

“I Am What I (Don’t) Eat”: Establishing an Identity Independent of an Eating Disorder

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Although substantial advances have been made in developing effective treatments for bulimia nervosa and, to a lesser extent, anorexia nervosa, a significant minority of individuals develop chronic or relapsing conditions that do not respond to standard treatments (1). Indeed, for some individuals with long-standing illness, the eating disorder can develop into an integral part of their identity. A well-intentioned therapist, whose goal is to ameliorate the symptoms of an eating disorder, can unwittingly threaten a central integrating factor of his or her patient’s sense of self.

This case report is of a woman with a 20-year history of a treatment-resistant eating disorder with whom one of us (C.M.B.) worked collaboratively to forge a therapeutic approach toward effective management of symptoms and relapses and toward developing an identity independent of her eating disorder. The patient participated actively in the development of this case report in the hope that it will convey important themes to clinicians who work with individuals with long-standing eating disorders.

The following report presents five phases of the patient’s therapy. Each phase is followed by a section titled “Therapist’s Perceptions and Countertransference Issues” to illustrate the delicate therapeutic stance that is often required when a patient’s identity has been intertwined with his or her disorder. The goals of this approach are to present the information available to the therapist as it unfolded and to illustrate the decisions and critical junctures that affected the ultimate outcome of the therapy.

Case Report

Referral, Presentation, and Initial Assessment

Ms. A was a 35-year-old married woman who was referred by an internist who was prescribing “phen-fen” (phentermine and fenfluramine) for weight loss under the unenforceable and unmonitorable condition that she refrain from any eating-disordered behaviors while taking the medication. He requested assistance from the therapist (C.M.B.) in dealing with the complexities of weight loss treatment in the context of an unstable eating disorder.

The initial assessment with Ms. A was delayed several times. After numerous phone calls to “check out the therapist’s credentials” and to complain about prior treatment she had received, and two visits to the emergency room secondary to laxatives abuse, Ms. A arrived for an assessment in a whirlwind and 30 minutes late. The therapist had difficulty completing the assessment because Ms. A was so pressured to outline in great detail the difficulties she had had with treatment in the past.

At Ms. A’s first examination she weighed more than 170 lb at 5 feet 7 inches and was engaging in bingeing, purging, and laxatives abuse on a daily basis. She was also depressed, anxious, and terribly angry with all health care professionals. She was under the care of the referring internist (for weight loss), a psychiatrist (located several hours from her home) whom she saw on an irregular basis for medication management, and her family practitioner. Her treatment was disjointed, with no single practitioner coordinating her care. She was taking phentermine and fenfluramine for weight loss, 80 mg/day of fluoxetine for the eating disorder and associated obsessive-compulsive symptoms, and 100 mg/day of trazodone to improve sleep.

“She claimed that a life without an eating disorder would be a life without an identity.”

Therapist’s Perceptions and Countertransference Issues

After the patient’s first session, it felt as if a tornado had passed through the office. The initial feelings the therapist had from the interaction with the patient were that of chaos and walking on eggshells. Both the patient and her “treatment team” were out of control. There appeared to be no logic to the treatment approach and minimal concern regarding her unorthodox and potentially dangerous medication regimen. The therapist also felt duly warned by the patient’s tirade about clinicians. The therapist’s first urge was to attempt to bring some order into the chaotic situation.

Phase 1: Crisis Management, Establishing a Relationship (2 months)

The therapist had a well-intentioned plan of gathering history, conducting a comprehensive psychiatric evaluation, ordering medical tests, and gathering medical records to begin the process of treatment consolidation. Unfortunately, the therapist’s plan was undermined by Ms. A’s sporadic attendance at therapy sessions and multiple additional emergency room visits for laxatives abuse. The only tangible intervention the therapist made was to discontinue Ms. A’s participation in the medical weight-loss program and her phen-fen therapy and refer her to a psychiatrist at the treatment facility in which she would be receiving therapy. However, Ms. A

had never truly engaged in outpatient therapy, and the therapist was unable to complete an assessment, let alone get her escalating eating disorder symptoms under control. An inpatient stay was recommended in order to interrupt her eating-disordered behaviors.

Although Ms. A was unhappy with the prospect of another inpatient stay, she realized that her behavior was out of control. It is of interest that the process of obtaining authorization from her insurance company for an out-of-state inpatient stay yielded an unexpected opportunity for trust building. The authorization process was arduous, and Ms. A could see that the therapist worked hard on her behalf. Responding in a way that was uncharacteristic of her usual attitude toward clinicians, she was very grateful and thankful for the therapist's help.

Therapist's Perceptions and Countertransference Issues

The first 2 months of therapy were frustrating, and the therapist felt she was blamed for the mistakes (perceived and real) of the therapists who had preceded her. The therapist chose to persevere with the case because she felt a real sense of desperation beneath the anger that the patient displayed. Without the patient's true engagement, the only option for controlling her spiraling symptoms seemed to be an inpatient stay. During the 3-week stay the therapist experienced a sense of relief and took the time to regroup, collect medical records, and begin to plan for postdischarge treatment.

Phase 2: Enlightening the Therapist: The History of Ms. A's Eating Disorder (6 months)

When Ms. A returned from the hospital, despite her continuing dissatisfaction with all health care professionals, her eating disorder symptoms were under sufficient control that therapy sessions could focus on reconstructing the history of her eating disorder.

Ms. A recalled that before the age of 12 she was healthy and talented in sports. At 12 she contracted coccidioidomycosis. During her protracted recovery she developed an array of obsessive thoughts and compulsive behaviors. Included among those were obsessive thoughts about weight and food. She began to fear that touching or even breathing around food would lead to weight gain. She reduced her food intake dramatically and experienced precipitous weight loss. Her lowest weight was 94 lb at 5 feet 7 inches. Even as an adolescent she felt as if she had never been a "good enough" anorexic, as people who "succeed" at the disease lose much more weight or die.

She was first treated for anorexia nervosa at age 12 by a local pediatrician. She recalled feeling as if no one knew how to help her, and in retrospect she realized that in having developed the disorder before widespread recognition of eating disorders, she encountered many practitioners who may not have known how best to proceed.

The restricting pattern of anorexia nervosa lasted until the age of 15 and her first hospitalization. She only gained a few pounds during the 2-month inpatient stay, during which she reported learning from a staff member how to self-induce vomiting and use laxatives. From age 14 until her late 20s, she had a gradual increase in

weight to the normal range, and binge eating, self-induced vomiting, and laxative abuse became firmly established as daily behaviors. At the worst period of her illness, she binged and purged more than 15 times per day. She developed a tolerance to stimulant laxatives and administered up to 50 times the recommended daily dose to achieve the desired effect. Her weight increased further when she was in her late 20s.

A review of her records indicated more than 20 hospitalizations for her eating disorder. She lost count of the number of emergency room visits; however, her medical records showed 14 emergency room visits to just one hospital over a period of 2.5 years, each hospitalization following a similar pattern. She would yield to the irresistible urge to use laxatives and ingest between 50 and 120 tablets, develop nausea, vomiting, abdominal pain, and diarrhea and then proceed to the emergency room. In the emergency room she was always frank about her laxative abuse and was typically described as a "pleasant and cooperative woman in marked distress." She was given fluids, potassium, antiemetics, and often morphine to control her abdominal pain.

In addition to having a primary eating disorder, Ms. A had experienced multiple episodes of major depression and numerous anxiety features throughout the course of her illness. Most notable among these were severe obsessions and compulsions (unrelated to food or eating) and panic attacks.

Ms. A had worked with several psychologists, psychiatrists, and internists in an outpatient setting. She recalled those individuals who had treated her "respectfully" with fondness and gratitude and those whom she perceived to have "not been able to see the person beneath the eating disorder" with contempt, resentment, and colorful expletives. She was treated with 80–100 mg/day of fluoxetine, which controlled her obsessions well; however, no medication had had a substantial effect on her urges to binge and purge. In addition she had had behavioral, cognitive-behavioral, psychodynamic, and supportive psychotherapy. Although some of the therapies had been for relatively brief periods, she had engaged in adequate trials with experienced therapists with whom she felt she worked well. Again, although brief periods of remission occurred, relapses seemed to be inevitable and were often temporarily debilitating. Several practitioners noted that Ms. A was "not committed to recovery" or "resistant to treatment."

During this phase of therapy Ms. A also was able to discuss her family and relationship history. She was the first of two children. She was especially close to her brother and mother and reported with sadness the long absences of her father, who was often away for extended periods on overseas business. She recalled that his problems with drinking served to strengthen her bonds with her brother and mother. She described her father as being in "an emotional orbit" around the rest of the family. Ms. A's family of origin had provided consistent support for her throughout her illness, although she experienced considerable guilt regarding the "hell" she had put them through with her eating disorder. She was raised in the Catholic faith, and her family instilled in her a deep sense of propriety and manners. Despite their living in different cities, she continued to speak with her parents on the telephone nightly and with her brother several times a day.

Ms. A had been married for 7 years and had no children. Although her husband was generally supportive, at times he would become frustrated with her eating disorder and have difficulty understanding her behavior. She also had a supportive and stable network of friends.

Despite having numerous setbacks to her education due to complications of the eating disorder, she completed the requirements for a bachelor's degree. She had a varied employment history ranging from clerical to managerial positions and had just returned to school for graduate study.

Therapist's Perceptions and Countertransference Issues

This phase of therapy was a process of discovery. A review of the records revealed a bewildering array of diagnoses—anorexia nervosa, bulimia nervosa, major depression, panic disorder, obsessive-compulsive disorder (OCD), borderline personality disorder, trichotillomania—with no sense of integration or appreciation of how all of the patient's symptoms fit together. Her list of prior treatments was equally extensive and disjointed. An objective review of the patient's records and listening to her commentary about prior treatment suggested that many clinicians had difficulty establishing and maintaining a therapeutic relationship with her and developing effective treatment plans.

Other perceptions that arose during this phase of therapy included some remarkable inconsistencies. Casual observations of the patient's interactions with office staff suggested an affable, outgoing, compassionate woman who was very well liked by the staff. In contrast, she would often start sessions with a full-scale assault on health care professionals. Throughout this phase of treatment, the patient would still frequently miss sessions, arrive late, and try to take therapy on her own terms. The therapist felt as if there were still missing pieces to the puzzle and was concerned that she, too, would become another therapist casualty on the patient's list unless the therapeutic relationship could be further solidified and treatment could become more regular.

Phase 3: Who's in Control? (2 months)

In this phase of treatment, the issue of who was in control of the therapy moved to the forefront. The therapist continued to recommend weekly sessions, and Ms. A regularly resisted. Rather than addressing the attendance issue directly, the therapist attempted a different approach. She acknowledged that Ms. A had been living with an eating disorder longer than she had been working in the field. The therapist made clear that she respected the knowledge and understanding that came with having lived with an eating disorder for so long. She then suggested that Ms. A become her own dose manager, meaning that Ms. A could titrate her "dose" of psychotherapy to suit her own needs. Ms. A had mentioned on several occasions that she had "had it up to here" (gesturing to her throat) with coercive treatment in the past. The therapist hoped that by giving Ms. A some degree of control over her own course of treatment she might become more comfortable with more regular ses-

sions. Moreover, Ms. A and the therapist engaged in a frank discussion about treatment goals. Would they work toward a total cure, or would they take a more moderate approach toward symptom management? Ms. A was clear that she believed "a cure" was a laughable goal for someone with as long-standing an eating disorder as hers and that symptom management was all that could be expected. The therapist stated that she had no illusions of possessing a magical intervention that her predecessors had not possessed that would lead to an instant cure but that she would be happy to work with Ms. A toward effective symptom management. The therapist also mentioned that one can be surprised when chronically ill patients occasionally turn the corner after years of suffering from an eating disorder. Although these approaches ran the risk of Ms. A's using therapy only for crisis intervention, the gamble paid off. Her attendance became more rather than less regular as she recognized that the therapist had no intention of "shoving treatment down [her] throat."

Therapist's Perceptions and Countertransference Issues

These interventions seemed like turning points in therapy, as there was a tangible shift in attitude and in the emotional tone of the sessions. The process behind the gamble was genuine, as the therapist had always believed that she had much to learn from her patients; however, at the same time she was worried that the suggestion of patient-led dose management could indeed backfire. Part of the rationale behind these interventions was the fact that the patient had often spoken of feeling disrespected by her clinicians. The therapist hoped that by conveying respect for the patient's knowledge, experience, and judgment that wise choices might ensue and the therapeutic bond could be further strengthened.

Phase 4: The Missing Piece: "I Am What I (Don't) Eat" (1 year)

After Ms. A was given control of her dose of psychotherapy, her attendance became more regular. Her symptoms remained at a low level, and the focus of therapy was able to move away from crisis management and dissatisfaction with health care providers toward more emphasis on understanding and managing her eating disorder. Ms. A was a bright and insightful woman. She was able to articulate that since she was age 12, her identity had been that of a person with an eating disorder. She claimed that a life without an eating disorder would be a life without an identity. Moreover, it had become a personal goal to "achieve" in terms of the eating disorder. She felt she had not been "successful" as an anorexic because she did not reach an extremely low weight. She believed that truly successful anorexics die of starvation and that somehow they should be revered for their accomplishment. Because of her "failure" as an anorexic, she felt that she had to attain certain standards as a bulimic—either taking the most laxatives, developing a serious medical complication, or living with the disorder for the longest. During more rational moments she could see the distorted and destructive nature of these thoughts. However, during relapses or when she heard or read about other patients with eating disorders, she

would begin to feel as if she had to continue to “achieve” at bulimia nervosa in order to retain the designation as the “best” patient with an eating disorder.

Ms. A also began to articulate the purpose that the cycle of laxative abuse and emergency room utilization served for her. Despite the pain and nausea, the cycle of laxative abuse had become a source of “predictable pain” and distraction from unpleasant thoughts or events. Her episodes of laxative overdose were usually in response to emotional conflict or a perceived sense of lack of control over some aspect of her life. She would normally take a large dose of laxatives, knowing that within 6 hours she would be feeling miserable. Being able to predict her physical reaction to the laxatives and being able to predict the intervention she would receive in the emergency room served to decrease her anxiety related to the ambiguity surrounding the precipitating events. Moreover, by making herself feel miserable, she was able to effectively focus all of her attention on the eating-disordered behaviors and at least temporarily shift her focus away from dealing directly with the precipitating issues. She would leave the emergency room somewhat dazed but feeling more in control and effective given that by virtue of taking laxatives, she was able to produce a predictable sequence of events. Thus, the experience was simultaneously self-punishing and comforting. After one of these episodes she was often able to go for weeks or months without having the urge to use laxatives again. Then the urges would return. Occasionally, they would return precipitously in response to an identified stressor. At other times she would become concerned that she had gone too long without engaging in eating-disordered behaviors and have almost existential concerns that she was not “living up” to her standards of how someone with an eating disorder should behave.

Therapist's Perceptions and Countertransference Issues

The therapist was consistently impressed by the patient's ability to articulate the meaning of and the purpose served by her eating disorder. It also became clear at this stage of therapy how frightening the prospect of a total cure would be for the patient. This was mirrored in a curious facet of therapy. Although it was perfectly acceptable for the therapist and patient to have discussions about slips and lapses of disordered-eating behavior, it was not acceptable to the patient for the therapist to praise her when she was doing well. Any acknowledgment of improvement or prolonged periods without a slip could increase the patient's anxiety about living up to the expectations associated with her identity as someone with an eating disorder. A comment about how well she was doing could catapult her into a renewed bout of laxative abuse in order to reestablish her identity. Although a significant amount of time could have been spent exploring this dynamic, the therapeutic relationship was sufficiently strong at this point that the patient and therapist agreed to a “you know that I know that you know” arrangement that allowed them to acknowledge progress without actually verbalizing it. It became a humorous interaction and gradually the topic of clinical improvement became less taboo.

Phase 5: Building a New Identity (1 year)

During the next year Ms. A had occasional bouts of taking small doses of laxatives, but there were no major relapses or visits to the emergency room. Ms. A was maintained with a dose of 100 mg/day of fluoxetine, prescribed by the psychiatrist at the same facility, which prevented any major fluctuations in mood and controlled her obsessional thoughts. In addition, all medical consultations related to her eating disorder (e.g., acid reflux and irritable bowel syndrome) were discussed with the therapist, who coordinated a small integrated team of herself, the psychiatrist, a gastrointestinal specialist, and a family practitioner. Each clinician knew Ms. A well, and they interfaced actively among each other.

In this phase of therapy, in addition to working on ongoing symptom control, Ms. A and the therapist worked toward consolidating and elaborating aspects of her identity and self-concept that were independent of the eating disorder. As Ms. A explored other facets of her self, a number of character strengths began to emerge that had been less apparent when her eating disorder was out of control. The personality that was so often visible in her interactions with the receptionists began to manifest in therapy sessions as well. Personal qualities such as a quick wit, an acerbic sense of humor, determination, and perseverance all became visible as Ms. A's eating disorder symptoms became less prominent.

Her determination to continue pursuing a career and to work to preserve her marriage in the face of potentially debilitating illnesses also attested to strengths that had been there all along but had been obscured by her eating disorder. Ms. A had observed numerous other patients give up or opt out of a productive life because of their eating disorders. Despite the integration of the eating disorder into her sense of self, she paradoxically refused to let it stop her. Occasionally, she would lament the negative effect that the eating disorder had on her ability to achieve her potential; however, she viewed her eating disorder as more of a handicap or a “cross [she] had to bear” rather than something to defeat her.

Ms. A also possessed a great deal of generosity and charitability. She had a number of close friends and acquaintances for whom she went out of her way. Her “do unto others” approach to life was rooted in her Catholic upbringing and in the values her family instilled in her. She was occasionally ambivalent about her charitability, although she could act no other way and remain comfortable with herself; she was hurt when others did not behave in the same manner toward her.

Before this phase of therapy Ms. A had rejected the use of any cognitive-behavioral techniques to help control her symptoms. During this phase she became more receptive to weaving in work with automatic thoughts and thought restructuring to address both her eating disorder and other issues at work and at home.

Another critical change concerned recognizing the warning signs of relapse. Ms. A became able to trust the therapist's perceptions of her deteriorating symptoms enough to accept recommendations for intervention. During the first 2 years of treatment Ms. A would not call the therapist outside of sessions, regardless of how bad she felt. Finally, the therapist convinced her that a brief call or e-mail message to her could be one of many strategies to forestall a slip or relapse. Gradually, Ms. A be-

came more comfortable using that as an option, and she never abused the privilege.

Parallel to her progress in therapy, during this phase Ms. A maintained stable employment and received favorable performance reviews and promotions in her work. She became a role model of assertiveness for many of her female co-workers (although it continued to be difficult for her to behave assertively, she pressed forward). After decades of occupying the “sick” role in her family, she started to be able to offer support and advice to her brother and parents, and they began turning to her with their concerns and problems. Although initially she had difficulty separating their pain from hers, gradually she became more proficient at drawing the boundary.

Ms. A developed an approach toward the therapist that is best described as “skeptical respect.” Humor was used both by Ms. A and the therapist consistently both during well periods and at the worst of times. The therapist continued to respect that Ms. A’s personal experiences held invaluable data for guiding treatment. Ms. A allowed herself to trust that the therapist’s recommendations were in her best interest and, with tongue in cheek, admitted that there may be value to the therapist’s cognitive techniques after all. The development of this mutual respect forged an individualized path toward symptom management rather than a complete cure. Paradoxically, Ms. A’s eating disorder improved beyond the level that either she or the therapist thought possible. By lowering her expectations about a cure, Ms. A and the therapist somehow permitted a further recovery.

Therapist’s Perceptions and Countertransference Issues

This stage of therapy was interactive and rewarding. The regular high dose of fluoxetine allowed the patient’s mood to remain stable, minimized her intrusive obsessional thoughts, and facilitated the progression of therapy beyond symptom management. The crafting of mutual respect and a cooperative relationship required substantial effort on the part of both the therapist and the patient. Perhaps one of the most satisfying aspects of therapy was watching the compassionate, charitable, humorous side of the patient emerge from under the cloud of her eating disorder. Even more gratifying was seeing her recognize that those features were core components of her identity.

Commentary

Several key points emerged from this case. First, there are limits to the applicability of evidenced-based treatments for eating disorders. Although brief structured interventions are appropriate for the majority of individuals with bulimia nervosa and the principles and techniques of those treatments have broad applicability, increased flexibility and creativity are required in order to find the optimal approach for individuals for whom these interventions fail. Yager (2) noted that in trying to develop the appropriate pace and therapeutic stance for patients with chronic recalcitrant eating disorders, “the clinician must establish therapeutic goals that neither grossly overestimate what can realistically be achieved nor underestimate the patient’s potential.” He also stated that “clinicians

must monitor their own therapeutic biases to assess their propensities toward undue therapeutic zeal or undue therapeutic helplessness.” Had the therapeutic relationship begun with the optimistic expectation of a complete cure, the patient would have been unimpressed by the therapist’s naive grandiosity. However, had the therapist not tried persistently to nudge treatment forward and help consolidate the patient’s non-eating-disordered identity, she would have been guilty of therapeutic neglect. Additional clinical trials using stepped-care models or focusing on treatment-resistant patients are necessary to help determine the optimal approaches for the treatment of individuals with chronic, refractory eating disorders.

Second, when a patient has incorporated his or her eating disorder into his or her identity, therapy can be a threat. Unlike many patients with other psychiatric disorders who desire to be free of their symptoms, patients with eating disorders are often terribly reluctant to “give up” the drive for thinness or low weight. They may also believe that there is a positive stigma to having an eating disorder; many discuss being part of the “eating disorder club.” Their lives can become filled with support groups, documentaries, therapy sessions, and full-time cognitions and thoughts about shape and weight. Among patients, the symptoms of an eating disorder can become a source of competition: who is the thinnest? who ate the least? who exercised most? Taking this all away without providing a replacement can leave a frightening void. The therapists’ awareness of the function that the eating disorder serves in terms of creating an identity is essential for treatment planning and pace.

Third, once an individual receives the label of “eating disordered,” professionals may tend to see all problems through that filter. Medical professionals respond negatively to patients with eating disorders and see them as reacting to external pressures and having a self-induced illness (3). This stereotyping leads to a false belief that all eating disorders are similarly caused and similarly cured. Although the core behavioral features are often constant across patients, the underlying complexity of biological and environmental factors that converge to create an eating disorder are unique to each individual. Another common misconception is the belief that disordered-eating behaviors are entirely willful. Although most clinicians would not imagine telling a patient with major depression or OCD to “snap out of it,” some continue to believe that individuals with bulimia nervosa should be able to stop vomiting at will. These sorts of attitudes serve to make patients distrustful of clinicians. Although there was no question that the patient in this case report was sensitized and hypervigilant to potential mistakes clinicians might make (which is not uncommon in individuals with long-standing patterns of high utilization), as the therapist interfaced with some of her providers, she encountered first hand many of the attitudes that had contributed to the patient’s discontent. Again, it is essential, regardless of frustrations and hurdles, for clinicians to “continue to treat the patient with compassion as a fully franchised human being” (2).

Finally, nonspecific factors of treatment appear to be especially relevant when working with individuals with chronic eating disorders. Integrated care, with one provider acting as the coordinator of treatment, can reduce the frustrations associated with a fragmented approach to intervention. In addition, the central elements of sound psychotherapy, including genuineness, positive regard, a nonjudgmental attitude, and accurate empathy, can assist in strengthening the therapeutic relationship. Patients with eating disorders are often acutely interpersonally sensitive and reactive to any real or perceived lack of genuineness on the part of the therapist. A therapeutic stance that includes honesty, recognition of the limitations of one's own knowledge, an ability to admit to and take responsibility for one's mistakes, and a genuine appreciation of the patient as a fellow human being are critical to building trust. Trust in the absence of competence, however, is not therapeutic. A therapist treating an individual with a long-standing eating disorder must have sufficient knowledge of the psychological and medical aspects of eating disorders to be able to manage such a case effectively and convey a sound sense of competence to the patient.

It is also important to work as a team with the patient in developing expectations that are commensurate with his or her ability and with the limitations imposed by the ill-

ness. From the therapist's perspective, the ongoing monitoring of countertransference issues as well as remaining patient, flexible in the therapeutic approach, and comfortable with mutually established treatment goals are important in being able to provide optimal care.

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