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Out of Control: An Exploration Into the Dynamics of Anorexia Nervosa and Bulimia and the Consequences for the Sufferer and Those Around Her

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Abstract

A theoretical and personal exploration into the dynamics of anorexia nervosa and bulimia was conducted with reviews of literature, interviews, and personal accounts. A basic definition of the problem according to the DSM-III was stated. Discussed in detail are factors which contribute to a possible predisposition for developing an eating disorder; these include the physiological/biological, psychological, familial and societal. The effects of eating disorders on those persons around an anorexic or bulimic were explained along with a special section emphasizing the epidemic of eating disorders on college campuses. Emphasis was placed on the importance of the role of helper in the relationship between helper and sufferer.

Introduction

At this moment, it is estimated that in this country, 1 in every 200 adolescent girls is suffering from anorexia nervosa. For girls over 16 in the private sector of education or for young women in university populations, the figure can be as high as 1 in 100. Of these, about 10% or 15% will actually die. Of the remainder, only half will recover to lead more or less normal lives. The rest are likely to relapse, or resort to alternating bouts of feasting and fasting, or, at best, to go through life waging a never-ceasing struggle with their own bodies in order to maintain an "ideal" weight which is barely above the danger line (Macleod, 1982).

The above description refers to the ever-increasing incidence of anorexia nervosa and bulimia among this country's females. The subject of anorexia and bulimia has become somewhat "trendy" in the media, although if greater awareness and understanding of this problem are the results, then so much the better. However, there are a few aspects of this issue which have been neglected, specifically, the role of friends, roommates, boyfriends, or relatives in attempting to help the anorexic or bulimic. There is little information on how to deal effectively with their own emotional reactions toward eating disorders, not to mention toward the sufferer herself.

Defining the Problem

A Definition and History of Anorexia Nervosa and Bulimia

Anorexia nervosa is difficult to understand since eating food is such a necessary part of living. Anorexia is not a new discovery. Cases of anorexia were reported nearly 100 years ago. The two earliest recorded accounts involve Sir William Withey Gull in 1873, and Dr. E. C. Lasegue, also in 1873. Sir Gull it seems is responsible for the naming of the eating disorder.

It was the belief of Gull and Lasegue that the disorder was an anomaly, a freak behavior stemming from some unknown cause, and very rare. In the last 100 years however much more has been learned about anorexia, while at the same time there seems to be a definite increase in the number of cases reported. To use the word epidemic may be too extreme for some; nevertheless the statistics are staggering.

A sampling of the reported statistics is as follows: A McLean Hospital study (Kinoy, 1984) showed that 1 - 4% of high school and college age women are anorexic; while in the entire female population, 1 out of 100 may be anorexic (Kinoy, 1984). Other facts about who a typical sufferer might be say that most are female with fewer than 1 in 10 male. Most of the sufferers are in their teens or twenties, with the onset of symptoms usually around age 15. There have been reported cases of weight

loss beginning at about age 10 and at age thirty and beyond. Usually though the weight loss begins just after puberty, or, in the case of older women, just before menopause. Cases of anorexia among men and boys have been documented, but since the symptoms are more difficult to recognize in males there is more of a chance that the family members or doctor will not label the problem as such.

These numbers may actually be too conservative. It is difficult to determine the actual number of cases since often only the more severe ones are seen by physicians. In fact, many of the less severe cases may be sick for a decade or more before their body gives away its secret. Anorexia is not a disorder to be taken lightly though since, according to Palmer (1980) "death or chronic illness may be the outcome of the disorder in perhaps one in ten cases who [sic] come to the attention of doctors" (p.43).

Palmer (1980) quotes an anorexic mortality rate of 10%, while Rumney (1983) claims it is somewhere between 7 and 15%. "In 1975, twelve people between the ages of fifteen and fifty (eleven females and one male) were certified as having died of anorexia nervosa in the United Kingdom" (Palmer, 1980, p.44).

But what exactly is this puzzling eating disorder known as anorexia nervosa? Finding a conclusive definition was really quite impossible. Anorexia has been described at various times as a food phobia, a weight phobia, a fear reaction to growing up, a death-wish, a denial of sexuality, or the slimming disease.

Rumney (1983) believes anorexia nervosa is a psychological disorder. Clinically, it is a diagnosis applied to individuals who are more than 20% underweight and who for psychological reasons refuse to eat. The American Anorexia/Bulimia Association defines it as a serious illness of deliberate self-starvation with profound psychiatric and physical components (Kinoy, 1984).

For the purpose of this paper however, the following definition provided by the American Psychiatric Association will be used. The essential features of anorexia nervosa are "intense fear of becoming obese, disturbance of body image, significant weight loss, refusal to maintain a minimal normal body weight, and amenorrhea (in females). The disturbance cannot be accounted for by a known physical disorder. (The term "anorexia" is a misnomer, since loss of appetite is usually rare until late in the illness.)

Individuals with this disorder say they "feel fat" when they are of normal weight or even emaciated. They are preoccupied with their body size and often gaze at themselves in a mirror. At least 25% of their original body weight is lost, and a minimal normal weight for age and height is not maintained.

The weight loss is usually accomplished by a reduction in total food intake, with a disproportionate decrease in high carbohydrate-and fat-containing foods, self-induced vomiting, use of laxatives or diuretics, and extensive exercising" (p.68).

The essential features of bulimia are "episodic binge eating accompanied by an awareness that the eating pattern is

abnormal, fear of not being able to stop eating voluntarily, and depressed mood and self-deprecating thoughts following the eating binges. The bulimic episodes are not due to Anorexia Nervosa or any known physical disorder.

Eating binges may be planned. The food consumed during a binge often has a high caloric content, a sweet taste, and a texture that facilitates rapid eating. The food is usually eaten as inconspicuously as possible, or secretly. The food is usually gobbled down quite rapidly, with little chewing. Once eating has begun, additional food may be sought to continue the binge, and often there is a feeling of loss of control or inability to stop eating. A binge is usually terminated by abdominal pain, sleep, social interruption, or induced vomiting. Vomiting decreases the physical pain of abdominal distention, allowing either continued eating or termination of the binge, and often reduces post-binge anguish. Although eating binges may be pleasurable, disparaging self-criticism and a depressed mood follow.

Individuals with Bulimia usually exhibit great concern about their weight and make repeated attempts to control it by dieting, vomiting, or the use of cathartics or diuretics. Frequent weight fluctuations due to alternating binges and fasts are common. Often these individuals feel that their life is dominated by conflicts about eating" (p.70).

In essence then the central features of anorexia are an abnormally low body weight, an attitude and behavior which tends to maintain this weight, and other features such as cessation of

menses (amenorrhea) which suggest a disordered physiology. It is important to note that the previous three features denote "primary anorexia," which is reserved for a weight phobia and is not to be confused with "secondary anorexia." Secondary anorexia refers to other states: a psychotic disorder with delusions about contamination of food, depression of mood with true loss of appetite, obsessional states and interpersonal difficulties with those involved in providing food (Palmer, 1980).

There are two types of anorexia nervosa and this paper will deal exclusively with primary anorexia and the two kinds of eating patterns within primary anorexia. The first is called abstinent anorexia nervosa, and is characterized by "ordinary slimming occurring in the inappropriate context of an abnormally low body weight. She works hard at limiting her diet and weight even though she is already very thin" (Palmer, 1980, p.23). A sufferer will avoid fattening foods, especially high carbohydrate ones, but may instead eat lots of bulky but low-calorie foods such as celery, carrots, etc. Food becomes a source of morbid fascination; every calorie is counted, a single sausage will be grilled without fat, each morsel is carefully selected or prepared.

The second eating pattern, which resembles the anorexic/bulimic eating behavior, is characterized by overeating, self-induced vomiting, and often by the abuse of laxatives and other drugs. The sufferer will begin to vomit if feeling bloated or uncomfortable after overindulging and eating too much. The

sufferer may also feel guilty, although later in the illness he/she will become dependent upon vomiting, since it is a type of insurance policy against ever overeating. It becomes a habit which "started as a response to unwelcome inner feelings, may become premeditated. Anorexic subjects often develop considerable facility for vomiting. An individual may come to be able to vomit at will without, for instance, the need to stick her fingers down her throat" (Palmer, 1980, p.25).

Bulimia, also sometimes called the binge-purge syndrome, is much more difficult to recognize in a person. Not all bulimics vomit, but they do all binge. Although the symptoms may include low body weight and absent menstrual periods, sometimes these signs aren't enough since a vomiting anorexic or bulimic may actually seem to be of normal weight.

The statistics that are available though are just as alarming as the ones for anorexia, even more so if recording the disorder accurately is so difficult. Current estimates are that 16 - 30% of all women are bulimic, or, according to the McLean Hospital study (Kinoy, 1984) 6.5 - 18.6% of high school and college age women are bulimic.

Physical Complications of Anorexia and Bulimia

The physical effects of anorexia and bulimia can be devastating, and, as mentioned above, may even lead to death. The anorexic's metabolism slows down, leading to a drop in body

temperature, cold skin, a bluish coloring to the arms and legs, and possibly a sudden flush to the skin after eating due to the rise in metabolism and temperature. There is an increase in general body hair (known as lanugo), loss of head hair (especially after regaining weight), constipation, abdominal pain, disorders of swallowing, chronic diarrhea, dehydration, high carotene and cholesterol levels in blood, abnormal glucose tolerance, and increased pulse and blood pressure levels. If vomiting occurs, there is a loss of digestive juices, and a depletion of potassium leading to kidney malfunction, with the low levels of potassium affecting the heart.

The bulimic may suffer from puffiness around the eyes, broken blood vessels in the cheeks, swollen parotid glands, scars on the fingers, tooth decay resulting from the hydrochloric acid brought up from the stomach, a ruptured stomach, a high Ph level in the blood (which can lead to alkalosis, or loss of calcium), tingling in the fingers, tetany, collapse, and eventual damage to the liver and lungs. If laxatives are used, diarrhea causes sodium and potassium to be washed out of the body, and can also cause rectal bleeding, heart fibrillations and arrhythmia, and electrolyte damage.

It is interesting to note that anorexics whose main problem is overeating and vomiting have the most severe physical complications. Their compliance is usually less than complete and their tendency to relapse is considerable (Palmer, 1980).

In fact, one author mentioned that one of the major

differences between an anorexic and bulimic is the level of denial exhibited, with the anorexic having the most denial.

Anorexic and Bulimic Behavior

The anorexic and bulimic become very adept at disguising their weight loss and any behavior which may draw attention to them, and thus leading to discovery. In an ironic twist, it is interesting that physically the body can adapt so well that a medical emergency may be slow in coming, which in many cases is necessary for the family to become aware of the problem.

Many of these protective behaviors, or strategies, can be seen in both anorexics and bulimics, but some tend to be used more by anorexics than bulimics. For example, an anorexic may be able to conceal her weight loss for months or even years through the wearing of loose or over-sized clothes, by never undressing in public, or by avoiding close physical contact with another person.

An anorexic can survive on less than 1,000 calories a day, as opposed to a normal diet of two or three times as much. In order to maintain this weight, an anorexic may also take purgatives, or laxatives, and diuretics. Many are also very physically active. They can be very determined in spite of any debilitating physical condition. Anorexics remain active mainly for two reasons: they believe the exercise will burn off calories (thinness is equated with fitness), with the

overactivity also distracting them from feeling hungry. It has been suggested the anorexic is experiencing the force of some more basic biological urge in that it is a characteristic often shown by half-starved animals that they keep on the move (Palmer, 1980).

The behavior of an anorexic may become somewhat extreme, especially when the anorexic also engages in vomiting, similar to a bulimic. Some financially secure individuals may look through the garbage for scraps, or begin to shoplift. It can really be quite an expensive form of addiction. Only when this extreme behavior causes the anorexic to feel anxious and out of control will the sufferer sometimes admit to needing help.

The impulse to eat becomes very strong and dominating and the bulimic becomes obsessed with thoughts of food. "Extraordinary amounts of food of all kinds may be eaten in binges which go on until the stomach can take no more and copious vomiting follows. Such massive and impulsive overeating is known as bulimia" (Palmer, 1980, p.26). This pattern of vomiting may allow the anorexic to eat "normally" three times a day, allowing the sufferer to keep the secret undiscovered. However, the result of this constant seesawing between abstinence and bingeing and vomiting leads to a chaotic existence. The bulimic will lead an active lifestyle, but will have problems of instability in both behavior and personal relationships.

Behavior patterns shared by anorexics and bulimics include: avoiding eating with others at regular and established

mealtimes; eating food at odd times or in a ritualized way (same time, same place); disturbed sleep with an early awakening common; symptoms of excessive behavior such as intense studying or pursuit of academics to the exclusion of all else; a compulsive checking of weight; enjoyment from preparing food for others; reading dieting books extensively; using lots of energy to avoid eating; compulsive exercising. Finally, a sufferer's relationships tend to reflect his/her patterns of eating. An anorexic will tend to withdraw from human contact, or at least narrow it to some degree. The bulimic or overeater has more varied contact, but it will be characterized as frantic or chaotic.

So far this paper has outlined many of the elements which are typically associated with anorexia and bulimia, yet for many, there is a nagging concern and puzzlement over why a person chooses to engage in this behavior in the first place.

Factors Contributing to the Development of Eating Disorders

The question which comes to mind is whether the root of the problem is found to be physical or psychological. The sufferer is obviously not well physically, but it can be reasonably assumed that he/she is not well emotionally either.

In essence there are really several contributing factors which may in some way predispose a person to become anorexic, bulimic, or suffer from any other form of eating disorder. These

factors are social, cultural, psychological, familial, and biological.

Physiological and Biological Factors

There are several theories on the books which suggest that a sufferer's disordered eating behavior is due to biological causes.

Palmer (1980) states that "appetite, eating, mood, sexual feeling, and menstruation may all be influenced by a part of the brain known as the hypothalamus and it is plausible that malfunction of the hypothalamus could be the primary disorder, and that the complicated emotional tangles which are often so evident within and around the anorexic subject could be secondary" (p.10).

This is an interesting proposition, but unfortunately it may be too simple. Treatment programs using hormone injections have not been found to increase the sufferer's weight, nor alter her behavior or mood. The literature supports that at low body weight the responsiveness of the pituitary is reduced or even switched off, but that the hormone levels of FSH and LH will rise with weight gain.

While it has been documented that hormonal disturbances or imbalances can have an effect on behavior, this does not however support a disorder of the endocrine system as the cause of eating disorders, rather that these hormone levels are reacting to the

anorexic's low body weight--in other words, after the fact.

In support of psychological as opposed to biological factors for engaging in eating disorder behavior, Rumney (1983) believes "the anorexic is impelled by an unquenchable need to please others because her own sense of self-worth is dependent on other's approval. She decides to starve herself to acquire the love, attention and approbation she seeks. However, it is an endless quest, since no matter how thin the anorexic becomes, she still lacks an internal sense of self-worth and believes that if only she were thinner, and were more pleasing to others, she would attain this" (p.ix).

The familial, sexual, and societal factors will be discussed more completely in the following sections.

Psychological Factors: Personality Development and Characteristics

There seem to be several personality characteristics anorexics and bulimics share which may suggest a possible predisposition to acquiring an eating disorder. These characteristics are patterns of thought which could be considered common denominators among sufferers.

According to the literature, these thinking patterns include a quest for perfection; a desire for others' approval; a competitive belief system; a distortion of body image; an on-going struggle for control; a fear of impending physical

maturity and sexuality; denial or non-recognition of bodily stimuli (hunger, fatigue, emotional feelings); an overpowering sense of ineffectiveness; extreme sensitivity to criticism; a fear of rejection. Other behaviors which reflect these thought patterns include manipulation of others, a tendency to lie and irritability.

These factors may have their foundations in purely genetic explanations. The personality characteristics may in turn, even if proven to be inherited, be influenced by environmental and familial factors. By all accounts, the literature suggests an interesting mutual influence of the psychological factors and the environment. For example, Palmer (1980) presents the psychological regression hypothesis, and says "anorexia is a disorder based on a psychological regression triggered by nutritional deprivation which becomes fixed by the opportunity it offers the subject for the phobia avoidance of personal conflict and emotional turmoil" (p.46-49). This is a controversial hypothesis, and as of this time it has not yet been scientifically supported. Scientific efforts, however, need to recognize that certain individuals may indeed be predisposed to developing eating disorders.

The first contributing thought pattern involves the sufferer's need for perfection in all that he/she does, be it academically, physically, or whatever. The sufferer believes he/she must excel, and yet whatever is done isn't quite good enough. This attitude is especially strong when it comes to the

belief that one can never be thin enough either. In fact, this is an especially difficult belief system to break, since the sufferer's sense of self-worth is gained only through accomplishments, and any criticism of his/her behavior may ironically reinforce the sufferer's thinking he/she's a failure. The general lack of self-esteem only encourages the sufferer to find success by becoming thinner and thinner.

An outcome of the sufferer's drive for perfection is a competitive attitude. The sufferer will approach any and all activities, social situations, etc. as a form of competition, yet the sufferer also believes that he/she will ultimately lose in the competition.

It has been suggested that this sense of competition is a result of the sufferer as an infant believing that receiving attention from the mother was a form of competition in itself; there was a limited amount of love to go around (Rumney, 1983). As the infant becomes an adolescent and more weight-conscious, the anorexia--specifically, not eating--is in response to the mother and a competition over who would be thinner.

Particularly with female sufferers, the competition with the mother also begins to influence the sufferer's relationships with other women. In a social situation for instance, the sufferer will compare herself to the other women in the room unmercifully, with the winner the thinnest. Rumney (1983), herself an anorexic for many years, writes: "Anorexics compete

most strenuously with other anorexics. If two anorexics are together in a high school class, a ballet company, or a hospital ward, the competition becomes vicious. No anorexic wants anyone to be thinner than she is. And always, the competition is for some imagined accolade that will be her reward for being the thinnest--recognition and attention which will take the place of the self-esteem and pride in herself that she lacks" (p.12).

Not only other women are seen as a threat to the sufferer however. In regard to a relationship with a man, the female sufferer believes that even the relationship itself is some form of competition in which only one person will be proclaimed the victor. This forces her to focus too much attention on who will have their needs met within the relationship. The sufferer's logic is such that it tells her that he always gets what he wants anyway, so of course she must lose. Thus in a supreme effort to please him anyway, she will overadapt to the man's demands, bringing her anger and bitterness in the long run though since she--not surprisingly--does not get what she wants.

"When it comes to competition, compromise is defeat. What is significant to her is not what is accomplished in arriving at an agreement but what is lost in the settlement" (Rumney, 1983, p.10).

The sufferer ultimately fears rejection, and so to avoid such an occurrance the sufferer will not let others close enough to criticize--which to a perfectionist is comparable to rejection. The sufferer deliberately sets his/her own rigid

standards, and criticizes him/herself much more severely than anyone else.

Two examples of persons who match these characteristics are Cherry Boone O'Neill, daughter of Pat Boone, and Lisa Davenport, Miss California 1985. Both were making guest appearances on the religiously-affiliated "700 Club" on March 27, 1987.

Cherry, author of Starving for Attention, went from 140 pounds to 92 pounds during the course of her illness. She said she was proud of what she'd created from fat, and that she truly believed that weight was the image of what she was. She went on to explain that she calls herself a perfectionist, and that she focused on her failures which served to prove that she would nevertheless always fall short of her family's and society's expectations.

Lisa could more accurately be described as a bulimic. In keeping with the demands of pageant expectations, she attempted to keep her weight low through bingeing and purging. In fact, Lisa said she was actually reinforced to work harder at keeping the weight off after receiving compliments on her looks. Lisa took this as a sign of accomplishment, and decided this was the way to gain acceptance. Lisa never knew when enough was enough however, for even when hearing praise and receiving attention she felt she wasn't pretty enough, and could only focus on the standards she was falling short of.

It was evident listening to these women tell their stories that they suffered from a definite distortion of body image.

Sufferers, especially anorexics, see their body in an extreme and distorted manner. They will consistently see themselves as fat, even when emaciated. This high level of concern over body weight and shape is not just a strange concept of what is fat and what is thin.

Some experts believe that there may be specific factors in one's life which may influence one's body image. For example, it is suggested that what parents may say, do, or feel about their child's body, whether indirectly or directly, can have a potentially negative impact.

In support of this theory, Rumney (1983) provides the following quote by Bruch (1973) "According to the German neurologist, P. Schilder, motility during development plays an essential role in the individual's definition of boundaries and differentiation of himself from the environment. Schilder suggests that the integration of perceptual and muscular feedback contribute to the formation of a dynamic body concept" (pp.88-89). Rumney (1983) concurs stating "restrictions on movement and limitations to taking physical risks imposed, albeit unwittingly, by over-cautious parents on the exploratory age infant hinder the child's conceptualization of how her body fits in space. The child does not develop the capacity to be flexible and to adapt easily to changes in her physical surroundings and furthermore does not acquire a sense of integration or cooperative interaction of the parts of her body" (p.23).

So long as the sufferer persists in believing that a normal

body weight is still fat, the sufferer will be uncomfortable at this weight. The sufferer will not experience it as his/her body but as a structure which is simply inhabited and whose size is not under control.

Ultimately it could be determined the sufferer, be he/she anorexic or bulimic, is waging a losing battle over control of his/her life and body. Dealing effectively with emotions is especially difficult. A review of the literature seems to indicate the anorexic in particular does not experience a full range of feelings: the sufferer may be depressed, even angry, but will deny the anger and hurt by typically adapting to the other's mood, and then expressing what is thought ought to be expressed while denying his/her own identity and feelings.

In essence, the sufferer attempts to retain control over an otherwise chaotic body. In a desperate attempt to regain autonomy the sufferer struggles to achieve a sense of identity and self-esteem by starving. The sufferer believes he/she possesses a power over his/her body that validates a position of superiority over others.

"In anorexia, the problem with grief is related to the issue of control. The anorexic is determined to maintain control in order to avoid experiencing the pain--the fear, the anger and the grief--of someone else's being in charge and denying her what she needs or wants. The anorexic will attempt to assert and maintain control of situations, particularly where they relate to food. The prospect of loss of control is very scary to the

anorexic. Without control, she will experience that emptiness, that void, which feels threatening, cold, deathlike. By hoarding and saving food, she can control the presence (to her the existence) of food" (p.16).

The above statement suggests that developing an eating disorder is a way of controlling, coping with, and avoiding emotional distress which is too difficult to handle. But the attempts of the sufferer to take more control of his/her life may not always be beneficial. Often the sufferer has problems starting and stopping various activities. This difficulty is reflected in the eating behavior itself, as the sufferer is caught in a desperate struggle between continuing to eat, at the risk of getting fat, or stopping, and experiencing the grief discussed above. In fact, "'finishing' to her represents separating from something familiar and comforting, an integral part of herself" (Rumney, 1983, p.17).

Rumney (1983) suggests the self control needed to continue such depriving behavior is often seen as having rewarding results. These sufferers achieve a sense of satisfaction which is dangerously addictive. For instance, a person may start slimming down by dieting, but an anorexic may find he/she can lose weight quickly and easily--and may in fact be good at it. Something goes wrong though somewhere along the way, prolonging the loss of weight to beyond what is healthy.

Furthermore, Rumney (1983) believes once the process of dieting begins and becomes characteristic of anorexia, the

sufferer becomes trapped by an exaggerated fear of the consequences of gaining weight. While initially the anorexic will feel safe or in control of the weight, such feelings are tempered by the fact that they can be threatened by any weight gain.

This form of coping is not deliberate. The sufferer finds him/herself in a position in which the eating experience is significantly different and finds that to be otherwise has come to seem frightening and unacceptable. Eventually, says Palmer (1980), "the preservation of her new position against change or the threat of change becomes a central preoccupation which tends to distort other interests, concerns, and relationships" (p.22).

Particularly for females, a stage in life which is fraught with control issues is adolescence. Adolescence brings a young female to the realization that her body is changing, and with these changes, the advent of sexuality. Adolescence is commonly a time of personal uncertainty and self-consciousness, and (Palmer, 1980) it seems likely that "the young person who develops anorexia nervosa may well have been experiencing more than the usual difficulty in negotiating the tricky transition from child to adult even before she fell ill" (p.18).

Many teenage girls feel that dieting, slimming, and molding their body is a way to self-improvement and acceptance by the opposite sex. Others however seem to want to avoid becoming sexually mature persons. Looked at in this light, an eating disorder can be seen as an attempt at withdrawal from adolescent

experience. In other words, the anorexic refuses to grow up and take responsibility for herself, to define her reasons, motives or goals, or to assume responsibility for her own sexuality.

Sufferers of eating disorders are described by Palmer (1980) as denying their sexual feelings due to a fear of adult sexuality and pregnancy. Even though sufferers may be naive about sexual matters--they may not even be curious--they still believe they're appealing to men, even when extremely thin. They engage in seductive behaviors and want desperately to be thought of as attractive.

When it comes to actual male-female relationships, the sufferer is jealous of her mate's female friends, believing these friends can provide something the sufferer herself cannot. She may constantly compete with her mate, as discussed earlier, while at the same time asking for reassurance of his need and approval for her.

The research suggests that sufferers don't enjoy sexual activities themselves, that the sexual feelings and drive of a sufferer may decrease (although it doesn't seem to go away altogether) during the illness. Beumont, George & Smart (1976) in Palmer's book (1980) gave an interesting statistic: those who overeat and vomit are more likely to have had sexual intercourse before their illness and to remain sexually active within it.

One hypothesis purports that the sufferer is basically suffering from a lack of nurturing from her mother, and that she may therefore never mature beyond a need for touching and

cuddling to a need for sexual pleasure. Or, put another way, sex and nurturing are confused for a sufferer.

The onset of amenorrhea (cessation of menstruation) in eating disorder patients, especially anorexics, has been linked to the psychological dimension of the patient wishing to control her body to such a degree that she trys to eliminate her sexuality, which menstruation represents. The similarity between the neuroendocrine changes which occur in an anorexic and the physical state of a pre-puberty female are startling.

While it may seem fantastic that a sufferer could control her cycle so easily, in essence her drop in body weight achieves this quite well. Medical evidence taken during treatment of anorexics has shown that even with attainment of normal body weight, menstruation often does not resume until psychological counseling is begun.

Familial Factors

There is a tendency in the mental health field to delve quickly into the family background of a patient to find out "what went wrong." Family members are understandably put off by these inferences, and care must be taken not to blame a patient's family, especially parents, of messing up the child's life. There are times when careful investigation into the family dynamics can provide revealing information which can aid the patient and there may indeed be certain predisposing

circumstances in many sufferers' families. It is important to remember that although many of the factors described in this writing exist in many sufferer's backgrounds, it is the view of the world the sufferer sees which counts, not just how the rest of the world sees it.

There have been recent reports that anorexia and bulimia are illnesses that affect the upper and middle class of society--perhaps a reaction to and reflection of higher demands and expectations. For example, Rumney (1983) purports "A family fostering the development of an anorexic is typically upper middle class and achievement-oriented, possessing values to some extent reinforced by society. The mother is typically joyless and ambitious and the father is warm but passive and retiring. Exemplary performance is valued but without a sense of personal pride or pleasure" (p.2). It has been suggested that the rigid and high expectations for the children, regardless of class status, in combination with a lack of a rebellion period, leads to the formation of the disorder as a form of rebellion.

Evidence does not suggest this problem is restricted to certain classes as much today as it might have been at one time. There are many other familial factors which can be found in families from all social strata. For example, there can be found many a family structure in which personhood or selfhood is not recognized as a value but rather possessions and appearances are esteemed. Families of sufferers often show characteristic patterns of interaction in which the speaker assumes the person

to whom he is speaking will understand his frame of reference without an explanation, and will perhaps even finish the speaker's sentence for him. Feelings are not discussed (Rumney, 1983).

Other contributing factors often found by Rumney (1983) in the family include: alcoholism; depression; instability (as in a threat of divorce); weight problems; hostility toward one another; absent parent(s); ill members; parent psychiatric illness; disturbance in elder siblings; major family crisis; emphasis on dieting; food an emotional topic.

A review of the literature finds a large amount of research focused on the mother-daughter relationship and its possible contribution to the development of an eating disorder. For example, one explanation found in the literature suggests that the anorexic's lack of self-esteem and self-worth is due to a mother who is anxious, and who, while taking care of the child's physical needs, does not give the stroking, holding, etc. needed to give the baby a sense of importance. The baby learns that love is conditional, and that mother can only be pleased by what he/she does, not by who he/she is. Thus the baby learns to deny his/her own needs while growing up (Rumney, 1983).

However, there still exists the issue of unresolved grief, which refers to the above-mentioned loss of the mother's love late in infancy. Again, Rumney (1983) suggests the baby learns to stop feeling in order to keep from getting hurt; the baby only shows feelings to which the mother will respond positively. The

mother may also be overprotective at the same time, and is thus not meeting a balance between allowing freedom and giving support.

Furthermore, particularly for females, "the anorexic lacks her own self-identify and does not differentiate from her mother. Yet she does not want to identify with her mother and views her mother's personality and way of life as undesirable. Hence the anorexic does not want to develop physically or emotionally into a woman for fear that she will be like her mother. Because she has had a relatively sheltered life, and never viewed herself as separate from her mother, the anorexic also does not emulate other adult women as role models but instead views them as competitors who possess some elusive capacity to succeed as women, a quality the anorexic lacks and envies. By starving herself, she prevents her body from developing physically, and by not separating herself from her mother and establishing her own self-identity, she remains immature emotionally. With her father, the anorexic has a dependent, seductive relationship. Typically the father and daughter collude to reinforce a disparaging view of the mother" (Rumney, 1983, P.3).

The psychoanalytic tradition on the other hand places great emphasis on the association of feeding and human contact in the earliest experience of the infant. The bond between mother and child is of great significance, forming a model for later in life. At the center of this modeling and bonding is feeding.

"Feeding and comfort, feeding and contentment, feeding and contact, feeding and pleasure are intimately mixed from the earliest moments of infantile experience. On the other hand, feeding difficulty and hunger are associated with discomfort and displeasure" (Palmer, 1980, p.78).

The child learns at an early age that food is symbolic. If nurtured as an infant, it was usually during feeding, and thus food came to be assoicated with comfort. Palmer (1981) for instance recognizes continuity between infant feeding, thumb sucking, and overeating at times of stress.

Eating in itself is not a simple activity, for both culturally and socially great significance is given to food. For example, fasting has been seen historically (and religiously) as mastering control over one's body, a pathway to achieving rewarding control over one's inner drives and impulses. Similarily, the hunger strike is recognized as a form of protest. Within the family structure too there are important social messages around the custom of eating together as a family. In essence then a refusal to eat can be a powerful message which the sufferer is sending, and an effective weapon against the status quo.

MacLeod (1982)--an anorexic herself--concurs, writing: "I was trying to resolve something, trying to prove something and, through the language of my symptoms, to say something. Whether she knows it or not, and however obliquely metaphorical the language of her symptoms may appear, the anorexic is trying to

tell us something, and something quite specific about herself and the context in which she exists. We know, from the outside, that it is something of tremendous importance because some anorexics would rather die than stop saying it" (p.xi).

Societal Factors

Recently much attention has been focused on the potentially detrimental impact of the pressures of society on the children of today. In American society especially physical appearance has become overloaded with importance and meaning. Health, fitness, and attractiveness are the yardsticks by which people measure one another. A potential sufferer of an eating disorder may begin to view others in the world in terms of how thin or fat they are compared to him/herself. The potential sufferer has high expectations for change for the better, yet the unrelenting approach to an ideal of health and beauty is undermining the very affects the sufferer wishes to produce. In a society which places heavy emphasis on physical appearances it is easy to understand how people, especially young females, can feel inferior and have a poor body image.

It is tempting to blame America's male-dominated society for this sense of female inferiority, but it is interesting to note that it is often women, not men, who influence women the most. As mentioned in the section on competition, it is the other woman a female will often compare herself to and fall

short.

This intensity of competition is of course not universal and there are many women out there who are confident in who they are and what they look like. But a recent poll by a national magazine indicated that over 80 percent of the women surveyed were dissatisfied with their bodies. This is a sad state of affairs which needs to be explored further and dealt with more effectively.

Some mental health professionals feel that the increase in the number of cases of eating disorders is in response to the current redefinition of women's roles in society. The anorexic for instance has been socialized by her family to be non-assertive and dependent and yet at the same time is encouraged to take on typically male professions and roles outside of the home. The sufferer, unable to assume the role of an adult woman who can compete with men on an equal footing, rebels and attempts to deny her own womanhood. Here again, the mother of an anorexic may have been too submissive for a role model, and the daughter, in that never-ending battle with her mother, begins to rebel.

Eventually there develops a definite antithesis between mother and daughter--the daughter wants to be absolutely different from the mother, especially when it comes to interactions with men, yet the paradox is that her only role model <u>is</u> her mother.

The concept of the daughter competing with the mother for

the father or other male figure is only one explanation and their research suggests different explanations. For instance, the mother, for her part, could be attempting to live through her daughter, thus reinforcing certain behavior and attitudes unwittingly.

"It may be important to remember that whereas for the parents the adolescence of their daughter is a significant psychological and interpersonal process, for the daughter it is also a biological process" (Palmer, 1980, p.85). Anorexia arises within and is perpetuated by characteristic family dynamics; the anorexic can only attain cure if either the family dynamics change, or if the anorexic, living outside of her family of origin, learns a new way of relating. Awareness of this need to change family interaction is evident in the media as of late. In an article in Self Magazine, February 1987, the author suggests that a close father is anorexia insurance for daughters. This article goes on to say: "In a recent study of anorexic girls age nine to 23, more than nine out of ten described their fathers as emotionally distant....As teenage girls begin trying to redefine themselves as women, they often look especially to fathers for reassurance that they're on the right track. But this transition time may not be the most comfortable for a father either--and if he's ill-at-ease with the woman his daughter is becoming, he may give off negative messages or, sometimes just as damaging, no reaction at all (page unknown).

Furthermore, the author suggests that the daughter will

adopt the anorexic's belief that feminine-equals-skinny if there aren't any other standards with which to measure herself. To prevent the formation of such a belief, fathers need to show more recognition, give a little physical affection.

Societal factors are perhaps the most subtle yet influential of all in a vulnerable and insecure boy or girl's life. Peer pressure, advertising, television, mom and dad's attitude, etc, all serve to twist somehow the shape of the sufferer's belief system. In support of this claim this paper will focus on one group in particular which is uniquely susceptible to these outside influences.

Eating Disorders on College Campuses

The seventeen- or eighteen-year old who leaves home for the first time to attend college is under a considerable amount of stress. Not only does the academic lifestyle take getting used to, but the separation from the support of family can be particularly trying. In fact, for females, "the emotional stress of leaving home causes an estimated 20 percent to stop menstruating or become highly irregular" (Squire, 1983, p.69).

The new undergraduate will be faced with hundreds of new decisions on how to budget time and establish priorities. Along with the increase in social and academic pressures there may also be anxiety about the future. For females, it is interesting to note that a girl's father plays an important part in her feelings

about herself. It seems fathers tend to have a negative influence on their daughters, especially those in sororities. The father's image of the perfect, thin little girl can be devastating when thrown insensitively at a young person during a stressful period.

The living arrangement itself, especially in the dormitories, provides plenty of opportunity for "pass-along behaviors to soften classical collegiate depression" (Squire, 1983, p.70). The notorious stress-releasers drugs, alcohol, and smoking are now giving way to dieting, bingeing, and vomiting. Due to the competitive environment the risk of developing a stress-related eating disorder increases.

Raymond C. Hawkins II, Ph.D. and colleague Pamelia F. Clement, Ph.D. developed a "Binge Scale" questionnaire and tested the binge-eating behavior of undergraduates at the University of Texas. "They found that 79 percent of female undergraduate subjects, of varying weights, admitted to binge-eating episodes. Binges were reported as frequently among normal-weight women as among overweight women. But only 5 percent of the female bingers, regardless of weight, were also vomiters" (Squire, 1983, p.69). Their assumption was that most of the bingers they saw were not vomiters but rigid dieters. David M. Garner, Ph.D., and Paul E. Garfinkel, M.D., have surveyed thousands of women with the Eating Attitudes Test (EAT) they designed to determine the degree of anorexic behaviors and attitudes held by the women. They calculate that "about 12 percent of college-age women have

serious difficulties....with their eating behavior. By serious, Dr. Garner means that worries about food occupy an extreme proportion of their time and they will use drastic weight-control techniques, including laxatives and diuretics, as well as vomiting" (Squire, 1983, p.71).

Squire (1983) reported that another research team, Michael G. Thompson, Ph.D., and Donald M. Schwartz, Ph.D., had the following to say about their results from the EAT: "'The most dramatic finding,' Thompson and Schwartz reported, 'was the prevalence of anorexic-like behaviors among normally functioning college women. These women were not impaired in their work, though they often felt that they were struggling. The frequently intense feelings of inadequacy they reported appeared to arise from violation of high internal standards.' As far as dieting goes, it was so widespread that the researchers found its frequency impossible to measure. Almost all of the anorexic-like women and many of the problem-free women said simply that they were always dieting" (p.71). An interesting note is that even women who did not share anorexic attitudes seemed to demonstrate a constant preoccupation with the desire to eat and the need for will power.

A finding which was surprising in its intensity was reported at Ohio State University, where Judith Cusin, M.S.W., and Dale Svendsen, M.D., administered the EAT to three groups: sorority women, dance majors, and regular coeds. They found that 9 percent of the regulars, 16 percent of the sorority members and

23 percent of the dance majors could be identified as having symptoms of anorexia nervosa (Squire, 1983). The illness itself may not have been common at the OSU campus, but anorexic attitudes sure were.

The intense pressure to succeed both socially and academically at college leads many to desperate measures. Sorority women in particular are hard-pressed to be more socially oriented and appearance-conscious than non-sorority women. It seems sororities are about as notorious as ballet schools for the spawning and maintaining of anorexic attitudes and behavior (Squire, 1983).

Not all college-age females display eating disorder behavior which can be clearly labeled as anorexic or bulimic. Situational binge-vomiters are women who don't suffer from intense psychological problems; they may even like their bodies. Often the behavior is a result of the infamous Freshman 10, the weight gain that is so common when eating the fried, sugary, starchy dorm food. These eaters may be simply looking for a quick method of coping with temporary stress. Situational bulimia it seems can be carried on without serious consequences for most. As long as the on-going psychological need for it is lacking, the behavior won't become habitual (Squire, 1983).

An excellent example from England of the incidious manner in which an eating disorder can take hold is this: "Christine was a twenty-year-old student at university who, in common with many of her friends, decided to diet for cosmetic reasons even

though she was only marginally overweight. She was especially concerned about the shape of her hips and thighs. She had for a number of reasons been rather unhappy, and in particular a relationship with a boyfriend was going badly. Almost to her surprise she found that she was able to control her eating without much difficulty and before long eating any substantial amount gave her a feeling of being 'bloated.' On the other hand the sensation of 'emptiness' and of suppressed hunger gave her a 'good, clean feeling.' Her flatmates confronted her after they had seen her undressed..." (Palmer, 1981, (p.21).

Interviews held on the campus of Western Michigan seem to support such activity. Discussions with the boyfriend and friends of a bulimic living in university housing were conducted with special attention being paid to the emotional reactions of the helper.

According to helper accounts, this particular bulimic exhibited classic behaviors, including constantly asking whether she was too fat or not pretty enough; dissappearing before and after meals without explanation; lying about her true destination when actually going to the bathroom to vomit; allowing personal hygiene and grooming to deteriorate.

The effect of this behavior upon the helper/boyfriend was considerable. Social gatherings were times for potential embarrassment over the bulimic's eating habits. Comments by the helper in reference to eating habits or weight had to be made carefully for fear of alienating the bulimic. Further

information gathered from interviews suggests that the lack of grooming and maintenance of personal hygiene affects the intimate relationship between the bulimic and partner, and may lead to problems within the relationship. In addition, an interesting example of coping by the helper, instances of "contracts" or "pacts" were evident between helper and sufferer. Often these involved agreements limiting the amount of bingeing and vomiting.

A particular aspect of college life is the general lack of privacy and confidentiality, especially for those living in university housing. With many persons eating and living together, word travels quickly about who does what and who eats what. The interview further revealed that the sufferer did not appreciate others giving advice on what to do and what not to do since the sufferer believed they did not know what they were talking about and couldn't help.

Obviously there are strong social factors influencing a young person who is away from home, perhaps for the first time, and feels the pressure to succeed. A person who also has a history of family problems and perhaps several of the personality characteristics discussed earlier may have a predisposition for falling into eating disorder behavior.

In particular, the issue of eating disorders on university campuses is one which deserves greater attention. While specific schools do an excellent job of producing handouts, fliers, brochures, etc. on the subject, the content of most focus on the symptoms and warning signs of the conditions. This is fine, but

this information is lacking a vital aspect: it is forgetting perhaps the real victim.

The Helper's Role In Eating Disorders

The role of "helper" is an important one indeed. The helper may be a friend, boyfriend, roommate, residence hall advisor, co-worker, etc. To qualify as a helper one only need have a concern for the health and emotional well-being of the alleged anorexic or bulimic. The helper wishes to alert the sufferer to the seriousness of the problem, to help locate proper professional attention, and to be there when needed.

The role of helper may be a frightening one for many, since it implies assuming a certain level of responsibility for the sufferer and the course of the disorder. Often the helper does not make a conscious decision to get involved, but rather finds him or herself made aware of the situation almost accidentally. Often it's an unannounced entrance into a bathroom where the bulimic is vomiting, or seeing an anorexic without clothes on and experiencing the shock of seeing his or her emaciated frame that brings the realization that there is a real problem. Sometimes the sufferer may be quite open about his/her eating behavior. In extreme cases it may take an emergency trip to the hospital if the sufferer has managed to conceal abnormal eating behavior for some time.

There is a variable in all relationships which may be

referred to as the time and loyalty factor. Many individuals make the choice to get involved or not based on the level of commitment, sense of loyalty, the length of the relationship, and the future of the relationship. It may be difficult deciding where proper priorities and responsibility lay.

Macleod (1982) sums up best the effect an anorexic or bulimic can have on anyone: "The anorexic's behavior is puzzling and eventually becomes infuriating to those around her, who are reduced to helplessness in the face of her intransigence. She wounds those nearest her by rejecting all they have to offer her. To them, her persistent refusal to eat seems like the epitome of perversity: she is choosing death rather than life, sickness rather than health or, at best, a narrow existence in the preference to a full one" (p.ix). Thus it is the helper can find him or herself confused and torn between feelings of disgust and anger and support and understanding.

Parents in particular have a rough time accepting the fact that their child is actually doing something so "unnormal." A treatment program discussion group composed of parents is urged to discuss the frustation, rage, and guilt experienced upon learning that their child was anorexic or bulimic. They are also urged to discuss the coping behavior they as family members used during the illness, and the difficulties these behaviors spawned. Any confrontations, violence, sadness, and instances of separation were analyzed in terms of their connection with the child's weight loss.

An anorexic or bulimic is surrounded by chaos which most assuredly affects those around him or herself. It is now recognized that children and spouses of alcoholics are also victims--maybe not of the alcohol itself, but of the drinking member of the family. It took a while longer before society recognized others in the family may also need help. The private, inner turmoil of the sufferer has its counterpart in the helper.

There are many parallels and similarities between the disease of alcoholism and its affects upon friends and family and an eating disorder and its effect upon friends and family. Whether it is chemical dependency or anorexia nervosa, those around the victim or sufferer are affected in ways that are only now being explored. For instance, research indicates a profound similarity between the coping methods of friends and family in relationships with victims of chemical and alcohol dependency and the coping methods used by friends and family in relationships with eating disorder sufferers.

In addition, the role of "helper" in relationships with eating disorder sufferers can be found in relationships with chemical or alcohol dependency victims. For example, a helper role in a relationship with an alcoholic is recognized by Fajardo (1976) as having the following limitations: "As the concerned person your goal must be to start your alcoholic on a program of recovery and to keep him there. It is not to stop his drinking. That is the alcoholic's decision to make and his alone" (p.11).

The literature supports a limitation on accepting full

responsibility for a sufferer's or victim's problems. Care must be taken to recognize when the helper's abilities can be beneficial not only for himself but also for the sufferer or victim. Fajardo (1976) believes such a role cannot be a one-way street. The sufferer or victim must be willing to get help, and recognize the impact the sufferer or victim has on those around him or her. Fajardo states that even a dedicated helper must learn to set limits and expectations so as to ensure the survival of the helper him or herself.

For example, Fajardo (1976) writes, "I happen to believe in every person's right to choose his own destiny and life-style. But if he chooses to live with me or share my life in other ways, then he becomes involved in my philosophy and my preferences, and I may have to give him a chance to make a choice that may involve losing my company or sharing my house" (p.11).

Again, a helper must actively choose to aid a sufferer or victim albeit within the limits of his or her own resources. But a helper need not feel that he or she is incapable of really helping the sufferer or victim simply because of a lack of professional training. According to Johnson (1986) "anyone who sincerely wants to help, can help" (p.viii). Special expertise is not necessarily needed to help someone recover from a chemical dependency or eating disorder. Johnson (1986) disagrees with the belief of most people that nothing can be done to help a chemically dependent person until the person "hits bottom." He belives that simply trying to pick up the pieces is cruel and

dangerous. He emphasizes reaching out to the person now.

Persons involved in a relationship with a chemically dependent victim tend to experience various emotions in response to the relationship with the victim. Research and literature would seem to support that persons involved with sufferers of eating disorders would also experience such emotional turmoil.

Some of these feelings as listed by Johnson (1986) include anger, shame, hurt, fear and uncertainty, loneliness, a desire to be perfect, rebelliousness, apathy, and guilt. The friends and families of alcoholics in particular will turn to the unconscious use of defense mechanisms. The function of a defense is to protect the inividual from emotional hurt. These defenses, which were first discovered by Segmund Freud, are selected unconsciously. Perez (1986) lists nine defenses, yet emphasizes that these can blend with each other to form combinations difficult to separate. These defenses are as follows: denial; rationalization; projection; regression; fantasy; displacement; avoidance.

Ultimately, a helper may take on the role of protector as another means of defense against the feelings listed above. A protector will often make apologies and excuses for the victim or sufferer in an attempt to preserve appearances. An individual who becomes a protector may eventually become what Alcoholics Anonymous describes as an enabler. According to AA, an enabler is an individual who assumes too much responsibility for the victim. Although the enabler may believe he or she is protecting

and helping the victim, in actuality the enabler is "enabling" the victim into continuing the dependency. Ironically, "most enablers, in their zeal to protect, defend, and explain the alcoholic's behavior do not see that they are actually feeding and nurturing irresponsibility and immaturity." (Perez, 1986, p.36).

According to Perez (1986) enablers facilitate the alcoholic process in the family and are disposed to be overprotective, compulsive, and worriers. In fact, overprotective enablers are not loving but rejecting. The alcoholic is not seen as an individual. Similarly, for sufferers of eating disorders, the parents may be overprotective. The sufferer's parents do not understand the sufferer's need to mature through independent and responsible decision making behavior. An overprotective enabler may serve as a buffer between the alcoholic and the rest of the world. An overprotective helper may also attempt to shelter the sufferer from the rest of the world.

Furthermore, Perez (1986) states that "overprotective enablers are people who need to control and maniuplate." (p.36). This type of enabler is lacking in personal self-esteem, and finds that taking care of the alcoholic gives the enabler a sense of security. Ultimately, however, the constant care taking and protecting which began in an attempt to obtain loyalty from the alcoholic will lead to maintaining the alcoholism and driving the alcoholic farther away.

In addition, Perez (1986) maintains that an enabler tends

to be compulsive. An enabler will think he or she can solve any and all familyproblems. An enabler will take care of chores, but if he or she cannot complete them alone, another person will be supervised to perfection. It is this trait which leads to arguments and other stress in the family. Perez (1986) suggests this is the trait which alienates children especially, and may explain why they come to sympathize with the alcoholic and turn to them for closeness. "The enabler's compulsive ways may well be a prime reason that so many children of alcoholics become themselves alcoholic" (p.37). An explanation for this may lie in the enabler's response to the chaos in the family, resulting in an attempt to bring order. Thus compulsiveness helps enablers to deny the reality of their own and the family's situation.

Enablers are also worriers who are unwilling or unable to see alcoholism or eating disorders or the insidious effects of it in the family. Due to a deep sense of guilt, their worries may lead them to "do something" for the alcoholic, bulimic, anorexic, or another family member. Both worry and guilt keep them on an emotional roller coaster.

"Enablers are enablers because of their need to control and dominate the alcoholic or because they are emotionally or economically dependent on the alcoholic. In either case they are unwilling, usually see themselves as unable to change their lives. In both cases they spend their lives in worry" (Perez, 1986, p.38).

Even enablers however can become effective helpers.

Johnson (1986) proposes that the greatest challenge a helper may face is deciding whether to be a helper or not. The following quote from Johnson's book exemplifies this concern.

"'I'm not married to the person - we're just friends. Doesn't intervention look like interference in his or her private life?'

'This is a genuine concern for some people. Most of us were raised to be polite, to respect others' privacy, and to mind our own business. We hesitate to be rude, or cruel - both of which intervention seems to require. It is not rude to help a sick person; it is not cruel to save someone's life. In fact, intervention is a profound act of caring'" (p.64-65).

In essence, both the enabler and alcoholic (or eating disorder sufferer) have to change their destructive ways if a family is going to move toward health. The first step to recovery however is an awareness of the disease which can facilitate an admission of its existence. The people who have a problem generally do not seek treatment of their own volition because they are not aware that they have it.

Johnson (1986) proposes a plan of "intervention" for the victim or sufferer. He emphasizes that the intervener or helper must first understand the problem, be it alcoholism or an eating disorder. Not only will the helper gain greater understanding, but learning about the problem can relieve some of the guilt. The helper must realize it is not his or her fault for the condition of the victim or sufferer.

Defined, intervention is "presenting reality to a person out of touch with it in a receivable way" (Johnson, 1986, p.61). Thus during an intervention session specific facts are presented in an objective, unequivocal, non-judgmental and caring manner. The intervention is an attack on the victim's or sufferer's defenses, not the person him or herself. Reality must be presented as an act of empathy.

An intervention session is designed to allow the victim or sufferer to face the facts and direct him or her to professional help. In sum, the literature supports a don't-give-up attitude for helpers. It seems such intervention has a cumulative effect, and one never knows when or what convinces the victim or sufferer to seek help.

A guide for helpers living with victims or suffers includes the following: 1) stop inappropriately confronting the victim or sufferer; 2) stop protecting the sufferer. And if the helper feels there is a need for professional help, get it. Above all, the literature warns that even if the sufferer resists help, don't let that refusal block the helper's recovery.

Johnson (1986) realizes that even if a helper follows the two suggestions mentioned above, an intervention session may be necessary and inevitable. In order to ensure a successful intervention, proper planning and preparation must occur.

The first steps for an intervention inlcude gathering an intervention team and gathering data. The intervention team should consist of meaningful persons in the sufferer's life. In

addition, best are those persons who "know something about chemical (or eating disorder) dependency, are willing to risk their relationship with the victim (or sufferer) and are emotionally adequate to be interveners" (Johnson, 1986, p.69).

As for gathering data, making lists of specific incidents in which the victim or sufferer is engaging in dependency-related activities is helpful. A written "log" can have quite an impact on a victim or sufferer. In addition, seeking out resources and agencies which can provide information, support, and professional help when needed is suggested. Being able to present the various treamtment options to the victim or sufferer should convince him or her of the helper's genuine concern and support. Johnson (1986) also believes an intervention should be conducted during a sober or quiet time, in a reassuring environment familiar to the victim or sufferer. At the very least, even if an intervention at first seems to fail, the helper must remember to continue trying, that no amount of concern will go unheeded.

In the meantime, the helper must strive to ensure that he or she does not slide into the role of enabler. Perez (1986) suggests the following "do's" for non-drinking family members, which could be as easily applied to non-eating disorder family members:

1. strengthen their own selves,
2. seek help,
3. strive constantly to enhance the alcoholic member,
4. establish a loving relationship with the alcoholic member, and

5. learn to relax about the problem.

Johnson purports that the intervention sessions have never failed when properly conducted, and it would seem plausible that for non-eating disorder family members such a session may indeed succeed as well. Combined with a change in family dynamics and the removal of enabling activities, the sufferer should at least be alerted to the various options open to him or her.

Conclusion

Once a friend or other close person becomes a helper, they naturally wonder "What next?" If it is a family member who takes this role, a visit to the family physician would be a good first step. If it is a friend or, in the case of a roommate who accepts the role of helper, then a talk with the resident advisor or other staff person might be appropriate.

I say <u>might</u> be appropriate. In any situation the probability of a confrontation is high. Since the circumstances under which the helper may have discovered the illness were likely to be confusing and confrontational, care must be taken to avoid such an episode. It is strongly suggested that respect for the sufferer must be of the utmost importance. Do not talk about the sufferer as if he/she were not a real person with feelings, especially to others. Again, especially in residence halls, gossip can be rampant, and a lot of potential problems can be

cleared up by talking frankly with the sufferer about how he/she wants you as helper to deal with the "public."

A key element in establishing a bond of trust and acceptance of the sufferer is a supportive environment. This can be created by understanding roommates, family members, etc. It should be clarified that to be understanding does not mean becoming an enabler. Just as with other addictions, firm understanding of the sufferer's problem is preferred over weak agreement to everything the sufferer does.

One of the best things a helper can do for both him/herself and the sufferer is become educated. A quick trip to the local library for a concise book on the topic of eating disorders, or to a local hospital or health center for brochures and other information would provide the necessary basics. The helper should also be encouraged to seek out professional counseling him/herself if they feel things are getting out of hand. It is the sufferer who has a problem, but if the helper does not take care of him or herself too, then he or she won't be as effective.

In regard to possible action against the sufferer within the school setting, the sufferer's personal rights supercede the general complaints of others who might find the behavior offensive or disturbing. At Western Michigan University in fact, the sufferer will only be referred to the director of the hall if the behavior is disrupting the rest of the students on the floor. The director has no legal rights to ask the sufferer to leave the hall, but the sufferer is urged to seek counseling.

Often the confrontation-like aspects of seeing the director are enough for the sufferer to either seek the counseling or leave the hall.

Interviews and research suggest that others in the sufferer's life tend to almost ignore the eating behavior. Especially in residence halls, the knowledge that so-and-so is anorexic or bulimic extracts an almost nonchalant "Really?" and is then promptly dismissed. It should be mentioned that there are other persons within the sufferer's social frame of reference to whom the sufferer may feel comfortable talking. These include dentists, teachers, ministers, residence hall staff, etc. These persons may also be the first to recognize the eating disorder symptoms.

Society must start looking at this problem with greater awareness. For instance, university and college campuses could begin to focus on the stresses which may facilitate the acquisition of eating disorder behavior due to their unique environment. In addition, realization that those around the anorexic or bulimic could be adversely affected could provide support for the many helpers of the sufferers. If the helper can come to terms with their own emotional reactions to the disorder then positive support can be extended to the sufferer.

A helper approach which does not include policing the anorexic or bulimic, but rather focuses on the sufferer obtaining professional attention is suggested. The helper is not the therapist--he or she can maintain a relationship with the

sufferer by recognizing and accepting positive as well as negative attributes. Leave the psychological analysis to the professionals, and simply work on being there when the sufferer needs you.

Eating disorders are a growing and complicated form of coping behavior. As Mcleod was quoted earlier, the anorexic or bulimic are trying to tell us something. The key to hearing what the sufferer is saying is to <u>listen.</u>

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