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The positive coping experiences of women with bulimia

by

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Dedication

This thesis is dedicated to the inspiring and courageous women who were willing to share their stories with me. Each story was unique to your own journey through bulimia and positive coping, but resilience, hope, and persistence were common to all of you in my eyes. Throughout our time together, it seemed like each of us were pleasantly surprised at the empowering nature of this research process. I feel truly honoured to have been witness to your bravery and inner strength.

Abstract

Bulimia nervosa (BN) affects nearly 1% of women in North America. Literature suggests that women with BN engage in binging and purging as a means of coping with negative emotions and experiences. What has yet to be explored, however, is how women with BN cope with difficult emotions in positive ways, without binging and purging. The purpose of this qualitative study was to understand, from the perspective of participants, the positive coping experiences and stories of women with BN. During semi-structured interviews with 6 participants, women described their experiences of positive coping. Using a narrative analysis methodology, women's experiences were described through individual narratives and common themes. Main themes that emerged were behavioural redirecting, constructive internal dialogue, social support, and self-awareness. These findings contribute an important understanding of the strengths of women with BN and may help inform strengths-based approaches to working with this population.

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CHAPTER 1

Introduction

Background

Eating disorders are a prevalent and serious issue in society, although social discourse of this problem remains fairly mute (National Eating Disorders Association, 2006). This silence may in part be related to the shame and guilt associated with eating disorders. Regardless of how difficult this dialogue can be, a substantial number of people suffer from eating disorders. In Canada and the United States, up to 10 million adolescent girls and women are estimated to struggle with eating disorders (National Eating Disorders Association, 2006). Beyond this statistic, sub-clinical eating disorders are even more pervasive (Maine, 2001). Based on epidemiological studies examined by the WHO, it is estimated that 5 to 13% of women suffer from partial eating disorder symptoms (WHO, 2007).

One type of eating disorder is bulimia nervosa (BN), which is estimated to be present in approximately 1 to 1.5% of young women in the general population. BN is characterized by episodes of binge eating followed by compensatory behaviours such as purging, laxative use, and/or exercise (APA, 2000; Garfinkel, Lin, Goering, Spegg, Goldbloom, Kennedy, Kaplan, & Woodside, 1995; Proulx, 2008; Zhu & Walsh, 2002). Bulimia is also associated with a morbid fear of becoming fat or concerns regarding weight and shape that become an undue influence in people's evaluation of themselves (Russell, 1979). However, these

weight and shape concerns are usually linked to a much deeper pain for people with BN. Farber (2007) tells us:

> Anorexia and bulimia are not always about vanity. It`s not always about wanting to be thin. For many people it is more about emotional pain. And for many people who have problem with eating have difficulty using words to express their emotional pain. So when someone says 'I feel fat' they can really mean 'I feel anxious,' 'I feel depressed/lonely.' For many people with eating disorders, the obsession with their physical appearance is just a cover for much deeper emotional pain. (p. 22)

BN is associated with several potentially severe health consequences, including slowed breathing, irregular heartbeat, convulsions, and even coma (Walters, Neale, Eaves, Heath, Kessler, & Kendler, 1992). Moreover, a lack of balance in dietary intake also has important psychological consequences; for instance, starvation and the avoidance of carbohydrates can lead to imbalance in levels of serotonin, resulting in mood instability and depression (Buckroyd & Rother 2008). These outcomes from bulimia, among many others, highlight the ongoing need to research this disorder.

Many researchers have investigated the role that bulimia plays in women's lives, documenting a common struggle among women with this eating disorder. In particular, this population appears to have difficulty regulating emotions and feelings (Esplen, Garfinkel, & Gallop, 2000; Eversmann, Schottke, & Wiedl, 2007). Kopp (1989) described emotion regulation as "the processes and characteristics involved in coping with heightened levels of positive and negative

emotions" (p. 343). Coping has been conceptualized as "regulation under stress" (Compas et al., 1997, p. 119), referring to the "conscious and volitional efforts to regulate emotion, cognition, behaviour, physiology, and the environment in response to stressful events or circumstances" (Compas et al., 2001, p. 89). The way in which people actually respond to or regulate stress then, can be thought of as coping (Skinner & Zimmer-Gembeck, 2007). In this sense, individuals may exhibit negative forms of coping (e.g., binging and purging, drug abuse) or positive forms of coping (going for a walk, talking with someone). Thus, it is apparent that women with bulimia often utilize negative, unhealthy behaviours to cope with difficult emotions and experiences.

Furthermore, the literature suggests that individuals with bulimia are highly self-critical and experience frequent feelings of guilt, shame, and failure to live up to their own expectations (Lehman & Rodin, 1989). Researchers speculate that women with bulimia are particularly reactive to negative events in their lives, and much less reactive to positive events. They perceive positive events as occurring less frequently and derive less pleasure from such events; this ultimately leads to a greater weight placed on the negative events, thus perpetuating feelings of shame and guilt (Lehman & Rodin, 1989). Finally, women with bulimia seem more likely to have a negative outlook on life events and may not always recognize and acknowledge their successes in life (Lehman & Rodin, 1989).

Taken together, the current literature focuses largely on the pathology and aetiology of bulimia nervosa. Researchers have dedicated much of their efforts

toward examining the development and maintenance of bulimia nervosa and the domains of functioning with which women struggle. What appears to be relatively absent from the literature on BN, however, are studies that focus on experiences and stories of resilience in the experiences of women with bulimia, where resilience is defined as "as a process of bouncing back or rebounding from significant negative experiences" (Van Vliet, 2008, p. 234). Resilience can serve as a buffer against a range of disorders (Howard, 2009) and thus may be an important focus of attention for counselling interventions.

Statement of Purpose

The aim of this narrative research study was to explore the positive coping experiences of women with BN in response to difficult emotions or negative events. Positive coping experiences were defined as those that are adaptive, healthy, and do not involve binging and purging. With an understanding of women's stories and experiences of strength, counselling psychologists can potentially help women with BN build on their strengths and re-story their lives, going from a pathological standpoint to a resilience one. The emphasis on amplifying pre-existing strengths and resilience in clients is foundational to both narrative and solution-focused counselling theory. The "exceptions" framework underlying these theoretical approaches help frame the purpose and narrative approach of this study. Exceptions are considered "times that the problem is not as bad as usual" (Jacob, 2001, p. 14). These unique outcomes, or exceptions, will be studied through an in-depth, contextualized exploration of women's accounts of positive coping experiences.

Research Questions

The main research question for this study was "What are the positive coping experiences of women with bulimia?" Three sub-questions accompanied the main research inquiry:

- What are the positive ways that women with bulimia cope?
- What helps women with bulimia cope in these positive ways?
- What hinders positive coping behaviours in women with bulimia?

Understanding how women with bulimia cope positively during emotionally difficult or distressing events, as well as what aids or hinders positive coping, from the perspective of participants, could be helpful to clinicians working with this population.

Overview of the Thesis

The remainder of this thesis is divided into four chapters. Chapter two covers the current literature relevant to bulimia nervosa. It describes the definition and prevalence of bulimia, conceptualizations of the role of emotion regulation and coping in bulimia, treatment approaches, and resilience. It also covers the treatment approaches associated with narrative and solution-focused counselling and research. The third chapter describes the narrative research methodology, data collection and analysis methods, establishment of rigour, ethical considerations, and my position as the researcher. Chapter four presents the findings from the study, including participants' narratives, along with the common themes and sub-themes across the narratives. The final chapter discusses the findings in relation to the current research literature. It also outlines the recommendations for future

research and implications of the findings on counselling with women with bulimia.

CHAPTER 2

Literature Review

Bulimia Nervosa: Definition and Prevalence

It is estimated that the prevalence of eating disorders has doubled since the 1960s (Public Health Services Office in Women's Health, 2000). The eating disorder of bulimia is characterized by episodes of binge eating followed by compensatory behaviours such as purging, laxative use, and/or exercise (American Psychiatric Association, 2000; Proulx, 2008; Zhu & Walsh, 2002). It is associated with a morbid fear of becoming fat or concerns regarding weight and shape that become an undue influence in people's self-evaluations (Russell, 1979). According to the *Diagnostic and Statistical Manual of Mental Disorders-IV* (American Psychiatric Association [APA], 2000), binge eating is characterized by eating, in a discrete period of time (e.g., within any two-hour period), an amount of food that is larger than most people would eat during a similar period of time and under similar circumstances (APA, 2000). Individuals with bulimia engage in such binges and frequently experience a sense of lack of control over eating during the episode. The episode is defined by a feeling that one cannot stop eating or control what or how much one is eating (APA, 2000). Recurrent inappropriate compensatory behaviours follow the binge episodes, including self-induced vomiting, diet pills, laxatives, diuretics, medications, fasting, and excessive exercise.

Although frequency estimates of eating disorders vary, the eating disorder bulimia nervosa is found in about 1 to 5% of the population of young women

(Garfinkel et al., 1995). The lifetime prevalence of bulimia has ranged from 1.1% to 2.6% across studies (e.g. Kendler et al., 1991; National Eating Disorders Association, 2006). Research indicates that this disorder often surfaces during the transition from adolescence to early adulthood (American Psychological Association, 2000). The age of onset typically ranges from 17 to 25 years (American Psychological Association, 2000; Halmi, Falk, & Schwartz, 1981; Riess, 2002). No ethnic, racial, or socioeconomic groups escape its effects (Franko, Becker, Thomas, & Herzog, 2007). One of the most significant challenges in detecting bulimia is that those with this eating disorder are often of normal weight or overweight (Proulx, 2008).

Struggles with emotion regulation and adaptive coping. Eating disorders such as bulimia are a function of many combined factors such as psychological susceptibility, biological vulnerabilities, sociocultural issues, and family predispositions (Dohnt & Tiggemann, 2006; Fairburn, Marcus, & Wilson, 1993; Herzog, 1988). There is, however, a central characteristic of women with bulimia, regardless of one's theoretical stance: they struggle with regulating emotion (Agras, 2010; Telch, 1997; Safer, Telch, & Chen, 2009). A significant obstacle in understanding the experiences of women's binging and purging resides in the difficulties these individuals have with identifying and verbally expressing a variety of physical and emotional tensions (Lehman & Rodin, 1989). Women with bulimia often report being in a state that is "incommunicable" at times, where they experience a nonspecific "state of tension" (Esplen, Garfinkel, & Gallop, 2000, p. 97).

Conceptualizations of Eating Disorders

Awareness of the central place of emotion and affect regulation in eating disorders, and bulimia in particular, has for decades shaped research into the origins of these conditions. A number of early conceptualizations, based on psychoanalytical precepts, framed eating disorders as an attempt to fill emotional needs unmet in one's interpersonal relationships. Later approaches, making use of cognitive, behavioural, and addictions models, have understood eating disorder behaviours as ways of alleviating or escaping from negative emotions.

Psychoanalytic conceptualizations. In his 1948 psychoanalytic conceptualization, Freud proposed that food becomes the vehicle through which individuals cope with emotional difficulties because it is the first transitional object or bridge between a mother and her child (Freud, 1948; Geist, 1989; Ruangsri, 2009). If food becomes the mechanism through which someone copes with all affect, this increases the person's susceptibility to an eating disorder (Hayaki, 2009).

Bruch's (1973) theory drew on a number of Freudian ideas to posit that women's disordered eating stems from early relational experiences. In particular, eating disorders were thought to originate from a mother responding to all of her infant's needs with the giving of food, or failing to respond to the child's hunger with feeding. As a function of these experiences, the child becomes unable to correctly identify and differentiate signals of hunger and other bodily and emotional sensations (Bruch, 1973). For instance, physical hunger (the physiological craving for nourishment) may be confused with emotional hunger,

which is a "complex mix of needs, desires, and feelings" (Hall & Cohn, 1999, p. 156). Unfortunately, as Hall and Cohn (1999) argue, "all of the food in the world cannot satisfy emotional needs" (p. 156).

Cognitive and behavioural conceptualizations. While approaches based on psychoanalytic precepts emphasized the interpersonal characteristics of emotion, more recent conceptualizations have conceived of bulimia in more cognitive terms, as a way of controlling or providing relief from negative emotions, which stem from negative self-beliefs. One potential consequence of negative self-beliefs is thought to be compensatory activities (e.g. through dieting/bulimic behaviours; Cooper, Wells, & Todd, 2004), or the pursuit of escape from self-awareness (e.g. Heatherton & Baumeister, 1991). Over time, these behaviours and responses may become operantly conditioned in women with bulimia (e.g. Lehman & Rodin, 1989). These cognitive and behavioural approaches, described below, have employed a variety of conceptual frameworks in their models of bulimia.

Cooper, Wells, and Todd (2004), for example, provided a cognitive model of bulimia. This model offers insight into both etiological and maintenance factors for bulimic symptomology. The authors explain that early negative experiences in women's lives may lead to persisting negative beliefs about themselves, and these beliefs produce significant emotional distress (Copper, Wells, & Todd, 2008; Fairburn, 1995). Women may come to believe that certain eating behaviours, such as dieting, will help counteract their feelings of inadequacy; dieting will ensure they are acceptable to themselves ("If I lose weight, it means I'm successful"),

and accepted by others (e.g. “If I lose weight, others will like me more;” Cooper, Wells, & Todd, 2008). Weight and shape, then, become a means of self-acceptance and acceptance by others (Cooper, Wells, & Todd). Concurrent to these beliefs around dieting, however, women also develop the belief that food will help alleviate emotional distress (Cooper, Wells, & Todd). In the case of women with bulimia, negative self-beliefs are accompanied by automatic negative self-talk (e.g. “I’m not good enough”); as this inner dialogue is triggered, emotional distress ensues and sets in motion the “vicious circle of binging and purging” (Cooper, Wells, & Todd, p. 4, 2008). Women begin to consume food in efforts to assuage their distress, but their fear that food will contribute to weight gain “soon dominates over positive beliefs about eating, and the person switches from eating to purging” (Cooper, Wells, & Todd, p. 4). In this way, women with bulimia move back and forth between binging and purging behaviours as they attempt to cope with their negative thoughts and difficult emotions.

The negative self-beliefs common to many women with bulimia may also fuel a desire to escape self-awareness, which women try to achieve through binge eating (Heatherton & Baumeister, 1991). Indeed, people’s struggles with emotion processing may relate to a lower level of emotional awareness and an impaired ability to identify emotions (Bydlowski et al., 2005). Longitudinal research supports the importance of poor interoceptive/interceptive awareness in the development of bulimia; the inability to recognize and label internal emotional states appears to be a strong predictor of the development of eating disorder symptoms in adolescents (Fassino, et al., 2004). From this viewpoint, people

sometimes find it burdensome and aversive to be aware of themselves, so they seek to escape (Duval & Wicklund, 1972). It is difficult, however, to simply turn off one's awareness of self. The common strategy is therefore to narrow the focus of attention to the present and immediate stimulus environment (Baumeister, 1989, 1990). This keeps self-awareness at a relatively low level and avoids meaningful thought about ongoing identity and the implications of various events.

From the perspective of other researchers (e.g. Lehman & Rodin, 1989), eating symptomology in bulimia becomes operantly conditioned responses to difficult emotions. Binge episodes provide negative reinforcement, a momentary relief from aversive emotions (Lehman & Rodin, 1989; Mauler, Hamm, Weike, & Tuschen-Caffier, 2006; Polivy & Herman, 1993; Proulx, 2008). The temporary relief provided strengthens the binge eating and/or purging as an emotion regulation strategy (Smyth et al., 2007). These behaviours become automatic, overlearned responses to emotion dysregulation, thereby pushing aside more adaptive strategies (Lehman & Rodin).

Literature also points to the important role played by reward sensitivity (e.g. deriving pleasure from food) and punishment sensitivity (e.g. anxiety and harm avoidance) in the development and maintenance of eating disorders. For instance, Dawe and Loxton (2004) indicated that increased reward sensitivity is particularly associated with vulnerability toward developing binge-eating behaviour, which is a primary symptom of bulimia. In the context of bulimia, research shows that women with bulimia have greater sensitivity to food reward than do women without eating disorders, and even more so than women with

anorexia (Harrison, Treasure, & Smillie, 2011). Furthermore, they tend to maintain attention towards cues of potential reward significantly more compared to non-ED participants (Harrison, Treasure, & Smillie, 2011). In a systematic review of 25 studies, Harrison and colleague's (2011) found that individuals with bulimia nervosa (BN) had elevated scores on reward sensitivity and punishment sensitivity questionnaires in comparison to controls.

Addiction and biological conceptualizations. An addictions model of eating disorders incorporates both cognitive and behavioural principles (Sheppard, 1993), two principles discussed in the previous conceptualizations. Some professionals have linked the behaviour patterns seen in eating disorders to those commonly identified with substance abuse or addictions (NEDIC, 1989). For instance, many people with eating disorders experience comorbid substance abuse (e.g. drugs and alcohol; Holderness, Brooks-Gunn, & Warren, 1994), and have personality features similar to those with addictions such as impulsivity (Halmi, 2005). Commonalities between women with bulimia and those with pathological gambling addictions have been demonstrated (Álvarez-Moya, et al., 2009, Duchesne et al., 2004, Roberts et al., 2007). In one particular study, Álvarez-Moya and colleagues (2009) examined the executive functioning and decision-making of a clinical population of 30 women from an Eating Disorders Unit and a Pathological Gambling Unit. Both groups demonstrated elevated impulsivity and behavioural disinhibition, as measured by the Wisconsin Card Sorting Test and the Stroop Color and Word Test. The authors asserted, however, that the nature of these executive dysfunctions may differ. Specifically, women with BN had higher

distractibility and susceptibility to interference during test tasks compared to pathological gambling participants.

In addition to engaging in avoidance strategies, women with bulimia engage in binging and purging behaviours that may, as noted above, have some immediate benefits (e.g., tension and anxiety relief), but in the long run, become self-destructive with dire consequences (Proulx, 2008; Russell, 1979; Safer, Telch, & Chen, 2009). As such, people with bulimia may act to obtain immediate gratification in spite of long-term negative consequences (Liao et al., 2009). Liao and colleagues (2009) examined decision-making in 26 women with bulimia, using the Iowa Gambling Task (IGT; Bechara, Damasio, Damasio, & Anderson, 1994). The test measures participants' decision-making ability to sacrifice immediate rewards in order to achieve long-term gain, using a computerized "gambling" game with cards (Bechara, Damasio, Tranel, & Damasio, 1997). Liao et al.'s (2009) results demonstrated that women with bulimia did indeed have poorer decision making compared to healthy control participants. Specifically, whereas the latter group improved their performance by learning to avoid disadvantageous card picks, people with bulimia did not show improvement. This study offered support for the impulsive nature of bulimic symptomology.

Although research shows evidence of associations between EDs and addictions, the robustness of an addictions model of eating disorders has yet to be determined (von Ranson & Cassin, 2007). An addictions model remains contested by researchers in part due to disparities between how addictions are defined. Other areas of concern relate to which eating disorder symptoms constitute an

actual addiction (von Ranson & Cassin). For example, von Ranson and Cassin ask whether binge eating, purging, excessive exercise, food restriction, or some combination of the above have addictive elements; research has yet to address this issue of specificity (von Ransen & Cassin).

As discussed in the literature above, coping with difficult emotions and experiences is a struggle common to women with bulimia. Understanding the concepts of coping and emotion regulation, then, are important facets of this review, and are discussed next.

Conceptualizations of Emotion Regulation and Coping

Gross (1998, 2001), a pioneer in emotion regulation research, defined emotion regulation as the processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions. These regulatory processes may be automatic or controlled, conscious or unconscious (Gross, 1998). Emotion regulation is deemed particularly essential when emotional experience is negative. This is relevant to knowledge about women with bulimia, who are more frequently plagued with heightened levels of negative emotions, particularly around the binge/purge cycle (Hall & Cohn, 1999; Smyth et al., 2007; Yager, Rorty, & Rossotto, 1995).

Emotion regulation is closely tied to coping behaviour. Early definitions of coping conceptualized it as "cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). It may be considered as “regulation under stress” (Compass et al., 2007, p. 89), referring to the

"conscious and volitional efforts to regulate emotion, cognition, behaviour, physiology, and the environment in response to stressful events or circumstances (Compas, 2001, p. 89). Some literature, however, posits that all emotion regulation strategies can be considered ways of coping (Bridges & Grolnick 1995).

As Gross (1998) has argued, although traditional definitions of coping overlap with contemporary conceptions of emotion regulation, the two concepts should not be perceived as redundant. Emotion regulation includes processes that may or may not tax the individual's resources, as well as processes not traditionally considered in the coping literature, such as sustaining or augmenting *positive* emotions (see Folkman, 1997). Coping, on the other hand, may translate beyond the regulation of emotion in the face of stress. People attempt not only to deal with emotional experience, expression, and physiological reactions, but also to coordinate motor behaviour, attention, cognition, and reactions from the social and physical environments (Compas et al. 2001, Lazarus & Folkman 1984).

The ways in which people actually respond to or regulate stress, then, is known as coping (Skinner & Zimmer-Gembeck, 2007) and is the primary focus of my study on narratives from women with bulimia. Coping is related to emotion regulation, although it more generally refers to what individuals actually *do* (their emotional, cognitive, and behavioural responses) in dealing with specific difficulties in real-life contexts (Skinner & Zimmer-Gembeck).

Types of coping behaviour. Coping can take on a variety of adaptive forms such as meditation, talking to a friend, or progressive muscle relaxation

(Gilbert, 2005; Lehman & Rodin, 1989). Coping responses are infinite in their variety and are shaped by the resources and contexts in which they unfold (Skinner & Zimmer-Gembeck, 2007). Individuals may adopt negative forms of coping (e.g., binging and purging, drug abuse) or positive forms of coping (going for a walk or talking with someone). In the face of adverse emotions and experiences, it is well known that women with bulimia frequently cope in ways that are harmful to both their physical and emotional well-being. They may use food in efforts to regulate tension or anxiety (Johnson, Lewis, & Hagman, 1984), and provide themselves comfort, warmth, and well-being (Esplen, Garfinkel, & Gallop, 2000).

Coping styles characteristic of women with bulimia. Researchers have examined the types of coping strategies utilized by women with bulimia. Raizman (1999) studied the copying styles of 123 women who were attending an inpatient treatment program for eating disorders. The researchers found that, when compared to healthy controls, the women with bulimia were more likely to use oral/somatic forms of self-regulation and were less likely to use contemplative strategies or interpersonal behaviours for self-regulation. Yager, Rorty, and Rossotto (1995) also examined coping styles, but their sample included 40 women recovered from bulimia, 40 women struggling with bulimia, and a healthy control group. They found that coping styles differed between the recovered and nonrecovered women, but not between the recovered women and non-eating-disordered control subjects. Specifically, the recovered women were more likely than nonrecovered individuals to seek emotional support from others and

displayed higher levels of problem solving, including active coping and planning. The results also showed that lower levels of planning and seeking emotional support were predictive of greater bulimic symptomology and food preoccupation (Yager, Rorty, & Rossotto, 1995). Yager and colleagues suggested that people may come to rely on food because they cannot have their interpersonal needs met from people. Ironically, the secretive behaviours associated with bulimia (i.e. binging/purging) concurrently force the person to give up relating to people as a source of comfort and a way to cope (Sands, 2001). Seeking social support is a well-documented area in which women with bulimia struggle (Ghaderi & Scott, 2000; Soukup, Beiler, & Terrell, 1990).

Villa and colleagues (2009), in their clinical sample of 56 women with eating disorders, found that participants with bulimia used less functional coping strategies than healthy participants. In particular, they were less inclined to seek social support. Several other studies (e.g. Ghaderi & Scott, 2000; Soukup, Beiler, & Terrell, 1990) have shown that women with bulimia often use avoidance strategies in stressful situations (e.g., avoiding confronting problems, reluctance to share problems with others). For instance, Corstorphine, Mountford, Tomlinson, Waller, and Meyer (2006) explored distress tolerance in a sample of 72 women with an eating disorder, 25 of whom had bulimia. Participants completed measures that reflected people's means of coping with emotional states. Findings showed that eating-disordered women were significantly more likely to engage in emotional avoidance. This contrasted with the problem solving to reduce emotional states utilized by non-clinical participants (the *accept and manage*

strategy).

In addition to engaging in avoidance strategies, women with bulimia also appear to be defensive of their bulimic behaviours. Ondercin's (1984) work highlighted the way in which women may be defensive of such behaviours and may struggle to admit they need help. Her study comprised a clinical sample of 50 women identified as bulimic, anorexic, and obese, along with 70 women in nonclinical control groups. Ondercin found that women with bulimia were more reluctant to admit their faults and weaknesses and showed a greater need to defend themselves against attack than were women in the control group (Ondercin). Overly defensive people may be hypersensitive to criticism, chronically angry, and depressed (Lehman & Rodin, 1989). Not surprisingly, the behaviours in which women with bulimia engage are secretive (Hall & Cohn), and line up with these problems of defensiveness and shame found in Ondercin's study.

Moreover, women with bulimia have been found to be particularly sensitive to negative affect and events and tend to be much less reactive to positive events (Lehman & Rodin, 1989). There also appears to be greater difficulty accepting negative events and reframing them constructively (Villa et al., 2009). Furthermore, women with bulimia perceive positive events as occurring less frequently to them, and derive less pleasure from such events (Hall & Cohn, 1999; Lehman & Rodin, 1989). This ultimately leads to a greater weight placed on the negative events, thus perpetuating feelings of shame and guilt (Lehman & Rodin). Women with bulimia appear to perceive themselves to be

under higher than average degrees of stress (Soukup, Beiler, & Terrell, 1990). Finally, studies have demonstrated that this population is more likely to have a negative outlook on life events and may not always recognize and acknowledge successes in life (Lehman & Rodin, 1989).

As women with bulimia engage in maladaptive forms of coping, confidence in the ability to utilize more adaptive coping strategies may subside over time (Root, 1990; Villa et al., 2009). Although aware of the maladaptive nature of bulimia in their lives, many women have difficulty choosing adaptive methods of coping. This lack of confidence likely stems in part from a highly self-critical nature; women with BN experience frequent feelings of guilt, shame, and failure to live up to their own expectations (Lehman & Rodin, 1989; Steinberg & Shaw, 1997).

The Binge/Purge Cycle: A Rollercoaster of Emotions

A number of researchers have focused on cycles of binging and purging that appear to be characteristic of BN. Firstly, behaviours exhibited in bulimia are often in response to the individuals' intense experiences of negative affect (Hinrichsen, Morrison, Waller, & Schmidt, 2007; Lehman & Rodin, 1989; Proulx, 2008). Prior to binging, women frequently report feelings of shame, anxiety, guilt, and anger; and most perceive these feelings as triggers to their behaviour (Abraham & Beaumont, 1982; Hinrichsen, Morrison, Waller, & Schmidt, 2007; Johnson, 1985). Binging may temporarily distract or relieve these difficult emotions. As Cohn and Hall (1999) stated, after a woman's purging episode "she is drained, relaxed, and high" (p. 50). However, this abatement in negative

feelings and emotions is only momentary (Proulx, 2008). Once the binge-purge episode ends, women are once again faced with feelings of disgust and shame, which they then try to assuage with the comforting effect of another binge and purging episode (Ruggiero, 2008). Gallop (2002) describes that the overall binge-purge cycle appears to reinforce women's inner feelings of self-hatred, which may be obscured by a pleasing facade which covers deep feelings of hurt and anger. If purging subsequent to a binging episode is rendered impossible for women with bulimia, this relief is left unobtained (Buree, Papageorgis, & Hare, 1990; Mauler, Hamm, Weike, & Tuschen-Caffier, 2006).

In controlled studies where purging was removed as an option after binging, women with bulimia reported negative affect and anxiety after eating, along with feelings of depression and fear related to gaining weight (e.g. Staiger, Dawe, & McCarthy, 2000). A study examining the retrospective self-reports of women with bulimia (Cooper, Morrison, Bigman, Abramowitz, Levin, & Krener, 1988) provides support for the relieving effect of purging. The authors recruited 31 participants with bulimia and 10 with a concurrent affective disorder. The researchers found that all women, regardless of whether they had an affective disorder or not, appeared to undergo similar mood changes throughout the binge-purge cycle. Namely, high levels of energy and excitement, panic, and helplessness were characteristic of the binge phase. Subsequent to the binge and prior to the purging behaviours, women reported feelings of an emphatically unpleasant mood state; feelings of energy and excitement dropped to their lowest levels, along with those of security and relief. In contrast, helplessness and panic

stayed elevated, and feelings of guilt, disgust, and anger peaked to their highest level. Following the purge, women felt relatively calm and pleasurable.

Smyth and colleagues (2007) used an ecological momentary assessment, or "real life" approach, to study the relationship between moods, stress, and disordered eating in 121 women with bulimia. In contrast to these previous studies, Smyth et al. obtained momentary data by having participants complete daily diaries on palmtop computers at home. Such measures help limit retrospective recall, which allowed researcher to examine temporal patterns leading up to and following participants' binge/purge cycles (Smyth et al., 2007). Preceding a binge, women's negative affect, anger, and stress ratings increased, and positive affect decreased. Negative affect and anger decreased immediately following the binge, and positive affect increased. Their findings support other claims of the reinforcing nature of the binge/purge cycle. Furthermore, Smyth and colleagues found that women's overall moods were much worse on binge/purge days; even at their "best mood," this level was still lower in comparison to non-binge/purge days.

Approaches to Treating Bulimia Nervosa

Behavioural and cognitive approaches. Course and treatment outcomes for bulimia reveal that approximately 20 to 30% of patients will remain chronically ill, one-third will continue to have some symptoms of the disorder or relapse, and one-half will recover (Keel & Herzog, 2004). Given the complex etiology of bulimia nervosa, a variety of treatment approaches have been developed. The most common approaches include dialectical behavioural therapy

(DBT; e.g. Telch, 1997; Safer, Telch, & Chen, 2009), cognitive behavioural therapy (CBT; e.g. Fairburn, 1995; Wilson, Fairburn, & Agras, 1997), and psychoeducational instruction (PET; e.g. Connors, Johnson, & Stuckey, 1984; Garner, Rockert, Olmstead, Johnson, & Coscina, 1985).

DBT has gained significant support among clinicians in the treatment of bulimia. Lehman (1993) developed this approach based on the recognition of women with bulimia's emotional regulation difficulties. The primary goal of DBT treatment is for clients to stop binge eating and purging and to stop all other problem eating behaviours such as mindless eating, urges, cravings, capitulating to binge eating (Safer, Telch, & Chen, 2009). These goals are accompanied by teaching clients adaptive emotion regulation and distress tolerance skills. Adaptive emotion regulation skills require the ability to label, monitor, and modify one's emotional reactions, including the ability to accept and tolerate emotional experiences when emotions cannot, in the short run, be changed (Safer, Telch, & Chen, 2009).

Although fairly new in its application to treatment for bulimia, the research to date suggests that DBT is highly effective (Linehan & Chen, 2005; Safer, Telch, & Chen, 2009). In the first randomized control trial, Safer, Telch, and Agras (2001) randomly assigned 25 women who met full criteria for BN to one of two conditions: 20 weeks of dialectical behaviour therapy or 20 weeks of a wait list. Significant treatment effects for both the frequency of binge eating and purging behaviours were found. Furthermore, results from several questionnaires

pre- and post-treatment suggest that DBT helped decrease participants' vulnerability to negative emotions associated with the urge to binge and purge.

Cognitive behavioural therapy (CBT) focuses on normalizing disordered eating patterns and tackling overvalued ideas regarding weight and shape (Fairburn, 1995; Wilson, Fairburn, & Agras, 1997). From a CBT standpoint, understanding the relationships between thoughts, emotions and actions is extremely important for women with bulimia (Wilson, 1997). Controlled studies suggest that CBT eliminates bulimic symptomology in about 50% of participants, and reduces it in many others (Fairburn et al., 1993; Fairburn et al., 1995). Furthermore, maladaptive dieting and distorted body image also are substantially improved (Fairburn, et al., 1991; Fairburn, et al., 1995; Wilson, 2004). Despite such positive outcome reports, there is paucity of long-term follow-up studies on the use of CBT for women with BN. Riess and Dockray-Miller (2002) warn that this poses a challenge in determining how long-lasting the reported decreases in symptomatology will be.

Psychoeducational instruction (PET) operates on the assumption that scientific information about factors perpetuating the eating disorder will increase motivation to discontinue symptoms (Connors, Johnson, & Stuckey, 1984; Garner, Rockert, Olmstead, Johnson, & Coscina, 1985). As far back as 1985, researchers (e.g. Garner, et al., 1985) proposed PET as one component of treatment for both anorexia and bulimia nervosa. This form of treatment adopts the principle that a lack of information and misconceptions about factors that cause and maintain symptoms are often present in individuals with BN (Riess &

Dockray-Miller, 2002). Given the general consensus that eating disorders are a function of many combined factors such as psychological susceptibility, biological vulnerabilities, sociocultural issues, and family predispositions (e.g. Dohnt & Tiggemann, 2006; Fairburn, Marcus, & Wilson, 1993; Herzog, 1988), a psychoeducational phase of treatment to discuss these areas seems to benefit clients. Inclusion of educationally oriented therapy sessions has facilitated significant behavioural change in some patients (Olmstead, Davis, Garner, Rockert, Irvine, & Eagle, 1991; Ordman & Kirshenbaum, 1986).

Constructionist approaches. Traditional research on eating disorders has focused primarily on identifying and addressing specific risk factors and deficits that "need fixing" (Steck, Abrams, & Phelps, 2004). However, problem-focused work may lead to feelings of inadequacy and hopelessness (Jacob, 2001). Given the negative self-evaluations characteristic of women with bulimia, such an approach may be problematic (Jacob, 2001). In fact, over the past 50 years, psychologists have learned that "the disease model does not move psychology closer to the prevention of these serious problems" (Seligman & Csikszentmihalyi, 2000, p. 7).

Over the past several decades, a number of approaches have emerged that shift from a disease model to focus on exceptions to the harmful coping behaviours of women with bulimia. The application of strengths-based approaches to treatment is highly relevant to working with bulimia. Narrative therapy, for instance, is one such approach. Proponents of narrative therapy believe that we live storied lives and organize and assign meaning to our lived

experiences through stories about them (White & Epston, 1990). As a pioneer of narrative therapy, White (1991) asserted that our told stories change depending on the context, along with the meanings we ascribe to them. The fluidity of our stories means that certain aspects of them are left out or rendered invisible (White & Epston, 1990). Our stories then, are not neutral; sharing them allows for their de-construction and reconstruction (White, 1991). Through this process, we can "re-author" our narratives, thereby challenging our dominant perspectives (Brown, 2003). In particular, the technique of externalization in narrative therapy, or separating the individual from the problem, facilitates the co-construction of alternative stories with unique outcomes (Brown, 2003; Daiute & Lightfoot, 2004; White, 1991).

A narrative therapy approach is particularly relevant to women struggling with bulimia. This population often engages in internalizing conversations, in that they think and talk about having bulimia as something "within" themselves (Espton & Maisel, 2004). Broader society reflects this internalization of bulimia when we use phrases like "She's a bulimic." These social and individual practices "construct eating disorders as psychological or medical problems that originate from within the disordered mind/self of the person" (Epston & Maisel, p. 213). Epston and Maisel asserted that "these bio/psychological accounts all too easily obscure the interpersonal, social and historical contexts that are so often implicated in the difficulties people experience" (p. 213). Narrative therapists come from the perspective of "the person is not the problem – the problem is the problem" (White, 1989, p. 43). Through externalizing conversations, women can

learn to separate themselves from their unhelpful dominant stories of "being bulimic," and experience agency and a capacity to "intervene in their own lives and relationships" (White & Epston, 1990, p. 16). Externalizing the eating disorder, or viewing it as an entity whose existence is quite distinct from the sufferer (Morgan, 2000), helps women see that "the problem is the problem, not the person" (White, 2007, p. 9). Reconstructing women's stories stems from the opportunity to explore "times that the problem is not as bad as usual" (Jacob, 2001, p. 14). These unique outcomes, or exceptions, are amplified through the therapy process. Noticing and verbalizing unique outcomes highlights the existence of other stories, and offers rich alternatives that can begin to form reconstructed stories (Brown, 2003).

The efficacy of narrative therapeutic approaches with eating disorders has been demonstrated in several settings (Epston & Maisel, 2009; Maisel, Epston, & Borden, 2004). For instance, eating-disordered participants in a group therapy study experienced a reduction in their overall eating disorder symptoms (Weber, Davis, & McPhie, 2006). In particular, participants' ability to externalize and disengage from their eating disorders appeared to be especially effective (Weber, Davis, & McPhie). In a recent case study of a woman with anorexia, Hanstock and Patterson-Kane (2013) highlighted the potential effectiveness of a narrative approach with eating disorder treatment. Over 10 sessions of narrative therapy, the client made significant progress in the form of externalizing her anorexia and lowering the degree to which she adhered to its physical demands. She also developed and learned how to express her "non eating disorder character and

values" (Hanstock & Patterson-Kane, p. 1), an aspect of her identity that for many years, had been silenced by anorexia.

Other evidence for the utility of a narrative approach primarily consists of informal case study material (e.g., Epston, 1999; Maisel et al., 2004; Nylund, 2002); however, this work contains valuable learning for clinicians regarding its implementation (Hanstock & Patterson-Kane, 2013). For instance, Maisel, Epston, and Borden (2004) detailed 15 years of work with individuals struggling with anorexia and bulimia in their book entitled *Biting The Hand That Starves You: Inspiring Resistance to Anorexia/Bulimia*. Through externalizing conversations with clients, the researchers demonstrated the transformative power of narrative therapy, and allowed "sufferers, professionals, and loved ones to unite against anorexia/bulimia" (Maisel, Epston, and Borden, p. 156). Brown, Weber, and Ali (2008) also provided support for a narrative approach to eating disorders. In their 18 months with a client, Shayna, Brown and colleagues helped her explore the meaning she ascribes to her eating disorder, how she can externalize this issue, and explore unique outcomes for herself to envision and enact. Brown, Weber, and Ali (2008) provide compelling research into the helpfulness of narrative therapeutic approaches.

Solution-focused therapy is another approach showing promise in its effectiveness for eating disorder treatment. (e.g. Jacob, 2001, O'Halloran, 1999; Martin, Guterman, & Shatz, 2012). It shares with narrative therapy an emphasis on clients' strengths. Solution-focused therapy emphasizes the individual's existing and potential resources (Guterman, 2006; Martin, Guterman, & Shatz,

2012). This approach to therapy is also informed by a postmodern social constructionist perspective, similar to narrative therapy. In the counselling environment, the client and the therapist co-create problem definitions and solutions (Jacob, 2001). Conceptualizations of client issues do not occur in isolation; both the individual and their therapist play a role in their development. Martin and colleagues (2012) explain that having a problem also entails the existence of exceptions, either actual or potential. Exceptions are "times when positive coping skills are applied or when the problem is solved." An example might be the case of a client with bulimia who defines the problem as ineffective coping with stress (through binging/purging). A solution-focused approach to therapy would involve identifying and amplifying times when she coped adaptively with stress, and did not binge/purge. Jacob (2001) began this process with a client who claimed she was "constantly vomiting." He wondered aloud whether she could think of exceptions to this statement. He asked "Always? Even when you are asleep? Hanging out the wash? Even when you walk your children to school?" Solution-focused therapists look for evidence in the client's story that proves that however bad the circumstances, he or she is already doing something which prevents the problem worsening (Jacob, 2001, p. 10). As the focus is brought to exceptions in clients' experiences, a new dialogue opens up that allows for new stories to be told, specifically, stories that highlight the clients' existing support structures and coping strategies (Jacob, 2001). The client is then encouraged to do more of what works. In the context of women with bulimia, this therapy approach can help them replace problem thinking with new coping

strategies and solutions. It is not to say, however, that solution-focused therapy dismisses the discussion of client problems. In Jacob's (2001) view, any therapist, regardless of therapeutic stance, should allow clients space to discuss their struggles. Solution-focused clinicians, however, acknowledge and sympathize with these difficulties, but concurrently highlight "resources, coping-strategies and strengths which have enabled the client to survive" (Jacob, 2001, p. 14).

A number of researchers have provided evidence and case examples on the effectiveness of solution-focused approaches for helping people with eating disorders. For instance, Berg and Steiner (2003) found solution-focused therapy to be helpful in treating children with eating disorders, and McFarland (1995) detailed the usefulness of brief therapy from a solution-focused perspective with women struggling with EDs. O'Halloran (1999) provided an example of a solution-focused brief therapy family-based approach with an adolescent in the family who was anorexic.

Summary

In the preceding sections, I have discussed current literature relevant to bulimia nervosa, including prevalence and conceptualizations of the eating disorder, treatment approaches, and resilience. From the above, it is apparent that for many years, dominant discourse appears to have pathologized bulimia, and highlighted the ongoing struggles of women with this eating disorder. Research has often neglected the existing resources and strengths in women with bulimia, in spite of this difficult condition. The current study aimed to facilitate a different type of dialogue between researchers, and among clinicians and their clients with

bulimia. Specifically, the purpose of this research study was to explore the positive coping experiences of women with BN in response to difficult emotions or negative events, and increase our understanding of women's existing strengths.

CHAPTER 3

Methods

In the following section, I outline my methodology along with the theoretical and philosophical assumptions associated with it. I also detail my position as the researcher and the method of data collection and analysis I used to conduct this study. Finally, I describe the establishment of rigour and ethical considerations for this investigation.

Methodology: Theoretical and Philosophical Assumptions

The methodology in a study is "the research design that shapes our choice and use of particular methods and links them to the desired outcomes" (Crotty, 1998, p.7). A narrative methodology was chosen for this study. This approach to research begins with the experiences as expressed in lived and told stories of individuals (Clandinin & Connelly, 2002; Polkinghorne, 1995). It is best for capturing the detailed stories or life experiences of a single life or the lives of a small number of individuals (Creswell, 2007). Narrative, a primary form by which human existence is made meaningful, is a necessary part of our understanding of human behaviour (Lieblich, Tuval-Mashiach, Zilber, 1998; Polkinghone, 1988, 1995). Human experiences tend to be fused into temporally meaningful episodes, and these stories are the gems sought out by narrative researchers. Lieblich, Tuval-Mashiach, and Zilber noted that people are story tellers by nature. By the same token:

> Stories imitate life and present an inner reality to the outside world; at the same time, however, they shape and construct the narrator's personality

> and reality…We know or discover ourselves, and reveal ourselves to others, by the stories we tell (p. 7).

A narrative research methodology fits well with the current research goals, in that I hoped to help women narrate aspects of their story that have, until now, remained unappreciated or unnoticed. There is significant value to uncovering and amplifying the exceptions to women with bulimia's typical coping experiences. By focusing on their moments of positive coping, women can begin to integrate this knowledge into their understanding of who they are and what they are capable of. As Brown and Augusta-Scott (2007) explained, "there is a distinct and complex relationship between the dominant self-stories people tell about themselves and those they disqualify" (p. xxv). Narrative conversations tease out what is said and hold a deep curiosity about what is not said; those details that have yet to be included in the story (Brown & Augusta-Scott, 2007).

Theoretically, narrative inquiry draws upon the hermeneutic tradition, which is a form of interpretivism (Crotty, 1998; McLeod, 2001). Interpretivists propose that we create meaning within our social contexts, and our own realities are created through these interactions (Leahy & Dowd, 2002; Crotty, 1998). Hermeneutics is concerned with the interpretation of human experiences, where all experiences are created in a cultural-historical context (McLoed, 2001, p. 23). Any interpretation of participants' experiences, then, transpires through the lens of the researcher, who inevitably comes from a different context. I acknowledge that my "historical consciousness" (Gadamer, 1975, p. 12) frames my understanding of the text. As a member of culture and user of language, my

understanding of participant experiences will always be influenced by my own pre-existing assumptions and history. Similarly, my past is joined with my present, which cannot be separated from my history and culture (Elliott, Fischer, & Rennie, 1999; McLeod, 2001).

Philosophically, a constructivist epistemology underlies narrative research (Clandinin & Connelly, 2000; Crotty, 1998;). Epistemology is "a way of understanding and explaining how we know what we know" (Crotty, 1998, p. 3). A researcher's epistemology encompasses what she understands as knowledge and what status can be ascribed to it (Crotty, 1998, p. 2). In approaching research through this constructivist paradigm, I assume a relativist ontology, or rather, that there are multiple realities (Denzin & Lincoln, 2005). Since each of my participants experience their lives from their own point of view, each of them hold a different reality (Kraus, 2005). I also come from a subjective epistemology, such that the participants and I, the researcher, co-create understandings and knowledge.

Position as the Researcher

As qualitative researchers, we inevitably bring a number of assumptions to our chosen methodology. "We need, as best we can, to state what these assumptions are" (Crotty, 1998, p. 7). As in other forms of qualitative research, the inquirer is the primary instrument for data collection and analysis (McLeod, 2001); all material regarding the participant (e.g., interviews, observations) filters through her. Working from a constructivist epistemological perspective, I acknowledge my active role in the construction of this study.

This study evolved from my personal and professional interest in the field of eating disorders, particularly the issue of bulimia nervosa. Prior research on this topic led me to this endeavour; my devotion to this area of research and clinical practice has steadily increased over time. My dedication to expanding our understanding of women with bulimia's experiences was also influenced by my relationships with women who struggle or have struggled with this issue. These relationships occurred on both a personal (i.e., with friends) and professional (i.e., through counselling clients) level. The meaningful and powerful conversations I experienced with these individuals provided further impetus for my continued search for knowledge and understanding.

Coming into this study, I was aware of my biases and presuppositions about the positive coping experiences of women with bulimia. For instance, I expected that social support would be a significant factor in helping women through moments of distress. I also assumed that a form of self-awareness regarding one's emotions would be important in their stories. Although research repeatedly indicates that this population lacks emotional awareness, I witnessed other individuals in my life who had exemplified this skill during moments of resilience. Another assumption I had related to the non-linear process of gaining freedom from an eating disorder. Namely, I expected that each participant would enter my study from a different stage in her bulimia. Based on my previous experiences, I was cognizant of the hills and valleys associated with bulimia; women often experience periods of time when their symptoms are essentially "better" or "worse." As such, I expected that women would differ in their

recollections of positive coping experiences, and for some more than others, remembering these moments of strength may be very challenging.

Given these assumptions, it was important for me to record and reflect upon them, both at the beginning and throughout the research process. The process of setting aside one's assumptions and biases is often regarded as "bracketing," in which "investigators set aside their experiences, as much as possible, to take a fresh perspective toward the study's topic of interest" (Creswell, 2007, p. 60). Later in this chapter, I detail my process of recording, or memoing, in my research journal.

Participants

Participant recruitment, selection, and inclusion criteria. Participants for the study were solicited through posters (Appendix G) at the University of Alberta's Education Clinical Services, Grant MacEwan University, The University of Alberta Hospital, and individual private psychotherapy practices (with permission). Advertisements were also placed in online community listservs (e.g., Kijiji and Craig's List). Remuneration for participants' time was offered in the form of a $25 gift certificate to a bookstore.

Participants were selected using purposeful sampling (Patton, 2002). Women above the age of 18 were selected for participation in the study. Rationale for this criterion resides in previous investigations on the age of onset for BN. The American Psychological Association (2000) found that the onset of bulimia appears to be concentrated in the transition from adolescence to early adulthood and typically ranges from 18 to 22 years.

A screening inventory was used to determine eating disorder symptomatology and bulimia behaviours. I met in-person for screening interviews to establish whether or not inclusion criteria were met for each participant. The screening interviews were held at Education Clinical Services at the University of Alberta. Prior to the interview, I asked each potential participant to read and complete an informed consent form for participation in the screening interview (Appendix A). Upon agreement to the terms outlined in the screening consent form, participants were asked to fill out two forms, one of which was a Participant Information Sheet (Appendix B). On this sheet, they were asked to choose a pseudonym to be used in place of their real name. The other form was the screening tool (Appendix C), described below.

Inclusion criteria for participation were meeting the criteria for bulimia nervosa as per the Bulimia Test-Revised (BULIT-R; Thelen, Farmer, Wonderlich, & Smith, 1991). The BULIT-R is a 36-item self-report multiple-choice measure that assesses bulimic attitudes and behaviour based on the criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; APA, 1994) for bulimia. The BULIT-R was developed to identify bulimic individuals in nonclinical as well as in clinical populations. Predictive validity of the BULIT-R was assessed in a population of 1,739 college women, comparing scores on this measure with structured clinical interviews (Thelen, Mintz, & Vander Wal, 1996). The specificity, positive predictive ability, and negative predictive value were .82 or higher, and the sensitivity was .62 (Thelen, Mintz, & Vander Wal, 1996). Twenty-eight of the 36 items are summed to provide an overall score. The

remaining 8 items are unscored and refer to specific weight control behaviours. The 28 scored items are rated using a 5-point Likert-type scale (5 = extreme disturbance, 1= absence of disturbance). The range of possible scores is 28 up to 140. A cutoff score of 104 is most widely used, as a score of 104 or higher indicates the presence of BN (Thelen, Farmer, Wonderlich, & Smith, 1991). This questionnaire was given to participants during the screening interview as a part of determining their eligibility for inclusion in the study. Given that a score of 104 or above has been found to represent an individual with bulimia, participants whose score met this criterion were eligible for participation in the study.

Upon completion of the forms, I provided each potential participant with a list of counselling referrals (Appendix D). This list was offered in order to provide support for possible challenging psychological issues that may arise throughout the screening interview and study itself. I subsequently thanked the participant for coming in. I also informed them that within one week, they would hear about whether or not they would be asked to participate in the study.

Participant demographics. Overall, six women from the general population were included in the current study; five of which were single/unmarried, and one that had a common-law partner. Women ranged from 20 to 30 years of age (M_{age} = 21 years) and were of Caucasian European-Canadian descent. The average age of onset for bulimia was 19 years, and on average, participants had bulimia for 5.9 years.

Data Collection

To gather women with bulimia's stories on their positive coping experiences, I used face-to-face, in depth, semi-structured interviews. Interviews have great potential for gaining rich and detailed accounts of people's experiences (Clandinin & Connelly, 2000; Kvale. 1996). Before the initial interview, each participant was asked to read over and sign a consent form for participation in the formal interview(s) (Appendix E), and was informed of the nature of her participation in the study. Initial interviews were conducted with all six participants, and were between 45 minutes to 1 ½ hours in length. I conducted the interviews with several guiding questions in mind (see Interview Protocol, Appendix F), but I remained open to the direction taken by participants. I introduced each interview to participants with a briefing wherein I explained the purpose of the interview, the use of the audio-recorder, and so on. I also emphasized with each participant that she was welcome to ask any questions throughout the interview and seek clarification if needed. I relayed that there were not right and wrong answers to my inquiries; descriptions of the participant's own thoughts and experiences were of the utmost importance to the research.

All audio-recorded interviews were transcribed verbatim and sent to participants to verify accuracy of the transcription. They were asked to read and review the interview transcript. Once participants reviewed their transcripts, in-person follow-up interviews took place with five of six participants. These secondary meetings are an essential component to narrative research, in that they can help thicken participant descriptions. They help clarify and enrich the details

already created from the first interview (Clandinin & Connelly, 2000). The participant with whom a follow-up interview was not completed emailed me to indicate that she had reviewed the transcript, and she confirmed its accuracy. This participant did not indicate that she no longer wished to participate in the study, but did not return requests for a follow-up interview.

Data Analysis

One component of data analysis involved the construction of a narrative for each participant. This involved the sequencing and ordering of events from women's accounts, which "operates by linking diverse happenings along a temporal dimension and by identifying the effect one event has on another" (Polkinghorne, 1998, p. 18). In addition to temporarily, other aspects of narrative I attended to were obstacles and turning points in the women's experiences of positive coping. The turning points and obstacles in narrative are important parts of a story's overall plot (Creswell, 2007). During the construction of narratives, it became increasingly apparent that these significant moments played instrumental roles in women's moments of resilience. Furthermore, attending to obstacles and turning points involved examining the interactions between participants and their social environment (Clandinin & Connelly, 2000). Our lived experiences occur in social contexts, with other people, and this was important to acknowledge throughout the construction of participant narratives.

Data analysis also involved the creation of themes through an interpretive approach, described by Braun and Clarke (2006) and by Merriam (2008). Braun and Clarke's (2006) thematic analysis, a method for identifying, analyzing, and

reporting patterns (themes) within the data, is well suited for many methodologies such as narrative research. To begin the formal stages of data analysis, I coded each transcript into units of data which are "any meaningful (or potentially meaningful) segment[s] of data" (Merriam, 1998, p. 179). I paid particular attention to coding units of data that related to women's stories, such as the chronology or temporality, the plot, obstacles, turning points, and social interactions. As coding for each new transcript took place, codes were compared to one another through the constant comparative method (Merriam, 2002). With constant comparison, codes were refined based on their underlying similarities and differences both within and across interview transcripts.

As this coding proceeded, codes with were grouped together into themes, which were at a higher level of abstraction than codes. Merriam (2008) has described themes as a developmental classification system of the patterns within the study. A theme captures something vital about the interviews in relation to the research question (Braun & Clarke, 2006). With this in mind, I reflected upon whether themes reflected my research question, "What are the positive coping experiences of women with bulimia?" I looked for themes both within each participant transcript, and also across transcripts. As part of the refinement process, I examined the data for whether or not a theme contained any sub-themes. Sub-themes are "themes-within-a-theme" (Braun & Clarke, p. 92), and can be useful for giving structure to a particularly large and complex theme, and also for demonstrating the hierarchy of meaning within the data (Braun & Clarke, p. 92).

Each theme was named in a way that was reflective of their essence, or content. Themes were also examined for conceptual congruence; that is, whether all themes were at the same level of abstraction (Merriam, 1998, p. 184). All data was re-examined in order to determine whether themes could be further refined, and whether each sufficiently "cut across the data" (Merriam, 2002, p. 7). The findings were then written into a descriptive account, where each theme and subtheme was supported by particularly vivid examples or extracts from participant interviews.

Evaluating the Study

Although reliability and validity are treated separately in quantitative studies, these terms are not viewed separately in qualitative research (Golafshani, 2003, p. 600). Rather, terms such as trustworthiness, credibility, and transferability are used, and encompass both concepts (Golafshani, 2003). At the root of trustworthiness is the question of how qualitative researchers can convince their audience that the results of their investigation are worth paying attention to and worth considering (Lincoln & Guba, 1985). Guba and Lincoln (1994) outlined four elements of qualitative research that contribute to its trustworthiness: credibility, fittingness (or transferability), auditability (or dependability), and confirmability. To establish credibility, the researcher's analysis must fit with the participants' realities and experiences (Streubert & Carpenter, 1999). To check that I represented participants' stories in ways that honour their unique experiences, I employed member checking and peer review. Member checking is described as "the most crucial technique for establishing

credibility" (Guba & Lincoln, 1985, p. 314). All participants were asked to review their interview transcripts, and encouraged to bring forth any ideas that arose from this review process. Furthermore, a collaborative process was established throughout the study by clarifying and following up on certain aspects of participants' accounts. During follow up interviews, for example, I shared my interpretations and thoughts about our first meeting, and feedback from participants informed the ongoing analyses. With these clarifications in mind, I moved back into my analysis, continuing my process of piecing together a new picture of how my participants coped positively with difficult emotions or experiences. Subsequent to follow-up interviews, I attempted to conduct a member check with each participant, including the participant who did not complete a follow-up meeting. The purpose of this step was to show each participant an abridged narrative of the interview transcript, and to gather feedback on themes that I found through my analysis. This process would also help me establish trustworthiness of the research findings. One participant shared her thoughts about the narrative with me, and indicated that she felt it was an accurate portrayal of her positive coping experiences. The remaining participants did not provide any feedback about their narratives.

Seeking assistance from a peer reviewer strengthens the credibility of a research study (Creswell & Miller, 2000). This process involves having someone who is familiar with the narrative process and/or the phenomenon under investigation review the narrative texts and the inquiry process (Creswell & Miller, 2000). This individual can offer support, challenge the inquirer's

assumptions, play devil's advocate, push the researcher methodologically, and asks questions about methods and interpretations (Lincoln & Guba, 1985). My thesis supervisor assisted as a peer reviewer for this study. Our collaborative relationship and regular meetings contributed to the study's credibility, as she reviewed my coding and analysis at all stages of the project.

Fittingness or transferability of research findings refers to the study findings' fitting outside that particular study (Jeanfreau, 2010). It is the degree to which a study's findings relate to literature and research on the phenomenon of interest (Lincoln & Guba, 1985; Streubert & Carpenter, 1999). A study exemplifies fittingness when its findings may have meaning to another group or could be applied in another context (Byrne, 2001; Streubert-Speziale, 2007). An accurate and rich description of research findings demonstrates fittingness or transferability by providing adequate information for evaluating the analysis of data. Meeting this criterion was addressed through purposeful sampling of participants who have experienced the phenomenon of interest (bulimia) (Gillis & Jackson, 2002). In addition, the construction of rich descriptions enables readers to make decisions about the applicability of the findings to other settings or similar contexts (Creswell & Miller, 2000). Findings from this study contain thick, rich descriptions and quotations to ensure that participant experiences are well represented.

The auditability or dependability of research is established through an audit trail, where individuals can examine the inquirer's process and methods used in the study (Tobin & Begley, 2004). Central to my audit trail was an

ongoing reflection through self-critical accounts of the research process, including my internal and external dialogue (Tobin & Begley, 2004). This ongoing reflection, also known as reflexive practice, requires researchers to "bend back or turn back one's awareness on oneself" (McLeod, 2001, p. 195). Working with narrative material requires dialogical listening (Bakhtin, 1981) to three voices, one of which includes that of the reflexive self (Clandinin & Connelly, 2000). The other two voices are that of the narrator, as represented by the audio-recording or text, and the theoretical framework, which provides concepts and tools for interpretation. Reflexive monitoring of the act of reading and interpretation involves a self-awareness of the decision process of drawing conclusions from the material. My engagement in this process was facilitated through the use of a research journal. Throughout the transcription and analysis process, the voice of my reflective self played out in the form of constant memoing in my journal. From inception to completion of the study, I kept this journal, first to record the development and design of the research study. Later it was used for reflexive practices in order to document my thoughts and observations throughout the research. I kept this journal in order to document my reactions, reflections, and impressions that resulted from the interviews. I recorded memos and initial analyses during data analysis. This documentation helped me examine my process as a researcher and my influence on the study. Memo writing or writing in a journal are highly advocated elements of qualitative research; they are a form of audit trail which outlines how one arrived at the findings (McLeod, 2001, p. 141; Merriam, 1998). Auditing can also be used to authenticate confirmability.

Confirmability means establishing that the data analysis and findings are not a product of the researcher but emerge from the data (Tobin & Begley, 2004). Confirmability was maintained through peer review with my supervisor, and through the coding process. For example, coding units of data and constant comparative analysis required that the analyses remain grounded in the data.

Ethical Considerations

Prior to commencing this study, a proposal was submitted to, and approved by, the Faculties of Education, Extension, and Augustana Research Ethics Board at the University of Alberta. The participants were protected by the strict implementation of the guidelines outlined by the Ethics Review Board.

Throughout the study, informed consent was described to, and obtained from each participant. Although remuneration for the participants' time and efforts was offered ($25 gift certificate), this was not used as coercion for continued participation in the study. Prior to each interview, the researcher and participant discussed the ongoing nature of informed consent. Participants were welcomed to ask any questions related to the consent process, and were free to terminate their involvement in the study should they wish to do so. Throughout the study, I monitored participants for any signs of distress during my contact with them (i.e., during interviews and follow-ups). I also provided participants with a list of counselling referrals (Appendix D).

Every effort was made to maintain participant confidentiality and anonymity. Within the transcribed texts from the interviews, participant-chosen pseudonyms were used and identifying information, including names,

organizations, and potentially recognizable details shared by participants were changed. Identifying information (e.g., names, phone numbers) was not attached to participant data. All documents such as the consent forms, demographic information sheets, and BULIT-R questionnaires were kept in a locked locker in the Education Clinic at the University of Alberta. Electronic documents such as transcripts, memos, and fieldnotes were encrypted on a password protected computer owned by the primary investigator. If I encountered any potential compromises to participants' anonymity, I discussed these concerns with my supervisor immediately. Participants were informed about my planned use of the collected data in my thesis, and other forms of dissemination, including (but not limited to) scholarly articles and conference presentations. Confidentiality will also be maintained by storing all records and data securely for at least five years.

CHAPTER 4

Findings

This chapter will begin with a narrative account of each woman's story, as they described their perspectives and positive coping experiences. A discussion of the themes and sub-themes that resulted from the analyses of their interviews will follow. The names of the six participants have been changed to protect their anonymity.

Personal Narratives

Melissa's narrative. Melissa is in her early 30s and has worked as a manager for several years in a large firm. She has had bulimia for about 11 years. Her eating disorder has been cyclical in nature in that she often had what she called "bad bouts" of symptoms like binging and purging for several months. Melissa explained that her symptoms abated for up to two years in the past. Once she was able to decrease the frequency of her binges, this seemed to help her gain momentum into a healthier frame of mind.

On and off throughout her life, Melissa had experienced depression in conjunction with bulimia. As a teenager, and into her early 20's, she saw psychiatrists for these issues; their approach to give her medications, however, was not fitting for Melissa. Later in her 20's, she sought a referral from her family doctor for a psychologist, whose treatment approach was Cognitive Behavioural Therapy (CBT). This way of addressing her depression and bulimia felt much more congruent to Melissa. The new approach was one that finally "armed" her with tools to help her cope and understand her struggles in healthier ways. These

tools helped address areas of her mindset that often hindered positive coping. Specifically, Melissa saw how her "black and white" or "all or nothing" thinking played out in the way she evaluated foods as being "acceptable" or "within her guidelines." If she ate something that was not deemed acceptable, such as a slice of pizza, she thought, "Well, you've already screwed up, what does it matter now, you may as well eat the whole damn thing because you've already ruined the day!" Furthermore, Melissa described an ongoing war between two forms of internal self-talk. On one hand, she considered herself an intelligent person; she held a reputable job, was educated about proper nutrition, and logically understood the importance of eating regularly. However, her logical mind was constantly in battle against her "crazy disordered eating" part, which encouraged the restriction of calories throughout the day, along with binging and purging behaviours. Melissa's ability to slow her thoughts down and talk back to negative self-talk was instrumental in helping her through difficult times. Returning to the example of the pizza, she took a step back, and looked at the situation from a different angle. She told herself that one piece of pizza "was not the end of the world, just deal with it." Rather than succumbing to the automatic thought of binging, she decided to negotiate with herself on food choices for the remaining part of her meal. Specifically, she stopped with the single slice of pizza, and had a salad, as this would help "balance things out." Her negotiation of food choices contributed to this positive coping experience for Melissa, and prevented escalation into a binge.

Melissa recalled another recent instance of using these tools to create a positive coping experience. It started with a conversation with a close friend, one to whom Melissa had recently disclosed her bulimia. The friend said that she thought Melissa's bulimia stemmed from residual feelings left unresolved from a previous relationship. Hearing this was difficult for Melissa, as it brought up painful feelings and triggered the desire to binge, as a way of avoiding "going there mentally." Since her teenage years, Melissa often "swept things under the rug," and used alcohol, food, and drugs at one point, to block out emotions that felt too upsetting to face. During this particular instance, Melissa started thinking about the conversation with her friend from the previous day. She decided to comfort herself with a noodle dish from a local take-out restaurant. As she looked at the items on the menu, she consciously counted up the calories of each item she examined, and weighed whether she would have to purge if she ate all those items. In recalling this incident, she described how, many times in the past, she found herself unexpectedly ordering food for several people, and would proceed to purge after consuming it all. During this instance, however, Melissa suddenly realized she did not want to go home and purge. She decided to simply get the one item she originally came for; she assured herself that this item was acceptable, and she would be comfortable eating it without purging. Making compromises with food and substitutions were an important part of Melissa's positive coping experiences. In the situation here, she compromised on the noodles and bought a diet Pepsi to fulfill the urge of feeling full. She proceeded to go home, ate the food she bought, and did not purge.

Melissa also talked about using raw vegetables as a substitute for her usual high-calorie binge food. For her, healthier food such as baby carrots or soup took some of the negativity out of a binge. Subsequent to eating large amounts of raw vegetables, Melissa felt like she made a healthier choice than going to other calorie-dense food, and the urge to purge was not present after eating large amounts of food like carrots. The feelings of guilt after consuming traditional binge foods almost always left her with an overwhelming urge to purge. When she ate whole, unprocessed food like salads and vegetables, she noticed feeling free of this guilt. Furthermore, she felt empowered by making a conscious choice to eat healthier items. By not automatically going along with her mental pattern or impulse, she felt like she took back some of the power the binges had over her.

Throughout her years with bulimia, Melissa learned how to identify her triggers, which helped prevent a binge from starting in the first place. Firstly, Melissa noticed that eating regularly throughout the day helped her feel more balanced and alert. This led to an overall sense of feeling more positive and capable of dealing effectively with stress. Experiencing "ravenous hunger" was a strong trigger for Melissa, so eating throughout the day reduced the chance binging. Her awareness of this trigger was especially important on her drive home from work. Eating something to satiate her significantly reduced the likelihood of picking up binge food along the way home. Melissa also emphasized how a lack of sleep reduced her ability to engage in positive coping. The ability to talk herself through difficult emotional situations depended largely on how rested she felt. When Melissa slept as little as three to four hours, she struggled to stop herself

when she was spiralling toward a binge. Ample energy was required to talk back to her negative internal dialogue; the more mentally alert she was, the more motivation she could muster to get through struggles in a healthier way.

Another contributor to Melissa's positive coping came from allowing other people to support her. Melissa recalled a significant turning point in her life upon returning from a trip to Mexico with family. She described feeling completely out of control with her bulimia. During this trip, Melissa purged up to twenty times a day; after coming home, she wanted to find help to reduce her symptoms. Although her online search for resources yielded disappointing results, she started to tell close friends about her eating disorder. She spoke to her therapist about this experience of asking for help, which felt vulnerable and uncomfortable in some ways. Up to that point, Melissa had never thought she needed to ask for help. She believed that doing so would be a sign of weakness. As these next few experiences of hers illustrate, however, Melissa came to realize the benefits of having a strong support system.

In one instance, a co-worker to whom she disclosed her bulimia became a strong source of support for Melissa. When fellow employees invited her out to lunch, and Melissa did not feel mentally capable of dealing with food, she turned to this friend and asked that they simply spend time together during the lunch break, away from food. In our second meeting together, Melissa had just handed in her resignation at her workplace. A few days earlier, she was experiencing significant anxiety over this move, especially when it came to talking to her boss the next day. Feeling like she could approach this fellow employee openly, she

texted her to share her worries about the coming day. Should there be food in the lunchroom the next day, Melissa asked that they leave the office together to avoid possible struggles with food. Melissa added that having close friends cognizant of her eating disorder helped her feel more authentic. For instance, she did not have to lie about why she could not attend work functions at buffet restaurants. These people understood the difficulties Melissa faced in such environments.

Over the months between our interviews, Melissa continued her efforts towards positive coping. During this time, she began to see a new therapist, as she decided to seek out more intensive and specific therapy for her eating disorder. Several months from the time of the interview, she would go on to see a specialist in eating disorders. In the meantime, however, she shared a coping strategy she learned from her new therapist. She was to hold ice cubes in her hands when the urge to binge arose, and do so until they completely melted. Melissa placed a sign on her fridge door as a reminder, and it read "Before you Eat, Hold the Ice Cubes." One night, she decided to attempt holding the ice cubes when she experienced an urge to binge. As she held the ice cubes, she described how painful this was, and laughed at the thought, "How could anyone recommend this!" Throughout this process, however, she described her thoughts as being far from the idea of binging. Rather, she was focused on the pain of the ice and how numb her hands were. By the time the ice was melted, she did not binge and purge, and instead went to play a video game.

Over time, Melissa noticed the psychological benefits that accrued from coping with distressing emotions in positive ways. For her, there was a sense of

accomplishment that accompanied positive coping. No matter how small the step forward may seem, she gave herself credit for taking it. As she strove to build a stable and positive outlook on her eating habits, one night of no binging or purging represented a significant achievement. This one success left Melissa feeling proud and hopeful, regardless of whether other aspects of her day did not go as she would have liked. Furthermore, upon waking from an evening where she used more positive ways to cope, she expressed feeling less heavy and drained compared to when she purged. Melissa described feeling hopeful about her future pursuits of sustaining these positive coping skills already instilled in her. She knew a greater sense of freedom from bulimia was possible for her, and looked forward to seeing that time come.

Jane's narrative. Jane is in her mid-20s and recently completed her graduate studies. Six years ago, bulimia entered Jane's life. Prior to the onset of her bulimia, Jane was attending therapy, and she continues to see the same psychologist today.

Jane recalled how her first positive coping experience initially filled her with an overwhelming fear of the unknown but ended with a true blessing. Several years ago, Jane found out that she was five months pregnant with her daughter. This news was shocking and frightening for her at the time. She was overwhelmed about the process of pregnancy, along with the fact that she was still in graduate school. Feeling very lost, Jane turned to her best friend, who had shown unconditional support for Jane throughout her struggles with bulimia. They met at a coffee shop to discuss Jane's worries. Jane's best friend was very

reassuring during this experience; she offered helpful feedback and assured Jane that “everything was a good choice.” She was nonjudgmental, for which Jane was appreciative. Their discussions allowed Jane to “purge out the bad feelings.” Jane’s perspective of the situation started to change, as her friend helped her see the positives in life and recognize that there would be more to life than pregnancy. Without her assistance, Jane doubted she would have arrived at this mindset alone.

During her struggles, Jane also reached out for support from her boyfriend at the time, who is also the father of her child. While pregnant, Jane described experiencing significant amounts of frustration and stress over his behaviour. Specifically, he was very controlling; he dominated their conversations with assertions that it would be his decision as to what their child would and would not do in its life, where they would live, and so forth. She wished that he would respect her role in the decision-making process for their child. Jane found herself struggling against the familiar urge to binge and purge as an attempt to regain a sense of control. Jane talked to her best friend about her expectations of being involved in decisions, and wondered whether they were unreasonable. The social support exemplified by her best friend was crucial to Jane’s positive coping experiences. She validated Jane’s frustrations and reassured Jane that her expectations of her partner were not unreasonable. She was “not crazy,” her friend said, for wanting to be included and valued in decisions about her child.

The support shown by Jane’s best friend was also demonstrated by Jane’s family. Their unwavering support throughout her eating disorder and pregnancy

provided Jane with a sense of never being alone. She understood how difficult it was for them to see their daughter suffer, but they never left her side. Furthermore, they educated themselves on eating disorders to further their understanding of Jane's experiences. Jane recalled a time when her mother's support guided her through a difficult emotional situation. After speaking with her boyfriend, she had become very frustrated. Although her friend was unavailable at that time, Jane decided to speak with her mother. They discussed Jane's confusion regarding why her partner would not listen to her. Together, Jane and her mother brainstormed ideas on how to approach this situation in the future. Jane felt like she was able to release her frustration in a positive way through talking with her mother. She also felt listened to and validated in how she was feeling about the situation. After their talk, Jane felt relieved of emotional distress and no longer felt the urge to binge and purge.

Jane's Taekwondo group also supported her pursuit toward healthier coping. The individuals in this group encouraged Jane to adopt healthier eating habits. They highlighted the importance of being properly fuelled by food so that Jane could maximize her potential in the sport. Specifically, they helped her believe in the possibility of testing for her black belt in the future. Their social support motivated Jane to work on balancing her eating habits. Beyond the members' support, Taekwondo provided Jane with a positive, physical outlet for her stress and anxiety. For Jane, exercise was not motivated by the pursuit of weight loss; rather, she appreciated the controlled environment of the sport. With a defined time allotment in her weekly schedule, Taekwondo provided structure to

Jane's life. The structured nature of the classes meant that Jane would not "overdo it" with exercise.

Aside from participating in Taekwondo, other behaviours such as knitting were helpful, as they promoted a change in perspective. During Jane's pregnancy, the repetitive nature of knitting was gratifying for her and helped reduce anxiety when she felt stressed about thesis work and pregnancy. Furthermore, it was not food-related; she did not have to worry about the negative outcomes of purging when she engaged in knitting. Knitting helped Jane put her struggles at the back of her mind, which created space for insights and alternative perspectives to spontaneously arise for her. This form of coping contrasted significantly with the "emotional rollercoaster" that seemed to ensue when Jane binged and purged.

In addition to Jane's social network, support from her psychologist was instrumental to Jane's positive coping. Jane felt reassured by her therapist; she helped normalize Jane's struggles with bulimia. For instance, she was honest with Jane by explaining that she did have a problem, but at the same time, it was "okay to have this problem." Once Jane discovered she was pregnant, she shared how fearful she was about gaining weight. Her therapist addressed these sources of insecurity by assuring her that it was "okay to get to a healthy weight." Jane felt like this feedback normalized weight gain during pregnancy. She appreciated the pleasant reminder of her daughter that was offered through her body's changes. She started to understand that her body would change, as every mother-to-be's body changed. To Jane's surprise, this loss of control over her body became positive for her.

Soon after discovering she was pregnant, Jane knew that the needs of her child took precedence over her self-proclaimed "warped ideas" of how she should look. Not only was her own health a point of concern, but even more importantly, the health of her baby was top priority. She realized that it was not fair to hurt her child with binging and purging behaviours. This propelled Jane into finding other ways to cope, and throughout her pregnancy she developed a variety of strategies for releasing the anxiety and stress that she sometimes experienced. Furthermore, pregnancy changed Jane's perspective on food. Food evolved into a source of nourishment for her growing child. Jane gave herself permission to keep food down, and focused significantly on continuing this habit. Jane felt as though pregnancy helped reorganize her life's priorities. As pregnancy progressed, Jane reflected on the visual reminder of her baby's presence. This helped facilitate her continued efforts towards positive coping.

After the birth of Jane's daughter, spending time caring for her became a positive coping tool in Jane's life. Despite enduring post-partum depression and urges to binge, staying engaged with her daughter kept Jane occupied both physically and mentally. If an urge to binge arose, and she went to seek food, Jane returned to her daughter immediately if she began to cry. The urge subsequently dissipated. In the past, when Jane's efforts to binge were thwarted, the desire to binge nonetheless remained at the back of her mind. When she cared for her daughter, however, she no longer ruminated subconsciously about binging. That impulse to fill the urge faded for Jane because she was having fun and felt happy to be with her child. As her daughter aged, Jane expressed the joy she felt when

playing dolls with her. In these instances where Jane attended to her daughter, she recalled feeling satisfied after not turning to binging and purging. She felt a sense of accomplishment from overcoming a longstanding habit that, for many years, had been automatic for Jane.

Jane also recognized the importance of modeling what she considered "normal" eating behaviours for her daughter. This led Jane to seek out information to ensure the nutritional health of her child. Gaining more understanding about general nutrition in turn helped Jane implement important changes to her own life. For instance, Jane met with a dietician, who offered advice on portion sizes and dietary needs. Their discussions deepened Jane's understanding of her daughter's nutritional requirements and those required for Jane's general health. At home, Jane implemented healthy portion sizes for the two of them; this contributed to Jane's regular eating behaviours. Throughout her learning process, Jane discovered ways to incorporate foods she often enjoyed during binges, but in healthier forms and portions. For instance, she described pre-portioning certain foods, such as fruit, for easy access at home and at work. Jane traditionally enjoyed sweets when it came to binges. Rather than having chocolates or candy, however, she incorporated fruit to satisfy her urge for sugar. This helped prevent Jane from feeling deprived of the food she enjoyed. Furthermore, Jane snacked on items that took time and energy to consume, which distracted her from the urge to binge throughout long work days. Raisins were a great snack for Jane to spend time "working on;" removing the stems off them as

she snacked helped pass the time, and allowed her to have something in her mouth without overeating mindlessly.

Over the past few months, Jane has sought out cues from other people's eating behaviours in public. She described an instance of having a birthday cake in the office. As she took her first piece, she reminded herself that other people had to have cake as well, so the option to binge on the cake was not feasible. Jane watched people eat and socialize between bites of food, and she tried to emulate these behaviours. During her internal dialogue, she reminded herself to clean off her fork before taking another piece off, and to focus on not "shovelling in" the food. Jane felt that her developing self-awareness in public helped her feel more comfortable eating with other people.

Hannah's narrative. Hannah is woman in her mid-20s whose bulimia began approximately 10 years ago. For many years of her life, Hannah felt a deep-rooted sadness within herself. She feared never being good enough and from an early age tended toward a strong focus on her body. She felt that her experience of sexual assault at five years old contributed to her bulimia and emotional struggles. Hannah felt responsible for the behaviour of her perpetrator; she felt like an inherently bad person and developed a strong sense of shame about her body. Furthermore, she felt as though her body and sex were her only contributions to an intimate relationship. Hannah's body consciousness was heightened through her days of figure skating in early adolescence. At the age of 10, she felt abnormal compared to her peers, in part due to her advanced physical development. Comments from her peers and family about her size stayed with her throughout

her life. As the years progressed, her sense of being abnormal persisted, and around the age of 16, bulimia entered Hannah's life.

For much of her life, Hannah believed she would only be worthy of love through being thin. Before ending a recent relationship, she felt insecure about her boyfriend's love for her. She thought that if she were thinner, she would win her boyfriend's affection, and feel less insecure about him leaving her for someone else. Even after dwindling to her lowest weight, Hannah's sense of inadequacy persisted. She described her bulimia as a personification of self-hate, and tied into this was using alcohol to further mask her pain. Over the years, Hannah turned to alcohol to numb emotions relating to her sense of being a failure and feeling uncomfortable in her skin.

Hannah had seen doctors and psychiatrists over the course of her bulimia and alcohol use, but to no avail. She then heard of a doctor who specialized in eating disorders, and meeting her proved to be a turning point in Hannah's journey toward positive coping. Not only was Hannah inspired by her doctor, who had overcome an ED herself, but Hannah also realized the severity of her bulimia. She came to understand that an in-patient program for her bulimia and alcohol use was essential for her well-being. Thus she volunteered herself into a three-month program.

Prior to entering the program, Hannah was required to stop drinking a week beforehand. It was during this time that Hannah showed herself that she could cope in more positive ways. One day, Hannah was in distress; given that binging or drinking were not an option, she decided to plug in her iPod and go for

a run. Hannah possessed a strong desire to run throughout her life, but the detrimental health effects of her bulimia held her back from this activity. Once she was able to attempt running, she felt exhilarated to be "doing something with her body rather than thrashing it." Furthermore, Hannah was proud of herself for following through on something she wanted to do. In the past, Hannah often felt like she did not see her plans through, such as a few years earlier, when she quit university. Showing herself that she could run, however, ignited that faith in her ability to see actions come to life. This experience left Hannah with a deep sense of accomplishment. As she employed more positive coping tools, her body started to heal and retain energy to support this activity.

While running recently became a helpful activity for Hannah, this was not the case when she was younger. " Hannah grew up with a father who ran excessively and seemed to be perpetually on a diet. Her father often commented about his need to exercise to compensate for food he ate. His focus on appearance translated into how he validated Hannah as a person; he would often comment on her physical appearance and in particular would complement her when she lost weight. In attempts to gain her father's approval, she recalled engaging in unhealthy behaviours. Once Hannah entered treatment, however, she became aware of how important it was to talk to her father about his appearance-focused feedback. This self-awareness helped her remain cognizant of what motivated her to run; in particular, Hannah knew it was important that she not "pursue running for the wrong reasons." Running became very positive for her, as she was no longer running for her father's compliments. She ran to be strong, to conquer a

challenge, and to show herself that self-worth spans far wider than her physical appearance. Upon returning for a second interview, Hannah enthusiastically shared that she ran her first 5 kilometre race a few months before.

In addition to Hannah's developing self-awareness, her social network also contributed significantly to her positive coping. For instance, in the treatment program for her bulimia and alcohol struggles, Hannah felt a sense of camaraderie with the other women in the program. They shared their admiration for attributes in Hannah that she had never acknowledged before: her sense of humour, positive energy, intellect, and beauty. Hannah deemed their compliments genuine in nature and began seeing herself as more than just her body; she appreciated being valued for who she was on the inside. Furthermore, she began to recognize that she was an intelligent woman – a strength she had doubted since she had quit university years earlier. Hearing people's honest feedback also helped her begin to challenge negative self-talk. Coming out of treatment, Hannah vowed to continue employing more positive forms of coping, and did not want to use "either binging/purging or alcohol as methods of self-soothing."

Hannah's mother was another strong source of support in Hannah's life. She was someone on whom Hannah could always depend; she was her best friend and showed unconditional love and support for her. After Hannah experienced a breakup with her boyfriend, she immediately drove to her mother's house for the weekend. Going there helped ease feelings of loneliness and isolation that Hannah often felt when she was home alone. With her mother, Hannah kept occupied in conversations and activities; in general, being busy was helpful towards reducing

the likelihood of a binge. At times, Hannah overate at her mother's, but normalized this behaviour through her internal dialogue. She assured herself that people periodically overeat; as long as it wasn't a regular occurrence, she did not need to be overly concerned.

Hannah's network of support expanded to friends in her life on whom she could rely. A particularly close friend of Hannah's was someone who had also experienced an eating disorder. Hannah felt understood by this friend, and she helped Hannah continue to challenge the negative inner critic that sometimes invaded her mind. Hannah recalled the moment she weighed herself after months of not doing so. The resulting weight gain she observed propelled her into a day or two of binging and purging. She did, however, immediately seek out her friend's support and shared this upsetting experience with her. She protested that she would be happy if she could just be thinner. Her friend responded by reminding Hannah that even at her lowest weight in her "anorexic jeans," she was terribly unhappy. Being thin was not the answer to Hannah's happiness. Furthermore, this friend told Hannah that she was beautiful and made a point to remind her of this throughout their friendship. Having people who did not listen to her eating disorder voice helped Hannah see her struggles from a different perspective. Furthermore, the support helped Hannah talk back to the inner critic voice who encouraged the symptoms of bulimia. Hannah was also inspired by how comfortable her friend was in her own skin. Despite struggling with an eating disorder herself, her friend radiated a carefree attitude about her looks and

bodyweight. Hannah admired this greatly and recalled asking herself why she could not love her body as well.

Over recent months, Hannah felt like she has come closer to living what she considers a normal life. Developing her positive coping skills and sense of autonomy significantly contributed to Hannah's overall wellbeing. Each day she wakes up for work, "like normal people do," has breakfast and coffee, and at the end of the day she does some physical activity. She feels ready to engage in a relationship and "show off this version of herself."Hannah even felt like she could return to school someday; she has been able to envision herself handling the weight of this responsibility effectively. As Hannah's rubric of positive coping tools continues to grow, so too does her faith in her ability to face emotional distress. She no longer feels as though drinking or purging have to be numbing agents to pain; she can cope with it effectively. Hannah created a vision board for herself, which includes a list of things she looks forward to in life. She uses this to maintain her focus aimed at the future; she focuses on the version of herself she wants to be, not the "version of Hannah that she was." With each passing day, the "sicker form" of Hannah feels more and more like a distant vision of the past.

Michelle's narrative. Michelle is in her early 20s and is currently working on a graduate degree. Michelle started binging and purging four years ago, and the intensity of her bulimia comes in waves. Over the past several months, Michelle's symptoms of the eating disorder were fairly frequent.

As Michelle recalled, her binging and purging arose more in response to boredom than from stress. This feeling of boredom routinely occurred in the

evenings for Michelle, when she was not busy doing activities. It was during these times that she often experienced what felt like "unbearable urges" to binge, at which point she would cycle through alternative behaviours. Although she worried about how effective these alternatives would be in distracting her, Michelle continued to consider options until one hopefully "clicked."

Being productive often alleviated Michelle's sense of boredom and the urge to binge. She tried to redirect her behaviours through activities like cooking, school work at the library, scheduling a class, or going out to a movie with a friend. One instance of positive coping included Michelle making meals for the week. Once Michelle was immersed in her cooking activities, she would often breathe a sigh of relief for not "ruining her night" by binging and purging. Furthermore, cooking contributed to Michelle's sense of productivity and accomplishment.

In addition to redirecting her behaviours, Michelle had a "cut-off" time for binging, which also helped prevent binges at times. For instance, she liked to take at least several hours for a binge. That way, she could really settle in to the binge, or in her words, "relax and enjoy it." Once it was eleven o'clock at night, as in the example above, she could not complete binging and purging by her cut-off time of two o'clock. At this point, she would not be able to immerse herself in the binge. Michelle's cooking, described here, took upwards of four hours, and went on past her cut-off time for binging. Thus cooking was a means of forestalling her urge to binge.

Not only did Michelle attempt to cope through redirecting her behaviours towards cooking, but exercise also contributed to her positive coping. Engaging in exercise left her feeling more accomplished and energized. Michelle wanted to live a healthy lifestyle, and incorporating exercise into her routine facilitated that sense of healthy living. The benefits Michelle experienced from exercising also had a carry-over effect into how she dealt with the urge to binge. Michelle thought that exercising facilitated a sense of being on a "healthier roll" for the day; when the urge to binge arose, she felt more capable of dealing with that urge constructively.

During our first interview, Michelle reflected on a potential future means of positive coping. Specifically, she contemplated the idea of seeking social support. At the time of our interview, Michelle had not disclosed her bulimia to anyone. Sharing this aspect of her life with a close friend of hers was something she often contemplated. Michelle expressed feeling like it may be helpful to have someone to whom she could turn, especially when the urge to binge arose. A particular friend of Michelle's was someone she felt could be supportive, someone she could "call up and vent her feelings." Having this friend to turn to could also benefit Michelle, as she could go out with her when binging was likely. Michelle was hesitant, however, about sharing her bulimia with this individual. She feared that her friend might accidentally disclose her eating disorder to fellow classmates. Her professional reputation was very important to Michelle; she felt like her bulimia would damage people's perceptions of her. Despite Michelle's

reservations about opening up to people, it appeared that social support may become part of her future positive coping experiences.

Cat's narrative. Cat is in her early 20s and has been binging and purging for over a year. Over the past several years, Cat restricted calories throughout the day and would often binge and purge in the evening. Bulimia in Cat's life was as a "cop out," or a "safety net" - something she could turn to when she had too much food for her comfort level. Cat grew up in a household where the spoken rule around eating was that you finish what is on your plate. There was little money for food, so Cat was required to eat what she was given. She expressed how difficult this was, as she was often fed meat, which she did not enjoy. Regardless of her food preferences, however, Cat was required to finish her food, even if she sat at the table for most of the night. Should she refuse to complete her meal, she was given leftovers for breakfast. As Cat grew older, she developed anxiety around food. Part of her binging behaviour stemmed from feeling like she could not leave food uneaten. Unfortunately, this behaviour often clashed with her deep fear of losing control with food and gaining weight. Cat worried about "being fat," and becoming the "old cat lady and gross, dying alone." Cat struggled with eating in public, especially in the presence of people who commented on her eating. The judgement she felt from such individuals often heightened her anxiety and propelled her into a purge.

With this said, having people in her life who showed nonjudgement and care toward Cat was instrumental in her positive coping. Cat did not see herself as "overly social" in nature, but the few people with whom Cat could share her

feelings and struggles facilitated more positive coping choices. She valued their feedback and opinions, and talking with them helped her through some difficult times in her life. One of Cat's recollections of positive coping involved calling her ex-boyfriend's aunt, to whom she felt close. A year ago, Cat was laid off from her job. She felt "freaked out" and was in tears as she left work that day. Cat decided to call her aunt, as this individual was non-judgemental, and Cat trusted that she would respond to her distress with reassurance and an unbiased viewpoint. Cat proceeded to phone her aunt, and explained what happened and how upset she felt. Talking with her aunt made Cat feel better, as she could "vent" her struggles to someone she trusted. In this situation, and other moments of positive coping, Cat's self-awareness often helped her redirect her behaviour when binging was likely. For instance, when Cat initially received the news about being let go from her job, she wanted to go home, "get cozy, and eat." Cat knew, however, that going home would only lead to "one bad thing or another." After talking with her aunt, she decided to walk around outside, and did so until she felt that she could go home without risking a binge.

Another way Cat often redirected her behaviour and attention was through shopping. This activity was something Cat enjoyed; she would walk around the mall or grocery stores, even when she did not have money to spend. She particularly liked browsing grocery stores, which provided a type of "visual binge" from looking at all of the items she would like to consume. These trips felt positive for Cat, because she felt in control of her eating. Furthermore, waking up after going shopping or browsing, Cat felt happy and healthy. She recognized the

rewards of positive coping, as they contrasted significantly with how she felt after an evening of binging, where she felt hung over from excess food and a sense of regret over her decisions.

Upon returning for our second meeting together, Cat reflected on how our first interview seemed to further Cat's introspection and positive coping tools. After talking together, she realized how much storytelling played a role in previous coping experiences with emotional struggles. As far back as childhood, Cat recalled telling people about incidents that bothered her. Sharing with others seemed to alter her perspective about the severity of the problem, and helped normalize her experience. Talking with others in general about her experiences seemed to help Cat cope in healthier ways. When she was upset, Cat experienced a "welling up feeling," like she was "blowing up like a balloon." Having the opportunity to release and deflate this tension through conversation was beneficial to her, and contributed to positive coping experiences. Her aunt, for instance, provided an ear to Cat during times of need.

Cat also depicted an important conversation she had with her boyfriend after our first interview, and how much of an impact this had on subsequent positive coping. Prior to this conversation, Cat felt like she lacked the reassurance and validation that made her feel secure with her partner. For Cat, compliments and reassurance from those close to her facilitated a sense of security in their relationship. She sometimes worried about whether her boyfriend would still love her if she gained weight. Moreover, she wished that he would verbalize how special she was to him. One evening she let out all her insecurities and feelings to

him, but expected that he would "think she was crazy." She was surprised, however, when his reaction was the complete opposite. He explained how much he wanted to be there for her, no matter what, and how he wished to treat her like a princess. Her boyfriend expressed that he struggled with sharing his emotions, but wanted to open up more to her in the future. After this conversation, Cat felt a positive transition in their relationship. When the urge to binge arose for Cat, she reminded herself of her boyfriend's sincerity and care for her. Knowing she was loved and supported helped her stop herself before the binge cycle began. Together, both Cat and her boyfriend started eating healthy, regular meals together. Cat was inspired to keep up these healthier habits whenever she reminded herself of their important conversation.

Other perspectives and behaviours that changed for Cat related to her exercising habits. In our second interview, she explained how exercise on her basement elliptical machine started to feel unhealthy over the past several months. She recalled being home alone while her partner worked nightshifts. When alone with her thoughts, Cat often fell into a cycle of excessive exercise, and would often binge afterwards. More recently, however, Cat began to feel like a slave to the elliptical's digital screen and the calorie count. Although she understood the value of exercise to stay healthy, Cat decided to go for walks outside, which allowed her the benefits of exercise without an excessive focus on calorie burning. The more natural activity of walking around the city felt healthier for Cat. Furthermore, she could engage in activities like walking with her boyfriend after they enjoyed a healthy meal together.

Cat's evolving perspective extended to how she regarded her body and how she spoke to herself. Cat's relationship with her body was often difficult, as she felt insecure in her skin, especially if she had gained weight. In our follow-up meeting, however, she explained how "silly" these concerns sounded once they were put into words. Talking aloud helped put her struggles into perspective; the verbalization of her internal dialogue was like listening to someone else. She then contemplated what she would say to someone in her situation, and realized she would reassure them that they looked good. This seemed to facilitate a more compassionate response in how Cat talked to herself. She began to observe people as well, which furthered her changed perspective. Specifically, when people she knew expressed that they gained weight, Cat realized they looked no different in her eyes. She then reconsidered her evaluation of how others saw her; if she did not notice other people's apparent weight gain, this likely held true for Cat's situation as well.

Cat also developed an understanding of her healthy limits with food. She recalled a time at work when coworkers ordered food for a birthday at lunchtime. Not wanting the hamburger and fries that were about to be ordered, Cat indicated she did not want any food. As such, Cat chose "lesser of two evils;" she sufficed with her lunch of carrots and yogurt. Cat rationally knew that more food would be ideal for a meal, but went with her instincts, which told her to eat something she could handle emotionally at that point in time. These types of decisions help build Cat's confidence to pursue healthier coping strategies.

At the end of our second interview, Cat reflected on how much she tried to "mentally record" her moments of positive coping so that she can repeat them in the future. Although her journey through bulimia is challenging, she felt like she was moving down the "right path" for her health and happiness.

Lorraine's narrative. Lorraine is an undergraduate student in her early 20's, and around three and half years ago, she started binging and purging. She described feeling unable to face the existing issues in her life, and diverting her attention away from them through bulimia was how she coped. For some time, bulimia successfully helped her avoid problems, and silenced her emotions. Bulimia also allowed Lorraine to immerse herself in one aspect of life over which she felt in control; her body image was the "one thing that she could be selfish with." Lorraine communicated a strong sense of how bulimia stemmed from her upbringing. She came from a family whose mantra was to "take one for the team." Lorraine felt obligated to follow the unspoken rules in her family and felt required to subordinate her needs for others. Whenever Lorraine experienced strong emotions, she often felt pressured by her parents to explain and justify why she felt as she did. When she was unable to do so, she felt defeated and invalidated. In addition, Lorraine grew up trying to maintain the outward appearance of what many people told her was a "perfect family." She felt pressured to maintain this image of perfection, despite her internal struggles. Bulimia was one aspect of Lorraine's life over which she could exert control and do as she wanted.

Until recently, Lorraine had not disclosed the eating disorder to anyone. Seven months prior to our first meeting, however, Lorraine came to realize the

significant degree to which bulimia "ruled her life." For a long while, Lorraine assured her mother that her noticeable anxiety stemmed from exam stress, when in reality, Lorraine was stressed over being bulimic. After years of masking her true anxieties, the weight of her bulimia finally led Lorraine to "crack under pressure." One day, while talking with her mother, she told her that she was bulimic. This moment sparked a turning point for Lorraine. She realized how much bulimia was affecting her quality of life, and knew she "had to start getting better."

Over the next several months, Lorraine gradually revealed her bulimia to close family, her best friend, and eventually her boyfriend. This was a safe level of exposure for Lorraine, as she feared having too many people know about her bulimia. Lorraine felt a kind of "silent encouragement" from these individuals; they assured her that "we're behind you on this, you can do it." Furthermore, the support of her family and friends helped give Lorraine the courage to initiate therapy. She knew that no one could force treatment upon her; she would need to take that first step towards healthier coping herself. With that, Lorraine began working with a psychologist, and started along her journey of recovery. When she first started therapy, Lorraine learned how to identify and conceptualize emotions. This was a significant challenge for Lorraine, because growing up, she felt as though she was raised to "not really feel things." The therapist helped Lorraine develop awareness of her emotions through a list of emotions, each categorized under the concepts of strong, medium, and low emotions. This concrete approach felt fitting to Lorraine, and it helped her put words to her feelings.

Lorraine's developing self-awareness was further fostered through journalling. Journalling helped Lorraine identify and understand the messages of her feelings and thoughts, particularly when she felt overwhelmed. Journalling was most helpful for Lorraine when it was purposeful and deliberate, in that she sought to decipher the message of her emotions. Once aware of the root of her stress, Lorraine reflected on what, if anything, she needed to do to alleviate the situation. While journalling, Lorraine also made strong efforts to reassure herself that "it's okay to feel things" like loneliness and frustration. Although her negative inner critic shamed her for feeling emotions and having bulimia, Lorraine sometimes challenged that negative self-talk through normalizing her emotions. This constructive inner dialogue validated her emotions, and assured her that she was not a bad person for developing bulimia.

Lorraine recalled another example of how journalling helped her decipher whether action was needed to resolve her emotional struggles. For instance, Lorraine documented a challenging issue between her and her boyfriend. Initially, she did not want to confront him about it until she felt sure that the issue was important enough to bring up. Over time, Lorraine journalled further about this situation, and recognized that it was in fact important to discuss with her partner. At that point, she went on to conceptualize what the problem was, and what she wanted to say to him. Part of Lorraine's waiting stemmed from not wanting to step on other people's toes. Despite her hesitation, facing that issue with her boyfriend provided the closure she needed. She ended up being surprised by his expression of support and understanding for what she brought to his attention.

Lorraine was appreciative of his compassionate response, and very importantly, felt validated in how she felt.

Although feeling validated could contribute to her positive coping, Lorraine acknowledged that she relied excessively on people's opinions in order to feel secure in her decisions. For example, in deciding whether to take "alone time" to write, she looked to others to validate her decision. Her self-awareness and desire to change for her own health guided Lorraine to work on this issue in therapy. Over the several months between interviews, Lorraine worked on establishing her own reasons for going to spend time alone. Asserting herself with family was especially important, as she was often questioned about why she journalled. Lorraine's firmer approach to communication was not always welcomed by her family, but she continued to work on prioritizing her own needs. She recognized that this would be an important piece to her recovery process, and continued reminding herself of this through reassuring and compassionate self-talk.

Lorraine's deeper understanding of her bulimia seemed to coincide with another positive coping tool that helped her through feelings of shame and disappointment. This tool stemmed from her journalling habits; specifically, she would write poems, record a video of herself reading them, and then watch the video. Observing herself reading the poems was like receiving encouragement from someone who knew her well. When Lorraine couldn't find that inner voice of reassurance, watching these videos helped her see that brighter days were ahead. Lorraine recalled writing a poem on a "good day" and wrote this for

herself to read on a "darker day" when she struggled with feeling overwhelmed about her bulimia. The videos seemed to be beneficial for Lorraine particularly because of their externalizing features; they helped "remove" Lorraine from her difficult experiences. As she watched, it was "like watching this person reading the poem, it was someone else saying it, and that it was okay."Watching these recordings helped Lorraine forgive herself for developing bulimia. Extending forgiveness inward was something with which Lorraine often struggled, but continued to work on in therapy.

Themes in Participants' Stories of Positive Coping

While each of the participant's stories was unique, four common themes appeared across the women's accounts of positive coping: Social Support, Constructive Internal Dialogue, Self-Awareness, and Behavioural Redirecting. The themes and their sub-themes are summarized in Table 1 below.

Table 1

Themes and Sub-Themes Generated From Participant Interviews

Themes	Sub-themes
Social Support	Encouragement and Positive Feedback
	Safety and Nonjudgement
	Advice and Guidance
	Having People Available
Constructive Internal Dialogue	Challenge Negative Self-talk
	Intentional Decision Making
	Normalizing One's Experiences
	Affirming Success
Self-Awareness	Awareness of Triggers
	Awareness of Motives for Behaviour
	Noticing Rewards of Positive Coping
Behavioural Redirecting	Setting up an Optimal Environment
	Perspective Changing Activities and Events
	Asserting One's Needs

Theme 1: Social Support

The importance of social support was evident across five of the women's narratives. This theme encompasses the nature of women's social ties and how they contributed to the women's positive coping experiences. Woven through the fabric of the participants' recollections was the positive impact of support from those individuals closest to them. The people in women's social networks were encouraging and communicated confidence in participants' abilities. Participants also felt supported through people's advice and guidance. A sense of safety and non-judgement within this interpersonal space was central to participants' continuing reliance on such support. Finally, participants' accounts reflected a strong emphasis on knowing that someone would be there for them. Having reliable individuals in their lives and feeling secure in their ongoing presence helped women cope in more positive ways.

Encouragement and positive feedback. Five of the six participants described the people in their support system as being encouraging and offering positive feedback. Some women detailed their appreciation of friends and family members who offered reassurance and validation when participants doubted themselves. For instance, Jane expressed a strong appreciation for the consistent encouragement shown by her Taekwondo group:

> [They were] a good group of people that were really positive and encouraging….They would encourage me to eat *healthily* instead of binging and purging. They kept reiterating the importance of being *healthy*

> because they thought if I was going to be healthy, then I could test for my black belt.

This support helped Jane focus on maintaining more regular eating patterns so that she could continue thriving in this sport.

Hannah recollected feeling encouraged by her doctor, who herself lived through an eating disorder:

> She knows what it's like. She's been through it and she reminds me that I'm healthier now. She reminds me how to *be* healthy. I remember when I first saw her, I thought I was eating too much and I was not even close to eating enough. Being encouraged to eat more was awesome! I love to eat!

For Cat, receiving compliments on her physical appearance was a form of encouragement that eased her body anxiety:

> I guess it helps having people in your life who are constantly telling you nice things and stuff, but that's not realistic. It just makes me feel more secure if it felt sincere, I guess. I wouldn't worry as much or get as much anxiety about my body image or the way that I look.

Advice and guidance. The social support in women's positive coping narratives also reflected guidance and advice. Four of the women described talking to friends, family, and health professionals about their struggles. In turn, they received helpful insight and perspective that contributed to their journeys through positive coping. For instance, in moments of high emotional stress, they felt comfortable turning to sources of support who helped brainstorm ideas on how to cope, how to deal with similar situations in the future, and so on. Several

women described receiving invaluable guidance from their psychologists and/or doctors. Their suggestions helped women develop self-awareness and understanding of their coping behaviours.

Melissa struggled with depression throughout her life, and although she had previously received medications for this issue, it was a counselling that proved to be most helpful for her:

> I talked to my family doctor about it and he referred me to a doctor whose primary method was not to use drugs, but was talk therapy and using CBT. I think that was the first time where I felt like I'd actually been armed with some tools to actually try and look at what was happening and find a way to deal with it instead of just, here's some pills!

Jane was thankful for the guidance and advice offered by her mother:

> I was able to get out all of the anxiety and the negative feelings and talk through it with my mom. I would describe what the situation was, like what my boyfriend and I had been talking about and why it upset me, and try to figure out why he wouldn't listen or had to do things his way – he wouldn't consider things I had to say. So being able to talk about those things and then think of ways to maybe deal with a similar situation in the future helped.

Hannah recalled the impact her doctor had on seeking help, not only for her eating disorder, but her alcohol use. Prior to treatment, she explained, "I was an alcoholic and I had all this *baggage* and I cried for no reason and, I was taking

medications and all this stuff." Through interactions with the doctor, Hannah was given the advice and guidance to seek proper treatment for her bulimia.

Safety and nonjudgement. Five of the participants' positive coping narratives highlighted a feeling of safety around those they turned to, without fear of judgement. Women's comfort with individuals from their social networks contributed to the helpfulness of the received support. They felt safe approaching these individuals when in distress. Participants' feelings of being emotionally supported were illustrated in recollections of being understood and validated by others. The women described confiding in their support network of friends and family, having confidence that these individuals would be there to listen and help them feel understood.

For Jane, knowing her best friend and family saw past her eating disorder was crucial to her positive coping experiences:

> It was nice to have just even just a small group of people that looked past it, like having my own really close best friend. I think there had been about three friends I've had that really stuck with me through the worst part of the eating disorder, whereas a lot of people I don't think understand it, or they're kind of intimidated or scared so they just pull back. So that's hard. But she's really awesome.

Although Cat often felt judged about her eating habits by other people, Cat felt comfortable around her aunt because of her nonjudgemental nature:

> Yeah when it's in front of everybody it's just…people judging my portion sizes and stuff, it's just worrisome. It really helps to eat around

> nonjudgemental people, somebody like my aunt. She wouldn't say anything about how much I ate. I could probably be comfortable eating anything around her. Like I've eaten a giant steak in front of her and she hasn't said a thing about it, good or bad. She doesn't judge me on what I eat or what I don't eat.

Cat explained that her sense of security around her aunt helped her eat more regularly in social settings involving food.

Lorraine suffered through her bulimia for many years on her own but recently shared this struggle with individuals around whom she felt safe:

> I think exposure [is important], but yet safe exposure. Only around six people in my life know that I am suffering from bulimia, like my family, my boyfriend, and my best friend… I think safe exposure has helped me, knowing that I have support. Even if it's silent, like that encouragement that's like, 'We're behind you on this, you can do it' kinda thing. That exposure has helped me in the last seven months, knowing people are behind me and want me to be better.

Having people available. Four women's stories highlighted having reliable and consistent individuals to whom they could turn during times of distress. Having people available facilitated women's positive coping experiences, in that they could always count on people to be there for them.

Hannah's mother had always been there for her, and continued to be a positive presence in her life:

> My mom's just my best friend in a way, like she's always been there. She's watched me go through a *lot*... Because a lot of my pain stems from isolation. I live with my brother, but sometimes he's not there, and sometimes my other friends aren't there. So I go to my mom's because she's *always* there.

During her emotional struggles, Jane was thankful for the consistent presence and support of her best friend and family:

> They [family] were really good. Although I talk mostly with my friend, my mom and dad were there to listen a lot of the time too, when I couldn't talk with my friend. I could just wander and find my mom or dad to talk to. It was nice to talk with my family, my friend, and people at Taekwondo, who are positive people out there. I know that I'm not doing *any* of it by myself, because I find with the eating disorder, a lot of the time it's almost very isolating.

Theme 2: Constructive Internal Dialogue

Five participants described an internal dialogue within the context of their stories. For instance, several women identified the presence of a critic voice, or "ED voice" that manifested itself, particularly when they were struggling emotionally. This critical voice encouraged binging in participants, saying that they would feel better upon doing so. Any other form of coping would never work as effectively as the binge and purge episodes, according to the critic. Being aware of their negative self-talk, however, facilitated a change in how they spoke to themselves, which resulted in more positive coping strategies. Furthermore,

participants engaged in more constructive self-talk subsequent to positive coping experiences, when they affirmed their success.

Challenging negative self-talk. Three of six participants vocalized the importance of talking back to their inner critic during emotionally difficult situations. Although engaging in this dialogue took considerable energy for Melissa, she slowly developed the ability to challenge her negative self-talk:

> Going through that process, a lot of it was writing things down and it was based on a chart. Like you'd write down what an event was, and then you'd write how it made you feel, and then you wrote down what your negative self thought was. And then you had to counter that and be like, why is this inaccurate? Then I got to the point where I didn't like writing it down. I got pretty good doing that in my head as a way to deal with my depression. And that was really helpful. So I think that's a lot of what's given me the ability to do that.

Hannah took a stand against negative self-talk after continuously observing the confidence with which her good friend carried herself:

> I'm like if *she* can do it then why can't I? Like I'm smaller than her, I'm shorter than her, and I'm thinner than her, and if she can be just fine with who she is, then why can't I?

Hannah also found herself questioning self-perceptions while in treatment. She described getting a moral boost from other women's compliments about her smarts and creativity.

Intentional decision making. Five of six participants described engaging in a form of intentional decision making during moments when a binge was likely. The nature of this process looked different for some participants, but the idea of making deliberate decisions was evident in women's positive coping narratives. This process seemed to transpire in part because of the conflict participants experienced internally. Namely, several women described experiencing a battle of voices; they felt a very real conflict between two sides of their self-talk. One part encouraged binging behaviour, whereas the other resisted this automatic response to stress or boredom. The second voice seemed to guide participants towards finding more positive coping behaviours. Participants described being cognizant of their hesitation during moments of internal conflict. They did not want to go through with this behaviour, and spend their evenings purging, just to wake up and feel exhausted and regretful the next morning. Their awareness of this conflict led some participants to engage in a conscious back-and-forth of how to find an alternative to binging.

In her attempts to choose more positive forms of coping, Michelle often experienced an internal debate about other options she had aside from binging:

> I never want to binge so it's always a battle in my head of... I'm constantly like, okay, well I could do this or I could do this, and it seems to be just going through it until hopefully something in my head clicks, and I choose that over binging.

Michelle would cycle through a variety of ideas, and sometimes certain ideas would "click" for her.

A particular scenario in Melissa's story highlights the important role played by her decision-making process, especially while ordering food:

> It's almost like running through the different scenarios of what would happen. Like if I do this, this is going to be the result. And I was just looking at it, and I was like, I don't want to go home and throw up. I don't want to spend my evening doing that. So I can't get the food so now how, how am I *not* going to get the food? And how are the words not going to just magically come out when they come to take my order and all of a sudden I've just ordered four things? Because it seems like that's happened before too. You don't even quite realize what you've ordered and then, here's a big bag of food!

Slowing down her thoughts and having a mental check was instrumental to Melissa's positive coping narrative:

> It's very important for me to first think about okay, this is food, just stop, think, and review this! And if I can't get that hey, stop, and think, and it's just a bad day where I eat automatically….Then I guess that check doesn't exist.

Normalizing one's experiences. The importance of normalizing feelings and experiences was prominent in five of the participants' narratives. Women talked themselves through difficult emotions or situations by recognizing that their struggles were a natural part of being human.

Lorraine attempted to normalize her emotions during moments of distress by assuring herself that she was human:

> Just telling myself [helped], like, it's okay to feel things. Often I would divert away from things because I didn't like feeling icky feelings. I didn't like feeling sad or alone or anything like that, so I would turn to binging and purging. And I think that working through those processes [helped], and being like, it's okay to be lonely, it's okay to be frustrated, and not have to silence those feelings by binging and purging.

Lorraine tried normalizing feelings both in her mind and on paper. Journalling was a concrete way through which she could assure herself that she was human.

Hannah used self-normalization, particularly when it came to her eating habits:

> I mean yeah, sometimes I still overeat, but I've come to more of a place of it's acceptable that sometimes normal people do overeat, especially when it's really good food, so as long as I'm not making a habit of it.

Melissa's ability to reframe the situation often contributed to positive coping experiences:

> Deal with it! A piece of pizza isn't the end of the world. And maybe now, instead of having the full dinner you were planning, maybe now you just have a salad. It'll balance it out. And I've found that being able to do that can definitely help with progressing into a binge.

When Jane first discovered she was pregnant, her psychologist helped her normalize pregnancy; the changes in her body that would occur, and how her body would be after pregnancy ended:

> It was really helpful to have her to talk to because she knows what to expect, because then your body changes again all of a sudden… It was good to have her to reinforce that it's okay, you've had a baby so, bodies change. But then it can be a pleasant reminder that you've overcome this and you have a lovely little girl!

Affirming success. After their experiences of positive coping, four women reported attempts to praise themselves for their choices. They recognized the challenge overcome by adopting healthier coping skills. Furthermore, women's sense of relief and physical well-being after coping positively seemed to contribute to an overall sense of success and accomplishment.

Taking up running, for instance, was tantamount to building Hannah's sense of accomplishment:

> It felt like I had actually taken something that I wanted to do and started to *do* it. So, to actually think about going for a run and then *doing* it rather than anything else that would have negatively affected me, felt really good.

Not only did she express pride in carrying out this desire, but it also helped her develop an appreciation for her body's capabilities:

> For me it's become more about seeing what my body can do. For instance, I can walk upstairs and not die, and I can almost run 5k!I think the biggest thing is running for the sake of getting stronger, and trying to look at my body for what it *does* rather than for what it looks like.

Hannah, Lorraine, Jane, and Cat described the importance of acknowledging their steps toward positive coping. Taking a moment to recognize her accomplishments was important for Cat's continued growth:

> If I were just to have those positive things happen, be okay with it, get over it, and forget about it and move onto the next experience… I could very easily do that, but I guess I wouldn't grow at all.

Lorraine, Hannah, and Jane reflected on how far they had come through their bulimia. Although their symptoms of bulimia ebbed and flowed, moments of success helped inspire participants' continued efforts toward positive coping. Lorraine often struggled to forgive herself for binging and purging behaviours, and this was an ongoing challenge for her. When she took a step back, however, and allowed herself to see how far she'd come, this helped keep her in a positive frame of mind.

Melissa acknowledged her growth toward positive coping behaviours when she made the deliberate choice of eating healthier foods:

> I don't have that feeling of really being weak, because typically like the weak is giving into eating crap. If I'm basically binging on veggies, that took a step in and of itself in being like, I'm going to eat vegetables instead, I'm not going to eat X, Y and Z, I'm going to eat this instead. That's like, I guess the first conscious choice.

Theme 3: Self-Awareness

Women's stories highlighted an acknowledgement of internal processes related to their struggles. They seemed cognisant of emotional and environmental

factors that could trigger a binge/purge episode and were aware of underlying motives for their behaviours. Women's self-awareness was instrumental in their positive coping experiences. Participants' narratives also highlighted an awareness of the rewarding nature of positive coping; they noticed positive changes in their mental and physical well-being after these experiences. Participants' self-awareness also seemed to empower them to choose more positive forms of coping. As such, the overarching theme of self-awareness is tied to many other themes described here.

Awareness of triggers. Across all six narratives, women described knowing the emotional and situational factors that often triggered binge and purge episodes. Participants verbalized a strong sense of knowing what types of feelings were associated with binges. Often, women used this knowledge of themselves to facilitate other methods of coping.

Several of the women reported that binging often occurred at night-time, when they were alone. Being alone left some women feeling lonely, which often led to binges. Other participants specified that nighttime and being alone was "risky" because no one could witness their binge/purge.

Hannah described how binging is easy to do when the worry of having someone see her is out of the picture:

> If I'm alone, there's no one there to see what I'm eating or how much I'm eating. There's no one there to ensure that I'm not buying booze or that I'm not sneaking food up to my room to eat it in secret and vomit.

Michelle echoed similar sentiments; having someone present in the home would potentially ward off these behaviours:

> If no one's home, then I know that they're not going to hear me. They're not going to wonder why I'm walking to the kitchen a gazillion times in a row or why I'm in the bathroom for an hour and a half. Just knowing that other people aren't going to see it makes it difficult, because then I don't have that in the back of my mind to prevent it.

Feelings such as stress and being overwhelmed were also identified as triggers for several women. For Melissa, these conditions, along with a lack of sleep at times, posed as possible triggers for binging:

> I have issues sleeping. There's days where I'm running off of three or four hours of sleep, and I'm trying to work and I'm not happy about the lack of sleep that I get…It's frustrating to be tired, and I know that I'm definitely more prone to turning to a binge if that happens.

Not knowing the outcome of certain life situations was a significant tension point for Lorraine:

> I think a big stressor for me is the unknown. I will binge and purge because I have an exam in a week, because I just don't know what my mark is. I'm not stressed about the *exam*, I'm stressed about the *unknown* of the mark. I don't care that I could possibly fail the exam, the problem is the unknown, not the fact that I have an exam in a week and the next week is stressful. I just don't know what my mark is.

Participants illustrated strong self- awareness when it came to reading their triggers and knowing what factors contributed to binge/purge episodes. As described in other themes within this chapter, this self-awareness guided women towards other coping strategies during times of distress.

Awareness of motives for behaviour. Five participants identified influences on their behaviours or self-perceptions. For instance, seeking external validation from family or friends was something many women discussed. They were aware of how people's compliments or perceptions influenced and sometimes reinforced harmful behaviours associated with their bulimia. Women were also aware of how they sometimes pursued behaviours but for the "wrong reasons." Specifically, they did them for the purpose of gaining other people's validation. Overall, women reflected on how these influences could hinder their pursuit of coping in more positive ways, and how they may not be beneficial for their overall health.

Hannah often took time to reflect on her reasons for exercising, because she wanted to "make sure she wasn't running for the wrong reasons:"

> My father has a tendency to be exercise bulimic, so I have to be careful that I'm not running for the wrong reasons. You can tell that when you've been exercising, the validation just goes way up. So it's something we've really got to watch out for.

Cat was aware of how people's compliments contributed to her deep fear of "becoming fat," because she received the most validation when at her lowest body weight:

> A lot of the reason why I worry about my body image is because the times I've been at my lowest weights, all I get it compliments…When people see me drop twenty pounds in two months, they don't say what's wrong, are you unhealthy? They say oh my god you look so great! So it's like, well why wouldn't I, right?

Lorraine echoed a similar awareness of how others' approval could influence her behaviours:

> I think something for me that's helped, but I'm trying to remove myself from, is getting validation from other people. I'd be like I need alone time, and someone would say yes, good idea, you should take alone time. And I would think yes, perfect, I'll go take alone time… So the validation from other people feels like I'm doing this right, this is correct… I'm working in counselling to get away from that and just take time away for myself because I need it.

Noticing rewards of positive coping. Five women noticed a sense of reward that accompanied not binging and purging. This contrasted their sentiments after a binge/purge cycle, where they felt disappointed with their choices. Both during and subsequent to positive coping experiences, women described noticing relief for not having binged and purged. Hannah, for example, reflected on the health improvements that she experienced since choosing to reduce her binging and purging behaviours and increase her positive coping behaviours:

> Back then I was dizzy all the time, like I was malnourished and I'm sure my electrolytes were a disaster. I know my vitamins were all over the

> place. [Now], more than anything, it's the way I feel physically; I'm not hungry all the time, I'm not dizzy. I can walk up a flight of stairs without wanting to faint at the top.

Melissa enjoyed waking up feeling less "weighed down," both in her body and her mind:

> [I feel] physically better, I don't feel as heavy and drained…[After binging/purging], there's that initial feeling of oh crap, did it again. If that doesn't exist, then it's a lot easier to start the day.

Michelle's sense of release from finding more positive coping activities was central to her stories:

> Once I get going in that activity, and things are on the stove, I am able to focus on that. Then you feel better because you're not binging right? Once I've gotten past that point of having such a ridiculous urge to binge, it's like a release because that's all I had been I'm thinking about.

Theme 4: Behavioural Redirecting

In their narratives of positive coping experiences, five participants described a redirection of behaviour, leaving them much less likely to binge and purge. For instance, women's behaviours were sometimes redirected for the purpose of setting up an optimal environment where binging and purging was less likely to transpire. In addition, women redirected behaviours that were usually associated with binging. Participants shifted from being passive or stuffing down their feelings to actively asserting themselves and their needs with other people. Their self-awareness of potential binge triggers seemed to inform these decisions.

Other activities and experiences functioned to change women's perspectives. These types of experiences often helped women develop a clearer understanding of their feelings and eased their anxieties. Exercise, for instance, provided a venue for releasing energy and tension; it also contributed to women's sense of being healthy. They found release and a sense of accomplishment in physical exercise, which seemed to set them up for more positive forms of coping.

Setting up an optimal environment. Five participants described active ways in which they attempted to set themselves up for more positive coping. Given the self-awareness they possess regarding their triggers for potential binge/purge behaviours, some women took what could be thought of as preventative measures to ensure they would not binge.

When Cat was upset about being laid off from work, she knew it was best to stay out of her home, as going home would only result in a binge:

> I was like, I'm going to go home and go do one bad thing or another, so I'll just stay out of the house. That's always worked. It seems like whenever I have a stressful situation, as long as I don't go home I'm usually okay until I calm down.

Hannah understood herself enough to know that being lonely was not ideal, as this feeling often led her to a binge:

> If my brother's not home. I either go visit my aunt and her children because I love them…or I go to my mom's house. I know better than to be alone right now.

Knowing that being ravenously hungry after work could lead to a binge, Melissa set herself up to arrive at home feeling more satiated:

> Another one that I try to do, sometimes it seems to work sometimes it doesn't, is trying to eat something small before I leave the office, so that before I've gotten in the car I'm not ravenously hungry! And trying to get from the office to home where I may have cereal and soymilk, which sounds like a great dinner in theory. But if I've veered off and gone to A & W, and McDonalds, and Burger King, that cereal's pointless. As long as I'm not starving when I leave, it seems easier to just go home.

Perspective changing activities and events. Some activities and events appeared to facilitate a change in women's perspectives of their current situation. This altering of perspectives helped them see the possibilities for healthier coping choices. This can be seen in Jane's case, where becoming pregnant helped her reprioritize what was most important to her. Her baby was "quite the little blessing." Jane also described how knitting helped her gain new perspectives:

> It was a nice *relief*, because then I can just focus on [my knitting] and forget other things or have time to almost think about them in the back of my mind so that maybe there's something I overlooked or missed, more calmly and rationally and logically…[put] everything else aside and go somewhere else. I've been sitting, knitting before and then all of a sudden I just had an idea or revelation about what problems I was having with my stuff. Then I could set it down and go fix something and then come back

> to it and it was a good, almost a nice break, where I could escape from the negativity in it.

Three participants' positive coping recollections detailed an importance of exercise in their lives. Some women described that the physical vigour of exercise allowed for a release of emotion and tension, leaving them feeling accomplished and relieved after engaging in such activities. Physical activity also helped women feel healthier as individuals and focused them on appreciating what their bodies could *do*, not just what they *looked* like. Hannah recalled how much she appreciated having the opportunity to use her body for good rather than abusing it:

> In treatment we did a kickboxing class every Monday, and I *loved* being physically exerted and feeling like I was *doing* something with my body rather than thrashing it….[Now] I've started running, for the sake of getting stronger. I think that's one of the biggest things - trying to look at my body for what it *does* rather than for what it looks like. It was good because at the end of running, I'd felt like I'd accomplished something whereas I never really felt accomplished after a binge and purge session.

Michelle described a positive "carryover" effect of exercise in her life:

> When I exercise, if I do get the urge to binge later on, I find it's not as strong. And then when I'm going through things I want to do, I'm more able to choose something and successfully go with it. Even if I exercised earlier in the day, I'm more likely to choose the activity. It's easier to choose something else and avoid [binging and purging] when I have exercised that day.

Asserting one's needs. For several participants, behavioural redirecting involved more than moving away from situations in which they would be more likely to binge. Women also shifted from behaviours that were associated with binging, such as disregarding or stuffing down their feelings, to those that made binging less likely. More specifically, women's positive coping was facilitated when they asserted themselves.

Hannah described the importance of asserting her boundaries with her father in order to move forward with positive coping:

> In treatment we talked to my dad about how it's not really okay for him to validate the way I look. Because, I had gotten to the point where I was doing unhealthy things to look a certain way to seek that validation from him.

In Cat's relationship with her boyfriend, she generally "tried not to involve him in the deeper part of her craziness." Subsequent to the first interview, however, Cat decided to talk to him about needs that she felt were unmet in their relationship:

> I kinda just like laid it all out on him and said my ex treated me like I was the cat's ass all the time, and said things like [it] doesn't matter how you look, you're beautiful, you're a princess. My boyfriend though, he's not like Mr. Compliments all the time. It's just because he doesn't think about it and stuff. So I vented hard on him and said am I gonna just die like a cat lady and gross, and there's nobody around who feels that way about me? Hearing I'm the best person in the world, it's nice to have that.

Despite Cat's hesitation to share this with her boyfriend, she was pleasantly surprised when he responded supportively to her thoughts and feelings. This conversation was extremely helpful in facilitating Cat's future positive coping.

CHAPTER 5

Discussion

Summary

The semi-structured interviews with six women who have bulimia nervosa yielded a rich set of accounts of the participants' positive coping experiences and the ways through which they created these experiences. While each participant's specific experiences and insights were unique, their shared elements were reflected in several overarching themes and subthemes. The findings suggested that the women's experiences of positive coping involved social support, constructive internal dialogue, self-awareness, and behavioural redirecting. Participants identified several helpful features of the social support they received, one of which was safety and nonjudgement. Within the theme of constructive internal dialogue, the participants relayed the importance of engaging in intentional decision making and challenging negative self-talk. With self-awareness, participants found that it was particularly helpful to be aware of their triggers and motives for behaviour. Finally, the theme of behavioural redirecting included the women's reflections on setting up an optimal environment and the impact of perspective-changing activities and events. The following sections discuss my findings in the context of the current research literature. Limitations of this study, future research directions, and implications for counsellors are also discussed.

Social Support

Participants in the current study greatly appreciated the helpfulness of their social networks during moments of distress. Having people on whom they could rely, without fear of judgment, contributed to the benefits of social support. Social support is known as "behaviours that, whether directly or indirectly, communicate to an individual that she is valued and cared for by others" (Barnes & Duck, 1994, p. 176). As this definition suggests, the size of one's social network is not crucial, but rather it is the *perceived* adequacy of the available social support that is important to individuals (Tiller, Schmidt, Ali, & Treasure, 1995). Unfortunately, many women with bulimia experience poor social adjustment and difficulties with interpersonal relationships; they may therefore have difficulty in forming adequately supportive networks (Schmidt, Tiller, & Treasure, 1993; Striegel-Moore, Silberstein, & Rodin, 1993). Indeed, many women with bulimia have reported poor satisfaction with the quality of their social support, even more so than women with anorexia (Rorty, Yager, Buckwalter, & Rossotto, 1999; Tiller, Schmidt, Ali, & Treasure, 1995). The current study presents important information regarding how social support can facilitate positive coping in women with bulimia.

Participants in this investigation found it particularly important to seek out relationships where they could feel safe and accepted. Experiencing unconditional support from individuals to whom the participants felt close was crucial to their positive coping. Although in-depth studies on women recovered from bulimia are limited, the findings here are consistent with research in this field (Maisel, Epston

& Borden, 2004; Nakamura, 2012; Rorty, Yager, Buckwalter, Rosotto, 1999; Rorty et al., 2003). For example, Nakamura's (2012) qualitative study in Japan investigated the individual recovery narratives of people who had previously overcome bulimia. The results illuminated the nature of social support received by individuals. For instance, receiving affirmations and acceptance from others was crucial to participants' recovery process. This acceptance came in a variety of forms, such as unconditional support from family members/romantic partners and encouragement from self-help groups for eating disorders. Stories from participants in Rorty, Yager, and Rossotto's (1993) study also highlight the importance of empathic and caring relationships throughout the recovery process. When the authors asked what advice their 40 recovered participants would give to other women with bulimia, almost half encouraged people to reach out to others, such as friends. Furthermore, these initial benefits of a strong support system are likely to carry forward in women's lives. After two and a half years, women in full remission from bulimia have been found to seek out social support significantly more than women in partial remission and those who maintain full syndrome BN (Bloks, Furth, Callewaert, & Hoek, 2010).

One way of thinking about these findings may be to examine a model by Uchino (2004), which suggests that social support may reduce the act of disordered eating in bulimia. Uchino's (2004) model suggests two possible ways in which social support can help reduce stress in individuals. The first path, which is consistent with the findings in the present study, suggests that social support can aid in avoiding or reducing exposure to negative events or disordered

behaviour (Uchino, 2004). In the context of the current study, this path would represent socially supportive interactions exhibited prior to disordered eating behaviour, such as binging and purging. The interpersonal relations identified by women in our study facilitated positive forms of coping and those that did not involve disordered eating behaviours like binging/purging.

Constructive Internal Dialogue

Just as participants' social environment played a crucial role in their positive coping experiences, the women's internal processes were also shown to be helpful. Specifically, several participants used constructive internal dialogue such as intentional decision making and challenging negative self-talk when faced with the urge to binge. They were aware of and recognized their feelings of conflict relating to binging/purging and made attempts to slow down their thinking before automatically acting on these urges. Participants' intentional decision making then facilitated actions that prevented a binge/purge episode. These instances may be considered illustrative of problem-focused coping, as depicted in Yager et al.'s (2005) study. Yager and colleagues explored coping styles among women recovered from bulimia and women still living with the eating disorder. The recovered participants in Yager et al.'s study were more likely to engage in problem-focused coping, which involves thinking constructively about how to cope with a stressor and initiate direct action to solve the problem or mitigate its negative effects (Yager et al., 1995).

By undertaking intentional decision making and challenging negative inner dialogue on their own, participants engaged in strategies encouraged in the

framework of CBT. For instance, CBT teaches clients how to make and commit to decisions during moments of uncertainty and fear (Leitenberg, 1995). Participants experienced significant uncertainty as they faced the urge to binge, and through intentional decision making, women created positive coping experiences for themselves. In CBT, clients are also asked to repeatedly notice and record extreme and unhelpful thoughts, and then begin to challenge these thoughts (Beck, 1976; Leitenberg, 1995; Williams & Garland, 2002). Research has clearly documented that women with bulimia are highly critical of themselves and often struggle with cognitive rigidity, especially as it relates to food (Bauer & Anderson, 1989; Lehman & Rodin, 1989). Moreover, the shaming nature of women with bulimia's self-talk or inner dialogue becomes even more extreme prior to a binge/purge episode (Hinrichsen, Morrison, Waller, & Schmidt, 2007). Not surprisingly, a vast majority of eating disorder clients report that self-talk messages or inner dialogues are a "critical factor in altering their problem behaviours for the better" (McFarland, 1995, p. 156). The results from this study illustrate that adopting a gentler approach toward oneself, potentially through challenging negative self-talk, may facilitate healthier coping behaviours. Women in this study challenged their unhelpful "ED critic voice," which often inundated participants with "all or nothing," catastrophic messages prior to binging. Taking a stand against these automatic thoughts allowed for new opportunities of positive coping.

Self-Awareness

It is clear that a transformation in women's coping styles was critical to their positive coping experiences. Participants' accounts, however, reveal that these coping styles were largely contingent on an attitude of self-awareness. The women used their awareness of motives for behaviours and binge triggers to create positive coping moments in their lives. For instance, they were aware of their tendency to seek external validation and acknowledged the detrimental effects of this habit. The literature indicates that many women with bulimia rely on external validation from others in order to accept themselves (Hall & Cohn); however, this study demonstrates that women are aware of this unhealthy habit and recognize the importance of distancing themselves from it. Furthermore, the literature has often cited a desire to escape self-awareness in women with bulimia (e.g., Heatherton & Baumeister, 1991). Interestingly, participants here demonstrated an ability to maintain awareness during moments of emotional distress. This finding makes an important contribution to our current understanding of how self-awareness may be embraced by women with bulimia and used effectively to create more positive coping outcomes.

In many ways, women's self-awareness, which helped them create positive coping experiences, is reflective of the concept of mindfulness. Being mindful involves paying attention on purpose (Kabat-Zinn, 1990). This ability to notice or be aware also involves being nonjudgmental and present-oriented, or here-and-now. Being mindful is fundamental to deciding what skilful action to take (Safer, Telch, & Chen, 2009). For women with bulimia, then, becoming

mindful of their thoughts and feelings can be a first step towards making healthier coping choices. This is congruent with literature suggesting that mindfulness helps individuals with bulimia skilfully regulate their emotions (Proulx, 2008; Safer, Telch, & Chen). Proulx's (2008) phenomenological investigation of the experiences of six women with bulimia in a mindfulness-based eating disorder (M-BED) treatment group reflects this idea. Participants' post-treatment accounts of their experiences suggested that they built their self-awareness, interpersonal connections, and positive coping skills. M-BED also helped women reduce intense emotional reactivity and judgemental thoughts. The self-awareness demonstrated by participants in this study will likely continue to foster positive coping experiences, especially if women's broader mindfulness skills are developed.

Behavioural Redirecting

Through being aware of feelings and circumstances that may trigger bulimic behaviours, the participants were able to redirect their behaviours in order to create moments of positive coping. Perspective-changing activities and events, such as exercise, also contributed to the women's resilience.

The women in this study actively changed their behaviours during circumstances that typically resulted in binging; this was a constructive way to carry out more positive coping behaviours. For instance, most participants reported that being alone at night was a trigger for binging, so they incorporated other activities at this time of day to lower the likelihood of a binge. Women's attempts to alter their behaviours as a primary measure of reducing binging

behaviours were consonant with Behavioural Activation Theory (BAT; Ferster, 1973), which holds that an individual's surrounding environment, rather than internal factors such as cognitions, is a more efficacious realm in which to intervene for treatment. As such, this theory may contribute to the understanding of what contributed to women's successful positive coping. Behavioural Activation (BA) was developed by Ferster (1973) as an approach to treating depression; since its conception, it has successfully implemented in the treatment of other issues such as suicidality and impulsivity in individuals with Borderline Personality Disorder (BPD, Hopko, Sanchez, Hopko, Dvir, & Lejuez, 2003). Given the co-occurrence of BPD with a number of Axis I conditions that include eating disorders, mood, anxiety, and substance abuse (Adams, Bernat, & Luscher, 2001), applying BAT to the context of this study seems relevant. The women in this investigation exemplified the utility of "modifying overt behaviour that is more directly in their control, rather than trying to rid themselves of maladaptive cognitions or aversive emotions that are perceived as more difficult to change" (Hopko, et al., 2003, p. 467). In other words, BA seeks to help people understand environmental sources of their bulimia and seeks to target behaviours that might maintain or worsen the issue. Situation factors such as being alone, hungry, or around binge food often maintained the harmful cycle of binging and purging for women in this study. However, their experiences of exceptions to these behaviours coincided with the recommendations of BAT; that is, women actively redirected their behaviours towards more healthy coping activities.

Perspective-changing activities and events also played a role in the women's positive coping experiences. Exercise, for instance, was a very constructive, healthy tool for the participants to see themselves and their circumstances from a different perspective. Being active helped the women change their perspectives; it allowed them to appreciate what their bodies could do, regardless of their physical appearance. Furthermore, it helped them constructively release tension. From the women's perspectives, their physical activity contributed to a sense of accomplishment in doing something healthy for their bodies, and exercise was not pursued out of a desire to expend calories.

This suggests an important qualification to much research on exercise in relation to bulimia, which has focused mostly on the prevalence of bulimia in sports and the use of excessive exercise in eating disordered individuals in general (e.g. Murphy, 2012; Pen˜ as-Lledo´, Vaz Leal, & Waller). Exercise is typically viewed as a contributor to the maintenance of eating disorders, as women who struggle with EDs often use excessive exercising as a form of purging (Shroff, et al., 2006). For instance, the estimated prevalence of excessive exercise for people with eating disorders may be around 39% (Shroff, et al., 2006). Most operational definitions of "excessive exercise," however, are one-dimensional, and ignore the multidimensional nature of excessive exercise (Hausenblas, Cook, & Chittester , 2008). Hausenblas and colleagues posit that women's psychological motivation to exercise (e.g., compulsion to burn calories from meals), and not their exercise behaviour itself (i.e., duration, intensity, etc.), is the mediating factor in eating-disordered individuals. This argument is relevant to the current study; the women

I interviewed made explicit that their motives for physical activity were not fuelled by a desire to purge calories. Furthermore, they described an awareness of how they *could* pursue exercise for the wrong reasons. In addition, most participants who engaged in exercise did so to a moderate degree, such as attending a weekly Taekwondo class. Together, findings from this study offer support for Hausenblas and colleagues' (2008) emphasis on women's psychological motivations for exercise.

The dominant view of exercise as a negative influence on eating disorders thus fails to acknowledge how exercise can be constructive for women with bulimia (Hausenblas, Cook, & Chittester, 2008). Regular exercise comes with a variety of psychological, physiological, and social benefits, even for individuals with eating disorders (e.g. Sundgot-Borgen Rosenvinge, Bahr, & Sundgot Schneider, 2002). Women with EDs have described using exercise to control negative moods (Long, Smith, Midgley, & Cassidy, 1993). Similarly, women who exercise show significantly higher coping self-efficacy (Craft, 2005), which is highly relevant to women with bulimia. Participants in the current study echoed similar sentiments relating to the positive effects of exercise on mental health.

Indeed, exercise is known to increase stress tolerance and reduce bodily tensions/negative mood, all of which are well-known binge triggers for women with bulimia (Alpers & Tuschen-Caiffier, 2001). In fact, Hausenblas, Cook, and Chittester (2008) reviewed six recent studies on interventions with eating-disordered populations. Across studies, the psychological benefits of exercise included improved body satisfaction, positive mood states, and quality of life

(Hausenblas, et al., 2008). Women with bulimia in Sundgot-Borgen et al.'s (2002) study experienced a reduction in bulimic symptoms, drive for thinness, and body dissatisfaction through an exercise program. These biopsychological improvements were greater than those observed in the control and CBT treatment groups. Moreover, 6 and 18 month follow-ups with participants demonstrated the long-lasting effects of exercise on women with bulimia. Sundgot-Borgen and colleagues (2002) suggest that implementing exercise alongside CBT may be a valuable area of exploration for future studies. Perhaps in response to this suggestion, Pendleton et al. (2002) conducted a randomized control study using CBT and exercise with a population women with binge-eating disorder (BED). Over the 16-month long study period, the female participants who received CBT with aerobic exercise experienced significant reductions in binge eating frequency compared to women who received CBT alone. Their study showed a significant incremental effect of exercise on CBT treatments for binge eating disorder. Although the study was not conducted using women with bulimia, much of the research on BED has been useful to inform studies on women with bulimia (Safer, Telch, & Chen, 2009). The potential utility of combining psychotherapy and exercise is reflected in the current study, where several women who identified physical activity as contributing to their positive coping experiences were also attending regular therapy sessions at the time of the study.

Limitations

Several limitations warrant discussion. Firstly, because participants were recruited through advertisement, the convenience sample may not be

representative of women in the community who have bulimia nervosa. For instance, bulimia may be a heterogeneous disorder with distinct subgroups (Herzog et al., 1991); indeed, there are purging and non-purging subtypes of bulimia according to the DSM-IV, but this study did not differentiate between these categories. In addition, as with many other studies on bulimia (e.g., Nakamura, 2012), the community sample utilized here may differ from women in clinic-based samples, whose illness may undergo a different course and outcome.

Second, as with the majority of research on bulimia, this study was based on retrospective reports in that participants were asked to recall previous experiences of positive coping. These recollections are subject to recall bias, which can be problematic, as this methodology requires individuals to recall details such as stressors and transient mood states over extended periods of times (Smyth et al., 2001). However, this study's focus was on the subjective experiences of women with bulimia. Given that therapy begins with a client's subjective experiences, counsellors need to take this into account, and not discredit the importance of these recollections.

Many studies have employed the DSM-IV criteria of bulimia nervosa for participant inclusion (e.g. Cortorphine, et al., 2007; Hinrichsen, Morrison, Waller, & Schmidt, 2007; Smyth, et al., 2007). Furthermore, many researchers specifically used participants with the binge/purge subtype of bulimia. The current study utilized the BULIT-R to ascertain that criteria for bulimia were met, as this questionnaire's validity has been well established in identifying women with bulimia (Thelen, Mintz, & Vander Wal, 1996; Welch, Thompson, & Hall, 1993).

The cutoff score of 104 was implemented for inclusion to the study, and women tended to vary in their overall scores. Specifically, the highest BULIT-R score was 132 and the lowest was 104. As such, the participants in this study may have differed in their symptoms of bulimia; some may have been more in line with the binge/purge subtype, whereas others may have been more in line with an anorexia-bulimia subtype. Indeed, although the BULIT-R shows acceptable levels of reliability and validity, it does not distinguish clearly between different types of eating disorders (Thelen, Mintz, & Vander Wal). The test is best used as a screening measure that is followed by a diagnostic interview (Thelen, Mintz, & Vander Wal).

Although the DSM-IV was not employed here, the demographics form completed by all participants collected specific data on the monthly frequency of binges/purges, along with women's method(s) of purging. This did not fill the role of a clinical interview to determine DSM-IV criteria, but ascertained that all participants met DSM-IV criteria for binge/purge frequencies over a three-month period.

By virtue of this study's focus on the positive coping in women with bulimia, I may have drawn in participants who had inherently different characteristics from women who did not feel that they had exceptions to discuss. For instance, if these women perceived that they had positive coping experiences to share, they may differ from other women who do not immediately recognize their own positive experiences. On a similar note, four participants actively sought therapy for their bulimia prior to the study. Several women specifically indicated

that they were trying to recover from their eating disorder. This may be another feature that differentiates participants from a population of women who have not sought professional help. Regardless of these factors, our participants met the inclusion criteria for bulimia.

Despite these limitations, the main goal of this study was to explore the ways women with bulimia cope in more positive ways, without binging and purging. Generating rich narratives and descriptions of how these women coped positively was a significant focus of the researcher.

Considerations for Future Research

This preliminary qualitative investigation into the positive coping experiences of women with bulimia has provided an in-depth examination of six women's perspectives. Further study of the process of positive coping is warranted, given the need to deepen our understanding of how we can help individuals free themselves from bulimia. Other qualitative studies, including both males and females, with larger sample sizes and with participants from varying cultural backgrounds, are essential to add to the voices of women that have been documented here. The subtleties of the positive coping process should also be further examined by comparing individuals with bulimia to those who are in partial remission/full remission from the eating disorder. Another avenue to explore is the positive coping experiences of women with anorexia, as bulimia and anorexia are commonly compared and contrasted in the literature. In addition, specific research on facilitating the process of positive coping within a therapeutic context could contribute to clinical practice.

Implications for Counsellors

A trusting, positive relationship between the therapist and client is an important foundation to a therapeutic environment (Rogers, 1957) where the oftentimes shameful experience of having an eating disorder can be addressed (Brown, Weber, & Ali, 2008). Therapy can significantly contribute to women with bulimia's process of freeing themselves from their eating disorder (Cooper, 2003; Hall & Cohn, 1999; Maisel, Epston, & Borden, 2004). In particular, exploring and promoting positive coping experiences in clients with bulimia may be crucial to the therapist's role. This study points to the importance of focusing on moments of resilience in clients' lives, and to potential ways in which therapists and clients can work together to create more moments like this in the future. Based on the findings of this study and how they relate to current literature, I offer five distinct suggestions for counsellors, all of which relate to the themes discussed earlier.

1. Promoting nonjudgemental social support and assertiveness skills in interpersonal relationships. The value of having a supportive and nonjudgemental social network seems paramount to individuals struggling through bulimia. In the context of counselling, it may be helpful to explore the nature of clients' social ties. Given the features (e.g. safety/nonjudegment, advice/guidance, encouragement/positive feedback) characteristic of participants' social networks, clients could be encouraged to reflect on the people in their lives that embody these qualities. Developing their assertiveness skills in the safety of a counselling environment may also assist women in communicating their needs to

others. Expressing feelings and needs through assertiveness is a dimension of social functioning with which this population is known to struggle, particularly as it pertains to family and friends (Schmidt, Tiller, Blanchard, Andrews, & Treasure, 1997). However, the positive coping experiences detailed here evolved in part from participants' ability to assert their needs. Assertiveness skills training is a common component to ED treatment approaches (Safer, Telch, & Chen, 2009), as it often coincides with social skills training such as teaching women how to establish and maintain healthy interpersonal boundaries. Studies show that assertiveness training can help build confidence, assist with managing difficult emotions, and improve coping skills for emotional health and well-being (Safer, Telch, & Chen, 2009; Schneider & Agras, 1985). Shiina et al. (2005) included assertiveness training (e.g., role playing) in their combined group cognitive behavioural therapy (CGCBT) with 24 women meeting criteria for either bulimia, anorexia, or EDNOS. The 10-week long program yielded promising results in women's social functioning and binge-eating behaviour. Namely, participants' assertiveness skills significantly improved, and bulimic symptoms significantly reduced over the course of treatment. As such, counsellors are encouraged to engage in their own role playing with clients. Once the therapist and client discuss actual/potential scenarios the client faces that would be improved by assertiveness skills, they can practice these role playing exercises together in the safety of a counselling environment. For instance, some women in this study found that assertiveness was most needed when other people were questioning their need for "alone time," whereas other women found assertiveness was important when

family members made unhealthy comments about their weight and shape. Helping clients develop their sense of efficacy with assertiveness skills may critically improve their overall well-being and ability to create positive coping experiences for themselves.

2. Promoting physical activity and exercise psychoeducation. Given the utility of exercise in women's positive coping experiences here, it is possible that physical activity holds much promise for women attempting to recover from bulimia. Incorporating exercise into everyday activities may contribute to women's self-efficacy, emotional well-being, and may even help prevent binging and purging. Health professionals working with clients who have bulimia are encouraged to engage in open dialogue about exercise, without fear that physical activity will only come in "excess" for these individuals. Given the efficacy of psychoeducation in the treatment of EDs (Connors, Johnson, & Stuckey, 1984; Garner, Rockert, Olmstead, Johnson, & Coscina, 1985), educating clients about exercise and how it can be used in a balanced, healthy way may significantly contribute to their overall well-being. Counsellors are encouraged to explore how clients have engaged in physical activity and how they ascribe meaning to exercise in their lives. Therapists should also facilitate women's self-reflections about how they will recognize when exercise is used for constructive reasons, and when it becomes unhealthy. Women in the current study, for instance, emphasized the importance of setting performance goals in their exercise routines and knew that using exercise to purge their food was an unhealthy approach to physical activity.

Although some researchers caution the use of exercise as a facet of eating disorder treatment, the experiences of women in the present study suggest that exercise has significant utility in creating positive coping experiences for women struggling with bulimia. From the perspective of these women, exercise ameliorated and contributed to their emotional well-being. On a social level, exercise has the potential to develop women's relationships (Carron, Hausenblas, & Mack, 1996). Given the isolating nature of bulimia, exercise may offer women the opportunity to socialize and develop social bonds.

3. Promoting the set up of optimal environments. Incorporating aspects of Behavioural Activation Theory into therapy may encourage women to identify their binge-triggering environments and plan alternative behaviours that will result in more positive outcomes. Behavioural Activation may be a particularly non-threatening approach to use with this population of women, as BAT emphasizes first changing behaviours rather than thoughts and feelings. Understanding and expressing internal states is a common struggle for women with bulimia (Esplen, Garfinkel, & Gallop, 2000). For women who are initially overwhelmed by their feelings, BA may be a useful and non-threatening starting point in therapy and might provide greater opportunities for initial success. Women in this study highly benefited from shifting their behaviours away from environmental factors that put them at risk for binging (e.g., being alone at night, having binge food in the house). As such, it is advisable that counsellors explore clients' risk factors or binge triggers and help clients develop potential plans of action that will help them set up an optimal environment for positive coping.

From a BA perspective, as women increase their exposure to the rewards of healthier coping behaviours, this may increase the frequency of healthy behaviours, while decreasing those associated with bulimia (e.g. binging/purging; Lejuez, Hopko, & Hopko, 2001). As rewarding experiences increase in frequency, more positive thoughts and emotions evolve (Hopko, et al., 2003), with subsequent decreases in the likelihood of engaging in incompatible unhealthy acts that include binging and purging behaviours.

4. Promoting constructive self-talk and mindfulness. Clients should be encouraged to examine their "eating disorder critic" and learn to replace negative thoughts with positive affirmations. These positive affirmations may come in the form of normalizing experiences through self-reassurance, such as in the current study. As participants learned to replace automatic, negative thoughts that fuel binges with more constructive dialogue, healthy coping opportunities became possible. In the therapy setting, clients are often unclear about the specific thoughts or events that helped them when they experienced exceptions to their behaviours (McFarland, 1995, p. 156); it may be helpful, then, for therapists to direct clients to an increased awareness of inner dialogues. In addition, because women with bulimia often struggle with issues of perfection, control, and extremely harsh self-criticism (Proulx, 2008), the gentle and compassionate intention behind therapeutic approaches such as Mindfulness-Based Stress Reduction (MBSR), Dialectical Behavioural Therapy (DBT), Acceptance Commitment Therapy (ACT), and Compassionate Mind Therapy (CMT) offer alternative lifestyle approaches that can become lifelong practices unique to each

person (Proulx, 2008, p. 53). As an example, mindfulness-based interventions with this population have the potential to develop several areas of women's well-being (Proulx, 2008): self-awareness (Mason & Hargreaves, 2001), affect regulation (Dalai Lama & Goleman, 2003), interpersonal skills (Shapiro, Schwartz, & Bonner, 1998), coping and problem solving (Segal, Williams, & Teasdale, 2002), compassion (Shapiro, Schwartz, & Bonner, 1998), and impulse control (Kristeller & Hallett, 1999). Although counsellors may encounter clients who feel helpless against their automatic negative thoughts, women in this study illustrate that if individuals can just *stop,* even for a moment, as their negative inner dialogue occurs, this can be a crucial first step towards positive coping. Furthermore, normalizing their emotions (e.g. anger, frustration) and behaviour (e.g. overeating on occasion) was also important to participants. Reassuring clients that their experiences are common to many human beings may help women regard themselves with more compassion. Role-playing exercises may also be of value here; for instance, the therapist and client can engage in a "play by play" to examine how the client can slow down and alter her thinking and actions in the moments when negative self-talk arises.

5. Promoting the acknowledgement and affirmation of positive coping moments. The process of freeing oneself from bulimia is, as one participant put it, "full of hills and valleys." In the therapeutic setting, many women struggle to progress, and when they do, they may not recognize their successes (Lehman & Rodin, 1989). The value of recognizing the client's existing strengths is emphasized in the clinical literature which advocates focusing on exceptions to

the problem in people's lives (e.g. Jacob, 2001). The experiences of the women in the present study highlight the importance of affirming successes and the importance of being surrounded by supportive people. As such, counsellors may find it useful to highlight that even women with bulimia can and do experience moments when their eating disorder is not as powerful. Although women in this study were not recovered, their stories highlight hope amidst the arduous process of freeing oneself from bulimia. In other words, "Don't give up. The path will take you in all different directions but it's worth it. Feel the feelings and expect to slip. No matter how long it takes, you're better off in recovery than you are in the throes of bulimia" (Rorty, Yager, & Rossotto, 1993, p. 258).

Conclusions

Coping with difficult emotions and experiences is a challenge for women with bulimia, and overcoming the urge to binge and purge can often feel insurmountable. This investigation, however, illuminates the positive coping experiences and strengths of women with bulimia in the face of the eating disorder. As literature has yet to explore positive coping experiences of individuals currently struggling with bulimia, this study offers an exploration into the important exceptions in the lives of people living with this issue. Overarching themes relating to positive coping experiences emerged from the participants' collective stories and provided insights into the factors that have allowed them to cope positively. Participants' narratives highlight the ongoing, non-linear process that is characteristic of many women seeking freedom or recovery from their

eating disorder. In the words of one participant, “It’s a matter of concentrating on the version of me that I *want* to be, not the version of me that I was.”

References

Abraham, S. F., & Beaumont, P. J. V. (1982). How patients describe bulimia or binge eating. *Psychological Medicine, 12*, 625-635. doi: 10.1017/S0033291700055732

Agras, W. Stewart (Ed.). (2010). *The Oxford handbook of eating disorders*. (pp. 452-479). New York: Oxford University Press.

Alpers, G., & Tuschen-Caiffier, B. (2001). Negative feelings and the desire to eat in bulimia nervosa. *Eating Behaviors, 2*, 339-352. doi: 10.1016/S1471-0153%2801%2900040-X

Álvarez-Moya, E.M, Jiménez-Murcia, S., Moragas, L., Gómez-Peña, M., Aymamí, M. N., Ochoa, C., Sánchez-Díaz, I., Menchón, J. M., & Fernández-Aranda, F. (2009). Executive functioning among female pathological gambling and bulimia nervosa patients: Preliminary findings. *Journal of the International Neuropsychological Society, 15*, 302-306. doi: 10.1017/S1355617709090377

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author. San Francisco, CA: Jossey-Bass.

Bakhtin, M. M. (1981). *The dialogic imagination*. Austin: University of Texas Press.

Bechara, A., Damasio, A., Damasio, H., & Anderson, S. (1994). Insensitivity to future consequences following damage to human prefrontal cortex. *Cognition, 50*, 7-15. doi: 10.1016/0010-0277%2894%2990018-3

Bechara, A., Damasio, H., Tranel, D., & Damasio, A. R. (1997). Deciding advantageously before knowing the advantageous strategy. *Science, 275*, 1293-1295. doi: 10.1126/science.275.5304.1293

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.

Berg, I. K., & Steiner, T. (2003). *Children's solution work*. New York, NY: Norton.

Boeka, A. G., & Lokken, K. L. (2006). The Iowa gambling task as a measure of decision making in women with bulimia nervosa. *Journal of the International Neuropsychological Society, 12*, 741-745. doi:10.1017/S1355617706060887

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101. doi: 10.1191/1478088706qp063oa

Brotman, A. W., Alonso, A., & Herzog, D. B. (1985). Group therapy for bulimia: Clinical experience and practical recommendations. *Group, 9*, 15-23. doi: 10.1007/BF01456577

Bruch, H. (1973). *Eating disorders: Obesity, anorexia nervosa and the person within*. Basic Books: New York.

Bruner, J. (2005). The narrative creation of self. In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 3-14). Thousand Oaks, CA: Sage.

Buckroyd, J., & Rother, (Eds.). (2008). *Psychological responses to eating disorders and obesity: Recent and innovative work*. Chichester: John Wiley & Sons Ltd.

Buree, B. U., Papageorgis, D., & Hare, R. D. (1990). Eating in anorexia nervosa and bulimia nervosa: An application of the tripartite model of anxiety. *Canadian Journal of Behavioural Science, 22,* 207-218. doi: 10.1037/h0078891

Bydlowski, Corcos, M., Jeammet, P., Paterniti, S., Berthoz, S., Laurier, C., Chambry, J., & Consoli, S. M. (2005). Emotion-processing deficits in eating disorders. *International Journal of Eating Disorders, 37,* 321–329. doi: 10.1002/eat.20132

Carron, A., Hausenblas, H., & Mack, D. (1996). Social influence and exercise: a meta-analysis. *Journal of Sports Exercise Psychology, 18(1),* 1-16.

Cavedini, P., Bassi, T., Ubbiali, A., Casolari, A., Giordani, S., & Zorzi, C. (2004). Neuropsychological investigation of decision-making in anorexia nervosa. *Psychiatry Research, 127*, 259-266. doi: 10.1016/j.psychres.2004.03.012

Chase, S. E. (1996). Personal vulnerability and interpretive authority in narrative research. In R. Josselson (Ed.), *Ethics and process in the narrative study of lives* (pp. 45-59). Thousand Oaks, CA: Sage.

Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in qualitative research.* San Francisco, CA: Jossey-Bass.

Clandinin, D. J. (Ed.). (2007). *Handbook of narrative inquiry: Mapping a methodology*. Thousand Oaks, CA: Sage.

Compas, B. E., Connor, J., Osowiecki, D., & Welch, A. (1997). Effortful and involuntary responses to stress: implications for coping with chronic stress. In B. H. Gottlieb (Ed.), *Coping with chronic stress* (pp. 105–130). New York: Plenum.

Compas, B. E., Connor-Smith, J. K., Saltzman, H., Thomsen, A. H., & Wadsworth, M. E. (2001). Coping with stress during childhood and adolescence: Problems, progress, and potential in theory and research. *Psychological Bulletin, 127*, 87-127. doi: 10.1037//0033-2909.127.1.87

Connors, M. E., Johnson, C. L., & Stuckey, M. K. (1984). Treatment of bulimia with brief psychoeducational group therapy. *American Journal of Psychiatry, 141(12)*, 1512-1516.

Cooper, J. L., Morrison, T. L., Bigman, O. L., Abramowitz, S. I., Levin, S., Krener, P. (1988). Mood changes and affective disorder in the bulimic binge—Purge cycle. *International Journal of Eating Disorders, 7*, 469-474. doi: 10.1002/1098-108X(198807)7:4<469::AID-EAT2260070404>3.0.CO;2-O

Cooper, M. (2003). *The Psychology of bulimia nervosa: A cognitive perspective*. New York: Oxford University Press.

Cooper, M. J., Wells, A. & Todd, G. (2004). A cognitive theory of bulimia nervosa. *British Journal of Clinical Psychology, 43*, 1-16.

Corbin, M., & Strauss, A. L. (2008). *Basics of qualitative research: techniques and procedures for developing*. Thousand Oaks, CA: Sage.

Corey, M. S., Corey, G., & Corey, C. (2006). *Groups: Process and Practice*. Belmont, CA: Brooks/Cole.

Corstorphinea, E., Mountforda, V., Tomlinsona, S., Wallera, G., & Meyer, C. (2007). Distress tolerance in the eating disorders. *Eating Behaviors, 8*, 91-97. doi: 10.1016/j.eatbeh.2006.02.003

Costin, C. (2007). *The eating disorder sourcebook* (3rd ed.). New York: McGraw Hill. Chernin, K. (1981). *The obsession: Reflections on the tyranny of slenderness*. New York: Harper & Row.

Courtney, J., & Williams, J. (2000). Linking lives: Working with women experiencing eating problems. *Gecko, 2*, 16-23.

Craft, L. L. (2005). Exercise and clinical depression: Examining two psychological mechanisms. *Psychology of Sport and Exercise, 6*, 151–171. doi: 10.1016/j.psychsport.2003.11.003

Creswell, J. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice, 39*, 124-130.

Crotty, M. (1998). *The foundation of social research: Meaning and perspective in the research process*. Thousand Oaks, CA: Sage.

Daiute, C., & Lightfoot, C. G. (2004). *Narrative analysis: Studying the development of individuals in society*. Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (2005). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE*

handbook of qualitative research (3rd ed., pp. 695-727). Thousand Oaks, CA: Sage.

Dohnt, H., & Tiggemann, M. (2006). Body image concerns in young girls: The role of peers and media prior to adolescence. *Journal of Youth and Adolescence, 35,* 141-151. doi: 10.1007/s10964-005-9020-7

Duchesne, M., Mattos, P., Fontenelle, L. F., Veiga, H., Rizo, L., & Appolinario, J. C. (2004). Neuropsychology of eating disorders: A systematic review of the literature. *Revista Brasileira de Psiquiatria, 26,* 107-117. doi: 10.1590/S1516-44462004000200008

Duval, S. & Wicklund, R.A. (1972). *A theory of objective self-awareness.* New York: Academic Press.

Esplen, M. J., & Garfinkel, P. E. (1998). Guided imagery treatment to promote self-soothing in bulimia nervosa: A theoretical rationale. *The Journal of Psychotherapy Practice and Research, 7(2),* 102–118.

Esplen, M. J., Garfinkel, P., & Gallop, R. (2000). Relationship between self-soothing, aloneness, and evocative memory in bulimia nervosa. *International Journal of Eating Disorders, 27,* 96-100. doi: 10.1002/%28SICI%291098-108X%28200001%2927:1%3C96::AID-EAT11%3E3.0.CO;2-S

Eversmann, J., Schottke, H., & Wiedl, K. H. (2007). Binge eating: Cause or consequence of negative affects? Toward a problem-oriented model of affect regulation for binge eating episodes in bulimia nervosa. *Verhaltenstherapie, 17,* 151-157. doi: 10.1159/000107596

Fairburn, C. G., Jones, R., Peveler, R. C., Carr, S. J., Solomon, R. A., O'Connor, M. E., Burton, J., & Hope, R. A. (1991). Three psychological treatments for bulimia nervosa: A comparative trial. *Archives of General Psychiatry, 48,* 463-469. doi: 10.1001/archpsyc.1991.01810290075014

Fairburn, C. G., Norman, P. A., Welch, S. L., O'Connor, M. E., Doll, H. A., & Peveler, R. C. (1995). A prospective study of outcome in bulimia nervosa and the long-term effects of three psychological treatments. *Archives of General Psychiatry, 52,* 304–312. doi: 10.1001/archpsyc.1995.03950160054010

Farber, S. (2007). Dissociation, traumatic attachments, and self-harm: Eating disorders and self-mutilation. *Clinical Social Work Journal, 36,* 63-72. doi: 10.1007/s10615-007-0104-6

Fassino, S., Piero, A., Levi, M., Gramaglia, C., et al. (2004). Psychological treatment of eating disorders: A review of the literature. *Panminerva Medica, 46,* 189-198.

Ferster, C. B. (1973) A functional analysis of depression. *American Psychologist, 28(10),* 857–870.

Fontana, A., & Frey, J. H. (2005). The interview: From neutral stance to political involvement. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (3rd ed., pp.695-727). Thousand Oaks, CA: Sage.

Franko, D. L, Becker, A. E., Thomas, J. J., & Herzog, D. B. (2007). Cross-ethnic differences in eating disorder symptoms and related distress. *International Journal of Eating Disorders. 40,* 156-164. doi: 10.1002/eat.20341

Freud, A. (1948). The psychoanalytic study of infantile feeding disturbances. *Psychoanalytic Study of the Child, 2*, 119-132.

Gadamer, H. (Ed.). (1975). *Truth and method*. New York: Continuum

Gallop, R. (2002). Failure of the capacity for self-soothing in women who have a history of abuse and self-harm. *Journal of the American Psychiatric Nurses Association. 8,* 20-26. doi: 10.1067/mpn.2002.122425

Garfinkel, P. E., Lin, E., Goering, P., Spegg, C., Goldbloom, D. S., Kennedy, S., Kaplan, A.S., & Woodside, D. B. (1995). Bulimia nervosa in a Canadian community sample: Prevalence and comparison of subgroups. *The American Journal of Psychiatry, 152,* 1052-1058.

Ghaderi, A., & Scott, B. (2000). Coping in dieting and eating disorders: A population-based study. *Journal of Nervous Mental Disease, 188*, 273–279. doi: 10.1097/00005053-200005000-00004

Gillis, A. & Jackson, W. (2002). *Research for nurses: Methods and interpretation.* Philadelphia, PA: F. A. Davis Co.

Goodsitt, A. (1985). Self psychology and the treatment of anorexia nervosa. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of therapv for anorexia nervosa and bulimia,* (pp 55-82). New York: The Guilford Press.

Grant, K. E., Compas, B.E., Stuhlmacher, A. F., Thurm, A. F., McMahon, S. D., Halpert, J. A. (2003). Stressors and child and adolescent psychopathology: moving from markers to mechanisms of risk. *Psychological Bulletin, 129,* 447–466. doi: 10.1037/0033-2909.129.3.447

Gross, J. J. (1998). The emerging field of emotion regulation: An integrative review. *Review of General Psychology, 2,* 271-299. doi: 10.1037/1089-2680.2.3.271

Gross, J. J. (2001). Emotion regulation in adulthood: Timing is everything. *Current Directions in Psychological Science, 10,* 214-219. doi: 10.1111/1467-8721.00152

Guba E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks, CA: Sage.

Hall, L., & Cohn, L. (1999). *Bulimia: A guide to recovery*. Carlsbad, CA: Gurze Books.

Halmi, K. A., Falk, J. R., & Schwartz, E. (1981). Binge-eating and vomiting: A survey of a college population. *Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences, 11,* 697-706. doi: 10.1017/S0033291700041192

Halmi, K. (2005). Psychopathology of anorexia nervosa. *International Journal of Eating Disorders, 37,* S20–S21. doi: 10.1002/eat.20110

Hammersley, M. (1992). *What's wrong with ethnography? Methodological explorations.* London: Routledge.

Hammersley, M., & Atkinson, P. (1983). *Ethnography: Principles in practice* (2nd ed.). New York: Routledge.

Harrison, A., Treasure, J., & Smillie, L. D. (2011). Approach and avoidance motivation in eating disorders. *Psychiatry Research, 188,* 396-401. doi: 10.1016/j.psychres.2011.04.022

Hayaki, J. (2009). Negative reinforcement eating expectancies, emotion dysregulation, and symptoms of bulimia nervosa. *International Journal of Eating Disorders, 42,* 552–556. doi: 10.1002/eat.20646

Hays, S. C., Follette, & Linehan, M. M. (2004). *Mindfulness and acceptance: Expanding the cognitive-behavioral tradition* (pp. 66-95). New York: Guilford Press.

Heatherton, T. F., & Baumeister, R. F. (1991) Binge eating as escape from self-awareness. *Psychological Bulletin, 110,* 86-108. doi: 10.1037/0033-2909.110.1.86

Herzog, D. B. (1988). Eating disorders. In A. M. Nicholi (Ed.), *Harvard guide to modern Psychiatry* (pp. 434-445). Cambridge, MA: Harvard University Press.

Hinrichsen, H., Morrison, T., Waller, G., Schmidt, U. (2007). Triggers of self-induced vomiting in bulimic disorders: The roles of core beliefs and imagery. *Journal of Cognitive Psychotherapy, 21(3),* 261-272.

Hoffart, A., Lysebo, H., Sommerfeldt, B., & Ro, O. (2010). Change processes in residential cognitive therapy for bulimia nervosa. *BMC Psychiatry, 10*, 367-75. doi: 10.1002/erv.980

Holderness, C. C., Brooks-Gunn, J. and Warren, M. P. (1994). Co-morbidity of eating disorders and substance abuse review of the literature. *International Journal of Eating Disorders, 16,* 1–34. doi: 10.1002/1098-108X(199407)16:1<1::AID-EAT2260160102>3.0.CO;2-T.

Hopko, D. R., Sanchez, L., Hopko, S. D., Dvir, S., & Lejuez, C. W. (2003). Behavioral activation and the prevention of suicidal behaviors in patients with Borderline Personality Disorder. *Journal of Personality Disorders, 17(5),* 460-478.

Johnson, C. (1985). Initial consultation with bulimia and anorexia nervosa. In D. M. Garner and P. E. Garfinkel (Eds.), *Handbook of psychotherapy for anorexia nervosa and bulimia* (pp. 19–51). New York: Guilford.

Josselson, R. (1996). On writing other people's lives. In R. Josselson (Ed.), *Ethics and process in the narrative study of lives* (pp. 60-71). Thousand Oaks, CA: Sage.

Josselson, R. (2007). The ethical attitude in *narrative research: Principles and practicalities. In D. J. Clandinin (Ed.), Handbook of narrative inquiry: Mapping a methodology* (pp. 537-566). Thousand Oaks, CA: Sage.

Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York: Delta Trade Paperbacks.

Keel, P.K., & Herzog, D.B. (2004). Long-term outcome, course of illness, and mortality and in anorexia nervosa, bulimia nervosa, and binge eating disorder. In T.D. Brewerton (Ed.) Clinical handbook of eating disorders: An integrated approach (pp. 97-116). New York: Informa Health Care.

Kendler, K. S., MacLean, C., Neale, M., Kessler, R., Heath, A., & Leaves, L. (1991). The genetic epidemiology of bulimia nervosa. *The American Journal of Psychiatry, 148(12),* 1627-1637.

Kopp, C. B. (1989). Regulation of distress and negative emotions: A developmental view. *Developmental Psychology, 25*, 343-354. doi: 10.1037/0012-1649.25.3.343

Kraus, S. E. (2005). Research paradigms and meaning making: A primer. *The Qualitative Report, 10*, 758-770. doi: 10.1176/appi.ajp.162.10.1985

Kristeller, J. L., & Hallett, C. B. (1999). An exploratory study of a meditation-based intervention for binge eating disorder. *Journal of Health Psychology, 4*, 357– 363. doi: 10.1177/135910539900400305

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. London: Sage.

Lee, N. F. (2006). Cognitive-behavioral group therapy for bulimia. *International Journal of Eating Disorders, 5*, 599-615. doi: 10.1002/1098-108X%28198605%295:4%3C599::AID-EAT2260050402%3E3.0.CO;2W

Lehman, A. K., & Rodin, J. (1989). Styles of self-nurturance and disordered eating. *Journal of Consulting and Clinical Psychology, 57(1)*, 117-122.

Leitenberg H. (1995). Cognitive behavioral treatment of bulimia nervosa. *Behavioral Change, 12*, 81-97.

Lewis, E., Alissi, A. S., Goodman, H., Craig, C. D. and Levinsky, L. (2003). 'Book Reviews', *Social Work With Groups, 25*, 85-100.

Liao, P. C., Uher, R., Lawrence, N., Treasure, J., Schmidt, U., Campbell, I. C., Collier, D. A., & Tchanturia, K. (2009). An examination of decision making in bulimia nervosa. *Journal of Clinical and Experimental Neuropsychology, 31*, 455-461. doi: 10.1080/13803390802251378

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. (1998) *Narrative research: Reading, analysis and interpretation.* Thousand Oaks, London and New Delhi: Sage.

Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder*. New York: Gilford Press.

Linehan, M. M., & Chen, E. Y. (2005). Dialectical behavioral therapy for eating disorders. In A. Freeman (Ed.), *Encyclopedia of cognitive behavioral therapy* (pp. 168-171). New York: Springer.

Long, C., Smith, J., Midgley, M., & Cassidy, T. (1993). Over-exercising in anorexic and normal samples: behaviors and attitudes. *Journal of Mental Health, 2(4)*, 321-327.

Loxton, N. J., & Dawe, S. (2001). Alcohol abuse and dysfunctional eating in adolescent girls: the influence of individual differences in sensitivity to reward and punishment. *International Journal of Eating Disorders, 29*, 455-62. doi: 10.1002/eat.1042

Maine, M. (2001). Altering women's relationship with food: A relational, developmental approach. *Journal of Clinical Psychology in Session, 57*, 1301-1310. doi: 10.1002/jclp.1098

Maisel, R., Epston, D., & Borden, A. (2004). *Biting the hand that starves you: Inspiring resistance to anorexia/bulimia*. New York, NY: Norton.

Martin, C.V., Guterman, J.T., & Shatz, K. (2012). Solution-focused counseling for eating disorders. VISTAS, 1-11. Retrieved from http://www.counseling.org/Resources/Library/VISTAS/2012_Vol_1_67-

104/2_2012-ACA-PDFs/Article_88.pdf.

Mascolo, M. F., & Pollack, R. D. (1997). Frontiers of constructivism: Problems and prospects. *Journal of Constructivist Psychology, 10,* 1-5. doi: 10.1080/10720539708404608

Masten, A. S., Hubbard, J. J., Gest, S. D., Tellegen, A., Garmezy, N., Ramirez, M. L. (1999). Competence in the context of adversity: pathways to resilience and maladaptation from childhood to adolescence. *Developmental Psychopathology, 11,* 143-169.

Mauler, B. I., Hamm, A. O., Weike, A. I., & Tuschen-Caffier, B. (2006). Affect Regulation and food intake in bulimia nervosa: Emotional responding to food cues after deprivation and subsequent eating. *Journal of Abnormal Psychology, 115,* 567-579. doi: 10.1037/0021-843X.115.3.567

McCance, T. V., McKenna, H. P., & Boore, J. R. (2001). Exploring caring using narrative methodology: An analysis of the approach. *Journal of Advanced Nursing, 33,* 350-356. doi: 10.1046/j.1365-2648.2001.01671.x

McFarland, B. (1995). *Brief therapy and eating disorders: A practical guide to solution-focused work with clients*. San Francisco, CA: Jossey-Bass.

McLeod, J. (2001). *Qualitative research in counselling and psychotherapy*. Thousand Oaks, CA: Sage.

Merriam, S. B. (1998). *Qualitative research and case study applications in education*. San Francisco, CA: Jossey Bass.

Merriam, S. B. (2002). *Qualitative research in practice: Examples for discussion and analysis*. San Francisco, CA: Jossey-Bass.

Merriam, S. B. (2008). *Qualitative research: A guide to design and implementation*. San Francisco, CA: Jossey-Bass.

Merwin, R.M., Zucker, N. L. , Lacy, J. L., & Elliott, C. A. (2010). Interoceptive awareness in eating disorders: Distinguishing lack of clarity from non-acceptance of internal experience. *Cognition & Emotion, 24,* 892- 902. doi: 10.1080/02699930902985845

Meyer, C., Waller, G., & Waters, A. (1998). Emotional states and bulimic psychopathology. In H. Hoek, M. Katzman, & J. Treasure (Eds.) *The neurobiological basis of eating disorders* (pp. 271–289). Chichester: Wiley.

Mishler, E. G. (1986). *Research interviewing: Context and narrative*. Cambridge, MS: Harvard University Press.

Morgan, A. (2000). *What is narrative therapy? An easy-to-read introduction*. Adelaide, South Australia: Dulwich Centre.

Morse, J. M., & Richards, L. (2002). *Readme first for a user's guide to qualitative methods.* Thousand Oaks, CA: Sage.

Murphy, S. M. (Ed.). (2012). The Oxford handbook of sport and performance psychology. New York, NY: Oxford University Press.

National Eating Disorders Association. (2006). General Eating Disorders Information: Facts for Activists. Retrieved October 10, 2010, from http://www.edap.org/p.asp?WebPage_ID=320&Profile_ID=95634.

Nylund, D. (2002). Poetic means to anti-anorexic ends. *Journal of Systemic Therapies, 21,* 18-34. doi:10.1521/jsyt.21.4.18.23323

O'Halloran, M. S. (1999). Family involvement in the treatment of anorexia nervosa: A solution-focused approach. *The Family Journal, 7(4),* 384-388.

Olmstead, M. P., David, R., Garner, D. M., Rockert, W., Irvine, M. J., & Eagle. M. (1991). Efficacy of a brief group psychoeducational intervention for bulimia nervosa. *Behavior Research and Therapy*, *29*, 71-83. doi: 10.1016/S0005-7967%2809%2980009-0

Ondercin, P. A. (1984). Organization of needs in anorectic, bulimic, and obese college women. *Journal of Personality Assessment*, *48*, 162-167. doi: 10.1207/s15327752jpa4802_10

Ordman, A. N., & Kirshenbaum, D. S. (1986). Bulimia: Assessment of eating, Psychological adjustment, and familial characteristics. International Journal of Eating Disorders, 5, 865-878. doi: 10.1002/1098-108X%28198607%295:5%3C865::AID-EAT2260050508%3E3.0.CO;2-I

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Pen˜ as-Lledo´, E., Vaz Leal, F., & Waller, G. (2002). Excessive exercise in anorexia nervosa and bulimia nervosa: relation to eating characteristics and general psychopathology. *International Journal of Eating Disorder, 31*, 370-375. doi: 10.1002/eat.10042

Pendleton, V. R., Goodrick, G. K., Poston, W. S. C., Reeves, R. S., & Foreyt, J. P. (2002). Exercise augments the effects of cognitive-behavioral therapy in the treatment of binge eating. *International Journal of Eating Disorders, 31*, 172–184. doi: 10.1002/eat.10010

Polivy, J., & Herman, C.P. (1993). Etiology of binge eating: Psychological mechanisms. In C. Fairburn (Ed.), *Binge eating* (pp. 173-205). London: Guilford Press.

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. Albany, NY: State University of New York Press.

Polkinghorne, D. E. (1995). Narrative configuration in qualitative analysis. *Qualitative Studies in Education, 8*, 5-23.

Proulx, K. (2008). Experiences of women with bulimia nervosa in a mindfulness-based eating disorder treatment group. *Eating Disorders, 16*, 52-72. doi: 10.1080/10640260701773496

Public Health Services Office in Women's Health, Eating Disorders Information Sheet. (2000). Retrieved from www.anad.org/get-information/about-eating-disorders/eating-disorders-statistics

Riess, H., & Rutan, S. J. (1992). Group therapy for eating disorders: A step-wise approach. *Group, 16*, 79-83. doi: 10.1007/BF01459707

Riess, H. (2002). Integrative time-limited group therapy for bulimia nervosa. *International Journal of Group Psychotherapy, 52*, 1-26. doi: 10.1521/ijgp.52.1.1.45469

Riessman, C. K. (1993). *Narrative analysis*. London: Sage. Riessman, C. K. (2008). *Narrative methods for the human sciences.* London: Sage.

Riessman, C. K. (2008). *Narrative methods for the human sciences.* London: Sage.

Roberts, M. E., Tchanturia, K., Stahl, D., Southgate, L., & Treasure, J. (2007). A systematic review and meta-analysis of set-shifting ability in eating disorders. *Psychological Medicine, 37*, 1075-1084. doi: 10.1017/S0033291707009877

Roemer, L., & Orsillo, S. M. (2009). *Mindfulness- & acceptance-based behavioral therapies in practice*. New York: The Guilford Press.

Rorty, M., Yager, J., & Rossotto, E. (1993). Why and how do women recover? The subjective appraisals of forty women recovered for a year or more. *International Journal of Eating Disorders, 14*, 249-260. doi: 10.1002/1098-108X(199311)

Ruangsri, T. (2009). Why food? An exploration of the psychodynamics of the use of food in eating disordered clients and the implications for treatment. Dissertations and Abstracts International.

Ruggerio, A. (2008). *Bulimia.* San Francisco, CA: Greenhaven Press.

Russell, G. F. M. (1979) Bulimia nervosa: an ominous variant of anorexia nervosa. *Psychological Medicine, 9*, 429-448. doi: 10.1017/S0033291700031974

Safer, D. L., Telch, C. F., & Agras, W. S. (2001). Dialectical behavior therapy for bulimia nervosa. *American Journal of Psychiatry, 158*, 632-634. doi: 10.1176/appi.ajp.158.4.632

Safer, D. L., Telch, C. F., & Chen, E. Y. (2009). *Dialectical behavior therapy for binge eating and bulimia nervosa.* New York: The Guilford Press.

Sands, S. (1991). Bulimia, dissociation, and empathy: A self-psychological view. In C. Johnson (Ed.), *Psychodynamic treatment of anorexia nervosa and bulimia (pp. 34-50).* New York, NY: Guilford Press.

Schaffner, A. D., & Buchanan, L. P. (2008). Integrating evidence-based Treatments with individual needs in an outpatient. *Eating Disorders, 16*, 378-392. doi: 10.1080/10640260802370549

Schwandt, T.A. (1997). *Qualitative inquiry: A dictionary of terms*. Thousand Oaks, CA: Sage.

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse.* New York: The Guilford Press.

Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55*, 5-14. doi: 10.1037/0003-066X.56.1.89

Shapiro, S. L., Schwartz, G. E., & Bonner, G. (1998). Effects of mindfulness-based stress reduction on medical and premedical students. *Journal of Behavioral Medicine, 21*, 581–599. doi: 0160-7715 /98/1200-0581

Sheppard, K. (1993). *Food addiction: The body knows.* Deerfield Beach, FL: Health Communications, Inc.

Shroff, H., Reba, L., Thornton, L., Tozzi, F., Klump, K. L., Berrettini, W. H., Brandt, H., Crawford, S., Crow, S., Fichter, M. M., Goldman, D., Halmi, K. A., Johnson, C., Kaplan, A. S., Keel, P., & LaVia, M., Mitchell, J., Rotonda, A., Strober, M., Treasure, J., Woodside, D. B., Kaye, W. H., &

Bulik, C. M. (2006). Features associated with excessive exercise in women with eating disorders. *International Journal of Eating Disorders, 39*, 454-461. doi: 10.1002/eat.20247

Skinner, E. A., & Zimmer-Gembeck, M. J. (2007). The development of coping. *Annual Review of Psychology, 58*, 119–144. doi: 1 0.1146/annurev.psych.58.110405.085705

Smyth, J., Wonderlich, S., Crosby, R., Miltenberger, R., Mitchell, J., & Rorty, M. (2001). The use of ecological momentary assessment approaches in eating disorder research. *International Journal of Eating Disorders, 30*, 83–95. doi: 10.1002/eat.1057

Smyth, J. M., Wonderlich, S. A., Heron, K. E., Sliwinski, M. J., Crosby, R. D., Mitchell, J. E., & Engel, S. G. (2007). Daily and momentary mood and stress are associated with binge eating and vomiting in bulimia nervosa patients in the natural environment. *Journal of Consulting and Clinical Psychology. 75,* 629-638. doi: 10.1037/0022-006X.75.4.629

Soukup, V. M., Beiler, M. E., & Terrell, F. (1990). Stress, coping style, and problem solving ability among eating-disordered inpatients. *Journal of Clinical Psychology, 46*, 592–599. doi: 10.1002/1097-4679(199009)

Streubert, H. J. & Carpenter, D. R. (1999). *Qualitative research in nursing: Advancing the humanistic imperative* (2nd et.). Philidelphia, PA: Lippincott.

Strober, M. (1984). Stressful life events associated with bulimia in anorexia nervosa: Empirical findings and theoretical speculations. *International Journal of Eating Disorders, 3*, 3-16. doi: 10.1002/1098-108X%28198424%293:2%3C3::AID-EAT2260030203%3E3.0.CO;2-6

Sundgot-Borgen, J., Rosenvinge, J., Bahr, R., & Sundgot Schneider, L. (2002). The effect of exercise, cognitive therapy, and nutritional counseling in treating bulimia nervosa. *Medicine & Science in Sports & Exercise, 34*, 190-195. doi: 10.1097/00005768-200202000-00002

Tabin, C. J., & Tabin, J. K. (1988). Bulimia and anorexia: understanding their gender specificity and their complex of symptoms. In H. J. Schwartz (Ed.), *Bulimia: Psychoanalytic Treatment and Theory* (pp. 173–225). Madison, CT: International Universities Press, Inc.

Tchanturia, K., Liao, P. C., Uher, R., Lawrence, N., Treasure, J., & Campbell, I. C. (2007). An investigation of decision making in anorexia nervosa using the Iowa Gambling Task and skin conductance measurements. *Journal of the International Neuropsychological Society Journal, 13,* 635-641. doi: 10.1017/S1355617707070798

Thelen, M. H., Farmer, J., Wonderlich, S., & Smith, M. C. (1991). A revision of the Bulimia Test: The BULIT-R. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 3*, 119-124. doi: 10.1037/1040-3590.3.1.119

Thelen, M. H., Mintz, L. B., & Vander Wal, J. S. (1996). The Bulimia Test-Revised: Validation with DSM–IV criteria for bulimia nervosa. *Psychological Assessment, 8,* 219-221. doi: 10.1037/1040-3590.8.2.219

Tobin, G. A. & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing, 48,* 388-396. doi: 10.1111/j.1365-2648.2004.03207.x

Villa, V., Manzoni, G. M., Pagnini, F., Castelnuovo, G., Cesa, G. L., & Molinari, E. (2009). Do coping strategies discriminate eating disordered individuals better than eating disorder features? An explorative study on female inpatients with anorexia and bulimia nervosa. *Journal of Clinical Psychology in Medical Settings, 16,* 297-303. doi: 10.1007/s10880-009-9172-9

von Ranson., K. M., & Cassin, S. E. (2007). Eating disorders and Addiction: Theory and evidence. In J. S. Rubin, *Weight Loss Research,* (pp. 1-37). Nova Science Publishers Inc.

Waller, G., Shah, R., Ohanian, V., & Elliott, P. (2001). Core beliefs in bulimia nervosa and depression: The discriminant validity of Young's Schema Questionnaire. *Behavior Therapy, 32,* 139-153. doi: 10.1016/S0005-7894(01)80049-6

Walters, E. E., Neale, M. C., Eaves, L. J., Heath, A. C., Kessler, R. C., & Kendler, K. S. (1992). Bulimia nervosa and major depression: a study of common genetic and environmental factors. *Psychological Medicine, 22,* 617-662. doi: 10.1017/S0033291700038071

Ward, A., Ramsay, R., & Treasure, J. (2001). Attachment research in eating disorders. *British Journal of Medical Psychology, 75*, 31-51. doi: 10.1348/000711200160282

Welch, G., Thompson, L., & Hall, A. (1993). The BULIT-R: Its reliability and clinical validity as a screening tool for DSM-III-R bulimia nervosa in a female tertiary education population. *International Journal of Eating Disorders, 14*, 95-105. doi: 10.1002/1098-108X(199307)

White, M. (2007). *Maps of narrative practice*. New York: W.W. Norton & Company.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: WW Norton.

Wilfley, D. E., Agras, W. S., Telch, C. F., Rossiter, E. M., Schneider, J. A., Cole, A. G., Sifford, L., & Raeburn, S. D. (1993). Group cognitive-behavioral therapy and group interpersonal psychotherapy for the nonpurging bulimic individual: A controlled comparison. *Journal of Consulting and Clinical Psychology, 61,* 296-305. doi: 10.1037/0022-006X.61.2.296

Williams, C., & Garland, A. (2002). Identifying and challenging unhelpful thinking. *Advances in Psychiatric Treatment, 8,* 377-386. doi: 10.1192/apt.8.5.377

Wilson, G. T. (2004). Acceptance and change in the treatment of eating disorders: The evolution of manual-based cognitive-behavioral therapy. In S. C. Hayes, V. M. Follette, & M. M.

Wilson, G. T., Fairburn, C. G., & Agras, W. S. (1997). Cognitive-behavioral therapy for bulimia nervosa. In D. M. Garner & P. E Garfinkel (Eds.), Handbook of treatment for eating disorders (2nd ed., pp. 67-93). New York: Guilford Press.

Wilson, G. T., Grilo, C. M., & Vitousek, K. M. (2007). Psychological treatment of eating disorders. *American Psychologist, 62,* 199-216. doi: 10.1037/0003-066X.62.3.199

Wonderlich, S. A., Joiner, T. E., Jr., Keel, P. K., Williamson, D. A., & Crosby, R. D. (2007). Eating disorder diagnoses: Empirical approaches to classification. *American Psychologist, 62,* 167-180. doi: 10.1037/0003-066X.62.3.167

World Health Organization (2007). Mental health: Strengthening mental health promotion. Retrieved from http://www.who.int/mediacentre/factsheets/fs220/en/.

Yager, J., Rorty, M., & Rossotto, E. (1995). Coping styles differ between recovered and nonrecovered women with bulimia nervosa, but not between recovered women and non-eating-disordered control subjects. *Journal of Nervous and Mental Disease, 183,* 86-94. doi: 10.1097/00005053-199502000-00004

Zhu A. J., & Walsh, B. T. (2002). In review: Pharmacologic treatment of eating disorders. *Canadian Journal of Psychiatry, 47(3),* 227-234.

Appendix A

Consent to Screening Interview

Name of Study: Positive Coping Experiences of Women with Bulimia

Principal Investigator: Katie Poirier [kpoirier@ualberta.ca]

Research Supervisor: Dr. Jessica Van Vliet
[(780) 492-5894, jvanvliet@ualberta.ca]

Thank you for your interest in participating in the study "Positive Coping Experiences of Women with Bulimia"

You are being asked to participate in a screening interview for a research study. The study is designed to explore and understand women with bulimia's positive coping experiences. That is, the researcher would like to explore how women with bulimia have coped with difficult events or experiences in ways that are positive, adaptive and do not involve binging and purging. Participation in this study screening interview is completely voluntary.

Please read the information below and ask questions about anything that you do not understand before deciding if you want to participate.

There are no known harms or discomforts associated with this screening interview beyond those encountered in normal daily life. This interview will involve approximately 20 minutes of your time. You will be asked to fill out a psychological questionnaire related to your eating behaviours as well as a brief demographic information form. Upon completion of the screening interview, a list of counselling referrals will be provided to you.

Your participation is completely voluntary. You may withdraw from this interview at any time without penalty and you are also free to not answer any question without explanation or penalty.

All information obtained in this screening interview will be kept strictly **confidential.** All identifying information will be removed from individual responses, and all materials will be stored in a locked office at the University of Alberta. All electronic data will be encrypted and stored on a password protected computer.

Limits to confidentiality: If the researcher suspects that you seriously intend to harm yourself or someone else, she may be required to notify others of the risk in order to help ensure safety.

By signing this consent form, you are indicating that you fully understand the above information and agree to participate in this study screening interview.

Participant Name (please print)

Participant's Signature

Date:

If you have any questions about this study, please contact the researcher, Katie Poirier [kpoirier@ualberta.ca] or Dr. Jessica Van Vliet [(780)-492-5894, jvanvliet@ualberta.ca].

This research has been reviewed and approved by the University of Alberta Research Ethics Board. If you have any questions or concerns about the ethics of this study, you may contact Chair of the University of Alberta Research Ethics Board, Dr. Stanley Varnhagen, by stanley.varnhagen@ualberta.ca or by telephone (780-492-3641).

Appendix B

Participant Information Sheet

Please fill out the following information to the degree to which you feel comfortable:

1. **Pseudonym: _____**

2. **Age**: _____

3. **Gender**: Female ____ Male ____ Trans-identified/gender-variant____

4. **Marital status**: □ Single □ Married/Common-law
   □ Divorced/Separated □ Widowed

5. **Ethnic background (please check one)**:

□ European /European-Canadian □ French-Canadian
□ Aboriginal □ Métis
□ Asian / Asian-Canadian □ South Asian / South Asian Canadian
□ African / African Canadian □ Caribbean / Caribbean Canadian
□ Middle Eastern / Middle Eastern Canadian □ Latin American/Latin American Canadian
Other (Please specify): _____

6. **Phone number** (For study contact purposes):
   _____

7. **Highest level of education**:

   High school __ College diploma __ Undergraduate degree __ Graduate degree __

   Other (please specify) _____

8. **Please indicate the frequency of your binging (please circle)**:

   1 = 1-2 times a week **2** = 3-4 times a week **3** = 4-5 times a week

   4 = 6-7 times a week **5** = more than 7 times a week

9. **Please indicate the frequency of your purging (please circle):**

   1 = 1-2 times a week **2** = 3-4 times a week **3** = 4-5 times a week

4 = 6-7 times a week **5** = more than 7 times a week

10. Please indicate the method of purging you use (e.g. vomiting, laxatives, exercise, etc.)

_____

_____

11. How long have you engaged in binging and purging behaviours?
_____Years _____ Months

Appendix C

BULIT-R

Answer each question by circling one response from each question, and please respond based on the past 3 months.

Please respond to each item as honestly as possible; remember that all of the information you provide will be kept strictly confidential.

1. I am satisfied with my eating patterns.
    1. agree
    2. neutral
    3. disagree a little
    4. disagree
    5. disagree strongly

2. Would you presently call yourself a “binge eater.”
    1. yes, absolutely
    2. yes
    3. yes, probably
    4. yes, possibly
    5. no, probably not

3. Do you feel you have control over the amount of food you consume?
    1. most or all of the time
    2. a lot of the time
    3. occasionally
    4. rarely
    5. never

4. I am satisfied with the shape and size of my body.
    1. frequently or always
    2. sometimes
    3. occasionally
    4. rarely
    5. seldom or never

5. When I feel that my eating behaviour is out of control, I try to take rather extreme measures to get back on course (strict dieting, fasting, laxatives, diuretics, self-induced vomiting, or vigorous exercise).
    1. always
    2. almost always

3. frequently
4. sometimes
5. never or my eating behaviour is never out of control

6. I use laxatives or suppositories to help control my weight.
    1. Once a day or more
    2. 3-6 times a week
    3. Once or twice a week
    4. 2-3 times a month
    5. Once a month or less (or never)

7. I am obsessed about the size and shape of my body.
    1. Always
    2. Almost always
    3. Frequently
    4. Sometimes
    5. Seldom or never

8. There are times when I rapidly eat a very large amount of food.
    1. More than twice a week
    2. Twice a week
    3. Once a week
    4. 2-3 times a month
    5. Once a month or less (or never)

9. How long have you been binge eating (eating uncontrollably to the point of stuffing yourself)?
    1. Not applicable; I don't binge
    2. Less than 3 months
    3. 3 months – 1 year
    4. 1-3 years
    5. 3 or more years

10. Most people I know would be amazed if they knew how much food I consume at one sitting.
    1. Without a doubt
    2. Very probably
    3. Probably
    4. Possibly
    5. No

11. I exercise in order to burn calories.
    1. More than 2 hours per day
    2. About 2 hours per day
    3. More than 1 but less than 2 hours per day
    4. Once hour or less per day
    5. I exercise but not to burn calories or I don't exercise

12. Compared with women your age, how preoccupied are you about your weight and body shape?
    1. A great deal more than average
    2. Much more than average
    3. More than average
    4. A little more than average
    5. Average or less than average

13. I am afraid to eat anything for fear that I won't be able to stop.
    1. Always
    2. Almost always
    3. Frequently
    4. Sometimes
    5. Seldom or never

14. I feel tormented by the idea that I am fat or might gain weight.
    1. Always
    2. Almost always
    3. Frequently
    4. Sometimes
    5. Seldom or never

15. How often do you intentionally vomit after eating?
    1. 2 or more times a week
    2. Once a week
    3. 2-3 times a month
    4. Once a month
    5. Less than once a month or never

16. I eat a lot of food when I'm not even hungry.
    1. Very frequently
    2. Frequently
    3. Occasionally
    4. Sometimes
    5. Seldom or never

17. My eating patterns are different from the eating patterns of most people.
    1. Always
    2. Almost always
    3. Frequently
    4. Sometimes
    5. Seldom or never

18. After I binge I turn to one of several strict methods to try to keep from gaining weight (vigorous exercise, strict dieting, fasting, self-induced vomiting, laxatives, or diuretics).
    1. Never or I don't binge eat
    2. Rarely
    3. Occasionally
    4. A lot of the time
    5. Most or all of the time

19. I have tried to lose weight by fasting or going on strict diets.
    1. Not in the past year
    2. Once in the past year
    3. 2-3 times in the past year
    4. 4-5 times in the past year
    5. More than 5 times in the past year

20. I exercise vigorously and for long periods of time in order to burn calories.
    1. Average or less than average
    2. A little more than average
    3. More than average
    4. Much more than average
    5. A great deal more than average

21. When engaged in an eating binge, I tend to eat foods that are high carbohydrates (sweets and starches).
    1. Always
    2. Almost always
    3. Frequently
    4. Sometimes
    5. Seldom, I don't binge

22. Compared to most people, my ability to control my eating behaviour seems to be:

1. Greater than other's ability
2. About the same
3. Less
4. Much less
5. I have absolutely no control

23. I would presently label myself a "compulsive eater" (one who engages in episodes of uncontrolled eating).
    1. Absolutely
    2. Yes
    3. Yes, probably
    4. Yes, possibly
    5. No, probably not

24. I hate the way my body looks after I eat too much.
    1. Seldom or never
    2. Sometimes
    3. Frequently
    4. Almost always
    5. Always

25. When I am trying to keep from gaining weight, I feel that I have to resort to vigorous exercise, strict dieting, fasting, self-induced vomiting, laxatives, or diuretics.
    1. Never
    2. Rarely
    3. Occasionally
    4. A lot of the time
    5. Most or all of the time

26. Do you believe that is it easier for you to vomit than it is for most people?
    1. Yes, it's no problem at all for me
    2. Yes, it's easier
    3. Yes, it's a little easier
    4. About the same
    5. No, it's less easy

27. I use diuretics (water pills) to help control my weight.
    1. Never
    2. Seldom
    3. Sometimes
    4. Frequently

5. Very frequently

28. I feel that food controls my life.
    1. Always
    2. Almost always
    3. Frequently
    4. Sometimes
    5. Seldom or never

29. I try to control my weight by eating little or no food for a day or longer.
    1. Never
    2. Seldom
    3. Sometimes
    4. Frequently
    5. Very frequently
30. When consuming a large quantity of food, at what speed do you usually eat?
    1. More rapidly than most people have ever eaten in their whole lives
    2. A lot more rapidly than most people
    3. A little more rapidly than most people
    4. About the same rate as most people
    5. More slowly than most people (or not applicable)

31. I use laxatives or suppositories to help control my weight.
    1. Never
    2. Seldom
    3. Sometimes
    4. Frequently
    5. Very frequently

32. Right after I binge I feel:
    1. So fat and bloated I can't stand it
    2. Extremely fat
    3. Fat
    4. A little fat
    5. OK about how my body looks or I never binge eat

33. Compared to other people of my sex, my ability to always feel in control of how much I eat is:
    1. About the same or greater
    2. A little less
    3. Less

4. Much less
5. A great deal less

34. In the last 3 months, on the average how often did you binge eat (eat uncontrollably to the point of stuffing yourself)?
    1. Once a month or less (or never)
    2. 2-3 times a month
    3. Once a week
    4. Twice a week
    5. More than twice a week

35. Most people I know would be surprised about how fat I look after I eat a lot of food.
    1. Yes, definitely
    2. Yes
    3. Yes, probably
    4. Yes, possibly
    5. No, probably not or I never eat a lot of food

36. I use diuretics (water pills) to help control my weight.
    1. 3 times a week or more
    2. Once or twice a week
    3. 2-3 times a month
    4. Once a month
    5. Never

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Appendix D

List of Counselling Referrals

The Support Network (www.thesupportnetwork.com)

24-Hour Distress Line: 780-482-HELP(4357)

Walk-in Counselling also available (780-482-0198)

Eating Disorder Program: University of Alberta Hospital

780-407-6114

Referral Needed: Yes

Note: Fax 780-407-6672 or phone 780-407-6575 Dr. Piktel with referral for initial assessment in his office. Please provide as much information as possible regarding current medical/psychiatric status, height/weight, recent labwork if applicable and severity of current symptoms.

Anorexics and Bulimics Anonymous (Support Group)

780-443-6077

University of Alberta – Education Clinical Services

Counselling Centre (individual, couple, family; first come basis; apply Sept –

March)

780-492-3746

The Family Centre (http://the-family-centre.com/)

#20, 9912-106 Street

1st time appointments: (780) 424-5580

Reception: (780) 423-2831

The YWCA of Edmonton (http://www.ywcaofedmonton.org/)

#100, 10350 124 Street NW

Counselling Centre: (780) 423 – YWCA (9922) ext. 222

Appendix E

Informed Consent

Name of Study: Positive Coping Experiences of Women with Bulimia

Principal Investigator: Katie Poirier [kpoirier@ualberta.ca]

Research Supervisor: Dr. Jessica Van Vliet

[(780) 492-5894, jvanvliet@ualberta.ca]

Thank you for your interest in participating in the study "Positive Coping Experiences of Women with Bulimia."
You are being asked to participate in a research study designed to explore and understand women with bulimia's experiences of positive coping behaviours. Participation in this study is completely voluntary.

Please read the information below and ask questions about anything that you do not understand before deciding if you want to participate.

There are no known harms or discomforts associated with this study beyond those encountered in normal daily life. The study will involve approximately 2-3 hours of your time. Firstly, you will be asked to participate in an interview with the researcher that will be approximately 45-60 minutes. This interview will involve questions about your experiences of having bulimia nervosa and how you cope with things like stress, negative feelings, and distressing situations or experiences. Upon completion of the interview, a list of counselling referrals will be provided to you. The interviews will be audio-recorded and transcribed. You will be later asked to read the transcripts and given the opportunity to elaborate upon your perspectives in a follow up interview of about 20-30 minutes. Subsequently, you will have the opportunity to review the findings and experiences shared in the study.

Your participation is completely voluntary. You may withdraw from this study at any time without penalty and you are also free to not answer any question that you deem to be objectionable.

All information obtained in this study will be kept strictly **confidential.** All identifying information will be removed from individual responses, and all materials, including audio tapings, will be stored in the locked Clinical Services Office at the University of Alberta. The computer/digital files created from

transcribing interviews will be password protected on a private computer belonging to the principal investigator.

Limits to confidentiality: If the researcher suspects that you seriously intend to harm yourself or someone else, she may be required to notify others of the risk in order to help ensure safety.

The findings of this research may be presented at scholarly and professional conferences or published in academic or professional journals. No identifiable information will be presented.

By signing this consent form, you are indicating that you fully understand the above information and agree to participate in this study.

Participant Name (please print)

Participant's Signature

Date:

If you have any questions about this study, please contact the researcher, Katie Poirier [kpoirier@ualberta.ca] or Dr. Jessica Van Vliet [(780)-492-5894, jvanvliet@ualberta.ca].

This research has been reviewed and approved by the University of Alberta Research Ethics Board. If you have any questions or concerns about the ethics of this study, you may contact Chair of the University of Alberta Research Ethics Board, Dr. Stanley Varnhagen, by stanley.varnhagen@ualberta.ca or by telephone (780-492-3641).

Appendix F

Guiding Questions: Interview Protocol

Research Question: What are the positive coping experiences of women with bulimia?

Questions

1. Please describe what bulimia looks like for you in your life.
2. Describe a time (or times) when you coped with negative feelings or experiences in a positive way, and when you did not binge and purge.
    A. Please describe how you coped in as much detail as possible.
    B. What was happening for you at the time?
    C. How, specifically, did you cope in this positive way?
3. Was there anything that helped or made it easier for you to cope in this way?
4. Was there anything that hindered or made it more difficult for you to cope in this way?
5. Are there any other positive coping experiences that you can think of?
6. Is there anything else you would like to add? Are there any other aspects about your positive coping experience that I didn't ask about?

Appendix G

Study Recruitment Poster

UNIVERSITY OF ALBERTA

ARE YOU COPING WITH BULIMIA?

Research participants are needed for a study on positive coping experiences of women with bulimia nervosa

If you are a female older than 18 and have bulimia nervosa, we welcome you to participate in a study at the University of Alberta examining this question:

What are the positive coping experiences of women with bulimia?

Participation will involve approximately 2 ½ hours of your time

If you are interested in participating, please contact:

kpoirier@ualberta.ca

This research has been reviewed and approved by the University of Alberta Research Ethics Board

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