

Quod Me Nutri Me Destruit

That Which Nourishes Me Also Destroys Me

How Common Misconceptions about Eating Disorders are
Negatively Affecting the Diagnosis, Treatment, and Perceived
Epidemiology of the World's Most Deadly Psychiatric Disease

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INTRODUCTION

Eating disorders are a well known societal ailment, yet many misconceptions remain with respect to its psychological and social origins. Misconceptions about eating disorders stem from the focus on obvious physical symptoms of eating disorders, such as dramatic changes in weight, food consumption, and menstruation. This focus has influenced the development of diagnostic criteria, treatment methods and options, and ultimately, recovery of such disorders, particularly Anorexia Nervosa, by neglecting less-easily observable yet critical causes and behaviors. Consequences of overlooking these complexities may range from misdiagnosis to preventable death. In short, the recovery and survival rate of those with Anorexia Nervosa may decline as a direct result of treating only some of the associated symptoms and causes.

This paper will explore how eating disorders are defined and diagnosed, and how a shift in the focus of eating disorder research from merely the over- or under-consumption of food to the initial core issues and their causes, could allow for a better understanding of the eating disorder etiology.

DIAGNOSTIC CRITERIA

According to the DSM-IV-TR, eating disorders are "...characterized by severe disturbances in eating behavior." These disorders include the two very specific diagnoses Anorexia Nervosa and Bulimia Nervosa, and a third category labeled Eating Disorder Not Otherwise Specified (EDNOS) in which similar disorders are coded that do not fully meet the diagnostic criteria of either Anorexia or Bulimia Nervosa (APA, 2000).

The current diagnostic criteria for 307.1 Anorexia

Nervosa as they appear in the DSM-IV-TR are as follows:

- A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth leading to body weight less than 85% of that expected).**
- B. Intense fear of gaining weight or becoming fat, even though underweight.**
- C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.**
- D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)"**

Following diagnosis using these criteria, the disease is further dichotomized by the appearance of specific behaviors associated with the two subtypes of Anorexia Nervosa: Restricting Type and Binge-Eating/Purging Type. An individual with Anorexia Nervosa Restricting Type has "...during the current episode of Anorexia Nervosa...not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)" and is thus primarily characterized by the restriction of caloric intake. An individual with Anorexia Nervosa Binge-Eating/Purging Type has "...during the current episode of Anorexia Nervosa...regularly engaged in binge-

eating or purging behavior,” but still meets diagnostic criteria for Anorexia Nervosa before it is categorized by type. Some individuals within this subtype do not binge, but habitually purge following the consumption of small amounts of food. Sufficient information is not yet available to specify a minimum frequency of binge-eating/purging (APA, 2000).

The current diagnostic criteria for 307.51 Bulimia Nervosa as they appear in the DSM-IV-TR are:

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

- 1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
- 2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average at least twice a week for three months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.”

In addition to the above criteria, like Anorexia Nervosa, Bulimia Nervosa is further categorized, with respect to behaviors intended to “compensate” for eating, into two subtypes: Purging Type and Nonpurging Type. An individual with Bulimia Nervosa Purging Type, during an episode, “...regularly [engages] in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.” An individual with Bulimia Nervosa Nonpurging Type, during an episode, uses “... inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas (APA, 2000).”

The category of EDNOS in the DSM-IV-TR currently lists six examples of what would be considered an eating disorder other than Anorexia Nervosa and

Bulimia Nervosa:

1. For females, all of the criteria for Anorexia Nervosa are met except that the individual has regular menses.
2. All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual’s current weight is in the normal range.
3. All of the criteria for bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months.
4. The regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies).
5. Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
6. Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa...”

Suggested research criteria are listed in the DSM-IV-TR for possible classification of Binge-Eating disorder as a Specified Diagnosis.

An almost immediate question arises upon consideration of the previous diagnostic criteria: What if someone has obvious disordered eating behaviors but doesn’t meet the criteria for having an eating disorder? Although this is primarily addressed by the category of EDNOS, there is still plenty of variation among eating behaviors considered to be disordered (e.g., an individual who engages in binge/purge episodes three times a day for a month and a half rather than the pre-set criteria of twice a week for three months to qualify for Bulimia Nervosa, an individual who eats regularly but deliberately engages in frighteningly frequent methamphetamine use and sex as a means of “burning calories,” or an individual who deliberately binges on foods that have the notorious reputation for burning more calories through the process of digestion than the caloric value of the food itself). Experts believe that the DSM-V, expected to be released in 2012, will include some of the collections of behaviors in EDNOS as separate disorders (Martin, 2007), but for now, several individuals are being turned away from the opportunity of receiving insurance-covered expensive treatment for a disease that was ignored simply because the numbers

didn't add up. The disregard of the early or less-visible signs of eating disorders can be comparable to a physician turning away a patient who is HIV positive, and saying to him, 'Come back when you have full-blown AIDS.'

The assumption of having recovered simply because the observable symptoms go away is potentially problematic. The consumption of food, weight gain, and returned menstruation do not reflect the state of mind of an individual with Anorexia Nervosa. This "miraculous recovery" may only be another symptom of the disorder: the willingness to gain weight to get out of treatment in order to continue disordered behavior. This concept is poetically illustrated in Geneen Roth's *When Food Is Love* (1991), which describes disorders such as Binge-Eating Disorder as a compulsion in which food is used as a substitute for intimacy when it appears to be lacking or unattainable. Roth writes, "The hardest part about compulsion is that when the behavior ends, the emptiness does not (Roth, 1991)."

These consequences appear, in part, to result from the rigid adherence to not only the observable symptoms, but also the measurable symptoms, despite a cautionary statement within the first few pages of the DSM-IV-TR indicating that the application of such criteria may not always result in the proper diagnosis (APA, 2000). More and more individuals who observe, treat, or experience eating disorders on a regular basis, are beginning to notice that the miscellaneous category of EDNOS, in attempt to measure the potentially immeasurable, is showing the "art" as opposed to the "science" of eating disorders (Martin, 2007).

BACKGROUND

The prevalence of eating disorders as of 2000 presented in the DSM-IV-TR is a lifetime figure of 0.5% for Anorexia Nervosa and disorders classified as EDNOS, and 1%-3% for Bulimia Nervosa among females. For all three categories of eating disorders, the DSM-IV-TR reveals an estimate of the prevalence among males to be one-tenth that of the prevalence in females. According to recent statistics derived from a ten-year study conducted by the National Association of Anorexia Nervosa and Associated Eating Disorders (ANAD, 1995-2005), "Eating disorders have reached epidemic levels in America" with the current reported prevalence of seven million women and one million men (ANAD, 2009). Nevertheless, added prevalence of eating disorders not reported possibly because of

the nature of secrecy associated with the shame of and desire to prolong eating disorders, ANAD estimates that 12 million Americans have suffered from an eating disorder at some point in their lives (ANAD, 2009). The DSM-IV-TR indicates that over recent decades, eating disorder incidence has apparently increased. The more recent statistics presented by organizations such as ANAD indicate that incidence is continuing to rise at an alarming rate, making Anorexia Nervosa the third most common chronic illness in female adolescents, and the mental illness with the highest mortality rate; an estimated six percent of serious cases die. The duration of an eating disorder can run from one to fifteen years and only 50% of those diagnosed report being cured (ANAD, 2009).

The assumptions surrounding these statistics, even the most surprising of them, are manifested in the way eating disorders are viewed as issues of public health. Possibly the most common of these assumptions is relevant in the gender bias with regard to the stigma assigned to individuals who are diagnosed with eating disorders. The extreme gap between males and females suffering from eating disorders may be, according to clinicians, a direct result of many males with eating disorders simply not reporting them for fear of having a predominantly 'feminine' disease (The Center, Inc, 2008). This is unfortunate considering the emphasis of masculine identity placed in the involvement of males in organized sports. The nation-wide involvement of males of all ages in sports and other activities, in which success is directly measured by physical ability, fitness, and animalistic competitiveness, suggests that the prevalence of eating disorders in males is underreported.

Another common misconception from the above statistics is the age of those commonly susceptible to developing eating disorders. The DSM-IV-TR indicates that the most common age of onset for Anorexia Nervosa is typically mid-to-late adolescence (ages 14-18) and that females over age 40 are rarely even plagued by the disease. The age of onset for Bulimia Nervosa is estimated at late adolescence or early adulthood. The mention of males in the consideration of age of onset is absent (APA, 2000). Recent research reveals that 86% of individuals diagnosed with an eating disorder reported onset of their disease before age 20, and 10% report onset at or before age 10 (ANAD, 2005). To further illustrate the deviation from an accepted age range as an accurate statistic for the development of eating disorders, the information revealed following the public outcry at a

2008 documentary featuring a girl named Dana who was dubbed “The Eight Year-Old Anorexic,” showed that this title was incorrectly assigned; it should have been “AN Eight Year-Old Anorexic.” Dr. Dee Dawson, clinician and founder of Rhodes Farm Clinic, a London treatment center for teenage girls with eating disorders where Dana was sent for a 12-week treatment program, revealed to reporters that in recent years, the average age of girls she treats has decreased as a result of the increase of eight, nine, and ten year-olds admitted to Rhodes Farm (Hanks, 2008).

To yet further the severity of misconception within the gathering and interpretation of both gender- and age-specific statistics of eating disorders, the devoted calorie restricting moderator of the “world’s largest pro-anorexia website,” <http://community.livejournal.com/proanorexia> with more than 40,000 members, over three million posts, an application process, and a waiting period to join, is a 58 year-old man (LiveJournal, Inc., 2009 & mamaVision, 2009).

ETIOLOGY

Although research has confirmed that United States culture, with all of its perks of capitalism, materialism, and perfectionism, does, indeed have a significant influence over the development of eating disorders (Martin, 2007), another gross misinterpretation and widely-accepted assumption is derived from such research: that eating disorders are experienced in predominantly white and industrialized nations. There is some evidence, however, directly revealing the development of eating disorders in an underdeveloped nation upon exposure to western globalization via the media. A study conducted of society within the Fijian Islands (Becker, et al., 2002) revealed that this robust body size valuing culture, upon the introduction of television to the town of Nadroga in 1995, was significantly affected by the messages of westernization and industrialization. The message most prominent in this case was to lose weight and this message was taken seriously considering that the percentage of Fijian females who reported self-induced vomiting as a means of losing weight was 0% in 1995, and grew to 11.3% by 1998 (Costin, 2007). In spite of this example, although it is revealing the underlying message that eating disorders may be considered exclusively industrialized, recent research has shown that more than forty countries worldwide have reported eating disorders, and some of these countries hardly

resemble the body-image obsessed United States (e.g., India, Nigeria, Mexico, and South Africa). These reports led to the shocking conclusion that the global prevalence of eating disorders has grown to 70 million (Martin, 2007); a far cry from a common assumption of the prevalence of eating disorders being a couple hundred thousand American cheerleaders.

Attempting to pinpoint a single influential risk factor as responsible for the development of an eating disorder is comparable to blaming one cow for the smell of the entire barn. No matter how much research has correlated the offensiveness of this one cow and the smell of the barn, removing her from the barn will not make much of a difference (if any) on the intensity of the smell, regardless of how “likely” she “appears” to be “contributing” to the “majority” of its foulness. This example of the whole being greater than the sum of its parts is analogous to the numerous identified causal influences of eating disorders: the removal of one cause is not likely to result in a cure.

Unfortunately, many of the current identified risk factors (e.g., intense fear of becoming overweight and involvement in activities requiring strict diet and adherence to exercise routines, trainings, and regular physical performance evaluations), though clearly relevant to the development of eating disorders like Anorexia Nervosa, seem to stem from the extreme physical symptoms that qualify an individual for diagnosis; the symptoms of the disease include dramatic weight loss so the individual’s heavily-monitored treatment is centered on cognitive behavioral therapy emphasizing healthy eating habits and a balance of moderate exercise to restore weight, muscle mass, and overall health, in conjunction with repetitive group sessions on why he or she thinks that the world only values skinny people, in spite of the messages sent by the media. The emphasis of the previous hypothetical is on what can be observed, measured, and numerically defined (in other words, quantified): weight, exercise, muscle mass, the world’s value of weight, and frequent presentation of this value. The ability of experts to observe and quantify the physical symptoms of eating disorders to a diagnosable severity (i.e., utilizing the calculation of BMI to determine how much an individual has deviated from the medically defined “ideal” weight relative to height, and the number of times per week an individual engages in a binge-eating episode followed by compensatory behavior) may have potentially created a numerical standard to which risk factors must also be adhered. For example, the absence of observable,

definite, and quantifiable measurement of a potential risk factor (e.g., how a twelve year-old girl feels about her worth and purpose, and assumed lack thereof, as a valuable member of her family) should not negate the possibility that it played a part in the development of an individual's eating disorder.

A factor that further complicates the public opinion on potential causes of eating disorders is the commonality that when a potential cause is identified, those associated with the presumed cause engage in an endless cycle of denial and finger-pointing. For example, many people assign the majority (if not all) of the blame for the development of eating disorders to the media, particularly the ideals projected by the modeling industry. This accusation put immense pressure on the Council of Fashion Designers of America (CFDA) to address the obvious physical frailty of high-fashion models, particularly in Fall 2006 fashion shows when, not only did the publicized images of the runway models resemble those of starving Ugandan children in a National Geographic shock the public, but also did the deaths of two Brazilian runway models, Carla Sobrado Casalle (age 22) and Ana Carolina Reston (age 21), who both died of organ failure as a result of Anorexia Nervosa only two days apart. These events influenced the modeling industry of Spain to set BMI requirements for its models, but not much more than a few recommendations that models believing they may have eating disorders "seek treatment," was done by the rest of the international industry (mamaVision, 2006). Ultimately, however, when a prominent presence within the industry, for this example international Victoria's Secret supermodel Gisele Bundchen, posed as a spokesperson for anorexia, she exerted with conviction that, "Parents are responsible [for anorexia], not the fashion industry." Immediately, the outraged National Eating Disorders Association responded with the clear message that families are not responsible for the development of any eating disorder. This message was echoed and elaborated by the National Institute of Mental Health when its director, Dr. Thomas R. Insel, M.D., announced that "While symptoms are behavioral, [Anorexia Nervosa] has a biological core, with genetic components, changes in brain activity, and neural pathways currently under study (mamaVision, 2007)."

Although there is growing evidence supporting the existence of specific genetic components being primarily responsible for eating disorders, the DSM-IV-TR lists only a few examples of research indicating a familial pattern, particularly that which has revealed

an increased risk of eating disorders among first-degree biological relatives and monozygotic twins of individuals with eating disorders (APA, 2000). It cannot be overlooked, however, that this increased risk could be partially resulting from association, familial influence, and learned behaviors. Moreover, in her analysis of Becker, et al.'s (2000) study of the influence of television on the Fijian Island culture, Carolyn Costin, M.A., M.Ed., M.F.T., emphasizes that "Fijian girls did not develop new genes during this study. They developed a desire to fit into new jeans and engaged in behaviors to help themselves do so (Costin, 2007)."

Any psychology student will attest to repeatedly hearing the phrase "Genes load the gun; environment pulls the trigger." The 'Nature vs. Nurture' debate which has continued for decades in the field of social science has shown time and time again that both constructs are significant in the shaping of individual behavior. The case of eating disorders is no exception. While one may carry the genetic components associated with eating disorders, his or her social and physical environment are not without shared responsibility for a disorder's development.

At the heart of numerous destructive behaviors, many professionals believe is the underlying core issue. The core issue (sometimes referred to as an unresolved emotional issue) is the deeper, more encompassing, and more crucial problem experienced by the individual, and is believed to be a critical portion of what drives the behavior. Examples of core issues include the feeling that one is unlovable, the feeling that one can't do anything right, the feeling that one needs to constantly be in control, and the idea that one is of no worth without significant accomplishment (Craig, 2003-2009). Treatment for eating disorders has shown that core issues are not only apparent among patients (Craig, 2003-2009), but are also environmentally caused (Donaldson-Pressman & Pessman, 1994).

A relatively well-known example of destructive behavior resulting from environmentally-influenced core issues is the multitude of evidence from cases of Adult Children of Alcoholism (ACOA). The last two and a half decades have produced a myriad of data strongly suggesting that the regular and fairly common exposure to violence, abuse (physical, sexual, and emotional), and domestic dysfunction experienced by children with alcoholic parents has indeed played a central role in the development of these children's personalities. As these children progressed through adulthood, many have entered therapy sessions with

quite similar symptoms that were ultimately and directly linked to the messages sent to their developing brains upon experiencing violent and abusive behavior of one or more alcoholic parents. These symptoms were similar core issues, most strikingly the feeling of being unlovable. This core issue was made apparent in the seemingly inherent beliefs and affects expressed by the patients. These included particularly an unassailable low self-esteem, a stark absence of self-understanding, a constant need to please, a frequent need to be validated, and the belief that the bad things that happened to them were their fault while the good things were likely to be accidents; the same beliefs and affects expressed by individuals seeking therapy for eating disorders (Donaldson-Pressman & Pressman, 1994). It is all but common knowledge, however, that an individual does not need to have been beaten, raped, screamed at, a witness to domestic violence, or the child of an alcoholic parent to develop an eating disorder. Herein lies the diagnostic dilemma: trauma is a potential risk factor for the development of eating disorders, but it is not always as overt as physical or sexual abuse.

Stephanie Donaldson-Pressman and Robert M. Pressman made a striking observation while working with patients at the Rhode Island Psychological Center roughly two decades ago. They noticed that some patients were expressing the same core issues and related beliefs and behaviors as those classified as ACOA, but these patients were not beaten, raped, or molested, nor did they have alcoholic parents. Upon initial examination, these patients reported having relatively normal and violent-free childhoods, having entered therapy primarily because they themselves were unaware of why they possessed such personal beliefs and destructive behaviors associated with depression, eating disorders, suicidal thoughts, or simply an overall dissatisfaction of life. Nevertheless, as the sessions continued, a common and previously unacknowledged denominator began to unfold as each of these patients disclosed the details of the environments in which they were raised. This undeniable and ever-present characteristic was that of the needs of the parents taking precedence over the needs of the children. Donaldson-Pressman and Pressman dubbed this dysfunctional dynamic ‘the narcissistic family (Donaldson-Pressman & Pressman, 1994).’

Although not possessing the more blatant physical and sexual abuse seen in individuals fitting the criteria for ACOA, patients coming from narcissistic families endured abuse that was more subtle and gradual than

those qualifying as ACOA, but equally catastrophic. Within the narcissistic family, a child’s critical emotional and psychological needs of trust and safety are not met because the emotional needs of the parents become the responsibility of the child. Instead, for example, the child is taught to behave according to what won’t upset an anger-prone or substance abusing father, what will make a severely depressed mother come out of her room, or what will not hurt either parent’s feelings amidst a brewing divorce. Children are not only taught to fear and be reactive to their parents’ behavior, but they are also often made to believe that their behavior is the cause of tension and emotional upset within the family system. In a healthy and emotionally safe family environment, a less-than-acceptable grade would be met with concern, rationality, and supportive reinforcement as a realistic plan was devised to assist the child in obtaining a better grade. In a narcissistic family, the child would be explicitly made to feel like a failure, having his or her behavior directly affect the emotional instability of the parents and cause significant uproar within the family unit. The parent-child roles become reversed, and instead of meeting his own needs with help from his parents, he is meeting their needs while suffering a long and painful neglect, and slowly learning that his worth is dependent upon his ability to please others (Donaldson-Pressman & Pressman, 1994).

The belief that worth must be proven was shown to be a common core issue among patients who grew up in a narcissistic family and were receiving therapy at the Rhode Island Psychological Center with eating disorders at the tops of their lists. Donaldson-Pressman and Pressman believe that the absence of control in a narcissistic family causes the children as adults to have no faith in their own abilities to succeed and thus, need “quick fixes” in order to make themselves feel better. These quick fixes, at least among those from narcissistic homes, include what are known as “the big three,” drugs and alcohol, food, and over-spending money (Donaldson-Pressman & Pressman, 1994). Regarding the cases in which behavior involving food was the primary quick fix, Donaldson-Pressman and Pressman wrote:

A significant number of the adults we treat from narcissistic family systems are bulimic. Their more usual pattern is not binge and purge, but rather binge and diet. They need the quick fix, so they binge; then they feel guilty and ashamed, so they starve. They then feel deprived and depressed, so they eat again to feel better. Because they are externally motivated and

have little sense of their inherent worth, they look at pictures of models or women on television and feel unattractive, so they starve again. With many of these patients, this is a lifetime pattern of eating. They are usually reluctant to bring it up in therapy... We believe that they are also afraid that the therapist will make them give it up, and they do not know any other way to live.

(1994)

The findings from cases in which individuals were raised in a narcissistic family system add to the list of potential causal factors of eating disorders and reiterate that not all influences are easily detectable.

NEW DISORDERS AND FURTHER ETIOLOGY

As if things aren't already complicated enough, some individuals (from those who are fairly new to the cold hard facts of eating disorders to the physicians, psychologist, nutritionists, and psychiatrists who have treated them for decades) are coming forward with new risk factors, and ultimately, new eating disorders. Dr. Steven Bratman, M.D., in his book *Health Food Junkies* (2003) describes a condition in which disturbed patterns of eating are observed and can eventually lead to death by starvation or specific organ failure. He coined the term "Orthorexia Nervosa" and attributes this practice of strict monitoring of food intake to the increasing pressure to purify the body using only the healthiest foods available. Bratman argues that, although Orthorexia Nervosa can lead to similar results of Anorexia Nervosa (primarily death), it is not induced by the fear of being fat. Instead, it appears that Orthorexia Nervosa is created purely by the gluten-free, whole grain, organically-grown, pesticide-free, non-hormone-enhanced, juicing, new-fruit-discovering, flax seed oil-consuming, soy-emphasizing society of individuals so concerned, to the point of obsession, about what they are putting in their bodies, that they eventually become the very antithesis of what they so desire. Although academic investigation into this condition has begun, Orthorexia Nervosa is not included in the DSM-IV-TR (Bratman, 2003).

Another new term used to classify eating disorders with very specific behaviors or causes is "Social Anorexia," referring to anorexia stemming from no more than the desire to be thin and thusly "beautiful," in accordance with the emphasis on body image as it is portrayed by the media (mamaVision, 2008). Once again, this assumption is pointing the finger right back at the fashion industry, which is once again, pointing the

finger at someone else. The Los Angeles Times reports that prominent corporate individuals within the fashion industry blame even bigger media big-wigs like Rachel Zoe, the stylist responsible for the sudden boosts of celebrity careers including those of Nicole Richie and Lindsay Lohan, by turning stars' eating disorders into iconic attributions (Martin, 2007).

So, whose fault is it? Is it the fashion industry's, is it in our genes, is it a coping mechanism to combat childhood trauma, is it stereotypical peer pressure, is it the media's, or is it the result of dysfunctional family dynamics? Recent research has revealed that it seems to be all of the above, and perhaps more. In her groundbreaking work on eating disorders, *Perfect Girls, Starving Daughters* (2007), Courtney E. Martin reveals the intriguing results of over 100 interviews regarding the pressures women face when it comes to appearance, and covers a vast list of potential causes of eating disorders and the surrounding evidence supporting them. These potential causes and others already addressed, though numerous, are only broad categorizations of some of the biological and environmental components that have been shown to influence the development of eating disorders, and that each alone is not necessarily essential or sufficient in the causation of eating disorders. In combination, however, these factors can be significant predictors of self-destructive behavior. Martin provides raw evidence that eating disorders of all types can be and are caused by a variety of influential factors and that pinpointing one factor or passing the blame is a complete waste of time (Martin, 2007).

Martin also reveals an all-too-often overlooked potential cause of eating disorders that can be portrayed by those of all ages, genders, ethnicities, and variable SES; with full-blown Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder, Obesity, addictions to exercise and plastic surgery, and even disorders currently under classification; those just beginning a diet, or exposed to any of the previously mentioned risk factors. This potential cause can be at the heart of any eating disorder, however classified, and wherever it falls on the spectrum of eating behavior: It is the construct of self-hatred developed by the feeling of being unlovable (Martin, 2007). When this simple yet deadly idea is taken into account, though difficult to quantify, invisible, and not directly related to food, self-hatred can be associated with every eating disorder and every identified risk factor mentioned thus far. It can quite possibly be the one thing that the 70 million worldwide eating disorder sufferers have in common. I

strongly believe that the absence of the concept of core issues such as self-hatred, the possible initial contagion of eating disorders, may be one of the most relevant reasons as to why international statistics continually disprove our assumptions of eating disorders and why the only statistic to remain relatively constant across the decades is the rate of recovery.

The vast methodology behind the treatment of eating disorders (e.g., psychoanalysis, cognitive-behavioral therapy, psychodynamic therapy, interpersonal therapy, Dialectical Behavioral therapy, the Maudsley Method, addiction approach using the Twelve-Step Method, group and individual therapy, used in conjunction with nutrition consultation and medications such as Topamax, Prozac, Zyprexa, and SSRIs like Zoloft) have been shown to provide significant benefits for hundreds of thousands, if not millions, of individuals with diagnosed eating disorders (Costin, 2007). I believe, however, that beginning any session with asking the simple question, “Do you consider yourself loveable?” can open a door to recovery that has been sadly neglected. This begs the unavoidable question of whether Anorexia Nervosa is a disease with the symptom of self-hatred or if Anorexia Nervosa is a symptom of the greater condition of self-hatred.

A powerful example illustrating this paradox can be found in the work of Dr. Dan Baker, Ph.D. and Director of the Life Enhancement Program at Canyon Ranch, in which, instead of confronting individuals with diagnosed Anorexia Nervosa with the traditional approach to the physical symptoms and eating behaviors, he focuses purely on the individual, without ever even mentioning food. His technique, dubbed “positive psychology” and heavily addresses the client’s self-hate and obsession with being “perfect,” has shown an impressive success rate in reducing not only the observable symptoms of Anorexia Nervosa, but also the painful psychological thought process within individuals, to the point at which they are cured (Baker, 2003).

CONCLUSION

In spite of new treatments, developments, discoveries, of eating disorders, there is still no clear-cut identifying recipe of variables that undoubtedly causes their development. If only the complex and unpredictable diagnostic criteria could look more like a page in a cookbook:

Anorexia Nervosa

1 cup self-hatred
 2 lbs. media exposure
 2 authoritarian parents
 (preferably 1 overly-emotional mother & 1 emotionally unavailable father)
 1 adolescence of observation of your mother’s obsession over her weight
 1 entire bag of humiliation you have always felt for not being as pretty as everyone else
 4 heaping tablespoons of the feeling of personal responsibility for your parents’ divorce
 2 yrs on the high school volleyball team
 1 sr. year of competitive cheerleading
 1 unhealthy relationship (more can be added depending on taste)
 1 or more additional emotional disorders (i.e., depression, anxiety, OCD, etc.)
 2 silicone breasts (as a birthday present)
 1 above average IQ
 100 mg/day of your favorite appetite-suppressing substance (can be OTC, Rx, or illicit)

Cover entire mixture with the overwhelming sense of worthlessness and pressure to overachieve. Mix twice a day, seven days a week on an elliptical at the gym. Bake for ten years on high exposure to inferred disappointment and failure. Cool in front of unlimited internet access. Garnish with detoxifying superfruit. NOTE: ALL INGREDIENTS MUST BE ORGANIC, FAT-FREE, SUGAR-FREE, AND PURCHASED AT *WHOLE FOODS*.

Just as there is no clear-cut list of risk factors, there is no clear-cut treatment. The diversity of this disease is so massive that the only approach is a group of approaches that appear to most likely benefit the individual.

“The body has become the primary canvas on which girls express their identities, insecurities, ambitions, and struggles.” –Lauren Greenfield (Martin, 2007). The idea represented within this quotation and

the growing evidence presented indicates the high probability that characterizing symptoms of eating disorders are merely a fraction of the manifestations, visual or otherwise, of much deeper psychological disturbance. I believe this disturbance to be separate from other psychological disturbances prevalent in many individuals who have been diagnosed with eating disorders; which typically involve body image, fear of gaining weight, and perceived lack of control (APA, 2000). The additional disturbance to which I refer resembles an overwhelming self-hatred accompanied by feelings of unconditional worthlessness, absenteeism of lovability, and similar thought patterns. I argue that this psychological disturbance, whatever the causes, may be present before, in conjunction with, and after the appearance of physical and medical diagnostic features of defined eating disorders and many disordered eating behaviors, and could potentially be considered as strong and consistent a commonality among eating disorders as eating behavior itself.

Potential societal consequences resulting from further utilization of physically manifested diagnostic criteria may include a continued worldwide increase in incidence and prevalence of Anorexia Nervosa and other eating disorders, an increase in mortality from secondary diagnoses brought on by Anorexia Nervosa, the continuation of wasting time and money on ineffective treatment, and the further fostering of acceptance of disordered thinking and behavior associated with eating disorders, all manifesting as a continual and self-reinforcing downward spiral of physical and psychological public health.

I believe that the research to be performed on eating disorders must prioritize the search for early potentially causal factors of such self-hatred, the overwhelming belief that one's worth is determined only by achievement, and the insatiable drive toward a state of immortal and effortless perfection that will never be achieved. Waiting to treat an eating disorder until the observation of physical symptoms may already be too late. By the time the visible and medically quantifiable symptoms of Anorexia Nervosa currently required for diagnosis manifest themselves on the outside, the individual experiencing them is already dead on the inside.

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Author Bio

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