Appallingly, a girl named Sarah Jacob died in 1967 following fasting supervised by a team of nurses who would allow her neither food nor water. The autopsy revealed that she died of dehydration and renal failure – not anorexia.

It appears that the medico-clinical approach, which deals with the clinical manifestation of anorexia, remains fairly static historically. However there is a second approach which is considered to be dynamic, being the socio-cultural approach to causation. During the last century, westernized society began to invest great value in thinness. Up until the early 1920's, physical amplitude was a sign of beauty – consider Renoir's famous portraits of nudes.

Throughout the 1920s, curvaceous figures became less and less popular, with *Vogue* and *Ladies Home Journal* magazines expressing rejection of amplitude. Although no statistics exist to show the prevalence of anorexia during this time, there was a reported fall in body weight among students, and increased reference to self-starvation.

During the 1930's and 1940's, fashion dictated that curvier bodies were acceptable, but from 1950 to 1981, the emphasis returned to thinness and documented increases in anorexia corresponded with this time.

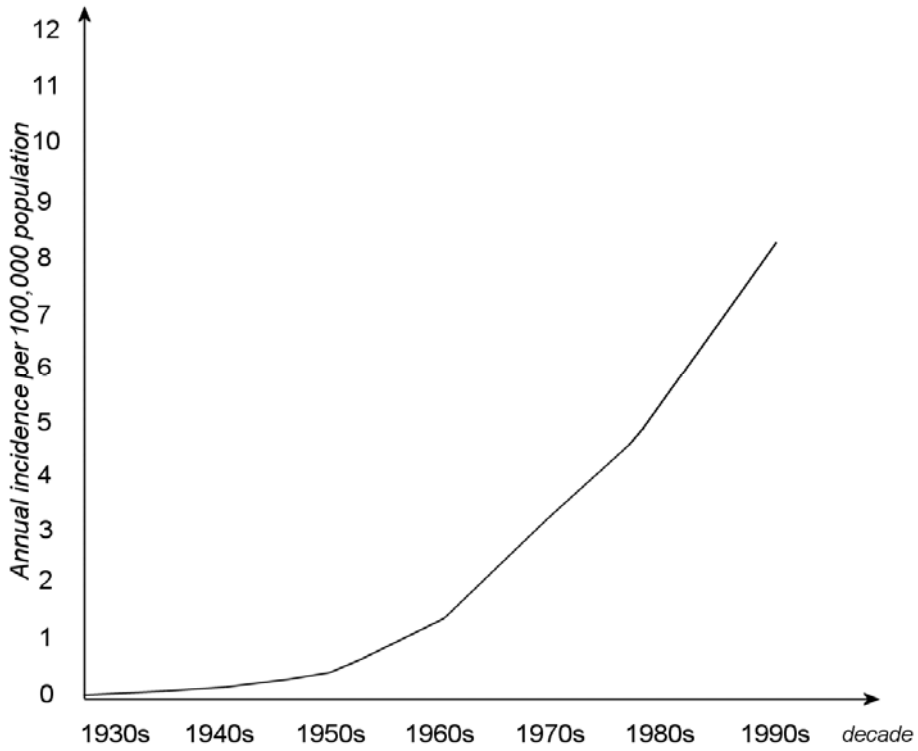
Although it is a great mistake to assume that a girl suffering from anorexia is vainly attempting to look like a model, certainly the image of the painfully-thin model gives the appearance of acceptability and therefore provides an image to follow.

Social pressures are constantly being brought to bear on young women – pressures to diet, to calorie-count, to buy small-size fashion items of clothing, to be athletic, to be sexually attractive.

TUTOR TALK: In summary, the psychological expression of anorexia is liable to change over time, with the current, modern, emphasis being on thinness. If, in the future, fat becomes fashionable, anorexia will still exist, but with a different emphasis as yet unpredictable.

There have been many studies on the incidence of anorexia over the last few decades. All of these studies have been undertaken in Western civilisation – in Eastern culture it is much rarer which implies that the Western culture is to blame, with its higher rate of dysfunctional families and greater pressure for conformity being two important factors.

The results of the studies have been represented on a graph which clearly shows the rising incidence of anorexia. The investigators attribute this to changes in culturally determined attitudes or behaviour patterns over time.



Bulimia nervosa was not in fact described and named as a variation of anorexia until 1979, and, possibly due to the fact that many bulimics had been diagnosed as anorexics prior to 1979, the incidence of bulimia increased rapidly so that by the end of the 1980's, bulimia was more prevalent than anorexia.

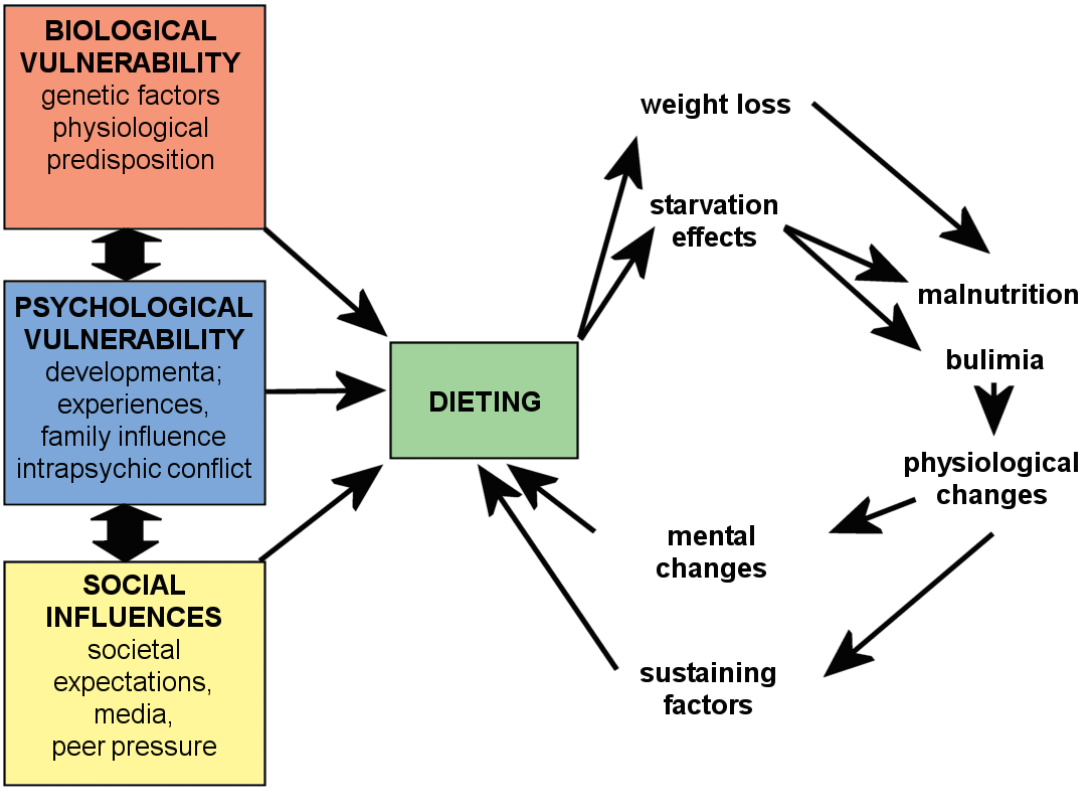
In 1970, Gerald Russell proposed 3 criteria for diagnosing anorexia nervosa:

- behaviour that is designed to produce marked weight loss
- a morbid fear of becoming fat, which is the characteristic psychological disturbance
- evidence of an endocrine disorder which in the post-pubertal girl causes the cessation of menstruation

Subsequently in 1979 he proposed the following criteria for bulimia nervosa:

- a powerful and intractable urge to overeat, resulting in episodes of overeating
- avoidance of "fattening" effects of food by inducing vomiting or abusing purgatives or both
- a morbid fear of becoming fat

TUTOR TALK: Before moving on to the most recent criteria for anorexia and bulimia, the student should examine the following diagram – a multi-dimensional model for both disorders.



The close link between the two variations of disorder can be seen, the main variable being the areas of malnutrition and bulimia. Statistics show that the majority of bulimics progressed from being anorexic, and they may swing between the two.

DIAGNOSTIC AND STATISTIC MANUAL

An American manual, the DSM is a diagnostic classification handbook. As the DSM is updated, (at the time of writing DSM-IV) so some helpful advances are made as far as diagnostic sub-classifications are concerned.

Anorexia nervosa patients have been divided into:

- predominantly food restrictors
- binge/purgers at anorexic weights

Bulimia is now separated from **binge eating disorder.**

DSM-IV states the following definitions:

ANOREXIA NERVOSA

1. 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).

2. Intense fear of gaining weight or becoming fat, even though underweight.

3. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or denial of the seriousness of current low body weight.

4. In post-menarchal females, amenorrhoea, i.e. the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhoea if her periods occur only following hormone, e.g. oestrogen, administration.)

Specify type

Restricting type: During the episode of anorexia nervosa, the person does not regularly engage in binge eating or purging behaviour (i.e. self-induced vomiting or the misuse of laxatives or diuretics).

Binge eating/purging type: During the episode of anorexia nervosa, the person regularly engages in binge eating or purging behaviour (i.e. self-induced vomiting or the misuse of laxatives or diuretics).

BULIMIA NERVOSA

1. Recurrent episodes of binge-eating. An episode of binge-eating is characterized by both (1) eating, in a discrete period of time (e.g. in any two hour period), an amount of food that is definitely larger than most people would eat in a similar period of time (taking into account time since last meal and social context in which eating occurred); and (2) a sense of lack of control over eating during the episodes (e.g. a feeling that one can't stop eating or control what or how much one is eating).

2. Recurrent use of inappropriate compensatory behaviour to avoid weight gain; e.g. self-induced vomiting.

3. A minimum average of two episodes of binge-eating and two inappropriate compensatory behaviours a week for at least three months.

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

5. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Specify type

Purging type: These individuals regularly purge after binge-eating via self-induced vomiting or the abuse of laxatives.

Non-purging types: These individuals do not engage in self-induced vomiting or laxative abuse. Some may use compensatory methods of dieting and exercising.

BINGE-EATING DISORDER

1. Recurrent episodes of binge-eating. An episode of binge-eating is characterized by both (1) eating, in a discrete period of time (e.g. in any two hour period), an amount of food that is definitely larger than most people would eat in a similar period of time (taking into account time since last meal and social context in which eating occurred); and (2) a sense of lack of control over eating during the episodes (e.g. a feeling that one can't stop eating or control what or how much one is eating).

2. At least three of the following behavioural indicators of loss of control are associated with binge-eating: (1) eating much more rapidly than normal; (2) eating until feeling uncomfortably full; (3) eating large amounts when not feeling physically hungry; (4) eating alone because they are embarrassed by the amount they eat; (5) feeling depressed, disgusted or guilty about overeating; (6) feeling their eating is out of control; (7) eating what most people would consider to be an unusually large amount of food.

3. Marked distress regarding binge-eating or the struggle against binge-eating.

4. The binge-eating occurs, on average, at least twice a week for a six-month period.

5. During an episode of illness, the individual does not meet the criteria for bulimia nervosa and does not abuse medication (e.g. laxatives or diet pills) in an attempt to avoid weight gain.