REFERENCES

Berry, J. (1955). Life plans of college women. *Journal of the National Association of Women Deans and Counselors, 18,* 76-80.

Bernard, J. (1964). *Academic women.* University Park, PA: The Pennsylvania State University Press.

Davis, A. E. (1969). Women as a minority group in higher education. In A. Theodore (Ed.), *The professional woman* (pp. 589-598). Cambridge, MA: Schenkman Publishing.

Evans, N. J. (1984). [Development of women]. Unpublished raw data.

Helson, R. (1972). The changing image of the career woman. *Journal of Society Issues, 28,* 33-45.

Poloma, M. M., & Garland, T. N. (1970). The myth of the egalitarian family: Familial roles and the professionally employed wife. In A. Theodore (Ed.), *The professional woman* (pp. 741-761). Cambridge, MA: Schenkman Publishing.

Prather, J. (1971). Why can't women be more like men? *American Behavioral Scientist, 15,* 172-182.

Rand, L. (1968). Masculinity or femininity? Differentiating career-oriented and homemaking-oriented college freshman women. In A. Theodore (Ed.), *The professional woman* (pp. 156-166). Cambridge, MA: Schenkman Publishing.

Rothman, S. M. (1978). *Women's proper place.* New York: Basic Books.

Spock, B. (1963). Should mothers work? *Ladies Home Journal, 18,* 14-21.

United States Department of Labor, Women's Bureau (1966). College women seven years after graduation: Resurvey of women graduates, class of 1957 (Bulletin 292). In A. Theodore (Ed.), *The professional woman* (pp. 467-493). Cambridge, MA: Schenkman Publishing.

Watlety, D. J. (1969). Career or marriage: A longitudinal study of able young women. In A. Theodore (Ed.), *The professional woman* (pp. 260-274). Cambridge, MA: Schenkman Publishing.

Weil, M. W. (1961). An analysis of the factors influencing married women's actual or planned work participation. In A. Theodore (Ed.), *The professional woman* (pp. 453-464). Cambridge, MA: Schenkman Publishing.

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BULIMIA IN COLLEGE WOMEN

Tamera J. Mowery

This article explores bulimia and suggests possible implications for residence hall staffs. Characteristics of bulimics, and the causes and effects of the illness are also examined.

Introduction

"College campuses have always been places where vitality, attractiveness, freedom, and experimentation have been valued and prized" (Kubistant, 1982). Living up to these values can be difficult. On campus, bulimia is an accepted method of staying in control of one's diet, as well as one's self-esteem. Bulimia is almost epidemic in this setting (Kubistant, 1982). The purpose of this paper is to give a general overview of bulimia as it relates to the college campus.

Definition

The word, bulimia, also known as "bulimarexia", "binge-vomiting", and "gorge-purging", is derived from the Greek, *bonus limos,* meaning "ox hunger" or "insatiable appetite." Victims of bulimia regularly gorge themselves with food, especially high calorie food, for periods lasting up to several hours (Cauwels, 1983). The frequency and duration of binging episodes among bulimics was studied by Mitchell, Pyle, and Eckert (1981) in an outpatient setting. Their research indicated that an average of 13.7 hours are spent in binge eating weekly, with a range from 15 minutes to 8 hours for each binge. The calories consumed ranged from 1,200 to 11,500 calories per binge with carbohydrates as the primary food.

To avoid gaining weight, bulimics purge themselves after each binge through self-induced vomiting, laxative or diuretic abuse, or a combination of these methods (Cauwels, 1983). Wermuth, Davis, Hollister, and Stunkard (1977) estimated that 5% to 25% of all young women age 18 to 35 do some form of gorging and purging. Halmi, Falk, and Schwartz (1981) obtained data by questionnaire from students at the State University of New York indicating that within the normal college population, 13% of the students are bulimic. An average of 10% of all the students surveyed used self-induced vomiting or laxatives for purging.

Wermuth *et al.* (1977) provided a description of a typical binge episode.

> It occurs when the person is alone and has an air of secretiveness. The food is usually consumed rapidly with little or no chewing. The foods eaten tend to be sweet and starchy items that lend themselves to rapid consumption. Often there is little preparation of the foods and they are eaten directly from their containers, often without the usual preparation such as thawing or heating. As the episode of binge eating progresses there is decreased selectivity of food items and unusual food combinations or foods not generally enjoyed are then consumed. The binge

> usually lasts one to two hours but can be as brief as twenty minutes or as long as an entire day. The binge is terminated by severe abdominal discomfort, vomiting, or sleep. Immediately after the binge, the person experiences strong self-contempt and guilt. (p. 1251)

Characteristics

Generally, bulimics exhibit low self-esteem, perfectionism, and social isolation. In a study at Cornell University, Boskind-Lodahl and Sirlin (1977) confirmed the sense of low self-esteem, particularly noting the bulimic's overconcern with their bodies. Although the bulimics in this study blamed their problems on their appearance, they were neither overly fat nor unattractive. They seemed to view themselves in an internal fun house mirror, instead of viewing themselves realistically (Boskind-Lodahl & Sirlin, 1977). The idea of attractiveness being the solution to all of life's problems is related to the perfectionism often observed in bulimics (Cauwels, 1983).

Bulimics expect themselves to be entirely free of faults (Kubistant, 1982). Failure to live up to their perfectionistic standards may lead to feelings of worthlessness and self-blame (Dunn & Ondercin, 1981). A study by Ondercin (1979) supported that eating alleviates unpleasant emotional states for compulsive eaters. A binge may provide temporary relief from these feelings, but feelings of shame and guilt soon replace this momentary respite and contribute to a low sense of self-esteem and depression (Russell, 1979).

Bulimics may become socially isolated through time-consuming binge eating episodes and their obsession with food (LeClair & Berkowitz, 1983). The binge must be carried out in privacy, and the secrecy of the act isolates them even further from others (Boskind-Lodahl & Sirlin, 1977). Although bulimics may long for companionship, they often retreat to the safety of food rather than risk relating to people (LeClair & Berkowitz, 1983). A study by Johnson and Larson (1982) confirmed that bulimics spend much more time alone and involved with food than the normal population. In post-trial interviews, several bulimics stated that food had become their closest companion and that they would often choose to stay home and binge rather than be with their friends or family.

Effects

The effects of bulimia depend on the "eating patterns, the amount and type of food retained, the frequency of the purges, and the activity and constitution (as opposed to the weight) of the binger" (Cauwels, 1983, p. 83). The most common physical effects of bulimia include "raspy and gravel-type voice, dental problems (from the vomited digestive fluids), blisters on the roof of the mouth (from fingernail scratches during vomiting), infrequent menstruation, and general lethargy and weakness" (Kubistant, 1982, p. 334). The long-term physical effects include ulcers, hernias, anemia, various blood chemical imbalances, and sometimes death (Boskind-Lodahl & Sirlin, 1977).

The bulimic's body does not know what to expect. Being starved, the bulimic ingests great quantities of food. The digestive process begins, then suddenly, the food is vomited. The bulimic's metabolism is disrupted by these radical eating

patterns. The body begins to weaken and break down, having lost a base from which to consistently operate (Kubistant, 1982).

Causes

There has been much speculation about the cause of bulimia. Everything from biological factors to neurological problems have been considered as probable causes (Cauwels, 1983). Some specific factors which may be contributing to the rise of bulimia include depression and anxiety, family background, relationships, and contemporary society.

A study by Ondercin (1979) utilizing a self-report questionnaire indicated that the pattern of compulsive eating is related to anxiety and depression in college women. A high correlation between the statement "eating seems to calm me down or make me feel better," and the compulsive eating variable was found. The study indicated that the tension-reducing or pleasure-giving qualities of eating are important for compulsive eaters.

Families of bulimics tend to suffer from intense conflicts, and often do not offer mutual support or show concern for each other (Cauwels, 1983). Many bulimics view their parents as demanding, controlling, and manipulative (Boskind-Lodahl & Sirlin, 1977). The bulimic desires approval. When they do not receive comfort, nurturance, and good feelings from their parents, they turn to food for comfort. When the daughter feels guilty about wanting comfort, she can get rid of the food and the guilt by purging (Cauwels, 1983).

When bulimics are not able to have their needs for love and acceptance met by their families, they may place emphasis on romantic relationships. These relationships often fail, being idealized and exaggerated by the bulimic. Many first binges and purges may occur due to rejection in a romantic relationship (Kubistant, 1982).

Modern society places great emphasis on weight and body image. Many women attempt to achieve the slenderness society so greatly values, living by the Gloria Vanderbilt saying, "You can never be too rich or too thin" (Kubistant, 1982, p. 333). Society is nearly schizophrenic in its values surrounding attractiveness and eating. We value and emulate models, ballet dancers, and marathon runners. Yet many of us were raised to eat everything on our plate, or were told that eating was a measure of how much we loved our mothers (Kubistant, 1982). It is not surprising that it is difficult to combine eating with the idea of attractiveness encouraged by society. Bulimia may be understood as a compromise between the values of attractiveness and eating.

Implications for Residence Life

Since bulimia is a serious problem which can become progressive and chronic, the bulimic requires professional help (Cauwels, 1983). Therefore, it is important for residence life staffs to work with the campus counseling center. This is especially important in halls that are predominantly female. A member of the college or community counseling center should present an eating disorders program for residence life staffs. The program could include a description of what bulimia is, what the observable symptoms in a possible bulimic are, and how to make an effective referral. Getting bulimics to go to counseling is difficult. Secrecy and

embarrassment cause many bulimics to fear that nothing can be done, they would not be able to change, or no one would understand them (Kubistant, 1982).

Cheney, Varhely, and Hipple (1983) found that the best method for helping bulimics was a support system gained through joining a therapy group. The residence life staff member may be the bulimic's first support. It is important to reassure bulimics that they are not the only ones who binge and purge. Boskind-Lodahl and Sirlin (1977) found that most women expressed relief finding that other women had the same problem. The residence life staff member should explain to the bulimic what will occur at the college or community counseling center, and if appropriate, emphasize that others have been involved in eating disorder counseling at the center.

College women are continuously attempting to lose weight. Awareness of a safe method of losing weight through good eating habits and regular exercise may reduce the number of women who go to extremes to lose weight. Programs held in the residence halls to increase awareness of eating habits could include good nutrition, proper weight control, and a general session on eating disorders. A unit or even the entire campus could have a health awareness week with major programs on eating disorders.

Residence life staff members may want to begin regular exercise groups on their floors or in their units at the beginning of the year. When floor members are aware that exercises will be held at a specific time and place, they will be more likely to continue participating. Working together toward a common goal will also keep floor members in touch with each other. A chart could be maintained which marked each time a person attended the exercise session or achieved a certain number of exercises.

These types of programs are important to increase students' awareness of eating disorders and proper weight loss methods. The programs may help students to recognize bulimia in themselves or in their friends.

The issue of self-acceptance must be continually addressed with bulimics (Kubistant, 1982). Programs on self-acceptance and increasing self-esteem are valuable for college students. College students frequently doubt themselves and are continually comparing themselves to others. Instead of striving for an unrealistic standard of perfection, increased self-awareness, such as clarified values and beliefs, may help students to accept themselves.

Conclusion

Due to the growing prevalence of bulimia on college campuses, it is important that residence life staff members better understand this disorder. Increased public awareness and open discussion about bulimia may encourage individuals to seek therapeutic intervention in their struggle with bulimia (LeClair & Berkowitz, 1983). Public awareness may also help bulimics realize that they are not alone, and may help to remove some of the stigma attached to bulimia.

REFERENCES

Boskind-Lodahl, M., & Sirlin, J. (1977). The gorging-purging syndrome. *Psychology Today, 3,* 50-52, 82-85.

Cauwels, J. M. (1983). *Bulimia: The binge-purge compulsion.* New York: Doubleday & Company, Inc.

Cheney, A. B., Varhely, S., & Hipple, J. L. (1983). Recruitment strategy in forming a counseling group for bulimic women. *The Journal of College Student Personnel, 24,* 368-369.

Dunn, P. K., & Ondercin, P. (1981). Personality variables related to compulsive eating in college women. *Journal of Clinical Psychology, 37,* 43-49.

Halmi, K. A., Falk, J. R., & Schwartz, E. (1981). Binge eating and vomiting: A survey of a college population. *Psychological Medicine, 11,* 679-706.

Johnson, C., & Larson, R. (1982). Bulimia: An analysis of moods and behavior. *Psychosomatic Medicine, 44,* 341-351.

Kubistant, T. (1982). Bulimarexia. *The Journal of College Student Personnel, 23,* 333-339.

LeClair, M. J., & Berkowitz, B. (1983). Counseling concerns for the individual with bulimia. *The Personnel and Guidance Journal, 61,* 352-355.

Mitchell, J. E., Pyle, R. L., & Eckert, E. D. (1981). Bulimia: A report of 34 cases. *American Journal of Psychiatry, 138,* 835-836.

Ondercin, P. A. (1979). Compulsive eating in college women. *The Journal of College Student Personnel, 20,* 153-157.

Russell, G. (1979). Bulimia nervosa: An ominous varient of anorexia nervosa. *Psychological Medicine, 9,* 429-448.

Wermuth, B. M., Davis, K. L., Hollister, L. E., & Stunkard, A. J. (1977). Phenytoin treatment of the binge-eating syndrome. *American Journal of Psychiatry, 134,* 1249-1253.

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