

External Locus of Control

Subject 1

S: Well, you know, one thing I think was wrong, but I was talking with my mom about a while ago was that growing up mm, you know, all I heard was oh, like I'd do something good and it was, "Oh, we're proud of you, oh we're proud of you." Then I started turning to them to see if they were proud of me or turning to other people and I never really felt proud of myself.

Subject 2

S: You know, like, but I've always looked for other people for my acceptance to feel I'm O.K.

Subject 3

S: Well, yeah, one way of thinking of it would be while I was bulimic I felt like a puppet. Other people were pulling my strings. If it was to put up a smile on my face, raise my right hand, someone, something would pull my hand, pull the little string mm, you know, something was always above me, controlling me, someone's opinion, someone's comment, uh, someone's behavior towards me, whatever, those were things that were controlling me.

Subject 4

S: And that had a lot to do with the start of bulimia, that right there because, you know, you see this bulge (on subject's stomach), you immediately say, oh I've got to lose weight.

I: Get rid of that.

S: You know, that's not going to work because I had it, you know, before. It was just an anomaly on me and, you know, I've still got it but I can live with it now, but mm, I know that has a lot to do with it and, you know, he kept pressure, he put pressure on me in the fact that the girls he admired on T.V. or something

I: All had the flat stomach.
S: Yeah, but they were very thin.

I: Very thin.

S: And very tall and very blonde. He never liked anybody but a blonde.

**Subject 5**

S: Well, I thought I didn't, but the reason I got skinny was for everybody else so they would all like me, I mean I wanted all these honors and titles so that everybody would like me and think I was neat. They would say, "There goes --- (subject), wow, you know, wish I could be her.

I: Mm hm.

S: Something like that. I think that was what it was all for. And that is so external and yet so superficial, you know. That is so selfish in one way and then so selfless, I mean, in another way, like because I have nothing that's done for me inside. Everything's done for everybody else.

External Locus of Control, like Dichotomous Thinking, is part of the way one looks at the world. External Locus of Control is more exaggerated for the bulimic. This external influence comes from culture, peers, and families. Since the bulimic has such dissatisfaction with her Self Identity and Physical Image, the External Locus of Control is that much more powerful. Jones (1985) noted that our culture is phobic about female weight gain and the families of these women can be even more extreme; for example, "a bulimic woman painfully recalled her father calling her mother 'lard ass' when the mother outgrew a size six pants suit" (p. 307). It has also been noted that athletes "make attempts to be more appealing to their mentors by being thin" (Borgen & Corbin, 1987, p.90). External Locus of Control is a good example of a category which is inclusive; for example, it can
influence the categories of Self Identity or Physical Image. Once the bulimic can strengthen her perception and understanding of herself, reaffirming her Self Identity, then her orientation to the world can begin to change its balance and she can develop trust in herself and her opinions.

**Dichotomous Thinking**

**Subject 1**

S: I'll wake up, I won't miss class. I'll not only rewrite my notes every night, but I'll probably type them, have every word in alphabetical order, and then after I burn out I won't go to class. The first time I miss class I won't go back.

**Subject 2**

S: I had an experience this week of the same nature, all or nothing mm, either everything was going great at work—I'm dieting, I'm exercising and I love myself or everything was going bad at work—I'm eating a lot, I'm not exercising and I hate myself.

**Subject 3**

S: Right and wrong, good and bad—it's like black and white. Everything was pretty much either good or bad. You were good with food or you were bad with food. You are good with grades or bad with grades. Someone liked you or didn't like you. It's pretty, it was real cut-out; the way I saw things. There was no grey area.

**Subject 4**

S: Even to this day I'm not a perfectionist in school, but as far as food goes mm, and we talked about this some in the sessions mm, you eat one cookie and it's all over. You might as well eat all of them. That kind of extremist.
Subject 5

S: I was always better than everybody or worse than everybody. I've never been able to sit back and just say, I am equal to everybody else, we are all here on this earth and we're here to live our own lives. I was always skinnier than all those people or fatter than those people or smarter or stupider or I was real competitive. I'm not near as much like that any more. And I loved it if I was better, and if I was worse I had to do something to get better. Perfection.

When one's orientation to the world is *either or* or *all or nothing,* then one's life is governed by extremes. The bulimic's view of the world becomes distorted with Dichotomous Thinking and events assume catastrophic proportions. There is no middle ground or grey area. Ambiguities do not exist; for example, with shape dissatisfaction the bulimic sets up a system of dichotomous beliefs. If one part of a bulimic's body looks a little out of proportion, then the bulimic perceives that her entire figure looks bad. Distorted underlying assumptions need to be addressed and modified (Garner & Davis, 1986). This black or white view of the world is evident in the bulimic's affective instability (Johnson & Maddi, 1986). Dichotomous Thinking keeps the bulimic out of equilibrium with the reality of life.

*Strategy Code, Behavioral Tendencies*

*Obsessive Compulsive*

Subject 1

S: I mean the bulimia was getting worse and then I started getting into shoplifting and mm, then, you know, there was more feelings that were getting caught up in that, I mean stuff like like that really made me start questioning myself because I knew that, that underneath all of it that I wasn't dishonest, but there's all these
things, I mean the stealing and the lying and, you know, all this crap was getting built up.

**Subject 2**

S: And that was the first time I got sick. And then after that I became obsessed with gaining the weight back because I'd eaten so much and I'd unleashed this uncontrollable urge to eat a lot of food, so every time I'd eat, I'd throw up after a meal. And that's the first day it started.

**Subject 3**

S: I would take stuff from other people, I would replace it like it was, be a friend had it, a jar, a cannister in her room full of candy, and first I'd go in and visit and take one. Then, when she was in the bathroom, I'd go and take two more handfuls, stick them in my pocket. What I would try to do is like she would go out on a date, I'd go polish off the rest of those candies, zip to the store, come back and fill it up.

**Subject 4**

S: That makes you gain weight is, you know, you're gonna, you're gonna, like the premeditation, you know you're gonna give up lunch so you can have all this gum during class and it's things like that, or I'll have yogurt because I just, you know,

I: You said gum during class?

S: Yeah, I mean like I chew gum like it's going out of style. I always have. This is, you know, before bulimia, you know, I'll put it in my mouth, chew it for five minutes, spit it out, put another piece in my mouth.

**Subject 5**

S: I was just obsessed.

I: You were just obsessed with your body, how you looked.

S: Obsession is kind of even a theme of my life.

I: Obsession.
S: I think it is with most anorexics and bulimics.

I: Hm. (pause)

S: During all that time I was counting the calories every day, every single day, every single meal. I was mm, I still am to this day almost intrigued by obsession.

It is important to remember that the very nature of bulimic behavior involves Obsessive Compulsive acts, namely the acts of binging and purging (Casper et al., 1980; Pope & Hudson, 1984). Bulimics are also Obsessive Compulsive about their weight, the knowledge of food and often achievement (Maddocks & Bachor, 1986). Among the five subjects, Obsessive Compulsive tendencies exist on a continuum, some showing more and some less. Of them all, S5 would seem to be the most extreme while S3 or S4 would be the least. Obsessive Compulsive behavior can result in caloric deprivation, semi-starvation, the hoarding of food and increased obsession with food (Johnson & Maddi, 1986). Pressure from the environment on the bulimic to look thin and be successful encourages the bulimic to act in an Obsessive Compulsive way.

Excitement and Thrill

Subject 1

S: It’s weird that, that mm, attitude is carried over. I never had that attitude before until I started that and then, once I started the bulimia, it’s like what can I get away with, if there is, if there is a flaw in the system I’m going to find it and I’m going to take the short cut.
Subject 2

S: Sure. It was the one part of me that didn't follow suit, that didn't do what my parents said to do probably. There was one part of me that was like mad, angry. It was like no way, you're not telling me not to do this, I mean I can remember really being angry at them when they would suggest that I didn't need to eat that, that I didn't need to eat the cookies or the ice cream or whatever.

I: Mm hm. That is kind of sneaky to go back and uh, you know, grab a few little cookies when no one was looking.

S: Well, I was just, I was always, eating became secretive then because people were very, Mom and Dad were very conscious of me working on my weight and they wanted to help me out so, you know, when after dinner, when everyone was watching T.V., Mom and Dad would go back to the bedroom to maybe wash their face or change in their pajamas, and I'd run into the kitchen and make myself a bowl of ice cream or I'd put the ice cream in a cup so it looked like it was a coke and then I'd take it back in there.

Subject 3

S: I like the thrill of kind of taking more of a chance and maybe there was that thrill too when I was bulimic. There was the thrill of being secret.

Subject 4

I: Do you feel yourself as, you like to play pranks—you said that—do you see yourself and some people call this a secretive and lying disease, O.K.

S: Yeah, that's

I: You know, it's part of it. Do you see that as part, that sort of, it grew in, you grew into that or that was always sort of part of a little you, you know,

S: Mm mm. Oh gosh, well, I think mainly it was kind of something to get away with from the very beginning.
Subject 5

S: I would walk around with an empty coke can, not diet but regular coke can, and pretend I drank it. I would put empty M and M packages in my purse so it would look like I had eaten those so people wouldn't bug me. I mean all that deceit and dishonesty.

I: A lot of, yeah, there's a lot of dishonesty, a lot of deceit. It's an amazing part of it.

S: I had to. It was like I, I mean I had to, to get away with all that you have to be dishonest, you have to be deceitful. (pause)

This characteristic of bulimia may be broken down into problems with impulsivity; for example, the bulimic feels she cannot stop herself and, on the other hand, she enjoys getting away with it (Mitchell, Hatsukami, Pyle & Eckert, 1986). From the data of this study, it appears that all five subjects enjoyed the Excitement and Thrill of getting away with something. Johnson et al., (1986) observed that Excitement and Thrill "allows them to get away with something without getting caught or having to pay the price of overeating" (p. 16).

An associated problem of Excitement and Thrill can be kleptomania (Pope & Hudson, 1984; Mitchell et al., 1986). Subject 1 and S5 had suffered from this offshoot of bulimic behavior.

Since the bulimic blocks most of her emotions, it is possible that Excitement and Thrill provide the bulimic with an immediate rush of gratifying sensations denied to her for the most part because of internal and environmental distortion.
Achievement/Recognition

Subject 1

S: Yeah, I probably would have wanted to put the spotlight up and made me center stage, I mean (laughs) uh, I mean all the time just like a transportable spotlight. Wherever I go, there it is, wonder woman.

I: Would you really like to have had, you know, you answered that very quickly. You knew exactly (pause), isn’t that interesting. So you really sort of wanted to be noticed, you wanted to really be seen as the queen bee.

S: I always did.

Subject 2

S: Yeah, I was real happy and I started getting involved in everything, and I guess I had a little support system with --- (boy) and, all of a sudden, you know, this whole world of people opened up to me when I was dating ---, I mean it was like all of a sudden I was “in” or something; I was part of the group or whatever and mm, then I just became real involved in school.

Subject 3

S: When I was a sophomore, one of my good friends—this girlfriend who was two years older than I was—had been getting straight A’s from her soph, from her ninth grade up, she’d been getting straight A’s, so I entered since I got straight A’s in ninth grade. I thought if she made it, I want to go for valedictorian too. She’s shooting for valedictorian, I’m going to do it.

Subject 4

I: No big hurdles except for academics, it sounds like.

S: Yeah, right now I mean because academics is going to be my career and I’ve got to think of it that way too. I’m not just here to get a job after school, you know, which all my friends will be doing, you know. When you go into research it’s basically academic the whole time, so that’s probably why I found some focus in that way.
Subject 5

S: Oh, I was too worried about my independence in being Miss Drill Team and being Miss Smart and being oh, valedictorian; no, I didn't want to be valedictorian. I wanted to be salutatorian. I didn't want to be first, I wanted to be second. I don't know why. I just thought that sounded neat, so just 'cos also I knew that with my other activities I couldn't be first, so I wanted to be second. Oh, I wanted, I got involved in every club, I was making money. Do you think I had time for guys?

Achievement/Recognition is a category prevalent in differing degrees with the subjects of this study. Some bulimics use competitiveness with the achievement and desire for recognition. Just coming up with the right number on the scale can be a high achievement. Academic achievement is also an important area in this category. This category distances the bulimic and keeps her further away from developing her own Self Identity. The words of S5 illustrate this very effectively:

S: I just wanted everything that would make me better, make me a more complete person because I was becoming so incomplete, so empty, just because I judged my completeness on external things, all these titles and honors. I thought about it before, like it's got to the point where I was -(subject) the cheerleader, -- the drill team person, --- the honors student . . . I mean everything was -(subject), the something. There was no --.

I: Like really finding your real true self.

S: There was no -(subject). It was all everything else. That, that was how I identified myself.

Control

Subject 1

S: I was starting to realize, I was starting to feel that I didn't have any control over any area of my life . . . and it was something that was mine, not that I could just play
with, but it was something that I could have control over, you know, if you eat, you get sick. I have control over my weight, you know, this is one area that I can count on. I can’t depend on other people or things, but I can depend on this, I guess,

Subject 2

S: I think the whole idea of expectations is a big key, I mean even for people that are getting over bulimia, expectations in relationships, expectations in themselves, expectations in others, I mean they expect things a lot to be handed to them or they expect things to go their own way, “their way”. If things don’t go their way and they can’t control them, that’s where Control gets into it. Then they can become bulimic, or then the bulimic feelings come, come to the surface.

I: Which are

S: Which are feelings of not being under control. That’s the way I would describe it.

Subject 3

S: It’s just like pulling you in. You feel like you’re sinking pretty soon because it, it becomes so much a part of your life, I mean real out of control. You really feel out of control. Something else is controlling you mm, you become obsessed.

I: Become obsessed.

S: And it’s the Control issue mm, I always think, sometimes I even think that I want to be completely in control or someone’s controlling me and that way I can blame, you know, I can blame everything on bulimia.

Subject 4

S: I do think that’s probably, you know, the key thing with all this ‘cos even now that’s what I don’t understand is I don’t have the control to stop it when I don’t even need it, and mm, I think the times I do get frustrated are things, well

I: What about when you get frustrated?
S: I do like to have control of situations, definitely, and if I don't have it then I usually adapt pretty well but it's pretty stressful.

Subject 5

S: Oh, I mean everything had to be perfect.

I: That word rings out a lot, doesn't it, perfect?

S: I hate that word.

I: You must hate the word, but it sort of hung, hung on you though in ninth grade though didn't it?

S: It's hung on me my whole life. I'm trying to compromise now and realize that I don't need to be perfect but just

I: Or someone says, or said to me, it is interesting to hear it, "Don't try to control the world."

S: Oh, that's what I do.

I: Is that part of it too, controlling the world?

S: I see it, like before I don't think I ever could have seen it, and now that I'm starting to get better and not control the world, I'm seeing how much I have done it and how much I still do it.

Control, as a category for this study, is one which includes the bulimic's desire to control her environment. This desire is manifested through the quest for perfection, control of body weight or pleasing others. The deceptive paradox of bulimia is clearly seen in the dynamic of Control. The bulimic believes that she has found a way to control her weight whereas, in fact, the disease, in becoming more chronic, actually has the opposite effect and ends up controlling the bulimic. This category demonstrates again the generally inclusive nature of the
characteristics of bulimia; in this case, Control is integrated into the Obsessive Compulsive behavior of the bulimic.

**Internal Reliability**

A form with a Likert-like response was developed by the researcher and given to 11 raters. Photocopies of selections chosen by the researcher from the transcripts were given to the raters along with a list of categorical definitions. A cassette tape recording from the different interviews, which corresponded to the photocopies the raters were given, was played to them while they read the excerpts of the transcripts. The raters then marked in the appropriate spaces on the Likert scale indicating the degree that a certain category was present or not present in the selected passages. A mean was calculated for each individual rater. In Part I, the accuracy and overall clarity of the transcript was evaluated, five being the highest numerical value. There were six entries in Part I and the range of the means was from 4.18 to 4.81. Part II dealt with the presence or non presence of the categories in the transcriptions. There was a choice of four possible categories for each selection. Five on the scale represented the obvious presence of a category. There were 36 entries in Part II and the mean of their selections for each category was compared to the rating which had been done by the researcher. The numerical value of one was used to measure agreement and greater than one to measure disagreement. The results indicated that there was agreement in 31 out of 36 entries indicating an 86.1% agreement.
The following week another evaluation was administered to seven raters from the same pool. This group was given five different random selections from the transcripts but this time there were no category choices pre-selected for them with each passage as there had been in the first evaluation. The raters were presented with the nine categories from which they were supposed to make what they considered the appropriate choice for each selection. They were not given directions on how many categories to list for each passage. Some agreement percentages were calculated based on the evaluation of the researcher:

1. At least one or more categories in agreement with the researcher—34 out of 35 which is 97.1%

2. At least two or more categories in agreement with this researcher—22 out of 35 which is 62.9%

Seven of the 11 raters took part in the second evaluation. The ratings for the first evaluation including those of the researcher are shown in Appendix D. The results of the second evaluation are shown in Appendix E.

The raters who took part in the evaluation of this study were graduate students in a doctoral course on qualitative analysis. The instructor of the course was also one of the raters.
Analysis of Research Questions

After 22 1/2 hours of interviews with five bulimic women, a number of possible explanations evolved that might elucidate the world of the bulimic.

1. What are some possible explanations for the occurrence of bulimia in the subjects in this study?

Research Question 1 asked what are the possible explanations for the occurrence of bulimia in the subjects in this study? One of the most basic and underlying causes of bulimia found in this study is within the category of Physical Image. The five subjects in this study had a phobia of being fat and this fear pervaded their lives in an Obsessive Compulsive way. Subject 4 gives the following response on being fat:

I: Do you have a fear, I mean a real fear, not just sort of casual, of being fat?

S: Oh yeah.

I: That's something that really gets to you.

S: Mm hm.

I: Fear of being fat.

S: Definitely.

Subject 5 says:

S: It was yeah, it was more, more an obsession with not being fat than it was with being skinny. I don't want to be skinny, but I don't want to be fat.

Subject 2 shows how food becomes a natural outlet for relieving tensions and blocking emotions. Bulimia acts as an anesthetizer:

S: And so food always represented happiness and mothering and security and warmth and mm, it's easy for
me to see why I turned to food because that was just something I felt very comfortable with.

Another possible explanation for the occurrence of bulimia can be the influence of family interaction. Subject 2 remembers:

S: I needed a role model. I needed a mother who had confidence in herself. I needed a mother who was outgoing, who liked herself, who thought she was O.K. whether she was pretty or not, who made the most of herself and wasn't a quitter, and my mom was a quitter. My mom basically said I'm ugly, I'm not that pretty, so therefore I quit . . . . And I think I grew up feeling like I was doomed. It was a doomed situation.

Sometimes bulimia may begin from an external source of control like a boyfriend who could tip the balance, as seen in the transcription of S4:

S: I know that has a lot to do with it and, you know, he kept pressure, he put pressure on me in the fact that the girls he admired on T.V. or something

I: All had the flat stomach.

S: Yeah, but they were very thin.

I: Very thin.

S: And very tall and very blonde. He never liked anybody but a blonde.

Another possible explanation for bulimia is its development in relationship to affective disorder and bouts of depression. This is shown most clearly by S2 and S5. Subject 5 observes:

S: I think depression is a big part of bulimia, I mean I think everybody goes through, well, that's part of it. (pause)

And then, a few moments later:

I: Interesting how you see that emotions of depression weave through bulimia.
S: It's kind of like a vicious circle. The more depressed I would get, the more I would need the food and more I did the food the more depressed I would get.

Summarizing Research Question 1, some possible explanations for the occurrence of bulimia among the five subjects of this study include an obsession with Physical Image, which encompasses a phobia of fatness, as well as stress, family interaction, the influence of External Locus of Control upon the bulimic, and varying degrees of depression depending upon the premorbid personality of the bulimic.

2. What is the process and understanding with regard to the bulimic and herself? (a) How does she see herself? (b) How does she construct reality?

Research Question 2 asked how does the bulimic see herself and how does she construct reality? The bulimic has extreme difficulty in finding her true self and, therefore, reality becomes distorted for her. In this study, S2, for example, sees herself as awkward and out of place.

S: I certainly didn't feel normal. My feelings were feelings of abnormal mm, feelings were somehow not fitting in, not really feeling comfortable with people, not feeling comfortable communicating with people.

One insight into how a bulimic sees herself while in the midst of the disease is given by S3, a recovered bulimic.

S: I think the unreal me was during my bulimic period when I didn't know up from down. I didn't know if I was really happy. I didn't know if it was more important to please people or to please myself, and oftentimes it would be pleasing others . . . and the unreal me was someone I didn't know, I didn't know myself.
The data of this study showed that the bulimic masks feelings with the binge/purge syndrome. In the words of S3:

S: You could pick a feeling and I would say a bulimic goes through denying that feeling. (pause)

The struggle for the bulimic is in defining boundaries, for instance, between dependence and independence. Subject 1 says:

S: Oh yeah. I have more of an attitude like, you know, I mean I see myself as a, I see myself totally separate from anyone else now, whereas before I really didn’t.

The tension between dependence and independence is connected to the questions of maturity and responsibility. Here S4 connects her growing up with being drawn to bulimia:

S: Yeah, I’ll break it soon (bulimia). I just don’t know when, but I won’t go on after college with it because it’s just not something I can be worried about then, you know, maybe, maybe it’s just, somebody said it’s maybe not growing up, you know, not wanting to grow up.

Subject 2 expresses her view:

S: If I was to put a symbol on binging and purging I would think it was nurturing or mothering or, I mean to me it seems like it was my act of trying to stay very childlike, trying to stay very mm, I don’t know, just trying to stay like a child.

In summarizing Research Question 2, the bulimic sees herself in a distorted light which blurs her perception of reality. Boundaries are difficult to construct and she sees herself as isolated from others. Food assumes the place of relationships. Dependence and independence are issues for the bulimic as is a resistance to growing up.

3. What is the process and understanding with regard to the bulimic and her interpersonal relationships? (a) How does she handle
conflict and tension? (b) How does she handle success and failure? (c) What does she hear and feel from her peers? (d) Is she assertive?

Research Question 3 asked what is the process and understanding with regard to the bulimic and her interpersonal relationships? The relationships of a bulimic may become so distorted that the issues of success and failure are dismissed or buried. Subject 5 talks about her fear of relationships:

S: I didn't think about that because the times when, I guess, thoughts like that would come into my head, I would run to the food and escape from them.

I: Relationships really conjured up a lot of anxiety.

S: Yeah, I didn't know it until recently. I'm real scared of relationships.

I: So, you recently found out that relationships get you upset.

S: I'm scared. I run.

Research Question 3 also asked how does the bulimic handle conflict and tension, and success and failure. The interviews revealed that success and failure, as well as tension and conflict, are issues that are difficult for bulimics to handle since these issues usually involve interpersonal relationships. The Self Identity and Physical Image of a bulimic are in a precarious state. Successes are often defined by the outside world, as S5 describes it:

S: Yeah, I think that success, like now I see success on a more personal level, like before success was the thing that looked best to the population as a whole, and now success for me could be something that somebody else wouldn't even think of as being success, like getting through the day without throwing up.
Subject 3 echoes a similar chord when she talks of her attitude to success as a bulimic and as a recovered bulimic.

S: And so now success means a little bit different to me mm, success before first, before when I was bulimic meant the recognition, being kind of held up on a pedestal and, you know, just being mm, looked up to.

She continues:

S: Yeah, and so I have little success now like whether it's my apartment, putting that together the way I want to mm, a success is Christmas, going hunting . . .

The nature of conflict and tension for the bulimic depends on how she internalizes them. For most bulimics binging and purging provide a tension regulating device. Subject 5 has the following illustration:

S: It is a quick fix. It is something like an alcoholic thinking I don't know, "I need a drink," with food. And it did, and the reason why I think, me and everybody else hangs on to it, hangs on bulimia for so long is because it really does work, you know, if you're scared about something or you feel that you're about to explode for some reason, explode in your head, I mean if you binge and throw up it pretty much does the trick, you know, it takes care of that tension and that anxiety, you know, for that minute.

Research Question 3 also asked what does the bulimic hear and feel from her peers? Essentially, the bulimic has retreated from the world into her bulimic state and has isolated herself physically and emotionally. The following dialogue shows S5's perception:

I: Did you feel isolated? Is that a word that would

S: I was so lonely.

I: Lonely.

S: Isolated is hard enough, yes, I mean physically because I didn't, I kept myself isolated. I didn't
I: Isolated—I'm sorry—you said isolated like what?

S: Physically because I didn't really get to know the girls there that much and so I didn't spend too much time with them.

I: Mm hm.

S: And emotionally isolated because of the physical isolation, emotionally also because I studied more than the rest of them did. I was always more into my studies rather than into people and mm, I was bulimic like every other day that year.

At times, the bulimic may even have a paranoid perception of the world. She jumps to conclusions that people are talking about her and disliking her although there is no evidence to support this. Subject 5 says:

S: I took that all so personally and I just assumed that none of them would like me and that all of them thought they were too good for me, so I withdrew from them and I didn't make too many friends there.

I: So you do a lot of personalizing with that kind of stuff.

S: Yes. I'm trying to get out of that now and I am getting out of it a lot more, but the amazing thing is somebody would just say something or look a certain way or have a certain twang in their voice and I'll just know that it's completely directed at me.

The bulimic may have a weak self image and the inability to internalize a Control system and so may lack assertiveness and confidence thus resorting to pleasing other people in the hope of controlling the relationship. This is expressed by S2:

S: I would say that bulimics on the whole tend to have a low self esteem, and when you have a low self esteem and don't think that much of yourself, you're more likely to try to be O.K., but be O.K. through someone else's eyes. And that's where people pleasing lies. People pleasing lies in
my lack of self esteem for myself, because, if I had that self esteem, I wouldn't need to try to please other people or try to be who they wanted me to be.

In summarizing Research Question 3, interpersonal relationships are difficult for the bulimic to sustain. There is a lack of Self Identity. Success and failure are connected to the bulimic's distortion of relationships and are dictated by the External Locus of Control. The bulimic's own opinions and beliefs are not valued. Conflict and tension are regulated through binging and purging. The bulimic is not assertive because of the lack of an internal control system and will often resort to pleasing others.

4. What are some thoughts and feelings that have been continuous for the bulimic? (a) Are there any basic themes? (b) What are feelings that are present during and after binging and purging? (c) What are feelings that are camouflaged during binging and purging?

Research question 4 asked what are some thoughts and feelings that have been continuous for the bulimic? Obsessive Compulsive behavior and thought patterns are continuous for the bulimic. The feelings are those of panic and anxiety. Subject 2 reveals this Obsessive Compulsive bulimic pattern in describing binging and purging:

S: Yeah, I mean it was a chain, it was a chain reaction, but it was also what—what do they call it—mm, it was a continual circle that you couldn't get yourself out of because when you started being bulimic or you started throwing up you wouldn't, it would cause you to get into just a circle. It would, the pattern would repeat itself over and over and over again and it was really hard to break it, the pattern, I mean you'd get, it got to where there were days in college when I would be getting sick six and seven times a day. I'd be, because the getting sick would make
you feel bad about yourself and make you feel rotten and
you'd get up and then you'd be even farther behind and
then you'd be upset with yourself and then you'd eat even
more and you'd throw up again and then you'd be tired.
Then you'd maybe crash for a lot of sleep or go watch T.V.
or, you know, it seemed that it just mushroomed from
there, and it was really hard to stop the cycle and we'd get
it stopped for a couple of days or something, and then the
anxiety and the tension would build up again and it would
be just like you'd be just terrified that you knew, you knew
any minute you were going to go down again, and you
wanted to stop it and wanted to keep it from happening,
but when the feelings would get to that certain level again,
it would start all over again.

Anger is another feeling that is part of the bulimic's existence.

Subject 2's opinion is as follows:

I: Do you think underneath this people pleasing there's
that emotion of anger for you?

S: Yeah, very much so mm, that's probably the only
thing that I still haven't quite gotten a handle on, or still
haven't quite been able to figure out why there's so much
anger and exactly who it's directed toward, but mm, there, it's definitely there and it definitely still crops up.
It's like it's the one thing that I'm able to keep submerged
fairly often, but then when it finally has to come out it, I
either eat or I haven't been eating lately or I lash out at
people, and it usually doesn't have anything to do with the
person that I lash out at.

Another theme found in the transcripts involves impulsivity and
extremes. The bulimic may have problems in formulating hasty
unreasonable conclusions. Perspective is lost and the bulimic
unthinkingly finds herself in situations or relationships that may later
cause regret. Subject 3 recounts:

S: That was, I was starting to have sexual feelings, but I
don't know if I was dealing with them health, healthfully,
healthfully, you know, starting that quickly in a
relationship. I don't know, I was real desperate too, and
he, I mean that was just a real desperate move, and at the
same time
I: What was the desperate move, the purging, the binging and purging?

S: Mm, yeah, I'd go to just desperate extremes like that and go to desperate extremes in a relationship like that. I was doing a lot more things very impulsive, I wasn't thinking like I used to, I mean my thinking was different now. I was going to extremes. (pause)

Research Question 4 also asked what are immediate feelings during binging and purging and which feelings are camouflaged. Bulimic behavior is used by the bulimic to block or camouflage the true feelings, thus keeping them at a safe distance. The feelings during and after a binge and purge are a release for the moment. Subject 2 and S3 compared binging and purging to the actions and feelings of a smoker; for example, S3 notes:

S: I can never look that good, so that was kind of a helpless feeling that, you know, the bulimia isn't really helping me like having a cigarette.

I: The bulimia.

S: When somebody gets up in the morning and lights a cigarette, someone uh, you know, you tell them some bad news, first thing they do is light up a cigarette mm,

I: For you it was bulimia.

S: Cigarette, mm hm, cigarette smoking, I have never really smoked but smoking is a great analogy to my bulimia. (pause)

Subject 2 makes the following point:

S: Well, I think that cigarettes are, are a habit just like, I mean I don't, I think it's of human nature to try to relax or to try to maybe suppress feelings you're having about things or to, I mean eating is a calming thing whether it's out of control or not, and I think some people turn to cigarettes, you know, they're tense, they're nervous, they're upset about something. They grab a cigarette.
Subject 5 compares the bulimic to someone who drinks or uses drugs but makes the point that bulimia is not against the law:

S: Food is legal, I mean alcohol, you get drunk, you get in trouble. You do drugs, you're going to get in trouble somehow. No, you're not going to get in trouble for eating and throwing up. There's nobody going to come arrest you.

For some bulimics, binging and purging creates a calming and relaxing effect. Subject 2 describes her feelings during and after binging and purging as follows:

S: I know that tension and anxiety would build just to an extreme and eating was calming and throwing up was too, I mean when I, 'cos I mean I would throw up and then I would be drained and all I'd want to do is crawl into bed and sleep. There was something about the anxiety and just the fact of just feeling wired that you just had to get rid of that feeling and you just, I mean when you would get, is when you'd start being bulimic and you'd be just wired and you'd be angry at the world and you'd be just like gr, gr, you know, and eating or throwing up would, would get rid of those feelings. It would calm me down and you'd relax and you'd feel sleepy.

Subject 1 describes feelings of euphoria as well as relaxation:

I: I wonder if some bulimics get high on purging, just sort of get a real, I understand it's really

S: Euphoric.

I: Yeah, euphoric.

S: Kind of dizzy, I mean

I: You get dizzy and you're tired too.

S: Mm hm.

I: For you it's kind of a release.

S: You can just sleep, I mean
I: You can sleep after it's finished.

S: Oh, gah, just crash. (pause)

Excitement and Thrill are feelings that the bulimic derives from the planning and execution of binging and purging. The bulimic feels that she is getting away with something. This increases the possibility for secrecy and dishonesty which then envelops the whole act of binging and purging. The bulimic may camouflage this secrecy with denial.

Subject 5 says:

S: I remember going to sorority meetings and leaving 30 minutes early because I could not sit there any longer. I had to leave and go get food. I had to leave. I would pretend like I had a biology lab or something.

Subject 5 continues:

S: Yeah, but I never dealt with it in my mind, I mean I did, I really did know it was there. I could feel it, but I never dealt with it, I mean I'd always escape to the food.

She adds:

S: And it's not like I ever thought of myself as consciously denying it, saying, I don't want to deal with this. But that's in essence what I was doing.

Subject 1 admits that her preoccupation with food is really a cover for something else:

I: Food was like the substitute for what?

S: (long pause) I guess, exploring my feelings.

Subject 1 offers an interesting insight into her feelings concerning the time she first started binging and purging:

I: But what was it like, do you think, the first time you did it?

S: Well, I was like so excited, I mean I felt like I had the secret of the world.
Another feeling that occurs during binging and purging is loss of control, as S3 observes:

S: When I started manipulating and using food, it became frightening because I lost control. Food was controlling me and mm, that was so difficult because it was a real conflict.

In summarizing Research Question 4, the basic feelings and thoughts that are continuous for the bulimic are immediate feelings of panic and anxiety followed by a sense of release, while feelings such as anger and denial may be camouflaged.

5. How much influence does the social-cultural variable affect her bulimia? (a) What effect does the environment have? (b) What are her relationships with males like? (c) What are her relationships with females like?

Research Question 5 asked how much influence does the social-cultural variable affect bulimia? The effect of this theme can be determined from one of the nine categories, namely External Locus of Control.

Subject 3 explains how she was influenced by her boyfriend's words:

S: I go, "--- (boyfriend), do you think I'm getting fat?" and he goes, "If you feel like you're gaining, you know, if you're gaining weight," he wouldn't say I'm getting fat. "If you're gaining weight, just exercise, just diet." Well, hearing those kind of things, you know, exercise and diet is for someone fat and he, I was just talking about getting into shape and so I started twisting things and internalizing more things that, I was using that rule as to, oh, it was definitely by eleventh grade it was there for sure.

The bulimic is insecure about herself and, as a result, her relationships with males and females are tentative, distancing and
disconnected. The totally committed bulimic has an exclusive relationship with bulimia, much like a relationship with a person. This is disclosed by S5:

S: Love just makes you so irrational and it's just, bulimia is like the same thing. I found that the first time I made that analogy, I just started crying. I was so scared that I was in love with this.

I: Your analogy and love.

S: A love/hate relationship with bulimia just the same way that you can have with another person. That was so scary when I first thought of that. It was a couple of months ago, well no, it was probably the end of the summer.

I: Mm hm.

S: Six months ago when I was just talking and I came up with that analogy and I started crying.

I: You started crying about it.

S: Oh yes. It just, I mean just that it was so deep rooted and meant so much to me and, I mean how, how I'd gotten involved in something so destructive.

As far as the bulimic's relationships to males and females are concerned, there are individual differences among the subjects of this study. As we have just seen in the above excerpt, S5's overriding preoccupation was with the bulimia rather than any person, male or female. Subject 5 felt initially that a man could not understand what she had gone through in her bulimia, but later changed her mind and felt comfortable with this researcher. Subject 1 felt easier around males than females. When asked what it was like to be interviewed by a man rather than by a woman, she responded:
S: Mm hm, probably doesn't feel as judgmental being with a guy.

I: It probably does not feel as judgmental being with a guy.

S: Yes, probably feels more comfortable.

Subject 3 and S4 felt equally comfortable with a male interviewer. Subject 4 felt herself able to blend in with almost any kind of person:

S: I've always had no problem getting to know just about any kind of person. I have this way of just blending into them. I don't know if that's good or bad, you know, I, I can mm, I can adjust to just about any personality and sometimes even kind of acquire it for a little while, you know, depending on friends.

Subject 2 had the greatest difficulty in dealing with males because of personality disturbances going back to her father.

S: I've never really been able to recognize where in my past this inability to feel comfortable with males has occurred or why I've grown up with it, but I have. I don't know if I mentioned in my last interview that I went through a stage in my life and I still even mm, wouldn't, where I didn't want my dad to hug me, didn't want him to get near me and I would just cringe when he would come to give me a hug.

When S2 was asked about how she felt about interviewing with the researcher, she responded differently in two of her interviews. In S2's second interview she was asked by the researcher whether she felt comfortable talking and she responded as follows:

S: Yeah, yeah, like I'm comfortable with you now, but I mean

I: Good.

S: I'm just saying at first it was different.

Subject 2 revealed at the beginning of the third interview that:
S: It's older figures, older men and mm, and it even, when I narrowed it down, I was able to narrow it down further when I thought about who were the men in the past that I have been uncomfortable around, and a lot of them either had grey hair or have just grey hair on the sides of their head . . . my parents said Dr --- had grey sides on his hair and I just, I had, you know, I really want to go to, this is kind of embarrassing.

The interviewer had grey hair and S2 was reminded of some frightening experiences she had had in the past with a certain doctor with grey hair. It should be noted, though, that in spite of her uncomfortable feelings about men that S2 talked very freely and at depth of her experiences with bulimia in all her interviews.

In summarizing Research Question 5, the social-cultural variable is an influential factor in bulimia. Relationships with males and females differed among the subjects. Some were more unstable than others. In some instances, bulimia itself can take on human characteristics.

6. If the bulimic patient is improving, what are some of the elements that have contributed to the change? (a) What internal changes have taken place? (b) Are there any specific modifications that have altered her perception about herself and the world?

Research Question 6 asked what are some of the elements that have contributed to the improvement, if any, of the bulimic? Subject 2 recognizes that improvement occurs when the bulimic behavior, or binging and purging, is reduced partially or completely:

S: Well, I'm beginning to find that after the bulimic, after you stop that behavior, the bulimic personality doesn't end at all whatsoever. If anything, I think it intensifies because the whole act of binging and purging was getting rid or suppressing that bulimic personality.
When you’re not eating and binging and purging and more, that personality becomes your everyday personality.

In relating an observation about one of her counselors, S2 shows the importance of addressing the emotions of the bulimic rather than being distracted by the behavior:

S: You know, I was bulimic all the way through college and probably the last half of my senior year I really started getting a hold of it because I was trying to see a counselor down in --- (college town). She was a female counselor. She thought bulimia was, I mean she’d never really read anything about it so throwing up didn’t matter to her; it had nothing to do with it.

I: Big deal.

S: Yeah, so she never asked about it. She never asked about what it was, the things it was related to, if I got sick. She just dealt with emotional problems, and although I think she was right in many, in that bulimia is caused by emotional things, I do think that she should have taken more stock in the bulimia and seen what it pointed out to, you know, what it, the things that it point to that were going wrong in my life. So I really didn’t get a lot out of that, but I did find myself getting better the last half of my senior year.

The bulimic, with counseling, may develop a renewed awareness of her own feelings, for which she is able to take responsibility, and the ability to share her feelings with others. The process can be lengthy and uneven. Subject 2 shares her experiences of this time in her life:

S: It just seems like it’s all been a gradual process. I’ve been gradually letting go of the bulimia, gradually feeling my feelings, gradually coming to terms with being. It’s all been real slow and just taking one step at a time and it’s been, it’s been hard to let it go slowly.

I: Sure.

S: Because I wanted to control it. Just like I wanted to control bulimia, I wanted to control my recovery. I wanted to take it from here to here in one day. And so
that's been a learning experience just realizing that it's going to take a long time and relaxing and sitting back and saying O.K., let's just take it slow, let's just follow along with this, and I think over the past couple of months I've made the most progress and it's the past couple of months that I've finally just let myself be a little human.

In the following excerpt, S3 reveals the importance of the bulimic being able to feel affect. It is through this dynamic that there can be modification in the way that the bulimic perceives herself and the world.

I: What happened when you approached tense, tense pockets, tense little pockets in your life?

S: Mm, sometimes those were, when I would start feeling things a lot of times because I'd been at such an extreme of not showing emotions and now I'm starting to, it would be like a quick teeter-totter and I'd start feeling not only the tension, but the tense moments, the anxiety there, I'd start feeling a whole lot of other things for the first time and I, it was a confused, you know, I couldn't understand why I would be so confused about a little thing that was upsetting me and it was just 'cos I was, it was the first time I had opened myself up to be exposed to that.

Subject 3 realizes that the foundation of her recovery lies in the fact that she takes responsibility for her own life. The emergence of her real self is within her capacity as an individual.

S: There's a factor that's missing here, it's my decision and my own wants and needs. And so when I started recognizing that, it made an incredible difference on that. When you talked about the Locus of Control, I realized I was in control of a thing I thought was out of control, the bulimia.

I: Mm hm.

S: I could, you can't control all situations, but I could mm, I felt more secure with myself. I guess there is that inner feeling of feeling, of self satisfaction and a security within yourself.
Subject 2 continues:

S: ... like with the death (of subject's grandmother) and some, realizing some friends of mine had been using me and setting me up for being hurt. Seeing that vulnerable part, but I had to see that and experience that because I started realizing my character wasn't as weak as I thought it was. I wasn't as vulnerable of a person if I didn't want to be mm, if I viewed myself as being fat, you know, then that, you know, if I didn't want to view myself that way, then do something about it. And so, I guess, I started thinking it's more important what I felt and thought rather than what people thought and what they felt.

In summarizing Research Question 6, improvement for the bulimic may occur with the gradual reduction of bulimic behavior of binging and purging, allowing time to concentrate on modifying the bulimic personality and the emotions which are involved with it. The improvement may begin when the bulimic tries to stop controlling her world and begins to set realistic daily goals for herself. A changed perception of the bulimic's Self Identity, a search for the true self and the setting of small but realistic goals may help in reducing bulimic behavior. Internal changes for the recovering bulimic can take place with a growing awareness of and responsibility for the bulimic's true feelings. This can in time change the bulimic's perception about herself and the world.

In summarizing the six research questions, the data of this study suggest that some possible explanations for the occurrence of bulimia are found in characteristics as outlined in the nine categories of this study such as Physical Image and External Locus of Control. These characteristics may have been part of the bulimic's personality before the onset of the disease. Similarly, depression may be part of the
development of bulimia depending upon the premorbid personality of the bulimic, as seen in the transcriptions of S2 and S5. In analyzing the research questions, the data of this study indicate that the combination of self-distortion and the influence of the environment create difficulty for the bulimic in defining boundaries and in assuming responsibility for her life. Success and failure may be dismissed or buried because of a lack of assertiveness and dependence on the External Locus of Control. Relationships become secondary to the preoccupation with food. Conflict and tension are regulated by the frequency of binging and purging and mask a full spectrum of emotions. Improvement for the bulimic, according to the evaluation of data in this study, involves the reduction of bulimic behavior and concentration on modification of the bulimic personality.

Discussion

The data from this study indicate that bulimia should not be thought of in terms of having just one necessary and sufficient cause, but might be seen rather as a cluster of characteristics which evolve out of and into the premorbid personality of the individual.

According to the transcripts in this study, predicting who will be bulimic and who will not is merely speculative. A certain profile may be identified in people who become bulimic. These characteristics are outlined in the nine categories developed from the interviews the researcher conducted with the five subjects. To a greater or lesser degree, each subject maintained characteristics from all the nine categories. The data in this study reveal that often categories overlap;
for example, External Locus of Control, Obsessive Compulsive tendencies, Physical Image, Self Identity, and Control can be found merging together in some passages.

One of the categories that emerged from the transcriptions concerned the issue of Control. One characteristic of Control from the data of the study revealed that Control can be paradoxical in nature. The bulimic believes that through bulimic behavior she can control her weight, image, attitude, and feelings. The bulimic thinks that if she looks good, she will feel good. The reality is that the bulimic is controlled by the disease she believes she is controlling.

Another issue that arose from the data of this study concerns the issue of boundaries for the bulimic, including the struggle between dependence and independence. There is often resistance to being mature, growing up, and assuming responsibilities. The data show that out of this resistance, anger, impulsivity and extremes develop, and concur with the findings of Williamson, Kelley, Davis, Ruggiero and Bloom (1985) and Brenner-Liss (1986). All these characteristics impact on how the bulimic views the world. The data also indicate that the anger has another source than immediate bulimic behavior. Anger sometimes arises because of poor family communication, which can be a source of distress and fury (Fallon & Root, 1986) or because of a weak Self Identity brought on by the bulimic's perception of how she is viewed by her family. This was the case for S1 and especially for S2.

The findings of this study are in agreement with Williamson, Prather, Upton, Davis, Ruggiero and Van Buren (1987) and indicate that depression is part of the bulimic personality. The degree of
depression depends on the premorbid personality of the individual. This finding concurs with Katz, Kuperberg, Pollack, Walsh, Zumoff and Weiner (1986). In this study the data show that S2 and S5 were significantly more depressed and vulnerable, even before the bulimia, than the other three subjects.

The five subjects all used bulimia as an anesthetizer, an avenue to relieve tensions and block emotions. The data of this study support the findings of Rosen and Leitenberg (1982), Hooker and Convisser (1983), and Leitenberg et al. (1984). All the subjects had difficulty with Self Identity as well as orientation towards the world. Some subjects, however, were controlled more than others by the opinions and judgements of the environment or by the External Locus of Control. The data from this study seem to agree with the findings of Mitchell et al. (1986) who believe that "for many patients the onset of the disorder coincides with perceived pressure from family or friends to lose weight" (p. 168).

The world of the bulimic is often in black and white. The data in this study confirm the findings of Jones (1985) that there is a dichotomy between the good self and the bad self. It is difficult to perceive grey areas. If the bulimic eats one cookie, she reasons that she might just as well eat the whole package. There is an unreal and magnified sense of catastrophe that defies reality.

The data of this study support the view that one of the important goals in the treatment of bulimia is for the bulimic to learn to tell the truth while being open about the disease. The data confirm the findings of Johnson et al. (1976) regarding the feeling of the bulimic
that she is getting away with something by binging and purging. Secrecy and dishonesty are part of the bulimic way of life which was revealed most clearly in the interviews with S1, S3 and S5.

The prognosis of a bulimic may vary significantly as the data of this study show, thus agreeing with the findings of Swift et al. (1987) who found that bulimia has "a heterogeneous outcome pattern with some patients doing well and others remaining severely afflicted" (p. 52). The data from this study show there is a definite contrast between S3, for example, who has recovered from bulimic behavior and the bulimic personality and S2 who has recovered from the behavior but is still working in therapy with aspects of bulimic personality. Subject 4 continues with her bulimic behavior, as does S5, but yet the degree to which S5 is still involved with bulimia is far greater in its intensity than is the case with S4. Subject 1 is less intense than S5 but is still confronting her bulimic behavior and attempting to deal with her bulimic personality. Garner and Davis (1986) briefly describe bulimia as "both a symptom and a syndrome" (p. 185) but they do not pursue the concept. Mitchell et al. (1986) recognize that it is important to address the affective aspects of bulimia as well as the binge eating.

An experience of S2's mentioned in Research Question 6 underscores the point that the therapist needs to concentrate on the personality of the bulimic and not only her behavior. Subject 2 was being treated by a therapist who had no experience in treating eating disorders, so the therapist did not dwell on her bulimic behavior but concentrated on her feelings. Of course, a therapist should not overlook a bulimic patient's behavior and yet, in the case of S2, she
started to get better because the therapist, if unknowingly, was concentrating on the underlying emotional problems of bulimic behavior.

The findings of Hotelling (1986) who views the social-cultural perspective as a major influence in the development of bulimia are not entirely supported in the data of this study. This researcher found that the social-cultural influence is apparent but not the major factor in contributing to the etiology of bulimia. Perhaps the reason that the social-cultural theme is stressed in bulimia is because it is one of the more easily identifiable characteristics of the disease. In the second evaluation of the transcripts, shown in Appendix E, in two passages, when External Locus of Control was indicated in the transcript, all seven raters identified this category correctly. The researcher, however, believes that the influence of the social-cultural theme is only part of the total profile of the bulimic and should not be unduly stressed.

There is an unfortunate and rather disturbing trend in the current literature of bulimia, which seems to echo the characteristics of Dichotomous Thinking, presenting an all-or-nothing, black and white approach to the research in bulimia. This kind of thinking is communicated by Hotelling's (1986) belief in the central power of the social-cultural influence on bulimia and is not in agreement with the context of this study. Neither are the findings of Cesari (1986), who attempted to make the case that there should be two definite bulimic distinctions, "fad" bulimia (less food ingested) and clinical bulimia (more consumption). This also falls into the trap of Dichotomous
Thinking since in "fad" bulimia and clinical bulimia, an artificial distinction is created. Bulimia, in Cesari's "fad" stage, may or may not progress to the more severe "clinical stage." Cesari's analysis defines bulimics into unrealistically divided developmental stages which could be unhelpful in treatment and possibly be unsafe. At this time, concrete evidence of a cause and effect nature cannot definitively be found in the literature where the length or direction of a bulimic's condition can be predicted.

Questions that need further consideration with regard to bulimia are varied. One concerns the degree to which the bulimic perceives her condition in anthropomorphic terms, often attributing human characteristics to it. This was touched on by S5 who painfully realized that in some way she was in love with bulimia. Another question which deserves further investigation is to what degree, if at all, bulimic behavior, specifically binging and purging, is a sequestered uncontrollable psychotic episode. Subject 2, S3 and S5 indicated through their interviews that at the moment of binging and purging, they thought of themselves as a different person. A third area of exploration examined by Garfinkel and Garner (1982), which might be elucidated by the qualitative/phenomenological method, would be to compare sexual desire with the acts of binging and purging. The ideas above were not originally considered in the preparation of this study, but emerged from the interviews with allusions and comments by the subjects. One of the aspects of qualitative/phenomenological research is the continual emergence of unanticipated, unplanned ideas and concepts.
In studying the data from the transcripts, bulimia can be regarded as elusive and sometimes incomplete. This thought is reinforced by the fact that between 1980 and 1987 the APA adjusted its diagnosis and wording of the definition of bulimia in the DSM III R; for example, the DSM III (1980) entitles the entry "Bulimia" (p. 69), while the DSM III R has titled it "Bulimia Nervosa" (p. 67). There is every reason to believe that, considering the nature of the disease, the next revision of the DSM might again be amended. The DSM III R has also added to its diagnostic criteria the description, "persistent overconcern with body shape and weight" (p. 69), which the data from this study find appropriate in the sense that this description moves closer to the obvious Obsessive Compulsive nature of bulimia, but in another sense somewhat short-sighted in that the DSM III R does not go further in characterizing bulimia.

The data from this study seem to indicate that when the bulimic behavior ceases, bulimia may not necessarily have ended. The cessation of bulimic behavior is, rather, an important milestone. According to Brenner-Liss (1986):

It is a major breakthrough when an individual becomes willing and able to stop binging and vomiting as a regulatory mechanism and instead becomes able to take the "leap of faith" to feeling and enduring what is going on inside. (p. 214)

The data from this study would seem to show that when the bulimic is able to take that leap, enabling her to concentrate on modifying her personality, a flood of emotions may be experienced. The transcripts of the five subjects seem to indicate that once the bulimic
cadence of binging and purging is reduced or ended, the bulimic feels a need to replace this Obsessive Compulsive behavior with something else to fill the vacuum. This might take the form of excessive exercise, work or study.

Conclusion

The data of this study seem to reveal a distinction between the bulimic personality and bulimic behavior. Such an awareness might be of use in the future understanding and treatment of bulimia, since the bulimic personality may remain once the bulimic behavior has been controlled.

The emergence of the nine categories out of the interviews indicates the cluster effect of the bulimic personality. The data of this study would seem to suggest that there is no one single or dominant category identifiable in bulimia; rather there is a blending of the various categories as well as a developmental process of certain categories within the bulimic. With this in mind, the data of this study would seem to suggest that researchers and mental health professionals might be wise to refrain from "pigeon hole" diagnoses or prognoses for the bulimic. A medical model alone could stifle future research and treatment of this affective/cognitive/behavioral disorder.

Recommendations

On the basis of the findings and conclusion of this study, with its limited subject pool, some tentative recommendations are presented that might be useful in studying or treating bulimia:
1. One should not be misled by assuming that the binging and purging are at the core of the issues. Food is a symbol. It is a distraction from the real issues of Emotional Blocking and faulty cognition.

2. Self Identity issues need to be disclosed and understood.

3. The counselor should be open-minded in order to understand the distortions of the bulimic world with regard to behavior, cognition and affect.

4. In dealing with bulimia, the counselor should focus on feelings and perceptions and not dwell on the binging and purging. The obsessive layer of detail concerning binging and purging should be underplayed.

5. The bulimic needs to struggle to make her own decisions and form her own opinions. This is a lengthy process and requires patience on the part of the counselor. By the time the counselor sees the client, the disease has probably lasted for several years and may be deeply embedded.
NOTICE OF CONSENT

I understand that I am participating in a research project and that I am assured anonymity in the report of the findings of this study. I am aware that I can withdraw from the project at any time. I have a clear understanding and explanation of this project. I agree to cooperate fully in three one and one-half hour interview sessions with the researcher. I understand that audio tape recordings will be made to be used by the researcher for analysis of data. I also understand that these recordings will be held in strict confidence by the researcher.

Name ___________________________ Date ___________________________
APPENDIX B
Open-Ended Questionnaire

Please complete each open-ended statement with your own response. You may take as much time as you like to complete each statement.

1. When I was growing up . . .

2. I always felt I had to . . .

3. My body . . .

4. For me to believe in myself . . .

5. For me food is . . .

6. When I purge(d) I . . .

7. When I feel successful I . . .

8. Failure is . . .
9. I am angry at/when/with . . .

10. I stand up for myself . . .

11. I sense within myself . . .

12. The world seems . . .
APPENDIX C
EVALUATOR'S INFORMATION SHEET

Thank you for your time. For purposes of data collection, please fill out the information below.

Name.............................................................................................................................

Address.................................................................Phone ( )..............................

........................................................................................................................................

Place of birth.................................................................Age..................................

Educational Background........................................................................................................

........................................................................................................................................

Current job description........................................................................................................

........................................................................................................................................

1. Previous knowledge of eating disorders. Circle one of the following:

   1(none)  2  3  4  5 (thorough)

   If 3 or greater, please give details

2. Have you known anyone personally who has had an eating disorder. Yes or no. If yes, please explain.

3. In this section, please fill in any information you would like to share about yourself.
EVALUATOR'S ANALYSIS

Part I

You will be listening to two excerpts from my taped transcripts of interviews with bulimic subjects, and you will also be given the corresponding written transcription. Please evaluate each passage according to the following scale:

1 completely inaccurate
2 accuracy questionable
3 generally accurate
4 accurate (only occasional inaccuracies)
5 very accurate; clearly understood

Please circle your response, and then write it at the end of the line.

Passage 1
Accuracy of Transcription 1 2 3 4 5 ......
Phrasing and Punctuation 1 2 3 4 5 ......
Overall clarity 1 2 3 4 5 ......

Passage 2
Accuracy of Transcription 1 2 3 4 5 ......
Phrasing and Punctuation 1 2 3 4 5 ......
Overall clarity 1 2 3 4 5 ......

Part II

In this section, you should listen to and read the corresponding selections. For each passage there are variables that can be deduced from the transcript. Please indicate your preference based on the scale below. Circle your response and write it again on the end of the line:

0 undecided
1 definitely not present
2 not present
3 present but not obvious
4 present
5 obviously present

Passage 1
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Emotional Blocking 0 1 2 3 4 5 ......
Control 0 1 2 3 4 5 ......
Dichotomous Thinking 0 1 2 3 4 5 ......
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### Legends for Part I and Part II

(* Denotes disagreement with Researcher)

#### Part I

1. Completely inaccurate
2. Accuracy questionable
3. Generally accurate
4. Accurate (only occasional inaccuracies)
5. Very accurate: clearly understood

#### Part II

0. Undecided
1. Definitely not present
2. Not present
3. Present but not obvious
4. Present
5. Obviously present

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**BOLD signifies agreement with researcher**

**CATEGORY ABBREVIATIONS (as defined in Chapter Two)**

- **PI**: Physical image
- **SI**: Self identity
- **EB**: Emotional blocking
- **ELOC**: External locus of control
- **DT**: Dichotomous thinking
- **OC**: Obsessive compulsive
- **ET**: Excitement/thrill
- **AR**: Achievement/recognition
- **C**: Control
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