CHAPTER 7

THE RELEVANCE OF PATHOLOGICAL ALTRUISM TO EATING DISORDERS

Rachel Bachner-Melman

KEY CONCEPTS

- Individuals with eating disorders tend to sacrifice their own needs and interests and devote themselves instead to helping and serving others.
- Selflessness and concern for appropriateness, concepts linked to pathological altruism, have been shown to characterize women with eating disorders.
- Developmental, interpersonal, family, cultural, genetic, personality, and social factors no doubt combine to make pathological altruism a characteristic of people who develop eating disorders.

IT IS NOT uncommon to observe people on self-imposed starvation diets deriving pleasure from serving food to others or cooking for them. This tendency of individuals with eating disorders (anorexia nervosa, bulimia nervosa, binge eating disorder, and eating disorder not otherwise specified) to deprive themselves while satisfying others' needs is by no means restricted to nutrition, and has been frequently observed and described in research and in clinical settings. It is common for eating-disordered patients in treatment programs to devote themselves to taking care of each other. According to self-psychologists (Bachar, 1998; Geist, 1998; Goodsitt, 1997), patients with eating disorders feel and behave like selfless souls serving others' needs. Salvador Minuchin, a family therapist, described the self-sacrifice of anorexic patients in the service of their family's needs (Minuchin, Rosman, & Baker, 1987). Women with anorexia nervosa interviewed by Wechselblatt, Gurnick, and Simon (2000) felt they had been encouraged by their families and cultural environments to substitute others' needs for their own.

A self-report Selflessness Scale measuring the tendency to relinquish one's own interests and ignore one's own needs in order to serve the interests and well-being of others has been developed by Eytan Bachar and his colleagues for use in

empirical research (Bachar et al. 2002). Scores on this questionnaire have been found to distinguish between women with eating disorders and control women (Bachar et al., 2002) to be positively associated with the severity of anorexic symptomatology (Bachner-Melman, Zohar, Ebstein, & Bachar, 2007) and to predict the development of eating pathology in adolescent schoolgirls with 82% sensitivity and 63% specificity. Low selflessness scores seem to offer some degree of protection from eating problems (Bachar, Gur, Canetti, Berry, & Stein, 2010).

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Research conclusions may be convincing and rational, yet the most potent descriptions of pathological altruism as part and parcel of eating disorders come, perhaps, from those in recovery. "All of my life I lived for other people," writes one ex-patient, "not out of choice, but because I didn't know any other way. It wasn't until years later that I found out that I didn't actually have a self. I became what other people liked, thought, said, and did: without respect for myself, going day by day trying to please other people so that I could be good enough" (Claude-Pierre, 1997; p. 256). A 44-year-old woman recovering from anorexia after over 20 years of illness, writes: "I was a pleaser from a very young age to my father, mother, and other family members and friends, and this took away my freedom to make choices that were right for me. . . . The happiness of others was primary in my life . . . I was the super woman at our local swim club where my kids swam. I did everything from ordering suits to running meets. I volunteered for every job, every week" (D. Friedman, personal communication, September 7, 2009).

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The vast majority of eating-disordered patients (approximately 90%) are women. Sociological theories suggest that women, in general, focus more than men on the needs of other people (Gilligan, Rogers, & Tolman, 1991). Moreover, even the healthiest people—women and men—derive a sense of competence, pleasure, and self-worth from being kind, helpful, and generous toward others.

How, then, can altruism be pathological? The point at which giving becomes unhealthy is difficult to define. The crucial factors differentiating "normal altruism" from "pathological altruism," as seen in the eating disorders, include the motivation for giving, the price paid, and the degree of sacrifice and associated negative affect involved.

The major motivations for giving in healthy altruism are openness to new experiences and a desire for personal growth (Stone, 2000). In contrast, the major motivation for giving in eating-disordered individuals is to please others, gain approval, and avoid criticism and rejection. Unlike healthy altruism, pathological altruism enhances a sense of self-worth via significant self-sacrifice and self-deprivation (Seelig & Rosof, 2001). Hilde Bruch, a psychoanalyst and pioneer in the treatment of eating disorders, pointed out that individuals with eating disorders give to others at great expense to the development of their own identity. They often crave connections and wish to maintain them at all costs. A frequent motivation for giving and accommodating themselves to others' tastes, opinions, and needs is the hope of receiving much-needed affection

and acceptance. Giving to other people may be seen as a precondition for love or positive regard. The other side of this coin is a fear of rejection and of feeling lost should a relationship be disrupted (Bruch, 1978).

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In the pathological altruism that so often accompanies eating disorders, the simple and natural joy of giving is tainted by anger and frustration, conscious or unconscious, at sacrificing so much and receiving so little in return. The tendency of women with anorexia to repress needs and feelings, especially anger, to protect interpersonal relationships has been supported from a cognitive and sociological perspective by Geller, Cockell, Goldner, and Flett (2000). Yet, even though a high emotional price is paid for constant compromise, pathological altruism has significant adaptive value for eating-disordered patients, because in the short term its rewards mask and provide relief from feelings of worthlessness and inefficacy. Since pathological altruism in the eating disorders often involves satisfaction as part of the inner conflict created by giving, it would usually be defined by Seelig and Rosof (2001) as "conflicted" as opposed to healthy or "generative" altruism. However, in cases when caretaking becomes compulsive, joyless, and martyr-like, it might fall into their category of "pseudoaltruism."

How and when do eating-disordered individuals come to prioritize others' needs above their own? Clinicians and theoreticians have described developmental processes explaining the emergence of pathological altruism long before the onset of an eating disorder (usually in adolescence or early adulthood). Since prospective research on these processes remains impractical and sparse, support for these explanations must generally be gathered retrospectively, after the onset of the disorder. For this reason, descriptions of and explanations for the development of pathological altruism in childhood as a precursor to eating disorders should currently be regarded as hypotheses supported by much anecdotal, clinical, theoretical, and retrospective narrative evidence. Whereas pathological altruism is in no way limited to individuals who go on to develop eating disorders, it seems to be particularly characteristic of this population.

The etiology of eating disorders is complex and multifactorial. Genetic, biological, temperamental, developmental, family, personality, sociocultural, interpersonal, and circumstantial factors contribute collectively to risk. The developmental and interpersonal processes described below fit into a large and intricate puzzle explaining the development of eating disorders, yet are presented here because they seem central to an understanding of pathological altruism as a contributing factor. Heinz Kohut's self-psychology (Kohut, 1971, 1977), in particular, provides us with a theoretical framework that lends itself aptly to a description of the development of pathological altruism as seen in the eating disorders.

To develop healthily, children need the feeling that they are special, appreciated, and worthy of admiration—"mirroring," in Kohut's terminology. It is age-appropriate, for example, for small children to believe that they are cute and gorgeous, their scribbles are masterpieces, what they say is worth listening to, and they are the center of their parents' world. Kohut (1971) believed this infantile or "archaic" grandiosity to be normal and necessary for the development of

a cohesive sense of self, good self-esteem, and healthy goals. Children whose mirroring (and other) needs are met are able to develop a wholesome sense of identity and to be confident that their basic needs can be satisfied by those close to them. They are able to turn to others in a healthy way and use them as "selfobjects," as Kohut (1968) called people who serve the function of fulfilling others' needs.

When parents or caregivers are immersed in their own physical, psychological, interpersonal, and/or circumstantial preoccupations, they are not fully available, responsive, and empathic to the needs of their children. Possible evidence for a tendency of mothers of girls with eating disorders to be preoccupied with their own issues was found in a recent study showing low levels of selflessness in mothers of daughters with anorexia (Bachar et al., 2010). Interestingly, the daughters showed heightened selflessness when their mothers, but not their fathers, exhibited depressive tendencies. Although these results may highlight a tendency in girls with anorexia to worry about and try to protect their mothers by adopting their concerns, this study was conducted after the onset of anorexia, leaving the premorbid picture unclear.

According to Kohut's theory, when needs for external mirroring are insufficiently met in childhood, the "archaic grandiosity" (Kohut, 1971) described above is not transformed and incorporated into a cohesive, healthy self. As a result, an exaggerated and permanent need for responsiveness from others develops, to the extent that some people come to feel they exist largely in the eye of the beholder (Goodsitt, 1984). Alas, as time passes, the sense of positive self-esteem that failed to crystallize during early childhood is less and less likely to be established. Later on, receiving good things may provoke a sense of unease and guilt. Compliments, acts of caring, and admiration for genuine virtues, intelligence, talents, skills, or competencies often fall like water from a duck's back, leaving the individual tragically starved for the very reinforcement being offered.

Such circumstances are not limited to objectively deprived or abused children. Sometimes the subjective experience of unmet needs may result from an extreme sensitivity to the social environment resulting primarily from genetic, temperamental, and/or biological factors, or from a mismatch between the child's personality and parenting style (Strober, 1991). How do sensitive children cope with the unmet needs they experience to be cared for, held, understood, and admired? They cut off and ignore them. They come to regard them as excessive and unjustified. They become ashamed of their desire to be seen, helped, and served; ashamed of being dependent on others; ashamed of needs for acknowledgment and mirroring. Some children who sense their caretakers are burdened learn very early on not to add to their burden and strive to lighten it by not making demands and coping with life on their own. In extreme cases, they make it a top priority not to be a burden on anybody. Ashamed of their "true" self, they hide behind an appearance of self-sufficiency (Modell, 1965) and develop a façade molded by other's expectations—coined a "false self" by the psychoanalyst and leading object-relations theorist Donald Winnicott (Winnicott, 1965). Desperate for appreciation and longing to be listened to, they dismiss their inner values, experiences, initiatives, and needs (Goodsitt, 1984).

Clinicians and theoreticians have described this in eating disorders. Bruch (1978), for example, wrote that her anorexic patients had spent their lives learning how to adapt themselves to others in order to lessen demands on them. Selvini Palazzoli (1978), a family therapist from the Milan systems group of

therapists, emphasized the guilt experienced by children who later develop eating disorders in response to their needs, and described family dynamics that lead them to feel responsible for their parents' well-being. Richard Geist (1989a) and Eytan Bacher (1998), Kohutian "self-psychologists," point out that eating-disordered patients often recall feeling responsible for their parents and taking on a comforting, organizing role in the home.

The core symptom of eating disorders involves denial of one of the most basic biological needs: the need for food. In eating disorders, food ingestion comes to be regarded as an unjustifiable self-indulgence, a selfish and illegitimate act. In anorexia, the rejection of pleasure and condemnation of anything that smacks of indulgence (Mogul, 1980) is communicated via an emaciated body shape. Eating disorders involve a denial of needs far beyond the need for food, often including denial of other biological needs, such as the need for rest, sleep, sex, and medical care, and of interpersonal needs for affection, support, and help. Eating healthily means caring for oneself, giving oneself sustenance, responding to inner needs, and allowing oneself pleasure. All these things are problematic for those suffering from eating disorders.

Eating disorders provide an effective strategy to avoid satisfying inner wishes and needs via a highly regimented and ritualized daily schedule regulated by behavioral and moral rules. Helping others usually appears very high up on a long list of obligations. Much anger and aggression is inherent in the symptoms of an eating disorder. People with these disorders invariably disown and condemn anger, aggression, and greed, and often devote themselves to listening to others, taking care of them, helping and serving them (Bruch, 1973). Feeling they have no right to exist in their own right (Goodsitt, 1997), they consistently adopt, in the language of self-psychology, the role of selfobject. Their raison d'être becomes to maintain others' well-being. They give what they themselves would like to receive but cannot. Their illness could even be seen as thinking so much of other people and so little of themselves that others are forced to step in and take over the function of self-care. In other words, they are "consummate caretakers" (Bruch, 1978) or experts in "pathological altruism."

Contemporary society overvalues independence (Fineman, 2005), causing autonomy to appear deceptively adaptive. Those who appear to cope without help tend to be admired at the personal, familial, and broader cultural level. Pathological altruism, too, can look misleadingly healthy. Altruism is socially approved; parents, teachers, religious leaders, and society at large teach us the value of giving to family members, siblings, classmates, friends, and the needy. The autonomy and altruism of children and adolescents who go on to develop eating disorders are all too often misinterpreted as signs of health and good adjustment by parents, peers, loved ones, colleagues, teachers, and society at large. It is not uncommon for the parents of adolescents with eating disorders, particularly anorexia, to overlook and deny their child's illness as long as possible and to react with incredulity and disbelief when confronted with it. How, they ask, could such an easy, sweet-natured, undemanding, and disciplined person possibly be ill?

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Parents are on no account to be blamed for their children's eating disorders. Whereas the vast majority of parents are self-absorbed to

varying degrees, very few children become pathological altruists, and a tiny majority eventually develop eating disorders. Gender is the most significant risk factor for an eating disorder, and the role of genetics is paramount (Bulik et al., 2008; Holland, Sicotte, & Treasure, 1988; Mazzeo et al., 2009; Strober, Freeman, Lampert, Diamond, & Kaye, 2000). Not only does heredity play a role in eating disorders, but also in altruism; conceivably, certain genetic pathways are shared. Twin studies have demonstrated that a significant proportion of the differences between people's prosocial attitudes is due to heredity (Asbury, Dunn, Pike, & Plomin, 2003), and specific genes associated with altruism as measured by the Selflessness Scale (*DRD4*, *IGF2,* and *DRD5*) have been preliminarily identified (Bachner-Melman et al., 2005). Interestingly, two of these genes are related to the "reward" neurotransmitter dopamine, supporting the notion that helping others may be reinforced by reward. What exactly is passed on genetically is not clear. It is possible that an inherited sensitivity factor predisposes some children to be particularly attuned to interpersonal cues, and later to take on responsibility for other's well-being, and that interaction with other genetic and environmental factors contributes to risk for an eating disorder.

A lack of clear self-definition, so intricately linked to pathological altruism, interacts with cultural, biological, personality, and genetic factors to create a risk profile for the development of eating disorders. Michael Strober, for example, sees anorexia nervosa basically as a failure to establish a clear and stable sense of self, but his conceptualization extends beyond this. He believes that a specific, genetically based personality style as measured by Cloninger's (1987) Tridimensional Personality Questionnaire (high harm-avoidance, low novelty seeking, and high reward dependence) inhibits the natural exploration necessary for normal self-development and contributes to a lack of goodness-of-fit between child and parenting style (Strober, 1991).

Pathologically altruistic behavior that stems from a lack of a sense of self involves reading, anticipating, or guessing others' needs and giving these priority over one's own. People with eating disorders appear to be very adept at this. External environment and circumstances take precedence over an internal compass of what is beneficial for self. Such an internal compass seems absent in women with eating disorders. Bruch (1973, 1978) commented that women with anorexia depend on external sources for their self-esteem and become experts at reading cues from others about how to feel and behave. Vitousek and Ewald (1993) emphasized the combined contribution of genetic and environmental factors to the failure to develop a clear sense of self, leading to an overreliance on social and environmental cues. Boskind-Lodahl (1976) emphasized cultural and social pressures in the lack of identity experienced by girls with eating disorders. In Schupak-Neuberg and Nemeroff's (1993) view, the absence of a true self underlying bulimia nervosa stems from an overemphasis on cultural factors and physical appearance.

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Endorsement of the current thin beauty ideal that underlies disturbed eating attitudes and behaviors might be seen as an extended expression of pathological altruism, in the sense that the biological need to eat is sacrificed for the broader "needs" or dictates of society concerning body shape. This hypothesis was explored in research (Bachner-Melman et al., 2009) using the construct

"concern for appropriateness," first introduced in the field of social psychology and measured by a self-report questionnaire called the Concern for Appropriateness Scale (Lennox & Wolfe, 1984). Concern for appropriateness involves constant efforts to read others' needs and expectations in order to evaluate appropriate behavior strategies and adopt them, out of a fear of being different or standing out. It is associated with a general tendency to understand and be influenced behaviorally by interpersonal and media messages (Bearden & Rose, 1990; Johnson, 1989).

What counts as a desirable, socially "appropriate" identity varies sharply from one cultural-historical setting to another (Schlenker, 1982). In contemporary Westernized societies, a steady diet of stereotyped thin images persists in the media and motivates many women to strive for thinness. Yet, not all women exposed to the media are similarly influenced by the messages to which they are exposed.

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It was hypothesized that people concerned with appropriateness may be more vigilant than others concerning cultural norms on physical appearance and the culturally "appropriate" body shape, motivating them to attain it at any price, even if they have to sacrifice their health to do so. Concern for appropriateness was indeed found to characterize women with a present or past history of anorexia nervosa and to be associated with symptom severity (Bachner-Melman et al., 2009). Moreover, this association was fully mediated by sociocultural attitudes toward appearance. The most plausible interpretation of these results is that women highly concerned with social appropriateness tend to endorse, inter alia, prevailing cultural attitudes toward appearance, including the importance of being thin. The endorsement of the thin ideal in turn predisposes them to disturbed eating attitudes and behaviors, and presumably in extreme cases, to eating disorders.

The adult cultural ideal of thinness becomes personally relevant during puberty (Hermes & Keel, 2003). Adolescence is typically characterized by a preoccupation with appearance and identity development, heightening susceptibility to pressures and influences from the media (Wertheim, Paxton, Schultz, & Muir, 1997). Teenagers are among the heaviest users of many forms of mass media, particularly magazines (Arnett, Larson, & Offer, 1995). It therefore hardly seems surprising that adolescence is the peak onset period for eating disorders.

Media influences, however, constitute only one avenue for the transmission of sociocultural messages. Teenagers tend to be extremely sensitive about appearance-related comments (Striegel-Moore, & Kearney-Cooke, 1994). Also, peer pressure peaks during adolescence (Heaven, 1991). Adolescent girls often talk about dieting and weight issues, and the peer group's degree of weight concerns influences and predicts a girl's own behavior (Paxton, 1996). Girls who sacrifice their health to present a proscribed, desired body shape are paying a high price to fulfill a group requirement, give the group what it needs, seek approval, and avoid being discounted. Conforming to a group ideal of thinness to the extent that an eating disorder develops can in itself therefore be regarded as an expression of pathological altruism.

Concern for appropriateness is no doubt both environmentally and genetically based. It has been found to be associated with a vasopressin receptor AVPR1A

promoter region microsatellite (Bachner-Melman et al., 2005b), and the same microsatellite was found to be associated with disordered eating (Bachner-Melman et al., 2004). Assuming a link between concern for appropriateness and pathological altruism, the vasopressin receptor gene may be contributing risk for anorexia, at least in part, via pathological altruism. This line of investigation should be further explored in future research.

One major anomaly in the association between pathological altruism and eating disorders deserves some explanation. Freud defined altruism as "the opposite of egoism" (Freud, 1957, p. 418), and indeed, the term is commonly used as an antonym of selfishness or narcissism. Yet, despite eating-disordered individuals' frequent surrender to others, they often describe themselves as narcissistic and selfish. Core symptoms of eating disorders such as self-destructive starvation, binge-eating, purging, defiant self-sufficiency, noncommunication, and social isolation appear manipulative, controlling, and self-centered—so far removed from altruism, in fact, that they invariably trigger hostile reactions and earn eating-disordered patients a reputation of being notoriously difficult to understand and treat (Kaplan & Garfinkel, 1999). Indeed, narcissism is a frequently documented characteristic of eating-disordered patients (Johnson, 1991; Riebel, 2000; Steiger, Jabalpurwala, Champagne, & Stotland, 1997). Rather than fulfilling full criteria according to the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV) for narcissistic personality disorder, eating-disordered patients tend to fit Gabbard's (1989) description of "hypervigilant narcissists," about whom he writes: "At the core of their inner world is a deep sense of shame related to their secret wish to exhibit themselves in a grandiose manner. . . . Attention is continually directed toward others . . . they study others intensely to figure out how to behave." So, if pathological altruism is a characteristic of eating disorders that needs to be addressed in treatment and recovery, how can it be reconciled with undeniable narcissism?

It seems that, in the eating disorders, as in other pathology, narcissism and altruism represent two sides of the same coin. With the onset of an eating disorder, frustration at constantly giving so much, sacrificing so much of self, comes to a peak. One thing that can be possessed and held on to is food intake and a low weight. An eating disorder makes it legitimate to express the wish to be the center at least of a narrowly defined world. Unmet grandiose needs and wishes break through and gratification is obtained in a disguised way (Goodsit, 1984). Symptoms of weight loss, remaining thin despite overeating, "rising above" natural appetite, maintaining a dangerously low weight, and/or purging without becoming ill (Riebel, 2000) create the grandiose illusion of being empowered, special, and superior to others. When they first start to lose weight, women with anorexia report feeling "delighted, inspired, triumphant, proud, and powerful . . . special, superior, and deserving of the respect and admiration of others" (Bemis, 1986, quoted in Vitousek & Ewald, 1993). This initial "high" could conceivably be connected with changes in levels of endorphins, associated with a feeling of elevation in runners (Huebner, 1993) and in levels of the neurotransmitter dopamine, associated with reward (Bachner-Melman et al., 2007; Barry & Klawans, 1976; Levitan et al., 2004).

We have seen that, in the eating disorders, food consumption is viewed as selfish, whereas self-starvation is experienced as depriving, selfless, and therefore paradoxically nourishing, satisfying, and commendable. Fasting is, in most religions, a means of drawing close to the Divine. In eating disorders, as in extreme forms of religion, self-indulgence and pleasures of the flesh tend to be

shunned (Mogul, 1980; Lelwica, 2009; Vandereycken & van Deth, 1990). Freedom from body and bodily needs can lead to a feeling of immortality, omnipotence, spiritual purity, and moral superiority (Green, 2001). It is evident that a sense of satisfaction and superiority is achieved, paradoxically, via self-deprivation. A sense of triumph is achieved by relinquishing parts of oneself (Green, 2001). When autonomy and self-sufficiency are valued (after thinness) above all else, giving to others becomes, despite its high price, one of the only permissible sources of pleasure.

The functions of the narcissism described above are primarily defensive. Although eating disorders may appear to stem from an egotistical desire to improve one's appearance, motivation to improve body shape stems from a sense of being ugly and inadequate. Feeling strengthened and superior to others is an antidote for feelings of weakness and inefficacy (Goodsit, 1984). Grandiose fantasies of omnipotence and invulnerability coexist with and protect against a terrifying awareness of helplessness and vulnerability that characterizes a poorly defined identity (Tobin, 1993).

To conclude, the pathological altruism seen in conjunction with eating-disorder symptomatology has important implications for recovery, treatment, and prevention. Concerning recovery, cross-sectional research has shown levels of selflessness and concern for appropriateness in women completely recovered from anorexia to be similar to those of women with no history of an eating disorder (Bachner-Melman, Zohar, Ebstein, & Bachar, 2007; Bachner-Melman et al., 2009). Pathological altruism therefore may be an aspect of an eating disorder that, thankfully, can heal with recovery from eating and weight symptoms.

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Concerning treatment, therapy provides an unfamiliar experience for eating-disordered patients: an opportunity to focus on their needs and not those of others. One potential trap for therapists lies in the character of pathological altruism itself; patients may be hypersensitive to the therapists' reactions, expectations, and narcissistic needs, and respond "appropriately" instead of exploring and expressing genuine feelings and lacks. Important objectives in therapy include learning to recognize and fulfill authentic needs, developing and consolidating a sense of identity, learning to distinguish and respect clear boundaries between self and other, developing the courage to differ, and learning to buffer vulnerability and counteract negative messages from the media, teachers, friends, and family (Piran, 1997). Family therapy is often helpful for younger patients, since family roles can be shifted to relieve the eating-disordered child from the responsibility of constantly serving others.

Much anecdotal, clinical, narrative, and empirical evidence suggests that pathological altruism may be a precursor of, and therefore a risk factor for, eating disorders.

The overlap between pathological altruism and eating disorders also has potential implications in the field of prevention. Further research should examine and clarify whether, and how specifically, pathological altruism predicts the emergence of an eating disorder as opposed to other psychopathology such as depression or obsessive-compulsive disorder. In the meantime, much anecdotal, clinical, narrative, and empirical evidence suggests that pathological altruism may be a

precursor of, and therefore a risk factor for, eating disorders. Parents, teachers, coaches, doctors, and the public at large should be educated to be on the lookout for overly giving, self-sacrificing children and teenagers, and awareness should be increased that such individuals may be experiencing serious and undetected distress. Pathological altruism, if detected early enough, could provide a valuable warning about the threat of an impending eating disorder. Such a sign, together with other risk factors, such as specific personality traits and genetic markers to be determined by prospective research, could form the basis of a recognized risk profile for eating disorders. If high risk can be recognized, preemptive interventions such as individual psychotherapy, family therapy, nutritional guidance, psychoeducation, assertiveness training, or changes in social or study environment may be able to prevent the enormous pain and suffering inflicted by an eating disorder, and possibly even save lives.

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