A LONGITUDINAL STUDY OF EATING DISORDER SYMPTOMOTOLOGY OF WOMEN

by

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Proposal For

A Master's Research Project Submitted in Partial Fulfillment

of the Requirements for the Degree

Master of Arts

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January 1995

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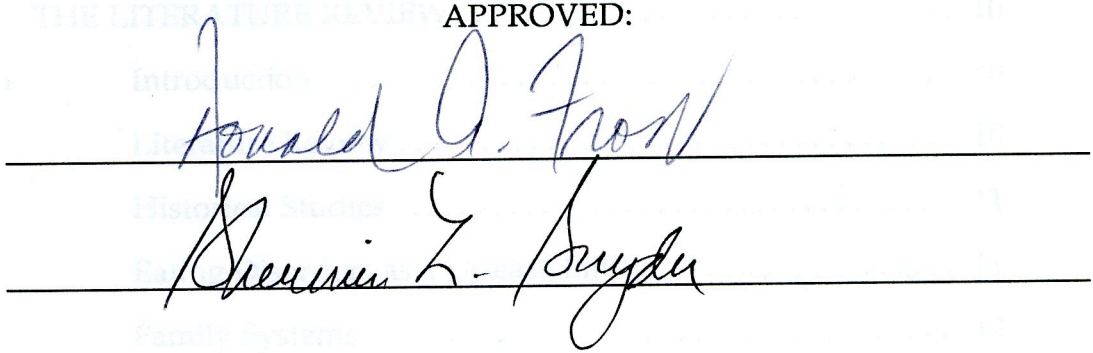

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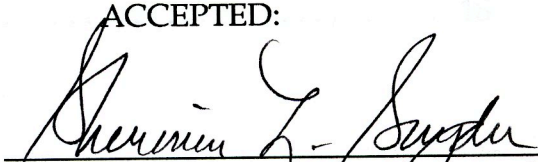

Director of Graduate Studies

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CHAPTER 1

THE PROBLEM

Introduction

The focus of this study is an investigative follow-up on women who in 1985 participated in a research study on the impact of pregnancy on anorexia nervosa, bulimia or mixed eating disorder. At that time 43 women were surveyed who had an active eating disorder involving anorexia nervosa, bulimia or mixed symptoms six months prior to their first pregnancy. Information was gathered on attitudes toward becoming pregnant, fears and concerns related to the unborn child, the impact of pregnancy prenatal and postnatal on eating disorder behaviors, weight gain and weight of the baby as an indicator of its health, and the obstetrician's view of the pregnancy and health status of the infant upon delivery.

The current research will focus on the status of this population in terms of eating disorder behaviors eight years later, a comparison of symptomology compared to initial research, current treatment related to eating disorder behaviors, current eating disorder behaviors, and level of recovery. This research will also examine the first-born child's attitudes concerning weight gain, dieting, eating disorder symptomotology, developmental or physical delays and psychiatric treatment. A 27-item questionnaire was completed by the subjects to obtain this information.

Background of the Study

The area of study in this research work is to investigate women who had an active eating disorder, anorexia nervosa, bulimia or mixed eating disorder, six months prior to becoming pregnant for the first time who had participated in a study 8 years ago with regard to their attitudes of the impact of pregnancy on eating disorder behavior and attitudes toward becoming pregnant, fears and concerns related to the unborn child, prenatal and postnatal impact on eating disordered behaviors health status of the infant. This current study will focus on the women's eating disorder behaviors, current treatment and level of recovery. The attitude of the first-born child concerning weight gain, dieting, eating disorder symptomotology, developmental or physical delays and psychiatric treatment.

In today's society, a person with anorexia nervosa is often times viewed as an inordinately thin person. Although some individuals do become emaciated, it has been found that eating disordered individuals are preoccupied with calories, food, eating and some anorexic individuals with binge/purge behaviors (Garner & Garfinkel, 1985).

"Purging" may be accomplished in any number of ways, however, the primary use of any behavior to rid oneself of food is compensatory, that is, it seeks to compensate for the intake of food (and the psychic disturbance this causes) by eliminating food from the body. Patients in this group may use vomiting, purgatives (Syrup of Ipecac), diuretics, laxatives, or may exercise after a binge.

The following is the diagnostic criteria for Anorexia Nervosa:

A. Refusal to maintain body weight over a minimal normal weight for age and height, e.g., weight loss leading to maintenance of body weight 15% below the expected, or failure to make expected weight gain during period of growth leading to body weight 15% below 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, size, or shape is experienced, e.g., the person claims to "feel fat" even when emaciated, believes that one area of the body is "too fat" even when obviously underweight.

D. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary amenorrhea). A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration (DSM III-R, 1987).

The following is the diagnostic criteria for Bulimia Nervosa:

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).

B. A feeling of lack of control over eating behavior during the eating binges.

C. The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.

D. A minimum average of two binge eating episodes a week for at least three months.

E. Persistent overconcern with body shape and weight (DSM III-R, 1987).

The following diagnostic criteria for Mixed Eating Disorder include:

Disorders of eating that do not meet the criteria for a specific Eating Disorder.

Examples:

(1) A person of average weight who does not have binge eating episodes, but frequently engages in self-induced vomiting for fear of gaining weight.

(2) All of the features of Anorexia Nervosa in a female except absence of menses.

(3) All of the features of Bulimia Nervosa except the frequency of binge eating episodes (DSM III-R, 1987).

Purpose of the Study

The purpose of this paper is to report on the eating disorder behaviors of 13 of 43 women who were investigated eight years ago questioning the impact of pregnancy on Anorexia Nervosa, Bulimia or mixed eating disorder symptoms. There have been no longitudinal studies done on women who were previously surveyed regarding the impact of pregnancy on anorexia nervosa, bulimia or mixed eating disorder after one year of childbirth. Also examined in this research is the first born child's attitudes concerning weight gain, dieting, eating disorder symptomotology, developmental or physical delays and psychiatric treatment as reported by the parent.

Research Question

The research questions for the purpose of this study is what impact has childrearing and maturity had on the status of the eating disorder since the original study eight years ago with regards to symptomotology and level of recovery? Does this population have a higher risk of producing children who will develop an eating disorder? To explore this question, the first born child's attitudes concerning weight gain, dieting, eating disorder symptomotology, developmental or physical delays and psychiatric treatment are examined.

Theoretical Base

The theoretical base for this study is the impact of childrearing parenting and eating disorders on a population that was researched 8 years prior to investigate the impact of pregnancy on anorexia nervosa, bulimia or mixed eating disorder.

Namir, Melman and Yager (1986) interviewed six restricter-type anorexics during their pregnancy and re-interviewed four of the women three to four months after childbirth. As in the Blinder and Hagman study, it was observed that the women felt obliged to care for themselves better in order to be better mothers. Eating habits improved overall, although the women continued to have difficulties with poor body-image and generally were unable to distinguish being pregnant from being "fat." Most feared that their weight gain would become out-of-control. Of the women studied, one-half experienced serious anxiety and depression during the pregnancy. Toward the end of pregnancy there was less food preoccupation and anorexic thinking. However, of the four studied at follow-up, all became re-invested in the anorexic symptoms with three of the four women losing weight to lower levels than prior to pregnancy.

Lacey and Smith (1987) investigated the pregnancies of 20 normal weight bulimic. They reported a significant reduction in the eating disorder symptoms in the majority of women during the course of pregnancy with 75% having complete cessation of bingeing and purging by the third trimester. Also, consistent with previous reports, the majority of women regressed in the post-partum period. However, the authors note that a full 25% of the sample appeared to be cured of their eating disorder symptoms.

In the largest study to date, Lemberg and Phillips (1989) interviewed 43 women who had an active eating disorder six months prior to becoming pregnant for the first time. Of these 43 women 43% were self-identified as having bulimia, 5% as having anorexia nervosa and 52% as having a

combination of both symptoms. Additionally, as a validity check for inclusion into the study, subjects were asked about the presence of specific symptoms, including weight, restriction of intake, and binge-purge behavior. Based on an analysis of this information, the sample appeared to contain 5%-7% restricter-type anorexics, 77% bulimics, and the remaining 16% having a combination of both anorexia and bulimic symptoms. In this study, pregnancy appears to have a pronounced beneficial impact on both anorexic and bulimic symptoms with 70% of the women in the study reporting overall improvement and 56% as seeing themselves as largely in remission with their eating disorder symptoms during pregnancy. These trends toward the positive benefit of pregnancy are consistent with the majority of literature (Blinder and Hagman, 1984: Namir; et. al., 1986).

Significance of Study

Very little is known about the impact of pregnancy on women with anorexia nervosa, bulimia and mixed eating disorder. Less still is known about the impact of childrearing, and long term effects of pregnancy on the eating disorder behaviors. This study is the first to do a follow-up research on 13 of 43 women previously researched eight years ago on the impact of pregnancy on their eating disorder and body-image concerns. At the time of this research there is no information available on the attitudes and concerns of dieting, weight concerns, eating disorder symptomotology, developmental or physical delays and psychiatric treatment of the first born child of a mother with an eating disorder.

Operational Definitions

Amenorrhea - In females, the absence of at least three consecutive menstrual cycles when otherwise expected to occur.

Anorexia Nervosa - Significant weight loss with disturbance in body-image. Intense fear of becoming overweight and unrelenting drive toward thinness. Severe malnutrition, muscle loss, fatigue, and heart abnormalities.

Bingeing - The sudden, compulsive ingestion of, sometimes, very large amounts of food in a very short time, usually with subsequent agitation and self-condemnation (Bruch, 1973).

Bulimic Anorexics/Bulimarexics/Bingeing Anorexics - The group of anorexics which also exhibit bulimic behavior and fall within the DSM III-R clinical diagnosis of Anorexia Nervosa.

Bulimia Nervosa - Episodic binge-eating of a large quantity of food at a single sitting. Binge-eating is alternated by attempts to lose weight and is often accompanied by various methods of purging food and calories.

Chronicity - The length of time that a clinical disorder is manifested.

Epidemiology - Data describing the characteristics of anorexia nervosa; characteristics regarding age, gender, culture, family, personality factors, interests, etc.

Purge - The act of ridding one's self of food from the body either by inducing vomiting, purgatives, diuretics, laxatives or exercise.

Psychopathology - Clinical mental or emotional disorders classified in the DSM III-R Manual for Psychiatric Disorders.

Somatic Preoccupation - An inordinate preoccupation with one's body, bodily processes, symptoms or illnesses.

Assumptions and Limitations

This research work is based on the assumption that the participants answered the questionnaires honestly. One of the advantages of this study is that 13 of the 43 participants of the original study will be completing the questionnaires because they have a vested interest in the topic.

A limitation of this study is that the data gathered were from the participants' self-report, and thus may not be objective. Another limitation is the lack of

predictive power; the researcher discovers "what is," but is unable to generalize or predict "what will be."

Organization of the remainder of the Study

Chapter Two, The Review of Literature, provides an introduction and organizational structure of the chapter. Discussed are the key topics involved in this research work. The history and epidemiology of eating disorders is discussed, the types of families in which eating disorders develop, and the impact of pregnancy on individuals with anorexia nervosa, bulimia or mixed eating disorder.

Chapter Three, The Methodology, provides an introduction reviewing the purpose of the study and a description of the methodology utilized. This is followed by a description of the design of the study, the sample and population source of the data, the instruments used, and a discussion of the respective validity and reliability. How data were collected is detailed followed by how data were analyzed.

Chapter Four, Presentation and Analysis of the Data, provides the findings of the study in terms of the participant's education; status of the participant's eating disorder symptomotology at the time of the original study and current eating disorder symptomotology; current eating disorder symptomotology as compared to the first year after childbirth; current treatment modalities; ages of first born children; reasons for not having more than one child; the extent to which the subjects felt that the first born child is concerned about food, weight or body-image; the subject's concerns of the first born child developing an eating disorder; eating disorder symptomotology exhibited by the first born child; structured versus unstructured meal times in these families; the first born child's view on good and bad foods; developmental and/or psychiatric problems

with the first born child; and lastly, comments shared by the participants of the study.

Chapter Five, Summary, Conclusions and Recommendations, provides a summary of the research, conclusion and recommendations insofar as further research with regard to the first born child's development of an eating disorder and/or developmental or psychiatric adjustment.

CHAPTER 2

REVIEW OF THE LITERATURE

Introduction

Today's anorexic is one of a long line of predominately women and girls throughout history who have used control of appetite, food, and body as a focus of their symbolic language. Although anorexia nervosa, bulimia and bulimia nervosa are relatively new disorders, female fasting is not a new behavior. There is a long history of food-refusing behavior and appetite control in women dating back at least to the medieval world (Brumberg, 1988).

Historical Studies

Historical, anthropological and psychological studies suggest women use appetite as a form of expression more often than men. Medieval scholars demonstrated that there have been moments in the past when large numbers of women and girls refused to eat regularly or practiced extraordinary forms of appetite control (Foucault, 1985).

In medieval Europe, particularly in the years between 1200 and 1500, many women refused their food and prolonged fasting was considered a female miracle. The best known was Catherine of Sienna (1347-1380), a saint, who ate only a handful of herbs each day and occasionally shoved twigs down her throat to bring up any other food she was forced to eat. Thirteenth-century figures such as Mary of Oigenes and Beatrice of Nazareth vomited from the mere smell of

meat, and their throats swelled shut in the presence of food. Other women saints covered their faces at the sight of food, refused to partake of family meals and some such as the 15th century saint, Columba of Rieti, actually died of self-starvation. Later, in the seventeenth century, Saint Veronica ate nothing at all for three days at a time but on Fridays permitted herself to chew on five orange seeds, in memory of the find wounds of Jesus. Although fasting and restrictive eating was a widely noted characteristic of medieval spirituality, it was not practiced both genders in the same manner or to the same degree. There are few cases of male saints who claimed or were claimed by others to be incapable of eating (Weinstein & Bell, 1982).

Hilde Bruch, Eugene Bliss, C.H. Hardin Branch, Joseph Silverman and other doctors claim that anorexia nervosa was first identified in 1694 by Richard Morton in *Phthisologia; or a Treatise on Consumptions*. Morton, physician to James II, did indeed describe the existence of a form of nervous consumption caused by "sadness and anxious cares" and presented two case histories of adolescents; an eighteen year old and sixteen year old girl (Brumberg, 1988).

Strachey (1966), reports that Sigmund Freud regarded the anorexic as a girl who feared adult womanhood and heterosexuality. In 1895 he wrote: "The famous anorexia nervosa of young girls seems to be to be a melancholia where sexuality is undeveloped" (Strachey, 1986,p. 213). In Freudian terms, eating, like all appetites, is an expression of libido or sexual drive. Clinicians confirm the direction of the Freudian interpretation: anorexics are not sexually active adolescents (Strachey, 1966).

Eating Disorders as a Disease Entity

Starting in the 1940s, analysts paid attention to anorexia nervosa as a disease entity in which conflicts around orality and primitive aspects of female

sexuality were the focus (Kaufman, 1964). The view of not eating, vomiting, and weight loss with amenorrhea as a defense against unconscious fantasies of oral impregnation was elevated to the role of a specific determinant. Some patients, especially unsophisticated ones, do report such fantasies or behave in ways consistent with them. Classical psychoanalytic treatment, however, particularly in its focus on primitive drives, has proven either unacceptable to, beyond the capacity of, or in any event, ineffective for most anorectics.

Family Systems

In the 1980s a great deal of attention was being paid to values and patterns of interaction within anorexic families. Family systems therapy provides one of today's most important theoretical perspectives on eating disorders. According to family systems theorist Salvador Minunchin, certain kinds of family environments encourage passive methods of defiance (for example, not eating) and make it difficult for members to assert their individuality. Minunchin describes this "psychosomatic family" as controlling, perfectionistic, and nonconfrontational, adjectives that apply equally well to their eating disordered daughter. On the basis of clinical work with these families, mental health professionals have come to describe the anorexic and bulimic as "enmeshed," meaning that the normal process of individuation is blocked by the complex interaction of psychological needs of the girl, her parents, even her siblings. In family systems theory not just the patient has an eating disorder; the family too has the disorder (Liebman, Minunchin and Baker, 1974).

The three types of families which most often are seen to contribute to the development of an eating disorder are: the perfect family; the overprotective family; and the chaotic family (Liebman, 1974). The perfect family is characterized by high achievement. This may include achieving at work, sports and appearance. The family's reputation and identity are all important; shame

and failure for one member is shame and failure for all. Development of an individual identity that is different than the family's is discouraged. Approval and acceptance by others is of great importance. Disturbing family rules creates an immediate demand by the family to restore harmony. In this family negative feelings such as anger and pain are discouraged or ignored. Individuals are allowed to make decisions as long as they are the "right" decisions. Pressures to conform can be subtle or overt. Being a member of this family is to look perfect; for a woman, this means being thin. Disapproval is voiced if a member is at a higher weight than the family feels is appropriate. An eating disorder is one way that an individual can be less than perfect and rebel in such a way that on the surface allows the individual to conform to family rules. An eating disorder, especially bulimia, allows the individual to repress unacceptable feelings, such as anger so that others' feelings are not hurt and it is also a way of avoiding disapproval or rejection by the family (Liebman, 1974).

In the overprotective family, there is a lack of recognition and encouragement of the child's competencies and their need for growth and independence especially as he/she reaches the teen years. Parents have a difficult time letting go of their children. There is a lack of opportunity for decision-making by the children but rather decisions are made "in the best interests" of the children. This makes it difficult for the child to leave home successfully because the protection by the parents have not allowed the necessary opportunities for risk taking towards separation and independence by their children. This family is cohesive by guilt and overinvolvement. The sense of self of the child is dependent on parental approval. Anger is perceived as a hurtful emotion so that instead of being expressed directly, it is often expressed in passive-aggressive actions or statements. Parents have difficulty in letting go of their children and children must learn to out manipulate the adults. Rebellion is done quietly and

the risk of depression is ever present. Typically it is the youngest child that is most vulnerable to developing an eating disorder because the issues of letting go and leaving home are central to this family. The youngest is most affected as she/he is the last to leave; the parents will have no one to look after when she leaves and will be faced with being a couple again. An eating disorder enables the child to stay young and dependent and at the same time passively rebel and create personal space. The eating disorder supports the parents' worry that the child needs their protection and can be used against the child as evidence that they are not able to take care of themselves (Liebman, 1974).

The chaotic family is characterized by lack of consistent rules and organization. Love is unpredictable and its members are unsure who is available to them for emotional support and help. The parents may be emotionally and/or physically unavailable due to their emotional problems or substance abuse. There is little approval from parents and members are seen as under-involved with each other. There is a lack of appropriate models for conflict resolution; anger, frustration and attempts to control members may be physically or psychologically abusive. Physical, emotional or sexual abuse is almost always present. There may also be a pattern of suicide attempts or psychological disturbances in family members. Alcohol and/or drug abuse is frequently observed in this family. It is the oldest child in the chaotic family who is most vulnerable to developing bulimia. She/he tries to provide predictability in an unpredictable environment. She/he gives up her/his childhood to take responsibility of keeping the family together. She/he tries to parent her/his siblings and parents without knowing the limits or how to manage this responsibility. Drugs, alcohol and bulimia become ways to block out anger which may not be safe to express in this family and block out pain and hurt. Bulimia can be a means to ask for help and search

for affection and nurturance from the family while numbing the rage and hurt (Fredrich, Fallon and Root, 1984).

Severe anorexia nervosa precludes pregnancy. Not only is there lack of sexual desire and activity but the physiological basis of fertility is shut down. However, with all the psychological and physiological forces arraigned against reproduction in women with eating disorders, some anorectic women want to have children, and in fact, do so.

Blinder and Hagman (1984) interviewed six women with anorexia nervosa or bulimia who had given birth while actively symptomatic. Most of the women reported developing better control over their symptoms during the pregnancy and were motivated by wanting to have healthy children and to be healthy themselves in order to be better caretakers. However, following the deliveries they regressed to former dysfunctional eating patterns, often with an increase in severity.

Namir, Melman and Yager (1986) interviewed six restricter-type anorexics during their pregnancy and re-interviewed four 3-4 months after childbirth. As in the Blinder and Hagman study, it was observed that the women felt obliged to care for themselves better in order to be better mothers. Eating habits improved overall, although the women continued to have difficulties with poor body image and generally were unable to distinguish being pregnant from being "fat." Most feared that their weight gain would become out-of-control. Of the women studied, one-half experienced serious anxiety and depression during the pregnancy. Toward the end of pregnancy there was less food preoccupation and anorexic thinking. However, of the four studied at follow-up, all became reinvested in the anorexic symptoms with three of the four women losing weight to lower levels than prior to pregnancy.

Lacey and Smith (1987) investigated the pregnancies of 20 normal weight bulimic women. They reported a significant reduction in the eating disorder symptoms in the majority of women during the course of pregnancy with 75% having a complete cessation of bingeing and purging by the third trimester. Also, consistent with previous reports, the majority of women regressed in the postpartum period. However, the authors note that a full 25% of the sample appeared to be cured of their eating disorder symptoms.

In the largest study to date, Lemberg and Phillips (1989) interviewed 43 women who had an active eating disorder six months prior to becoming pregnant for the first time. Of these 43 women 43% were self-identified as having bulimia, 5% as having anorexia nervosa and 52% as having a combination of both symptoms. Additionally, as a validity check for inclusion into the study, subjects were asked about the presence of specific symptoms, including weight, restriction of intake, and binge-purge behavior. Based on an analysis of this information, the sample appeared to contain 5%-7% restricter-type anorexics, 77% bulimics, and the remaining 16% having a combination of both anorexia and bulimic symptoms. In this study, pregnancy appears to have a pronounced beneficial impact on both anorexic and bulimic symptoms with 70% of the women in the study reporting overall improvement and 56% as seeing themselves as largely in remission with their eating disorder symptoms during pregnancy. These trends toward the positive benefit of pregnancy are consistent with the majority of existing literature (Blinder and Hagman, 1984: Namir, et al., 1986).

Disappointingly, about half of the women who made significant improvement in their eating disorder symptoms during pregnancy regressed in the first year after birth and attributed their regression to "feeling fat" and therefore wanting to lose weight. A few respondents also attributed their

regression to feeling inadequate in being able to fulfill both responsibilities of motherhood and a career outside the home. However, even with significant regression in the first year, nearly one-half of the women in the study viewed themselves as functioning better in terms of eating disorder symptoms in the first year as compared with before pregnancy (Lemberg, Phillips, 1989).

About a quarter of the sample did quite well following the birth and appeared to maintain improvements in eating disorder symptoms and in greater body-image acceptance. This percentage of "cured" women matches almost exactly what Lacey and Smith (1987) reported.

In contemporary society young women easily attach themselves to dieting precisely because it is a widely practiced and admired form of cultural expression. A pathology such as anorexia nervosa or bulimia is not caused by dieting alone, but the centrality of dieting and appetite control in the lives of women is a critical context for explaining the disproportionate number of female anorexics and bulimics in the late-twentieth-century.

The cultural force which has contributed to the increasing evidence of eating disorders is personal aesthetics. In the twentieth century the body not the face became the special focus of female beauty. As a consequence, dieting moved from the periphery to the center of women's lives and culture. In the modern world dieting involves a self-conscious effort to reduce the body for the purpose of attaining an ideal of outward physical, as opposed to spiritual beauty (Ohlson, 1976).

Conclusion

For nearly a century, from the time of William Gull and Charles Lasegue until the 1970s anorexia nervosa was relatively unknown outside the medical community. Today the disorder is all too familiar. Although a portion of the current epidemic is certainly attributable to the spread of information about the disorder among young women themselves and to increased use of the diagnosis by doctors, there has also been a rise in incidence since the mid 1960s. Today, an estimated 10 percent of American women experience eating disorders and among those in college the figure is roughly 20 percent (Herzog and Copeland, 1986).

The number of young women who have fallen prey to this disorder since 1960 confirms the general relationship between acute social change and the intensification of bodily controls.

In the 1990s eating disorders constitute a modern credo of self-denial that has much to say about the situation of young women and about contemporary values. The disorder illustrates the predicament of the privileged but vulnerable adolescent female in a rapidly changing society that elevates thinness to the highest moral plane. To the historian eating disorders appear to be a secular addiction to a new kind of perfectionism, one that links personal salvation to the achievement of an external body configuration rather than an internal spiritual state.

CHAPTER 3

METHODOLOGY

Introduction

The purpose of this research is to report on the eating disorder behaviors of women who were investigated eight years ago, all of whom were actively anorexic, bulimic or having a mixed eating disorder six months prior to their first pregnancy and whose results at that time indicated that after one year post-delivery their eating disorders were nonimproved in 70% of the subjects.

The problem, for the purpose of this research is to investigate if childrearing and maturity had a positive effect on these women's eating disorders and if their first born children are at risk of developing an eating disorder. Therefore, the first born child's attitudes regarding dieting, weight, eating disorder symptomotology, developmental or physical delays and psychiatric treatment are examined.

Description of the Methodology

This research work is a longitudinal descriptive study which gathers data from the same sample population over a period of eight years who initially participated in a research study on the impact of pregnancy on anorexia nervosa and bulimia.

Eating disorder behaviors were compared eight years later on symptoms, recovery, and treatment. The first born child's attitudes towards weight gain,

dieting, eating disorder symptomotology, physical or developmental delays and psychiatric treatment were also examined.

However, the longitudinal sample may not be comparable to the earlier sample because only 13 of the original 43 subjects may not follow the random pattern that would be equivalent to attrition of the larger population. Consequently, results may be biased.

A 27-item, self-administered questionnaire was used to gather data for this research.

Design of the Study

The researcher-designed questionnaire assessed eating disordered behaviors of the individuals who participated in the original study eight years ago, regarding their perceptions of recovery, current treatment, current eating disorder symptomotology, as well as the attitudes of the first born child regarding weight gain, dieting, eating disorder symptomotology, developmental or physical delays and psychiatric treatment.

Sample Population and Resource Data

The sample of 13 of 43 women who were previously investigated eight years ago provided the source of information for this research. In the original study eight years ago these subjects were obtained by therapists who attended the Fourth Annual Conference of the Center for the Study of Anorexia and Bulimia subscribers from the following self-help newsletters: *American Anorexia/Bulimia Association, Anorexia Nervosa and Related Disorders Alert, Consuming Passions, National Anorexia Aid Society, and Self-Help for Eating Disorders of Phoenix.*

Instrumentation

The instrumentation used for the collection of data for this study is a researcher-designed questionnaire based on the findings from the original research eight years ago, as well as the necessity to examine the attitudes of this population's children with regard to eating disordered symptomotology. The questionnaire focused on the symptoms of eating disorder behaviors to date, current treatment for eating disorders, level of recovery as well as the first born child's attitude concerning weight, dieting, eating disorder symptomotology, developmental or physical delays and psychiatric treatment. A copy of the questionnaire and cover letter are found in Appendix A.

Data Collection

Of the 43 subjects who participated in the original 1985-86 study on the impact of pregnancy on anorexia nervosa and bulimia, 13 subjects were located. Subjects for the study were obtained by sending a letter to their previous address from eight years ago. The letter asked if they would be interested in participating in a follow-up research study to explore the status of their eating disorder symptomotology, current treatment and comparison of current eating disorder symptoms with eating disorder behaviors post-partum, as well as the first born child's attitudes concerning weight gain, dieting, eating disorder symptomotology, developmental or physical delays and psychiatric treatment. Additionally the subjects were asked to share comments and opinions they might have with regard to their eating disorder, recovery or child. A consent form and postage paid envelope were included to facilitate response rate and return.

All 13 of the subjects returned the consent forms indicating their interest to participate in the research. Approximately two months later the researcher

mailed the 27-item open questionnaire and preaddressed postage paid envelope. A cover letter and second questionnaire were sent to those respondents who failed to return the questionnaire within approximately six weeks. A copy of the follow-up letter is found in Appendix B.

Data was analyzed by tallying responses to each question and the mean and percentage of responses were calculated. Each category from the questionnaire was cited and comments by the subjects were included when indicated.

CHAPTER 4

PRESENTATION AND ANALYSIS OF THE DATA

Findings of the Study

The respondents comprised a sample representing seven states throughout the United States. All of the respondents were Caucasian and ranged from ages 34 to 47 with a mean age of 40.3 years. In terms of education:

23% had high school degrees

31% had high school degrees with some college

15% college degrees

8% had Masters

15% had Masters + and Doctorate degrees

Of the 13 women included in this sample:

46% were self-identified as currently bulimic

15% as currently anorexic

39% as recovered from their eating disorder

At the time of the original study eight years ago:

5 were self-identified as being bulimic and anorexic

2 as anorexic

6 as bulimic

Compared to the first year after childbirth the subjects reported that:

0 were much worse

1 was worse

1 was the same

2 were better

9 were much better

This indicates 69% of the subjects described themselves as much better.

In terms of treatment, 23% were engaged in some form of treatment which included individual psychotherapy, self-help and attendance at a Jenny Craig Diet Center. One individual reported being anorexic, being 15% below normal weight for age and height and restricting food intake. Three individuals reported being bulimic, reporting binge eating, feeling out-of-control, binge eating twice a week, purging by vomiting, taking one diet pill a day, laxatives once a day and persistent concerns with body-image. In terms of recovered persons, one subject stated being completely recovered for eight years with a complete recovery rate of 8%.

Ages of first born children ranged from 20 years to eight years of age with a mean of 12.4 years, with six females and seven males. Data on height and weight are not reported due to the large array of ages.

The reasons reported for those who had only one child included:

Wanted more but unable to become pregnant

Only wanted one child

Mate preferred only one child

In examining the extent to which the subjects felt that the first born child is concerned about food, weight or body-image:

1 was very concerned

1 one was concerned

4 had average concerns

2 had few concerns

5 had no concerns

With regard to the subject's concerns of the first born child developing an eating disorder, responses included:

3 were very concerned

1 was concerned

5 had average concerns

4 had no concerns at all

Three of the respondents reported that their first born child exhibited the following signs of an eating disorder:

Fear of wearing certain clothes

Fear of gaining weight

Complaining of feeling fat

Diets or skips meals and reports feeling shame and guilt after eating

Three of the subjects reported having routine meals and 10 not having a routine around meal time. Reasons for unstructured meals included:

Eat breakfast together but schedules are so different usually don't eat dinner together except on Sundays

Too busy to enforce

A routine; both children are boys who play baseball, basketball and soccer so meal times are when we can eat

We eat when we are hungry

Four in family and everyone eats at different times and is responsible for fixing their own

We never eat together or as a group

Rather haphazard; eat when hungry and often don't eat same foods

We eat together when we are hungry and try to eat together when we are all at home

We have a lousy schedule and I don't cook much

We encourage son to eat when hungry, we are quite relaxed regarding eating routines.

With regard to the first born child's view on good and bad foods:

1 out of 13 reported the child as viewing foods as good and or bad.

From a developmental point of view, the first born children first walked between the ages of eight months and 15 months with a mean age of 11.3 months. The children began kindergarten between the ages of four and six with a mean of five and entered elementary school between the ages of five and six with a mean of 5.4 years.

Psychiatrically, of the 13 first born children born to this subject sample, one child was reported to have a diagnosis of Attention Deficit Disorder and Hyperactive Disorder. None of the children had been diagnosed with depression or Obsessive-Compulsive Disorder. Two of the 13 children were reported to be on medication, one child on Ritalin and another child on Prozac. One child out of 13 was reported to have had a strabismus and one out of the 13 was reported to have a developmental delay stating:
"Very slight, always bigger for his age, goes to special education classes and has been held back one year."

Following are the comments of those who chose to discuss their opinions regarding their eating disorder, recovery and/or child:

My recovery is going well. I saw a therapist and a doctor who gave

me Prozac. I'm continuing with both since last November and feel I am overprotective of my son but am working on it. I have realized that in my therapy I have had to do a lot of grief work that I had repressed with food. I recently read a book called, "Motherless Daughters" and it was quite helpful for me.

Although my child has never suffered from depression I fear he will inherit it from me. He is very sensitive. He is very smart.

At this writing my first born child is getting all A's as a sophomore in high school in "weighted" classes. He is involved in sports and after school clubs. He is highly competitive, even with himself.

I'd like to say I'm completely free of relapse; however, I'm constantly bombarded with media stuff about thin women and diets! We have to change within ourselves, yes, but just as importantly our society has to change also!

I still binge/purge usually once a day. I now have an alcohol problem too. When I drink I tend to binge/purge more. My child has always been developmentally lower than his peers. He is in second grade but at a first grade level. He goes to special classes to help him speed up a little. He is a slow learner. He cannot read yet. He has been on Ritalin for three years for Attention Deficit Disorder. He can't concentrate and is very impulsive. The medicine helps him calm down and concentrate. He has had three eye surgeries for strabismus from the age of eight months to one and one half years old (his eyes were severely crossed--had to go in and cut the eye muscle). He was held back and had to go back to kindergarten.

Having an eating disorder is something I have to be aware of always, but over the years I learned my limitations and have learned to listen to my body. Because of the eating disorder I have had digestive problems and I have to be very careful. I also lost my period for quite sometime. I have since worked through all of this and a lot of other emotional problems. Out of three pregnancies I was unable to carry my last baby to full term. My second child came a month early and was in the hospital two weeks after delivery. When she started school she was always behind. We held her back also because of her size. She now is 14 and has caught up and is doing very well in school. She is a very healthy eater and very athletic, however, she is very tiny. At the time I was pregnant with her I was very bulimic and I'm afraid she never got the proper nourishment. I also could not nurse as I had no milk. My third child is hyperactive and is on Ritalin. She is extremely thin but eats very healthy and is a good eater. She is very aware of fat and thin. We have to work

work with her always and try to help her build a good self-esteem. I did not have good pregnancies and attribute a lot of it to being bulimic and anorexic. It has been a long slow recovery but I have learned to look in the mirror and like what I see. I'm okay with me. I also have an inner peace, that wounded child inside of me has started to heal. I've learned to let go, the past is the past. Life is too precious and I have a wonderful husband and 3 beautiful children to live for and me.

I am more concerned about my second child, five year old -----, as I raise her to accept her female body as a healthy tool for enjoyable living. So far, she thrives on physical challenges, whereasmy son is sedentary and noncompetitive. My second pregnancy was much more complicated by spousal concerns about effect of bulimia on the fetus. Her infant weight loss and gain, crying habits convinced my parents and spouse and thus me, that I was physically deficient to mother her. "Failure to thrive" syndrome was written on ----- chart. The psychological and emotional scars of my eating disorder may effect ---- for life I'm afraid. She has been very dependent, non-risk assuming and breast fed until quite recently. I am worried about my ability to steer a clear course with her through puberty, through her necessary rejection of me, etc.

I am greatly improved, seldom think about it but still have binge periods and probably abnormal relationship to food and body-image. Consider myself more of a chronic dieter now rather than bulimic.

I sought treatment after the birth of my second child. At that time I suffered an extreme depression, panic attacks, had an electrolyte imbalance. Treatment options by that time were well publicized. I took the anti-depressant Deseryl and was able to stop obsessing. My second child also is LD.

My first born is gifted and IQ above 130. I was bulimic during the pregnancy. My second born has cerebral palsy and I was recovered by then and not bulimic with him.

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

This study is an investigative follow-up of women who participated in a 1985 research study on the impact of pregnancy on anorexia nervosa, bulimia or mixed eating disorder. At that time 43 women were surveyed who had an active eating disorder involving anorexia nervosa, bulimia or mixed symptoms six months prior to their first pregnancy. Information was gathered on attitudes toward becoming pregnant, fears and concerns related to the unborn child, the impact of pregnancy on eating disorder behaviors prenatal and postnatal, weight gain and weight of the baby as an indicator of its health, and the obstetrician's view of the pregnancy and health status of the infant upon delivery.

The current research focused on the status of this population in terms of eating disorder behaviors eight years later, a comparison of symptomotology compared to initial research, current treatment related to eating disorder behaviors, current eating disorder behaviors, level of recovery, the first born child's attitudes concerning weight gain, dieting, eating disorder symptomotology. developmental or physical delays and psychiatric treatment.

A letter was sent to all of the participants of the original study asking if they would be willing to participate in a follow-up study. Thirteen individuals responded by sending back an enclosed consent form which was attached with the letter of inquiry in a pre-addressed envelope. Two months later a 27-item

open questionnaire was sent to the 13 respondents in an enclosed self-addressed envelope. A cover letter and second questionnaire were sent to those respondents who failed to return the questionnaire within approximately six weeks. Data was analyzed by tallying responses to each question and the mean and percentage of responses were calculated.

Conclusions

Since the original research eight years ago, eating disorder symptomotology in this sample population has improved with 69% responding that they are much better now than the first year following childbirth. About half of the women in the original study who made significant improvement in their eating disorder symptoms during pregnancy regressed in the first year after birth of their child (Lemberg, Phillips, 1989). It is interesting to postulate whether treatment, maturity, parenting or the passage of time was an emotionally stabilizing force. On average there was an eight year chronicity of the eating disorder prior to the birth of the first child and eight years larger the findings are indicative of overall improvement. One subject reported being completely recovered for eight years.

Currently three out of 10 women are in some form of treatment for their eating disorder including individual psychotherapy, self-help and attendance at a Jenny Craig Diet Center.

Compared to Lemberg & Phillips (1989) who reported that one-half of the women in the original study who reported their eating disorder to their obstetrician perceived that it was a negative experience, it is interesting with the current research that none of the respondents reported not wanting to have other children due to their perceived negative reaction from their physician or experience at his office. Reasons reported for only having one child included:

"wanted more but unable to become pregnant; only wanted one child and mate preferred only one child."

The mean number of children was 2.6 with a mean age of 12.4 years with six female and seven male children.

With the epidemic of eating disorders in this country it is interesting that four of the women reported having no concerns that their child would develop an eating disorder, three were very concerned, one was concerned, five had average concerns, zero and few concerns and four had no concern. Many of the women contacted by this researcher express the fear that "they will pass on their disorder to their young."

Regarding the child's feelings toward food, weight and body-image five of the women reported that their child had no concerns, two had few concerns, four had average concerns, one was concerned and one was very concerned which seems to suggest nonabnormal development of the child in spite of the mother's eating disorder.

The symptoms exhibited by three of the children, fear of wearing certain clothes, fear of gaining weight and complaining of feeling fat, dieting or skipping meals and feeling shame and guilt after eating are common themes in the disordered population.

Only one subject reported that their first born child referred to food as good and/or bad and those who commented on whether mealtimes were structured seemed consistent in that schedules were very busy but there was a relaxed atmosphere with regard to food.

All of the first born children walked between the ages of eight months and 15 months which is within the normal range suggesting no physical delays; began kindergarten between the ages of four and six years which is consistent with enrollment of kindergarten children and entered elementary school between the

ages of five and six which again is consistent with the ages that children begin first grade.

Of the 13 children born to this subject sample, only one child was reported to have a diagnosis of both Attention Deficit Disorder and Hyperactive Disorder. Two of the children were reported to be on medication, one on Ritalin and another child on Prozac. In terms of developmental delays, one child was reported to have a physical handicap of a strabismus and one was reported to have developmental delays of ADHD.

Recommendations

More research needs to be done on the offspring of eating disordered individuals. On the basis of the information obtained from this research it appears that the first born children of these individuals do not seem at risk of developing an eating disorder. However, it would be interesting to do longitudinal study on the first born children several years from now investigating whether in later years these children will develop any eating disorder behaviors and if so is it a result of having been reared by a mother was had suffered with an eating disorder or did our culture impose its values in terms of weight, dieting and body-image.

Longitudinal studies are an imperative part of research as this study is able to track individuals over the course of time.

Clinicians must be made aware of the impact of pregnancy on this population as the body undergoes drastic changes which are quite the contrary to how an individual with an eating disorder commands of herself in terms of thinness and perfection. What changes occur in the psychology and physiology of an individual to be able to let go of her symptoms of her eating disorder behaviors?

Is it maturity, childrearing, pregnancy or therapy that has allowed these individuals to recover to the extent which they have reported?

With the results obtained from this questionnaire the question also presents itself, are individuals predisposed to developing an eating disorder or is it through one's environment that an eating disorder develops? Are eating disorders biological or environmental?

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APPENDIX A

Cover Letter and Questionnaire

SHED

3337 N. Miller, Suite 105
Scottsdale, Az. 85251
(602) 947-3217
(602) 994-9773

January 12, 1994

Dear

The purpose of this letter is to once again ask for your help in a study on anorexia nervosa and bulimia. Eating disorders continue to be in epidemic proportions and your willingness to participate will help provide rich information which will be useful in their treatment.

In 1985 you participated in research conducted by myself and Dr. Ray Lemberg. As my Master's thesis, I am planning on doing a further study of these same women to determine the status of their eating disorder.

Therefore I would be grateful if you will again take the time to complete a short questionnaire so that I may collect this very important data. To indicate your willingness to participate, please fill out the enclosed card and return it to me in the self-addressed envelope. You should be receiving the questionnaires approximately 6 to 8 weeks after I hear back from you.

This information is of great importance as there have been no other studies of this kind to date. Therefore your participation is desperately needed in order to continue learning about the impact of eating disorders and ways to effectively treat them.

If you have any questions please do not hesitate to contact me at 602-994-9773 or 602-947-3217.

Sincerely,

Jeanne Phillips, BA, CEDC

CONSENT FORM

By signing below you are agreeing to participate in the Masters Thesis Project of Jeanne Phillips. The study requires that you complete a questionnaire designed by Ms. Phillips.

It is understood that the study is completely confidential and anonymous, and that the results will be reported as a group.

Thank you for your participation.

_____ _____

Participant's Signature Date

If you would like a summary of the results please print name, address and phone number below.

Name_____

Address_____

City, State and Zip Code_____

Phone_____

FOLLOW-UP STUDY ON THE IMPACT OF PREGNANCY ON ANOREXIA AND BULIMIA SYMPTOMS

Please answer all questions by checking the appropriate box or response when indicated. There will be space left on the last page if you would wish to share any comments or add pertinent information.

1. What is your current age? _____

2. What is your ethnic background?

[ ] Caucasian
[ ] African American
[ ] Hispanic
[ ] Asian
[ ] Native American
[ ] Other, specify:_____

3. What is your highest level of education?

[ ] Elementary Education
[ ] High School Degree or equivalent
[ ] College Degree
[ ] Masters Degree
[ ] Masters+
[ ] Doctorate Degree
[ ] Other_____

4. At the time of the first research questionnaire were you?

[ ] Anorexic
[ ] Bulimic
[ ] Both

5. As compared to the first year after giving birth to your first child, is your eating disorder?

[ ] Much Worse
[ ] Worse
[ ] Same
[ ] Better
[ ] Much Better

6. Are you currently in treatment for your eating disorder? (If no, please skip to #8.)

[ ] Yes
[ ] No

7. If you are in treatment, check those that apply:

[ ] Individual Psychotherapy
[ ] Group Therapy
[ ] Family Therapy
[ ] Marital/Couples Therapy
[ ] Support Group
[ ] OA
[ ] Dietary Counseling (Dietitian)
[ ] Other (please specify)_____

8. Are you currently Anorexic?

[ ] Yes If yes go to 8a

[ ] No If no go to 8b

8a. If you currently are **anorexic** check all those that apply:

[ ] Less than 15% below normal body weight for age and height.
[ ] Have an intense fear of gaining weight or becoming fat even though underweight.
[ ] Have an absence of at least three consecutive menstrual cycles when otherwise expected (primary or secondary amenorrhea). (Women are considered amenorrheic if periods occur only following hormone administration.)
[ ] Restricting food/fat intake

8b. Are you currently Bulimic?

[ ] Yes If yes go to 8c

[ ] No If no go to 9

8c. If you are currently **bulimic** check all those that apply:

[ ] Binge eating (rapid consumption of a large amount of food in a discrete period of time.
[ ] Feeling out-of-control over eating behavior during the eating binges.
[ ] Regularly engaging in either self-induced vomiting, use laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.
[ ] Have a minimum average of two binge eating episodes a week for at least three months.
[ ] Have persistent overconcern with body shape and weight.

9. Which of the following describes you currently? Mark all that apply:

[ ]	Restricting	Frequency*_____
[ ]	Bingeing	Frequency_____
[ ]	Bingeing and vomiting	Frequency_____
[ ]	Restricting and vomiting	Frequency_____
[ ]	Using laxatives	Frequency_____
[ ]	Using diuretics	Frequency_____
[ ]	Using diet pills	Frequency_____
[ ]	Using Syrup of Ipecac	Frequency_____
[ ]	Over-exercising	Frequency_____

*(For example, daily, more than one time per day, weekly, number of times per week, monthly, number of times per month)

10. If you are recovered from your eating disorder, (for example, no longer fear certain foods, weight gain and the scale, don't let numbers dictate your life, no longer "feel fat", have body acceptance), how long have you been completely free of relapse? If not applicable, skip to #11.

_____Years
_____Months

11. How many children do you have?

_____

12. How old is your first born child?

_____

[ ] Male
[ ] Female
_____Height
_____Weight

13. If you have only one child, which of the following reasons play a role in not having more children? If you have more than one birth child go to #14.

[ ] Experience at OB/GYN office
[ ] Only wanted one child
[ ] Mate only preferred one child
[ ] Fear of weight gain
[ ] Divorced
[ ] Widowed
[ ] Wanted more but unable to become pregnant
[ ] Other (please specify)_____

14. To what extent do you feel your first child is concerned about food, weight or body-image?

[ ] Very concerned
[ ] Concerned
[ ] Average concerns
[ ] Few concerns
[ ] No concerns at all

15. To what extent are you concerned that your first child will develop an eating disorder?

[ ] Very concerned
[ ] Concerned
[ ] Average concerns
[ ] Few concerns
[ ] No concern at all

16. If your first born child has exhibited any signs of an eating disorder, please check those that apply:

[ ] Fear of gaining weight
[ ] Complains of feeling fat
[ ] Weighs self on a consistent basis (daily, or sometimes more than once a day)
[ ] Fears wearing certain clothes, e.g., bathing suits, shorts.
[ ] Diets or skips meals on a regular basis
[ ] Reports feeling shame or guilt after eating

17. In your household, does your first child talk about foods as being "good food" and "bad food"?

[ ] Yes
[ ] No

18. Are your mealtimes currently routinized?

[ ] Yes
[ ] No

If yes, explain:_____

If no, explain:_____

19. Age that first born child walked:

_____Months
_____Years

20. Age that first born child began kindergarten:

_____Years

21 Age that first born child entered elementary school:

_____Years

22. Has your first child ever been diagnosed with a learning disability?

[ ] Yes
[ ] No

If yes, what was the diagnosis?_____

23. Has your first born child ever been given the diagnosis of depression?

[ ] Yes
[ ] No

If yes, specify diagnosis:_____

24. Has your first born child ever been given the diagnosis of Obsessive Compulsive Disorder?

[ ] Yes
[ ] No

25. Has your first born child ever been on psychiatric medication?

[ ] Yes
[ ] No

If so, what kind and when?_____

26 Has your first born child ever been diagnosed with a physical disability?

[ ] Yes
[ ] No

If so, what was the diagnosis?_____

27. Has your first born child had any developmental delays? (Physical & mentally)

[ ] Yes
[ ] No

If yes, please explain_____

Please share comments and opinions you might have with regard to your eating disorder, recovery, or child:

APPENDIX B

Follow-Up Letter

Ray Lemberg, Ph.D., P.C.

3337 N. Miller Rd., Ste 105
Scottsdale, AZ 85251
602-994-9773

1201 S. Alma School Rd., Ste 6950
Mesa, AZ 85210
602-644-0050

Lori Hass, M.S.W.
Sally Lemberg, A.C.S.W., B.C.D.
Erika Neuberg, M.A.
Jeanne Phillips
Bonny Tabah, R.D.

March 1, 1994

Dear

In mid-January I sent you a letter requesting your help in a study of Anorexia Nervosa and Bulimia. Eating disorders continue to be in epidemic proportions and your willingness to participate will help provide rich information which will be useful in their treatment.

Enclosed is a copy of my original letter and consent form. Please take the time once again to help out with this research. I have enclosed a self-addressed and stamped envelope for your convenience to return the consent form.

Thank you very much for your participation.

Sincerely,

Jeanne Phillips, BA, CEDC

14 34590 OTTAWA: TH
28 MIS 01/17/98 3349-