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Anorexia nervosa and bulimia at the secondary school level

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Abstract

The eating disorders of anorexia nervosa and bulimia have not been just recently documented; in fact, anorexia nervosa has been recognized in medical literature for centuries, as references were made by Morton (1694), Gull (1874) and Laseque (1873), and bulimia has been recognized 1 by that term for the last few decades (Peters, Butterfield, Swassing, & McKay, 1984). It has been in recent years, however, that these eating disorders have received considerable attention in literature and research. Partially responsible for this relatively new-found prominence is the large number of young adolescents who are involved.

ANOREXIA NERVOSA AND BULIMIA AT THE SECONDARY SCHOOL LEVEL

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The eating disorders of anorexia nervosa and bulimia have not been just recently documented; in fact, anorexia nervosa has been recognized in medical literature for centuries, as references were made by Morton (1694), Gull (1874) and Laseque (1873), and bulimia has been recognized by that term for the last few decades (Peters, Butterfield, Swassing, & McKay, 1984). It has been in recent years, however, that these eating disorders have received considerable attention in literature and research. Partially responsible for this relatively new-found prominence is the large number of young adolescents who are involved.

In a 1971 study of Swedish adolescent population, it was discovered that approximately 1 in 150 teenage girls was anorexic (Nylander, 1971). In a later study (1976) in England, it was estimated that 1 in 200 teenage girls had advanced cases of anorexia (Crisp, 1976). In another report it was stated that 1 out of 250 girls in the United States between the ages of 12 and 18 develop anorexia (Romeo, 1984). Furthermore, there is evidence that an even larger number may be bulimic (Neuman & Halvorson, 1983). Some theorists suggest that bulimia is an outgrowth of anorexia (Stein & Unell, 1986), while others maintain that anorexia and bulimia are two separate, distinct disorders (Neuman & Halvorson, 1983). Another factor in the increased interest in anorexia

and bulimia is their seriousness, with estimated mortality rates of anorexics being from 4% to 25%.

What constitutes a diagnosis of anorexia or bulimia needs to be clearly defined. Anorexics are often characterized by weight loss of at least 25% of their original body weight, resulting in child-like body proportions and no physical illness to account for the weight loss (Diagnostic and Statistical Manual of Mental Disorders: DSM III, 1987). Another major identifier is amenorrhea (absence of menstruation). Bulimia, a more recently documented disorder, is characterized by an uncontrollable urge to eat, consideration of oneself as a binge eater, feelings of guilt and negative self-thoughts, actual food binging and purging, and a fear of not being able to stop eating once it is begun. When three of these characteristics are present, bulimia is recognized as a distinct disorder.

The purpose of this paper is to help the secondary school counselor develop a deeper awareness of the causes and effects of anorexia nervosa and bulimia. Furthermore, it is also the purpose of this paper to provide identification strategies and intervention techniques for the secondary school counselor to use in working with these students. In this paper anorexics/bulimics will be referred to in the female gender,

as females with eating disorders outnumber males 9 to 1 (Andersen, 1981).

Causes of Eating Disorders

There are multiple opinions regarding the causes for so many young girls to engage in harmful eating behaviors. Researchers have offered diverse opinions as to possible underlying factors involved in the expression of the diseases: issues of control (Bruch, 1981), family systems disturbance (Minuchin, Rosman, & Baker, 1978) and the psychoanalytic explanations of sex drive, oral impregnation fantasies and object relations (Sours, 1980).

Not to be underplayed, however, is the fact that this age group is acutely aware of what our society defines as acceptable, as evidenced by the bombardment of messages, "thin is in." Over the last several decades in the United States there has been a shift in the ideal standard toward a thinner body for females (Garner, Garfinkel, Schwartz, & Thompson, 1980), and most female adolescents believe that slimness and attractiveness are necessary qualities for interpersonal happiness and success (Laws, 1976; Hawkins & Clement, 1980).

Closer to home, many adolescents have parents and siblings involved in the fitness craze and are being encouraged to "lose weight," "tone up," "no pain, no gain," to the point

that for many anorexics and bulimics, compulsive overexercise is overlooked, or worse yet, is the object of parental praise (Neuman & Halvorson, 1983). Ours is, after all, "the first generation of children that have been brought up by mothers in Weight Watchers" (Neuman & Halvorson, 1983, p. 27).

Another factor is that the onset of anorexia/bulimia tends to be associated with stressful life situations, combined with a lack of healthful coping skills. Peak times for anorexia and bulimia to begin are around the transition from junior high to senior high school and from senior high school to college. For many of these young girls, change is very difficult and their eating disorder is what they have used for a coping mechanism (Lynch, December 12, 1988).

One stressful life situation which often triggers an eating disorder is that of disengagement from family. Salvadore Minuchin, an American expert on family systems, indicates that there are a number of family features which encourage anorexia: enmeshment, rigidity, overprotectiveness and a lack of conflict resolution (1978). Many of the young girls from families with the above-named features have been overly obedient as children, which makes it difficult to become assertive. This lack of assertiveness often impairs decision making and autonomy. Gone are the days when a female was seen only as "the daughter of" or "the wife of." Females

now have to claim their own distinction, which, for many, is unfamiliar territory (Neuman & Halvorson, 1983). When the young woman comes from an overprotective, rigid family, this claim for her own identity is even more painful.

In a 1980 clinical study it was suggested that a lack of control over a strong appetite might be a factor in the development of bulimia, (Casper, et al., 1980), although the strong appetite is not related to hunger alone. The appetite may be for larger needs, such as identity and meaningfulness (Chernin, 1981).

Some researchers with a psychoanalytical theory base have proposed that both anorexia and bulimia are caused by sexual conflict (Romeo, 1984). For the anorexic, the conflict may be in rejecting femininity, and for the bulimic the conflict may be in overly identifying with femininity and the need to please others (Neuman & Halvorson, 1983).

As noted, there are many opinions for causes of anorexia and bulimia. What is most consistent in the literature, however, is that "the causes for anorexia and bulimia are more likely to be well-educated guesses based upon clinical observation than definitive answers" (Neuman & Halvorson, 1983, p. 35).

Effects of Eating Disorders

There are many negative consequences that go along with eating disorder behaviors. Physiological consequences for the anorexic may include a lowered heart rate and body temperature, lowered blood pressure, and lanugo (fine baby-like hair) appearance on the skin (Garfinkel & Garner, 1982). Serious physical damages can occur, such as heart damage and electrolyte imbalance, and in severe cases, the victim may die (Garfinkel & Garner, 1982).

The bulimic often faces the complications of dehydration, hypokalemia (low levels of potassium), heart arrhythmias and hypokalemic nephropathy (kidney damage due to low potassium levels) (Frey, 1984). Repeated vomiting often removes teeth enamel and may also cause esophagal damage (Neuman & Halvorson, 1983). Many binge-vomiters develop broken blood vessels under their eyes and in their necks and suffer from headaches (Cauwels, 1983). Sometimes the bulimic's/anorexic's skin becomes gray (Lynch, December 12, 1988).

Psychological effects for both the anorexic and bulimic often include impaired judgment and a distorted body image. Especially the anorexic will perceive herself as being overweight, even if she is severely emaciated (Frey, 1984). The anorexic will often be heavily engaged in denial that there is a concern; the bulimic will often realize that their

behavior is not normal, but they deny the possibility that there are others who are engaged in the same behaviors and that there is help available to them (Stein & Unell, 1986).

Identification of the Eating Disorder Victim

Unfortunately, the prognosis for anorexia and bulimia is not promising (Minuchin, 1978). What is known is that early detection and competent counseling have been found to work well with the victims (Cauwels, 1983), which emphasizes the urgency of identifying the eating disorder victim. As with most illnesses, there are varying degrees of severity of anorexia nervosa and bulimia. The amount of time that the individual engages in harmful eating behaviors may greatly contribute to the severity of her illness. Those who are identified while in the experimental stage have a better prognosis than do confirmed anorexics/bulimics (Minuchin, 1978).

There are at-risk students for eating disorders. These individuals often include gymnasts, drill team members, wrestlers, cheerleaders, track team members, and students involved in dance, drama, and performing arts (Frey, 1984). This is not to imply that students involved in the aforementioned activities are automatically victims of eating disorders, but rather to make the counselor aware that the

students involved in these activities are at higher risk according to research (Cauwels, 1983).

In attempting to identify the anorexic/bulimic, some symptoms are more readily observable than others. The anorexic is perhaps the easier to identify because the physical changes are more apparent. As these individuals lose weight, they often try to conceal the weight loss by wearing baggy, oversized clothes, but their faces frequently take on a gaunt appearance and their hair may become course and lose its shine due to protein loss (Lynch, December 12, 1988). Dry, flaky skin is also characteristic of many anorexics because of a lack of oil in the body. Lanugo may appear on the skin, especially on the arms and face, which is quite noticeable (Peters, Butterfield, Swassing, & McKay, 1984). The anorexic may frequently complain of being cold, as her body temperature is lowered, and her hands may often be icy cold (Garfinkel & Garner, 1982).

The bulimic usually maintains a normal body weight or may even be overweight (Neuman & Halvorson, 1983), which makes her more difficult to identify. There are, however, symptoms that can alert the close observer. Bulimics often make frequent requests to use the restroom, especially around lunch time. Although many of their binges are secretive, some bulimics will gorge themselves in public and discount

the quantity of food consumed with such explanations that they have a high metabolic rate, or that they haven't eaten anything all day.

Both the anorexic and the bulimic are obsessed with food and are very disciplined in their approach to it in the cafeteria (Lynch, December 12, 1988). Although an anorexic may be able to relate the caloric content of each type of food her friends consume, she will often just rearrange the food on her own tray, or she will avoid the cafeteria altogether (Lynch, December 12, 1988). The bulimic may also avoid the cafeteria so that she can fast or binge privately.

These are several physical symptoms resulting from this lack of nutrition which can aid in the identification of an eating disorder victim. The anorexic frequently reacts by fainting (Neuman & Halvorson, 1983). In addition, both the anorexic and the bulimic often sleep in class due to the lack of sleep related to their eating behaviors (Stein & Unell, 1986). Some victims of eating disorders plan their binges late at night when the others in the home are sleeping in order to insure complete privacy. Also, the anorexic may sleep due to a lack of energy resulting from poor nutritional intake. Less obvious physical symptoms result from laxative and diuretic abuse, vomiting, and amenorrhea (Neuman & Halvorson, 1983).

In addition to the physical signs that a student is anorexic/bulimic, there are also some psychological indicators. The close observer will often be able to detect mood swings, periods of depression, enormous anger and signs of low self-esteem (Cauwels, 1983). There may also be a noticeable lack of judgment and concentration in both the anorexic and bulimic (Lynch, December 12, 1988). But even the close observer often overlooks another psychological symptom--the student's perfectionistic tendencies. Her perfectionism may take the form of getting caught in the superwoman syndrome, carrying overwhelming and unrealistic expectations for herself. Along with this, she may have trouble expressing negative emotions, such as anger, as she may perceive these emotions as less-than-perfect (Minuchin, 1978). The student may display model student characteristics, such as punctuality, conscientiousness, and great academic achievement (Cauwels, 1983). Many times this student will go to great lengths to please others and has a history of being a "model child" (Neuman & Halvorson, 1983).

As the eating disorder victim's illness progresses, she may engage in behaviors which are seemingly atypical for this student. One of the common behaviors is lying. Although the anorexic/bulimic may have lived, in fact, through years of lying to herself about family problems, outwardly she

often has a history of appearing very upstanding; consequently, the victim's lying will stand out more markedly (Cauwels, 1983). Frequently the anorexic/bulimic will lie about food and will create fantasy stories about what happened to an entire chocolate cake, etc. (Cauwels, 1983).

Another seemingly atypical behavior is stealing. The student may steal food or the money with which to buy food (Cauwels, 1983). Although most bulimics tend to be highly principled, stealing for the purpose of buying food is common (Neuman & Halvorson, 1983). This stealing may occur during the school day, such as in a locker room while others are in the gym, or in the student's home from siblings or parents.

It will be important for the counselor to recognize that any of these symptoms, such as weight loss, mood swings, perfectionistic tendencies, needs to be considered in the total picture of the student. When the counselor is aware that at least three of these symptoms are in a student, an eating disorder is definitely a possibility (Lynch, December 12, 1988).

Role of the Counselor

Unfortunately, many students display several symptoms of having an eating disorder, yet go undetected due to the lack of awareness by parents, peers and educational staff.

The counselor's role in working to combat anorexia nervosa and bulimia is multifaceted (Cauwels, 1983).

One major area of intervention is for the counselor to facilitate in the education of students, parents, and educational staff. In order to educate parents, for example, pamphlets or a letter outlining the disorders and symptoms can be disseminated. In the high school a program can be coordinated with the health/physical education instructors to incorporate a unit dealing with eating disorders (Frey, 1984). Other subject areas for the counselor to consider working with are social studies and language arts. These teachers could encourage their students to consider the "persuasiveness of the media in promoting the value of thinness in our society while they are studying the psychological and cultural aspects of advertising in general" (Neuman & Halvorson, 1983, p. 168).

Additionally, as a staff educator, the counselor can arrange for a faculty in-service meeting at which a professional eating disorder consultant could give an in-depth presentation on anorexia and bulimia (Neuman & Halvorson, 1983). Due to the complexities of the illnesses, two separate in-service meetings may be necessary.

When coordinating the above-mentioned activities, the counselor will need to clearly define how a referral can be

made (Frey, 1984). An important message that must be included in this information is that if a parent, peer, or staff member observes these symptoms in a student, a referral should be made to the guidance office (Lynch, December 12, 1988). The need to make a referral may sound risky to the peer who is concerned with losing a friendship or the parent who is apprehensive about misreading a symptom. This apprehension needs to be acknowledged in an empathic manner, but at the same time the counselor needs to remind the parent or other person that an eating disorder is potentially deadly and that early intervention is often the greatest contributor to a successful prognosis (Cauwels, 1983).

In addition to information sharing and education of staff and parents, the counselor has other important roles when dealing with cases of anorexia or bulimia. It is the responsibility of the counselor to develop appropriate referral sources who understand the dynamics of eating disorders (Lynch, December 12, 1988). Having this referral base will make the initial intervention a smoother process. During the initial stage of intervention, the counselor will be the primary source in the collaboration of teachers, family members, and friends of the eating disorder victim (Neuman & Halvorson, 1983).

Additionally, a third role that the counselor may wish to consider is to have weekly or biweekly informal sessions to counsel the student, as well as to maintain a close contact and continue to make observations. The counselor will be involved in a delicate relationship at this time (Frey, 1984). Often the client will be resistant, frightened, and angry. Although the eating disorder student may be secretly relieved about "being found out," they will usually deny that there is a problem (Cauwels, 1983). The counselor needs to proceed cautiously during this denial stage, as she/he may not only be meeting with student denial--the parents might also be denying the existence of a serious problem (Neuman & Halvorson, 1983). To facilitate a more successful intervention, the counselor should be prepared for this meeting. Not only should factual information about eating disorders be shared with the parents and child, but also specific observed behaviors in the student.

Because of the risk of death for students having eating disorders, it is not recommended that the counselor treat these students without the assistance of a qualified clinician (Frey, 1984). Even the most informed, competent counselor should utilize outside referral sources for these students. In situations in which the student has received in-hospital treatment for her eating disorder, the counselor can play a

major role in her re-entry to the school setting. The recovering anorexic/bulimic may need a great deal of sensitivity and support from the school staff; in order for this to occur, the staff will need to be educated on some pertinent issues. The recovering student should be treated as normally as possible, but with heightened sensitivity (Neuman & Halvorson, 1983). For example, supportive comments should be directed to how the student is feeling and behaving, rather than any change in appearance (Peters, Butterfield, Swassing, & McKay, 1984). The student may be acutely aware that her appearance is changing, but may not think that the change is positive.

Another important issue which the counselor needs to address with the staff is food. During in-hospital treatment the student will have been educated on her nutritional needs and will not want to be constantly reminded by staff or peers (Lynch, December 12, 1988). The issue of food should be avoided by the staff in their interaction with the student.

Besides educating the staff prior to the student's re-entry after hospitalization, the counselor could make him/herself readily available to the recovering student. Especially at the beginning of reintegration, the counselor could act as a sounding board for feelings that the student may need to express (Frey, 1984). Although it is true that

many of these eating disorder victims will choose to continue not expressing their feelings, the opportunity could at least be made available to them.

Another of the many roles of the counselor is to facilitate or co-facilitate an on-site support group (Lenihan & Sanders, 1984). In doing so, the counselor will need to determine the logistics of the group, such as meeting site, time, duration, membership selection, agenda content, amount of facilitator interaction, open or closed status, etc. Because eating disorders have a social etiology, group therapy is often an effective treatment modality (Baskind-Lodahl & Sirlin, 1977; Garner, Garfinkel, Schwartz, & Thompson, 1980). This will allow social interaction to be in the form of support, as well as confrontation of feelings and behaviors.

In support groups in which there are two facilitators, it is advantageous to have a male and female who can represent the victim's own familial situation to some extent, while at the same time removing them from their own situation (Frey, 1984). The male and female counselors are also able to model healthy social interaction. It is important that the counselors have non-neurotic attitudes and practices with regard to food, eating patterns, exercise and body image, as the anorexic/bulimic will be quick to observe any counselor discomfort or unusual food practices (Lynch, December 12,

1988). It is equally important that the counselors have calm, nonjudgmental, flexible approaches (Stein & Unell, 1986).

Since modeling has been found to be effective in encouraging the acquisition of new behaviors (Bandura, 1977), the counselor could use this opportunity as a support group facilitator to be a role model and to show the acceptability of feeling and expressing many emotions (Lenihan & Sanders, 1984). The group members themselves can explore and confront various beliefs and behaviors, while at the same time offering support of one who is experiencing the same struggle (Lenihan & Sanders, 1984). Throughout the lifetime of the group (usually 12 to 14 weeks), it is desirable to evolve through the various stages, such as trust establishment, sharing of concerns, confrontations, and finally, a personal plan for change. As the group progresses, the student should be able to experience and appreciate the building phases of a relationship, that is: the entering, building, maintaining, and ending. The counselor can help students realize that these learned skills can be used outside the group setting in forming and maintaining other interpersonal relationships (Lenihan & Sanders, 1984).

There are typical issues that will arise in a support group and an emphasis needs to be at least placed on attending to the interaction of the behavioral, cognitive, and affective

domains (LeClair & Berkowitz, 1983). Within the cognitive domain, issues of body image, nutrition, and people-pleasing, perfectionistic tendencies can be addressed with strategies of nutritional information, weight-height ranges, fad diet analysis (Lenihan & Sanders, 1984), and cognitive behavior therapy.

Affective issues to be uncovered include attitudes toward sexuality, family interaction and disengagement, becoming an adult, guilt patterns and feelings of control/helplessness (Lenihan & Sanders, 1984). Useful strategies for this domain are group discussions on fears of sexuality, feminist perspectives on role behavior (Jongeward & Scott, 1976; Phillips, 1980), group analysis of family dysfunction and family myths (Palazzoli, 1977), independent counseling sessions with families of individual members of the group (Halpern, 1976), rational-emotive strategies, and converting "learned helplessness" to relaxed free choice (Lenihan & Sanders, 1984).

Finally, in working as a support group facilitator, the counselor needs a great deal of patience. Often a student will need the opportunity of consecutive support groups, as it is rare that full recovery can be accomplished during the lifetime of one group (Neuman & Halvorson, 1983).

In working with students having eating disorders, the counselor could accept multiple roles. He/she could be a

facilitator in the education of faculty/staff, students and parents. Also, as noted, the counselor could play a vital role in developing referral sources, as well as providing personal counseling for the victim and facilitating an on-site support group.

Conclusion

The eating disorders of anorexia and bulimia are a source of serious concern at the secondary school level. There are a number of opinions of causes for these disorders, as well as a number of detrimental consequences. Anorexia and bulimia are not short term illnesses and the prognosis for the victims is not promising. However, with the prognosis being more positive in cases of early identification, intervention, and competent counseling, the case for secondary school counselor involvement becomes increasingly imperative. The secondary school counselor who is aided by a strong informational background, sound referral base, and a personal commitment can be in a position to help the eating disorder victim fight for life.

References

Andersen, A. (1981). Psychiatric aspects of bulimia. Directions in Psychiatry, 14, 1-7.

Bandura, A. (1977). Social learning theory. Englewood Cliffs, New Jersey: Prentice-Hall.

Baskind-Lodahl, M., & Sirlin, J. The gorging-purging syndrome. Psychology Today, 11, 50-52; 82-85.

Bruch, H. (1973). Eating disorders. New York: Basic Books.

Bruch, H. (1981). Developmental considerations of anorexia nervosa. Canadian Journal of Psychiatry, 26.

Casper, R. C., Eckert, E. D., Halmi, K. A., Goldberg, S. C., & Davis, J. M. (1980). Bulimia: Its incidence and clinical importance in patients with anorexia nervosa. Archives of General Psychiatry, 37, 1030-1035.

Cauwels, J. M. (1983). Bulimia--The binge-purge compulsion. New York: Doubleday and Company.

Chernin, K. (1981). The obsession: Reflection on the tyranny of slenderness. New York: Harper and Row.

Crisp, A. H., et al. (1976). How common is anorexia nervosa? A prevalence study. British Journal of Psychiatry, 128, 127.

Diagnostic and Statistical Manual of Mental Disorders: DSM-III-R. 3rd ed., revised. (1987). Washington, D. C. American Psychiatric Association.

Frey, D. (1984). The counselor's role in the treatment of anorexia nervosa and bulimia. Journal of Counseling and Development, 63, 248-249.

Garfinkel, P., & Garner, D. (1982). Anorexia nervosa: A multidimensional perspective. New York: Brunner/Mazel.

Garner, D. M., Garfinkel, P. E., Schwartz, D., & Thompson, M. (1980). Cultural expectations of thinness in women. Psychological Reports, 47, 483-491.

Halpern, H. N. (1976). Cutting loose. New York: Simon & Schuster.

Hawkins, R. C., & Clement, P. F. (1980). Development and construct validation of a self-report measure of binge eating tendencies. Addictive Behaviors, 5, 219-226.

Jongeward, D., & Scott, D. (1976). Women as winners. Reading, MA: Addison-Wesley.

Laws, J. L. (1976). Women as objects, second x. New York: Elsevier Science.

LeClair, N. J., & Berkowitz, B. (1983). Counseling concerns for the individual with bulimia. Personnel and Guidance Journal, Feb., 352-355.

Lenihan, G. O., & Sanders, C. D. (1984). Guidelines for group therapy with eating disorder victims. Journal of Counseling and Development, 63, 252-254.

Minuchin, S., Baker, L., Rosman, B., Liebman, R., Milman, L., & Todd, T. (1975). A conceptual model of psychosomatic illness in children. Archives in General Psychiatry, 32, 1031-1038.

Minuchin, S., Rosman, B. L., & Baker, L. (1978). Psychosomatic Families: Anorexia Nervosa in Context. Cambridge, MA: Harvard University Press.

Neuman, P. A., & Halvorson, P. A. (1983). Anorexic Nervosa and Bulimia: A handbook for counselors and therapists. Van Nostrand Reinhold Company.

Nylander, I. (1971). The feeling of being fat and dieting in a school girl population: An epidemiologic interview investigation. Acta Sociomedica Scandinavica, 3, 17.

Palazzoli, M. S. (1977). Self-starvation: From the intraphysic to the transpersonal approach to anorexia nervosa. New York: Jason Aronson.

Palmer, R. L. (1984). Anorexia nervosa: A guide for sufferers and their families. New York: Penguin Books.

Peters, C., Butterfield, P., Swassing, C. S., & McKay, G. (1984). Assessment and treatment of anorexia nervosa and bulimia in school age children. School Psychology Review, 13, 183-190.

Phillips, D. (1980). Sexual confidence. Boston Houghton Mifflin.

Romeo, F. F. (1984). Adolescence, sexual conflict and anorexia nervosa. Adolescence, 19, 551-555.

Sours, J. A. (1980). Starving to death in a sea of objects. New York: Jason Aronson.

Stein, P. M., & Unell, B. C., (1986). Anorexia nervosa: Finding the life line. Minneapolis, MN: Comp Care Publications.