Introduction

The standard for body size and weight is socially determined. It is a cultural phenomenon that demands that the current ideal physique is slim. Countries that commonly experience the threat of famine have virtually no cases of anorexia or bulimia, and obesity is considered desirable (Bruch, 1973). In previous eras in the United States, larger bodies were associated with prosperity, in contrast with current mores that associate thinness with affluence. Obesity is now considered a correlate of the lower class. Continuous images indoctrinate the public with the message that to be considered successful, masterful, and acceptable, one must display a thin physique (Vandereycken, 1993). This image is one that emphasizes self-control and discipline over self-indulgence. For women, this message is especially strong. Since Twiggy reigned as a premier fashion model in the late 1960s, America has promoted a thinner and thinner standard for the female ideal (Garner, Garfinkel, Schwartz, & Thompson, 1980). It is within this context that the current escalation of eating disorders in the United States is occurring.

Among the most powerful transmitters of social standards is the media. According to Garner and Garfinkel (1980), "the potential impact of the media in establishing identificatory role models cannot he overemphasized" (p. 652). Newspapers, television, movies, magazines, and billboards bombard the public with images and messages about appropriate behavior, dress, food, entertainment, appearance, and beliefs. Avoiding the overt and covert messages of society portrayed through the media is virtually impossible. For men, the standards portrayed include fitness, power, and independence. For women, the standards portrayed include thinness, femininity, and beauty.

The female ideal as defined by the culture fluctuates. The power of these fluctuations is revealed by a study (Garner et al., 1980) comparing the weight and measurements of Playboy centerfolds and Miss America Pageant contestants from 1959 to 1978. There was a significant decrease in body weight and body measurements for both groups, despite an increase in height. Additionally the Miss America Pageant winners were significantly slimmer than the average contestant in the same pageant. This trend also occurred at the same time that the average woman under age 30 was becoming heavier.

The trend toward a slim female ideal is also illustrated by the recent changes in diet advertisements. Between 1973 and 1991, the United States witnessed a consistent increase in television commercials featuring diet products (Wiseman, Gunning, & Gray, 1993). Interestingly, 1,179 different food and diet advertisements appeared in the women's magazines, compared to 10 in the men's magazines. Anderson and DiDomenico (1992) also found that women's magazines contain over 10 times the number of diet advertisements and articles as men's magazines. The inherent double message is that women need to indulge in various foods and that they need to diet in order to avoid weight gain.

Few would argue that men and women are socialized in different ways. The female and male socialization experiences can be viewed as representative of different cultures. Women are socialized to draw their self-esteem from their physical appearance rather than from what they do (Beattie, 1988). For men, self-esteem tends to be more frequently related to success. This
discrepancy, combined with the ideal standards for female appearance, increases a woman's vulnerability to eating disorders.

Body image is the perception of one's own shape and size. Women who compare themselves to models or other ideals often distort their own body image negatively. The body is perceived to be inadequate if it fails to meet ideal criteria. It is not unusual to hear women, or even young girls state "I feel so fat," even when their weight is normal. Among women, it is now the norm to diet. Polivy and Herman (1987) found that the majority of women are dissatisfied with their bodies and have dieted, even though it may not be healthy.

Body image distortions are more prevalent among women than among men. In a study of college males, 65% of a sample of 340 reported that they weighed within 5 percentage points of their ideal weight (Franco, Tamburrino, Carroll, & Bernal, 1988), in contrast to the typical body dissatisfaction of their female peers. Women tend to exhibit greater body dissatisfaction and body image distortion than men (Connor-Greene, 1988). Even among men with bulimia, the desired ideal weight has been found to be more realistic than the desired ideal weight of women with bulimia (Schneider & Agras, 1987).

THE PROBLEM

The prevalence of eating disorders has consistently increased in the United States across the last 30 years. Increasing emphasis on thinness and physical fitness has altered the standard for appearance for women. The fitness movement is a misnomer. Individuals flock to gyms and aerobics classes under the guise of cardiovascular health, but in reality they are seeking to achieve the physical ideal of attractiveness. The current trends are not in danger of reversing, which leaves the social climate primed for a continuing increase in eating pathology.

Risk Factors

Gender. Although anorexia and bulimia are typically characterized as female afflictions, they cross gender lines. Although these disturbances do appear more frequently among females, males can develop either disorder. It is likely that many cases of anorexia or bulimia among males go unreported for several reasons: men are reluctant to admit symptoms of a "female disorder," eating large quantities of food is not considered abnormal by adolescent boys and young men, and clinicians are less likely to explore eating disorder symptoms among males. Even considering the potential underreporting among males, women are at higher risk for developing anorexia or bulimia due to the value placed on their appearance. (The gender differences are reflected by the use of the female pronoun throughout this article, unless specifically referring to males.)

Age. Adolescence is a high-risk period for the development of eating disorders, with the most frequent emergence of anorexia and bulimia occurring between the ages 14 and 18. However, atypical onset patterns exist. The developmental tasks of adolescence interact with the physical and social demands of maturation to create a vulnerability to developing eating disorders during adolescence or early adulthood.

Adolescence poses a variety of developmental tasks and social demands: establishing greater autonomy, creating stronger peer attachments, and developing a personal identity. These tasks represent a struggle for all adolescents. When combined with the physical maturation that occurs during this period, the expectations may seem overwhelming. For females, physical maturation can appear incongruent with the tasks of developing peer and romantic relationships because the childishly thin physique is often seen as the ideal for attractiveness.
**Socioeconomic Level.** Women with anorexia and bulimia have most frequently come from the middle to upper-middle socioeconomic class (Anderson & Hay, 1985), and obesity tends to be associated with lower socioeconomic status. This pattern is not consistent, however, especially among youth with upwardly mobile aspirations, such as first-generation college students.

**Family characteristics.** The families of those with eating disorders are described as chaotic and conflicted in the case of the bulimic (Schwartz, Barrett, & Saba, 1985; Boumann & Yates, 1993) or overcontrolling and rigid in the case of the anorexic (Sargent, Liebman, & Silver, 1985). Although these are simplified, stereotypical portrayals, family problems are common among the eating disordered population. It is also common for another family member to have struggled with weight problems or an eating disorder. A review of research indicates convergent evidence that the families of eating disordered individuals have a higher rate of affective disorders, alcoholism, and conflictual and controlling family relationships (Kog & Vandereycken, 1985).

**Identification with socialized norms.** In a sample of 682 college students, Mintz and Betz (1988) reported that disordered eating was strongly related to the endorsement of sociocultural norms that regard female thinness and attractiveness as an indication of worth. Those women who hold beliefs similar to the traditional gender expectations are at greater risk for eating disorders.

Although many of the risk factors prominent in eating disorders are featured in other disturbances of youth, such as alcohol and drug abuse or depression, the sociocultural and gender pressures are the distinguishing features of anorexia nervosa and bulimia.

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**Anorexia Nervosa:**
**Definitions, Symptoms, and Etiology**

The prevalence of anorexia nervosa (typically referred to as anorexia) among the general population is reported to be between 0.5% to 1.0% (American Psychiatric Association [APA], 1994), but it is believed to be higher among high school and college populations (Mintz & Betz, 1988). Approximately 90% of the cases of anorexia nervosa are female. Cases with eating disturbances that do not meet all the criteria for anorexia nervosa are more common. The onset is most likely to occur in adolescence and early adulthood, but cases of earlier and later onset have been reported, with a later onset more common among ethnic minorities (Anderson & Hay, 1985). The reason for the later onset among minorities is as yet unknown.

Anorexia nervosa is a constellation of symptoms in which an extreme drive for thinness, fear of becoming fat, and a restriction of food intake are central. *Anorexia nervosa* is actually a misnomer. Literally translated, anorexia nervosa means nervous lack of appetite. Although there is a denial of hunger, actual hunger loss does not occur until the very advanced stages of the disorder.

The recently revised diagnostic criteria presented in the *DSM-IV* (APA, 1994, pp. 544-545)
allow for greater specificity in diagnosis and highlight the similarity of some symptoms common to both anorexia nervosa and bulimia nervosa (see also Tables 1, 2, and 3). The critical elements of anorexia include:

- refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less that 85% of that expected; or failure to make expected weight gain during periods of growth, leading to body weight less than 85% of that expected);
- intense fear of gaining weight or becoming fat, even though underweight;
- disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight; and
- in postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Further, the DSM-IV specifies two types of anorexia:

- restricting type. During the current episode of anorexia nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).
- binge-eating/purging type. During the current episode of anorexia nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Among the first noticeable symptoms of anorexia are a preoccupation with food, particularly a focus on the fat and calorie content of food. The woman with anorexia may begin by restricting herself to a healthy diet or may begin exercising more than usual. The most striking feature is the determination she evidences. As the disorder progresses, she may begin removing herself from social dining situations. She may be too busy to eat lunch with friends or will excuse herself from an invitation by claiming to have already eaten. As her weight begins to drop she may conceal herself with loose fitting clothes or wear warmer clothing than necessary. She may become compulsive with list making, being sure that no free time exists in her schedule. As her work or activities begin to consume all of her day, she may stay up late at night in an effort to burn more calories. As others begin to notice the change in her appearance or behavior, she is likely to become defensive and isolate herself further. She takes any comment regarding her weight loss as a compliment and a sign of success.

Table 1. Symptoms of Anorexia Nervosa

<table>
<thead>
<tr>
<th>Psychological</th>
</tr>
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<tbody>
<tr>
<td>Perfectionism</td>
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<tr>
<td>Denial of problem</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Anxiety</td>
</tr>
<tr>
<td>Distorted body image</td>
</tr>
<tr>
<td>Thoughts of suicide</td>
</tr>
<tr>
<td>Intense fear of food and weight gain</td>
</tr>
<tr>
<td>High need for control</td>
</tr>
<tr>
<td>Mood lability</td>
</tr>
<tr>
<td>Inflexibility in thought and behavior</td>
</tr>
<tr>
<td>Poor self-esteem</td>
</tr>
<tr>
<td>Compliance</td>
</tr>
</tbody>
</table>
Feelings of guilt about eating

Behavioral

- Extreme food restriction
- Preoccupation with food and eating
- Isolation from friends and family
- Extreme physical activity
- Fatigue and irritability
- Eating alone
- Compulsive exercise
- Adoption of loose clothing
- Vomiting meals
- High caffeine intake
- Abuse of laxatives, diet pills, or diuretics

Physical

- Noticeable weight loss—15% or more of total body weight
- Lanugo—growth of fine facial and body hair
- Absent or erratic menses
- Malnutrition
- Exhaustion
- Cognitive disturbances
- Cardiac disturbances
- Electrolyte imbalance
- Distortion of hunger and satiety
- Hypersensitivity to cold
- Absent or erratic menses
- Lowered metabolism

Table 2. Symptoms of Bulimia Nervosa

Psychological

- Low self-esteem
- Feeling out of control
- Depression
- Suicidal thoughts/feelings
- Anxiety
- High need for approval
- Feelings of worthlessness
- Overconcern with weight and body image

Behavioral

- Cyclical bingeing and purging
- Preoccupation with food and body image
- Bingeing on high calorie foods (carbohydrates/fats)
- Eating in secret
- Hoarding food
- Increasing time spent on bingeing/purging
- Isolation from friends and family
- Abuse of laxatives, diet pills, diuretics, or exercise
- Poor impulse control
- Abusing alcohol or drugs
- Restroom visits after meals
Physical

- Normal weight
- Occasional burst blood vessel in the eye
- Dehydration
- Gastrointestinal problems
- Irritability
- Esophageal erosion
- Fatigue
- Tooth decay/gum disease
- Swollen neck glands
- Cardiac irregularities
- Electrolyte imbalance

Table 3. Distinguishing Features Between Anorexia Nervosa and Bulimia Nervosa

<table>
<thead>
<tr>
<th>Anorexia</th>
<th>Bulimia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great weight loss</td>
<td>Minor weight fluctuations</td>
</tr>
<tr>
<td>More introverted</td>
<td>More extroverted</td>
</tr>
<tr>
<td>Pride in weight and food control</td>
<td>Shame in bulimic behavior</td>
</tr>
<tr>
<td>Less sexually active</td>
<td>More sexually active</td>
</tr>
<tr>
<td>Feels in control with food</td>
<td>Feels out of control with food</td>
</tr>
</tbody>
</table>

As the disorder progresses, her cognitive functions become less sharp, decisions are more difficult, and her obsession with food becomes unrelenting.

Throughout the process, she becomes more and more entrenched in her behavior. She appears rigid, reacts with denial if confronted, and becomes more secretive in her eating rituals. She becomes more depressed and anxious, and mood swings are frequent. Her sense of self-worth becomes intimately linked with her control of food, largely as a mask for her pervasive feeling of ineffectiveness and inadequacy. She strives for extreme achievement and perfection in her endeavors. Her emotional development and social interactions are less mature than that of her peers (see Table 1).

A single etiology of anorexia has yet to be determined. It is currently accepted that the disorder is of a multidimensional nature. Although the anorexic appears to the world to be a perfect child who is a high achiever, is compassionate toward others, and is respectful toward authority, it is believed that personality deficits precede the onset of the illness (Steiger & Houle, 1991). The extreme control exhibited in the young woman with anorexia becomes a compensation for poor coping skills and feelings of instability (Bruch, 1973).

Psychoanalytic theory postulates that anorexia serves as a defense against maturation. Fears about becoming a woman and developing sexually inspire attempts to control the body. The maintenance of a child-like physique is seen as an unconscious strategy to forestall adult relationships and sexuality. Developmentalists view anorexia as an adaptive tool used to combat great anxiety about developmental crises, such as increased expectations and responsibilities. Sociocultural theorists claim that it is the striving for perfection in appearance as a visible hallmark of success that motivates the woman with anorexia. Learning theory is related to this sociocultural explanation in that initial weight loss is met with praise and positive reinforcement. As she becomes emaciated, the attention received from others turns to concern, which may be positively reinforcing as well. Internal reinforcement operates simultaneously as
the anorexic prides herself on her self-control. The control issue escalates as she resists others’ attempts to feed her and refuses external intervention. Negative reinforcement maintains the pattern as the fears of food and fat provide the incentive for the avoidance of food. Family theorists hypothesize that the behavior is a means of gaining control and independence from a critical and overcontrolling parent. Food and the body become the areas in which the anorexic can exert control. It is most reasonable to propose a multietiological perspective that incorporates several theoretical considerations while recognizing that no single etiological course can apply to each case.

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**Bulimia Nervosa: Definitions, Symptoms, and Etiology**

Prevalence estimates for bulimia nervosa vary from 1% to 3% for women and 0.3% for men (APA, 1994) to between 11% and 13% in college populations (Coric & Murstein, 1993; Gray & Ford, 1985). Despite these considerable statistics, a great number of people exhibit bulimic symptoms without meeting the complete diagnostic criteria. As with anorexia, the typical onset of bulimia nervosa is during adolescence and early adulthood.

Bulimia nervosa (commonly known as bulimia) is a disorder characterized by cyclical periods of binge eating, typically followed by purging behavior (vomiting, laxative use, diuretic use, or exercising). The latest diagnostic criteria (APA, 1994, pp. 549-550) have specified two types of bulimia, although in practice the occasional overlap of symptoms make the distinctions less clear. The diagnostic criteria for bulimia nervosa are recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

- eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances; and a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control how much one is eating).
- recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise;
- the binge eating and inappropriate compensatory behavior both occur, on average, at least twice a week for 3 months;
- self-evaluation is unduly influenced by body shape and weight; and
- the disturbance does not occur exclusively during episodes of anorexia nervosa.

Further, the DSM-IV specifies two types of bulimia nervosa:

- *purging type.* During the current episode of bulimia nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.
- *nonpurging type.* During the current episode of bulimia nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Perhaps the first identifiable symptom of bulimia is an occasional binge-eating episode. The episode may be in response to feeling a need to nurture oneself with food, or to indulge oneself following a period of dieting or restricted food intake. The reinforcement of the binge (feeling soothed, reduced anxiety) leads to repeated binges. The fear of weight gain is often the impetus for later purging behavior, but the purge can also be an accidental discovery (as when spontaneous vomiting following a large meal affords physical relief). As with addictive behaviors, the cycle escalates from an occasional episode to a daily habit.

Binges most commonly occur in the late afternoon or late evening, often after a day of food
restriction, but may begin in the early morning. It is not unusual for bingeing to occur on a daily basis, and for normal meals during the day to be vomited as well. Binges are frequently planned, and time alone must be negotiated. Social activities become limited as activities are scheduled with bingeing and purging episodes in mind. The woman with bulimia may withdraw most noticeably from meals at which she could be observed, and she becomes very anxious if prevented from purging (either by interruption or situational factors). Mood swings are common. As the disorder progresses, the bulimic's body image becomes more distorted, and her sense of being out of control is less tolerable. As she puts more effort into controlling her food intake, she increases her sense of deprivation and sets the scenario for future binges.

Increasingly, the binge/purge cycle becomes a means of managing all painful emotions, and her awareness of her feelings becomes muted. Although her weight is likely to remain stable, fluctuating within 5 pounds, she begins to look less physically well. Her face and neck may appear swollen, and she may develop a burst blood vessel in the eye from the force of vomiting (see Table 2).

The woman with bulimia is susceptible to depression and has low self-esteem and poor impulse control. She may abuse drugs or alcohol in the way that she abuses food. Her body image is invariably distorted, and she is highly self-critical. She may define herself as a people pleaser and be fearful of confrontation, conflict, or anger. Frequently she identifies feeling lonely, despite the fact that her isolation is typically self-imposed.

The etiology of bulimia is not agreed upon, and it appears that there may be many avenues to onset. Some women develop bulimic symptoms following a diet. A transition or move may trigger bulimic behavior or intensify existing symptoms. Losses (such as deaths, parental separations) are particularly painful and difficult for the bulimic to manage (Armstrong & Roth, 1989).

Increasingly, the etiology of bulimia nervosa is being viewed as multidimensional. A risk factor model has been proposed that posits an interaction between biological, family, developmental, personality, and sociocultural factors (Johnson, Tobin, & Steinberg, 1989). The biological factor most implicated is the correlation between bulimia and affective disorders, particularly depression. The affective instability typically appears prior to the onset of bulimia and suggests a biological vulnerability to bulimic symptoms. Although the disorder may begin with restrictive dieting, the biological urge for food preempts a binge episode. This cycle is maintained by the physical need for food and the soothing emotional benefits of the binge (Lacey, Coker, & Birtchnell, 1986).

Research has supported the position of family theorists that eating disorders are a response or adaptation to coping with a dysfunctional family (Lundholm & Waters, 1991). The family factors that tend to be related to bulimia include a family environment that is chaotic, conflicted, and neglectful, resulting in children who feel insecure, anxious, and disorganized. The inability of the bulimic to identify internal states is seen as a developmental deficit resulting from the parent's inability to respond to the child in a manner that allowed the child to internalize her own awareness. Contributing personality factors are low self-esteem, feelings of ineffectiveness, sensitivity to rejection, and compliance with others. They have persistent shame and guilt about not meeting their idealized goals. Sociocultural factors include the changing gender roles in the dominant culture, the increased pressure for thinness, and the use of the pursuit of thinness as a means of adaptation and social acceptability.

The Secret Obsessions: Anorexia and Bulimia - Part 2
Case Study: The Story of Carrie

Carrie is a 19-year-old female of White/Latina heritage. She is in the second semester of her freshman year at a large university. She originally sought counseling to deal with her increasing sense of depression. During her first session with the psychologist, she presented as bright and cheerful, in contrast to her reported feelings of sadness and hopelessness. She was immaculately groomed, of normal weight, and casually dressed.

As Carrie described her current situation, her pain was evident even as she smiled through the tears she fought to keep from falling. She just didn't understand why she couldn't control herself. She had been bingeing and purging since her junior year of high school and was feeling increasing shame and powerlessness. Although there had been periods when she binged and purged less often (such as during the football season when she was busy with cheerleading and had less time alone), the transition to college escalated the pattern from occasionally to daily. She was also now taking laxatives several times a week and often went for an entire day without eating in order to pay for having binged the day before. This eventually led to another late night binge, which she vomited, and the cycle began again. However, even these efforts in conjunction with 2 hours of daily aerobic exercise did little to conquer her intense fear that she would gain an enormous amount of weight.

She had begun by self-inducing vomiting when she had overeaten or been drinking alcohol. She had been an unpopular child, and once she had made the cheerleading squad in high school she feared that she would gain weight and lose her new-found social status. She lived in terror that she would be discovered to be as inadequate as she felt.

She described her parents as perfect and her younger sister as the baby of the family. Mom was a perfectionist who was hardworking and demanded the same from her oldest daughter. Dad worked long hours and was not as involved with the family. Carrie did not mention until a later session that her mother was generally quite critical, especially of Carrie's appearance, and had very high expectations, or that her dad drank frequently on the occasions when he was home with the family.

During the first session Carrie described the painful pattern of her daily life:

Carrie: I just can't seem to control anything. It feels like this is never going to end.
Dr. W: That sounds pretty hopeless.
Carrie: It is hopeless. I've been depressed since I first got here. At first I thought it was just homesickness, but everything seems to be falling apart. I can barely get out bed, except to eat, and I can't have another semester with the grades as bad as last semester. Everything seems dark, like there's no escape.
Dr. W: Can you tell me what feels so overwhelming?
Carrie: Every day feels overwhelming. It starts out with my planning not to eat at all. Because once I start I know it's all over.
Dr. W: All over?
Carrie: Yeah, I'll start to eat and I won't be able to stop. When I finally realize how much I've eaten, it's too late and my stomach is huge, and I have to get rid of it.
Dr. W: It sounds like you aren't aware of your behavior when you're in the middle of a binge.
Carrie: I'm not. It's like I just go numb. Then I feel horrible at what I've done and I get sick.
Dr. W: Does that mean that you intentionally vomit?
Carrie: I don't call it that, but that's the only way I will truly feel better. If I can get rid of it, then maybe I'm not so bad and maybe I don't have to feel too guilty.
Dr. W: It doesn't feel like you deserve to eat?
Carrie: Not when I can't control myself. And I usually end up eating bad food anyway.
Dr. W: Bad food?
Carrie: You know, crackers and cookies and ice cream and bread and pizza.
Dr. W: And how are those bad?
Carrie: Do you know the calorie and fat content of that stuff? I don't allow myself to eat that kind of food.
Dr. W: So, the food you don't feel you deserve is the food you end up craving. Can you tell me what happens right before you binge?
Carrie: Nothing happens. I just start eating and don't stop.
Dr. W: Are you aware of the circumstances or what you are feeling?
Carrie: I've never thought about it, but I guess I'm scared and lonely, which I feel all the time.
Dr. W: How about when you get angry?
Carrie: I never get angry, but I cry a lot.
Dr. W: Could it be that you know when you're sad or hurt but not when you're angry?
Carrie: No, I just don't get angry. Except at myself when I eat a bunch of bad stuff. I get mad when I don't do what I should.
Dr. W: When would that be?
Carrie: Like when I don't study enough, or call my mom enough, or work out enough, or when I eat too much.
Dr. W: Sounds like you're pretty hard on yourself and your expectations are pretty high. I wonder if anyone could expect to live up those expectations? It doesn't seem like you give yourself much room to make mistakes or to be human.
Carrie: I'm supposed to be better than that--I shouldn't have to make mistakes.

Approaches To Prevention

Individual
Approaches to prevention at the individual level are typically identified as educational programming, especially among groups of high-risk individuals, and early detection of symptoms. In the case of Carrie, high-risk factors were prominent. Her low self-esteem was not ameliorated by her acceptance to a popular peer group and her cheerleading status (a high-risk group in itself). In addition, her family situation compounded the self-esteem and depression. Never feeling adequate for her mother's standards, and feeling alienated from her father, left her feeling no sense of safety or acceptance, making her acceptance within her peer group that much more significant.

Programs aimed at high-risk groups might have helped Carrie to identify her problems earlier. A more important task might be to assist young, developing women in maintaining self-esteem through adolescence when their sense of self-esteem is most tenuous. Prevention efforts aimed at the individual also require that friends and family members take an active role in identifying the warning signs and confronting the behavior of the person.

Family
The role of the family in the prevention of eating disorders is rarely discussed. Although the dysfunctional characteristics of the family with an eating-disordered member have been identified, intervention at the family level is more common than prevention. The family can, however, be significant in deterring the development of these disorders.
Avoiding the dysfunctional dynamics that contribute to eating pathology is prudent for family members. Family environments that foster an eating disorder tend to be overcontrolling, neglectful, and conflictual, but members do not express their feelings. Families should be encouraged to keep communication open, including discussing unpleasant feelings like anger. Further, parents should be taught to nurture developmental separation, as is appropriate throughout the adolescent years. With each year, the child is learning to take on new levels of independence and responsibility. This task is impeded when the parents are critical or doubtful, or refuse to allow the child the freedom to grow.

The family can also model an acceptance of making mistakes. This includes a tolerance of human mistakes by themselves and their children. Tolerance is also warranted with regard to appearance. Families who place a strong emphasis on appearance (how each member looks) and on appearances (what others think) tend to imbue this value in their children. It is the lack of tolerance with imperfection that characterizes the unrealistically high self-standards of the eating-disordered adolescent. Removing the value of appearance from the family environment also requires a reduced emphasis on food and weight. Even learning to manage such concerns by family activity or exercise is an improvement over the diet-obsessed family.

Tertiary prevention can take the form of early symptom identification. Because pathological eating is so common (Betz & Fitzgerald, 1993; Polivy & Herman, 1987) and eating disorders are difficult to understand, many families do not acknowledge the problem until the illness is in the advanced stages. In their study of 14 European exchange students diagnosed with eating disorders while in the United States, Van den Broucke and Vandereycken (1986) noted that most of the students had evidence of disturbed eating or weight preoccupation prior to their departure from home. These disturbances went ignored by the natural parents and were not identified in the medical examination required before leaving home. These authors recommended early detection of the more obvious risk factors by family members and professionals (doctors, school nurses, and teachers).

Carrie's family could have been most helpful had they identified the dysfunctional family patterns that allowed Carrie's disorder to escalate without acknowledgment. Addressing the family conflicts, critical style, and withdrawal via alcohol could have prevented an extended course of her bulimia.

School
High school and junior high personnel are in an important position to assist with the prevention and early detection of eating disorders among adolescents. Omizo & Omizo (1992) suggested that a school counselor should be aware of the risk factors and be watchful of those in high-risk groups such as cheerleaders, drill team members, wrestlers, track team members, gymnasts, and those in the performing arts. In addition to the emphasis on weight and appearance, these are highly competitive environments made more stressful by perfectionist tendencies and the potential for failure.

The first responsibility of the school counselor is recognition of the symptoms of anorexia and bulimia. The counselor should be aware that some students will not admit eating problems or acknowledge their behavior as a problem. Without the student's willingness to participate, treatment is likely to be ineffective.

Although some school counselors may be trained to work with eating-disordered clients, a decision to undertake treatment in a high school setting should be made with caution. Despite the ethical consideration of counseling minors, especially those with serious disorders, the treatment is likely to be more involved than an overextended school counselor could manage.
Due to the setting and frequent contact with groups at high risk for eating disorders, school counselors might most profitably aim their energies toward education and prevention programs. Some programs that have incorporated eating disorder education and evaluation into the school curriculum have been successful in prevention and early detection efforts (Moriarty, Shore, & Maxim, 1990). The impact of such programs may be most significant among at-risk groups (Killen et al., 1993) because most adolescents will not develop an eating disorder. Such programs might have helped Carrie identify her dilemma and recognize that help was available.

Community
At present, community prevention has occurred primarily through the media by publicizing famous cases of anorexia. Perhaps because anorexia is considered more glamorous than bulimia, less attention has been given to the latter. Actresses and athletes who have struggled with anorexia have been highlighted through news programs and magazine articles. Talk shows have aired episodes that interview eating-disordered individuals with less fame. Television movies have portrayed the consequences of the progression of eating disorders. We have yet to see public service announcements that warn of the dangers of extreme dieting. Given the heavy investment in thinness as the social norm and the profits generated by the diet industry, warnings against dieting are not likely to emerge soon.

The most important community intervention might be to address the larger societal issues. The strong influence of the media on the development and maintenance of eating disorders has led most authors to suggest that a change in the societal norms is necessary (Jasper, 1993; Polivy & Herman, 1987; Ussery & Prentice-Dunn, 1992). Without a reduced emphasis on the value of thinness, prevention efforts will remain primarily early detection devices. The task of shifting societal standards, although seemingly monumental, is central to the prevention effort at the community level. It is unlikely that Carrie would have developed an eating disorder as a means of managing her distress had not the emphasis on women's appearance been so prominent in our culture.

The Secret Obsessions:
Anorexia and Bulimia - Part 3

Editor's note: This is part three of a four-part feature discussing eating disorders and their prevalence among young populations. Part one described the problem and defined the terms. In part two we looked at the story of Carrie, a 19-year-old woman who has been bingeing and purging since her junior year of high school, and we examined various prevention strategies. In part three we look at some intervention approaches. Then, in part four we will provide an overview of eating disorders in different population groups, and conclude the series.

Intervention Strategies

Given the enormity of the challenge in preventing eating disorders, the majority of theorizing and research has been in the area of intervention and treatment of eating disorders.

Individual
Individual interventions vary depending upon the theoretical approach used in conceptualization. Psychoanalytic, cognitive-behavioral, developmental, and feminist counselors may approach the treatment of eating disorders in different ways; however, there are some central unifying principles. Regardless of counseling orientation, an initial consideration is the medical stability of the client. Consultation with a physician is essential during the assessment phase. The medical complications arising from anorexia or bulimia are dangerous, and the need to monitor the client's physical condition is imperative.
A medical evaluation of blood pressure, heart rate, and body temperature helps determine the extent of the client’s physical danger. Further laboratory tests are necessary to evaluate vulnerable physical conditions: electrolyte levels, estrogen and cholesterol levels, liver and thyroid functioning, and cardiac functioning. Further monitoring by a physician is appropriate when the medical condition of the client warrants close observation, but a medical evaluation should be a component of treatment with all eating-disordered clients as a precaution.

A second consideration is the need for nutritional restabilization. Without adequate nutrition, counseling is less effective due to the cognitive and affective disturbances that result from starvation. For bulimics, as well as anorexics, the quality of the nutritional state is highly compromised as a result of the eating pathology (Story, 1986). For the anorexic, the nutritional goal is a restoration of body weight. For the bulimic, the goal is a restabilization of the nutritional process. Consultation with a nutritionist skilled in nutritional restoration among an eating-disordered population is a useful adjunct to treatment.

Once a therapeutic relationship is built through support and trust, individual counseling can proceed based on the therapeutic orientation. An eclectic approach may be most suited to the multidimensional nature of eating disorders. Treatment should address the behavioral, cognitive, affective, and interpersonal disturbances as they apply to each client. Initial steps in counseling may include helping the client manage affect in more appropriate ways. Learning alternate means of expressing emotions and self-soothing can interrupt the dysfunctional behavioral patterns. By increasing the client’s awareness of the distinction between physiological and emotional states, the client becomes more adept at managing denied feelings. Expressing affect, becoming more self-directed and autonomous, and tolerating ambiguity are reasonable goals for counseling. Cognitive interventions are intended to challenge the distorted thought processes that have served to maintain and support the disordered eating. Challenging the irrational beliefs inherent in eating disorder pathology can address issues of body image and self-esteem. Progress in these areas may lead to the exploration of interpersonal and intrapersonal conflicts that plague anorexic and bulimic clients.

When feasible, family counseling can be a powerful component of treatment for the eating-disordered client (Sargent et al., 1985; Schwartz et al., 1985). In addition to addressing the distress created in the family by the eating disordered, family counseling can intervene in any dysfunctional interpersonal relationships. Common issues in these families are enmeshment, overprotection, hostility, and rigidity (Kog & Vandereycken, 1985). The goals of family counseling might include expression of feelings, resolution of conflict, and fostering autonomy.

Group counseling has also been used successfully with eating-disordered clients, although it has been less frequently recommended for anorexics (Lee & Rush, 1986). The use of group counseling in conjunction with individual counseling or for individuals at a more advanced stage of recovery allows clients to reduce the isolation and shame of their disorders. Groups can be effective venues for developing interpersonal skills and challenging dysfunctional thoughts and behaviors. Anorexic clients should be carefully screened for level of rigidity and weight competitiveness prior to admission in a counseling group (Hall, 1985).

Pharmacological treatment, especially for bulimia, has gained favor in recent years (Mitchell, 1988). The use of antidepressant medication has had some success in treating the related depression and in reducing the compulsion to binge. Although controversial, treatments employing a pharmacological component may be a reflection of the current trend toward a biological-based etiology. The use of medication in the treatment of bulimia should be undertaken with caution, and not prior to evaluating the potential risks.

Inpatient treatment is warranted in severe cases. Especially for anorexic clients who have lost
25% of their expected body weight, inpatient treatment is considered necessary. Some bulimic clients, especially those who refuse or are unable to sustain any meals or who have severe depression associated with their disorder, are recommended for inpatient treatment. Individuals with eating disorders may also be referred for inpatient treatment if they have not responded to outpatient treatment. Clients may be admitted by the family if they are under legal age, but it is most therapeutically useful if the client voluntarily agrees to inpatient care.

The structured environment of an inpatient setting often helps to reduce the anxiety of the eating-disordered client. The treatment protocol differs, however, depending on the disorder. The focus for anorexic clients is often weight restoration. For bulimic clients, the focus is on a normalization of the eating process. Both of these strategies are used in combination with individual, group, and family therapy. Close follow-up and extensive outpatient treatment is necessary for these clients due to the high rate of relapse.

Prognosis of eating disorders has been related to type of disorder and body weight. Bulimia has a more positive prognosis than anorexia, and anorexic clients with lower body weights have the poorest prognosis (Herzog et al., 1993). Clinical observation also indicates that anorexia is the more intractable disorder and requires longer term counseling.

Family
Family therapy is considered by some to be among the most effective treatments for eating disorders and, at the very least, should be considered as an adjunct to other treatment modalities (Schwartz, Barrett, & Saba, 1985). The families of anorexic clients have been described as overcontrolling and rigid (Sargent et al., 1985) while the families of bulimic clients have been described as conflicted and chaotic (Schwartz et al., 1985). Despite these differences, some universal principles in family counseling for eating-disordered clients have been prescribed.

Common issues to be addressed in family counseling often include strengthening boundaries between parents and children, dealing with family and parental conflict in more healthy ways, and openly dealing with other disorders such as depression or alcoholism of another family member (Schwartz et al., 1985). Teaching the family to allow appropriate development of adolescents (which includes allowing less reliance on the parents) is also necessary. Particularly for younger clients, family counseling is considered an important piece of the treatment process.

School
Although few school counselors are trained in the treatment of eating disorders, it may be the school personnel who first identify disturbed eating patterns. School personnel should be aware of the eating disorder symptomology and be prepared to encourage youths suspected of such disturbances to seek counseling. Resources and referrals that are available to the students seeking treatment should be current.

Some school settings offer support groups for eating disorders, and this is reasonable if the counselor is skilled in group counseling with eating-disordered clients and treatment consent can be obtained. An assessment of the extent of the student's disorder is prudent prior to beginning any type of intervention at the school level.

Community
Community interventions are as yet minimal. Perhaps due to the perceived rarity of these disorders, wide-scale community interventions are not practiced. Another possibility for the lack of community-level intervention is the inherent challenge of the societal standard of beauty should such interventions be proposed. Changes at the community level require a concerted
effort toward abolishing the value placed on thinness. Currently, the fervor does not appear to exist to orchestrate such a rebellion.

The Secret Obsessions:
Anorexia and Bulimia - Part 4

Editor's note: This is part four of a four-part feature discussing eating disorders and their prevalence among young populations. Part one described the problem and defined the terms. In part two we looked at the story of Carrie, a 19-year-old woman who has been bingeing and purging since her junior year of high school, and we examined various prevention strategies. In part three we examined some intervention approaches. In part four we provide an overview of eating disorders in different population groups, and conclude the series.

Eating Disorders and Diversity Issues

Ethnicity
The cultural norms of the United States have historically been dominated by the values of the White middle class. Although the stereotypical picture of the eating disordered client is a young White American adolescent female, the recent increase of anorexia and bulimia among non-White women must be explored (Root, 1990). An important consideration, given the impact of the media on eating disorders, is that few non-White women are featured in the media, and those that do appear tend to have physical characteristics that are similar to the White standard of beauty (Osvold & Sodowsky, 1993). It is as yet unclear what impact these images have on women of color.

A further consideration is that because eating disorders have been related to socioeconomic status, the increasing status of non-White populations in the United States may serve to increase their vulnerability to eating disorders (Anderson & Hay, 1985). Additionally, Hsu (1987) noted that as African Americans become more upwardly mobile they may be more likely to adopt traditional White middle-class values and the related disorders as well. As African Americans more commonly live biculturally, an internalized devaluing of their own race can occur. This can result in greater acceptance of White standards. The typical help-seeking patterns and underutilization of mental health services by people of color may, however, continue to obscure the prevalence of the disorders among these groups (Root, 1990). It has been suggested that underutilization of mental health services by people of color may be the result of these groups seeking help in alternate ways in their communities or to the lack of experience and understanding of these groups by mental health personnel or poor accessibility to mental health services. Although Dolan (1991) warned against using broad statements about racial groups, the following discussion of cultural considerations attempts to highlight the similarities and differences between cultures with respect to eating disorders.

African American women. Historically, African American women have not been at risk for developing anorexia or bulimia due to several protective factors. They have typically not identified with the standards of the White culture (including the standards for thinness), and they have displayed greater acceptance of their body sizes, despite being heavier than their White peers (Gray, Ford, & Kelly, 1987). Even among the high-risk group of ballet dancers, Black females have reported lower rates of disturbed eating (Hamilton, Brooks-Gunn, & Warren, 1985). Most eating disorders develop during adolescence, and among African-American women this period has been brief by White standards. Eating disorders among this population tend to develop at a later age (Anderson & Hay, 1985). The socialization of many African American women also differs from that of women in the White culture. African American women are expected to be independent and successful, in contrast to the White values for women to be attractive and feminine (Osvold & Sodowsky, 1993). African American women are raised with a more pragmatic attitude and may have little time or energy for food and weight preoccupations.
A survey of 507 male and female undergraduate students at a Black university revealed that 3% of the sample fit the *DSM-IV* criteria for bulimia. When compared to a similar White sample, however, the African American students reported less emphasis on food and weight (Gray et al., 1987).

Silber (1986) suggested that the rarely seen case of anorexia among African Americans and Hispanics may be due more to misdiagnosis than scarcity of the disorder. Although it has been concluded that the symptoms present themselves similarly in Caucasian and African American women (Anderson & Hay, 1985), Osvald and Sodowsky (1993) highlighted the importance of culture in the etiology of anorexia nervosa. Counselors and researchers are urged to be conscious of the later-aged occurrence of anorexia and bulimia among African American women. Additionally, as acculturation to the dominant White culture increases, a higher incidence of eating disorder symptoms among African American women is likely.

**Hispanic women.** Studies of eating disorders among Latina women are practically nonexistent. One study compared the treatment outcomes of 10 Hispanic women (6 Mexican Americans, 2 Colombians, and 2 Mexicans) and 20 White women with diagnoses of anorexia nervosa in San Diego (Heibert, Felice, Wingard, Munoz, & Ferguson 1988). No differences between the two groups were reported with regard to clinical characteristic or treatment outcome.

Another study (Smith & Krejci, 1991) with a large male and female high school sample (327 Hispanics, 129 Native Americans and 89 Whites) found considerable eating pathology among the Hispanic group. On most measures of disturbed eating (fasting, induced vomiting, bingeing) the Hispanic group scored comparably to the White group but not as high as the Native American group. The prevalence of eating pathology among Latina women remains illusive. The interaction among ethnicity, social environment and level of acculturation could be a rich direction for future investigations.

**Native American women.** Few data are available on the prevalence of eating disorders among Native American women. One study found that among 85 Chippewa girls and women living on a reservation in Michigan, 74% reported dieting in order to lose weight, and of those, the majority had purged used diet pills, and fasted (Rosen et al., 1988). Although, generalizations cannot be made from this sample, the prevalence of eating disorders among Native American women may have been previously underestimated.

A similar conclusion has been drawn by Smith & Krejci (1991). In a comparison of disturbed eating patterns among Native American, Hispanic and White high school students, the Native American group scored higher than the comparison groups on all measures of disturbed eating. The Native American students were heavier that the comparison group, and student who were heavier reported more body dissatisfaction, greater fear of weight gain, more frequent extreme dieting and more frequent vomiting as a weight control technique. Further exploration is needed before any reasonable conclusions can be drawn about eating disorders among Native Americans.

**Asian American women.** Although anorexia is well known in Japan (including a specially named binge episode related to anorexia), studies of eating disorders among Asian American women have not been reported in the literature. Studies of other Asian populations are rare. High rates of body image distortion and body dissatisfaction have been observed among school children and adolescents in Japan (Ohtahara, Ohzeki, Hanaki, Motozumi, & Shiraki, 1993). Case studies have also been reported involving two women of Chinese decent who were raised in England (Schmidt, 1993). The bicultural existence and family histories of obesity are cited as onset and maintenance factors.
Asian American populations have been the least-researched ethnic group. Without adequate data, speculation about the prevalence of eating disorders within this population is unwise.

**International women.** The literature has begun to accumulate evidence suggesting that the risk for eating disorders among international women increases with the level of acculturation of White standards. Assuming a continuum of eating disorder symptomology, Hooper & Garner (1986) compared Black, White, and mixed race schoolgirls in Zimbabwe on eating disorder symptomology. The White group showed the greatest symptomology, the Black group showed the lowest, and the mixed race group had scores that fell between the comparison groups. The researchers concluded that the acculturation and adoption of Western ideals influences the development of eating disorders.

Even Caucasians from different cultures have been susceptible to the influences of American White, middle-class standards. Van den Broucke and Vandereycken (1986) studied 14 European exchange students in the United States who had been diagnosed with an eating disorder during their year-long stay. Most evidenced at least minor eating disorder symptomology prior to departing from home, but the challenges of adolescence combined with the culture shock, separation from family, and the stress of academic and social adjustment served to exacerbate the disorders.

Recommendations for counseling women of color and of nondominant cultures include an awareness of the cultural aspect of the disorders. It is necessary to assess the extent of identification a woman has with her own ethnic culture and that of the dominant White society in addition to the eating disorder diagnostic criteria (Osvold & Sodowsky, 1993), criteria that Root (1990) reminded us were developed from observations of White clients. Mental health professionals should be cognizant of the socially sanctioned stereotypes of women of color and avoid such stereotypes from influencing the assessment process (Root, 1990).

Prevention efforts among ethnically diverse groups should address the previous lack of prevention involvement in communities of color. Outreach programs can be established with these communities only after allowing for time to build relationships with key leaders and showing genuine interest in the group (Root, 1990). Outreach and prevention programs need to take into account the norms of the community with regard to help-seeking patterns, beliefs about causation and healing, and meaning of the disorder. This strategy might allow for greater inclusion of people of color into research protocols and prevention/treatment programs. (For recommendations regarding inclusion of people of color in empirical studies, see Root, 1990.)

**Gender**

Although females have been the most affected by eating disorders, the prevalence among males may be underestimated (Lachenmeyer & Muni-Brander, 1988). Steiger and Hoole (1991) suggested that factors that make women vulnerable also operate to make men vulnerable. One risk factor is that of athletic involvement, especially in sports that have a weight or physical appearance orientation, such as wrestling or body building (Franco et al., 1988). A second risk factor for men is a history of obesity (Franco et al., 1988). Males with bulimia were found to have relatively higher current weights and histories of higher past adolescent and prepubescent weights. A third risk factor for men is homosexuality. It appears that the heterosexual male population is more protected from standards that emphasize physical appearance, but that gay men feel more pressure to be thin or attractive (Schneider & Agras, 1987).

Although men tend to score lower on the Eating Disorders Inventory *drive for thinness* scale and report less body dissatisfaction (Schneider & Agras, 1987), a correlate of the drive for thinness among women may be the drive for fitness among men (Ussery & Prentice-Dunn, 1992).
Ussery and Prentice-Dunn (1992) found that the strongest predictors of bulimia among men were similar to the predictors of bulimia among women: restrained eating, lack of interoceptive awareness, and lack of confidence in identifying one's emotions, which leads to underdeveloped coping skills.

In a comparison of men and women with comparable bulimic histories, Schneider & Agras (1987) found some gender differences. Men with bulimia have been noted to differ from women with bulimia in that they are less likely to identify the intake of large amounts of food as a binge; are less likely to report laxative, diuretic, or diet pill use; and are less likely to exercise excessively. Men also report greater success with diet plans than women. Women tend to binge in private, but male binges tend to occur during meal times with larger quantities of food, and they are less likely to report feeling guilty about eating in public.

An exception to the previous discussions of ethnicity is the report of an investigation of bulimia among African American college students, in which Black males were more likely than their Caucasian counterparts to report significantly more frequent bingeing, dieting, and fasting (Gray et al., 1987).

Men and women may be differentially affected by the cultural pressure for weight and body shape. Social cues that determine appropriate or desired weight hold women to a more stringent standard (Schneider & Agras, 1987). In addition, males with bulimia may go undiagnosed. Men may experience greater embarrassment at acknowledging symptoms that have been characterized as a disorder of adolescent females (Schneider & Agras, 1987).

Although eating disorders occur more rarely in men, and even more rarely in men of color, the disorders do exist in these populations (Gray et al., 1987; Lawlor, Burket, & Hodgin, 1987), and risk factors alone may not alert the clinician. For example, eating disorders have been present in male clients who come from lower socioeconomic groups and do not fit the typical clinical picture. Clinicians should be cautious of dismissing this diagnosis among atypical populations.

**Affectional Orientation**

Homosexuality has been reported to be a risk factor for developing eating disorders among men, but not women. Most samples of eating-disordered females report very small percentages of identified lesbians (Herzog, Newman, Yeh, & Warshaw, 1992). For women, homosexuality may offer protection from a vulnerability to eating disorder symptomology. Several factors have been cited as potential explanations for this phenomenon. Unlike heterosexual women, lesbian women are reported to be more satisfied with their bodies (Herzog et al., 1992).

In a study of 64 heterosexual and 45 lesbian unmarried women (Herzog et al., 1992), significantly more heterosexual women wanted to lose weight, despite the fact that the lesbian women among the sample were heavier than the heterosexual women. Both groups chose ideal weights below the appropriate life weight tables (Metropolitan Life Insurance Company, 1983), but lesbian women were more likely to choose higher weights, closer to the norm. The heterosexual women were more likely to diet and were more susceptible to the image society portrays as the female ideal. It may be, as Brown (1987) noted, that feminist ideology rejects the cultural standards of beauty as well as reducing the guilt associated with eating that is found in the majority of the traditional female culture.

Herzog et al. (1992) concluded that the dissatisfaction with one's body that increases the risk of eating disorders among the heterosexual female population is less prominent among the lesbian population and may explain the lower incidence of eating disorders among lesbian women. Caution is warranted, however, in discarding the potential eating disorder diagnosis among lesbians. The incidence of anorexia and bulimia among lesbian women is low, but not
Gay men have been reported to have eating disorder symptomology at higher rates than are found among heterosexual men (Yager, Kurtzman, Landsverk, & Wiesmeier, 1988). Compared to heterosexual men, gay men have been more likely to be underweight, to choose an ideal weight that is lower, and to believe that a thinner body type will be more attractive to potential partners (Herzog, Newman, & Warshaw, 1991). They also reported that heterosexual men were less likely to be influenced by their perceptions of women's preferences for male physique. Their desired weight was less than these men believed women preferred.

When 48 nonclinical gay men were compared to 300 nonclinical heterosexual men, the gay male sample was reported to present past problems with binge eating, use of diuretics, feeling fat despite others' perceptions of them, and feeling terrified of becoming fat. Additionally, gay men scored higher than their heterosexual peers on the EDI scales of drive for thinness, interoceptive awareness, bulimia, body dissatisfaction, ineffectiveness, maturity fears, and the total overall scale.

Findings of higher than expected rates of disordered eating among the gay male population may be related to the tendency toward the effeminate for at least some gay men (Yager et al., 1988). A more reasonable explanation might be that some gay men feel the same pressure that heterosexual women feel to be attractive to males and might be more conscious of the competition for partners. This explanation is further supported by the long tradition among men in general to seek attractive partners. Herzog et al. (1991) noted that gay males may fear weight gain more than heterosexual males because weight gain might surpass their ideal body weight and the weight they believe is most attractive to a partner.

Investigations of eating pathology among the gay/lesbian culture is in preliminary stages, and explanations of the increased prevalence can only be speculative.

**Athletes**

Despite anecdotal data, evidence suggests that athletes are not, as a group, at greater risk for developing eating disorders. Certain sport groups do, however, increase the vulnerability for developing eating disorder symptoms (Stoutjesdyk & Jevne, 1993). Among a sample of 191 Canadian athletes, eating disorder prevalence was not higher for females than is found in the general and college populations. The prevalence of disturbed eating patterns for men was, however, higher than has been reported in college and general populations. For women, the risk factors included being involved in a sport that emphasized leanness or physical appearance (such as diving or gymnastics) or that had weight restrictions (such as judo or lightweight rowing). For both men and women, eating disorder symptomology was related to the level of competition. Only those athletes who regularly competed on the national or international level showed elevated scores on a measure of disturbed eating behaviors and attitudes. It was concluded that the combination of high-level competition and weight or aesthetic considerations within the sport makes for a vulnerability to disturbed eating.

Similarly, Depalma et al. (1993) studied 131 lightweight college football players and found that 9.9% fit the criteria for an eating disorder and 42% evidenced disturbed eating patterns. Wrestlers are also at high risk for eating disorder pathology. Steen and Brownell (1990) found that 30 to 40% of high school and college wrestlers reported pathological eating, including food restriction, fasting, vomiting, using laxatives and diuretics, and bingeing after matches. Preoccupation with weight and food was common among this sample of 431 male wrestlers.

Dancers have also been considered to be at high risk for the development of eating disorders, but this generalization has been challenged. Hamilton, Brooks-Gunn, Warren, and Hamilton
(1988) contended that those ballet dancers who are most successful show similar rates of eating disorder pathology as is found in the general population. Those dancers who are struggling to gain recognition in a major dance company, however, are more likely to report eating pathology. This pattern held true for dancers in both American and Chinese ballet companies.

Johnson and Tobin (1991) noted a steady increase in the use of exercise as a purging strategy, especially in recent years as the standard of thinness for women is being replaced with the standard of physical fitness or strength. Given this trend, they warn those involved in the supervision of athletics, such as athletic trainers, to be observant of suspicious behavior. Trainers may be the initial contact for someone struggling with an eating disorder, and they need to be informed and capable of providing a safe environment for the disclosure of psychological problems.

Proposed prevention efforts are aimed at educating athletes and sports management personnel (coaches and trainers) in the dangers of disturbed eating (Grandjean, 1991; Johnson & Tobin, 1991; Thompson & Sherman, 1993). In addition to increasing the awareness of eating disorder symptoms, it is recommended that weight be de-emphasized and that group weigh-ins be eliminated. In sports where weight is a determinant for competition, unhealthy weight management strategies should not be condoned, even passively.

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**Summary**

A clear conclusion is that eating disorders reflect an interaction of social, interpersonal, intrapersonal, and physical variables. The societal ideal for women to be thin and attractive promotes greater pressure for women with regard to appearance and places them at greater risk for developing eating disorders. It is during adolescence or young adulthood that these disorders manifest, usually as a means of coping with problems or life transitions. Other risk factors include socioeconomic status, participation in some types of athletics, disturbed family dynamics, and low self-esteem. Although a small proportion of the population may develop a clinical eating disorder, great numbers of individuals suffer with subclinical symptoms of disturbed eating and dieting patterns.

Treatment may include individual, group, and/or family counseling. A medical evaluation and nutritional counseling are also recommended. In severe cases, inpatient or pharmacological treatment may be warranted. Treating the eating-disordered client requires patience and an understanding of the psychological depth of the disorder. Recovery from an eating disorder is often a slow process, and the relapse rate is high.

Prevention efforts at the individual, family, school, and community levels should be considered by those involved with adolescents or young adults, especially those youths in high-risk groups. Special attention should be paid to atypical groups such as people of color, men, and gay and lesbian youths. These groups are least likely to be identified as at risk for an eating disorder and may be neglected in treatment and research of eating disorders.

The power of society and the media should not be overlooked. It is the responsibility of each individual to challenge the damaging and demeaning messages of our culture. It is equally important to teach our youth to challenge those same messages, whether the messages stem from the media, their peers, their families, or from their own minds.