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Eating Disorders and Adolescents: Conflict of Self Image

Curriculum Unit 84.05.05
by Frances F. Conte

AN INTRODUCTION

Anorexia nervosa (self-starvation leading to extreme weight loss) is a disorder which has been around for hundreds of years, but it has, along with its associated syndrome, bulimia (excessive morbid hunger and fear of fatness leading to gorging/purging compulsion), shown an enormous increase in occurrence and interest in the last decades. The number of victims affected is staggering. There may be as many as 500,000 or more afflicted with these disorders, and for many the suffering is a life-long problem, often leading to death. The emotional and physiological damage to the victims of these eating disorders is extremely dangerous and deeply painful to themselves but also to their families who are impotent to control the self-imposed starvation and obsessions of their children.

The questions I should like to pose in writing this curriculum unit are: Why are these disorders of such alarming, epidemic proportions in this country? Can we educate teachers, families, professionals and adolescents to some of the forces that predispose them to this type of behavior? Can we undertake a prevention program in the schools that combines nutritional and emotional education? Can we assist adolescents in becoming more aware of their strengths and facilitate development of appropriate coping strategies in dealing with conflict? Can we help them in achieving a better understanding and acceptance of who they are?

OBJECTIVES

In writing a curriculum unit on eating disorders as they relate to the adolescent's conflict of self image, I will attempt to define the cultural significance of this phenomenon and to provide some background concerning the nature of the conflicts, pressures and stress experienced by adolescents in relation to issues of self esteem, dependency, acceptance and responsibility. I will try to show how these conflicts may be symbolically represented in behavior that may lead to a pattern of obsessive dieting, self starvation, gorging and purging, and a preoccupation with food.

Adolescents are subjected to a barrage of messages and pressures affecting how they view themselves and

how they believe they should look. Television, films, sports and magazines project an unrealistic image for teenagers to emulate. Parents' expectations for their children are often unreasonably high, resulting in the belief that they can never reach the high standards set for them. Adolescence is a time of confusion and conflict about growing up, finding one's identity and becoming comfortable with one's emerging sexuality. I will attempt to examine some of these particular issues while providing opportunities for students to develop skills and gain insight that may lead to greater self awareness and perhaps a more "self-management life style."

It seems of grave importance to provide the teacher with sufficient insight into these complex eating disorders, and, therefore, the first part of this unit will be devoted to a discussion of anorexia nervosa and bulimia. Included will be an overview of current diagnostic criteria, secondary effects on the health of victims, and some general characteristics of anorectics and bulimics. I will attempt to examine some of the causal theories and cultural influences on youth which exploit and glorify thinness and may contribute to a teenager's distortion of body image. A brief discussion of the interpersonal conflicts that may predispose adolescents to this maladaptive behavior will be offered as well as some thought on why these disorders are prevalent in Western societies.

I have included a brief description of current therapeutic modalities used in the treatment of anorexia and bulimia. I have also provided a list of national organizations that serve as resource and support groups.

The second part of this curriculum unit is devoted to student activities. In order to help students understand the complexities of these eating disorders and the underlying factors which may contribute to their onset and development, I am presenting three case studies and specific study questions. Additional student activities are designed to help them explore the various aspects and manifestations of these eating disorders and assist them in identifying and expressing their own conflicts of self image.

GENERAL INFORMATION

What is anorexia nervosa? The term implies a loss of appetite due to a nervous condition, but given the complexity of this disorder, the term appears to be a contradiction. Anorectics are obsessed with food, but stubbornly refuse to eat or retain it because of a fear of being fat and an obsession with thinness.

The diagnostic criteria for anorexia nervosa according to the American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition) are:

- "A. Intense fear of becoming obese, which does not diminish as weight loss progresses.
- B. Disturbance of body image, e.g., claiming to 'feel fat' even when emaciated.
- C. Weight loss of at least 25 percent of original body weight or, if under 18 years of age, weight loss from original body weight plus projected weight gain expected from growth charts may be combined to make the 25 percent.
- D. Refusal to maintain body weight over a minimal normal weight for age and height.
- E. No known physical illness that would account for the weight loss." ¹

Some individuals with this disorder cannot exert continuous control over their intended voluntary restriction of food intake and have bulimic episodes (eating binges), often followed by vomiting.

The anorectic consistently denies that she has a problem. She cannot be persuaded to eat, but instead is tyrannical over her body and food intake. Often control of food and dieting are the only things about which anorectics feel they have any power. As the self imposed starvation escalates, the anorectic becomes more and more obsessed with the preparation of food and often will plan and prepare elaborate meals for others but will avoid eating. In time the lack of nutrition may affect the anorectic's judgment, which may account for her extreme negativism and stubbornness, although they may actually cover up her lack of independence and self confidence.

Anorectics involve themselves in strenuous exercise and physical activity for the purpose of burning calories. This exercise usually includes bicycling, jogging, running, aerobics, swimming or calisthenics, all pursued with speed and an inordinate sense of endurance. While they may feel more energetic initially and exhilarated in their newly acquired self discipline and control, in time the affects of this regimen begin to take their toll on the body.

The anorectic will become increasingly restless and often have difficulty sleeping. Starvation results in cessation of menstruation. Anorectics experience loss of scalp hair, while, at the same time, in response to the lowering of body temperature, a downy growth of hair called, Lanugo hair, appears on the face, back and extremities to help conserve heat. Blood pressure drops. The pulse slows. Eventually the body feeds off its own muscle tissue, including that of the heart and other vital organs.

Bulimia . Although there is some controversy concerning the name and etiology of a syndrome consisting of episodes of binge eating and purging, most authors are able to agree on a basic conceptualization of the problem most commonly referred to as bulimia. Individuals with bulimia have a morbid fear of gaining weight and make repeated attempts to control it through dieting. Feeling deprived, bulimics find they can no longer restrict their food intake and experience intense hunger leading to episodes of overeating. These food binges are usually followed by self-induced vomiting, laxative or diuretic abuse in order to avoid the dreaded weight gain.

The diagnostic criteria for bulimia, according to the American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition) are as follows:

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

B. At least three of the following:

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

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

D. Depressed mood and self-deprecating thoughts following eating binges.

E. The bulimic episodes are not due to Anorexia Nervosa or any known physical disorder.”²

The amounts of food ingested by a bulimic patient are typically extreme. Subjects have reported consuming from 10,000 to 50,000 calories in a day. Actual episodes of binge eating occur most frequently late in the evening or during the night, throughout time of stress and periods of unstructured time.

The frequency of self-induced vomiting, laxative and diuretic abuse varies greatly. Reports indicate that some bulimic patients have vomited from as few as several times a month to as many as five times a day. Those who abuse laxatives may consume 100 tablets daily, while diuretic abusers may take up to 600 mg. daily.

There are a number of severe health problems associated with bulimia. (See Appendix A and B). The most threatening consequences are the results of self-induced vomiting, laxative and diuretic abuse. Such consequences as severe hypokalemic alkalosis, dry mouth, muscle spasms or tetany, parotid gland swelling, gastroesophageal symptoms, periorbital edema, dark circles under the eyes, lacerations on the back of the throat, constipation and dizziness may present themselves. Other medical consequences include the loss of tooth enamel, ear canal problems, electrolyte imbalance, anemia and loss of scalp hair. Scars on the dorsum of the hand have been observed—the result of frequent self-induced vomiting.

In contrast to those with anorexia nervosa, patients with bulimia do not have severely lowered weight which is why it has been referred to as the “secret addiction.” Patients are typically within five to ten percent of their normal body weight. Bulimic patients do not deny hunger as many classic anorectics do, nor do they display the pride and exhilaration characteristic of the anorectic’s self control. Patients with classic anorexia nervosa restrict their food intake to the point of emaciation, often in response to perceptual distortion of their body size. Bulimics are more aware of bodily discomfort, and experience dysphoric mood states from depression, anxiety and guilt. The most frequent psychological consequence of bulimia is a distressing sense of loss of control, with subsequent guilt, demoralization and feeling of helplessness in the presence of these bulimic urges and episodes.

ONSET AND CAUSES OF BATING DISORDERS

Classic anorexia nervosa (self-starvers) occurs most frequently in adolescent girls between 10-15. Self-starving and episodes of bingeing is most frequent among girls ages 15-18, while binge/purgers make up an older group between 19-30.

What are the forces occurring during adolescence that propel a young girl into this love/hate relationship with food?

Girls are more apt to diet because of the cultural pressure that give the message: THIN IS BEAUTIFUL! At a time when a young girl's body shape is changing and growing, particularly in the breasts, hips and thighs, a young girl's perception of her body image becomes unstable or confused. For young girls with an early onset of anorexia nervosa it has been found that menstruation had been a traumatic experience for them, having been ill prepared for the changes they would experience. Fears and conflicts about sexuality and impending sexual confrontation are powerful triggers often resulting in extreme anxiety and social withdrawal. Decision making and accepting criticism, particularly from family members and peers are particularly distressful. Comments about being chubby, or plump can have dire consequences for the potential anorectics who already have a conceptualized distortion of their body, believing that they look much heavier than they actually are, or at best—are ordinary. This distortion in attitudes about oneself may contribute to the self-loathing and poor self esteem that weight gain in later years produces.

The cultural message to be thin is communicated to children from many sources—television, motion pictures, magazines, books, family, friends and teachers. This value of the perfect body then becomes introjected. However, the other message that children receive from the media and advertising is that food tastes great—any time, any place! Food is a part of family life, recreation, socializing, watching television, snacking alone, between meals, in the movies, in school. Desserts are tempting! Fast food chains are convenient! These mixed messages have an enormously conflicting effect on susceptible children. Juxtaposed to these advertisements exalting the joy of eating are those reinforcing the terror of being fat! Diet soft drinks, lite beers, appetite suppressants, exercise and fitness commercials are all cultural persuasions to achieve thinness. The message seems to say that being thin and extraordinary looking will solve all of life's problems, bring success, transformation and an end to suffering. Unhappily, dieting and the pursuit of thinness will become the focus of the adolescent's life, distracting her from pain, loneliness and insecurity and providing her with a sense of meaning and purpose.

In almost 50 percent of anorectics some traumatic event precipitated the onset of the disorder. Among those that have been reported to trigger anorexia in a predisposed adolescent are: death of a loved one, divorce, illness of a parent or family member, or romantic rejection which the adolescent believes was the result of being overweight.

It is difficult to account for the increase in eating disorders in Western societies, but some suggestions have been offered:

1. The greater availability of improved nutrition in the more affluent countries of the world, which makes food easily accessible and not something a family works for directly.
2. The incidence of early onset of menstruation in Western societies which abruptly terminates childhood and hastens the adolescent to premature adulthood.

3. The increase in parental demands for social and academic accomplishment in their children.
4. The limbo of adolescence which makes developmental issues of disengagement from parental control and individuation more difficult to negotiate.
5. Increased insecurity and lack of trust in social and cultural institutions such as schools and government.
6. Lack of intimacy and close interpersonal relationships which are often shallow and open to exploitation.
7. Love of self (narcissism) and preoccupation with instant gratification, and distrust of the future.

3

It might be useful to present a perspective on the emotional conflicts experienced by an individual who may become a disordered eating victim. Listed below are several underlying principles:

1. The (pre) anorectic is compliant, approval seeking and cooperative as a child. She may actually assume the role of assisting or supporting the family emotionally. She may become a high achiever, a pleaser of others, thus raising family morale. At the same time she may lack trust and self assurance.
2. She may seek an externally perfect image to cover up her inward feelings of insecurity, inadequacy and fear of rejection.
3. She may outwardly avoid and control sexual contact and enjoyment while inwardly fearing that others will discover her sexual fantasies.
4. She may have difficulty expressing anger and hold her feelings in. She may feel manipulated and exploited and retaliates by reclaiming her life through self starvation which is her way of gaining power over others.
5. While her behavior may appear supportive, her anger at being cast in the role of nurturer emerges as she gains power through rejection of food, thus becoming a challenge to her family, and/or punishing them.
6. She must work frantically to be perfect in everything she does. In fact, she becomes at once a demanding and rejecting parent to herself.

“These factors and others blur the boundaries of the self, make people feel vulnerable to passivity, loss of

control and liable to intrusion, invasion, and control by vague, outside forces. Anorexics dread obliteration by the outside world—a fear represented by food.”⁴ (From: John Sours, *Starving to Death in a Sea of Objects*)

DESCRIPTION OF TREATMENT PROGRAMS

In seeking professional help for the treatment of anorexia and bulimia, it is important to find a therapist who is knowledgeable of the complexities of these syndromes.

While there is some disagreement in which approach is more successful in overcoming these disorders, there is consensus that the most recommended treatment programs combine individual, group and family therapy along with nutritional counseling. Long term and follow-up counseling seems to be preferred. The relationship between the patient and therapist is crucial and without doubt the most significant factor influencing change.

A number of approaches to the treatment of eating disorders can be viewed. I am including a description of some therapeutic modalities available to eating disorder victims.

Eating Disorder Clinics . Currently associated with universities throughout the country, they have an eclectic approach combined with a structured program that includes lectures, group therapy, assertiveness training, drug therapy and nutritional counseling.

Self Help Groups . These are often led by a volunteer who has recovered from the disorder. Sessions are usually free. Some psychotherapists prefer to treat eating disorder victims exclusively in a group setting. In some situations support groups for parents of anorexics and bulimics have been established and have proved to be effective. Often group therapy is undertaken as an adjunct to private individual therapy.

Overeaters Anonymous . This non-profit organization, patterned after Alcoholics Anonymous, has been helpful as a support system for victims of bulimia. Its focus on outreach and acceptance can help patients improve self esteem and serve as a contact source for those struggling with bingeing urges.

Workshop Programs. These are intensive programs designed to help victims of bulimia confront their behavior. These workshops are often scheduled over a weekend with follow up meetings arranged and referrals for long term therapy made. A criticism of these programs is that referrals and follow up are not provided.

Traditional Psychotherapy . Dynamically oriented therapy which explores inner conflicts and provides insight into problems of low self esteem, guilt, anxiety depression, obsessive-compulsive behavior and a sense of helplessness.

Structural Family Therapy . Intervention designed to restructure the family system and change the patterns of family interaction, dynamics and enmeshment which maintain the behavior of eating disorder victims.

Behavioral Therapy . An analysis of the antecedents, and consequences of behavior designed to help victims set up strategies to expand their coping skills. Such skills may include cognitive restructuring, thought stopping, relaxation techniques, assertiveness training and positive reinforcement.

Cognitive Therapy . This approach is designed to manipulate and challenge thoughts and attitudes. Patients are provided with information which rationally opposes prevailing beliefs about their helplessness, depression and low self esteem.

The following organizations may be contacted for additional information and materials relating to Anorexia and Bulimia: (Enclose a self-addressed stamped envelope)

American Anorexia Nervosa Association, Inc. (AANA)

133 Cedar Lane

Teaneck, New Jersey 07666

Anorexia Nervosa and Related Eating Disorders, Inc.

(ANRED)

P.O. Box 5102

Eugene, Oregon 97405

Help Anorexia, Inc.

5143 Overland Avenue

Culver City, California

Maryland Association for Anorexia Nervosa and Bulimia

222 Gateswood Road

Lutherville, Maryland 21093

National Anorexic Aid Society, Inc. (NAAS)

P.O. Box 29461

Columbus, Ohio 43220

National Association of Anorexia Nervosa and

Related Disorders (ANAD)

Box 271

Highland Park, Illinois 60035

New York Anorexia and Bulimia Aid

One West 91st Street

New York, New York 10024

STUDENT ACTIVITIES

In preparing student activities for this curriculum unit it seemed appropriate to include the various aspects of this complex syndrome. To this end, I have associated each activity with a particular component or facet of Anorexia Nervosa and Bulimia. There are five Lesson Plans which can be used over a period of 1-2 weeks depending on the grade level and subject area in which this unit will be used.

1. Lesson Plan I (The Survey) is designed to acquaint students with certain facts and manifestations of anorexia and bulimia.
2. Lesson Plan II (Case Studies) presents vignettes and study questions relating to the precipitating factors of these disorders.
3. Lesson Plan III (The Food Diary) enables students to become aware of the relationship between food and feelings.
4. Lesson Plan IV (The Journal) identifies the patterns of family and social interaction which may lead to conflict and powerlessness which are major underlying factors of eating disorders.
5. Lesson Plan V (The Media Survey) will help students to become more aware of the cultural influences on self-image as expressed through television, magazines and newspapers.

Lesson Plan I. True or False Survey

Objectives Students will be able to learn the facts about eating disorders.

Strategy This survey may be given before the unit on eating disorders to determine what students may already know. It may also be used as a post test to assess how well they have understood the ideas presented.

Students may indicate a True or False response.

1. Anorexia Nervosa (self-starvation) occurs most frequently in adolescent girls between 10-15 years old.
2. The cultural message that “you can’t be too thin” is communicated to impressionable youngsters through the media, family and friends.
3. Bulimics have a morbid fear of gaining weight; have episodes of binge eating, followed by purging through self-induced vomiting, or laxative abuse.
4. The incidence of anorexia and bulimia has increased during the last 10 years.
5. Bulimia is a secret addiction often undetected because bulimics usually are within 5% of their normal weight.
6. Anorectics engage in strenuous exercises after every meager meal to burn up the calories they have eaten.

7. Anorexia often begins innocently with a young person's decision to diet.
8. Eating disorders affect more women than men.
9. Prolonged self starvation can lead to the loss of muscle tissue, cardiac arrest and/or brain damage.
10. The binge/purge cycle can upset the body's fluid balance.
11. Anorectics are pleasers who use starvation to gain control of their lives.

*The responses are all true.

Lesson Plan II. Case Studies .

Objectives These vignettes and the accompanying study questions will enable students to identify some of the causal factors and conflicts which are precursors to anorexia and bulimia.

Strategy

1. Have students read each case study and respond to the study questions.
2. Ask students to share their responses with the class.
3. Encourage students to comment on their own experiences with dieting or conflicts.

Case Study—Irene (adapted from *The Golden Cage* by Hilde Bruch)

As a child Irene had not been preoccupied with her weight. When she was 11 years old several girls in her class talked about dieting and she found this peculiar because they looked all right to her; she felt lucky to like her own figure. However, a year later when she showed early pubertal development, her pediatrician made some casual remark about her getting too plump. This triggered a concern about growing up, dating and believing that her mother might become overly interested in her life. Irene suddenly began a rigorous weight-watching program, not permitting her weight to rise above 95 lbs. Though she kept on growing, she did not menstruate. She began to avoid people and stayed to herself. At age 15 her parents separated. At that time she began to starve herself and lost a dramatic amount of weight, striving to be as thin as possible and hating herself for gaining even an ounce. ⁵

1. What prompted Irene to begin dieting?
2. What effect on her healthy development did this loss of weight produce?
3. Why do you think Irene turned to dieting again at age 15?
4. What other aspects of her development was Irene avoiding?

Case Study—Sheila (Adapted from *The Art of Starvation* , by Sheila MacLeod)

At 14, Sheila attended an upper class boarding school on a government scholarship. Living away from home she felt out of place in the family and a misfit in school. She felt worthless, hopeless and empty.

At this point Sheila decided to go on a diet so as not to look “dumpy and ordinary.” Immediately, as the weight dropped off she began to feel exhilarated and more in control of those feelings of helplessness and self-loathing. She eventually lost so much weight that when she returned home she was mistaken for a young boy.

Sheila was the eldest of three daughters. Her father was a school teacher; her mother had never reconciled her homesickness for the country. Sheila was bright and gifted. The family was extremely mannerly. Anger was not openly expressed, and conflicts were avoided. Sheila got the message that in going away to school she was expected to succeed—to become extraordinary—to make the family happy. ⁶

1. What demands did Sheila perceive her family placed on her?
2. What provoked Sheila’s decision to diet?
3. What did Sheila gain from refusing food?
4. What conflicts was Sheila experiencing?

Case Study—Cherry (Adapted from *Starving for Attention* , by Cherry Boone O’Neill)

At 16, Cherry, the eldest of four daughters, was slightly overweight at 140 lbs. Wanting to be a good role model for her younger sisters and anxious to please her parents, she began dieting. Cherry stole her mother’s diet pills to keep her appetite in check and exercised six hours a day. Eventually she got down to 90 lbs. She wore extra layers of clothing to hide her protruding bones. Her eating habits grew more bizarre. She began binge eating, followed by ingesting massive doses of laxatives. After a grim struggle over a period of 10 years, Cherry finally stabilized her life with psychiatric help and support from her husband and family. She now weighs 114 lbs. Cherry says, “I want my daughter to feel good about herself as she gets older because of who she is and not how she looks.” ⁷

1. In trying to please her parents what was Cherry saying about her self image?
2. What message did Cherry’s mother communicate in using diet pills herself?
3. What do you think Cherry’s message to her daughter means?

4. What do you think the title of her book, *Starving For Attention* , means?

Lesson Plan III. Food Diary

Objectives *People need food in order to live. Food is a life-giving source and not something to be avoided or misused.*

Strategies *Ask students to keep a record of their food intake for one week. (a sample food diary is provided) After completing the food diary students will be asked to share their eating patterns with the class.*

Additional questions may prompt further discussion from students.

(Sample Food Diary):

Day & Time / What I Ate / Feelings Before and After Eating

1. What did you learn about when, what and why you eat?
2. Do you sometimes eat when you're not hungry? What happened to make you think of eating?
3. Do you ever eat so much your stomach hurts?
4. Do you eat junk food? Do you feel guilty and hate yourself when you do?
5. Do you go without solid food for 24 hours or more? Why?
6. Do you ever eat because you are lonely, upset or anxious?
7. What do you think you learned about the relationship between food and feelings?

Lesson Plan IV. Journal

Objectives *To help students identify personal and family interactions that may lead to conflicts?*

Materials *Sample questions, folders, pencils, paper.*

Strategies *Have students make entries in response to the questions found in their journal folders. Allow students to add or substitute comments or concerns.*

Encourage students to talk about these issues in class, but respect the fact that some students may choose not to share comments.

(Sample Questions):

1. What is the general emotional mood of your family?
2. What are the rules in your family? Who sets up the rules? How are they carried out?
3. How are decisions made in your family?
4. What are the sources of trouble in your home?
5. How is conflict handled in your family? Anger?
6. How is affection expressed in your family?
7. Who has the power in your family? How is it used?
8. Who are you most like in your family?
9. How are you different from others in your family?
10. Who has influenced you most in your family?
11. Name five things your parent(s) expect of you?
12. How well do you think you are fulfilling these expectations?
13. How often do you feel that too much is expected of you? If so, what do you do about it?
14. How accurately does the following statement describe your own attitude:

I hate my life. It's all messed up. I wish I could start over again and do everything right. ⁸

Your teacher may ask you to share some of the feelings expressed in your journal. Sharing with others may help you see that you have many things in common.

Lesson Plan V. Media Survey

Objectives To enable students to become aware of the role the media and advertising industry play in exploiting cultural trends.

Strategies In preparation for class discussion on the influence of the media and the advertising industry, students will be asked to collect pictures from magazines and newspapers that advertise, glorify or exploit dieting, body image, and/or thinness.

Students will compile a list of television commercials and shows which promote external appearance, slimness and an “ideal body.”

The pictures may then be used for a class mural or collage.

Notes

1. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition. Washington, D.C., APA, 1980.
2. *Ibid* .
3. Sours, John. *Starving to Death in a Sea of Objects*. New York: Jason Aronson, 1980.
4. *Ibid* .
5. Bruch, Hilde, *The Golden Cage* . Cambridge: Harvard University Press, 1978.
6. MacLeod, Sheila, *The Art of Starvation* . New York: Schocken Books, 1981.
7. O’Neill, Cherry Boone, *Starving for Attention*. New York: Continuum Publishing Co., 1982.
8. Kagan, Dona M. and Squires, Rose L., “Dieting, Compulsive Eating, and Feelings of Failure Among Adolescents,” *International Journal of Eating Disorders*, 1983, 3:15-26.
9. National Association of Anorexia Nervosa and Associated Disorders, (ANAD). Highland Park, Illinois. *Information Bulletin*, 1983.

STUDENT BIBLIOGRAPHY

Hudlow, Emily Ellison, *Alabaster Chambers* . New York: St. Martin’s Press, Inc., 1979. Fictionalized account of a young, married woman’s struggle with anorexia and the therapy which helps her to discover herself. A good account of the progress of this syndrome in a readable story.

Levenkron, Steven, *The Best Little Girl in the World*. Chicago: Contemporary Books, Inc., 1978. A novelized case study of a 15 year old anorectic describing the behaviors, thoughts, feelings and circumstances with which anorectics and their families contend. This book was adapted for television and may be familiar to students.

MacLeod, Sheila, *The Art of Starvation* . New York: Schocken Books 1981. An outstanding personal account of the author's early confrontation with anorexia at the age of 14 and her 18 month ordeal with self-starvation. It is also an informative essay on current research and literature on anorexia.

Myers, Irma. *Why You Feel Down— & What You Can Do About It*. New York: Scribners, 1982. A straight talk, self help book for teenagers on how to cope with feelings of depression. Pages 62-70 cover the topic of "Changing Bodies."

O'Neill, Cherry Boone, *Starving For Attention*. New York: "I was a celebrity's daughter. I thought I had to be perfect. And I nearly killed myself trying." A quote from Cherry's revealing account of her 10 year ordeal with anorexia. Must reading for everyone affected by our culture's obsession with thinness.

Orbach, Susie, *Fat Is a Feminist Issue* . New York: Paddington Press, Ltd., 1977. A self-help book for compulsive eaters and those preoccupied with thoughts of food. I strongly recommend the book. Pages 161-175 deal with self starvation which Ms. Orbach describes as "the other side of the coin of compulsive eating."

TEACHER BIBLIOGRAPHY

Boskind-White, Marlene, *Bulimarexia : the binge-purge cycle* . New York: W. W. Norton & Co., 1983. An excellent book on the binge/purge syndrome by Marlene Boskind White and her husband, William White of Cornell University. Presents their therapeutic approach to breaking the binge/purge cycle and offers specific strategies for handling stressful life situations.

Bruch, Hilde, *The Golden Cage* . Cambridge: Harvard University Press, 1978. Dr. Bruch, a renowned psychiatrist and leading authority on anorexia, details from her own case studies the causes, effects and possible treatment of this disorder. Especially useful for teachers and counselors of young teenagers.

Cauwels, Janice M. *Bulimia: the binge-purge compulsion*. New York: Doubleday & Co., Inc., 1983. A definitive book on bulimia including possible causes, relationship to social and family pressures and their effect on the body. An excellent source of information for getting help for those afflicted.

Garfinkel, Paul, *Anorexia Nervosa : A Multidimensional Perspective* . New York: Brunner/Mazel Publishers, 1982. A clinically oriented, scientific reference on the syndrome of anorexia nervosa which addresses the complexities of the causes and treatment.

Landau, Elaine, *Why Are They Starving Themselves?* New York: Julian Messner, 1983. An overview of bulimia and anorexia.

Levenkron, Steven, *Treating and Overcoming Anorexia Nervosa* . New York: Charles Scribner's Sons, 1982. The author presents case studies and describes the effectiveness of his Nurturant-Authoritative Therapy in treating disordered eating patients. A comprehensive guide for mental health practitioners, but a useful reference for educators.

Minuchin, Salvador, *Psychosomatic Families* . Cambridge: Harvard University Press, 1978. A presentation of the Family Systems Theory and Practice in the treatment of anorexia. A clinical model of intervention with four families is offered. Especially useful in understanding family interaction, conflict, enmeshment and control.

Appendix A

(The following is from the Information Bulletin of the National Association of Anorexia Nervosa and Associated Disorders (ANAD))

PARTIAL LISTING of PHYSICAL PROBLEMS BROUGHT ABOUT BY EATING DISORDERS ⁹

(figure available in print form)

Appendix B

GLOSSARY

Medical Terms Associated with Eating Disorders

Anorexia Nervosa: Literally, not eating because of nervous causes; a strong and persistent obsession with achieving thinness through self starvation.

Bulimia : Excessive, morbid hunger and fear of fatness leading to gorging(bingeing)/purging compulsion.

Cachexia : Extreme emaciation due to a serious disease as in tuberculosis, carcinoma, syphilis, and anorexia nervosa.

Electrolyte imbalance : Imbalance of fluids and minerals in extracellular-intracellular spaces, often leading to renal, central nervous system, and cardiovascular disturbances.

Amenorrhea: No menstrual period.

Hyperalimentation : Supplemental nutrition, usually by way of intravenous feedings, for profound starvation.

Hypokalemic syndrome : Low serum potassium producing cardiac and skeletal muscle fatigue; cardiac rhythm irregularities and heart arrest can occur.

Lanugo hair: Downy growth of hair often seen on the face, back and extremities of young women with anorexia nervosa.

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