

TOO FAT OR TOO THIN?

A Reference Guide to
Eating Disorders

Cynthia R. Kalodner PhD



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1



Introduction

Is thinner really better? Is there really only one body size or shape that is beautiful? Am I morally weak or ugly because I don't look like a model? Does this make me unworthy of friendship, attention, or love? Does it make sense that my self-worth should be measured by my ability to fit into a size four skirt?

(Radcliffe, 1993, p. 140)

Today I never worry about what or how much I eat. I just eat naturally, and for the most part, healthfully. I usually exercise three times a week, but if for some reason I don't manage to exercise, I don't feel anxious or guilty. I rarely weigh myself, nor is weight a problem for me. In other words, I have not only recovered from my eating disorder, I have freed myself from the diet/weight conflict.

(Kano, 1993, p. 110)

TINKERBELL AND BARBIE: WHAT DO THEY MEAN FOR EATING DISORDERS?

In the Disney movie *Peter Pan*, there is a scene in which Tinkerbell (the little fairy that follows Peter Pan everywhere) lands on a mirror and looks down at her body. She makes a face of disgust when she sees the size of her hips, and it is clear that she believes her hips are too wide. This is a movie seen by young children. My daughter asked me about this scene one day, and I responded, "Tinkerbell is looking at herself in the mirror. What do

you think she is thinking?" My four-year-old daughter told me that Tinkerbelle didn't like her hips.

One of the most popular dolls in American culture, with almost \$2 billion in sales each year, is Mattel's Barbie. Mattel estimates that two dolls are sold every second. Annual sales surveys indicate that Barbie is always on the top ten list of toy sales, usually first or second (Nussbaum, 1997). Over 90 percent of all American girls from three to eleven years old own one or more Barbies (even my daughter has a few). Toys are important objects in the sense that they reflect the values of the society in which they exist (Maine, 2000). The average American girl has at least one Barbie by the time she is three years old, and collects seven Barbies during her childhood (Lord, 1994).

Barbie is an "aspirational role model" that almost no one can achieve; there is a chance less than 1 in 100,000 that someone could have a body like Barbie's (Pederson & Markee, 1991). If Barbie were a real person, she would be 5'9" tall and would weigh 110 pounds. Her body measurements would be 39-18-33. Her heels, permanently molded in a high-heeled position, would be a child's size 3. At her height, a minimum expected weight is 145 pounds; at 110, she would be at a weight that poses a medical risk. She has no body fat or belly. If she were a real person, she would not menstruate. Her rib cage is indented in such a way that she would have had to have plastic surgery and the removal of ribs. In the fall of 1997, Mattel announced that Barbie was in need of a make-over, which would include a more realistic shape. However, only 1 of the 24 new Barbies was changed.

Maine (2000) compared Barbie to a Lands' End sizing chart for a woman's size 10. Here I include comparisons between Barbie's size and Lands' End sizing for girls large, girls slim, and a woman's small:

	Barbie	Girls Large	Girls Slim	Woman's Small
Bust	39"	32	31	34-35
Waist	18"	26	24	26-27
Hips	33"	34	32 ¹ / ₂	28-29 ¹ / ₂

As you can see from reviewing this chart, Barbie's bust is considerably larger than any of the sizes for girls or women, and her waist is much smaller. Barbie's hourglass shape of large bust, narrow waist, and wide hips is just not the same as the shapes of girls or women.

Barbie, Tinkerbelle, and countless others (celebrities such as models, performers, and some of those in the political spotlight) reinforce the societal message about the value of thinness. These messages may become

internalized and have tremendous implications for females and, increasingly, for males. These influences effect children, adolescents, adults, and the elderly.

Children and adolescents form ideas about the negative aspects of being larger and begin to worry at a young age that they might get fat. Alarmingly, this concern about weight and body shape is evident in young children; 21 percent of five-year-old girls worried about their weight (Davison, Markey, & Birch, 2000). Young girls are more weight dissatisfied than are boys (Cusumano & Thompson, 2001), and body dissatisfaction increases as the child gets older (see Smolak & Levine, 2001). Dieting among young children is not uncommon; in large surveys of nine- and ten-year-old children, 42 percent of the nine-year-old black girls and 37 percent of the nine-year-old white girls reported that they were trying to lose weight. The corresponding percentages for the 10 year olds are 44 percent and 37 percent (Schreiber, Robins, Striegel-Moore, Obarzanek, Morrison, & Wright, 1996).

Plastic surgery in children and adolescents has increased 80 percent from 1996 and 138 percent from 1994 (Sarwer, 2001); almost 25,000 people under the age of eighteen underwent cosmetic procedures in 1998 (last year the data are available). Liposuction is the sixth most frequently performed procedure in adolescents (it is the most common in adults). Sarwer (2001) suggests that the increase in plastic surgery is reflective of the high levels of body dissatisfaction in children and adolescents, but he warns that there is little research to document the effects of surgical intervention on the psychological well-being of those who elect to use these techniques.

As adolescents get older, weight and body concerns often intensify. The Centers for Disease Control and Prevention in Atlanta sponsored a large study of high school students, and findings indicated that girls in grades 9–12 were much more likely to be attempting to lose weight (42.5%–45.3%) than male students (14.5%–16%; Serdula, Collins, Williamson, Anda, Pamuk, & Byers, 1993). Males were more often interested in gaining weight, an issue that is discussed later in this book. Studies of college students indicate a wide range of eating disturbances and disorders; between 19 percent and 23 percent of female students have symptoms of eating disorders (Mintz, O'Halloran, Mulholland, & Schneider, 1997; Mulholland & Mintz, 2001).

The American Psychiatric Association (2000) estimates that there is a .5 percent lifetime prevalence of anorexia nervosa for females. The prevalence for males is one-tenth that of females. Approximately 1 percent to 3 percent of females meet the criteria for bulimia nervosa. In addition, for

every one male with bulimia, there are ten females with bulimia. However, both anorexia and bulimia may be underdiagnosed in males.

It is noteworthy that there are no nationally representative data regarding the prevalence and basic demographic descriptions of eating disorders (Garvin & Striegel-Moore, 2001; Striegel-Moore & Smolak, 2001). Some researchers assert that due to the tremendous cost of conducting large epidemiological studies, it is not economical to focus solely on the prevalence of eating disorders, but rather studies should be done to assess a variety of psychological problems and the factors for each of these disorders (Garvin & Striegel-Moore, 2001). More information about the available statistics concerning eating disorders and symptoms of eating disorders is found in this book.

There is a much higher prevalence of eating disorders in women relative to men, with 90 percent of cases of anorexia and bulimia occurring in females (APA, 2000). Reports of eating disorders in males do exist, and some researchers have noted that eating problems in males are becoming more prevalent (Andersen, Cohn, & Holbrook, 2000). Until recently, eating disorders were typically described as a Western cultural phenomenon facing primarily middle- to upper-class white females. There is evidence, however, that symptoms of eating disorders exist among various ethnic and cultural minority groups in the United States and in the whole world (APA, 2000; Smolak & Striegel-Moore, 2001).

MEDIA ATTENTION TO EATING DISORDERS

Eating disorders fascinate and intrigue people. Television talk shows featuring people who have anorexia nervosa or bulimia nervosa continue to bring attention to eating disorders. In some cases, these shows have “ballooned into circus sideshows” and sometimes seem like “a spectator sport for the non-afflicted public” (Levenkron, 2001, p. 11). Oprah covered the story of Rudine, a woman with severe anorexia nervosa who died in 1995 weighing only 38 pounds. Maury Povich hosted the twins Michaela and Samantha Kendall who both had anorexia nervosa; Michaela died in 1994 and Samantha died in 1997.

Magazines also include many articles about people with eating disorders (Bishop, 2001). In a review of forty-seven articles about eating disorders published in popular magazines from 1980 until 2000, Bishop (2001) found that people with eating disorders are described as suffering alone, self-absorbed, fixated in images of thinness in the media, driven by perfectionism, and have a strong need to be in control. The person with an eating disorder in the articles was a female (except in two cases), Cau-

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Anorexia Nervosa

A person with anorexia spends all of her time, energy, and thought in pursuit of something—namely being very thin—that accomplishes absolutely nothing of eternal value.

(Reiff, 1993, p. 200)

I could finally admit—if only to myself—that being thin meant absolutely nothing in the grand scheme of things. I had been thin, thinner than most people ever dream of being, and what had it gotten me? Not much. Rotten teeth, cold hands and feet, and embarrassing questions from curious people.

(Rubel, 1993, pp. 41–42)

Anorexia nervosa is a major eating disorder associated with refusal to maintain a minimally normal weight. The word “anorexia” is derived from the Greek for lack of appetite or avoidance of food (Blinder & Chao, 1994). Although lack of appetite is a misnomer, people who have anorexia nervosa do avoid food. They are quite thin—too thin—and they want to be thinner. In fact, they think they are fat and have an intense fear of gaining weight or becoming fat. It is common for individuals with anorexia to deny the seriousness of low body weight.

What, exactly, is anorexia nervosa? Most people have heard of anorexia, but it is important to know the criteria used to determine if a person has this eating disorder. The *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (APA, 2000a) provides the criteria for defining anorexia nervosa. The specific criteria used to define each kind of psychi-

atric or psychological disorder are contained in this book. In the case of anorexia, there are four criteria. The first, most important, and well-known facet of anorexia is low weight. People who have anorexia refuse to maintain a body weight that is normal for their age and height. They weigh much less than is healthy for them. Criterion B refers to the intense fear of gaining weight. This may be called a “drive for thinness,” and it is an essential part of understanding anorexia nervosa. People with a strong drive for thinness report feeling guilty after overeating, terrified of gaining weight, and preoccupied with the desire to be thinner. They worry that they will become fat, even though their weight is quite low. It is not possible to convince people with anorexia that they will not get fat if they eat a balanced meal. Criterion C refers to the perception that people with anorexia have about their bodies. They do not see their body accurately; a person with anorexia sees an image with more weight than is actually there. This “fatter than reality” image is a major concern; it is a primary issue in life.

A final criterion concerns the absence of menstrual cycles. This is a criterion for females who have already begun to menstruate. This is called amenorrhea; a person is considered to meet this criterion if she has not had a menstrual cycle three months in a row. For younger girls, the beginning of the menstrual cycles may be delayed by the development of anorexia. Although this criterion does not apply to males, it has been noted that the male reproductive system is affected by anorexia nervosa. As females have reduced estrogen, males have diminished levels of testosterone. Many males with anorexia have reduced sexual interest and potency (Herzog & Delinski, 2001).

There are two types of anorexia: restricting and binge-eating/purging. These types are defined in the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (APA, 2000a). Individuals with anorexia nervosa may alternate between these types during the course of their illness. The type of anorexia that is most well known is the restricting type. In the restricting type, the person does not binge eat or use any method of purging (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). People with the restricting type restrict their diet quite significantly or fast for periods of time and may exercise to lose weight. For example, a person with restricting anorexia may eat only salad and certain fruit, and drink only diet soda and coffee. A person may fast, which means not eating any food at all for a certain period of time. People with restricting anorexia may exercise a great deal. An example of excessive exercising might be a five-mile run, an aerobics class, and an hour on a Stairmaster or other exercise machine in one day!



Medical Care and Physical Health Issues Associated with Eating Disorders

I had a complete physical, but as far as my physician could tell me, there was nothing wrong with me. “Just bad luck—a lot of bugs going around,” he concluded after all the test results came back. But I continued to get sick, again and again.

(Kano, 1993, p. 123)

Eating disorders are associated with a variety of physical health problems and medical complications due to starvation, vomiting, and use of laxatives, diuretics, or other medications. These complications may be mild, moderate, or life threatening. In eating disorders not otherwise specified, the medical issues depend on the type of eating problem, the presence or absence of purging, and the type of purging used. In anorexia, the health issues that arise are often the result of starvation and malnutrition. In anorexia of the binge eating/purging type, there may be physical complications similar to those experienced by those with bulimia. In the purging type of bulimia, health issues usually develop as a consequence of the methods of purging used. Vomiting, laxative, or diuretic abuse can cause different physical effects in the body. Individuals with eating disturbances may also experience some of the health issues described here.

Many of these health issues are relevant to all types of eating disorders and may require medical attention. However, it is interesting to note that people with bulimia seem to have more physical complaints than patients with anorexia nervosa despite the fact that the physical condition of patients with bulimia is not generally as seriously impacted as in anorexia

(Mitchell, Pomeroy, & Adson, 1997). People with bulimia generally look healthy on physical examination (Walsh, Wheat, & Freund, 2000). Patients with anorexia may not describe present physical complaints, despite their emaciated state (Mitchell et al., 1997). They may minimize the physical consequences of their situation and their medical problems may not be obvious until there is a detailed medical examination. Often, individuals with anorexia are able to maintain regular physical activity.

The medical management of anorexia is more complicated than bulimia. This is largely due to the medical issues that arise from starvation. Although patients with both anorexia and bulimia require routine medical screening, ongoing medical issues are more often associated with anorexia than bulimia. Medical assessment of individuals with eating disorders includes detailed questions about eating, fasting, starvation, vomiting, use of laxatives, diuretics, or diet pills, and any use of ipecac. It is important to look for other medical issues that may complicate the treatment of an eating disorder. Diabetes is an example of such a medical problem (Peveler, 2000). A physical examination includes accurate assessment of height and weight, hydration (the amount of water in the body), and blood pressure. The physical exam may also include examination of the teeth to assess for signs of damage due to vomiting. Laboratory analysis of blood and urine is necessary to look for electrolyte levels, liver function tests, and tests of thyroid functioning (among many other things). Other tests such as an electrocardiogram (EKG) of the heart might be ordered. Some of these laboratory analyses may not be sensitive to detecting eating disorders in early stages.

Medical consultation with a physician knowledgeable about eating disorders is necessary to assess the health of individuals with eating disorders. A curriculum used to educate pediatricians, obstetricians, internists, and nurses about eating disorders includes training in the diagnosis, medical assessment, and treatment of eating disorders (Gurney & Halmi, 2001). However, this presentation was limited to only one hour, and eating disorders may receive “cursory attention in medical schools” (Gurney & Halmi, 2001), thus it is wise to seek out a physician with special expertise in eating disorders. (This article also contains detailed information regarding the training of social workers, which is much more comprehensive.) Medical doctors who specialize in working with individuals who have eating disorders are trained to look for abdominal pain/bloating, constipation, irregular menses, swollen cheeks or glands, dental complaints, and overall weakness as symptoms of eating disorders. They are also advised to ask about eating behavior, vomiting, use of laxatives and diuretics, attitudes about body weight and shape, physical exercise, mood

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A Reference Guide to Eating Disorders

Do you find the deluge of information regarding eating disorders mystifying and misleading?

Is it difficult knowing where to begin and who to trust?

This practical resource guide for professionals, students, and parents dispels the myths surrounding eating disorders by providing factual and historical information on how our understanding of these problems has evolved. In addition to chapters on anorexia nervosa and bulimia nervosa, compulsive overeating and eating disturbances are also discussed. These are defined as problems associated with eating and body image but which are not severe enough to warrant a diagnosis of any specific eating disorder. The book makes use of numerous case studies and contains the most current research to describe and explain symptoms, dangers, and current theories about what causes such disorders.

The medical and psychological issues are thoroughly discussed in a manner that makes the material accessible to students of all levels. Numerous psychological therapies and other forms of treatment are described, providing each treatment's history and effectiveness. Additional material focuses on the prevention of eating problems, the relationship between image disturbances and popular culture, and controversies in the field of diagnosis and treatment.

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