Initial Consultation for Patients with Bulimia and Anorexia Nervosa

CRAIG JOHNSON

INTRODUCTION

The recent increase in the incidence of anorexia nervosa and bulimia has created a significant demand for clinical services for patients who present with these eating disorders. There is also a growing awareness among therapists that the psychological, biological, and sociocultural aspects of these two disorders, as well as the heterogeneity of patients affected, require multidimensional and specialized treatment programs. An underattened, yet critical component of constructing a specialized treatment program is the development of a sophisticated initial diagnostic interview.

The current chapter on the initial consultation is written with three goals in mind. First, it introduces a standardized interview format (Diagnostic Survey for Eating Disorders, or DSED) for obtaining intake information that has both clinical and research utility. Second, it presents various clinical observations that will help therapists identify the bio/psycho/social factors that have contributed to the onset and perpetuation of a patient’s eating behavior. Finally, it offers preliminary observations regarding various subtypes of eating-disordered patients and what treatment strategies are useful with the subgroups.

Description of the Instrument

The DSED (see Appendix) is a multi-item survey that focuses on various aspects of anorexia nervosa and bulimia. The questionnaire is divided into 12 sections, which provide information on demographic factors, weight history and body image, dieting behavior, binge eating behavior, purging behavior, exercise, related behaviors, sexual functioning, menstruation, medical and psychiatric history, life adjustment, and family history.

The survey can be used as a self-report instrument, or as a semi-structured interview guide. Our clinic makes use of the instrument in both forms. Following the initial phone contact, we request that patients complete and return the questionnaire prior to their actual first visit. During the consultation, the interviewer then reviews the self-reported information in the various sections for validation of the self-report, to elicit

Craig Johnson. Institute of Psychiatry, Eating Disorders Program, Northwestern University Medical School, Northwestern Memorial Hospital, Chicago, Illinois.
more details, and to assess the affective responses to the various topics covered in the survey.

The DSED was not constructed with the intention of developing a scaled instrument. Instead, the purpose was to provide a standardized format for collecting relevant information that would enhance communication between various treatment centers regarding descriptions of different patient groups.

Overall Philosophy of the Clinic

We attempt to establish an overall frame of reference in our clinic, which we refer to as the “adaptive context.” Essentially, we emphasize to staff and patients that anorexia nervosa and bulimia are multidetermined disorders that affect a wide range of patients, and that the symptoms are adaptations to a variety of biological, intrapsychic, familial, and sociocultural issues. We further stress that anorexia nervosa and bulimia are desperate behaviors that usually reflect desperate attempts to adapt to desperate circumstances. We emphasize the adaptive context, because patients with bulimia and anorexia nervosa are often difficult and frustrating individuals whose resistance to change can provoke significant countertransference as early as the initial interview. Establishing the adaptive context as a frame of reference often helps staff “maintain perspective” as resistance heightens and provocative behavior ensues.

The First 5 Minutes of the Consultation

It has been our experience with eating-disordered patients that the first several minutes of the consultation are extremely important. The interview is usually initiated by inquiring how the person is feeling about coming for the consultation. The objective in asking the question is to assess whether the person is seeking help voluntarily or through various degrees of coercion from friends, family, or the community. Although there are always exceptions, bulimic patients are usually at the consultation on a much more voluntary basis than anorexia nervosa patients.

Shortly after the initial inquiry, we ask if the patient has ever talked with anyone specifically about her difficulties with food. Our purpose with the question is to assess how ego-syntonic the symptoms are and to attempt to be sensitive to the fact that many individuals have never acknowledged their difficulties with food and feel very ashamed and humiliated in doing so. This is particularly true for patients who present with bulimic symptoms.

After the two initial questions, the agenda for the consultation is presented to the patient. We mention to her that we have many questions to ask, some of which may seem intrusive. We acknowledge that our reason for asking so many questions in such a short space of time is to assess, as quickly as possible, where she is in the course of the eating disorder so that we can make treatment recommendations.

Overall, the most important task of the first 5 minutes is to communicate to the patient, either directly through words or through the spirit of the interview, that we are interested in a collaborative inquiry, rather than an inquisition into the events that may have resulted in the onset of her symptoms.

1. Throughout the chapter, the feminine pronoun is used to refer to anorexic and bulimic patients.
Structured versus Unstructured Interview

While there may be some important advantages to conducting an unstructured interview, we believe that the costs outweigh the benefits. While waiting patiently and quietly for the patient to disclose her difficulties can yield important information about her capacity for tension regulation in an unstructured situation, the level of her social skills, and her capacity to articulate internal states without assistance, it may also be viewed by the patient as sadistic withholding or as evidence that the therapist does not have specific knowledge regarding her particular problems. The structured interview allows the therapist to demonstrate an awareness of some of the unique aspects of eating problems through knowledgeable inquiry. It also establishes a common language at the outset. Most of the eating-disordered patients’ lives revolve around food-related thoughts and behavior; consequently, their language reflects this preoccupation. While the task of the treatment is to provide different ways to organize their lives (or a different language), in the initial stages of contact, we have found it helpful to inquire directly about food-related attitudes and behaviors. We have found this to be particularly important with patients who, in previous treatments, have been discouraged from talking specifically about these matters.

WEIGHT HISTORY AND BODY IMAGE

The structured interview begins with questions regarding the patient’s weight history and feelings toward her body. The overall objective in this section is to investigate how much weight preoccupations and fluctuations have affected the patient’s self-esteem and life adjustment.

After obtaining the patient’s current height, weight, and ideal weight, we investigate whether there are occupational considerations that affect the patient’s attitudes toward her weight. Individuals in the entertainment and fashion industries are high-risk groups because of rigorous and often unrealistic criteria for weight regulation (Druss & Silverman, 1979; Garner & Garfinkel, 1980). These groups are often special treatment problems because their self-esteem and livelihood are unalterably tied to industries that demand a weight maintenance that is debilitatingly subnormal.

After gathering information regarding current weight and occupational considerations, an inquiry is made about the patient’s highest and lowest past weights since the age of 13. If periods of significant weight fluctuations are mentioned, potential correlations with specific life events, such as major transitions, separations or losses, family problems, recurring illness, and the like, are investigated. This early process of inquiry regarding possible psychological correlates of weight fluctuations can help the patient begin to think psychologically about the relationship of her food, weight, and body-related behavior to events in her life.

During the initial consultation, patients will often, for the first time, see patterns and repetitions between their weight-related behaviors and life events. For example, many of our patients realize that when they are rejected in a romantic relationship, they attempt to “start over” or restore a sense of control by dieting or losing weight. It is interesting to note that if this process is repeatedly successful at restoring control and self-esteem following some rejection (and it is often successful because our culture responds favorably to weight loss, particularly among women), then initiating
weight loss or dieting can eventually become a generalized response to a wide range of traumatic situations.

Information about weight during childhood and early adolescent years is often unreliable. Consequently, we focus on how much emphasis the family and peer milieu have placed on such factors as thinness, dieting, and appearance—and what influences this emphasis has had on the patient’s self-concept and beliefs about such issues as self-control, social acceptance, and the like. We also inquire very specifically whether the patient has been teased about her weight. It is important to establish the extent of the teasing, the context, the content, who specifically was doing the teasing, and its impact on the patient.

Periods of significant weight decrease are important to determine—with particular attention paid to the speed and method of weight loss. Recent research indicates important personality and outcome distinctions between patients who lose weight by restricting their food intake and patients who lose weight as a result of purging behavior accompanied by episodes of binge eating (Casper, Eckert, Halmi, Goldberg, & Davis, 1980; Garfinkel, Moldofsky, & Garner, 1980). We also inquire whether amenorrhea developed during the weight loss, and, if so, within what range it occurred.

Body Image

Body image perception among eating-disordered patients ranges from mild distortion/dissatisfaction to severely delusional thoughts regarding body size. Likewise, the degree to which body image perception affects life adjustment falls along a continuum from mild to severely debilitating. Consequently, the primary task of this phase of the interview is to assess the level of body image distortion, what psychological adaptation it may be serving, and investigate to what extent it is interfering with life adjustment.

While most women do report that they are dissatisfied with the size and shape of their bodies, their dissatisfaction does not necessarily interfere with life functioning. We attempt to investigate how much the patient’s self-consciousness about her body affects her life adjustment by inquiring whether the dissatisfaction prevents her from doing certain things, such as dating, becoming sexually involved, exercising, or participating in activities that require some bodily exposure. While investigating this interface, we also attempt to assess the discrepancy between the patient’s perception of her body size and her actual body size. If the body perception is quite distorted, we often ask the patient if others disagree with her perception of her body size. Patients with more delusional body image distortion are threatened by this inquiry, and often react with hostile resistance.

Assessing the degree of body image distortion is most important because outcome research with anorexic patients indicates that those individuals who persistently maintain the cognitive distortion that they are terribly fat despite their emaciated condition show the poorest improvement with treatment (Garfinkel, Moldofsky, & Garner, 1977). We have found this finding to have particular clinical relevance because of the psychological adaptation that the more delusional distortion serves for the anorexic patient.

It is our opinion that the anorexic's distorted belief about her body is a necessary distortion that allows her to develop a psychological organization that gives her life meaning and purpose (Casper, 1982; Garner & Bemis, 1982; Chapter 6, this volume;
Garner & Garfinkel, 1982; Garner, Garfinkel, & Bemis, 1982). It can be viewed as similar to the paranoid-state patient who suddenly and without apparent evidence decides that the next-door neighbor is trying to kill him or her. The paranoid-state patient will then develop an extensive psychological organization to protect himself or herself against the perceived threat. The defense of the self against the perceived threat then provides a mechanism for structuring his or her life. Obviously, the patient has to cling to the one central distorted belief, because if the one belief is not true, then all the subsequent behavior does not make sense.

The distorted body image allows the anorexic patient to develop a cognitive system organized around a perceived threat (fat); this gives her a sense of purpose, and the fear associated with the perceived threat (fat) provides motivation to avoid the perceived threat. If she acknowledges her thinness (no fat), then purpose and motivation are lost. Essentially, she must believe she is fat in order to preserve the psychological system she has created.

It follows, then, that those patients who cling most tenaciously to the distorted body image are most susceptible to experiencing a psychological collapse as a result of relinquishing the delusional organization. Consequently, these patients also have the poorest outcome because of the brittleness of their intrapsychic structure.

To reiterate, the important assessment to make in this section is to determine the extent of the delusional distortion, as opposed to dissatisfaction, and to identify what impact the distortion is having upon life adjustment.

**DIETING BEHAVIOR**

The primary purpose of this section is to assess the length of time the patient has been involved in dieting behavior, how much psychological and physiological deprivation is being experienced, and the cognitive-emotional system that has evolved around the behavior. We attempt to learn when dieting first began, why, and whether there was a particular source of encouragement.

Of particular interest is how preoccupied other members of the family are with food and weight. As one would suspect, we find that many of our patients have parents who are food and weight preoccupied (Kalucy, Crisp, & Harding, 1977). We are also beginning, like others (Crisp, 1980; Garfinkel & Garner, 1982), to see families that have several children who have had, or are currently having, difficulty with anorexia nervosa or bulimia.

It is also important to assess how much of a psychological system has developed around the concept of dieting. We inquire whether the patient thinks of food as “good” or “bad,” and how it affects her to eat either “good” or “bad” foods. We also try to assess how much magical or superstitious thinking is associated with the food-related behavior (Garner & Bemis, 1982) by asking the patient to explain her understanding of what calories are, how food is digested, what the function of fat is, and how most fad diets work.

Finally, we attempt to assess to what extent either psychological or physiological deprivation may be triggering such behavior as binge eating or specific food cravings (Garner, Rockert, Olmsted, Johnson, & Cosicina, Chapter 21, this volume; Wardle, 1980; Wardle & Beinart, 1981). We are particularly interested in determining whether the patient is avoiding any specific food groups, such as complex carbohydrates (Wurtman, Wurtman, Growdon, Henry, Lipscomb, & Zeisel, 1981).
SCALE BEHAVIOR AND EXERCISE

Ritualized behavior around body measurement and exercise are common side effects of a chronic preoccupation with dieting. It is important to assess how frequently the patient weighs or measures herself, how ritualized the behavior is, and how minor fluctuations in weight affect self-concept and daily activities.

We also investigate the longest period of time during the past 6 months that the patient has gone without weighing or measuring herself, and what events correlate with this period of time. We will often ask whether the patient would be willing to temporarily delegate the monitoring of her body to the clinic staff to assess how integral the measurement process is to her psychological homeostasis.

Exercise, like scale behavior, can become highly ritualized and quite debilitating. We find it most important to investigate what adaptive function the exercise serves in the patient's psychological system. Inquiry regarding how the patient experiences the absence of exercise often offers clues regarding the adaptive context. We have found that the exercise can serve a variety of purposes, including a hypomanic defense against a fear of paralyzing depression, a form of masochistic self-punishment, a goal-oriented pursuit of achievement serving narcissistic/exhibitionistic concerns, or as a general mechanism for regulating such tension states as anxiety, anger, and the like.

BINGE EATING

Our objective during this phase of the interview is to investigate, at both a micro level and a macro level, the adaptive significance of the binge-eating behavior. At the macro level, we are interested in determining when the problem eating began, the precipitating circumstances, and whether fluctuations in the eating behavior correlate with recurring life events.

Information about the absence of binge-eating behavior is also critical. We inquire about the longest period the patient has gone without binge eating and investigate the circumstances that facilitated the binge-free period. Vacations away from home, entering relationships, and escaping bad relationships or bad work situations are times when patients will often have symptom-free periods. Patients' affective responses to symptom-free periods often vary, and we inquire whether the patients experience a greater or lesser degree of disorganization, sense of loss, anxiety, or depression.

We usually begin the micro-level inquiry by asking the patient to describe her daily eating pattern. We have her describe in detail the previous day's activities, including meals, binge episodes, and routine events. Initially, we are particularly interested in learning when and to what extent she is eating meals. We also want to know what she regards as a reasonable meal and a binge, because many bulimic and anorexic patients have come to interpret any consumption of food as a loss of control.

After describing her daily eating patterns, we have the patient focus more specifically on her binge-eating episodes. We attempt to assess whether there are particular foods, events, times, or emotional states that recurrently trigger binge-eating episodes. Research has indicated that most patients have difficulty with food when they are alone in unstructured situations. This is usually during evening hours when they are at home alone (Larson & Johnson, in press; Pyle, Mitchell, & Eckert, 1981).
They generally binge on foods they normally deprive themselves of, such as sweets or carbohydrates, which they regard as bad foods. We have learned that, unfortunately, most of our patients will not eat during the day, the period of time that is most structured, and will attempt to eat at night, which is their most unstructured time. These high-risk evening hours are thus made more difficult because the patients are usually calorie-deprived at their most vulnerable period during the day.

At this point in the interview, we also investigate the patients' phenomenological experience of binge eating. We are specifically trying to discover what type of tension states they are attempting to regulate, or what type of affective release they are seeking through the binge eating.

Boredom, loneliness, anger, and depression are the affective states that appear to be the most troublesome (Johnson, Stuckey, Lewis, & Schwartz, 1982). There are, however, any number of adaptations the binge eating can serve. These may include eroticized impulse expression, aggressive impulse expression, pleasurable discontrol, oppositional acting out, self-soothing, disassociation, self-punishment, and so on (Johnson, Lewis, & Hagman, 1984). It is clear that the act of binge eating carries a unique significance for each patient, and it is incumbent upon the interviewer to try to understand what specific function or functions the behavior serves.

**PURGING BEHAVIOR**

Overall, in this part of the interview, we want to determine the onset, precipitants, duration, frequency, and method of purging behavior. Early research has indicated that most bulimic patients use self-induced vomiting as a preferred evacuation technique, and that they begin purging approximately 1 year after the onset of binge eating (Johnson et al., 1982; Pyle et al., 1981).

The act of purging, like binge eating, can serve several adaptive purposes. The purging behavior can serve as a release of a dysphoric affect, such as anger, or as a means to return to a sense of self-control after feeling out of control with the binge eating. It can also serve as a self-punishment or an undoing behavior that expiates guilt. As a masochistic act it can serve a function similar to self-mutilation, in that it reorganizes or reorients a patient who may be fragmenting under the impact of an intense feeling state. It is unquestionably a powerful reinforcer, simply by the fact that it protects the patient from the dreaded weight gain, and frees them from the constraints of chronic restrained eating. Since abstinence from purging can be a crucial tool for recovery, it is important to understand how primary the purging behavior has become in the binge-purge sequence. Some of our initial research has suggested that, for many bulimic patients, the act of purging is more tension regulating than binge eating (Johnson & Larson, 1982). Our clinical experiences have confirmed the early research, in that for some patients a transformation occurs over time whereby they begin to binge eat so that they can purge, rather than purge so that they can binge eat.

As with the binge eating, it is important to inquire about the longest period of time the patient has gone without purging since the onset of the behavior. It is important to know what precipitated the abstinence, what effect it had on the binge eating, and how uncomfortable the patient was during this time.

Recent research has indicated that laxative abuse is very predictive of life impair-
ment (Johnson & Love, 1984). Consequently, we make a particular effort to explore how laxative abusing patients think about their laxative abuse. Our experience has been that the laxative abusers are usually misguided about the effectiveness of laxatives as a mechanism for controlling fat. They often have rather peculiar notions about the laxatives, which indicate more serious cognitive disturbances. We explain to these patients the ineffectiveness of laxatives to control calorie absorption, as demonstrated by a recent study (Bo-Lynn, Santa-Ana, Morawski, & Fordtran, 1983). One of our objectives in providing this information is to assess to what degree the patients can take advantage of didactic information to correct their distorted beliefs.

After exploring the adaptive context of the binge eating and purging behavior, we find it useful to learn what strategies the patient has attempted to use to manage the symptomatic behavior. Questions about efforts to stop or prevent the behaviors often shed light on how ego-syntonic the symptoms are and allow the interviewer to assess the degree to which the patient feels helpless or hopeless.

Recent studies have indicated that most eating-disordered patients (particularly bulimics who purge) experience a depressive phenomenon that has been referred to as “learned helplessness” (Seligman, 1975). Learned helplessness is a construct that has emerged from work with laboratory animals exposed to repeated shocks without opportunity for escape. Observers noted that after a prolonged period of time these animals would not even use an escape if it were provided. Essentially, they had developed a type of amotivational syndrome as a result of feeling trapped by their circumstances.

Like these animals, many bulimic patients experience a type of “learned helplessness,” and feel hopelessly trapped by the binge-purge cycle. For these patients the symptoms are ego-syntonic; they have come to feel that there is little or no chance for escape. One important function the initial consultation can serve is to provide the hope that the symptomatic behavior can be managed, so that it does not seriously disrupt the patient’s life. There is preliminary evidence that simply restoring hopefulness to these patients in an initial meeting provides sufficient motivation to reduce binge-eating episodes by up to 50% (Connors, Johnson, & Stuckey, in press).

RELATED BEHAVIORS

Affective Illness

During this phase of the interview, we want to investigate the nature of the depressive experience. We are particularly interested in determining whether the patient has a primary affective disorder, as opposed to a more psychological depression.

Recent research has indicated that bulimic patients in particular may be at significant risk for primary affective disorder (Strober, Salkin, Burroughs, & Morrell, 1982). Primary affective disorder is a depressive state characterized by vegetative symptoms, such as mood variability, persistent fatigue, sleep difficulty, frequent crying episodes, irritability, listlessness, and appetite disorders. Preliminary work has suggested that tricyclic medication and monoamine oxidase (MAO) inhibitors have been helpful with bulimic patients who present with this type of mood disorder (Pope, Hudson, Jonas, & Yurgelun-Todd, 1983).

Even in the absence of a biologically based affective disorder, most eating-disordered patients report significant psychological depression (Johnson et al., 1982;
Pyle et al., 1981). We attempt to identify whether the patient has a more anaclitic depression (Lidz, 1976; Sugarman, Quinlan, & DeVenis, 1981) or a more introjective depression (Blatt, 1974), and to what extent she has become amotivational as a result of learned helplessness.

Patients with anaclitic depressions are highly dependent and have an intense need to be directly connected to a need-satisfying object. They feel disorganized and lost when alone, because they lack the internal resources to direct themselves when others are not present. They generally have very fragile boundaries and are quite vulnerable to loss of impulse control and enmeshment in interpersonal relationships. These patients are usually frightened of being abandoned and present as quite weak and helpless.

In contrast, patients with more introjective depressions present with a more obsessive preoccupation with performance, achievement, and perfectionistic strivings. They critically judge all their efforts and report a persistent sense of guilt and shame. They generally feel they have failed to meet expectations and standards, and there is usually a desperate attempt to gain approval and acceptance through their achievements.

Essentially, these distinctions are helpful in making treatment recommendations, which are discussed more fully in a subsequent section.

Multiple Substance Abuse and Impulse Problems

In this part of the interview, we attempt to assess whether the symptomatic eating behavior is only one aspect of a generalized borderline personality organization. Recent research has indicated that bulimic patients in particular often present with positive histories of multiple substance abuse and various impulse-dominated behaviors, such as shoplifting, promiscuity, and self-mutilation (Casper et al., 1980; Garfinkel et al., 1980). These individuals have poor outcomes, have significant structural and characterological deficits, and represent a more disturbed subgroup among the spectrum of eating-disordered patients.

SEXUAL AND MENSTRUAL HISTORY

Traditionally, anorexia nervosa has been regarded as based in a fear of sexuality and the self-starvation, with its concomitant loss of secondary sexual characteristics, has been viewed as an attempt to achieve a prepubescent state (Crisp, 1980). However, research has shown that sexual drive, sexual behavior, and feelings about sexuality vary greatly among anorexics and bulimics (Abraham & Beumont, 1982; Beumont, Abraham, & Simpson, 1981). More recent conceptualization suggests that for eating-disordered women, problems with sexuality may simply be a reflection of more basic difficulties with autonomy and self-regulation (Bruch, 1973). Thus, the main objective in this part of the interview is to strive to understand the individual's specific sexual feelings and experience as part of her overall adjustment.

It is well known that libido usually decreases dramatically in individuals with anorexic weight levels and sexual behavior also usually decreases (Keys, Brozek, Henschel, Mickelsen, & Taylor, 1950). Nonetheless, we find it useful to inquire about the individual's thoughts, feelings, and interest in sex as well as her actual behavior.
Research indicates that some anorexic women who are married or in a steady relationship continue to engage in sex despite little pleasure or interest (Beumont et al., 1981).

Eating-disordered women have reported a full range of sexual interest and behavior up to frank promiscuity. Women who binge or who binge and purge tend to report more frequent sexual activity and interest. This is often interpreted as part of a larger problem with impulse control. Women who merely restrict their food intake seem to be on the whole less interested in sex (Abraham & Beumont, 1982).

The major reason we obtain a menstrual history is to determine if amenorrhea has occurred. Cessation of menses usually accompanies anorexic body weights and it is useful to inquire within what weight range it occurred. We try to use the menstrual weight as the target weight if weight restoration is necessary. However, amenorrhea can also occur in normal-weight women, in women who frequently binge and purge, and in women whose weight fluctuates markedly (Beumont et al., 1981). We find it helpful to inquire about the premorbid menstrual history to evaluate the current impact of the disordered eating on the menstrual cycle. We also inquire whether the eating problems vary according to the menstrual cycle. Clinical evidence is beginning to suggest that these may be related in some women, especially those prone to premenstrual syndrome. These women sometimes report that their appetite, especially for sweets and carbohydrates, increases just prior to menstruation. An understanding of the possible impact of the menstrual cycle on appetite and eating may be helpful in planning treatment.

FAMILY HISTORY

When taking the family history, we are particularly interested in assessing the patient's biological vulnerability to illness (psychiatric and medical) and in investigating the nature of the family environment.

Research has indicated that affective disorders and alcoholism are highly prevalent among first-degree relatives of bulimic patients. A positive family history and positive vegetative symptoms of depression among patients are usually indications that a trial of antidepressant medication may be beneficial.

When investigating the family environment, we generally try to assess several parameters. Following the observations of Minuchin, Rosman, and Baker (1978), we try to determine whether the family is enmeshed, disengaged, overcontrolled, or undercontrolled. We also try to assess how much free expression of affect exists, the extent of achievement orientation or perfectionism, and how much stability and flexibility exists in the system. We also attempt to explore the quality of the parent-child relationship and the extent to which the child's symptomatic behavior may be serving an adaptive function within the family system.

While data-based studies of eating-disordered families are scarce in the literature, preliminary reports have indicated significant family disturbance. Johnson and Flack (1984) found that when compared to a control sample screened for eating disorders, normal-weight bulimic women reported higher levels of conflict and negativity, and lower expressiveness and emphasis on independence in their families.

Anorexic families have been characterized as enmeshed, overprotective, rigid, and lacking in capacity for conflict resolution (Minuchin et al., 1978). In a series of data-based studies, Strober et al. (1982) found important family differences between bulimic anorexics and restricting anorexics. Bulimic anorexics' families were character-
ized by high levels of conflict, marital discord, and negativity among family members. Bulimic anorexics also reported feeling more distant from both parents, but particularly from their fathers.

Several personality attributes were also found to differentiate parents of bulimic anorexics from parents of restricting anorexics. Fathers of bulimic anorexics were more impulsive, were more hostile, and reported lower frustration tolerance. In contrast, fathers of restricting anorexics appeared more withdrawn and submissive. Mothers of bulimic anorexics were more psychosomatically preoccupied and depressed, compared to mothers of restricting anorexics, who were more introverted and phobic. Both mothers and fathers of bulimic anorexics reported more family problems, higher hostility, and less inner control than parents of restricting anorexics.

Although more research is needed, preliminary reports suggest that, overall, bulimic families appear to be openly conflicted, with more parental impulse disturbance and depression. In contrast, families of restricting anorexics appear to be more rigidly enmeshed, with more introverted and phobic parents.

LIFE ADJUSTMENT

In this section of the interview, we want to assess the overall quality of the patient's life and to determine how much the symptomatic behavior has affected her work, daily activities, interpersonal relationships, and sexual activity. Outcome studies with anorexia nervosa patients indicate that the syndrome is quite debilitating. Reviewing 700 cases across 12 outcome studies of anorexia nervosa patients, Schwartz and Thompson (1981) found that 49% were cured of their weight difficulties, 26% continued to have fluctuating weight problems or became obese, 18% remained chronically anorexic, and 7% died of anorexia or suicide. The original outcome studies reported very little about the quality of the patients' lives or the extent of continued food-related thoughts and behavior. Overall, the studies indicated that 90% of the anorexics worked, but that only 47% had married or were maintaining active heterosexual lives.

Although extensive outcome studies with bulimics are not available, a preliminary report by Johnson and Berndt (1983) indicated that bulimic patients, when compared to a community sample, had significantly more impaired life adjustment in the areas of work, social and leisure activities, family life, marital adjustment, and overall adjustment.

It is also important in this section to investigate the extent to which the patient is capable of engaging in self-enhancing activities. What is the breadth and quality of her involvement in hobbies or activities that give her pleasure? It has been our experience that eating-disordered patients are self-sacrificing, achievement-oriented individuals who take much better care of others than of themselves, and who are often too goal oriented to simply enjoy activities.

MEDICAL ISSUES

The task of this section of the interview is to investigate whether the patient has ever experienced a major illness, whether she is currently on medication, and the date of the most recent medical evaluation. All eating-disordered patients should be medically evaluated and followed accordingly during the course of treatment.
The most common physical symptoms observed with anorexics and bulimics include electrolyte abnormalities, tooth decay, enlarged parotid glands, edema, hypothermia, fatigue, dizziness, sleep difficulties, gastrointestinal problems, and menstrual difficulties (Fairburn, 1982; Garner et al., Chapter 21, this volume; Mitchell & Pyle, 1982; Russell, 1979). These symptoms should be noted and monitored throughout treatment.

THE FINAL FEW MINUTES

Before making treatment recommendations, we usually pose the following question to normal-weight patients who are purging: "Would you be willing to gain ten pounds in exchange for not having any more difficulty with binge eating, purging, or food preoccupation?" We explain to the patient that the question reflects our experience that if the purging behavior is curtailed, then binge eating often dramatically decreases in quantity and frequency. Interrupting the purging behavior restores some restraint, because the biological and psychological consequences of unrestrained eating (nausea, painful fullness, weight gain) cannot be avoided.

One group of patients often assures us that they would rather be dead than gain 10 pounds. This is the group of patients who have experienced a Cinderella-like transformation as a result of losing weight. These women have either become socioeconomically upwardly mobile, or their romantic-social life has improved significantly as they have achieved thinness. Their weight loss is usually accomplished vis-à-vis highly restrictive dieting, which cannot be maintained over a long period of time. Rather than return to what they experience as a "social isolation," which they feel would occur with weight gain, they begin to use various purging techniques so they can abandon the restrictive diets and yet maintain thinness. They are frightened of change, because they have actually experienced the social discrimination and alienation of overweight individuals, particularly toward females, in our current culture. Their severe dread of gaining 10 pounds reflects an entrenched yet fragile psychological integration, and is not a favorable prognostic indicator.

TREATMENT RECOMMENDATIONS

Throughout this chapter, we suggest that anorexia nervosa and bulimia are multidetermined eating disorders and are affecting an increasingly heterogeneous group of patients. Given the multidetermined and heterogeneous nature of the disorders, comprehensive outpatient clinics should have access to a variety of treatment modalities that include individual, group, family, and marital psychotherapy, pharmacotherapy, and medical consultation. Assigning a patient to a particular mode of treatment depends upon the unique needs of the patient.

Certain eating-disordered patients may require hospitalization. The criteria we use to make this decision after the initial consultation include the following: significant medical difficulties resulting from low body weight or persistent self-induced vomiting, laxative, or diuretic abuse; significant suicide risk or demonstrated inability to provide self-care; inability of family or current living arrangement to provide an adequate psychological environment for improvement to occur; the need to facilitate
a complex differential diagnosis; and, on occasion, the need to interrupt the binge-purge cycle.

While it is difficult to subclassify anorexic and bulimic patients because of the heterogeneity of the group, we have found one method helpful in making outpatient treatment recommendations. Swift and Stern (1982) have suggested that eating-disordered patients can be broadly characterized as falling along a continuum of intrapsychic structure ranging from borderline personality organization to identity conflicted (see Figure 3-1). The following paragraphs outline major characteristics of these different groups, as well as the treatment modalities we have found most helpful.

Borderline Personality Organization

Patients who fall into this category (Masterson, 1977) are usually polysymptomatic; their eating disorder is secondary to a more serious problem of understructured internal resources. They present generally chaotic and impulse-dominated life histories. Their affect is quite labile, fluctuating between rageful agitation and an anaclitic, empty depression. Intrapsychically, they are diffuse and undifferentiated, and have fragile self-other and inner-outer boundaries. Interpersonally, they intensely seek need-gratifying relationships and are very dependent upon external sources for tension regulation and self-management. Their cognitive style is concrete and dichotomous. They generally think in black-and-white, all-or-none terms, and can be quite superstitious and magical (Garner & Bemis, 1982). Their primary defenses are primitive denial, splitting, and projective identification. Among the bulimic patients, binge eating is often experienced more as depersonalization than as disassociation, and purging is often very masochistic (similar to self-cutting)—an attempt to ward off self-fragmentation (Goodsitt, 1977).

Our experience has been that these patients respond most favorably to highly structured, directive, supportive interventions that are aimed at life management. Abstract, insight-oriented therapy is often difficult because of the concrete and impulse-dominated cognitive milieu. We find that “more is better” with these patients. A team approach, consisting of individual, group, family, and medical treatment, is important because of the intense demands that these patients’ needs place on a treatment setting. Food-related symptoms will usually remit only after the patients feel securely “held” by the treatment setting.

False Self

The group of patients with “false self” organizations (Winnicott, 1965) is loosely grouped together by some common dynamics. They are not as seriously disturbed as the borderline patients, and yet they seem to have more psychological difficulty than the identity-conflicted group. In our opinion, this group is distinguished more by what
we do not know about them than what we do know. They generally present with life histories that appear uneventful, and their current life adjustments appear quite adequate.

During the initial consultation, one often feels that the interview questions are painfully and threateningly intrusive to these patients, to a degree that one feels reluctant to pursue the inquiry. They are also reluctant to talk about food-related behavior, because to do so is to expose a less-than-adequate aspect of self. They are generally very compliant and nondemanding patients, who seem very careful about becoming too involved in treatment.

The nature of the relationship these patients develop with a therapist seems to reflect the overall nature of their interpersonal world. They superficially accommodate to treatment demands without becoming involved in intimate disclosure. They continue in treatment without complaint, but the therapist feels that he or she is not quite connecting with such patients in a significant way. Their compliance and avoidance of controversial issues seem to be efforts to avoid actually relating to the therapist. There is usually a prevailing feeling in the therapist that he or she has a fragile alliance with patients who want to be in treatment, but are very frightened about the potential development of the therapeutic relationship. It has been our experience that this ambivalence represents a basic wish–fear dilemma that is a central dynamic.

Essentially, we have found that there is often a common developmental theme among “false self” patients that has resulted in the wish–fear dilemma. We have learned that for one reason or another (physical or psychological illness of the mother during a patient’s infancy, or a situation in the family that has resulted in early physical or psychological separation), the patients were forced to separate prematurely and develop psychological autonomy. A successful pseudomaturity adaptation was an enormous relief to such a child’s mother or the system, with the result that the child received positive reinforcement and a sense of self-esteem for compliant, nondemanding behavior.

The prefix “pseudo-” is appropriate, because while the child had adequate structure to make the superficial adaptation, she did not have adequate structure to accommodate all of her infantile needs. Since the mother, or the system, could not respond to the infantile needs, the needs became split off, isolated, and interpreted by the patient as troublesome, perhaps destructive, or even as a sign of being out of control. Progressively, the patient feels that she is two people: one who appears to be competently in control of things, and another who feels needy and out of control. The wish–fear dilemma revolves around the patient’s wish for someone to identify and respond to her needs, which is juxtaposed against her fear that allowing someone to see the needy and dependent side will collapse the self-esteem and self-organization that has evolved as a result of the pseudomaturity behavior.

Food, for these patients, is their safest and most trusted ally. Essentially, they will allow themselves to behave in the presence of food in ways they would not allow any other person to observe. They will also invest food with the ability to regulate different tension states. Allowing a person to help with these feelings would mean risking too much exposure.

The treatment recommendation for these patients is long-term, relationship-oriented, individual psychotherapy. We have found that a nondirective, nonintrusive approach is most helpful. Directive interventions aimed at the food-related behavior are usually met with resistance until a consistent and stable relationship has developed.
with the therapist. Group therapy is usually refused by these patients because of their fear of exposure.

Identity Conflicted

Identity conflicted patients primarily represent those who have adequate intrapsychic structure and have become involved in food-related behavior for more neurotic reasons. There are often clear precipitants for the onset of the behavior, or the behavior can be conceptualized as a developmental adjustment reaction. The pursuit of thinness among this group often revolves around identity and achievement issues; for bulimics, the eating behavior may be a compensatory alternative to conflictual drives, such as aggression or sexuality. If depression is observed, it is usually the introjective type of depression described earlier.

Cognitively, this group of patients is very capable of functioning abstractly, and their behavior can be understood and interpreted in a symbolic manner. Their interpersonal relationships are differentiated and developmentally appropriate. These patients often respond quite well to short-term, symptom-focused interventions. Both individual and group interventions that challenge their beliefs about dieting behavior, the pursuit of thinness, achievement, guilt, failure, rejection, assertiveness, approval, and sexuality can interrupt the symptomatic behavior rather quickly.

SUMMARY AND COMMENTS

The initial consultation serves a vital function in most comprehensive treatment programs. It is a delicate task with multiple demands. The clinician must obtain sufficient information to render a diagnosis; must make treatment recommendations according to observed distinctions among patients; and must quickly establish a therapeutic relationship with the patient that simultaneously challenges, supports, and offers hope.

As our ability to accomplish these tasks in the initial consultation improves, so will our treatment effectiveness. The clinical observations, as well as the DSED (see Appendix), are offered in the hope that they will contribute to an increasing sophistication in conducting initial consultations.
APPENDIX

D.S.E.D.
DIAGNOSTIC SURVEY FOR EATING DISORDERS

INSTRUCTIONS: This questionnaire covers several eating problems that may or may not apply to you. You may find it difficult to answer some questions if your eating pattern is irregular or has changed recently. Please read each question carefully and choose the answer that best describes your situation most of the time. Also, please feel free to write remarks in the margins if this will clarify your answer. Thank you.

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
<tr>
<td>Current Address</td>
</tr>
<tr>
<td>Permanent Address</td>
</tr>
<tr>
<td>Current Telephone</td>
</tr>
<tr>
<td>Permanent Telephone</td>
</tr>
<tr>
<td>Social Security Number</td>
</tr>
</tbody>
</table>

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I would like to thank the following people for their suggestions during the construction of the DSED: Arnold Andersen, MD; Elke Eckert, MD; David Garner, PhD; James Mitchell, MD; Richard Pyle, MD; and Michael Strober, PhD. Parts of the DSED were adapted from the Social and Psychiatric History Form for Eating Disorders used at the University of Minnesota Medical School.
# Identifying and Demographic Information

<table>
<thead>
<tr>
<th>Sex</th>
<th>Male ☐ 1</th>
<th>Female ☐ 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>(16) 19</td>
</tr>
<tr>
<td>Race</td>
<td>White ☐ 1</td>
<td>Black ☐ 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(17-18) (19)</td>
</tr>
<tr>
<td>Religion</td>
<td>Protestant ☐ 1</td>
<td>Catholic ☐ 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(20) 3 5</td>
</tr>
<tr>
<td>Family of origin</td>
<td>Protestant ☐ 1</td>
<td>Catholic ☐ 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(21) 3 5</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Presently in first marriage ☐ 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Divorced and presently remarried ☐ 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Divorced or separated and not presently remarried ☐ 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Widowed and presently remarried ☐ 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Widowed and not presently remarried ☐ 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Never married ☐ 6</td>
<td></td>
</tr>
<tr>
<td>Role</td>
<td>Wage earner ☐ 1</td>
<td>Housewife ☐ 2</td>
</tr>
<tr>
<td>Highest Occupational level attained</td>
<td>Self ☐ 1</td>
<td>Father ☐ 2</td>
</tr>
<tr>
<td></td>
<td>Higher executive, proprietor of large concern. ☐ 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Major professional ☐ 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Business manager of large concern, proprietor of medium sized business, lesser professional ☐ 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Administrative personnel, owner of small independent business, minor professional, owner of large farm ☐ 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clerical or sales worker, technican, owner of little business, owner of medium sized farm ☐ 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled manual employee, owner of small business ☐ 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Machine operator, semiskilled employee, tenant farmer who owns little equipment ☐ 7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unskilled employee, sharecropper ☐ 8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Does not apply (Never worked in paid employment) ☐ 9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Does not apply (No spouse) ☐ 10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Information not available ☐ 11</td>
<td></td>
</tr>
</tbody>
</table>
Current living arrangement (Check one)

With Parents or relatives □ 1
Dorm or
Shared apartment with Friend □ 2
Conjugal (intimate relationship with one other person, including spouse, boyfriend, etc.) □ 3
Alone □ 4

Highest level of education

Self
Completed post-graduate training □ 1
Some post-graduate training □ 2
Completed college, received four year academic degree □ 3
Attended college, but didn’t receive four year academic degree □ 4
Completed high school; may have attended or completed trade school or other non-academic training requiring high school completion □ 5
Attended high school □ 6
Completed grammar school (8th grade) □ 7
Attended grammar school □ 8
No schooling □ 9
Does not apply (No spouse) □ 10
Information not available (Specify why) □ 11

Check one for each person

Spouse

Please describe your current occupation:

---

Weight History

Current weight ___ lbs. (41-43)
Current height ___ inches (44-45)
Desired weight ___ lbs. (46-48)

Adult Years
Highest adult weight since age 18 ___ lbs. at age ___ (49-51)
Lowest adult weight since age 18 ___ lbs. at age ___ (54-55)
How long did you remain at your lowest adult weight? ___ days ___ months ___ years (59-61)

Adolescent Years
Highest weight between ages 12-18 ___ lbs. at age ___ (62-64)
Lowest weight between ages 12-18 ___ lbs. at age ___ (67-71)

Childhood
How did you perceive your weight as a child between the ages 6-12 years old?

<table>
<thead>
<tr>
<th>Extremely Thin</th>
<th>Somewhat Thin</th>
<th>Normal Weight</th>
<th>Somewhat Overweight</th>
<th>Extremely Overweight</th>
</tr>
</thead>
</table>
| 1             | 2             | 3             | 4                   | 5                   | (72)
Initial Consultation

As a child were you teased about your weight?
Yes about being underweight □ 1;
Yes about being overweight □ 2

To what extent were you teased?

<table>
<thead>
<tr>
<th>Extremely</th>
<th>Very Much</th>
<th>Moderately</th>
<th>Slightly</th>
<th>Not at All</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

At your current weight do you feel that you are (Circle one)

<table>
<thead>
<tr>
<th>Extremely Thin</th>
<th>Somewhat Thin</th>
<th>Normal Weight</th>
<th>Moderately Overweight</th>
<th>Extremely Overweight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Are you involved in an occupation that requires you to maintain a certain weight?

Yes □ 1  No □ 2

Please explain:

How much does a two-pound weight gain affect your feelings about yourself?

<table>
<thead>
<tr>
<th>Extremely</th>
<th>Very Much</th>
<th>Moderately</th>
<th>Slightly</th>
<th>Not at All</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

How much does a two-pound weight loss affect your feelings about yourself?

<table>
<thead>
<tr>
<th>Extremely</th>
<th>Very Much</th>
<th>Moderately</th>
<th>Slightly</th>
<th>Not at All</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Has there ever been a time when your feelings about yourself or your social life have changed substantially as a result of losing weight?

Yes □ 1  No □ 2

Please explain:

How dissatisfied are you with the way your body is proportioned?

<table>
<thead>
<tr>
<th>Extremely Dissatisfied</th>
<th>Very Dissatisfied</th>
<th>Moderately Dissatisfied</th>
<th>Slightly Dissatisfied</th>
<th>Not at All Dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please indicate on the scales below how you feel about the different areas of your body.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Positive</th>
<th>Moderately Positive</th>
<th>Neutral</th>
<th>Moderately Negative</th>
<th>Strongly Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Arms</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Shoulders</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Breasts</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Stomach</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Buttocks</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Thighs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
How fat do you feel?

<table>
<thead>
<tr>
<th>Extremely Fat</th>
<th>Very Fat</th>
<th>Fat</th>
<th>Somewhat Fat</th>
<th>Not at all Fat</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

How often do you weigh or measure your body size?

- More than daily □ 1
- Daily □ 2
- More than weekly □ 3
- Weekly □ 4
- Monthly □ 5
- Less than monthly □ 6

**Dieting Behavior**

Have you ever been on a diet?

- Yes □ 1
- No □ 2

At what age did you begin to restrict your food intake due to concern over your body size?

□ years old

In your first year of dieting how many times did you start a diet?

□ No. of times

Over the last year how often have you begun a diet?

□ No. of times

Please rank from 1-9 your preferred way of dieting (1 = most preferred, 9 = least preferred)

- Skip meals
- Completely fast
- Restrict carbohydrates
- Restrict sweets
- Restrict fats
- Reduce portions
- Go on fad diets
- Reduce calories
- Other (specify)

If you have ever been encouraged to diet, please rank from 1-10 the people that encouraged you to diet the most (1 = most encouraged, 10 = least encouraged)

- Boyfriends
- Girlfriends
- Mother
- Father
- Brother
- Sister
- Employer
- Teacher/Coach
- Other relative
- Other (Please specify)

**Binge Eating Behavior**

Have you ever had an episode of eating a large amount of food in a short space of time (an eating binge)

- Yes □ 1
- No □ 2

How old were you when you first had an eating binge?

□ years old
Initial Consultation

Please circle on the scales below, how characteristic the following symptoms are of your binge eating

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>I consume a large amount of food during a binge</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I eat very rapidly</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I feel out of control when I eat</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I feel miserable or annoyed after a binge</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I get uncontrollable urges to eat and eat until I feel physically ill</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I binge eat in private</td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

How long does a binge usually last

- Less than one hour □ 1
- 1 - 2 hours □ 2
- More than 2 hours □ 3

Please rank 1-9 the times of day that you are most likely to binge (1 = most likely, 9 = least likely)

<table>
<thead>
<tr>
<th>Time</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 am - 10 am</td>
<td></td>
</tr>
<tr>
<td>10 am - 12 pm</td>
<td></td>
</tr>
<tr>
<td>12 pm - 2 pm</td>
<td></td>
</tr>
<tr>
<td>2 pm - 4 pm</td>
<td></td>
</tr>
<tr>
<td>4 pm - 6 pm</td>
<td></td>
</tr>
<tr>
<td>6 pm - 8 pm</td>
<td></td>
</tr>
<tr>
<td>8 pm - 10 pm</td>
<td></td>
</tr>
<tr>
<td>10 pm - 12 am</td>
<td></td>
</tr>
<tr>
<td>After midnight</td>
<td></td>
</tr>
</tbody>
</table>

Please rank from 1-6 the places where you are most likely to binge (1 = most likely, 6 = least likely)

- Home
- Work
- Restaurant
- Car
- Party
- Other: Please specify

Please rank from 1-5 how likely you are to binge eat in the presence of the following people

- (1 = most likely, 5 = least likely)

- Friends
- Parents
- Alone
- Spouse/Significant Other
- Children

How old were you when you began binge eating

—— years old

39
How long have you had a problem with binge eating?

___ Days  ___ Months  ___ Years

Within the last month, what has been your average number of binge episodes per week?

___ Binges

What is the longest period you have had without binge eating since the onset of the problem?

___ Days  ___ Months  ___ Years

What were the circumstances that helped you to stop binge eating for that period of time (If more than one event is applicable please rank order the importance of the event with 1 = most important)

Began dieting
Started exercising
Sought professional help
Began romantic relationship
Left romantic relationship
Developed illness
Left home
Divorce
Marriage
Pregnancy
Work
Vacation
Other: Please specify

Please rank from 1-7 the foods that you are most likely to binge on: (1 = most likely, 7 = least likely)

Bread/cereal/pasta
Cheese/milk/yogurt
Fruit
Meat/fish/poultry/eggs
Salty snack foods
Sweets
Vegetables

Please rank from 1-7 the foods that you are most likely to eat when you are not bingeing: (1 = most likely, 7 = least likely)

Bread/cereal/pasta
Cheese/milk/yogurt
Fruit
Meat/fish/poultry/eggs
Salty snack foods
Sweets
Vegetables

Were there any special feelings related to binge eating?

Using the scale from 1 - 7, please rank how these feelings relate to binge eating: (1 = most likely, 7 = least likely)

Extro
Calm
Empt
Conf
Excit
Angr
Saci
Inad
Disg
Lone

Have you

Yes
Initial Consultation

Were there any particular events in your life, either positive or negative, which preceded or coincided with the onset of your eating problems? (Check as many as applicable)

- Death of significant other
- Leaving home
- Illness or injury to self
- Failure at school or work
- Difficult sexual experience
- Illness or injury to family member or significant other
- Problems in romantic relationship
- Family problems
- Teasing about appearance
- Prolonged period of dieting
- Marriage
- Pregnancy
- Work transition
- Other: Please specify

Using the scale below, please select the number which indicates the intensity of each of the following feelings before a binge

<table>
<thead>
<tr>
<th>Extremely Intense</th>
<th>Very Intense</th>
<th>Moderately Intense</th>
<th>Slightly Intense</th>
<th>Not at all Intense</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empty</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confused</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excited</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spaced out</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inadequate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disgusted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lonely</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bored</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frustrated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panicked</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relieved</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guilty</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervous</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: Please specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Using the scale below, please select the number which indicates the intensity of each of the following feelings after a binge

<table>
<thead>
<tr>
<th>Extremely Intense</th>
<th>Very Intense</th>
<th>Moderately Intense</th>
<th>Slightly Intense</th>
<th>Not at all Intense</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empty</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confused</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excited</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spaced out</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inadequate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disgusted</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lonely</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bored</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frustrated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panicked</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relieved</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guilty</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervous</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: Please specify</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you noticed a relationship between the frequency of your binge eating and your menstrual cycle?

Yes □ 1  No □ 2
If yes, please indicate when during your cycle you feel most vulnerable to binge eating.

- During Menstruation ☐
- 11-14 days prior to menstruation ☐
- 7-10 days prior to menstruation ☐
- 3-6 days prior to menstruation ☐
- 1-2 days prior to menstruation ☐
- After menstruation ☐

How uncomfortable are you with your binge eating behavior?

<table>
<thead>
<tr>
<th>Extremely uncomfortable</th>
<th>Very uncomfortable</th>
<th>Uncomfortable</th>
<th>Somewhat uncomfortable</th>
<th>Not at all uncomfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

How willing would you be to gain 10 pounds in exchange for not binge eating any more?

<table>
<thead>
<tr>
<th>Extremely willing</th>
<th>Very willing</th>
<th>Willing</th>
<th>Somewhat willing</th>
<th>Not at all willing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Purguing Behavior**

Have you ever vomited or spit out food after eating in order to get rid of the food eaten?

Yes ☐
No ☐

How old were you when you induced vomiting for the first time?

- Years old

How long have you been using self-induced vomiting?

- Days
- Months
- Years

Have you ever used laxatives to control your weight or "get rid of food"?

Yes ☐
No ☐

How old were you when you first took laxatives for weight control?

- Years

How long have you been using laxatives for weight control?

- Days
- Months
- Years

How often are you now able to eat a "normal" meal without "binge eating" and without vomiting?

- Never ☐
- Several meals a week ☐
- Less than one meal a week ☐
- One meal a day ☐
- About one meal a week ☐
- More than one meal a day ☐

How soon after eating do you induce vomiting?

- 0 - 15 minutes ☐
- 16 - 30 minutes ☐
- 31 - 45 minutes ☐
- 46 - 60 minutes ☐
- One hour or longer ☐

Which of the behaviors, "binge eating" or vomiting after meals came first?

- "Binge eating" came first ☐
- Vomiting came first ☐
- They both occurred at the same time ☐
- Neither came first, I have never had "binge eating" or vomiting episodes ☐
- Neither came first. I have only "Binge eating" episodes ☐
- Neither came first. I have only vomiting episodes ☐
Initial Consultation

During the entire last month, what is the average frequency that you have engaged in the following behaviors? (Check one for each behavior)

- Binge eating
- Vomiting
- Laxative use
- Use of diet pills
- Use of water pills
- Use of enemas
- Exercise to control weight
- Fasting (Skipping meals for entire day)

Using the scale below, please select the number which indicates the intensity of each of the following feelings state before a purge.

Using the scale below, please select the number which indicates the intensity of each of the following feelings state after a purge.

Exercise

How many minutes a day do you currently exercise (including going on walks, riding bicycle, etc.)? ______ Minutes
THE CONTEXT FOR PSYCHOTHERAPY

Have you ever competed in any of the following physical activities? (Check as many as are applicable)

- Distance running □
- Weight lifting □
- Dancing □
- Gymnastics □
- Wrestling □
- Tennis □
- Swimming □
- Other: Please specify □

**Other Behavior**

Do you feel that you have ever had an alcohol or drug abuse problem? (Circle one)

<table>
<thead>
<tr>
<th>Extreme</th>
<th>Very Much</th>
<th>Moderate</th>
<th>Slight</th>
<th>Not at All</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

When did the drug or alcohol problem start in relationship to the eating problem?

- I never had a drug or alcohol problem □
- Before the eating problem began □
- After the eating problem began □
- At the same time the eating problem began □

Please indicate how frequently you have used the following substances since the onset of your eating problem.

<table>
<thead>
<tr>
<th>Substance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol (specify type)</td>
</tr>
<tr>
<td>Amphetamines (Uppers)</td>
</tr>
<tr>
<td>Barbiturates (Downers)</td>
</tr>
<tr>
<td>Hallucinogens</td>
</tr>
<tr>
<td>Marijuana</td>
</tr>
<tr>
<td>Tranquilizers</td>
</tr>
<tr>
<td>Cocaine</td>
</tr>
<tr>
<td>Cigarettes: None □</td>
</tr>
</tbody>
</table>

**Amount**

<table>
<thead>
<tr>
<th>Daily 1</th>
<th>Weekly 2</th>
<th>Monthly 3</th>
<th>Less than Monthly 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alcohol (specify type)</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Daily 1</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you ever made a suicide attempt? Yes □ 1  No □ 2

Describe: ________________________________

Have you ever tried to physically hurt yourself (i.e., cut yourself, hit yourself with intent to hurt, burn yourself with cigarettes)? Yes □ 1  No □ 2

Describe: ________________________________
Initial Consultation

Since the onset of your eating problem, have you been involved in stealing?
Yes ☐ 1 No ☐ 2
If yes, please describe types of items stolen:

Sexual History

Have you ever engaged in sexual intercourse?
Yes ☐ 1 No ☐ 2
If your answer is yes, at what age did you first engage in sexual intercourse?
Age __________

Have you ever engaged in masturbation?
Yes ☐ 1 No ☐ 2
If your answer is yes, at what age did you first engage in masturbation?
Age __________

Please indicate on the line below your interest in sex before the onset of your eating problem:

<table>
<thead>
<tr>
<th>No Interest</th>
<th>Somewhat Interested</th>
<th>Interested</th>
<th>Very Interested</th>
<th>Extremely Interested</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please indicate on the scale below whether there has been a change in your sexual interest since the onset of your eating problem:

<table>
<thead>
<tr>
<th>Much Less Interested</th>
<th>Somewhat Less Interested</th>
<th>Equally Interested</th>
<th>Somewhat More Interested</th>
<th>Much More Interested</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please check your sexual preference:
- Exclusively heterosexual ☐ 1
- Primarily heterosexual, some homosexual ☐ 2
- Bisexual ☐ 3
- Primarily homosexual, some heterosexual ☐ 4
- Exclusively homosexual ☐ 5
- Asexual (no sexual preference) ☐ 6
- Autosexual (prefer masturbation to sexual relations with others) ☐ 7

Marriage and pregnancy (Check as many as applicable)

<table>
<thead>
<tr>
<th></th>
<th>Yes ☐ 1</th>
<th>No ☐ 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was married before onset of the eating disorder</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Was married after the onset of the eating disorder</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Was pregnant before onset of the eating disorder</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Was pregnant after onset of the eating disorder</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Have one or more children</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

How satisfied are you with the quality of your sexual activity?

<table>
<thead>
<tr>
<th>Extremely Satisfied</th>
<th>Very Satisfied</th>
<th>Satisfied</th>
<th>Somewhat Satisfied</th>
<th>Not At All Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Menstrual History

Age at onset of menses (if you have never gotten your period please mark 0)
______ Years

Since the onset of your eating problems, how many times have you stopped menstruating for three months or more (which were unrelated to pregnancy)
______ Number of times

Before the onset of your eating problems, how many times had you stopped menstruating for three months or more (which was not related to pregnancy)
______ Number of times

Since the onset of your eating problems, what is the total number of months that you have not menstruated (months unrelated to pregnancy)
______ Months

Before the onset of your eating problems, what was the total number of months that you did not menstruate (months unrelated to pregnancy)
______ Months

Approximate regularity of cycles before onset of eating difficulties (Check one)
- Fairly regular (Same number of days +3)
- Somewhat irregular (Variation 4-10 days)
- Very irregular (Variation greater than 10 days)
- Never menstruated

Approximate regularity of cycles since the onset of eating difficulties (Check one)
- Fairly regular (Same number days +3)
- Somewhat irregular (Variation 4-10 days)
- Very irregular (Variation greater than 10 days)
- Never menstruated

How many times in the past have you had episodes of loss of menstrual periods lasting 3 months or more associated with significant weight loss when you were not "binge eating" or pregnant?
______ Number of times

Medical and Psychiatric History

Have you ever had any serious medical difficulties?
Yes □ 1  No □ 2
Please explain:
Initial Consultation

Please indicate any prior hospitalization for eating or emotional problems.

<table>
<thead>
<tr>
<th>Date Admitted</th>
<th>Most Recent</th>
<th>Second Prior</th>
<th>Third Prior</th>
<th>Fourth Prior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date discharged</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary reason for admission*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Use number code: 1=bulimia; 2=anorexia nervosa; 3=chemical dependency; 4=depression; 5=psychiatric other than depression; 6=other

Prior outpatient treatment for eating or emotional problems (i.e., a logically continuous series of treatments)

<table>
<thead>
<tr>
<th>Date begun</th>
<th>Most Recent</th>
<th>Second Prior</th>
<th>Third Prior</th>
<th>Fourth Prior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date last visit of series</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration (weeks)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary reason for treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Use number code: 1=bulimia; 2=anorexia nervosa; 3=chemical dependency; 4=depression; 5=psychiatric disorder other than depression; 6=other

Please indicate the types of treatment you have been involved with

<table>
<thead>
<tr>
<th>Most Recent</th>
<th>Second Prior</th>
<th>Third Prior</th>
<th>Fourth Prior</th>
</tr>
</thead>
</table>

*Use number code: 1=individual psychotherapy; 2=group psychotherapy; 3=psychiatric medication

Are you currently on any medication?

Yes ☐  No ☐

Please identify: __________________________

What physical problems have you had since the onset of your eating problems? (If more than one response is applicable please rank order your answers with 1 = most troublesome, 8 = least troublesome)

Sore Throat | __________________________
Weakness or tiredness | __________________________
Seizures | __________________________
Feeling "bloated" | __________________________
Stomach pains | __________________________
Sores or calluses on fingers due to induction of vomiting | __________________________
Dental problems | __________________________
Other | __________________________

Have you ever taken psychiatric medication?

Yes ☐  No ☐

Please identify: __________________________
## Life Adjustment

Please circle on the scale below how frequently you experience the following symptoms:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Difficulty getting up in the morning</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Crying episodes</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Irritability</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Fatigue</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Difficulty falling asleep</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### Have a: (First d)
- U
- C
- A
- D
- M
- Sc
- Pa
- Ht
- Ol
- Al
- Dr
- Se
- Ph
- Bu
- An
- Sui
- Oth

## Life Adjustment

Please circle on the scale below the quality of your relationship with each of the following:

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Terrible</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Father</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Husband/Other</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Male Friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Female Friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Children</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Please circle on the scale below how much your eating problems interfere with the following:

<table>
<thead>
<tr>
<th>Area</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Daily activities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>(other than work)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoughts</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Feelings about myself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Personal relationships</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Have any of your first degree relatives had any of the following problems?
(First degree relatives include children, brothers, sisters, parents)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of persons</th>
<th>Relationship to (eg, sister)</th>
<th>Require Outpatient Care? (If yes, check below)</th>
<th>Require Hospitalization? (If yes, check below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulcers</td>
<td>28:29</td>
<td>30:34</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>Colitis</td>
<td>37:36</td>
<td>39:43</td>
<td>44</td>
<td>45</td>
</tr>
<tr>
<td>Asthma</td>
<td>46:47</td>
<td>48:52</td>
<td>53</td>
<td>54</td>
</tr>
<tr>
<td>Depression</td>
<td>55:56</td>
<td>57:61</td>
<td>62</td>
<td>63</td>
</tr>
<tr>
<td>Manic-Depressive</td>
<td>64:65</td>
<td>66:70</td>
<td>71</td>
<td>72</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>10:11</td>
<td>12:16</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>Paranoid Thinking</td>
<td>19:20</td>
<td>21:25</td>
<td>26</td>
<td>27</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>28:29</td>
<td>30:34</td>
<td>35</td>
<td>36</td>
</tr>
<tr>
<td>Obesity</td>
<td>37:38</td>
<td>39:43</td>
<td>44</td>
<td>45</td>
</tr>
<tr>
<td>Alcohol</td>
<td>46:47</td>
<td>48:52</td>
<td>53</td>
<td>54</td>
</tr>
<tr>
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REFERENCES


