Anorexia Nervosa and Bulimarexia: Dangerous Dieting?

An Honors Thesis (TD 400)

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When does a fad cease to be a fad and turn into a preoccupation? How far will our society go in the pursuit of the body beautiful? In modern day America, the glorification of thinness has gone a bit too far. What started as a healthy concern for physical fitness seems to have blossomed into an all out obsession. Individuals are constantly bombarded by the notion of the ideal body and what should be done to achieve it.

Diets, exercise programs, and an unending number of fads proclaim the easy way to the perfect figure. The media also extends this emphasis by promoting extremely conflicting images. Consumers see and hear that "thin is in," but at the same time are overwhelmed with food commercials and ads to tempt them away from thinness. In reality, for most individuals, the two messages are not compatible.

What actually constitutes the ideal physique? An ultra-slim sleek appearance is achieved only by precious few high fashion models. Why then are we so driven to reach this often unattainable and unhealthy goal? This answer is not completely clear, but this phenomenon may have brought about some serious consequences. As a likely result of our society's preoccupation with thinness, eating disorders are becoming more and more prevalent. It is of little wonder that many have turned to food or its denial as a crutch. In many cases,
these eating disorders are not merely an extreme form of dieting, but are often a manifestation of underlying emotional problems. Individuals affected with eating disorders involve food in their attempt to solve problems. Two such disorders that involve food as a means to solve problems, are anorexia nervosa and bulimarexia. Although every case is distinct in its own way, many similarities and parallels can be drawn. The signs, symptoms, treatments and prognoses surrounding these disorders will be presented in this paper in an attempt to offer insight into problems.

Defining the disorders

"The condition of self-inflicted starvation, without recognizable organic disease and in the midst of ample food is usually diagnosed as anorexia nervosa." There seems to be vast agreement that anorexia nervosa involves the willful and irrational starving of oneself. It is an extreme pursuit of weight loss that often times becomes life threatening.

This disorder, although receiving much recent attention, has in actuality been in existence for many hundreds of years. Dating from almost 300 years ago, we can find various evidence of the existence of anorexia nervosa. In 1689, an English physician, Richard Morton, published a dissertation on what he termed "nervous consumption." With his description of
emaciation, amenorrhea and other symptoms, one can now see that he was describing anorexia nervosa.

The actual term "anorexia nervosa" originated in 1873. Sir William Withey Gull, also an English physician, accurately described the symptoms of the disorder and so named it. These early accounts were fairly accurate descriptions, even by today's standards. But while these citings were fairly accurate in their descriptions, these findings were considered very rare.

In 1960, researchers Bliss and ranch defined anorexia nervosa as "a nonspecific diagnosis relating to weight loss from any emotional cause." They believed that anorexia nervosa was a symptom of psychiatric disorders rather than a distinct disorder in itself. The patients in their studies had nothing more in common than weight loss.

After 1960, there was an increase in research and materials published, probably due to the fact that cases of anorexia nervosa have been increasing in frequency. This increase seems to be linked with society's attitudes and the role of women today. At the present time, it is estimated that as many as one in two hundred fifty females between the ages of twelve and eighteen years of age will develop the disorder. The condition also occurs in males, but with only one-tenth the frequency.

With the increase in research, the symptoms of anorexia
nervosa have now been better defined. In recent years, Hilde Bruch has done much to further our knowledge on the subject. Professor of Psychiatry at Baylor College of Medicine, Bruch is one of the foremost authorities on anorexia nervosa. Not until her research, was anorexia nervosa considered a distinct disorder. Now experts have agreed upon three major criteria for diagnosis which include: (1) loss of at least twenty-five percent of original body weight, (2) amenorrhea for at least three months and (3) a distorted body image.

The first characteristic, that of weight loss, is fairly self-explanatory. Original body weight refers to weight before the illness and before any measurable loss. This loss of 25 per cent of the patients body weight most often is a result of slimming gone haywire. For the majority of anorectics, slimming may start as a reasonable weight loss program, but as the anorectic finds that she is successful at losing weight, this in itself becomes reward enough to continue lowering her weight to extremes.

The second diagnostic characteristic, amenorrhea, occurs in virtually all anorectic patients. This cessation of the menstrual cycle may well be linked to the loss of body fat. Studies have indicated that the beginning of the menstrual cycle is most influenced by body-fat composition (often reflected in weight) rather than age, so in effect, this loss of body weight causes something like a reversal of
puberty. It is interesting to note, however, that in many cases, the cessation of menstruation preceeds weight loss. And in many cases, even with weight gain, there may still be menstrual problems.

The third characteristic is a distorted body image. Hilde Bruch was the first to suggest that there is an identifiable disturbance in body image among anorectics. Since then, it has been accepted and is used as a major characteristic for diagnosis. Even in extreme cases, the anorectic patient will deny that her state of emaciation is abnormal. Various studies, support the belief that anorectics have a deluded body conception. Using instruments designed by Slade and Russell, researchers have asked anorectics to estimate various objects and body dimensions. It has generally been found that anorectics overestimate body width, while they can fairly accurately estimate their height and widths of inanimate objects. It is true that all females in general overestimate body width. The difference, however, lies in the degree of overestimation and subsequent denial of weight loss even at the point of emaciation.

While these three characteristics are agreed upon as diagnostic of anorexia nervosa, there are also other characteristics that are useful in further defining the disorder. A team of researchers in St. Louis, Missouri furthored the definition in 1972 with what are now termed the Feighner
Criteria. Psychiatrists Feighner, Robins, and Guze produced a helpful guide for distinguishing cases of anorexia nervosa from other disorders.¹⁴ One Feighner characteristic states that the onset of the disorder must be before age 25. This is most likely due to the fact that girls of this age are concerned with fitting in with their peers. Teens often become weight conscious as they are very aware of their bodies and the changes occurring in them. Forming their bodies seems to be an easy way to self-improvement. Other characteristics distinguish separate phases of attitudes toward food and nutrition, and toward the handling of food itself. These attitudes include the denial of the experience of hunger and the refusal to eat. Other attitudes toward food refer to rituals and behaviors concerning preparation, eating, and hoarding of food. The final Feighner characteristic states that there must be no other illness that could account for the weight loss.¹⁵ These criteria simply serve to better define the line between actual anorexia nervosa and other disorders.

As indicated earlier, certain physical characteristics serve as criteria for anorexia nervosa. Weight loss is one such characteristic. Other physical characteristics also accompany the disorder, although they are not necessarily diagnostic in nature as is weight loss. When the disease takes hold, the entire body is affected. Because of the
extreme loss of body fat, the bones show through the surface of the skin, and the anorectic may have trouble sitting, or remaining in one position for any period of time. The skin becomes dry and develops an ashen yellow coloring. The hair and nails become very brittle. Low blood pressure and a slow pulse also accompany the disorder.16

The second disorder that involves the use of food as a means of resolving problems is bulimarexia, also known as bulimia. Coined in 1974 by Marlene Boskind-Lodahl, "bulimarexia" is a fairly recent term used to describe the practice of gorging followed by fasting, vomiting, or purging.17 While the term is fairly new, the practice is not. In ancient Rome, guests at feasts would gorge themselves, vomit, and then continue to eat. In Rome, however, this ritual was practiced predominantly by men, while today, women are the primary participants.18 This practice is being used as a means of weight control, mainly among young women today. The number of persons demonstrating bulimarectic weight control is not accurately known, since patients with this disorder are typically very secretive about their problem. Studies, however, indicate that one out of every five college age women may exhibit bulimarectic behavior at some time.19

Since the nature of bulimarexia is very secretive, it is difficult to pinpoint specific criteria. Unlike anorexia nervosa, there is not necessarily a marked weight loss to
signal the disorder. Some patients are only slightly underweight, while most are of normal weight or slightly overweight. The majority, however, have had weight problems in the past.

As with anorexia nervosa, a preoccupation with food exists, but this preoccupation manifests itself in quite a different manner. The bulimarectic does not decrease her intake of food, but rather will arrange to overeat in secret eating binges. She will then rid her body of the food by secretly vomiting or using laxatives. It is likely that most cases, therefore, go unnoticed because of this secrecy. The bulimarectic will veil her actions in secrecy because of guilt over what she feels is a disgusting practice. Friends and relatives then are often of little help in detecting the problem, since weight remains fairly constant and social eating habits may seem normal.

In the late 1970's, there was an increase in the amount of research and interest on the subject of bulimarexia. Since that time, three diagnostic features have been used to define the disorder. These criteria are (1) a powerful urge to overeat, (2) an attempt to compensate for overeating by vomiting or use of laxatives, and (3) a pronounced fear of weight gain.

In a study by Gerald Russell, of the Academic Department of Psychiatry of the Royal Free Hospital in London, bulimarectics described their powerful urge to overeat. Several
bulimarectics said that their thoughts were constantly on food and some even had dreams about food. While their thoughts were constantly about food, it was not because of hunger. One patient described her reasons for overeating as not because of hunger, but to fill a void. Eating seemed to meet and fill an emotional gap.\(^2^5\) To the bulimarectic, any problem or stressful situation could trigger an episode of binging. These bouts of binging seem to stem from a lack of impulse control. This lack of control can also manifest itself in other ways, such as kleptomania or alcoholism.\(^2^6\)

The binge, which is most often described as "an action to fill an emotional gap", has many striking similarities between cases. The typical binge is always done while alone, although it is still not kept as secretive as the actual vomiting.\(^2^7\)

In a personal interview with "Carrie" (fictitious name) a 21 year old bulimarectic, she described what for her was a characteristic binge. "My typical binge always took place when I was alone, and usually at home. Many times, I would plan as much as a day ahead what I was going to eat. Most often, I ate things that were simple to make, like toast for example. Foods that need little or no preparation were what I ate most....things like ice cream and junk food."\(^2^8\) Carrie's case is amazingly similar to those reported in the literature.
On other occasions, Carrie reported planning her route home from work in order to stop at various fast food establishments where she would consume whole dinners in the car.

Once the binging has taken place, the bulimarectic will then resort to the second of the diagnostic criteria, that of ridding herself of the binged food. In Carrie's case, this behavior was learned from peers as a means to prevent weight gain. To many, it initially seems to be an easy alternative to dieting. In a study by Suzanne F. Abraham and P. J. V. Beumont of the University of Sydney, Australia, 32 patients were studied with regard to their binging and purging behavior. Out of those 32 patients, the majority reported use of laxatives at one time or another. Most often, these medications were taken in large amounts promptly after a binge. Of those who used vomiting as a means of food elimination, one-half of the patients did so by simply contracting their stomach muscles. The remaining half had to use their fingers or other objects to induce vomiting.29

Again, it must be remembered that the major contributing factor in this cycle is the patients extreme fear of fatness. This pronounced fear of weight gain is the third and final feature of the disorder. This is more easily understood if one recalls that the vast majority of bulimaretics have had weight problems and feel themselves to
be over their desired weight.

In bulimarexia, as with anorexia nervosa, various problems accompany the disorder. Because of the frequent vomiting behavior, problems with the digestive system are almost inevitable. In some cases, stomach acid from the bouts of vomiting have been known to burn the esophagus and other areas involved in the regurgitation process. This regurgitation of stomach acid also causes tooth decay, and can infect the salivary glands. This vomiting behavior can even alter the patients ability to swallow properly.

In a 1979 study of bulimarectic behaviors by Gerald Russell, it was concluded that in patients employing both vomiting and the use of laxatives, vomiting was the more dangerous of the two. The resulting complications were of a more serious and harmful nature. Besides the complications associated with the actual digestive processes, other very serious disorders have also been known to accompany the disorder. Potassium deficiency as well as other deficiency disorders, such as anemia, often occur in the majority of bulimarectic patients. To a lesser extent, but worthy of note, are cases of hypertension, renal failure and even epileptic seizures.

In both anorexia nervosa and bulimarexia, there tend to be very similar traits from one patient to another. The typical anorectic is female and in her mid to late teens or
early twenties. This seems logical because of the added pressures of adolescence and young adulthood. As stated earlier, she is often at that point in her life when she wants to fit in with her peers, and conforming with her body is a way to do so.

The typical anorectic is usually of middle or upper class background, and more often than not, is Caucasian. In the past few years, however, the occurrence of the disease has spread to a lesser extent to almost all socioeconomic backgrounds.

Typically, the anorectic patient is one who has been considered the 'perfect child.' Usually of fairly high intelligence, the anorectic is well behaved, pretty, and a model student. Often she is seen as an overachiever, and this overachieving is often fueled by parental pressure. Her family is most often close knit. Usually, there are two children in her family, and often the other sibling is female. Dominant mothers and/or very authoritative parents seem to play a definite role in the picture.

Unlike the anorectic patient, there is no detailed personality profile on the bulimarectic at this time. This may be due to the fact that the behavior is so secretive. In comparison to the anorectic, however, the bulimarectic does seem to be more socially active and outgoing. But while she is more outgoing, she has a definite lack of self
esteem, as does the anorectic.

Bulimarectics generally start to eat in binges in their late teens. Vomiting behavior then usually begins around one year later. This vomiting behavior continues for the average duration of 4.5 years. This duration of the illness is much longer than that of anorexia nervosa, and when help is sought, the prognosis is often not as promising. 38

As stated, most bulimarectics have had some type of weight problem in the past. This bulimarectic behavior may well then be a result of frustration at keeping their weight at their desired level.

Underlying Problems

While the anorectic is usually diagnosed because of severe weight loss, this weight loss is only one of the problems. The underlying problems may be of even greater severity. While the typical anorectic was initially a model child, once the disease starts to take hold, there are marked changes in her personality as well as in bodily appearance. Although originally outgoing and a high achiever, the anorectic often behaves in a very regressive manner. She may withdraw from relationships and usual activities and become unapproachable in many conversational areas.

The underlying problems are difficult to define. Anorexia nervosa cannot be pinpointed to one specific cause. Rather,
the reasons behind anorexia nervosa are many and varied. There are several typical underlying factors which may have
(1) biological, (2) psychological, and (3) environmental bases.39

Whereas psychological factors were once thought to be of sole or primary importance in the development of anorexia nervosa, now biologic factors are being researched more extensively. Studies now seem to support that there may be a hypothalamus/pituitary/ovary dysfunction.40 The hypothalamus seems to regulate some basic behaviors such as eating, aggression, and moods.41 It is now thought that perhaps the hypothalamus misregulating hormones may be a predetermining factor for anorexia nervosa. The dysfunction of the hypothalamus causes amenorrhea, and in 20 to 65 per cent of anorexia nervosa cases, amenorrhea comes before weight loss.42 So perhaps hormone imbalance may be a factor in the development of anorexia nervosa. At this point, however, this type of research is still in the early stages, so no definite conclusions are available yet.

Psychological factors do seem to play a central role in the development of anorexia nervosa. One contributing factor may be the patient’s self-perceived inability to live up to her own expectations or those of her authoritative parents.43 Such behavior seems logical, since the anorectic is often a high achiever. Often high parental expectations, coupled with continual complianc, lead her to feel totally inadequate.
In an attempt to overcome these feelings of inadequacy, the anorectic-to-be will start to diet as a means of conquering and controlling those feelings, giving her a measure of independence in her own mind.

Control itself, seems to be another important issue in the development of anorexia nervosa. Hilde Bruch accurately expresses the dilemma of the anorectic in terms of "a sparrow in a golden cage". The anorectic has all of the luxuries and privileges she could want, but is deprived of the freedom to do as she wishes. Bruch describes the anorectic's whole life as an attempt to live up to the expectations of her family. As the model child, always doing what she is told, anorectic behavior may well be an attempt to control something in her life. With weight control or reduction, she can control her body, as well as manipulate those around her. In a sense, her loss of weight, is a form of a power play.

Another factor in the development of the disorder may be a major change in the life of the anorectic. This change may be a bodily change such as puberty. A change in the body of the anorectic-to-be can bring about the fear of becoming a woman. Becoming a woman can be very frightening, for with it comes sexual feelings. Also, maturation brings with it the need for adult decision making. With the loss of weight, the body of the child returns, menstruation ceases, and thus
this reversal of puberty may be a way to delay this matura-
tion process.\footnote{40}

Many of the preceding psychological factors seem to
stem from an environmental basis. Although the anorectic's
family life seems ideal on the surface, often there are
underlying conflicts. As seen in the psychological factors,
family pressures and the issue of control seem central to
the disorder. So then, it appears, psychological factors
and environmental factors almost seem to be one in the same.

The cause or etiological factors underlying bulimarexia
again seem to point to the extreme fear of weight gain. At
the same time, however, several of the factors that contribute
to anorectic behavior apply also to bulimarexia. In the case
of Carrie, her bulimarectic behavior was a way to control
something in her life. Carrie's home environment read:
exactly as the profile of the anorectic. With Carrie, as well
as being an element of control, her binging and vomiting was
a means of letting her feelings and frustrations out. She
had always complied with everyone's wishes and thus had never
learned to express her own feelings. Her binging and vomit-
ing then, was "a way to take out my frustrations. If I am
mad at someone, it is easier to binge and get mad at myself
instead of someone else. It's less of a threat to get mad at
myself; it makes me take no chances."\footnote{50}
Thus it appears that the bulimarectic, like the anorectic, has an extreme lack of self esteem. The bulimarectic, however, has a much greater fear of becoming fat than does the anorectic. Again, this points back to the extreme fear of weight gain as the primary determinant of bulimarectic behavior.

Treatment

Just as the problems underlying eating disorders have a complex basis, the treatment must be focused on many levels. It is important that the patient return to healthy nutritional status, psychological problems must be resolved, and family conflicts must be addressed. 51

First and foremost, the patient's physical health must be upgraded. In some cases, the patient may be near the point of death. In these very serious instances, the issue of saving her life comes first. In these, as well as the less serious instances, the anorectic will be easier to reason with once the body has returned to a somewhat healthier state. Anorectic patients are irrational in their thinking, and until normal body processes are resumed, there will be little progress.

Weight gain seems to be agreed upon as being the most urgent of treatment procedures. There is a question, however, as to whether this should be accomplished through
hospitalization, or on an outpatient basis. The mode of therapy will depend a great deal upon the amount of weight lost and on the time period over which it was lost. Most physicians tend to request hospitalization for several reasons. First, hospitalization allows for thorough physical assessment. Secondly, hospitalization removes the patient from the family setting. This is beneficial to both patient and family, because it helps to alleviate some of the stress encountered. Thirdly, hospitalization allows for the treating physician to form an understanding relationship with the patient.\(^5\)

Weight gain has been accomplished in many ways. Drugs are sometimes used to stimulate the anorectic's appetite. Other times, intravenous feeding is implemented. These techniques, however, are only used in extreme cases. Loss of forty per cent body weight or loss of twenty-five to thirty per cent of body weight in less than three months would constitute criteria for intravenous feeding. The most successful method, however, is to encourage oral feeding.\(^5\)

A behavior modification program can be undertaken with regard to eating habits. Reinforcers or special privileges may be used to try to coax the patient to eat. In this way, the patient, unless near death, is allowed to feel in control of her eating. With this method of treatment also comes the deemphasis on eating. With the focus taken off of the
patient's eating habits, she is allowed to feel she is controlling not only her weight, but even those in charge.54

By gaining weight, the anorectic may be allowed visiting privileges or some similar reinforcement. Since the anorectic is usually extremely afraid of and opposed to weight gain, bargains can be made as to small amounts of weight gain. Keeping the amount of weight gain expected in small quantities will keep the anorectic's distress to a minimum.

Often times a "contract" can be agreed upon by physicians and patients as to what behavior will receive rewards. One must realize, however, that there will probably be setbacks in the treatment of the anorectic. Hospitalized patients have devised many methods to try to deceive the health care system. The patient may add weight under her hospital gown to falsify weight gain,55 or the anorectic may gain weight in order to be released from the hospital and then return to her previous behavior. Anorectics have also been known to hide or dispose of their food. Some, when being fed intravenously, have even disconnected their IVs. If there are others also suffering from anorexia nervosa nearby, they will often help each other to deceive the medical staff. These setbacks are normal, but it does not necessarily mean failure in the end.

Recovery from anorexia nervosa is a slow process, and it is important to realize that simple weight gain does not
mean that the anorectic patient is cured. Even after fairly normal weight and nutrition are resumed, the preoccupation with food and weight may still remain. Thus, behavior modification is most successful when coupled with psychological and family therapy.

To resolve the inner conflicts that overpower the anorectic, she must be made to feel in control of her life. Successful therapy must help the anorectic to mature emotionally and be able to understand and properly channel her feelings. This must also be coupled with therapy to improve her self image.

The family of the anorectic is critical in helping with this therapy. The family of the anorectic must be made to understand that not only the patient has problems. Anorexia is a problem of the whole family, and a problem that needs family support. Therefore, the family support system must be strengthened and reinforced. Use of the family as a support system depends largely on their ability to change their behaviors. In the book, Treating and Overcoming Anorexia Nervosa, by Steven Levenkron, the author provides basic behaviors for parents coping with an anorectic child. One basic theme that runs throughout Levenkron's book is that of not demanding decisions of the anorectic. Fewer choices forced upon the patient will ease her distress in coping with situations. Above all, Levenkron states the need to
adopt a "nurturant yet authoritative" posture toward their anorectic child.\textsuperscript{57}

In contrast to anorectics, bulimarectics are harder to treat. With the extreme secrecy surrounding the behavior, it is oftentimes hard to get the bulimarectic to admit she has a problem. Once the problem has been discovered though, treatment is usually undertaken on an outpatient basis. In the treating of these individuals, there are two primary goals. The first is to stop the cycle of binging and purging, and the second is to change the patients attitudes toward eating and weight gain. Behavior modification techniques are used, plus a change in thinking is required for full treatment.\textsuperscript{58} It takes a skilled therapist to build trust and start to reverse the cycle.

At the onset of treatment, much is needed to help control the behavior. The dangers of the behavior are often spelled out and the patient is asked to record when and what she eats. In this manner, the doctor can examine eating habits and attitudes about those eating habits. The patient is instructed to only eat at certain times and ways to increase self-control are discussed. Important in the treatment is the creation of a receptive environment for recovery. For example, having support from friends and relatives is very helpful. Once the binging and purging have been somewhat controlled the therapist can begin to help the patient
change her attitudes toward food and toward herself. 69

Prognosis

The road to recovery from an eating disorder is a tough one. It takes a great deal of time and patience on the part of the patient, and by all those around her. At the present time, the mortality rate from anorexia nervosa ranges from six to fifteen per cent. 60 John Hopkins University statistics show that one-fourth of anorectics are not helped by treatment, one-half improve but are vulnerable to developing future problems, and only the remaining one-fourth recover completely. 61 Statistics show, however, that the younger the patient at the onset of the illness, the better the chance for recovery. 62

Whereas the treatment of anorexia nervosa is fairly well-documented, there have been few satisfactory reports on the treatment of bulimarexia. 63 There have been various ineffective treatments attempted, and problems have been complicated by lack of trained therapists. 64 Successful treatment depends on the patient's ability to acknowledge the problem and want to change. 65 At this point, only a limited prognosis can be made because of the limited amount of research available. It can be said that at this point in time, the treatment outcome of bulimarexia is less favourable than that of anorexia nervosa. Bulimarectic patients
are very resistant to treatment, encounter dangerous complications, and are very prone to suicide.66

There is still much to be learned about eating disorders. Only with time and patience will any solution ever be reached. In the meantime, however, there are national support groups as well as local self-help groups. Two such groups are the National Anorectic Aid Society in Columbus, Ohio, and the American Anorexia Nervosa Association in Teaneck, New Jersey.67 These groups can be contacted for information on where to seek help. The first step, though, is just asking for help. Eating disorders are a serious problem, and not something that can be overcome alone.

If you suspect that someone close to you has an eating disorder, there are certain danger signals to be aware of:

1. Obsession with food, hoarding, counting calories, food a constant subject of conversation
2. Formation of rituals around food
3. Overconsumption of diet drinks
4. Exercising to extremes
5. Change in personality
6. Loss of menstrual period68

Above all, if someone you know does have a problem, urge her to seek help. Eating disorders are a serious problem, and a problem that is increasing in frequency. At present, we are far from possessing all of the answers. We know that
simply repairing the body is not enough, but what is to be done?

As with any problem, the best solution must stem from the source. Instead of solely focusing on the cures for eating disorders, perhaps we should focus on the attitudes underlying the problems. Anorexia nervosa and bulimia nervosa are only two more escape mechanisms in a long list. In a society with such other problems as alcoholism and drug abuse, would not the better solution be to teach people to cope?

Before there will be any change, there must be a change in the attitudes of our society. Perhaps it is time that we try to break the myths that are starting to rule the lives of our young, and in the words of M. Hilde Bruch, break that "golden cage". 69
NOTES


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25 Russell, p. 434.


27 Abraham, Suzanne F. and P. J. V. Beumont, "How patients describe bulimia or binge eating," Psychological Medicine, 12, 1982, p. 629.

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50Carrie, June 1, 1983

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56. Reece, p. 125
58. Fairburn, p. 710.
59. Ibid.
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63. Fairburn, p. 707.
64. Lucas, p. 399.
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APPENDIX

Information on eating disorders and support groups can be obtained from the National Aid Society, Inc., P.O. Box 29461, Columbus OH 43229 and the American Anorexia Nervosa Association, Inc., 133 Cedar Lane, Teaneck NJ 07666.

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