Living with Anorexia: A Case Report

Robin Connor

Carroll College, Helena, MT

Follow this and additional works at: https://scholars.carroll.edu/nursing_theses

Part of the Nursing Commons

Recommended Citation


https://scholars.carroll.edu/nursing_theses/42

This Thesis is brought to you for free and open access by the Nursing at Carroll Scholars. It has been accepted for inclusion in Nursing Undergraduate Theses by an authorized administrator of Carroll Scholars. For more information, please contact tkratz@carroll.edu.
Living with Anorexia:
A Case Report
Robin C. Connor
Carroll College
This thesis for honors recognition has been approved for the Department of Nursing.
Dedication

For my parents, who have encouraged and supported me every step of the way.

Without your faith in me, I would have never found faith in myself.

Thank you for your continued love and inspiration.

And for Joni Walton,

you have been a constant source of motivation and support.

I thank you for all the help with this endeavor.
Table of Contents

DEDICATION .................................................................................................................. 3
ABSTRACT ....................................................................................................................... 6
CHAPTER I ....................................................................................................................... 7
SCOPe OF EATING DISORDERS .................................................................................... 7
  DIAGNOSTIC CHARACTERISTICS .............................................................................. 7
    Anorexia nervosa ........................................................................................................ 7
    Bulimia nervosa ......................................................................................................... 7
  ETIOLOGY AND RISK FACTORS ............................................................................... 8
  SIGNS AND SYMPTOMS ............................................................................................. 9
  IMPACT ON INDIVIDUALS WITH EATING DISORDERS ............................................... 10
    Physical impact ......................................................................................................... 10
    Social impact ........................................................................................................... 10
    Financial impact ...................................................................................................... 11
  THEORETICAL FRAMEWORK FOR NURSING PRACTICE .......................................... 11

CHAPTER II .................................................................................................................... 13
REVIEW OF LITERATURE ............................................................................................. 13
  PREVENTION IN EATING DISORDERS ....................................................................... 13
    The thin ideal ........................................................................................................... 13
    Education .................................................................................................................. 14
    Prevention programs ............................................................................................... 15
  UNDERSTANDING THE ILLNESS THROUGH PERSONAL PERSPECTIVES .................. 15
    Bulimia nervosa ...................................................................................................... 16
    Anorexia nervosa .................................................................................................... 17
  TREATMENT .................................................................................................................. 18
    Subjective accounts ................................................................................................. 18
    Multidisciplinary approach ...................................................................................... 19
    Parental involvement ............................................................................................... 19
    Social and cultural considerations ......................................................................... 20
  NURSING ROLE .......................................................................................................... 20
    The therapeutic relationship .................................................................................... 20
    Nursing education .................................................................................................... 22

CHAPTER III ................................................................................................................... 24
METHODOLOGY ............................................................................................................. 24
  DESIGN ......................................................................................................................... 24
    Phenomenology method .......................................................................................... 24
    Avoiding bias .......................................................................................................... 24
  SAMPLE ....................................................................................................................... 25
  PROCEDURE ............................................................................................................... 25
  ANALYSIS ................................................................................................................... 26
  PARTICIPANT DEMOGRAPHICS ............................................................................... 26

CHAPTER IV .................................................................................................................. 28
RESULTS ......................................................................................................................... 28
  Theme 1: STRIVING FOR PERFECTION ...................................................................... 28
  Theme 2: SUCCEEDING IN HER PROFESSION ............................................................ 29
  Theme 3: CONDITIONING YOURSELF TO BELIEVE YOU ARE FAT ............................ 29
  Theme 4: LIVING A SKINNY LIFESTYLE ...................................................................... 30
CHAPTER V ............................................................................................................................... 32
DISCUSSION ............................................................................................................................. 32
   BODY IMAGE AND SELF-CONCEPT .................................................................................. 32
   PERFECTIONISM ............................................................................................................... 33
   OUTSIDE INFLUENCES ................................................................................................. 34
   FUTURE RESEARCH ..................................................................................................... 34
   CONCLUSION .................................................................................................................. 35
REFERENCES .......................................................................................................................... 36
Abstract

Eating disorders have recently become one of the most prevalent diseases affecting adolescent girls. The National Eating Disorder Association estimates that 10 million females in the United States have an eating disorder; however due to the stigma surrounding the condition, many more people likely suffer from eating disorders that have not been diagnosed, or treated. By recognizing the many risk factors that predispose young women to the development of an eating disorder, nurses can play a vital role in preventing this condition. The purpose of this study is to gain an understanding of the lived experience of those with eating disorders. Phenomenology was used as a research method to interview one adult woman with anorexia nervosa. In order to analyze data from the interview, Giorgi’s method was utilized. Four major themes were identified after analyzing the data. These themes included striving for perfection, succeeding in her profession, conditioning herself to believe she was fat, and living a skinny lifestyle. By examining these themes, one gains a better understanding of the experiences faced when living with an eating disorder.
Living with Anorexia

Chapter I

Scope of Eating Disorders

Eating disorders have recently become one of the most prevalent diseases affecting adolescent girls. The National Eating Disorder Association (NEDA) estimates that 10 million females in the United States have an eating disorder; however due to the stigma surrounding the condition, many more people likely suffer from eating disorders that have not been diagnosed, or treated. Those at the highest risk for eating disorders are females between the ages of 15 and 24. Within this age group, eating disorders are the number one cause of mortality in females, outnumbering all other causes of death combined (NEDA, 2002). By recognizing the many risk factors that predispose young women to the development of an eating disorder, nurses can play a vital role in preventing this condition.

Diagnostic Characteristics

Anorexia nervosa. Certain factors must be present for one to be diagnosed with anorexia nervosa. For diagnostic purposes, those with anorexia nervosa must have a body weight under what is acceptable for age and height, and the absence of three consecutive menstrual cycles. In addition, individuals must display an intense fear of gaining weight despite the fact that they are underweight, use body weight to self-evaluate, and have a disturbed way of viewing body shape or weight (Boyd, 2005).

Bulimia nervosa. The diagnostic criteria for bulimia nervosa include repeated binge eating episodes which are characterized as “[e]ating in a discrete period of time an amount larger than most people would eat during a similar period of time and under
similar circumstances; sense of lack of control over eating during the episode” (Boyd, 2005, p. 513). After periods of binge eating, compensatory behavior such as self-induced vomiting, laxative use, or excessive exercise must be present. These binging and purging behaviors must be present at least twice a week for three months. In addition, self-evaluation must be overly influenced by body weight (Boyd, 2005).

Etiology and Risk Factors

There is no one cause for eating disorders; however, many factors can place one at risk for developing an eating disorder. One of the main risk factors for eating disorders is gender. Females have a much higher chance for developing anorexia nervosa or bulimia nervosa. Out of every 10 people with an eating disorder, nine are female (NEDA, 2002). Another risk factor is ethnicity. Caucasians from industrialized countries are much more inclined to develop an eating disorder compared to Asians, Native Americans, and African Americans. Additionally, recent research has found that a genetic link may exist in the risk for eating disorders; however, these findings are still immature (Academy for Eating Disorders [AED], 2006). Although genetic information may be inconclusive at this time, there have been findings to indicate a familial link in eating disorders. The findings in a study performed by Francis and Birch (2005) indicated that mothers who made attempts to influence their daughters’ weight and eating may have led to restrictive eating behaviors and placed the daughters at risk for eating disorders.

In addition to these risk factors, certain behaviors can increase the likelihood for development of an eating disorder. Personality characteristics such as low self-esteem and perfectionism are traits found in many individuals that have been diagnosed with eating disorders. Those with these personality traits may use eating disorders to distract
focus from problems that are too painful to deal with (National Alliance on Mental Illness [NAMI], 2003). Other characteristics that increase the likelihood of developing an eating disorder include the following: preoccupation with weight and body shape, history of dieting, other psychiatric diagnoses such as depression and anxiety, and a history of childhood difficulties such as sexual abuse (AED, 2006).

 Signs and Symptoms

According to Harris, Eberly, and Cumella (2004) those with eating disorders may present with a variety of physiologic and psychological signs and symptoms. With anorexia nervosa the physiological signs and symptoms include the following: weight loss of 15% of original weight, cold intolerance, irregular or absent menstrual periods, dry skin, brittle nails, slow heart rate, cardiac arrhythmias related to electrolyte imbalances, malnutrition, dehydration, and low fasting blood glucose levels. Unlike anorexia nervosa, those suffering from bulimia nervosa may not have weight loss. Individuals with bulimia nervosa may have the following: sores on their hands, enlarged parotid glands, electrolyte imbalances, arrhythmias, heartburn, and blood in their vomit (Harris et al.).

In addition to physiological signs and symptoms of anorexia nervosa and bulimia nervosa, many psychological factors indicate an eating disorder. Those with anorexia nervosa become preoccupied with food. These individuals may have odd eating habits such as cutting their food into little bits, making a display of cooking for others and/or making excuses regarding eating habits (National Institute of Mental Health [NIMH], 2006). Bulimia nervosa may have similar psychological signs and symptoms. In addition
those with bulimia nervosa may avoid eating with others, express guilt after eating, and withdraw from friends and family (NEDA, 2002).

**Impact on Individuals with Eating Disorders**

*Physical impact.* Those with eating disorders experience many adverse physical effects or even death. An estimated six percent of those with anorexia nervosa, and one percent of those with bulimia nervosa will die from complications of their disorder (Harris et al., 2004). Physical complications of anorexia nervosa are related to starvation and include the following: anemia, cardiovascular problems due to electrolyte imbalances, and osteoporosis. Similarly, complications related to bulimia nervosa also involve cardiac arrhythmias. Other physical complications of bulimia nervosa are esophageal tears and rupture of the stomach due to repeated vomiting. In addition, those with bulimia nervosa may have an assortment of dental problems related to enamel erosion (AED, 2006).

*Social impact.* Those suffering from eating disorders are preoccupied with food and have an intense fear of gaining weight; therefore individuals may have a difficult time performing their daily routine. Negative effects may include isolation from friends and family, decreased job performance, and inability to maintain professional and social relationships. Often eating disorders co-occur with other psychological disorders such as depression and anxiety, further affecting the individual’s quality of life. The profound social and psychological implications affecting those with eating disorders is a high treatment priority given that one of the leading causes of death in patients with eating disorders is suicide (AED, 2006).
Financial impact. Although eating disorders are the leading cause of death in females ages 15-24, the funding for treatment and research is relatively low compared to other diseases. Eating disorders are almost twice as prevalent as Alzheimer's disease; however funding for eating disorder research is approximately 75% less than funding for Alzheimer's (NEDA, 2002). Furthermore, eating disorders occur more frequently than schizophrenia; however research funding for eating disorders is approximately $1.20 per affected individual compared to $159 per clients with schizophrenia (NEDA, 2002).

Theoretical Framework for Nursing Practice

In examining the nursing diagnosis of disturbed body image, a nursing theory that takes the individual as a whole into account is necessary. Many theories of nursing base their framework on a community or disease process, rather than on individual clients. Rosemarie Parse’s theory of human becoming is unlike many nursing theories in that the focus lies on the individual as a spiritual entity rather than on a bio-medical premise (Cody, 2006). Parse’s theory concentrates on the perspectives of individuals, rather than a disease or condition affecting a population as a whole. Psychiatric conditions such as eating disorders are highly individualized; therefore attention in treatment needs to focus on each client in order to be successful (Cody, 2006).

The theory of human becoming contains three themes. The first of these themes is meaning. Meaning is described as individuals using self-expression to live the values they deem real, in a way they choose. The second theme is rhythmicity which focuses on living moment-to-moment, meeting opportunities as well as limitations when encountering others. The final theme is transcendence which means pushing oneself
beyond the present to develop a personal path. These themes guide individuals to develop hope and control (Cody, 2006).

The intentions of human becoming are based on the theory that people must participate in living life day-to-day and developing an individualized route to an ultimate goal. Human becoming provides the framework for individuals to look inside themselves, and discover what they believe to be important and valuable in their own lives. This form of self-exploration can apply to those with eating disorders. In order to be successful in treatment, eating disorder sufferers must explore their body image, as well as other psychosocial aspects of themselves. Nursing theories that have a bio-medical basis would provide little aid in the treatment of eating disorders. A more holistic based theory, such as Rosemarie Parse’s theory of human becoming, is necessary when considering complex physiological conditions like eating disorders (Cody, 2006).
Chapter II

Review of Literature

Eating disorders are the most prevalent psychiatric illness in adolescent females. The NEDA (2002) estimates that up to 80% of females, ages 15 and 24, will suffer from distorted thoughts regarding food and body image. As healthcare providers, it is necessary to attain knowledge and seek education regarding the signs, symptoms, and early risk factors associated with disturbed eating habits. Additionally, healthcare providers need to take strides to increase the population’s awareness of eating disorders as a means for prevention and early recognition.

Prevention in Eating Disorders

*The thin ideal.* The thin ideal in Western society has been correlated with individuals’ preoccupation with body weight and shape. Concern with body weight and shape has proven to be a leading risk factor for the development of eating disorders (AED, 2006).

A study conducted by Warren, Gleaves, Cepeda-Benito, Fernandez, and Rodriguez-Ruíz (2005) examined the awareness and internalization of the thin ideal. The purpose of the study was to consider the potential for ethnicity to protect against the internalization of the thin ideal, as well as evaluate the sociocultural model of disordered eating. The sample included 103 Mexican American females, 101 European American females, and 115 Spanish females. The participants completed the Sociocultural Attitudes Towards Appearance Questionnaire-Revised and the Body Shape Questionnaire. The study found that Mexican American females were less likely than the European American and Spanish females to internalize the thin ideal. Additionally, the European Americans
had more overall body dissatisfaction compared to the Mexican American and Spanish subjects. These findings are important for clinicians when examining prevention measures for females at risk for disturbed eating behaviors. The results of the study suggest, "For Western culture to prevent the development of body dissatisfaction, it should strongly denounce the ultrathin ideal propagated by current mainstream" (Warren et al., 2005, p. 247).

Limitations of this study include the cross-sectional nature of the data, which does not allow for casual presumptions. Furthermore, the study does not analyze the degree to which individuals associate with their ethnic group. Results may have been affected based on strong versus weak identification with participants’ respective cultures (Warren, et al., 2005).

A similar study that evaluated the thin body preoccupation in young women examined a culturally diverse sample of females, grades six to nine in school. The findings of the study emphasized the role of social pressure and culture as risk factors in the development of eating disorders in young females. Conclusions of the study indicated reduction in social, cultural, and other sources of thin body preoccupation may be necessary in preventing eating disorders (McKnight Investigators, 2003).

*Education.* Prevention of eating disorders requires those at risk to be given tools through education to discredit the current societal image of the perfect body, and adopt healthy eating and exercise behaviors. Matusek, Wendt, and Wiseman (2004) explored two separate approaches in education to prevent eating disorders. The first method used cognitive dissonance focused on deconstruction of the thin-ideal (DTI), while the second method used psychoeducation to provide subjects with information about healthy eating
Anorexia
and exercise habits (HB). When compared to the control group, those that participated in the DTI and HB educational programs reported an improvement in thin-ideal internalization, body image, and eating habits. Education proves to be a valuable resource in the prevention of eating disorders (Matusek et al., 2004).

Prevention programs. The development of useful and cost effective measures that can be generalized to a large population is vital for successful prevention of eating disorders. A prevention program called Food, Mood, and Attitude (FMA) was examined in a study by Franko et al. (2005). FMA, a CD-ROM program, was developed to reduce risk factors for eating disorders. The program presented information of the ideal body that has been portrayed in the media over the past five decades. The participant served as a peer counselor to three females with different abnormal eating and exercise problems. At the end of the program, the user was given ideas on how to resist the current thin ideal. After completion of the program, both at-risk and low-risk subjects reported an increase in their level of knowledge concerning weight and shape concerns and risk factors for eating disorders. FMA proved to be a cost-effective, time-efficient resource for females that may be at risk for eating disorders. Furthermore, FMA was helpful in increasing eating disorder awareness in females at low risk for eating disorders (Franko et al., 2005).

Understanding the Illness through Personal Perspectives

Much research has been done regarding the personal experiences of women with active eating disorders, as well as those in recovery. In order to adequately address the issue of eating disorders, subjective experiences need to be examined. This point is examined in a qualitative study by Broussard (2005), “Understanding the experience of
living with this disorder is the first step in providing sensitive care for people who suffer from eating disorders” (Broussard, 2005, p. 44).

*Bulimia nervosa.* Broussard (2005) attempted to interpret and understand the perspectives of women with bulimia nervosa. Participants included 13 women between the ages of 18 and 36 years old who reported being actively bulimic. Duration of the illness was 1 to 23 years. The researcher gathered data by interviews and a demographic questionnaire.

Four major themes emerged upon analysis of the personal accounts of living with bulimia: isolating self, living in fear, being at war with the mind, and pacifying the brain. Participants in the study reported making strides to maintain their abnormal eating behaviors, while attempting to have the appearance of a normal life. By isolating themselves from friends and family, those with the disorder were better able to hide their illness. In addition to feeling isolated, subjects reported living in constant fear of gaining weight and becoming fat. One subject stated, “I’m afraid that if I were to gain weight my level of self-love would just keep decreasing” (Broussard, 2005, p. 47). Participants also felt they were at war with their mind. Many of the subjects took strides to rationalize their behavior, minimizing the severity of their condition. Those interviewed reported feeling possessed by their illness at times. A final theme presented during the study was pacifying the brain. The women expressed overwhelming feelings to eat a lot, followed by an even more overpowering need to rid themselves of the food consumed and the feeling of fullness. The participants reported a loss of control when it came to food and profound feelings of disappointment in themselves after a binge.
These four themes illustrate the internal conflicts that those suffering from bulimia face. The subjects are in a constant struggle to uphold their destructive eating practices while maintaining a seemingly normal appearance in their day-to-day lives. Strengths of this study include a strong range in the length of illness, a wide participant age range and ethnic background, and open-endedness of the data generation method. Limitations to the study were a small participant group who were selected from a limited setting (Broussard, 2005).

Anorexia nervosa. Another personal account of living with an eating disorder is described in a case study in which an adolescent female reflects on her personal journey with the illness. Control became a constant theme with the young woman. She expressed having the belief that her weight was something she had ultimate control over. A similar account of this issue of control is noted by another individual suffering from anorexia, “After awhile, eating becomes a battle you can win, unlike all the other impossible battles” (Keeley, 2005, p. 145). The young woman confessed seeing her family and friends as the enemy, hindering her from achieving her goals. Furthermore, the individual felt the rest of the world was against her, simply trying to get her to eat, and ultimately fail at the game she had invented for herself. After suffering from anorexia for over a year, the subject described her skinniness and the eating disorder as the key parts of her identity. The young woman at hand was ultimately able to recover from anorexia, however not without considerable physical and emotional loss (Hughes, 2004).

Evidently those that face the struggles associated with eating disorders have many internal conflicts, and are constantly fighting a battle with themselves. Additionally,
individuals with eating disorders feel compelled to maintain the appearance of a normal life, which appears to be vastly challenging at times.

*Treatment*

*Subjective accounts.* No universally accepted treatment of eating disorders exists at this point. For this reason, it is helpful to examine aspects of recovery that have been helpful for individual clients with eating disorders.

Tozzi, Sullivan, Fear, McKenzie, and Bulik (2003) examined the personal perspective of females that have recovered from anorexia nervosa. In their study Tozzi et al. assessed the subjective experiences of women who had been diagnosed with anorexia nervosa, focusing on factors that contributed to their recovery. The sample included 69 women with a history of anorexia nervosa. Information was collected through extensive interviews with the subjects. The interviews included a standardized and structured diagnostic interview, as well as an interview geared towards the subjects’ personal opinions concerning their recovery from anorexia nervosa. The study reported three main factors contributing to the successful recovery of the subjects. These factors included a supportive relationship, maturation or growing out of the disorder, and therapy or counseling. The supportive relationships deemed valuable by the subjects included family members, friends, healthcare professionals, and counselors or psychologists.

The limitations and also the strengths of this study were the concentration on subjective perspectives. The subjects may have given false meaning to their experiences in an effort to explain their stressful history with an eating disorder. However, subjective experiences are a large component of understanding any illness (Tozzi et al., 2003).
The findings of this study promote the need for a multidisciplinary approach to treatment of those with eating disorders. Evidently valuable relationships with a variety of individuals proved helpful to the subjects that had recovered from anorexia nervosa.

*Multidisciplinary approach.* As noted, a multidisciplinary approach to the treatment of those with eating disorders is essential. In a study examining the beliefs of women concerning the usefulness of various components in the treatment of eating disorders, subjects perceived general practitioners, counselors, dietitians, friends, family members, and social workers as playing roles in treatment of bulimia nervosa.

Collaboration of a diverse group of individuals was deemed important by the subjects of this study, further emphasizing the need for a multidisciplinary approach to the treatment of eating disorders (Mond, Hay, Rodgers, Owen, & Beumont, 2004).

*Parental involvement.* When considering treatment of young people with eating disorders, parents are vital components of the treatment team that often remain overlooked. The findings of a study conducted by McMaster, Beale, Hillege and Nagy (2004) showed the struggles parents had when dealing with healthcare professionals regarding their child’s treatment. Researchers found that parents felt a lack of involvement in their child’s care, and became frustrated concerning the deficit of information they were provided. Many parents in the study were ready and willing to be involved in the care of their child; however healthcare professionals made this involvement very difficult. The authors of the study stated, “The lack of involvement that was forced upon the parents and family encouraged a number of children to be secretive in their communication with the family and increased the child’s isolation” (McMaster et al., 2004, p. 70). Parents are a necessary part of the treatment team, and typically the
primary caregivers to their children after discharge. Healthcare professionals, specifically nurses, need to take strides to involve the parents in the ongoing care of their children in order to promote successful treatment of young people with eating disorders (McMaster et al., 2004).

Social and cultural considerations. Social and cultural considerations have played an integral role in risk factors for eating disorders; therefore attention needs to be paid to these factors in treatment as well. A study performed by Pamela Hardin (2003) described the root of recovery being located in social and cultural practices rather than individual treatment. Hardin asserts that a shift needs to be made away from the thin ideal within Western society and culture for eating disorder treatment to be successful. Furthermore, by approaching treatment of eating disorders from a broader social and cultural point, more varied forms of treatment may be available to females with eating disorders (Hardin, 2003).

Nursing Role

The therapeutic relationship. Nurses challenged with the care of adolescents diagnosed with eating disorders face a number of difficulties and obstacles in attempting to establish a therapeutic relationship with these clients. The development of a successful therapeutic relationship requires that the nurse and patient have trust, good communication, and a solid rapport (McQueen, 2000).

Ramjan (2004) examined the barriers that hinder the development of the therapeutic relationship between registered nurses and young people diagnosed with anorexia nervosa. Ramjan conducted interviews with 10 registered nurses from a children’s hospital. None of the sampled nurses had formal mental health training.
Certain themes emerged through the interviews conducted with the sample registered nurses. Overall the nurses felt they had little understanding of anorexia nervosa. The nurses felt they were in a constant struggle for power and control with their clients, acting more as inflictors of punishment than trustworthy figures. The authority-figure role the nurses felt they were required to take on led to rebellion by their clients.

The lack of understanding the nurses had for the complex disorder and their struggles for control made establishing a therapeutic relationship extremely difficult. The nurses found themselves blaming their clients for their condition, believing the young people were causing themselves to be ill. In holding their clients responsible, nurses found it challenging to be sympathetic. Additionally, the nurses interviewed asserted they were unable to trust the adolescents diagnosed with anorexia nervosa, believing these clients were manipulative. This lack of trust was mutual between the nurses and the clients, making the development of a therapeutic relationship impossible.

The findings of the study indicate a growing need for support of nurses responsible for the care of clients diagnosed with eating disorders. One limitation to this study was the absence of a sample group including nurses that had been trained in mental healthcare. By examining nurses educated in caring for young people with anorexia nervosa, a better understanding of the usefulness of proper training could be obtained. A second limitation to the study was that the nurses had an average of only two years of experience working with those diagnosed with anorexia nervosa. This deficit of experience may have also contributed to the nurses’ lack of understanding and knowledge (Ramjan, 2004).
Nursing education. A study by Dichter, Cohen, and Connolly (2002) found that enhancement of knowledge and awareness through education and exposure of advanced practice nurses caring for young female patients was essential in the recognition and prevention of eating disorders. Advanced practice nurses are in an ideal position for identifying those with, and at risk for, bulimia nervosa because they have frequent and longer visits with many female patients. Researchers found that the advanced practice nurses that participated in the study had a general lack of awareness regarding the signs, symptoms, and diagnostic criteria for bulimia nervosa. This lack of understanding could lead to missed diagnoses and/or inadequate screening processes. Advanced practice nurses need to be properly educated and trained to screen for these disorders, and their risk factors (Dichter et al., 2002).

In addition to education for recognition and prevention of eating disorders, further training for nurses involved with the treatment of those with eating disorders is needed. A study of registered nurses caring for clients with eating disorders conducted by King and Turner (2000) found that the nurses caring for those with eating disorders were overwhelming frustrated. Their frustration when providing care for their clients with eating disorders caused them to ultimately distance themselves from these patients. This form of “turning-off” was a result of feelings of failure in the treatment of young people with eating disorders. Participants felt they were unable to uphold their core nursing values when caring for these clients, further adding to their frustration and helplessness. The participants described their core nursing values based on themes such as equality of care, trust, and being non-judgmental, all of which were challenged when caring for those with eating disorders. The study asserts that through proper education, nurses faced with
caring for individuals with eating disorders can learn to distinguish between their ideals and the realities of nursing, understanding that care without cure can still be a component of effective nursing (King & Turner, 2000)
Chapter III

Methodology

Design

Eating disorders have recently become one of the most prevalent diseases affecting adolescent girls. Examining the experiences of those that have lived with eating disorders is essential in providing holistic nursing care. Exploring the subjective accounts of those with eating disorders will give healthcare providers a more accurate description of the psychological and emotional implications of eating disorders. In order to gain knowledge of lived experiences, a phenomenological case study will be examined.

Phenomenology method. Phenomenology is a research approach that examines the experiences that individuals encounter. As described in Fain (2004), “phenomenology is both a philosophy and a research method that explores and describes everyday experiences in order to generate and enhance the understanding of what it means to be human” (p. 220). Phenomenological research analyzes, in depth, the lived experiences of people. All phenomenological interpretations are derived directly from human experience (Fain, 2004).

Avoiding bias. In phenomenology, bracketing must occur in order for this research method to be successful. Bracketing is described as the “identification of any previous knowledge, ideas, or beliefs about the phenomenon under investigation” (Fain, 2004, p. 219). In order to avoid bias in this research study, bracketing will occur to identify any preconceived notions that the researcher may have. Furthermore, open-ended questions were used in an effort to eliminate the influence of bias in the study. The
interview will be conducted in a manner that is free from judgment or bias from the researcher.

Sample

This is a case study examination, and will include one person who experienced an eating disorder, and is willing to share her personal account. In order to participate in this study, the participant must be female and have an active eating disorder, or be in recovery from an eating disorder. The participant will be selected on a voluntary basis. A volunteer will be recruited by flyers posted on the Carroll College campus, and by word of mouth. The interview will be conducted in a setting that is mutually agreed upon by the researcher and the participant. Confidentiality will be strictly adhered to. Informed consent will be obtained prior to the conduction of the interview through a detailed consent form. The name of the participant will not appear in any of the research materials, and a pseudonym will be provided to the participant in the study.

Procedure

Prior to the study being conducted, the researcher will perform a self-assessment, identifying personal bias through bracketing. Data will be collected from the participant through an unstructured interview, consisting of open-ended questions. The questions used will give the participant an opportunity to describe and expand on her lived experience. The interviews will be recorded by audio tape for accuracy. Certain background information such as age, current status of the eating disorder, and age of onset of the eating disorder will be obtained prior to the interview. The researcher will attempt to establish a trusting relationship with the participant to facilitate an environment that is comfortable for the participant to freely express herself.
Analysis

Data will be analyzed after thorough and lengthy examination of the data collected. Giorgi’s method of data analysis will be used. Giorgi’s method includes the following steps:

1. Read the entire disclosure of the lived experience straight through to obtain a sense of the whole.
2. Reread the disclosure to discover the essences of the lived experience under study. Look for each time a transition in meaning occurs. Abstract these meaning units or themes.
3. Examine meaning units for redundancies, clarification, or elaboration. Relate meaning units to each other and to a sense of the whole.
4. Reflect on the meaning units, and extrapolate the essence of the experience for each participant. Transform each meaning unit into the language of science when relevant.
5. Formulate a consistent description of the meaning structures of the lived experience for all participants. (Fain, 2004, p. 230)

Participant Demographics

The participant, Danielle (a pseudonym), is 30 years old. She is currently living in the north-western United States. Danielle met the qualifications for this case study in that she has been struggling with anorexia since she was 12 years old. Danielle used restrictive eating behaviors and over-use of exercise in order to lose weight and achieve her thin ideal. Additionally, Danielle has spent much of her life as a professional dancer, a career that requires a certain body type, further influencing her thin ideal. Currently,
Danielle still has negative feelings about her body, and reoccurring thoughts and desires to restrict her food consumption and over-exercise; however she feels she is a healthy weight and much stronger than she has been in the past.
Chapter IV

Results

The purpose of this study was to evaluate the research and case studies concerning anorexia nervosa, and to describe the experience of one woman that lived with anorexia. By examining a personal account of living with anorexia, nurses can gain insight into the experience, and therefore be more equipped to treat those with anorexia. Throughout the interview with Danielle, four major themes became evident. These themes include the following: striving for perfection, succeeding in her profession, conditioning herself to believe she was fat, and living a skinny lifestyle. Through examining these themes, one can attain a better understanding of the actual experiences those with anorexia face.

Theme 1: Striving for Perfection

A deep rooted need for perfection in all aspects of life was one of the major self-reported contributions to the development, and growth of Danielle’s eating disorder. Danielle states that her eating disorder stems from a strive for perfection; “I’m still not convinced that I have an eating disorder, no I know I have an eating disorder. . .well it stems from a strive for perfection rather than an inner desire or struggle with food or any of those things.” Danielle goes on to describe her preoccupation with perfection; “I think it was more a strive for perfection, an ideal I was trying to reach; it wasn’t that I didn’t want to eat, I wanted to eat but eating normal foods would make me not look like the professional dancer that I wanted to look like.”
Theme 2: Succeeding in Her Profession

Danielle reported that another contributing factor to her disordered eating habits was her dancing career. Many professionals in Danielle’s field placed pressure on her to lose weight. Danielle described comments made by one of her dance instructors; “She told me that if I had to eat, if I had to eat, to eat lettuce, if I had to eat, if you have to eat, if you are starving, eat lettuce.” Danielle spoke of the leverage her dance instructors had over her weight by threatening her with roles. Danielle describes one encounter she had with a dance instructor, “She pulled me aside and said, ‘I want to cast you in this role but you have to lose at least five pounds’.” Danielle asserts that the maintenance of job status in the ballet world depended on weight and body shape; she described this body requirement, “Until you have that skinny body, they won’t use you, so you have to be an understudy.” In addition, the threat of being replaced by other dancers weighed heavy on Danielle’s mind; she described the competition; “For every job out there, there are 20 dancers without a job who can walk that fine line between being too weak and being too heavy; they are right there to take your place.”

Theme 3: Conditioning Yourself to Believe You Are Fat

A major theme that appeared in the interview with Danielle was the fact that she did not initially believe she was fat; she had to be trained by outside forces to think of herself as fat. The forces that contributed to training Danielle to believe she was fat mainly consisted of her fellow dancers and dancing instructors. Additionally, Danielle reported that her family also influenced her restrictive eating behavior. Danielle described having an issue with finding the motivation to lose weight when she did not consider herself fat in the first place; she stated; “I didn’t feel like I looked that much heavier than
any of the other dancers so it was really hard to think I was fat; it was really hard to look in the mirror and tell myself I was fat.” Danielle reported that in order to restrict her eating, and be constantly exercising she had to convince herself she was fat. Without the belief that she had to lose weight, the drive to work toward a thinner body did not exist. Danielle stated; “I had to tell myself that I must be fat; I must be fat because everybody else thinks I am; up to this point in my life all my teachers think I am.”

*Theme 4: Living a Skinny Lifestyle*

After years of being preoccupied with her weight, Danielle eventually made her weight and effort to be thinner a constant part of her lifestyle. Danielle became alienated from her family and friends outside of the dancing world. Danielle described her life while dealing with anorexia; “Eventually I remember not talking to my family; I remember feeling really alone and confused, like nobody would help me, and I didn’t understand why I couldn’t lose more weight, but yet I was still dancing, and I still had some energy, and you know I woke up 80 pounds.” Maintaining a lifestyle that appeared healthy, but also promoted the constant strive for thinness was a priority in Danielle’s lifestyle. Danielle gives a description of this lifestyle; “I kind of got a high from never having food in my house. I would try to fool my parents if they would come over. I would cook dinner and buy all this food to show that I did eat, that I was healthy.” As time went by, Danielle described the struggle she faced in maintaining her skinny lifestyle; “It just seemed like I was fighting all the time, it was making me so tired. Fighting always to lose weight, fighting to stay afloat, fighting to keep my job, fighting to prove that I may not have a dancer’s body, but I’m a great dancer.” Ultimately, Danielle
was unable to maintain the skinny lifestyle she had grown accustomed to, and after numerous injuries, sought treatment in an inpatient treatment facility.

The results of this interview and the main themes addressed give insight into the experiences Danielle faced. When attempting to identify and treat anorexia, nurses must examine each individual’s experience in order to provide a plan of care that is effective to each different case. Examining the way in which those with anorexia view the disorder can give nurses much insight and provide for more holistic, successful treatment.
Body Image and Self-Concept

A core theme in this case study and in current research is the presence of a distorted body image and self-concept deficits in women with eating disorders. The case study participant described having a constant worry about how others viewed her body; she regularly felt that those around her were viewing her physical imperfections, and nothing else. After time, the participant reported not being able to look in the mirror due to her dissatisfaction with her body. The way people perceive their own bodies, and the way that others see their bodies, is core to body image and self-concept. Those with eating disorders have an unrealistic view of their body. A study conducted by Benninghoven et al. (2006) examined changes in body image of anorexic and bulimic patients in a treatment setting. The study found that patients with anorexia extremely overestimated their own body size. With this in mind, the study focused on effective treatment for eating disorders in relation to disturbed body image. A key component to successful treatment is utilization of body focused therapy. The study describes the potential benefits of this therapy, “This might help to change the obviously pervasive perceptual body size distortion in anorexia nervosa at a later stage of recovery and provide patients with the chance to adapt their body perception to a higher body weight” (Benninghoven et al., 2006, p. 93).

Another study performed by Jacobi, Paul, Zwaan, Nutzinger, and Dahme (2002) examined self-esteem and self-concept in women with anorexia compared to a healthy control group. This study found that a negative self-esteem was much more pronounced
in anorexic patients when compared to the control group. Results of the study established that “[p]atients with eating disorders display self-concept deficits in comparison to matched healthy control groups” (Jacobi et al., 2002, p. 207). These findings are significant when considering the underlying forces driving the disease in those with eating disorders. To effectively treat an eating disorder, the distorted perception of body image and self-concept deficits must be addressed and prioritized.

**Perfectionism**

An obsession with perfectionism was a leading theme in the case study. Danielle expressed great concern for making a mistake and consequently not reaching her professional goals. Current research has found a distinct relationship between perfectionism and the development and treatment of eating disorders. A recent study examined perfectionism in relation to eating disorders. The findings of the study indicated that high score on the Multidimensional Perfectionism Scale were closely connected with the presence of anorexia (Bulik et al., 2003).

Additionally, the trait of perfectionism has a vast influence on the successful treatment of those with eating disorders. Sutandar-Pinnock, Woodside, Carter, Olmsted, and Kaplin (2003) examined the relationship between perfectionism and the outcome of anorexia. The researchers reviewed participants that had four weeks of treatment for anorexia and compared them to a healthy control group. The study found that those individuals that are highly concerned with perfectionism have a more difficult time successfully completing treatment. The findings indicate that the focus on perfectionism impairs the ability to give up an eating disorder.
The results of these studies suggest that recognition of perfectionism in individuals with anorexia is an important factor when developing a plan for treatment. Moreover, this information can be used in prevention of anorexia through early identification of indicative personality traits.

Outside Influences

Throughout the case study, the concept of outside forces influencing Danielle’s eating and exercise behavior was a reoccurring theme. Danielle reported that her dancing instructors, peers, friends, colleagues, and family all contributed to the development of her eating disorder. Studies have been done examining parental influences on the development of eating disorders in their children. One study found a direct link to mothers’ preoccupation with weight and eating to their daughters’ restrictive eating behaviors (Francis & Birch, 2005). The conclusion that family can influence the development of an eating disorder can be drawn from research; however further investigation is required to examine the effect mentors, instructors, friends, and colleagues have on the development of eating disorders. By identifying contributing factors of eating disorders, a better understanding of how to prevent and treat this life-threatening condition can be attained.

Future Research

Much research has been done on prevention and recognition of risk factors for eating disorders; however there appears to be a disparity in the research regarding treatment. Although prevention is the most effective method of treatment, further research needs to be conducted concerning those that have already been diagnosed with anorexia or bulimia. Eating disorders are the number one cause of mortality in females
ages 15 to 24, outnumbering all other causes of death combined (NEDA, 2002). With this in mind, extensive research of diverse treatment methods is vital in decreasing the mortality of young females.

Additionally, recent research has found a possible genetic link in eating disorders. The research on this topic remains immature at this point; however identification of further risk factors, such as genetics, would increase the chances of early detection of features that place one at greater risk for developing an eating disorder. Further research in the area of genetics in relation to eating disorders should be actively pursued.

In addition to research disparities in treatment and genetic links in eating disorders, further research should be conducted concerning the spiritual influences on those diagnosed with eating disorders. Spirituality has proven to be a profound component in traditional healthcare; however more information is needed regarding spirituality in eating disorders. Spirituality research would further emphasize a holistic approach to the care of clients with eating disorders.

Conclusion

The growing prevalence of eating disorders in Western society is of great concern to healthcare professionals. Nurses play a significant role in early identification and screening of those adolescents at risk for this potentially fatal illness. Promotion of education, awareness, prevention programs, and effective treatment methods is vital in decreasing the mortality rate of young females.
References


