BINGE EATING IN THE CONTEXT OF EATING DISORDERS: A REFERENCE FOR COUNSELLORS

by

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ABSTRACT

This study reviews the literature on binge eating in the context of the eating disorders anorexia nervosa and bulimia and the weight disorder obesity. Binge eating, defined as the episodic, uncontrolled ingestion of large quanitities of food is common to these three conditions. The available research is examined historically and methodologically; the development of the field is assessed. The semantic and conceptual confusion in the eating and weight disorder literature is discussed as is the spectrum of disordered eating patterns. A clinical description reviews demographic information, prevalence, incidence, frequency, intensity, precipitants, setting, duration and termination of binge eating episodes as well as related behaviour, compensatory strategies (i.e., dieting, vomiting) and the consequences. Psychological constructs associated with binge eating behaviour are described. The social and cultural factors that effect women differentially are discussed. A risk-factor etiological model is described. Biological, psychological and sociological treatment strategies specific to binge eating are presented. The presentation of the information is designed to assist counsellors who treat binge eaters.

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Alice Ages used her fine mind on my behalf. Susan Riley gave me a gift of time and love that made it possible for this to be written.

DEDICATION

To Emilie, who helped me unlock doors.

To Laurie, who said "Why not?"

To the binge eating women who wanted me to write this.

To Bodo, whose love and support has been unfailing.

To the part of myself that had no voice.

INTRODUCTION

Binge eating is a pattern of eating behaviour common to three conditions: anorexia nervosa, bulimia and obesity. It is also experienced by many people who do not qualify for diagnostic labels. A binge eater is usually exceedingly distressed by the experience of feeling utterly out of control around food, of eating in a compulsive and bizarre fashion, of suffering intense self-recrimination and shame for eating, of feeling their entire life is dominated by an endless struggle with food, and despair of ever breaking the cycle. In spite of difficulties in other areas of life, most frequently it is the experience of being out of control during bouts of excessive eating that prompts people to seek professional help (Bruch, 1973, p. 123).

Binge eating has rarely been studied as a subject in its own right (Abraham and Beumont, 1982; Wardle and Beinhart, 1981). More commonly it is a feature of one of the Eating Disorders (DSM-III, 1980) or the weight disorder obesity. There is no unified theory of binge eating, either in terms of etiology or treatment.

Eating disorders, once rare, are now considered epidemic. According to Davis (1985), "anorexia and bulimia have undergone a remarkable metamorphorsis--from psychiatric curiosities to publically recognized mental health emergencies...Indeed, eating disorders can be described as the emotional disturbances that most characterize and captivate the present time."

Binge eating is a source of shame and secrecy and clients are reticent about their eating problems. Often clients will present

themselves complaining of "depression, unsatisfying relationships, loneliness, and anxieties of one sort or another." (Boskind-White and White, 1983, p. 15). The counsellor needs an "educated ear" to hear vague references to "a bit of a problem with food" or "sometimes I eat" as possible markers of grossly disturbed eating --regardless of the person's weight, achievements, or apparent health conciousness. Counsellors and other helping professionals are unlikely to receive any formal training in the identification, assessment, treatment and evaluation of eating problems. Current therapies for obesity do not address binge eating. The counsellor needs to be desensitized to stories of excessive eating bouts, forced vomiting and laxative abuse before being confronted with a client whose greatest fear is that if they disclose their behaviour, they will disgust others and be rejected. A counsellor familiar with the parameters of binge eating will be much more helpful in assisting someone to fully disclose their relationship to food than someone ignorant of the range of likely behaviour.

The unprepared counsellor is likely to react in a number of ways that are non-theraputic and possibly damaging to the client. Reactions of disgust as mentioned above are one. Dismissing as trivial or unimportant a young woman's concerns about her body, her weight, or food are not helpful, but common especially for women who are slim and attractive. Counsellors have been reported to have reacted to disclosure of eating problems with shock, bafflement and judgements (Wooley and Wooley, 1985). Ignorant of a client's food issues, a counsellor may unwittingly collude with the client's split between her public self (competent, achieving, in-control) and her shameful, private

self (compulsive, out-of-control, "self-destructive") (Boskind-White and White, 1983, p. 33).

These disorders have been described as having damaging and irreverisible effects on health (Garner, Rockert, Olmsted, Johnson, and Coscina, 1985; Mitchell, Pyle, Hatsukami, and Lentz, 1983), or as life-threatening through suicide (Russel, 1979). Many of the "psychological" symptoms of binge eaters are the direct result of chronic food deprivation (Bruch, 1979, p. 11; Garner et al., 1985; Nesbitt, 1972). Food deprivation may not be suspected in people who grossly overeat or who are overweight, yet it is fundamental to the genesis and maintainance of these problems.

Social and cultural factors that impact women more forcibly than men appear to contribute to the development and maintainence of problem eating. Unrealistically thin ideals of the female figure, cultural myths regarding the effectiveness of reducing diets, the national obsession with thinness, and ambiguous social roles for women are associated with problem eating. A counsellor needs to understand the social and cultural forces involved to assist the client to identify and resist "toxic" messages.

Without a strenuous personal effort a counsellor is unlikely to have acquired the requisite knowledge of binge eating. The main purpose of this study is to bring together what has been written to date about binge eating, and to present it in a form useful to counsellors, primarily for those who treat binge eaters, but also for the benefit of

those who wish to research further the many questions in the field.

Therefore, the purpose of this thesis is to a) describe the behavioural, cognitive and affective parameters that constitute binge eating patterns; b) describe the relationship of binge eating behaviour to the Eating Disorders of anorexia nervosa and Bulimia, and the weight disorder of obesity; c) describe the social and cultural factors relevant to the development, study and treatment of binge eating with special emphasis on factors that explain why women are disproportionately afflicted and why the incidence of these disorders is increasing so dramatically in the 1970's and 1980's; d) extract, integrate and critically evaluate the research literature on this subject; and e) provide counsellors with the information available in order to increase the likelihood of effective help for binge eaters.

Methodology

Data Collection

This study reviews and critiques the literature on binge eating.

To gather information, a search of Psychological Abstracts and Index Medicus for articles on the description, treatment and evaluation of binge eating was conducted. A computer search of the Psychological Abstracts was done, using "binge," "binge eating," "hyperphagia," "eating patterns," and "compulsive eating" as descriptors. Limits of "English language" and "human subjects" were stipulated. No limits were placed on the dates of materials. Most articles were published within the last ten years. In addition, pertinent articles from a previous Psychinfo search of Eating Disorders were used. Most citations were original journal articles. The remainder were from books. Every effort was made to secure primary sources in preference to secondary sources.

Drug studies were excluded for three reasons. Counsellors, unlike physicians, are not directly involved in the administration and evaluation of drugs. Furthermore, the pharmacological agents most widely used for binge eaters are anti-depressant compounds. Counsellors may, at present, refer any depressed client to a physician for anti-depressant medication; binge eaters are no exception. Thus, while it is vital for counsellors to be aware of the association between binge eating and depression, the action of a particular compound is beyond their province. The third reason drug studies were excluded is, that aside from anti-depressants, most of the drug research is experimental and therefore the results are not yet applicable by counsellors or

physicians to their day-to-day practices.

Animal research was excluded; in part, to provide reasonable limits to the study, in part because differentiating between a binge and overeating entails a subjective judgement by the binge eater. Animals are unable to provide that information.

While the majority of references were available through local libraries, the University of Victoria Library, and the Interlibrary Loan service, complete dissertations were not. The expense of acquiring them was prohibitive. The one dissertation that indisputably addressed binge eating (Boskind-Lodahl, 1979) was used. In addition, two references from the Journal of Obesity and Weight Regulation, while appropriate, were unavailable.

A large and growing popular literature of magazine articles, fiction and personal accounts of anorexia and bulimia exists, but were not suitable for this review. A selection of these writings is included in the list of readings for clients in Appendix B.

Data Analysis

Once the data were collected by the methods outlined above, articles were sorted along three dimensions: subject, research design and research aim.

Articles were sorted into subject categories by topic: ie., prevalence, clinical descriptions, social and cultural factors, etc. The descriptive sections of the thesis were drawn from these sources (Feldman, 1971; Good, 1966). Clinical descriptions common to a number of studies were emphasized rather than isolated, idiosyncratic

observations. Similarities and differences of binge eaters from the anorexic, Bulimic and obese populations were sought.

The articles were sorted into two categories of research design: naturalistic designs and empirical designs. Naturalistic designs included correlational techniques, survey procedures, field observations, and ex post facto methods; empirical designs, included own-control studies, pre-post control group procedures and factorial designs.

Once categorized by research design, the confounding variables within a given design as described by Campbell and Stanley (1966) were examined and applied to the literature on binge eating. Particular attention was paid to sampling methods and subsequent generalizability, definition of terms permitting comparisons across studies, specificity of procedures, instruments and conditions, and the relation between the evidence and conclusion reached.

This method of grouping studies by research design was chosen in recognition that standards applied to experimental research may not be the most useful means to judge the merits of naturalistic research. The two types of research "tend to concern themselves with different research questions, focus on different levels of data, and frequently seek to achieve different scientific goals" (Millon and Diesenhaus, 1972).

Millon and Diesenhaus (1972) identify three aims of research: exploration, description and confirmation. Table 1 illustrates the distinguishing characteristics of these three aims. The available

TABLE 1: RESEARCH AIMS AND THEIR DISTINGUISHING CHARACTERISTICS

	Exploration	Description	Confirmation
1. Primary Aim	Probe hunches: generate new hypotheses and strategies for later research	Establish natural quantitative distribution and (degree and kind of) relationships among variables	Test causal hypotheses and calculate functional relationships
2. Dependence on:			
a. Prior theory	Conceptualization minimally developed	Conceptual role of variables well understood	Conceptualization of variables and relationships well developed
b. Prior data	Impressionistic	Scattered	Substantial
c. Nature of hypotheses	Loosely formulated or unformulated, though tentative, vague lines of speculation used to guide study	Loosely formulated or unformulated (for incidence studies), well formulated (for relationship studies) as quantitative statements about relationship among clearly identified variables	Explicitly formulated as deductive or predictive cause effect statements about operationally defined variables
3. Design Features			
a. Sampling	Little concern with representative sampling	Careful consideration of sampling representativeness	Random sampling often employed
b. Controls	Minimal	Often employed	Rigorous
c. Design	Informal, naturalistic &/or experimental	Formal, statistical naturalistic	Formal, experimental
4. Data Collection Methods	Flexible, guided by nature of findings	Predetermined valid and reliable techniques	Predetermined valid and reliable techniques

research was assessed and tabulated by these criteria to assess the stage of theoretical development this field of inquiry had reached and to identify the needs for future research.

A theoretical model of the etiology of binge eating was devised. A program of interventions likely to be helpful in the treatment of binge eating was described.

Assumptions and Limitations

One assumption of this thesis is that organized knowledge of binge eating behaviour is pertinent to the practice of counselling. Counsellors working with populations older than 25 may never encounter a case of anorexia nervosa or Bulimia, although obesity is a common problem. However, for counsellors working with young women, knowledge of these disorders is becoming essential.

One limitation of this thesis is the lack of assurance that all studies investigating binge eating were located in the process of data collection. As binge eating is often imbedded in studies of eating disorders, pertinent material may have been missed. The author's previous review of the Eating Disorder literature helped offset this problem.

Mouley (1978) identified a limitation that applies to this thesis. He acknowledged the valuable contribution that integration and synthesis of current knowledge can make, but cautions that it takes considerable insight and perspective into the overall problem in order to do bibliographic research well. Lack of perspective due to my relatively unadvanced knowledge of the factors involved in binge eating is one possible limitation of this study. Hopefully, the comprehensive review of the literature offset this limitation. My training as a health professional and a zoologist permitted access to the medical and biological literature not available to the average counsellor and to present this information in terms understandable to a counsellor untrained in these areas.

CHAPTER III

BINGE EATING IN THE CONTEXT OF EATING AND WEIGHT DISORDERS

The purpose of this chapter is to define binge eating and other necessary terms, and to describe the relationship of binge eating to the eating disorders of anorexia nervosa, Bulimia and the weight disorder obesity. In order to fulfill the last objective it is necessary to examine the concepts and conceptual models that dominate the eating disorder field. In addition to placing binge eating into context, this section is intended as a guide to understanding and evaluating the diverse and confusing literature on diagnosis and the relationships of the disorders to one another.

Definitions of Terms and Diagnostic Criteria

binge eating: episodes of eating that are experienced by the eater as uncontrolled and excessive (Fairburn, 1983). Usually large quantities of food are consumed rapidly.

binge eater: a person who periodically binge eats and is troubled or distressed by this eating pattern.

bulimia: a term synonomous with "binge"--gorging on food, bouts of excessive eating. Despite the literal meaning of "ox hunger," no association with appetite or hunger is implied. In this study it is a behaviour description. Note the lower case "b", to distingish it from Bulimia the Eating Disorder.

Eating Disorder: A subclass of psychological disorders characterized by gross disturbances in eating behaviour as defined by the DSM-III (1980). This system classifies Anorexia Nervosa and Bulimia as

Eating Disorders and obesity as a physical disorder.

Bulimia: an Eating Disorder as defined by the DSM-III. The diagnostic criteria are:

A. recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours).

B. At least three of the following:

1. consumption of high-caloric, easily ingested food during a binge
2. inconspicuous eating during a binge
3. termination of such episodes by abdominal pain, sleep, social interruption, or self-induced vomiting.
4. repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics.
5. frequent weight fluctuations greater than ten pounds due to alternating binges and fasts.

C. awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily.

D. depressed mood and self-depreciating thoughts following eating binges.

E. the bulimic episodes are not due to Anorexia Nervosa or any known physical disorder.

Note: The disorder Bulimia will be capitalized to distinguish it from bulimia, the symptom, meaning to binge eat.

Anorexia nervosa: an Eating disorder as defined by the DSM-III. The diagnostic criteria are:

A. intense fear of becoming obese, which does not diminish as weight loss progresses.

B. disturbance of body image, e.g., claiming to "feel fat" even when emaciated.

C. weight loss of at least 25% of original body weight or, if under 18 years of age, weight loss from original body weight plus projected weight gain expected from growth charts may be combined to make the 25%.

D. refusal to maintain body weight over a minimal normal weight for age and height.

E. no known physical illness that would account for the weight loss.

restrictor anorexic: ("starver") a person with anorexia nervosa who achieves and maintains their low weight by continuous voluntary restriction of their food intake.

bulimic anorexic: ("binger") a person with anorexia nervosa who cannot maintain the continuous control over voluntary food intake and has periodic bulimic episodes often followed by vomiting or purging.

purging: the evacuation of the bowels with laxatives or enemas. Some authors use it to mean vomiting as well.

vomiting: disgorging the contents of the stomach through the mouth. In this study, vomiting refers to self-induced vomiting.

non-compensatory bulimia: binge eating without compensatory practices to

keep weight within the normal range. Obese binge eaters are likely in this category.

obesity: a disorder of body weight defined as body weight in excess of 20 percent of an ideal body weight as defined by a standard weight chart. A body state in which there is an excessive accumulation of fat in both the relative and absolute sense; that is the per cent of body weight present as fat is greater than normal, and the total body weight is abnormally high (Craft, 1972).

Morbid obesity: body weight twice the ideal weight or more (Drenick, 1979).

self-regulation: a person maintains a body weight within a normal range with little concious control over a long period of time. Food intake and energy levels for this individual are balanced and somewhat effortless. (Bennet and Gurin, 1982, p. 7; Squires, 1983, p. 12).

Semantic and Conceptual Confusion

Within the context of the DSM-III (1980), the subject of eating disorders appears to be a well-defined, clearly conceptualized field of inquiry. However, beyond the classification the DSM-III offers, the literature displays considerable semantic and conceptual confusion about eating and weight. Three distinct concepts are commonly employed interchangably:

1. internal feeling states (i.e., appetite, hunger, satiation)
2. physical consequences of disordered eating (i.e., high or low body weight---emaciation or obesity)
3. abnormal patterns of eating behaviour (i.e., binge eating,

fasting) (Rau and Green, 1975).

Unsubstantiated, but common, assumptions about the relationships between these three concepts profoundly effect the nomenclature, conceptualizations, research questions, treatment methods, treatment evaluation and selection of research subjects used in the field of weight and eating.

The nomenclature of the basic terms vividly demonstrates the basic semantic and conceptual confusion.

"Anorexia" and "bulimia" are medical terms for the symptoms of "lack of appetite" and "insatiable hunger" respectively (Miller and Keans, 1972). Thus, to be anorexic when ill is a universal and common experience. While "bulimia" literally translates as "ox hunger" (an internal feeling state) the term is applied to excessive consumption (an eating pattern). Thus, the incorporation of "anorexia" and "bulimia" in the names of disorders implies, incorrectly, that appetite is important in those conditions. However, the term "anorexia nervosa" literally meaning "lack of appetite for nervous reasons" is applied to a syndrome in which people refuse food in spite of intense hunger. Only at the extremes of starvation does hunger cease (Bruch, 1973, p. 253). Similarily, "bulimia" used to name the binge/purge syndrome suggests a large appetite when the actual problem is "large consumption". However, in the only study to detail precipitants to binge eating (Abraham and Beaumont, 1982) hunger was only <u>one</u> of twelve precipitants to binge eating and ranked as seventh. Often a major task of therapy is to persuade a Bulimic client to eat when hungry.

Furthermore, the syndrome of Bulimia has been described and named independantly by various authors: bulimarexia (Boskind-Lodhal and Sirlin, 1977); bulimia nervosa (Russel, 1979); compulsive eating (Rau and Green, 1974, 1975); dietary chaos syndrome (Palmer, 1979); abnormal weight control syndrome (Crisp, 1969); "thin-fat" (Bruch, 1973, p. 194); dysorexia (Guiora, 1967). Anorexia nervosa has a history of many names also:

> "the hunger disease," "the diet disease," " the affluent neurosis," "nervous malnutrition," "essential dieting," "pubertal starvation--ammenorrhea," "Kylin's syndrome," "late pubertal cachexia," "adolescent weight phobia," "dysorexia" ...in Germany it is referred to as "addiction to thinness in puberty" (Pubertatsmagersucht). In France and Italy it is known as "anorexia mentale" (Sours, 1980, p. 221).

The term "obesity" is applied to the consequences of eating as expressed in an abnormally high body weight, but its derivation from Latin (ob = over and edere = to eat) refers to abnormal eating patterns. While it is true that obese people eat more than their bodies require to maintain a normal weight, the common assumption is that obese people eat more than lean people (Wooley and Wooley, 1979). Research has failed to substantiate this belief. In a review of 20 studies on the topic, 19 studies found the obese consume equal or less food than the non-obese (Wooley and Wooley, 1979).

Furthermore, obesity and overweight are not synonymous terms, despite their frequent usage as such. Obesity refers to excess body fat and overweight refers to excess body weight. Although people who are significantly overweight are usually also overfat, at weights closer to average this is not necessarily the case. Also, some people who are

overweight (athletes for example) are actually underfat and some people who are underweight may be overfat (older sedentary people) (Powers, 1982).

Obesity is defined as a deviation of weight above a standard. However, two standards are used in North America to define a "weight problem. One standard is medical, the other cultural. For men, there is little discrepancy between the two but for women the current cultural standards for an ideal weight are significantly lower the medical ones (MacKenzie, 1976). Garner, Rockert, Olmsted, Johnson, Coscina (1985) note that the weights for women promoted by the media and fashion industries are in the lowest 5% of the normal distribution of body weights for the population. A large number of women consider themselves fat at weights consistant with or below the standard medical weights (Boskind-White, 1985).

Only when weight exceeds the bounds of normality do physicians become concerned with the health risks; eating patterns traditionally have not been of concern to them. Perhaps this accounts for the fact that anorexia nervosa and obesity have both been considered physical diseases but Bulimia has not.

Historically, anorexia was viewed as a weight disorder as obesity is today. However, further investigation revealed a consistant cluster of symptoms and weight loss from other causes was eliminated. Whether this is a forerunner of the direction for obesity remains to be seen.

Discrete Syndrome vs Spectrum of Eating Patterns

Traditionally, disorders are conceptualized as clusters of recognizable symptoms forming discrete syndromes. "Syndrome methods of diagnosis are...methods of convention, methods which are essentially arbitrary but nonetheless necessary, valid, reliable, and useful" (Anderson, 1977). The definitions given in this chapter and the categories in the DSM-III are examples of typologies based on this concept. This paradigm is exceedingly useful to the researcher whose need is for subjects that can be identified as alike in terms of given diagnostic criteria. The discrete syndrome concept is almost universally used in professional literature. However, other information emerges when eating and weight behaviours are viewed as a continuum from which discrete syndromes emerge as markers.

Neuman and Halvorson (1983, p. 62) write:

> We are probably not yet even aware of the full spectrum of eating disorders. Anorexia and bulimia have only recently come to the attention of counselors and therapists. Of the two, anorexia is the more familiar. We have only begun to recognize bulimia, let alone untangle its mysteries. In clinical settings other atypical eating problems surface as well. A significant number of people do not fit the criteria for either anorexia or bulimia yet experience similar problems--people such as those who are extremely preoccupied with food and weight and have many other characteristics in common with anorexics and/or bulimics but who have not yet indulged in the extreme behavior. These people have a psychological focus on food but do not display the overt behaviors.

A number of researchers have noted that people who did not qualify for a diagnosis of an eating disorder, nonetheless showed various degrees of disordered eating. Nylander (1971) found a 0.6% prevalence of anorexia nervosa but that another 10% had "mild cases." Garner and

Garfinkel (1980) found 7% of a population of dancers to have anorexia by strict diagnostic criteria, but 38% had weight concerns that went beyond benign dieting and displayed marked psychological symptomology. Halmi (1981) found 13% of a college population met the DSM-III criteria for Bulimia, but 30% had some Bulimic symptoms. The on-going controversy of the relationship of anorexia nervosa to Bulimia may be an artifact of catagorization.

Schwartz, Thompson and Johnson (1982) screened 125 women at a private college. One quarter of them scored higher on the Eating Attitudes Test than ballet students, a known high risk group, (Garner and Garfinkel, 1978) had done. This group exhibited "an extraordinary amount of eating disorder pathology". In the "high problem group" 52% were moderate to severe binge eaters comparable to 54% of the anorexic control group. Twenty-three percent of the "no problem group" reported moderate binge eating. Fifty-two per cent of the "high problem group" habitually vomited compared to 48% of the anorexic controls. They conclude:

> it would be almost impossible to distinguish the primary anorexic subjects from many of the normal women with anorexic-like symptoms. They speak in the same ways of their bodies, their food worries, their exhausting battles with the impulse to eat. Oftentimes these preoccupations become a life focus...we are impressed by the tendency of some normally-functioning, normal-weight women to organize their thinking, their emotional distress and their social lives around anorexic-like concerns. Only one woman out of the 25 in the high-problem group was in treatment of any kind.

The bulk of the research on anorexia nervosa and Bulimia has used hospitalized subjects. Yet most mental health practioners encounter non-hospitalized people (Leclair and Berkowitz, 1983). The likelihood

that the more severe cases are reported in the literature is increased by the use of strict diagnostic criteria and by selection and referral biases.

Figure 1 attempts to represent graphically what Squires (1983) describes as an "eating arc" of disturbed eating behaviour. Beyond the well known categories of anorexia nervosa (both types) and Bulimia, she describes situational purgers (also called occasional or episodic purgers) who, for a specific reason, will employ self-induced vomiting but who are not obsessed with their behaviour nor do they hate themselves for it. A binge dieter is a binge eater who diets, fasts or exercises for compensation but does not purge themselves. Chronic dieters are either on a diet, usually a fad diet, or they constantly nibble at food. Often they gain and lose 10 pounds repeatedly. Non-compensatory bulimics are the overweight-to-obese binge eaters who may diet periodically, but use no consistant compensation method. Their weight is often high but stable. Their compulsive eating bothers them. This is the sub-category of the obese that this thesis is concerned with. The morbidly obese are those whose weight is 100 per cent or more above the ideal. An occasional dieter will cut back on food after a food- filled holiday, but though they watch their weight, they are not preoccupied with it. They avoid both extreme dieting and overeating.

A normal eater is content with their body regardless of weight. They think about food and eat it only when they are hungry, stop eating when they feel full and maintain the same weight for years without thinking about it (Squires, 1983, p. 10).

Figure 1: The Eating Arc *Adapted from Squires, 1980*

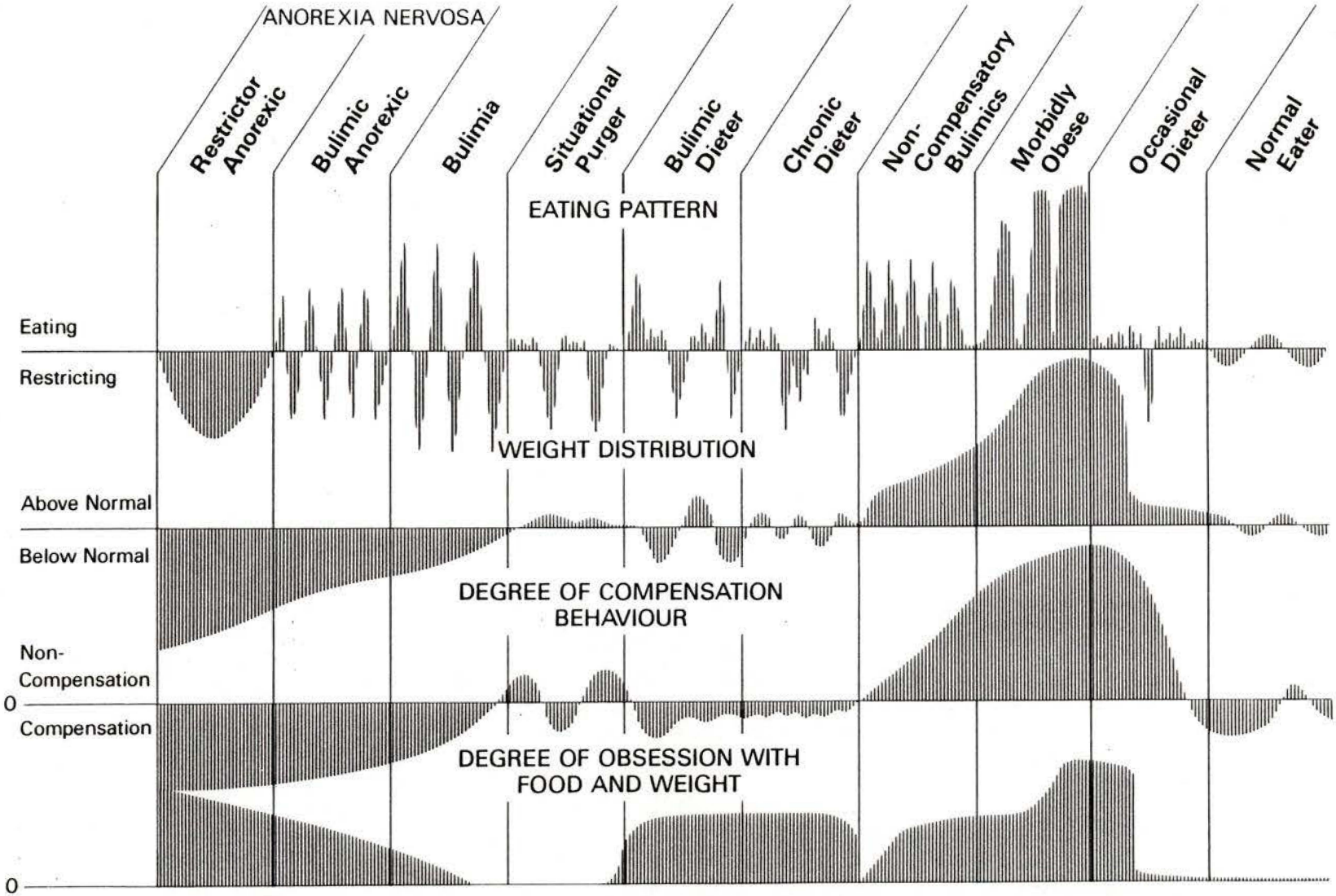


TABLE 2
PATTERNS OF CONSUMPTION AND COMPENSATION BY CATEGORY

Category of Disturbance	Binge Episodes	Overeat	Eat Normally	Diet/Fast Restrict	Vomit	Purge	Excessive Exercise
Restrictor Anorexic				X	X	X	X
Bulimic Anorexic	X			X	X	X	X
Bulimia	X			X	X	X	
Situational Purger			X			X	
Bulimic Dieter	X		X	X			
Chronic Dieter		X		X			
Non-Compensatory Bulimic	X	X	X				
Morbidly Obese	X	X	?				
Occasional Dieter			X	X			
Normal Eater			X				

Figures 1 and Table 2 illustrate the above information.

Squires also recognizes the overlap and interchange in the eating behaviours described. For example, a teenager may be an occasional dieter, possibly overweight. At college she goes on a strict diet and changes from a size 12 to a size 6, but then loses control and becomes bulimic dieter. Not wanting to gain weight, but unable to regain control, she begins to vomit and becomes a Bulimic (p. 13).

Guiora (1967) comments on the "remarkable" interchangeability of anorexia nervosa and bulimia in the history of his patients, but gives no data. Cooper and Fairburn (1983) found Bulimics to be more likely than a community sample of women to have been significantly overweight and significantly underweight in the past. Pyle, Mitchell and Eckert (1981) found weights had fluctuated markedly since the onset of Bulimia. Eleven of 34 subjects had experienced weight changes (gain or loss) of at least 15 kg (33 pounds) that could not be accounted for developmentally. Some people repeatedly cycled between periods of fairly dramatic weight gain and weight loss. Bulimic anorexics are approximately three times more likely to have a history of premorbid obesity than restrictor anorexics (Beaumont, George and Smart, 1976; Strober, 1981). Clearly, the various eating and weight disorders are related. One individual can qualify for anorexia nervosa, Bulimia and obesity at different times in their life.

Wooley and Wooley (1980) write:

> It would seem to be advantageous to categorize weight and eating disorders along 2 separate and partially independent dimensions. The first is the extent to which body weight deviates from population norms. The second dimension is the extent to which the

> desire to lose weight becomes a chronic focus of effort and worry, with adverse effects on well-being and overall functioning. This dimension represents a little-acknowledged continuum marked at one end by satisfaction with one's body or, more commonly, occasional desires to lose weight which are easily realized or forgotten. At the other extreme is anorexia nervosa, in which the drive to be thin becomes so all-consuming, with such severe distortions of body image, that the desire to achieve the distorted ideal may lead to death. In between lie a number of syndromes which appear to be increasingly common in women...There is tremendous variability among patients on this dimension of weight obsession, but it appears to bear little relationship to actual body weight. Hall (Note 1) reported that half of the applicants to a weight-loss program were within normal weight limits...the intensity of the disturbance often seems greatest in those who are minimally overweight...severe distress is by no means limited to anorexic patients. The development of an appropriate diagnostic category would increase detection and permit quantification of an aspect of weight disorders which, at present, is often ignored or left to chance improvement.

Suggested Parameters of Eating/Weight Disturbances

Given the information presented in this chapter, I suggest five dimensions describe eating disturbances:

1. deviation of body weight from two norms: the population norm and the person's own weight norm as defined by the weight they were before attempts to control weight were instituted and/or the person's weight when no weight control measures are being used (Bennet and Gurin, 1982, p. 7).

2. deviation of body weight from the norm over time, that is, a weight history including highest and lowest weights and the pattern of weight loss and gain.

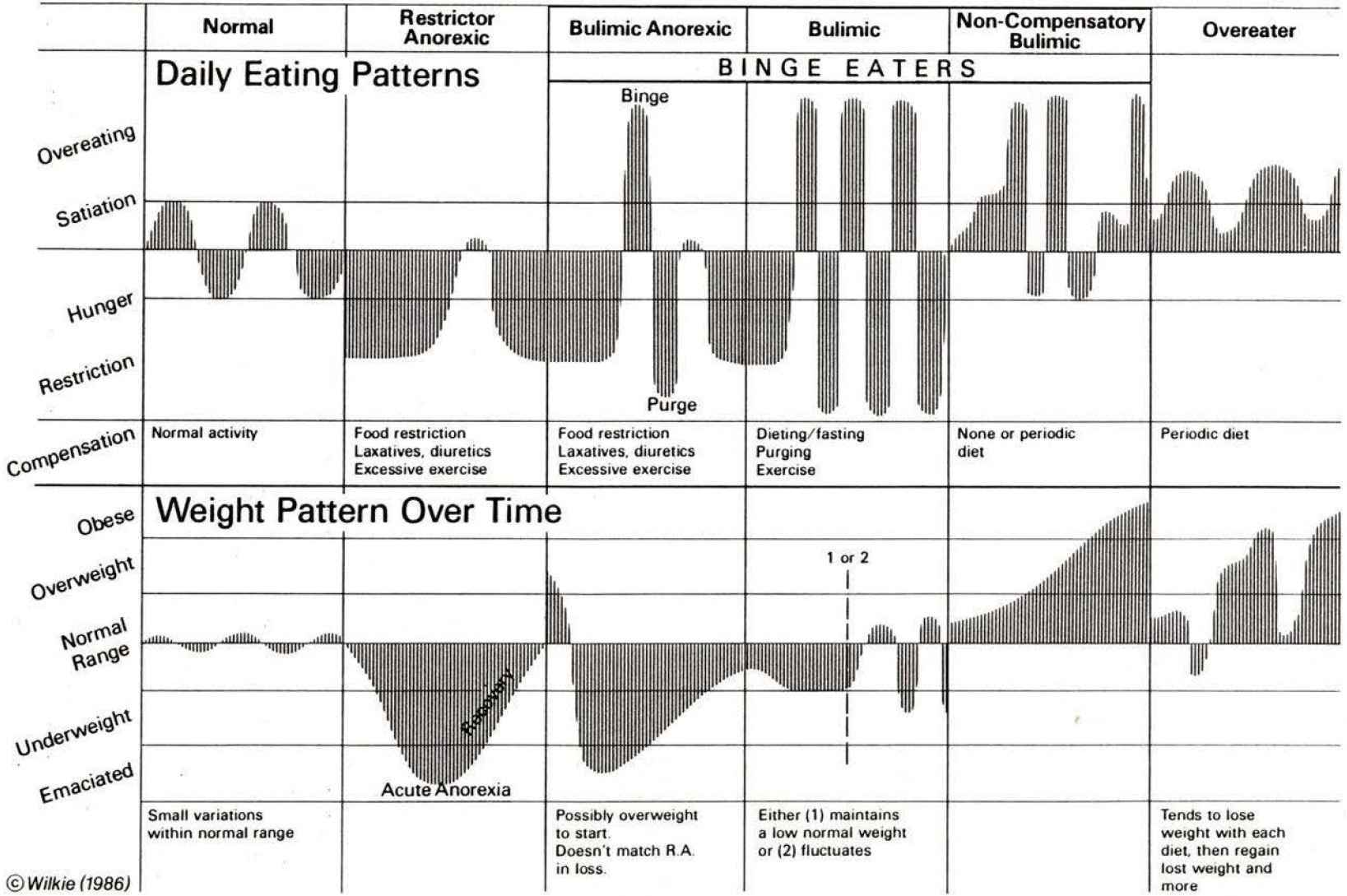
3. the degree of obsession with food, eating, weight and compensatory activities such as dieting, vomiting, purging, fasting, exercising and drugs.

4. the pattern and frequency of eating behaviour. Patterns of food restriction, overeating, and binge eating are important both daily and long term.

5. the pattern and frequency of compensatory behaviour such as food restriction, vomiting, purging, fasting, exercising and drugs.

Figure 2 is an attempt to graphically illustrate these dimensions in the major conditions of this study.

Figure 2: Eating and Weight Patterns by Category



CHAPTER IV

CLINICAL DESCRIPTION OF BINGE EATING

Physical / Behavioural

Demographic Information

Demographic information about binge eaters is sparse and fragmentary for a number of reasons: (a) there is a dearth of studies on binge eating, (b) few studies on eating disorders include demographic information, (c) the type of information reported is inconsistant from study to study, (d) there have been no large epidemiological studies of Bulimia in the general population, (e) there is a lack of correlation between demographic variables and subtypes of the eating disorders. For example, it is known that anorexics are often upper class and that approximately one-half of anorexics are bulimic. Do the demographic variables vary with subtype, as personality variables do? Similarily: do obese binge eaters have the same social profile as obese people in general?

The subjects of the one study that examines binge eaters, exclusive of other clinical features, were 32 patients who, distressed by binge eating, consecutively presented themselves at an Eating Disorders clinic (Abraham and Beaumont, 1982). Thirty were female, two were male, their educational and socioeconomic status covered all community groups. Race and religion were not mentioned; presumably they were Caucasian. The majority (21) were single, nine were married or living with a sexual partner, one was separated, and one was divorced. The mean age of onset for binging was 17 years, the mean age at presentation was 24. All but

six had achieved weights that could be considered obese or low weight categories. Six people had reached body weights in both categories at some stage.

The following demographic information is gleaned from the Eating Disorder literature. A helpful "rule of thumb" to bear in mind is that one half of anorexics, all Bulimics and perhaps one half of the obese are binge eaters.

Sex

Meyer (1975) writes anorexia nervosa "shows a sex ratio which attains proportions otherwise unknown in psychiatry." Bulimia is similar. Approximately 90 to 95% of anorexics and Bulimics are female (Bruch, 1973, p 255; Crisp and Tom, 1972; Crisp, Kalucy, Lacey and Harding, 1977; Garfinkel and Garner, 1982, p. 104; Halmi et al., 1980; Hertzog, 1982; Johnson et al., 1983; Jones, Fox, Babigan and Hutton, 1980; Kendell, Hall, Hailey, and Babigan, 1973; Lucas, 1978; Pyle et al., 1981; Strangler and Printz, 1980). Table 3 summarizes the findings of the relevant studies.

Obesity, too, is largely a women's problem, but the sex ratio is less startling. In the 22-44 year old range 22.6% of women are obese in contrast to 12.2% of men. In the 45-64 year old range 38.1% of women are obese in contrast to 8.4% of the men, a greater than 4 to 1 ratio (National Center for Health Statistics, cited Bray, 1979, p. 14).

There is some evidence that anorexia is increasing among women and not accelerating among men (Garfinkel and Garner, 1982, p. 104; Jones et al., 1980).

TABLE 3: PERCENTAGE OF FEMALES AND MALES

ANOREXIA NERVOSA				
Author	No of Subjects	Population	%F	%M
Bruch, 1973	70	Psychiatric Clinic	86	14
Crisp & Tom, 1972		Clinic	93	6
Crisp, et al., 1977	337	Clinic	92	8
Garfinkel & Garner, 1982	55(1970-75) 221(1976-81)	Clinic	92.8 96.7	7.2 3.3
Garfinkel, et al., 1980	68(Bulimic) 73(Restrictor)	Clinic	96.9 94.2	3.1 5.8
Kendall, et al., 1973	30 Scotland 17 New York 8 England	Psychiatric Registries	93.3 70 100	6.7 30 0
Lucas, 1978	1781	Mayo Clinic	91	9
BULIMIA				
Halmi, 1980	46	College Students	87	13
Hertzog, 1982	30 Bulimic 30 Anorexic	Clinic	96.6 96.6	3.4 3.4
Johnson, et al., 1983	509	Magazine Readers Self-Selected	99.2	0.8
Pyle, et al., 1981	34	Eating Disorder Clinic	100	0
Strangler & Printz, 1980	46	University Clinic	89.4	10.6

Crisp et al., (1977) suggests "that males are very resistant to the development of anorexia nervosa and only develop it within the context of overwhelming psychopathology and /or premorbid obesity."

Socio-economic Status

Over a century ago Fenwick (1880, p. 107) commented that anorexia nervosa was more common in "the wealthier classes of society than amongst those who have to procure their bread by daily labour." This overrepresentation of the upper social classes has since been frequently observed by clinicians (Beaumont, Abraham, Argall, George and Glaun, 1978; Button and Whitehouse, 1977; Crisp, 1965; Crisp et al., 1976, 1977; Garfinkel and Garner, 1982, p. 100; Halmi, Goldberg and Cunningham, 1977; Theander, 1970). Anorexia nervosa is not confined to the upper and middle classes but the association is strong (Crisp, Palmer and Kalucy, 1976). However, reliable epidemiological surveys are not available (Lucas, 1981).

The socio-economic status of those with Bulimia remains essentially unknown. Indications are that Bulimics tend to be middle or upper class, but only one study provides actual figures. Johnson, Stuckey, Lewis and Schwartz (1983) described 509 Bulimics who responsed to a magazine article. The results were, in terms of Hollingshead classifications: Class I: 29.4%; Class II: 12.9%; Class III: 25.8%; Class IV: 27.6%; Class V: 4.3%. Hertzog (1982) described 30 Bulimic subjects as generally middle or upper class.

Obesity has long been associated with lower class (Bruch, 1973, p. 20). The Midtown Manhattan Study (Goldblatt, Moore and Stunkard, 1965)

found a striking association between socio-economic status and the prevalence of obesity, particularly for women. Thiry per cent of lower class women were obese compared to 16 per cent among those of middle social class and no more than 5 per cent in the upper social class. Stunkard (1980) writes: "a number of other studies have confirmed the strong relationship between social factors and obesity; social factors must be considered as among the most important, if not the most important, infuence on the prevalence of obesity today."

One could speculate that each social class has a predominate eating problem: anorexia nervosa in the upper class, Bulimia in the middle class and obesity in the lower class.

All eating disorders are rare in underdeveloped countries and where they do occur, it is in the privileged classes. Disordered eating only manifests under conditions of plenty. Among primitive people obesity is virtually unknown; often plumpness in women is valued. Gorging on food in times of plenty is adaptive where the food supply is uneven (Bruch, 1973, p. 14).

Race

Caucasians are most likely to experience anorexia and Bulimia. Until recently, anorexia was unknown among blacks. In 1973 Bruch wrote "it is worth mentioning that in the United Stated anorexia nervosa has not been reported in Negros and members of otherunderpriveleged groups" (p. 13). However, in 1982, Garfinkel and Garner wrote:

> While previously almost unheard of in blacks or East Indians (Rowland, 1970), anorexia nervosa is now occurring in these groups (Jones et al., 1980; Kendell et al., 1973; Nwaefuna, 1981; Warren

> and Vande Wiele, 1973) Prior to 1979 no black patients presented to our consultation practices, but during the last two years, we have seen four black patients out of 120 (3.3%) and three of them were from upper class, professional families" (p. 103).

For Bulimia, only three studies mention race. Hertzog (1982) and Pyle et al., (1981) found 100% of their subjects were white. Johnson et al., found, of 509 Bulimics, 96.0% were white, 1.4% Asian, 1.1% Hispanic, 0.5% American Indian, 0.3% were black and 0.6% other.

Religion

Little is written about the religious affiliations of disturbed eaters. Without comparison of the sample to population norms, little of significance can be determined.

In Canada, Garfinkel, Moldofsky, and Garner (1980) found both bulimic anorexics and restrictor anorexics to be similiar to each other in religious affiliation (20% Jewish, 20% Catholic, 20% other and 36% Protestant). No comparison was made to the general population.

Hertzog (1982) found a normal distrubution of Jews (37%), Protestants (37%), and Catholics (27%) in a study of 30 Bulimics. They differed from a group of anorexics in being more likely to be Jewish and less likely to be Catholic. By comparison, Pyle et al., (1981) found one third of 34 Bulimics were Catholic where the expected percentage was 15%.

Knowledge of religious practices may be helpful given that:

> in the instance of 19 [of 34 anorexic] patients, there was exposure in the family to orthodox and strict religious beliefs, particularly in regard to diet and periodic fasting (Jewish, Roman Catholic, Muslim, Apostolic, Greek Orthodox and Hindu). In 3 of the patients the onset of anorexia nervosa was a continuation of a formal religious fast (Beaumont et al., 1978)

Education

Anorexics often excell academically (Bruch, 1979, p. 55; Bemis, 1978). When they present, they are usually in high school or the first years of college. Bulimics are most frequently college students or graduates (83%, Johnson and Larson, 1981; 92.8% Johnson et al., 1983; 73% Pyle et al., 1981). None of these studies were conducted on a campus.

Marital Status

The majority of anorexic and Bulimic persons are unmarried at the time of presentation (Fairburn and Cooper, 1982; Garfinkel et al., 1980; Johnson et al., 1983; Johnson and Larson, 1982; Pyle et al., 1981; Wiess and Ebert, 1983). In all the samples, up to 20% may be married, and a small number, perhaps 1 in 30 are divorced, remarried, or widowed. So, while single people predominate, marital status in any category is possible.

Prevalence of Binge Eating

The exact prevalence of binge eating in the general population is unknown. Most people have had the experience of overeating on occasion, and large numbers have had the occasional food binge, yet the number of people for whom the behaviour causes emotional, physical or social difficulties is not known. Available evidence suggests it is common for both sexes, for people of all weights, for those with recognizable eating disorders and those without problems.

Because binge eating is rarely the topic of prime interest to the

reseacher, the estimates of binge eating found in studies of other subjects are likely to be very conservative. Those who have examined binge eating directly have found the highest incidence, particularly for anorexia nervosa. Clinical impressions are that binge eating is a widespread phenonemon (Abraham and Beaumont, 1982; Bruch, 1973, p. 123; Hawkins and Clement, 1980; Pyle et al., 1981; Wiess and Ebert, 1983).

Since 1980, four studies have attempted to estimate the prevalence of binge eating in general (ie., non-clinical) populations, independant of weight status or diagnosis of an eating disorder (Cooper and Fairburn, 1983; Edelman, 1981; Halmi et al., 1981; Hawkins and Clement, 1980). Their estimates are that 26% to 79% of women and 30% to 49% of men binge eat on a regular basis. See Table 4.

Hawkins and Clement (1980) reported the largest prevalence of any study to date: 79% of the women and 49% of the men reported binge eating occurrences. Their replication sample revealed the same pattern of sex differences. Notably, the same proportion of overweight women as normal weight women reported binge eating.

Halmi et al., (1981) found 65% of their 355 subjects had experienced an episode of binge eating. On 5 binge eating variables in the survey, 50% of the women and 30% of the men responded affirmatively--an average of 43% of their population. Interestingly, while the scores for actual binge eating behaviors were high, the scores for self-definition as a binge eater were low, especially for males. For example, 48% reported "uncontrollable urges to eat," 65% had had an episode of binge eating, 24% could not voluntarily stop eating yet only

TABLE 4: PERCENTAGE OF POPULATIONS THAT BINGE EAT

Author	Subjects			Population	Age		Definition of a Binge	% of Pop. Who Binge		
	Total	F	M		Range	Mean		Average	F	M
Cooper & Fairburn 1983	369	369	0	Community sample consecutive attenders at English Family Planning Clinic	15-40	24.1± 5.5	Episode of uncontrollable excessive eating		20.9 recent 26.4 ever	
Edelman 1981	100	49	51	Random sample of pool of U.S. Navy employees	21-54		Non-hunger eating in response to a particular mood at least 3 time/month	40	51	29
Halmi, et al. 1981	355	33.4%	59.8%	College students (psychology)	14-67	25.6± 10.7	1. Uncontrollable urge to eat. 2. Episode of binge eating 3. Cannot voluntarily stop eating. 4. Feels miserable & annoyed after eating. 5. Considers ones-self a binge eater.	65 ever 43	50	30
Hawkins & Clement 1980	391	281	110	College students all ages & subjects		20	A period of uncontrolled excessive eating	66	79	49

7.8% of the men and 35% of the women considered themselves to be a binge eater. This substantiates Hawkins and Clement's (1980) observation that "women more readily label themselves "bingers" than do males and they are considerably more concerned about their binge eating tendencies."

Halmi et al., (1981) found the frequency of binge eating to be higher among males than they expected. The average number of people responding positively to all 5 binge eating variables was 43% (50% female and 30% male). The number of suspected Bulimics was 13% (87% female and 13% male). These figures were higher than any study had reported previously. In this sample, binge eating is far more prevalent than Bulimia.

Edelman (1981) randomly sampled 100 people from a large pool of U.S. Navy employees in order to study a non-college, adult sample. Forty percent of the sample binge-ate at least 3 times a month; 51% of the women and 29% of the men. She found no relationship between the degree of overweight and the prevalence of binge eating. Instead non-overweight people compensated for a binge by reducing their subsequent intake. Overweight people reported they binged more often than non-overweights, a similar finding to Hawkins and Clement (1980).

Edelman found men and women differ in the types of non-hunger eating but not the prevalence. Fifty-one percent of the women, as compared to 29% of the men, reported binge eating in response to emotional distress. There was an opposite difference for external eating (defined as eating in response to environmental food stimuli when not hungry)--41% of the men as compared to 11% of the women. There was

no significant sex difference when both types of non-hunger eating were combined. This study bears replicating as it has very significant theoretical implications for externiality and psychosomatic theories of overeating.

A British study supports Edelman's findings that binge eating is not confined to student populations (Fairburn and Cooper, 1982). Less than one-quarter of their community based sample were students, the majority were over 20 years old. All were female as the subjects were 369 attenders at a family planning clinic. Of the subjects, 20.9% had experienced binge eating in the previous two months. In contrast, the probable prevalence of Bulimia was 1.9%.

Thus, it would appear that binge eating is a widespread phenonemon in the U.S. and U.K. On the basis of the available data, it may be more prevalent in the U.S. than in Britian. While women are more prone to binge, men are by no means immune. Unfortunately there are no figures for British males. Also, women are more likely to label themselves as a "binge-eater" than men are. Binge eating is far more prevalent than the eating disorder Bulimia, lending credence to the concept of a continuum of eating patterns. The younger the populations studied, the higher the prevalence.

The literature on eating disorders contains some information relevant to the prevalence of binge eating. For anorexia nervosa, the critical determinant of whether binge eating is studied in conjuction with an eating disorder appears to be less the existance of the phenonemon than the interest of the researcher. Those who have looked

for it have found the highest prevalence of bulimic anorexics (Garfinkel et al., 1980; Casper, Eckert, Halmi, Goldberg, 1980). Bulimia, by definition, is concerned with binge eating. The lack of attention to binge eating in the multitude of studies on obesity is surprising.

Prevalence of Binge Eating in Anorexia Nervosa

Since the first description of anorexia nervosa in 1874 when Gull wrote: "Occasionally, for a day or two the appetite was voracious" (cited Garfinkel and Garner, 1982, p. 4) it has been recognized that bulimia occurs in some anorexic people. The question is: what proportion of anorexics are bingers? Wide variations exist between studies.

In 1965, Crisp mentioned eating binges as an occasional feature of anorexia nervosa, but by 1980 he estimated 30% of anorexics would experience bulimia at some point in their illness. Halmi (1974) found binge eating in 10% of 94 cases, Theander (1970) in 16% of his 94 cases, while Bruch (1973, p. 267) reported it as characteristic of 22% of her anorexic patients. Beaumont et al., (1976) found 30% of their 31 anorexic patients gorged. Halmi et al., (1977) found half of her 44 patients binged at the time of first assessment. Hsu, Crisp and Harding (1979) found 44% of their 105 anorexic subjects were bulimic. In these studies binging is but one of many factors being investigated and not the primary question.

The two studies which have specifically examined bulimia in anorexia nervosa found the highest incidence. Casper et al., (1980) found approximately half (47%) of their 105 patients binged while the other

53% consistantly fasted. Similarly, Garfinkel et al., (1980) found 48% of their 141 anorexics were bulimic at the time of their first consultation. This estimate is conservative because evidence of bulimia that surfaced or developed subsequent to the initial assessment was not added to the data.

Retrospective studies of hospital records as in Hsu et al., (1979) and Beaumont et al., (1976) are subject to several sources of error: inconsistent diagnosis, assessment, reporting, interview questions, etc. They are also subject to changes in knowledge and biases over time. While the studies that most rigorously evaluated the occurance of bulimia have tended to find the higher rates, referral and selection bias may also influence their results.

Prevalence of Anorexia Nervosa

No truly random study of the prevalence of anorexia nervosa in the general population exists and until a few years ago there were no adequate investigations of anorexia nervosa in selected populations.

In Sweden, Nylander (1971) concluded the disorder is present in a severe form in one in every 155 adolescent girls, while the prevalence of "mild cases" or anorexic behaviour was approximately 10%. He suggests the difference between mild and severe forms is one of degree only.

Crisp et al., (1976) completed a detailed survey of 9 schools in London. The overall prevalence was 4.5 per thousand, or approximately one girl in every 225. Under age 16 this amounted to a prevalence of 1.7 per thousand or 1 case for every 588 girls. Among the 4000 or so

girls aged 16 years and over the prevalence was 10.5 per thousand or 1 case for every 100 girls. Because this study included only very severe cases and because they were dealing with girls of high school age, these figures are likely to underestimate the problem. The authors suspect the disorder is even more common among university students and their age peers.

Button and Whitehouse (1981) found a prevalence of 1 severe case for every 220 females between the ages of 16 and the early 20's at an English College of Technology. Ten percent of the students in the "Beauty Therapy" department scored in the anorexic range on the Eating Attitudes Test. Like other authors, they noted a range of disordered eating patterns and weight distributions of which clinical anorexia nervosa was the most extreme form.

In Canada, Garfinkel and Garner (1980) tested the hypothesis that women who must focus increased attention on a slim body shape are at risk for anorexia nervosa by studying dance and modelling students and by using university and music students as controls. Seven per cent of the dancers and 6.5% of the models were identified as having anorexia by strict criteria. No cases were found in the control groups.

Prevalence of Binge eating in Bulimia

By definition (DSM-III), 100% of Bulimics are binge eaters.

Prevalence of Bulimia

Far more is known about anorexia nervosa than about Bulimia. Although its actual incidence has not been clearly established, evidence exists that Bulimia "is alarmingly prevalent, certainly far more so than

anorexia" (Neuman and Halvorson, 1983, p. 48). Whether this has always been true is unknown.

Strangler and Printz (1980) found Bulimia to be the eighth most common DSM-III (Axis 1) diagnosis at a University Psychiatric clinic, exceeding anorexia nervosa by 6 times. In their self-selected sample of 500 student patients, 4% were Bulimic (89.5% female and 10.5% male). Cases of Bulimia that were revealed during therapy for other conditions were not recorded in this report. They believe their figures are a very conservative estimate.

Halmi et al., (1981) conducted a systematic survey of Bulimia in a normal American college population. They found a prevalence of 13% among their 355 respondants. Eighty-seven percent of the Bulimics were female and 13% were male. These results suggested a much higher prevalence of Bulimia than previously reported. Again, it is possible that these numbers are conservative, given that the 34% of the population who did not respond may contain large numbers of Bulimics unwilling to be the subject of an investigation.

Cooper and Fairburn (1983) in a study of a normal community sample calculated the probable prevalence of Bulimia to be 1.9% (1900 per 100,000) and a further 1.6% as possible Bulimics.

Some authors report receiving "floods" of responses and inquiries by Bulimics and professionals whenever they are publically associated with Bulimia (Boskind-White and White, 1983, p. 18; Neuman and Halvorson, 1983, p. 51; Fairburn and Cooper, 1982). While this type of evidence on the prevalence of Bulimia is exceedingly "soft", a number of

independant, respected researchers consistantly report the same experience. For example, Boskind-White and White (1983, p. 18) report that in 1977, while they still considered Bulimia to be a "limited phenonemon" they published two articles (in Psychology Today and Signs: Journal of Women in Culture and Society) and were unprepared for "the deluge of responses" those articles elicited--800 women from age 12-85 and over 100 professionals, many employed on college campuses, wrote seeking help in treating the increasing numbers of students they were seeing with this problem. Later articles in popular magazines prompted another "flood of responses" from women in all walks of life: lawyers, physicians, dancers, athletes, psychologists, and business women.

In Britain, Fairburn and Cooper (1982) placed a notice in the health pages of a popular women's magazine requesting people to write the author if they used vomiting as a means of weight control and if they were willing to complete a confidential questionaire. Over 1000 replies to this request were received. One hundred percent of their subjects were binge eaters. Of the 620 women they studied:

> over half (56.4%) thought they definitely needed medical help to overcome their problem, yet only 2.5% were currently receiving treatment. Surprisingly, of the group who wanted help, fewer than half (43%) had ever mentioned the problem to a doctor, of the entire group with bulimia only 30.1% had done so.

Until a large epidemiological studies of Bulimia in the general population are done, the prevalence, incidence, age and social class distribution will remain uncertain. We are left with a small number of studies on selected populations, mainly college students, and the clinical impressions of a number of authors that Bulimia is "widespread"

and "epidemic" among young women.

Prevalence of Binge Eating in Obesity.

It is clear from the literature that eating binges or compulsive eating is characteristic of some obese people. It is not known what proportion of the overweight population this includes, nor is it known if binging overweights differ from non-binging overweights in any other way.

In 1959, Stunkard described a pattern of binge eating in three out of 40 obese subjects, and suggested that less than 5% of the obese population were Binge Eaters; 10% exhibited the Night Eating Syndrome. In contrast, Bruch (1973, p. 123) also an authority on eating disorders states:

> Among the many hundreds of patients whose psychological problems I have observed in detail over a long period, I have found not more that 2 or 3 instances which would fit Stunkard's picture of the Night Eating Syndrome but innumerable Binge Eaters...eating binges, uncontrolled eating in response to the slightest insult or disappointment, have occurred at some time or another in practically all my fat patients. Quite often it was these uncontrollable eating bouts that had led to the psychiatric consultation (p. 123).

Gormally, Black, Daston, and Rardin (1982) developed an instrument to assess binge eating among obese persons. They tested two samples of overweight persons seeking behavioural obesity treatment at two different settings. They found:

> It appears that persons seeking obesity treatment do vary in the extent they report behaviours/feelings characteristic of binge eating. The majority of the participants (55%) were judged by the interviewers as having moderate problems with binge eating, while 22% appeared to have little or no problem and 23% had very serious problems. Binge eating scores were uncorrelated with percentage overweight in both samples.

Loro and Orleans (1981) found a substantial number of obese patients engage in binge eating. Of 280 patients seeking treatment at a medical centre, 74.6% reported binge eating frequencies from 2 times a week to once every 3 months; 50.7% binged weekly or more frequently. They cite similar figures by Jackson and Ormiston (1977): 50% of moderately overweight patients binged weekly or more frequently.

While these studies are useful, the lack of random selection and the use of clinical populations make it unwise to generalize these results to the general population. Studies on non-clinical populations are below.

Edelman (1981) examined binge eating in response to emotional stress in a random sample of Navy employees. She too found no relationship between degree of overweight and binge eating. Forty percent of 100 subjects binged at least 3 times a month (this is the most sensitive scale used). Forty-eight per cent of the bingers were normal weight while 52% were at least 30% overweight. Overweight individuals binged more often than non-overweight.

Hawkins and Clement (1980) reported that for both overweight and normal weight college women the proportion of binge eaters in the sample was 79%. However overweight women binged more often: 33% of the normal weight women binged at least once a week as compared to 40% of the overweight women.

Halmi et al.(1981) found that 73.9% of their overweight subjects responded affirmatively to the five binging variables, as did 92.9% of

the very overweight. This study used a college population.

Prevalence of obesity

Bruch (1973, p. 3) writes "The incidence of obesity and overweight in the U.S. has been estimated to be as high as 30% or more, suggesting there are 60-70 million people or more whose weight is above the statistical average." The National Center of Health Statistics reports that for 1971 to 1974, 14% of American men are 20% or more above their desirable weight; a comparable figure for women is 24%.

Evidence For An Increase In Incidence

The previous section discussed prevalence, the proportion of a population known to have a disorder at one time. In contrast, incidence is the rate that new cases of a disorder develop in a given time, usually per year, per unit of population. Ideally populations are small enough to be enumerated, isolated enough to reduce the probability that immigration and emigration will seriously alter the population composition in a short time and well enough served that any case of the disorder is likely to be diagnosed as such and recorded somewhere (Mayer, 1961). Any evidence for an increase in binge eating must be inferred from evidence for an increase in eating disorders, as the incidence of binge eating has not been studied.

Before discussing the evidence for an increase in eating disorders, a review of the arguements that the increase is more apparent than real is in order. The increase could be due to:

1. better record keeping and reporting.
2. an absolute increase in the number of adolescents and young adults--a product of the post-war Baby Boom.

3. a function of an increase in interest in eating disorders by professionals and the public. Neither are immune to fad effects.
4. a function of the fact that individuals and centres specializing in treatment of Eating Disorders may confuse the increase in the number of referrals, due to increased awareness, with actual increases in the disorder (Schwartz, Thompson, and Johnson, 1980).

Incidence of Anorexia Nervosa

The evidence that anorexia is increasing ranges from expert clinical opinion to emperical studies.

Firstly, all the leading authorities in the field seem to agree there has been an increase. None have seriously made a case against an increase though all temper their statements with cautionary notes about referral and selection biases (Bemis, 1978; Bruch, 1979; Crisp et al., 1977; Garfinkel and Garner, 1982; Halmi, 1974).

Bruch (1979, p. viii) writes:

> Anorexoa nervosa is occurring at a rapidly increasing rate. Formerly it was exceedingly rare. Most physicians recognized the name as something they heard about in medical school, but never saw in real life. Now it is a real problem in high schools and colleges. One might speak of an epidemeic illness, only there is no contagious agent; the spread must be attributed to psychosocial factors.

Some empirical evidence for an increase in anorexia exists. Case registry studies have demonstrated an increase in the number of patients reporting to psychiatrists. Theander (1970) published a description and follow-up of 94 female anorexics in Sweden over a period of 30 years. He found an overall incidence for women to be 0.24 per 100,000 population per year. However, there was a sharp increase in the final decade of the study: from 1951 to 1961 the annual incidence was 4.5

cases or approximately double the rate of the entire life span of the study. This was reflected in an increase from an average of 1.1 new cases per year to 5.8 new cases per year.

Kendall et al.,'s (1973) survey of case registers from 3 countries (London, England, Scotland, and Monroe County, New York) revealed a significant increase in the second half of the period under study: 43 cases versus 25 in the first half. The incidence varied from 0.37 per 100,000 per year in Monroe County to 0.66 in London to 1.6 in Scotland. Despite the fourfold difference in incidence between the U.S. location and the Scottish one, in all cases there were more cases reported in the second half of the time span than the first. Replication of this study in the 1980's would be informative.

More recently, Jones et al., (1980) used the psychiatric case register and hospital records from a major teaching hospital to estimate the incidence of anorexia nervosa in Monroe County over two time periods: 1960-1969 (same as study above) and 1970-1976. They found the number of diagnosed cases almost doubled from 0.35 to 0.64 per 100,000 in the second time period. Moreover the increase occurred among females but not males and was most prominent in the 15-24 year old age group.

As discussed earlier, the severe limitation of the case register method is the necessity for the afflicted to be a psychiatric or medical patient and the many anorexics who recieve no treatment or are treated by nonmedical personnel escape identification.

Duddle (1973) found a sharp increase in the diagnosis of anorexia nervosa in a university population: from zero in 1966 and 1967, to 7 in

1970, to 13 in 1971. There was no coincidental change in the pattern of other diagnoses and the sex ratio at the university remained unchanged despite an increase in the numbers of students.

The final evidence for an increase in anorexia is the tremendous growth of the literature on the subject. Up until 1950 there were perhaps 250 cases--usually individual case reports-- described in the literature. There are now perhaps 5000 patients reported in studies ranging in sample size from 20 to 350 anorexics. Even in the unlikely event that the increased incidence of anorexia is an artifact of statistics or record keeping, it would still be worthwhile to question the change in interest and attention to eating disorders in both the lay and professional communities (Schwartz, et al., 1982).

The cumulative effect of the above evidence supports the assertion that anorexia is increasing in incidence.

Incidence of Bulimia

Unfortunately, the information on incidence of Bulimia is virtually nonexistant. There is little or no epidemiological data on the condition in the present, let alone a fund of historical documentation with which to make comparisions.

Only indirect evidence exists in the form of more reports of more subjects over time. When Linder's classic case study of "Laura" was published in 1955, Bulimia was regarded as a rare neurotic condition. In contrast, in 1982 Halmi et al., found 13% of the college population met the DSM-III criteria for Bulimia and 30% to exhibited bulimic symptoms. Either Bulimia was rare in 1955 and is common in the 1980's,

and therefore the incidence of it has increased markedly in 30 years, or alternatively, clinicians from 1955 to 1980 were unaware and ignorant of a condition that has a high prevalence but low visibility. The question then becomes: Why have clinicians become more aware and less ignorant? A real increase in incidence seems more likely.

Frequency Of Eating Binges

Clinically, the frequency of binge-eating is a useful objective and subjective index of the severity of the problem. The higher the frequency reported by the client, the greater is their distress over their behaviour (Loro and Orleans, 1981), and the greater the negative impact on their physiology (Russel, 1979). While this may be true for assessing and assisting an individual, the literature affords no such opportunity for the problem in general.

Table 5 reveals most dramatically the lack of consistency and specificity across studies. In addition, a number of factors render much of the information suspect. Binge eaters are renown for their reluctance to reveal the full extent of their abnormal eating (Newman and Halverson, 1983, p. 51). The data on frequency was gathered on the first interview and not revised if any new information was forthcoming during treatment (Russel, 1979; Garfinkel et al., 1980).

The scales used to measure frequency of binge eating lacked sensitivity in some studies. For example, in Loro and Orlean's (1981) report on obese binge eaters, the greatest frequency possible to report was "2 or more times per week". This category had the highest percentages of responses (28%). Data on a "daily" or "number of times a

TABLE 5: FREQUENCY OF BINGES (%)

Author	Subjects	Daily	Several Times Per Week	Weekly	Times/Month	Ever
Casper et al., 1980	49 F Bulimic anorexics	16	66	24		
Cooper & Fairburn, 1983	369 F Community sample	.5		6.8	20.9 in last 2 months	26.4
Edelman, 1981	49 F Random pool 51 M sample				40 3 times/ month 51% F 29% M	
Garfinkel et al., 1980	66 F Bulimic 2 M anorexics	38	41		22 3 times/ month	
Hawkins & Clement, 1980	391 College students			33 normal weight 40 over-weight		
Johnson & Berndt, 1983	80 F DSM-III Bulimics	51		41	8 several times/month	
Johnson & Larsen, 1982	15 F DSM-III Bulimics	1.4 binge / day		100		
Loro & Orleans, 1981	230 F Obese 50 M clinic patients		28.6	22.1	17.5 once a month	80
Mitchell et al., 1981	34 F DSM-III Bulimics	56	35	9		
Pyle et al., 1981	80 F DSM-III Bulimics	most common pattern		mean = 11.7 binges/week range 1-46		
Russel, 1979	28 F Bulimia 2 M nervosa	usually at least once daily				

day" basis would have enhanced comparisons with Bulimics Edelman (1981) selected three times a month to distinguish binge eaters from non-binge eaters. While it suited the purpose of that study, much valuable data was lost and comparisons of her groups with others is hampered.

Lack of information on range and variability also detracts from the usefulness of the frequency information in these studies. For example, on "good" days a binge eater may not indulge at all, while on "bad" days she may binge several times; another may only binge once a day, but has had only 3 binge free days in as many years (Wilkie, 1986). The majority of these reports do not state whether the frequencies of binges are averages or extremes.

Meaningful comparisons of frequency between studies and groups are difficult because of the lack of consistant measurement. However, it is clear that for those people identified as having an eating or weight disorder, binges occur most frequently on a daily to weekly basis, with the most severe cases binging several times a day.

For DSM-III Bulimics, the majority binge at least daily (Johnson and Berndt, 1983; Johnson and Larson, 1982; Mitchell et al., 1981; Pyle et al., 1981). Mention of individuals is revealing: 30 times a day (Fairburn, 1981), 6 times a day (Abraham and Beamont, 1982), 5 times a day (Mitchell et al., 1981). Anorexic bulimics also commonly binge daily to several times weekly (Casper et al., 1980; Garfinkel et al., 1980).

The relative lack of information on frequency of binge eating among obese binge eaters--while a glaring omission in this context--is an

accurate reflection of the lack of research done on eating patterns in this population.

An estimate of the frequency of binging in the general population relies on two studies. The community sample of Cooper and Fairburn (1983) of 369 women reveals that in a "normal" population 6.8% binged weekly and 0.5% binged daily, 20.9% had binged at least once in the previous two months and 26.4% had experienced binge eating during their lifetime. The mean age of this group was 24.1 years. Hawkins and Clement (1980) found a much higher incidence among American college students. Of the 391 male and female students, 33% of normal weight and 40% of overweight subjects binge at least weekly. The mean age of this sample was 20 years. This would support the position that college students are at greater risk than the general population.

Precipitants To Binge Eating Episodes

The data on precipitants to binge eating episodes is chiefly anecdotal.

Hawkins and Clement (1980) report that "the majority of males and females (71% of normals and 52% of overweights) could not identify the precipitating cause of their eating binges."

Abraham and Beaumont's (1980) descriptive study of 32 binge eaters of all weights is the most specific:

> Patients described a number of factors which they saw as precipitating episides of bulimia...In decreasing order of frequency cited these were: tension, 91%; eating something (ie, anything at all), 84%; being alone, 78%; thinking of food, 78%; going home, 72%; feeling bored and feeling lonely, 59%; feeling hungry, 44%; drinking alcohol, 44%; going out with a member of the opposite sex, 25%; eating out, 22%; and going to parties, 22%.

> Less frequently cited precipitants included visiting with relatives and arguments with parents, boyfriends or husbands. Despite the rigid dieting practises by patients between episodes of bulimia, 66% did not recognize hunger as a precipitant. Those not citing 'thinking about food' explained that they were always thinking about food anyway.

Food related cues are common. Cravings for a particular food are frequently cited by bingers (Jackson and Ormiston, 1977, cited in Loro and Orleans, 1981; Pyle et al., 1981). Eating a small amount of a favorite food or a "forbidden" food can trigger a eating episode in some people also (Wardle and Beinhart, 1981; Loro and Orleans, 1981). "Uncontrolled appetite" and "being unhappy" were both cited by 70% of the DSM-III Bulimics seen by Pyle et al., (1981). Loro and Orleans (1981) state: "seeing, tasting, smelling or having access to preferred and fattening foods and engaging in activities associated with eating such as attending a cocktail party or sporting event have also been found to trigger binges." Specific food precipitants indicate a possiblity of an allergic response (Mandell and Scanlon, 1979, Mandell and Mandell, 1983).

Casper et al., (1980) report that patients eat to relieve distressing emotions. They conceptualize bulimia as originating from a failure to control overwhelming feelings of hunger and, with the discovery of the emotionally soothing effects of food, binge eating is triggered not only by hunger but by other feeling states such as frustration, tension, emptiness, boredom, depression, guilt and anxiety: "Normal eating is not sufficient to dispel this tension but binge-eating does, even though it is accompanied by a constant fear of not being able

to stop eating."

Boskind-White and White (1983, p. 50) concur, stating:

> Rejection, confrontation, disappointments and anxiety are often major precursors of a binge...anger is a rare emotion for these women...The decision to binge, more often than not is related to the inability of bulimarexic women to assert themselves and deal with their problems in a direct way...In time binging and purging become habitual and precipitating factors become irrelevant because binging then occurs at any time and under any circumstance.

Setting of Binge Eating Episodes

Time and Place

Late afternoon and evening are the most frequent time of occurrence of binge eating episodes (Johnson and Berndt, 1978; Johnson and Larson, 1982; Mitchell et al., 1981; Wardle and Beinhart, 1981). The most common pattern is to begin to binge after returning from work or school. Purging then goes into the evening (Johnson and Larson, 1982; Pyle et al., 1981).

Other authors, following Stundard's (1959) lead, have looked for patterns of late night eating. Five to 20% of all binges occurred late at night for the Bulimics studied by Johnson and Larson (1982). Twelve per cent of the binges recorded by Mitchell et al., (1981) occurred late at night.

Binges also tend to cluster on weekends (Johnson and Larson, 1982; Wardle and Beinhart, 1981).

Whether the occurrence of binges during the late afternoon, evening and weekend merely reflect the likelihood of being home alone and therefore having a "ideal" or "safe" setting in which to binge, whether being alone is a trigger, or whether other factors are operating is not

known.

The large majority of binges occur at home, though other settings may be used as well such as cars, restaurants or on the street (Hawkins and Clement, 1980; Johnson and Larson, 1982; Pyle et al., 1981). Lack of binge food at home or fear of discovery may prompt people to binge eat elsewhere than at home.

Social Setting

Binge eating is primarily a solitary event. All Bulimics studied by Pyle et al., (1981) preferred to binge eat alone:

> 18 of 34 indicated that under certain circumstances they would [binge eat] in front of family or friends. However, no one indicated a preference to be with others while binge eating and some were quite adamant in insisting they would never binge eat if anyone could see them. (emphasis mine)

This fact has profound implications for research, both the research done to date and the research of the future. The solitary, secretive nature of binging renders laboratory studies of eating behaviour useless as a binge eater will alter her behaviour under any kind of public scrutiny. It may also explain why, in the vast amount of research on obesity, so little concentrates on binge eating while externiality theory, which lends itself so readily to laboratory research, has been so popular.

Types of Food Consumed

Only a few authors have specified what food are consumed during a binge eating episode. In their study of 40 DSM-III Bulimics, Mitchell et al., (1981) state:

Most patients reported they consumed more than one food per binge

> and the foods most commonly consumed during a typical binge-eating episode included ice cream (N=14), bread-toast (N=11), candy (N=10), doughnuts (N=8), soft drinks (N=7), salads or sandwiches (N=6), and cookies, popcorn, milk, cheese or cereal (N=5).

Abraham and Beaumont's (1982) analysis of the food records of binge eaters revealed discrepancies between the patient's perceptions of food eaten and what had actually been eaten. Bingers claimed they would eat until all the food was consumed, but usually what they were referring to was "binge food", "bad food", or "junk food", that is, foods they did not allow themselves to eat at other times; for example: ice cream and cake.

> Contrary to the patient's impressions that the food eaten during binges was exceptionally high in carbohydrate, analysis of the 10 completed records of food actually consumed in a binge revealed that they were just as likely to contain excessive fat or protien. One patient became a vegetarian in order to control weight and changed from binges high in fat to binges of fresh vegetables, for example, 5 to 7 pounds of raw carrots. The amount, type and nutritional content of the food eaten by patients was entirely dependant on what was available in the home. They would eat anything, including tinned food, baby food, frozen food, and scraps that had been placed in the rubbish bins. Although patients did not usually eat inappropriate raw or frozen foods, 30% did so on some occasions. 34% had actually eaten everything in the cupboards and fridge. There were no reports of pica: i.e., the eating of substances of no nutritional value.

Wermuth, Davis, Hollister and Stunkard (1977) also notes the predominance of sweet and starchy food (simple carbohydrates) that favour rapid consumption. In addition, as the binge progresses there is a decrease in selectivity. Foods not usually enjoyed will be eaten. The food is consumed rapidly with little or no chewing. If the food runs out before the termination of the binge, the person will go out and buy more.

Often the binge concentrates on a particular favorite food (Loro and Orleans, 1981). In one study 77% of the binge eaters craved a particular food or type of food at least half the time they binged, while the minority reported they would eat any high calorie food or any type of food available (Jackson and Ormiston, 1977, cited by Loro and Orleans, 1981).

Food selection for those who purge may be influenced by vomiting considerations. One quarter of Abraham and Beaumont's (1982) binge eaters used "markers". They would commence a binge with a distinctively coloured food they could recognize in the vomitus--a red apple or licorice. Some people would select soft fluid or milky foods near the end of the binge episode to aid regurgitation.

Intensity: Amount Eaten Per Binge and/or per Day

Data on the intensity of binge eating, as measured by the amount of food consumed are primarily anecdotal. There is also wide variation in the upper limit figures.

Mitchell et al., (1981) in their study of 25 Bulimics state:

> although a few patients considered a binge episode to be what others would call a large meal (5 patients reported consuming less than 2000 calories during an average binge), the usual pattern was to grossy exceed what would be considered normal caloric intake. A few patients in this series were consuming as many as 50,000 calories per day (as many as 10 binges of 5000 calories each). The average was 3,415 calories per episode. The range was 1,200 to 11,500 calories per binge.

Loro and Orleans's (1981) description of 280 obese binge eaters contains similar figures of 1,000 to 10,000 calories per binge. However, as the number of binges per day was not specified, actual

similarity of the two groups remains in doubt.

Both Russel (1979) and Stunkard (1959) report on cases of people consuming 20,000 calories during a single binge eating episode.

The largest numbers reported are in Abraham and Beaumont's (1982) study of 34 binge eaters where a "bad day " of binge eating resulted in the ingestion of 3 to 27 times the Recommended Daily Energy Allowance.

A counsellor confronted with a binge eater needs to ascertain what the person means by "a binge" or "I eat a lot". Clearly, a person binging on 50,000 calories per day is likely to be having greater social, financial and emotional difficulties than someone who binges on 2000 calories once a week.

Duration of Binge Episodes

Abraham and Beaumont (1982) explains the difficulty of describing the length of an episode:

> It is difficult to be certain about what patients meant by the length of an episode. They described episodes ranging from 15 minutes to 3 weeks in duration. Some patients, especially those who had only recently developed abnormal eating patterns saw their bulimia as occurring in discrete episodes, up to 6 in one day. Other patients, often with long histories of binge eating described episodes lasting for days or weeks. These latter patients reported the urge to binge was continuous, i.e., present when they went to sleep and on waking. The time between bulimic episodes was also highly variable both within and between individuals, varying from hours to weeks.

Other authors concentrated on the length of time of discrete episodes. Fiteen minutes to one hour are frequently mentioned figures (Hawkins and Clement, 1980; Jackson and Ormiston (1977), cited by Loro and Orleans, 1981; Loro and Orleans, 1981; Wermuth et al., 1981). Included are "rare" exceptions: 4 hours (Jackson and Ormiston, cited in

Loro and Orleans, 1981), 8 hours (Hawkins and Clement, 1980), and an entire day (Wermuth et al., 1981).

Termination of Binge Episodes

The DSM-III (1980) states "binge-eating episodes are typically terminated by the induction of vomiting, sleep, significant abdominal pain or interruption." Abraham and Beaumont's (1982) 32 binge eaters report a variety of factors may terminate a binge: some simply "ran out of steam," felt full or nauseous, the presence of others, having vomited or the lack of binge foods. Forty per cent slept, the others resumed normal activities.

For Bulimics, vomiting is the usual means of terminating binge eating episodes (Mitchell et al., 1981; DSM-III, 1980).

Binge-related Behaviour

Abraham and Beaumont (1982) found that all patients gave evidence of planning at least some of their binges but only 75% admitted to this. Reports of hoarding, buying and preparing food for times of binging were taken as evidence of planning:

> Most patients prepared and cooked food while binge eating, usually simple things like grilled cheese on toast, but some would prepare and cook more elaborate dishes such as biscuits, cakes, casseroles and chickens. Most patients also bought food especially to eat during episodes of bulimia. Leaving time free in a busy schedule to be alone and undisturbed was also taken as indirect evidence of planning to binge eat.

Shopping for food before, during or after binging in order to obtain more food or replace food eaten is noted by Abraham and Beaumont (1982) and Pyle et al., (1981). Some bingers will go from grocery store to grocery store or bakery to bakery buying one or two chocolate bars or

cream puffs at each place. They may also eat one meal in one restaurant followed by another meal at another restaurant. One binge eater known personally to the writer binge eats most seriously on car trips by herself, stopping at every ice cream outlet on the highway. In a 4 hour trip she averages 15 stops.

The financial burden of supporting a major food "habit" can severely tax the binger or their family. Johnson et al., (1983) calculated 361 Bulimic women averaged $8.30 per binge with the range being $1.00 to $55.00. One woman making $40,000 per year was forced to declare personal bankrupcy due to her $100 per day food costs (Neuman and Halverson, 1983, p. 58). Sometimes a person will work at 2 jobs to pay for their food (Mitchell et al., 1981). Several authors have reported that stealing is a behaviour found with high frequency among anorexic bulimics and Bulimics (Garfinkel and Garner, 1982, p. 46; Crisp, Hsu and Harding, 1980, Casper et al., 1980; Pyle et al., 1981). Pyle et al., (1981) specifies that food was stolen either as part of the binge ritual or because they could not afford to buy enough food to meet their binging requirements.

Maintaining the secrecy of their activities results in particular behaviors also. To dispose of empty food packages a binger may hide them until gargage day, or use garbage facilities at a distance from home, or, as in shopping, use a number of sites to dispose of food containers. Lying to significant others, either by omission or commision, is common. That deception is successful is supported by reports of Bulimics hiding their entire disorder from husbands or

parents for years (Boskind-White and White, 1983, p. 117; Russel, 1979).

Resistance to Binging Behaviour

Little has been written about behaviour designed to resist the urge to binge eat, a reflection, I believe, of the interests of the researchers, not the experience of the bingers.

Abraham and Beaumont (1982) write:

> All (32) patients had attempted at times to resist the urge to binge. Resistance was manifested in many forms of behavior--for example, chewing food and spitting it out, not finishing particular food, not cooking food or going out to social gatherings where they would be expected to eat, avoiding family meals, locking themselves in the bathroom, driving into the country where no food was available, keeping no money in their purse, trying to do something else such as knitting or telephoning friends, trying not to be alone, planning to be completely occupied at all times, working overtime where no food was available, freezing food so it could not be eaten, eating only minute quantities of food at a time, trying to keep to a strict diet, and going for long walks and returning home via a route which avoided food shops. Patient 8 was so desparate that she attempted to wire her jaws together by passing a wire through her gums after using a topical local anaesthetic gel. Patient 16 cut the tips of her fingers so they would be too sore to induce vomiting, hoping this would stop her from undertaking a binge.

Wermuth et al., (1977) state most of their 20 binge eaters had undergone many treatments for their binge eating including diets, medications, hypnosis, commericial or self-help weight control programs, and psychotherapy. No treatment had been successful.

Pyle et al., (1981) state: "Despite financial difficulties, constriction of interests and deteriorating interpersonal relationships, none of these [34 Bulimic] individuals had been able to stop binge eating although all stated they had tried."

Compensatory Behaviour To Prevent Weight Gain

One or more strategies to compensate for excessive food intake and to maintain or decrease weight may be chosen and used by a binge eater: self-induced vomiting, abstinence from food, vigorous exercise, laxative purges, abusing diuretics and/or using "diet" drugs (Abraham and Beaumont, 1982; Boskind-White and White, 1983, p. 44; Cooper and Fairburn, 1983; Garfinkel and Garner, 1982, p. 5; Johnson and Berndt, 1983; Johnson and Larson, 1982; Mitchell et al., 1981; Pyle et al., 1981; Russel, 1979; Weiss and Ebert, 1983).

1. Self-Induced Vomiting

> Forced vomiting is the most dramatic and immediate method of purging. It also appears to be the most common, perhaps because it is the easiest and most efficient form of weight control. It may be the most self-destructive. The issue of immediacy is probably central, because women often say that they can throw up before the calories have a chance to take effect. Vomiting also provides instant relief for the painfully full stomachs (Boskind-White and White, 1983, p. 42).

Psychologically, vomiting can relieve the intense anxiety, guilt, and self-recrimination that follows a binge (Abraham and Beaumont, 1982; Boskind-White and White, 1983, p. 49).

A single suggestion may be all that preceeds "learning" to throw up. The discovery of vomiting as a means of weight control is often greeted with initial delight as the binger realizes she can eat what she likes without putting on weight (Abraham and Beaumont, 1982; Boskind-White and White, 1983, p. 42). The extreme suggestability of potential Bulimics and bulimic anorexics and the social exchange of information result in the odd situation of a psychological disorder that "could be regarded as "contagious" and in which something akin to "epidemics" may

TABLE 6: INCIDENCE OF COMPENSATION STRATEGIES (%)

Author	Subjects	Sex	Food restriction	Vomiting	Laxative	Vomiting & Laxative	Diuretics	Exercise	Drugs
Abraham & Beaumont, 1982	32 Binge eaters	30F 2M	100	53	75	41	41	3	66
Casper et al., 1980	105 Anorexia nervosa 49 Bulimic 56 Restrictor	105F	 100 100	 57 18	37 27				
Cooper & Fairburn, 1983	384 Community sample	384F		6.5 ever 2.9 last 2 months	4.9			7.3	
Johnson & Berndt, 1983	80 DSM-III Bulimics	80F		77	33	25.7			
Johnson & Larson, 1982	15 DSM-III Bulimics	15F		100					
Mitchell et al., 1981	40 DSM-III Bulimics	40F		93					
Pyle et al., 1981				88	53		29	76	
Russel, 1979	30 Bulimia nervosa	30F		90	6.6	5.3			
Weiss & Ebert, 1983			100	93	6.3	40			

appear" (Wooley and Wooley, 1980).

Pyle et al., (1981) state most of their 34 DSM-III Bulimic subjects experienced some initial difficulty when they began to vomit regularly and resorted to manoevres such as sticking their fingers down their throats, but most had learned to vomit on a reflex basis. Russel (1979) found 21 of 27 patients used their fingers or a toothbrush to induce vomiting. Some ascribed magical qualities to their particular toothbrush. Q-tips, spoons and other stimulators may be used (Abraham and Beaumont, 1982; Boskind-White and White, 1983, p. 44). Russel (1979) states:

> Others found it no longer necessary to stimulate their throats to induce vomiting. They described it as effortless 'I can just make myself sick'. They qualified this by saying that vomiting was eased by the large quantities of food and fluid they had consumed.

One patient demonstrated how she vomited: while standing bent over, she applied slight hand pressure to her abdomen causing the gastric contents to "simply pour out" (Russell, 1979). Individuals develop ritualistic patterns: counting 35-40 retchings after vomiting, drinking water between vomits until the returns are clear (Abraham and Beaumont, 1982; Russel, 1979).

Johnson and Berndt's (1983) study of 80 DSM-III Bulimic women suggests reliance on evacuation techniques begins approximately one year after binge eating begins. While suggestive, further research is needed to substantiate this.

Purging tends to increase in a step-wise fashion with binge eating. Sometimes Bulimics become extemely preoccupied with the purging itself.

Consequently, food that is consumed during every meal is thrown up in addition to food consumed during binges. At some point, in at least some cases, it appears Bulimics begin to eat in order to purge, rather than purge in order to rid themselves of what they have eaten (CSAB, Bulimia). Purging is often described by both clinicians and sufferers as "habit-forming," "adddictive like smoking or alcohol," "a syndrome that approaches addiction" (Boskind-White and White, 1983, p. 43; Cooper and Fairburn, 1983; Russel, 1979).

The frequency of vomiting varies considerably between patients, depending on the severity of the disorder, the length of time they have been using the behaviour and the population studied. Russel (1979) reported a range of frequencies from once every two weeks in a patient trying to stop, to several times a day after each meal, up to 15 times a day. Johnson and Berndt (1983) consider the frequency of purging behaviour to be quite high: 59.2% of their sample 80 DSM-III bulimic women induced vomiting one or more times a day, 28.6% vomited weekly, and the remaining 12.2% vomited monthly. Wiess and Ebert (1983) found that fourteen out of fifteen Bulimics were vomiters whose average frequency of episodes ranged from once every 2 weeks to 15 times per day. Mitchell et al., (1981) write:

> Of the 40 patients [DSM-III bulimics] 37 vomited as part of the syndrome. The mean frequency of vomiting episodes was 11.7 per week. Although some patients would punctuate binge-eating episodes with vomiting and others would binge eat at times without vomiting, the usual pattern was to terminate the binge eating episode by vomiting.

Johnson and Larson (1982) randomly called 15 DSM-III Bulimics and found:

> purges were reported slightly less frequently than binges, a total of 144 over the period of paging (1 week), an average of 11.1 per person at a rate of 1.3 per day. The range in the rate of purging was between 3.0 per day and 0.0.

The above describes studies of Bulimics. I was unable to find similar data for anorexics. There is considerable attention as to whether anorexics vomit or not, but none on the frequency. There is an assumption that the obese do not use purge methods but there is no data to support or refute that assumption.

2. Reduced Consumption: Dieting, Fasting, Starvation

Food restriction is strongly associated with binge eating (Abraham and Beaumont, 1982; Garfinkel and Garner, 1983; Loro and Orleans, 1981; Lucas, 1983; Russel, 1979; Wardle and Beinhart, 1981; Wooley and Wooley, 1981). Despite repeated references to dieting, food avoidance, fasting and "prolonged starvation between eating orgies" associated with binge eating, little description of these behaviors exists. The entire eating pattern, both consumption and restriction is instructive. Periodic gorging of food is more understandable once the profound food restriction is recognized.

Weiss and Ebert (1983) studied 15 DSM-III Bulimic women and 15 normal weight control women and they provide the only specific description available:

> ten bulimics and 1 control fasted regularly. Chi square (1)=11.63 $p<0.0007$. Fifteen bulimics (habitually) and four controls (occasionally) abstained from food when hungry chi square (1)=17.37, $p<0.0001$. Bulimics tended to eat at irregular intervals with long foodless hiatuses. For example, one subject ate her first meal at 3 p.m. and her second at 11 p.m. Another usually ate at 6 a.m., 8 a.m., and 5:30 p.m. Six bulimics and 11 controls typically consumed 3 meals a day at times considered normal, i.e.,

> morning, noon and evening. Bulimics ate an average of 2.9 ± 1.5 times per day (meals and snacks included, binges excluded); controls ate an average 4.6 times per day (meals and snacks included) $t=3.91$ $p<0.001$. Ten bulimics tried to limit scheduled meals to low calorie foods, controls ate a greater variety of foods.

Pyle et al., (1981) writes of DSM-III Bulimics:

> They tended to alternate between periods of fasting and binge eating. Not uncommonly following an episode of binge eating they would fast for nearly 24 hours, then find themselves very hungry and initiate another binge.

Russel (1979) states "Prolonged starvation between eating orgies was common " for his 30 "bulimia nervosa" patients.

3. Exercise

While excercising for weight control is mentioned in relation to disordered eating, no descriptions have been made. Some have suggested that excessive exercise may be a male equivalent to vomiting/purging behaviour (Sours, 1980, p. 283). Anorexics may impose vigorous and relentless activity regimes on themselves, and harshly castigate themselves for any deviance from their self-prescribed program (Neuman and Halverson, 1983, p. 60). Severely emaciated anorexics will continue vigorous activities such as swimming, jogging or calesthenics.

One difficulty with defining excessive exercising is that anorexics or Bulimics may be dancers or gymnasts or marathon runners--people whose exercise level far surpasses that of average person. The attitude determines the excess. Neuman and Halvorson, 1983, p. 60 write:

> The regimes tend to be rigid and joyless compulsions which cannot be eliminated without panic. The behaviors are not comfortably varied to fit circumstances, mood, or the needs of others: they are designed to elicit admiration and to ensure a successful image. However, the eating-disordered individuals themselves remain

unconvinced and self-dissatisfied.

4. Drugs: Laxatives, Diuretics and Appetite Suppressants

Laxatives use may begin when dieting reduces bulk and constipation results. Laxative abuse can become severe. Often laxatives are used when too much time has elapsed since eating for vomiting to be effective or there is no privacy to vomit; they are considered "a second-best attempt to interfere with the absorption of food" (Russel, 1979). Some people take daily doses of laxatives, some take large amounts less often or moderate doses frequently enough to be considered reliant on them (Russel, 1979).

Laxatives are easy to obtain without prescription and can be used without detection.

Diuretics are used to decrease weight by removing fluid from the body and to counteract the swelling of hands and feet that may accompany overeating or starvation. The abuse of diuretics is uncommon but not unknown (Garfinkel and Garner, 1982, p. 45). However lying and stealing may be needed to acquire them.

Appetite suppressants include a number of drugs. The most well known and widely prescribed are amphetamines. Beside their anorexic action, amphetamines produce euphoria, a sense of well-being and a feeling of energy (Seevers, 1968). Accessibility is a hurdle to abuse.

Physical Consequences

While the responsibility for treatment of the physical consequences of binge eating and its sequelae belongs to the physician, counsellors and other helping professionals need to be alert to the existance of

physical problems, to recognize the significance of symptoms clients exhibit, to know the potential severity of the complications, and to use this knowledge to educate their clients. Immediate referral to appropriate medical professionals is imperative in the face of serious complications. Counsellors can assist clients to fully disclose their disordered eating patterns, enabling a physician to accurately assess the person's physical status. The counsellor needs to know the impact of starvation on the psychology and behaviour of people in order to intervene effectively. Garner et al., (1985) believe that "the understanding of these risks play a major role in solidifying many patient's commitment to abstain from binging and purging."

The severity of physical symptoms varies with the intensity and duration of the physical abuse inflicted on the body. Most complications are reversible when adequate nutrition is restored and when compensatory behaviour such as vomiting or purging cease.

Physical Consequences of Binge Eating

Anyone who has overindulged at a holiday dinner knows the physical discomforts that follow excessive consumption: lethargy, abdominal bloating, abdominal pain, possibly nausea or intestinal gas or diarrhea, sometimes headache or sleepiness.

Carried to an extreme, excessive overeating can result in gastric dilation (stomach stretching) severe enough to warrant hospitalization (Mitchell, Pyle and Miner, 1982). Rarely, rupture of the stomach has occurred with fatal consequences (Matikainen, 1979, cited Mitchell et al., 1981). This is of greatest concern in an emaciated person.

Binge eating by a person with insulin dependant diabetes can result in a life threatening situation. The diabetic person binges but does not adjust their insulin dose to "handle" the food load for two reasons. They resolve daily to control their blood sugar by giving up binging and they fear increasing their insulin would cause weight gain (Hillard, Lobo and Keeling, 1983). Frequent recurrent binges of sweet and sugary foods may stress the capacity of the pancreas, thereby increasing the chances of developing diabetes in susceptible individuals (CSAB, Bulimia). Once developed, diabetes is rarely reversible, it profoundly effects the life of the person and may result in serious long term complications such as blindness and circulatory difficulties.

Hypoglycemia (low blood sugar) is another condition controlled by diet and exaccerbated by binge eating. Binges of sweet sugary food cause the blood sugar to fall, leaving the person fatigued, sometimes disoriented, and craving sweet food, leading further into a pattern of cyclic binging.

Food allergies may be exacerbated as the binge eater becomes less discriminating (CSAB, Bulimia). In addition, foods selected for binges, foods that are "craved", foods belong to the "once-I-start-I-can't-stop" category are likely to be food allergens. The most common food allergens in North America are wheat, milk, corn, coffee, eggs, yeast, beef and pork. The resultant stress on the immune system of frequent large exposures to allergens can result in increasing ill health. Any body system may be adversely affected (Mandell and Scanlon, 1980; Randolf and Moss, 1980).

Physical Consequences of Compensatory Strategies

a) Self induced vomiting: The complications secondary to self induced vomiting range from trivial to life-threatening. Chronic irritation of the mouth and throat, blisters on the roof of the mouth, chronic sore throat, a hoarse, raspy voice may occur from the chemical and mechanical irritation of the vomitus (Kibistant, 1982; Pyle et al., 1981). Acids from the stomach erode tooth enamel causing irreversible dental decay. Tooth color changes from white to brown or gray and may require extensive dental work or removal of the teeth (CSAB, Bulimia; Garner et al., 1985; Lucas, 1981; Pyle et al., 1981). The parotid glands, located on the insides of the cheeks, may become swollen and/or infected (CSAB, Bulimia; Lucas 1981; Pyle et al., 1981; Russel, 1979).

Calluses or open wounds may appear on the back of the hand used to induce vomiting (Russel, 1979). The force of vomiting and straining can cause rupture of the small blood vessels in the eyes giving a "bloodshot" look (CSAB, Bulimia). The body may adapt to long term vomiting by developing difficulties swallowing and retaining food: spontaneous regurgitation may develop (CSAB, Bulimia; Russel, 1979).

Loss of electrolytes is the most dangerous complication of self induced vomiting, laxative abuse and diuretic abuse. Sodium, chloride and potassium are essential to the body for metabolic processes, and well as for the normal functioning of nerve and muscle cells. Significant amounts of potassium may be lost through vomiting, leading to dehydration, muscle weaknesss, muscle twitches and a cramping curling of fingers and toes (tetany). Further potassium depletion will cause

low blood pressure, irregular heart rhythmns, heart failure, and kidney failure. Permenant damage to the heart tissue is possible (Casper et al., 1980; Lucas, 1981; Mitchell et al., 1983). Sudden death is possible due the irregular and dangerous heart rhythmns, particularly during exercise (Garner et al., 1985).

Electrolyte disturbances have also been associated with abnormal electrical charges in the brain. Epileptic seizures have been reported in 4 of 30 cases of Bulimia described by Russel (1979). Kidney damage has been reported in patients with potassium deficiencies (Russel, 1979; Wigley, 1960; Wolff et al., 1968). Urinary tract infections have been reported, as was a case of a woman, who, after 8 years of self-induced vomiting, developed kidney failure and required a kidney transplant (Russel, 1979).

Mitchell et al., (1983) have found electrolyte disturbances in almost 49% of the non-anorexic patients with bulimia. These abnormalities were clearly associated with frequency of self-induced vomiting.

Normally, vitamin and mineral deficiencies do not develop, but are possible depending on the nature of the diet and the extent of vomiting and purging (Lucas, 1981).

b) Reduced consumption: dieting, fasting and starvation

Food restriction profoundly effects both physical and psychological functioning; recovery is lengthy. The information in this section is from Keys, Brozek, Henschel, Mickelsen and Taylor (1950) unless otherwise stated. Keys et al., (1950) experimentally reduced the body

weights of 36 young, healthy, psychologically normal men by restricting their food intake to half of the normal amount over six months. On average they lost 25% of their body weight, an amount comparable to anorexia nervosa. A three month recovery period of refeeding followed, but it was over a year before their body composition returned to pre-starvation proportions.

This information applies to any person using food restriction, regardless of their weight. An overweight person on a diet is subject to the same effects as a normal weight person on a diet. If the person has a history of previous food restriction, as many overweight people do, the effects may be magnified (Garner et al., 1985; Miller and Parsonage, 1975; Wooley, Wooley et al., 1979).

Weight is lost when food is restricted below the person's caloric requirements for Basic Metabolic Rate (BMR) and activity. The initial loss is water, glycogen, and muscle tissue, including the vital organs (Cannon and Einzig, 1983, p. 28). Some body fat is lost. As the restriction continues hunger increases and accumulates (Bennet and Gurin, 1982, p. 68). Episodes of uncontrolled binge eating will occur if food is available. If eating is opposed by cognitive controls, the binge is followed by intense self-recrimination.

There is a dramatic increase in preoccupation with food. Hungry people constantly think of food and eating, it becomes the primary topic of conversation, reading and daydreams. They collect recipes, cook books and kitchen utensils. There is a generalized tendency to hoard objects. Much of the day is spent planning when and how to eat. Food

is eaten slowly and often in weird combinations. There is a marked increase in the use of salt and spices.

Psychologically healthy people experience significant emotional changes as a result of food deprivation. They become irritable, angry, anxious and apathetic. About 20% of the 36 young volunteers experienced extreme emotional deterioration. MMPI scores indicated increase in depression, hysteria, and hypocondriasis, known as the "neurotic triad." These emotional aberrations persisted for many weeks after refeeding. Personality testing prior to food deprivation did not predict the emotional response to calorie deprivation. The severe reactions are similar to those described in obese individual exposed to "therapeutic" semi-starvation (Glucksman and Hirsch, 1969; Rowland, 1970).

Social changes occur. Food-deprived people become progressively withdrawn, isolated and socially inadequate. Sexual interest declines sharply and is slow to return with renutrition.

There is a slowing of the body's physiological processes: temperature, heart rate and respiration. The BMR is the amount of energy the body needs at rest to function and accounts for two-thirds of the body's total energy needs. In response to food restriction, the body's BMR drops 40% from normal.

In the starvation experiment, weight declined about 25%, the percentage of body fat fell to almost 70% and muscle decreased about 40%. Upon refeeding a greater proportion of the "new weight" was fat. In the eighth month of rehabilitation, the volunteers were at 110% of their original body weight but had 140% of their original body fat. The

men were distressed at the tendency for the weight to accumulate in the abdomen and buttocks. It took one year for body weight and relative body fat to return to pre-experimental levels. Huge appetites were evident during refeeding but diminished to normal as their body weights normalized.

The similarities in behaviour and psychology of anorexic and Bulimic clients to food deprived subjects is astounding. The problems of chronic dieters with increased body fat and lowered metabolic rates are also remarkably described. Bruch (1979, p. 102) writes:

> it looks as if there is a certain critical level of weight below which the toxic influence of malnutrition maintains an abnormal mental state. The exact figure for this critical weight is, of course, related to the height and body build of a patient. It is usually around ninety to ninety-five pounds. Though this weight is still far below the normal weight, it is compatible with more normal psychological functioning and the exploration of important and relevant problems can begin.

c) Exercise No information specific to eating disorders.

d) Drugs: Laxatives, Diuretics, Appetite Suppressants:

Laxatives cause abdominal cramping, abdominal pain, the passage of liquid and semi-liquid stools, intestinal gas and irritation of the lower bowel and anal region. Electrolytes, especially potassium, are lost in diarrhea, but the initial effects are less severe than with vomiting. Prolonged abuse of laxatives can lead to the serious fluid and electrolyte disturbances as described above, to complete dependance on laxatives for normal evacuation, and loss of normal bowel reactivity (Merck, 1977).

Duiretics increase the frequency and the amount of urination. The

result is increased thirst, urgency of urination, decreased skin firmness (turgor). The most serious complication is potassium loss as described above.

Use of amphetamines on a continuing basis will lead to strong psychological dependance. The person will then use the drug compulsively and seek other sources of supply to meet the increased need. Apprehension, volubility, tremor, excitement are evident at high doses. Toxic states are possible but physical dependance does not develop. When discontinued, physical and psychological depression results (Kalant, 1973; Seevers, 1968).

Physical Consequences of Non-Compensation

If the amounts of food ingested during binges does not exceed the energy of requirements of the body, there may be no weight consequences to periodic gorging. Indeed, according to set point theory, the binge may be the body's way to get the calories needed to maintain its preferred biological weight in the face of dietary restraint (Bennet and Gurin, 1982).

However, excessive ingestion over a prolonged period is likely to result in a weight gain above standard body weight resulting in obesity.

Psychological Description

This section describes the subjective experience of binge eating and describes emotional and cognitive factors characteristic of people who engage in binge eating.

Garfinkel and Garner (1982, p. 192) distinguish between factors that predispose an individual to a disorder, factors that precipitate a disorder, and factors that sustain the disorder. This section principally addresses presenting, sustaining and perpetuating factors.

The most useful and meaningful way to present the psychological issues of binge eating is in terms of psychological constructs, that is groupings of related thoughts, feelings and states. The intent was to extract, synthesize and present clinical descriptions of the pertinent emotional and cognitive elements separate from the theoretical formulations of the author. For example, an inability to recognize internal sensations such as hunger or anger has variously been attributed to faulty mother-child interaction (Bruch, 1973, p. 44), to interference of the body's signals by chronic dieting (Bennet and Gurin, 1982, p. 41), or to female socialization (Boskind-White and White, 1983, p. 114). The presenting and sustaining factor is still poor internal awareness. Naturally, complete separation of description and theory was not always possible, or even desirable. When a particular theoretical model is used, its presence is noted.

The psychological constructs selected to organize this data were drawn from the author's general reading, from Brice (1981), and Garner, Olmsted and Polivy (1983). Under each heading is a description of the

item and the clinical sources from which the ideas were drawn. The separation of these issues is, naturally, artificial. Interrelationships between constructs are apparent i.e., self-hatred and body-hatred. No individual will exhibit all of these qualities, nor will the issues be equally strong in different individuals.

The Phenomenological Experience Of Binge Eating

Little has been written about the actual binge experience, yet Wooley and Wooley (1985) write "Nothing does more to increase the confidence of the patient than to have the interviewer ask questions or make comments that convey an understanding of the phenomenology of the eating-disordered patient's experience."

People often describe the experience of binging as operating in a state of mind where their reflective, rational or conscious self is not choosing or guiding their actions. Some describe themselves as not truly conscious while they are on a binge (Johnson et al., 1983; Millman, 1981, p. 132). A degree of dissociation is apparent:

> I remember whole days that were like a fog where I stayed in my apartment eating (Ellin, cited Millman, 1981, p. 132).
>
> The problem with trying to tell you what binging is like, is that the "I" that's telling you this, the "I" that I am most of my life, that is competent and bright and "with it" isn't around when I binge. Sometime before I find myself eating, my normal "I" just fades out and there I am feeding my face, feeling not much of anything, kinda vague and flat and blank. Way far away from the part of me that's stuffing food in there's a disconnected tape running in my head..."you shouldn't be doing this...that's Joe's cake" but it doesn't have the slightest impact on what I'm doing. Binging for me is a kind of non-feeling state quite different from how I usually experience myself (M., cited Wilkie, 1986).
>
> I feel fatigued, "behind the scenes", out of the picture, embarrassed, ashamed and astonished at my behaviour, but mostly

> prey to some voracious, powerful yet voiceless aspect of myself which requires my withdrawal from life and from awareness (R., cited Wilkie, 1986).
>
> It starts with what feels like a mindless, driven stuffing down of food (Orbach, 1982, p. 43).
>
> Sometimes I don't even know I'm binging until I find myself going back to the same cupboards for the third or fourth time or eating something I don't much like, like peanut butter (W., cited Wilkie, 1986).
>
> My sense of time shifts when I'm binging--time warps. It can speed up as in "My God, what has happened to the last two hours? I can't have spent them eating!" to a slow timeless "time-out" space where the rest of the world kind of retreats--it becomes irrelevant and removed from the only reality--me and my eating (N., cited Wilkie, 1986).

Some people describe binging not only as taking place outside of rational conciousness, but, like getting drunk, as an activity that actually produces a state of unconciousness (Millman, 1981, p. 133):

> Food literally anethetizes me. I feel all calm and peaceful and blitzed out when I get stuffed. Everything seems distant and insignficant. I don't feel anything. I suppose there's things to feel, like I never get scared or anxious or depressed like other people. But I do eat. Trouble is, sometimes I wake up feeling hung over--it's a food hang over alright. I don't drink (W., cited Wilkie, 1986).
>
> Binges you don't even taste. I pig out to avoid thinking of something else. Binging happens when I have experiences I don't want to remember, feelings I don't want to keep (Claire Stewart, cited Millman, 1981, p. 133).

Binge eaters may characterize binge eating as being out of control, not so much because they are unaware of what they are doing but because their actions contradict what they believe is right, permissible or good for them (Millman, 1981, p. 134):

> Eating, any eating, is so fraught with "do's" and "don'ts" and timetables and calorie values and all my judgements about "good food" and "bad food" that I hate to eat. But when I binge, I

> really hate it--inside my head I'm yelling at myself "Dont't eat that--it's bad for you," "You'll get fat" and on and on. And there I am, eating away like a pig. I'd be ashamed to let people see how I eat. I'll eat when I'm full, I'll eat when I'm nauseous, knowing all the while that I shouldn't (N., cited Wilkie, 1986).

Eating may be experienced as an assertion of self and an act of self-preservation against outside forces that are experienced as annihilating (Millman, 1981, p. 135):

> I sense that the need to binge is a staving off of extremely disintegrating forces. I experience my binging as a means of keeping me here, connected to the earth and my centre. When I binge I'm trying to reassert control over my life. I put this food from here to here. From out of this into me. It's infantile. Binging is out-of-control taking control. Of course, its a perversion and it's out of control itself, but its origins are to reestablish control (Rose Daniel, cited Millman, 1981, p. 135).

> Sometimes I need to feel full all the time just to be OK. It's like I can't afford to be empty. I don't know why, but I do know that when I feel that way, being full its the most important thing in my life and I make damn sure I'm full all day. I both overeat and binge then, even if my stomach hurts, even if I blow my diet, even if anything (W., cited Wilkie, 1986).

Food is experienced as compelling and overpowering as the binge eater obsesses about it:

> I might wake up and all I can think of is the ice cream in the freezer. I'll say "I shouldn't...No, don't be silly...He'll notice...Not for breakfast...you can't eat that, you ate a lot yesterday" and on and on and I go to the freezer and start eating out of the tub..."just a taste...one more spoonful and that's it...oh, God, it's half gone...I'll have to go out and get some more so he won't know...I can't eat a whole tub of ice cream" but I do. When my husband comes home how can I say "I've lost a whole day of my life, I've eaten all the goodies in the house and I hate myself"? (W., cited Wilkie, 1986).

> Compulsive eating means thinking about food night and day...I would think about the different store I was going to go to and what I would get there. I would remember that little piece of cake in the refrigerator and wait until I could get it. To this day I can tell you where every morsel of food is in our house. I know what's in the gargage and whether I can get it out (Ellin, cited Millman,

1981, p. 140).

Intense self-recrimination usually follows the binge. Schwartz, Barrett and Saba (1985) believe the self-denigration that follows binge eating is the factor responsible for perpetuating Bulimia.

Figure 3 illustrates the cycle of Bulimia.

> I don't hate myself nearly as much as I used to afterwards but I still feel sick and disgusted and loathsome and repulsive. I can't stand having anyone close to me then, they might somehow know how disgusting I really am (W., cited Wilkie, 1986).

> There's no way to express how I feel afterward, it's so horrible. Vomiting makes me feel cleaner and purer, but I'm still disgusted with myself for eating. I can't believe what I do. If I could get rid of the part of me that binges I'd do it in a minute, I'd kill her, she's so awful, she's sick, disgusting, horrible, crazy (N., cited Wilkie, 1986).

The study of 32 binge eaters by Abraham and Beaumont (1982) indicates the range of experiences:

> All patients made a clear distinction between merely eating too much (overeating) and bulimia or binge eating which they described as episodes of overeating which they felt unable to control...All said they usually felt anxious and tense before a binge, and 80% described physical concomitants of anxiety--for example, palpitations, tremulousness and sweating. Feelings of depersonalization and derealization were reported by 75%. Thirty-four per cent of patients described relief from anxiety during the binge, but for 3 patients the relief was temporary and anxious feelings returned as soon as they stopped eating. Sixty-six per cent described freedom from anxious feelings after the binge had concluded.
>
> Seventy-two per cent said that they were free of negative mood states while binge eating. This relief was temporary for 6 patients. Forty-four per cent reported the frequent occurrence of negative feelings after concluding a binge.
>
> From patients' reports, the ability to induce vomiting after a binge appeared to influence the quality of the post-binge mood, those patients who did not vomit being more likely to report negative moods and anxiety.

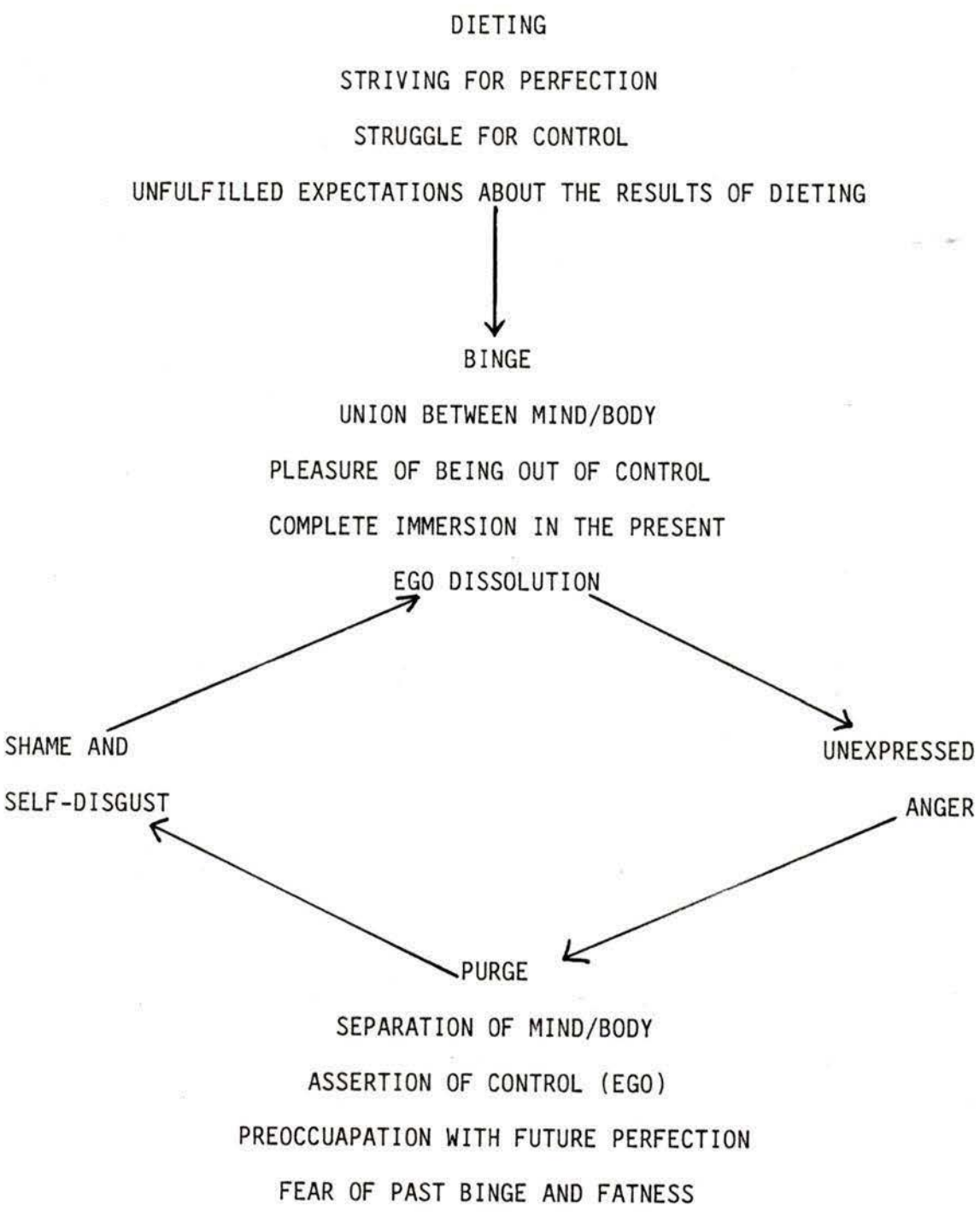


Figure 3: The Psychodynamics of Bulimia

Adapted from Boskind-Lodhal (1976)

1. Body Image: Disparagement, Disowning And Distortion

Three components of body image disturbance will be discussed. Body disparagement is an intense feeling of loathing or body hatred. Body disowning is the separation of the self from the body. Distortion refers to the misperception of the size of the body.

Disparagement of the Body

Dissatisfaction with the body is common for women in our culture (Chernin, 1981, p. 22; Boskind-White, 1985; Wooley and Wooley, 1985), it is not confined to the eating disordered. Among the obese and eating disordered, hatred of one's own body is not universal. However, of anorexics and Bulimics, Wooley and Wooley (1985) write:

> the only experience readily accessible to the typical patient is body loathing, which seems to require no explanation--it is the natural consequence of having a loathsome body, and she expects the therapist to understand this as she does.

Furthermore, bodily perceptions, by their very nature do not readily lend themselves to articulation. They found strong initial resistance to body image therapy: "Feelings about the body are evidently so painful or shame-producing, or communication of them so threatening, that any retreat will be sought" (Wooley and Wooley, 1985).

Bulimics, Boskind-White and White (1983, p.38) found:

> loathed their bodies to a much greater extent than did women with non-food related problems...[They] appear to regard their bodies more critically than so called "normal" women or women with other types of emotional problems regard theirs. They are perfectionists. Thin is never thin enough. Their body proportions are never right. Their breasts are too small, thighs too big and so forth.

The body-hatred of Bulimics seems bizarre to others, as these women are often extremely attractive by current standards but seem unable to

perceive themselves as such (Boskind-White and White, 1983, p. 53). The body-hatred of the obese binge eater, while equally strong may be percieved as "natural" given their size. However, while one might expect body disparagement in all obese people and that it would be central to their problem, Stunkard (1967) writes: "Body image disturbances do not occur in emotionally healthy obese persons and we have found them in only a minority of neurotic obese persons."

The disparagement that exists in the obese is described as:

> the appraisal of his own body as grotesque and even loathsome and the feeling that others view it only with horror and contempt...a preoccupation with obesity, often to the exclusion of any other personal characteristic. It may make no difference whether the person be talented, wealthy or intelligent, his weight is his overwhelming concern and he sees the world in terms of body weight..he envies persons thinner than he and feels contempt for those who are fatter. The intensity of the body image disturbances fluctuates widely even over short periods of time. When things are going well and a person with a body image disturbance is in good spirits, he may be troubled little or not at all by his disability, although it is rarely far from awareness. Let things go badly, however, let a depressive mood ensue, and at once all the derogatory and unpleasant things in his life become focused on his obesity and his body becomes the explanation and symbol of his unhappiness (Stunkard, 1967).

Bruch (1973, p. 100) found the hatred and disgust with the body was:

> only a surface response; it is a concrete symbol of everything one dislikes in oneself and what one considers contemptible and bad. Many will state that their fatness is only what shows on the outside; their deeper shame is their conviction of being awkward and ugly on the inside.

Hartred of the body is frequently independant of how one actually looks and therefore can persist despite radical changes and the correction of the hated feature. The obese person who reduces may find,

much to their surprise their body hatred is as virulent as ever (Stunkard, 1967).

Both Bruch (1973, p. 99) and Stunkard (1967) stress that the hostile attitudes of family to overweight children were a determining factor in the development of body hatred. In families where weight was valued as sign of health and strength, their overweight children developed basically self-accepting attitudes.

Ownership And Identification With The Body

Binge eaters may suffer from a lack of feeling that their body belongs to them and that it is an integral and valuable part of the self. Bruch (1973, p. 102) found that her anorexic and obese clients: "experienced their bodies as not being truly their own, as being under the influence of others. They felt they had no control over their bodies and its function." So extreme was the lack of identification, that anorexic clients lacked the awareness that they and their bodies would be involved and suffer in starvation (Bruch, p. 103).

Millman (1981, p. 180) writes:

> One of the most common adaptations to being fat is to disembody oneself--to live only in one's head. Fat people often think of themselves solely in terms of the "neck up." Their bodies are disowned, alienated, foriegn, perhaps stubbornly present but not truly part of the real self.

It could be argued that disowning the body is not necessarily an adaptation to being fat, but may be a precondition to becoming fat. It is easier to abuse that which is not yours.

Bruch (1973, p. 103) expresses ideas similar to Millman's:

Fat people tend to talk about their bodies as external to

> themselves. They do not feel identified with this bothersome and ugly thing they are condemned to carry through life, in which they feel confined and imprisoned.

The degree of identification of Bulimics with their bodies has not been examined. However, the act of dieting when at a biologically appropriate weight suggests some degree of separation between the self and the body.

Owning the body has been shown to be a precondition to permanant weight loss (Bruch, 1973, p. 91; Colvin and Olson, 1985; Orbach, 1977, p. 91). Colvin and Olson (1985) found women required a major transition to feel their bodies belonged solely to them. Men, apparently, had no need of this as "they never questioned that their bodies were theirs in the first place."

Distortion In Perception Of Body Size

> Body image perception among eating-disordered patients ranges from mild distortion/dissatisfaction to severely delusional thoughts regarding body size. Likewise, the degree to which body image perception affects life adjustment falls along a continuum from mild to severely debilitating (Johnson, 1985).

Body image distortion is a poorly understood phenomenon. The usual perceptual error is overestimation of the size of one's body or of particular body parts. Overestimation is used by obese, Bulimic and anorexic subjects (Garner and Garfinkel, 1977; Wooley and Wooley, 1985). Most anorexics have distorted perceptions of themselves. Complete denial of emaciation, with the conviction the body is grossly overfleshed is typical at extremely low weights. Others percieve their extreme thinness as attractive and "just right." Some can recognize their emaciation. Bruch (1973, p. 89) implies that the stage of illness is a variable in

the anorexics ability to "see" herself as thin. Anorexic patients who persistantly maintain a distorted body image show the poorest response to treatment (Garfinkel et al., 1977; Johnson, 1985).

Bulimics share, to a lesser degree, similar size misperceptions as anorexics. Pyle et al., (1981) writes:

> All the [34 Bulimics] in our series expressed an exaggerated fear of becoming obese and most seemed to see themselves as overweight. Actually most of these patients were quite thin. Twenty-five of the 34 weighed below the median weight for their height...12 of the 34 weighed below the minimum acceptable weight.

The misperception of a client's body size by a parent may be problematic. Bruch (1973, p. 91) describes mothers of fat children who say "They say he's too fat, he doesn't look that way to me," or Crisp et al., (1977) who report the parents of anorexics who place their teenage daughter's ideal weight as prepubertal.

Bruch (1979, p. 90) considers: "a realistic body-image concept is a precondition for recovery in anorexia nervosa. Many patients will gain weight for a variety of reasons but no real or lasting cure is achieved without the correction of the body image perception."

Of anorexic and Bulimic women, Wooley and Wooley (1985) write:

> Complete remission of symptoms is possible only when the patient's body image is such that dieting is no longer considered desirable, necessary or even helpful. A patient can reach this point in more than one way: She can change her attitude toward the ideal body image (i.e., decide that it is not ideal for her). She can change her attitude toward her own body (i.e., decide that even if it is not ideal, she loves it anyway). She can de-emphasize appearence in her life and let self-esteem rest on other attributes. She can decide that being thin and adhering to a low-calorie but nutritionally sound diet are "worth it." This is especially true in occupations requiring thinness, such as modeling, dance, and competitive athletics.

2. Deficits In Introceptive Awareness

The ability to percieve, identify and appropriately respond to one's internal sensations and to discriminate one feeling (i.e., hunger) from another (i.e., sadness) is necessary for healthy functioning. However, the ability to recognize and respond to different body sensations and feelings can be reduced or absent in persons who binge eat (Bruch, 1973, p. 44, 1979, p. 43; Garfinkel and Garner, 1983, p. 148; Orbach, 1977, p. 105; Schacter, 1968, cited Bennet and Gurin, 1982, p. 285; Stolz, 1985).

> At the extremes, one finds the grotesquely obese person who is haunted by the fear of starvation and the emaciated anorexic who is oblivious, or claims to be oblivious, to the pangs of hunger and other painful consequences of undernutrition (Bruch, 1979, p. 43).

Bruch (1973, p. 50) writes:

> I have come to recognize as the crucial issues in many patients with serious eating disorders [anorexia nervosa and obesity] namely, the basic delusion of not having an identity of their own, of not even owning their body and its sensations, with the specific inability of recognizing hunger as a signal of nutritional need... these patients act as if for them the regulation for food intake was outside their own bodies...the nutritional function can be misused in the service of complex emotional and interpersonal problems.

The long and contradictory list of psychological issues associated with obesity which has been chronicled (Bruch, 1973, p. 44; Kaplan and Kaplan, 1957; Stunkard, 1967) and used to discredit a psychoanalytic approach to overeating, could, if Bruch's thesis is correct, be the result of a single fundamental deficit: the inability to discriminate basic body sensations into distinct feelings and needs. Of obese people she writes:

> Many fat patients, when questioned on this point, will answer, with an immediate sense of recognition, that all their lives they had suffered from such an inability...During eating binges they feel driven to eat against their wish not to gain more weight, and even consume food they ordinarily dislike. They experience neither hunger nor pleasure nor satiation during this kind of eating. They may find temporary relief from the anxious and depressive feelings that have been mistakenly experienced as "need to eat," but it is short-lived and the cycle of "not feeling right" and unsatisfying eating is endlessly repeated (Bruch, 1973, p. 45).

Russel (1979) considers failure of satiety in his Bulimic clients. Pyle et al., (1981) writes that 29 out of 34 Bulimics "had difficulty eating regular meals when they were not binge eating. They reported they had difficulty knowing when they were full at the end of a "normal meal."

Deficits in introceptive awareness can vary from vague confusion in affective labelling to a complete distrust of one's internal state (Garfinkel and Garner, 1982, p. 149). Of anorexic clients Garfinkel and Garner (1982, p. 148) write:

> Anorexics have remarkable difficulty in focusing on, and accurately reporting, their emotional and physical states...Inquiries about their emotions may result in defensive or hostile responses to what is viewed as an intrusion into an area that they do not understand. Often they are evasive or vague about their sensations and feelings. At other times, their sincere attempts at self-reporting lack congruence or conviction and have a "parrot-like" quality. Apparently flippant comments, such as "I guess I should feel angry or maybe happy--take your pick," may reflect confusion rather than indifference. A common complaint is the feeling of emptiness, hollowness or blankness inside.

Because of deficits in internal awareness, binge eaters may be unduly reliant or influenced by external factors. The "externality" of the obese has been a topic of much research (Bennet and Gurin, 1982, p. 34). Brice (1981) describes compulsive overeaters as externally focused:

they blame external forces for the emotional feelings that lead to overeating and look to external sources or "magic" to force them to stop.

> The anorexic's conviction that others are more attuned to her inner world than she is herself may be behind complaints of feeling controlled, dominated, and exploited by others. For example, another patient explained that, when others showed pleasure at her eating, she could not continue because she was not sure whether she was eating for herself or for them. It was as if eating were not intrinsically under her own area of influence (Garfinkel and Garner, 1982, p. 149).

3. Self-Hatred

Hatred of the self, whether generally or specifically after binge eating, is one consistant finding for all categories of problem eaters, whether they have anorexia nervosa (Bruch, 1973, p. 101, 1979, p. 144; Crisp, 1980; CSAB, Anorexia Nervosa; Garner and Bemis, 1985), have Bulimia (Boskind-White and White, 1983, p. 16, CSAB, Bulimia; Weiss and Ebert, 1983), are obese (Gormally et al., 1982; Cohen, 1977; Griffin, 1985; Loro and Orleans, 1981) are complusive eaters (Brice, 1981; Orbach, 1977, p.69; Stolz, 1985) or are from normal populations (Hawkins and Clement, 1980).

Brice (1981) eloquently covers the main points:

> I have never met a compulsive overeater with a 'good' self image. The (C.O.er) who is overweight usually hates the size and shape of her physical body, and relates this emotional feeling directly to her sense of human worth. The (C.O.er) who is not overweight usually does exactly the same. I have worked with (P's) who were actually underweight...and they have told me how awful they look and feel. And, more importantly, these people have the infallible belief that they are worthless human beings.
>
> Also I think the personal rating system these (P's) adopt is far more intrinsic than is often thought. Many overweight (P's) will devoutly deny a poor self image, but nevertheless act in ways to substantiate the fact of it. Their conscious evaluation is

> rationalized in terms of equality, and they insist they are "as good as the next person". Their automatic or subconsciously motivated behavior however, is usually something of a paradox. These (P's) typically have a desperate need to be loved and approved of. They seek secure love relationships, and are seldom satisfied when they have them. They tend to be very suspicious of their partner's loyalty, and often create pressures that the relationship can't stand. This comes from the belief that they are not worth being loved. Almost classical in this regard is the need to achieve perfectly in most, if not all, of their daily endeavors. These people rate their personal value as humans in terms of both the (number of) people who like and approve of them, as well as how perfectly they perform and how attractive they look.
>
> Possibly the most important point...is that when the (P) fails to achieve these super-human tasks, it is easy to seek solace in eating food. In the cases where a weight [or eating] problem has been present for some years, the (P) often lose sight of the fact that they had these negative perceptions of self <u>before</u> they gained weight.

> One might say that anorexia nervosa by its very existance proves that the hateful self-contempt is not really related to the excess weight, but to some deep inner disatisfaction. Not one of the anorexic patients whom I have come to know over the years had set out to reach this state of pitiful emaciation. All they had wanted to achieve was to feel better about themselves. Since they had felt that "being too fat" was the cause of their despair, they were determined to correct it (Bruch, 1973, p. 101).

> Deep down every anorexic is convinced that her basic personality is defective, gross, not good enough, "the scum of the earth," and all her efforts are directed toward hiding the fatal flaw of her basic inadequacy (Bruch, 1979, p. 114).

Actual overweight, perceived overweight, binge eating and/or vomiting, and self-disgust at their behavior can all be blamed for the binge eater's feelings of being unworthy and unlovable (Boskind-White and White, 1983, p. 49; Orbach, 1977).

In addition to a basic assumption of being "a worthless human being," they may be actively and constantly evaluating their self-worth on their performance of self-imposed and extreme weight or eating goals. By dismissing, invalidating, or not recognizing any other aspect of the

self, they infer their self-worth from their weakest and most problematic area. Weight is an attractive measure as it is unambiguous, observable, quantifiable and has positive social connotations (Garner and Bemis, 1985). Many Bulimic women, as the binge/purge behaviour increases in intensity, will conclude that the Bulimic part of their personality is the "real" woman. This belief then undermines successes experienced in other areas of life (Boskind-White and White, 1983, p. 33).

Mahoney (1974, cited Garner and Bemis, 1985) writes of a "cycle of inflationary self-evaluations" where "the replication of past excellence becomes routinely expected and future endeavours must always set new highs." The ever-escalating standard becomes self-defeating as person experiences diminishing returns for their efforts in dieting and in weight loss.

Self-acceptance independant of performance and unconditional positive self-regard are likely to be foreign concepts to the binge eater (Boskind-White and White, 1983, p. 39; Brice, 1981; Garfinkel and Garner, 1982, p. 281).

The "infallible belief that they are worthless human beings" may explain two aspects of the psychology of binge eating: the desire for magical personality transformations (Boskind-White and White, 1983, p. 98) and the choice of weight control to achieve that end. If one is worthless, only transformation will provide worth; there is nothing within of value to bring to light. Similarly, if one's qualities are of no value, weight is, at least, controllable, changable and valued by

society.

Self-Hatred After Binge Eating

Intense feelings about the self usually follow binge eating.

In a study of a normal college population Hawkins and Clement (1980) found that of the 125 women and 23 men who reported binge eating episodes:

> Thirty-three women (23 normals, 10 overweights) stated that they "hated themselves" after a binge, while no male subject felt this way. Forty-seven women (34 normals, 13 overweights), but no men, reported becoming "moderately" to "very" depressed after having gone on a binge.

Gormally et al., (1982) studied three groups of obese: severe binge eaters, moderate binge eaters and no-binge eaters and found:

> Another notable difference between the three groups was the emotional consequences of overeating. Severe binge eaters react to their loss of control with extreme guilt and self-hate, while moderate bingers appeared more tolerant of their lapses. The non-bingers reported little emotional responses to their overeating, which may be a function of their view of overeating as doing something enjoyable rather than losing control.

4. Split In Self-Concept

Major discrepancies between the "thin self" and the "fat self" and between the "inner self" and the "public self" are common in binge eaters (Bruch, 1973, p. 100; Orbach, 1977, p. 83).

A person's self-concept may be split into ~~have~~ two components: their "thin self" and their "fat self" (Bruch, 1973, p. 100; Orbach, 1977, p.75, 1985). The association of particular personal qualities with particular body weights may undermine attempts to stabilize weight and eating patterns (Orbach, 1977, p. 87).

Bruch (1973, p. 100) writes:

> Many speak quite openly of feeling like a dual person, a fat one and a thin one. "I seem to be two people; one wants to be thin, but the other wants to be fat." When asked about the personality of the fat and thin person, it turns out that many fat people conceive of the thin person as one who is doing everything that is expected of a young girl, who is conforming, studying, socially active, well-groomed, and well-dressed, but who deep down is a selfish and undesirable person who lacks inner qualities and values and who relies on looks, is ruthless, and babbles socially, "having a line." In contrast, the fat girl, the one who procrastinates with her studies, who is unhappy about moping around the home, who is the constant butt of her parents' and friends' belittling remarks, is deep down a worthwhile person, kind and considerate, honest in dealing with people and truly valuing her friends. The deepest pain is felt because the family and society at large praise and admire the thin one, regardless of her selfish and ruthless traits, and devalue and despise the fat one with the much more valuable human qualities.

Orbach's (1977) book, "Fat is a Feminist Issue" is largely devoted to the discrepancies compulsive eaters experience between their fat selves and their thin selves. Generally the attractions of being thin are concious: being healthy, admired, light, attractive, energetic (p.75), whereas, the attractions of being fat are unconcious but active in promoting compulsive eating and weight gain (p. 42).

> Women unconciously fear being thin. If one is thin then one is expected to fit the norm. If one is thin others will equate conforming in body size with conforming with stereotyped female behavior. If one is thin how can one be self-defining? It is precisely these confusions that keep many women away from permenant thinness, and it is these underlying issues that need to be confronted so that a woman can experience the choice of being thin and being herself (Orbach, 1977, p. 103).

Bulimic and anorexic binge eaters also have a split in their concepts of "fat" and "thin" and an inability to define themselves as different than the implied meanings of their size. Wooley and Wooley (1985) write:

> They described how being small was associated with being alone,

> having no demands placed on you. When large, "You have to take care of everyone else." There was apprehension about the selflessness and nurturance implied (demanded) by largeness. It was not an image of strength or independence, but of enslavement.

The discrepancy between the inner and outer self may be most startling for Bulimic people, as they appear normal in terms of weight, and social and professional competence. Their outer appearence seldom reveals the intense misery they describe (Russel, 1979). "Some of these women feel as though they have split into two people. One is the competent woman the outside world sees, the other is the driven, out-of-control woman who will cheat, steal or lie to satisfy her urge to binge" (Boskind-White and White, 1983, p. 33). The external world does not see the out-of-control part of her and the "binging" part cannot acknowledge the assets of the public part (Boskind-White and White, 1983, p. 50).

Behind a facade of independence, is often a need for dependancy that is not expressed in obvious ways (CSAB, Bulimia; Johnson, 1985; LeClaire and Berkowitz, 1983). Of eating disordered people with a "false self" personality organization, Johnson (1985) writes:

> Progressively, the patient feels that she is two people: one who appears to be competently in control of things, and another who feels needy and out of control. The wish-fear dilemma revolves around the patient's wish for someone to identify and respond to her needs, which is juxtaposed against her fear that allowing someone to see the needy and dependent side will collapse the self-esteem and self-organization that has evolved...Food, for these patients, is their safest and most trusted ally. Essentially, they will allow themselves to behave in the presence of food in ways they would not allow any other person to observe. They will also invest food with the ability to regulate different tension states. Allowing a person to help with these feelings would mean risking too much exposure.

5. Drive For Thinness

Garner et al., (1983) define "drive for thinness" as excessive concern with dieting, preoccupation with weight, and an entrenchment in an extreme pursuit of thinness. It reflects both an ardent desire to lose weight as well as a fear of weight gain. While anorexic and Bulimic clients may be more successful in becoming thin, the drive for thinness is independant of any weight category.

The drive for thinness includes obsessive thoughts of food, eating, and weight, "feeling fat" regardless of actual weight, investing a particular weight with personal meaning, and fearing fat.

The actual time a person spends binging (and/or purging) is misleading and irrelevant; the time spent thinking about food eating and weight is the real handicap. A problem eater may spend virtually every waking minute thinking about what to eat, what not to eat, when to eat, when not to eat, how much to eat, how fat they feel, how soon they can lose it, how much they ate yesterday, how to hide the pound they have gained, what to do about that dinner invitation, how to avoid the bakery on the way home, fearing they won't avoid the bakery on the way home, etc., etc., etc. (Boskind-White and White, 1983, p. 44; Brice, 1981; Russel, 1979) with a resulting impairment in concentration and energy.

Hawkins and Clement (1980) found in a survey of a college population that "None of the men but 22% of the normal weight women and 32% of the overweight women reported frequent or constant thoughts of food."

Although Bulimics and anorexics are slim by any standard (Boskind-White and White, 1983, p. 29), they invariably "feel fat".

Fairburn (1985) states: "the thought "I feel fat" may have several meanings, including "I am overweight," "I look overweight to myself," "I look overweight to others"; or it may refer to unpleasant affective states that make the patient feel unattractive." The subjective experience of "feeling fat" is poorly correlated to any weight change.

Many authors (Cooper and Fairburn, 1983; Johnson et al., 1983; Pyle et al., 1981; Russel, 1979; Weiss and Ebert, 1982) describe differences between a person's healthy constitutional weight and their desired ideal weight, typically about twelve pounds. Pyle et al., (1981) writes:

> Thirty-one of the 34 [Bulimics] indicated a "desired weight" (defined as what they wanted to weigh) less than their weight at the time of evaluation, and 20 of the 34 indicated a desired weight below the minimum for their height (small frame). Most chose an "ideal weight" (defined as what they should weigh) very similar to their desired weight, and were not concerned that this would be too thin.

Another aspect of the drive for thinness is the personal significance of a particular weight to the individual. Bingers (particularly anorexic and Bulimic) will attach excessive importance to a ceiling weight which they are reluctant to exceed (Fairburn, 1982; Russel, 1979). If under the ceiling weight, the person may feel some self-esteem, if over the threshold, they are susceptible to intense self-recrimination. Boskind-White and White (1983, p. 37) describe a woman who is 128 pounds and 5' 6", and feels "very unattractive if I'm over the weight I desire by even one pound." Often the person will strive to weigh a few pounds less than their desired weight as a safeguard against binge eating (Russel, 1979).

Orbach (1977, p. 155) writes of the power given to numbers:

> Compulsive eaters are frequently hooked on scales. Every morning or night there is the ritual of evaluation; one finds out whether one has been "good" or "bad." The pounds of wisdom have in the past given one the right either to binge or to starve. In general, for the compulsive eater, the scales are the real judge. If you have done well (lost weight) then the scales allow you to eat. If you have done badly (gained weight) the scales throw you into a depression only relieved by a binge or a plan to lose the weight yet again.

Beyond feeling fat, binger eaters fear fat. Russel (1979) characterizes Bulimics as having a "morbid fear of fatness...fearing fatness which they described in excessively harsh terms out of keeping with sensible standards." Garfinkel and Garner (1982, p. 150) report:

> Anorexics frequently report fearing that if they take one bite of food they are not going to be able to stop eating and will suddenly develop into grotesque obesity. This terrifying possiblity is countered by rigid control of eating.

Similary, Orbach (1977, p. 107) asserts "the compulsive eater is quite afraid of food and what it can do to her."

6. Ineffectiveness

This construct includes feelings of general inadequacy, insecurtiy and not being in control of one's life. Locus of control is a part of this concept (Garner et al., 1983). The literature clearly demonstrates that binge eaters of all types experience a lack of effectiveness. However, different authors emphasize different aspects both descriptively and etiologically. In this area, the separation of description from theory proved too difficult, and so will be presented as found.

An external locus of control is characteristic of binge eaters (Brice, 1981). "External focusing" and "responsibility shifting" are

considered to be central to the problem. Brice (1981) writes: The person who externally focuses blames outside influences for the emotional feelings which lead to overeating, and they also look for an outside or "magic" force to stop them...in their estimation, the fault lies with such things as family tensions or work pressures, loneliness, boredom, anxiety, food manufacturers and advertisers, and the lack of any reliable, ethical or capable type of treatment."

Weiss and Ebert (1983) administered the Nowicki-Strickland Locus of Control instrument to 15 DSM-III Bulimics and 15 controls and found "the bulimics scored significantly lower than the controls in the belief that they had mastery over their own lives. Outside forces such as powerful others and chance were regarded as controlling factors."

Bruch (1977) writes of anorexia and developmental obesity:

> the conspicuous stubborness and negativism are nothing more than a facade over the underlying sense of ineffectiveness and the feeling of being controlled by others from whom they don't feel truly separated. They experience themselves as not owning their own bodies and they feel powerless to exercise control over their bodily functions or to direct their lives in general. Helpless and ineffective, they act and behave as if they were the misshapen product of someone else's actions, as if their center of gravity were not within themselves.

Bruch (1973, 1979) attributes this sense of ineffectiveness to developmental deficits based on faulty mother-child interactions.

Boskind-White and White (1983) found Bulimics felt powerless and readily gave men the power to define how they should think, feel and act (p. 127). Many Bulimics act "as if they were in dire need of being rescued," and would readily trade their individual talents and careers for release from responsibility for the self (p. 120). The "myth of

feminine fragility" that these young women have learned (p.89) has left them with "crippling and irrational fantasies about their own fragility, helplessness, and powerlessness" (p. 86). Ineffectiveness is attributed to "learned helplessness" (p. 158) inherent in the socialization to be passive, dependant, and approval-seeking.

Whatever the developmental history contributes to ineffectiveness, the constant attempts to control one's food and weight increase and reinforce a sense of personal ineffectiveness. Wooley and Wooley (1980) write "others show progressive degrees of preoccupation with a problem they cannot solve."

> The compulsive overeater is failure oriented. After what has usually been numerous abortive attempts at reducing, the belief is firmly established that there is very little hope of ever acquiring the longed-for slimness. Every failed attempt, every unsuccessful diet or exercise programme further reinforces the hopeless feelings...The never ending battle of try, fail, try-again, fail-again, is nothing more than a vicious cycle of negative belief compounding (Brice, 1981).

Gormally et al., (1982) found a low personal efficacy combined with high standards to increase the likelihood of binging. A binge is then interpreted as a need for even stricter control in future.

Control is a critical issue for binge eaters of all weights. Riebel (1985) considers the "obsession with grasping and maintaining control, so important to the eating disordered client" as a "reaction formation against a desparate sense of powerlessness."

Assertion of control over the body, usually by beginning a diet, is a choice made by many women when control over their world is threatened (Orbach, 1982, p. 29; Wooley and Wooley, 1980). Dieting can initially

be associated with feeling "marvelous, pure, uncriticizable, almost high" (Orbach, 1977, p. 88). "Dieting provides a sense of meaning and purpose--a distraction from pain, loneliness, and insecurity. Many girls derive feelings of power from this form of self-denial...[It] can create tempory feelings of self-esteem (Boskind-White and White, 1983, p. 100). Wooley and Wooley (1980) state:

> It seems to be a reasonable hypothesis that for many women, the ability to control food intake and body weight becomes a symbol or index of the ability to control life in general, with the result that successes are experienced with a pleasure disproportionate to the tangible social or physical benefits of reduced body weight, while failure is experienced as profoundly demoralizing. This phenomenon is widely recognized as a central feature of anorexia nervosa, but it is rarely discussed in connection with overweight. We have observed that women often seem to seek psychological treatment for overweight when the sense of ineffectiveness produced by diet failures has generalized to other areas of living or, the converse, when they attempt to counteract a sense of helplessness in areas unrelated to eating by reinstating control over food. The control over food produces an almost "artificial" sense of power. Although weight loss per se may be irrelevant to the real source of difficulty, the feeling of control may "spill over" with good results. This effect is apt to be temporary, however, since weight is usually regained.

Weight control can be understood as a metaphor in many women's lives (Wooley and Wooley, 1980). However, ultimately, food and weight control is ineffective in resolving existential dilemmas, interpersonal problems, or social/political inequities.

Control over rejection may be involved in the manipulation of body size. For example, McLeod (1981, p. 104), a recovered anorexic, writes "in becoming so thin as to render myself totally undesirable sexually, I was saying, 'I may be unattractive, but this is because I choose to be this way.' when really she felt there was no hope she could succeed as a

woman. Similarily, Millman (1981, p. 137) states:

> Many fat children feel their parents do not love them or would only love them under certain conditions. To assuage this painful feeling, many flaunt their excess weight, convincing themselves that they have personally triggered rejection by choosing to be fat...women often gain a few pounds to achieve a false sense of control over their husband's lack of sexual interest. The implication is that they could attract their husbands again any time they choose to go on a diet.

7. Maladaptive Cognitive Patterns

Limiting mental patterns have been described in different ways by various authors: irrational beliefs (Ellis, 1962, 1974), logical errors (Beck, 1976), personal constructs (Kelly, 1963), deep structures (Bandler and Grinder, 1975), second-order reality (Watzlawick, 1976), scripts (Berne, 1961, 1976), early decisions (Goulding and Goulding, 1978). Included are thoughts, attitudes, beliefs and values of which the client is aware, as well as the implicit, unarticulated underlying rules of which they are unaware. Usually the problematic beliefs are extreme or concretized (Bruch, 1979, p. 48) forms of widely held social attitudes; it is their strength, personal significance and inflexibility that render them dysfunctional (Fairburn, 1985).

Bruch (1979, p. 144) writes:

> patients will adhere to their distorted concepts, the false reality with which they have lived, since it represents their only way of having experiences and communicating; they will let go of this only slowly and reluctantly. Their whole life is based on certain faulty assumptions that need to be exposed and corrected.

For anorexia nervosa, maladaptive attitudes and beliefs about eating and weight frequently persist in clinically recovered as well as symptomatic patients (Garner and Bemis, 1985) and are sometimes referred

to as "anorexic thinking." Dally and Gomez (1979) concluded that abnormal attitudes to food and weight are among "the most distressing and long lasting features of anorexia nervosa...and are likely to continue or recur in situations of crisis for many years" (cited Garner and Bemis, 1985).

Behaviour that appears bizarre or dysfunctional is likely to make perfect sense within the context of the governing belief system. The eating disordered may be operating out of a "weight-related self-schemata" (Garner and Bemis, 1985). For example, a binge eater may believe "it is absolutely essential that I be thin," assume that her self worth is fundamentally dependant on achieving a low weight, and expect thinness will merit respect from of others.

Dichotomous Thinking

Typically, binge eaters use all-or-nothing, black-or-white, good-or-bad, either-or reasoning. This results in absolutist, moralistic and perfectionistic positions; splitting is a term commonly used to describe this phenonemon (Garfinkel and Garner, 1982, p. 272).

The division of food into "good" and "bad," "moral" and "immoral" categories, the fear that gaining a pound is tantamount to obesity, the equation of any deviation from rigid dietary control as total personal failure are examples of dichotomous thinking. Common moralistic attitudes are: thin is good, fat is bad; hunger is good, eating is bad; total control is good, spontaneity is bad.

> Much of the dichotomous logic revolves around volitional issues related to self-control: "If I am not in complete control, I will lose all control," "If I learn to enjoy sweets, I will not be able

> to restrain myself," "If I stop exercising for even one day, I will never exercise," "If I enjoy sexual contact, I will become promiscuous," "If I become angry I will devastate others with my rage." (Garner and Bemis, 1985).

Dichotomous thinking applied to the qualities of the self will provoke strong fears. The person experiences " a precarious hold on one quality (courage, restraint, etc.) which was always poised to slide ignominiously, permanently into its horrid, unacceptable opposite" (Riebel, 1985). If one is not silent, one becomes a complainer, if one is not a success, one becomes a failure, if one is not perfect, one becomes worthless. The belief that characteristics such as self-control and independance must be completely and continously maintained leads to idealized and unattainable notions of happiness, self-confidence and success (Garfinkel and Garner, 1985, p. 272).

Other people, including the counsellor, are considered to be either perfect human beings or intolerable monsters (Garfinkel and Garner, 1982, p. 273; Garner and Bemis, 1985). Women may invest their men with "heroic qualities" in contrast to their own sense of worthlessness (Boskind-White and White, 1983, p. 113). Absolutist attitudes may also be evident in the pursuit of sports, school, career and social acceptance.

Perfectionism is the manifestation of dichotomous reasoning most commonly cited (Boskind-White and White, 1983, p. 106; Brice, 1981; Browning, 1985; Bruch, 1979, p. 155; CSAB, Bulimia; Garner, et al., 1983; Gormally, et al., 1982; Kubistant, 1982; Lucas, 1981).

> Bulimarexics expect themselves to be perfect; that is, void of any faults. The more they try to live with these expectations,

> however, the more they become aware of their faults and feelings of worthlessness...Their usual response to this awareness is to increase the control over their lives. And what better area to have total control than over their eating habits. "In each case their efforts to perfect themselves through dieting has led them to their first eating binge. After the binge came a renewed compulsion to lose weight (Boskind-Lodahl and Sirlin, 1977, p. 50)...The more they try to perfect and control their lives through discipline and purging the more they ensure they will eventually binge. Thus, the existing distorted belief system and eating cycles are perpetuated and even intensified (Kubistant, 1982).

Constantly comparing one's self, one's body, and one's performance to others, invariably to one's detriment is a aspect of perfectionism. Riebel (1985) suspects "the food-obsessed notice only those who stand higher than themselves"; they discount their successes, escalate their goals, and shift their reference group to the next higher rank.

Vows to reform, declarations of radical change by binge eaters are more perfectionistic demands on the self and exaccerbate the control problems. Gormally et al., (1982) describe a typical binge eater who would say "Today will be a perfect dieting day," but did not believe herself as she had broken that vow so often. Boskind-White and White (1983, p. 166) consider expectations such as "I will never binge again" or "I am going to give this up forever" to be counter-productive. Negative expectations such as "I know I'll never be binge free" are a commitment to failure and perpetuate binge eating patterns.

The most extreme perfectionistic stance is the anorexic's grandiose position of "life is not worth living unless one is perfect" (Goodsitt, 1985). Boskind-White and White (1983, p.39) note the concept of "I may not be perfect, but parts of me are excellent" is foreign to Bulimics.

Errors of Attribution and Personalization

Attributing cause to the wrong source is an error of attribution. An example is attributing monthly fluid changes from the menstrual cycle to overeating (Fairburn, 1985). A common error of attribution is personalization: making ego-centric interpretations of impersonal events or overinterpreting events relating to the self (Garfinkel and Garner, 1982, p. 273; Garner and Bemis, 1985). "Believing one's behavior is the center of other people's attention...is dysfunctional as it allows a person to infer disapproval from others and contributes to self-degradation" (Garfinkel and Garner, 1985, p. 273).

A common error of attribution, imputing rejection to being too fat, can tragically precipitate an eating disorder:

> Many women also say that a rejection (generally by a boy) in adolescence was the traumatic event that precipitated their first diet. More often than not, however, the girl fantasizes that she has been rejected because she is too fat. Most actually never heard this from the boys who rejected them..."My first real boyfriend dropped me without any explanation. All I felt was rage at myself for being so fat and ugly and I vowed never to be that way again." (Boskind-White and White, 1983, p. 98).

A binge eater may have personal, very strict standards for herself. For example, a Bulimic woman may be willing to accept that thinness or high achievement is not necessary or desirable for everyone, but have great difficulty in modifying her feelings about her own thinness or achievement (Riebel, 1985; Wooley and Wooley, 1985).

Superstitious or Magical Thinking

Superstitious or magical thinking is the belief in a cause-and-effect relationship between unrelated events (Garfinkel and Garner,

1982, p. 157). Riebel (1985) identifies superstitious beliefs in terms of "if-then" statements: If I feel or do A, then B is the dreaded consequence. Examples are: "If I give into pleasure, I will want a lot of it," "If I dwell on my success, then it will go away," "If I give up binging, I may become an alcoholic."

Boskind-White and White (1983) give a number of examples of magical thinking used by Bulimic women: "A common fantasy is that their lives would be transformed if only they were thin enough (p. 174)...In searching for "magical cures" for their existential crises, both groups--preanorexics and prebulimarexics--focus on THE DIET as their ticket to success and happiness.(p.35)...young women who believe that if they can conform to the ideal, be perfect in body, life's major problems will be magically solved" (p. 58).

A particular weight may be a "magic weight" of particular biological or psychological significance (Garner and Bemis, 1985).

Millman (1981, p. 192) writes:

> Wheras other stigmatized characteristics (such as a physical deformity or an "ugly" face), do not lend themselves to fantasies of before and after, obesity does. The fat person is always theoretically capable of getting rid of her problem: weight can be lost, transformation achieved. Thus many fat [and those who believe themselves to be fat] people, assuming life will start in earnest after thery are thin, postpone living.

Magnification

Magnification is an overestimation of the significance of undesirable consequent events (Garfinkel and Garner, 1982, p. 157). Examples given are: "gaining 5 pounds would push me over the brink", "If others comment on my weight, I won't be able to stand it", "I've gained

2 pounds so I can't wear shorts any more."

> "Catastrophizing" may be seen as involving the absolutistic DEMAND that something MUST or MUST NOT happen, and this psychological stance virtually always leads to anxiety, regardless of the outcome. The patient who DEMANDS thinness in order to be happy is obviously anxious when she considers herself "fat." (Garner and Bemis, 1985).

Boskind-White and White (1983, p. 163) describe Bulimic women as prone to "rehearsing for catastrophe" as they approach new or challenging situations, and this pattern contributes to binge eating.

Judging Emotions and Sensations

Beliefs about the appropriateness, acceptability or justification of any emotion can conflict with the experience and expression of that feeling. Rules about the acceptability of a feeling, and overreliance on external sources to determine what one should feel can be maladaptive (Garner and Bemis, 1985; Boskind-White and White, p. 121).

> The inconsistancy between a patient's experience of an emotion and her judgements about its appropriateness often lead her to the conclusion that the feeling must not really exist. For example, one patient assumed that anger was appropriate if its objects were malevolent in every regard. In trying to decide whether or not she was angry at her mother, her reasoning followed this syllogism: 1) I could only be angry at my mother if she were a bad person; 2) my mother is not a bad person; and 3) therefore, I must not be angry at my mother. Her "logic" disregarded her experience as sufficient validation of her anger; the result was confusion about the feeling (Garner and Bemis, 1985).

Judgements about body sensations, particularly hunger and satiety, as "correct" or "incorrect" will result in distorted perceptions and the eventual inability to accurately identify the sensations.

> Food, eating and satiety, usually associated with pleasure, become NEGATIVE events, while dieting and hunger acquire the new positive meaning of "virtue" and "self-control." The need to eat is deprecated as bad, wrong, or even disgusting. Biological signals

> indicating its presence are systematically ignored or suppressed. From this converse system of meanings, a myriad of logically consistent beliefs develop that contradict the bodily messages related to hunger and satiety...Trust in "natural" biological processes is replaced with "intrapersonal paranoia" (Selvini-Palazzoli, 1974) (Garner and Bemis, 1985).

Internal Dialogue

Schwartz et al., (1985) refer to the:

> incessant internal argument which it seems all bulimics are cursed...a bulimic can usually identify at least two separate "voices" in these internal dialogues, which represent two fairly distinct parts of her. Ususally one is hypercritical and demands perfection while the other is rebellious, is impulsive and advocates extremes of self-indulgence.

One part of this dialogue can be a litany of "shoulds" about food, eating, weight, performance (Garner and Bemis, 1985; Schwartz et al., 1985). Binging may be the person's only means to express non-compliance or rebellion against harsh and overcontrolling demands. White (1985) believes women binge (and purge) when "the child within them" has no other avenue for expression. In Transactional Analysis terms, the ego states in operation in a diet-binge cycle are: Critical Parent, Adapted Child and Rebellious Child (Lister, Rosen, and Wright, 1985).

Past / Present / Future

A maladaptive cognitive pattern identified by Boskind-White and White (1983, p. 163) of Bulimics is their focus on the past or future at the expense of the present. "When confronted by a situation that is moderately challenging, they look to the past for coping strategies (binging) or look ahead and rehearse for tragedy (nothing will work out)." They encourage the binge eater to ask themselves "What tense am I in?", to talk to themselves in the moment and to take a "present,

action-oriented attitude."

Life Scripts

Life scripts are persistant core beliefs that people use to structure their lives. Lister et al., (1985) write:

> The most common fat-making script is the "loveless" or "looking for love" script (Bruno, 1978)...The most common script driver messages (Kahler, 1974) we have found among overweight people are:
>
> Be Perfect
> Please Me (often "look after mother")
>
> The most common injunctions (Goulding and Goulding, 1979) are:
>
> Don't Exist
> Don't Be You
> Don't Be Important
> Don't Feel (especially anger)
> Don't Grow Up ("Be Daddy's Little Girl")
> Don't Think (in certain areas)
> Don't Be Sexual
> Don't Be Close
> Don't Cry

8. Interpersonal Difficulties: Barriers to Intimacy

Binge eaters are likely to be socially isolated, or involved in relationships that lack intimacy (Boskind-White and White, 1983, p. 46; CSAB§ Bulimia,). Bing eating episodes are time-consuming and the obsession with food takes energy that others use is self-development and social contact (Leclair and Berkowitz, 1983; Boskind-White and White, 1983, p. 106). Of Bulimics, Leclair and Berkowitz (1983) write: "even though they long for companionship, they may, in fact, retreat to the safety of focusing on food and eating rather than undergo the risk of relating to people."

In a study of social adjustment by Johnson and Berndt (1983), 80 Bulimic (DSM-III) women were found to have a pattern of life impairment most comparable to the alcoholic women's pattern. The authors conclude:

> Although the results of our study do not allow us to conclude that the bulimic symptoms are responsible for the observed impairment in

> life adjustment, our clinical observations suggest that the deterioration in functioning is a result of progressive involvement in the chaotic eating.

Two obstacles to satisfying relationships are shame and secrecy about binge eating and purging. Binge eating is experienced as uncontrollable, inexplicable, disgusting, freakish, bizarre, abnormal and frightening, but most of all as shameful.

Secrecy is used to hide the shameful aspects from others:

> The secretiveness associated with bulimia leads to dishonesty even in primary relationships. For instance, women report dreaming up excuses to get rid of boyfriends or spouses long enough to engage in binge-vomiting episodes. The typical lack of assertiveness and the avoidance of dealing with negative feelings further impede the bulimic's development of close, intimate relationships. Additionally, the constant preoccupation with food intrudes. It is difficult to participate in conversation, for example, when all one can think about is food. A comment or two may be thrown into conversation occasionally so that the preoccupation won't be so obvious, but often conversation has little meaning for the bulimic individual (neuman and Halvoerson, 1983, p. 58).

Boskind-White and White (1983, p. 46) found the basically dishonest life style of the bulimic was a prime obstacle in their failure to create close relationships with either men or women:

> It is not surprising that bulimarexics have few friends--so much of their time is spent in supporting their habit and in keeping others from knowing about it. Some refuse to answer the telephone or the doorbell while under the influence of their "fat attacks." Others are simply too worn out from binging to accept invitations or are afraid they will not be able to keep the date when the time comes. "If I was binging and someone knocked on my door, I wouldn't answer, I'd tell people I'd be there and never show up."

Garner et al., (1983) use a construct of "Interpersonal Distrust" to describe people with anorexia nervosa. It "reflects a sense of alienation and a general reluctance to form close relationships...it is to be distinguished from paranoid thinking and relates to an inability

to form attachments or feel comfortable expressing emotions towards others."

Neuman and Halverson (1983, p. 58) write:

> While bulimics tend to be more extroverted than their anorexic counterparts who are not bulimic, their relationships nevertheless tend to be superficial and lack genuineness. They are adept at distancing themselves from people even while seeming to be very friendly and sociable. The bulimic's underlying fear and belief is, "If this person really gets to know me he or she won't like me."

The psychological aspects previously described may interact to further distance binge eaters from people: They expect few conditional "strokes" from others and no unconditional ones (Lister et al, 1985). Their investment in perfection, their belief in their own unlovability, their difficulty appropriately asserting themselves contribute to difficult relationships. The "split" in the self and the desire to hide the unwanted parts of themselves make it hard for them to be genuine. Their harsh self-criticism is projected onto others and they believe others will be as harsh to them as they are to themselves. Indeed, they may be extremely sensitive to any real or percieved criticism to which they are ever vulnerable because only perfection is OK.

9. Adaptive Functions

A number of authors (Boskind-White and White, 1983, p. 50; Brice, 1981; Bruch, 1973, p. 44; Crisp, 1980; Garner and Bemis, 1985; Millman, 1981; Orbach, 1977, p. 11; Stolz, 1985) have independantly identified ways in which people "misuse the eating functon in their efforts to solve or camouflage problems of living that to them appear otherwise insoluble" (Bruch, 1973, p. 3). Like other psychological problems, food

abuse and manipulation of body size can be adaptive, that is, the presenting "problem" functions as a "solution" to other difficulties. Orbach (1977, p. 62) writes:

> Because the syndrome of compulsive eating, compulsive dieting, weight loss and weight gain is so highly developed and, in a sense, so absorbing a preoccupation in itself, it may be hard to get outside it enough to realize just what it is doing for you. In a sense, compulsive eating provides a beautiful, insulated world: obessing about how terrible you are for overeating leads to feelings of self-disgust; these feelings have no outlet and are quickly covered up or numbed by the intake of food or banished by the fantasy of reincarnation after the plan for the new diet has been made. All negative feelings get harnessed to complaints and self-loathing about body size and eating habits and the fat [real or imagined] provides a less threatening issue to worry about than other possible problems. It may also be true that while the fat has one meaning for you today, it has had quite another when it originally developed.

Body size and food abuse can be statements about diverse issues that are personal and idiosyncratic (Stolz, 1985). For example, sexual protection is a common function of eating and weight problems (Brice, 1981; Orbach, 1977, p. 60; Stolz, 1985) but if applied indiscriminately discounts the individual's metaphor of distress (Stolz, 1985). Orbach (1977, p. 132) writes:

> In the context of the group, where everyone's fat means something different, it is starkly demonstrated that having the fat speak for you does not necessarily get the message across. Of course, as in the case of unassertive behavior outside the group, the fat rarely succeeds in the job it is meant to do either, but the fantasy can cling. Within the group, not only can one begin to express oneself more directly, but one has to. Without specific articulation the magical meaning of the individual's fat will never come through.

Coping with difficult emotions

Edelman (1981) writes:

> The present results suggest that binge-eating or eating in response to emotional distress happens frequently particularliy among women

> and may occur for a variety of reasons. However, these reasons often vary markedly from person to person. For a given individual, one or perhaps two emotional states are likely to result in binge-eating while other emotional states are relatively unlikely to produce such a reaction...emotional distress is too broad a term to be useful for the purposes of describing the conditions under which people are likely to overeat. Some people eat in response to loneliness, others in response to frustration, anxiety, depression, etc. This finding suggests that laboratory experiments which manipulate only one kind of emotional experience will affect the eating of only a very few people.

Often a binge eater does not feel the difficult feeling but finds herself inexplicably eating instead after situations that would elicit that feeling in others (Wilkie, 1986).

Anger and appropriate self-assertion have consistantly been found to be difficult for people with anoexia nervosa, Bulimia and obesity (Bruch, 1979, p. 152; Boskind-White and White, 1983, p. 49; Garner and Bemis, 1985; Loro and Orleans, 1981; Orbach, 1977, p. 56). Boskind-White and White (1983, p. 49) write:

> The decision to binge, more often than not, is related to the inability of bulimarexic women to assert themselves and deal with their problems in a direct way. Anger is a rare emotion for these women; they have been well socialized to be agreeable, compliant, and nonassertive. Most lack awareness of their inability to express anger...This sense of shame and guilt over their disordered eating pattern also effectively helps them to suppress anger. Thus, the action and problem solving that can follow the experience of anger and assertion--the very things that can result in productive change--are denied to most bulimarexics. They are stuck with ~~with~~ the tried and true "feminine" way of dealing with pain and discomfort.

Women are actively discouraged from feeling or expressing anger, rage, resentment or hostility. Anger as a legitimate emotion for women has no cultural validation. "It is not surprising therefore to find that for many women the unconcious motivation behind the weight gain is

a flight from anger. In this case the symbolic meaning of the fat is a "Fuck You!"" (Orbach, 1977, p. 56).

Examples of other indirectly expressed messages are resentment against family pressure to be perfect coupled with a need to hide (Orbach, 1977, p. 63) or simultaneously covering and exposing the person's percieved terribleness (Orbach, 1977, p. 69). Millman (1981, p. 169) writes of a woman whose fat meant "There is obviously something wrong." For her, "something wrong" was a highly sexualized relationship with her father. For some, food and fat represent "fuel for the furnace" they need to continue to nurture others. For other women, their food and fat represent a rejection of just that kind of service (Orbach, 1977, p. 159).

A woman may be unable to lose "those last few pounds" if she believes everything will be perfect in her life when she is thin. She may unconciously feel that when thin there is no room for pain or sadness, that she must be as perfect emotionally, too.

Protection

Brice (1981) considers psychological protection to be the most common adaptive use of body weight. Orbach (1977, p. 43) writes:

> Being fat felt very safe as though it were an excuse for failure...Some women felt that being fat protected them insofar as it allowed them to contain their feelings...However, the most common benefits that women saw in being large had to do with a sexual protection. In seeing herself as fat, a woman is often able to desexualize herself; the fat prevents her from feeling sexual... many women felt a relief at not having to concieve of themselves as sexual. Fatness took them out of the category of women and put them in the androgynous state of "big girl."

Anorexia nervosa can safely place one in the category of "little

girl." Crisp (1980) concieves anorexia nervosa as a weight phobia designed to keep the female body below the weight threshold necessary for menstruation and female maturity.

Bulimics may use their compulsive eating in the same fashion as overweight binge eaters use fat: as a means to handle difficulties with sexuality. They feel and act as if they were fat. "I'm too stuffed to want sex" "Who'd want to sleep with a pig like me?" (Boskind-White and White, 1983, p. 50).

> A further paradox is encapsulated in the compulsive eater whose imagined sense of herself thin is as the powerfully attractive sexual woman. As she subscribes to the image of the thin, sexual woman--a view offered to her consistently by the mass media--she reaches for the elusive power that this image promises but does not deliver. It is precisely this non-recognition of the person in the thin sexual image that causes her unconsciously to reject this thinness. For many women, "thin=sexy=powerful" is an experience that lasts no more than the fleeting moment when she makes her entrance, her initial impact. After that, her image is appropriated by others and translates into "thin=sexy=powerless" and at the same time she may find no way to handle being thin, sexy and in charge. It is this critical question of how women can define and manage their own sexuality that is being grappled with so often in the fat/thin dilemma (Orbach, 1977, p. 72).

An issue related to sexual protection is sexual competition by women for men. Fat and eating problems may serve to blot out competitive feelings, to feel that because of one's size one is "out of the game", or to protect disavowed competitive feelings from exposure (Orbach, 1977, p. 50, p. 84).

Power / Competence / Strength

Stolz (1985), writing of "foodaholics" of all weights, found food abuse and body size manipulation was a means for some to express competence on the job.

> Another common subconcious reason to remain fat is to give the woman more "power." In a society where she often feels to a greater or lesser extent socially repressed, the fatness symbolically (albeit literally) gives her more weight to throw around. Many feel they will be treated differently and in ways they couldn't handle emotionally if they became slim. At a concious level they may believe they will have more confidence when they lose weight, but this idea doesn't hold good when questioned at a subconcious level (Brice, 1981).

Women may use eating or weight difficulties as a means of avoiding feeling or being "too powerful," of doing "too well," of exceeding their social place. Women have little cultural validation for being powerful in their own right, they have been socialized to yield to others and they fear social isolation. Women caught in the succeed-but-don't-succeed-too-much-dear syndrome are very likely to engage in struggles with the self over weight or eating (Boskind-White and White, 1983, p. 104; McLeod, 1981, p. 165; Orbach, 1977, p. 46).

> Just as many women first become fat in an attempt to avoid being made into sexual objects at the beginning of their adult lives, so many women remain fat as a way of neutralizing their sexual identity...In this way, they can hope to be taken seriously in their working lives outside the home. It is unusual for women to be accepted for their competence in this sphere. When they lose weight, that is, begin to look like a perfect female, they find themselves being treated frivolously by their male colleagues. When women are thin, they <u>are</u> treated frivolously: thin=sexy=incompetent worker. But if a woman loses weight, she herself may not yet be able to separate thinness from the packaged sexuality around her which simultaneously defines her as incompetent. "When I'm fat, I feel I can hold my own. Whenever I get thin I feel I'm being treated like a little doll who doesn't know which end is up." (Orbach, 1977, p. 25)

Women may have difficulty taking themselves seriously professionally and collude with male collegues in trivializing their work.

Boundaries

The ability to separate the self from the rest of the world, to set and maintain personal boundaries can be problematic for binge eaters (Boskind-White and White, 1983, p. 114; Orbach, 1977, p. 83; 1982, p. 52; Stolz, 1985). Typically, the interpersonal boundaries in the family of origin are lax (Minuchin, Rosman, and Baker, 1978; Riebel, 1985).

Riebel (1985) describes women with disordered eating as having deficient boundaries relative to feedback from others. They are unable to take in praise or acknowledgement but are hyperattuned to criticism, remembering and rehearsing all shortcomings and errors.

Many feel unable to repel sexual advances of men they do not desire (Orbach, 1977, p. 61; Riebel, 1985) and may use chaotic eating as a reason not to see someone or put on weight in an effort to halt advances.

Fat can express an attempt both to merge with others and, paradoxically, to provide an impenetrable wall around a person. If fat has been a way to express separateness and space, thinness can represent defenselessness and intolerable vulnerability (Orbach, 1977, p. 83).

Eating can be used as a source of emotional replenishment when depleted:

> Being the one who gives to every one is a significant part of being a woman...I am the giver, the nurturer of last resort. If everyone else goes to hell ultimately I am the one, no matter how bad I feel, to give. I will pull myself together and give what needs to be given. No matter what happens--no matter how angry or tired or hurt...If that means suppressing my own needs and feelings, then I will. And that's when I eat...I'm taking care of everyone else and food is taking care of me (Millman, 1981, p. 105).

Excess weight can express both a shapeless capacity to absorb and to repel outside demands: "It's as though a woman can take on everyone else's needs without them actually penetrating her, the weight acts as a shock-absorber for others and as a cushion against her becoming too affected" (Orbach, 1977, p. 59).

Mother-Daughter Relationships

Compulsive eating can be "an expression of the complex relationships between mothers and daughters" (Orbach, 1977, p. 26). Boskind-White and White (1983, p. 69) write: "The problem for many daughters is that in their attempts to move away from their mothers' legacy, they do not move toward other alternatives (except food)."

Eating and weight problems can represent a desparate bid for some kind of autonomy in a situation where a daughter feels controlled, most often by her mother.

For anorexia nervosa, Garfinkel and Garner (1982, p. 10) identifies "starvation as a statement about autonomy." Its mirror image, obesity, can also be an indirect statement about autonomy: "When the mother criticizes her daughter's size, the latter blasts back that her fat is her own, that it is something for which she alone is responsible that her mother cannot take away too" (cited Orbach, 1977, p. 33).

Bruch (1979, p. 38) cites a case of anorexia nervosa that began after her mother criticized her last friend.

"In overfeeding herself the daughter may be trying to reject her mother's role while at the same time reproaching the mother for inadequate nurturing; or she may be attempting to retain a sense of

identity with her mother" (Orbach, 1977, p.32).

Stolz (1985) discusses food problems as part of a "Don't Outdo Me" message from mother to daughter.

The Social Role of Women

Often "grown-up femininity is assumed to be unproblematic," and the refusal to accept the role is seen as pathological, per se, and not "an extremely complicated response to a confusing social role" (Orbach, 1985a). She argues that without a feminist understanding, anorexia, Bulimia and compulsive eating are difficult to comprehend and treat. A person's struggle with food and body size may be an attempt to express the self as different from the packaged sexuality and preordained social role with which she is presented (Boskind-White and White, 1983, p. 19; McLeod, 1981, p. 78; Millman, 1981; Orbach, 1977, 1985a, 1985b).

The avoidance of female maturity by anorexia nervosa has been recognized by many (Bruch, 1973, p. 277; Crisp, 1980; Garfinkel and Garner, 1982, p. 9; McLeod, 1981, p. 70). What has gone unrecognized is that:

> getting fat can be understood as a definite and purposeful act; it is a directed, concious or unconcious, challenge to the sex-role sterotyping and culturally defined experience of womanhood...Fat is a social disease and fat is a feminist issue ...It is a response to the inequality of the sexes (Orbach, 1977, p. 18).

"Many women experience the social expectations placed on them as unattainable, unrealistic, undesirable, burdensome and oppressive" (Orbach, 1977, p. 44). McLeod (1981, p. 60), a recovered anorexic, writes "I must, in my unconcious, have wanted to grow up, but at the same time, I was determined not to, because the models of potential

adulthood with which I was presented were either repugnant or impossible to attain."

The relationship between food abuse and the mature female social role in Western society revolve around three issues: role confusion, gender and role avoidance, and role protest.

Role confusion is likely whenever "what does it mean to be a woman?" is asked. Wooley and Wooley (1985) consider: "Fear of womanhood may be less a fear of sexuality than of woman's role. But the male role is also unacceptable. Women long for the advantages enjoyed by men, but rarely feel comfortable emulating their behavior." Bardwick (cited Boskind-White and White, 1983, p. 89) writes that "to a very large extent women are their bodies." Men have been taught to view themselves as much more than their bodies (Boskind-White and White, 1983, p.117). Historically, women have often been "prisioners of their bodies,"and the question "Is biology destiny for women, or not?" is still critically important.

One woman writes of the female role models available to her in her adolescence:

> As far as I was concerned there were two types of women, the true type and the failed type. The true type, as personified by my own and other mothers, was destined to bear child after child, some of whom could miscarry, some of whom could die, and all of whom were a perpetual source of worry and expense. This true type, having found her man, was forced to accept that biology was indeed destiny. But I couldn't accept any such thing. The failed type of woman, as personified by most of the teachers at school, had been unable to find a man. All the same, they were no freer, no happier, than the true type ...they were 'dried up old spinsters', miserable biological failures. At that stage in my life I couldn't take any kind of failure, and so this latter model of womanhood was as unacceptable to me as the former (McLeod, 1981, p. 78).

This woman "choose" anorexia nervosa to avoid womanhood.

Recently women's roles have been radically redefined and women now are competing with men for power and prestige. As Wooley and Wooley (1985) write:

> this creates for young women a formidiable challenge: to mimic men both physically and behaviorally, and to resolve intense conflicts over identification with their mothers and fathers. They are the first generation of women to be raised by highly weight-concious mothers who have experienced themselves as failures by the prevalent standards.

Tremendous ambivalence exists about women's roles. The media consistantly protrays women as subordinate to men, dependant, whose power lies in being sexually attractive. For all the new occupational opportunities available to women, most women are deeply uncertain about how far they can go and at what price. Perhaps, the body is the only source of real power available after all. McLeod (1981, p. 102) writes:

> Selvini Palazzoli's contention that the anorexic, despite her apparent rejection of womanhood, is also showing "a keen desire, however distorted, to become an autonomous adult", and, indeed, an autonomous woman. But to the anorexic, that last phrase is a contradiction in terms; autonomy and femininity have been shown to be irreconcilable. And yet she cannot surrender either of them completely.

Interestingly, dieting can be a means for an adolescent to express her various aspects:

> By interesting herself in diet, the daughter "acts like a woman," imitating her mother and affiming her identification with her. By assuming firm control of her own body, she differentiates herself from her mother and emulates the "control" exercised by men especially her father. If she succeeds in getting thinner than her mother, she enjoys revenge for past criticism. And finally, suffering and self-denial alleviate her guilt over abandoning and surpasssing her mother; dieting is a way to be "good" that avoids the loss of self she has observed in her mother (Wooley and Wooley,

1985).

Eating and weight issues can be used in the service of gender and role avoidance.

Bruch, 1979, p. 72) states that for some anorexic girls, puberty marked the "end of secret dreams of growing up to be a boy." Crisp (1980) views anorexia nervosa as a retreat from female maturity by the maintaince of a prepubertal weight and notes the panic associated with return to a weight that will rekindle the maturational processes. McLeod (1981, p. 77) concurs, stating: "I rejected womanhood, not because I preferred manhood, but because I preferred girlhood." Obese women often reject pregnancy and the mature maternal role "with the unspoken desire that the woman herself wants to stay a child" (Bruch, 1973, p. 130).

While anorexia nervosa and obesity have been interpreted as avoiding the mature female role as too problematic, Bulimia has been concieved as a "deeply rooted commitment to traditional feminine values...characterized by severe conflict." The Bulimic woman appears to be willing to do anything to look like "a real woman" should but is unable to sustain herself as such except by constant struggle with herself and her body.

Protest against limitation and caricature of the conficts of socially defined femininity is another use of binge eating and its results. Orbach (1977, p. 33) writes:

> Fat is a way of saying "no" to powerlessness and self-denial, to a limiting sexual expression which demands that females look and act a certain way, and to an image of womanhood that defines a specific

> social role. Fat offends Western ideals of female beauty and, as such, every "overweight" woman creates a crack in the popular culture's ability to make us mere products.

Of anorexia nervosa, Orbach (1985) writes:

> She has become smaller and smaller as today's culture demands, but so small that her body becomes an indictment against the idealized feminine sexuality of today's society...her invisibility clamors for recognition...In controlling her food so very tightly she is caricaturing the message beamed at all women...And in denying her needs--as women are so often reminded to do--she creates a person who will not impose on or ask for things from others. Thus, she excels as the "good girl." At the same time she steadfastly attempts to meet those needs in a most persistent and tenacious manner. Her anorexia is a paradoxical embodiment of stereotyped femininity and its very opposite.

10. Depression and Suicide

Depression is commonly associated with binge eating, particularly for Bulimics (Bruch, 1973, p. 127, p. 282; Fairburn, 1983; 1985; Johnson, 1985; Leclair and Berkowitz, 1983; Pyle et al., 1981; Weiss and Ebert, 1983).

Boskind-White and White (1983, p. 15) found Bulimics did not initially present with eating obsessions, but rather complained of "depression, unsatisfying relationships, loneliness and anxieties of one sort or another."

Fairburn (1985), speaking of Bulimic clients, writes:

> Depressive thoughts, difficulty in concentrating, and depressed mood are particularly common. The clinical evaluation of such symptoms is complicated by the direct effects of the eating disorder on mood, appetite, weight, sleep, energy, interests, and concentration. Careful history taking usually indicates that the eating disorder began prior to the onset of significant depressive symptom, and that the patient's mood closely corresponds to the degree of control over eating. This suggests that the mood disturbance is a secondary phenomenon; this proposition is supported by the finding that in practice the depressive features usually respond to measures that enhance control over eating.

> However, a minority of patients appear to have a coexisting affective disorder; in addition to treatment for their eating problem, they require antidepressant medication.

On a standard psychiatric rating scale Bulimic women showed no evidence of psychiatric symptomology. But when asked specifically about symptoms of anxiety or depression in conjunction with their eating disturbance, they reported a high degree of distress (Johnson et al., 1983).

Boskind-White and White (1983, p. 16) describe Bulimics as "more desparate about and more dominated by their binge/purge syndrome that by any other aspect of their lives" and were "disillusioned, frightened and despaired that they would ever be able to control their behavior"..."I am desperate and contemplating suicide because of this."

Russel (1979) states that even though the symptoms were not of endogeous depression "it was nervertheless treacherous as regards the risk of suicide."

In a report of 509 DSM-III Bulimics, Johnson et al., (1983) found "more than half of the women (50.4%) reported a history of suicidal ideation, 14.1% reported making a gesture or plea for help and 5.0% reported serious suicide attempts."

"Early death in anorexics is mainly suicide or from one or the other of the profound metabolic and physiological distrubances" (Crisp, 1974, 1979).

For the obese, bingers or not, Bruch (1973, p. 127) writes:

> All the statistics agree that obese people have a higher morbidity and mortality rate from a whole string of diseases--with one exception: their suicide rate is significantly lower. I have often

> been impressed with the fact that the situations in reaction to which obesity developed were situations to which others might have reacted with despair. However much a handicap obesity may become, as a defensive reaction it is less destructive than suicide or paralyzing deep depression.

Obesity has been considered by some as a depressive equivalent. Bruch (1973, p. 127) writes: "overeating and excess weight may have a stabilizing effect in a precarious overall adjustment, and that even a severe depression may not manifest as long as the excess weight persists."

11. Impulse Problems

Bulimic clients may present with a history of multiple substance abuse, alcohol abuse, and various impulse dominated behaviours, such as shop-lifting, promiscuity, impulse buying, and self-mutilation (Hatsukami et al., 1982; Mitchell et al., 1981; Pyle et al., 1981; Weiss and Ebert, 1983). Johnson (1985) suggests that poor impulse control can be associated with a borderline personality structure where their "eating problem is secondary to a more serious problem of understructured internal resources." They represent a more seriously disturbed subgroup among the eating disordered.

Family Description

In spite of initial reports of an "anorexic family," current opinion is that no one type of family has an anorexic or bulimic member (Anderson, Morse and Santmyer, 1985; Garfinkel et al., 1985; Wooley and Wooley, 1985). Wooley and Wooley caution: "it is advisable to keep an open mind about what is occurring in the family, and to avoid premature diagnosis of the classic "anorexogenic" constellation, since many adaptations are possible and, in our experience, many are found."

Because anorexics are usually living with their parents, are younger than Bulimics and their weight loss so visible, much more work has been done with anorexic families. Only Schwartz et al., (1985) were found to specifically address family therapy with Bulimic clients.

"There are few conditions that provoke so much concern, but also frustration, rage, and anger, as the spectacle of a starving child refusing food." writes Bruch (1977). Family dysfunction can be the result of the disorganizing experience of coping with the disorder, not the cause. There may be some common risk factors within families.

Often the family exhibits an excessive and overdetermined interest in food, weight, dietary habits and shape, which take on special family meanings in the realm of self-control, self-esteem, emotional expression and development (Crisp et al., 1977; Beaumont et al., 1978). The "taking of exercises has a very moral tone in these families" (Crisp et al., 1977). Schwartz et al., (1985) found families with a Bulimic member to be extremely appearance concious.

There may be specific pathologies within family members that

directly contribute to the development of the child's problems. Kalucy et al., (1985) has noted particularly the effect that a severely phobic, obsessional or depressed parent can have in altering the system in which the future patient grows up and in generating within the vulnerable child urgent needs to care for the sick parent (Kalucy et al., 1977). Depression in the fathers is mentioned by Achimovich (1985). Stern, Whitaker, Hagemann, Anderson, and Bargman (1981) believes that all members of the anorexic family are developmentally arrested in the area of separation-individuation and therefore unconciously avoid separation at all costs. Bruch (1979, p. 131) states that anorexics are:

> often the most valued child, one who at the same time had been most rigidly controlled (p. 131)...The parents had taken it for granted that it was their task to make all plans and decisions, to direct the child in every respect. These parents speak with conviction of their approach to life as right, normal, and desirable, and of them being entitled to expect that this child will fulfill their dreams and wishes (p. 38)...These children believe they must prove something about their parents, that it is their task to make them feel good, successful, and superior (p.26)...many girls express a feeling of having a special responsibiliy for their mother (p.31).

Specific "systems pathologies" can mitigate against separation, individuation, autonomy and identity formation. Minuchin et al.,(1978) have identified characteristic patterns of transactions in "psychosomatic" families. The classic "anorexogenic" family shows patterns of enmeshment, rigidity, overprotectivness, lack of conflict resolution and the child's involvement in parental conflict. Enmeshment describes inappropriately diffuse interpersonal boundaries between family members. There is excessive togetherness and sharing, a lack of privacy and intrusions into one another's thoughts and feelings. Bruch

describes a "confusion of pronouns" because each person speaks for the other qualifying and discounting what the other has said. Loyalty and protection are valued over autonomy and self-realization.

Rigidity in the family system is a commitment to the status quo, despite developmental changes within the system, or external stress. Overprotectiveness is associated with undue concern over one another's welfare. The child's psychological and bodily functions are the subject of undue family interest, long after it is developmentally appropriate. Conflict is diffused, as tolerence for conflict is low. The fifth characteristic is the child's involvement in parental conflict either by a stable coalition of the anorexic child and one parent, or a detouring of conflict through the child: when discord is about to erupt, the child's symptoms become the focus. Selvini Palazzoli (1974, p. 211) found open alliances between parent and child were prohibited but the child is relegated to the role of secret ally to both father and mother. This is dubbed "three way matrimony".

In most of the 30 families of Bulimics studied, Schwartz et al., (1985) found the above characteristics and three more: isolation, consciousness of appearances, and a special meaning attatched to food and eating. Wooley and Wooley (1985) report that Bulimic families are less cohesive and more explosive than anorexic families are preported to be. "Daughters have often been the targets of verbal and physical abuse from desperately unhappy parents."

CHAPTER IV

SOCIAL AND CULTURAL FACTORS

Given that all individuals exposed to the same culture do not develop a disorder, social factors alone cannot account for pathology (Bruch, 1973, p. 22; Garfinkel and Garner, 1982, p. 118; Garner et al., 1983). As Garner et al., (1983) explain: "a "culture" cannot "cause" a disorder...Cultural predisposing factors can only be understood as they might affect the psychology and biology of the vulnerable individual and his or her family." Disorders can occur in the absence of sociocultural risk factors such as when anorexia nervosa affects males, older women or working class people. Anorexia nervosa was observed in the last century when social pressures were quite different. All women today are exposed to media images of women at variance with their own image. Yet, while ever more are becoming afflicted with eating problems, the majority do not succumb. However, to ignore the influence of cultural attitudes in search of individual difficulty is to miss much that could contribute to our understanding of eating disorders, women and our society. Social influences are considered one important factor in conditions now thought to be multidetermined: binge eating, the eating disorders and obesity. Cultural pressures best account for the recent rapid increase in incidence of eating problems among women.

After reading anorexia nervosa "is a disease that selectively befalls the young, rich and beautiful...affecting the daughters of well-to-do, educated, successful families, not only in the United States but in many other affluent countries" (Bruch, 1979, p.i), one would

expect some inquiry into the relationship between affluence, social class and this condition. Beyond the meager descriptive data given in the previous chapter, no research has been done.

If anorexia nervosa is distributed unevenly by socioeconomic classes as is commonly believed, organic theories of causation could be laid to rest. However, as Bemis (1978) in her review article indicated, the methodological issues of selection and referral biases continue to cloud the data to such a degree that the question of organic cause cannot be eliminated.

Similarily, the startling sex ratio of these disorders (90-95% women to 5-10% men for anorexia nervosa and Bulimia and two to one for obesity), is not often mentioned and even less often examined for meaning. Chernin (1983, p. 63) writes:

> No less than 90 per cent of the people suffering from anorexia are female. But knowing this, we would expect that the most recent writers on anorexia would wonder about the relationship between the will to starve the body and the fact of being a woman. Aside, however, from Margaret Atwood, who is a novelist, almost no one does. The scientists, the psychologists, the family therapists all seem to be keeping a steady silence here. It is this fact that causes Sandra Gilbert (who is a literary historian) to ask this series of provocative questions:
>
> 'Why are 90 per cent of anorexics female? Why don't most writers about anorexia explain why 90 per cent of anorexics are female? Why has anorexia nervosa suddenly surfaced as the subject of so much popular speculation?...Although a number of books and articles I've read on the subject are useful and interesting, none makes the slightest attempt to answer any of these questions...It is surprising, even puzzling, that none of these scientists attempts seriously to explore the evidently crucial relationship between anorexia nervosa and femaleness.'

While the above quote addresses anorexia nervosa, the same questions would apply to Bulimia, binge eating, and obesity.

CULTURAL IDEAL OF THE FEMALE BODY

Bruch (1979, p. viii) writes "I am inclined to relate (the prevalence of anorexia) to the enormous emphasis Fashion places on slimness." Indeed, the current cultural ideal of extreme thinness for women is the one factor many authors mention (Bennet and Gurin, 1982, p. 165; Boskind-White and White, 1982, p. 58; Garfinkel and Garner, p. 112; Garner and Bemis, 1985; Newmann and Halverson, 1982, p. 24; Orbach, 1977, 1985b; Wooley and Wooley, 1985).

What is the current ideal body shape for women in Western culture? One description is: bony thinness. Rakoff (1967) describes actresses "who resemble prepubertal girls onto whom the secondary sexual characteristics of mature women have been grafted." Bennet and Gurin (1982, p. 168) describe two contempory, distinct and incompatible ideals: the high fashion models found in Vogue magazine and the more fleshy figures found in Playboy magazine. The former, "bean lean, narrow as an arrow, pencil thin," are often portrayed in sketches or with angular mannequins, presumably because no woman, even a model can achieve such proportions.

> In 1980, a top model for Vogue and Bazaar was Christine Conan, 12 years old, a preadolescent girl, with slender arms and shoulders, undeveloped breasts and hips and thighs, whose body has been covered in sexy clothes, whose face has been painted with a false allure and whose eyes imitate a sexuality she has, by her own admission, never experienced. And this, fashion says, is what a mature woman should attempt to look like (Chernin, 1981, p. 93).

The Playboy centerfold, while hardly the shape of typical woman, is at least a mature and living one. Time Magazine (1982) wrote of the changing styles in women's bodies in the wake of the recent interest in

fitness. The newest "look" is that of an athlete, muscular, lithe and strong. Orbach (1978, p. 21) also points out that the one constant in the multitude of women's images that survives changing clothing and hairstyle fashions is thinness.

Not only is the current ideal very thin, it has become progessively thinner over the last few years. "From Mae West to Marilyn Monroe to Twiggy to Christine Conan there has been a definite progression" (Chernin, 1981, p. 95). Visitors to Madam Tussaud's London Waxwork are asked who they regard as the most beautiful woman in the world. From 1970 Elizabeth Taylor has fallen steadily from the top of the list and Twiggy (an idealized anorexic at 5'7" 92 lb.) has risen from the top five in 1974 to number one in 1976 (Wallenchinsky, Wallace and Wallace, 1977, p. 77).

In an attempt to quantify and document the apparent shift in cultural standards to an extremely thin body shape, Garner, Garfinkel, Schwartz and Thompson (1980) collected data from Playboy magazine centerfolds and Miss America Pageant contestants and winners over a twenty year period from 1959 to 1979. Within each group, when height and age were controlled, weight declined across the 20 year period. There were no differences between the winners and the contestants in the Pagent until 1970 after which the winners weighed less than the average weight of all the contestants. Also over the 20 years surveyed, a "change of shape" towards a more tubular or androgynous form for Playboy models was apparent.

These findings are particularly striking when contrasted to actuarial statistics that indicate the average weight for adult women

under 30 has actually increased over the same twenty years by 5 to 6 pounds, presumably due to improved nutrition (Build and Blood Pressure Study, 1979, cited Garner et al., 1980). Thus, the realities of biology conflict with the demands of culture for the definition of appropriate body weight for women. The stage is set for dieting.

The thin-and-getting-thinner body ideal is a historically recent development, both over the last six centuries and within this century. Bennet and Gurin (1982, p. 171) write:

> In all, Western taste has idealized three types of woman since about 1400. The first was tummy-centered and often quite fat; we call her the reproductive figure. Somewhere around 1650--certainly by 1700--taste changed pretty much thoughout Europe. The new ideal was all bosom and bottom; her narrow waist only emphasized these ample endowments. Although slender women of this outline which we call the maternal, were sometimes portrayed on canvas, the overwhelming majority were at least plump by any standard. Then, rather rapidly between 1910 and 1920, the full-blown figure lost its place in the sensual aesthetic mainly of Anglo-American culture. The new woman was lean, with no remnant of the promising, reproductive tummy and with minimal breasts and buttocks. This slender, at times almost tubular, form has become emblematic of the sexual free agent, the third idealized type. Also in this era, the taste of men and women has diverged, with the men's preference clinging somewhat to the unstylish maternal figure.
>
> In this succession of types, we believe Western sexual symbolism has superimposed changing values on biological reality. For millennia, fatness not only represented fertility, it also contributed in fact to a woman's reproductive success. Since about 1910, limitation of fertility has become increasingly important to men and women, and so has sexual expression. The cultural conflicts engendered by these two trends have been expressed in a cultural obsession with weight control--even as birth control has made it technically easy for a woman to have sex but not babies.

Within this century, in Western society, there have been shifts in preference for female forms. In the early part of the century a buxom appearence was desired, followed by the flat-chested flapper of the 1920's, slimness in the 1930's, more curves during Wartime, and a return

to bustiness and the hourglass figure in the 1950's (Garfinkel and Garner, 1982, p. 106). Since the 1960's the desired form has been slim.

So enculturated are we with "thin is in" it is hard to credit the following quote was written by a doctor in this century:

> One must mention here that aesthetic errors of a worldly nature to which all women submit, may make them want to stay obese for reasons of a fashionable appearance. It is beyond a doubt that in order to have an impressive decollete each woman feels herself duty bound to be fat around the neck, over the clavicle and in her breasts. Now it happens that fat accumulates with the greatest difficulty in these places and one can be sure, even without examining such a woman, that the abdomen and hips and thighs and the lower members are hopelessly fat. As to treatment, one cannot obtain weight reduction of the abdomen without the woman sacrificing in her spirits the upper part of her body. To her it is a true sacrifice because she gives up what the world considers most beautiful (Heckel, 1911, cited Bruch, 1973, p. 19)

Until the 1900's desirable body forms remained in vogue for centuries and were the province of women of the 'haute bourgoisie' and courtesans (Orbach, 1985b). Only in the last 65 years have the great mass of women and, to a lesser degree, men, embraced an idealized and rapidly altering female form.

POWER OF THE CULTURAL IDEAL

Why is the current cultural standard so powerful that young anorexic women starving themselves to death meet "more approval than disapproval from family and friends" (Branch and Eurman, 1980)? And why do women appear so willing to subscribe to a standard detrimental to their health and well-being that for most is probably unattainable? Three major reasons are: thinness has become associated with attributes strongly valued in our culture, alternative images are virtually non existant, the current ideal is ubiquitous. Furthermore, society offers

both real and perceived rewards to women who comply with the ideal and stigmatizes and discriminates against women who do not comply.

As Bennet and Gurin (1982, p.4) so aptly put it: "the central tenant...is that thin people are <u>better</u> than fat people--more beautiful, healthier, stronger of will," or as Cannon and Einzig (1983, p.195) suggest: "In our society only thin is good." Orbach (1982, p.28) writes:

> success, beauty, wealth, love, sexuality, and happiness are promoted as attatched to and depending upon slimness. Slimness instantly conveys these qualities as though they automatically go together like salt and pepper, gin and tonic, Saturday night and Sunday morning. In other words, slimness is made into a fetish and abstracted from what it is -- just one particular body shape. Slimness sells women's bodies back to them promising in its wake the good life. Of course, none of these marketed attributes are remotely connected to slimness, which stripped bare is nothing more than a fashion, a current ideal."

Boskind-White (1985) explores the associations of "thin" with "rich, young, feminine and healthy" versus "poor, old, masculine and unhealthy."

In a provocative article entitled "Obesity as Failure in American Culture" Mackenzie (1976) writes "American culture defines an adult as self-controlled, competent, morally responsible, rational, productive and independant. The obese contradict every one of these American values."

Originally, in the 1920's, the thin body symbolized "athleticism, non-reproductive sexuality, and a kind of androgynous indepedence" as women began to claim the right to move as freely as men, to separate sexual expression from reproduction and to pursue their own destinies independently of men. Since then it has become strongly associated with

higher social status, with sexual competitiveness and self-mastery. What began as a symbol of sexual and social freedom has now become as oppressive as earlier social barriers by demanding of women an unrealistically thin shape despite their biological propensities (Bennet and Gurin, 1982, p. 177).

The lack of alternative positive images of women's bodies adds to the power of the current cultural ideal. In reality, women exist is an array of shapes and sizes, some are short, some tall, some have broad hips, some narrow, some have large fleshy breasts, some have small, firm ones, some have round bellies, others have flat ones, etc. "But the extraordinary variety that is woman's body is systematically ignored in our culture. The richness of our different shapes is reduced to the overriding image of slimness" (Orbach, 1982, p. 29).

The current female image is inescapable in any contemporary visual media: television, newspapers, magazines, advertizements and movies. In contrast to the 1400's when "people probably saw few images of any kind, let alone the kind of purportedly realistic representations that create erotic standards,"(Bennet and Gurin, 1982, p. 172), we are innudated with images of the current female figure. Einzig (1983, p. 203) writes:

> In Great Britain alone over ten million images of women naked to the waist are printed every day in popular newspapers. The female body is everywhere--on billboards and magazine covers, in shop window displays, selling rum, car radios, double glazing, cheese, insurance and rust remover. As we wait for a train our eyes are forced to wander over bits of body, a Colgate smile, Silvikrin hair, the Lee Bottom...It is hard for women to see themselves whole. Neither, very often, do men see women whole. I'm a bum man." "I'm tits man." "I go for legs."

Presumably women see more images of other--very thin--women than

they do of themselves. When they look in a mirror they compare their own body to the cultural images they have internalized (Orbach, 1985b). Even if their general body shape conforms, some part will be wrong.

The thinness ideal is not confined to the media. Bruch (1973, p. 203) condemns physicians, psychologists and parents in promoting unrealistic weights. She states:

> chronic malnutrition based on abnormal preoccupation with weight is common, but not readily recognized as abnormal because it appears under the guise of desirabe slimness...It has been customary to prescribe tranquilizers, three square meals a day would be a more logical solution but one that is equally unacceptable to physicians and patient alike (Bruch, 1973, p. 198).

Doctors are no less susceptible than other people to cultural ideas about beauty and thinness and frequently feel entitled to comment on the size of their patient's body even when their medical problems are not related to it (Orbach, 1978, p. 176). Nurses, psychologists, physicians, social workers and physical and occupational therapists ranked obese children as the least socially desirable against children of various handicaps (Wooley and Wooley, 1979).

Social pressure toward extreme thinness is likely to be encountered in families. This is the first generation of women to be brought up by mothers who went to Weight Watchers (Boskind-White and White, 1983, p. 58; Wooley and Wooley, 1985). Branch and Eurman (1980) found anorexics elicited admiration from friends and relatives. Crisp et al., (1977) found parents may desire a prepubertal weight for their daughter. One common observation in the eating disorder literature is that one or more family members of a client with a disorder is likely to be intensely involved with food, dieting, body weight, appearence (Kalucy et al.,

1977).

Overweight is severely stigmatized in our society. Monello and Mayer (1963, p. 38) compare obese girls' "obsessive concern" with weight to chronic feelings of helplessness, anxiety and impending doom experienced by victims of racial discrimination and anti-Semitism. They conclude "it is not far-fetched to say that obese persons in the United States may form a minority group suffering from prejudice and discrimination." Bennet and Gurin (1982, p. 278) consider fat people "virtually the last target of guilt-free discrimination."

Wooley et al., (1979) have compiled an extensive array of articles documenting the hatred and stigmatization of overweight and the strong effect on females. They introduce their review with:

> The intensity of shame engendered by overweight can only be understood by recognizing the extreme ostracism and hatred to which overweight children are subjected...studies show that at an early age, children of both sexes develop distinct aversions to chubby bodies...the child whose build is socially 'deviant' comes early in life to be regarded by others as responsible for his/her condition and deserving of social disapproval...

Two of the studies cited reported the obese children were more stigmatized that handicapped children. It appears the reason the obese are so disliked is because they are believed responsible for their condition. The conclusion of the review is:

> These studies document the hatred of obese children by other children and adults. The impact this hatred has on the individual child is probably irreversible. It is not only the obese child who suffers from this hatred; anti-fat attitudes learned in childhood no doubt become the basis for self-hatred among those who become obese at later ages, and a source of anxiety and self-doubt for anyone fearful of becoming overweight.
>
> There are also data to suggest that women are more harshly

penalized than men for failure to achieve slenderness as, in general, women are more often denied or granted access to social privilege on the basis of physical appearance. Canning and Mayer (1966) showed that obese high school girls were less likely than slender peers to be accepted to colleges, despite comparable qualifications. The Midtown Manhattan study showed obese women, but not men, to be downwardly socially mobile (Goldblatt, Moore, and Stunkard, 1965). The inverse relationship between weight and social class was far stronger for women than for men. Explicit weight criteria for admission to training are relatively common in the female-dominated profession of nursing, but rare or non-existant in medical training. Although hard data are lacking, one strongly suspects that job discrimination on the basis of weight is more common for women.

Why do women appear so willing to adopt a standard of body weight at odds with biological reality? Why are women apparently willing to sacrifice their health and well-being for the pursuit of a weight goal that is unattainable for most, and if attained, likely short-lived? Three prominent issues emerge: (1) ambivalence among both sexes towards female power (2) uncertainty about the social rewards available to women and the route to the attainment of social reward for women in this culture and (3) confusion of health and cultural concerns resulting in misinformation and ignorance.

Sinderbrand (cited Baker, 1984, p. 16) draws parallels between the fashions of women and the position of women in Western society over several centuries. In periods of social and political restriction, the

fashions women wore provided maximum physical space. The large skirts and high elaborate hairstyles of Marie Antoinette in pre-Revolutionary France contrast to the simple Empire styles of the Empress Josephine when women were accorded more liberty. During the 20th century, as women have gained in economic, political and social power, their clothing has become reduced in size and style. Baker wonders if the reduction of clothing has proceeded as far as is possible and the process is continued in the reduction of body size. The demand for thinness is strongest for women with the most power and privilege: the upper class woman, the female executive, the high fashion model and the movie star.

> Since the 1960's two divergent "women's" movements have emerged: one is a movement toward feminine power, the other a retreat from it, supported by the fashion and diet industries, which share a fear of women's power...the groups that arise among feminists are dedicated to the enlargemnt of women...in the feminist groups the emphasis is significantly upon liberation--upon release of power, the unfettering of long-suppressed ability, the freeing of one's potential, a woman shaking off restraints and delivering herself from limitations. But in the appetite control groups [i.e., Weight Watchers, Lean Line] the emphasis is upon restraint and prohibition, the keeping watch over appetites and urges, the confining of impulses, the control of the hungers of the self (Chernin, 1981, p. 100)

One movement seeks relief from personal and cultural dilemmas in the public domain of political and social policy, the other seeks relief in the private domain of the size and appetites of the body. Interestingly, a woman can simultaneously be involved in both movements: "The behaviors we direct towards the social world may well express our radical orientation towards a woman's self-development. But

the behaviors we direct towards our own body express our implicit loyalty to the conventional world" (Chernin, 1981, p. 108).

Baker (1984, p. 201) suggests women's ambivalence about the aquisition of economic or social power (a traditionally masculine pursuit) in one area of her life, may prompt "superfeminine" behaviour in another area. Physical appearance, a traditionally female concern, may become a superfeminine expression.

One recurrent theme is if a woman becomes "too big," either physically or in terms of power, she becomes threatening. Yet, why would a fully developed female be considered threatening? Why are women willing to be other than fully developed? Chernin (1981, p. 127-161) citing Dinnerstein (1967) and Becker (no date) proposes that the fully developed female body threatens to evoke intense feelings from infancy, from the time of complete dependance on the then-all-powerful mother and her then-deeply-needed body. Part of the infant's experience is terror as, helpless and in need, the infant realizes the mother's body is not theirs to control. As an adult, the male desires to maintain the reversal of the infant state, and so desires power over women, fears their power. For the female, puberty brings to her own being the body of a woman towards which she can direct the same hostility and ambivalence as the man does. Chernin writes:

> Our obsession [with thinness] is, at heart, an attempt to solve this primordial terror, which an entire school of modern thinkers has described as fundamental to our existence. For all its seeming triviality, this compulsive urge to reduce the size of the body is nothing less than a struggle to gain control over a universe that threatens us with abandonment and annihilation (Chernin, 1981, p. 151).

The changing roles of women in this society have been associated with eating and weight difficulties. Bruch (1979, p. ix) writes: "Growing girls can experience this liberation as a demand and feel that they have to do something outstanding." The ambiguity of the social messages is important. MacLeod (1981, p. 171) describes a recipe for the creation of an anorexic; the first ingredient is social context:

> The perfect society is one in which women are granted more or less equal opportunities in theory, but in practice and through series of pressures, some more subtle than others, denied the right to fulfill them. Their skills and talents...should be encouraged, but at the same time they must be made to feel that they are less than women if they fail to recognise that their prime function in life is to act as helpmeet to some man, either in the home, the factory or the office, and to bear and nurture children.

Selvini Palozzi (1974, cited MacLeod, 1981) suggests that marked increases in the incidence of anorexia nervosa coincide with sudden change in the social position of women. Could the rise in Bulimia be similar? Of course, such a position is impossible to verify. A concrete example of uneven social change is provided by MacLeod:

> There is a pretense of social equity, just as there is a pretence of equity between boys and girls, and in the latter case, a promise of equity that cannot be fulfilled. Many schools encourage girls to specialise in subjects which have traditionally been the preserve of boys. It may be that this attitude, in itself admirable, can lead to confusion within the teenage girl as to her own role: she may pass her O-levels in physics and technical drawing, but it will be the boy who gets the job. And it is important for her to get a job because she can no longer look on marriage and children as a full-time permanent career. At the same time she has been educated beyond the menial sort of work her mother or other female relatives may have been forced to take in order to supplement the family income. Once she has a few O-levels to her credit, the working-class girl will be less likely to opt for immediate marriage or a job on the assembly line than was her mother. But because unemployment is high, she may have to to or feel she has to. A university graduate may find herself in a similar position

(MacLeod, 1981, p. 164).

In the face of uncertainty and doubt about the real rewards of her efforts and the ever present thin beautiful of the media for whom nothing is amiss and all things are theirs, is it any wonder Orbach (1982, p. 29) can write:

> slimness is believed to be the answer to difficult social and personal circumstances. Many a woman has described the solution to an unfortunate encounter,, a disappointing weekend, a job not secured, a lousy day with the kids, a squabble with her husband, a low exam result, in terms of "if only I were slim" or "I'm going to lose weight this week." That women seek such a route is hardly surprising. That it is ineffective is a tragic comment on the complexities of how we are first robbed of our bodies, and our access to many of life's activities and then thrust back on a narrow, individualistic non-solution--slimness.

Here, we return to the idea of two routes available to women to solve their difficulties.

Kim Chernin (1982, p. 104) gives a graphic account of a depressed, overweight, frumpy middle-aged woman whose husband of twenty-five years has left her, working in a "poverty wage, no-where job." She "feels a thousand years old and looks sixty." She blames herself and her fatness for everything that has gone wrong in her life. In one scenario she joins a conciousness raising group where "no one believes her rounded belly is the cause of these complex failures." In another scenario she joins a group where her social and personal problems are attributed to being fat and her salvation is seen to be weight reduction:

> We are assured that we, too, if only we will lose weight, can be "filled with energy, go aggressively after a better job and with a new figure, a revitalized personality, and an exciting new social life, (like) the formerly dowdy and half-sized Faye, (soon) be sitting on top of the world.
>
> The hidden message in this story is profoundly disturbing.

> Implicitly, we are asked to believe that if every woman lost twenty-five or thirty pounds she would be able to overcome the misogyny in our land; her social problems would be solved, the business world would suddenly fling wide its gates and welcome her into its privileges...There is a profound untruth here...women are directed to turn their dissatisfaction and depression toward their own bodies...Consider what it means to persuade a woman who is depressed and sorrowful and disheartened by her entire life, that if only she succeeds in reducing herself, in becoming even less than she already is, she will be acceptable to this culture which cannot tolerate her if she is any larger or more developed than an adolescent girl. The radical protest she might utter, if she correctly understood the source of her despair and depression, has been directed toward herself and away from her culture and society.

The third reason for the willingness of women to adopt an unhealthy standard is the obscurantism of health and beauty issues. Mackenzie (1976) writes:

> Obesity is not only a medical disease; it is a cultural one in the United States, and the medical and cultural diseases are not synonymous. There is no known increased risk of any disease until a person weighs 30% over the standards set by insurance companies -- and 30% is a very noticeable weight gain. Once that level is exceeded, then the risk of all diseases increases, including the risk of cancer and of accidents, not merely of heart disease and of hypertension. Yet people censure those who are overweight long before they reach 30% more than the actuarial tables state, asking them directly how they could let themselves go like that, or remarking even more severely to others that the fat person is out of control. Americans diagnose obesity culturally long before it exists medically. As a cultural disease obesity is not limited to those who weigh more than the ideal. Especially among women, there are thse who believe they are obese when they weigh less than the insurance norms.

The health hazards of obesity are well publicized, but little is said of health hazards of underweight, the specific health effects of recurrent weight gains and losses (the yo-yo syndrome, or the rhythm method of girth control (Mayer, 1968, p. 2). The dangers of 5 pounds of fat arouse the same alarm as fifty pounds. The medical profession and the popular media rarely informs the public about the health hazards of

dieting (Chernin, 1981, p. 41; Garner et al., 1985). An irony of the situation is that the extreme thinness of the current ideal may place a woman below the "fat threshold" necessary for menstruation and reproduction (Garner et al., 1980).

The overlay of health concerns on an issue of female appetites has historical parallels with the Victorian medical concerns about female sexual desire (Chernin, 1981, p. 39). Some of the literature on the perils of obesity are reminiscent of the "the old fire-and-brimstone sermons, intended to frighten men and women away from the delights and pleasures of sexual experience of their bodies" (Chernin, 1983, p. 43).

WOMEN AND FAT

Before puberty there is little or no difference in the body compostion of males and females. At the onset of puberty, girls increase their fat stores relative to boys. At the end of puberty, females have between 20 to 25% body fat, wheras males have only 15 to 18% (Bray, 1979, p. 14). Nylander (1971) reported most Swedish female adolescents "felt fat" and that this feeling increased with age. Fifty percent of the 14-year-olds felt fat as did 70% of the 18-year-olds. Studies of American girls are similar. Huenemann, Shapiro, Hampton and Mitchell (1966) found 56% of Grade Twelve girls considered themselves fat when only 25% were judged so by the researchers. Bruch (1979, p. 61) speaking of anorexics states "they act as if no one had ever told them that developing curves and a certain roundness is a part of normal puberty" and "normal development and changes are interpreted as fatness" (p. 65). While it could be argued they have received this message

unstintingly from the media, another idea is suggestive. Could the "fear of fatness" be a "fear of femaleness"? Could the "I'm too fat" feelings result from being "too female" in a male-orieted society? More than one author considers anorexia nervosa an attempt to avoid what Chernin calls "an unavoidable disaster"--becoming a woman (Crisp, 1980; Chernin, 1981, p. 64; Garfinkel and Garner, 1982).

DIETING AS A CULTURAL PHENOMENON

The most common solution to the discrepancy between the actual body weight and the desired ideal body weight is the reducing diet. Believed by most to be the rational and scientific treatment of excessive body fat, examination of the phenonemon leads one to question this assumption. Bennet and Gurin (1982, p. 4) write:

> The failure (of diets) lies in the misconceptions about weight and weight control that dominate our belief system. Most of what we are routinely told about how fat is gained or lost is either wrong, misleading, or meaningless. It is not just The Beverly Hills Diet, sauna suits, or Maxi-Slim pills ...The standard, "sensible" recommendations to change eating habits and diligently use calorie charts are also no more than elaborate folklore, expressions of faith in a world that ought to exist, but in fact does not.
>
> Although the reducing diet is not an effective means of weight control, it has become our modern ritual of self-improvement and self-purification...it is argued that virtually anybody can, with a reasonable amount of conscious effort, control how fat he or she becomes. But the best evidence and common experience both contradict this rationalization. With rare exceptions, dieters lose weight temporarily and then, despite great determination, gradually regain it.

Two major review articles on obesity treatment outcome indicate that approximately 4 percent of people entering outpatient diet clinics were successful in losing as much as forty pounds and keeping it off for 2 years (Stunkard and McLaren-Hume, 1959). The 1978 update covering 112

new reports found little improvment, an average weight loss of 11 pounds and generally inadequate followup (Wing and Jeffery, 1978). These rates do not indicate effective treatment. Why a treatment with a 4 percent success rate would be so frequently prescribed both culturally and medically for several decades and its failure attributed to the weakness of the patients is an interesting question. The belief in the efficay of dieting appears to parallel the beliefs in the benefits of bleeding by leeches that dominated medicine for many years.

Possibly, because following a reducing diet results in a weight loss of a few pounds in the short period, common experience is the basis for the belief in the effectiveness of dieting. Yet the almost universal failure of those who try to achieve significant weight loss and to stay on a diet for long periods, also a common experience, is not credited. Instead of sparking a research effort to find a more effective treatment, the emphasis has been how to help people stay on a diet. Because of our cultural beliefs, it is a difficult idea to grasp that dieting, now considered the number one treatment for obesity may, in fact, be a cause of obesity (Bennet and Gurin, 1982. p. 85; Cannon and Einzig, 1983, p. 26-55; Garner et al., 1985; Remington, Fisher and Parent, 1983, p. 94; Wooley et al., 1979).

Despite its ineffectiveness, dieting is the preferred method of weight loss and weight control for women. Huenmann et al. (1966) found many more adolescent girls were concerned about being overweight than actually were, but girls preferred diet restriction to exercise as a means of weight reduction by a ratio of two and a half to one. For

every boy who considered exercise five girls mentioned dieting; 65% of the girls were attempting to modify their weight, only 25% were judged as overweight. Dwyer, Feldman, Seltzer and Mayer (1969) found that 61% of high school women had dieted and 31% were actually on a diet on the day surveyed. This is in contrast to the 6% of men on diets and the 24% who had ever dieted. Halstead, Kelley, Roe and Young (1977) reported that 11% of college women were on a diet and a further 75% were consciously trying to limit their food intake.

Garfinkel et al., (1980) documented an increase in interest in dieting from 1959 to 1978. Diet articles in five popular women's magazines significantly increased from a yearly mean of 17.1 in the first decade to 29.6 in the second decade of study. This is the same period the Playboy models and Miss America Pagent winners were becoming more slender. Straus (1966) writes "society's recent preoccupation with weight control and diet is, of course, a relatively recent phenonemon. It was only twenty years ago that a prominent soft drink company was proudly advertizing "more bounce per ounce" and stressing that its product contained greater caloric value than its nearest competitor.

While dieting may appear to be a rational treatment of overweight in the interests of good health, the "rationality" is belied by other factors. The first is the number of dieters who would not be considered overweight by medical standards who believe themselves to be "too fat" by cultural standards. Part of this is the denial that females naturally carry more fat than men. The second is the tendency of women to diet when personal difficulties unrelated to weight are attributed to

not being thin enough. The third is the persistant application of a solution that does not work except in the short term and the personal, cultural and medical denial that dieting does not work. The fourth is, when weight is lost the diet is deemed successful, when weight is regained, the failure is attributed to the weakness of character of the dieter.

CHAPTER V

ETIOLOGY: A RISK FACTOR MODEL

No single factor is known to account for binge eating. Indeed, the search for a single, linear theory of causation of binge eating that can also account for the recent increase in the phenomenon is futile and results in logical absurdities. For example, if binge eating is primarily or only the result of arbitrary mothering, then "one must infer that for some reason there has been an increased incidence of warping, unempathic mothering in the western world" in the last 20 years. Or, using the family systems model to explaining incidence suggests there has been an epidemic of enmeshed, rigid, conflicted families (Schwartz et al., 1982).

The eating disorders anorexia nervosa and Bulimia and the weight disorder obesity are now generally viewed as multi-determined (Bemis, 1978; Bray, 1979; Bruch, 1973, 1975; Garfinkel and Garner, 1982, p. 188; Garner and Garfinkel, 1985; Johnson, 1985; Orbach, 1985a; Rosen and Leitenberg, 1985; Russel, 1979; Schwartz et al., 1982, 1985; Strober and Yager, 1985; White, 1985). Binge eating, a behaviour pattern associated with those disorders and found in normal weight people, is also multidetermined. It can be viewed as a final common pathway of a number of etiological factors.

A risk factor model suggests that a number of factors from different domains may be of etiological significance. Broadly speaking, for binge eating the domains are biological, psychological and sociological. Any one factor places a person at risk of developing a disorder; two or more

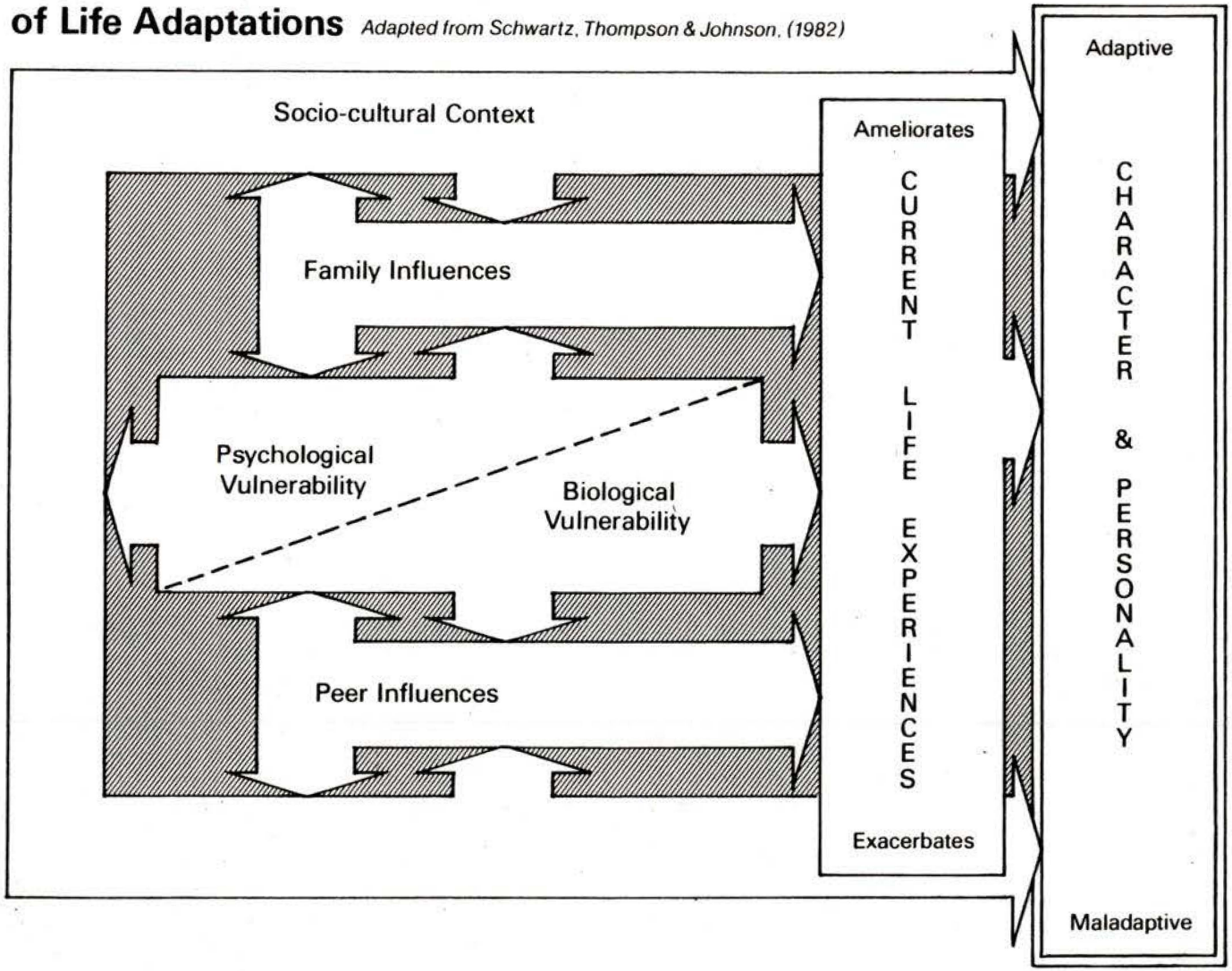
factors increases the risk expotentially not additively (Schwartz et al., 1982). Single factors are unlikely to be potent enough to cause a problem. For instance, cultural pressures to be thin are seen as "powerless to produce...pathology unless a predisposing vulnerability and/or an enmeshed family system were also present" (Piazza, Piazza, and Rollins, 1980; Bruch, 1973, p. 22).

In any population, some people will exhibit some predisposing factors and be at risk. However, not everyone at risk will develop the problem. Only a few risk factors will be present in any one person, and the combination of factors will vary from person to person. Furthermore, a predisposing factor can develop differently in one person than another (Garfinkel and Garner, 1982, p. 191).

Schwartz et al., (1982) developed a comprehensive risk factor model for anorexia nervosa which has been adapted for binge eating in this study. Figure 3 is a representation of the model. Schwartz et al., (1985) write:

> The model presents a conceptual way of understanding an individual's present form of life adaptation in the world. Life adaptation includes the more enduring internal factors which we generally think of as character and personality. These are what depth psychologists call psychic structure and the personalogists call personality traits. Life adaptation also includes the more or less consistant patterns of behavior which an individual displays across time and across situations. This side of the life adaptation equation, an individual's behavior, is shaped by his current life situation. Whether an individual's more or less enduring way of being in the world finds easy or difficult expression depends on the environment in which the person finds (or in some cases puts) him or herself. The current life situation determines whether the person is likely to find his way of being in the world as successful or unsuccessful. When someone's way of understanding, experiencing and behaving in the world is less successful, stress is unavoidable. Such stress is inevitably uncomfortable and can lead to the extremes of symptoms

Figure 4: A Social Psychological Model of Life Adaptations *Adapted from Schwartz, Thompson & Johnson, (1982)*



> and emotional disorders on the one hand, or adaptive growth and change on the other hand. Which outcome is likely depends largely on the extent and breadth of internal strength and structure which already exists within the individual. [These elements are represented by large vertical columns on the right of the diagram].

The horizontal elements in the center of the diagram represent the role of early developmental factors. Biological vulnerability includes genetic, neurological and adaptive factors. For binge eating, this may be the most influential sector. Psychological vulnerability includes the possibility of some constitiutional diathesis, an innate disposition ~~which~~ that makes the individual vulnerable to psychological distress, as well as one or more early life traumata such as overly negligent or overly intrusive parenting.

> These most primary influences on character are continually in transaction with the several other forces at work on the individual in the environment...these are broken down into the proximal influences of family and peers, and the more distal influences of society and culture. These forces may transmute or intensify the effects of constitutional disposition and/or early life traumata both during the formative years, when character is most malleable, and later, when character is fairly well established. This is why the model expresses the idea that early developmental factors of all kinds may have a direct and /or indirect effect on current life adaptation (Schwartz et al., 1982).

Social-Cultural Context

The socio-cultural context in which binge eating flourishes has been described in Chapter V.

Eating disorders are suspected of being this "culture's pet mental disturbance" (Kluckholn, cited Schwartz et al., 1982). Schwartz et al., (1982) suggests that individuals "who in any culture are more vulnerable to stress and more likely to react to that stress with some kind of emotional problem or symptom" are likely, in this culture, to "choose"

eating problems. This may account in part for the increase in incidence and descriptions that are not "classic."

Family Influences

Family characteristics have been described in Chapter III. The family acts on the developing individual in two ways: directly, in the present, and by introjects of the family patterns. Thus, a person's family may change, but the individual can go on reacting to their "old" family (Benson and Futterman, 1985; Kalucy et al., 1985).

Psychological Vulnerability

Bruch (1973, p. 56) proposed that poor introceptive awareness of both sensations and feelings is a result of early mother-child interaction. She postulates that hunger awareness is not innate, but the outcome of a reciprocal relationship between a child and her mother. If the mother responds appropriately to the child's signals of distress, the child will gradually organize her diffuse urges into differentiated patterns of awareness. She will learn to distinguish the discomfort of hunger form the discomfort of fatigue from the discomfort of sadness, as well as appropriate responses to each state. If, however, the mother does not respond to the child's expression of need, but rather imposes her idea of good care (perhaps by a timetable) or she neglects to respond or she indiscriminately feeds her child at any sign of distress, the child fails to develop a self-referent "body identity." Most confusing to the child is a mother who interprets every action by the child as something expressive of the mother: eating is considered an expression of love for the mother and non-eating is criticism of her.

Biological Vulnerability

Genetic predispositions to depression, to addictions and to food allergies are possible etiological factors. Controversy exists as to the role of depression in Bulimia. Several studies have found a higher than expected incidences of primary affective disorder (a biological disorder) and alcoholism among first-degree relatives of anorexic or Bulimic patients (Gwirtsman, Roy-Byrne, Yager and Gerner, 1983; Hudson, Laffer and Pope, 1982; Hudson, Pope, Jonas, and Yurgelun-Todd, 1983; Pyle et al., 1981).

Neurological dysregulation, similar to epilepsy, had been proposed by Rau and Green (1975). They identified a subgroup of compulsive eaters whose eating binges were ego-dystonic, discrete and episodic, usually preceded by auralike sensations. Their electroencephalograms (EEG's) showed abnormalities and some patients responded to anti-convulsant medication by decreasing the frequency of eating binges. However controlled studies (Wermuth et al., 1977) of the drug were not definitive.

The susceptibility of the individual to develop allergic reactions to foods is a biological vulnerability. Food cravings, binge eating, "addictive eating," fluid retention, disassociation, and disordered thinking can be the direct result of the body's reaction to a favorite or commonly eaten food (Mandell and Mandell, 1983; Mandell and Scanlon, 1980). Mitchell et al., (1981) listed typical "binge foods" as ice cream, toast, candy, doughnuts, soft drinks, salads or sandwiches, cookies, popcorn, milk, cheese or cereal. Wheat and milk, very common

allergens, are in 10 out of 12 of these foods.

Dieting, the voluntary restriction of food, is considered to be the major precursor to binge eating (Abraham and Beumont, 1982; Bennet and Gurin, 1982, p. 67; Hawkins and Clement, 1980; Johnson and Berndt, 1983; Keys et al., 1950; Pyle et al., 1981; Smead, 1982; Wardle and Beinhart, 1981; Weiss and Ebert, 1983; Wooley and Wooley, 1981; 1985; Wooley et al., 1979). Binge eating is a known and predictable result of food deprivation and weight loss (Keys et al., 1950). Dwyer (1985) states "it is simplistic to regard dieting as necessary and sufficient in itself to cause anorexia. However, the mind sets, attitudes, and behaviors associated with dieting may predispose individuals to develop these disorders." She also notes that "adolescent females as a group are so sedentary that, in order to maintain energy balance, their calorie intakes must be several hundred calories below the current Recommended Dietary Allowances." However, Wooley and Wooley (1985) write:

> in the current cultural climate, dieting (starvation) itself may be a sufficient condition for the development of anorexia nervosa and bulimia. Relative vulnerabiltiy is a function of (1) intensity of perceived social and familial pressure to be thin, and accompanying body image disturbances; (2) genetic and constitutional variablility in the body's responses to starvation and weight loss...and (3) the extent to which eating disorders serve to express the conflicts over parental identification experienced by young women (i.e., become a suitable language [Shoenberg, 1975] for such unarticulated feelings as the longing for power, rage over powerlessness, apprehension over loss of the female role and its protective cloak, and guilt over abandonment of female qualities of "goodness").

Evidence is accumulating that "dieting--the major treatment for obesity may also be a major cause of obesity" (Wooley and Wooley, 1979). Dieting appears to trigger adaptive metabolic mechanisms the body uses

to defend its natural weight (Bennet and Gurin, 1982, p. 87; Cannon and Einzig, 1983, p. 52) as described in Chapter III.

Peer Influences

The influence of peers on binge eaters is unknown. It is clear that social isolation is a perpetuating factor. Nothing of etiological significance is suggested by the literature.

Current Life Experience

Garfinkel and Garner (1982, p. 191), citing Weiner (1977), note that the onset of a disorder is determined by an individual's failure to adapt to the demands in which she is placed. These demands can be highly varied. Also initiating events can be quite different from predisposing events. Furthermore, the "lack of an apparent environmental change is misleading, since with biological maturation the same environment may require new personal and social behavior." Halmi et al., (1977) have suggested that when anorexia develops without external stressors, there is greater underlying pathology and resistance to treatment.

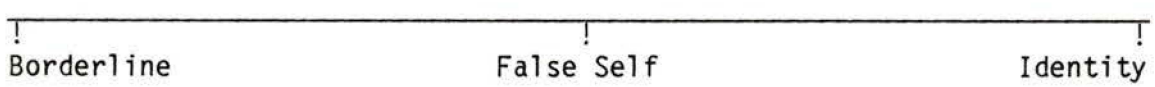
No single predisposing event has been identified for binge eating, anorexia nervosa, Bulimia or obesity, although many anecdotal individual reports are available. For anorexia nervosa, Garfinkel and Garner (1982, p. 204) write: "What the initiators of anorexia nervosa do have in common is that, whatever the event, the individual percieves personal distress in the form of 1) a threat of loss of self-control and/or 2) a threat of actual loss of self-worth." This leads to a heightened preoccupation with her body and the eventual conviction that she will feel better about herself if she loses weight.

Orbach (1977, p. 55) discusses a mechanism whereby some people begin to compulsively eat in circumstances of psychological safety and security, long after a traumatic period has passed:

> A girl grows up in a difficult environment, but needs to survive it intact as much as possible in order to get out. Any expression of breakdown or weakness would only prolong the imprisonment and make escape more difficult. All her resources are harnessed so that she can endure the horrible circumstances and prepare for an exit. She finally leaves this setting and puts herself in a safer place. As she begins to relax in her new-found safety and lets her defenses down all the wretched feelings from the past have a chance to come up. It is not as though in leaving the situation she has left the feelings behind. The safety and security of the new situation provides for a detoxification process. But these feelings are very powerful and very often extremely painful and the human organism may respond by trying to continue to ward them off. In the case of someone who starts compulsive eating at this point, what is happening is that the feelings are coming up but are experienced as too dangerous to confront. The woman turns to compulsive eating to anaesthetize the feelings and cover them with a layer of fat. The feelings do not get expressed and cleansed; instead they get transformed into a symptom which then has to be demystified before it can be made to go away.

Character and Personality

Swift and Stern (1982, cited Johnson, 1985) have suggested that eating disordered patient can be broadly characterized as falling along a continuum of intra-psychic structure ranging from borderline personality organization through a "false self" organization to identity conflicted. The following material is from Johnson (1985).



Borderline Personality Organization

> [These patients] (Masterson, 1977) are usually polysymptomatic; their eating disorder is secondary to a more serious problem of understructured internal resources. They present generally chaotic

and impulse-dominated life histories. Their affect is quite labile, fluctuating between rageful agitation and an anaclitic, empty depression. Intrapsychically, they are diffuse and undifferentiated, and have fragile self-other and inner-outer boundaries. Interpersonally, they intensely seek need-gratifying relationships and are very dependent upon external sources for tension regulation and self-management. Their cognitive style is concrete and dichotomous... binge eating is often experienced more as depersonalization than as dissociation, and purging is often very masochistic (similar to self-cutting)--an attempt to ward off self-fragmentation (Goodsitt, 1977).

False Self Personality Organization

These patients...generally present with life histories that appear uneventful, and their current life adjustments appear quite adequate...they are reluctant to talk about food-related behavior because to do so is to expose a less-than-adequate aspect of self. They are generally very compliant and nondemanding patients, who seem very careful about becoming too involved in treatment...there is often a common developmental theme among "false self" patients that has resulted in [a] wish-fear dilemma...for one reason or another (physical or psychological illness of the mother during a patient's infancy, or a situation in the family that has resulted in early physical or psychological separation), the patients were forced to separate prematurely and develop psychological autonomy. A successful pseudomature adaptation was an enormous relief to such a child's mother or the system, with the result that the child received positive reinforcement and a sense of self-esteem for compliant, non-demanding behavior.

The prefix "pseudo-" is appropriate, because while the child had adequate structure to make the superficial adaptation, she did not have adequate structure to accommodate all of her infantile needs, the needs became split off, isolated, and interpreted by the patient as troublesome, perhaps destructive, or even as a sign of being out of control. Progressively, the patient feels that she is two people: one who appears to be competently in control of things, and another who feels needy and out of control. The wish-fear dilemma revolves around the patient's wish for someone to identify and respond to her needs, which is juxtaposed against her fear that allowing someone to see the needy and dependent side will collapse the self-esteem and self-organization that has evolved as a result of the pseudomature behavior.

Identity Conflicted

Identity conflicted patients primarily represent those who have adequate intrapsychic structure and have become involved in food-related behavior for more neurotic reasons. There are often

clear precipitants for the onset of the behavior, or the behavior can be conceptualized as a developmental adjustment reaction. The pursuit of thinness among this group often revolves around identity and achievement issues; for bulimics, the eating behavior may be a compensatory alternative to conflictual drives, such as aggression or sexuality. If depression is observed, it is usually the introjective type (Johnson, 1985).

Critical Interactions

This model suggests a number of different interactions as possible. A number have been found to occur frequently. Nodal points appear to be the conflict between the female biological weight endowment and the cultural ideal of a "good" and "beautiful" woman. The other is when family needs conflict with the maturation of one of its members. The final node is when a person's internal resources are inadequate to meet developmental or situational demands and they choose to alter their biology in response.

A common and potent sequence appears to be: a person suffers a threat to their self-esteem or self-control, focuses their dissatisfaction onto their body as they are directed to do by their culture, and decides to diet. Temporarily, the diet provides feelings of power, self-esteem and accomplishment. However dietary restriction eventually results in biological consequences, one of which is a powerful urge to binge eat. This undermines the woman's sense of control and she institutes measures to combat the urge: she increases dietary restraint and eventually may begin to purge.

CHAPTER VI

TREATMENT OF BINGE EATING

The treatments described in the literature on binge eating, eating and weight disorders are diverse. Over time the trend has been away from rigid application of a particular theoretical model towards multimodal treatments designed specifically for these conditions. Virtually all studies are uncontrolled, clinical descriptions with little or no outcome data. The lack of common criteria for the evaluation of change makes comparisons between treatment effectiveness virtually impossible. Russel (1985) states "in view of the embryonic nature of the subject" one should refrain from harsh judgement about the relative lack of objective evidence to support efficacy.

The purpose of Table 7 is to provide a reference source of the major therapeutic efforts in the field of eating disorders. These authors have provided sufficient detail that another could attempt to replicate their methods. Most of these authors have published numerous times; these selections represent their most explicit treatment descriptions.

The recent publication of the "Handbook of Psychotherapy for Anorexia Nervosa and Bulimia" edited by Garner and Garfinkel (1985), provides in one source a detailed description and review of the treatments offered. It is strongly recommended.

A growing integration between traditionally opposing theoretical proponents is apparent: the psychodynamic theorists are now appreciating the need to address directly issues of food and weight. Cognitive-behavioural therapists are focusing on self-concept deficits and the

TABLE 7: TYPES OF THERAPY DESCRIBED

Type of Therapy	Author & Date	Disorder	Format	Emphasis/Comments
Ego Psychology	Bruch, 1973	Anorexia nervosa Thin-Fat Obesity	individual & family therapy	-"fact-finding" non-interpretive -significant issues are autonomy, identity & body ownership
	Browning, 1985	Bulimia	long term group	-pschodynamic
	Giest, 1985	Anorexia nervosa	long term individual	-'self-psychology' model
	Goodsitt, 1985	Anorexia nervosa	individual & family hospitalization at times	-'self-psychology' model
	Orbach, 1985	Anorexia nervosa	individual	-accepts the symptom -feminist/psychoanalytic
Behavioral	Halmi, 1985	Anorexia nervosa	hospitalization & individual after care & family therapy	
	Rosen & Leitenberg, 1985	Bulimia	individual	-anxiety reduction model
Cognitive-Behavioral	Boskind-White & White, 1983	Bulimia	short-term group	-feminist -group is "a social cure for a social neurosis"
	Fairburn, 1985	Bulimia	individual-5 months	-3 stage model

TABLE 7: TYPES OF THERAPY DESCRIBED (Continued)

Type of Therapy	Author & Date	Disorder	Format	Emphasis/Comments
Cognitive-Behavioral (continued)	Garner & Bernis 1985	Anorexia nervosa	individual	-numerous cognitive strategies
	Loro & Orleans, 1981	Obese binge eaters	individual	-reviews behavioral strategies
Family	Minuchin, et al., 1978	Anorexia nervosa	family systems & hospitalization	-high success rate with young anorexics
	Schwartz et at., 1985	Bulimia	family & marital	-issues particular to bulimics families
Multicomponent	Garfinkel & Garner, 1985	Anorexia nervosa -includes bulimic anorexia	individual/family & hospitalized	-very comprehensive
	Lacey, 1985	Bulimia	individual & group	-2 programs for 2 types of bulimics
	Orbach, 1977	Compulsive eater presumably obese	group	-feminist & unique -some body image work
	Wooley & Wooley, 1985	Anorexia & Bulimia	individual/group/ family	-body image treatment described

theraputic relationship. "Therapists from different schools emphasize the recognition and expression of affect; the value of exploring family interactional patterns; and the relevance of such developmental issues as separation, autonomy, sexual fears, and identity formation" (Garner and Garfinkel, 1985). Many therapists now use and advocate a mixture of psychodynamic, behavioural, cognitive and family methods.

Treatment specific to binge eating alone has not be described, although the literature on Bulimia contains many appropriate interventions. Loro and Orleans (1981) reviewed behavioural interventions for obese binge eaters.

The following section is based on the general trend in the recent literature towards beginning treatment with a strong behavioural program to bring the chaotic eating under the person's control followed by a focus on intrapsychic and interpersonal concerns. Family therapy, if appropriate for the individual, may occur concurrently or in the second phase.

Philosophy

A multidimensional treatment plan is recommended. It is imperative that the treatment be individualized (Boskind-White and White, 1983, p.160; Johnson, 1985; Orbach, 1977, p. 132; Wilson, 1976). Pertinent questions are "How does this patient use food to handle which particular difficulties of living?" and "What factors are sustaining the behaviour in this patient?"

The responsibiltiy for change must be the client's (Boskind-White

and White, 1983, p. 192; Brice, 1981; Colvin and Olson, 1985; Orbach, 1985; Lacey, 1985). Control is a particularly difficult issue. Lacey (1985) writes:

> For a disorder that is marked by behavioral chaos, control is essential. Dietary chaos is the presenting complaint, and the bulimic patient craves order. However, her wish is ambivalent: Vigorous attempts to impose outside control will lead to anger, aggression, and avoidance. The high dropout rate of some treatments stems from such therapeutic zeal. Rather, control has to be exerted through the patient--yet the patient herself has usually made repeated efforts in vain to achieve just such discipline. The program must therefore provide a structure that will enable the patient to bring order to her eating.

The binge eater is both overcontrolled and undercontrolled (Gormally et al., 1980) and requires both structure and setting of limits (Neuman and Halvorson, 1983, p. 79; Leverkon, 1985).

It is necessary to address both the eating/weight issues and the psychological issues if meaningful long-term change is to occur (Bruch, 1973, p. 327, 349; Garfinkel and Garner, 1982, p. 289; Goodsitt, 1985; Lacey, 1985; Orbach, 1977, p. 136). Fairburn (1981) found that bulimic patients were "so demoralized by their loss of control and so preoccupied with food and eating that they [were] inaccessable to complex cognitive interventions."

Assessment of the Counsellor

Knowledge of eating disorders and their psychological aspects is important (Garfinkel and Garner, 1982, p. 262; Lacey, 1985; Strober and Yager, 1985). Most important is the ability to be warm and accepting, to "keep in check any impulse to blame or scold" (Strober and Yager, 1985).

There appears to be no evidence to support the intrinsic benefit of

one sex over the other in individual therapy (Garfinkel and Garner, 1982, p. 261; Fairburn, 1985; Sargent, Liebman, and Silver, 1985) despite the recommendation of some of a female therapist (Boskind-Lodhal, 1976; Selvini Palazzoli (1978) and others of a male therapist ~~therapist~~ (Szyrynski, 1973). The particulars of the patient may indicate one sex as preferable. Lacey (1985) found the counsellor's sex to be less critical in individual treatment than in group treatment. In group therapy, two women were strongly preferred over a man and a woman therapist by Bulimics. The issues addressed varied according to the sexes of the therapists. Boskind-White and White (1983, p. 170) use a woman leader for certain issues and a woman/man team at other times in their group program. For family therapy, the sex of the therapist was less important than their repetoire of responses and their ability to be "gentle and firm with both men and women" (Sargent et al., 1985).

It is important for counsellors to assess and clarify their attitudes towards food, weight, the body, women's roles and capabilities. Treating anorexia nervosa taxes the counsellor's emotional capacity. Cohler (1977) found working with anorexics "leads to intense emotional reactions in the therapist; perhaps the most intense encountered in a therapeutic relationship." The capacity of the therapist to bear the feelings of "hopelessness, manipulation and powerlessness" is important.

Lacey (1985) outlines another consideration:

> clearly the psychopathology of the the therapist must be important for patient outcome. Women therapists may find themselves drawn to treating eating disorders by difficulties of a similar nature within

> themselves. Such therapists do badly: In simple terms, they tend to relate to the patient's problem rather than to form an alliance with that part of the patient's mind that wishes to get better. Male therapists, on the other hand, can get into difficulties when they misunderstand the psychopathology of the disorder. The bulimic is a woman "out of control," and the sexuality of this can be vicariously enjoyed by the poorly trained or inadequate male therapist.

Associated Services

A reliable liason with a physican is required (Levenkron, 1984; Neuman and Halvorson, 1983, p. 85; Sargent et al., 1985) as eating disordered clients should be medically evaluated and followed (Johnson, 1985). A client require counselling support to fully disclose her disordered eating to a physican. A warm, understanding and knowledgable physician is essential (Neuman and Halvorson, 1983. p. 85). If a counsellor suspects the signs of depression are of a biological origin, a referral to a physican for anti-depressant therapy is indicated. Neuman and Halvorson, 1983, p. 85) write:

> the general consensus seems to be that if 15 percent of the client's original weight has been lost (including the weight she would normally have gained due to growth), she should at least be seeing a physician regularly. If the client's weight is 25 percent below what it should be, hospitalization is imperative.

A close working alliance with the doctor and other professionals is necessary to avoid having one professional played off against another.

Assessment and treatment of food allergies is a delicate matter due to theoretical differences in the medical profession. Generally speaking, a Clinical Ecologist (an M.D.) or a naturopath is preferrable to a traditional allergist. A counsellor can learn to use biokinesiology to screen her clients. A well-motivated client may opt for self care. Knowledge of local allergy support organizations is useful.

A useful adjunct to therapy in many cases is a referral to a dietician. However, the choice of dietician is critical. An understanding of the psychology of eating disorders is crucial. Kalucy et al. (1985) write: "the dietetic profession attracts an unusual number of adherents who have anorexia nervosa, anorexic attitudes, or, at a minimum, unusually overdetermined value systems about food, weight, and fitness." He also notes that the values of the profession (good foods versus bad foods and thinness=health) reinforce beliefs the counsellor is working to eliminate or modify in his client.

The dietician must be directly informed of the client's diagnosis by the counsellor or the anorexic will say she wants to lose weight and the Bulimic that she has a bit of a problem with overeating (Neuman and Halverson, 1983, p. 151).

Assessment of the Client

Johnson (1985) have developed an standardized interview format, the Diagnostic Survey for Eating Disorders, or DSED. The following is taken primarily from their article.

The ~~the~~ first few minutes of the initial interview is extremely important. The first inquiry is into how the person feels about coming to the interview. The intent is to discover the extent to which they are voluntarily seeking help and the degree of coercion from family and friends. He next asks if the client has ever talked with anyone specifically about her difficulties with food. This assesses the degree to which the symptoms are ego-syntonic and acknowledges the secrecy and discomfort of the client.

Johnson favors a structured interview for a variety of reasons: it allows the therapist to demonstrate awareness of some of the unique problems of disordered eating; it provides a common language; it overtly addresses the eating problem which may have been ignored in previous treatments. Wooley and Wooley (1985) state:

> The interviewer should never be timid about inquiring about unusual behaviors or feelings, since the very questions reassure the patient that the therapist knows the terrain, and they give ~~the~~ the patient permission to be more self-disclosing without risk of shocking the therapist.

A weight history is obtained: current height, weight, and ideal weight, occupational considerations regarding weight, and highest and lowest weights since age 13. If significant fluctuations are mentioned, Johnson explores correlations with specific life events such as separations, losses, major transi$tions, family problems etc. This assists the client in beginning to think psychologically about her body, eating and weight concerns. Family and peer emphasis on thinness, dieting and appearance and influences on the client's self concept and beliefs about self-control and social acceptance are examined. He inquires in detail about being teased about one's weight or body.

Body image is then discussed in order to assess the degree of body image delusion (versus dissatisfaction or distortion), the psychological adaptation it may be serving, and the degree to which it interferes with life adjustment. He asks if body dissatisfaction prevents the woman from engaging in activities such as dating, sexual relations, exercising etc. If the body distortion appears excessive, he will ask if others disagree with her perception of her body size. A hostile, resistant response

indicates a more delusional stance.

Dieting behaviour is assessed: how long the client has been involved in dieting, how much physical and psychological deprivation has been experienced, and the cognitive-emotional system that has evolved. Johnson inquires when dieting first began, why, particular sources of encouragement. Of particular interest is the preoccupation of other family members with food and weight. To assess the cognitive style (i.e. magical thinking etc.) he asks the client to explain her understanding of what calories are, how food is digested, what the function of fat is, and how fad diets work. Calorie-deprived binging or psychological-derived binging is considered. The avoidance of particular food categories such as complex carbohydrates is questioned.

Chronic preoccupation with dieting leads to ritualized behaviour around body measurement and exercise. The client is asked how often she weighs or measures herself, how ritualized the behaviour is, and how minor fluctuations in weight affect her self-esteem and daily activities. The longest period of time in the last 6 months she has gone without weighing or measuring herself, the events that correlated with that time period, and her willingness to let others temporarily monitor her status is determined. Exercise can become highly ritualized and quite debilitating. An attempt to understand its adaptive function is made:

> Inquiry regarding how the patient experiences the absence of exercise often offers clues...We have found that the exercise can serve a variety of purposes, including a hypomanic defense against a fear of paralyzing depression, a form of masochistic self-punishment, a goal-oriented pursuit of achievement serving narcissistic/exhibitionistic concerns, or as a general mechanism for regulating such tension states as anxiety, anger, and the like.

Binge eating is assessed at a micro and macro level. He determines when the problem began, the precipitating circumstances, and whether fluctuations in eating behaviour correlate with recurring life events. Information about the absence of binge eating is also critical: the longest period the person has gone without binge eating and the circumstances involved. The person may experience a variety of reactions to being symptom-free: a greater or lesser degree of disorganization, sense of loss, anxiety, or depression.

On a micro-level, the client is asked to describe her daily eating pattern in detail: the previous day's activities, including meals, binge episodes, and routine events. Of particular interest is the extent to which she is eating meals and what she considers a reasonable meal and a binge. The particular foods, events, times, or emotional states that recurrently trigger binges are determined. To begin the identification of possible food allergens inquiry into the "foods I can't stop once I start" and the "I can't imagine living life without this food" are needed (Mandell and Scanlon, 1980). Johnson explores the patient's phenomenological experience of binge eating in an attempt to discover what type of tension states they are attempting to regulate or what type of affective release they are seeking through binge eating. He writes "it is clear that the act of binge eating carries a unique significance for each patient, and it is incumbent upon the interviewer to try to understand what specific function or functions the behavior serves."

In assessing purging behaviour, the onset, precipitants, duration,

frequency and method of purging are determined. The adaptive function of purging is explored as it, too, may serve a variety of purposes: release of affect such as anger, a means to reestablish control after a binge, self-punishment or as a masochistic act like self-cutting that reorganizes or reorients a patient who may be fragmenting under the impact of an intense feeling state. How primary the behaviour has become is important; some people binge in order to purge and some purge to undo the binge. The longest period of abstinence, the precipitants of abstinence, the effect on binge eating and the degree of discomfort are explored.

As laxative abuse has been shown to be very predictive of life impairment (Johnson and Love, 1984, cited Johnson, 1985), careful inquiry into their use is made. Users often have peculiar ideas about how laxatives work, which offers an opportunty to assess cognitive distortions. Johnson then gives didactic information about laxtive use to assess a person's capacity to modify their distorted beliefs.

An attempt to learn what strategies the person has employed to stop or manage the symptomatic behaviour illuminates how ege-syntonic the symptoms are and the degree of helplessness and hopelessness involved. Johnson discusses the concept of "learned helplessness" in regard to the binge-purge cycle. In his experience, providing hope in the initial interview that the symptom can be managed can reduce binge eating episodes up to 50%.

Related problems can be affective illness, multiple substance abuse and impulse problems. Johnson investigates the nature of the depressive

experience. The purpose of inquiry into substance abuse and other impulse problems is to determine if the eating problems are secondary to a generalized borderline personality organization.

A sexual and menstrual history is taken. The objective is to understand the individual's specific sexual feelings and behaviour as part of her overall adjustment. It is useful to inquire about the person's thoughts, feelings, and interest in sex as well as her actual behaviour as these may be divergent. Oppenheimer, Palmer and Brandon (1984) strongly recommend inquiring about sexual abuse and providing an opportunity to discuss such experiences in an intial interview. The menstrual history determines if ammenorrhea (cessation of menstruation) has occurred and at what body weight. This is useful information if a restored body weight must be calculated. Sometimes eating problems vary with the menstrual cycle, particularly with women who suffer from premenstrual syndrome.

The family history attempts to asssess the person's biological vulnerability to illness (psychiatric and medical) and the family environment. A positive family history of affective illness and/or alcoholism and positive vegetative symptoms of depression are usually indications that a trial of antidepressant medication may be helpful. A family history of allergies of any sort and/or alcoholism should alert the counsellor.

The family environment is discussed in an attempt to determine whether the family is enmeshed, disengaged, overcontrolled, or undercontrolled as well as how much free expression of affect exists,

the extent of achievement orientation or perfectionism, and how much stability and flexiblility exists in the system. The quality of the parent-child relationships and the degree to which a client's symptomatic behaviour may be serving an adaptive function within the family system is examined.

Life adjustment is considered: how the symptoms have affected her work, daily activities, relationships, and sexual activity. The capacity of the client to engage in self-enhancing activities is explored. Often eating-disordered clients are self-sacrificing, achievement-oriented people who take much better care of others than of themselves, and are too goal-oriented to simply enjoy activities.

Garfinkel and Garner (1982, p. 268) ask the underweight person "Although I understand you would prefer not to gain weight, if you were to gain, at what point would you begin to experience panic?" Many people identify a particular weight. If this weight corresponds to the threshold for the return of the menstrual function, it is appropriate to introduce the idea of weight loss as a means of not "growing up."

For normal weight people who are purging, Johnson asks "Would you be willing to gain ten pounds in exchange for not having any more difficulty with binge eating, purging, or food preoccupation?" One group assures him they would rather be dead than gain 10 pounds. Generally, these women have experienced first hand "Cinderella-like transformations" in their socio-economic status or their romantic lives as a result of past weight loss. "They have actually experienced the social discrimination and alienation of overweight individuals,

particularly towards females, in our current culture."

Wooley and Wooley (1985) like to ask "You have lived with this problem for a long time and you know yourself better that anyone else. What do you think caused this? Why did you, in particular, develop this problem; and why do you think it is so hard to give it up?" Most people have great deal to say and provide much useful information in response.

Goal of Treatment

The goal of treatment as described here is to eliminate or reduce the eating pattern of binge eating without precipitating or exacerbating a weight disorder. It is to break the addictive relationship to food (Lacey, 1985; Orbach, 1977, p. 126).

Treatment Strategies

The following have been divided into biological, psychological and sociological for clarity of description. Naturally, such distinctions are arbitrary and interactive. Frequently treatment initially focuses on controlling the chaotic eating with the "biological" interventions. The client is then more available and interested in emotional, cognitive and behavioural aspects. However, some clients are very resistant to dealing with food or weight issues until a trusting relationship is well established (Johnson, 1985).

Biological

1. Food Allergy Identification and Treatment. Identification begins in the initial assessment. Suspect foods are the person's favorite, the most frequently eaten item, any food the person eats at every meal, any food they cannot imagine living without, any food that once they start

to eat them they cannot stop voluntarily. Binge eaters should be screened for food allergies before being treated psychologically. This is especially true if a history of allergy or alcoholism is present. Recommended reading for counsellors and clients is "Dr. Mandell's Five Day Allergy Relief System" (Mandell and Scanlon, 1980) or "It's not Your Fault You're Fat" (Mandell and Mandell, 1983).

2. Establish a regular pattern of eating. As one of the major driving forces of binge eating is undoubtedly food deprivation, the eating of regular meals is strongly recommended (Fairburn, 1985; Lacey 1983, 1985; Mitchell et al., 1985; Wooley and Wooley, 1985). The methods of meal planning vary somewhat by author but it is the structure provided that is most helpful. The client needs the reassurance that her eating will not be allowed to get out of control and make her obese; she has little idea of what constitutes a normal meal; her hunger and satiety mechanisms are likely to be faulty and will take several months to regain normality after chronic dieting. The general rule is that the quantity be consistant and sufficient to ultimately reduce hunger (Garner et al., 1985).

For a Bulimic who has been dieting and purging only the experience that a "normal" diet does not result in obesity will convince her of the validity of the approach. This critical discovery usually occurs in the third week of treatment (Lacey, 1985).

A gradual introduction to previously "forbidden foods" (after the determination they truly are safe from an allergenic point of view) is needed. Usually complex carbohydrates and "fattening foods" have been

excluded and need to be reintroduced in discrete amounts to counter the fear that consumption of them will lead unerringly to total dyscontrol and obesity. Garner et al., (1985) prescribe them as "medicine." Beliefs that any food is "good" or "bad" or inherently fattening need to be challenged.

Many habitually delay eating as long as possible in the day or as long as possible after a binge. Regular meals must be eaten, regardless of recent binges (Fairburn, 1985; Garner et al., 1985; Lacey, 1985).

Educating the client about the effects of food deprivation on control of eating, deposition of body fat, set point theory and metabolic rate is very useful in gaining their cooperation in following this regime.

3. Stabilize the current weight. Naturally, this recommendation is inappropriate for a severely emaciated anorexic or grossly obese person whose weight is imminently threatening their health or life. For the majority of binge eaters stablizing body weight is necessary to regain control of eating. A number of purposes are served: it interrupts the yo-yo of gains and losses; it reassures the client that the purpose is not merely to "fatten her up"; it is likely to be a success experience; and it immediately decreases the internal pressure to change her weight. It supports the body's mechanisms for regulating appetite, weight and body fat. It is achievable. A reducing diet is inconsistant with the goals of treatment (Garner et al., 1985; Lacey, 1985; Mitchell et al., 1985).

Therefore, the initial contract with the client is to maintain and

stabilize the current weight. The ultimate goal is for the client to achieve and maintain a healthy weight for height. When, and if, to institute measures to change the person's weight is dependant on a number of factors. First, the client will wish to be smaller and this is part of the disorder. She will likely desire a weight that perpetuates her eating problems and cannot be easily maintained. If underweight, she will need to accept a higher than desired weight if she is to be symptom-free. The obese binge eater will no doubt wish to lose weight as well, but dieting is contraindicated. She may well lose weight without dieting when binging is controlled. She may require a great deal of support and education to use other methods or to accept her body as it is.

The counsellor may need to determine the weight range to be used as a target. A range of 3-5 pounds around a weight appropriate to age and height is preferrable to a specific weight (Neuman and Halvorson, 1983, p. 80). For young clients, Russel (1979) defines a healthy weight as "her weight during her early 'teens when she was still in good health and unconcerned with dieting." Garfinkel, Garner and Kennedy (1985) prefer determining the person's own "normal weight range" to using statistical tables. They state "the final target weight should be a range in which (1) the patient can maintain the weight without undue dieting, (2) there is normal hormonal functioning, and (3) the cognitive and affective sequelae of starvation are improved.

4. Normalize exercise. Regular aerobic exercise at moderate intensity appears to be important for weight maintainence and body composition

(Bennet and Gurin, 1983, p. 101; Remington, Fisher and Parent, 1983, p.7), and should be encouraged for the sedentary or the self-concious. However, exercise for self-punishment, overachievement, or compensation for chaotic eating by ritualistic and compulsive exercisers (Johnson, 1985) needs to be modified. The goal is to reduce the obsessional behaviour and to introduce fun, pleasure and self-awareness. Two strategies are time structuring, and education about the recent understanding of exercise and body physiology (Bennet and Gurin, 1982; Cannon and Einzig, 1983; Remington, et al., 1983). Exercise can be a useful alternative to a binge eating episode.

Psychological

The techniques presented here are appropriate to individual or group counselling. Family therapy is discussed elsewhere.

Emotional

Establishing a trusting relationship is primary. While this is true for all therapy, it may be particularly difficult with the these clients. Bulimics and anorexics have difficultly allowing themselves to get close to anyone. The anorexic is unlikely to feel herself in need of help and perceives the counsellor as an adversary whose only interest is to fatten her up. The binge eater's shame and secrecy and inadequate self are threatened with exposure in counselling (Garfinkel and Garner, 1982, p. 263, Bruch, 1979, p. 145; Neuman and Halvorson, 1983, p. 75).

A caring attitude, warmth, and genuine concern for the individual is needed (Brice, 1981; Bruch, 1973; Garfinkel and Garner, 1982, p. 263; Strober and Yager, 1985). The counsellor must convey their understanding

that the problems extend beyond the issues of food and weight. Simplistic interpretations of the symptoms should be avoided and clear language, free of jargon be used (Garfinkel and Garner, 1982, p. 264) Inappropriate or intense warmth will trigger negative reactions as "he appears to like me and I know I am worthless" or feeling "undeserving of such caring" or panic at being too close (Garfinkel and Garner, 1982, p. 263).

Bruch (1963; 1973, p. 338) advocates an approach she calls "the constructive use of ignorance":

> for effective treatment it is decisive that the patient experience himself as an active participant in the therapeutic process. If there are things to be uncovered and interpreted, it is important that the patient makes the discovery on his own and has a chance to say it first. The therapist has the privilege of agreeing or disagreeing.

Bruch (1973, p. 338) recommends the counsellor and client act as co-detectives, "true collaborators in the search for unknown factors." It is important that the client feel that the therapist does not have some secret knowledge which is held back. The experience of being listened to is necessary and may be new.

A primary treatment goal is the genuine and appropriate expression of feeling. Some clients are "not even able to identify feelings much less to express them. Some individuals are aware of their feelings but lack the skills and/or the belief system which would support the expression of those feelings" (Neuman and Halvorson, 1983, p. 90). Goodsitt (1985) writes:

> Often [the therapist] knows, by close observation of facial expression and behavior, that the patient is depressed, angry, or

> disturbed before the patient is aware of it. When the patient denies that anything is wrong, he asks her to look inward to find out what she is feeling. When she explains her bingeing or vomiting as simply habit, he asks her to examine more carefully what was occurring and how she was feeling immediately prior to the binge-purge.

Gentle probes into generalized or vague complaints such as "depression" are needed, as well as discerning genuine and fake feelings in themselves and others, an area that may be undeveloped (Bruch, 1985). The client will need help to elaborate a vague sense of "feeling bingy" into the complex and varied emotions this phrase covers. Dysfunctional beliefs about feelings need to be identified and modified. For an anorexic unable to identify feelings, approaches that strongly promote the expression of feeling (such as Gestalt, existential, and Encounter) can be "devastating and well beyond [their] immediate capacity" (Garfinkel and Garner, 1982, p. 277), yet may be used to good effect for more emotionally robust Bulimic clients (Boskind-White and White, 1983; Wooley and Wooley, 1985).

The intense feelings of body hatred, self-hatred, and fears of fat and eating need to be accepted as valid for the client at the time by the counsellor (Garner and Bemis, 1985; Goodsitt, 1985; Giest, 1985; Orbach, 1985; Strober and Yager, 1985). Giest (1985) gives an excellent example of empathically responding to an anorexic's fear of fat. When she first said she felt fat, the therapist "didn't tell me I didn't look fat, show me a mirror, or tell me I had to gain weight"; he asked her whether her whole self or part of her felt fat.

Fear may be expressed as resistance, disruptive behavior, deceit about food, hostility to the therapist. These behaviours are likely to

provoke strong reactions in helpers (Garfinkel et al., 1985) who do not understand the motives as fear of weight gain and fear of closeness. The person may be saying "It will be less painful if you reject me now for my unacceptable behavior than later when you recognize my intrinsic inadequacy" (Garfinkel and Garner, 1982, p. 265).

"Insight into the relationship between binging behavior and emotions facilitates learning how to express unacceptable feelings in more conservative ways" (Leclair and Berkowitz, 1983). Appropriate expression of feeling is the goal those whose binges serve to contain, anaesthetize or indirectly express one or more feeling states. The emotions of difficulty must be identified and alternate means of expression found. The counsellor can serve as a model for a full range of feeling as well as validate and support the client's expression of a broader range of feeling.

Anxiety is likely when the disordered pattern is challenged. Orbach (1977, p. 107) states: "contrary to popular images of greed, the compulsive eater is quite frightened of food and what it can do to her," and so may be anxious at the beginning to eat normally. Beginning to express feelings, beginning to gain weight (for the underweight), beginning to lose weight (for the overweight), nearing the target weight, resuming menstration can evoke intense anxiety. The person will need support to tolerate the experience and thereby learn that anxiety does not harm people (Wooley and Wooley, 1985).

Because anger and self-assertion have consistantly been identified as difficult for the eating disordered, assertiveness training has been

widely recommended. However, Wooley and Wooley (1985) contend that:

> learning the techniques of assertion and expression do nothing to ensure that they will ever be used when they are needed most--in emotionally charged situations, in which there is typically an enormous, unarticulated fear of repercussions. We find it useful to provide skills training, but only after a group experience in which patients have become desensitized to the danger of saying what they mean.

Their clients "embrace these techniques precisely because they have acquired the emotional strength to use them for purposes more pressing than sending back an overcooked steak."

Neuman and Halvorson (1983, p. 91) found eating disordered people had a tendency to "catch feelings" from others, particularly in groups, and developed a technique called "separating away." At the end of the group session, each member is asked to mentally separate her identity from the identity of other members, especially those she has related to emotionally in the session.

Wooley and Wooley (1985) and (Orbach, 1977) present a number of techniques for working with body image: videotaping, drawing whole body outlines followed by tracings of the body outline, awareness exercises of being fat and thin in various situations, acting out their mother's body movements, art work depicting their bodies and their families, clay modelling, viewing themselves in the mirror for many minutes, experimenting with clothing styles and creating more positive images of women's bodies. The non-verbal techniques have been found to be powerful and to release previously unavailable experience and feeling.

Orbach (1977, p. 75) uses guided fantasy to access the person's fat and thin self-images. Imagining themselves at parties, or at the beach,

or at work with larger and smaller body sizes is done. The fear of food is explored by fantasy shopping trips and kitchens filled with all one's favorite foods.

Cognitive

Cognitive interventions are very widely used for the eating disordered (Bruch, 1973, p. 143; 1979, p. 144; Boskind-White and White, 1983, p. 153; Fairburn, 1985; Garfinkel and Garner, 1982, p. 270; Strober and Yager, 1985).

Educational approaches have a definite place in the treatment of binge eating. Learning that their apparently unrelated symptoms are "starvation symptoms" or that inexplicable binge eating is a natural result of food restriction helps them to integrate their experience, increases willingness to enter and pursue treatment, provides an alternative weight control scheme (Garfinkel and Garner, 1982, p. 267; Wooley and Wooley, 1985). At carefully chosen points in treatment, the following topics are covered (1) weight regulation in terms of "setpoint", (2) the effects of starvation and/or the binge-purge cycle, (3) the effects of bulimia on health, and (4) the recovery process. The best single source currently available is the article by Garner et al. (1985).

Anaylsis of the function binges serve in the person's world is useful (Boskind-White and White, 1983; Brice, 1981; Crisp, 1980; Fairburn, 1985; Johnson, 1985; Orbach, 1977). This is most feasible when eating has become less chaotic. Fairburn (1985) writes: "The idea that binge eating serves a function is novel to most patients. Usually they

find this notion reassuring, since it starts to make sense of the eating problem. Each time the person overeats she should be encouraged to examine why she did so."

Six common beliefs have been identified by Boskind-White and White (1983, p. 153) and White (1985) that, if not identified and challenged by the counsellor, will interfere with the treatment effectiveness of bulimarexia. These beliefs are very similar to ideas Marlatt and Gordon (1985) consider likely to result in relapses after treatment. They are likely in any binge eater and have been modified for that group:

> Binging is a disease that must be cured.
> It has taken years to develop so will take years to cure.
> If I am going to give it up, I must do so alone.
> As a binge eater, I am powerless in the face of food.
> Life will be great when I stop binging.
> I must know why I binge in order to stop.

Neuman and Halvorson (1983, p. 106) ask clients to identify thoughts that lead to a binge or to a diet (which they say are surprisingly similar from person to person) by writing them down before, during and after a binge. This expands a person's awareness and, hopefully, breaks into the automatic response pattern. The client then develops a list of the most common messages and learns to refute them. Practice is important. The client learns what her "binge thoughts" are and develops the skill to replace them with more adaptive ideas. Garner and Bemis (1985), Garfinkel and Garner (1982), and Fairburn (1985) use similar methods.

As clients may already be distrustful and unsure of their thoughts and feelings; direct challenge of their thinking is likely to reinforce

their sense of inadequacy or trigger resistance. Probes and suggestions must occur in an atmosphere of acceptance. Like all aspects of treatment, individualized application is necessary (Garner and Bemis, 1985).

Specific techniques described Garner and Bemis (1985) are:

(1) Articulation of Beliefs: Expressing the essence of a belief in simple phrases is useful. The mere act of articulating can change the belief, or the distortion within it is highly apparent and easily identified.

(2) Decentering: This technique involves applying the same evaluative standards to others that the client is applying to themselves. "Does your admiration for friends or teachers correspond directly to their weight?" "You've never asked about my grades, how do you know I'm a worthwhile and competent counsellor?"

(4) Challenging the "Shoulds." Awareness of "should," "must" and "ought" thoughts is needed. "Should-resisting" experiements are devised and carried out. Garner and Bemis (1985) note that these experiments expose conflict in the client and can elicit intense anxiety. Considerable support may be required and tasks graded to minimize the failure. The client needs to learn "can't" means "won't" and "never" and "forever" assure continued binging (White, 1985).

(5) Challenging Beliefs through behavioural exercises. Corrective experiences by personal experiments are jointly devised by the client and counsellor.

(6) Parroting. This is the repetitive reciting of adaptive phrases in

the face of anxiety in problem situations. For example, a Bulimic who has accepted the need for regular meals may find herself "assaulted" with thoughts about fat and intense urges to vomit after eating. She "parrots" the adaptive beliefs of "I will not get fat" "I need food to be healthy" over and over. The phrases must be accepted by the client or they will not work.

Self-worth valuations and performance expectations are examples of the psychological issues that can benefit from a cognitive component. The consequences relying on others' opinions and on one's performance to determine self-worth can be explored (Garner and Bemis, 1985): there is no assurance others will not reject; self-worth can be gained or lost daily; performance ratings are ambiguous: how much liking from a friend is needed for a person to be OK? How many friends are needed to prove one's worth? Discussions about how to determine specific amounts of worth for various traits and qualities will reveal difficulties in maintaining that position. Doing things purely for pleasure, rewarding the self, and "being lazy" need to be encouraged.

Kubistant (1982) uses a number of techniques to broaden the measures of self-esteem from the narrow focus on weight and eating. He redefines calorie intake from quantity only to quality and redirects their valuations to include strength, endurance and performance. To combat the evaluations of how they fit into their clothes, he has them consider energy level, and how one moves. They monitor their heart rates daily to measure cardiovascular fitness. On a symbolic level, they begin to see that "expanding" can be beneficial.

Paradoxical techniques have been used to good effect for binge eaters (Browning, 1985; Kalucy et al., 1985; Loro and Orleans, 1981; Schwartz et al., 1985). Loro and Orleans (1981) describe "programmed binging" as useful for rebellious binge eating, for those who percieve themselves as having little control over their binging, and for clients with a history of slips and relapses following a binge-free period. The counsellor asks the client to voluntarily binge at a certain place and time, to purchase the needed supplies and to keep careful records of the incident. The counsellor explains this is necessary to gather all the data and to fully understand the situation. This stategy is paradoxical in a number of ways: first, by asking the client to perform the problem behaviour on demand, the client is forced to think of it in new and different ways. Secondly, the request implies the behaviour is under the control of the client. Thirdly, the voluntary binge provides the experience controlling a previous uncontrollable behaviour. Finally, as the binge has the permission of the therapist, the client is freed from making destructive self-attributions of failure and weakness. If the client does binge as requested, a wealth of information is generated. However, "many report an inability to follow through with the binge, feeling disinterested in eating, while others are unable to eat as much food as planned" (Loro and Orleans, 1981). Schwartz et al., (1981) prescribe a relapse for Bulimic families near the end of their course of family therapy. The family and patient are directed to recreate the patterns of interaction and thinking that form the bulimic context. This is effective whether or not the prescription is followed. Browning

(1985) asks the client to decide to binge as many times in the coming week as she had in the previous week. Kalucy et al., (1985) gives permission to binge and vomit, provided they make a conscious decision to do so and carefully record not only their thoughts but their feelings prior to the act.

Neuman and Halvorson (1983, p. 98) encourage people to be concious of making a decision to binge, by having them write down "I am choosing to binge" or "I am choosing not to binge" each time the urge comes up.

Exploring the initial purpose of dieting or of binging or of purging is useful. Since the original purpose was to feel better about the self, or to gain freedom, and/or to be successful, questions of "Is this working?" "Are you getting what you want?" and "Does the method you've choosen work?" can assist the person to give up maladaptive stategies and try something else (Garner and Gemis, 1983; Garfinkel and Garner, 1982, p. 26; Neuman and Halvorson, 1983, p. 77; Smead, 1982).

Behavioural

A widely recommended and used technique is a food diary (Fairburn, 1985; Leclair and Berkowitz, 1983; Lacey, 1985; Mitchell et al., 1985; Neuman and Halvorson, 1983, p. 97; Orbach, 1977, p. 148; Rosen and Leitenberg, 1985; Wooley and Wooley, 1980, 1985). Initially, a food diary accomplishes three objectives: 1) documentation of baseline data of frequency of binging (and purging) 2) identification of patterns of daily life events that precipitate the binging behaviour and 3) the development of an objective source for ongoing feedback regarding behavioural change (Leclair and Berkowitz, 1983). Allergenic food

triggers can be determined. The patterns of both food intake and food avoidance are made clear. The binge eater herself can make connections between restraint, hunger and binge eating. Emotional issues "hidden" by the binge eating will emerge. Of particular interest are appropriate emotions not felt and appropriate actions not taken prior to a binge (Wilkie, 1986). An alternative to a food diary is a binge diary that focuses on the antecedents and consequences of the binge.

As a counterpoint, Boskind-White and White's (1983, p. 25) bulimarexic groups gave feedback that food diaries were ineffective or detrimental. They felt it gave them permission to obsess about food during valuable group time that was more productively spent on other aspects of their lives.

Goals for binge reduction need to be individualized and graduated. Leclair and Berkowitz (1983) measure success in terms of "free days," meaning days free of binges and/or purges. For people who binge many times a day, achieving a single free day is a significant step. Fairburn (1985) and Lacey (1985) recommend first establishing control over eating in the least problematic part of the day, usually the morning, and then extend the times to include the evenings.

The standard behavioural treatment regime used for overeating associated with obesity is inadequate for treating binge eating (Meyer, 1974). Wilson (1976) discusses his observations that binge eaters are not especially vulnerable to food stimuli; instead the conditions that govern the binges include such variables as interpersonal conflict and unassertiveness. However, stimulus control can be useful in other ways.

Reducing the use of or eliminating the weight scale is used by a number of authors (Boskind-White and White, 1983, p. 187; Brice, 1981; Orbach, 1977). Often clinicans will take over the weighing of a patient for the length of treatment (Garfinkel and Garner, 1982, p. 287; Lacey, 1985). Leaving food of all kinds on the plate and throwing away food are helpful (Fairburn, 1985; Orbach, 1977, p. 123). Having an adequate supply of food available and getting rid of stashes of "binge foods," shopping from a list, shopping when not hungry and carrying small amounts of money during times of poor control have been used (Boskind-White and White, 1983, p. 179; Fairburn, 1985; Orbach, 1977, p. 123). Getting rid of clothes that belong to an unhealthy body size is advocated also (Neuman and Halvorson, 1983, p. 84).

Alternative behaviours to binge eating must be devised and used. White (1985) has bingers make a hierarchy of precursors to binge eating, with at least two alternatives. No single behavior is powerful enough to displace binge eating under stress, a number of alternatives are needed (Boskind-White and White, 1983, p. 165). Fairburn (1985) has clients construct a list of pleasurable activities that are incompatible with binging to use at times of difficulty: having a bath, exercising, or phoning friends. Orbach (1977, p. 121) stresses the need to "feed" oneself with activities that nourish the orginal desire such as seeing a friend when lonely instead of binging. Boskind-White and White (1983, p. 180) strongly advocate the binge eater reach out for social support in times of stress. Specific contracts with friends and relatives about how they can help are necessary and it is important to have a number of

contact people, not just one. Garner et al., (1985) suggest a short list of alternative behaviours that must be done before binging. These are to be as self-enhancing and pleasurable as possible. The example they give is of a person who listened to a favourite song and read one page of poetry before she would consider vomiting. This served to interupt the familiar pattern.

Relapse Work

Marlatt and Gordon (1980) have researched the course of relapses and suggest methods to counteract or contain the damage. Typically, a high-risk situation involves two factors: 1) a negative emotional state, that is feelings of anger or frustration or boredom once handled by binging, and (2) overstepping skill level, that is, the situation requires a skill level not yet mastered and the response is to binge.

Post-binge a predictable but destructive pattern is likely. A "back-to-square-one" mentality occurs. The client will have extremely negative thoughts about herself, feel very bad, and consider herself totally unworthy and hopeless. The slip is taken as proof of her inability to recover and she will give herself no credit for gains made to date. Marlatt (1985) calls this the "Abstinence Violation Effect (AVE)." The person's reaction to the AVE determines whether the first "slip" becomes a full-blown "relapse." If no self-intervention occurs, the person will play down the importance of the goal of stopping binge eating. She will develop a strong case that she is OK as a binger, that recovery is not important or probable anyway and proceed to binge excessively.

The alternative is to teach the client about the AVE and strategies to deal with it. The negative feelings and thoughts of the AVE will pass if the person allows them to. The relapse is to be considered a necessary and positive step in skill building and as an opportunity to examine remaining difficulties and practice new coping strategies.

Techniques used in relapse work are relapse rehearsal by dry runs or covert modeling, teaching about the AVE, giving the client "reminder cards" to carry with them for use mid-relapse, analyzing the relapse and skill building. Metaphors used are learning to ride a bike, and learning fire drill procedures. Fairburn (1985) has the client devise her own "care plan" to be instituted at relapse. Neuman and Halvorson (1983, p. 101) contact binging clients after missed appointments as often they are in post-relapse guilt and are having difficulty returning to see the counsellor. Fairburn (1985) recommends the "unit of control" should be hour-by-hour. If a daily measure is used, one slip and the rest of the day goes for binge eating.

Sociological

An area of proven vulnerability for the binge eater is the tendency to compare herself unfavourably to the cultural ideals of women's bodies. A binge eater is likely to benefit from a concious awareness of the conflict between the cultural images of women and her own biology. Boskind-White and White (1983, p. 205) state that "hundreds of women strive for a feminine ideal that is practically impossible to attain." A portion of their therapy groups are devoted to "redefining feminitity" in terms of health and strength and personal satisfaction. Giving one's

power away to men and the social ideals is examined.

Garner and Bemis (1985) discuss the inherent difficulty of relaxing overvalued ideals of thinness and achievement when subjected to constant and consistant media messages that promote those attributes. The counsellor must never assault the patient's values, yet the client needs to be encouraged to critically examine their values. One method is to provide evidence related to the conflict between the biological determinants of weight and the recent cultural preferences for thinness for women and examples of performance values that the client can examine for themselves.

Hall and Havassy (1981) liken a compulsive eater in the kitchen to an alcoholic bartender, yet no author suggests women assign cooking or shopping to others. The usual strategy is to help a woman cope better with these high risk situations. Sex-role stereotyping is reinforced by default. It is incumbent on the counsellor to expand their ideas.

Wooley and Wooley (1985) have found benefit in addressing sociocultural issues in their body image groups. However, they caution timing is important: "our impression is that premature introduction of this issue may delay or mitigate the exploration of personal and familial sources of poor body image." They show educational films about portrayal of women in the media, distribute feminist articles, and have clients rewrite advertizing copy that capitalizes on stereotypes of women.

Family Therapy

Family therapy is frequently used and recommended for the eating disordered in conjunction with individual, group and marital therapies (Anderson, 1985; Bruch, 1973; Bologna, in Newman and Halvorson, 1983, p. 116; Garfinkel et al., 1985; Kalucy et al., 1985; Strober and Yager, 1985; Wooley and Wooley, 1985). Others use it as a primary mode of treatment (Minuchin, Rosman and Baker, 1978; Sargent, et al., 1985; Schwartz et al., 1985). Neuman and Halvorson (1983, p. 117) recommend family therapy for clients under 16 and/or living at home. Although Bulimic clients are often older and living apart from their families, they may be deeply involved with their families (Schwartz et al., 1985).

"Family therapy" appears to vary greatly. Fairburn (1985) has the occasional meeting with family and friends of Bulimic clients so the secret eating problem may be disclosed and the significant others become helpful. At the opposite pole is the integrated, carefully planned series of interventions by two therapists directed at restructuring the family system (Sargent et al., 1985; Schwartz et al., 1985). Family systems therapy as described by Minuchin et al., (1978) is widely used.

"Shame- and guilt-laden topics, sources of anger, family secrets, disappointments, and injustices eventually need to be faced" (Wooley and Wooley, 1985). The usual response is the "sick child in a well family" recovers and previously unacknowledged marital or parental problems emerge for treatment and resolution.

CHAPTER VII

ASSESSMENT AND SUMMARY OF THE LITERATURE

The theoretical and practical problems associated with disordered eating have, to date, been primarily of interest to the clinicians responsible for treating them. The literature in this field reflects the training, needs and biases of this population of researchers. The majority of authors cited either actively treat eating and weight problems (i.e., Bruch, Crisp, Garfinkel and Garner, Russel) or have had eating or weight problems (i.e., Chernin, McLeod, Millman, Orbach) or both (i.e., Chernin, Orbach). The stereotypic "pure," "theoretical," "experimental," "academic," "abstract" researcher is notably absent. Instead, research is one activity of those active in other fields: as physicians, psychiatrists, psychologists, and university counsellors. Their formulations reflect the populations they treat. For example, the high-achieving, goal-oriented bulimarexics described by Boskind-White and White (1983) at Cornell University are less seriously disturbed than those seen in medical settings after multiple treatment failures (Johnson, 1985; Wooley and Wooley, 1985). Theoretically, orientations vary from a medical-illness model, through the major schools of psychological thought, to feminist analysis. Their audience for their publications are each other and other clinicians interested in these problems. Clinical, not statistical significance is the major concern.

Research into eating and weight disorders is historically recent. While the symptoms of anorexia nervosa were found in a young prince in the 11th century, it was not named and described in Western medicine

until 1868. (In 1863, the first published reducing diet had been devised by an ear surgeon). Anorexia nervosa went through a descriptive phase (1868-1910), then a medical phase (1910-1938), then a psychoanalytic period (1938-1960) (Sours, 1980, p. 203). In contrast, Bulimia emerged in the 1940's as a psychiatric rarity. The study of Bulimia separate from anorexia nervosa is no more than five to ten years old (Casper, 1983, cited Emmet, 1985). For anorexia nervosa, diagnostic criteria evolved over the last 25 years. For Bulimia, the first diagnostic criteria were published in 1980 (DSM-III, 1980). Fundamental information on incidence, diagnosis, etiology, treatment, outcome and mortality is only now emerging.

Using Millon and Diesenhaus's (1972) criteria in Table 1 (page 8), the infancy of Bulimia and youth of anorexia nervosa are apparent. The medical-psychoanalytic heritage is also evident in choice of research design. The majority of studies are case studies, usually amalgamated into groups. These and other naturalistic designs clearly place this field of inquiry into the "Exploration" phase. The handful of incidence studies (Cooper and Fairburn, 1983; Edelman, 1981; Halmi et al., 1981; Hawkins and Clement, 1980) and the occasional recent study of Bulimia using sample sizes greater than 10 and control groups (Boskind-Lodhal, 1979; Hatsukami et al., 1983; Johnson and Berndt, 1983; Johnson and Larson, 1982; Weiss and Ebert, 1983) would signal the beginning of the "descriptive" phase. No study to date would qualify for the "Confirmation" designation.

The majority of studies on eating disorders are the observations,

formulations and descriptions of cases by the person who treated them. These are, essentially, descriptive studies, groupings of single cases seen over time for diagnosis and treatment. Examples are Bruch (1973), Garfinkel, et al., (1980), and Russel (1979). To illustrate, Russel (1979) published an article describing "Bulimia Nervosa" in 30 patients seen consecutively by the author over a period of 6 years. His purpose was to describe the clinical features of this group as distinct from anorexia nervosa. This had not been done before in England. He extracted information from case notes on 30 anorexia nervosa patients who had been hospitalized during the same period to serve as a comparison group. The article tabulates information on the Bulimia nervosa patients such as age, age of onset, previous anorexia nervosa, previous healthy weight and minimum weight; the text is a detailed description of clinical observations, illustrative cases studies, a tentative theoretical model and a description of treatment in hospital. He concludes the prognosis is poorer than for anorexia nervosa.

Studies of this type serve a heuristic purpose. The material covered had not been published before and the article remains as useful source of basic descriptive data. However, a number of methodological weaknesses are inherent in the case study design (Campbell and Stanley (1966). Internal validity is threatened by four uncontrolled variables: selection, mortality, history, and maturation. In addition a number of treatments were used simultaneously. Maturation is particularly critical as the question of whether bulimia is a symptom of chronicity in anorexia nervosa, or if it is a syndrome in its own right, is unanswered.

Despite the methodological weakness, a volume of clinical observations, research reports, case histories, theoretical formulations and outcome studies has accumulated and yeilds a general, and surprisingly consistant, picture. Anorexia nervosa has been the prototype eating disorder and this accumulative process is well advanced. The subject of Bulimia, only recently separated from anorexia nervosa, is not as developed, but is benefitting from the "explosion" of research interest in eating disorders. Binge eating among the obese remains an obscure and undeveloped topic.

The design weakness of the case study is magnified by inconsistant and non-specific reporting. Comparisons between studies are difficult when the information is "ambiguous, confusing, and at times misleading" (Schwartz and Thompson, 1981). The most critical difficulty in this field is the description of the subjects. Until diagnostic criteria were developed and adopted, a reviewer could not be certain the same disorder was being described in different articles. Bliss and Branch's (1960) definition of anorexia nervosa as "any weight loss of 25 pounds or more from psychological causes" has been replaced by the rigorous criteria of Feighner, Robin, Guze, Woodrull, Winokur, and Munoz (1972) and the DSM-III (1980). Obesity remains defined by weight criteria alone. The DSM-III (1980) criteria for Bulimia excludes anorexia nervosa but not obesity as a concurrent diagnosis. Despite the widely used criteria, some researchers retain their own formulations such as Boskind-White and White (1983) name of "bulimarexia" for the gorge-purge syndrome that is almost certainly a common subtype of Bulimia as defined

by the DSM-III (1980).

Subgroups within diagnostic categories are problematic. The bulimic anorexics and restrictor anorexics are often homogenously grouped as "anorexics." In some instances, this is appropriate, but treatment methods, treatment response, family variables, prognosis and outcome are all known to vary by subgroup. Males are rarely described, and one suspects they were excluded in studies done before Feighner et al. (1972) when ammenorhea was commonly considered a necessary symptom of anorexia nervosa. Neuman and Halvorson (1983, p. 62) note that "we are probably not even aware of the full spectrum of eating disorders ...In clinical settings, other atypical eating problems surface as well", indicating that new subgroups or diagnoses may yet emerge.

Few studies include demographic variables, age, duration of the condition, age of onset, precipitants, weight at consultation, highest and lowest weights unless this information is the focus of the study. Bruch (1973, p. 328) notes that severity and duration has important implications for the observed features, treatment response and prognosis, yet these variables are rarely included in the description of subjects. People having all degrees of severity often are included in the same study. The methods of obtaining information are often unspecified. Given the proclivity for secrecy, the experience and method of the interviewer should be stated.

Representativeness of the subjects is most important in the incidence studies. The limitations on generalizability were clearly stated in all cases. There were no unfounded claims.

Before the publication of The Handbook of Psychotherapy for Anorexia Nervosa and Bulimia (1985) there was a dearth of detailed description of what clinicians actually did in therapy. Critical examination and replication without specific information was impossible. This volume permits comparison and contrast of various methods. There is a lack of objective evidence to support the effectiveness of any of the treatment methods of treatment. Russel (1985) suggests one should "refrain from harsh judgement, in view of the embryonic nature of the subject."

For binge eating in association with obesity, no treatment protocol has been described.

Outcome data for anorexia nervosa is accumulating (Halmi, Brodland, and Loney, 1973; Halmi, Brodland and Rigas, 1975; Hsu, 1980; Hsu, Crisp and Harding, 1979; Schwartz and Thompson, 1981; Sturzenberger, Cantwell, Burroughs, Salkin and Green, 1977). Problems in comparing studies result from investigators' failure to present the data in a form that can be compared to other studies. Important areas of outcome and life adjustment are inconsistantly examined. The issues of physical appearance, weight, and eating symptoms are reported, but social, vocational and family adjustment are often lacking or weak (Schwartz and Thompson, 1981). Outcome research on Bulimia has begun (Boskind-Lodhal, 1976; Lacey, 1985; Mitchell et al., 1985; White, 1985). Recommended time for followup is four years after termination of treatment.

Recommendations for Future Research

Thompson and Gans (1985) write: "The field of bulimia research now needs what Chairman Mao prescribed: Let a hundred flowers bloom." Research is needed in all aspects of the disorder and in all possible treatments for it. Anorexia nervosa needs documentation and testing of treatment effectiveness. Binge eating associated with obesity needs research in all areas also.

Basic research in human physiology is needed to understand the mechanisms and relationships between appetite regulation, weight regulation, body fat regulation and metabolism. The set point theory of weight regulation needs to be empirically validated. Studies of people who effortlessly regulate their body weight could be compared to people with dysregulated eating and weight. "Normal weight controls" need to be selected by an eating and weight history that rules out dsyregulation. Similarly, work needs to be done to distinguish types of obesity. Fat regulation in females needs to be studied in particular. The propensity for some women to experience feeding disorders and sudden weight gain at crucial epochs in the life cycle: puberty, during and after pregancy, and at the menopause has recieved little attention. These periods are of both psychological and biological significance (Garrow, Crisp, Jordan, Meyer, Russel, Silverstone, Stunkard, Van Itallie, 1975). Sex of subjects is important as fat storage is a fundamental biological difference between the sexes.

Further research on the development of female body identity and body image is needed. Women who have developed a positive body image in

a culture hostile to the normal female body size and shape should be studied to determine what factors protect a woman from toxic social and cultural messages. The negative impact of a mother's critical assessment of her daughter's body on the girl's body image (Debs et al., 1983, cited Wooley and Wooley, 1985) needs to be explored.

The study of Edelman (1981) needs to be replicated and its findings used to reevaluate the externality and psychosomatic theories of overeating and to prompt new research.

A comparison of protien-calorie malnutrition to anorexia nervosa, chronic dieters, and obese people using modern psychological, hormonal and endocrine methods would be useful (Virensky and Anderson, 1977). Further understanding of the long term effects of food restriction and of alternate feast and famine regimes on body composition and metabolism is needed.

Theoretical questions about the relationship of eating and weight disorders to each other, to social trends and to biological mechanisms need further development.

A comprehensive study of bulimia in obese people is overdue. The speculation that dieting, currently the major treatment of overweight, may be the cause of obesity (Wooley and Wooley, 1985) needs immediate verification. Studies of weight and dieting histories of normal weight and obese people are one way to proceed.

Diagnostic criteria need to be evaluated and refined on an ongoing basis. The development and adoption of a standardized diagnostic and assessment instrument for research subjects would greatly facilitate

evaluation research. Johnson's (1985) Diagnostic Survey for Eating Disorders, or DSED may fulfill this need if adopted.

A direct comparison of restrictor anorexics, bulimic anorexics, Bulimics and obese binge eaters on demographic and clinical variables would be invaluable. All studies should report information on eating behaviour, follow-up reports should present separate data on eating behaviour and weight (Schwartz and Thompson, 1981).

A true estimate of incidence and prevalence of eating disorders and binge eating is needed (Virensky and Anderson, 1977). Replication of earlier prevalence studies to determine incidence could be done. The work of Halmi et al., (1981), and Cooper and Fairburn (1983) lend themselves to replication. Incidence studies also could be replicated: Kendall et al., (1973), Jones et al., (1980), and Duddle (1973).

The phenomenology of binge eating is a neglected topic.

Families of Bulimics need to be studied. Empirical evidence for family interactional patterns described by clinicians is needed. The descriptions of families to date are largely impressionistic. Video taped analyses of family sessions by independant raters could be done.

Delaying treatment of people with serious, possibly life-threatening conditions in order to secure control subjects is unethical and dangerous. Alternative means for providing control is to randomly assign clients to two or more different treatments within a centre. Inter-center studies would provide a larger pool of clients to assign to different treatment formats.

Treatments of body image disturbances are scarce, as is treatment of binge eating associated with obesity. The influence of sex of the

therapist on outcome and content of therapy for eating disorders has not been tested.

A standardized outcome instrument is needed. It should include basic information on weight and eating patterns, menstruation, attitudes to food and body weight, self-esteem, social, familial and vocational adjustment. Schwartz and Thompson (1981) would include a standardized symptom-assessment instrument such as the Hopkins Symptom Checklist or the Katz scales. Long term follow-up of at least 4 years is needed.

Prevention programs for adolescent girls need to be developed, tested and disseminated.

SUMMARY

Binge eating is a bio-psycho-social phenomenon that challenges any counsellor's understanding, knowledge and skill. Masked in secrecy and shame, and hidden within dramatic eating disorders, it is a complicated and difficult behaviour pattern.

The field from which binge eating emerges is in the early stages of development and inquiry. While research is rapidly expanding the area of available knowledge, there remains a great deal to learn, in basic biology, in the psychology of eating and weight, and in the boundary between psychology and sociology. For the counsellor interested in research, there are many opportunities. If, in fact, eating disorders are modern equivalent of Victorian hysteria associated with sexual repression, it may be another generation than ours that understands the meaning of our "culture's pet mental disturbance."

The counsellor faced with a client who binge eats has two tasks: to help this person discover other means than food to "handle the problems of living" and to assist her to support rather than fight her body. The client is in need of someone who compassionately accepts that which she feels is shameful, who understands the biology and psychology of her difficulties, and who is willing to see beyond the obvious eating and weight issues to the troubled person within.

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APPENDIX I: SOURCES OF INFORMATION

Overeaters Anonymous, World Service Office
2190 190th Street
Torrance, California 90504

National Anorexic Aid Society, Inc
P. O. Box 29461
Columbus, Ohio 43229

Anorexia Nervosa and Related Eating Disorders, Inc.
P. O. Box 5102
Eugene, Oregon 97405
Phone: 503/ 344-1144 (24 hour Hotline)

American Anorexia Nervosa Association, Inc.
133 Cedar Lane
Teaneck, New Jersey 07666
201/836-1800; weekdays 10:00 A. M. - 2:00 P. M. EST

National Association of Anorexia Nervosa
and Associated Eating Disorders, Inc.
Box 271
Highland Park, Illinois 60035
312/ 831-3438 (Hotline)

The Anorexia Nervosa Aid Society of Massachusetts, Inc.
Box 213
Lincoln Center, Mass. 01773

The Center for the Study of Anorexia and Bulimia
Institute for Contemporary Psychotherapy
1 West 91 Street
New York, New York 10024
212/ 595-3449

National Eating Disorder Information Centre
1560 Bayview Ave., Ste. 304
Toronto, Ontario, M4G 3B9
(416) 486-6023

Feeding Ourselves
30 Bartlett Avenue
Arlington, Massachusetts 02174
617/ 661-3727

The International Journal of Eating Disorders
Van Nostrand Reinhold
Professional Journals and Periodicals Division
7625 Empire Drive
Florence, Kentucky 41042

APPENDIX II: Suggested Client Reading List

Recommended Books

Bennet and Gurin (1982). The Dieter's Dilemma: Eating Less and Weighing More. New York: Basic Books.

Bruch, H. (1973). Eating Disorders: Obesity, Anorexia Nervosa and The Person Within. New York: Basic Books

Bruch, H. (1979). The Golden Cage. Cambridge, Mass: Harvard University Press.

Chernin, K. (1981). Obsession: Reflections on the Tyranny of Slenderness. New York: Harper Row.

Cannon, G. and Einzig, H. (1983). Dieting Makes You Fat. London: Sphere Books.

Kaplan, J. R. (1980). A Woman's Conflict: The Special Relationship Between Women and Food. Englewood Cliffs: Prentice-Hall.

Levenkron, S. (1978). The Best Little Girl in the World. New York: Contemporary Books.

MacLeod, S. (1981). The Art of Starvation. London: Virago.

Millman, M. (1980). Such A Pretty Face: Being Fat in America. New York: Berkley Books.

Orbach, S. (1977). Fat Is A Feminist Issue. New York: Paddington Press.

O'Neill, C. B. (1982). Starving for Attention. New York: Continuum.

Vincent, L. M. (1979). Competing With the Sylph. New York: Andrews and McMeel.

Woodman, M. (1980). The Owl Was the Baker's Daughter: Obestiy, Anorexia Nervosa, and the Repressed Feminine. Toronto: Inner City Books.

Woodman, M. (1982). Addiction to Perfection: The Still Unravished Bride. Toronto: Inner City Books.

Popular Magazine Articles

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Chestnut, Jane. New Light on What Causes Obesity. Woman's Day, May, 10, 1982.

Cohen, T. Why Diets Don't Word. New York Magazine, May 1979.

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Glamour, Febuary, 1984. Feeling Fat in a Thin Society.

Harting, J. Bulimia: The New Danger In Dieting. Harper's Bazaar. March, 1982.

Mithers, C. L. Body Image: How to Ditch Your Hang-ups and Love What You've Got. Mademoiselle, July, 1981.

Rabkin, Brenda, The Psychology of Fat. Homemakers, June, 1983.

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Place of Birth: PORT ALBERNI, B. C. Date of Birth: December, 20, 1952

Educational Institutions Attended, with Dates of Entering and Leaving:

UNIVERSITY OF BRITISH COLUMBIA, VANCOUVER	1970 to 1975
BRITISH COLUMBIA INSTITUTE OF TECHNOLOGY	1975 To 1977
UNIVERSITY OF VICTORIA	1981 To 1986

Degrees, Diplomas, Etc., Awarded, with Dates and Names of Institutions:

B.Sc. (Zool.)	1975	University of British Columbia
Diploma of Nursing (R.N.)	1977	British Columbia Institute of Technology

Honors and Awards:

Norman MacKenzie Scholarship, 1970

Sannich Penninsula Savings Credit Union Scholarship, 1983

Publications:

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Title of Thesis

BINGE EATING IN THE CONTEXT OF EATING DISORDERS: A REFERENCE FOR COUNSELLORS

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Mary Anne Wilkie
Name

June, 1986
Date