Original article

Bulimia and binge eating disorder: systematic review and metasynthesis

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INTRODUCTION

Eating disorders, including their subclinical or partial forms, are psychiatric conditions that affect especially young and adolescent women, with high morbidity and mortality rates.[1]

This study specifically deals with bulimia nervosa (BN) and binge eating disorder (BED); although they are independently classified, both disorders are closely related. BED differs from BN because it does not present the use of compensatory behaviors.

BN is characterized by a quick intake of large amounts of food, with the feeling of loss of control – the so-called bulimic episodes. These are followed by inadequate compensatory methods for weight control, such as self-induced vomits (in more than 90% of cases), use of drugs (diuretics, laxatives and appetite inhibitors), diets and physical exercises, abuse of caffeine or use of cocaine.[2]

The criteria proposed for BED are listed in the appendix B of the Diagnostic and Statistical Manual of Mental Disorder (DSM-IV),[3] recently inserted, in 1995, and still in research stage to be approved as a new diagnostic category. This disorder is characterized by binge eating followed by anxiety, feeling of loss of control and absence of regular behaviors towards the elimination of excess food intake. Epidemiological studies state that BN occurs in about 1% of young Western women,[4] and that partial syndromes of eating disorders or eating disorders without any other specification, applying DSM-IV criteria, occur in 2-5% of young women.[5] Most patients with this disorder are obese. Its prevalence in the general population is around 2%.[6]

Coutinho & Povoa,[7] based on a multi-centered study with 1,984 individuals, found BED prevalence of 30% among patients undergoing treatment to lose weight. In Brazil, Borges[8] found a BED frequency of 16% in obese women in a weight watchers program.

The increasing interest towards eating disorders, however, is not restricted to epidemiological studies. Qualitative studies associating eating disorders with individual experiences and perceptions, which represent a major theme for public health, already exist in a considerable and growing number.

Qualitative research promotes a comprehensive understanding about the psychosocial and cultural dynamics underlying these disorders, and may provide clues to clarify new aspects and reveal others that remain obscure in quantitative studies.

Nevertheless, as far as we know, there is no register of a systematic review followed by metasynthesis about how life experience is in this type of disorders and how these conditions are perceived by patients.

Considering that eating disorders are a relevant study area, not only from the clinical point of view, but from the quality of life of individuals, we intend to perform a systematic review, followed by metasynthesis, with the aim of mapping and synthesizing the findings in qualitative research available in the scientific literature.

METHODS

This research comprehended three different stages: (1) systematic review of the literature; (2) critical evaluation of articles; (3) metasynthesis.

Systematic review

Data sources

An extensive electronic bibliographic search using the following databases: PubMed, LILACS, SciELO, ISI, PsycINFO and EMBASE.

Search strategy for electronic databases

This research used the following key words: “eating disorder,” “bulimia nervosa,” “binge eating disorder,” “binge,” “overeating and qualitative research,” “qualitative study,” “phenomenology,” “perspective,” “perception,” “experiences,” “comprehension” and “memory,” respecting the peculiarities of each database.

After the electronic search, the references of studies considered relevant were revised to find articles that were not located in the initial research.

Selection of qualitative studies

Inclusion criteria were:

- Qualitative studies published in Portuguese, English, Spanish or French.

- Studies published between 1990 and 2005.

- Qualitative studies that describe the experience of eating disorders (BN and BED), according to DSM-IV criteria, based on the patients' perspective.

- Qualitative studies with the following methodological structure were included: original study with participants of both genders; purposeful samples, with number of participants defined by the process of information saturation; adolescent and adult participants; analysis with explicit strategies of material assessment and adequate techniques to obtain statements, i.e., that allow to capture the phenomenon in its complexity, such as in-depth interviews, focal group, among others.

Exclusion criteria were:

- Chapters or books, as well as master's dissertation or thesis.

- Studies whose main focus is on other psychiatric disorders other than eating disorders.

- Studies assessing children or elderly subjects.

- Studies whose research design is poorly defined and explicit.

- Studies that reused data obtained by previous works.

Critical evaluation of articles

Quality criteria adopted were recommended by the standardized form Critical Appraisal Skills Programme (CASP),[9] which provides guidelines to assess the quality of qualitative research. CASP is composed of 10 items that allow the classification of articles into categories, according to the methodological structure. Studies were classified into categories A and B.

Category A: It means that they have a low risk of bias. They meet up to, at least, nine out of the 10 items proposed. Adopted criteria are the following: 1) clear and justified objective; 2) methodological design is adequate to the objectives; 3) methodological procedures are presented and discussed; 4) purposeful sample selection; 5) data collection is described, explicit instruments, saturation process; 6) relationship between researcher and interviewee is considered; 7) ethical cares; 8) dense and well-based analysis; 9) results are presented and discussed, point to the credibility aspect, use of triangulation; 10) discuss about the contributions and implications of the knowledge generated by the research, as well as its limitations.

Category B: They meet at least five out of the 10 items proposed. It means that they partially meet adopted criteria, presenting risk of moderate bias. Case studies and convenience sample belong to this category.

Data collection and analysis

Selected studies were read and evaluated. Division into categories was performed by two independent reviewers. The categories used for evaluation and metasynthesis were consensually obtained by reviewers.

Metasynthesis

Noblit & Hare[10] refer to the term metasynthesis as the research method that aims at performing a detailed analysis of the theory, methods and results obtained by studies that used the qualitative methodological approach. The objective of the metasynthesis is significantly different from the meta-analysis, since it is more an interpretation than an aggregation of numeric indexes.

This third stage used a meta-ethnographic approach to analyze and synthesize the data. Division into categories was performed by two independent reviewers. The categories used for evaluation and metasynthesis were consensually obtained by reviewers. Metasynthesis was carried out based on the following steps, proposed by Noblit & Hare:[10]

- Initially, the area of interest should be defined and the studies located, i.e., formulate the starting question and develop search strategies.

- Select relevant studies that will be part of the sample. At this moment, inclusion and exclusion criteria are applied to define which studies will be included in the research.

- Read the studies again, making notes. In this stage, the researcher should read the studies and record information, aiming to identify key words, main topics and categories. Readings should be repeated.

- At this moment, how studies are related should be determined. The authors stress that the studies may be related due to similarity, as long as they have aspects in common and, on the other hand, when there are disagreements.

- Compare the studies between themselves.

- Synthesize the findings, aiming at integrating them.

- At this last step, results of the metasynthesis should be documented and disclosed.

RESULTS

Initially, 3,415 bibliographic citations were identified. The studies whose title and abstract indicated an approach to the theme were selected for complete reading of the text. Of these, 15 met the inclusion criteria, and 3,400 did not meet the criteria due to the following reasons: study with other objectives, not focusing on the theme, population in a different age group (elderly or children), studies were not original, theoretical studies, insufficient description of methodology, inappropriate methodology, clinical descriptions, epidemiological studies in clinical samples and epidemiological studies in the community.

According to the quality criteria applied, six studies were classified as A, and nine as B.

It was possible to note a given uniformity in study findings; however, we cannot exclude the singularity of each research carried out. Therefore, we noted recurrent aspects between different

studies, regarding perceptions, experiences and behaviors, while identifying variable aspects. Identified studies are listed in tables 1 to 3, grouped by type of eating disorder.

Table 1 - Studies on bulimia nervosa (n = 7)

Author/year	Type of eating disorder	Parents	Participants	Method/data collection	Quality
Rorty et al.[11]	Bulimia nervosa	USA	40 female patients (18-35 years)	Quantitative and qualitative study, codified interviews	B
Brooks et al.[12]	Bulimia nervosa	Australia	10 female patients 1 male patient (19-53 years)	Interviews	B
Orbanic[13]	Bulimia nervosa	USA	6 female patients (22-54 years)	Interview (phenomenological study)	B
Serpell & Treasure[14]	Bulimia nervosa	England	30 female patients (mean age: 29.5 years)	Letters	B
Jeppson et al.[15]	Bulimia nervosa	USA	8 female patients (20-39 years)	Semi-structured interviews	A
Wasson[16]	Bulimia nervosa	USA	26 women (20-59 years)	Focal group – interviews	A
Broussard[17]	Bulimia nervosa	USA	13 female patients (18-36 years)	Interview, personal diary, demographic questionnaires	B

Table 2 - Studies on binge eating (n = 2)

Author/year	Type of eating disorder	Country	Participants	Data collection method	Quality
Lyons[18]	Binge eating	USA	6 female patients (25-55 years)	Open interview	A
Ronel & Libman[19]	Binge eating	Israel	80 female patients 8 male patients (15-63 years)	Open interview	A

Table 3 - Mixed studies (bulimia, binge eating and anorexia) (n = 6)

Author/year	Type of eating disorder	Country	Participants	Method/data collection	Quality
Nevonen & Broberg[20]	Mixed eating disorders	Sweden	103 female patients BN = 65 BED = 38 (18-25 years)	Quantitative and qualitative grounded theory	A
Drummond[21]	Mixed eating disorders	Australia	8 male patients Age (---)	In-depth interviews	B
Etxeberria et al.[22]	Mixed eating disorders (anorexia and bulimia)	Spain	12 patients Age (---)	4 focal groups	A
Redenbach & Lawler[23]	Mixed eating disorders	Australia	5 female patients (> 18 years)	Interviews	B

D'Abundo & Chally[24]	Mixed eating disorders	USA	20 female patients (17-46 years)	Interviews, focal group, participant observation	B
Keski-Rahkonen & Tozzi[25]	Mixed eating disorders	USA	123 female patients 3 male patients (13-53 years)	Internet messages	B

BED = binge eating disorder; BN = bulimia nervosa.

From the described analysis process, we identified the following main themes: illness representation; negative feelings; positive feelings; symptom function; sociocultural context; personal history; recovery. On its turn, main themes have specific categories, which are described next:

Illness representation

In this category, we studied the interpretative process and the meaning patients give to their condition. It refers to the perception patients have about their condition and to the form they experience it.

Through the reports of several studies, we could verify the attribution of the following meanings: a) as loss of control or impossibility of controlling themselves during binge eating episodes; b) as an external form that dominates; c) as a disease in its strict sense; d) as a personality trait.

Some used the medical criterion that bulimia is a disease, as described in the International Classification of Diseases (ICD-10),[26] and notions of loss of control, personality trait and external force are also present in the reports.

Through the studies, we identified that the patients do not always have a clear perception of their eating disorder. This information is important, since the way these subjects evaluate themselves determines the treatment course and their recovery. Next, we present the forms of problem identification:

a) Loss of control.[13,17-19,23] In Broussard's[17] study, there is the following description:

"I know this is dramatic, but having bulimia is like being possessed, because it's something you're obsessed about and think about it all the time. But when you realize what you're doing, you can't control yourself."

"I shouldn't be doing it, so why do I do it?"[18]

b) External force.[12,19] Here, the individual appears as a victim, as if the disease is an external force that guides and dominates them. Therefore, responsibility for their actions is attributed to something external.

"Bulimia is a cruel thing, because when you realize, it destroys your life..."[12]

c) Disease.[17,19,21] There are few studies that classify the perception of the problem as a disease by the participants. Even those who believe it is an abnormal behavior tend to believe their behavior is not so severe and that they are victims of a negative perception by people in general.

According to Ronel's[19] study, the disease may be expressed in three levels: physical, mental and spiritual; it may be considered in only one level or in all of them.

Drummond's[21] study, focusing on male patients, reports that men are resentful that eating disorders are still seen only as a gender disease, requiring the same level of attention and care women receive.

d) Personality trait.[12,13] "(...) It's part of me and I need it."[13]

Negative feelings

The experience of a person with eating disorder is permeated by multiple feelings and ideas, sometimes negative, sometimes positive. The patients, in synthesized studies, identified a variety of

negative feelings in relation to binge eating episodes. The most often mentioned are: loneliness, fear, guilt, anger and sadness.

a) Loneliness.[13,16,17,19,22] Patients start living exclusively for the diet, food, weight and body shape, restricting their interests and leading to a gradual social isolation. Etxeberria et al.[22] stress that most of these patients lose contact with their friends due to their own isolation, because they do not feel understood or avoid social gatherings related to food.

b) Fear.[16,17,23,25] The morbid fear of gaining weight and dying stand out.

c) Guilt.[14,16-19,21] Feeling of guilt is often reported. Some manifestations are guilty for eating, guilty for induction of vomits and guilty for not being able to control the episodes.

d) Anger.[12,14,16] The passage below is a good example of the feelings of anger and guilt:

"I feel very bad about it, it's as if I were a pig. I get disappointed."[12]

e) Sadness.[19,22] The disease affects the individual's mood.

"I'm less happy, it's hard for me to talk and smile."[22]

f) Low self-esteem.[14,19,23] The feeling of low self-esteem and inadequacy is also mentioned. Low self-esteem necessarily depends on the individuals' body shape and weight.

Positive feelings

a) Self-control.[13-15,23,24] In eating disorders, body control seems to be the control of life itself. The scale is a concrete way of checking this control. According to Redenbach,[23] the primary objective of an eating disorder is reaching a sense of control; body image comes in second place.

b) Power.[12,15,21,24] Eating disorders are related to the issue of power over the body and control over oneself and the other. Therefore, the notion of power found in the studies is associated with the false idea of control.

c) Remaining thin.[14,15] The following statement is a good example of the feelings mentioned above (self-control, power and remaining thin):

"It's the only way I have of feeling power, allowing me to go out and eat anything I want (…) without gaining weight – this is the only sense of power I have, of really being in control."[15]

Personal history

In this category, we verified that the individual's relationship with their own body is marked by the experiences they had in the past. We will approach aspects related to the body and major traumatic situations in the life of those people.

a) Overweight.[18,20] We could note that some studies point a strong relationship between personal history of overweight/obesity and eating disorders.

History of obesity is pointed as a risk factor for eating disorders.[27,28]

b) Traumatic experiences.[18,20] Traumatic experiences are pointed in some studies, such as loss or premature separation of parents. Such experiences may have precipitated the occurrence of dysfunctional eating standards.

For Andrade,[29] the biography of people who have a fragile personality structure and low self-esteem predispose them to the development of eating disorders.

Symptom function

Symptoms seem to have many functions. They may occur as tranquilizer, anesthetic and comfort for lonely times. Another aspect demonstrated by the studies was the use of food as satisfaction of other needs different from physiological hunger, thus representing a form of compensation.

a) Management of negative emotions.[12-18] "... It's like a survival instinct… It's like a mechanism we learn… I used food as crutches and a way of bearing things for a longer period of time, then I just go to the kitchen and eat."[15]

"It's easier to eat and throw up than getting sad. This is how I deal with my emotions… When I can disconnect my mind doing this, I don't have to think about bad feelings. I don't have to feel anything."[13]

"Food is the only thing that makes me feel well. It always comforts me (…)"

b) Management of positive emotions.[16,18] Positive emotional states are also triggers for binge eating. Food, in these cases, is used to intensify positive feelings, cause excitement and celebrate good times.

"When I'm happy, the feeling is extended when I eat (…)"[16]

Interpersonal relationships

a) Avoiding intimacy and proximity.[16,19,22] Studies pointed that interpersonal relationships are markedly distant and superficial, characterized by guilt and shame, besides the feeling of rejection attributed to poor physical shape. A certain discomfort in maintaining proximity with people is noted. There is also a clear difficulty in establishing borders and limits between the self and others.

"About boys, I don't even want to see them; I feel rejected in terms of sexuality, I hate when people look at me."[22]

b) Family relationships.[19,22,23] Family relationships are seriously compromised in this type of disorders. Arguments increase and communication is reduced. Lying is the only way of disguising a dysfunctional behavior. The issue of rivalry between siblings also emerges more markedly.

Redenbach[23] stresses, in his study, the exaggerated concern and difficulty these people have in meeting their parents' expectations, which represents another stressing factor.

"You become more reserved, people ask you, since you can't explain, they don't understand you."[22]

Sociocultural context

The influence of physical fitness and pressure to be thin women suffer in Western societies, especially teenagers, seems to be associated with the triggering of this type of behavior.[12,15,19,21,23]

"The influence of media in young people, because at our age we're not aware of this, there's nothing you can do, it's so insidious, we're constantly surrounded by it."[12]

"Bulimia is a metaphor for women's oppression."[12]

Redenbach[23] did not note, in his research, that sociocultural aspects worked as triggers for these disorders, but as maintenance factors.

The influence of the social environment was pointed by the study in exclusively male patients by Drummond.[21]

Recovery

The issue of recovery in eating disorders has been a reason for theoretical debates, both in discussions on treatment efficacy and regarding public health, as it is considered a crucial factor.

In some studies, specifically focused on the perspective that patients themselves have about recovery, factors of extraprofessional help were considered of equal or superior importance in relation to conventional treatments, in terms of positive impact on recovery. Empathic understanding and support emerged as the most common factors.[25]

a) Factors that contributed to production of change:

- Self-determination.[23-25] "I looked myself in the mirror and thought that if I had enough strength to cause so many bad things to myself, I could be strong enough to recovery. I've decided I wanted to become a new person without eating disorder."[23]

- Self-acceptance.[11,23,24] Self-acceptance and self-approval seem to be crucial for positive changes. Part of self-acceptance is releasing oneself from the need of other's approval and opinion, which is a key aspect in this type of eating disorders.

- Spirituality.[19,24] Spirituality is seen as a major condition to confront the disease in some studies. The exercise of spirituality, independent of religion, brings a feeling of hope and value to life and helps the patient to better understand his condition.

- Relationship with others.[11,18,24] Relationship of trust with a significant other seems to play a relevant role in the recovery process. These relationships are essential, since, after establishing a bond of trust, they provide support, strength and affection.

D'Abundo[23] stresses that, in most times, this significant other is the mother or the father, which is an interesting piece of information, since relatives are usually identified as factors that maintain the disease.

- Professional help.[11,25] Professional help is related to recommended conventional treatments, such as follow-up with doctor, psychologists and dietitians, groups of mutual help, among others.

According to Keskin & Tozzi,[25] the value of professional help is associated with the patients' predisposition for change. If patients are not prepared for this, the treatment will not be successful.

- Groups of mutual help.[11,18,19,23] Groups work as a laboratory of social relationships, in which people can share their experience and establish deep relationships in an environment of understanding and respect.

"In the group of anonymous binge eaters, I feel that people really want to help each other, totally and authentically, without expecting anything in return. Only by sharing, participating and helping each other."[19]

b) Factors that limited production of change:

- Anger, fight and isolation from other people. These are symptom triggers.

"I should be close to someone. They've asked if I wanted to do something together, like walking, talking on the phone, being a friend. I was afraid and thought I wouldn't like to have a friend. I want to be alone. Alone with the food. (...)"[16]

- Self-control test.[16] When patients feel well and believe they may incur a dysfunctional behavior to be sure of their self-control, this often results in recurrence.

- Relatives and friends try to impose control.[11] "I do it and there's nothing you can do about it."[15]

DISCUSSION

Throughout this review, we noted some characteristics of the scientific production on qualitative studies about bulimia and binge eating. What we verified was a scientific production originally concentrated in the USA, comprehending eight studies, which accounts for more than half of the studies. Australia comes in second place, with three studies. Sweden, England, Spain and Israel have one study each. In this category, most articles were published after 2000, with only three studies before that year.

With regard to the procedures used, great part is composed of studies that used semi-structured interviews, three used focal group and one used letters.

Joint studies account for approximately 484 female participants and 12 male participants.

Age group ranged from 13 to 63 years, and studies that used participants older than 18 years were prevalent.

Although bulimia has its onset in adolescence, there are few studies using this age group, although some comprehend adolescence and early adulthood. The prevalence of studies using adult participants is possibly due to the fact that BN starts in late adolescence or early adulthood, and the treatment is generally sought in adulthood; most research projects use patients undergoing treatment.

Understanding the disease from the patient's point of view, i.e., from their experience of the disorder, is approached in seven studies, involving understanding of psychodynamic aspects, such as low self-esteem, anxiety, guilt, difficulty in controlling impulses, as well as ambiguity of feelings. Issues related to treatment and process of recovery/recurrence are also treated with

emphasis in six studies. Regarding quality of life, only one study was found. Studies involving social influences are rare, despite the concern over these aspects being pointed in the literature.

Studies exclusively using male participants are incipient, and only one study was identified.[21] Two studies used male and female participants.[12,25]

Eating disorders are much less frequent in men than in women. For that reason, men have been relatively neglected and ignored by specialists.

Eating disorders are present in 90 to 95% of cases in women. According to some authors, an increase in the number of cases has been observed in men and women of all ages, with prevalence rates between 1 and 4%.[30,31]

In the process of study synthesis, attention was drawn to their convergence in relation to the experience of individuals with bulimia and binge eating.

The main findings are highlighted below:

The representation patients have of their standard of dysfunctional eating is very complex in relation to the definition proposed by ICD-10 and DSM-IV. The reports listed in the studies comprehend the notions of loss of control, personality trait, external force and disease, but personality trait and external force are not part of the symptomatological management of diagnostic classifications.

It was identified that the experience of bulimic patients involves a certain ambiguity, since it comprehends negative and positive feelings simultaneously. The egosyntonic nature of some of its symptoms compromises motivation for change. Among negative feelings, guilt stands out. Among positive feelings, false feeling of control and power are stressed.

Symptoms may play several functions in the patients' life and are often used as a form of defending them from emotional difficulties, either acting as tranquilizer or a means of satisfying other needs.

It is worth stressing that positive emotional states are also triggers for binge eating. Food, in these cases, is used to intensify positive feelings, cause excitement and celebrate good times.

For Castillo,[32] when food is inappropriately used to supply different emotional states, distinguishing emotional states from physiological signs, such as hunger, is difficult. Therefore, food becomes a key aspect that is extremely important for the patients' life and, independent of the source and nature of restlessness, is indiscriminately used.

In the "personal history" category, the idea of traumatic experience found in our review was limited to the separation or early loss of parents. Exposure to emotional, physical and sexual abuse in childhood in individuals with eating disorder, widely referred in the specialized literature,[29,33-35] was not contemplated in our studies.

In relation to the "interpersonal relationships" category, we verified it is a very delicate dimension in the life of these individuals. Close and intimate contact is avoided, relationships tend to be more superficial and, for that reason, symptoms can remain silent and sometimes in secret.

The sociocultural aspect is one of the key components of body image. Therefore, these people's imagery is invaded by the current standard of good physical fitness, symbolized by thinness. Such body is incompatible for most people, which end up getting involved in dysfunctional eating practices and behaviors with the aim of achieving this so-called ideal body.

According to Drummond,[21] the social environment also influences male physical appearance. For men, there is a double demand: they have to be strong, with muscles and, at the same time, lean.

Recovery is referred as a very complex process, which conditions the value of professional help to the disposition patients have for change. Thus, recovery goes well beyond conventional treatments. Self-acceptance, discipline, spirituality and social network are equally important elements.

Based on this metasynthesis, we aimed the construction of a frame that is not completely closed, since many aspects were undoubtedly left out, and others could not be analyzed in-depth due to the reduced number of studies. On the other hand, we should acknowledge that the study on the perception of affected subjects must cover multiple senses. However, some key factors of the

emotional dynamics of these patients were revealed, such as self-perception, personal history and interpersonal relationships, allowing a better understanding of the process of getting sick and recovering from these diseases.

Some limitations may be identified in our study. Firstly, the limited number of qualitative investigations involving individuals with bulimia and binge eating. Secondly, we identified that great part of the identified studies was conducted with some methodological limitations, such as sampling strategies and analysis techniques. Finally, attention was drawn to the reduced number of published studies and the scientific production concentrated in a few developed countries, which may generate a culturally-driven perception.

Due to the short scientific production in this area, further studies are needed to deepen the issues under investigation.

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ABSTRACT

Objective: *The aim of this systematic review is to identify the scope of qualitative investigations on the life experience of patients with bulimia and binge eating disorder.*

Methodology: *Searches were conducted using the following databases: PubMed, ISI, PsycInfo, Embase, LILACS and Scielo, for articles published between 1990 and 2005. Inclusion criteria were: 1) articles with main focus on bulimia or binge eating disorders; 2) original research reported in English, Spanish, French or Portuguese; 3) use of any qualitative method, such as interview, focal group or field observation. Exclusion criteria were exclusively theoretical articles and those assessing children or elderly subjects. A meta-ethnographic approach was used to synthesize the data. Each study was carefully read, and their thematic categories were interpreted and compared to the categories of all other studies.*

Results: *Fifteen studies were included of a total of 3,415 articles. Seven overlapping main themes were identified: illness representation; negative feelings (fear, guilt, anger, loneliness, loss of control); positive feelings (self-control, power); symptom function; interpersonal relationships; sociocultural context; recovery.*

Conclusions: *Although many issues were negative, the overall experience was not reported as being only bad. Some aspects of eating disorders were considered beneficial by the patients.*

Keywords: *Review literature, qualitative research, bulimia.*

Title: *Bulimia and binge eating disorder: systematic review and metasynthesis*

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