20

ANOREXIA NERVOSA AND BULIMIA
The Development of Deviant Identities

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Symbolic interactionists claim that deviance is relative depending on the situation and who is perceiving the act of deviance. Thus, according to *labeling theory,* people label certain acts as deviant and others as normal. This reading by Penelope McLorg and Diane Taub, both professors at Southern Illinois University at Carbondale, further illustrates this subjective process of deviance identification. In the reading below, originally published in 1987, McLorg and Taub employ labeling theory to explain how eating disorders have become defined as deviant behaviors and how some young women acquire deviant identities by modifying their self-concepts to conform to the societal labels of a person with an eating disorder.

Introduction

Current appearance norms stipulate thinness for women and muscularity for men; these expectations, like any norms, entail rewards for compliance and negative sanctions for violations. Fear of being overweight—of being visually deviant—has led to a striving for thinness, especially among women. In the extreme, this avoidance of overweight engenders eating disorders, which themselves constitute deviance. Anorexia nervosa, or purposeful starvation, embodies visual as well as behavioral deviation; bulimia, binge-eating followed by vomiting and/or laxative abuse, is primarily behaviorally deviant.

Besides a fear of fatness, anorexics and bulimics exhibit distorted body images. In anorexia nervosa, a 20–25 percent loss of initial body weight occurs, resulting from self-starvation alone or in combination with excessive exercising, occasional binge-eating, vomiting and/or laxative abuse. Bulimia denotes cyclical (daily, weekly, for example) binge-eating followed by vomiting or laxative abuse; weight is normal or close to normal (Humphries, Wrobel, and Weigert 1982). Common physical manifestations of these eating disorders include menstrual cessation or irregularities and electrolyte imbal-

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ances; among behavioral traits are depression, obsessions/compulsions, and anxiety (Russell 1979; Thompson and Schwartz 1982).

Increasingly prevalent in the past two decades, anorexia nervosa and bulimia have emerged as major health and social problems. Termed an epidemic on college campuses (Brody, as quoted in Schur 1984:76), bulimia affects 13 percent of college students (Halmi, Falk, and Schwartz 1981). Less prevalent, anorexia nervosa was diagnosed in 0.6 percent of students utilizing a university health center (Stangler and Printz 1980). However, the overall mortality rate of anorexia nervosa is 6 percent (Schwartz and Thompson 1981) to 20 percent (Humphries et al. 1982); bulimia appears to be less life-threatening (Russell 1979).

Particularly affecting certain demographic groups, eating disorders are most prevalent among young, white, affluent (upper-middle to upper class) women in modern, industrialized countries (Crisp 1977; Willi and Grossman 1983). Combining all of these risk factors (female sex, youth, high socioeconomic status, and residence in an industrialized country), prevalence of anorexia nervosa in upper-class English girls' schools is reported at 1 in 100 (Crisp, Palmer, and Kalucy 1976). The age of onset for anorexia nervosa is bimodal at 14.5 and 18 years (Humphries et al. 1982); the most frequent age of onset for bulimia is 18 (Russell 1979).

Eating disorders have primarily been studied from psychological and medical perspectives.[1] Theories of etiology have generally fallen into three categories: the ego psychological (involving an impaired child-maternal environment); the family systems (implicating enmeshed, rigid families); and the endocrinological (involving a precipitating hormonal defect). Although relatively ignored in previous studies, the sociocultural components of anorexia nervosa and bulimia (the slimness norm and its agents of reinforcement, such as role models) have been postulated as accounting for the recent, dramatic increases in these disorders (Boskind-White 1985; Schwartz, Thompson, and Johnson 1982).[2]

Medical and psychological approaches to anorexia nervosa and bulimia obscure the social facets of the disorders and neglect the individuals' own definitions of their situations. Among the social processes involved in the development of an eating disorder is the sequence of conforming behavior, primary deviance, and secondary deviance. Societal reaction is the critical mediator affecting the movement through the deviant career (Becker 1973). Within a framework of labeling theory, this study focuses on the emergence of anorexic and bulimic identities, as well as on the consequences of being career deviants.

Methodology

Sampling and Procedures

Most research on eating disorders has utilized clinical subjects or nonclinical respondents completing questionnaires. Such studies can be criticized for simply counting and describing behaviors and/or neglecting the social construction of the disorders. Moreover, the work of clinicians is often limited by therapeutic orientation. Previous research may also have included individuals who were not in therapy on their own volition and who resisted admitting that they had an eating disorder.

Past studies thus disregard the intersubjective meanings respondents attach to their behavior and emphasize researchers' criteria for definition as anorexic or bulimic. In order to supplement these sampling and procedural designs, the present study utilizes participant observation of a group of self-defined anorexics and bulimics.[3] As the individuals had acknowledged their eating disorders, frank discussion and disclosure were facilitated.

Data are derived from a self-help group, BANISH, Bulimics/Anorexics in Self-Help, which met at a university in an urban center of the mid-South. Founded by one of the researchers (D.E.T.), BANISH was advertised in local newspapers as offering a group experience for individuals who were anorexic or bulimic. Despite the local advertisements, the campus location of the meeting may have selectively encouraged university students to attend. Nonetheless, in view of the modal age of onset and socioeconomic status of individuals with eating disorders, college students have been considered target populations (Crisp et al. 1976; Halmi et al. 1981).

The group's weekly two-hour meetings were observed for two years. During the course of this study, 30 individuals attended at least one of the meetings. Attendance at meetings was varied: Ten individuals came nearly every Sunday; five attended approximately twice a month; and the remaining 15 participated once a month or less frequently, often when their eating problems were "more severe" or "bizarre." The modal number of members at meetings was 12. The diversity in attendance was to be expected in self-help groups of anorexics and bulimics:

> Most people's involvement will not be forever or even a long time. Most people get the support they need and drop out. Some take the time to help others after they themselves have been helped but even they may withdraw after a time. It is a natural and in many cases *necessary* process (emphasis in original). (American Anorexia and Bulimia Association 1983)

Modeled after Alcoholics Anonymous, BANISH allowed participants to discuss their backgrounds and experiences with others who empathized. For many members, the group constituted their only source of help; these respondents were reluctant to contact health professionals because of shame, embarrassment, or financial difficulties.

In addition to field notes from group meetings, records of other encounters with all members were maintained. Participants visited the office of one of the researchers (D.E.T.), called both researchers by phone, and invited them to their homes or out for a cup of coffee. Such interaction facilitated genuine communication and mutual trust. Even among the 15 individuals who did not attend the meetings regularly, contact was maintained with 10 members on a monthly basis.

Supplementing field notes were informal interviews with 15 group members, lasting from two to four hours. Because they appeared to represent more extensive experience with eating disorders, these interviewees were chosen to amplify their comments about the labeling process, made during group meetings. Conducted near the end of the two-year observation period, the interviews focused on what the respondents thought antedated and maintained their eating disorders. In addition, participants described others' reactions to their behaviors as well as their own interpretations of these reactions. To protect the confidentiality of individuals quoted in the study, pseudonyms are employed.

Description of Members

The demographic composite of the sample typifies what has been found in other studies (Crisp 1977; Fox and James 1976; Herzog 1982; Schlesier-Stropp 1984). Group members' ages ranged from 19 to 36, with the modal age being 21. The respondents were white, and all but one were female. The sole male and three of the females were anorexic; the remaining females were bulimic.[4]

Primarily composed of college students, the group included four nonstudents, three of whom had college degrees. Nearly all members derived from upper-middle- or lower-upper-class households. Eighteen students and two nonstudents were never married and uninvolved in serious relationships; two nonstudents were married (one with two children); two students were divorced (one with two children); and six students were involved in serious relationships. The duration of eating disorders ranged from 3 to 15 years.

Conforming Behavior

In the backgrounds of most anorexics and bulimics, dieting figures prominently, beginning in the teen years (Crisp 1977; Johnson, Stuckey, Lewis, and Schwartz 1982; Lacey, Coker, and Birtchnell 1986). As dieters, these individuals are conformist in their adherence to the cultural norms emphasizing thinness (Garner, Garfinkel, Schwartz, and Thompson 1980; Schwartz, Thompson, and Johnson 1982). In our society, slim bodies are regarded as the most worthy and attractive; overweight is viewed as physically and morally unhealthy—"obscene," "lazy," "slothful," and "gluttonous" (DeJong 1980; Ritenbaugh 1982; Schwartz et al. 1982).

Among the agents of socialization promoting the slimness norm is advertising. Female models in newspaper, magazine, and television advertisements are uniformly slender. In addition, product names and slogans exploit the thin orientation; examples include "Ultra Slim Lipstick," "Miller Lite," and "Virginia Slims." While retaining pressures toward thinness, an Ayds commercial attempts a compromise for those wanting to savor food: "Ayds . . . so you can taste, chew, and enjoy, while you lose weight." Appealing particularly to women, a nationwide fast-food restaurant chain offers low-calorie selections, so individuals can have a "license to eat." In the latter two examples, the notion of enjoying food is combined with the message to be slim. Food and restaurant advertisements overall convey the pleasures of eating, whereas advertisements for other products, such as fashions and diet aids, reinforce the idea that fatness is undesirable.

Emphasis on being slim affects everyone in our culture, but it influences women especially because of society's traditional emphasis on women's appearance. The slimness norm and its concomitant narrow beauty standards exacerbate the objectification of women (Schur 1984). Women view themselves as visual entities and recognize that conforming to appearance expectations and "becoming attractive object[s] [are] role obligation[s]" (Laws, as quoted in Schur 1984:66). Demonstrating the beauty motivation behind dieting, a Nielson survey indicated that of the 56 percent of all women aged 24 to 54 who dieted during the previous year, 76 percent did so for cosmetic, rather than health, reasons (Schwartz et al. 1982). For most female group members, dieting was viewed as a means of gaining attractiveness and appeal to the opposite sex. The male respondent, as well, indicated that "when I was fat, girls didn't look at me, but when I got thinner, I was suddenly popular."

In addition to responding to the specter of obesity, individuals who develop anorexia nervosa and bulimia are conformist in their strong commitment to other conventional norms and goals. They consistently excel at school and work (Bruch 1981; Humphries et al. 1982; Russell 1979), maintaining high aspirations in both areas (Lacey et al. 1986; Theander 1970). Group members generally completed college-preparatory courses in high school, aware from an early age that they would strive for a college degree. Also, in college as well as high school, respondents joined honor societies and academic clubs.

Moreover, pre-anorexics and -bulimics display notable conventionality as "model children" (Humphries et al. 1982:199), "the pride and joy" of their parents (Bruch 1981:215), accommodating themselves to the wishes of others. Parents of these individuals emphasize conformity and value achievement (Bruch 1981). Respondents felt that perfect or near-perfect grades were expected of them; however, good grades were not rewarded by parents, because "A's" were common for these children. In addition, their parents suppressed conflicts, to preserve the image of the "all-American family" (Humphries et al. 1982). Group members reported that they seldom, if ever, heard their parents argue or raise their voices.

Also conformist in their affective ties, individuals who develop anorexia nervosa and bulimia are strongly, even excessively, attached to their parents. Respondents' families appeared close-knit, demonstrating palpable emotional ties. Several group members, for example, reported habitually calling home at prescribed times, whether or not they had any news. Such families have been termed "enmeshed" and "overprotective," displaying intense interaction and concern for members' welfare (Minuchin, Rosman, and Baker 1978; Selvini-Palazzoli 1978). These qualities could be viewed as marked conformity to the norm of familial closeness.[5]

Another element of notable conformity in the family milieu of pre-anorexics and -bulimics concerns eating, body weight and shape, and exercising (Humphries et al. 1982; Kalucy, Crisp, and Harding 1977). Respondents reported their fathers' preoccupation with exercising and their mothers' engrossment in food preparation. When group members dieted and lost weight, they received an extraordinary amount of approval. Among the family, body size became a matter of "friendly rivalry." One bulimic informant recalled that she, her mother, and her coed sister all strived to wear a size 5, regardless of their heights and body frames. Subsequent to this study, the researchers learned that both the mother and sister had become bulimic.

As pre-anorexics and -bulimics, group members thus exhibited marked conformity to cultural norms of thinness, achievement, compliance, and parental attachment. Their families reinforced their conformity by adherence to norms of family closeness and weight and body shape consciousness.

Primary Deviance

Even with familial encouragement, respondents, like nearly all dieters (Chernin 1981), failed to maintain their lowered weights. Many cited their lack of willpower to eat only restricted foods. For the emerging anorexics and bulimics, extremes such as purposeful starvation or binging accompanied by vomiting and/or laxative abuse appeared as "obvious solutions" to the problem of retaining weight loss. Associated with these behaviors was a regained feeling of control in lives that had been disrupted by a major crisis. Group members' extreme weight-loss efforts operated as coping mechanisms for entering college, leaving home, or feeling rejected by the opposite sex.

The primary inducement for both eating adaptations was the drive for slimness: With slimness came more self-respect and a feeling of superiority over "unsuccessful dieters." Brian, for example, experienced a "power trip" upon consistent weight loss through starvation. Binges allowed the purging respondents to cope with stress through eating while maintaining a slim appearance. As former strict dieters, Teresa and Jennifer used binging and purging as an alternative to the constant self-denial of starvation. Acknowledging their parents' desires for them to be slim, most respondents still felt it

was a conscious choice on their part to continue extreme weight-loss efforts. Being thin became the "most important thing" in their lives—their "greatest ambition."

In explaining the development of an anorexic or bulimic identity, Lemert's (1951, 1967) concept of primary deviance is salient. Primary deviance refers to a transitory period of norm violations which do not affect an individual's self-concept or performance of social roles. Although respondents were exhibiting anorexic or bulimic behavior, they did not consider themselves to be anorexic or bulimic.

At first, anorexics' significant others complimented their weight loss, expounding on their new "sleekness" and "good looks." Branch and Eurman (1980) also found anorexics' families and friends describing them as "well groomed," "neat," "fashionable," and "victorious" (p. 631). Not until the respondents approached emaciation did some parents or friends become concerned and withdraw their praise. Significant others also became increasingly aware of the anorexics' compulsive exercising, preoccupation with food preparation (but not consumption), and ritualistic eating patterns (such as cutting food into minute pieces and eating only certain foods at prescribed times).

For bulimics, friends or family members began to question how the respondents could eat such large amounts of food (often in excess of 10,000 calories a day) and stay slim. Significant others also noticed calluses across the bulimics' hands, which were caused by repeated inducement of vomiting. Several bulimics were "caught in the act," bent over commodes. Generally, friends and family required substantial evidence before believing that the respondents' binging or purging was no longer sporadic.

Secondary Deviance

Heightened awareness of group members' eating behavior ultimately led others to label the respondents "anorexic" or "bulimic." Respondents differed in their histories of being labeled and accepting the labels. Generally first termed anorexic by friends, family, or medical personnel, the anorexics initially vigorously denied the label. They felt they were not "anorexic enough," not skinny enough; Robin did not regard herself as having the "skeletal" appearance she associated with anorexia nervosa. These group members found it difficult to differentiate between socially approved modes of weight loss—eating less and exercising more—and the extremes of those behaviors. In fact, many of their activities—cheerleading, modeling, gymnastics, aerobics—reinforced their pursuit of thinness. Like other anorexics, Chris felt she was being "ultra-healthy," with "total control" over her body.

For several respondents, admitting they were anorexic followed the realization that their lives were disrupted by their eating disorder. Anorexics' inflexible eating patterns unsettled family meals and holiday gatherings.

Their regimented lifestyle of compulsively scheduled activities—exercising, school, and meals—precluded any spontaneous social interactions. Realization of their adverse behaviors preceded the anorexics' acknowledgment of their subnormal body weight and size.

Contrasting with anorexics, the binge/purgers, when confronted, more readily admitted that they were bulimic and that their means of weight loss was "abnormal." Teresa, for example, knew "very well" that her bulimic behavior was "wrong and unhealthy," although "worth the physical risks." While the bulimics initially maintained that their purging was only a temporary weight-loss method, they eventually realized that their disorder represented a "loss of control." Although these respondents regretted the self-indulgence, "shame," and "wasted time," they acknowledged their growing dependence on binging and purging for weight management and stress regulation.

The application of anorexic or bulimic labels precipitated secondary deviance, wherein group members internalized these identities. Secondary deviance refers to norm violations which are a response to society's labeling: "Secondary deviation . . . becomes a means of social defense, attack or adaptation to the overt and covert problems created by the societal reaction to primary deviance" (Lemert 1967:17). In contrast to primary deviance, secondary deviance is generally prolonged, alters the individual's self-concept, and affects the performance of his/her social roles.

As secondary deviants, respondents felt that their disorders "gave a purpose" to their lives. Nicole resisted attaining a normal weight because it was not "her"—she accepted her anorexic weight as her "true" weight. For Teresa, bulimia became a "companion"; and Julie felt "every aspect of her life," including time management and social activities, was affected by her bulimia. Group members' eating disorders became the salient element of their self-concepts so that they related to familiar people and new acquaintances as anorexics or bulimics. For example, respondents regularly compared their body shapes and sizes with those of others. They also became sensitized to comments about their appearance, whether or not the remarks were made by someone aware of their eating disorder.

With their behavior increasingly attuned to their eating disorders, group members exhibited role engulfment (Schur 1971). Through accepting anorexic or bulimic identities, individuals centered activities around their deviant role, downgrading other social roles. Their obligations as students, family members, and friends became subordinate to their eating and exercising rituals. Socializing, for example, was gradually curtailed because it interfered with compulsive exercising, binging, or purging.

Labeled anorexic or bulimic, respondents were ascribed a new status with a different set of role expectations. Regardless of other positions the individuals occupied, their deviant status, or master status (Becker 1973; Hughes 1958), was identified before all others. Among group members, Nicole, who was known as the "school's brain," became known as the "school's anorexic."

No longer viewed as conforming model individuals, some respondents were termed "starving waifs" or "pigs."

Because of their identities as deviants, anorexics' and bulimics' interactions with others were altered. Group members' eating habits were scrutinized by friends and family and used as a "catchall" for everything negative that happened to them. Respondents felt self-conscious around individuals who knew of their disorders; for example, Robin imagined people "watching and whispering" behind her. In addition, group members believed others expected them to "act" anorexic or bulimic. Friends of some anorexic group members never offered them food or drink, assuming continued disinterest on the respondents' part. While being hospitalized, Denise felt she had to prove to others she was not still vomiting, by keeping her bathroom door open. Other bulimics, who lived in dormitories, were hesitant to use the restroom for normal purposes lest several friends be huddling at the door, listening for vomiting. In general, individuals interacted with the respondents largely on the basis of their eating disorder; in doing so, they reinforced anorexic and bulimic behaviors.

Bulimic respondents, whose weight-loss behavior was not generally detectable from their appearance, tried earnestly to hide their bulimia by binging and purging in secret. Their main purpose in concealment was to avoid the negative consequences of being known as a bulimic. For these individuals, bulimia connoted a "cop-out": Like "weak anorexics," bulimics pursued thinness but yielded to urges to eat. Respondents felt other people regarded bulimia as "gross" and had little sympathy for the sufferer. To avoid these stigmas or "spoiled identities," the bulimics shrouded their behaviors.

Distinguishing types of stigma, Goffman (1963) describes discredited (visible) stigmas and discreditable (invisible) stigmas. Bulimics, whose weight was approximately normal or even slightly elevated, harbored discreditable stigmas. Anorexics, on the other hand, suffered both discreditable and discredited stigmas—the latter due to their emaciated appearance. Certain anorexics were more reconciled than the bulimics to their stigmas: For Brian, the "stigma of anorexia was better than being fat." Common to the stigmatized individuals was an inability to interact spontaneously with others. Respondents were constantly on guard against topics of eating and body size.

Both anorexics and bulimics were held responsible by others for their behavior and presumed able to "get out of it if they tried." Many anorexics reported being told to "just eat more," while bulimics were enjoined to simply "stop eating so much." Such appeals were made without regard for the complexities of the problem. Ostracized by certain friends and family members, anorexics and bulimics felt increasingly isolated. For respondents, the self-help group presented a nonthreatening forum for discussing their disorders. Here, they found mutual understanding, empathy, and support. Many participants viewed BANISH as a haven from stigmatization by "others."

Group members, as secondary deviants, thus endured negative consequences, such as stigmatization, from being labeled. As they internalized

the labels anorexic or bulimic, individuals' self-concepts were significantly influenced. When others interacted with the respondents on the basis of their eating disorders, anorexic or bulimic identities were encouraged. Moreover, group members' efforts to counteract the deviant labels were thwarted by their master status.

Discussion

Previous research on eating disorders has dwelt almost exclusively on medical and psychological facets. Although necessary for a comprehensive understanding of anorexia nervosa and bulimia, these approaches neglect the social processes involved. The phenomena of eating disorders transcend concrete disease entities and clinical diagnoses. Multifaceted and complex, anorexia nervosa and bulimia require a holistic research design, in which sociological insights must be included.

A limitation of medical and psychiatric studies, in particular, is researchers' use of a priori criteria in establishing salient variables. Rather than utilizing predetermined standards of inclusion, the present study allows respondents to construct their own reality. Concomitant to this innovative approach to eating disorders is the selection of a sample of self-admitted anorexics and bulimics. Individuals' perceptions of what it means to become anorexic or bulimic are explored. Although based on a small sample, findings can be used to guide researchers in other settings.

With only 5 to 10 percent of reported cases appearing in males (Crisp 1977; Stangler and Printz 1980), eating disorders are primarily a women's aberrance. The deviance of anorexia nervosa and bulimia is rooted in the visual objectification of women and attendant slimness norm. Indeed, purposeful starvation and binging and purging reinforce the notion that "a society gets the deviance it deserves" (Schur 1979:71). As noted (Schur 1984), the sociology of deviance has generally bypassed systematic studies of women's norm violations. Like male deviants, females endure label applications, internalizations, and fulfillments.

The social processes involved in developing anorexic or bulimic identities comprise the sequence of conforming behavior, primary deviance, and secondary deviance. With a background of exceptional adherence to conventional norms, especially the striving for thinness, respondents subsequently exhibit the primary deviance of starving or binging and purging. Societal reaction to these behaviors leads to secondary deviance, wherein respondents' self-concepts and master statuses become anorexic or bulimic. Within this framework of labeling theory, the persistence of eating disorders, as well as the effects of stigmatization, are elucidated.

Although during the course of this research some respondents alleviated their symptoms through psychiatric help or hospital treatment programs, no one was labeled "cured." An anorexic is considered recovered when

weight is normal for two years; a bulimic is termed recovered after being symptom-free for one and one-half years (American Anorexia and Bulimia Association Newsletter 1985). Thus deviance disavowal (Schur 1971), or efforts after normalization to counteract deviant labels, remains a topic for future exploration.

ENDNOTES

[1] Although instructive, an integration of the medical, psychological, and sociocultural perspectives on eating disorders is beyond the scope of this paper.

[2] Exceptions to the neglect of sociocultural factors are discussions of sex-role socialization in the development of eating disorders. Anorexics' girlish appearance has been interpreted as a rejection of femininity and womanhood (Bruch 1981; Orbach 1979, 1985). In contrast, bulimics have been characterized as overconforming to traditional female sex roles (Boskind-Lodahl 1976).

[3] Although a group experience for self-defined bulimics has been reported (Boskind-Lodahl 1976), the researcher, from the outset, focused on Gestalt and behaviorist techniques within a feminist orientation.

[4] One explanation for fewer anorexics than bulimics in the sample is that, in the general population, anorexics are outnumbered by bulimics at 8 or 10 to 1 (Lawson, as reprinted in American Anorexia and Bulimia Association Newsletter 1985:1). The proportion of bulimics to anorexics in the sample is 6.5 to 1. In addition, compared to bulimics, anorexics may be less likely to attend a self-help group as they have a greater tendency to deny the existence of an eating problem (Humphries et al. 1982). However, the four anorexics in the present study were among the members who attended the meetings most often.

[5] Interactions in the families of anorexics and bulimics might seem deviant in being inordinately close. However, in the larger societal context, the family members epitomize the norms of family cohesiveness. Perhaps unusual in their occurrence, these families are still within the realm of conformity. Humphries and colleagues (1982) refer to the "highly enmeshed and protective" family as part of the "idealized family myth" (p. 202).

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