Practice Guidelines for Screening and Early Detection of Eating Disorders in Adolescent Females

Catherine J. Wiernasz
Michigan State University

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Rachel Schiffman, Ph.D., R.N.
Michigan State University
College of Nursing
A230 Life Sciences Building
East Lansing MI 48824-1317

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Abstract

Anorexia nervosa and bulimia are classified as eating disorders and affect a large portion of our adolescent female population. Many of these females do not meet the strict diagnostic criteria for an eating disorder, but still experience many symptoms. Within the literature there lacks a systematic approach to screening for risk factors regarding eating disorders. Specifically, there is little emphasis placed on behavior towards food. An Advanced Practice Nurse given the correct tool should be able to detect high risk behaviors or tendencies toward eating disorders. This scholarly project proposes to develop a screening method to easily assess for risk factors and early detection of eating disorders in the adolescent female population.

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Introduction

The purpose of this scholarly project is to develop a screening method (tool) that can be used in the primary care setting to assess for risk factors as well as early onset of eating disorders in adolescent females. The adolescent female is at high risk for the development of eating disorders. The extra layer (fat) deposited during puberty enables females to have monthly menstrual cycles. For years, the onset of a young woman's period marks her entry into adulthood and was looked upon as a positive thing. In today's society however, girls become depressed about changes with their bodies. Girls as young as 9 start to worry about getting fat. By eighth grade only 3 out of 10 girls like their bodies (Peterson, 1994).

Anorexia nervosa and bulimia are the two most prevalent eating disorders. Anorexia is the act of self starvation. It is accompanied by significant weight loss. Many who experience anorexia have a fear of becoming fat. Bulimia is the act of eating a large quantity of food in a short amount of time followed by self induced purging to help regulate weight gain.

The primary differences between anorexia nervosa and bulimia involve self starvation and binging followed by purging. Anorexic persons use self starvation to rid themselves of fat while bulimics eat enormous amounts of food and then purge to rid themselves of the calories (Smith, 1984). The anorexic and

bulimic have impractical images of their bodies, seeing themselves as "fat" when in reality they are suffering from "thinness", though not all bulimics will become noticeably thin. Some bulimic persons will stay at a normal weight, but will suffer from many psychosocial as well as medical problems. Both anorexics and bulimics may start out by "just" dieting and then become obsessed with food and dieting. Many anorexics experience bulimic behavior because at some point they will be placed in a social situation were they must ingest food. This causes great anxiety and a need to rid herself of the food. The anorexic deprives herself of food and when she eats guilt takes over and purging begins.

Historical Perspective

Anorexia has been documented throughout history, the earliest cases being seen in the 1800's. The nineteenth century physician saw anorexia as a sign of disease, but not a disease by itself. Loss of appetite was described in many medical journals as relating to such diseases as tuberculosis, cancer, stomach diseases, anemias, and nausea with pregnancy (Brumberg, 1989). In the late eighteenth and early nineteenth centuries, public and private asylums provided physicians with knowledge, as well as experience with patients who refused to eat. In 1859, the American Journal of Insanity published an article, the first of its kind in America, regarding "sitomania" which was a "phase of insanity characterized by intense dread of food". This article, written by William Stout Chipley, described his observations and

clinical experience within the asylum. He distinguished that many young women were being brought to the asylums by their parents because of their refusal to eat. Most came in a state of emaciation. Chipley believed that the young women who refused to eat were seeking attention and he called their behavior manipulative. Chipley's work was significant to the development of anorexia nervosa being described as a disease (Brumberg, 1989).

It wasn't until 1873, after two clinical reports were published, that medical physicians began talking about anorexia in young girls. Sir William Withey Gull established anorexia nervosa as a disease entity different from starvation of the insane. It was then determined that anorexia nervosa was most often associated with young females possessing a specific behavior - lack of appetite. This was described as nervous in origin and was found in the wealthier classes (Brumberg, 1989).

Hilde Bruch published a book in 1978 entitled "The Golden Cage" concerning anorexia nervosa. In this book written for the public, she explains how anorexia nervosa was presenting itself at a rapid rate. In fact it was so common that many of the young women in high schools and colleges were suffering from it. This book got the publics attention and promoted the belief that this disease was reaching levels of epidemic proportion. "In effect, anorexia nervosa was the disease of the 1970's..." (Brumberg, 1988, p. 10).

There are dramatic consequences resulting from long term

anorexic and/or bulimic behaviors. In January of 1983 the public was stunned when it was announced that singer Karen Carpenter died of heart failure associated with prolonged self starvation related to anorexia nervosa. In that same year Jane Fonda revealed her battle with bulimia.Her bulimia began when she was attending Vassar College. Her personal disclosure helped to bring bulimia into the nations consciousness.

These silent by deadly diseases have hit epidemic proportions. The American Anorexia and Bulimia Association (1994) states one million women each year are afflicted with an eating disorder. They also report that 30,000 women begin abusing laxatives each year. One hundred fifty thousand American women die annually from anorexia. "Statistically, it appears that bulimia affects mostly middle- or upper-class females with some college education...Typically, the condition begins in late adolescence after completion of a diet...30 percent of all college women may suffer from this disorder" (Keller, 1986, p. 42).

In today's society women are expected to be a size 4, whatever it takes. Present culture encourages women in society to base self-worth on the shape of their bodies. If a woman does not look like a model she is not respected as a valuable human being. In the past television programs have aired shows on how "skinny" women get jobs whereas "obese" women are passed over or paid less for the same job. On the opposite side of the coin, society also sends out the message that food is a source of

"love" and "comfort". This can lead to confusion and conflict regarding eating.

Society forgets to place emphasis on the body images of our truly beautiful women. The women who are pregnant with our children, the mothers, aunts, and grandmothers of our future generations, the working women, the wives, the lovers, the lesbians, the sisters; every woman who is a contributing member of society. Women come in all colors, shapes, sizes, and ethnic backgrounds. They are not all blond, blue eyed, buxom, thin-waisted, long-legged beauties, but western society says they should be.

Many women today have distorted images of what their bodies should look like. Adolescent females today see how women must take on several different roles. The simple act of growing up in today's society provides our female youth with distorted ideas of what they should do, be, and of-course, look like. Women have always based their worth on their external appearance and less on their abilities, and it is no different today. Being fat is not looked upon as a positive way of life. Many young girls begin feeling the pressure of "external appearances" and begin dieting. As dieting becomes a way of life and they can no longer just diet; they begin to fall into an eating disorder.

Diagnositc Criteria

An advanced practice nurse working in a primary care setting must not ignore symptoms of eating disorders. This author is concerned with diagnosing risk factors, tendencies and early

detection of eating disorders, but also sees the importance of acquiring the information to medically diagnose an eating disorder. The main medical diagnostic criteria for eating disorders is the DSM-IV from the American Psychiatric Association (see appendix 1).

Physical Effects

The physical effects of anorexia and bulimia include the following: brittle nails and hair, amenorrhea, loss of muscle mass, dry skin, cold hands and feet, constipation, digestive problems, insomnia, hypothermia, edema, hypotension, bradycardia, lanugo, infertility, dehydration, electrolyte imbalance, epileptic seizure, abnormal heart rhythm, kidney failure, and osteoporosis. Anorexics and bulimics may develop more dangerous problems, such as increased susceptibility to infections, stress fractures, ketosis, and weakness of the cardiac muscle. Often these symptoms can lead to death. Bulimia can also cause tooth erosion, hiatal hernia, and abraded esophagus (Fogel & Woods, 1995). As stated earlier, this author is interested in early detection and prevention of eating disorders, but symptomatology will not be ignored, merely acknowledged.

Problem Statement

There is not a systematic approach to screening for risk factors regarding eating disorders. The method most commonly used is the routine history and physical, but with this method the questions asked relate to nutritional status and intake. Much less emphasis in the routine history and physical is placed

on behaviors toward food. Screening for risk factors regarding eating disorders requires more emphasis on behaviors toward food.

Many women do not meet the strict diagnostic criteria for an eating disorder, but experience many of the symptoms or have many of the signs, such as preoccupations with food and weight. The Advanced Practice Nurse (APN) based in a primary practice setting given the correct tool should be able to detect high risk behaviors or tendencies toward eating disorders. It is important for the APN to possess a tool that is both convenient and practical, one which will be used daily during health histories and physical examinations. This author is concerned with the need to detect this disease early on as well as to screen for risk factors before hospitalization or peripheral nutrition is needed.

Purpose

The purpose of this scholarly project was to develop a screening method (tool) that could be easily implemented in the primary care setting to assess for risk factors and early development of eating disorders in females. This work focused on the adolescent population. This screening tool can be used with all adolescent females who arrive at the clinic for primary care such as family planning, sports physicals, annual physicals, pregnancy tests, or nutrition consults. The primary use of this tool is for screening high risk behaviors which may lead to eating disorders, but the tool may also be used for early detection. This screening tool should be used in conjunction

with a routine health and family history so that a patient's background information can be incorporated.

This tool was developed to: (1) assist that advanced practice nurse to determine more comprehensively the risk factors for eating disorders as well as the early onset of eating disorder(s). (2) specifically identify the types of questions to ask females regarding factors associated with eating disorders: developmental-psychological characteristics, family dynamics, body image, women's role in society, and media impact.

Conceptual Model

The conceptual model used for this scholarly project was the Women's Self-Definition in Adulthood Model developed by Peck in 1986. This model incorporated the impact of a woman's relationships and the timing of events in her life on her development. Peck (1986) suggests that within this model "is the assumption that a woman is self-reflective, capable of understanding her own behavior, and able to communicate her sense of self to another" (p. 277).

It is this author's belief that Peck was influenced by not only Gilligan's work in 1982, but also Chodorow's 1974 and 1978 work. Peck may not have been directly influenced by Chodorow, but because Gilligan incorporates much of her work with Chodorow it would be impossible to discount it. Gilligan and Chodorow express the belief that female development is based on women's ability to sustain relationships; Gilligan using the word "attachments". As stated before, male dominated society looks

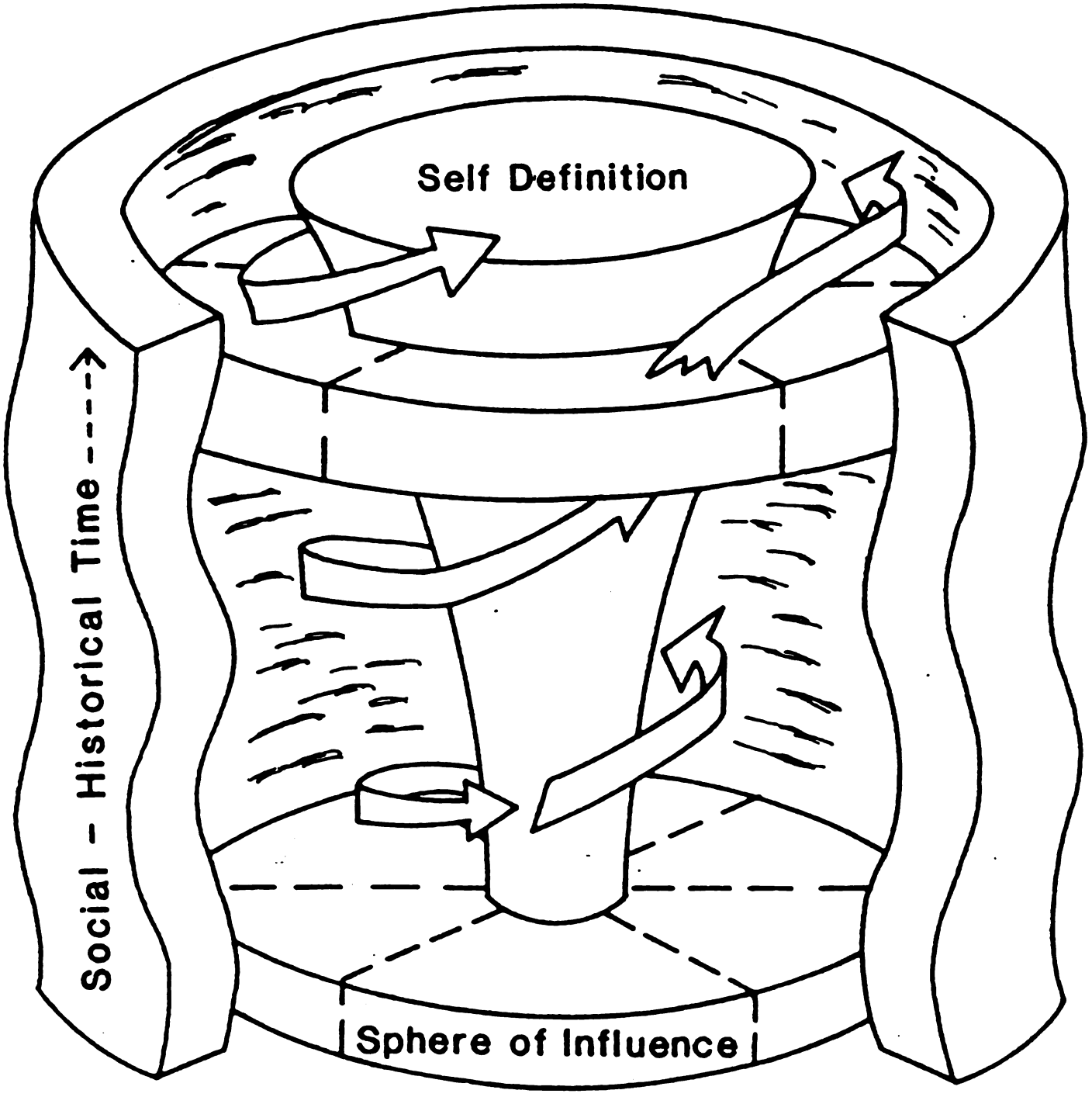

Figure 1 The Model: Women's Self-definition in Adulthood: From a Different Model? Peck,T.A. (1986). *Psychology of Women Quarterly*, **10**, 278.

more favorably on individualization that on attachment. Normal female development would then have to take into consideration how women perceive themselves (i.e. connected with others) and not how society perceives them in the male model (i.e. individualized) would.

This model, even though it is titled Women's Self-Definition in **Adulthood**, is appropriate to use when assessing for risk factors or early detection of eating disorders in adolescent females. It is this authors belief that an adolescent female has begun the hard task of self-definition as a young woman. she has begun her spiraling motion and all experiences will lead to how she defines herself. This model is flexible and appropriate specifically for women taking into account their roles and socialization.

This model is an excellent diagram for assisting in understanding a woman's self-definition. The model illustrates the importance of the association between "external events" and "internal experiences" which help to outline a woman's self-definition as an adult. This is an ongoing process which allows the woman to observe her self-awareness and knowledge gained" through connectedness, not through separateness...a woman's relationships can either foster of impede the clarity and certainty within which self-knowledge may develop" (p. 282). The model, shaped like a cylinder, has three main parts: social historical time dimension, sphere of influence, and self-definition (see figure 1).

Social-Historical Time Dimension

This layer of the model encompasses the social, emotional, and political aspects within which a woman defines herself. The wall of the social-historical layer is **flexible**. When the wall is loose, a woman will have more choices and freedom regarding roles and experiences, but when the wall is constricted she will have "fewer opportunities for role variation". This layer (social-historical) also includes the chronological time and physiological aging.

Sphere of Influence

This is the inner layer which consists of all the relationships a woman is involved in including spouse/lover, children, family, friends, and work peers. This model concentrates on a woman's "degree of satisfaction" and "sense of competence" instead of simply being employed in an outside job or working within the home. A woman defines herself in part through identity with a specific group. "The label 'sphere of influence' is used to indicate the bi-directions affect of relationships. On the one hand, there are ways in which a woman may exert influence upon others and thus receive confirmation of her impact in the world. On the other hand, relationships are strong influences upon the woman's sense of self" (Peck, 1986, p. 279).

Two characteristics of the sphere of influence are flexibility and elasticity. **Flexibility** implies that the sphere can "expand" to encompass new relationships as well as "contract" to hinder the development of new relationships. It also allows

the woman to "redistribute" her emotions regarding individual relationships which will permit her to accept outside support. **Elasticity** suggests the importance of individual relationships and their responsiveness to a "woman's changing needs, motivations, and self-definition. Elasticity is the primary way in which a woman can see effects of her own influence upon the people around her and therefore can see herself as having some control over the extent to which others' needs and expectations affect her behavior and her ability to differentiate others' concerns form her own" (p. 280).

A woman who achieves flexibility as well as "key elastic relationships" within her sphere of influence will possess a strong sense of "information about her personality, competence, and ability to function in the world". A woman who lacks flexibility and elasticity "attempt[s] to change her relationships and life circumstance and to risk the concomitant 'loss of self'" (p. 280).

Self-Definition

Self-definition, which is shown as the funnel-shaped force emanating from the sphere of influence, encompasses all of the social-historical aspects as well as flexibility and elasticity of the sphere of influence. It is unique to each woman because each woman will have her own individual agenda. As the funnel shape of the sphere widens, self-definition becomes more clear over time. This clarification of self-definition depends "upon the extent and quality of involvement in relationships the woman

experiences". The process of self-definition occurs by means of a spiral motion. These spiraling motions permit a woman to constantly observe her own personal growth which may effect her relationships. The spiral action allows the woman to "change subtly her degree of involvement in relationships as the prime factor in a clearer self-definition".

Modification of the original model

Integrating Eating Disorders within the Women's Self-Definition Model with incorporated Review of Literature

Integrating eating disorders within the model can easily be done. The young adolescent female is growing and beginning to define herself. Her social, emotional, and political self is developing, but is affected by outside forces: friends, family and others. She begins to see where she fits into specific groups yet she may not agree with all of their points of view.

She begins to develop emotional relationships outside her family, opening up, allowing herself to become vulnerable. She begins looking for satisfaction with herself and her life and not to others to make her decisions for her. She sees them as her decisions to make. She is easily influenced by peers and media. This author does not believe that in early adolescence a young woman has achieved a high level of flexibility and/or elasticity. She is still trying to find herself.

The following section will provide the Women's Self-Definition Model integrated with the concept of Eating Disorders with the review of literature incorporated into each specific

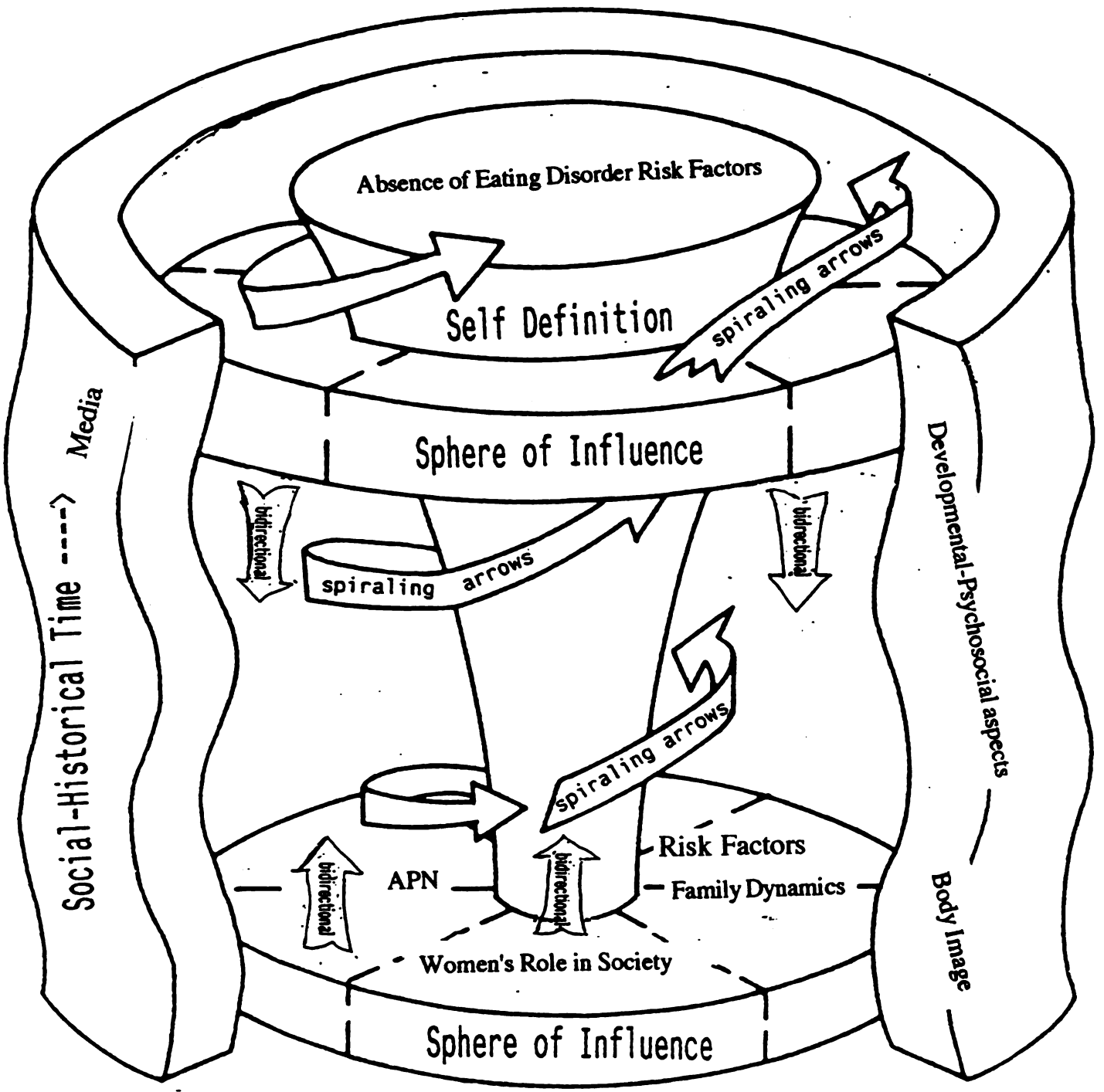

Figure 2 An adaptation of the model Women's Self-definition in Adulthood: From a Different Model? Peck, T.A. (1986), *Psychology of Women Quarterly*, **10**, 278; using the concepts of body image, developmental-psychosocial aspects,women's role in society, family dynamics, APN, and absence of eating disorder risk factors.

section of the model. At the end of each concept the conceptual definition for this scholarly project will be presents.

Social-Historical Time

body image

The concept of body image fits into the social-historical time dimension. The adolescent female is defining who she is; at the same time society is telling her that who she is depends on what she looks like. This pressure from society may change her perceptions of her body image.

Body image is clearly culturally motivated, meaning that not all cultures have the same idea of what the ideal body image is. Body image can be positive as well as negative and is affected by outside feedback. Rucker and Cash (1992) define body image using two subgroups: the perceptual body image and the attitudinal body image. The perceptual body image includes "estimation of one's body size, including perceptual distortion and discrepancy from idealized standards" (p. 291). The attitudinal body image comprises "affect, cognitions, and behaviors concerning one's size/appearance" (p. 291). McFarland and Baumann (1990) state that there is a correlation between body image, body satisfaction and self-image. In McFarland and Baumann's group sessions women stated the "when they were thinner, they liked themselves better, had more self-confidence and got along better with others (p. 80-1). Women who are satisfied with their body have a higher sense of self-concept.

Disturbances with body image have been experienced by more

American women. They have distorted feelings and perceptions of their body size; usually their perception is much different from their actual size or shape. Most often they find their thighs, arms, and legs to be "too fat"; while at same time their breasts are never large enough.

For purposes of this scholarly project body image was defined as (1) feelings and/or perceptions of body size, (2) effect of outside feedback, and (3) level of satisfaction with body shape/size.

developmental-psychological aspects

Developmental-psychological aspects also fit into the social-historical time dimension. The adolescent female is trying to make choices regarding the roles she will accept and the experiences she will have.

When examining the developmental aspects of an eating disorder "...anorexic patients often struggle for autonomy, identity, self-respect, and self-control. An additional dynamic may be their fear of rejection of adulthood" (Haller, 1992, p. 658). Anorexics and bulimics are usually perfectionists who tend to feel inadequate and guilty when they do not measure up to their own personal high standards. These standards are often unreasonable, irrational, and unattainable. "High-risk traits for both the bulimic and anorexic include a perfectionist attitude, a low frustration level, passive behavior, exaggerated guilt feelings, and unidentified or confused sexual role, lack of control over their life, and compulsive behaviors toward food and

weight control" (Winters, 1990, p. 25-6). They use the "eating disorder" as a coping skill to combat, avoid or even forget feelings such as anger, sadness, and anxiety. "To be less than perfect is to fail. They feel they must always please others, because acceptance is conditional on pleasing others and being perfect" (Buckner, 1991, p. 211).

Most often people who have anorexia or bulimia are secretive. They do not want people to see them consuming food. Anorexics will choose not to eat while bulimics will eat and then excuse themselves from the table to purge, returning to the table as if everything were normal. "A common pattern is that a preteen is found to be anorectic and is treated. However, the patient's perception regarding weight and the fear of uncontrollable weight gain remain. To continue to control food intake but reduce the pressure from parents or others, the patient changes to bulimic behavior. In the later stages of bulimia, some of the fear of uncontrollable weight gain becomes a secondary concern and the binge-purge ritual is used to cope with tension, stress, anxiety, and pressure. With this change, the patient begins to binge and purge when placed in an emotionally uncomfortable situation..." (Buckner, 1991, p. 209-10).

Many times anorexics and bulimics will become obsessed with food, how many calories they take in and how many they can get rid of. Many become addicted to exercise using running or aerobics to burn off the calories they took in. The fear of gaining weight overtakes their lives and they become obsessed

with he way they look. No matter how much weight they lose they still think they must lose 5 more pounds. "Patients with anorexia nervosa sometimes recover, only to find themselves in the grips of bulimia nervosa. A patient may have both disorders simultaneously, a particularly dangerous combination, since the consequences of bulimia nervosa are then superimposed on the compromised, underweight state of anorexia nervosa" (Waller, 1988, p. 52).

"Eating diseases are often interpreted as symptomatic of a neurotic need for control. But surely it is a sign of mental health to try to control something that controls you, especially if you are a young woman facing a massive industry fueled by the needs of an entire determined world order" (Wolf, 1991, p. 198). The anorexics conflict with eating is an emotional struggle for independence and self-control over her life. Anorexics believe that they are being judged on how well they control what they eat. This leads to anxiety when eating around people. "Performance results in either perfection or failure. The desire to be perfect and the demands placed on these patients to excel can come together in a deadly combination...because perfectionism and pleasing others are so much a part of the personality makeup of these patients..." (Buckner, 1991, p. 211).

For purposes of this study developmental-psychosocial aspects of eating disorders were defined as representing the following: (1) a need for control over ones life and surroundings, (2) perfectionism, and (3) unreasonable, irrational

high personal standards.

media

Media also fits into the social-historical time dimension because it can influence how an adolescent female sees herself within society. Many feel that the media has to take some of the responsibility for the increased number of women suffering from an eating disorder. "The media convey that women should be and do want to be thinner and more attractive than in earlier times. This emphasis on increasing thinness and a less curvaceous look is present in the men's magazines (e.g., Playboy) as well as women's magazines (e.g., Ladies Home Journal and Vogue)" (Fallon, 1994, p. 163).

In 1994 the average model or actress was 95 percent thinner than the average woman. Women consciously and/or unconsciously compare themselves to the women in the media. They look at a magazine, then in the mirror. They see a movie, then go home and worry about the movie popcorn they ate. "When a woman compares herself to the models before her visual field, she becomes painfully aware that her attractiveness is less than the model and is likely to give herself and others around her a low evaluation of attractiveness. These 'natural looking' characters can create unrealistic expectations for men as well" (Fallon, 1994, p. 164).

Peterson (1994) explains that many magazines use young girls who have not yet reached puberty as their models. Makeup and camera angles are used to make them look older. Only about 1% of

women look like the skinny models. Many girls still want to look like these models because they believe that is what they are supposed to look like. This can lead to dangerous dieting and possibly eating disorders.

For purposes of this scholarly project media (defined as magazines, television, movies, and newsprint) represented: (1) unrealistic body images of women, and (2) age inappropriate models.

Sphere of Influence

Women's Role in Society

The concept of women's role in society fits into the sphere of influence. This concept encompasses the outside relationships the adolescent female has in her sphere of influence. Some of these relationships will bring her strength and direction while others will be barriers to self-definition. It is important to remember that these relationships are bi-directional; this will allow her to redistribute (flexibility) her emotions to allow a supportive relationship.

The adolescent female may expand her sphere of influence to permit new relationships with people such as teachers, health care providers (APN), or clergy, which would be important in her development toward self-definition. As the adolescent female proceeds through her natural growth and development she will choose relationships that are receptive (elasticity) to her changing needs which will in turn change her self-definition. Once she acquires flexibility, as well as elasticity within her

relationships, she will possess a strong sense of her personality.

Todays society has a patriarchal focus. This means that anything associated with femininity has been "devalued" as well as "discounted". At the same time all things associated with masculinity have been raised to superior positions, leaving females in "subordinate" and "inferior" positions. This patriarchal culture stresses masculine characteristics such as "competition, superiority, and perfection" (Brownmiller, 1984; Freedman, 1986). This encourages females to deny and reject feminine aspects of themselves leaving them with a "sense of being fragmented". Many women who suffer from eating disorders tend to reject their femininity, finding disgust in their need for food, sex, and their inability to attain complete independence. They view the natural process of life as signs of "weakness, los of control, and inferiority". These same persons will struggle to attain masculine values and leave their feminine ones behind (McFarland & Baumann, 1990).

For purposes of this scholarly project women's role in society encompassed: (1) number and level of attachments, (2) self perception of one's own role, and (3) level of conflict with role in society.

family dynamics

The concept of family dynamics also fits into the sphere of influence. This concept encompasses all the "inside" relationships the adolescent female has in her sphere of

influence. These relationships, as with those in the women's role in society, are bi-directional allowing her to redistribute her emotions to allow more supportive relationships in.

Family plays an important role in the origin of anorexia or bulimia. "Family dynamics appear to be paramount in the development of anorexia nervosa..." (Smith, 1984, p. 758). Quite often these are typed "dysfunctional" families who experience problems with communications, boundary issues, rigid rules, difficulty with change, perfectionist standards, and may experience over-involvement or under-involvement. If the parents have a difficult time accepting their own body shape or have a bad body image it will make it difficult for them to be supportive and understanding of an adolescent who is dealing with feelings of inadequacy or imperfection.

Gender expectations within the family can also create an atmosphere to encourage eating disorders. Due to the socialization of men and women, quite often starting at birth a mother and father will treat male and female children differently. Parents described their baby girls with such adjectives as beautiful, soft, pretty, cute and delicate contrary to adjectives used for their baby boys who were strong, large featured, better coordinated and heartier (Rubin, J; Provenzano, R; & Luria, Z., 1974). Another study asked the question "what do you want your children to become?"; parents answered more often for their daughters that they wanted them to be attractive and have a good marriage (Henschel-Ambert, 1973). Studies have

revealed mothers are often more cautious with their daughter than with their sons (Broverman et al, 1970). Daughters are restricted in venturing out and exploring. Sons are provided with a greater physical distance to explore.

Smith (1984) provides some insight into family dynamics. The author explains that many times the families of anorexics are the "model of success", but most often the parents relationship is not what it appears. There is a "lack of fulfillment" in the parents relationship which leads the parents to become "over involved" and begin to have "excessive expectations" with the daughter's life. The daughter then feels that "she must be the model child in order to please her parents, earn their acceptance, meet their expectations, and make up for their personal disappointments and dissatisfactions with each other" (Smith, 1984, p. 758). "In a home where anorexia or bulimia is a problem, food has often been important. Frequently, the availability or absence of food is used to reward of punish behavior, which translates for the patient into terms of goodness or badness" (Buckner, 1991, p. 210).

For purposes of this scholarly project family dynamics encompassed the following: (1) gender expectations of each family member, (2) level of dysfunction within the family unit, (3) level of importance placed on food within the family, and (4) relationships between members of the family unit.

Self-Definition

anorexia nervosa and bulimia

Anorexia and bulimia are the concepts that fit into the dimension of self-definition. Adolescent females will develop anorexia and/or bulimia if their self-definition is not strong and positive. It will be each females agenda to develop or not to develop an eating disorder. Both anorexia and bulimia depend on what is happening to the adolescent female in the social-historical time dimension and the sphere of influence.

Anorexia nervosa is a disorder characterized by tremendous weight loss. The anorexic person uses starvation to control their weight. "...many patients with anorexia nervosa experience feelings of hunger that they pride themselves in resisting..." (Smith, 1984, p. 758). Women suffering from anorexia nervosa have an intense fear of becoming obese, which does not diminish as weight loss progresses. The anorexic person sees themselves as being "fat" even when they are emaciated. They refuse to maintain body weight over a minimal normal weight for their age and height. There is no known physical illness responsible for the up to 15% of original weight loss.

Health care providers agree that anorexia nervosa is a chronic condition which needs to be treated with a "team" approach over time. "Anorexia has a reported increased mortality rate of 5 percent with five year follow up (Yates, 1987, p. 740). Anorexia nervosa is less prevalent than bulimia nervosa, but many anorexic will have bulimic tendencies. Anorexia is more common

in women than men; less than 8 percent of all anorexics are male (Chernin, 1985, p. 13).

For purposes of this scholarly project anorexia was defined as encompassing: (1) a fear of becoming obese, (2) no present physical illness, and (3) inadequate nutritional intake.

Bulimia is the act of regular binging (eating large amounts of soft, easily swallowed high carbohydrate foods) and purging (self-induced vomiting, ipecac, diuretics and laxative use) to regulate weight gain and loss. "Bulimia...is an ancient custom recently rediscovered by an estimated 20 to 30 percent of the female college population" (Freedman, 1986, p. 160). Bulimics can consume up to 7000 calories in one sitting and then purge to get rid of all calories. Some bulimics do not use vomiting or laxatives but instead use starvation as their "purge". The bulimics weight can very often by normal or just above normal making it harder to identify. For purposes of this scholarly project bulimia was defined as the act of binging followed by self induced purging.

At the age of adolescence the funnel shape of self-definition is narrow, meaning females do not have a clear self-definition. The self-definition will clarify as she has more involvement with other women and shares her experiences with others. She will begin to understand how her external events and internal emotions respond to each other. The spiral action is this young females growing and maturing; allowing her to have new relationships, and experiences. As such, she forms her self-

definition.

An eating disorder can develop in a young female who has yet to have a stable self-definition. Many areas such as flexibility and elasticity can keep people within her circle of support as well as keep them out. She may be influenced by the media thinking that this is the self that she wants to be portrayed as. She may be lacking adequate female role models to support her.

As her self-definition becomes more clear she will have more self confidence in herself and be less likely to look toward an eating disorder as a way to define herself. She may be willing to take risk without fear of failure because she now understands that without failure one will never learn what the meaning of success is.

Summary of Integrating Eating Disorders within the Women's Self-Definition Model

The model of Women's Self-Definition in Adulthood provides the perfect framework to allow the APN the ability to assess adolescent females for risk factors and early detection of eating disorders. Using this model the APN may better understand the adolescent female's social-historical time dimension and sphere of influence as well as the level of self-definition which is attained. Knowing all of this will help the APN to assess the adolescent female's attitude toward eating disorders and health care providers. Once the APN uses the model to identify unhealthy relationships or high risk behaviors a plan can be developed to help make the adolescent female's self-definition

more positive. This model can be applied in practice as a framework for assessment, treatment and further research.

Critique of the Review of Literature

Reviewing the literature proved to be futile when seeking information regarding early detection and prevention of eating disorders. Research and non-research based articles written by physicians, as well as advanced practice nurses pertained to diagnosing eating disorders as well as treatment of eating disorders. Information regarding early detection was quite often ignored. Though several articles stated risk factors to look for, few delineated a plan for a detailed assessment. Plans for "early" prevention techniques for those persons with high tendencies toward eating disorders were also rare in the literature.

Much, if not all, of the literature regarding assessing eating disorders is written by "feminist" women who are writing to and for women. Many of these women have their degrees in social work, psychology and sociology. Many have held group encounters for women to come together and discuss their hardships with eating disorders. Other writers have had women write to them and tell their stories. Though this literature helps to understand anorexia and bulimia it does not help to diagnose them when they occur.

Project Development

Approach and Procedures

There are several tools that are specific to diagnosing

eating disorders, but there is no tool that integrates different aspects of eating disorders (e.g. EDE-Q, BSQ, EAT) into one singular tool for screening purposes. The tool to assess eating disorders for this scholarly project must be concise as well as easy to use.

The APN in a primary care setting must be able to screen these potential risk factors as well as determine if the patient will be compliant with a plan developed to alter anorexic and/or bulimic behavior. This tool will be used in a primary care setting either given by the APN or given to the patient and then reviewed with the patient by the APN. This is a tool to screen for eating disorders used as a primary prevention technique. It is not the intent of the author that only the tool should be used. This author recommends that the tool be used in conjunction with the routine health and family history. It will be important for the APN to use his/her assessment and interviewing skills to complete a more in-depth assessment. The screening tool will help screen for risk factors or early symptoms of eating disorders. If the patient does not have signs or symptoms of eating disorders the screening tool may be used as a way to open discussion and allow for teaching regarding eating disorders.

Making sure the patient is not answering the questions in the tool to be compliant with what they think the APN wants to hear is important. Anorexics and bulimics tend to strive for perfection and show passive behavior (Winters, 1990). They will

present as "models of success" (Smith, 1984). They will strive to please those they come in contact with. When the APN is using the tool with a female it will be very important to clarify any questions that reveal high risk behaviors.

If sufficient symptoms are uncovered using this screening tool in conjunction with the routine health and family history it will be the APN's responsibility to go directly to the diagnostic criteria using the DSM-IV. Actual diagnosis using the DSM-IV should not be done solely by the APN. There are no strict guidelines as to the exact number of symptoms which are to be uncovered by the APN using either the screening tool derived for this project of the DSM-IV. The APN must rely on his/her knowledge of eating disorders and clinical skills, but this does not mean that the APN cannot consult an expert to make a final decision.

When using this tool the APN must have a referral source for those clients who are diagnosed with anorexia or bulimia. Diagnosis can only be made using the standard criteria (DSM-IV), but the screening tool may clarify the need for further diagnosis with the DSM-IV tool. As stated earlier it is this author's belief that eating disorders must be treated with a team approach. Some patients will answer questions that lead to a diagnosis of <u>high risk</u> behaviors toward eating disorders. These patients will need to be monitored and a plan made for lifestyle changes. It will be important to encourage healthy living and eating habits. The APN must also role model healthy living and

eating habits.

It may be important to assess: (1) how the patient relates to difficult situations; and (2) what is triggering the "eating disorder" behavior. Once the trigger has been defined, then a plan must be made to help the patient deal with the "trigger" and the behavior that follows. Referrals to counseling, family therapy, and eating disorder clinics may also be appropriate.

Target Group

Adolescent females were chosen as the population of focus for this scholarly project screening tool for eating disorders. The adolescent female population was the obvious target group because they are the population at greatest risk. The adolescent females must be between the ages of 10 and 19. For purposes of this scholarly project the females must speak English as well as have the ability to read English. The specific adolescent population used for initial evaluation of the tool was found in an inner city high school based clinic. The population was 99% African-American and in a low to middle socioeconomic class. Each student had a signed parental consent form, required by the clinic before participating.

Tool Development

The tool was compiled for this scholarly project consisting of (1) a section asking questions regarding anorexic behavior, (2) a section asking questions regarding bulimic behavior, and (3) a section asking questions regarding body image disturbances. Each section is composed of five questions bringing the total to

15. Each section was scored individually then the total point value for each section was totaled. Each section was evaluated separately since each section identified specific risk factors.

The questions regarding anorexia were taken from the "The Eating Attitudes Test" developed by Drs. David Garner and Paul Garfinkel and used since 1979. No information regarding validity and reliability was found, though it was stated that it is a quick and reliable tool to determine if a person has symptoms of anorexia nervosa. The tool as a whole is 40 questions. This author has taken 5 of them to incorporate into this scholarly project. For each statement the person indicates which statement best describes them: (1) Always, (2) Very Often, (3) Often, (4) Sometimes, (5) Rarely, and (6) Never. If the person answers never to the first two questions it is a "red flag" for high risk anorexic behavior. It is important to remember that when using the tool different questions will be "red flagged" for different girls. This is done in part because the APN may take into account family history or social factors which will play an important role in high risk behaviors toward eating disorders. The following three questions when answered Always, Very Often, of Often should be followed up closely as high risk behavior (see appendix 2 for tool with specific questions).

The five questions chosen in this section help to screen for anorexic behavior. When assessing this section the APN is looking for answers which show behavior toward anorexia. The client may answer one or all five of the questions leaning toward

anorexia. The client does not have to answer all questions with anorexic answers. Even one question answered in an anorexic way needs follow up. An example of an anorexic way would be a female answering that she never enjoys eating with others. The questions asked are looking for how the client feels about eating with other people, regular menstrual periods, eating diet foods, giving much time and thought regarding food, and engaging in diet behavior. These are more prevalent red flag behaviors toward anorexia.

The next section regarding bulimia was taken from the "Bulimia Test" (BULIT) developed by Marcia Smith and Mark Thelen in 1984 to measure symptoms of bulimia. The tool has a total of 36 questions; five were chosen for this scholarly project based on the review of literature. No information regarding validity or reliability was found. Each statement has five possible responses each given a number value. All values are then totaled and the higher the number, the more serious the problem with bulimia.

The five questions in this section screen for bulimic behavior. The questions in this section assess for binging, purging, diet behavior, weight loss, and food within life. As stated before the client may answer one or all five in a bulimic pattern. These questions are most basic to bulimic behavior any answered in bulimic fashion must be followed up.

The final section regarding body image was taken from the "Ben-Tovim Walker Body Attitudes Questionnaire" developed by

David Ben-Tovim and M. Kay Walker in 1991 to measure a wide range of attitudes women hold regarding their bodies. The tool has 44 items with sub-scales to encompass six different aspects of body image. Each item has five possible responses: (1) Strongly Agree, (2) Agree, (3) Neutral, (4) Disagree, or (5) Strongly Disagree. Each response is given a value and following the completion of the questionnaire all values are then totaled, with higher values indicating lower body image.

The reliability of the Body Attitudes Questionnaire was assessed two ways. The first was the "split-half" reliability of the entire questionnaire. The Kuder Richardson correlation-coefficient was 0.92 which was stated to be suitably high. The second was the short-term test-retest reliability which was found to show a satisfactory degree of reliability. The convergent (criterion) and discriminant validity of the questionnaire was also examined. It was stated that because the Body Attitudes Questionnaire identified several "body related attitudes" which had not previously been measured it would be hard to establish convergent (criterion) validity, but it does appear that the BAQ "has good convergent validity with existing instruments: (Ben-Tovim, 1991, p. 780). Lastly, discriminant validity was examined to show that when using the BAQ the responses of anorexics would be different from non-anorexics. The Student's *t* test was used, "the responses of the anorexic patients to each of the subscales differed significantly from those of the community sample at the $P<0.0001$ level (Ben-Tovim, 1991, p. 781).

For purposes of this scholarly project five items have been selected from the Body Attitudes Questionnaire; one from each sub-scale (lower body fatness, strength/fitness, salience, disparagement, and feeling fat).

The five questions in this section screen for body image disturbances. The questions chosen from the above addressed sub-scales assess for regular weighing, level of fitness, time spent thinking about food, negative feelings regarding body shape, and feelings of being fat. These questions were chosen so that each sub-scale would be screened for, instead of using all questions from a specific sub-scale. It was the authors hope that the questions would be more well rounded with all sub-scales used (see appendix 2).

Rationale for Item Selection within the Screening Tool

The following table provides detailed information regarding the questions in the screening tool. This table provides the concept that the question was trying to identify. The table also details if the concept is a risk factor or a symptom, and finally provides the source in which the question was taken. The last section of the table provides referencing so the reader may go to the literature within the scholarly project to find evidence of the question's worth within the screening tool (see Table 1).

Pilot or Pretest

A pilot of the tool was not conducted for this scholarly project; instead the tool was given to the following persons for them to review. The tool was given to 8 adolescent females who

presented to a primary care setting (i.e. school-based-clinic) for family planning, sports physicals, annual physicals, pregnancy tests, or nutrition consults. They were approached in the waiting area or when they scheduled their appointment and asked if they were interested in reviewing a questionnaire regarding their eating and dieting habits.

After completing the answers, they spoke with the APN and discussed pertinent findings that needed to be evaluated, and questions they did not understand.

Table 1

Rationale for Item Selection within the Screening Tool

Concept	**Risk Factor Symptom**	**Item/ Question**	**Source**	**Reference**
Secretive eating	Risk Factor	1 (Sec. I)	Eating Attitudes	page 12
Amenorrhea	Symptom	2 (Sec. I)	""	page 5
Obsession with food	Risk Factor	3,4,5 (Sec. I) 5 (Sec. II) 3 (Sec. III)	"" BULIT Body Attitudes	page 13 "" ""
Eating binges	Risk Factor	1 (Sec. II)	BULIT	page 2, 19
Purging	Symptom	2 (Sec. II)	BULIT	""
Starvation	Risk Factor	3 (Sec. II)	BULIT	page 2, 18
Severe wt. loss	Symptom	4 (Sec. II)	BULIT	page 2, 18 & DSM-IV
Fear of becoming fat	Risk Factor	1,5 (Sec. III)	Body Attitudes	page 2
Body image distortion	Risk Factor	2,4 (Sec. III)	Body Attitudes	page 11

The tool was also given to a panel of 4 colleagues for review of content validity and usability. The panel consisted of 2 APNs in a family practice setting, 1 social worker, and 1 lay person. After the peer review the tool was modified as needed for validity, practicality, and easy usage.

Evaluation of Tool

To this authors dismay the review of the tool by the adolescent females was not as expected with regard to detecting risk factors or early detections of eating disorders. Eight adolescent females agreed to review the tool. Seven of the eight females stated that they did not have regular periods, but they pointed out that it was not due to their eating habits, but that they had never been regular. Five of the eight females stated that they eat diet foods, but this was because their parents or guardians purchased this food for their homes. An example would be fat free or low fat cookies. All eight females stated they engaged in diet behaviors, but defined diet behaviors as "skipped having breakfast," "ate a bag of chips for mid-morning snack," or "skipped lunch and stopped off at a fast food establishment before going home."

The second section which pertained to bulimic behavior was confusing to the adolescent females when they were using the scales. Seven of the eight females stated they ate large amounts over the weekend. It was hard to understand if they were actually binges. None of the females stated they intentionally vomited. All eight females said they had fasted, meaning they

had skipped meals, but all said they ate once during the day and preferred it to be fast food. None of the females stated they felt food controlled their lives. Many of the females did not understand what was meant by food controlling ones life.

The final section which pertained to body image proved to be useless with this group. All stated they did not weigh themselves regularly. One out of eight females stated she tried to keep fit, but the others did no regular exercise. All eight stated they did not spend much time thinking about food, unless the question pertained to decisions about where to go for lunch or dinner. None of the females said they felt bad about their shape. Two out of the eight females stated they felt fat at times, but none of the girls did anything about it, meaning they did not chose any diet behaviors.

As stated earlier the screening tool did not detect risk factors for eating disorders but it is this author's belief that the adolescent review of the tool provided the perfect situation to discuss prevention of eating disorders with young females. The adolescent review was able to increase communication regarding food and issues surrounding food. The adolescent review was most helpful in showing the author which questions were inappropriate for the adolescent population and questions that were missed entirely. The outcome of the review allowed the author to state that not only can this screening tool be used to screen for risk factors, but also can be used to initiate communication regarding eating disorders.

The peer review proved to be less effective than what was originally expected. It is the author's belief that the peers who reviewed the tool did not want to upset the author with any negative comments. The two APN's felt the tool was practical and easily used; one stated the questions "looked good". The social worker, who gave the best comments, said the scales were confusing and the author should try to keep to one scale. The social worker went on to comment that many of the questions needed to be more detailed, if possible giving examples, so the females would not guess as to what was being asked. Finally, the lay person thought there should be more questions.

Revision of the Screening Tool

After careful examination of the screening tool and comments made by the adolescents as well as the peer review, revisions to the tool were inevitable. Specific questions were removed and others were added. Many of the questions looking at the same concepts were dispersed throughout the tool so that the author would not be concerned with response set. The wording of questions was also changed so that the questions would be answered in the first person "I" making the questions more personal.

It is obvious that the concept of eating disorders fits within the chosen model perfectly therefore it is this author's belief that the model should be integrated with the tool. So that if someone were using the screening tool they could go directly to the model and identify the concepts and where each

fits within the adolescent's self-definition development.

In the first section the question regarding regular menstrual periods was removed; even though much of the literature as well as the DSM-IV uses it as a symptom marker for diagnosis of eating disorders, it is not appropriate for the adolescent population. Many adolescent females have not established a "regular" menstrual cycle. Because of this assessing for amenorrhea is not a valid symptom marker for <u>early</u> detection.

The questions regarding diet foods was also removed because too many adolescents have no choice in what they eat it their parents do the shopping. The next questions regarding giving too much time and thought to food was also removed because the question was confusing to the target population and therefore provided no answer. The question "I feel that food controls my life" was also removed for the same reasons, as was "I spend too much time thinking about food".

The last two questions removed were "I try to keep fit" and "If I catch sight of myself in a mirror or shop window it makes me feel bad about my shape" because the questions did not get at the concept of body image. The adolescent who completed the pilot tool felt almost ambivalent about the questions.

Rationale for Item Selection of Revised Screening Tool

The following table provides some rationale for the additional questions within the revised screening too. This table presents the same information as the previous rationale table. It is important to remember when looking at this table one should be able

to look at the model and the model's concepts within the screening tool (see Table 2).

Future Evaluation of the Tool

A future review is needed with a diverse population. The population used in this review was 99% African-American adolescent females. This author would also like to peer review, this time providing the tool to two APN's working in teen health clinics. This author wishes to see if APN's working in adolescent settings are more knowledgeable regarding screening for eating disorders than those working in family practice settings, which may allow them to make more recommendations toward this author's tool.

It will also be necessary to provide the revised tool to an expert in the field of eating disorders. This expert could verify content validity. This author has begun to establish content validity by documenting the literature which represents the concepts and questions.

Another pilot test must be done. It will be important to assess for internal consistency to document reliability. This may be done by assessing for consistency with answers to all questions examining the same concept through coefficient alpha reliability testing. Another way this author may show reliability is to have another practitioner use the tool with similar populations and see if their results are the same. The revised tool's stability must also be assessed by using the tool over a period of time which will help to prove its reliability.

Table 2

Rationale for Item Selection of Revised Screening Tool

Concept	Risk Factor/ Symptom	Item/ Question	Source	Reference
Developmental/Psychological & Women's Role in Society				
Perfectionism	Risk Factor	3	Present Author	page 12
Body image	Risk Factor	5	Present Author	page 11
Family Dynamics				
Family disfunction	Risk Factor	10,13,16	Present Author	page 16,17
Body Image				
Fear of becoming fat	Risk Factor	12, 15	Body Attitudes	page 2
Body image	Risk Factor	14	Present Author	page 11
Media Impact & Eating Disorder Behaviors				
Secretive eating	Risk Factor	1	Eating Attitudes	page 12
High risk diet behavior	Risk Factor	2, 11	Present Author	page 2,19
		7	BULIT	page 2,18
Binging/ purging	Symptom	6,8	BULIT	page 2,19
Severe wt. loss	Symptom	9	BULIT	page 2, 18 & DSM-IV

Implications for the Advanced Practice Nurse

Since the APN working in a primary care site has the specific task of health promotion and illness prevention, it is the perfect time to screen for risky behaviors which can lead to poor health. The APN is in a position to screen for eating disorder behavior as well as make diagnoses early during several visits; example: history and physical exams, family planning exams, sports physical exams, and acute care visits. This author believes that the screening tool should be used with all adolescent females who attend the clinic for primary care visits.

The APN will determine if the patient has risk factors for eating disorders or not. For those adolescent females who do not have risk factors, the APN is able to open discussion regarding eating disorders as well as nutrition. Using the tool in this manner will provide the adolescent with knowledge regarding eating disorders and hopefully prevent onset of the disease.

The APN is in a position to provide education regarding eating disorder behavior to small groups within a specific practice or health system. The APN could lecture or provide guest lecturers, give out pamphlets, allow survivors of anorexia and bulimia to speak, as well as run question and answer round tables. This would allow the APN to reach many adolescent females at one time instead of only focusing on the one on one relationship. For-example, the tool might be given to a group of adolescent females and then their results could be discussed. This author recommends that in this type of situation each female

keep her completed tool and the APN will review possible answers. This will provide each adolescent girl with confidentiality regarding her test scores.

This author firmly believes that before the APN begins using this tool to assess for eating disorder behavior it will be important that a specific plan of care be in place so that if a diagnosis of an eating disorder seems likely specific referral services will already be in place. As stated throughout this scholarly project this author believes that the diagnosis and treatment of anorexia and/or bulimia must be done through a team approach. A diagnosis of an eating disorder should not be made using the revised screening tool. The APN must go to the DSM-IV.

It will be important to have all team members identified so time is not wasted finding colleagues willing to participate in the treatment plan. It might also be wise to identify different team members who cover specific insurance companies so the client is not left with a bill because they did not use their circle of health care providers.

Just as important will be the development of a specific plan for interventions. This is to be used when an adolescent female is not diagnosed with an eating disorder but is showing risky behavior toward eating disorders when using the revised screening tool. These interventions should be within the APN's scope of practice. It is preferable that there is written documentation of these interventions so follow up by other practitioners can be easily done. This author believes that each intervention will be

geared specifically toward each individual adolescent, but there must be basic interventions to follow; such as routine follow up, diet diaries, possible family discussions, and monitoring of weight.

It is this author's belief that once the tool has been revised and refined it has the potential for broader application. It may have a use for screening females between the ages of 20 and 30, possibly older. Anorexia and bulimia do not stop at age 19; there may in fact be a population of females suffering from eating disorders going undiagnosed due to lack of screening techniques.

It will be hard to combat the media with regard to their influences and images of women, but it is also this author's belief that something should be done. A small step, but one that all APN's could participate in is to refuse to purchase such magazines for their office waiting rooms. APN's should look through magazines and seek out ones who chose to portray women in all shapes, sizes, ages, and races. APN's should also encourage clientele to do the same thing with the magazines they choose for their homes.

As we increase our knowledge regarding eating disorders and the freedom to speak out about experiences with eating disorders becomes more prevalent; females will feel more at ease to raising questions regarding eating disorders. Practitioners will be more conscious regarding eating disorder behavior and feel comfortable making pertinent diagnoses. Society must raise the question:

"What role models do we want for our future generations?" Women must demand that they be measured by what they can do and not what they look like.

Appendix 1

The DSM-IV Criteria for Anorexia Nervosa

A. Refusal to maintain body weight over a minimal normal weight for age and height, e.g., weight loss leading to maintenance of body weight 15% below that expected; failure to make expected weight gain during a period of growth, leading to body weight 15% below that expected.
B. Intense fear of gaining weight or becoming fat, even though underweight.
C. Disturbance in the way in which one's body weight, size, or shape is experience, e.g., the person claims to "feel fat" even when emaciated, believes that one area of body is "too fat" even when obviously underweight.
D. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary amenorrhea).

The DSM-IV Criteria for Bulimia

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).
B. A feeling of lack of control over eating behavior during the eating binges.
C. The person regularly engages in either self-induced vomiting, use of laxative or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.
D. A minimum average of two binge eating episodes a week for at least three months.
E. Persistent over concern with body shape and weight.

[From the International Journal of Eating Disorders, Vol. 11, No. 4, 301-304, (1992)].

Appendix 2

Eating Disorder Risk Factor Assessment Tool

Section I

Indicate which statement best describes you using one of the following: "Always", "Very Often", "Often", "Sometimes", "Rarely", or "Never".

(1) I like eating with other people

(2) I have regular menstrual periods

(3) I eat diet foods

(4) I give too much time and thought to food

(5) I engage in diet behavior

Section II

Answer each question by circling the appropriate letter.

(1) Do you ever eat uncontrollably to the point of stuffing yourself (i.e., going on eating binges)?

A. Once a month or less (never)

B. 2-3 times a month

C. Once or twice a week

D. 3-6 times a week

E. Once a day or more

(2) How often do you intentionally vomit after eating?

A. 2 or more times a week

B. Once a week

C. 2-3 times a month

D. Once a month

E. Less than once a month (or never)

(3) I have tried to lose weight by fasting or going on 'crash' diets.

A. Not in the past year

B. Once in the past year

C. 2-3 times in the past year

D. 4-5 times in the past year

E. More than 5 times in the past year

(4) What is the most weight you've ever lost in 1 month?

A. Over 20 pounds

B. 12-20 pounds

C. 8-11 pounds

D. 4-7 pounds

E. Less than 4 pounds

(5) I feel that food controls my life.

1. Always

2. Almost always

3. Frequently

4. Sometimes

5. Seldom or never

Section III

Indicate if you "Strongly agree", "Agree", "Neutral", "Disagree", or "Strongly disagree" for each question.

(1) I like to weigh myself regularly

(2) I try and keep fit

(3) I spend too much time thinking about food

(4) If I catch sight of myself in a mirror or shop window it makes me feel bad about my shape

(5) I often feel fat

Appendix 3

Revised Eating Disorder Risk Factor Assessment Tool

(1) I like eating with other people. (Circle one)

Always Very Often Often Sometimes Rarely Never

(2) I use or have used diet pills. (Circle one)

Always Very Often Often Sometimes Rarely Never

(3) I am a perfectionist. (Circle one)

Always Very Often Often Sometimes Rarely Never

(4) I set very high goals for myself. (Circle one)

Always Very Often Often Sometimes Rarely Never

(5) I fantasize about being thinner. (Circle one)

Always Very Often Often Sometimes Rarely Never

(6) I eat uncontrollably to the point of stuffing myself--eating binges. (Circle one)

a. Once a month of less (never)
b. 2-3 times a month
c. Once or twice a week
d. 3-6 times a week
e. Once a day or more

(7) I have tried to lose weight by fasting or going on 'crash' diets. (Circle one)

a. Not in the past year
b. Once in the past year
c. 2-3 times in the past year
d. 4-5 times in the past year
e. More than 5 times in the past year

(8) I have intentionally vomited after eating. (Circle one)

a. 2 or more times a week
b. Once a week
c. 2-3 times a month
d. Once a month
e. Less than once a month (or never)

(9) The most weight I have ever lost in 1 month is... (Circle one)

a. Over 20 pounds
b. 12-20 pounds
c. 8-11 pounds
d. 4-7 pounds
e. Less than 4 pounds

(10) I have trouble talking with my parents. (Circle one)

Strongly Agree Agree Neutral Disagree Strongly Disagree

(11) I have used laxatives to rid myself of food I ate. (Circle one)

Always Very Often Often Sometimes Rarely Never

(12) I like to weigh myself regularly. (Circle one)

Strongly Agree Agree Neutral Disagree Strongly Disagree

(13) My parents put pressure on me to be perfect. (Circle one)

Strongly Agree Agree Neutral Disagree Strongly Disagree

(14) I avoid allowing others to see my body without clothes on. (Circle one)

Strongly Agree Agree Neutral Disagree Strongly Disagree

(15) I often feel fat. (Circle one)

Strongly Agree Agree Neutral Disagree Strongly Disagree

(16) My parents are always invading my privacy. (Circle one)

Strongly Agree Agree Neutral Disagree Strongly Disagree

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