In 1994, in the first edition of this book, I wrote that “only a few years ago anorexia nervosa and its related illness, bulimia, were conditions not ordinarily seen in the course of one’s professional life.” Since then, it is likely that most professionals in the health, psychology, and education fields have encountered someone suffering from an eating disorder and have learned to recognize the variations and combinations that may be presented. These conditions have not gone away; more are recognized, more are treated, and there are many prevention programs in colleges and high schools that did not exist in the early nineties. Hence our offering of this updated edition. And it’s unlikely that these conditions will abate soon. Statistics vary, but the 1 percent statistic for young women suffering from anorexia nervosa in industrialized societies remains fairly constant, with the percentage of those suffering from bulimia ten times higher.
Special groups of the population, namely, college-age women, suffer markedly. Jennifer Biely, director of the Eating Disorders Awareness and Prevention organization (EDAP), recently estimated that 5–7 percent of America’s twelve million undergraduates are afflicted. (PEOPLE, 1999)

In most countries where the disorders are identified, it is estimated that 90 percent of those suffering from an eating disorder are female. The concentration in the teenage and young adult years makes it a disturbing impediment to health. An alarming number of prepubescent girls in the United States are already worried about weight and are beginning to diet. It is evident that the syndrome finds its way into cultures of plenty, or seeming plenty, where starvation is not the common rule. One may safely generalize that atypical eating and its consequences are rooted in our society, reflecting—often painfully and grotesquely—our miniworlds of strivings for identity, value, self-esteem, and ease from distress.

Various causes have been identified in different centuries. In medieval times, spiritual and mystical religious connections were seen; more recently, connections have been made to the family environment, the individual’s attitude, and medical considerations. In the early part of the twentieth century, medicine increasingly focused on possible pituitary defects or other physical abnormalities. A swing toward psychoanalytical considerations from the 1940s on brought deeper understanding of the vulnerabilities in personality development that made disruption and distortion of eating possible. Most recently, the expansion of theory and new findings have given us much knowledge and many tools that can be applied to treatment approaches. Among these are behavioral theory and technique, self-psychology, emphasis on maturational stages, relational aspects of living, nutritional information and protocols, and psychopharmaceutical innovations. Careful theorists and thoughtful pioneer practitioners have paved the way, among them Professor Arthur H. Crisp in England (Anorexia Nervosa: Let Me Be, 1980) and, in the United States, the late Dr. Hilde Bruch (The Golden Cage: The Enigma of Anorexia Nervosa, 1978).

In addition, the burgeoning feminist movement has encouraged a more specific exploration and understanding of the development of the girl-child into womanhood, thus pointing up the societal and
psychological hazards to healthy growth. We are more aware of the strain on the young girl’s identity formation as she views disparate images in the media and advertising. For instance, is she to mirror the sexy, slim, and sometimes sullen siren or the seductive childlike Lolita? What will make her seem the same as others so that she feels she “belongs,” or what will make her appear “different” so that she feels unique and appealing? Is intellectuality to be pursued, or will such a pathway discourage popularity? Expressions of unease take different forms for different groups of people. Girls and women have often focused on appearance—if the body is perfect, then all will be well. Years ago, when Karen Horney called for a new view of the female psyche, she commented on the way a group of women she had studied reduced their failures in relationships with men to seeming ugliness or a real or fancied defect in the body. She added that one of her patients had “fasted for weeks when her brother told her that her arms were too fat” (Quinn 1987). And now, more than six decades later, we still see unhappiness reflected in body dissatisfaction, often with a distorted body image. In many of the following chapters the reader will find the conflict and contradictions of our times echoed in the patients’ efforts to reach cognitive and emotional equilibrium.

A consolidation in the findings of sociological, psychological, and physiological studies show many factors that promote the development of eating disorders. Along with the physical state, we now consider matters of dependence, independence, sexuality, identity, gender, self-image, body image, obsessionalism, addiction, fear, depression, anxiety, and a host of other qualities that are ingredients of human existence. A multidetermined etiology is thought to be a more valid picture of causation. A treatment approach combining many different modalities, each addressing some aspect of the illness, is generally recognized as a thorough and effective plan for bringing about recovery.

The following collection of papers provides hands-on accounts of how professionals in this field approach their work by combining theory and knowledge in their own idiosyncratic way, from the vantage point of their particular discipline. The idea for this book was generated largely from the Wilkins Center for Eating Disorders, where the director, Diane W. Mickley, M.D., has ensured a
rich and intensive learning experience for those practitioners who have joined in a team effort to study and treat those who applied for care. The reader will find that the authors, for the most part, have used female pronouns—she, her—in their writings. This usage reflects the predominance of females over males who are known to suffer from eating disorders. While much discussed here is applicable to males, our views rest on our greater clinical experience with the female patient population. Boys and men have vastly different cultural and physiological imperatives that are the infrastructure in their development, and these have to be considered in their treatment.

Some of the authors have elected to write about aspects of their work that particularly engage them. Others have chosen to give an overview of their role (Thode on family therapy, for example, or Kahm on nutrition). Increasingly cognitive-behavioral therapy has become regarded as a potentially effective tool, which is reviewed in the Wegners’ chapter. Roloff’s chapter describes a current project utilizing some of the tenets of cognitive-behavioral therapy. A treatment dynamic, managed care, will be discussed in these and other chapters, as well as in the Ortmeyer chapter, describing a more lengthy treatment required to address the psychodynamic and developmental issues involved. The fact of managed care will be discussed in a separate chapter by Ortmeyer, describing both its enabling factors and its restrictive qualities related to treatment. Some authors discuss the therapist’s own reflections and countertransferral experience as they relate to personal angst and perplexities in the past, and often in the present, aroused and recalled through the work. Cases are described in different stages and levels of progress. The clinical beauty of a collaborative team is in the initial determination, the ongoing evaluation as to the appropriate treatment modality, the “fit” of therapist and patient, and the effectiveness of the whole.

Our implicit theme is recovery, for all therapeutic endeavors include that goal. The term, however, may mean simply that the symptoms are alleviated or that the person has developed other modes of living that are more productive, satisfying, and interrelated with others. In-between variations on being “better” also exist, depending on one’s individual makeup and position in life. Whether
partial, complete, or relative, recovery does occur; *something* brings it about. Our authors contribute their views on some of the factors that facilitate recovery. By no means has there been an attempt to cover all possible aspects, given the intangible complexities of human interaction. The therapist’s clinical observations, the patient’s assessment, and other people’s responses combine in the consideration of recovery.

Despite several follow-up studies revealing much significant material, hard data about what actually ensures recovery remain elusive. It has recently been said that “almost nothing is known about what facilitates recovery on an experiential level” (Hsu et al. 1992). In this same article it was reported that in a follow-up study twenty years later, six recovered anorexic patients considered the following as being important factors in recovery: *personality strength, self-confidence, being ready, and being understood*. And in reviewing research, Johnson and Connors (1987) observed, “This issue of patient character structure and the resulting ability and/or motivation to comply with anxiety-provoking demands of a particular treatment program is probably a very important variable, and one that remains relatively unexplored.” Since then, research has continued to seek out those factors that bring about improvement.

The contributors to this book have had extensive dialogue with recovered people. In our afterword, the reader will find patient reports compiled in a study by the Wilkins Center in 1987 and a summary of other research currently in progress at the time of this writing. Recovered patients often join us to participate actively in support groups, hot lines, and community presentations. Some have entered the medical or psychological professions themselves, thus utilizing what they have integrated into their own everyday lives.

We have therefore considered what “works” from the viewpoint of the clinician and of former patients who have talked of their experience in illness and in treatment. These papers, in discussing the workaday world of the practitioner, continue an essential dialogue. The very real burden of “how to” is a constant source of reflection for the practitioner whose expertise is continually challenged by life’s infinite variation.

Barbara P. Kinoy
References


