Predictors of treatment-seeking in women with subthreshold and full-syndrome bulimia.

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PREDICTORS OF TREATMENT-SEEKING IN WOMEN WITH SUBTHRESHOLD
AND FULL SYNDROME BULIMIA

by

Jeremy Frank, M. A.

A Dissertation
Submitted to the Faculty of Graduate Studies and Research
through the Department of Psychology
in Partial Fulfillment of the Requirements for
the Degree of Doctor of Philosophy at the
University of Windsor

Windsor, Ontario, Canada

2003

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ABSTRACT

Despite the fact that a variety of treatments for psychological disorders have been shown to be effective, a significant proportion of individuals who experience psychological problems do not seek professional help. Women with bulimia are particularly unlikely to seek help, with lower help seeking rates than those of individuals with other common psychological disorders (Smalec & Klinge, 2000). In the current study, qualitative interviews of 11 women with bulimic symptoms and 17 clinicians with expertise in the treatment of bulimia resulted in the development of a 53-item self-report measure of bulimic exclusive treatment fears. In a second quantitative stage of study, 354 women completed a series of self-report measures, and were categorized into four groups: 1) distressed non-bulimic non-help seekers, 2) distressed non-bulimic help seekers, 3) distressed non-help seekers with bulimic symptoms, and 4) distressed help seekers with bulimic symptoms. The above mentioned measure was subjected to principal component analysis and revealed a one-factor solution. Construct validity for the measure was supported as the factor scores significantly discriminated bulimic help-seekers from non-seekers but could not discriminate non-bulimic help seekers from non seekers. Further examination of help seeking correlates revealed the following: While high social pressure to seek help and low familial social support predicted non-bulimic treatment seeking, treatment seeking dynamics in women with bulimic symptoms were more complicated. High social pressure to seek help, positive attitudes toward help seeking, image concerns, and identified bulimic treatment fears predicted bulimic treatment seeking. Kushner and Sher's (1991) conceptualization of the decision to seek help as an approach-avoidance conflict may be particularly fitting for women with bulimic patterns, as they hold
ambivalent attitudes regarding help seeking, likely due to high levels of distress (approach tendency) and high levels of self-concealment and certain dimensions of treatment fearfulness (avoidance tendencies). Limitations to the present study include potential sampling bias (i.e., based on geography and level of education), and a slightly less than ideal sample size. These data suggest that researchers should begin to explore predictors of treatment seeking in different pathologies, as the decision to seek psychological help appears to be influenced by pathology-specific factors.
ACKNOWLEDGEMENTS

I would like to thank my dissertation committee members for their time, support, and effort. I am indebted to my advisor Dr. Cheryl Thomas for her continuous guidance and encouragement throughout my graduate training. I would also like to express my warm appreciation to Dr. Jim Porter for his mentorship and strong dedication to this project. A great deal of gratitude goes to Dr. Josee Jarry, Dr. Eleanor Maticka-Tyndale, and Dr. Ken Cramer for their valued insights and direction, particularly with respect to research design and statistical expertise.

I am particularly grateful to Christopher Meining, my close friend who contributed countless hours to the design and creation of the U-Studies software which allowed me to collect data over the internet. Chris’ dedication and ongoing support provided me with a reliable, effective, and affordable method for collecting data from across the continent. Without his help, this project could not have come to fruition. Special thanks are also extended to Sarah Bertrim, Kelty Berardi, Melanie Kelly, and Shannon Zaitsoff for their time and efforts in interviewing participants during the first phase of this study. I would also like to acknowledge the doctoral students in my research lab who contributed many valuable suggestions. I would like to acknowledge a special debt to the clinicians and research participants without whose collaboration and cooperation this project would not have been possible. I would particularly like to mention the clinic staff at the Bulimia and Anorexia Nervosa Association (BANA), McGill University Student Mental Health Services, and Queen’s University Adult Eating Disorder Clinic. Finally, I would like to thank my family and friends for their belief in me, encouragement, and tireless support.
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Introduction

Overview

Bulimia nervosa is a serious eating disorder marked by a cycle of binge eating and inappropriate compensatory behavior to avoid weight gain (Diagnostic and statistical manual of mental disorders – fourth edition (DSM-IV), American Psychiatric Association, 1994). Bulimics place excessive importance on their body shape and weight in their self-evaluations, and like those with anorexia nervosa, they experience intense fears of becoming fat. Binge episodes involve consumption of unusually large amounts of food in a limited period of time (usually less than two hours) during which the bulimic feels out of control of her eating (DSM-IV, 1994). Following binge episodes, bulimics engage in inappropriate compensatory behaviours in order to prevent weight gain. Self-induced vomiting is the most commonly used compensatory technique, engaged in by 80-90% of bulimics. Approximately one third of bulimics engage in laxative use after bingeing, and diuretics are also commonly used (DSM-IV, 1994). Finally, some bulimics fast for a day or exercise excessively in order to prevent weight gain. Bulimics are further classified into one of two subtypes. Those who engage in self-induced vomiting, or who misuse laxatives or diuretics are labeled as suffering from “bulimia nervosa, purging type,” whereas those who use other inappropriate compensatory techniques such as fasting or excessive exercise are said to be suffering from “bulimia nervosa, nonpurging type” (DSM-IV, 1994).

Bulimics usually feel ashamed of their eating problems, and they typically put forth great effort to conceal them from others. They are likely to shop for food, binge, and purge in secrecy, and they often keep their disorder hidden from even their family
and close friends (Freeman, 1986; Herzog, Keller, Lavori, & Sacks, 1991). Feeling out of control (of both eating behaviour and emotions in general) and the related fear of having control taken from them are commonly described features of bulimia (Chrisler, 1991; Mizes, 1994). In contrast to anorexics, bulimics are typically within the normal weight range. They are likely to suffer from comorbid depressive symptoms or disorders (Keller et al., 1989; Schlesier-Stropp, 1984), as well as anxious symptomology (Schlesier-Stropp, 1984). Approximately one third of bulimics also carry substance abuse or substance dependence diagnoses (Holderness, Brooks-Gunn, & Warren, 1994; Yager, Landsverk, Edelstein, & Jarvik, 1988). Finally, impaired social functioning is common among bulimics (Keller, Herzog, Lavori, Bradburn, & Majoney, 1992; Whitaker et al., 1990) and 30-50% of bulimics meet criteria for one or more personality disorders, particularly borderline personality disorder (DSM-IV, 1994). Herzog, Hopkins, and Burns (1993) argue that bulimia is a chronic disorder that encompasses periods of subclinical symptomology. An ongoing cycle of remission and relapse has also been noted (Keller et al., 1992; Maddocks, Kaplan, Woodside, Langdon, & Piran, 1992).

Bulimics are prone to suffer from a variety of health complications. Frequent purge behaviour can result in hypokalemia, hypochloremia, hyponatremia, and other fluid and electrolyte imbalances (DSM-IV, 1994; Schlesier-Stropp, 1984; Yager et al., 1988), sometimes leading to serious medical risks. Metabolic acidosis secondary to laxative abuse is also possible, as is metabolic alkalosis secondary to a reduction in stomach acid caused by excessive vomiting. Dental problems (e.g., loss of dental enamel, chipped teeth, increase in dental cavities) as well as enlarged salivary glands can result from excessive vomiting. Menstrual irregularity and laxative dependence are also possible.
Rare but very serious medical complications include gastric rupture, cardiac arrhythmias, and esophageal tears (DSM-IV, 1994; Schlesier-Stropp, 1984; Yager et al., 1988).

Prevalence studies have found that 2.5% of high school students meet criteria for bulimia (Striegel-Moore, Silberstein, Frensch, & Rodin, 1989; Whitaker et al., 1990). Studies on college campuses have yielded varying rates of prevalence ranging from 2-5% (Kurth, Krahn, Nairn, & Drewnowski, 1995; Stein, 1991; Smalec & Klinge, 2000) to over 10% (Prouty, Protinsky, & Canady, 2002). It has also been estimated that over 10% of college students exhibit subclinical (yet still distressing and maladaptive) bulimic patterns (Kurth et al., 1995). Kurth et al. (1995) surveyed 1367 freshman college women, and concluded that 2% were “probably bulimic,” 19% were “dieters at risk,” 21% were “intense dieters,” 23% were “moderate dieters,” 26% were “casual dieters,” and 9% were “nondieters.”

In summary, bulimia is a serious disorder that is associated with a variety of health complications, social impairment, and psychiatric comorbidity (Keller et al., 1992; Schlesier-Stropp, 1984). Women suffering from bulimia typically experience chronic distress which they often do not disclose to others, and as such deal with their difficulties in isolation (Freeman, 1986). Prevalence studies have demonstrated that a significant number of women suffer from bulimia at both subclinical and clinical levels (Kurth et al., 1995; Prouty et al., 2002; Smalec & Klinge, 2000).

Fortunately, a variety of psychological treatments for bulimia have been shown to be effective. Garner, Fairburn, and Davis (1987) reviewed the literature on the efficacy of cognitive-behavioural treatments for bulimia, and reported treatment success rates ranging from 50% to 95.5%. There is also some evidence to suggest that early
intervention predicts long term outcome (Reas, Williamson, Martin, & Zucker, 2000). Reas et al. (2000) examined follow up data of 44 bulimics (on average nine years following treatment termination), and found that while participants who were initially treated within the first few years had good chances of recovery (over 80%), participants with pre-treatment histories of bulimia of several years or more had significantly poorer chances of recovering. Participants with pre-treatment histories of bulimia of fifteen years or more had only a 20% chance of recovery. Using an empirically derived cut-off at the 50th percentile, Reas et al. (2000) determined that participants with pre-treatment histories of bulimia of less than 9.34 years were likely (that is, greater than 50% chance) to recover. Strikingly, when age of onset, diagnoses of other psychological disorders (on both Axes I and II), age at presentation, history of prior treatment, Body Mass Index, initial eating pathology and depression scales, family history of depression and alcohol abuse, and duration of pre-treatment bulimia were entered into a regression equation to predict long term outcome, duration of pre-treatment bulimia was the only factor that significantly predicted recovery (Reas et al., 2000).

These findings highlight the importance of shortening the time span between the onset of bulimic symptomology and psychological treatment. Unfortunately, examinations of service utilization rates by bulimics indicate that only a small number enter treatment (Garvin et al., 2001; Smalec & Klinge, 2000; Striegel-Moore, Leslie, Petrill, & Rosenheck, 2000; Whitaker et al., 1990). Studies examining the percentage of bulimics who report a history of psychological treatment yield rates of 28% and 40% for high school bulimics (Whitaker et al., 1990) and college bulimics (Drewnowski, Hopkins, & Kessler, 1988), respectively. These help seeking rates are considerably lower
than those reported by sufferers of major depressive disorder (58%) and Generalized Anxiety Disorder (60%) (Whitaker et al., 1990). Fairburn and Cooper (1984) reported that 75% of bulimics believe that they need professional help, but that only one third of this group seeks help. Kent and Clopton (1988) reported that of 26 college women who met full diagnostic criteria for bulimia and who reported clinical levels of distress, none of them had sought treatment for their eating disorder.

Bulimics who do enter treatment typically report a two to four year history of the disorder prior to seeking help (Burket & Hodgin, 1993; Freeman, 1986). Moreover, they often fail to show for initial sessions (Burket & Hodgin, 1993) or drop out prematurely (Deeble, Crisp, Lacey, & Blat, 1990; Garner et al., 1987; Yager, Landsverk, & Edelstein, 1989). Given the effectiveness of treatments for bulimia (Garner et al., 1987) and the importance of early intervention (Reas et al., 2000), the markedly low treatment seeking rates among bulimics (Smalec & Klinge, 2000; Whitaker et al., 1990) and the fact that those who do seek treatment typically do not do so early in the course of their illness (Burket & Hodgin, 1993; Freeman, 1986) is discouraging. Moreover, there is a dearth of systematic investigations of help seeking dynamics, and to date, we know relatively little about pathways and barriers to help seeking in women with bulimia (Crawford, 1998; Garvin et al., 2001). This is likely due to the fact that for the most part, researchers have conceptualized the decision to seek help as ‘person specific’ as opposed to ‘problem specific’ (Koenan, Goodwin, Struening, Hellman, & Guardino, 2003; Kushner & Sher, 1991). Until recently, few have examined pathways and barriers to help seeking for specific psychological problems. Interestingly, functional variables (e.g., attitudes, beliefs, and other psychological variables) have been shown to better explain variability
in treatment-seeking than do demographic variables in general mental health populations (Crawford, 1998). It logically follows that the type of problem for which one is seeking help (i.e., a functional variable) might significantly moderate the effects of various treatment-seeking predictors. In fact, Kushner and Sher (1991) had cautioned that the type of problem for which help is sought might play an important role in determining the differential importance of predictors of help seeking.

In summary, bulimia is a serious eating disorder that is associated with significant impairments in many domains (Keller et al., 1992; Schlesier-Stropp, 1984). A variety of psychological treatments are known to be effective (Garner et al., 1987), and are possibly more effective when intervention occurs early in the course of the disorder (Reas et al., 2000). Women with bulimia seek help with even less frequency than do those suffering from other disorders (Whitaker et al., 1990). To date, we know little about the pathways and barriers to treatment in bulimics, and a systematic exploration of what is unique about their help seeking patterns is sorely needed.

There is some evidence that eating disordered individuals display distinctly different help seeking patterns than other distressed individuals. Oliver, Reed, Katz, and Haugh (1999) looked at several possible informal and formal sources of help for college students in distress. Both genders revealed similar patterns (in order of preference): friends, family, romantic partners, clergy, teachers, school counselors, and professional counselors. Very few participants reported speaking to co-workers about their problems. However, individuals classified as having eating problems displayed a distinctly different pattern with respect to whom they were likely to entrust with their problems. The only source of help that they rated with any significant frequency was co-workers (Oliver et
al., 1999). The authors noted that individuals with eating problems generally refrained from sharing their problems with anybody, unless they felt that they had to, in effect creating a powerful barrier to treatment. The current author postulates that such individuals may find themselves in situations at work (e.g., over lunch) where others notice their eating problems, compelling them to discuss them.

The goal of the current investigation was to further our understanding of help seeking in women with bulimic symptoms, and of how this process might differ from that in women without bulimic symptoms. Prior to the articulation of research questions, a brief review of demographic factors predicting bulimic help seeking is presented to provide context, and then environmental and psychological correlates of help seeking in both general medical/mental health populations and bulimic populations are considered in the context of a basic model of help seeking. It should be noted that almost all the studies reviewed examined treatment-seeking by comparing characteristics of individuals who have sought treatment with those who have not, but without examining the processes involved in the decision to seek treatment. Stated differently, for the most part (and unless otherwise indicated), participants in these studies were not queried specifically about why they sought treatment when they did.

**Demographic Correlates of Help seeking in Bulimic Populations**

Examinations of the influence of demographic variables on help seeking in bulimic populations have been minimal (Crawford, 1998). Level of education has been shown to influence treatment-seeking. College bulimics are more likely to seek treatment than are high school bulimics, with rates of 40% and 28% respectively (Whitaker et al., 1990; Drewnowski et al., 1988). Unfortunately, the influence of age cannot be teased
apart in these studies. In the only study to date that examined the influence of age, Wills (1994) found no differences in age between bulimics who had (n=50) and had not (n=27) sought treatment. However, years of education did distinguish between these two groups (Wills, 1994). Cachelin, Rebeck, Veisel, and Striegel-Moore (2001) reported that eating disordered women from minority groups may be particularly unlikely to seek treatment because of financial reasons. With respect to accessibility factors, Kent and Clopton (1992) asked bulimics why they had not sought treatment, and found that lack of treatment availability was an important factor. However, in the first systematic investigation primarily focused on the treatment-seeking behaviour of bulimics, Crawford (1988) asked bulimics who had sought treatment, bulimics who had engaged in self-change tactics, and active bulimics who had not sought treatment about their decision as to whether they sought treatment, and found characteristics of treatment facilities and the inconvenience of seeking help to be unimportant. While these structural variables do influence treatment-seeking, their effect has actually been shown to be relatively minimal when functional variables (e.g., environmental, psychological) are considered (Crawford, 1988).

The Approach-Avoidance Model: A Heuristic for Understanding Functional Correlates of Help seeking

Kushner and Sher (1991) postulated that the decision to seek professional psychological help can be conceptualized in the context of a classic approach-avoidance model (Miller, 1944). More specifically, they suggested that the help seeking decision involves a conflict between “approach tendencies” (e.g., pressure from others to seek help, distress) and “avoidance tendencies” (e.g., cost, time commitment, scheduling
inconveniences, doubts regarding treatment effectiveness, treatment fearfulness) (Kushner & Sher, 1991). They further argued that the approach-avoidance conflict becomes charged by increasing levels of distress. Stated differently, latent emotion-based barriers such as fear become activated as the need for treatment elevates (Kushner & Sher, 1989; Kushner & Sher, 1991). In this model, one seeks treatment when the influence of approach tendencies outweighs the influence of avoidance tendencies. For the most part, the treatment seeking correlates reviewed by the current author are categorized as “approach tendency variables” (variables that might facilitate treatment seeking), and “avoidance tendency variables” (variables that might impede treatment seeking). Several additional treatment seeking correlates are described that are sometimes considered approach tendencies while at other times are considered avoidance tendencies.

*Approach Tendencies Explored in General Mental Health Populations*

A host of approach tendency variables have been examined in general mental health populations:

*Distress and severity of symptoms.* The two most commonly found psychological approach tendencies are severity of symptoms, and subjective level of distress. Treatment-seeking has been found to be associated with the degree to which symptoms interfere with occupational and social functioning in a wide range of mental health populations (Cockerham, 1992). Distress has been often been demonstrated to be the strongest predictor of help seeking (Oliver et al., 1999; Rickwood & Braithwaite, 1994). However, distress may not always act as an approach tendency. Ogletree (1993) argued that despite the positive correlation regularly found between distress and likelihood of
help seeking, only a minority of individuals with very high levels of distress (and need for help) seek treatment.

*Life changes and events.* Stressful life changes (Padgett & Brodsky, 1992) as well as the number or severity of negative life events (Rubio & Lubin, 1986) have been shown to facilitate treatment-seeking.

*Impaired functioning.* Degree of impairment in family, social, and occupational functioning has also been shown to be associated with help seeking (Crawford, 1998) and would be considered approach tendencies. In substance and alcohol abuse populations for example, such impairment is often what propels the abuser to seek help, as opposed to the problematic behaviors themselves (Carroll & Rounsaville, 1992; Tucker, 1995; Tucker & Gladsjo, 1993).

*Social pressure to seek help.* Social pressure to seek help has been shown to be a powerful approach tendency in substance abusers, possibly due to the havoc substance abuse can reek on relationships (George & Tucker, 1996; Room, 1989). For instance, Room (1989) reported that treatment seekers for alcohol abuse usually recalled direct social pressure to cut down on drinking before they entered treatment. To the current author’s knowledge, social pressure to seek help has been largely ignored outside of substance abuse populations.

*Avoidance Tendencies Explored in General Mental Health Populations*

*Self-concealment.* One variable that may act as an avoidance tendency in regard to treatment seeking is self-concealment, and has recently received attention by researchers investigating help seeking behaviour. Larson and Chastain (1990, p. 440) define self-concealment as “a predisposition to actively conceal from others personal information
that one perceives as distressing or negative.” Kelly and Achter (1995) entered self-concealment, depression, gender, social support, and help seeking attitudes into a multiple regression equation, and accounted for 20% of the variance in help seeking intentions. Self-concealment and attitudes toward help seeking were the only two variables to uniquely explain variance in help seeking intentions. However, examinations of the relationship between self-concealment and help seeking have yielded mixed results (Cramer, 1999; Cepeda-Benito & Short, 1998; Kelly & Achter, 1995).

Kelly and Achter (1995) found high self-concealers to have more negative attitudes toward psychotherapy. However, they were 50% more likely to have sought help from a therapist in the past than were low self-concealers. Distress and social support were found to be associated with self-concealment, but were not found to predict perceived likelihood of seeking help. The authors hypothesized that high self-concealers were more likely to seek help because they were unable to ask for help from social support networks. They further postulated that their less favourable attitudes toward psychotherapy reflected their fears of having to open up in therapy (Kelly & Achter, 1995). In a study of a sample of 732 college students in psychology courses, Cepeda-Benito and Short (1998) found high self-concealers to be over three times more likely (than low self-concealers) to report needing, but not seeking, professional help. They concluded that high levels of self-concealment predict treatment avoidance. Cramer (1999) subjected Kelly and Achter’s (1995) and Cepeda-Benito and Short’s (1998) data to path analysis in an attempt to correct for methodological problems and explain the discrepancies in their findings. Several path models were tested in both samples, yielding one model that fit both samples nicely. According to this model, individuals are more
likely to seek help when they are distressed, and when they have positive attitudes toward counseling. They are likely to be distressed when social support networks are impaired, and when they conceal personal negative information from others. These high self-concealers are likely to have negative attitudes toward counseling, and impaired social support. According to Cramer’s (1999) model, degree of social support does not directly predict likelihood of help seeking. Cramer (1999) posited that high self-concealers may experience more psychological turmoil, and if symptoms are severe enough, their likelihood of seeking professional help increases. In support of Kushner and Sher’s (1991) approach-avoidance conflict model of help seeking, Cramer (1999) concluded that high self-concealers are likely to hold negative views of counseling that inhibit help seeking for distressing problems that they are unlikely to have disclosed to others.

Treatment fearfulness. Another avoidance tendency variable that has received considerable attention is treatment fearfulness. Kushner and Sher (1989) defined treatment fearfulness as “the subjective state of apprehension that arises from expectations about the seeking and consumption of mental health services” (p. 251). They argued that treatment fearfulness is a multi-faceted phenomenon, as there are many different types of treatment fearfulness, each explained by a different set of predictors and circumstances.

Kushner and Sher (1991) posited that a number of demographic variables should be considered in the conceptualization of treatment fearfulness. For instance, they postulated that minority populations’ use of a white middle class mental health system brings about a unique set of fears experienced by minority members specifically. Kushner and Sher (1989) examined the effects of gender on treatment fearfulness in general, and
found that women reported higher degrees of treatment fearfulness than did men, but were still more likely to seek treatment. Leaf, Bruce, Tischler, and Holzer (1987) demonstrated a gender effect on a specific type of treatment fearfulness: men were more concerned than women that their families would be upset that they sought treatment. Kushner and Sher (1991) theorized that age influences the effects of treatment fearfulness on treatment-seeking. For example, parent fears are more relevant than children’s fears when predicting treatment-seeking for children. Furthermore, O’Leary, Shore, and Wieder (1984) pointed out that adolescents are developmentally prone to avoid necessary services, and likely hold different types of fears than do adults.

In their comprehensive review of the treatment fearfulness construct, Kushner and Sher (1991) identified a host of different types of treatment fearfulness that could influence treatment-seeking behaviour. First, potential treatment seekers might experience extreme embarrassment about highly personal and sensitive material and often fear the prospect of negative judgment by the helper. Second, despite the fact that potential treatment seekers are usually distressed, they are also likely to fear the possibility of real and lasting change. Bugental and Bugental (1984) suggested that some individuals fear that treatment will rid them of elements from their lives that they perceive as essential for their survival, despite the fact that they are maladaptive. Clinicians from the cognitive-behavioural camp have described similar processes. Ellis and Harper (1975) explained that because individuals are unaware of the degree of discomfort they may experience if they make important changes, they fear that it might surpass their present discomfort, and so rationalize their avoidance of change.
Another type of treatment fearfulness identified by Kushner and Sher (1991) is based on stereotypes of mental health professionals and services. They cited a number of studies that suggest that many people have negative stereotypes about mental health professionals, viewing them as incompetent or even evil. Stated differently, upon contemplating the decision to seek treatment, stereotypes about mental health services might provoke one to consider “what will they do to me?” Hendler and Redd (1986) demonstrated how stereotypes associated with labeled interventions can profoundly affect willingness to participate in treatment. In their study, cancer patients who were undergoing chemotherapy were less likely to participate in “hypnosis” than in “relaxation” or “passive relaxation with guided imagery,” despite the fact that the descriptions of the three treatments were identical.

Just as some people fear entering treatment because of unfounded stereotypes, others may have fears based on past aversive experiences with mental health services. Kushner and Sher (1991) cited the following examples of aversive experiences that could provoke fear about seeking further treatment: sexual advances by a past professional, incompetence on the part of the professional, exacerbation of symptoms perceived as occurring in response to past treatment, involuntary commitment, and side effects from medication.

Fear of negative judgment by others, or stigma concerns, is another identified form of treatment fearfulness, and has been considered to be an important barrier to treatment-seeking. Kusher and Sher (1991) cited a host of studies that demonstrate how individuals are less likely to seek help for problems that are perceived as being associated with greater negative judgment by others. They also pointed out that the influence of
stigma on treatment-seeking has been shown to vary across problems, cultures, and individual differences. Another form of treatment fearfulness identified by Kushner and Sher (1991) are those that are associated with specific types of problems. Many people with specific psychological disorders experience fear based on their (perhaps correct) assumptions that treatment will expose them to what they fear most. For instance, social phobics might avoid treatment because the act of talking about problems in front of a stranger is extremely anxiety provoking to them (Heimberg & Barlow, 1988). Moreover, victims of other phobias might fear the possibility of exposure to that which they are phobic of, and victims of trauma might fear the possibility of being asked to re-experience or talk about traumatic memories (Kushner & Sher, 1991). It is in these contexts that Kushner and Sher (1991) called for further investigations of treatment-seeking across a range of specific clinical populations, age ranges, and gender, and with particular focus on the effects of different forms of treatment fearfulness.

Pipes, Schwarz, and Crouch (1985) developed a psychometric measure of treatment fearfulness (Thoughts About Counseling Survey; TACS) that differentiated college students who had sought psychological treatment from those who did not seek such services. They demonstrated that the TACS tapped into two main factors, one representing fears about therapist competence and professionalism (or "therapist responsiveness"), and the other representing fears about how the individual would be perceived by others and by themselves for seeking help (or "image concerns"). Kushner and Sher (1989) revised the TACS by adding four items that tap fears of being pressured by the therapist to think, do or say things related to their problem. A factor analysis of the revised measure (which they labeled the Thoughts About Psychotherapy Survey or
TAPS) yielded a third factor which they coined “coercion concerns” as it measured fears of being coerced by the therapist. Using the revised measure, Kushner and Sher (1989) found treatment fearfulness to be positively related to psychological distress, and they were able to differentiate between treatment seekers and non-seekers. Moreover, their sample of “treatment avoiders” (college students who admitted to having needed treatment in the past but had not sought it) endorsed higher levels of treatment fearfulness than did college students who reported never having needed treatment, who in turn endorsed higher levels of treatment fearfulness than did college students who reported that they had needed treatment in the past and had sought it. Furthermore, participants who were about to enter treatment reported less treatment fearfulness than those who were not considering seeking help. Using a sample of 263 university students, Deane and Chamberlain (1994) added eleven items to the TAPS in order to sample social stigma concerns more effectively, yielding a fourth factor which they coined “stigma concerns.” These items tapped into fears of how employers, friends, and family members would feel about the responder entering therapy. Deane and Chamberlain (1994) concluded that there is a meaningful difference between fears of negative judgment by self or by therapist and fears of negative judgment by others.

Deane and Chamberlain (1994) found treatment fearfulness to be positively related to both state anxiety and general distress. For example, student participants who reported little distress also endorsed significantly lower levels of total, image, and coercion fears than participants who reported moderate and high levels of distress. Moreover, using multiple regression analyses, Deane and Chamberlain (1994) found image concerns, stigma concerns, coercion concerns, and distress to be significant
predictors of perceived likelihood of help seeking, albeit accounting for less than 10% of the variance. Because individuals over 20 years of age and females were more likely to seek help, multiple regressions were repeated separately for gender and age yielding significant equations for females only and for the older age group specifically. Stigma concerns and distress emerged as the sole predictors in both of the significant equations. Deane and Chamberlain (1994) concluded that the approach-avoidance hypothesis (Kushner & Sher, 1989) seemed to hold especially well for women over 20 years of age.

Deane and Todd (1996) found prior help seeking and exposure to mental health services to predict less treatment fearfulness in a sample of non-clinical university students. Level of distress and attitudes toward help seeking were not differentiated by help seeking status. Prior help-seekers reported that they would be more likely to seek help in the future should they need it, unless they had suicidal ideation. Stigma concerns were the only unique predictor in a multiple regression equation examining therapist-responsiveness fears, coercion concerns, image concerns, stigma concerns, distress, and gender as predictors of perceived likelihood of help seeking, explaining 30% of the variance. Interestingly, and consistent with Deane and Chamberlain’s (1994) findings, image concerns and coercion concerns were not found to be significant predictors. However, it is important to consider that these data were not examined in the context of specific types of problems. The identification of a particular clinical population’s fears about treatment could facilitate more specific targeting of education approaches in prevention programs. As such, image concerns and coercion concerns may be more salient predictors of help seeking in specific clinical populations.
Variables That Could Function as Approach or Avoidance Tendencies Explored in General Mental Health Populations

Some variables could act as either approach or avoidance tendencies in regard to help seeking:

*Attitudes toward seeking professional psychological help.* Attitudes toward seeking professional psychological help could facilitate or impede treatment seeking, depending on whether the attitude is positive or negative. Ballenger (1999) compared 75 non-help seeking university students with 75 university students who had sought help at the university’s counseling center and found that those who had sought treatment held significantly more positive attitudes toward counseling, and perceived it as more useful than did the non-help-seekers. It is important to consider however, that the treatment seekers in this study had already received counseling at the time that they participated. Their positive help seeking attitudes may be a reflection of exposure to counseling, and cannot be assumed to be predictive of treatment seeking. Attitudes toward help seeking have received much attention from researchers who have been interested in examining its correlates. Surgenor (1985) surveyed 411 New Zealanders recruited from various community groups to examine correlates of attitudes toward seeking professional psychological help. Being female, university educated, and having had prior contact with a professional counselor/psychologist were all associated with more positive attitudes toward psychological help seeking. Billingsley (1999) found that 66 younger (18-30 years old) and 66 older (65-80 years old) adults held similar attitudes toward psychological help seeking; on average, both groups reported mildly positive attitudes toward help seeking. Leong and Zachar (1999) examined the relationships between
attitudes toward help seeking, gender, and attitudes (i.e., benevolence) toward mental illness. In accordance with Surgenor's (1985) findings, females were found to have more positive attitudes toward help seeking than males, and positive attitudes toward mental illness significantly predicted positive attitudes toward help seeking when gender was held constant.

_Social support._ While there have also been a plethora of empirical support for social support influences on help seeking (Bowen & Richman, 1991; Crawford, 1988; Roberts, 1988), Roberts (1988) posited that they can also act as either an approach or an avoidance tendency toward help seeking, by alleviating or contributing to the distress that can lead to help seeking, by communicating beliefs and values regarding help seeking, by providing informal treatment, and by providing or withholding referrals. Cramer (1999) reviewed studies assessing social support influences on help seeking, and reported that research findings have been mixed, with some studies reporting that social support is unrelated to help seeking (e.g., Cepeda-Benito & Short, 1998; Kelly & Achter, 1995, Rickwood & Braithwaite, 1994) and other studies showing an inverse relationship between social support and help seeking (Sherbourne, 1988). Using path modeling analyses, Cramer (1999) concluded that impaired social support can lead to high levels of distress, which in turn can act as an approach tendency toward treatment-seeking.

_Readiness for change._ Another variable that can act as either an approach or an avoidance tendency is one’s readiness to change maladaptive patterns. Prochaska, DiClemente, & Norcross (1992) developed a comprehensive model that describes the different stages one goes through on the road to recovery. According to this model, an individual can identify with one of five stages. An individual is considered to be in the
“precontemplation” stage if he or she has no intention of changing the problem behaviour in the foreseeable future. Individuals in this stage are often unaware that they have a problem. Precontemplators only enter treatment in response to pressure from others, and they often feel coerced into changing their behaviours by insistent significant others. It is important to note that precontemplators can wish to change, but do not have serious intentions of doing so. An individual is considered to be in the “contemplation” stage if he or she is aware of the problem, is seriously thinking about making changes, but has yet to commit to take action. Individuals often remain stuck in this stage for long periods (i.e., sometimes for years). Contemplators typically feel conflicted about change, struggling with the pros and cons associated with change or with status quo. An individual is considered to be in the “preparation” stage if he or she is intending to engage in change behaviours within the next month. Typically, they already engage in small behavioural changes, though they have not yet engaged in effective action.

Individuals in the “action” stage have begun to make significant changes with respect to their experiences, behaviour, or environment in an effort to conquer their problems. Such action requires considerable motivation, energy, and effort. Finally, individuals are considered to be in the “maintenance” stage if they have already taken action, are working to consolidate their gains, and prevent relapse. The maintenance stage begins once the individuals have engaged in action for at least six months. For many behaviours, the maintenance stage is considered to last a lifetime (Prochaska et al., 1992). In the context of this model, an identification with the “preparation”, “action”, or “maintenance” stages could be considered an approach tendency with respect to help seeking.
Approach Tendencies Explored in Bulimic Populations

A number of approach tendencies have been explored in bulimic populations:

Social pressure to seek help. It has been suggested that direct social influence stands to play a critical role in helping bulimics get the treatment they need (Rorty, Yager, & Rossotto, 1993). Kent and Clopton (1992) posited that families who are aware of bulimics’ unsuccessful attempts to combat their eating problems might pressure them into seeking help. Crawford (1998) pointed out the consistency between these findings and those in medical, mental health, and substance abuse populations, where treatment-seeking has been shown to be promoted by social influence and symptom related psychosocial problems. With her comparison of bulimics in treatment, bulimics on a self-change regimen, and untreated active bulimics, Crawford (1998) demonstrated that whereas both self-change bulimics and treated bulimics endorsed more social network awareness of their problems than did non-treated bulimics, treated bulimics reported greater discouragement of bulimic tendencies and encouragement of help seeking from others than did both self-change and non-treated bulimics. Parents and friends were identified as most likely to be aware of bulimics’ eating problems and as most likely to promote help seeking. Crawford (1998) concluded that the secrecy that surrounds a typical bulimic’s eating habits might prevent exposure to social network influences that promote help seeking. Krey, Palmer, and Porcelli (1989) argued that bulimics need to be educated about the serious health consequences of their behaviours, as they are likely to hold inaccurate perceptions of their severity. Bulimics are likely to overlook health consequences of their disorder or mistake them for something else, because these complications are slow to evolve (e.g., risk for osteoporosis, dental erosion), nonspecific
(e.g., fatigue, depression, weakness), and often internal (e.g., dehydration, cardiac complications, electrolyte imbalances) (Smalec & Klinge, 2000). Janz and Becker (1984) theorized that advice from others directly influences perceptions of threat, and indirectly influences health-compromising behaviours. Smalec and Klinge (2000) demonstrated that bulimics are most effectively influenced by others to get help when they hear three messages. First, the serious health effects of their disorder need to be communicated in order to heighten bulimics’ perceived severity. Second, bulimics should hear that they are personally susceptible to developing these health complications. Smalec and Klinge (2000) further argued that accurate perceptions of susceptibility are particularly important for bulimics, as bulimia often plagues adolescents and young adults, age groups that typically hold inaccurate perceptions of their vulnerability. Finally, upon examining survey data from 43 self-described bulimics, Smalec and Klinge (2000) demonstrated that these messages of threat are likely to backfire if bulimics’ believe that treatments are ineffective, or believe that they are unable to utilize them (e.g., “I don’t have the courage to get help”). Stated differently, bulimics need to hear messages of threat coupled with messages of treatment efficacy and self efficacy.

*Family dysfunction.* Crawford (1998) reviewed the evidence of family dysfunction as a predictor of treatment-seeking in bulimics. Citing several studies that show that treated bulimics describe their families as displaying higher levels of conflict, low cohesion, and poor communication (e.g., Shisslak, McKeon, & Crago, 1990; Stern et al., 1989), and two studies that demonstrated no differences in family dysfunction between non-treated college bulimics and controls (Kent & Clopton, 1988; 1992),
Crawford (1998) hypothesized that treatment-seeking might be more a function of family problems than of bulimic pathology.

*Life events.* Life events have also been examined as facilitators (i.e., approach tendencies) of treatment-seeking in bulimics. Rorty et al. (1993) reported that 23% of the treated bulimics they interviewed attributed their decision to seek help to increased motivation associated with a positive life event. Sixty percent of this sample also recalled a significant life transition (e.g., beginning university, relationship changes, beginning in the work force) around the time that they commenced recovery. Bowen-Woodward & Levitz (1989) identified college stressors as a motivating factor for the bulimics in treatment that they surveyed. However, Crawford's (1998) groups of treated bulimics, self-change bulimics, and non-treated/active bulimics did not differ in occurrences of notable life events.

Several psychological variables have been examined as possible approach tendencies in bulimics:

*Symptom related variables.* Studies evaluating the influence of severity of symptoms on help seeking have yielded mixed results. Crawford (1998) administered structured interviews to 20 bulimics who had sought treatment, 16 bulimics who had engaged in a self-change regimen aimed at overcoming their bulimia, and 13 active bulimics who had not engaged in any change initiative. Weight history and bulimic behavior patterns were assessed, as were incentives and barriers to treatment, psychosocial problems, and social network feedback about their eating disorder. The treated bulimics had higher scores on global problem severity and psycho-social problems than did the self-change bulimics, who had higher scores than the active
bulimics who had not engaged in any change initiative. Help seeking was also found to be associated with perfectionism and impairment in interoceptive awareness. For the most part however, frequency and duration of specific bulimics behaviours did not differentiate the groups. The exception to this was that treated bulimics were found to be more likely to use diuretics than were bulimics in the other two groups. Moreover, treated bulimics were more likely to report negative health consequences of self-induced vomiting. Fifty percent of the bulimics who had sought treatment reported an increase in weight before seeking treatment, and 50 percent also reported increased binge eating and or purging behaviour prior to treatment. Crawford (1998) concluded that treatment-seeking was facilitated by impaired functioning secondary to the eating disorder rather than by the eating symptoms themselves.

Fairburn, Hay, and Welch (1993) found that clinical bulimics in treatment scored higher on binge eating and self-induced vomiting than did non-treated bulimics. However, no differences were found between the groups on dietary restraint, preoccupation with body shape and weight, or psychological disturbances. Mitchell, Pyle, Eckert, Pomeroy, and Hatsukami (1988) compared bulimics recruited through media advertisement with bulimics in treatment, and found no differences in age of onset, binge eating, induced self-vomiting, weight history, or presence of medical complications. Non-treated bulimics evidenced an earlier reported onset of laxative abuse. Burket and Hodgin (1993) compared 52 bulimics who followed through with treatment after an initial referral with 20 bulimics who were referred but did not attend treatment. Phone interviews were conducted within 24 hours of the initial referral and before the first treatment session. The two groups did not differ in reported frequency of binge eating or
vomiting, duration of their eating problem, history of previous treatment, or the presence of medical complications. Bulimics who did not attend treatment were more likely to report using laxatives and weighing more than their desired weight at referral. One noteworthy weakness of their design is that they were unable to account for the possibility that the no-show bulimics may have sought treatment elsewhere (Burket & Hodgin, 1993).

Wills (1994) compared 50 bulimics in treatment with 27 bulimics who had not sought treatment (all based on DSM-III-R criteria; Diagnostic and statistical manual of mental disorders – third edition, revised, American Psychiatric Association, 1987). Bulimics in treatment were more likely to report more medical problems, a past history of outpatient treatment for depression, greater frequency of binge episodes, using purging behaviours as their primary method of weight control, and more frequent self induced vomiting. The two groups did not differ in weight status, age, alcohol use, history of psychiatric hospitalizations, history of suicide attempts, family history of psychiatric treatment, or number of calories per binge. Treated and non-treated bulimics exhibited similar MMPI/MMPI-2 profiles, with a few exceptions. Treated bulimics had significantly higher scores on scale 3, a measure of histrionic personality components (Greene, 2000; Wills, 1994). Wills (1994) concluded that treated bulimics exhibit significantly more severe eating pathology and associated health consequences than do non-treated bulimics, but that the two groups exhibit similar profiles with respect to emotional distress and underlying psychopathology. Wills (1994) further concluded that medical consequences secondary to bulimic pathology might play a key role in propelling a bulimic into treatment.
In summary, some studies have shown degree of bulimic-specific symptomology to be associated with treatment-seeking, while other studies do not support this finding, emphasizing instead the difficulties and impairments secondary to the eating pathology. Investigations of the influence of medical complications on help seeking also yielded conflicting findings.

Avoidance Tendencies Explored in Bulimic Populations.

A number of variables have been examined as possible deterrents to help seeking in bulimic populations:

Comorbidity. Few researchers have examined the effects of comorbid psychological disorders on help seeking. However, there is some evidence that co-morbid social anxiety deters treatment seeking in bulimics (Goodwin and Fitzgibbon, 2002).

Treatment fearfulness. The process and effects of treatment fearfulness have been largely ignored in investigations of bulimic treatment-seeking. Freeman (1986) observed that half of bulimics in the contemplation stage of readiness are unable to advance to the action stage, as they are concerned with what they will have to give up if they were to change their bulimic behaviours. Freeman (1986) cited several common bulimic fears that deter the change process, including a fear of gaining weight, fear of being unable to cope with negative emotion without the use of food, and a fear of being unable to cope with carbohydrate cravings. Empirical evidence of treatment fearfulness in bulimia further reveals concerns about confidentiality (Bowen-Woodward & Levitz, 1989; Kent & Clopton, 1992; Meyer, 2001). In consideration of the clinical features of bulimia, Crawford (1998) suggests that fears of negative perceptions by others (e.g., the therapist) and of intense shame also inhibit help seeking. Garvin et al. (2001) offered clinical
observations suggestive of shame and denial as deterrents to help seeking in bulimia and noting a dearth in the literature, called for systematic studies to examine attitudinal and emotional predictors of treatment seeking in bulimia.

A Variable That Could Function As Either an Approach or Avoidance Tendency Explored in Bulimic Populations.

Readiness for change. Readiness for change has also been described and examined in bulimic populations and depending on one’s readiness for change, could act as either an approach or an avoidance tendency. Freeman (1986) described the clinical pictures observed with bulimics in the different stages of change. Freeman (1986) reported that few bulimics in the precontemplation stage present for treatment, but that very occasionally, one may be referred by a family physician or pressured into treatment by family members. Killick and Allen (1997) described the typical bulimic precontemplator as a young woman who is pressured into therapy by her family despite the fact that she still does not recognize that she has a problem. Most bulimics who present for treatment initially are in the contemplation stage, and have been so for an extended period of time. Freeman (1986) reported that the average length of time from the onset of bulimic symptoms to treatment-seeking is approximately four years. He hypothesized that the delay may be a function of both guilt about their behaviours and the shame that bulimics expect to feel when their disorder is publicized. Killick and Allen (1997) described the contemplating bulimic as having a “more equal balance of reasons for and against change” (p. 36). They present the example of a woman who desires to eat more normally but who also fears the consequential weight gain. Freeman (1986) argued that approximately half of the bulimics in the contemplation stage advance into the action
phase, while the other half remain in contemplation due to fears regarding the consequences of change. Killick and Allen (1997) argued that the action stage can include both preparation for change and actual behavioural changes (in effect, collapsing together the preparation and action stages originally proposed by Prochaska et al. (1992)). Freeman (1986) refrained from describing bulimics in the maintenance stage, citing a lack of adequate evidence as to how they function and cope.

While Killick and Allen (1997) and Freeman (1986) both provide some rich descriptions of bulimics in the different stages of treatment readiness, their reports are based on clinical observations. They fail to provide adequate empirical data to support their conclusions. Rorty et al. (1993) provided some support for the readiness for change model. They asked 40 bulimics who had been recovered for over a year about the factors that influenced them to begin their road to recovery. Fifty-five percent of respondents reported that their fear of negative social, professional, and medical consequences led them to seek help. Eighty percent of the sample identified feeling tired of having their bulimia dominate their lives as an influence, and 63% of the sample identified finally acknowledging that their eating patterns were problematic for them as an influence. Similarly, when comparing bulimics who had sought treatment with bulimics who had not, Crawford (1998) found that help seeking was facilitated by perceptions of having failed at quitting on one’s own, worries about related health concerns, and by identification of the eating disorder as a serious problem. On the other hand, Crawford (1998) found that the belief that the eating disorder was not serious enough to merit treatment (i.e., precontemplative cognitions) was a significant deterrent of help seeking. Moreover, Meyer (2001) surveyed bulimic adolescent girls regarding their reasons for not
seeking treatment. Consistent with Crawford’s (1998) findings, the primary reason conveyed by the participants was a perception that their eating problems were not problematic enough to merit counseling.

Blake, Turnbull, and Treasure (1997) measured 58 outpatient bulimics on their readiness for change (specifically with respect to binge eating and not weight control), and reported that 3.4% were precontemplators, 13.8% were contemplators, 82.8% were in the action stage, and none were in the maintenance stage. Treasure et al. (1999) reported that only 10% of their sample of 125 bulimics were in the action stage. They argue that the large discrepancy between the two samples could be accounted for by the fact that Blake et al.’s (1997) reported rate of 82.8% was derived by asking the participants how motivated they were to give up binge eating, while Treasure et al.’s (1999) reported rate of 10% was based on simply asking the participants how motivated they were to give up their eating disorder. Treasure et al. (1999) argued that the significantly lower percentage of bulimics scoring in the action stage in their sample may be a function of them having perceived the question to include weight control practices, as opposed to only binge eating. Mizes, Quirk, Dori, Mayer, and Wang (1997) examined the distribution of eating disorder patients (N=20) across the stages of change, and found 25% to be precontemplators, 35% to be contemplators, and 40% in the action stage. The range of percentage of patients in the action stage in these studies can be attributed to a lack of a standardized and psychometrically valid measure of readiness for change. More specifically, participants were categorized into a stage based on her responses to only one or two questions, and these questions changed from study to study. A psychometrically
valid self-report measure of readiness for changing bulimic patterns has yet to be
developed. As such, this variable will not be examined in the present investigation.

*Research Questions and Hypotheses Examined in the Current Study*

A basic goal of the current investigation was to expand our knowledge base with
respect to pathways and barriers to treatment for women with bulimic pathology. To date,
relatively little is known regarding predictors of treatment-seeking in bulimia, as little
research has been conducted and available findings are mixed and inconclusive. Still, a
number of predictor variables have shown promise, and appear worthy of further
clarification and utilization as starting points to expand our understanding of the
treatment-seeking process. A summary of the research questions, hypotheses, and
analytic methods employed in this study are presented in Table 1.

*Research question #1: Identifying fears of treatment that are specific to bulimic
pathology.* No studies to date have systematically examined treatment fearfulness in
bulimic populations. Bulimics are commonly described as feeling terrified of potential
weight gain or of losing control (Chrisler, 1991; DSM-IV, 1994; Mizes, 1994). It follows
that these fears along with other intense feelings typically associated with bulimia (e.g.,
shame; guilt) would translate into a host of fears regarding treatment that are not
experienced by other clinical populations. For instance, bulimics may fear that
interventions will result in them becoming fat, feeling out of control, having their primary
coping strategy for dealing with negative emotions (that is, food) taken from them, being
found out and doomed to experience profound shame (Crawford, 1998; Freeman, 1986;
Garvin et al., 2001; Kent & Clopton, 1992). Such bulimia-exclusive treatment fears have
been informally identified by clinicians, but have been largely ignored in systematic
Table 1

*Research Questions, Specific Hypotheses, and Analytic Methods Employed in the Current Study*

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Hypotheses</th>
<th>Means of Analyses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are there fears of treatment that are exclusive to bulimia? If so, will they be rated as of greater concern to bulimics than are more general fears?</td>
<td>Those with bulimic symptoms will identify fears of entering treatment that are specific to their pathology. These fears will be predictive of treatment seeking among bulimics but not among non-bulimics. These fears will be rated as of greater concern to bulimics than are therapist responsiveness concerns, coercion concerns, stigma concerns, and image concerns.</td>
<td>Qualitative Thematic Analysis Development of measure of bulimic treatment fears Paired Samples t-tests</td>
</tr>
<tr>
<td>2. Do the different types of treatment fearfulness (i.e., therapist responsiveness concerns, image concerns, stigma concerns, coercion concerns) differ as a function of whether or not one has bulimic pathology or as a function of whether or not one has sought help when distress is held constant? Do bulimic-exclusive fears improve the prediction of treatment seeking over and above these variables?</td>
<td>Stigma concern scores will be significantly lower among those who have sought help regardless of their pathology when distress is held constant. Those with bulimic pathology will score higher on coercion concerns than non-bulimic controls. Low coercion concerns will predict treatment seeking among those with bulimic symptoms when distress is controlled. Bulimic-exclusive fears will improve this distress, stigma concerns, and coercion concerns based prediction of treatment seeking.</td>
<td>2 X 2 Factorial MANCOVA</td>
</tr>
<tr>
<td>3. Are women with bulimic symptoms more likely to be high self-concealers than non-bulimic distressed women?</td>
<td>Self-concealment scores will be significantly higher among those with bulimic symptoms than among their non-bulimic counterparts.</td>
<td>Independent samples t-test</td>
</tr>
<tr>
<td>4a. To what degree can attitudes toward seeking professional psychological help, self-concealment, social support, social pressure to seek treatment, distress, and the different types of treatment fearfulness correctly classify treatment seekers and non-seekers among non-bulimic distressed controls?</td>
<td>Positive attitudes toward seeking professional psychological help, low self-concealment, low social support, high social pressure to seek treatment, high stigma concerns, and high distress will each contribute to the classification regarding treatment-seeking status.</td>
<td>Discriminant Function Analysis</td>
</tr>
</tbody>
</table>
4b. To what degree can attitudes toward seeking professional psychological help, distress, medical complications, degree of bulimic symptomology, self-concealment, social support, social pressure to seek treatment, and the different types of treatment fearfulness correctly classify treatment seekers and non-seekers among those with bulimic pathology?

Positive attitudes toward seeking professional psychological help, medical complications, high distress, higher levels of eating pathology, low self-concealment, low social support, high social pressure to seek treatment, high coercion concerns, high stigma concerns, and high bulimic-exclusive fears will each contribute to the classification regarding treatment-seeking status.
research. Considering the relatively low treatment-seeking rates found in bulimic populations (Whitaker et al., 1990), it is plausible that bulimics experience greater degrees of treatment fearfulness than other clinical groups, and that such bulimic-exclusive fears serve as a strong deterrent to treatment-seeking. An important objective of the current investigation was to better our understanding of the fear dynamics that deter bulimics from seeking help. It was hypothesized that sub-threshold and full-syndrome bulimics in the current study would identify fears of treatment that are specific to bulimic pathology, and that these fears would be rated higher (with respect to how much of a concern they are) than therapist responsiveness fears, coercion concerns, stigma concerns, and image concerns.

Research question #2: Examining treatment fearfulness. Therapist responsiveness concerns, image concerns, coercion concerns, and stigma concerns have all been identified as types of treatment fearfulness that deter people from seeking help (Deane & Chamberlain, 1994; Kushner & Sher, 1989; Kushner & Sher, 1991). In their examination of a non-clinical sample, Deane and Chamberlain (1994) reported that of these types of treatment fearfulness, stigma concerns were most influential. The relative influences of these types of treatment fearfulness in clinical samples remain unclear. It was hypothesized that low stigma concerns would predict treatment seeking (in participants with or without bulimic symptomology) when distress is held constant. Clinical descriptions suggest that bulimics often feel out of control (of both their emotions and their eating behaviours), and sensitive to the possibility of having their control taken from them (Chrisler, 1991; Mizes, 1994). Therefore, it was also hypothesized that bulimics in the current study would score higher on coercion concerns than non-bulimic controls, and
that low coercion concerns would predict treatment seeking in bulimics when distress is held constant. Finally, to test the relative importance of the bulimic-exclusive fears identified in this study, it was hypothesized that bulimic-exclusive fears would improve a distress, stigma concerns, and coercion concerns based prediction of treatment seeking.

Research question #3: Examining self-concealment. The relationship between self-concealment and treatment-seeking in general mental health populations is unclear. Cramer (1999) provided a parsimonious explanation of this relationship that accounted for previous conflicting findings. Cramer (1999) posited that self-concealment affects treatment-seeking, but only indirectly. Specifically, high self-concealers are more likely to have negative attitudes toward counseling (which would inhibit treatment-seeking) but higher levels of distress (which would facilitate treatment-seeking). Conflicting findings aside, investigators of these relationships all seem to agree that self-concealment plays an important role in the decision to seek treatment. Bulimics are known to typically hide their feelings and behaviours (particularly with respect to their eating patterns) from others (Freeman, 1986; Herzog et al., 1991). They are thought to be plagued by shame regarding their eating patterns, and by fears of negative perceptions of others (Crawford, 1998; Garvin et al., 2001). As such, one might deduce that bulimics are high self-concealers in general, but to the present author’s knowledge, this has yet to be empirically tested. Given the effects of social pressure to seek treatment on bulimic help seeking (Krey et al., 1989; Smaelec and Klinge, 2000), self-concealment (which could prevent others from applying such pressure) could potentially play a pivotal role in bulimic help seeking. As such, it was hypothesized that individuals with bulimic pathology would score higher on self-concealment than distressed non-bulimic women.
Research question #4a: Predicting treatment-seeking in non-bulimic distressed controls. In order to compare how treatment-seeking dynamics in bulimic populations differ from those in other populations that would benefit from treatment, the influence of a set of treatment-seeking predictors (attitudes toward seeking professional psychological help, self-concealment, distress, social support from family, social support from friends, social pressure to seek help, image concerns, therapist responsiveness concerns, coercion concerns, stigma concerns, and for sake of comparison with the bulimic group, identified bulimic fears, medical complications, and degree of eating pathology) were assessed in a sample of non-bulimic distressed controls. Specifically, it was hypothesized that positive attitudes toward seeking professional psychological help, high levels of distress, low self-concealment, low social support from family, low social support from friends, high social pressure to seek help, and high stigma concerns would contribute to the classification of treatment seekers versus non-seekers in the non-bulimic control group.

Research question #4b: Predicting treatment-seeking in individuals with bulimic symptomology. To date, few studies have examined predictors of treatment-seeking in bulimic populations. Of the studies that have been conducted, none explored the construct of treatment fearfulness. Given that fear is a core component in bulimic pathology, an understanding of the fears that deter bulimics from seeking treatment and of their influence is sorely needed for the improvement of prevention and treatment programs. The identical set of predictors was examined in an attempt to classify individuals with bulimic pathology who have never sought treatment with those who have but who have not yet become immersed in their treatment regimen.
It was hypothesized that high levels of distress, positive attitudes toward seeking professional psychological help, medical complications, high levels of bulimic pathology, low self-concealment, low social support from family, low social support from friends, high social pressure to seek treatment, and high levels of coercion concerns, stigma concerns, and identified bulimic fears would contribute to the classification of bulimic non-treatment seekers and treatment seekers.
Method

Overview

This study consisted of two stages. A preliminary qualitative investigation was carried out to identify treatment fears that are salient for women with bulimic symptoms. This stage of research involved conducting semi-structured interviews with 11 women with bulimic pathology, consulting with 17 mental health professionals who have expertise in the treatment of eating disorders, qualitative thematic analyses, and the development of a quantitative measure of bulimic exclusive treatment fears. This preliminary stage of research is described in detail in Appendix A. The second stage of this study (described in this Method section) employed traditional quantitative analyses of data collected from non-bulimic and bulimic women who have and have not sought professional psychological services. A major goal was to identify factors that differentiate those who have sought treatment from those who have not. We were particularly interested in assessing the importance of treatment fears identified by bulimic women in the earlier qualitative investigation.

Upon receiving ethics clearance from the University of Windsor's Research Ethics Board, data collection was carried out over a one year period beginning in May, 2002. This involved the administration of a battery of questionnaires to distressed bulimic and non-bulimic women who had and who had no history of having sought psychological services. In order to recruit participants from a variety of clinic settings, applications for ethics clearance were also submitted to Research Ethics Boards at the Douglas Hospital in Montreal, Quebec, Queen’s University in Kingston, Ontario, and the Windsor
Regional Hospital in Windsor, Ontario. Copies of clearance letters from these review boards can be found in Appendix B.

Recruitment

A major objective of this study was to assess the criterion validity of the TSFABS, the quantitative measure of bulimic treatment fears developed in the preliminary stage of research (see Appendix A). Specifically, we wanted to know whether the fears identified using qualitative methodologies would discriminate between treatment seekers and non-seekers and if so, whether these fears predict treatment seeking exclusively in women with bulimic pathology. In order to carry out these objectives, recruitment strategies targeted women in the following groups: (1) distressed individuals with bulimic symptoms who have recently sought help for the first time but have not yet initiated treatment, (2) distressed individuals with bulimic symptoms who have never sought psychological treatment, (3) distressed non-bulimic individuals who have recently sought help for the first time but have not yet initiated treatment, and (4) distressed non-bulimic individuals who have never sought psychological treatment. Participants were recruited via a variety of methods and sources (see Appendix C).

Measures

The questionnaire battery consisted of the following measures:

Background Information Sheet

Participants completed a background information sheet consisting of questions pertaining to age, ethnicity, level of education, treatment-seeking history (including time period of help seeking), treatment-seeking intentions, and duration of symptoms, reasons for not seeking help, perceived social pressure to seek treatment, and a checklist of
medical complications known to be associated with bulimia (Wills, 1994; see Appendix D). Perceived social pressure to seek treatment was measured by a single Likert-type question developed by the present author for this study: “Sometimes family or friends pressure people to seek professional help from a counselor, or psychotherapist for personal problems or emotional/psychological difficulties. Please indicate the degree to which in the past month, others have pressured you to seek professional help by circling the number that corresponds with your experience.” The scale ranged from 0 ("Others have not pressured me at all in the past month to seek help") to 8 ("Others have been constantly pressuring me to seek help over the past month").

The Eating Attitudes Test (EAT-26)

The EAT-26 (Garner, Olmsted, Bohr, & Garfinkel, 1982) is a widely used 26-item self-report measure that quantifies pathologic eating attitudes and behaviours (Beebe, 1995; Garner, 1995). Scores also reflect illness severity. Participants indicate how frequently they experience each of the 26 items on a Likert type scale ranging from one (Always) to six (Never). Items are then re-scored according to procedures outlined by Garner and Garfinkel (1979). The EAT-26 is an abbreviated version of the 40-item EAT (Garner & Garfinkel, 1979). The two scales have been shown to be highly correlated with each other ($r = 0.98$; Garner et al., 1982). The EAT-26 has been shown to have high internal consistency with both clinical and control groups, and good convergent validity ($r = .57$ with body image scores) and criterion validity (significantly discriminating between eating disordered individuals and controls; Garner et al., 1982). The EAT-26 can be broken down into three subscales: 1) Dieting, 2) Oral Control, and 3) Bulimia and Food Preoccupation. Although the entire 26 item scale was administered to participants,
the present study utilizes only this latter six-item subscale (Bulimia and Food Preoccupation) as a continuous measure of bulimic pathology. The EAT-26 items are presented in Appendix E.

*The Eating Disorder Diagnostic Scale (EDDS)*

The EDDS (Stice, Telch, & Rizvi, 2000) is a 22-item self-report scale designed to diagnose eating disorders according to *DSM-IV* (1994) diagnostic criteria. The scale employs a combination of Likert, yes-no, write-in response, and frequency formats, and assesses all of the DSM-IV criteria for anorexia, binge-eating disorder, and bulimia. In creating the measure, the authors consulted with fourteen eating disorder experts in order to ensure that the items were as valid as possible, and to weed out known problems associated with past eating disorder diagnostic measures. For instance, the term “binge” is not used in the scale, as past researchers have found that people have different perceptions of what constitutes a binge, making it difficult to interpret such items.

Classifications are made by means of different scoring algorithms for each of the eating disorder diagnoses, and in accordance with DSM-IV instructions, anorexia diagnoses preempt bulimia diagnoses which in turn preempt binge-eating disorder diagnoses. An overall symptom severity composite is also derived from participants’ responses. For the purposes of the present study, the EDDS was used to categorize participants as non-bulimics or as sub-threshold/full syndrome bulimics. Diagnoses derived from the EDDS have demonstrated very good test-retest reliability (mean kappa coefficients of .80), criterion validity (with interview diagnoses; mean kappa coefficients of .83), and convergent validity. The overall symptom composite has also shown very good test-retest reliability ($r = .87$), internal consistency (mean alpha coefficients of .89), and convergent
validity with other eating pathology scales (e.g., the overall symptom composite is significantly correlated with the Eating Concern subscale of the Eating Disorder Examination \( r = .54 \), and with the Disinhibition subscale of the Three-Factor Eating Questionnaire \( r = .63 \); Stice et al., 2000). In the present study, a 23rd item was added to the end of the scale in order to assess duration of eating symptomology. The EDDS items are presented in Appendix F.

*The Self Concealment Scale (SCS)*

The SCS (Larson & Chastain, 1990) is a 10 item self-report measure of an individual’s tendency to conceal negative or distressing personal information. Participants respond on a 1 (strongly agree) to 5 (strongly disagree) Likert type scale, yielding a total possible score from 10 to 50. Greater self-concealment is reflected in higher scores. The scale’s internal consistency appears to be strong (with alpha coefficients ranging from .83 to .88; Cramer & Barry, 1999; Larson & Chastain, 1990) and adequate test-retest reliability has been demonstrated \( r = 0.74 \); Cramer & Barry, 1999). Cramer and Barry (1999) also investigated the factor structure of the SCS in two different university populations, and found the scale to be structurally stable under a unidimensional conceptualization. Larson and Chastain (1990) reported good convergent validity, demonstrating that self-concealment is significantly related to but not redundant with self-disclosure \( r = -.27 \). Moreover, Larson and Chastain (1990) reported that higher self-concealment scores were significantly associated with a propensity to “tell no one” about negative life events and experiences \( r = .41 \). The SCS items are presented in Appendix G.
The Attitudes Toward Seeking Professional Psychological Help – Short form (ATSSPPH-S)

The ATSSPPH-S (Fischer & Farina, 1995) is a 10-item shortened version of the original 29-item version (Fischer & Turner, 1970), with some of the items slightly modified from the original scale. The ATSSPPH-S is designed to assess attitudes toward seeking professional help for psychological problems. Participants are asked to respond to a 4-point Likert type scale ranging from 0 (disagree) to 3 (agree), with more positive attitudes toward seeking professional psychological help reflected by higher scores. The ATSSPPH-S has demonstrated equally strong psychometric properties as the original version (Fischer & Farina, 1995), with scores from the shortened version highly correlating \( r = .87 \) with scores from the original version. The ATSSPPH-S has also yielded good internal consistency (coefficient alpha = .84), test re-test reliability \( r = .80 \) over a 4-week period, and construct validity (the point biserial correlation between having sought professional help in the past was significantly correlated with the attitude towards professional help scores \( r = .39 \); Fischer & Farina, 1995). The ATSSPPH-S items are presented in Appendix H.

The Hopkins Symptom Checklist – 21 items (HSCL-21)

The HSCL-21 (Green, Walkley, McCormick, & Taylor, 1988) is a shortened version of the original Hopkins Symptom Checklist (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) and breaks down into three subscales: general feelings of distress, somatic distress, and performance difficulty. This three-factor structure has been cross-validated in a number of samples, and deemed stable. Each subscale is comprised of seven self-report Likert-type items in which respondents indicate the degree to which
they have experienced each item over the past seven days. Response choices range from 1 (not at all) to 4 (extremely), yielding a score ranging from 7 to 28. The three subscale scores can also be tallied to derive an overall distress score ranging from 21 to 84. Higher scores are indicative of greater distress. Deane, Leatham, and Spicer (1992) compared a clinical sample of outpatient psychotherapy clients with a sample of registered nurses. Total distress scores in the nurses sample \( M = 35.58, SD = 8.52 \) were significantly lower than those produced by the clinical sample \( M = 44.32, SD = 11.29 \), \( t(360) = 8.35, p < .0005 \). Deane et al. (1992) argued that the sample of practicing nurses may experience higher levels of psychological distress as a function of their work than would other "normal" samples, and as such, mean differences between clinical and normal samples may be underestimated in their analysis. The current author chose a cut-off score of 35 on the total distress scale as an inclusion criterion in all comparison groups. This cut-off was chosen based on the observation that scores below 35 are closer to distress scores produced by non-clinical subjects, and as such could be considered to indicate non-clinical levels of distress. The HSCL-21 has evidenced good reliability (split-half reliability of .91 and internal consistency coefficient of .90) and adequate sensitivity and validity (Green et al., 1988). For instance, correlations between the HSCL-21 and the Maslach Burnout Inventory in a sample of nurses ranged from .19 to .56. Moreover, Deane et al., (1992) reported that psychotherapy clients scored higher than nurses on all subscales of the HSCL-21, demonstrated construct validity. Finally, Deane et al. (1992) reported correlations between total HSCL-21 scores and state and trait anxiety scales ranging from .63 to .81, providing additional evidence of construct validity. The HSCL-21 is presented in Appendix I.
The Perceived Social Support Scales (PSS) – shortened version

The PSS (Procidano & Heller, 1983) is composed of two 20-item subscales measuring perceived social support from friends (PSS-Fr) and from family members (PSS-Fa) respectively. These scales are designed to assess perceptions of social support (as opposed to actual social support), and ask participants about their perceptions regarding whether their needs for support and feedback from friends and family are fulfilled. Participants are asked to indicate “no”, “yes”, or “don’t know” for each of the items. Procidano and Heller (1983) report good construct validity (based on significant correlations with social competence ($r = .35$) and self-confidence ($r = -.43$) and internal consistency (Cronbach’s alpha = .88 and .90 for the PSS-Fr and PSS-Fa scales respectively. Ofosu (1999) created a shortened version of the PSS consisting of 10 items on each of the subscales. The PSS-Fa was shortened first, and assessed for psychometric equivalency with the original longer version. The shortened PSS-Fa, yielded a Cronbach’s alpha of .88 and a high correlation with the original 20-item measure ($r = .92$, $p < .001$). For the most part, items on both subscales appear with identical wording with the exception of replacing “family” with “friends” (e.g., “My family is sensitive to my personal needs” versus “my friends are sensitive to my personal needs”). As such, the PSS-Fr was shortened by deleting the items corresponding to those deleted from the PSS-Fa (Ofosu, 1999). For purposes of the present study, the subscale scores of the shortened version were converted to z-scores and then PSS-Fa and PSS-Fr z-scores were summed to create an overall composite score of perceived support. The PSS-Fa and PSS-Fr subscales are presented in Appendix J.
The Thoughts About Psychotherapy Survey (TAPS) Subscales

Based on the Thoughts About Counseling Survey (TACS; Pipes et al., 1985), the TAPS (Deane & Chamberlain, 1994; Kushner & Sher, 1989) is a 30-item self-report measure designed to assess fearfulness about entering psychological treatment. The original TACS had two subscales, measuring concerns regarding therapist competence and professionalism (which they called “therapist responsiveness concerns”), and fears regarding being judged by oneself or others for seeking treatment (which they labeled “image concerns”). Kushner and Sher (1989) modified some of the original measure’s wording, and added items to form a third subscale, measuring concerns regarding being pushed to think, do, or say things against one’s will (labeled “coercion concerns”). Deane and Chamberlain (1994) noted that with the exception of one item, the image concern subscale consists only of fears regarding negative feedback from oneself or one’s therapist. They added an additional 11 items to produce a fourth subscale measuring concerns about what other people (outside the client-therapist relationship) might think about one’s decision to seek treatment. They labeled this subscale “stigma concerns”.

Participants are asked to respond on a Likert scale ranging from 1 (no concern) to 5 (very concerned). Subscale scores are calculated by summing the ratings from the respective subscales. An overall TAPS score can be calculated by summing all of the TAPS items, but this overall score is not used in the present study. The therapist responsiveness concerns subscale can range from 6 to 30, the image concerns subscale can range from 8 to 40, the coercion concerns subscale can range from 4 to 20, and the stigma concerns subscale can range from 11 to 55. Higher scores on all subscales reflect greater treatment fearfulness. The TAPS subscales have demonstrated very good internal consistency.
(Cronbach's alpha for the subscales and overall TAPS score ranging from .79 to .94; Deane & Chamberlain, 1994), and strong concurrent validity (as evidenced by significant correlations between state anxiety and the TAPS subscales ranging from 0.13 to 0.48). The TAPS has also demonstrated adequate construct validity, as evidenced by modest but significant negative correlations with accuracy of expectations about therapy (ranging from 0.14 to 0.17; Deane & Chamberlain, 1994). The TAPS subscales are presented in Appendix K.

*The Treatment Seeking Fears Among Bulimics Scale (TSFABS)*

To date, there are no published measures to assess fears of treatment that are exclusive to bulimic populations. Moreover, there is virtually no research base regarding such fears. A major goal of the present study was to develop a quantitative measure of bulimic-exclusive treatment fearfulness. A detailed account of the preliminary stage of research whereby qualitative methodologies were employed to develop the TSFABS is presented in Appendix A. Briefly, the TSFABS was designed to reflect the fears spontaneously mentioned by interviewed women with bulimic symptoms (in an earlier study). The 53 items (see Appendix A6) were administered in the present study. Upon completion of the data collection phase, data reduction techniques were employed with the objectives of reducing the number of items in the final pool. A description of this process is presented in Appendix L. Principal Component Analysis revealed a one factor solution, and factor regression scores were computed to serve as the final measure of bulimic exclusive treatment fears.
Wrap Up

Upon completion of the questionnaires, participants were asked to confirm that they had not participated more than once in the study (see Appendix M).

A summary of variables and corresponding measures is presented in Table 2.

Participant Groups

This study aimed to identify factors that predict treatment seeking and to further our understanding of how treatment seeking predictors differ between bulimic and non-bulimic women. As such, we attempted to categorize the 354 participants on two dimensions: 1) distressed sub-threshold or full syndrome bulimics and distressed non-bulimics and 2) treatment seekers and non-treatment seekers. A summary of inclusion and exclusion criteria for group membership can be found in Table 3.

Bulimic Classification

Participants were classified as sub-threshold or full syndrome bulimic according to their EDDS responses and specifically if they met all of the following criteria: 1) their responses indicated that they have binged (that is, “eaten what other people would regard as an unusually large amount of food (e.g., a quart of ice cream) given the circumstances and experienced a loss of control (feel that they couldn’t stop or control what or how much they were eating’)) over the past six months, 2) they indicated that they have binged once a week (or more) over the past three months, 3) they indicated that their weight or shape significantly influenced how they think about (or judge) themselves as a person (as evidenced by a score of 3 or greater on EDDS item 3 or EDDS item 4), 4) they indicated that over the past three months, they have either a) vomited or used laxatives/diuretics to prevent weight gain or counteract the effects of eating at least once
<table>
<thead>
<tr>
<th>Variable</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eating Pathology</td>
<td>a. The Eating Disorder Diagnostic Scale (EDDS)</td>
</tr>
<tr>
<td></td>
<td>b. The Bulimia subscale of the Eating Attitudes Test – 26 (EAT-26)</td>
</tr>
<tr>
<td>2. Self-Concealment</td>
<td>The Self-Concealment Scale (SCS)</td>
</tr>
<tr>
<td>3. Treatment Fearfulness</td>
<td>a. The Thoughts about Psychotherapy Scale (TAPS) Subscales:</td>
</tr>
<tr>
<td></td>
<td>- Therapist responsiveness concerns subscale</td>
</tr>
<tr>
<td></td>
<td>- Image concerns subscale</td>
</tr>
<tr>
<td></td>
<td>- Stigma concerns subscale</td>
</tr>
<tr>
<td></td>
<td>- Coercion concerns subscale</td>
</tr>
<tr>
<td></td>
<td>b. Treatment Seeking Fears Among Bulimics Scale (TSFABS)</td>
</tr>
<tr>
<td>4. Perceived Social Support</td>
<td>The Perceived Social Support Scales</td>
</tr>
<tr>
<td></td>
<td>- Social Support – Family subscale</td>
</tr>
<tr>
<td></td>
<td>- Social Support – Friend subscale</td>
</tr>
<tr>
<td>5. Social Pressure to Seek Help</td>
<td>A single Likert type question on the background information sheet</td>
</tr>
<tr>
<td>6. Attitudes Toward Seeking Professional Psychological Help</td>
<td>The Attitudes Toward Seeking Professional Psychological Help – Short Form (ATSPPH-S)</td>
</tr>
<tr>
<td>7. Distress</td>
<td>The Hopkins Symptoms Checklist – 21 (HSCL-21)</td>
</tr>
<tr>
<td>8. Medical Complications</td>
<td>A checklist of medical complications on the background information sheet</td>
</tr>
</tbody>
</table>
Table 3

*Inclusion and Exclusion Criteria for the Four Participant Groups*

<table>
<thead>
<tr>
<th>Participant Group</th>
<th>Description of Group</th>
<th>Inclusion/Exclusion Criteria</th>
</tr>
</thead>
</table>
| 1. Bulimic Treatment Seekers (BTS) | Distressed women with sub-threshold or full-syndrome bulimia who have sought treatment but have not had significant exposure to therapy (i.e., they have had anywhere from 0-2 sessions) | 1. EDDS3>3 or EDDS4>3  
2. EDDS5=1 and EDDS6=1  
3. EDDS8>0  
4. EDDS15>0 or EDDS16>0 or EDDS17 +EDDS18>1  
5. Recruited from treatment facility or YES to sought help in past and YES to sought help in past two years.  
6. HSCL21 total distress > 34 and BMI>17.5  
7. Number of sessions attended to date < 3 (to allow for intake/assessment sessions) |
| 2. Bulimic Non-Treatment Seekers (BNTS) | Distressed women with subthreshold or full-syndrome bulimia who have never sought professional psychological help | 1. EDDS3>3 or EDDS4>3  
2. EDDS5=1 and EDDS6=1  
3. EDDS8>0  
4. EDDS15>0 or EDDS16>0 or EDDS17 +EDDS18>1  
5. Not recruited from a treatment facility  
6. HSCL21 total distress > 34 and BMI>17.5  
7. NO to sought help in the past |
| 3. Non-Bulimic Treatment Seekers (NBTS) | Distressed women who do not have bulimic symptoms, who have sought treatment, but have not had significant exposure to therapy (i.e., they have had anywhere from 0-2 sessions) | 1. EDDS8<1  
2. EDDS15=0 and EDDS16=0  
3. EDDS17+EDDS18<3  
4. HSCL21 total distress > 34  
5. Recruited from treatment facility or YES to sought help in past and YES to sought help in past two years.  
6. HSCL21 total distress > 34 and BMI>17.5  
7. Number of sessions attended to date < 3 (to allow for intake/assessment sessions) |
| 4. Non-Bulimic Non-Treatment Seekers (NBNTS) | Distressed women who do not have bulimic symptoms and who have never sought professional psychological help. | 1. EDDS8<1  
2. EDDS15=0 and EDDS16=0  
3. EDDS17+EDDS18<3  
4. HSCL21 total distress > 34  
5. Not recruited from a treatment facility  
6. HSCL21 total distress > 34 and BMI>17.5  
7. NO to sought help in the past |
a week or b) they have either fasted or engaged in excessive exercise to prevent weight
gain or counteract the effects of eating at least twice a week, 5) their Body Mass Index
(BMI; based on their self-reported weight and height) was at least 17.5 kg/m² (this latter
criterion was used to ensure that the participants did not meet DSM-IV diagnostic criteria
for Anorexia Nervosa; DSM-IV, 1994). These criteria were selected with the goal of
targeting women who meet either full DSM-IV diagnostic criteria for bulimia or who
present with enough bulimic symptoms as to warrant a sub-clinical classification. Using
these criteria, 59 women were classified as sub-threshold/full syndrome bulimic. More
specifically, 18 women met DSM-IV diagnostic criteria for full-syndrome Bulimia
Nervosa (as per cut-offs described by Stice et al., 2000) and the remaining 41 women are
considered to be sub-threshold bulimics.

Non-Bulimic Classification

Participants were classified as non-bulimic according to their EDDS responses
and specifically if they met all of the following criteria: 1) they either have never binged
or on average over the past three months, they have binged zero times per week, 2) on
average over the past three months, they have vomited or used laxatives/diuretics (to
prevent weight gain or counteract the effects of eating) zero times per week, 3) on
average over the past three months, they have fasted or engaged in excessive exercise
episodes (for purposes of preventing weight gain or counteracting the effects of eating)
less than three times, and 4) their Body Mass Index (BMI; based on their self-reported
weight and height) was at least 17.5 kg/m² (this latter criterion was used to ensure that the
participants did not meet DSM-IV diagnostic criteria for Anorexia Nervosa; DSM-IV,
1994). These criteria were selected so as to include only women without eating disorder
symptoms. Using these criteria, 86 women were classified as non-bulimic. We note that of the 354 women who participated in this study, 199 women did not meet criteria for either a bulimic classification or a non-bulimic classification. That is, their symptoms were too severe as to warrant a non-bulimic classification but not severe enough as to warrant a bulimic classification.

*Treatment Seeker Classification*

Participants were classified as treatment-seekers if they met all of the following criteria: 1) they were either recruited from a treatment facility or they indicated on the background information sheet that in they have sought “help from a counselor or therapist for a personal-emotional or psychological problem” and that they “have seen a therapist or counselor (even once) in the past two years”, 2) they indicated significant distress as evidenced by a score of 35 or greater on the HSCL-21 Total Distress scale, 3) they indicated on the information background sheet that the number of times they met with a therapist/counselor was less than three. This latter criterion was chosen in order to ensure that although participants had sought professional help, they had yet to be exposed to therapy, so as to avoid biased responses regarding treatment fears. We did however choose to include participants who have had one or two sessions as these first sessions were intakes or assessments, and the clinicians were unwilling to present information regarding the study until these assessments were complete. Using these criteria, 43 women were classified as treatment-seekers.

*Non-Treatment Seeker Classification*

Participants were classified as non-treatment seekers if they met all of the following criteria: 1) they were not recruited from a treatment facility, 2) they indicated
on the background information sheet that they have never “sought help from a counselor or therapist for a personal-emotional or psychological problem”, 3) they indicated significant distress as evidenced by a score of 35 or greater on the HSCL-21 Total Distress scale. Using these criteria, 102 women were classified as non-treatment-seekers. We note that of the 354 women who participated in this study, 209 women did not meet criteria for either a treatment seeking classification or a non-treatment seeking classification, That is, they have sought help in the past but they have seen a therapist more than twice in their life.

Summary

Considered collectively, 68 women were classified as non-bulimic non-treatment seekers, 17 women were classified as non-bulimic treatment seekers, 34 women were classified as sub-threshold/full syndrome bulimic non-treatment seekers, and 25 women were classified as sub-threshold/full syndrome bulimic treatment seekers. Recruitment source break-downs for each group are presented in Table 4.
Table 4

*Participant Groups Broken Down by Recruitment Source*

<table>
<thead>
<tr>
<th>Non-Bulimic Non-Treatment Seeking Group</th>
<th>Number Recruited</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undergraduate Participant Pool</td>
<td>65</td>
<td>95.59</td>
</tr>
<tr>
<td>Snowball Sampling via E-mail</td>
<td>3</td>
<td>4.41</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>68</td>
<td></td>
</tr>
</tbody>
</table>

*Note: 95.59% recruited from participants in Windsor, Ontario.*

<table>
<thead>
<tr>
<th>Non-Bulimic Treatment Seeking Group</th>
<th>Number Recruited</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undergraduate Participant Pool</td>
<td>2</td>
<td>11.8</td>
</tr>
<tr>
<td>Internet Based Eating Disorder Support</td>
<td>1</td>
<td>5.9</td>
</tr>
<tr>
<td>Group Bulletin Boards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centre for Psychological Services,</td>
<td>1</td>
<td>5.9</td>
</tr>
<tr>
<td>University of Ottawa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>McGill University Mental Health</td>
<td>13</td>
<td>76.5</td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL:</td>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>

*Note: 76.5% recruited from participants in Montreal, Quebec.*
### Bulimic Non-Treatment Seeking Group

<table>
<thead>
<tr>
<th>Source</th>
<th>Number Recruited</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undergraduate Participant Pool</td>
<td>21</td>
<td>61.8</td>
</tr>
<tr>
<td>Internet Based Eating Disorder Support Group Bulletin Boards</td>
<td>10</td>
<td>29.4</td>
</tr>
<tr>
<td>Snowball Sampling via E-mail</td>
<td>2</td>
<td>5.8</td>
</tr>
<tr>
<td>Internet Based Depression Support Group Bulletin Boards</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>34</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Note: 61.8% recruited from participants in Windsor, Ontario.*

### Bulimic Treatment Seeking Group

<table>
<thead>
<tr>
<th>Source</th>
<th>Number Recruited</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undergraduate Participant Pool</td>
<td>2</td>
<td>8.0</td>
</tr>
<tr>
<td>Internet Based Eating Disorder Support Group Bulletin Boards</td>
<td>4</td>
<td>16.0</td>
</tr>
<tr>
<td>Bulimia and Anorexia Association (BANA)</td>
<td>4</td>
<td>16.0</td>
</tr>
<tr>
<td>Eating Disorders Clinic, Douglas Hospital</td>
<td>2</td>
<td>8.0</td>
</tr>
<tr>
<td>Sheena’s Place</td>
<td>1</td>
<td>4.0</td>
</tr>
<tr>
<td>Queen’s University Adult Eating Disorder Clinic</td>
<td>4</td>
<td>16.0</td>
</tr>
<tr>
<td>McGill University Mental Health Services</td>
<td>8</td>
<td>32.0</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>25</strong></td>
<td></td>
</tr>
</tbody>
</table>
Results

All statistical analyses were computed using SPSS v. 11.02 for Windows. Unless otherwise indicated, the alpha level used to assess statistical significance was set to .05. With the exception of the statistical analyses conducted in the development of the TSFABS (described in Appendix L), all analyses aimed to compare bulimics and non-bulimics and treatment seekers and non-seekers. As such, the following summaries of data cleaning and statistical findings are based on the sub-sample of 144 non-bulimic and bulimic treatment seekers and non-seekers.

Demographic Information and Descriptive Statistics

Demographic information for each of the four groups and for the entire sample is presented in Table 5. Descriptive statistics for all variables in the present study are displayed for non-bulimic non-treatment seekers, non-bulimic treatment seekers, bulimic non-treatment seekers, and bulimic treatment seekers in Tables 6, 7, 8, and 9 respectively.

Data Screening

Missing values were rarely evidenced throughout the dataset, and were replaced with group means for each variable (Tabachnick & Fidell, 1996). All variables were first subjected to a screening process in order to test the assumptions required for multivariate analyses. Cronbach Alphas were computed for each variable revealing strong internal consistency for all measures (ranging from .81 to .97). Z-score equivalents were computed for each variable within each of the four groups in order to identify univariate outliers. One univariate outlier was found in the non-bulimic non-treatment seeking group on the Social Pressure to Seek Help measure. Two univariate outliers were found in the non-bulimic non-treatment seeking group and one univariate outlier was found in
Table 5

Demographic Information for Each of the Four Groups and for the Entire Sample.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Non-Bulimic Non-Treatment Seekers (n=68)</th>
<th>Non-Bulimic Treatment Seekers (n=17)</th>
<th>Bulimic Non-Treatment Seekers (n=34)</th>
<th>Bulimic Treatment Seekers (n=25)</th>
<th>Total Sample (n=144)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>M 21.28</td>
<td>M 23.12</td>
<td>M 21.19</td>
<td>M 22.52</td>
<td>M 21.87</td>
</tr>
<tr>
<td>SD</td>
<td>2.41</td>
<td>5.89</td>
<td>4.02</td>
<td>4.71</td>
<td>3.83</td>
</tr>
<tr>
<td>Ethnicity (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African-American / African-Canadian</td>
<td>8.8</td>
<td>0.0</td>
<td>5.9</td>
<td>0.0</td>
<td>5.6</td>
</tr>
<tr>
<td>Caucasian</td>
<td>63.2</td>
<td>58.8</td>
<td>61.8</td>
<td>72.0</td>
<td>63.9</td>
</tr>
<tr>
<td>East Asian</td>
<td>8.8</td>
<td>5.9</td>
<td>11.8</td>
<td>4.0</td>
<td>8.3</td>
</tr>
<tr>
<td>European</td>
<td>7.4</td>
<td>11.8</td>
<td>5.9</td>
<td>8.0</td>
<td>7.6</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1.5</td>
<td>5.9</td>
<td>2.9</td>
<td>0.0</td>
<td>2.1</td>
</tr>
<tr>
<td>South Asian</td>
<td>2.9</td>
<td>5.9</td>
<td>5.9</td>
<td>8.0</td>
<td>4.9</td>
</tr>
<tr>
<td>Other</td>
<td>7.4</td>
<td>11.8</td>
<td>5.9</td>
<td>8.0</td>
<td>7.6</td>
</tr>
<tr>
<td>Highest Level of Education Completed (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary School</td>
<td>1.5</td>
<td>0.0</td>
<td>2.9</td>
<td>4.0</td>
<td>1.4</td>
</tr>
<tr>
<td>High School</td>
<td>0.0</td>
<td>0.0</td>
<td>20.6</td>
<td>12.0</td>
<td>7.6</td>
</tr>
<tr>
<td>Some College or University</td>
<td>83.8</td>
<td>64.7</td>
<td>67.6</td>
<td>52.0</td>
<td>72.2</td>
</tr>
<tr>
<td>College or University Degree</td>
<td>11.8</td>
<td>11.8</td>
<td>5.9</td>
<td>20.0</td>
<td>11.8</td>
</tr>
<tr>
<td>Some Masters or Doctoral studies</td>
<td>1.5</td>
<td>17.6</td>
<td>2.9</td>
<td>8.0</td>
<td>4.9</td>
</tr>
<tr>
<td>Masters or Doctoral degree</td>
<td>1.5</td>
<td>5.9</td>
<td>0.0</td>
<td>4.0</td>
<td>2.1</td>
</tr>
</tbody>
</table>
Table 6

Means, Standard Deviations, and Ranges of All Variables for Non-Bulimic Non-Treatment Seekers ($N=68$)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>21.28</td>
<td>2.41</td>
<td>18 – 30</td>
</tr>
<tr>
<td>Attitudes Toward Help Seeking</td>
<td>17.05</td>
<td>5.12</td>
<td>7 – 27</td>
</tr>
<tr>
<td>HSCL-21 (Total Distress)</td>
<td>43.16</td>
<td>6.29</td>
<td>35 – 59</td>
</tr>
<tr>
<td>EAT-26 Bulimia Subscale</td>
<td>0.85</td>
<td>2.11</td>
<td>0 – 11</td>
</tr>
<tr>
<td>Number of endorsed medical problems</td>
<td>1.26</td>
<td>0.75</td>
<td>0 – 3</td>
</tr>
<tr>
<td>Self-Concealment Scale</td>
<td>28.43</td>
<td>8.52</td>
<td>10 – 50</td>
</tr>
<tr>
<td>Social Pressure to Seek Help</td>
<td>0.66</td>
<td>1.39</td>
<td>0 – 6</td>
</tr>
<tr>
<td>Social Support – Family</td>
<td>14.32</td>
<td>5.45</td>
<td>0 – 20</td>
</tr>
<tr>
<td>Social Support – Friends</td>
<td>14.85</td>
<td>4.52</td>
<td>2 – 20</td>
</tr>
<tr>
<td>Coercion Concerns</td>
<td>9.13</td>
<td>3.77</td>
<td>4 – 19</td>
</tr>
<tr>
<td>Image Concerns</td>
<td>18.19</td>
<td>7.09</td>
<td>8 – 37</td>
</tr>
<tr>
<td>Stigma Concerns</td>
<td>23.86</td>
<td>10.47</td>
<td>11 – 55</td>
</tr>
<tr>
<td>Therapist Responsiveness Concerns</td>
<td>14.25</td>
<td>6.24</td>
<td>6 – 30</td>
</tr>
<tr>
<td>Overall TAPS</td>
<td>67.86</td>
<td>22.49</td>
<td>30 - 137</td>
</tr>
<tr>
<td>TSFABS Regression Factor Scores</td>
<td>-0.07</td>
<td>0.83</td>
<td>-1.47 - 2.37</td>
</tr>
</tbody>
</table>
Table 7

*Means, Standard Deviations, and Ranges of All Variables for Non-Bulimic Treatment Seekers (N=17)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>23.12</td>
<td>5.89</td>
<td>18 – 44</td>
</tr>
<tr>
<td>Attitudes Toward Help Seeking</td>
<td>18.17</td>
<td>6.15</td>
<td>8 – 27</td>
</tr>
<tr>
<td>HSCL-21 (Total Distress)</td>
<td>48.34</td>
<td>11.59</td>
<td>36 – 75</td>
</tr>
<tr>
<td>EAT-26 Bulimia Subscale</td>
<td>0.47</td>
<td>1.28</td>
<td>0 – 5</td>
</tr>
<tr>
<td>Number of endorsed medical problems</td>
<td>1.00</td>
<td>0.87</td>
<td>0 – 3</td>
</tr>
<tr>
<td>Self-Concealment Scale</td>
<td>28.23</td>
<td>9.48</td>
<td>15 – 48</td>
</tr>
<tr>
<td>Social Pressure to Seek Help</td>
<td>2.29</td>
<td>2.20</td>
<td>0 - 7</td>
</tr>
<tr>
<td>Social Support – Family</td>
<td>10.06</td>
<td>5.97</td>
<td>1 – 18</td>
</tr>
<tr>
<td>Social Support – Friends</td>
<td>15.29</td>
<td>5.31</td>
<td>0 – 20</td>
</tr>
<tr>
<td>Coercion Concerns</td>
<td>7.98</td>
<td>3.79</td>
<td>4 – 16</td>
</tr>
<tr>
<td>Image Concerns</td>
<td>18.09</td>
<td>7.84</td>
<td>8 – 35</td>
</tr>
<tr>
<td>Stigma Concerns</td>
<td>21.39</td>
<td>7.92</td>
<td>11 – 37</td>
</tr>
<tr>
<td>Therapist Responsiveness Concerns</td>
<td>14.29</td>
<td>6.78</td>
<td>6 – 26</td>
</tr>
<tr>
<td>Overall TAPS</td>
<td>64.83</td>
<td>18.41</td>
<td>30 – 103</td>
</tr>
<tr>
<td>TSFABS Regression Factor Scores</td>
<td>-0.11</td>
<td>0.69</td>
<td>-1.25 – 1.13</td>
</tr>
</tbody>
</table>
Table 8

*Means, Standard Deviations, and Ranges of All Variables for Bulimic Non-Treatment Seekers (N=34)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>21.91</td>
<td>4.02</td>
<td>17–35</td>
</tr>
<tr>
<td>Attitudes Toward Help Seeking</td>
<td>15.62</td>
<td>6.05</td>
<td>3–29</td>
</tr>
<tr>
<td>HSCL-21 (Total Distress)</td>
<td>53.71</td>
<td>11.78</td>
<td>35–73</td>
</tr>
<tr>
<td>EAT-26 Bulimia Subscale</td>
<td>6.44</td>
<td>5.14</td>
<td>0–18</td>
</tr>
<tr>
<td>Number of endorsed medical problems</td>
<td>2.26</td>
<td>1.21</td>
<td>0–5</td>
</tr>
<tr>
<td>Self-Concealment Scale</td>
<td>36.79</td>
<td>9.57</td>
<td>16–50</td>
</tr>
<tr>
<td>Social Pressure to Seek Help</td>
<td>1.62</td>
<td>1.92</td>
<td>0–7</td>
</tr>
<tr>
<td>Social Support – Family</td>
<td>10.85</td>
<td>6.48</td>
<td>0–20</td>
</tr>
<tr>
<td>Social Support – Friends</td>
<td>12.00</td>
<td>6.31</td>
<td>0–20</td>
</tr>
<tr>
<td>Coercion Concerns</td>
<td>12.81</td>
<td>4.71</td>
<td>4–20</td>
</tr>
<tr>
<td>Image Concerns</td>
<td>26.18</td>
<td>8.46</td>
<td>9–40</td>
</tr>
<tr>
<td>Stigma Concerns</td>
<td>33.55</td>
<td>13.99</td>
<td>11–55</td>
</tr>
<tr>
<td>Therapist Responsiveness Concerns</td>
<td>19.43</td>
<td>6.18</td>
<td>9–30</td>
</tr>
<tr>
<td>Overall TAPS</td>
<td>94.59</td>
<td>30.25</td>
<td>39–147</td>
</tr>
<tr>
<td>TSFABS Regression-Factor Scores</td>
<td>0.90</td>
<td>1.01</td>
<td>-0.97–2.59</td>
</tr>
</tbody>
</table>
Table 9

*Means, Standard Deviations, and Ranges of All Variables for Bulimic Treatment Seekers*

*(N=25)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>22.52</td>
<td>4.71</td>
<td>18 – 37</td>
</tr>
<tr>
<td>Attitudes Toward Help Seeking</td>
<td>20.40</td>
<td>6.01</td>
<td>10 – 29</td>
</tr>
<tr>
<td>HSCL-21 (Total Distress)</td>
<td>57.40</td>
<td>13.71</td>
<td>35 – 80</td>
</tr>
<tr>
<td>EAT-26 Bulimia Subscale</td>
<td>8.76</td>
<td>5.49</td>
<td>0 – 18</td>
</tr>
<tr>
<td>Number of endorsed medical problems</td>
<td>2.08</td>
<td>1.35</td>
<td>0 – 4</td>
</tr>
<tr>
<td>Self-Concealment Scale</td>
<td>34.32</td>
<td>9.96</td>
<td>10 – 50</td>
</tr>
<tr>
<td>Social Pressure to Seek Help</td>
<td>3.32</td>
<td>2.58</td>
<td>0 – 7</td>
</tr>
<tr>
<td>Social Support – Family</td>
<td>11.68</td>
<td>5.07</td>
<td>2 – 20</td>
</tr>
<tr>
<td>Social Support – Friends</td>
<td>13.00</td>
<td>4.41</td>
<td>4 – 20</td>
</tr>
<tr>
<td>Coercion Concerns</td>
<td>10.64</td>
<td>4.86</td>
<td>4 – 20</td>
</tr>
<tr>
<td>Image Concerns</td>
<td>19.91</td>
<td>7.50</td>
<td>8 – 40</td>
</tr>
<tr>
<td>Stigma Concerns</td>
<td>26.48</td>
<td>13.81</td>
<td>11 – 55</td>
</tr>
<tr>
<td>Therapist Responsiveness Concerns</td>
<td>17.92</td>
<td>7.30</td>
<td>7 – 30</td>
</tr>
<tr>
<td>Overall TAPS</td>
<td>78.38</td>
<td>27.99</td>
<td>40 – 140</td>
</tr>
<tr>
<td>TSFABS Regression Factor Scores</td>
<td>0.18</td>
<td>0.95</td>
<td>-1.31 – 1.93</td>
</tr>
</tbody>
</table>
the non-bulimic treatment seeking group on the EAT-26 bulimic subscale score. These offending scores were altered to one unit larger than the next most extreme score in order to reduce their influence. Mahalanobis Distances were inspected for all variables within each of the four groups, and no multivariate outliers were identified. A number of variables were found to be moderately skewed in the four groups. However, transformations were not deemed necessary and were not utilized (Tabachnick & Fidell, 1996). Box M tests were computed for all MANOVAs and none were found significant at $p = .001$, indicating homogeneity of variance-covariance (Tabachnick & Fidell, 1996).

Given the unequal cell sizes and the relatively small size ($n=17$) of the non-bulimic treatment seeking group, all multivariate analyses were crosschecked with non-parametric equivalent analyses whereby variables were first converted to ordinal (ranked) data before being subjected to analyses. A summary of the non-parametric findings (and when they differed from the standard parametric findings) is presented in Appendix N.

**Exploration of Covariates**

In order to test the effects of age and distress on help seeking and bulimic status, two $2 \times 2$ factorial ANOVAs were computed with treatment seeking and bulimic status as independent variables. Age did not significantly vary as a function of bulimic status, $F(1,140) = .00, p = .99, MSE = 14.23$ or treatment seeking $F(1,140) = 2.88, p = .09, MSE = 14.23$, and the bulimic status X treatment seeking interaction was also not significant, $F(1,140) = .72, p = .39, MSE = 14.23$. Distress did significantly vary as a function a function of bulimic status, $F(1,140) = 27.12, p = .00, MSE = 99.22$ and as a function of treatment seeking, $F(1,140) = 5.54, p = .02, MSE = 99.22$. The interaction term was insignificant, $F(1,140) = .16, p = .69, MSE = 99.22$. Examination of cell means indicate
that women with bulimic symptoms were significantly more distressed \((M = 55.27, SD = 12.65)\) than non-bulimic women \((M = 44.19, SD = 7.85)\), and that treatment seekers were significantly more distressed \((M = 53.73, SD = 13.51)\) than non-treatment seekers \((M = 46.68, SD = 9.83)\). Distress was also significantly related to a number of the independent variables explored in this study. As such, it was used as a covariate in a number of analyses in order to test hypothesized relationships when distress is held constant.

The effects of level of education on help seeking and bulimic status were also assessed as a possible confounding variable. Education was originally measured ordinarily, and was therefore converted to an interval approximation of years of education using the following conversions: completed elementary school = 6 years, completed high school = 12 years, taken some college/university courses = 14 years, completed a college or university degree = 16 years, taken some Masters or Doctoral coursework = 17 years, completed a Masters or Doctoral degree = 19 years. A 2x2 ANOVA was computed and revealed a main effect for treatment seeking, \(F(1,140) = 6.05, p = .015, MSE = 2.45\) indicating that treatment seekers \((M = 14.59, SD = 2.12)\) were significantly more educated than non-treatment seekers \((M = 14.07, SD = 1.33)\). A main effect for bulimic status was also found, \(F(1,140) = 6.79, p = .01, MSE = 2.45\) indicating that non-bulimics \((M = 14.47, SD = 1.15)\) were significantly more educated than bulimics \((M = 13.86, SD = 2.06)\). The interaction term was not significant, \(F(1,140) = .001, p = .981, MSE = 2.45\).

Correlation matrices for each of the four groups (see Appendices O, P, Q, R, and S) were then examined to assess how education relates to the predictor variables explored in the analyses. In the bulimic non-treatment seeking group, years of education was negatively correlated with social pressure to seek help \((r = 0.52, p = .002)\) and positively correlated
with social support from friends \( r = .41, p = .016 \). In the bulimic treatment seeking group, years of education was positively correlated with distress \( r = .52, p = .008 \), therapist responsiveness concerns \( r = .40, p = .047 \), and image concerns \( r = .42, p = .034 \). Years of education was not significantly correlated with any predictor variable in the non-bulimics groups. With all four groups considered collectively, years of education correlated only with social support from friends \( r = .27, p = .001 \). Two strategies were employed in order to examine how education differences among the groups impacted on the analyses. First, since the bulimic groups had several participants that had not enrolled in college or university, all analyses that involved comparing the four groups were re-calculated with the inclusion of only those participants who indicated that they had enrolled in college or university. The pattern of results in these analyses remained identical to those produced with all participants included. Second, all analyses that involved comparing the four groups were re-calculated using years of education as a covariate. Once again, the pattern of results remained essentially the same (i.e., 100% concordance with respect to which variables were and were not significant) as those produced without the covariate. Since education was not included in any of the study’s hypotheses and yielded no significant effect on the pattern of results, it was not included as a covariate in the analyses reported in this document.

The effects of ethnicity on help seeking and bulimic status were also assessed as a potential confound. A chi-square test was performed to determine whether there were any differences between the four groups with respect to the number of ethnic minorities (i.e., non-Caucasians), \( \chi^2(1) = 1.078, p = .299 \), indicating that there were no significant
between-group differences in the number of participants who were members of ethnic minorities.

Research Question #1

Part A. It was hypothesized that bulimic exclusive treatment fears would be identified, and that these fears would be predictive of treatment seeking among bulimics but not among non-bulimics.

The identification of bulimic exclusive fears and the development of a quantitative measure of such fears are presented in Appendices A and L. In summary, 53 fear items were subjected to principal component analysis and best fit a one-factor solution (with one item dropped). To test whether this measure of bulimic exclusive fears predicts treatment seeking uniquely in bulimics, a 2 x 2 ANCOVA was calculated with the bulimic exclusive treatment fear factor scores as the dependent variable and distress as the covariate. With distress held constant, no main effect for bulimic status was found, $F(1, 139) = 2.39, p = .12, MSE = .62$. A main effect for treatment seeking status was found, with non-treatment seekers ($M = .043, SD = 1.05$) scoring significantly higher on the TSFABS factor than treatment seekers ($M = -.11, SD = .86$), $F(1, 139) = 13.66, p = .00, MSE = .62$. A significant 2-way interaction was also found, $F(1, 139) = 5.67, p = .02, MSE = .62$. However, the associations between the bulimic exclusive treatment fear factor scores and treatment seeking status and the interaction were quite low (partial $\eta^2 = .09$ and partial $\eta^2 = .04$ respectively). In order to explore the significant interaction term, the cell TSFABS factor score means were subjected to the Tukey HSD post-hoc test. The bulimic non-treatment seeking group yielded significantly higher TSFABS factor scores ($M = .77, SD = 1.19$) than the bulimic treatment seekers ($M = .02, SD = .98$), non-bulimic
non-treatment seekers ($M = -.32$, $SD = .76$), and non-bulimic treatment seekers ($M = -.29$, $SD = .65$) ($p < .01$ for all three comparisons). Moreover, the remaining three groups did not differ significantly from each other ($p > .05$). In summary, this hypothesis was supported, as bulimic non-treatment seekers produced higher TSFABS factor scores than did the other three groups, suggesting that the fears tapped by the TSFABS may play an important role of keeping women with bulimic symptoms from seeking help.

Part B. It was also hypothesized that the identified bulimic fears would be rated as of greater concern to bulimics than are therapist responsiveness concerns (TRC), coercion concerns (CC), stigma concerns (STC), and image concerns (IC). To test this hypothesis, mean item ratings (collapsing across bulimic groups) were computed for each of the five measures using the unranked scores (see Table 10) and four paired-samples t-tests were computed to test for mean differences between the TSFABS ratings and ratings on each of the four TAPS subscales. A Bonferroni type adjustment (Tabachnick & Fidell, 1996) was implemented (i.e., $p = .0125$ was used) in order to control for the possibility of inflated Type I error resulting from multiple comparisons. Not only was this hypothesis not supported but in fact, the TSFABS ratings were significantly lower than coercion concern ratings, $t(58) = 4.29$, $p < .001$, image concern ratings, $t(58) = 4.88$, $p < .001$, and therapist responsiveness concern ratings, $t(58) = 4.89$, $p < .001$. With the Bonferroni correction, the TSFABS ratings were not significantly different than stigma concern ratings, $t(58) = 2.09$, $p = .04$. 
Table 10

_Mean Item Ratings for the Coercion Concern, Image Concern, Stigma Concern, and Therapist Responsiveness Concern Subscales of the TAPS and for the TSFABS (n=59 women with bulimic symptoms)_

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coercion Concern Ratings</td>
<td>2.97</td>
<td>1.21</td>
</tr>
<tr>
<td>Image Concern Ratings</td>
<td>2.94</td>
<td>1.07</td>
</tr>
<tr>
<td>Stigma Concern Ratings</td>
<td>2.78</td>
<td>1.29</td>
</tr>
<tr>
<td>Therapist Responsiveness Concern Ratings</td>
<td>3.13</td>
<td>1.11</td>
</tr>
<tr>
<td>TSFABS Ratings</td>
<td>2.57</td>
<td>.97</td>
</tr>
</tbody>
</table>

1. Means are reflective of Likert type scale ratings where 1 = no concern at all, 2 = a little concerned, 3 = concerned, 4 = pretty concerned, and 5 = very concerned.
Research Question #2

Part A. It was hypothesized that the four general treatment fearfulness dimensions would vary as a function of treatment seeking and bulimic status when distress is held constant. Specifically, it was hypothesized that women who have not sought help would score higher than women who had sought help on stigma concerns (regardless of whether or not they have bulimic symptoms), and that women in the bulimic groups would score higher on coercion concerns than women in the non-bulimic groups (regardless of whether or not they have sought help). It was also hypothesized that bulimic non-treatment seekers would score higher on coercion concerns than bulimic treatment seekers. To test these hypotheses, a 2x2 MANCOVA was calculated using HSCL-21 distress scores as the covariate, treatment seeking and bulimic status as the independent variables, and the four TAPS subscale scores as dependent variables. With distress held constant, a main effect for treatment seeking was found, Wilks’ \( \Lambda = .90 \), \( F(4,136) = 3.74 \), \( p = .006 \). The association between the TAPS subscale scores and treatment seeking was fairly low however, partial \( \eta^2 = .10 \). The main effect for bulimic status (Wilk’s \( \Lambda = .95 \), \( F(4,136) = 1.62 \), \( p = .17 \)) and the bulimic status X treatment seeking interaction (Wilk’s \( \Lambda = .94 \), \( F(4,136) = 2.05 \), \( p = .09 \)) were not found to be significant. Using Bonferroni corrections (with alpha set to .0125), univariate Fs revealed significant main effects for treatment seeking on image concerns, \( F(1,139) = 13.58 \), \( p < .0001 \), \( MSE = 45.14 \), partial \( \eta^2 = .09 \), coercion concerns, \( F(1,139) = 10.43 \), \( p = .002 \), \( MSE = 14.99 \), partial \( \eta^2 = .07 \), and stigma concerns, \( F(1,139) = 9.28 \), \( p = .003 \), \( MSE = 123.65 \), partial \( \eta^2 = .06 \) with distress held constant. Non-treatment seekers scored higher on image concerns (\( M = 20.85 \), \( SD = 8.43 \)) than did treatment seekers (\( M = 19.18 \), \( SD = 7.60 \)). Non-treatment
seekers also scored significantly higher on coercion concerns ($M = 10.36$, $SD = 4.43$) than did treatment seekers ($M = 9.56$, $SD = 4.61$). Finally, non-treatment seekers scored higher on stigma concerns ($M = 27.09$, $SD = 12.56$) than did treatment seekers ($M = 24.42$, $SD = 11.94$). Non-treatment seekers and treatment seekers did not differ on therapist responsiveness concerns, $F(1,139) = 1.75$, $p = .188$, $MSE = 38.68$. In summary, the hypothesis that non-treatment seekers would score higher on stigma concerns than treatment seekers was supported. The hypothesis that women with bulimic symptoms would score higher on coercion concerns than women without bulimic symptoms was not supported. Finally, the hypothesis that specifically bulimic non-treatment seekers would score higher on coercion concerns than bulimic treatment seeker was not supported, as coercion concerns differed between treatment seekers and non-treatment seekers as a whole, and not exclusively in the bulimic groups.

**Part B.** It was further hypothesized that identified bulimic exclusive fears would improve the prediction of treatment seeking in women with bulimic symptoms, once distress and the treatment fear dimensions explored above are held constant. To test this hypothesis, a 2 X 2 ANCOVA on TSFABS factor scores was employed with distress, image concerns, stigma concerns, and coercion concerns as covariates. The therapist responsiveness concerns variable was left out of this equation as it was not significant in the MANCOVA described above. With these four covariates held constant, TSFABS factor scores contributed significantly to the two-way interaction term, $F(1,136) = 3.84$, $p = .052$, $MSE = .188$, partial $\eta^2 = .03$. No main effects for treatment seeking, $F(1,136) = .67$, $p = .415$, $MSE = .188$, or bulimic status, $F(1,136) = .09$, $p = .760$, $MSE = .188$ were found. In summary, this hypothesis was supported, as with distress, image concerns,
stigma concerns, and coercion concerns held constant, TSFABS factor scores were significantly higher among bulimic non-treatment seekers (M = .77, SD = 1.19) than among bulimic treatment seekers (M = .02, SD = .98) but did not differ between non-bulimic non-treatment seekers (M = -.32, SD = .76) and non-bulimic treatment seekers (M = -.29, SD = .65).

Research Question 3

It was hypothesized that women with bulimic symptoms would score higher on self-concealment than women without bulimic symptoms. To test this hypothesis, an independent samples t-test was conducted to compare the self-concealment means between non-bulimic and bulimic groups. Participants with bulimic symptoms scored higher (M = 35.75, SD = 9.73) on self-concealment than did their non-bulimic counterparts (M = 28.39, SD = 8.66), t(142) = -4.76, p < .0001, thereby supporting this hypothesis.

Research Question 4

A major objective of the present study was to explore differences in treatment seeking influences between non-bulimic and bulimic women. We wanted to assess how distress, attitudes toward seeking professional psychological help, self-concealment, social pressure to seek help, social support from family, social support from friends, medical complications, degree of eating pathology, four general treatment fear dimension (therapist responsiveness concerns, coercion concerns, image concerns, and stigma concerns) and identified bulimic-exclusive fears differentially influence treatment seeking in bulimic and non-bulimic women. Specifically, we set out to examine whether these variables could discriminate between non-treatment seekers and treatment seekers,
and the degree to which the discriminating variables could correctly classify treatment seekers and non-treatment seekers in women with bulimic symptoms and in women without eating pathology.

Part A. It was hypothesized that high distress, positive attitudes toward seeking professional psychological help, low self-concealment, high social pressure to seek help, low social support from family, low social support from friends, and low stigma concerns would predict treatment seeking in non-bulimic women. This hypothesis was tested in two steps. First, independent samples t-tests were conducted comparing non-bulimic non-treatment seekers and non-bulimic treatment seekers on each of the independent variables, in order to select predictors to be included in a discriminant function analysis. The modified t-test formula for comparing means with unequal variances in the groups was utilized when variables violated the homogeneity of variance assumption (based on Levene's test for equality of variances; Levene, 1960). Of all of the independent variables, only social pressure to seek help, $t(83) = -2.92, p = .009$ and social support from family, $t(83) = 2.83, p = .006$ were significant at the .05 level of significance, revealing that non-bulimic treatment seekers reported more social pressure to seek help ($M = 2.29, SD = 2.20$) than non-bulimic non-treatment seekers ($M = .66, SD = 1.39$) and less perceived social support from their family ($M = 10.05, SD = 5.97$) than non-bulimic non-treatment seekers ($M = 14.32, SD = 5.45$).

In order to assess the degree to which these two predictor variables could accurately classify treatment seekers and non-treatment seekers in non-bulimic women, a direct discriminant function analysis (DFA) was performed using social pressure to seek help and social support from family as predictors of treatment seeking. The resulting
discriminant function produced a $\Lambda = .77$, $\chi^2(2) = 21.15$, $p < .0001$. The canonical correlation was .48. Therefore, 23% of the variance in the discriminant function scores was shared between treatment seeking status and the two dependent variables. A summary of this DFA is presented in Table 11.

Examination of predictor loadings on the discriminant function reveals that social pressure to seek help was an excellent representation of the discriminant function and social support from family was a good representation of the discriminant function (Comrey & Lee, 1992). With a Bonferonni correction alpha of .025, social pressure to seek help and social support from family each significantly contributed to the discrimination of treatment seekers vs. non-seekers.

Overall, the discriminant function was able to correctly classify 77.6% of non-bulimic treatment seekers and non-treatment seekers (classification was based on the observed group sizes, as an assumption of equal cell sizes is unreasonable given help seeking rates in the population). Closer examination revealed that while 61 (89.7%) of the non-treatment seekers were correctly classified, only 5 (29.4%) of the treatment seekers were correctly classified by the discriminant function. It is noteworthy that the non-parametric equivalent analysis (see Appendix N) correctly classified 78.8% of non-bulimic treatment seekers and non-treatment seekers. The non-parametric DFA correctly classified 61 (89.7%) of the non-treatment seekers and 6 (35.3%) of the treatment seekers. In summary, this hypothesis was for the most part not supported, as only two of the hypothesized predictor variables discriminated between non-bulimic treatment seekers and non-treatment seekers. Moreover, the discriminating variables (social pressure to seek help and social support from family) were good at identifying non-
Table 11

*Discriminant Function Analysis of Treatment Seeking Predictors Among Non-Bulimics (n=85)*

<table>
<thead>
<tr>
<th>Predictor Variable</th>
<th>Correlations of predictors with discriminant function</th>
<th>Pooled within-group correlations</th>
<th>Univariate</th>
<th>SS-FAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Pressure to Seek Help (SPSH)</td>
<td>.77</td>
<td></td>
<td>14.55*</td>
<td>.08</td>
</tr>
<tr>
<td>Social Support from Family (SS-FAM)</td>
<td>-.57</td>
<td></td>
<td>8.03*</td>
<td></td>
</tr>
<tr>
<td>Canonical R</td>
<td>.48</td>
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<tr>
<td>Eigenvalue</td>
<td>.29</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p < .025 (Bonferonni correction employed)
treatment seekers, but only mediocre at identifying treatment seekers.

Part B. It was hypothesized that high distress, positive attitudes toward seeking professional psychological help, low self-concealment, high social pressure to seek help, low social support from family, low social support from friends, medical complications, high levels of eating pathology, low coercion concerns, low stigma concerns, and low identified bulimic fears would predict treatment seeking in bulimic women. This hypothesis was tested in two steps. First, independent samples t-tests were conducted comparing bulimic non-treatment seekers and bulimic treatment seekers on each of the independent variables, in order to select predictors to be included in a discriminant function analysis. The modified t-test formula for comparing means with unequal variances in the groups was utilized when variables violated the homogeneity of variance assumption (based on Levene’s test for equality of variances; Levine, 1960). Four of the hypothesized predictor variables came out significant at the .05 level: social pressure to seek help, $t(57) = -2.91, p = .008$, attitudes toward help seeking, $t(57) = -3.01, p = .004$, image concerns, $t(57) = 2.95, p = .005$, and identified bulimic fears (i.e., TSFABS factor scores), $t(57) = 2.57, p = .013$. Bulimic treatment seekers reported significantly more social pressure to seek help ($M = 3.32, SD = 2.58$) than did bulimic non-treatment seekers ($M = 1.62, SD = 1.92$), and more positive attitudes toward help seeking ($M = 20.40, SD = 6.01$) than did bulimic non-treatment seekers ($M = 15.62, SD = 6.04$). Bulimic treatment seekers also reported significantly less image concerns ($M = 19.91, SD = 7.50$) than did bulimic non-treatment seekers ($M = 26.18, SD = 8.46$) and less identified bulimic fears (i.e., TSFABS factor scores; $M = .02, SD = .98$) than did bulimic non-treatment seekers ($M = .77, SD = 1.19$).
In order to assess the degree to which these four predictor variables could accurately classify treatment seekers and non-treatment seekers in bulimic women, a direct discriminant function analysis (DFA) was performed using the four predictor variables (attitudes toward seeking professional psychological help, social pressure to seek help, image concerns, and identified bulimic fears). The resulting discriminant function produced a $\Lambda = .72$, $\chi^2(4) = 17.74$, $p = .001$. The canonical correlation was .53. Therefore, 28% of the variance in the discriminant function scores was shared between treatment seeking status and the dependent variables. A summary of this DFA is presented in Table 12. Examination of predictor loadings on the discriminant function reveals that attitudes toward help seeking, social pressure to seek help, and image concerns were each very good representations of the discriminant function and identified bulimics fears was a good representation of the discriminant function (Comrey & Lee, 1992). With a Bonferonni corrected alpha of .013, attitudes toward seeking professional psychological help, image concerns, and social pressure to seek help significantly contributed to the discrimination of treatment seekers vs. non-seekers. Identified bulimic fears ($p = .013$) hit the Bonferonni alpha cut-off, but was not technically below the alpha value. It is worth noting that in the non-parametric parallel analyses (see Appendix N), the $p$ value for identified bulimic fears was .008, and as such would be classified as significant. For the purposes of this study, we will consider identified bulimic fears to be a significant contributor to the discriminant function.

Overall, the discriminant function was able to correctly classify 72.9% of bulimic treatment seekers and non-treatment seekers (classification was based on the observed group sizes, as an assumption of equal cell sizes is unreasonable given help seeking rates
### Table 12

*Discriminant Function Analysis of Treatment Seeking Predictors Among Women with Bulimic Symptoms (n=59)*

<table>
<thead>
<tr>
<th>Predictor Variable</th>
<th>Correlations of predictors with discriminant function</th>
<th>Univariate F(1,57)</th>
<th>Pooled within group correlations among predictors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes Toward Seeking Professional Psychological Help (ATSPPH)</td>
<td>.65</td>
<td>9.06*</td>
<td>-.36</td>
</tr>
<tr>
<td>Image Concerns (IC)</td>
<td>-.63</td>
<td>8.69*</td>
<td>.03</td>
</tr>
<tr>
<td>Social Pressure to Seek Help (SPSH)</td>
<td>.62</td>
<td>8.46*</td>
<td>.10</td>
</tr>
<tr>
<td>Identified Bulimic Fears (Treatment seeking Fears Among Bulimics Scale – TSFABS)</td>
<td>.55</td>
<td>6.61**</td>
<td></td>
</tr>
<tr>
<td>Canonical R</td>
<td>.53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eigenvalue</td>
<td>.38</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p < .013 (Bonferonni corrected Alpha)  ** p = .013 (Bonferonni corrected Alpha)
in the population). Closer examination revealed that while 28 (82.4%) of the non-treatment seekers were correctly classified, only 15 (60.0%) of the treatment seekers were correctly classified by the discriminant function. In summary, this hypothesis was partly supported, with four of the 11 hypothesized predictor variables discriminating between bulimic treatment seekers and non-treatment seekers. Moreover, the discriminating variables (social pressure to seek help, attitudes toward help seeking, image concerns, and identified bulimic fears) were good at identifying non-treatment seekers, but only fair at identifying treatment seekers.

Additional Post-Hoc Analysis: The Role of Social Support from family

An examination of means on social support from family in the four groups revealed what appeared to be a treatment seeking x bulimic status interaction. A 2x2 ANCOVA was conducted on social support from family scores with distress as a covariate. No main effects for treatment seeking, $F(1,139) = 1.38, p = .242, MSE = 31.84$, or bulimic status, $F(1,139) = .00, p = .97, MSE = 31.84$ were found. However, a significant interaction was observed, $F(1,139) = 5.37, p = .022, MSE = 31.84, \text{partial } \eta^2 = .04$. Tukey’s HSD post-hoc tests were computed to test pair-wise comparisons between each cell mean. Non-bulimic non-treatment seekers reported more social support from family ($M = 14.32, SD = 5.45$) than did bulimic non-treatment seekers ($M = 10.85, SD = 6.48$) or non-bulimic treatment seekers ($M = 10.06, SD = 6.48$) ($p = .033$). None of the other paired comparisons were significant.
Discussion

The decision to seek professional psychological help has been conceptualized in the context of a classic approach-avoidance model (Kushner & Sher, 1991; Miller, 1944) whereby a conflict arises between “approach tendencies” and “avoidance tendencies.” One seeks treatment when the influence of approach tendencies outweighs the influence of avoidance tendencies. The objective of the current study was to examine a variety of approach and avoidance tendencies that are believed to be related to professional help seeking for psychological problems, and to assess how they differentially effect treatment seeking in distressed women with and without bulimic symptoms. The present findings highlight a number of significant differences in help seeking dynamics in these groups. Treatment seeking influences (i.e., both approach and avoidance tendencies) within each group are discussed first and are then contrasted.

*Predictors of Treatment Seeking in Distressed Women Without Bulimic Symptoms*

*Social pressure to seek help.* The strongest predictor of treatment seeking among distressed women without bulimic symptoms was a high degree of perceived social pressure to seek help. A few researchers have described how peers and family members could communicate beliefs and values regarding help seeking or choose to provide treatment referrals (Crawford, 1998; Roberts, 1988). However, the role of social pressure to seek help in predicting help seeking has received little attention outside the domain of alcohol and substance abuse populations, where it has been found to be an important predictor (Russel et al., 2001). As such, its place as most important predictor (relative to the other explored variables) in the current study is somewhat surprising. This finding should be considered cautiously and needs further exploration, as perceived social
pressure to seek help was measured by one Likert-type item, and has not been validated in past research. Nonetheless, researchers and clinicians should consider the possibility that social pressure to seek help plays an important role as an approach tendency for treatment seeking, even outside the context of substance abuse populations.

*Social support.* The perception of receiving little social support from one's family was also found to be an important predictor of treatment seeking in distressed women without bulimic symptoms. Past findings regarding the role of perceived social support in predicting help seeking have been mixed, with some finding no relationship between social support and help seeking (e.g., Cepeda-Benito & Short, 1998) and some finding an inverse relationship (e.g., Sherbourne, 1988). Through path analyses, Cramer (1999) concluded that low perceived social support leads to high distress and therefore indirectly leads to help seeking. This could not be tested in the current study (both due to small sample sizes and the fact that all participants in this study were distressed). In any event, the present findings cannot be directly compared with most of the past findings (e.g., Cepida-Benito & Short, 1998; Kelly & Achter, 1995), as those studies examined perceived likelihood of seeking help as opposed to actual help seeking. Moreover, it is noteworthy that past researchers have examined the role of a general social support network as a predictor of perceived likelihood of help seeking. One might speculate however, that social support from family and social support from friends have different effects on help seeking. The current data suggest that only low social support from family discriminates help-seekers from non-seekers. It is plausible that distressed women might choose to speak to professionals when they feel unable to discuss their problems with their family, or when their perceptions of low familial support are their focus of their
concerns. It is however worth considering that the present findings could reflect a sampling bias (that is, demographic differences between the non-treatment seeking and treatment seeking samples). Specifically, the non-treatment seeking group was recruited primarily at the University of Windsor where students primarily come from working class families in the Windsor and surrounding areas. The treatment seeking group was recruited primarily at McGill University and may have been more likely to have been studying abroad, far away from their families.

*Non-Predictors of Treatment Seeking in Distressed Women Without Bulimic Symptoms*

*Attitudes toward seeking professional psychological help.* Interestingly, the current data fail to show a relationship between attitudes toward help seeking and actual help seeking, with non-bulimic non-seekers and seekers both reporting mildly positive help seeking attitudes. Past investigations of attitudes toward help seeking have revealed positive correlations between attitudes toward help seeking and perceived likelihood of seeking help for hypothetical problems (Cepida-Benito & Short, 1998; Cramer, 1999; Kelly & Achter, 1995). However, high perceived likelihood of help seeking for a hypothetical problem does not necessarily translate into actual help seeking behaviour. Fischer and Farina (1995) argued that the relationship between attitude scores and actual treatment seeking behaviour has not been established, and to the author’s knowledge, this relationship has not been examined to date. Perhaps, one’s attitudes toward help seeking might relate to a belief that one would seek help if circumstances called for it, but that in reality, attitudes toward help seeking may not play an important role in actual help seeking behaviours. Past examinations of attitudes toward help seeking have also found that those who have had prior contact with mental health professionals have more
positive attitudes toward help seeking than do those who have not had prior contact (e.g., Ballenger, 1999; Surgenor, 1985). It is plausible that pre-exposure attitudes were very positive to begin with and acted as an approach tendency toward help seeking. Alternatively, it could be that exposure to a mental health professional may increase one’s positive attitudes toward help seeking (either because of a positive experience or because of cognitive dissonance). The non-bulimic non-treatment seekers held mildly positive attitudes regarding help seeking to begin with. Their treatment seeking counterparts had either no exposure to a professional at all, or underwent one or two intake sessions. The minimal exposure experienced by the seekers may be unlikely to instill attitude change, especially when their attitudes toward help seeking were likely to have been at least mildly positive before they sought help.

*Self-concealment.* Self-concealment failed to discriminate between non-bulimic non-seekers and non-bulimic treatment seekers. Self-concealment has been examined in the past as a predictor of perceived likelihood of seeking help, yielding mixed results (Cepida-Benito & Short, 1998; Cramer, 1999; Kelly & Achter, 1995). Of special interest, Cramer (1999) employed path analysis and concluded that while self-concealment does not directly relate to perceived likelihood of help seeking for hypothetical problems, high self-concealers are likely to be distressed and hold negative attitudes regarding help seeking. He proposed that high perceived likelihood of help seeking depends on level of distress. An attempt at replicating the complex web of relationships described by Cramer (1999) was beyond the scope of the current study. However, the fact that self-concealment did not discriminate between non-bulimic non-seekers and non-bulimic treatment seekers in the current study is consistent with Cramer’s (1999) assertion that
self-concealment is only indirectly related to help seeking, and might be due to the fact that only distressed women participated in this study.

Distress. At first glance, it appears that the failure of distress to discriminate non-bulimic treatment seekers and non-seekers stands in contrast to a large number of studies that have found distress to be an important approach tendency toward help seeking (e.g., Cramer, 1999; Oliver et al., 1999; Rickwood & Braithwaite, 1994). In fact, the present finding is not entirely surprising given that high distress was a requisite for inclusion in both the non-treatment seeking and treatment seeking groups, thereby creating a floor effect. Moreover, Ogletree (1993) has argued that despite the positive correlation regularly found between distress and help seeking, only a minority of individuals with very high levels of distress actually seek treatment. Therefore, it is plausible that while a baseline level of distress plays an important role in the prediction of treatment seeking, higher levels of distress over and above this baseline are not necessarily related to treatment seeking.

Treatment fearfulness. Perhaps one of the more intriguing findings in the current study, none of the treatment fearfulness measures discriminated between non-bulimic non-treatment seekers and treatment seekers. Coercion concerns (Deane & Chamberlain, 1994) and stigma concerns (Deane & Chamberlain, 1994; Deane & Todd, 1996) have been shown to predict perceived likelihood of help seeking for hypothetical problems (albeit with small effect sizes) in university student populations. Only one past study examined treatment fearfulness comparing individuals who were not considering seeking help with those who were about to enter therapy. Kushner and Sher (1989) found that those who were about to enter therapy had significantly less therapist responsiveness
concerns, coercion concerns, and image concerns than those not considering treatment (the stigma concern subscale had not yet been created). An inspection of treatment fearfulness cell means quickly identifies the culprit in the discrepancy: Relative to levels of treatment fearfulness reported in all three studies (Deane & Chamberlain, 1994; Deane & Todd, 1996; Kushner & Sher, 1989), non-bulimic women in the current study experienced markedly less treatment fear, regardless of whether they were seeking treatment. Indeed, non-seekers in the current investigation were even less fearful of treatment (on all measures) than were participants about to enter therapy in the Kushner and Sher (1989) sample. The discrepant results could possibly be accounted for by a history/cohort effect and a socio-environmental effect. More specifically, Deane and Chamberlain (1994) and Deane and Todd (1996) examined treatment fearfulness in New Zealand college students, where societal beliefs and values regarding psychological treatment may be different than those in North America. While Kushner and Sher (1989) examined treatment fearfulness in University of Missouri undergraduates, their data were collected approximately 15 years ago. In fact, Deane and Chamberlain (1994) noted that treatment fearfulness in their sample were lower than that reported by Kushner and Sher (1989) five years earlier. The present findings suggest that treatment fearfulness may have decreased even further since the mid 1990s. The non-bulimic women in the current study were primarily students at two Canadian universities. Their above average level of education might also help to explain their lower than expected levels of treatment fearfulness. It appears that non-bulimic women enrolled in Canadian universities in 2003 hold few fears regarding psychological treatment with respect to stigma, therapist responsiveness, coercion, or how treatment would impact on their self image. Media
coverage of mental health treatment and the presence of socialized, publicized, and readily available mental health care in Canada may have succeeded at reducing fears regarding mental health treatment over the past decade, and particularly among educated students. In summary, treatment fearfulness among non-bulimic women in the current study was negligible to begin with, and was generally not important in the prediction of treatment seeking.

Predictors of Treatment Seeking in Distressed Women With Bulimic Symptoms

Social pressure to seek help. As was the case with the non-bulimic participants, social pressure to seek help was directly related to actually seeking help among the bulimic participants. The importance of social pressure to seek help in the present study is consistent with a number of past observations and empirical studies (Crawford, 1998; Kent & Clopton, 1988; Krey et al., 1989; Rorty et al., 1993; Smalec and Klinge, 2000) that highlight the role of social pressure to seek help in the prediction of bulimic treatment seeking.

Attitudes toward seeking professional psychological help. To the author's knowledge, attitudes toward seeking professional psychological help have not been explored as a predictor of treatment seeking in bulimic women in the past, and the relative importance played by this predictor in the present study is intriguing. While bulimic non-treatment seekers revealed ambivalent attitudes regarding help seeking, bulimic seekers reported moderately positive help seeking attitudes. One possible explanation for this finding is that positive attitudes toward help seeking in part determine actual help seeking behaviour in women with bulimic symptoms. An alternate explanation assumes that most women with bulimic symptoms are ambivalent about help
seeking to begin with due to an approach-avoidance conflict characterized by an aversion to their symptoms and distress conflicting with negative expectations regarding what might actually happen in treatment. The treatment seekers in the present study may have expected treatment to have negative consequences and may have been initially ambivalent regarding help seeking, but even after minimal exposure to one or two intake sessions (whereby their negative expectations may have not been met), may have experienced attitudinal change.

*Treatment fearfulness.* A major focus of the current investigation was the identification of treatment fears that are particularly salient for women with bulimic symptoms. Semi-structured interviews with women with bulimic symptoms and consultation with clinicians with expertise in the treatment of bulimia ultimately led to a uni-dimensional measure of bulimic treatment fears. This identified bulimic fear construct was best represented by items reflecting fear that therapy would lead to shame, fear of how others would react to one's help seeking, fear of therapy leading to a sense of being overwhelmed by feelings, and fear that therapy will lead to feelings of worthlessness. Indeed, this measure predicted treatment seeking exclusively in the bulimic groups (albeit with a small effect size), even with distress and three other general treatment fearfulness scores held constant. Moreover, identified bulimic fears along with image concerns were two of the four variables in this study that were able to discriminate between bulimic non-treatment seekers and treatment seekers. Previous theorists and clinicians have described how bulimics may avoid seeking help in fear of what they would have to give up, gaining weight, being unable to cope with negative emotions without the use of food, being unable to cope with carbohydrate cravings, negative
perceptions by others (including the therapist), intense shame, and concerns regarding confidentiality (Bowen-Woodward & Levitz, 1989; Crawford, 1998; Freeman, 1986; Kent & Clopton, 1992). In the first empirical investigation of bulimic treatment fears, the present findings lend support to these observations, and highlight the importance of a constellation of treatment fears that appear to act as avoidance tendencies toward bulimic treatment seeking.

Interestingly, the participants with bulimic symptoms in this study rated the identified bulimic fears as of less concern to them than therapist responsiveness concerns, coercion concerns, and image concerns. As such, it is particularly intriguing that the identified bulimic fears discriminated bulimic non-seekers from seekers while therapist responsiveness concerns and coercion concerns did not. It is possible that women with bulimic symptoms are more affected by the fears captured in the identified bulimic fear measure than they believe themselves to be. Scenarios that they are only “a little concerned” about might be more salient in keeping them from treatment than are general fears that they are “concerned” about. Perhaps, women with bulimic symptoms are unaware of the power of certain fears, and instead see themselves as more concerned with more general and mainstream fears regarding treatment.

*Non-Predictors of Treatment Seeking in Distressed Women With Bulimic Symptoms.*

*Self-concealment.* In the first empirical study examining the relationship between self-concealment and help seeking in women with bulimic symptoms, self-concealment did not discriminate bulimic treatment seekers and non-seekers. Indeed, self-concealment ratings were notably high in both bulimic groups. It is plausible that self-concealment plays an indirect role in bulimic help seeking, and ought to be explored in future research.
For instance, given the importance of social pressure to seek help for bulimic help seeking, high levels of self-concealment may act as a powerful barrier from help seeking if a bulimic woman successfully hides her eating problems from others (Crawford, 1998).

*Social support.* Perceived social support from family and friends did not discriminate treatment seekers and non-seekers in women with bulimic symptoms. Mean ratings of social support from family and friends were low in both bulimic groups. One explanation for this finding is that women with bulimic symptoms (regardless of whether they seek help) indeed have less social support resources available to them than do non-bulimics. An alternative and likely explanation however, is that women with bulimic symptoms are likely to have certain personality traits that result in them perceiving themselves as having little social support, or being unable to make use of actual social support resources that are available to them. For instance, high levels of self-concealment might lead a bulimic to keep herself at a distance from her social supports. These findings appear to stand in contrast to Rorty et al. (1993) who argued that social support from family and friends help bulims begin their recovery. The discrepancy may be explained by how social support was measured in the two studies. Moreover, participants in the Rorty et al. (1993) study had been recovered for over a year, and were reporting their memories of pre-recovery social support. Crawford (1998) argued that family dysfunction predicts treatment seeking in bulimic women. The present study did not measure family dysfunction per se, but does suggest that bulimic non-treatment seekers and treatment seekers perceive themselves as having little support from their families.

*Severity of symptoms.* Level of distress did not discriminate bulimic non-treatment seekers and treatment seekers in the present study. Once again, this is not surprising
given that high distress was a criterion for inclusion in this study. To the author’s knowledge, distress has not been examined as a predictor of bulimic treatment seeking in past research. Instead, researchers have focused on symptom severity (i.e., degree of eating pathology) and have yielded mixed findings (Crawford, 1998; Fairburn et al., 1993; Wills, 1994). Degree of eating pathology and medical complications both failed to discriminate bulimic non-treatment seekers and treatment seekers in the present study. These findings are not surprising given that 41 of the 59 women in the bulimic groups were sub-threshold bulimics (that is, they did not meet criteria for Full-Syndrome bulimia nervosa; DSM-IV, 1994). It may be that severe levels of eating pathology facilitate treatment seeking in women with full-syndrome bulimia (Crawford, 1998). However as mentioned, findings have been mixed, and this issue needs further exploration. For instance, Fairburn et al. (1993) found no difference in symptom severity in bulimic non-seekers and seekers.

Treatment fearfulness. Three of the treatment fearfulness dimensions (coercion concerns, stigma concerns, and therapist responsiveness concerns) failed to discriminate bulimic non-treatment seekers from treatment seekers. However, the participants with bulimic symptoms in the present study did report some concern in these areas. Still, it appears that treatment seeking in women with bulimic symptoms is more influenced by fears of how seeking help would affect their self-image, their feelings (e.g., of being overwhelmed, shame), and their relationships with others (i.e., image concerns, identified bulimic fears) than by stigma concerns, coercion concerns, or therapist responsiveness concerns. Interestingly, this pattern of results is markedly similar to the treatment fears offered by the experienced clinicians (see Appendix A5), who did not offer any fears
regarding stigma or therapist responsiveness, and only one fear regarding coercion. In regard to coercion concerns, it is plausible that many bulimics keep their bulimic behaviours private even from their therapist, such that they may not be concerned that their therapist would pressure them to focus on their bulimic behaviours.

*Comparing Treatment Seeking Dynamics in Women With and Without Bulimic Symptoms*

The treatment seeking predictor variables in the present study were slightly more accurate in the classification of non-bulimic treatment seekers and non-seekers (77.6%) than in the classification of bulimic treatment seekers and non-seekers (72.9%). However, in regards to identifying treatment seekers specifically, the variables were more accurate in the classification of bulimic treatment seekers (better than chance, 60%) than in the classification of non-bulimic treatment seekers (less than chance, 29.4%). Several differences and similarities in result patterns between the non-bulimic and bulimic groups are worthy of mention:

*Self-concealment.* Self-concealment was found to be significantly higher in the bulimic groups than in the non-bulimic groups. Nevertheless, it did not predict help seeking in either group. One might speculate that high self-concealment plays an important (albeit indirect) role in bulimic help seeking. More specifically, if a bulimic woman successfully hides her problems from others, she may avoid social pressure to seek help (Crawford, 1998). One might further speculate that social pressure to seek help might become important in bulimic help seeking when a bulimic woman is no longer able to hide her problems from her family and peers. This possibility should be explored in future research.
Social pressure to seek help. Social pressure to seek help was found to have an important influence on help seeking in both non-bulimic and bulimic groups. This predictor has received little attention in the help seeking literature outside of specific pathologies such as alcohol and substance abuse and bulimia (e.g., Crawford, 1998; Kent & Clopton, 1988; Krey et al., 1989; Rorty et al., 1993; Russel et al., 2001; Smalec and Klinge, 2000). It is worth noting that health psychologists have described the importance of "subjective norms", a closely related variable that has been considered within the context of the Theory of Planned Behavior (Shearer & Evans, 2001). Subjective norms refer to one's beliefs about what others think is an appropriate or acceptable behavior. This theory postulates that people are more likely to seek help for a psychological problem if they believe that others would seek help in a similar situation. Whereas subjective norms might act as an internal pressure to seek help (e.g., "my friends would seek help if they were me so I should seek help"), social pressure to seek help, as measured in the current study, reflects an external pressure to seek help (i.e., "others have pressured me to seek help"). It is plausible that both types of pressure to seek help can act as approach tendencies.

The process of social pressure to seek professional help is poorly understood and merits further investigation. Are there specific characteristics that the pressuring individual should possess? Is social pressure to seek help more effective when it comes from a family member, a friend, or an individual who has had experiences with help seeking? How forceful should the pressure be, and what content should be conveyed? Volumes of social psychological research on persuasive communication and attitude change (Aronson, Wilson, Akert, & Fehr, 2002) could serve as a starting point for
answering these questions. However, the current author speculates that the answers to these questions might change, depending on the type of problem for which help would be sought. With respect to the eating disorders, little is known about how to best motivate someone to seek treatment. Geller (2002) has described a “motivational stance” that she has found to be effective for therapists who are helping anorexic women to become less attached to their symptoms. Briefly, Geller (2002) posits that clients are more likely to be open to change when the therapist refrains from making assumptions about the client’s experience, emphasizes the client’s role in decision making, and focuses on helping the client to understand the barriers to recovery. While her suggestions are directed toward therapists treating women with anorexia, they may be relevant for those trying to persuade bulimic women to seek help. For instance, it is possible that a bulimic woman might be most open to seeking treatment if she begins to understand why she has been avoiding treatment.

_Social support from family_. While non-bulimic treatment seekers reported less social support from their family than non-bulimic non-treatment seekers, the bulimic groups did not differ on familial social support. One might speculate that non-bulimic women seek help partly to explore familial problems. In contrast, it is plausible that the perception of little familial social support is a function of bulimic pathology, and that considered together with high self-concealment, treatment fears, and ambivalent attitudes regarding help seeking, does not necessarily influence actual help seeking.

_Attitudes toward help seeking_. In contrast with non-bulimic participants, positive attitudes toward help seeking played an important role in predicting bulimic treatment seeking. Whereas non-bulimic treatment seekers and non-seekers alike both revealed
mildly positive attitudes toward help seeking, bulimic non-seekers revealed notably
ambivalent attitudes and bulimic seekers revealed moderately positive attitudes toward
help seeking. How can we understand the finding that attitudes toward help seeking were
relatively important in the prediction of treatment seeking for bulimics but not for non-
bulimics? One might speculate that the ambivalent help seeking attitudes reported in the
bulimic non-treatment seeking group reflect an approach-avoidance conflict (Dollard,
1944; Kushner & Sher, 1991) marked by approach tendencies (e.g., high distress) and
avoidance tendencies (e.g., expectations of therapy, treatment fears), and that one or two
intake sessions may be enough exposure for such avoidance tendencies to be neutralized
such that seekers could experience a significant attitude increase. One might further
speculate that the mildly positive (i.e., not ambivalent) help seeking attitudes expressed
by the non-bulimic non-treatment seekers do not reflect avoidance tendencies, and as
such, would be unlikely to change in the face of only one or two intake sessions. In
summary, the current data suggest that the approach-avoidance model (Kushner & Sher,
1991; Miller, 1944) might be particularly useful for understanding treatment seeking
patterns among women with bulimic symptoms.

Distress. High distress was a criterion for inclusion in this study, and as such, did
not discriminate treatment seekers and non-seekers (in either group) due to a floor effect.
This suggests that once a baseline level of distress is considered, higher levels of distress
do not necessarily discriminate treatment seekers and non-seekers. This finding can be
accounted for by the fact that many non-seekers reported high levels of distress, and
lends support to Ogletree’s (1993) observation that only a minority of individuals with
very high levels of distress seek treatment.
Treatment fearfulness. In contrast to past research, treatment fearfulness does not appear to predict treatment seeking in non-bulimics, and was markedly low. It is plausible that most people in the present day have been exposed (through the media or education) to mental health treatment and that stigma, therapist responsiveness, image, and coercion concerns have decreased substantially. It is also possible that the low levels of treatment fearfulness found in the non-bulimics can be partly accounted for by the fact that they were a highly educated sample who may have considerable knowledge about psychological treatment. In contrast, image concerns and identified bulimic fears were important predictors of treatment seeking in the bulimic groups. Deane and Todd (1996) and Deane and Chamberlain (1994) argued that certain dimensions of treatment fearfulness might predict treatment seeking in specific clinical populations. One might speculate that in 2003, treatment fearfulness only acts as an avoidance tendency in individuals with psychological problems that involve core fear dynamics, such as bulimia. This possibility should be explored in future research.

Limitations to the Current Study

Several limitations to the current study are apparent. The gold standard in empirical research requires that participants are randomly assigned to experimental and control conditions so that it can be confidently ensured that all groups are identical, and that treatment effects strictly represent experimental manipulation, thus reflecting a high degree of internal validity. This standard is not realistic for most clinical studies involving people, due to logistical and ethical problems. In the present study, the non-bulimic and bulimic non-treatment seekers and treatment seekers may have been defined to some degree by sampling bias. For instance, whereas the non-bulimic non-treatment
seeking group was primarily recruited at the University of Windsor in Windsor, Ontario (95.6%), the non-bulimic treatment seeking group was primarily recruited at McGill University in Montreal, Quebec (76.5%). The author notes that McGill University has a wealthier and more educated student population, many of whom have moved away from home to study in Montreal. In contrast, students at the University of Windsor are more likely to have been brought up in working class families in Windsor and its surrounding areas. Interestingly, one might expect that wealthier and more educated individuals would generally have less treatment fears and more positive attitudes toward help seeking than that which would be propagated in a working class upbringing. In this context, this sampling bias would be expected to inflate the risk of Type I error with respect to the hypothesis that these groups would differ on these measures. In fact, these groups did not differ on attitudes toward help seeking or treatment fearfulness suggesting that at least with respect to these variables, sampling bias is probably of little concern. However, these two groups (that is, non-bulimic treatment seekers and non-seekers) did differ on familial social support with treatment seekers reporting less social support than non-treatment seekers. It is plausible that those recruited at McGill (who are more likely to be far away from home) would report less familial social support than those recruited at the University of Windsor. In sum, the possibility that findings and non-findings alike in this study could be due to demographic differences between samples is worthy of consideration.

On a related note, it is worth considering that the non-bulimic groups were more educated (primarily Canadian university students) than the bulimic groups (which were slightly more heterogeneous). Moreover, the four groups also differed with respect to
distress. Whenever possible, we used a variety of statistical controls to hold these variables constant when assessing the hypotheses. Still, the noise introduced by confounding variables beyond our control may have influenced the results. Future research could attempt to replicate these findings with an effort to reduce sampling bias by matching participants in the groups on a host of demographic variables.

Another limitation of the present study is the small sample size, particularly in the non-bulimic treatment seeking group (n=17). It is interesting to note the difficulties in finding treatment seeking participants who meet criteria for “non-bulimic”. More specifically, many participants were excluded from analyses because their eating patterns were not symptomatic enough for them to be considered sub-threshold bulimic, but too symptomatic for them to be considered non-bulimic. Consistent with Kurth et al. (1995), recruitment attempts in the present study reveal that a degree of problematic eating patterns appears to be the norm in college women. Future research should examine the hypotheses and relationships in the present study with larger samples. The present findings should be considered cautiously until they have been cross-validated in a larger sample. Moreover, it is possible that several variables did not emerge as significant predictors due to lack of statistical power. For instance, it is noted that several variables (i.e., distress, stigma concerns, coercion concerns) revealed main effects for treatment seeking when all participants in the four groups were included (n=144), but did not discriminate treatment seekers and non-seekers in non-bulimics (n=85) or in bulimics (n=59) when they were examined separately. It is possible that these variables might have emerged as significant in a larger sample.
Another limitation of the present study is the fact that treatment seekers were usually exposed to one or two intake sessions. Ideally, they would have participated before having any exposure whatsoever to a mental health professional. Quite understandably however, clinical facilities were not willing to ask their clients to participate in a lengthy research protocol containing questions about treatment fearfulness before having established a degree of rapport. This type of research would be more easily conducted by researchers who work as clinicians at clinical sites. Future researchers attempting to predict treatment seeking should follow the lead of Kushner and Sher (1989) and collect data from clients before any exposure to a professional.

The bulimic groups in the present study were largely sub-clinical in nature, with only 31% meeting full criteria for Bulimia Nervosa. Once more, without having a researcher on site at eating disorder treatment facilities, it was difficult to find full syndrome bulimic participants. There is some evidence to suggest that bulimic women report less eating pathology on self-report measures than in clinical interviews (Carter, Aimé, & Mills, 2001). Moreover, Herzog et al. (1993) argued that bulimia is a chronic disorder that encompasses periods of subclinical symptomology, and an ongoing cycle of remission and relapse has also been noted (Keller et al., 1992; Maddocks et al., 1992). As such, it is likely that some of the participants identified as sub-threshold bulimics are in actuality chronic bulimics. In order to further our knowledge of bulimic treatment seeking dynamics, future researchers should investigate treatment seeking in a larger sample of full syndrome bulimics.

A final limitation noted in the current study concerns the employment of ANCOVA and MANCOVA procedures to control for covariates. While these
methodologies are necessary in order to control for potentially confounding variables (e.g., distress), they come with the price of relying on artificial (albeit “statistically convenient”) participant data thereby potentially limiting the external validity of the study. Stated differently, individual differences that exist in the real world are statistically eliminated using these procedures. For instance, it is important to remember that cases of women with bulimic symptoms who are seeking help but who have no distress are extremely unlikely to occur. However, such a case is artificially created when bulimic treatment seekers are examined with distress held constant.

Conclusions and Future Directions

The current results support Kushner and Sher’s (1991) hypothesis that treatment seeking predictors differ depending on the problem for which one is seeking help. It is interesting to note that only two of the predictor variables in this study (social support from family and social pressure to seek help) were able to discriminate between non-bulimic treatment seekers and non-seekers. The non-bulimic groups could be considered a “catch-all” group of distressed women with a potpourri of psychopathologies. The heterogeneity inherent in these groups may have made it very difficult to identify significant predictor variables when they may very well be significant predictors of treatment seeking in specific groups of psychopathology. In contrast, and in support of this argument, several predictor variables were able to discriminate bulimic treatment seekers and non-seekers. In echo of Kushner and Sher (1991), the current author puts forth that research should start to conceptualize the decision to seek help as ‘problem specific’ and not ‘person specific’. In addition, secondary prevention programs that aim to help people to get treatment should be tailored to specific psychological problems. For
instance, the current results suggest that secondary prevention programs for bulimia might attempt to reduce treatment fears. Such an effort would likely be pointless however, for the typical non-bulimic Canadian university student who holds little fear regarding treatment to begin with.

The current results suggest that women with bulimic symptoms are likely to be high self-concealers and perceive themselves as having little social support. A constellation of treatment fears and ambivalent attitudes with respect to help seeking likely play an important role in keeping them from seeking help. Social pressure from others is likely to play an important role in their treatment seeking, but this requires that others are aware of their bulimic problems (Crawford, 1998). Secondary prevention programs targeting bulimics should aim to a) have others recognize bulimic problems that one is trying to conceal, and b) aim to reduce fears and negative attitudes regarding the treatment process. Unfortunately, we know very little about how to most effectively convey messages to bulimic women that decrease the saliency of avoidance tendencies and encourage them to seek treatment. Future researchers might evaluate the effectiveness of different communication approaches using experimental designs. For instance, non-treatment seeking bulimic women could be randomly assigned to watching one of two videos that utilize different approaches to addressing treatment fears. Participants could then be queried about their intentions to seek psychological help.

Cramer (1999) argued that a complex relationship exists between treatment seeking predictors that ultimately influence one’s decision to seek help. For instance, Cramer (1999) has suggested that self-concealment influences help seeking indirectly because high self-concealers typically deny themselves social supports and are more
distressed. Furthermore, they also hold negative attitudes toward seeking help, and only seek help when they become sufficiently distressed. In the present study, all participants were distressed, and this path model could not be tested. However, given the high levels of self-concealment and distress found in the bulimic groups, this model should be tested in bulimic populations in future research. Social pressure to seek help should be included in further modeling, in light of its importance as a predictor of treatment seeking in both non-bulimics and bulimics in the present study. Future researchers should employ such path modeling with a variety of pathologies. One might speculate that treatment fears also might account for variance in a model predicting treatment seeking when the pathology at hand involves fear dynamics (e.g., anxiety disorders).
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Appendix A

The Development of the Treatment Seeking Fears Among Bulimics Scale (TSFABS)

Overview

This appendix describes the first stage of research in this study whereby the TSFABS was developed in order to provide a quantitative measure of bulimic specific treatment fears. Qualitative research techniques were employed in order to identify treatment fears that are particularly salient for women with bulimia, and the TSFABS was constructed as outlined in the following three separate procedures:

Procedure One

The first procedure involved conducting semi-structured interviews with women with bulimic pathology in order to identify fears that prevent them from seeking psychological help. Upon receiving ethics clearance from the Department of Psychology Ethics Committee at the University of Windsor, this procedure was carried out over a six month period beginning in the Fall of 2001.

Recruitment. Participants were recruited from an undergraduate participant pool in the Department of Psychology at the University of Windsor. They were selected based on their responses to a screening battery (administered to all undergraduate students taking Introduction to Psychology during the Fall, 2001 semester) which indicated the presence of moderate to severe degrees of bulimic pathology. Participants were telephoned by one of four female doctoral students in clinical psychology and were invited to participate in an (approximately) 45 minute interview in exchange for course credit. Participants were told that they would be asked to discuss their reasons for not having seen a mental health professional in the past.
The four interviewers had all received formal training in interviewing techniques in the past. Moreover, they each attended a one-hour training workshop with both the current author and a senior psychologist who specializes in the treatment of eating disorders. This workshop focused on both general interviewing techniques as well as training topics specific to the interview protocol they were asked to follow.

Interviews took place in the present author's office in the Department of Psychology. Upon arrival, participants were asked to sign a consent form (see Appendix A1) and were then administered an oral version of the Eating Disorders Diagnostic Scale (EDDS; Stice et al, 2000; see Appendix F) which is designed to provide a DSM-IV Eating Disorder diagnosis. A thorough description of the EDDS is provided below. They then engaged in a semi-structured interview designed to assess possible fears that may have kept them from seeking help. The administration of the EDDS and the interviews were tape recorded and later transcribed verbatim for analysis. Following the interview, participants were debriefed and given the opportunity to ask questions (see Appendix A2).

Participants. Eleven women participated in the interviews. They ranged in age from 18 to 25 years, with a mean age of 20.18 years. Using criteria described by Stice et al. (2000), three participants met criteria for full syndrome bulimia – purging type, two participants met criteria for full syndrome bulimia – non-purging type, two participants met criteria for sub-threshold bulimia – purging type, two participants met criteria for sub-threshold bulimia – non-purging type, and two participants met criteria for Eating Disorder Not-Otherwise-Specified (ED-NOS). None of the participants reported a history
of any mental health services, although two had recently contacted the university’s Counseling Center for an appointment.

*Interview Protocol.* Interview questions focused on fears or concerns that the interviewee might have about seeking professional psychological services. Interviewers asked a number of standard questions (see Appendix A3) but were also free to explore whatever themes or topics that they saw fit. Generally, questions were open-ended and were geared toward the identification of fears that keep people from seeking help. Participants were asked to describe their feelings, opinions, thoughts, beliefs, and attitudes regarding what would happen if they were to seek therapy. Interviewers were trained to reflect back their understanding of what was being conveyed by the participant, and to ask for clarification and request feedback on their reflection of a participant’s intended meaning.

*Procedure Two*

The second procedure involved consulting with mental health clinicians who have expertise in the treatment of eating disorders. Clinicians were asked about their perceptions of the fears that prevent bulimic women from seeking professional help. Upon receiving ethics clearance from the University of Windsor Research Ethics Boards, this procedure was carried out during November, 2001.

Seventeen mental health professionals (Bachelor- and Masters-level social workers, PhD-level psychologists) who have expertise in the treatment of eating disorders were contacted by telephone or by e-mail and were asked to provide their beliefs regarding why bulimic women typically do not seek professional help. Clinicians across Canada who were known by the present author to have significant experience treating
eating disorder were contacted, as were all of the clinicians at a local treatment facility
for the eating disorders. Telephone conversations were transcribed and compiled along
with e-mails forming a larger list of clinician beliefs regarding bulimic treatment
fearfulness.

Procedure Three

The aim of the third procedure was to generate a pool of test items based on the
qualitative data collected in the preceding two procedures. In the Spring of 2002, the
interview narratives and feedback from clinicians were subjected to qualitative thematic
analyses. Following qualitative thematic extraction procedures outlined by Smith
(1995), fears about treatment were broken down into the following categories: shame
and embarrassment, burden on others, perceptions of others, relationship with parents,
perceptions of the therapist, general fears about therapy, changes in self-perception, and
life changes. Each of these themes was spontaneously mentioned in the interviews of at
least two participants, and many of the themes were important for four or more
participants. Moreover, each of these themes was spontaneously mentioned by at least
two of the clinicians. Interview quotes broken down by theme can be found in
Appendix A4. A condensed version of these themes along with sample quotes from
interviewees and clinician feedback is presented in Appendix A5.

Fifty-three test items were generated based on the themes extracted during the
qualitative analyses. In order to compare the relative importance of these fears with those
already identified by previous researchers who investigated general mental health
populations (e.g., Kushner & Sher, 1991), it was decided that the items would be rated on
the same Likert type scale as is utilized by the Thoughts About Psychotherapy Survey
(TAPS; Deane & Chamberlain, 1994; Kushner & Sher, 1989). That is, participants are asked to respond using a 5-point scale where 1 = No Concern At All and 5 = Very Concerned. A similar set of instructions used for the TAPS was also provided for TSFABS respondents. In an effort to reduce the number items in the pool and fine tune item wording, two psychologists and six social workers with expertise in the treatment of eating disorders were consulted. These clinicians were asked to rate each item on a five point scale where 1 = “does not capture the issue at hand for bulimics”, 3 = “adequate description of the issue at hand for bulimics” and 5 = “an excellent description of the issue at hand for bulimics”. Clinicians were encouraged to provide comments and editorial changes to the items. Mean ratings were calculated for each items. Initially, we had hoped to simply eliminate items with mean ratings that were less than three. However, careful analysis of the distribution of scores revealed a large degree of variability on every item. Stated differently, clinicians could not agree on the quality of items. In fact, none of the items were rated poorly by the majority of clinicians. Therefore, all of the items (some were re-worded) were included in the TSFABS that was provided to participants in the empirical study. These 53 test items are presented in Appendix A6.
Appendix A1

Consent Form to Participate in Research – Phase One

Participant Pool Consent Form

Researcher: Jeremy Frank, M.A.
Department of Psychology, University of Windsor
Supervisor: Dr. Cheryl Thomas, Ph.D.

I am a graduate student in Clinical Psychology, and am presently conducting a study for the completion of my doctoral degree. The purpose of the study will be to explore some of the thoughts and feelings people sometimes have about going to see a mental health practitioner (e.g., a psychologist, a social worker). The data collected in this study will be used solely to advance knowledge in the area of perceptions of psychological services, and the study has no further motive with which you have not been acquainted.

Participation in this study involves an interview with a trained doctoral student in clinical psychology for about 30 – 45 minutes. You will be asked questions about your eating patterns, and about your thoughts and feelings about seeing a therapist. The interview will be audiotaped, and at a later date will be transcribed. Your name and any other identifying information will be removed from the tape (and transcription), such that your answers will be anonymous. The ONLY person who will have information connecting your name with your interview will be the principal investigator. There are two exceptions to this confidentiality. If you give the interviewer good reason to believe that you intend to harm yourself or someone else, or that a child is at risk for being harmed, confidentiality would be broken. During the interview, you are free to refuse to answer any question or withhold any information that you want, and you are free to discontinue participating at any point without giving notice, and without negative consequences. You are also free to ask any questions you like. You will be granted one bonus mark for your psychology class for participating. The overall results of the study may be published.

If you have any questions regarding the study, you are welcome to contact the principal investigator (Jeremy Frank). Following your participation, if you wish, you will be contacted with a detailed description of the research questions investigated, and a short summary of the results will be sent to you as well.

This study has been reviewed by the University of Windsor’s Department of Psychology Ethics Committee. If you have any concerns regarding the ethics of the study, they may be addressed to the Chairperson of the Ethics Committee, Dr. Stewart Page, at the University of Windsor (Department of Psychology; phone: 253-4232, extension 2215). Other concerns or comments can be made to my thesis supervisor, Dr. Cheryl Thomas, Department of Psychology (extension 2252).

I have carefully studied and I understand this agreement, and consent and agree to participate in the study, as described.

Print name ___________________________ Your Signature ___________________________ Date ___________________________
BANA Participants - Consent Form

Researcher:  Jeremy Frank, M.A.
            Department of Psychology, University of Windsor
Supervisor:  Dr. Cheryl Thomas, Ph.D.

I am a graduate student in Clinical Psychology, and am presently conducting a study for the completion of my doctoral degree. The purpose of the study will be to explore some of the thoughts and feelings people sometimes have about going to see a mental health practitioner (e.g., a psychologist, a social worker). The data collected in this study will be used solely to advance knowledge in the area of perceptions of psychological services, and the study has no further motive with which you have not been acquainted.

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I have carefully studied and I understand this agreement, and consent and agree to participate in the study, as described.

Print name ___________________________  Your Signature ___________________________  Date ___________________________
Appendix A2

Phase One Debriefing

Debriefing:

Participants were told that their answers in the interview would be examined to identify themes of fears, and that the emerging themes would then be turned into a psychological questionnaire for other women to fill out.

Participants were then given the opportunity to ask any questions that they might have. They were also be given a list of referral sources should they be interested. They were given contact information to reach me the principal researcher should they have any questions in the future.

Referral Source Sheet:

Referral sources:

Bana = 969-2112

Psychological Services Centre – 973-7012 (for university students)

Medical and Heath Services – 253-3000 ext. 7002 (for university students)

Student Counselling Centre – 253-3000 ext. 4616 for university students)
Appendix A3

*Semi-Structured Interview Protocol Used for the Development of the Treatment Seeking Fears Among Bulimics Scale (TSFABS)*

Phase One participants were introduced to the semi-structured interview with the following blurb:

“Did you know that most women who binge and purge don't seek psychological services even though they could probably benefit from it? People have all sorts of reasons for not going to a therapist. Very often, people are really afraid of going. In fact, people have all sorts of concerns and fears about the idea of going into therapy.

I know this might be a little weird to talk about this with someone you don't know, but first I want to assure you that whatever you tell me is confidential and that your name will never be traced to anything you say. Also, a lot of people have a tough time talking about this stuff, but if we can learn more about the fears people have about going to see a therapist, we might be able to help a lot more people.”

Interviewers were provided with the following pool of questions. They were also free to follow any topic area with additional questions.

1. Have you ever sought professional help for a personal-emotional or psychological problem?
   
   IF YES, please ask #2 and #3)

2. Have you seen a therapist or a counsellor (even once) in the past two years?

3. Approximately when was the last time you saw the therapist or counsellor?

4. Ask details re: treatment seeking history (e.g., location, type of professional, circumstances…)

   ________________________________

   (If participant has never sought help):

   - Why haven't you sought help up to now?

   - I want you to imagine that you have decided to go see a psychologist for your eating problems. If it's ok with you, I'd like to get a sense from you of the types of concerns or fears that you might have if you were in this situation.

   ________________________________
(If participant has sought help):

- What made you seek help when you did?

- If it's ok with you, I'd like to get a sense from you of the types of concerns or fears about going into therapy that you might have had recently or might have now.

(All participants):

- I need you to help me understand what types of things you think about when it comes to this stuff. You're the expert here, and I need your help understanding it from your perspective.

- What fears would you (or do you) have about going into therapy?

- What might happen if you went into therapy? Can you name some bad things that might happen?

- What's the best thing that can happen to you if you went into therapy?

- What types of things do you worry about when you think about going for treatment?

- What do you worry most about?

- Why is that fear scary for you?

- Can you help me understand what about that would be particularly alarming or distressing?

- Why is that a fear (or is that scary) for you?

- What's realistic? What do you think will really happen?

- Social Support?

- Social pressure to seek help?

- Friends in therapy?

- Yours and your friends attitudes toward therapy
Appendix A4

Qualitative Thematic Analysis – Interview Quotes

The following is a summary of Phase One interviewee quotes reflective of treatment fears, broken down by fear category. Numbers in the column to the right indicates the identification number of the participant making the remark.

<table>
<thead>
<tr>
<th>Embarrassment</th>
<th>1</th>
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<tbody>
<tr>
<td>If I told guidance counselor I didn’t want her think I was a big pig or something like that.</td>
<td>1</td>
</tr>
<tr>
<td>I didn’t want people to think bad things about me. I didn’t want people to think oh that’s stupid.</td>
<td>1</td>
</tr>
<tr>
<td>I wouldn’t want my friends to find out. They’d say why are you going to see a counselor?</td>
<td>1</td>
</tr>
<tr>
<td>I look at it as such a disgusting thing and embarrassing thing. Like who does that? People would think “oh my god what’s wrong with her?” they’ll think less of me. Like there’s something wrong with that one.</td>
<td>1</td>
</tr>
<tr>
<td>I would be more embarrassed to tell someone that I overeat than to tell someone what was happening to me at home (being abused) because it’s disgusting and stupid. People would think I am abnormal or unstable. Hard to talk to strangers about eating. I’m also ashamed about it. I don’t want to admit something’s going on.</td>
<td>1</td>
</tr>
<tr>
<td>I didn’t want (family [noted below]) or friends and stuff to know. I live in a small community and everyone new about my sister, I didn’t want anyone to know, I wanted everyone to think that I was good and ok. I didn’t want them to think…. I was just embarrassed too that I had a problem that no one else seemed to have. I was worried that I wouldn’t be like everybody else. Everyone would know that I wasn’t the person they thought I was. Embarrassed about the fact that I couldn’t handle it I guess. If other people knew, I’d be ashamed. Other people don’t have problems. They don’t know I feel this way so I can hide it and I don’t have to think about it. If I went and got help, they would know and I would worry they would change how they think about me. I’d be embarrassed that I couldn’t control it and other people can and I have to go get help. It feels embarrassing that I can’t take care of things. I didn’t want my friends to know, it’s not embarrassing exactly, but I find people make assumptions about me. Always a fear of being judged. <strong>What would people judge?</strong> Like I can’t control my own life. That I’m a weak person. I’m not able to do things that others can do because of emotional problems. I’m afraid they’ll think less of me as a person. Or they’ll think it’s my fault. And I don’t want people to have that misconception. ...... Also the fear of people finding out why I’m seeking help. If they know I’m going for eating behaviours, they’ll judge me. ...... they (peers) judge me when I say I’m fat. I almost feel like some of them are angry at me for my weight because it’s less than them or different than them and when</td>
<td></td>
</tr>
</tbody>
</table>
they find out I'm unhappy they get more angry and if they find out I'm getting treatment, they'll be even more angry. It makes me feel terrible when they put me down and get angry with me for something I can't help. They don't understand, it's not like I'm doing this on purpose.

If I was to tell people I saw a therapist – I probably wouldn't tell them. It undermines you, makes you seem like you need help.

Probably being judged by people. I wouldn't want anyone to know. That would mean that I have a disorder, and it's a big thing and people would be concerned and I don't want that.

You mentioned before people would think you can't control your own life... tell me more I don't like being thought of as a weak person. And I think that would make me appear weak. I can't control something as simple as eating. Ok if she can't control her own eating, what else can't she do? I think a lot of people have a hard time distinguishing... like yeah it's probably more a mental problem with me, but would they think I'm getting therapy because of image problem with me or because she's crazy and she needs therapy because that's what crazy people do.

(friends) probably be fine like good, go get happy. But I would always think oh no, they think there's something wrong and they're not telling me. I know they'd be fine with it and they would support me, but I would still think they would think...

Didn't want my mom to know – I know she's suffering from this type of thing herself.

Don't want parents to know, they would have just given me their own counseling, and that's it

My father is more like take care of things yourself, very unsympathetic in that way. Mother has issues herself.

My parents will think I'm not strong, I can't take care of myself.

Mom always said things could be worse, and this little eating problem I have it could be overcome

Dad would say what the hell is wrong with you.

Mom might say why do you have to do that? I thought you were stronger than that

What would my family say? They never really accepted the fact that I have a problem, they know but

They don't think it's an issue. It would be awkward. They wouldn't support it.

I wouldn't have family support if I went. I know my family, I could just see it being... there would be family jokes.

I always wanted to make my parents proud. It would leave me feeling like I was letting them down.

I'm sure they'd understand. I just don't want to... I don't want them to know.

I just didn't want people to know that I... (bathroom break, crying). You said you were concerned about your parents? Yeah I didn't want my parents to know things were bothering me,

Any concerns or worries about telling family or boyfriend? Yeah I thought they'd get mad, like what do you need to do that for? Or come down on me. you'd get in trouble. Yeah.
I didn’t want my parents to know because I didn’t want them to think it was their fault. I didn’t want to put them in that position. … my mom and I have always argued about my eating habits. I know she won’t directly rub it in my face, but there will be that shift in our relationship. She is a great woman and she would never use it maliciously. But jokingly she might say I told you so, and it’s not a joke for me. Like it would be giving in after 5 or 6 years. She wouldn’t really use it again me but it would be there.

**How about your family?** Yeah it would be a problem if they knew. **How would they react? Would you be worried about them finding out?** No I could probably let them know. I don’t know.

People who go for counseling, are people that are abused. People with bigger problems. When you overeat or make yourself puke, you’re just being stupid. Like you’re controlling yourself, it’s not like my father is hitting me. Like get a grip and get a life.

The counselor will think well I gotta take care of this girl who’s a big pig and then I’ll take care of these girls whose really need the help. They are destroyed. And even though I felt destroyed, I was doing this to myself.

**How come you almost didn’t come?** Maybe I didn’t have a problem that was really bad. Maybe other people need the help more than me. **so you were concerned that the therapists here would look at you in a certain way?** Well, like they might think maybe you don’t need this help. **You’re overreacting.** Yeah. Like it’s all in my head and I don’t really have a problem. **ok and that you’re just taking up space.** Yeah I’ll just waste their time.

It will be weird. Always being a fear of them (therapists) laughing or telling me there’s nothing wrong, that’ I’m silly.

Therapist might say it’s all my parents fault. Because I love my parents, and my parent’s wouldn’t want that. Or my friends are bad. Or it’s more serious than I think it is.

I’d probably fear that they (therapists) would tell me I was doing something wrong. That they’d say that what I’m doing is wrong (re: eating). **So everyone would be going fine and you’d go in and they’d be concerned?** Yeah. I don’t think I have a… I’d be ok with going to a therapist or a counselor, but I don’t know… I don’t know…

I’d be afraid that they’d look at me and think I’m not serious about having a problem, and think “she’s saying this stuff and she doesn’t look like she has a problem” and they might shuffle me and not take me seriously. … I just think maybe counselors would only help you if it was really serious. And if it was a little problem, they might not help you as much. And they’d think “everyone goes through it” and a lot of girls do go through it. … it’s such a little problem but maybe they just don’t feel that my little problem will lead into a bigger problem, they’ll just think that she’ll be like that the rest of her life, while people with bigger problems could die or…

You have to sit there and talk about yourself and outline for the therapist all your problems and then there’s also the underlying fear of them judging you

**What would be realistic? What would happen if you went?** They’d say I was crazy or something.
I even feel like I’m being judged by whoever was – the psychologist, even though even though I know in my mind that they’re not trying to judge me but I would feel I was being judged.

**What kind of things would you be afraid that they might think?** That like oh it’s your own fault that you feel this way, and that it’s a good thing you came now, if you’re this big now you’ll be much bigger later. So you’d be concerned that they would think… appearance wise, I think that they – it kind of makes me feel a little weak like I can’t control my own problems. That’s why I don’t really talk to people about that… it’s important to keep these things private for you… yeah I don’t like to rock the boat. I don’t want others to concern themselves with me.

Like I have my own problems, but I don’t talk to my parents or siblings, sometimes my friends, but not very often. I feel everyone has their own problems and they don’t need mine too. You don’t want to burden others with your problems? Yeah

I just think… they would judge me and because that’s such a personal thing, that’s like all about me and who I am and really personal things and I would be really afraid they would think about them… they would get to know you for real and if they judged you that would be a lot more upsetting than if you were judged just on first appearance. Yeah can you tell me about what you would be worried they would be judging you on? I don’t know, I can’t think of what it would be specifically but I feel it would be something they would find. I can’t think of what that might be.

Emotionally I feel fat. I don’t like the way I look. Logically I think no it’s not a big deal, but then I’m afraid that someone else thinks it’s a big deal. My logical brain and my emotional brain conflict with each other. So if you decide to see somebody maybe you’d also worry about what someone else thought. Yeah like it is what you actually look like. So maybe the therapist would confirm how you feel about yourself. Yeah.

Judge. Like my physician. I knew what I was doing wasn’t healthy, I didn’t need to be told. She was giving me a sermon. That’s not what I came there for. I was there to get help. It was demeaning.

Going would mean that I would have to recognize that I can’t do this on my own. I consider myself to be independent. Going would challenge that perception.

Going would mean admitting that I actually did have a problem. I wanted to push it away and not think about it. Going would mean there was actually something I need help with. So going would mean there was something wrong with you yeah. Officially

**Greatest fear about going to see a therapist?** The therapist will think I have a problem. And you think you don’t? yeah and would that mean something about you? Yeah it would mean that I don’t have it together…. I wonder if therapy would be a problem like no surprises? Yeah it would, you go and it would be unpredictable. Like it slaps you in the face. Ok you’ve got this problem. That would be rough (they’d say you were crazy or something) – I guess we all have different reasons for why that would be horrible. What would yours be? Just because then I’d look at the roles that you play at school, in work, in your house and question well ok am I suitable to be in this role, like during the summer
I’m a camp counselor, I take care of kids. If they were to say I was crazy, how can I be a role model for kids? ... I’d rather not hear what’s wrong with me. Like they’re gonna tell me what’s wrong with me and they’d question like what? Like exactly what you’re doing right now, like question and you have to think more and answer it better and if they don’t like that then you have to answer it again. It’s not that I don’t like it I know it’s your study force you to look closer at yourself than you really care to? Yeah that’s it.

It’s a big part of my life, it’s what makes me me.

I’m afraid of being diagnosed with something, or put into a category. If I am, I’ll start to crash. I feel if they tell me I have a certain condition or a certain problem, I’ll either fall into that problem and use it as a shelter or I’m afraid I’ll fall into a stereotype of a certain diagnosis. I know if they tell me then it could have an adverse effect. ... If you put me in a category that encompasses all of that, and I only have a few of them, and people will generalize and put me in that category. I don’t think I can be put in a category.

I know this will never end. I’m scared that I will break at one point and either become a fat person again or even worse like obese or the point where I die or want to die.

Now that you’re here, you’ve battled the impulse not to come at all, as you’re sitting here, do you still have some negative fears hanging around? Yeah that I’m not going to get better. That I’ll stay doing this for the rest of my life. That I will get better or it will kill me. I know that.

If I went and I didn’t get better, I’d think there’s really something wrong with me. It would be so scary – if therapy isn’t helping, what else is there? I’d just be doomed to live like that for the rest of my life. Oh God it would be so scary. I guess if I did see somebody, maybe I couldn’t stick to it, get out of the habit. I couldn’t do it, it might be too hard. What might be too hard? Breaking the habit that I’ve gotten used to.

That it will be ok for a little bit and then start up again. I think my big thing is I don’t want to let people down. – friends, family, people here taking their time for doing things with me. if it starts up again, I don’t want them to feel that they wasted all that time on me. I just don’t want to let anybody down.

I’m afraid that say things are going great, and I’m doing things properly, and I think or somebody else thinks things are going good for you and it’s time you stop with the program and I can’t do it, and I have to stop. So if the people here thought you were doing pretty good and you don’t need to come anymore... yeah and if I did feel ready and I felt ok, and then a month later I’d turn around and I’d have to come back, and I don’t know if I ever could.

What would it mean to you if you failed? I’d fail my family, I’d fail me, I’d fail the people helping me. and I’m petrified of that – that I’d do better and then get worse and I’d fail everybody. Would people look at you in a different way if that happened? Yeah my family – they’re tired of having to put up with it. It’s not that I live at home or I talk about it when them all the time. The only thing I told them (mom, sister) is that I’m coming here.

There’s also the fear of there not being any solution. That this is just something I have to live with for the rest of my life. I don’t want to live with this for the rest of
my life. That’s scary.
There’s also the fear that I can’t do it. That I won’t have the motivation to do it. No one else can force me to change, and I ultimately need to be the one to make the changes and I don’t know if I can do that. And that’s scary.

Therapy wouldn’t be helpful if it just focused on eating.
That it won’t help.
I think the other stuff going on is the cause of these problems. I’m afraid they’ll focus on the eating. Like you’re concerned the therapist might miss the point and jump on your eating and not listen to the other problems? Yeah
Is that something you’ve been worried about for example coming here to talk about your eating, that they’d just give you a pill and send you on your way.
Yeah or else we can’t help you here. Or something like that. And then I’d have to find something else that would help.
I know it’s going to take time. That scare you? Yeah because it has taken me this long to... I feel like I’m nothing and I have to build all that back up again, and I don’t know if I’m strong enough.

What do you think therapy might be like? don’t know, I guess talking about the way I feel, and my image of myself. I can’t think of how somebody could convince me to think differently, I can’t do it so I don’t see how somebody else would be able to...
And I wouldn’t go if I didn’t think it would help me. If I did go to a therapist, I would want to go for a reasons, and they’d actually do something for me. I’m not going to go for them to tell me thing I have already heard before.... That it would be useful. Like I know there are somepeople who – like therapy suggestions that tell you what the sources there is. It’s not the source necessarily that I want to know, but how to treat and how to maintain. .... That they wouldn’t be approachable, that they weren’t going to help me, that there style wasn’t the style that I needed. A waste of time for them and me. There’s no point in going if they’re not giving you solutions that will work for you personally.

Would I be able to trust the person? I would want to know them.
I feel really weird talking to someone I don’t know about personal issues. That’s why I haven’t gone until now.
I don’t trust people. Even though it’s confidential and I totally believe that, you go and talk about yourself and lay yourself open. Are you concerned about how the therapist would react? Yeah in a sense, they’re supposed to be a therapist but what’s the difference between a therapist and another human being? Like I know you have the title, but I’ve never been to a therapist so that’s the fear – they’re just another human being. Like they won’t be able to help better than someone else?
Yeah
I just feel uncomfortable about sharing about myself when the person is not sharing.. just talking about myself makes me a little uneasy. I would feel like it would be about me. They would look at me and know my problems and that’s weird. I’d be forcing myself – I’d be telling myself don’t like, because this is supposed to help me. I can’t lie to this person. Otherwise I’d be oh I’m fine. Yeah like blow off your problems. Yeah and you have to say what you actually feel.
I would be more worried about the underlying problem. I wouldn’t want to deal with those issues. It would be stressful. In a way, having to go through all that stuff again rather than letting it be.

The idea of being stressed the whole way through is scary.

**Do you have other stressors with school and everything and it would be another one?** Yeah. Whereas now, I just keep it the way it is. **So maybe that’s another concern, that it would create more stress.** Yeah I’ve been able to not think about it.

If I went, I’d revert back to... I’ve got pretty good control of it now. **Fears about control?** Yeah.

**So what would worry you most?** The loss of control. Not having control of what’s going on. I’m a control freak. It would all end up coming out in the eating. I like to have control of something. If I don’t have control of my eating behaviour, I don’t have control of anything. It would be a loss of control all the way around.

Because my lack of eating habits are so ingrained in my routine, I almost feel like that’s normal for me. It would throw off my entire life to change that. It would throw off my routine. That’s scary too. **Having to adjust to a different life.**

I’ll tell them to wrong things... I’ll say why did I say that? I’m so scared about what I’ll tell them **worried you won’t be able to say as much as you’d like?**

Yeah.

I’m almost afraid of eating regularly, because of the consequences it will have on my body. I haven’t done that in so long. I’ll gain weight rapidly or nausea. It’s scary. 140 would be really fat to me. I don’t want to weigh 140. I know that if I got treatment and I gained weight, I’d feel so much worse about myself even if I was eating better. Terrifying. **A main reason for not going?** Definitely. I’ve always been under my ideal BMI until now. Even right now, I feel chubby. I know I’m not, but that’s how I feel. And I feel if I gain 5 more pounds, I’ll be fat. I think the weight gain is the main thing.

**What would you say would worry you the most if you went into some kind of therapy for help to talk about your eating problems?** Burdening other people. I wouldn’t want my parents to worry about me. They have enough problems of their own I wouldn’t want them to have to worry about me. **What would happen? How would it burden them?** I don’t think they would – they’d be concerned – but I know that it wouldn’t be a big deal, but I just feel... because there’s so much inside me that I don’t tell people, so I just think other people have the same secrets. I’d be worried about them feeling that it’s a lot of trouble for them to worry about me.
Appendix A5

Qualitative Thematic Analysis – Theme Representations

Theme One: Shame and Embarrassment

Number of interviewees who spontaneously conveyed this theme: 4

Examples:

“They’ll think I’m a pig.....Disgusting thing – who does that?..... People would think oh my god what’s wrong with her...I would be more embarrassed to tell someone I overeat than to tell someone about (hypothetical abuse) because it’s disgusting and stupid...” (23 year old woman who reported symptoms consistent with full syndrome bulimia, purging type)

“People would think I’m abnormal or unstable” (23 year old woman who reported symptoms consistent with sub-threshold bulimia, purging type)

“I’m ashamed of it.” (19 year old woman who reported symptoms consistent with sub-threshold bulimia, non-purging type)

“Worried I wouldn’t be like everybody else....If other people knew, I’d be ashamed” (19 year old woman who reported symptoms consistent with full syndrome bulimia, non-purging type)

Number of clinicians who spontaneously conveyed this theme: 13

Examples:

“Fear of somebody else knowing. Other mental illnesses are seen as caused by genetics, chemical imbalance. With eating disorders it’s self-induced, so ashamed because they know they can’t stop it, and the world thinks they can.”

“Misunderstanding that others do this. Eating Disorders haven’t lost its stigma.”

“Shame... embarrassment about how they binge. My secret will be known and I’ll feel embarrassed”

“Shameful behaviours to disclose”
Theme Two: Burden on Others

Number of interviewees who spontaneously conveyed this theme: 6

Examples:

“I would let my parents down” (19 year old woman who reported symptoms consistent with full syndrome bulimia, non-purging type)

“People would be concerned...I will waste the therapist’s time...I don’t want others to concern themselves with me. Everyone has their own problems, they don’t need mine too...Burdening other people. I wouldn’t want my parents to worry about me. They have enough problems on their own...There’s so much inside me that I don’t tell people, so I just think other people have the same secrets. I’d be worried about them feeling that it’s a lot of trouble for them to worry about me.” (19 year old woman with symptoms consistent with Eating Disorder Not Otherwise Specified)

“Don’t want my mom to know, she’s suffering from this type of thing herself...People with bigger problems need help...When you overeat and make yourself puke, you’re just being stupid. Like you’re controlling yourself, it’s like my father is hitting me. Like get a grip on life. They (other girls who really need help) are destroyed. And even though I felt destroyed, I was doing this to myself.” (23 year old woman who reported symptoms consistent with full syndrome bulimia, purging type)

“Maybe I don’t have a problem that is really bad...maybe other people need the help more than me...I think my big thing is I don’t want to let people down. Friends, family, people here (note: “here” refers to clinic where she recently sought help) taking their time for doing things with me. If it starts up again, I don’t want them to feel that they wasted all that time on me. I just don’t want to let anybody down. I’d fail my family, I’d fail me, I’d fail the people who are helping me, and I’m petrified of that...That I’d do better and then get worse and I’d fail everybody” (25 year old woman who reported symptoms consistent with full syndrome bulimia, purging type)

Number of clinicians who spontaneously conveyed this theme: 5

Examples:

“Fear of disappointing me (the therapist). They think ‘I’m probably wasting your time’ and ‘probably can’t recover’”

“Fear of being so toxic as to destroy the other. Fear that one’s problems or needs are overwhelming to others (e.g., the therapist)”
Theme Four: Relationship with Parents

Number of interviewees who spontaneously conveyed this theme: 5

Examples:

“They wouldn’t approve, unsympathetic” (23 year old woman who reported symptoms consistent with full syndrome bulimia, purging type)

“They (parents) wouldn’t support it (therapy), it would be awkward. They don’t think it’s an issue. I know my family, there would be family jokes” (19 year old woman who reported symptoms consistent with sub-threshold bulimia, purging type)

“They would think it’s my fault….it would change my relationship with them” (19 year old woman who reported symptoms consistent with full syndrome bulimia, non-purging type)

“They would think I’m weak…they would be angry” (23 year old woman who reported symptoms consistent with full syndrome bulimia, purging type)

Number of clinicians who spontaneously conveyed this theme: 2

Examples:

“They would be judged by possibly their family. They’re never crazy about finding out that their family will be involved”

“Fear of rejection from family”

Theme Five: Perceptions of the Therapist

Number of interviewees who spontaneously conveyed this theme: 9

Examples:

“The therapist will judge me.” (reported by seven of the interviewees)

“The therapist The therapist will say I’m crazy or something…will think I have a problem… tell me I’m doing something wrong” (19 year old woman who reported symptoms consistent with full syndrome bulimia, purging type)
“They would get to know me and then judge me and that would be worse, what would they find? ...They’ll tell me it’s my own fault that I feel this way and that it’s a good thing I came now because I’ll be much bigger later...” (19 year old woman who reported symptoms consistent with an Eating Disorder Not Otherwise Specified)

“The therapist will think I don’t deserve help because I’m doing this to myself...will think I’m a big pig.” (23 year old woman who reported symptoms consistent with full syndrome bulimia, purging type)

“The therapist won’t take me seriously... they’ll say it’s my parents fault.” (19 year old woman who recently sought treatment, reported symptoms consistent with full syndrome bulimia, non-purging type)

“The therapist won’t be approachable...They would look at me and know my problems and that’s weird.” (19 year old woman who reported symptoms consistent with an Eating Disorder Not Otherwise Specified)

*Number of clinicians who spontaneously conveyed this theme: 8*

Examples:

“They fear the therapist will judge them” (theme reported by four clinicians)

“Fear that the therapist will think they’re crazy, they’re surprised to know that others do this also”

“Fear that the person they are telling will be disgusted by them”

“Fear of being judged, condescended to, or told what to do”

“Fear of not being understood by the therapist”

*Theme Six: General Fears About Therapy*

*Number of interviewees who spontaneously conveyed this theme: 9*

Examples:

“Will I be able to trust the person? I would want to know them” (19 year old woman who reported symptoms consistent with full syndrome bulimia, purging type)
“I feel really weird talking to someone I don’t know about personal issues. That’s why I haven’t gone until now…” (19 year old woman who recently sought treatment, reported symptoms consistent with full syndrome bulimia, non-purging type)

“I’ll tell them the wrong things…I’ll say ‘why did I say that?’ I’m so scared about what I’ll tell them…I’m afraid they’ll just focus on the eating issues and I think the other stuff is important too.” (19 year old woman who reported symptoms consistent with subthreshold bulimia, non-purging type)

“You have to say what you actually feel” (19 year old woman who reported symptoms consistent with an Eating Disorder Not Otherwise Specified)

“They’ll tell me things are going great, and I’m doing things properly, and I think or somebody else thinks that things are going good for you and it’s time to stop with the program and I can’t do it, and I have to stop… and if I did feel ready and I felt ok, and then a month later I’d turn around and I’d have to come back, and I don’t know if I ever could… They’ll tell me that they can’t help me or just give me a pill” (25 year old woman who recently sought treatment, and who reported symptoms of full syndrome bulimia, purging type)

“I would be more worried about the underlying problem. I wouldn’t want to deal with those issues. It would be stressful. In a way, having to go through all that stuff again rather than just letting it be. The idea of being stressed the whole way through is scary.” (19 year old woman who reported symptoms consistent with subthreshold bulimia, purging type)

“That they wouldn’t help me, that their style isn’t what I needed…A waste of time for them and me” (19 year old woman who reported symptoms consistent with an Eating Disorder Not Otherwise Specified)

**Number of clinicians who spontaneously conveyed this theme: 10**

Examples:

“Fear of intimacy, letting others in, that kind of openness.”

“Fear that the professionals will try to stop their symptoms…and they do!”

“Most recognize that they are sitting on something intrapersonal but they are very afraid to look at that. They would have to experience emotional discomfort. They would rather experience physical discomfort because it goes away. The emotional discomfort might not go away, they can’t control that.”
“They have difficulties talking about the bulimic behaviours. They have awareness of more significant underlying reasons, i.e., depression, abuse.”

“They are afraid to face themselves and feel they are ‘damaged goods’”

“They are afraid of dealing with the intensity of the emotions that they feel inside. They feel that there is something wrong with them. They feel out of control during the binge, and in their anger. They may have to face that ticking time bomb.”

“They fear what they will feel in the process of therapy.”

“They fear being exposed to feelings of shame, guilt, low self-esteem, self-loathing”

“They fear experiencing uncomfortable feelings associated with social interactions (e.g., dating, men, sexuality, intimacy)”

“They fear therapy somehow will make things worse rather than better”

**Theme Seven: Changes in Self-Perception**

*Number of interviewees who spontaneously conveyed this theme: 6*

Examples:

“Going would mean recognizing I can’t do this on my own” (23 year old woman who reported symptoms consistent with full syndrome bulimia, purging type)

“I consider myself independent, going with challenge this” (23 year old woman who reported symptoms consistent with subthreshold bulimia, purging type)

“Going would mean admitting that I actually did have a problem. I wanted to push it away and not think about it. Going would mean there was actually something I need help with (so going would mean there’s something wrong with you...?) yeah. Officially...I’ve been able to not think about it.” (19 year old woman who reported symptoms consistent with full syndrome bulimia, non-purging type)

“It (therapy) slaps your face, like okay, you’ve got this problem...I’d rather not hear about what’s wrong with me, they’d tell me.” (19 year old woman who reported symptoms consistent with full syndrome bulimia, purging type)
Number of clinicians who spontaneously conveyed this theme: 8

Examples:

“Feeling like they failed because their weight has not been achieved normally”

“Need to appear perfect to others, a need to fix problems themselves without the involvement of others.”

“Fear of admitting that they have a problem” (theme reported by two clinicians)

“Fear of losing themselves. ‘Without my eating disorder, I don’t know why I am’”

“The fear is the psychic glue that holds them together. What will hold me together if I don’t have that? If I go and get help, what will hold me together, this will be taken away from them... People with bulimia don’t know what they will be like if they weren’t doing these behaviours. What would they be doing, thinking, how would they be? They don’t know what would replace it. If starving away the feelings was effective, then if they didn’t starve them away or stuff them away, then what would they do with them? They know what the effect of it is (the behaviours) on the feelings... The eating disorder becomes part of their identity and they’re afraid they will have to give that up. Who are they without it?”

“They might come to therapy and find out that they’re a bad person... ‘Therapy may validate exactly how I feel about myself inside, and how my family feels about me.’ (If someone is being berated in their family and are using the eating disorder to cope with it), if they come into therapy, their fears that they are this worthless person that they are being told they are and/or that they believe they are may become validated.”

Theme Eight: Life Changes

Number of interviewees who spontaneously conveyed this theme: 3

Examples:

“I’m afraid of being diagnosed. If I am, I’ll start to crash. I’ll fall into the problem or into a stereotype or use it as a shelter... The therapist might say it’s more serious than I think it is... Because my eating habits are so ingrained in my routine, I almost feel like that’s normal for me. It would throw off my entire life to change that. It would throw off my routine. That’s scary too. Having to adjust to a different life... I’m almost afraid of eating regularly because of the consequences it will have on my body. I haven’t done that in so
long. I’ll gain weight rapidly or feel nauseous. It’s scary. 140 would be rally fat for me. I don’t want to weigh 140. I know that if I got treatment and I gained weight, I’d feel so much worse about myself even if I was eating better. That’s terrifying. A main reason for not going? Definitely. I think the weight gain is the main thing… There’s also the fear that I can’t do it. That I won’t have the motivation to do it. No one else can force me to change, and I ultimately need to be the one to make the changes and I don’t know if I can do that. And that’s scary. ((19 year old woman who recently sought treatment and who reported symptoms consistent with full syndrome bulimia, non-purging type.)

“I know this will never end. I’m scared that I will break at one point and either become a fat person again or even worse like obese or to the point where I die or want to die…if I went and I didn’t get better, I’d think there’s something really wrong with me. It would be so scary, if therapy isn’t helping, what else is there? I’d just be doomed to live like that for the rest of my life. Oh God it would be so scary.” (23 year old woman who reported symptoms consistent with full syndrome bulimia, purging type)

“Maybe I couldn’t stick to it, maybe it would be too hard – breaking the habit that I’ve gotten used to. That it will be ok for a bit and then start up again…That I’m not going to get better. That I’ll stay doing this for the rest of my life. That I will get better or it will kill me.” (25 year old woman who recently sought treatment and who reported symptoms consistent with full syndrome bulimia, purging type)

Note: Only two interviewees identified weight gain as a fear that has kept them from seeking treatment.

*Number of clinicians who spontaneously conveyed this theme: 17*

Examples:

“Fear of weight gain” (theme reported by 13 clinicians)

“Fear of replacing the bulimia with a more “destructive behaviour” (e.g, increased substance use, self-harming)”

“Fear of loss of control” (theme reported by six clinicians)

“They’re not ready to change but just want to talk. So fear of change, or of being accountable”

“Fear of change. They know they have to make some changes, they’re not sure what they are. If they do make those changes, what will it mean for them?”

“With the eating disorder, it takes up so much time and energy, so they don’t spend time becoming competent and independent and effective in other areas, so
therapy might make them feel like they will have to manage those life tasks. Otherwise, they won’t have to. Those things are all unknown.”

“They might have to make a commitment, and they don’t have a lot of experience with that. ‘If I make a commitment, I’ll have to be responsible, and see this through’ (all areas of life). They always start a lot of things but they don’t follow through.”

“Fear of changing, letting go of the old. So ‘if I seek help, I will have to change and be confronted about how this is not working for me’”

“I will finally have to deal with it, I won’t be able to use it as a coping skill anymore, I can’t dismiss it as the way things are, this is how I do things. Confront it as a negative behaviour”

“Bingeing has almost been like a friend when they’re feeling stressed or upset, so what else would they do if they can’t binge? Seeking therapy would lead them to lose this. It’s all they have. Fear of the unknown.” (theme reported by two clinicians)

“If bingeing a lot, fear of getting close to somebody”

“Afraid of losing the emotional comfort associated with bingeing”

“Afraid of facing the responsibilities of life that the illness excused them from”

“Afraid that life will be empty without the daily cycle of bingeing and purging”

“Fear of having to give up the behaviour”

“Fear that the bulimia will be cured and that they will have nothing to replace the obsession”

“Lack of other strategies to manage stress/emotion – fears about being overwhelmed by stress, anxiety, anger, sadness, etc in the future. (theme reported by three clinicians)

“Fear of failure in treatment. They’re such perfectionists in other ways, this is another thing they will have to be perfect at, and they may not be able to. So fear of failure, and then feelings of worthlessness, helplessness, confirming that they are what they really think they are inside (worthless)” (theme reported by two clinicians)

“Fear that the problem is bigger than they are. If they sought help, they would have to face fear. Then it would really be hopeless if they sought help”
Appendix A6

*Treatment Seeking Fears Among Bulimics Scale – Items*

*Participants recruited from treatment facilities were shown the following set of instructions:*

Many people have different concerns about deciding to see a professional psychologist or counselor for a personal problem. The following items are about concerns you might have now that you have sought help from a professional.

*Participants recruited elsewhere were shown the following set of instructions:*

We would like you to imagine that you have decided to see a professional psychologist or counselor for a personal problem. The following items are about concerns you might have in this situation. Please circle the number which best describes your level of concern for each item.

Please answer the following questions by filling in the circles according to the following answer key:

1 = no concern at all       2 = a little concerned       3 = concerned
4 = pretty concerned       5 = very concerned

1. Attending therapy will lead me to feel like I could not deal with my own problems.

2. I will have to confront problems that I don't want to look at.

3. People will find out that I have a problem.

4. The therapist will have to go to a lot of trouble to help me.

5. The therapist will have unrealistic expectations of me.

6. I will have to disclose shameful behaviours.

7. My problems are too big for me to get someone else involved in them.

8. The therapist will think that others need help more than me.

9. Therapy will lead me to gain weight.

10. The therapist won't take me seriously.
11. Therapy will lead me or my life to change in an unpredictable way.

12. Attending therapy will lead me to feel like a failure.

13. The therapist will tell me I am doing something wrong.

14. Others will think that my problems are my fault.

15. Therapy will cause me to realize that I have to make changes that I know I can't make.

16. Attending therapy will result in me feeling hopeless and worthless.

17. I will fail at therapy.

18. My family will find out I was going to therapy.

19. The therapist will be disgusted with me.

20. I will think I don't deserve to be helped since my problems are my own fault.

21. I will feel judged by the therapist.

22. Therapy will lead me to lose my sense of who I am.

23. I am concerned that therapy will help me.

24. The therapist will be burdened by me.

25. Those close to me would be angry if they knew I attended therapy.

26. I will have to feel very uncomfortable emotions in therapy.

27. Attending therapy would mean I would have to recognize that I have a real problem.

28. My secret will be known and I will feel embarrassed.

29. I will waste the therapist's time.

30. Therapy will validate exactly how I feel about myself inside.

31. The therapist will think that I'm crazy.

32. Therapy will lead me to feel lots of stress.
33. Therapy will throw off my entire life.
34. The therapist will think I am wasting his or her time.
35. Those close to me would be unsympathetic if they knew I attended therapy.
36. Those close to me would be concerned if they knew I attended therapy.
37. I will get "better" on one hand, but will feel lost on the other hand.
38. Therapy will cause me to feel out of control.
39. People will think that I don't deserve to be helped.
40. Attending therapy will result in me not getting better.
41. Attending therapy will result in me letting other people down.
42. Attending therapy will result in me feeling very ashamed with myself.
43. People will think there's something wrong with me.
44. Therapy will confirm for me what I have thought all along, that I am worthless.
45. Therapy will leave me feeling overwhelmed by my feelings.
46. Therapy will lead me to realize that there is no solution to my problems.
47. Therapy will lead me to conclude that I will have to be like this for the rest of my life.
48. The therapist will judge me.
49. I will fail at therapy, disappointing myself or others.
50. Therapy will take away the very things that help me cope with my emotions.
51. I won't be able to trust the therapist.
52. I will have to face myself and find out that there is something so fundamentally wrong with me that it cannot be fixed.
53. Attending therapy will lead my family to judge me.

Please use this page to provide details of any additional fears you might have about going to see a counselor/therapist:
Appendix B

Approval Letters from Research Ethics Boards

University of Windsor
Department of Psychology

Approval for Ethics committee Review of Human Research

Project Director (Faculty Member): Cheryl Thomas, Ph.D., C. Psych
Student/Research Assistant: Jeremy Frank, M.A., principal investigator
Other Researchers involved in project (technicians, project staff, faculty):
Dory Becker, B.A., Research Assistant

Project Title: Predictors of treatment seeking in women with subthreshold and full syndrome bulimia

Type of Research:
___ Faculty ___ Graduate ___ Practicum ___ Internship ___ Undergraduate
___ Course Project (Course Number): ___

Other (specify): __________________________________________________________________

Thesis Research: XX Ph.D. ___ M.A. ___ Honours B.A.

Consent/Deception:
___ This study includes a comprehensive subject consent form.
XX This study DOES NOT involve any deception or withholding of significant information.

Enclosed materials include:
XX Completed Application Form
XX Outline of Methodology
XX Copies of all materials to be administered to subjects
___ Consent Form(s) *
XX Outline of Feedback or Debriefing information
___ Other (please specify): ______________________________________________________________

* Note: Signed consent is also normally required from any institutions involved (schools, businesses, residences, etc.).

Note: Residents recommended written consent be obtained if/when possible.

Student to check on question of legality of tapping, i.e., assuming one party's consent is
Windsor Regional Hospital
Research Ethics Board
1995 Lens Avenue
Windsor, Ontario
N8W 1L9

REB REVIEW FORM

Meeting Date: June 25, 2002

Project Title: Predictors of treatment seeking in Women with subthreshold and Full-Syndrome Bulimia

Principal Investigator: Jeremy Frank, M.A.

REB File Reference: 02-31

SUBMISSIONS REVIEWED:
Ethics Research Submission dated June 14, 2002

TYPE OF APPROVAL:

[ ] Category A: Approved
[X] Category B: Approval – with some concerns addressed – Board Comments attached
[ ] Category C: Decision deferred. More information/revisions required – Board Comments attached
[ ] Category D: Not Approved

This protocol was reviewed by a properly constituted Research Ethics Board and in a manner consistent with applicable regulations for voting concerning the approval of the study. A quorum was present and only Research Ethics Board members who are independent of the investigator(s) conducting the study participated in deliberations and voting concerning the approval of the study.
Appendix C

Recruitment Sources for the Second Stage of Research

Undergraduate Psychology Student Participant Pool

Women were recruited from an undergraduate psychology research participant pool at the University of Windsor. Students in Introductory Psychology classes were pre-screened at the beginning of their course with the following question: "Over the past two weeks, have you felt significant levels of distress on more days than not?" A random sample of those who responded "yes" to this question were contacted via e-mail (see Appendix C1) or by telephone, and asked to participate in a survey study that is investigating people's attitudes toward mental health services. They were offered one bonus point toward their psychology course in exchange for participating. Students were given the option of participating via an internet website or of completing a pencil-paper version of the questionnaires. Those who chose the latter were invited to meet with the researcher at his university office where they were given the hard-copy questionnaire packet to complete.

Business Cards and Flyers

Posters, flyers, and business cards (see Appendix C2) aimed at recruiting distressed or bulimic women (in exchange for entry into a lottery for a $50 gift certificate at a music store) were distributed around Windsor, Ontario in the following areas: 1) changing rooms in two women’s clothing stores, 2) toilet stalls at a popular bar downtown Windsor, 3) toilet stalls in a woman’s washroom at a fitness centre, 4) female locker rooms at a fitness centre, 5) a lobby at a fitness centre, 6) several public bulletin boards in the kinesiology department at the University of Windsor, and 7) several
university classes in the Business and Kinesiology Departments at the University of
Windsor (accompanied by a 30 second passage read to the class). After several months,
the researcher did not receive any inquiries via this method. Therefore, it was no longer
pursued.

*Snowball Sampling via E-Mail*

An e-mail describing the study and containing a web-site address for potential
participants was sent out to approximately 75 colleagues and friends of the principal
investigator. The e-mail asked recipients who self-identify as women who are distressed
and who have never sought psychological help to participate in exchange for entry into a
lottery for a $50 gift certificate at a music store. Recipients were also asked to forward
the e-mail to their peers in the hope that the e-mail reached many more people than the
original 75. Participants who were recruited in this manner identified a variety of
American and Canadian cities as their current living location. The contents of this e-mail
are presented in Appendix C3. Individuals recruited in this manner were only given the
option of participating online via the data collection website.

*Eating Disorder and Depression Internet-Based Support Group Bulletin Boards*

The principal investigator posted messages (identical in content to the e-mail
presented in Appendix C3 but without a request that the reader forward the e-mail to
others) on internet-based support groups for women who suffer from eating disorders or
depression. Potential recruits were offered entry into a lottery for a $50 gift certificate at a
music store in exchange for participation. They were also only given the one option of
participating online via the data collection website. Participants recruited on these
bulletin boards identified a variety of Canadian and American cities as their current living location.

Clinical Treatment Facilities

Four outpatient eating disorder treatment facilities and five outpatient general mental health treatment facilities across Ontario and in Montreal, Quebec agreed to refer clients for recruitment. Clinic staff were asked to solicit participation from female clients who were at least 18 years old and who were seeking psychological services for the first time.

Sheena’s Place. Sheena’s Place is an outpatient drop-in centre in downtown Toronto, Ontario that offers group therapy and psycho-education for women with eating disorders. Their clientele are self-referred and are each mailed an information packet upon registering for a program. A flyer for the current study with a website address that could be accessed by potential participants (see Appendix C4) was included in their standard information packet. Potential recruits were only given the option of participating online via the data collection website, and were offered entry into a lottery for a $50 gift certificate at a music store. Three women were recruited from Sheena’s Place and completed the questionnaires online. In order to address the concern that they may have registered for a program, completed the questionnaires online, but failed to attend the program, they each responded to an e-mail two months post-participation indicating that they did in fact attend groups at Sheena’s Place.

Bulimia and Anorexia Nervosa Association (BANA). BANA is an outpatient treatment facility in Windsor, Ontario that offers individual and group therapy for individuals with eating disorders. Their clientele are either self-referred or referred by
various professionals in the community. Clients undergo an individual assessment when they first seek treatment. In this assessment, clients are asked about their treatment history. At the end of the assessment interview, clients without a history of treatment seeking were presented with a flyer inviting them to participate in the present study (see Appendix C4) in exchange for entry into a lottery for a $50 gift certificate at a music store. Clients who chose to participate online were asked to do so before their first treatment session. Clients who chose to complete the paper-pencil version were given the option of completing it at the clinic or of taking it home and returning it at the beginning of their next appointment.

Eating Disorders Clinic, Douglas Hospital. This facility in Montreal, Quebec services both inpatients and outpatients with eating disorders and offers a wide range of treatments including individual and group therapy. Their clientele are either self-referred or referred by various professionals or agencies across Quebec. Patients undergo an individual assessment with an onsite research staff member when they first seek treatment. At the end of the assessment interview, patients without a history of treatment were presented with a flyer inviting them to participate in the present study (see Appendix C4) in exchange for entry into a lottery for a $50 gift certificate at a music store. A research assistant also telephoned a large number of individuals on the waitlist who had sought services but not yet been given an appointment. Patients who chose to participate online were asked to do so before their first treatment session. Patients who chose to complete the paper-pencil version were given the option of completing it at the clinic or of taking it home and returning it at the beginning of their next appointment.
Psychological Services Centre and Student Counseling Centre, University of Windsor. These facilities service a college mental health population at a midsize university in Southwestern Ontario. Their clientele are usually self-referred but can also be referred by other health agencies and professionals. Flyers (targeting women who were seeking help for the first time, see Appendix C4) were made available to clients either in the waiting room or by the clinician conducting the intake interview. Potential recruits were offered entry into a lottery for a $50 gift certificate to a music store, and were given the option of participating online via the data collection website or of completing a paper-pencil version of the questionnaire packet. They were asked to participate before their next appointment.

Community Mental Health Centres (Centre for Psychological Services at the University of Ottawa and the Community Mental Health Clinic at the Windsor Regional Hospital). These community mental health agencies service the public in Ottawa and Windsor, Ontario respectively. Clientele are typically self-referred but can also be referred by other health agencies and professionals. Flyers (targeting women who were seeking help for the first time, see Appendix C4) were made available to clients either in the waiting room or by the clinician conducting the intake interview. Potential recruits were offered entry into a lottery for a $50 gift certificate at a music store, and were given the option of participating online via the data collection website or of completing a paper-pencil version of the questionnaires. They were asked to participate before their next appointment.

McGill University Mental Health Services. This facility services a college mental health population at a large university in Montreal, Quebec. The service is comprised of
both a general mental health clinical team as well as a separate clinical division for the
treatment of eating disorders. Their clientele are usually self-referred but can also be
referred by other health agencies and professionals. Clinicians actively recruited their
clients on behalf of the researcher in the first intake session. Those who wished to
participate were offered entry into a lottery for a $50 gift certificate at a music store, and
were given the option of participating online via the data collection website or of
completing a pencil-paper version of the questionnaire battery. They were asked to
participate before their next appointment.

Queens University Adult Eating Disorder Clinic. This facility offers individual
and group therapies for individuals with eating disorders in the Kingston, Ontario area.
Their clientele are either self-referred or referred by various professionals in the
community. Clients undergo an individual assessment when they first seek treatment. In
this assessment, clients are asked about their treatment history. At the end of the
assessment interview, clients without a history of treatment seeking were presented with
a flyer inviting them to participate in the present study (see Appendix C4) in exchange
for entry into a lottery for a $50 gift certificate at a music store. Clients who chose to
participate online were asked to do so before their first treatment session. Clients who
chose to complete the paper-pencil version were given the option of completing it at the
clinic or of taking it home and returning it at the beginning of their next appointment.

Total Sample

In total, 354 women (all 18 years of age or older) participated. The number of
women recruited from each recruitment source is presented in Table C1. Before
completing the questionnaires, each recruit was asked to provide informed consent.
Table C1

*Participants Recruited By Recruitment Source (N=354)*

<table>
<thead>
<tr>
<th>Recruitment Source</th>
<th>Web-Site Participants</th>
<th>Hard Copy Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Undergraduate Participant Pool</td>
<td>209</td>
<td>11</td>
</tr>
<tr>
<td>2. Business cards/Flyers Distributed Publicly</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3. Snowball Sampling via E-mail</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>4. Internet-based Eating Disorder support group bulletin boards</td>
<td>38</td>
<td>0</td>
</tr>
<tr>
<td>5. Internet-based Depression support group bulletin boards</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>6. Sheena’s Place</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>7. Bulimia and Anorexia Association (BANA)</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>8. Eating Disorders Clinic, Douglas Hospital</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>9. Psychological Services Centre, University of Windsor</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>10. Student Counseling Centre, University of Windsor</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>11. Centre for Psychological Services, University of Ottawa</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>12. Community Mental Health Clinic, Windsor Regional Hospital</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>13. McGill University Mental Health Services</td>
<td>0</td>
<td>42</td>
</tr>
<tr>
<td>14. Queen’s University Adult Eating Disorder Clinic</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>290</strong></td>
<td><strong>64</strong></td>
</tr>
</tbody>
</table>
Those who completed the hard copy version were asked to sign a consent form (see Appendix C5) which was returned to the researcher separately from the questionnaire package. Those who participated online were asked to consent by clicking "submit" at the end of the informed consent form page (the content of which were identical to those provided to hard copy participants). The questionnaire battery was comprised of a background information and demographic questionnaire and eight additional self-report measures, administered in a random order to each participant. Upon completing the questionnaires, participants were asked permission for them to be contacted in the future for possible follow-up data collection. Those who agreed were asked to provide contact information. It was made clear that in contrast to consent form signatures, this contact information could be linked to their questionnaire responses. Participants who were offered a chance to win a gift certificate for fifty dollars were then asked to provide contact information if they wished to participate in the lottery. Finally, participants were debriefed regarding the study. In order to avoid biased follow-up data, those who agreed to be contacted in the future were only given possible referral sources should they be in distress, and were not provided with details regarding the studies hypothesis. Those who did not provide permission for future contact were given a debriefing sheet (see Appendix C6).
APPENDIX C1

Recruitment E-Mail for the Participant Pool

My name is Jeremy Frank, I'm one of the doctoral students in the Department of Psychology. I was given your name and e-mail address by the Participant Pool Committee (you signed up for the participant pool in order to receive bonus points in one of your Winter 2003 classes). I am writing to ask you to participate in my research study. Participation takes approximately 35-45 minutes, and involves filling out a series of questionnaires. Basically, my study involves an exploration of people's attitudes and feelings about psychologists, and stuff like that. You will be asked about a number of different behaviours, patterns, thoughts, attitudes, and feelings you might have.

Participation can take place either online on the web or by filling out a paper-pencil version of the questionnaires. In exchange for participating, you WILL RECEIVE 1 BONUS POINT toward the class that you are registered for bonus points in. If you are registered in more than 1 class, you can indicate which class you would like the points assigned to.

You are not required to participate in this study if you do not want to. I think you will find it interesting, and it certainly is an easy and convenient way to earn a bonus point. Participation is completely confidential. If you participate online on the web, you will NOT BE REQUIRED TO LEAVE YOUR NAME AT ALL — you can participate completely anonymously if you like. You will be asked at the end of the questionnaires to leave your student number and the class which you want your bonus points assigned to, but this student number will not be matched up with the answers you provide. This information will be forwarded automatically to the participant pool committee so that you are awarded the bonus point for your class. If you participate by filling out the paper-pencil version, you will be asked to sign an informed consent form, but once again, it will not be attached to the questionnaires and there will be no way of identifying your answers as belonging to you.

To participate online on the web, please go to http://www.ustudies.com/login.u?loginid=1-5-001-2-GO (If that link doesn't work for you, you can go to http://www.ustudies.com and when it asks you for a login ID, enter “1-5-001-2-GO” (exactly like that, don't forget the dashes)). Please make sure that you participate at a time when you are by yourself (so that you are not distracted and so that you will feel comfortable providing answers that you would not want others to know about). Please answer the questionnaires as honestly and completely as you can — you are free to not answer any question you do not feel comfortable answering.

If you do not have web access and you would like to participate, please reply this e-mail indicating that you would like to participate by completing the paper-pencil version, and I will e-mail you back to arrange a time to pick up and complete a questionnaire packet.
PLEASE NOTE #1: IF YOU ARE CONFIDENT THAT YOU HAVE ALREADY PARTICIPATED IN THIS STUDY, PLEASE DO NOT PARTICIPATE AGAIN, AND LET ME KNOW THAT YOU HAVE ALREADY PARTICIPATED.

PLEASE NOTE #2: IF YOU CHOOSE NOT TO PARTICIPATE, PLEASE E-MAIL ME BACK SO THAT I CAN PUT YOUR NAME BACK IN THE PARTICIPANT POOL SO THAT THE COMMITTEE CAN GIVE YOUR NAME TO ANOTHER RESEARCHER.

If you have any questions, please feel free to e-mail me or phone me in my office (ext. 2216).

Thanks so much,

Jeremy Frank, M.A.

519-253-3000 ext. 2216 (tel)
519-973-7021 (fax)
APPENDIX C2

Posters, Flyers, and Business Cards

Posters, flyers, and business cards were distributed with one of two messages:

1) Recruiting distressed women:

1. Do you regularly experience sadness, poor concentration, or trouble remembering things? Do others not understand you or seem unsympathetic? Have you been feeling lonely, blue, or inferior to others?

2. Are you a woman who is 18 years of age or older?

If this sounds like you and you’re willing to participate in a confidential research project:

Please call (519) 253-3000 ext. 2216 or e-mail a phone number where you can be reached to jfrank@uwindsor.ca (leave a message if no one answers). Lottery for $50.00 gift certificates at HMV. Option to participate online over the web, even anonymously if you like!

This project is being conducted through the Department of Psychology at the University of Windsor.

2) Recruiting bulimic women:

1. Do you eat large amounts of food and fear that your eating is uncontrollable?

2. Do you use self-induced vomiting, excessive exercise, fasting, laxatives, or diuretics to control your weight?

3. Are you a woman who is 18 years of age or older?

If you answered YES to all three questions, and you’re willing to participate in a confidential research project:

Please call (519) 253-3000 ext. 2216 or e-mail a phone number where you can be reached to jfrank@uwindsor.ca (leave a message if no one answers). Lottery for $50.00 gift certificates at HMV. Option to participate online over the web, even anonymously if you like!

This project is being conducted through the Department of Psychology at the University of Windsor.
APPENDIX C3

Recruitment E-mail: Snowball Sampling

Dear Friends and Friends of Friends,

I hate mass e-mails as much as the next person, and I particularly hate it when the e-mails begin with "I hate mass e-mails as much as the next person but....," BUT... I really need some help, and it would mean a lot to me if you could take a look at this and see if you can help me out.

As you may or may not know, I'm currently finishing up my doctoral dissertation at the University of Windsor. I am in the process of finding research participants for my study, and it is proving to be quite a difficult task. I need to find a total of approximately 120 people to participate, and so far, I'm about half way there, - about a 4x slower rate than I had anticipated. As such, I am sending this e-mail in hopes that you know someone (or some people!) who might be able to participate in my study, and who you could forward this e-mail to. You may have received a very similar e-mail from me last June, but in light of my continued need for participants, I thought I'd send this out again:

First, I'll introduce myself. My name is Jeremy Frank, I am a graduate student in psychology at the University of Windsor, in Windsor, Ontario, Canada. I am writing in hopes that you can help me with my research. The goal of my research is to explore some of the thoughts and feelings that people sometimes have about going to see a mental health practitioner (e.g., a psychologist, a social worker.) To complete my research, I need to find a fairly large number of participants, and it has been challenging (to say the least) to find people to help me. As you can imagine, this is an ambitious task, and it has been very hard for me to find people to help me. I guess I have several questions...

1) If you:
   a) are a woman who is 18 years of age or older

   b) have been feeling distressed (e.g., anxious, sad, depressed, etc.)over the past little while

   c) have never sought professional psychological treatment (e.g., therapy or counseling).

   d) have not already participated in my research study

would you be willing to help me out? Participating involves filling out a series of questionnaires on the web - it takes about 30-45 minutes to do, and you can do it completely anonymously if you like. At the end of the questionnaire, it asks you if you would like to leave your name so that you can be entered into a draw for a $50.00 gift
certificate to a record/CD store (e.g., HMV) - but this is optional. Your participation in
this study would be greatly appreciated!

If you are willing to participate, please go to
http://www.ustudies.com/login.u?loginid=1-5-125-2-GO

(If that link did not work for you, please go to www.ustudies.com and when it asks for
a login ID, enter "1-5-125-2-GO" (exactly like that - with the dashes). This will guide
you through the questionnaires.

2) If you do not fit the above description, do you know somebody who does? If so, I
would really appreciate it if you could forward along this e-mail - I am hoping to get a
good deal of participants through word of mouth, and this is the best way I know how
to do that. Alternatively, if it's alright with the person, you can send me their e-mail
and I can e-mail them directly.

I realize that "forwards" are a pain and can even be irritating. However, finding women
who are willing to disclose that they have been feeling distressed and who have not
sought therapy/counseling is very difficult, and if you have the time to help me out by
participating or by forwarding this to someone you know, it would make a very big
difference for me.

If you are able to, it would also be greatly appreciated if you could simply forward this
e-mail to people you know, even if you don't believe that they would be eligible to
participate, as they may know other people who are eligible. The more this gets spread
around, the better the odds are that I will find some participants.

Thanks so much,

Jeremy Frank, M.A.
Appendix C4

Recruitment Flyers

Generic Flyer Used for Recruitment at a Number of Clinical Facilities

Please take this flyer if you can answer yes to all of the following three questions:

1. Is this your first visit at ....?
2. Is this your very first time seeking psychological or counseling services?
3. Are you female, and at least 18 years of age?

Research Opportunity

- Jeremy Frank, a doctoral student in the psychology department at the University of Windsor is studying some of the thoughts and feelings people sometimes have about going to see a mental health professional (e.g., a psychologist, a social worker). He is looking for people to participate in his study. Participation would involve filling out a series of questionnaires, and would take approximately 30-45 minutes to complete.

- Jeremy would be very appreciative of your help in this, as it is hard to find enough participants for this type of research. If you agree to participate, you will be entered into a draw, and six people will be awarded $50.00 worth of gift certificates for redemption at a music store (e.g., HMV). If you participate, your answers will be kept completely confidential, and your name will never be attached to any of the answers you give. You have the right to refuse to participate or refuse to answer any question without any consequence.

- You are welcome to speak to Jeremy and ask any question you like. He can be reached at (519) 253-3000 ext. 2216, or by e-mail at research@jfrank.sent.com. This project has been fully approved by the University of Windsor’s Research Ethics Board.

- There are two ways you can participate. You can participate online, and you will not have to provide your name if you choose not to. Or, you can fill out the paper version, whereby you will be asked to sign an informed consent form first, but it will not be attached to the questionnaire so your answers can remain anonymous. To complete the paper version, please ask for a paper copy.

- To participate online, please go to www.ustudies.com- when it asks for a login ID, please enter “1-6-xxx-2-GO”. Please make sure you include the dashes. The web page will take you through the questionnaires and give you an opportunity to be in the draw.

- If you choose to participate, please make sure that you fill out all the questionnaires online anytime before your second appointment.
Flyer for Sheena's Place

Please read this flyer if you can answer yes to the following two questions:

1. Is your contact with Sheena's Place the first and only time you have sought help for an eating disorder?
2. Are you female, and at least 18 years of age?

- Jeremy Frank, a doctoral student in the psychology department at the University of Windsor is studying some of the thoughts and feelings people sometimes have about going to see a mental health professional (e.g., a psychologist, a social worker).

- He is looking for people to participate in his study. Participation would involve filling out a series of questionnaires on an internet web-page, and would take approximately 30-45 minutes to complete. Jeremy would be very appreciative of your help in this, as it is hard to find enough participants for this type of research. The purpose of this type of research is to make it easier for other people to get the help they need. If you agree to participate, you will be entered into a draw, and six people will be awarded $50.00 worth of gift certificates for redemption at a music store (e.g., HMV).

- If you participate, your answers will be kept completely confidential, and your name will never be attached to any of the answers you give. You have the right to refuse to participate or refuse to answer any question without any consequence. If you participate, you will be asked permission for the researcher to contact you (by e-mail or phone, whichever you prefer) to confirm that you have attended a group session at Sheena's Place.

- You are welcome to speak to Jeremy and ask any question you like. He can be reached at (519) 253-3000 ext. 2216, or by e-mail at research@jfrank.sent.com. This project has been fully approved by the University of Windsor's Research Ethics.

- To participate online, please go to www.ustudies.com- when it asks for a login ID, please enter "1-6-257-2-GO". Please make sure you include the dashes. The web page will take you through the questionnaires and give you an opportunity to be in the draw. If you choose to participate, please make sure that you fill out all the questionnaires online before you attend a group at Sheena's Place.
Flyer for the Douglas Hospital Eating Disorder Center

Please read this flyer if you can answer yes to the following two questions:

1. Is your contact with the Douglas Hospital’s Eating Disorders Program the first and only time you have sought psychological or counseling services?

2. Are you female, and at least 18 years of age?

Research Opportunity

- Jeremy Frank, a doctoral student in the psychology department at the University of Windsor is studying some of the thoughts and feelings people sometimes have about going to see a mental health professional (e.g., a psychologist, a social worker).

- He is looking for people to participate in his study. Participation would involve filling out a series of questionnaires on an internet web-page, and would take approximately 30-45 minutes to complete.

- Jeremy would be very appreciative of your help in this, as it is hard to find enough participants for this type of research. If you agree to participate, you will be entered into a draw, and six people will be awarded $50.00 worth of gift certificates for redemption at a music store (e.g., HMV).

- If you participate, your answers will be kept completely confidential, you don’t have to leave your name if you do not want to. If you choose to leave your name so you can be put in the draw for gift certificates, your name will never be attached to any of the answers you give. You have the right to refuse to participate or refuse to answer any question without any consequence.

- You are welcome to speak to Jeremy and ask any question you like. He can be reached at (519) 253-3000 ext. 2216, or by e-mail at research@jfrank.sent.com. This project has been fully approved by the University of Windsor’s Research Ethics Board and by the Douglas Hospital’s Research Ethics Board.

- To participate online, please go to www.ustudies.com - when it asks for a login ID, please enter “1-6-110-2-GO”. Please make sure you include the dashes. The web page will take you through the questionnaires and give you an opportunity to be in the draw.

- If you choose to participate, please make sure that you fill out all the questionnaires online before you next see a professional at the Eating Disorders program.
Appendix C5

Consent Forms to Participate in Research

Consent Form for Participant Pool Participants at the University of Windsor
March 15, 2002

Consent to Participate in Research

Title of the Research
Attitudes Toward Professional Help seeking

Researcher
You are asked to participate in a research study conducted by Jeremy Frank, M.A., a graduate student in the Department of Psychology at the University of Windsor. This research is being supervised by Cheryl Thomas, PhD.

Why are we doing this research?
The goal of the study is to explore some of the thoughts and feelings that people sometimes have about going to see a mental health practitioner (e.g., a psychologist, a social worker.) The data collected in this study will be used to advance knowledge in the area of perceptions of psychological services. Your participation in this study would be greatly appreciated!

What will happen during the research?
Your participation in the study will consist of completing a series of questionnaires, which have been designed to measure personality variables, psychological symptoms, and different ideas people have about psychological services. The questionnaire will take approximately 45 minutes to complete.

Are there good things and bad things about the research?
Completing the questionnaire may make you think about things that you have not considered before. For example, you might realize you have certain ideas about how you feel about getting help. This could make you happy or sad. If you have any reactions after completing this questionnaire that you want to discuss, please feel free to contact me (Jeremy Frank – 519-253-3000 ext. 2216) or my dissertation advisor, Dr. Cheryl Thomas (519-253-3000 ext. 2252). We would be more than happy to talk with you.

It could be interesting for you to participate in this study. It will also help mental health professionals and researchers to gain a better understanding of people’s feelings about help seeking. Following your participation, if you wish, you will be contacted with a detailed description of the research questions investigated, and a short summary of the results will be sent to you as well.

In exchange for participating, you will receive one bonus point towards your psychology class where bonus points are eligible.
Who will know about what I did in the research?
Your answers will be kept completely confidential. Your responses will be kept under strict confidentiality, and will only be accessible to the principal researcher (Jeremy Frank). You will not be asked to identify yourself in any manner on the questionnaire, and the consent forms and questionnaires will be stored separately from one another. Your responses will be stored in a database on a computer using an identification number (without your name). The data collected through this study may be published. Again, there will be no way of associating the results with your personal answers.

Can I decide if I want to be in the research?
You can choose to participate in this study or not without consequence. You can also choose to withdraw from the study at any point. You may also refuse to answer specific questions.

This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Research Ethics Co-ordinator
University of Windsor
Windsor, Ontario N9B 3P4
Telephone: 519-253-3000, ext. 3916
E-mail: ethics@uwindsor.ca

I understand the information provided for the study “Attitudes Toward Professional Help seeking” as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study.

__________________________________________
Your Name

__________________________________________
Your Signature

__________________________________________
Date
Consent Form for Other Participants Recruited Outside of Clinical Facilities

February 21, 2002

Consent to Participate in Research

Title of the Research
Attitudes Toward Professional Help seeking

Researcher
You are asked to participate in a research study conducted by Jeremy Frank, M.A., a graduate student in the Department of Psychology at the University of Windsor. This research is being supervised by Cheryl Thomas, PhD.

Why are we doing this research?
The goal of the study is to explore some of the thoughts and feelings that people sometimes have about going to see a mental health practitioner (e.g., a psychologist, a social worker.) The data collected in this study will be used to advance knowledge in the area of perceptions of psychological services. Your participation in this study would be greatly appreciated!

What will happen during the research?
Your participation in the study will consist of completing a series of questionnaires, which have been designed to measure personality variables, psychological symptoms, and different ideas people have about psychological services. The questionnaire will take approximately 45 minutes to complete.

Are there good things and bad things about the research?
Completing the questionnaire may make you think about things that you have not considered before. For example, you might realize you have certain ideas about how you feel about getting help. This could make you happy or sad. If you have any reactions after completing this questionnaire that you want to discuss, please feel free to contact me (Jeremy Frank – 519-253-3000 ext. 2216) or my dissertation advisor, Dr. Cheryl Thomas (519-253-3000 ext. 2252). We would be more than happy to talk with you.

It could be interesting for you to participate in this study. It will also help mental health professionals and researchers to gain a better understanding of people’s feelings about help seeking. Following your participation, if you wish, you will be contacted with a detailed description of the research questions investigated, and a short summary of the results will be sent to you as well.

In exchange for participating, your name will be entered into a lottery. Six names will be selected, and winners will receive gift certificates from a local CD retailer (e.g., HMV) valued at $50.00. Odds of winning are approximately 1 in 46.
Who will know about what I did in the research?
Your answers will be kept completely confidential. Your responses will be kept under strict confidentiality, and will only be accessible to the principal researcher (Jeremy Frank). You will not be asked to identify yourself in any manner on the questionnaire, and the consent forms and questionnaires will be stored separately from one another. Your responses will be stored in a database on a computer using an identification number (without your name). The data collected through this study may be published. Again, there will be no way of associating the results with your personal answers.

Can I decide if I want to be in the research?
You can choose to participate in this study or not without consequence. You can also choose to withdraw from the study at any point. You may also refuse to answer specific questions.

This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Research Ethics Co-ordinator
University of Windsor
Windsor, Ontario N9B 3P4

Telephone: 519-253-3000, ext. 3916
E-mail: ethics@uwindsor.ca

I understand the information provided for the study “Attitudes Toward Professional Help seeking” as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study.

________________________________________________________________________

Your Name

________________________________________________________________________

Your Signature                      Date
Consent to Participate in Research

Title of the Research
Attitudes Toward Professional Help seeking

Researcher
You are asked to participate in a research study conducted by Jeremy Frank, M.A., a graduate student in the Department of Psychology at the University of Windsor. This research is being supervised by Cheryl Thomas, PhD.

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Completing the questionnaire may make you think about things that you have not considered before. For example, you might realize you have certain ideas about how you feel about getting help. This could make you happy or sad. If you have any reactions after completing this questionnaire that you want to discuss, please feel free to contact me (Jeremy Frank – 519-253-3000 ext. 2216) or my dissertation advisor, Dr. Cheryl Thomas (519-253-3000 ext. 2252). We would be more than happy to talk with you.

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Can I decide if I want to be in the research?
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This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Research Ethics Co-ordinator
University of Windsor
Windsor, Ontario  N9B 3P4

Telephone: 519-253-3000, ext. 3916
E-mail: ethics@uwindsor.ca

I understand the information provided for the study “Attitudes Toward Professional Help seeking” as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study.

________________________________________
Your Name

________________________________________
Your Signature                   Date
Consent Form for Douglas Hospital Participants

Attitudes Toward Professional Help seeking

CONSENT FORM

Researchers
You are asked to participate in a research study conducted by Jeremy Frank, M.A., a graduate student in the Department of Psychology at the University of Windsor. This research is being supervised by Dr. Cheryl Thomas. Dr. Howard Steiger, the director of the Eating Disorders Unit at the Douglas Hospital, is collaborating on this project, and is overseeing all procedures taking place at the Douglas Hospital.

Reason for the Study
The goal of the study is to explore some of the thoughts and feelings that people sometimes have about going to see a mental health practitioner (e.g., a psychologist, a social worker.) The data collected in this study will be used to advance knowledge in the area of perceptions of psychological services. Your participation in this study would be greatly appreciated!

What will happen during the research?
Your participation in the study will consist of completing a series of questionnaires, which have been designed to measure personality variables, psychological symptoms, and different ideas people have about psychological services. The questionnaire will take approximately 45 minutes to complete.

Are there good things and bad things about the research?
Completing the questionnaire may make you think about things that you have not considered before. For example, you might realize you have certain ideas about how you feel about getting help. This could make you happy or sad.

It could be interesting for you to participate in this study. It will also help mental health professionals and researchers to gain a better understanding of people’s feelings about help seeking. Following your participation, if you wish, you will be contacted with a detailed description of the research questions investigated, and a short summary of the results will be sent to you as well.

In exchange for participating, your name will be entered into a draw. Six names will be selected, and winners will receive gift certificates from a local CD retailer (e.g., HMV) valued at $50.00. Odds of winning are approximately 1 in 46.
**Who will know about what I did in the research?**

Your answers will be kept completely confidential. Your responses will be kept under strict confidentiality, and will only be accessible to the principal researcher (Jeremy Frank). You will not be asked to identify yourself in any manner on the questionnaire, and the consent forms and questionnaires will be stored separately from one another. Your responses will be stored in a database on a computer using an identification number (without your name). The data collected through this study may be published. Again, there will be no way of associating the results with your personal answers.

**Who can I talk to if I have any questions about this study?**

If you have any questions that you would like to ask either before participating or after participating, please feel free to contact either Dr. Howard Steiger (who is collaborating on this project at the Douglas Hospital, and is the Douglas Hospital’s contact person) at 514-761-6131 ext. 2895, Jeremy Frank (the principal investigator) at 519-253-3000 ext. 2216 (or research@jfrank.mailbolt.com), or Dr. Cheryl Thomas (who is supervising this research) at 519-253-3000 ext. 2252. We would all be more than happy to talk with you.

This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board and through the Douglas Hospital’s Research Ethics Board. If you have any questions concerning your rights as a subject or patient in a research study, you can contact the Douglas Hospital Ombudsman (Mrs. Francine Y. Bourassa) at 514-761-6131 ext. 3287. The University of Windsor’s Research Ethics Board can be contacted at 519-253-3000 ext. 3916.

**Can I decide if I want to be in the research?**

You can choose to participate in this study or not without consequence. You can also choose to withdraw from the study at any point. You may also refuse to answer specific questions.

I understand the information provided for the study “Attitudes Toward Professional Help seeking” as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study.

______________________________  __________________________
Your Name                              Date
Consent Form for Queen’s Adult Eating Disorder Clinic Participants

Attitudes Toward Professional Help seeking

CONSENT FORM

Researchers
You are invited to participate in a research study being conducted by Jeremy Frank, M.A., a graduate student in the Department of Psychology at the University of Windsor. This research is being supervised by Dr. Cheryl Thomas. Eleanor Marquardt, the nurse coordinator at the Eating Disorders Clinic, is collaborating on this project, and is overseeing all procedures taking place at the Eating Disorders Clinic.

Reason for the Study
The goal of the study is to explore some of the thoughts and feelings that people sometimes have about going to see a mental health practitioner (e.g., a psychologist, a social worker.) The data collected in this study will be used to advance knowledge in the area of perceptions of psychological services. Your participation in this study would be greatly appreciated!

What will happen during the research?
Your participation in the study will consist of completing a series of questionnaires, which have been designed to measure personality variables, psychological symptoms, and different ideas people have about psychological services. The questionnaire will take approximately 45 minutes to complete.

Are there good things and bad things about the research?
Completing the questionnaire may make you think about things that you have not considered before. For example, you might realize you have certain ideas about how you feel about getting help. This could make you happy or sad.

It could be interesting for you to participate in this study. It will also help mental health professionals and researchers to gain a better understanding of people’s feelings about help seeking. Following your participation, if you wish, you will be contacted with a detailed description of the research questions investigated, and a short summary of the results will be sent to you as well.

In exchange for participating, your name will be entered into a draw. Six names will be selected, and winners will receive gift certificates from a local CD retailer (e.g., HMV) valued at $50.00. Odds of winning are approximately 1 in 46.

Who will know about what I did in the research?
Your answers will be kept completely confidential. Your responses will be kept under strict confidentiality, and will only be accessible to the principal researcher (Jeremy Frank). You will not be asked to identify yourself in any manner on the questionnaire,
and the consent forms and questionnaires will be stored separately from one another. Your responses will be stored in a database on a computer using an identification number (without your name). The data collected through this study may be published. Again, there will be no way of associating the results with your personal answers.

Who can I talk to if I have any questions about this study?
If you have any questions that you would like to ask either before participating or after participating, please feel free to contact either Eleanor Marquardt (who is collaborating on this project at the Eating Disorders Clinic and is the Eating Disorder Clinic’s contact person) at 613-548-6121, Jeremy Frank (the principal investigator) at 519-253-3000 ext. 2216 (or research@jfrank.sent.com), or Dr. Cheryl Thomas (who is supervising this research) at 519-253-3000 ext. 2252. We would all be more than happy to talk with you.

This study has been reviewed and received ethics clearance through the University of Windsor Research Ethics Board and through the Queen’s University Research Ethics Board. If you have any questions concerning your rights as a subject or patient in a research study, you can contact Dr. Albert Clark, chairperson of the Queen’s University Research Ethics Board at 613-533-6081. The University of Windsor’s Research Ethics Board chairperson, Dr. Maureen Muldoon, can be contacted at 519-253-3000 ext. 3916.

Can I decide if I want to be in the research?
You can choose to participate in this study or not without consequence. You can also choose to withdraw from the study at any point without consequences. You may also refuse to answer specific questions.

I understand the information provided for the study “Attitudes Toward Professional Help seeking” as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study.

__________________________
Your Name

__________________________
Your Signature

__________________________
Date
Consent Form for Participants Recruited From Sheena’s Place

August 15, 2002

Consent to Participate in Research

Title of the Research
Attitudes Toward Professional Help seeking

Researcher
You are asked to participate in a research study conducted by Jeremy Frank, M.A., a graduate student in the Department of Psychology at the University of Windsor. This research is being supervised by Cheryl Thomas, PhD.

Why are we doing this research?
The goal of the study is to explore some of the thoughts and feelings that people sometimes have about going to see a mental health practitioner (e.g., a psychologist, a social worker.) The data collected in this study will be used to advance knowledge in the area of perceptions of psychological services. Your participation in this study would be greatly appreciated!

What will happen during the research?
Your participation in the study will consist of completing a series of questionnaires, which have been designed to measure personality variables, psychological symptoms, and different ideas people have about psychological services. The questionnaire will take approximately 45 minutes to complete. Following your participation, the researcher will contact you in several weeks (either by phone or by e-mail, whichever you indicate on the questionnaire) to see whether you have attended a group at Sheena’s Place.

Are there good things and bad things about the research?
Completing the questionnaire may make you think about things that you have not considered before. For example, you might realize you have certain ideas about how you feel about getting help. This could make you happy or sad. If you have any questions you would like to ask before you participate, feel free to contact me (Jeremy Frank, 519-253-3000 ext. 2216 or research@jfrank.sent.com). If you have any reactions after completing this questionnaire that you want to discuss, please feel free to contact me or my dissertation advisor, Dr. Cheryl Thomas (519-253-3000 ext. 2252). We would be more than happy to talk with you.

It could be interesting for you to participate in this study. It will also help mental health professionals and researchers to gain a better understanding of people’s feelings about help seeking. Following your participation, if you wish, you will be contacted with a detailed description of the research questions investigated, and a short summary of the results will be sent to you as well.
In exchange for participating, your name will be entered into a lottery. Six names will be selected, and winners will receive gift certificates from a local CD retailer (e.g., HMV) valued at $50.00. Odds of winning are approximately 1 in 46.

Who will know about what I did in the research?
Your answers will be kept completely confidential. Your responses will be kept under strict confidentiality, and will only be accessible to the principal researcher (Jeremy Frank). You will not be asked to identify yourself in any manner on the questionnaire, and the consent forms and questionnaires will be stored separately from one another. Your responses will be stored in a database on a computer using an identification number (without your name). The data collected through this study may be published. Again, there will be no way of associating the results with your personal answers.

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University of Windsor
Windsor, Ontario  N9B 3P4

Telephone: 519-253-3000, ext. 3916
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I understand the information provided for the study “Attitudes Toward Professional Help seeking” as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study.

__________________________________________
Your Name

__________________________________________
Your Signature

__________________________________________
Date
Consent for Future Contact
(administered to all participants at the end of the questionnaire battery)

Consent for Future Contact

It is possible that in the future, the researcher might be interested in contacting you to see whether your original answers (to this phase of the study) are related to how you're doing in the future. It is entirely up to you whether you agree to be contacted in the future, and there are no negative consequences for refusing. If you agree to be contacted, the researcher will use discretion when asking for you, and will not provide anyone with any indication that you participated in a study in the past. Should you check "no" to the following question, you will not be contacted by the researcher.

I give permission for the principal researcher to contact me in the future in order to ask me some questions. _______ YES _______ NO

If you responded YES to this question, please provide any contact information that you can so that the researcher can contact you. Remember that this form will be separated from any responses you provide on the questionnaire or in the interview.

Address:

City, Province, Postal Code:

Do you prefer to be contacted by: _____ e-mail _____ telephone

e-mail address:

Telephone number:

Can the researcher leave a message for you? __________________________
Appendix C6

Research Debriefing Form

- All participants recruited from outside of a treatment facility were given a list of service referrals.

- Participants who agreed to be contacted in the future were not provided any debriefing information in order to prevent contamination of their future responses.

- Participants who did not agree to be contacted in the future were provided with the following information:

Thank you so much for agreeing to help me out with my research. Many distressed people have a tough time seeking help, and as such, avoid getting the help they need. One group of people that are particularly unlikely to seek psychological help are women with eating disorders. The purpose of my research is to examine the reasons why women (with and without eating disorders) seek or do not seek psychological help. A particular focus of this research involves the identification of fears that people have about going for help. The results of this research can help us reach out to as many women as possible.

If you have any questions, please feel free to contact me. My phone number is 519-253-3000 ext. 2216.

Once again, thanks so much for helping out.

Sincerely,

Jeremy Frank, M.A.
Appendix D

Background Information Sheet

Instructions: Please complete the following questionnaires as honestly as possible. Remember that the answers you provide are strictly confidential. Please print clearly, and try not to leave any questions unanswered. If you make a mistake, please erase clearly so that the researcher can easily identify the answer you are choosing. If you have any questions, please contact the researcher (Jeremy Frank) by e-mail (frank@uwindsor.ca) or at 519-253-3000 ext. 2216.

When you are finished, please look over the questionnaires to make sure that you did not leave anything out. Place the questionnaire packet in the addressed envelope provided and return it to the researcher.

SECTION A (to be completed by everybody)

Today's Date: ____________ Your birthday: ________________ Your age: ___

Your Ethnicity:
(Please fill in the appropriate circle)
- African-American or African-Canadian
- Caucasian
- East Asian
- European
- Hispanic
- South Asian
- Other: ____________

Please fill in the circle corresponding to your level of education:
- I have completed elementary school
- I have completed high school
- I have taken some courses in a college or university but I have not completed the requirements for a degree
- I have completed a college or undergraduate university degree
- I have completed coursework in a graduate (Masters or Doctoral level program) program but I have not completed the requirements for a graduate degree.
- I have completed a Masters or a Doctoral degree.
Sometimes family or friends pressure people to seek professional help from a counselor, or psychotherapist for personal problems or emotional/psychological difficulties. Please indicate the degree to which in the past month, others have pressured you to seek professional help by circling the number that corresponds with your experience.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Others have not pressured me at all in the past month to seek help.</td>
<td>Others have been constantly pressuring me to seek help over the past month.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you ever sought help from a counselor or therapist for a personal-emotional or psychological problem?

[If you are in the process of seeking help (e.g., you have contacted a clinic or a professional), circle yes].

Yes           No

If you answered "yes", please complete section B (on the back side of this page).

If you answered "no", please skip section B and proceed to Section C (on the next page).

SECTION B (to be completed by those who have sought help from a counselor or a therapist)

Have you seen a therapist or a counselor (even once) in the past two years?

Yes           No

When did you first experience personal-emotional or psychological problems that you thought warranted talking to a therapist or a counselor for?

- Yesterday or today
- Several days ago
- Several weeks ago - indicate approximately how many weeks ago:
- Several months ago - indicate approximately how many months ago:
- Several years ago - indicate approximately how many years ago:
When did you first seek help?

○ Yesterday or today
○ Several days ago
○ Several weeks ago - indicate approximately how many weeks ago:
○ Several months ago - indicate approximately how many months ago:
○ Several years ago - indicate approximately how many years ago:

When was the last time you saw the therapist or counselor?

○ I have never seen a therapist/counselor but I have an appointment to.
○ Yesterday or today
○ Several days ago
○ Several weeks ago - indicate approximately how many weeks ago:
○ Several months ago - indicate approximately how many months ago:
○ Several years ago - indicate approximately how many years ago:

Approximately how many times did you meet with the therapist/counselor?
(If you do not know, guess as accurately as you can)

The therapist/counselor I saw was:

○ A psychologist
○ A psychiatrist
○ A social worker
○ A medical doctor who is not a psychiatrist
○ A nurse
○ A substance abuse counselor
○ Other: ________________________________

Proceed to Section D.
SECTION C (to be completed by those who have never sought help from a counselor or therapist)

Please fill in the circles corresponding to your situation:
- I have never experienced any problems that were that upsetting for me.
- However, if I did have a personal-emotional problem, it is:
  - Extremely likely that I would seek professional help from a therapist or counselor
  - Very likely that I would seek professional help from a therapist or counselor
  - Somewhat likely that I would seek professional help from a therapist or counselor
  - I am indifferent / neutral
  - Somewhat unlikely that I would seek professional help from a therapist or counselor
  - Very unlikely that I would seek professional help from a therapist or counselor
  - Extremely unlikely that I would seek professional help from a therapist or counselor

- I have experienced problems that were (or are) upsetting to me, but I did not seek help because (fill in the blank):

SECTION D (to be completed by everybody)

Please fill in the circles corresponding to symptoms you have been experiencing over the past few weeks from the list below:

- Dental problems (e.g., loss of dental enamel, chipped teeth, increase in dental cavities)
- Enlarged salivary glands
- Irregularity in your menstrual cycle
- Laxative dependence for bowel movements
- Heart problems (diagnosed by a medical doctor)
- Osteoporosis
- Fatigue, weakness
- Other medical problems (please indicate which in as much detail as you can):

Your Gender:  ○ Female  ○ Male
Appendix E

The Eating Attitudes Test – 26 Items (Garner et al., 1982)

Directions: Please answer the following questions using the following answer key:

1 = always  2 = very often  3 = often  4 = sometimes  5 = rarely  6 = never

a. I am terrified about being overweight.
b. I avoid eating when I am hungry.
c. I find myself preoccupied with food.
d. I have gone on eating binges where I feel that I may not be able to stop.
e. I cut my food into small pieces.
f. I am aware of the caloric content of the foods that I eat.
g. I particularly avoid foods with high carbohydrate content (e.g., bread, potatoes, rice, etc.)
h. I feel that others would prefer if I ate more.
i. I vomit after I have eaten.
j. I feel extremely guilty about having eaten.
k. I am preoccupied with a desire to be thinner.
l. I think about burning calories when I exercise.
m. Other people think that I am too thin.
n. I am preoccupied with thoughts of having fat on my body.
o. I take longer than others to eat my meals.
p. I avoid eating foods with sugar in them.
q. I eat diet foods.
r. I feel that food controls my life.
s. I display self control around food.
t. I feel that others pressure me to eat.
u. I give too much thought and time to food.
v. I feel uncomfortable after eating sweets.
w. I engage in dieting behaviour.
x. I like my stomach to be empty.
y. I enjoy trying rich new foods.
z. I have the impulse to vomit after meals.

Scoring key:

1 (always) = 2, 2 (very often) = 2, 3 (often) = 1, 4 (sometimes) = 0, 5 (rarely) = 0, 6 (never) = 0

** Item # 25 (y. I enjoy trying rich new foods.) is reversed scored as follows:
6 (never) = 3, 5 (rarely) = 2, 4(sometimes) = 1, 3(often) = 0, 2(very often) = 0,
1 (always) = 0

The total score is the sum of the item values. Scores above 20 are in the clinical range.
Appendix F

*The Eating Disorder Diagnosis Scale (Stice et al., 2000)*

Over the past 3 months....

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you felt fat?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Have you had a definite fear that you might gain weight or become fat?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Has your weight influenced how you think about (judge) yourself as a person?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Has your shape influenced how you think about (judge) yourself as a person?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. During the past 6 months, have there been times when you felt you have eaten what other people would regard as an unusually large amount of food (e.g., a quart of ice cream) given the circumstances?</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. During the times when you ate an unusually large amount of food, did you experience a loss of control (feel that you couldn’t stop eating or control what or how much you were eating?)</td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. How many DAYS per week on average over the past 6 MONTHS have you eaten an unusually large amount of food and experienced a loss of control?</td>
<td>0 1 2 3 4 5 6 7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. How many TIMES per week on average over the past 3 MONTHS have you eaten an unusually large amount of food and experienced a loss of control?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

During these episodes of overeating and loss of control did you.....

| Question                                                                 | YES | NO |
| 9. Eat much more rapidly than normal?                                   |     |    |
| 10. Eat until you felt uncomfortably fat?                               |     |    |
| 11. Eat large amounts of food when you didn’t feel physically hungry?   |     |    |
| 12. Eat alone because you were embarrassed by how much you were eating? |     |    |
13. Feel disgusted with yourself, depressed, or very guilty after overeating?  YES  NO

14. Feel very upset about your uncontrollable overeating or resulting weight gain?  YES  NO

15. How many times per week on average over the past 3 months have you made yourself vomit to prevent weight gain or counteract the effects of eating?  
   0 1 2 3 4 5 6 7 8 9 10 11 12 13 14

16. How many times per week on average over the past 3 months have you used laxatives or diuretics to prevent weight gain or counteract the effects of eating?  
   0 1 2 3 4 5 6 7 8 9 10 11 12 13 14

17. How many times per week on average over the past 3 months have you fasted (skipped at least 2 meals in a row) to prevent weight gain or counteract the effects of eating?  
   0 1 2 3 4 5 6 7 8 9 10 11 12 13 14

18. How many times per week on average over the past 3 months have you engaged in excessive exercise specifically to counteract the effects of overeating episodes?  
   0 1 2 3 4 5 6 7 8 9 10 11 12 13 14


20. How tall are you? ___ ft ___ in.

21. Over the past 3 months, how many menstrual periods have you missed? 1 2 3 4 na

22. Have you been taking birth control pills during the past 3 months?  YES  NO

23. Approximately how long have you been engaging in these patterns? ___ Years ___ months

Scoring algorithm for Bulimia Nervosa:
“A diagnosis of DSM-IV bulimia nervosa is made if an individual reports (a) regular eating binges marked by a perceived loss of control and the consumption of a large amount of food as indexed by a response of yes to EDDS item 5, a yes to EDDS item 6, and a response of greater than 2 on EDDS item 8; (b) regular use of compensatory behaviors as indexed by a response of 8 or greater on the sum of EDDS items 15, 16, 17, and 18; and I undue influence on self-evaluation as indexed by a score of 4 or greater on either EDDS item 3 or 4.” (Stice, Telch, & Rizvi, 2000, p. 130).

To allow for inclusion of sub-threshold bulimics, individuals in the present study were classified in the bulimic group if they provided a response of 4 or greater on EDDS3 or EDDS4, they responded “Yes” to EDDS5 and EDDS6, they provided a response of 1 or greater on EDDS8, they provided a response of 1 or greater on EDDS15 or EDDS16 or a response of 2 or greater on the sum of EDDS17 and EDDS18.
Appendix G

*The Self-Concealment Scale (Larson & Chastain, 1990)*

Please answer the following questions using the following answer key:

1 = strongly disagree  2 = disagree  3 = in the middle  4 = agree  5 = strongly agree

1. I have an important secret that I haven’t shared with anyone.

2. If I shared all my secrets with my friends, they’d like me less.

3. There are lots of things about me that I keep to myself.

4. Some of my secrets have really tormented me.

5. When something bad happens to me, I tend to keep it to myself.

6. I’m often afraid I’ll reveal something I don’t want to.

7. Telling a secret often backfires and I wish I hadn’t told it.

8. I have a secret that is so private I would lie if anybody asked me about it.

9. My secrets are too embarrassing to share with others.

10. I have negative thoughts about myself that I never share with anyone.

The total score is the sum of the item values.
Appendix H

*The Attitudes Toward Seeking Professional Psychological Help—Short form (ATSPPH-S)*

*(Fischer & Farina, 1995)*

Please rate each of the following statements using the following key:

0 = disagree  1 = partly disagree  2 = partly agree  3 = agree

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

2. The idea of talking about my problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.

5. I would want to get psychological help if I were worried or upset for a long period of time.

6. I might want to have psychological counseling in the future.

7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

10. Personal and emotional troubles, like many things, tend to work out by themselves.

*Items 1, 3, 5, 6, and 7 are scored 3-2-1-0 and items 2, 4, 8, 9, and 10 (reversal items) are scores 0-1-2-3.*
Appendix I

_The Hopkins Symptom Checklist – 21 items (HSCL-21)_

_(Green et al., 1988)_

INSTRUCTIONS: How have you felt during the past seven days including today? Use the following scale to describe how distressing you have found these things over this time.

Not at all  A little  Quite a bit  Extremely
1        2        3        4

**Subscale #1: Performance Difficulty**

1. Difficulty in speaking when you are excited.
2. Trouble remembering things.
3. Worried about sloppiness or carelessness.
4. Having to do things very slowly in order to be sure you are doing them right.
5. Having to check and double-check what you do.
6. Your mind goes blank.
7. Trouble concentrating.

**Subscale #2: General Feelings of Distress**

1. Blaming yourself for things.
2. Feeling lonely.
4. Your feelings being easily hurt.
5. Feeling others do not understand you or are unsympathetic.
6. Feeling that people are unfriendly or dislike you.
7. Feeling inferior to others.

**Subscale #3: Somatic Distress**

1. Pain in the lower part of your back.
2. Soreness of your muscles.
3. Hot or cold spells.
4. Numbness or tingling in parts of your body.
5. A lump in your throat.
6. Weakness in parts of your body.
7. Heavy feelings in your arms and legs.

**Total Distress**

Add up the three subscale scores.
Appendix J

*The Perceived Social Support Scale – Short Form*

*(Procidano & Heller, 1983; shortened version by Ofosu, 1999)*

Perceived Social Support – Friends (PSS-Fr)

**Instructions:** The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with friends. For each statement there are three possible answers: Yes, No, Don’t Know. Please indicate your answers by circling the corresponding number to each statement such that 0 = no, 1 = yes, and 2 = don’t know.

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Don’t Know</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My friends give me the moral support I need.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. My friends enjoy hearing about what I think.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. I rely on my friends for emotional support.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. I feel that I’m on the fringe in my circle of friends. *</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. My friends and I are very open about what we think about things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6. My friends are sensitive to my personal needs.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7. My friends are good at helping me solve problems.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8. I have a deep sharing relationship with a number of my friends.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9. When I confide in friends, it makes me feel uncomfortable *.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10. I wish my friends were much different *</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
Perceived Social Support – Family (PSS-Fa)

Instructions: The statements which follow refer to feelings and experiences which occur to most people at one time or another in their relationships with family members. For each statement there are three possible answers: No, Yes, Don’t Know. Please indicate your answers by circling the corresponding number to each statement such that 0 = no, 1 = yes, 2 = don’t know.

<table>
<thead>
<tr>
<th>Statement</th>
<th>No</th>
<th>Don’t Know</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My family gives me the moral support I need.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. My family enjoys hearing about what I think.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Members of my family share many of my interests.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. I rely on my family for emotional support.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. My family and I are very open about what we think about things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6. My family is sensitive to my personal needs.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7. Members of my family are good at helping me solve problems.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8. I have a deep sharing relationship with a number of members of my family.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9. When I confide in members of my family, it makes me uncomfortable.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10. I wish my family were much different.</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

* Reverse scored
Appendix K

The Thoughts About Psychotherapy Survey Subscales

(Deane & Chamberlain, 1994; Kushner & Sher, 1989; Pipes et al., 1985)

Instructions to be given to participants recruited outside of clinical facilities:

We would like you to imagine that you have decided to see a professional psychologist or counselor for a personal problem. The following items are about concerns you might have in this situation. Please circle the number which best describes your level of concern for each item.

Instructions to be given to participants recruited from clinical facilities:

Many people have different concerns about deciding to see a professional psychologist or counselor for a personal problem. The following items are about concerns you might have now that you have sought help from a professional. Please circle the number which best describes your level of concern for each item.

<table>
<thead>
<tr>
<th>No Concern</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Very Concerned</th>
<th>5</th>
</tr>
</thead>
</table>

Subscale 1: Therapist Responsiveness Concerns

1. Whether I’ll be treated as a person in therapy.

2. Whether the therapist will be honest with me.

3. Whether the therapist will take my problem seriously.

4. Whether everything I say in therapy will be kept confidential.

5. Whether my therapist will understand my problem.

6. Whether the therapist will be competent to address my problem.
Subscale 2: Image Concerns

1. Whether the therapist will think I'm a bad person if I talk about everything I have been thinking and feeling.

2. Whether my friends will think I'm abnormal for coming.

3. Whether the therapist will think I'm more disturbed than I am.

4. Whether the therapist will find out things I don't want him/her to know about me and my life.

5. Whether I will learn things about myself I don't really want to know.

6. Whether I'll lose control of my emotions while in therapy.

7. Whether I'll be pressured into talking about things that I don't want to. *

8. The thought of seeing a therapist would cause me to worry, experience nervousness or feel fearful in general.

* This item is included in both the Image Concerns and the Coercion Concerns subscales.
Subscale 3: Coercion Concerns

<table>
<thead>
<tr>
<th>No Concern</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Concerned</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

1. Whether I will be pressured to do things in therapy I don’t want to do.

2. Whether I will be pressured to make changes in my lifestyle that I feel unwilling or unable to make right now.

3. Whether I will be pressured into talking about things that I don’t want to. *

4. Whether I will end up changing the way I think or feel about things and the world in general.

* This item is included in both the Image Concerns and the Coercion Concerns subscales.
Subscale 4: Stigma Concerns

1. Whether seeking treatment would affect my job or job prospects if an employer found out about it.

2. Whether an employer will question my ability if she/he knows I’m attending therapy.

3. Whether attending therapy will create a psychiatric label that might stay with me.

4. Whether friends and family will see my future behaviour as being attributable to having had psychological therapy.

5. Whether some people will like or respect me less if I say I am receiving psychological treatment.

6. Whether people treat me differently if they know I have been receiving therapy.

7. Whether people will think I’m weak because I can’t solve my own problems.

8. Whether I will lose my friends from my seeing a therapist.

9. Whether being in therapy will affect my relationship with those closest to me (partner, family, close friends).

10. Whether those closest to me (my family, partner, close friends) will think less of me for seeing a therapist.

11. Whether those closest to me will feel guilty as a result of my seeking therapy.
Appendix L

Principal Component Analysis of the TSFABS

In order to reduce the number of items in the TSFABS, a principal component analysis (PCA) was conducted on all 53 items using data collected from all participants. The entire sample consisted of 354 female participants ranging in age from 18-44 ($M = 22.22$, $SD = 4.39$). In regard to ethnicity, 6.5% of the sample identified themselves as African-American or African-Canadian, 66.4% as Caucasian, 5.1% as East Asian, 9.3% as European, 2.5% as Hispanic, 6.5% as South Asian, and 6.8% as Other. In regard to level of education, .8% of the sample reported having completed elementary school, 9% reported having completed high school, 71.5% reported that they are currently completing College or University coursework, 12.7% reported having earned a college or undergraduate degree, 3.4% reported that they are currently enrolled in graduate studies, and 2.3% reported having earned a Masters or Doctoral degree.

In an attempt to preserve the sample size for PCA, missing data were replaced by the means of the respective items (the PCA was re-analyzed with only complete data, and revealed comparable results). The variables were first assessed for normality and it was found that all 53 variables were positively skewed. In light of the small sample size (relative to the 53 TSFABS items), and the marked skewness in the variables, the data were converted to rank scores so as to compute the PCA non-parametrically. (A parametric PCA was computed on the unranked data and revealed comparable results). The results of the PCA showed nine factors with eigenvalues greater than 1. However, an examination of the scree plot and the extreme reduction in regression weights indicated that a one-factor solution best fits the data. More specifically, the first factor (eigenvalue
explained 42.5% of the variance while the second factor (eigenvalue = 2.80) explained only 5.3% of the variance. With the exception of item 23, every item adequately loaded on the factor (with loadings ranging from .47 to .76; see Table L1). Item 23 held a factor loading of .32. The content of this item ("I am concerned therapy will help me.") is ambiguous at best, and it was decided that the item would be dropped. The PCA was re-calculated without item 23. In the updated PCA equation, the first factor (eigenvalue = 22.44) explained 43.2% of the variance and the second factor (eigenvalue = 2.79) explained 5.4% of the variance. Reliability analyses were performed on the 52 remaining items using both the ranked and unranked data. Internal reliability and mean inter-item correlations were all acceptable (see Table L2). Eliminating the item with the lowest item-scale correlation did not significantly increase the internal reliability. As such, no further items were deleted. Using the updated PCA equation (without item 23), factor scores were computed for each participant to serve as the final measure of bulimic exclusive treatment fears.

A conservative examination of factor loadings (using ranked data, see Table L1) reveals 11 items with excellent factor loadings (.72 or higher, Tabachnick & Fidell, 1996). Corresponding item content to these 11 items is presented Table L3.
Table L1

*Exploration of Factor Loadings of the TSFABS*

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<th>TS-FAB Item</th>
<th>Factor 1 (ranked data)</th>
<th>Factor 1 (unranked data)</th>
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<td>.53</td>
</tr>
<tr>
<td>2</td>
<td>.60</td>
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<td>53</td>
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</tbody>
</table>
Table L2

*Psychometric Properties for the TSFABS*

<table>
<thead>
<tr>
<th></th>
<th>Cronbach’s Alpha</th>
<th>Mean Inter-item Correlation</th>
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<tbody>
<tr>
<td>Ranked Data</td>
<td>.97</td>
<td>.42</td>
</tr>
<tr>
<td>Unranked Data</td>
<td>.98</td>
<td>.45</td>
</tr>
</tbody>
</table>
Table L3

*Content of TSFABS Items with Excellent Factor Loadings (.72 or higher)*

<table>
<thead>
<tr>
<th>Item Content</th>
<th>Factor Loading (based on ranked data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Others will think that my problems are my fault.</td>
<td>.73</td>
</tr>
<tr>
<td>16. Attending therapy will result in me feeling hopeless and worthless.</td>
<td>.76</td>
</tr>
<tr>
<td>17. I will fail at therapy.</td>
<td>.72</td>
</tr>
<tr>
<td>19. The therapist will be disgusted with me.</td>
<td>.72</td>
</tr>
<tr>
<td>20. I will think I don’t deserve to be helped since my problems are my own fault.</td>
<td>.72</td>
</tr>
<tr>
<td>21. I will feel judged by the therapist.</td>
<td>.72</td>
</tr>
<tr>
<td>42. Attending therapy will result in me feeling very ashamed with myself.</td>
<td>.74</td>
</tr>
<tr>
<td>43. People will think there’s something wrong with me.</td>
<td>.72</td>
</tr>
<tr>
<td>44. Therapy will confirm for me what I have thought all along, that I am worthless.</td>
<td>.74</td>
</tr>
<tr>
<td>45. Therapy will leave me feeling overwhelmed by my feelings.</td>
<td>.72</td>
</tr>
<tr>
<td>49. I will fail at therapy, disappointing myself or others.</td>
<td>.73</td>
</tr>
</tbody>
</table>
Appendix M

Wrap-Up Sheet

Have you already completed this questionnaire package on a previous occasion such that this was NOT your first time participating?

_____ NO, this is my FIRST TIME participating in this study.

_____ YES, I had already completed these questionnaires on a previous occasion.

BEFORE YOU HAND IN YOUR QUESTIONNAIRE:

PLEASE CHECK YOUR ANSWERS TO MAKE SURE THAT YOU HAVE NOT LEFT ANY PAGES BLANK, AND THAT YOU HAVE ANSWERED EVERY QUESTION YOU FEEL COMFORTABLE ANSWERING.

PLEASE MAKE SURE THAT ALL OF YOUR RESPONSES ARE WRITTEN/MARKED CLEARLY AND ARE EASILY READABLE. IF YOU ARE UNSURE HOW TO ANSWER ANY OF THE QUESTIONS, PLEASE CONTACT THE RESEARCHER.

IF YOU HAVE ANY QUESTIONS OR IF A "DEBRIEFING INFORMATION SHEET" IS NOT GIVEN TO YOU ONCE YOU FILL OUT THE QUESTIONNAIRES AND YOU WOULD LIKE ONE SENT TO YOU, PLEASE CALL 519–253-3000 ext. 2216.

Thanks so much for participating!!!
## Appendix N

**Non-Parametric Parallel Analyses**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Analysis</th>
<th>Independent Variables</th>
<th>Dependent Variables</th>
<th>Results of Non-Parametric Test</th>
<th>Parametric Test Was</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testing</td>
<td>2 X 2</td>
<td>1. Bulimic Status</td>
<td>Age</td>
<td>1. $F(1,140) = .22, p = .638, MSE = 1728.83$</td>
<td>1. $p = .994$</td>
</tr>
<tr>
<td>Covariates</td>
<td>ANOVA</td>
<td>2. Treatment Seeking</td>
<td></td>
<td>2. $F(1,140) = 1.15, p = .286, MSE = 1728.83$</td>
<td>2. $p = .092$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1x2. $F(1,140) = .37, p = .545, MSE = 1728.83$</td>
<td>1x2 $p = .399$</td>
</tr>
<tr>
<td>Testing</td>
<td>2 X 2</td>
<td>1. Bulimic Status</td>
<td>Distress</td>
<td>1. $F(1,140) = 21.89, p &lt; .0001, MSE=1397.86$</td>
<td>1. $p &lt; .0001$</td>
</tr>
<tr>
<td>Covariates</td>
<td>ANOVA</td>
<td>2. Treatment Seeking</td>
<td></td>
<td>2. $F(1,140) = 3.06, p = .083, MSE = 1397.86$</td>
<td>2. $p = .020$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1x2. $F(1,140) = .26, p = .612, MSE = 361.78$</td>
<td>1x2 $p = .693$</td>
</tr>
<tr>
<td>Testing</td>
<td>2 X 2</td>
<td>1. Bulimic Status</td>
<td>Education</td>
<td>1. $F(1,140) = 5.91, p = .016, MSE = .565$</td>
<td>1. $p = .010$</td>
</tr>
<tr>
<td>Covariates</td>
<td>ANOVA</td>
<td>2. Treatment Seeking</td>
<td></td>
<td>2. $F(1,140) = 9.98, p = .002, MSE = .565$</td>
<td>2. $p = .015$</td>
</tr>
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<td></td>
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<td></td>
<td>1x2. $F(1,140) = .02, p = .878, MSE = .565$</td>
<td>3. $p = .981$</td>
</tr>
<tr>
<td>Hypothesis</td>
<td>2 X 2</td>
<td>Distress (Covariate)</td>
<td>TSFABS Factor Scores</td>
<td>1. $F(1,140) = 3.09, p = .081, MSE = .65$</td>
<td>1. $p = .124$</td>
</tr>
<tr>
<td>IA</td>
<td>ANCOVA</td>
<td>1. Bulimic Status</td>
<td></td>
<td>2. $F(1,140) = 11.02, p = .001, MSE = .65$</td>
<td>2. $p &lt; .0001$</td>
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<tr>
<td></td>
<td></td>
<td>2. Treatment Seeking</td>
<td></td>
<td>1x2. $F(1,140) = 4.00, p = .047, MSE = .65$</td>
<td>1x2 $p = .019$</td>
</tr>
<tr>
<td>Hypothesis</td>
<td>Tukey HSD and LSD Post-Hocs</td>
<td>1. Bulimic Status</td>
<td>2. Treatment Seeking</td>
<td>TSPABS Factor Scores</td>
<td>Both posthoc tests revealed that the Bulimic Non-Treatment Seekers scored significantly higher than the other three groups on the TSPABS factor scores ($p$ values range from .000 to .013). The other three groups did not differ from each other ($p&gt;.05$ across the board)</td>
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<tr>
<td>Hypothesis 1A</td>
<td>MANCOVA</td>
<td>Distress (covariate)</td>
<td>1. IC</td>
<td>1. Wilk’s $\Lambda = .96$, $F(4,136) = 1.56$, $p = .188$</td>
<td>1. $p = .172$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Bulimic Status</td>
<td>2. CC</td>
<td>2. Wilk’s $\Lambda = .92$, $F(4,136) = 2.81$, $p = .028$</td>
<td>2. $p = .006$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Treatment Seeking</td>
<td>3. STC</td>
<td>1x2 Wilk’s $\Lambda = .96$, $F(4,136) = 1.57$, $p = .186$</td>
<td>1x2 $p = .090$</td>
</tr>
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<td></td>
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<td>4. TRC</td>
<td></td>
<td></td>
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<tr>
<td>Hypothesis 2A</td>
<td>ANOVAs exploring main effect for seeking</td>
<td>Distress (covariate)</td>
<td>1. IC</td>
<td>1. $F(1,139) = 10.01$, $p = .002$, $MSE = 1225.07$</td>
<td>1. $p &lt; .0001$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Bulimic Status</td>
<td>2. CC</td>
<td>2. $F(1,139) = 8.49$, $p = .004$, $MSE = 1340.35$</td>
<td>2. $p = .002$</td>
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<td></td>
<td>2. Treatment Seeking</td>
<td>3. STC</td>
<td>3. $F(1,139) = 6.73$, $p = .010$, $MSE = 1461.90$</td>
<td>3. $p = .003$</td>
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<td></td>
<td>4. TRC</td>
<td>4. $F(1,139) = 1.43$, $p = .234$, $MSE = 1452.76$</td>
<td>4. $p = .188$</td>
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<tr>
<td>Hypothesis 2B</td>
<td>ANCOVA</td>
<td>Distress (covariate)</td>
<td>IC (covariate)</td>
<td>1. $F(1,136) = .32$, $p = .571$, $MSE = .195$</td>
<td>1. $p = .760$</td>
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<tr>
<td></td>
<td></td>
<td>1. Bulimic Status</td>
<td>CC (covariate)</td>
<td>2. $F(1,136) = .77$, $p = .381$, $MSE = .195$</td>
<td>2. $p = .415$</td>
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<td></td>
<td>STC (covariate)</td>
<td>1x2. $F(1,136) = 2.89$, $p = .091$, $MSE = .195$</td>
<td>1x2 $p = .052$</td>
<td></td>
</tr>
<tr>
<td>Hypothesis</td>
<td>Independent samples</td>
<td>1. Treatment Seeking</td>
<td>1. TRC</td>
<td>1. $t(83) = .02, p = .988$</td>
<td>1. $p = .980$</td>
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<tr>
<td>3A (non-bulimics)</td>
<td>t-tests</td>
<td>2. IC</td>
<td>2. $t(83) = .18, p = .855$</td>
<td>2. $p = .964$</td>
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<tr>
<td></td>
<td></td>
<td>3. CC</td>
<td>3. $t(83) = 1.21, p = .229$</td>
<td>3. $p = .263$</td>
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<td>4. STC</td>
<td>4. $t(83) = .72, p = .477$</td>
<td>4. $p = .367$</td>
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<tr>
<td></td>
<td></td>
<td>5. TSFABS</td>
<td>5. $t(83) = .18, p = .856$</td>
<td>5. $p = .885$</td>
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<tr>
<td></td>
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<td>6. SS-Fr</td>
<td>6. $t(83) = .65, p = .522$</td>
<td>6. $p = .726$</td>
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<tr>
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<td></td>
<td>7. SS-Fam</td>
<td>7. $t(83) = 2.79, p = .007$</td>
<td>7. $p = .006$</td>
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<tr>
<td></td>
<td></td>
<td>8. SPSH</td>
<td>8. $t(83) = -4.01, p &lt; .0001$</td>
<td>8. $p = .009$</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>9. ATSPPH</td>
<td>9. $t(83) = -6.9, p = .493$</td>
<td>9. $p = .442$</td>
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<tr>
<td></td>
<td></td>
<td>10. S-Conc</td>
<td>10. $t(83) = .27, p = .788$</td>
<td>10. $p = .935$</td>
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<tr>
<td></td>
<td></td>
<td>11. Distress</td>
<td>11. $t(83) = -1.69, p = .095$</td>
<td>11. $p = .092$</td>
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<tr>
<td>Hypothesis</td>
<td>DFA based on independent variables with significant t-test results.</td>
<td>1. SPSH</td>
<td>Treatment Seeking</td>
<td>$\Lambda = .78, \chi^2(2) = 28.89, p &lt; .0001$.</td>
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<tr>
<td>3A (non-bulimics)</td>
<td></td>
<td>2. SS-Fam</td>
<td>Canonical Correlation = .47, Eigenvalue = .29</td>
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<td></td>
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<td></td>
<td>Correlations of predictors with discriminant function</td>
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<td></td>
<td></td>
<td></td>
<td>and F values for each predictor: SPSH = .82, F(1,83) = 16.10, p &lt; .0001</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>SS-Fam = -.57, F(1,83) = 7.73, p = .007</td>
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<td>Classification: 78.8% accurate.</td>
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<td></td>
<td>$\Lambda = .77, \chi^2(2) = 21.15, p &lt; .0001$</td>
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<td></td>
<td></td>
<td>C.Corr = .48</td>
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<td></td>
<td>$p &lt; .0001$</td>
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<td></td>
<td>$p = .006$</td>
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<td>77.6% acc.</td>
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<tr>
<td>Hypothesis</td>
<td>Independent samples t-tests</td>
<td>1. Treatment Seeking</td>
<td>1. TRC</td>
<td>1. $\kappa(57) = .99, \ p = .324$</td>
<td>1. $p = .980$</td>
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<tr>
<td>3B (bulimics)</td>
<td></td>
<td>2. IC</td>
<td>2. $\kappa(57) = 2.86, \ p = .006$</td>
<td>2. $p = .005$</td>
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<tr>
<td></td>
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<td>3. CC</td>
<td>3. $\kappa(57) = 1.68, \ p = .098$</td>
<td>3. $p = .089$</td>
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<tr>
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<td>4. STC</td>
<td>4. $\kappa(57) = 1.95, \ p = .056$</td>
<td>4. $p = .059$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. TSFABS</td>
<td>5. $\kappa(57) = 2.77, \ p = .008$</td>
<td>5. $p = .013$</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. SS-Fr</td>
<td>6. $\kappa(57) = -.02, \ p = .988$</td>
<td>6. $p = .500$</td>
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</tr>
<tr>
<td></td>
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<td>7. SS-Fam</td>
<td>7. $\kappa(57) = .225, \ p = .823$</td>
<td>7. $p = .597$</td>
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<tr>
<td></td>
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<td>8. SPSH</td>
<td>8. $\kappa(57) = 2.34, \ p = .023$</td>
<td>8. $p = .008$</td>
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<tr>
<td></td>
<td></td>
<td>9. ATSPPH</td>
<td>9. $\kappa(57) = 2.79, \ p = .007$</td>
<td>9. $p = .004$</td>
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<tr>
<td></td>
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<td>10. S-Conc</td>
<td>10. $\kappa(57) = .98, \ p = .333$</td>
<td>10. $p = .339$</td>
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<tr>
<td></td>
<td></td>
<td>11. Distress</td>
<td>11. $\kappa(57) = -.81, \ p = .419$</td>
<td>11. $p = .272$</td>
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</tr>
<tr>
<td>Hypothesis</td>
<td>DFA based on independent variables with significant t-test results.</td>
<td>1. ATSPPH</td>
<td>2. SPSH</td>
<td>3. Image Concerns</td>
<td>4. Identified Bulimic Fears</td>
</tr>
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<tr>
<td>3B (bulimics)</td>
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<tr>
<td>Hypothesis 4</td>
<td>t-test</td>
<td>Bulimic status</td>
<td>S-Conc</td>
<td>$t(142) = -4.64$, $p &lt; .0001$</td>
<td>$p &lt; .0001$</td>
</tr>
<tr>
<td>Additional - SSFAM</td>
<td>ANCOVA</td>
<td>Distress (covariate)</td>
<td>SS-Fam</td>
<td>1. $F(1,139) = .01$, $p = .922$, $MSE = 1556.03$</td>
<td>$p = .968$</td>
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<tr>
<td>Additional - SSFAM</td>
<td>Tukey HSD Post-Hoc</td>
<td>1. Bulimic Status</td>
<td>2. Treatment Seeking</td>
<td>SS-Fam</td>
<td>Tukey’s HSD test revealed Non-bulimic non-treatment seekers reported more social support from family than did non-bulimic treatment seekers ($p = .030$). Bulimic non-treatment seekers did not differ on social support from family than bulimic treatment seekers ($p = .99$). Bulimic non-treatment seekers also reported significantly less social support from family than did non-bulimic non-treatment seekers ($p = .025$). Bulimic treatment seekers did not differ on social support from family than non-bulimic treatment seekers ($p = .904$).</td>
</tr>
</tbody>
</table>

**Note.** Boldface items indicate a discrepancy between parametric and non-parametric findings with respect to the statistical significance of the analysis. Bonferroni corrections to the Alpha level are applied when appropriate (.05/# of analyses)

\[\text{ATSPPH} = \text{Attitudes Toward Seeking Professional Psychological Help}\]
\[\text{IC} = \text{Image Concerns}\]
\[\text{SS-Fam} = \text{Social Support from Family}\]
\[\text{TRC} = \text{Therapist Responsiveness Concerns}\]

\[\text{CC} = \text{Coercion Concerns}\]
\[\text{S-Conc} = \text{Self Concealment}\]
\[\text{SS-Friend} = \text{Social Support from Friends}\]
\[\text{STC} = \text{Stigma Concerns}\]
\[\text{TSFABS} = \text{Treatment Seeking Fears Among Bulimics Scale factor scores} \]
Appendix O

Correlation Matrix of All Variables Collapsed Across All Four Groups (n=144)

<table>
<thead>
<tr>
<th></th>
<th>Distress</th>
<th>Social Pressure to Seek Help</th>
<th>Self-Concealment</th>
<th>Attitudes Toward Help seeking</th>
<th>Therapist Responsiveness Concerns</th>
<th>Image Concerns</th>
<th>Coercion Concerns</th>
<th>Stigma Concerns</th>
<th>Eat-26 Bulimia Subscale</th>
<th>TSFABS Factor Scores</th>
<th>Age</th>
<th>Social Support - Friend</th>
<th>Social Support - Family</th>
<th>Years of Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distress</td>
<td>1</td>
<td>.202*</td>
<td>.568**</td>
<td>-.069</td>
<td>.386**</td>
<td>.501**</td>
<td>.450**</td>
<td>.382**</td>
<td>.483**</td>
<td>.542**</td>
<td>-.011</td>
<td>-.346**</td>
<td>-.259**</td>
<td>-.044</td>
</tr>
<tr>
<td>Social Pressure to Seek Help</td>
<td>.202*</td>
<td>1</td>
<td>.130</td>
<td>.137</td>
<td>.104</td>
<td>.064</td>
<td>.115</td>
<td>.106</td>
<td>.260**</td>
<td>.135</td>
<td>.036</td>
<td>-.054</td>
<td>-.056</td>
<td>-.059</td>
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<tr>
<td>Self-Concealment</td>
<td>.568**</td>
<td>.130</td>
<td>1</td>
<td>-.210*</td>
<td>.489**</td>
<td>.691**</td>
<td>.619**</td>
<td>.561**</td>
<td>.425**</td>
<td>.709**</td>
<td>-.006</td>
<td>-.401**</td>
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<td>-.050</td>
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<tr>
<td>Attitudes Toward Help seeking</td>
<td>-.069</td>
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<td>-.210*</td>
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<td>-.193*</td>
<td>-.250**</td>
<td>-.236**</td>
<td>-.302**</td>
<td>.056</td>
<td>-.362**</td>
<td>.012</td>
<td>.132</td>
<td>.175**</td>
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<tr>
<td>Therapist Resp. Concerns</td>
<td>.389**</td>
<td>.104</td>
<td>.488**</td>
<td>.193*</td>
<td>1</td>
<td>.566**</td>
<td>.591**</td>
<td>.429**</td>
<td>.301**</td>
<td>.641**</td>
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<td>-.321**</td>
<td>-.187**</td>
<td>.009</td>
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<tr>
<td>Image Concerns</td>
<td>.501**</td>
<td>.084</td>
<td>.691**</td>
<td>-.250**</td>
<td>.566**</td>
<td>1</td>
<td>.832**</td>
<td>.689**</td>
<td>.313**</td>
<td>.848**</td>
<td>-.062</td>
<td>-.338**</td>
<td>-.250**</td>
<td>-.079</td>
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<tr>
<td>Coercion Concerns</td>
<td>.450**</td>
<td>.115</td>
<td>.619**</td>
<td>-.238**</td>
<td>.591**</td>
<td>.832**</td>
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<td>Stigma Concerns</td>
<td>.382**</td>
<td>.106</td>
<td>.581**</td>
<td>-.302**</td>
<td>.429**</td>
<td>.689**</td>
<td>.639**</td>
<td>1</td>
<td>.296**</td>
<td>.771**</td>
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<td>-.267**</td>
<td>-.097</td>
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<td>.260**</td>
<td>.425**</td>
<td>.056</td>
<td>.301**</td>
<td>.313**</td>
<td>.320**</td>
<td>.296**</td>
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<td>.393**</td>
<td>.043</td>
<td>-.357**</td>
<td>-.259**</td>
<td>-.114</td>
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<tr>
<td>TSFABS Factor Scores</td>
<td>.542**</td>
<td>.135</td>
<td>.709**</td>
<td>-.362**</td>
<td>.641**</td>
<td>.848**</td>
<td>.797**</td>
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* Correlation is significant at the .05 level, 2-tailed
** Correlation is significant at the .01 level, 2-tailed
### Appendix P

**Correlation Matrix of All Variables – Non-Bulimic Non-Treatment Seekers (n=68)**

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*Correlation is significant at the .05 level, 2-tailed

**Correlation is significant at the .01 level, 2-tailed
### Appendix Q

**Correlation Matrix of All Variables – Non-Bulimic Treatment Seekers (n=17)**

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*Correlation is significant at the .05 level, 2-tailed

**Correlation is significant at the .01 level, 2-tailed
Appendix R

Correlation Matrix of All Variables – Bulimic Non-Treatment Seekers (n=34)

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* Correlation is significant at the .05 level, 2-tailed
** Correlation is significant at the .01 level, 2-tailed
## Appendix S

**Correlation Matrix of All Variables – Bulimic Treatment Seekers (n=25)**

<table>
<thead>
<tr>
<th></th>
<th>Distress</th>
<th>Social Pressure to Seek Help</th>
<th>Self-Concealment</th>
<th>Attitudes Toward Help seeking</th>
<th>Therapist Responsiveness Concerns</th>
<th>Image Concerns</th>
<th>Coercion Concerns</th>
<th>Stigma Concerns</th>
<th>Eat-26 Bulimia Subscale</th>
<th>TSFABS Factor Scores</th>
<th>Age</th>
<th>Social Support - Friend</th>
<th>Social Support - Family</th>
<th>Years of Education</th>
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<td>0.575**</td>
<td>-0.322</td>
<td>0.376</td>
<td>0.656**</td>
<td>0.535**</td>
<td>0.389</td>
<td>0.335</td>
<td>0.641**</td>
<td>0.331</td>
<td>-0.156</td>
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<td>0.072</td>
<td>0.085</td>
<td>0.081</td>
<td>0.080</td>
<td>0.033</td>
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<td>0.227</td>
<td>0.168</td>
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<td>0.558**</td>
<td>0.561**</td>
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<td>-0.260</td>
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<td>-0.515**</td>
<td>-0.364</td>
<td>-0.132</td>
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<td>-0.085</td>
<td>0.258</td>
<td>-0.165</td>
<td>1</td>
<td>0.558**</td>
<td>0.608**</td>
<td>0.170</td>
<td>0.268</td>
<td>0.574**</td>
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<td>-0.271</td>
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<td>0.604**</td>
<td>0.502</td>
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* Correlation is significant at the .05 level, 2-tailed  
** Correlation is significant at the .01 level, 2-tailed
<table>
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