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CULTURAL PRESSURES TO BE THIN
AS RELATED TO
EATING DISORDERS AMONG COLLEGE-AGE WOMEN

by

Stephanie Ann Skumanich

A Thesis

Presented to the Graduate Committee

of Lehigh University

in Candidacy for the Degree of

Master of Arts

in

Social Relations

Lehigh University

1984

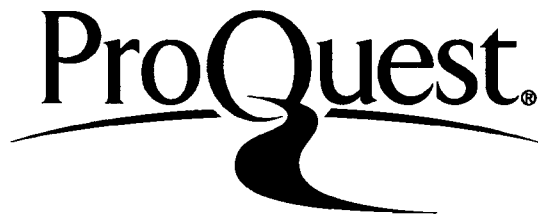
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The Women of Lehigh's Class of 1986

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ABSTRACT. This thesis examines our contemporary society's pressures on women to be thin and the relationship of these increasing stresses to high prevalence rates of diet-related disorders among women. The study is presented in five Chapters.

Chapter 1 is a discussion of the present "health"/fitness-oriented culture of the 1980's. These societal ideals are exemplified by the vast capital growth of diet and exercise-related industries (diet clinics, fitness clubs, etc.) and dramatic increases in advertisements for diet-related products (diet soft drinks, low calorie sweeteners, etc.) Chapter 2 contains background information on the eating disorders of anorexia nervosa (self-starvation) and bulimia (binge - purge syndrome).

Chapter 3 is a presentation of my study on the prevalence of dieting behaviors and eating disorders among a population of college-age women, and to what extent they feel pressures for slimness. Over 190 women between the ages of 18 and 21 completed questionnaires during the Spring 1983 academic semester. The study revealed that 11.5% of the women surveyed suffered from either anorexia or bulimia. Many more of the respondents, 33.9%, displayed some eating disorder symptoms, putting them at risk for developing the

clinical disorder at a later time. Statistical evaluation showed a significant relationship between the occurrence of eating disorders and the perception of external pressures to be thin, indicating that the disorders may arise from vulnerability to external sociocultural factors.

Chapter 4 is a discussion of etiological theories of eating disorders. These disorders appear to have a link to major affective disorders (major depression and minor depression). Strong evidence is also given that sociocultural influences play an important role in etiology.

The final Chapter is a summation of my work in examining the relationship between eating disorders and pressures for thinness. Although contemporary medical research has shown that eating disorders do appear to have a hereditary component and are related to major affective disorders, psychosocial factors are an important etiological component as well; the combination of medical and contemporary sociological factors may be the reason for the rampant occurrence of the disorders in today's slim-oriented society.

INTRODUCTION

In the past few years, there has been a growing preoccupation in the United States with dieting and weight loss. Accompanying this phenomenon has been increased concern with what some psychologists call "dieting gone awry"--the eating disorders of anorexia nervosa (self-starvation) and bulimia (binge-purge syndrome). These illnesses encompass psychological distortions of perceptions, as well as secondary physiological manifestations which can sometimes lead to death (19). The purpose of this study is to assess the prevalence of eating disorders and to examine the relationship between these disorders and pressures for thinness.

Although contemporary medical research has shown that eating disorders do appear to have a hereditary component and are related to major affective disorders, psychosocial factors may be an important etiological component as well; the combination of medical and contemporary sociological factors may be the reason for the rampant occurrence of the disorders in today's slim-oriented society.

CHAPTER 1: THE SLIM-ORIENTED 1980's

The thin ethic has become the mania of the 1980's.

Critic Kim Chernin states,

In this era, when inflation has assumed alarming proportions and the threat of nuclear war has become a serious danger, when violent crime is on the increase and unemployment a persistent social fact, five hundred people are asked by the pollsters what they fear most in the world and ninety of them answer that their greatest fear is 'getting fat' (6).

American women have become preoccupied with weight in an attempt to emulate a slim ideal; dieting and exercising have become national pastimes. Dozens of books and organizations (for the most part directed at women) are reaping financial successes because of the slimness boom (6):

BOOKS

Reduce with the Low Calorie Diet: Twenty-five printings since 1953

Dr. Atkin's Diet Revolution: Three million copies in print

The Doctor's Quick Weight Loss Diet: Five million copies sold

The Cheater's Diet: Five hundred million purse books sold

ORGANIZATIONS

DIET WORKSHOP: sixty-four workshops in thirty-one states, Canada and Bermuda. Fourteen hundred groups, forty-five thousand people, meeting weekly to control their weight.

OVER-EATERS ANONYMOUS: fourteen hundred groups where people talk about their problems with their bodies.

THE APPETITE CONTROL CENTER, offering another one hundred groups in New York, Pennsylvania, and Connecticut, where methods are taught to reduce the size of the flesh.

WHY WEIGHT, in Brooklyn, offering its services to one hundred and fifty thousand people who wish to make themselves smaller.

LEAN LINE, INC., with two hundred and fifty locations on the East coast, to which five hundred thousand people have taken themselves to subdue the flesh.

Standard & Poor's Standard Corporate Descriptions contains more detailed information on the multimillion-dollar diet industry (38). For example, Nutri/System, Inc. consists of 868 weight loss and figure control centers in the U.S. and Canada. Since its incorporation in 1978, Nutri/System has experienced amazing financial growth; year-end revenues for 1980 totalled \$23.2 million, increasing to \$49.2 million in 1981, \$124.7 million in 1982, and \$167 million in 1983.

The thin ethic is becoming bound to a new health/fitness movement. Health is equated with a slim body and youthful vigor; women are compelled to tone up their bodies

as well as diet. More and more women are jogging, playing tennis, and partaking in other physical exercise.

All classes of women are adopting these fads; jogging shoes can be seen at discount department stores as well as expensive sporting goods stores. Even the health spa is attracting many different types of women; a recent newsletter article reports, "The health spa, once a retreat of the rich and famous, has recently become as equalitarian as the local gym" (18). Health spas are no longer pampering resorts for the upper classes with the increasing number of Americans joining the health/fitness craze, "you are as likely to see a secretary as a millionairess, and massage and herbal wraps often take second place to weight-training and calisthenics" (18). A typical example of the modern spa would be the three-year-old Wood Door health spa, located in Wisconsin and overlooking Lake Geneva. Guests pay \$300 for a five-day stay, which includes a 900-calorie-a-day menu, sleeping in four-to-a-room bunk beds, and physical activities to fill virtually every waking moment of the day.

Noted psychotherapist Steven Levenkron comments (19):

A generation of young girls and women has been indoctrinated by the thin ethic. One has only to review magazine fashion advertisements and television commercials over the past fifteen years to observe the relentless thinning of models.

Indeed, there is concrete evidence of the increasing cultural emphasis on thinness. The research team of D. Garner, P. Garfinkel, and D. Schwartz found that in comparing Miss America Pageant contestants from 1959 to 1978, a distinct slimming trend is evident--an average decline of 0.13kg (0.28 lb.) per year, and each year's contest winners from 1970 to 1978 had a tendency to be below the average weight for all contestants of that year (10). The research team also analyzed Playboy centerfolds from 1959 to 1978, and found an overall decrease of 8% in average weight, relative to height. When the team examined six popular women's magazines over the same years, the number of diet-related articles was reported to have doubled.

Throughout history, the concept of feminine beauty has changed in response to various societal influences. At certain times, the beauty ideal was thinness; at other times, the beauty ideal was a certain degree of plumpness. Nonetheless, despite the historical period, the key issue among women has been the pressure to conform to an ideal.

Researchers have found that among the world's peasant cultures, starvation is commonplace, and a heavy figure is therefore an indication of prosperity (2). In contrast, thinness is valued in industrial societies where food is plentiful; hence, the saying "A woman can never be too rich, nor too thin" (3).

Social critic Susie Ohrbach explains why a woman in our society is taught to conform to the body ideal--in order to attract a man into a relationship (29):

She is brought up to marry by "catching" a man with her good looks and pleasing manner. . . .
Long and skinny one year, petite and demure the next, women are continually manipulated by images of proper womanhood . . . to ignore them means to risk being an outcast.

Psychologist Elissa Melamed expresses similar ideas on this topic (23):

From childhood we are trained in the importance of looks; the good girl in fairy tales is always the pretty one. Mothers, with a sharp eye on the marriage market, put their daughters on diets, straighten teeth, give ballet lessons, fix noses. . . .

This obsessive monitoring of our bodies is as much a part of our life as brushing our teeth. Surface and contour are scrutinized . . . and to all of us incipient (or clinical) anorexics, fat is the most revolting thing possible. We are taught early: How we look is who we are.

Susan Brownmiller, a noted feminist critic, openly criticized our society's emphasis on beauty, and feels that it imposes a constant vigilance on the part of the woman to keep herself thin (4):

At what age does a girl child begin to

review her assets and count her deficient parts? At what age does the process begin, this obsessive concentration on the minutiae of her physical being that will occupy some portion of her waking hours quite possibly for the rest of her life? When is she allowed to forget that her anatomy is being monitored by others, that there is a standard of desirable beauty, of individual parts, that she is measured against by boyfriends, loved ones, acquaintances at work, competitors, enemies and strangers?

In the book The Obsession: Reflections on the Tyranny of Slenderness, author Kim Chernin tells us that even slender, attractive women live with a constant fear of gaining weight and express great concern about staying slim (6):

Cheryl Prewitt, the 1980 winner of the Miss America contest, is a twenty-two year old woman, "slender, bright-eyed, and attractive." If there were a single woman alive in America today who might feel comfortable about the size and shape of her body, surely we would expect her to be Ms. Prewitt. And yet in order to make her body suitable for the swimsuit event of the beauty contest she has just won, Cheryl Prewitt "put herself through a grueling regimen, jogging long distances down back-country roads, pedaling for hours on her stationary bicycle." The bicycle is still kept in the living room of her parents' house so that she can take part in conversation while she works out. This body she has created, after an arduous struggle against nature, in conformity

with her culture's ideal standard for a woman, cannot now be left to its own desires. It must be perpetually shaped, monitored, and watched. If you were to visit her at her home in Ackerman, Mississippi, you might well find her riding her stationary bicycle in her parents' living room, "working off the calories from a large slice of homemade coconut cake she has just had for a snack."

It appears that great numbers of today's women feel an overwhelming desire to be slim, with concern over calories taking precedence over many other life matters.

CHAPTER 2: BACKGROUND INFORMATION ON ANOREXIA
NERVOSA AND BULIMIA

Anorexia Nervosa - Anorexia nervosa is an illness that is characterized by a relentless pursuit of thinness by self-starvation. Most clinicians diagnose the disorder using the criteria suggested by Feighner and Associates (37, 43):

1. Age of onset before 25 years of age
2. Loss of at least 25% of original body weight
3. A distorted attitude towards eating and weight^e
 - . Denial of illness
 - . Enjoyment of weight loss
 - . Desired body image of thinness
 - . Severely distorted personal body image
4. No other medical illnesses that could account for the weight loss
5. At least two of the following symptoms:
 - Amenorrhea
 - Periods of overactivity
 - Bulimia

The Schwabe research team notes that in recent years, professionals have chosen to accept one alteration of the classic Feighner theory: patients may be diagnosed as

anorectic if they show the psychiatric symptoms but present a lesser degree of weight loss; this allows for treatment of the psychological distortions before the weight-loss component of the illness has become so severe as to warrant further medical intervention.

A clinical study of anorectics at UCLA reported general demographic characteristics of the patients (37):

- Predominance of women
- Onset in late childhood and adolescence
- Predominantly white
- Middle to upper class families
- Normal to above average intelligence; characterized as good students and high achievers
- Preoccupation with food and nutrition

Anorexia is not only a threat to psychological health; it causes severe physical pathology also. The physiological disorders include amenorrhea (previously mentioned), fatigue, heart arrhythmia, hypotension, decreased thyroid function, and the end result of prolonged starvation--death (5, 19).

Bulimia - Bulimia is described as a pattern of binge-eating involving ingestion of large amounts of food in a short period of time. The binges are then followed by self-induced vomiting, taking excessive amounts of laxatives, starving for a period of time, or sleep (3, 14).

The bulimic may be up to 15% under or over normal weight according to weight charts (9). Like anorexia, bulimia predominantly affects women and is accompanied by a distorted body image; bulimics perceive themselves to be heavier than they actually are (29). Unlike anorexia, bulimia occurs in late adolescence and early adulthood; furthermore, the bulimic experiences binges as an uncontrollable impulse, in contrast to the anorectic, who exerts the utmost in control over her eating habits (9).

Some clinicians diagnose bulimia using the criteria suggested by Russell (7, 35):

1. Subjects must be currently binge-eating (established by a positive response to the question, "In the past two months have you experienced an episode of uncontrollable and excessive eating?")
2. Subjects must be currently vomiting as a means of weight control (established by a positive response to the question, "In the past two months have you used self-induced vomiting as a means of controlling your weight?")
3. Subjects must have a morbid fear of fatness (established by a positive response to the question, "Do you have a fear of being overweight?")

Other clinicians prefer to use the DSM-III diagnostic criteria for bulimia (36, 39):

1. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time, usually less than 2 hours).
2. At least three of the following:
 - Consumption of high-caloric, easily ingested food during a binge.
 - Inconspicuous eating during a binge.
 - Termination of such eating episodes by abdominal pain, sleep, social interruption, or self-induced vomiting.
 - Repeated attempt to lose weight by severely restricted diets, self-induced vomiting, or use of cathartics or diuretics.
 - Frequent weight fluctuations greater than 10 pounds due to alternating binges and fasts.
3. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily.
4. Depressed mood and self-deprecating thoughts following eating binges.
5. The bulimic episodes are not due to any known physical disorder.

U

Several studies report the following items as being characteristic of bulimics (15, 16, 30, 31, 32, 36):

- Predominance of women
- Onset in late teens or early twenties
- Predominantly white
- Obsession with food and weight

In addition, bulimics do not experience normal hunger/satiation and do not have an "appetite." Their eating cues come from a presently-unknown psychological and/or physiological cue.

The bulimic's self-induced vomiting and excessive use of laxatives causes many physical disorders. Excessive tooth decay may occur because the acidity of the vomitus deteriorates tooth enamel. Other dangers include tearing of the esophagus, dehydration, and pH imbalances resulting in potentially fatal kidney failure and heart failure (36).

CHAPTER 3: A PREVALENCE STORY

The following pages are a presentation of my study on the prevalence of dieting behaviors and eating disorders among a population of college-age women. Over 140 women between the ages of 18 and 21 completed questionnaires during the Spring 1983 academic semester. Their responses give clues as to what extent young women feel pressures for thinness, whether or not they experience distorted body perception, what diet-related behaviors they commonly practice, and whether or not they suffer from an eating disorder (anorexia nervosa or bulimia). By defining categories of increasingly erratic eating behaviors (excessive binging, purging by vomiting, etc.), the population will be separated into several levels of risk for developing a chronic eating disorder. Each group--the no disorder group, at-risk groups, borderline groups, and disorder groups--will be contrasted on attitudes and sources of diet-related pressures.

INTRODUCTION

Health professionals all agree that eating disorders are becoming a serious public health problem (3, 5, 6, 19, 22, 30, 44). The disorders have been in existence since "as long a time ago as the Ancient Egyptians (30); many physicians throughout history have commented on self-starvation and self-induced vomiting, but the cases were very rare (5)." The disorders were not defined clearly prior to the 1940's, and it is suspected that the few cases presented to modern physicians before that date were passed off as merely as "hysteria" (30).

However, for the last fifteen to twenty years, there has been an apparent increase in the number of patients with eating disorders (5). Physicians and researchers attribute some of the increase in number to an increased awareness on the part of the medical profession and the general public (22), but experts emphasize that there has been an enormous increase in the actual incidence rates of the disorders, as well (19).

In searches of current scientific literature on eating disorders, I find that there has been little research prior to 1980 on prevalence rates of anorexia nervosa and bulimia. Several studies have been done recently, but because of difficulties in quantifying data and obtaining representative populations, results are somewhat speculative. Even so, researchers agree that the numbers they report may be very

conservative estimates; tendencies toward denial and secretiveness seen in these patients may result in great underrepresentation in research.

Drs. Ronnie Stangler and Adolf Printz reviewed psychiatric diagnosis in a sample of 500 students at the University of Washington Psychiatric Clinic for Students (39). The clinic is an outpatient service for the University's 37,000 students. They found a 4.4% prevalence of eating disorders, with a breakdown of 3.8% bulimia and 0.6% anorexia. Of the 19 bulimics, 17 were women (5.3% of the 318 women) and 2 were men (1.1% of the 182 men); the sexes of the 3 anorectics was not reported. Because their study only included those individuals who had sought treatment, the authors stress that the prevalence rate for the entire student population may be much higher.

In 1981, Dr. Katherine Halmi led a research team in a study of bulimia on one of the campuses of the State University of New York (13). The sample included students ranging from ages 14 to 67,¹ and gender breakdown was 59.8% women, 33.4% men, and 6.7% not indicating their sex. Using DSM-III criteria, Halmi found 13% of the population was bulimic.²

¹Mean age was 25.6+ 10.7 years

²Researchers H. G. Pope and J. I. Hudson comment on Halmi's sample; they note that the sample contained more women than men, a large percentage of the subjects were in their teens, twenties, and thirties, and the population may have been skewed in favor of the upper social classes. However, Pope and Hudson came to this conclusion (30):

Dr. Richard Pyle and his associates conducted a study on bulimia, using confidential questionnaires on the freshman class at the University of North Dakota (32). Of the 180 men, 1.4% met the DSM-III criteria for bulimia; of the 575 women, 7.8% met the criteria. Using a more strict criterion--binges occurring once a week or more--Pyle found that 0.4% of the men and 4.5% of the women experienced this frequency of binges.

British researchers P. J. Cooper and C. G. Fairburn examined the prevalence of binge eating and self-induced vomiting among a sample of 369 consecutive attenders of a British family planning clinic (7). The study, published in 1983, found that 20.9% of the women reported episodes of uncontrollable and excessive eating (binges), 2.9% induced vomiting as a means of weight control, and 4.9% reported using laxatives. Cooper and Fairburn noted a link of binge-

Even if we divide the 13% figure by 6 to correct--generously--for these three statistical anomalies, and assume that the prevalence rate of bulimia in the population as a whole is only 2.2%, this would still mean that 5 million people in the United States have bulimia at some time in their lives.

³The mean age of the sample was 24.1 years; 63.6% of the women were in their twenties, none were below age 15, and 6.5% were over age 34. No men were included in the sample.

eating and self-induced vomiting with disturbed attitudes toward food and weight.

Drs. Harrison Pope and James Hudson performed prevalence studies of anorexia and bulimia at two universities and a secondary school (30). The first sample used was the senior class of a prestigious rural college for women. They found that 14.7% of the 287 women met the DSM-III criteria for bulimia at some point in their lives, and 10% of the women reported binges occurring once a week or more.

The second sample chosen was the senior class of an urban coeducational university. Out of 102 women, 19.6% met the DSM-III criteria for bulimia, and 12.9% reported binges occurring once a week or more. None of the 47 men in the study reported eating disorders.

In the secondary school, Pope and Hudson hypothesized that the prevalence rate would be lower than the university rates since bulimia tends to appear in the late teens to early twenties. Their findings were consistent with this idea; 8.4% of the 155 girls reported bulimia, and no cases were reported among the 105 boys.

Out of the 544 women in all three groups, only 3.4% met the DSM-III requirements for anorexia. The researchers explain that this statistic may not be representative because severe anorectics would probably not be in school at the time, and they might even have been in the hospital.

The previous studies indicate that eating disorders are a large problem, and that literally millions of people may suffer from anorexia or bulimia at some point in their lives. Also, data suggest that the prevalence has been increasing in recent years.

METHOD

The approach to gathering data was a three-page questionnaire distributed to all freshman women at a large private university in the Eastern United States. I chose this group because previous works have theorized that college-age women are most susceptible to the disorders, and because the sample was easily accessible to me; the results of this study may be indicative of what is happening among the population of U.S. college-aged women.

The survey was distributed to all freshman women (n = 432) through their dormitory advisors, who are upperclass women. The freshmen completed the survey if they wished, and were able to return it to the research office via a pre-addressed stamped envelope attached to the survey. No names were to be written on the pages and no coding system of any kind was used; complete confidentiality was insured.

The questionnaire consisted of fill-in-the-blank, Yes/ No, and multiple choice-type questions. The first section of the survey was designed to yield information on the background characteristics of the subject, including age, height/ weight, marital status of parents, and family income. The second part of the survey queried the subject on her attitudes towards her weight and what means, if any, she used to control her weight. The third part dealt with whether or not the subject had/has anorexia or bulimia.

A study of this nature does, indeed, have methodological limitations. Its reliance on self-report questionnaires meant that complex attitudes and behavior could not be explored, and individual differences were likely to be obscured (7). However, it is possible that data obtained through questionnaires, such as number of binges per week, may be more accurate than information obtained by interview methods. People with eating disorders tend to be secretive about their eating habits because of shame and guilt, so they may be reluctant to admit to these behaviors when anonymity is not preserved (7).

A related issue is the difficulty arising from the lack of a diagnostic tool that is reliable and widely accepted (20). Anorexia nervosa has been well documented in the scientific literature, and many diagnosticians favor the

Feighner criteria. Clinicians not satisfied with those standards usually use Feighner's criteria as a base to construct a seemingly more appropriate criteria, but not without individual idiosyncrasies represented.

On the other hand, bulimia has not been delineated fully in the literature yet. Early studies used criteria defined by Russell (7, 35), but as more complexities of the disorder have been uncovered, many clinicians feel that the Russell criteria are too broad and inadequate. Several recent studies are based in part on the DSM-III criteria, but the diagnostic validity remains inadequately tested (15).

The DSM-III scale appears to be more comprehensive than Russell's but it does not clearly define frequency of binge behavior; "recurrent episodes" does not specify the number of binges over time. Because of that particular inadequacy, the studies discussed previously added this criterion: frequency of binge behavior must be one or more times per week. They then labelled their diagnostic criteria as "DMS-III narrowly defined bulimia" or another similar term (15, 26, 30, 32, 39, 42).

Working within these limitations, I sought to construct a questionnaire that would be as concise and comprehensive as possible. I sought to make the survey brief (considering the depth of the topics under study), easily quantifiable, and not so probing as to make the subject uncomfortable (thereby discouraging completion and return of the papers).

For anorexia, I incorporated the Feighner criteria into the survey questions. With bulimia, the Russell criteria were too broad and vague, while the DSM-III criteria provided a more well-defined base to work from. The diagnostic format that I constructed is a modification of the key components of the DSM-III evaluation:

1. Effort to control food intake through dieting.
2. Eating swings from bingeing to fasting.
3. Binge behavior at least once a week.
4. Use of vomiting or laxatives as a way to control weight.

The bulimic is noted for her swings from bingeing to fasting. She attempts to control her weight and her food intake by dieting; she periodically loses control and binges. When she has lost her control of food intake, she will vomit or use laxatives (purging) in a desperate move to re-establish control over weight and avoid weight gain.

In addition to specifying disorder and no disorder groups, this study will categorize borderline and at risk groups based on the idea that eating disorders are chronic illnesses that develop on a time continuum. Current research findings support the dynamic or dimensional view of eating disorders; over the course of time, some changes of symptoms may be observed in the same patient (20,40,42).

The longer the history of disorder, the more likely the patient will experience alterations of eating behaviors and intensity of symptoms. It is also reported that response to treatment is much slower in patients who have had the disorder for a number of years before seeking medical intervention. Researchers Vandereycken and Pierloot refer to assessment of disorder at a given moment is comparable to "a snap-shot or cross-section of temporarily observed characteristics" (40).

In a 1983 study of abnormal eating attitudes, the research team utilized the categoration concept. They divided their sample population into four groups (20):

1. Nondieters - Individuals with no undue concern over weight and who report no conscious attempt to diet or to restrict food intake.
2. Normal dieters - ...Although there may be concern about weight and food intake, dieting is not a major pre-occupation in the lives of these individuals. A degree of control over dieting is maintained. . . .
3. Partial syndrome of anorexia nervosa - Individuals who demonstrate a major pre-occupation with weight and a distressing and troubling concern with food intake . . . there is a persistent drive to lose

weight and to achieve an unreasonably low weight Marked concern with shape and size is evident. . . .

4. Anorexia nervosa - The characteristic psychopathological features of anorexia nervosa as described in the partial syndrome are found together with marked loss of body weight and amenorrhea emaciated body and morbid fears of weight gain or of achieving a normal adolescent weight are central.

Several researchers see bulimia on a continuum as well (36, 42); concern over eating results in a preoccupation with food, which may then lead to a loss of control and frenetic binges. Schlesier-Stropp discusses this phenomenon (36):

Cognitions appear to be extremely important in bulimia. Bulimics are obsessed with thoughts of weight, food, eating, and ridding themselves of the ingested food. . . . These maladaptive thoughts about eating and misperceptions of body image may increase the probability of self-induced vomiting following eating binges.

It has also been discovered that the onset of overeating and the onset of vomiting do not begin at the same time. Fairborn and Cooper found that vomiting, on the average, begins one year after the onset of bingeing (7), while Russell reported that vomiting usually starts as many as three years after bingeing has started (35).

Considering the dimensional view of eating disorders and my own findings, a division of subjects into seven categories appeared to be most appropriate. The criteria for each category were arranged on a scale developed from varying degrees of intensity in the reporting of symptoms:

- . Anorexia
- . Borderline Anorexia
- . At Risk for Developing Anorexia
- . Bulimia
- . Borderline Bulimia
- . At Risk for Developing Bulimia
- . No Disorder

Each survey was analyzed for these symptoms, either reported directly or revealed by answers given to several key questions.

Women who reported having either anorexia or bulimia were automatically placed in the appropriate category. However, the possible occurrence of denial among sufferers led us to categorize those women as anorectic or bulimic who reported that they did not feel they had either illness, but responded to other questions so as to indicate the presence of the clinical symptoms. The criteria required for inclusion in the anorexia categories are shown in Table 1a. Borderline anorexia was determined by presentation of some

Table 1a

Responses to Questionnaire Indicating Anorexia

<u>Response</u>	<u>Categories</u>		
	<u>Anorexia</u>	<u>Borderline Anorexia</u>	<u>At Risk for Developing Anorexia</u>
Weight	Underweight	Underweight or normal weight	Underweight or normal weight
"I feel too fat." ^a	yes	yes	yes
"The thought of gaining weight is alarming to me." ^b	yes	yes	yes
"I am presently on a diet to lose weight." ^c	yes	yes	yes
Symptoms of amenorrhea, overactivity, and bulimia	At least two symptoms	At least one symptom	no symptoms

^aSymptom: distorted personal body image.

^bSymptom: intense fear of weight gain; emphasis on thinness.

^cSymptom: desire to diet although not overweight.

anorexia symptoms, but not to the extent seen in a fully-developed disorder. The population considered at risk of developing anorexia were those women who showed a pressing concern to lose weight despite being underweight or normal weight.

The subjects classified as exhibiting bulimia showed concern about weight control and dieting at the same time as reporting frequent binge - purge behavior (see Table 1b). The bulimics made efforts to control food intake through dieting, yet experienced impulses to binge⁴ (9). Borderline bulimia was defined as the presence of frequent bingeing, but without purging and without report of being on a diet; the borderline case has not yet developed the internal conflict

⁴It is very difficult to describe the term "binge," but in the context of this study, it is defined as ingestion of an excessive amount of food in a short period of time--eating at least 2,000 calories at a single instance. This criterion for a binge is based on results of a study done on bulimic patients in 1981 (26):

The mean number of calories consumed by 25 of the patients during an average binge-eating episode was 3,415, with some patients eating considerably more (range = 1,2000 - 11,500 calories). Although a few patients considered a binge-eating episode to be what others might call a large meal (5 patients reported consuming less than 2,000 calories during an average binge), the usual pattern was to grossly exceed what could be considered normal caloric intake. A few patients in this series were consuming as many as 50,000 calories a day (as many as 10 binges a day of 5,000 calories each).

Table 1b

Responses to Questionnaire Indicating Bulimia

<u>Response</u>	<u>Category</u>		
	<u>Bulimia</u>	<u>Borderline Bulimia</u>	<u>At Risk for Developing Bulimia</u>
"I am presently on a diet to lose weight."	yes	no	no
"My eating swings from overindulging to stringent fasting."	yes	yes	yes
			or
"I go on eating binges, consuming over 2,000 calories at a single instance--at least a few times a week."	yes	yes	yes
Use of fasting, vomiting or laxatives as a way to control weight.	yes	no	no

between binging (no control) and dieting (reasserting control). The population at risk of developing bulimia were those women who reported periodic binge behavior patterns, which could possibly intensify over time into a clinical disorder. All the remaining cases were classified as having no disorder.

RESULTS

Of the 432 questionnaires distributed, 192 were returned - a 44.4% return rate. The population consisted predominantly of women in late adolescence-early adulthood; 94.3% were ages 18 or 19, while 5.7% were ages 20 or 21. Their socioeconomic level was middle to upper class, with 49.5% having family incomes over \$40,000 a year, 23.4% having family incomes in the \$20,000 - \$39,000 per year range, and 27.1% having incomes less than \$20,999 per year. The family structure was intact in most cases; 87% had married parents, while 8.4% reported parents being divorced or separated, and 4.6% indicated that one parent was deceased.

In comparing the respondents' weight and height to a standard height/weight table (National Academy of Sciences, 1980), it was found that a majority held normal weight

levels, with the total percentages being 62% normal weight, 26% overweight, and 13.1% underweight.⁵

The prevalence rate is reported in Table 2. The data indicate that a total of 11.5% of the population suffers from clinical illness, and an additional 33.9% of the women exhibit abnormal eating behaviors. These numbers are evidence of the widespread occurrence of debilitating eating habits.

In addition to the prevalence of illness, the seven groups were also compared by weight, self-perceived weight, background variables, and pressures to be thin. The comparison of weight is shown in Table 3; significant differences were found among the groups. For instance, it was found that the anorectic women hovered around normal to low weights, while the bulimics exhibited normal to high weights. These findings are consistent with previous research: 1. a person with less than a weight loss of 25%

⁵Classification was based on these guidelines:
1. underweight - more than 10% under ideal weight;
2. normal weight - ideal weight + 10%;
and 3. overweight - more than 10% over ideal weight (26, 36, 42).

Table 2
Prevalence of Disorders

<u>Category</u>	<u>% Prevalence</u>	<u>n</u>
Anorexia	4.2	8
Borderline Anorexia	8.9	17
At Risk for Developing Anorexia	7.8	15
Bulimia	7.3	14
Borderline Bulimia	1.6	3
At Risk for Developing Bulimia	15.6	30
No Disorder	<u>54.6</u>	<u>105</u>
Total	100.0	192

Table 3
Distribution of Weight by Diagnostic Categories

Category	Weight			Total (n)
	% Underweight ^a	% Normal Weight ^b	% Overweight ^c	
Anorexia	50.0 (n=4)	50.0 (n=4)	0 (n=0)	8
Borderline Anorexia	0 (n=0)	100.0 (n=17)	0 (n=0)	17
At Risk for Developing Anorexia	0 (n=0)	100.0 (n=15)	0 (n=0)	15
Bulimia	14.2 (n=2)	35.8 (n=5)	50.0 (n=7)	14
Borderline Bulimia	0 (n=0)	100.0 (n=3)	0 (n=0)	3
At Risk for Devel- oping Bulimia	0 (n=0)	46.7 (n=14)	53.4 (n=16)	30
No Disorder	23.8 (n=25)	58.1 (n=61)	18.1 (n=19)	105
Total	31	119	42	192

p < .0005

^aUnderweight by more than 10% of suggested ideal weight

^bNormal suggested ideal weight \pm 10%

^cOverweight by more than 10% of suggested ideal weight

can still be considered anorexic if she shows all other clinical symptoms (37), and 2. bulimics may have a weight range of 15% over or under normal weight (9). In comparison, the no disorder group exhibited a standard statistical distribution of weights not found in the disorder groups.

Significant differences were also found between disorder and no disorder subjects in self-perceived weight, with the majority of women in all categories of disorder reporting "I feel too fat" (see Table 4). However, even among the group with no disorder, 41% felt too fat, as compared to 23.8% who were actually overweight; only 2.9% felt too thin, although 18.1% were underweight. The large number of no disorder women feeling too fat is certainly a disheartening manifestation of our society's emphasis on thinness, so that even a woman at a normal weight will feel she is "too fat" because she does not fit the prevailing ideal of thinness.

Of the anorectic population, 50% of the women responded that they felt too fat, but nearly 100% of the borderline. The prevalence might have been lower in the clinical anorexia category because three of the eight women are presently undergoing treatment and may be overcoming distorted body perception.

By comparison, most of the bulimics reported feeling

Table 4
Self-Perceived Weight

<u>Categories</u>	<u>% Response</u>			<u>Total n</u>
	<u>"I feel I am too fat."</u>	<u>"I feel I am too thin."</u>	<u>"I feel I am at a normal weight."</u>	
Anorexia	50 (n=4)	25 (n=2)	25 (n=2)	8
Borderline Anorexia	100.0 (n=8)	0 (n=0)	0 (n=0)	17
At Risk for Developing Anorexia	93.3 (n=14)	0 (n=0)	6.7 (n=1)	15
Bulimia	92.9 (n=13)	0 (n=0)	7.1 (n=1)	14
Borderline Bulimia	66.7 (n=2)	0 (n=0)	33.3 (n=1)	3
At Risk for Developing Bulimia	73.3 (n=22)	0 (n=0)	26.7 (n=8)	30
No Disorder	41.0 (n=43)	2.9 (n=3)	56.2 (n=59)	105
Total	115	5	72	192

p < .005

too fat. It may be that distorted perception is much greater in bulimia than anorexia, or the response may reflect the fact that, on the average, the bulimic group does weigh more. Of the 14 clinical bulimics, only one sought treatment. Perhaps more anorectics than bulimics sought treatment, because bulimia has received less publicity as a disorder until now, and bulimia treatment centers and therapy groups are now just coming into being.

The groups did not show strong correlations to several background variables, including education of mother ($p < .1$), occupation of mother ($p < .6$), education of father ($p < .5$), occupation of father ($p < .1$), marital status of parents ($p < .7$), family income ($p < .7$), and field of study ($p < .3$). The lack of significance of these factors may have been due to the homogeneity of the population under study.

The seven groups were also analyzed for the percentage of women who felt pressures to be thin from various origins. These origins included mother, father, male friends, female friends, media models, and societal pressures to be thin in order to be sexually attractive.

Parental pressures have been recorded in Table 5a and Table 5b. Pressure from mother was found to be insignificant. Low percentages of women in the anorexia and no disorder groups reported feeling pressure from father. These

Table 5a

Perceived Pressure from Mother to be Thin

<u>Category</u>	<u>Perceived Pressure</u>		
	<u>% Yes</u>	<u>% No</u>	<u>Total n</u>
Anorexia	14.3 (n=1)	85.7 (n=6)	7 (nr=1)
Borderline Anorexia	31.3 (n=5)	68.8 (n=11)	16 (nr=1)
At Risk for Developing Anorexia	13.3 (n=2)	86.7 (n=13)	15 (nr=0)
Bulimia	41.7 (n=5)	58.3 (n=7)	12 (nr=2)
Borderline Bulimia	0 (n=0)	100.0 (n=3)	3 (nr=0)
At Risk for Developing Bulimia	29.6 (n=8)	70.4 (n=19)	27 (nr=3)
No Disorder	18.4 (n=18)	81.6 (n=80)	98 (nr=7)
Total	39	139	178 (nr=14)

p<.300

Table 5b

Perceived Pressure from Father to be Thin

<u>Category</u>	<u>Perceived Pressure</u>		
	<u>% Yes</u>	<u>% No</u>	<u>Total n</u>
Anorexia	14.3 (n=1)	85.7 (n=6)	7 (nr=1)
Borderline Anorexia	6.3 (n=1)	93.8 (n=15)	16 (nr=1)
At Risk for Developing Anorexia	0 (n=0)	100.0 (n=15)	15 (nr=0)
Bulimia	41.0 (n=5)	58.3 (n=7)	12 (nr=2)
Borderline Bulimia	33.3 (n=1)	66.7 (n=2)	3 (nr=0)
At Risk for Developing Bulimia	19.2 (n=5)	80.8 (n=21)	26 (nr=4)
No Disorder	9.4 (n=9)	90.6 (n=87)	96 (nr=9)
Total	22	153	175 (nr=17)

p<.020

findings may refute many existing theories of origin for the disorder of anorexia; several prominent authorities have viewed anorexia as developing directly from parental pressures (25). However, our results represent perception of pressure, and it is possible, although unlikely, that they indicate that the parental pressures have been so subtle as not to be recognized.

On the other hand, the bulimic groups showed higher percentages of perceived pressure. Further research is necessary to determine why there are apparent differences in perceived parental pressure between anorectic subjects and bulimic subjects.

Friends were another source of pressure, with both the anorectic and bulimic groups exhibiting significantly higher percentages of perceived pressure than the no disorder group. These results have been recorded in Table 6a and Table 6b. Pressure from male friends was greater in all categories. An overall majority of the women perceived pressure to be thin from media models, but the percentages were significantly higher in the eating disorder groups (see Table 7). These large percentages illustrate how powerful the media is in perpetuating the "thin ethic" of today's society.

The last pressure studied was the pressure to be thin in order to be sexually attractive (see Table 8). Almost

Table 6a
Perceived Pressure from Male Friends to be Thin

<u>Category</u>	<u>Perceived Pressure</u>		<u>Total n</u>
	<u>%Yes</u>	<u>%No</u>	
Anorexia	57.1 (n=4)	42.9 (n=3)	7 (nr=1)
Borderline Anorexia	50.0 (n=8)	50.0 (n=8)	16 (nr=1)
At Risk for Developing Anorexia	46.7 (n=7)	53.3 (n=8)	15 (nr=0)
Bulimia	61.5 (n=8)	38.5 (n=5)	13 (nr=1)
Borderline Bulimia	0 (n=0)	100.0 (n=3)	3 (nr=0)
At Risk for Developing Bulimia	46.4 (n=13)	53.6 (n=15)	28 (nr=2)
No Disorder	20.4 (n=20)	79.6 (n=78)	98 (nr=7)
Total	60	120	180 (nr=12)

p<.0005

Table 6b
Perceived Pressure from Female Friends to be Thin

<u>Category</u>	<u>Perceived Pressure</u>		<u>Total n</u>
	<u>%Yes</u>	<u>%No</u>	
Anorexia	42.9 (n=3)	57.1 (n=4)	7 (nr=1)
Borderline Anorexia	31.3 (n=5)	68.8 (n=11)	16 (nr=1)
At Risk for Developing Anorexia	46.7 (n=7)	53.3 (n=8)	15 (nr=0)
Bulimia	58.3 (n=7)	41.7 (n=5)	12 (nr=2)
Borderline Bulimia	0 (n=0)	100.0 (n=3)	3 (nr=0)
At Risk for Developing Bulimia	37.0 (n=10)	63.0 (n=17)	27 (nr=3)
No Disorder	16.5 (n=16)	83.5 (n=81)	97 (nr=8)
Total	48	129	177 (nr=15)

p<.010

Table 7
Perceived Pressure from Media Models to be Thin

<u>Category</u>	<u>Perceived Pressure</u>		<u>Total n</u>
	<u>%Yes</u>	<u>%No</u>	
Anorexia	75.0 (n=6)	25.0 (n=2)	8 (nr=0)
Borderline Anorexia	94.1 (n=16)	5.9 (n=1)	17 (nr=0)
At Risk for Developing Anorexia	66.7 (n=10)	33.3 (n=5)	15 (nr=0)
Bulimia	92.3 (n=12)	7.7 (n=1)	13 (nr=1)
Borderline Bulimia	66.7 (n=2)	33.3 (n=1)	3 (nr=3)
At Risk for Developing Bulimia	60.7 (n=17)	39.3 (n=11)	28 (nr=2)
No Disorder	41.4 (n=41)	58.6 (n=58)	99 (nr=6)
Total	104	76	180 (nr=12)

p<.0005

Table 8

Perceived Pressure to be Thin so as to be Sexually Attractive

<u>Category</u>	<u>Perceived Pressure</u>		<u>Total n</u>
	<u>%Yes</u>	<u>%No</u>	
Anorexia	62.5 (n=5)	37.5 (n=3)	8 (nr=0)
Borderline Anorexia	81.3 (n=13)	18.8 (n=3)	16 (nr=1)
At Risk for Developing Anorexia	61.5 (n=8)	38.5 (n=5)	13 (nr=2)
Bulimia	100.0 (n=14)	0 (n=0)	14 (nr=0)
Borderline Bulimia	33.3 (n=1)	66.7 (n=2)	3 (nr=0)
At Risk for Developing Bulimia	70.4 (n=19)	29.6 (n=8)	27 (nr=3)
No Disorder	49.5 (n=51)	50.5 (n=52)	103 (nr=2)
Total	111	73	184 (nr=8)

p<.005

half of the no disorder group perceived this pressure, while significantly higher numbers of anorexia and bulimia subjects did. An interesting finding is that 100% of the fourteen bulimic women reported perceiving this pressure.

CHAPTER 4: ETIOLOGICAL ISSUES

My study revealed that 11.5% of the college women surveyed suffered from either anorexia or bulimia. Statistical evaluation showed a significant relationship between the eating disorders and the perception of external pressures to be thin. A question must be raised as to why the women with eating disorders feel more overt pressure than the no disorder group.

The answer to this question may be that eating disorders are outward signs of a profound emotional disturbance that is closely related to major affective disorders (major depression and bipolar depression) (15, 16, 22, 30). The depression, anxiety, and low self esteem found in patients with eating disorders would certainly make them more vulnerable to sociocultural forces than people without these symptoms.

In psychological inventories, patients with eating disorders do display significant evidence of psychological aberrations. Two separate research groups studied bulimics' scores on the MMPI (Minnesota Multiphasic Personality Inventory) (14, 31). The both found that bulimics are characterized by elevations on the following scales:

2 scale (depression)

4 scale (impulsivity, anger)

7 scale (anxiety, rumination)

8 scale (social withdrawal, idiosyncratic thinking)

Weiss and Ebert compared results of several psychological inventory tests of normal-weight bulimics and normal-weight controls⁶ (42). The bulimics scored consistently higher on depression and anxiety scales and lower on self-esteem scales than normal controls. Because of evidence of high levels of psychological pathology and disturbed mental function, they reach the conclusion that "bulimia does not appear to be simply a sociological aberration. . . ." (42).

Researchers Hudson and Pope report that about 80% of the bulimic patients they studied have had major affective disorder at some point during their lifetime (16, 30). Since random samples of general populations revealed occurrence of major affective disorders no greater than 26%, their finding is of great significance ($P < .000$). Patients reported depressive episodes occurring before and after the onset of the eating disorder; therefore, the eating disorder is not the cause of the depression.

Hudson and Pope also found a high prevalence rate of major affective disorders in the families of patients with

⁶The tests given to each patient included--The Symptom Checklist 90, The Piers-Harris Self-Esteem Scale, The Norwicki-Strickland Locus of Control Scale, The Maudsley Obsessive-Compulsive Inventory, The Holmes and Rake Social Readjustment Rating Scale, The Social Network Index, The Anorectic Attitude Questionnaire, The Goldberg Situational Discomfort Scale, and the WAIS vocabulary subtest.

eating disorders, which points to a possible role of hereditary factors. The occurrence of disorders within families may be genetic in origin, or may be due to psychological forces in the environment during a person's developmental periods. Because of the presence of this yet unresolved controversy, I prefer to use the term "hereditary" in describing this familial factor, rather than labelling it totally genetic or totally psychological. It is already a widely accepted idea among psychiatric researchers that there is a significant hereditary role in major depression and bipolar depression; in fact, if a patient has the bipolar form of major affective disorder, the chances may be up to 30% or 40% that a first-degree relative of that patient (parent, sibling, or child) will develop major affective disorders also (30). Several recent studies have confirmed the findings of Hudson and Pope and show strong evidence of some hereditary relationship between affective disorders and eating disorders (30,40,41).

An important point researchers make is that the depression seen in bulimics is endogenous depression, rather than reactive depression (30):

A reactive depression, in simple terms, is depression that develops in reaction to something, for purely psychological or situational reasons. . . . This type of depression presumably has little to do with a chemical imbalance in the brain; it is rarely associated with pro-

longed changes in sleep, appetite, or other physical functions; and antidepressant medications are usually ineffective for it.

Endogenous depression, on the other hand, is believed to arise from a chemical abnormality in the brain . . . endogenous depression usually causes sustained changes in sleep patterns, appetite, weight, energy level, concentration, sex drive, and other biological functions . . . and it can usually be treated successfully with antidepressant drugs.

Researchers have discovered many drugs that are very effective in the treatment of endogenous depressions; they include lithium carbonate, tricyclic antidepressants, monoamine oxidase inhibitors, trazodone, and several sympathomimetic agents. These drugs do not produce an artificial stimulant effect; they correct the underlying chemical imbalance that is causing the depression. As the imbalance is corrected, the patient is lifted out of the depressive state. Hudson and Pope explain this mechanism (30):

It's analogous to penicillin: If someone who has pneumonia takes it, the effect is often dramatic. The fact that imipramine does nothing in ordinary people, but displays a clear effect in major depression, is yet another piece of evidence suggesting that major depression is caused by some underlying biological disorder.

These same antidepressant medications have been used in recent months for the treatment of eating disorders; the results show a dramatic positive change in most of the patients (17, 21, 24, 27, 30, 34, 41). The antidepressants have an effect on the eating disorder subjects; therefore they must be experiencing some kind of affective disorder.

This is further evidence of an important link between eating disorders and affective disorders.

A question may be asked as to why all patients with major affective disorders do not develop eating disorders. The answer to this is that the group of illnesses related to major affective disorder⁷ creates such a vast array of symptoms that no one person could experience them all. One person may develop manic depression and agoraphobia, another person may experience major depression and agoraphobia, and a third person might suffer from major depression and anorexia nervosa.

Another important question is why a person would develop an eating disorder rather than another disorder. The answer is not known for certain, but there is strong evidence that sociocultural pressures on women for thinness may play a major role. Therapist S. Ohrbach supports this belief: "The fact that [eating disorders are] overwhelmingly a woman's problem suggests that it has something to do with the experience of being female in our society" (29).

Concern with our society's sex-role definition may be a key etiological component of disorder (12, 22, 33, 39). In

⁷ Related illnesses include depression, agoraphobia, alcoholism, drug addiction, obsessive compulsive disorder, etc. (30).

male-female relationships, women with eating disorders tend to show greater passivity, dependency, and unassertiveness in comparison to women without disorder (33). A study of bulimics (of the age range of late teens-early twenties) reports that there is a great fear among these women of not meeting the sexual demands of their partners and a strong view of their partners as superior to themselves (1).

Another study showed evidence of profound sense of helplessness among anorectics and bulimics (8). They tend to feel that they are externally controlled both by others who they feel to be superior to themselves and by a sense of fatalism. From this evidence, we can see that these women lay prey to the media bombardment of slimness, and easily become preoccupied with appearance in striving to meet this ideal.

Therapist S. Ohrbach has spent the past fifteen years working with women who suffer from eating disorders. She supports the view that the disorders have a strong cultural basis relating to the ascribed sex-role for women (29):

The relegation of women to the social roles of wife and mother has several significant consequences. . . . First, in order to become a wife and mother, a woman has to have a man. Getting a man is presented as an almost unattainable and yet essential goal. To get a man, a woman has to learn to regard herself as an item, a commodity, a sex object. Much of her experience and identity depends on how she and others see her.

Ohrbach continues, noting that because of constant scrutiny, a woman becomes extremely self-conscious and has great concerns about presenting herself as attractive as possible (29):

She attempts to make herself in the image of womanhood presented by billboards, newspapers, magazines and television. . . . She is brought up to marry by "catching" a man with her good looks and pleasing manner. . . . She offers her self-image on the marriage marketplace.

Ohrbach continues (29):

Since women are taught to see themselves from the outside as candidates for men, they become prey to the huge fashion and diet industries that first set up the ideal images and then exhort people to meet them. . . .

The one constant in these images is that a woman must be thin.

Ohrbach concludes that the fear of gaining weight, the obsession with food, and the secretiveness of eating has origins in the social conditions of women in our society (29): "Anorexia nervosa is the other side of the coin of compulsive eating. In her rigorous avoidance of food, the anorectic is responding to the same oppressive conditions as compulsive eaters."

Researchers Marlene Boskind-White and William C. White also believe that eating disorders result from the extreme pressure on women to be thin in order to attract a man (3). They observe that the disorders tend to occur during adolescence and young adulthood; they attribute this phenomenon to the idea that females feel more sex-role-related anxieties during these times. Adolescence is marked by development of secondary sex characteristics and, consequently, tremendous self-consciousness around members of the opposite sex. Women in their teens experience dating for the first time and feel anxieties over attracting boyfriends.

On the other hand, college-age women are undergoing another maturation process: They are on the threshold of adulthood with new expectations to meet; they feel anxieties over attracting a man to become their sexual partners and/or mates (3):

The women came to view college as "their big chance" (some viewed it as their last chance), and their definition of success was rigid and extreme: They must receive straight A's and they must be pursued by men. If they received lower marks than those to which they were accustomed, they felt despair. If they were not socially active and did not form intimate relationships with men, they considered themselves to be worthless and incomplete.

Women who develop eating disorders tend to have an intense fear of rejection from a man, and a rejection brings

on a sense of failure in meeting the demands of the traditional female role (3):

The insidious fear of rejection often evolves into irrational and crippling thoughts. These naive and unassertive women focus on rejection alone, rather than on the man who has rejected them. They rarely examine his human failings, nor can they conceive of themselves as fortunate to be rid of someone who does not value them. . . . Being rejected is therefore equated with being a "failure." ...They weave a rich fantasy around the experience, assuming the worst--that they have been rejected because they are too fat!

Dr. Hilda Bruch, a prominent researcher in the field of eating disorders, feels strongly that cultural pressures do play a role in the illnesses (5):

I am inclined to relate [the high prevalence of eating disorders] to the enormous emphasis that fashion places on slimness. A mother or older sister may communicate through her behavior or admonitions the urgency to stay slim. It is not uncommon that there is an older overweight sister or cousin in the family, and the younger child observes how much pain is provoked by being fat. Magazines and movies carry the same message, but most persistent is television, drumming it in, day in day out, that one can be loved and respected only when slender.

As a psychotherapist, her treatment focuses in on attempting to free her patient from the conceptual defects and distortions that have been embedded in their minds, and helping them to develop a more self-directed identity.

A clue to the interrelationship of affective disorders plus sociocultural factors comes from a recent historical analysis of eating disorder patients (37): "There is often a history of a preceding period of weight gain, followed by the perception of 'teasing' or a 'suggestion' that the patient is too fat and should diet." The usual pattern of the development of these disorders is that the young woman is teased about being "chubby" or "fat" as a child. She becomes more sensitive about her figure, and as she grows older, she attempts to alter her body to meet the socially-imposed ideal of thinness. The desire of the woman to be socially acceptable, sexually attractive, and meet the "ideal" standards imposed on women, combined with the almost military rigidity of a diet plan, puts her under an emotional stress that is intensified through depressive thought patterns. The woman then becomes vulnerable to development of either eating disorder; if her fear of being fat is so intense that she literally starves herself over a long period of time, she has become anorectic. If she begins binging as an emotional release, but feels such a strong fear of gaining weight that she resorts to purging behavior, she has become bulimic.

CHAPTER 5: SUMMARY AND CONCLUSION

This study was undertaken to examine the prevalence of eating disorders in a sample of college women in the United States, and to relate these disorders to our society's pressures for thinness. The results found in this project compare favorably to other recent studies on the subject; anorexia nervosa and bulimia are not uncommon among American women, and their etiology can be linked to both hereditary factors, and to our culture's emphasis on slenderness as a beauty ideal.

In evaluating the university women, the subjects' answers to key questions on a survey determined to which one of seven diagnostic categories they belonged. The prevalence rates for each category are as follows: 4.2% anorexia, 8.9% borderline anorexia, 7.8% at risk for developing anorexia, 7.3% bulimia, 1.6% borderline bulimia, 15.6% at risk for developing bulimia, and 54.7% having no disorder. The combined prevalence of anorexia and bulimia is 11.5%.

The groups were then analyzed for the variables of weight, self-perceived weight, background, and pressures to be thin. Weights were predictable for the groups, with anorectics showing normal to low weights, bulimics exhibiting

normal to high weights, and the no disorder group showing a bell curve of low, normal, and high weights.

In general, the respondents exhibited some level of body distortion; although only 26% of our sample population was 10% or more overweight, 59.9% of all the women reported "I feel too fat." It was found that the anorectics and bulimics showed significantly higher percentages of body distortion than the no disorder group.

The background variables we studied showed no significant correlation to disorder, perhaps because of the homogeneity of our sample. These variables included education of mother, occupation of mother, education of father, occupation of father, marital status of parents, family income, and field of study.

The groups were also analyzed for perceived pressures to be thin from various origins. Pressure from mother was found to be insignificant. A low percentage of the anorectic and no disorder women reported feeling paternal pressures, while the percentage was higher among the bulimics. Perceived pressures from male and female friends were reported in higher percentages than parental pressures, and the women in the eating disorder categories show significantly higher percentage of peer pressure than the no disorder group. The highest overall percentages were found with pressure from media models, and pressure to be thin in order

to be sexually attractive to males. Significantly higher percentages of perceived pressure were found in the eating disorder categories, especially among the bulimics; of the fourteen women in the bulimic category, 100% of them reported experiencing the pressure to be thin to be sexually attractive.

The occurrence of anorexia at 4.2% (n=8) and bulimia at 7.3% (n=14) show that eating disorders are not unusual among college-age women. However, our percentages may be much lower than actual occurrence because of the denial component of these illnesses; denial may have led to answering the questionnaire in such a manner as to hide the presence of the illness, or may have caused some women with disorders to disregard the survey and not participate in this study.

In attempting to explain the etiology of eating disorders, we have looked at two intertwined factors: 1. a hereditary component and 2. a sociocultural component. Medical research has linked anorexia nervosa and bulimia to major affective disorder. Women who suffer from depressive disorders have a high anxiety level, a low self-esteem, and a fear of rejection. These underlying factors cause these women to be greatly influenced by our society's ideal of thinness. They seek to be thin in order to attract a man; if they are rejected, they tend to feel that they are failures and attribute the rejection to being overweight

(even though the women may, in reality, not be overweight.)

The high prevalence rates reported here and in other studies indicate that eating disorders are becoming a serious health problem. In addition to the numbers of people with disorders, over one-third of the population I studied fell into the borderline and at risk groups. This indicates that many additional women may develop a disorder in the future; abnormal eating behaviors will be repeated, and life stresses may cause intensification of the eating behaviors to the point of clinical disorder. In addition, it was found that even the no disorder group was vulnerable to prevailing social stresses; many no disorder group women reported that they perceived external pressure to be thin, and many normal-to-underweight women thought of themselves as being overweight.

An important note must be made; men are now also becoming victims of our slim-oriented society. A 1983 article in The New England Journal of Medicine postulates that there may be a relationship between anorexia in young women and a subgroup of male athletes called "obligatory runners": men, usually in their thirties, forties, and fifties, who run more than 50 miles (80 km) a week (44).

The research team describes apparent similarities between the two groups, including inhibition of anger, tolerance of physical discomfort, denial of potentially

serious illness, and a tendency toward depression. The runners share the anorectic's concern--overweight (44):

The runners ideal of less than 5 per cent body fat represents [an abnormal degree of emaciation]. . . . Yet should the obligatory runner, through strict privation, attain 5 per cent body fat, he will aim for 4 per cent. It is not unusual for these runners to lose more than 25 per cent of their original weight within months of the decision to start running. . . .

The behavior of anorexic women and male runners becomes pathological because of the "extreme degree of constriction, inflexibility, repetitive thoughts, adherence to rituals, and need to control themselves and their environment" (44).

The age difference between the two groups is explained in terms of variation of self-concept between men and women (44):

...the self-concept of late-adolescent girls is based on physical attractiveness, whereas the self-concept of boys is related to their physical effectiveness. These values can become extremely important at the time of identity consolidation, especially when there is a scant preexisting sense of self. . . .

The reason that the identity crisis involving athleticism occurs later than the identity crisis involving eating behavior may be related to the establishment of self-worth. The girl's physical attractiveness is commonly put to the test as she enters the dating arena in early or mid-adolescence. . . .

The test of male physical effectiveness, which is closely related to vocational and sexual effectiveness, occurs in adulthood when careers stabilize and physical or sexual prowess begins to decline noticeably.

Anorectic women attempt to prove their worth through relentless dieting, while obligatory runners attempt to prove themselves through painful, excessive exertion.

* * *

In a final analysis, if we consider the severity of symptoms, the prevalence rates of eating disorders found by this study--and other recent studies--suggest that there may be many people across the country who are experiencing a great degree of mental and physical trauma. As society perpetuates its "thin ethic," the number of sufferers is expected to increase. The results of this research indicate that eating disorders present a serious threat to the health of American men and women.

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Appendix I: Sample Questionnaire

Annex

To all women Gryphons:

Please distribute one questionnaire to each freshman woman on your hall. This survey is part of a study being conducted through the Department of Social Relations here at Lehigh. Thank you for your help.

Stephanie Skumanich
Department of Social Relations
Price Hall
Lehigh University

In the past few years, there has been a growing preoccupation in our society with dieting and weight loss.

This questionnaire has been constructed to assess the personal attitudes of college women on the issues of weight-control and eating behaviors.

You are guaranteed complete confidentiality with your participation in this survey. To insure anonymity, do not write your name on any of the papers. Please return your completed questionnaire by MARCH 24 through campus mail, using the envelope provided.

If you have any questions, please call me at 867-6252. Thank you for your cooperation.

Stephanie Skumanich
Department of Social Relations
Price Hall
Lehigh University

First, we'd like some general information about yourself:

1. Age: _____

2. College (check appropriate answer):
 - a. Arts and Sciences _____
 - b. Business _____
 - c. Engineering _____

3. Height: _____

4. Weight: _____

5. Body frame (check appropriate answer):
 - a. Light _____
 - b. Medium _____
 - c. Heavy _____

6. Education of Mother: _____

7. Occupation of Mother: _____

8. Education of Father: _____

9. Occupation of Father: _____

10. Marital status of Parents (check appropriate answer(s)):
 - a. Married _____
 - b. Divorced _____
 - c. Separated _____
 - d. Mother deceased _____
 - e. Father deceased _____

11. Siblings (state number of each):
 - a. Brothers _____
 - b. Sisters _____

12. Approximate Family Income (check appropriate answer):
- a. Under \$20,000 _____
 - b. \$20,000 - \$39,999 _____
 - c. \$40,000 - \$59,999 _____
 - d. \$60,000 - \$79,999 _____
 - e. \$80,000 and over _____
 - f. Don't know _____

The next set of questions focus in on attitudes towards weight and eating. Please check the appropriate answer:

13. I feel I am . . .
- a. too fat _____
 - b. too thin _____
 - c. at a normal weight _____
14. The thinner I get, the better I feel.
- a. Yes _____
 - b. No _____
15. I eat the same foods at the same time every day.
- a. Yes _____
 - b. No _____
16. I think about food constantly.
- a. Yes _____
 - b. No _____
17. People have remarked about how thin I am.
- a. Yes _____
 - b. No _____
18. The thought of gaining weight is alarming to me.
- a. Yes _____
 - b. No _____
19. I am presently on a diet to lose weight.
- a. Yes _____
 - b. No _____
20. I have lost 25 lbs. or more in the past year.
- a. Yes _____
 - b. No _____

21. I frequently miss menstrual periods.
 a. Yes _____
 b. No _____
22. I exercise at least one hour every day, primarily in order to lose weight.
 a. Yes _____
 b. No _____
23. My eating swings from overindulging to strigent diets and fasting.
 a. Yes _____
 b. No _____
24. I feel pressured to be thin . . .
 a. by my mother. Yes _____ No _____
 b. by my father. Yes _____ No _____
 c. by male friends. Yes _____ No _____
 d. by female friends. Yes _____ No _____
 e. by seeing thin models in magazines and on TV. Yes _____ No _____
 f. in order to be sexually attractive to males. Yes _____ No _____
25. I go on eating binges, consuming over 2,000 calories at a single instance.
 a. Daily _____
 b. At least once a week _____
 c. Seldom _____
 d. Never _____
26. I use vomiting as a way of controlling my weight.
 a. Daily _____
 b. At least once a week _____
 c. Seldom _____
 d. Never _____
27. I use laxatives as a way of controlling my weight.
 a. Daily _____
 b. At least once a week _____
 c. Seldom _____
 d. Never _____

28. Do you suffer from any eating disorders?
 Anorexia Nervosa (self-starvation):
- a. I feel I have anorexia nervosa _____
 - b. I feel I do not have anorexia nervosa _____
 - c. I am a recovered anorexic _____

- Bulimia (excessive food binges):
- d. I feel I have bulimia _____
 - e. I feel I do not have bulimia _____
 - f. I am a recovered bulimic _____

29. If you have presently had either disorder, have you sought help?
- a. Yes _____
 - b. No _____

If you have sought help, please answer the following questions having to do with treatment:

30. From whom did you seek help, and for how long? (check more than one answer, if applicable):
- a. Physician _____ How long: _____
 - b. Psychiatrist _____ How long: _____
 - c. Psychologist _____ How long: _____
 - d. Social Worker _____ How long: _____
 - e. Other (specify): _____ How long: _____

31. What kinds of treatment did you receive, and for how long? (check more than one answer, if applicable):
- a. Individual psychotherapy _____ How long: _____
 - b. Group psychotherapy _____ How long: _____
 - c. Family therapy _____ How long: _____
 - d. Personal counseling _____ How long: _____
 - e. Drug therapy _____ How long: _____
 - f. Hospitalization _____ How long: _____
 - g. Hyperalimentation _____ How long: _____
 - h. Other (specify): _____ How long: _____

32. If you have had more than one type of therapy, which one do you feel was most effective? _____

33. Do you consider your therapy to have been successful?
(check one):

- a. Very successful _____
- b. Somewhat successful, but
prone to occasional relapse _____
- c. Successful in the short run,
but disorder has returned _____
- d. Not successful _____
- e. Too early in treatment
to know _____
- f. Therapy not successful,
but recovered on my own _____

34. Please add any additional comments you would like to
make:

Thank you very much for your cooperation in completing this
questionnaire.

Appendix II: Biography of the Author

Stephanie Ann Skumanich, daughter of Mr. and Mrs. Stephen Skumanich, was born in Bethlehem, Pennsylvania in 1960. She graduated from Liberty High School of Bethlehem in 1978. She received a B.A. in Biology from Lehigh University in 1982, with a Minor in Latin/Classics.

Ms. Skumanich was granted early admission to the Harvard School of Dental Medicine, Boston, Massachusetts. Upon completion of her first year of medical studies, she chose to return to Lehigh for further graduate studies in the areas of health and health-related research.

She will receive an M.A. in Social Relations from Lehigh in 1984. Ms. Skumanich has served as a Teaching Assistant in Social Relations for the 1983/84 academic year.

The honors she has received include membership to Phi Beta Kappa and Phi Eta Sigma academic honor societies, appointment to Omicron Delta Kappa leadership society, member of Dean's List every semester, and graduation with High Honors.