2

Eating disorders—an overview

Key points

- Women with eating disorders are preoccupied with thoughts of control over food, eating, or weight
- Anorexia nervosa disorders are characterized by weight loss and low body weight
- Bulimia nervosa disorders are characterized by binge eating and the use of extreme behaviour to prevent weight gain
- Eating disorders can be described as: high weight, low weight, vomiting, purging, binge eating, atypical exercise
- Onset of binge eating episodes are associated with anxiety, stress, and negative emotions
- Exercise rather than weight can be the focus of an eating disorder

'The human being is an open social system, each one, in its own way unique. My food problem is my somewhat unique reaction to a board of external and internal influences. Human beings prefer things in a state of organization, they dislike randomness and attempt to classify.'

Control of eating

The control of normal eating behaviour is not well understood. Although more is known about the many factors that influence the control of food

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intake, it is still puzzling how they all fit together. The discovery of leptin is an important recent advancement, as this hormone is involved in the energy balance in the body of humans. It is secreted by fat (adipose) tissue and reflects the amount of energy stored in the body as fat. The higher your body weight (fat), the higher the levels of leptin in your bloodstream.

Fact!

Leptin tells the body when you are satiated (full) and do not need further food.

Ghrenlin tells the body when you need to eat.

Receptors in the hypothalamus of the brain are sensitive to the levels of leptin and regulate the amount of body fat by controlling the appetite and increasing energy output. The most potent appetite stimulant in the brain is called neuropeptide Y (NPY); leptin decreases appetite by suppressing NPY. Another hormone in the body called ghrenlin has the opposite effect and stimulates NPY. Other hormones released from the stomach, intestines, and bloodstream including insulin and cholecystokinin in turn regulate leptin and ghrenlin. Insulin is a messenger of satiation and is produced by the pancreas in response to an increase in blood glucose. Cholecystokinin is produced by the duodenum and is thought to regulate the size of the meal eaten.

How the sight, smell, and taste sensations associated with food are integrated with the chemical and neural messages received by the brain is unclear, as these sensations may encourage or discourage eating.

Women with eating disorders often believe 'you are what you eat' and believe that they can control their body weight by the food they eat. In fact, 75% of the energy derived from foodstuffs is converted into heat, which is used to keep the cells of the body warm so that each cell can carry out the work it is designed to do to help the body function as a whole. Which receptors in the brain keep body weight so surprisingly stable in most individuals is unknown. We do know that increased levels of leptin in the blood increase the body's activity and heat production (in addition to decreasing food intake), resulting in increased energy loss. This may account, at least in part, for the relative stability of body weight for most people. What is also known is that these mechanisms and receptors fail to function when they are over- or understimulated by starvation or by gorging and binge eating. Somehow these messages to and from the brain are scrambled by these behaviours. A genetic failure of release of the leptin is also implicated in some cases of obesity.

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Fact!

Women with eating disorders feel that their perceptions of hunger and satiation (fullness) are not to be believed.

Defining an ideal weight

A number of calculations have been used to define maximum and minimum ideal weights. The simplest is a measurement of weight against height, as used by insurance companies (Figure 2.1). A more sophisticated measure takes into account the person's age, as well as weight and height, as obtained from a table prepared by the Society of Actuaries, and is called the average body weight (ABW).

The body mass index (BMI) is the third type of calculation and the one used in this book. Devised in 1871 by a Belgian astronomer and mathematician, Dr Quetelet, for defining obesity, it is equally valuable in reaching a diagnosis

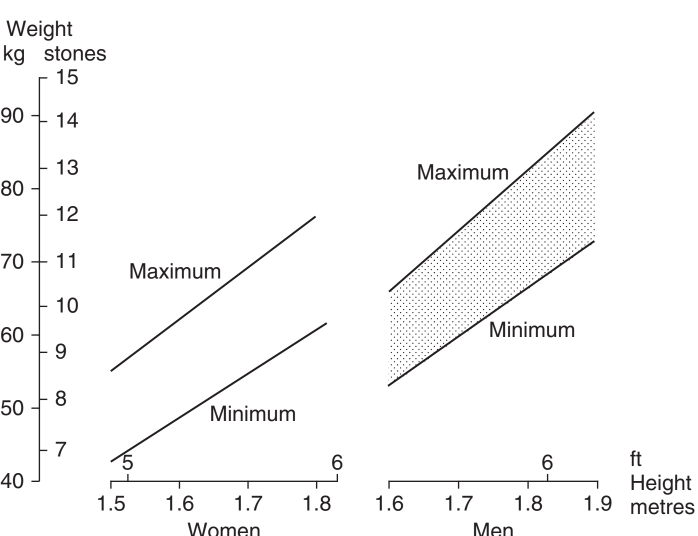

Figure 2.1 Maximum and minimum ideal weights for men and women of different heights wearing light clothing

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of anorexia nervosa. The Quetelet Index, which is now known as the BMI, is calculated from the simple formula:

$$\frac{\text{weight (kg)}}{\text{height (m)} \times \text{height (m)}} \text{ kg/m}^2$$

The person is weighed in indoor clothing without shoes (Figure 2.2). A table of heights and corresponding BMI values is available in Appendix A.

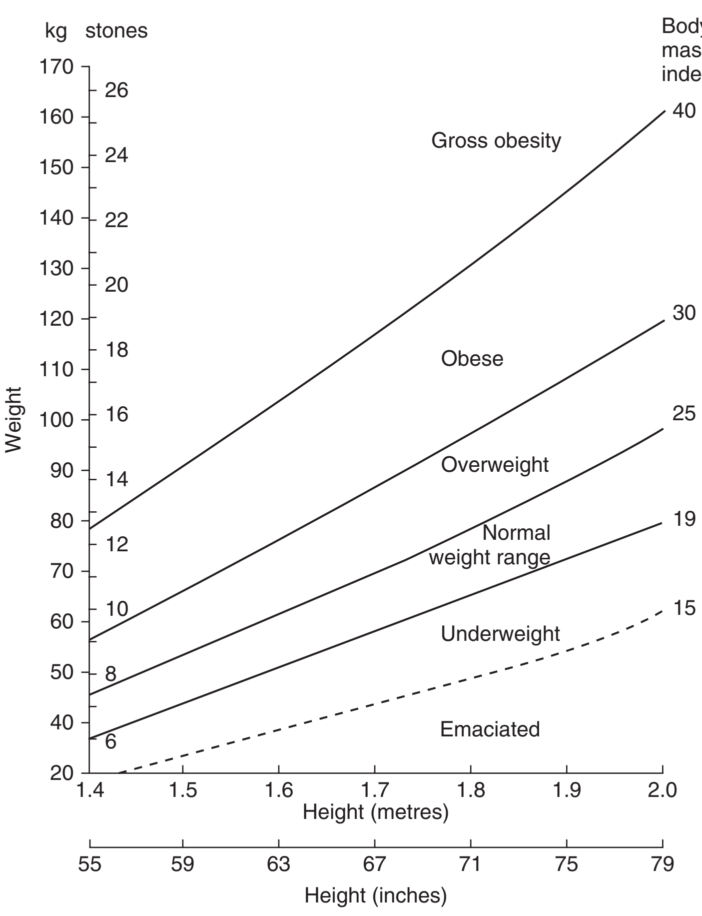

Figure 2.2 Body mass index (BMI kg/m^2)

Anorexia nervosa

> 'People may find it hard to believe or comprehend why a person, supposedly intelligent and quite attractive and with a good family upbringing, would throw it all away for an obsessive need—no, desire!—to be slender and praised for the will-power to diet so well and easily.'

The term anorexia nervosa was first used by an English physician, Sir William Gull, in 1873. He described a young woman, 'Miss A', whom he had first seen 7 years earlier:

> Her emaciation was very great. It was stated that she had lost 33 lbs. in weight. She was then 5 st. 12 lbs. Height, 5 ft. 5 in. Amenorrhoea for nearly a year. No cough. Respirations throughout chest everywhere normal. Heart sounds normal. Resp. 12; pulse, 56. No vomiting nor diarrhoea. Slight constipation. Complete anorexia for animal food, and almost complete anorexia for everything else. Abdomen shrunk and flat, collapsed. No abnormal pulsations of aorta. Tongue clean. Urine normal. Slight deposit of phosphates on boiling. The condition was one of simple starvation. There was but slight variation in her condition, though observed at intervals of three or four months . . . The case was regarded as one of simple anorexia.

> Various remedies were prescribed but no perceptible effect followed their administration. The diet also was varied, but without any effect upon the appetite. Occasionally for a day or two the appetite was voracious, but this was very rare and exceptional. The patient complained of no pain, but was restless and active. This was in fact a striking expression of the nervous state, for it seemed hardly possible that a body so wasted could undergo the exercise which seemed agreeable. There was some peevishness of temper, and a feeling of jealousy. No account could be given of the exciting cause. Miss A remained under my observation from January 1866 to March 1868, when she had much improved, and gained weight from 82 to 128 lbs. The improvement from this time continued, and I saw no more of her medically . . .

Sir William was in error: patients with anorexia nervosa do not have a lack of appetite. They are often hungry, but suppress their hunger and refuse to eat normally because of their relentless desire to be thin, even to the point of becoming emaciated, and their fear that they will lose control of their eating behaviour.

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Main features of anorexia nervosa

The diagnostic criteria for anorexia nervosa are outlined in the box below.

Current diagnostic criteria for anorexia nervosa

- An intense fear of gaining weight or becoming fat, even though the woman is underweight
- Refusal to maintain her body weight in the normal weight range for her age and height; this is not due to any physical or mental disorder
- A BMI equal to or less than 17.5
- A disturbance in the perception of her body weight, size, or shape
- Denial about the serious nature of her current low body weight
- If she has entered her reproductive years (i.e. has passed puberty), no menstrual periods (amenorrhoea) for at least 3 consecutive months

Two types of anorexia nervosa have been suggested: restricting type and binge eating/purging type.

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Weight loss

When presenting to a doctor, the woman has usually lost a considerable amount of weight, so that her BMI is 17.5 kg/m^2 or below. Once a physical or a mental illness has been excluded as a possible cause for the low body weight, a woman whose BMI is less than 17.5 is likely to have anorexia nervosa.

The BMI of prepubertal girls must be interpreted carefully as no accurate BMI tables that include age are available. Teenage girls who have not started menstruating have lower BMIs than girls of the same age who have menstruated (Figure 2.3). Using 85% of expected body weight for age and height is generally appropriate for children.

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Figure 2.3 A young woman suffering from anorexia nervosa

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Fact!

Asian women usually have a BMI value about one BMI point below Caucasian women.

Preoccupation with thoughts of weight or food

In the pursuit of thinness, women must remain ever vigilant in their quest and they become obsessed with thinking and planning their eating and weight-losing behaviour. The more starved the brain, the more obsessional the thoughts and behaviour become. They fear loss of control of their weight and their eating except at very low body weights, at BMIs of less than 15.5 kg/m^2, if at all. Thoughts about control over their body, food intake, activity, and weight-losing behaviours dictate how they live every moment of their life and it becomes increasingly difficult for them to separate their eating-disordered thoughts from their own thoughts. They appear to become consumed with their eating disorder to the point where they will cheat and lie to maintain their behaviour. *Preoccupation with eating-disordered thoughts interferes with their concentration on other things*.

Lack of menstruation

The third main feature of anorexia nervosa is that a girl who has started to menstruate ceases menstruating—she develops amenorrhoea. Most women cease to menstruate when their weight is in the BMI range of 17–19 kg/m^2 when they no longer have sufficient reserves of energy in their body to support a healthy pregnancy. If a woman is taking the oral contraceptive 'pill' or 'hormone replacement', this feature cannot be determined (see Chapter 7).

Perception of body image

'Before I started to lose weight, common sense tells me that my weight was not heavy for that height. But common sense had left me and I wanted to weigh about 43 kg (95 lb or 6 st 11 lb). And I achieved it! The strange thing is that whenever I went to buy new clothes, I always saw how revoltingly thin my image in the mirror actually was. But I still felt fat.'

Some experts claim that a distorted body image—the woman perceiving her body as larger, wider, and fatter than it is in reality—is a specific feature of anorexia nervosa. This is inaccurate, as many other women, such as pregnant women, who have recently changed their body shape have the same disturbed

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Table 2.1 What young women would like their weight to be

Preferred weight	Healthy women (%) (*n*=106)	Ballet dancers (%) (*n*=50)	Anorexia nervosa patients (%) (*n*=22)	Bulimia nervosa patients (%) (*n*=44)
A lot heavier	0	1	9	0
A little heavier	1	1	50	0
Present weight	19	5	5	15
A little lighter	48	62	23	20
A lot lighter	32	31	13	65

body image. Many women who have normal eating behaviour also overestimate their body size, and in some cases overestimate it considerably more than women who have anorexia nervosa, especially when looking at their hip width and their body from the side. We found this over-perception of size among various different women when we asked the question 'What would you prefer your weight to be?' The groups were women who were students, ballet dancers, or had eating disorders. Each of the groups wanted to be thinner, except for over half of the patients with anorexia nervosa who were already at a very low weight (Table 2.1).

It is also possible that some of the reports that say that a distorted body image is a specific feature of anorexia nervosa may be due to the patient deceiving the doctor, as in the *Patient's perspective* below.

Patient's perspective

'I've spoken to other anorexics and they realize just as I realize that at our lowest weights, we all knew we were damn thin. You'd have to be pretty stupid to think that you were not, but you have to hide it because if you let on to the doctors that you know you are thin, they will want to put weight on you. I won't tell my doctor though, because I want to stay like this: I feel safe, out of the world and men are too scared to touch me in case they break me. So I tell him, "Of course I'm not thin."'

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Like other teenagers, women who have anorexia nervosa look at parts of their body, rather than at their body as a whole, when they look at themselves in a mirror (page 9). They see their abdomen as 'bulgy' and they want it to be flat, and their thighs as large and heavy, and may want them to be smooth and thinner.

It is true that many severely emaciated women suffering from anorexia nervosa lose insight into how emaciated they are and describe themselves as 'feeling fat'. 'Feeling fat' is frequently associated with feeling bad, with being worthless and unhappy. *Anorexia nervosa patients can differentiate between 'feeling fat' and 'looking fat'.*

Bulimia nervosa

> 'Looking back on the reason I started binge eating, I think it was because of my obsession with dieting. And that stemmed from the fact that I thought I was overweight when in reality I was short and had inherited fatter arms and legs than the average person.'

Bulimia means 'to eat like an ox'. Although people have been known to 'eat like oxen' from antiquity, it was not until 1979 that a London psychiatrist, Gerald Russell, identified 40% of his patients with anorexia nervosa with an 'ominous variation' of the disorder, the variation being that they periodically went on eating binges.

By 1982, it became clear that women who had never been at a low body weight also binge ate. As well as feeling that they have a lack of control over their eating behaviour, sufferers binge eat very frequently and adopt measures, some of which are extreme, to prevent themselves becoming increasingly fat.

Bulimic women were found to divide their days into 'good days' when they had no compulsion to binge eat and 'bad days' when they found the need to binge eat irresistible. They were also aware that anxiety, boredom, stress, or unhappiness could precipitate an episode of binge eating. *Bulimic women associate unpleasant feelings with the onset of a binge-eating episode.*

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Features of bulimia nervosa

The diagnostic features of bulimia nervosa are outlined in the box below.

Current diagnostic criteria for bulimia nervosa

The woman:

- has recurrent episodes of binge eating, i.e. she rapidly consumes a large amount of food in a short period of time (usually less than 2 hours);
- feels that she lacks control over her eating behaviour during the eating binges;
- regularly engages in measures to prevent gaining weight, such as self-induced vomiting, misuse of laxatives or diuretics, strict dieting, fasting, or vigorous exercise;
- has had a minimum average of two binge-eating episodes a week (and the weight-gain prevention measures) for at least 3 months;
- has a persistent over-concern with her body shape and weight; and
- the eating disturbance does not occur exclusively in association with anorexia nervosa.

Two subtypes of bulimia nervosa have been suggested: purging and non-purging subtypes.

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Fact!

The features of patients with anorexia nervosa and bulimia nervosa are similar.

Fear of weight gain

Between binges, bulimia nervosa sufferers try to diet rigorously and may try to resist the urge to binge eat, rather as an alcoholic tries to resist the urge to

drink (at least 20% of patients with bulimia nervosa also abuse alcohol or drugs). Most resort to more extreme methods such as inducing themselves to vomit, taking large amounts of laxatives in the belief that the food eaten will not be absorbed, or using stimulant and 'party' drugs. A minority of binge eaters do not induce vomiting and maintain a very strict diet between eating binges, controlling their weight in this way. They may find that eating 'anything' leads to binge eating and they alternate starvation with binge eating. *A woman with bulimia nervosa is aware that binge eating and overeating are different.*

Preoccupation with thoughts of food and control of body weight

Eating is a temporary way of escaping from these thoughts and the unpleasant stresses of life. The feelings of unhappiness, anxiety, or stress that precipitated an eating binge are relieved to a greater extent among those patients with bulimia nervosa who induce vomiting than among those who use other behaviours to avoid weight gain.

Binge eating

Binge eating occurs when the woman's resistance to eating fails and she has an irresistible desire to eat. This leads her to ingest excessive amounts of food, far more than is needed to maintain good nutrition and far more than most other people in her culture normally eat. This causes her to be secretive about her binge eating, at least in the early stages of the illness. Attempts by others to prevent her binge eating may be met by hostility.

Atypical or eating disorders not otherwise specified

Features of 'eating disorder not otherwise specified'

- If female: all of the criteria for anorexia nervosa are met, except that the woman menstruates regularly
- All of the criteria for anorexia nervosa are met except that, despite significant weight loss, the person's current weight is in the normal range
- All of the criteria for bulimia nervosa are met except that the binge eating and inappropriate behaviours (i.e. purging, laxative abuse, etc.) occur less than twice a week or for a duration of less than 3 months

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- The person's weight is in the normal range, but they regularly induce vomiting after eating small amounts of food
- The person repeatedly chews and spits out large amounts of food rather than swallowing the food

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Physicians who specialize in evaluating and treating patients with eating disorders find that many of their patients do not fulfil all of the criteria for a diagnosis of either bulimia nervosa or anorexia nervosa, and they are not obese. This does not mean that their eating disorder is less severe. They are given a diagnosis of 'eating disorder not otherwise specified' (EDNOS) following the advice of the American Psychiatric Association. Those women who can best be described as 'chaotic eaters', with a seemingly unpredictable collection of eating and weight-losing behaviours, are included in this classification.

Some of the women falling into this category may be in the process of:

- developing all of the features needed for a diagnosis of bulimia nervosa or anorexia nervosa;
- recovering from bulimia nervosa or anorexia nervosa;
- relapsing;
- proceeding from one eating disorder diagnosis to a different eating disorder diagnosis; or
- becoming obsessed with exercise rather than body weight.

Exercise disorder

This covers women with eating disorders who describe themselves as exercising to control their weight, to control their mood, and to be fit and healthy (Table 2.2).

I have used the term 'exercise disorder' to refer to behaviour and thinking about exercise that is unhealthy and has a negative impact on someone's quality of life. The term was first used in 1990 to refer to women who were

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Table 2.2 Reasons for exercising given by people with exercise disorder

Reasons for exercise		
Mood	**Weight**	**Health**
To relieve anxious feelings	To lose weight	To be physically healthy
To relieve depressed feelings	To stop feeling guilty	To feel active
To stop feeling agitated	To burn energy	To stay in exercise routine
To block out unpleasant feelings	To feel thin	To help concentration
To relieve stress	To prevent weight gain	For a sense of achievement
To relieve anger/aggression	To feel in control	To feel good

seeking assisted conception because they were unable to modify their exercise to achieve pregnancy.

People with an exercise disorder usually:

- feel they must exercise (compulsively);
- feel preoccupied with thoughts of exercise that affect their concentration on other things;
- feel irritated or angry if their exercise is interrupted;
- do excessive amounts of exercise (for their health and injury status);
- allow exercise to take precedence over relationships and over most other daily activities;
- usually have to increase the amount of exercise to obtain the same effect; and
- are unable to stop exercising without physical and psychological 'withdrawal symptoms' of restlessness, agitation, or anger.

Approximately 15% of women with a normal-weight eating disorder also have an exercise disorder. The duration of an exercise disorder can be a few months to years. Currently, it is not known how many women have an exercise disorder after they have recovered from their eating disorder, or how many people in the community have an exercise disorder and have never had an eating disorder. A 'guestimate' would be less than 1%.

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Patient's perspective

Belinda suffered from bulimia nervosa. For the past 3 years, she has maintained a BMI of 22 and is happy with her appearance. Her eating patterns are normal and she no longer binge eats, but she is a compulsive exerciser.

'Each day of my life, I try to fit my day around at least one session of quite strenuous, routine exercising—usually either 20 laps of a 50 metre pool or a 45 minute strenuous aerobic workout.

If I cannot fit in my usual daily piece of exercise, I feel guilty, worried, and up to a point anxious. Exercise has become an important part of my life. I should say that the main reason I exercise is for the actual feeling of being fit and feeling relaxed, not because I want to lose weight or look thin. I like me as I am now.

I do have the will-power to reduce exercising to only one session a day, but I push myself to it, even if my body just wants to flop. Afterwards, I feel really happy, even though I didn't enjoy doing it at the time. I feel so sick of it all, but would feel so unhappy and insecure if I stopped altogether. When I am emotionally upset over something important to me, I punish my body even more severely and increase the exercise. I feel weakness and no strength during an exercise session but I cannot stop doing it. I feel that I couldn't cut out my exercising completely, but I am a strong-willed person and I feel positive about being able to live with myself if I reduce the intensity gradually. My aim is to keep doing three or four classes of aerobic exercise each week and have the occasional swim. Exercise used to be a really enjoyable feeling for me—now it is an addiction.'

Most women with eating disorders suffering from an exercise disorder talk of 'exercising so they can eat'; in other words, they are usually exercising when they have lower reserves of energy in their body.

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Binge-eating disorder

The proposed diagnostic features of binge-eating disorder are described in the box below.

Proposed diagnostic criteria for binge-eating disorder

- The woman has recurrent episodes of binge eating
- She lacks control over her eating during the binge-eating episode
- The binge-eating episodes are associated with at least three of the following: she eats much more rapidly than usual; she eats until she feels uncomfortably full; she eats large amounts of food when not feeling hungry; she eats alone, because she is embarrassed about how much she is eating; she feels disgusted with herself, depressed, or very guilty about overeating
- She is very distressed with regard to her binge eating
- The binge eating occurs, on average, at least 2 days a week for 6 months or more

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From time to time, many people binge eat (see bulimia nervosa). Usually these people have engaged in periods of dieting or not eaten for many hours before they start binge eating. It is not known why people binge eat and several other reasons have been suggested in addition to a history of episodes of dieting. These include anxiety, depression, and boredom.

Fact!

10–30% of obese people binge eat.

Women with binge-eating disorder may have suffered previously from anorexia nervosa or bulimia nervosa.

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By definition, people with binge-eating disorder do not have anorexia nervosa, as their weight is more than a BMI of 17.5. Neither do they have bulimia nervosa because they do not regularly use dangerous methods of weight control such as starvation, self-induced vomiting, and laxative abuse. Whether a diagnosis of binge-eating disorder should be made, as it is considered somewhat unstable, or whether such patients should be included as part of EDNOS and obesity, has not yet been decided by the American Psychiatric Association. In this book, it is included in both Chapter 9 as a bulimia nervosa-like disorder and in Chapter 11 under obesity and overeating.

Some experts believe that a diagnosis of binge-eating disorder should not be made unless a person is overweight or obese. Currently, we do not know if someone who does not eat during the day and then binge eats at night is any different from a person who does not binge but leads a solitary life so she can be at home by herself in the evening and leisurely eat the food she has bought, knowing that the amount she is consuming will lead to further weight gain.

Obesity

There is controversy among nutritionists as to whether obesity can be classified as an eating disorder. Researchers have shown that obese people choose to eat more food and eat it more quickly than non-obese people. Other researchers have argued that obesity, particularly severe (or morbid) obesity, occurs in people with psychological problems. However, a study of severely obese people in the USA suggested that anxiety, depression, low self-esteem, and poor body image reported by severely obese people were a result, rather than a cause, of their obesity. The experience of nutritionists who try to induce severely obese people to lose weight suggests that obesity is an eating disorder. They report that when severely obese patients are placed on low-energy diets, they have adverse emotional reactions as follows:

- 65–75% have a preoccupation with food;
- 60–70% become irritable;
- 40–50% become nervous; and
- 35–45% suffer from depression.

These symptoms are similar to those voiced by bulimic patients and women who have anorexia nervosa. For a few people, there may be a genetic factor that makes it difficult for them to achieve a 'normal' weight (see Chapter 3).

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Main features of obesity

High body weight

Obesity can be defined in several ways, some of which require complex investigations and are only practical in research. The simple and effective method is to use the BMI. Inaccuracies can occur for a few muscular men, who do not have sufficient body fat to place them in the obese range but who have a high body weight as muscle weighs more than fat. They can be differentiated from obese people relatively easily.

Two groups can be identified that relate to obesity (Table 2.3). When the person's weight places her in the classification of morbid obesity, medical conditions that are potentially life-threatening become more common and help is required more urgently. Obese, but not overweight, women are also at greater risk of developing medical problems. These groups are arbitrary to some extent.

As for the other eating disorders, there should be no medical or psychiatric illness to account for her high body weight including medications needed in the treatment of these conditions.

Inability to lose body weight

In most cases, it is difficult for an obese person to adhere to a stringent diet, which contains less than 5040 kJ (1200 kcal) per day, because previously she has eaten at least twice and often up to four times this amount of energy each day. She wants to keep to the diet but she is tempted to eat and may binge eat from time to time. The decision to keep to a diet becomes even harder when a severely obese person has already lost substantial weight. Every day, in every

Table 2.3 BMI related to ranges of body weight

Weight group	BMI range (kg/m^2)
Emaciated	Less than 15
Severely underweight	15.0–16.9
Underweight	17.0–18.9
Normal weight range	19.0–24.9
Overweight	25.0–29.9
Obese	30.0–39.9
Severely (morbidly) obese	40.0 or more

social situation, she has to make a decision, and keep to it, that she will not eat food that other people are eating freely. The more she plans to diet, the more she becomes preoccupied with food, and the harder it is for her to keep to her diet.

The main key to weight loss is the motivation to permanently alter eating behaviour, but the obese woman cannot do this, even when confronted with poor health and limited mobility.

Prevalence of eating disorders in the community

Fact!

Eating disorders can occur among woman of all social classes and racial groups.

The exact prevalence of eating disorders in the community is difficult to determine accurately. Most surveys are made of groups selected for ease of surveying, such as women attending educational institutions. Current information suggests that the figures in Table 2.4 give a reasonable estimate of the prevalence of the eating disorders in the developed world in women aged 15–30.

The prevalence of obesity is more difficult to estimate and it is increasing at different rates in different countries and among different socioeconomic groups. Obesity increases with age and reaches its peak prevalence in both women and men between the ages of 50 and 70.

Table 2.4 Estimation of the prevalence of eating disorders in women in the developed world aged 15–30

Anorexia nervosa	0.5–1.0%
Bulimia nervosa	2% (range 1–3%)
EDNOS*	12% (range 8–23%)
Obesity	10%

*Includes binge-eating disorder.

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Future diagnostic criteria

Good diagnostic criteria are needed for eating disorders for best treatment practices and strategies. The criteria given in this chapter are currently being reviewed by the American Psychiatric Association. Until these are available, we find it is useful to describe a person as having an eating disorder and then to refer to the characteristics of the eating disorder that are important for assessment and treatment of an individual person at that time. Patients can have more than one type of eating disorder at the same time and at different times. The types of eating disorder are:

- Low-weight type
- High-weight type
- Vomiting type
- Binge-eating type
- Exercising type
- Atypical, e.g. chewing and spitting.

Or, as we have done in this book, eating disorders can be classified as:

- Anorexia nervosa or anorexia nervosa-like
- Bulimia nervosa or bulimia nervosa-like (can include binge-eating disorder)
- Obesity or overeating disorder (can include binge-eating disorder).

The new criteria are expected to be modified to take into consideration changes in our society as people become more interested in health and fitness rather than body image. Menstrual disturbance will be omitted from the diagnostic criteria because, although it is an excellent measure of the body's reserves of energy, it cannot be determined in women taking oral contraception.

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