EATING DISORDERS

Introduction

Eating disorders are grouped into three categories: refusing to maintain a minimally normal body weight (anorexia nervosa), bingeing and purging (bulimia nervosa), and bingeing without purging (binge eating disorder). Bingeing is the rapid consumption of large amounts of food in a short period of time accompanied by a feeling of loss of control. Purging is self-induced vomiting or misuse of laxatives or enemas.

Eating disorders are far more common among women, especially younger women, than among men.

ANOREXIA NERVOSA

Anorexia nervosa is characterized by a distorted body image, an extreme fear of obesity, refusal to maintain a minimally normal body weight, and in women, the absence of menstrual periods.

Hereditary factors have been shown to play a role in the development of anorexia nervosa. Social factors are also important. The desire to be thin pervades Western society, and obesity is considered unattractive, unhealthy, and undesirable. Even before adolescence, children are aware of these attitudes, and two thirds of all adolescent girls diet or take other measures to control their weight. Yet only a small percentage of these girls develop anorexia nervosa. Other factors, such as psychologic susceptibility, probably predispose certain people to developing anorexia nervosa. In areas with a genuine food shortage, anorexia nervosa is rare.

About 95% of people who have anorexia nervosa are female. The disorder usually begins in adolescence, occasionally earlier, and less commonly in adulthood. Anorexia nervosa primarily affects people in middle and upper socioeconomic classes. In Western society, the number of people who have this disorder seems to be increasing: it has been estimated to affect about 1% of girls aged 12 to 18.

Symptoms

Anorexia nervosa may be mild and transient or severe and persistent. Because many people who develop anorexia nervosa are meticulous, compulsive, and intelligent, with very high standards for achievement and success, an eating disorder may easily go undetected. The first indications of the impending disorder may be a subtle increased concern with diet and body weight. Such concerns seem out of place, because most people who have anorexia nervosa are already thin. Preoccupation and anxiety about weight intensify as the person becomes thinner. Even when emaciated, the person claims to feel fat, denies that anything is wrong, does not complain about weight loss, and usually resists treatment. The person usually does not see a doctor until brought to one by concerned family members.

Anorexia means "lack of appetite," but people who have anorexia nervosa are actually hungry and preoccupied with food. They study diets and count calories; they hoard, conceal, and deliberately waste food; they collect recipes; and they prepare elaborate meals for others. Half of the people who have

anorexia nervosa binge and then purge by vomiting or taking laxatives. The other half simply restrict the amount of food they eat. They also frequently lie about how much they have eaten and conceal their vomiting and their peculiar dietary habits. Many also take diuretics to treat perceived bloating.

Women with anorexia nervosa stop having menstrual periods, sometimes before losing much weight. Women and men with the disorder may lose interest in sex. Typically, they have a low heart rate, low blood pressure, low body temperature, swelling of tissues caused by fluid accumulation (edema), and fine, soft hair or excessive body and facial hair. People with anorexia nervosa who become very thin tend to remain active, often exercising excessively to control their weight. Until they become emaciated, however, they have few symptoms of nutritional deficiencies. Depression is common.

Hormonal changes resulting from anorexia nervosa include markedly reduced levels of estrogen (in women) and thyroid hormone and increased levels of cortisol. If a person becomes seriously malnourished, every major organ system in the body is likely to be affected. When weight loss has been rapid or severe—for example, to more than 25% below the ideal body weight—restoring body weight quickly is crucial; such weight loss and the associated changes in electrolytes and fluid balance can be life threatening. Problems with the heart and with fluids and electrolytes (sodium, potassium, chloride) are the most dangerous. The heart gets weaker and pumps less blood through the body. The person may become dehydrated and prone to fainting. The blood may become alkaline (a condition called metabolic alkalosis and potassium levels in the blood may decrease. Vomiting and taking laxatives and diuretics can worsen the situation. Sudden death, probably from abnormal heart rhythms, may occur.

Diagnosis and Treatment

Anorexia nervosa is usually diagnosed on the basis of severe weight loss and the characteristic psychological symptoms. The typical person with anorexia nervosa is an adolescent girl who has lost at least 15% of her body weight, fears obesity, stops having menstrual periods, denies being sick, and otherwise appears healthy.

Treatment has two phases: short-term intervention to restore body weight and save the person's life and long-term therapy to improve psychological functioning and prevent relapse.

The initial treatment of severe or rapid weight loss is best provided in a hospital where experienced staff members firmly but gently encourage the person to eat. Rarely, the person is fed intravenously or by a tube inserted through the nose and passed into the stomach. Sometimes doctors confine those with severe disease in the hospital against their will after obtaining appropriate legal authorization from a parent, guardian, or the court.

When the person's nutritional status is acceptable and stabilized, long-term therapy is begun. Treatment is aimed at establishing a calm, concerned, stable environment while encouraging the consumption of an adequate amount of food. This treatment may include individual, group, and family psychotherapy as well as drug therapy. Combined treatment by the family doctor and a therapist often helps, and consultation with or referral to a specialist in eating disorders is wise.

When depression is diagnosed, antidepressants are prescribed. Certain antidepressants, particularly selective serotonin reuptake inhibitors, are useful for preventing relapse after weight has been restored.

As many as 10 to 20% of people diagnosed with anorexia nervosa die of it and its complications, which include fluid and electrolyte abnormalities, heart failure, and suicide resulting from depression. However, because mild cases may not be diagnosed, no one knows exactly how many people have anorexia nervosa or what percentage die of it.

Binge Eating Disorder

Binge eating disorder is characterized by bingeing that is not followed by purging.

In this disorder, bingeing contributes to excessive caloric intake and consequent weight gain. Unlike bulimia nervosa, binge eating disorder occurs most commonly in people who are obese and becomes more prevalent with increasing body weight. People who have binge eating disorder tend to be older than those who have anorexia nervosa or bulimia nervosa, and more (nearly half) are men.

The foods that binge eaters typically choose (binge foods) are high in calories (for example, cake and ice cream), and binges usually occur in secrecy.

People who have binge eating disorder are distressed by it, and about 50% of obese binge eaters are depressed. Although this disorder does not cause the physical problems that can occur with bulimia nervosa, it may lead to complications of obesity.

Treatment

Behaviour therapy, as it is used to treat obesity, may be the best treatment for binge eating disorder. Behaviour therapy has been shown to reduce body weight and the frequency of bingeing, even when no special attention is given to binge eating. Cognitive-behaviour therapy markedly reduces the frequency of bingeing as well, but without reducing body weight.

BULIMIA NERVOSA

Bulimia nervosa is characterized by the repeated rapid consumption of large quantities of food (bingeing), followed by attempts to rid the body of the excess food consumed (purging).

As in anorexia nervosa, bulimia nervosa is influenced by hereditary and social factors. Also as in anorexia nervosa, most people who have bulimia nervosa are young women, are deeply concerned about body shape and weight, and belong to the middle or upper socioeconomic classes. About 2% of college women, the population believed to be at highest risk, are bulimics.

Symptoms

People with bulimia nervosa engage in repeated episodes of bingeing, which involves consuming large amounts of food within a relatively short period of time, often within 2 hours. Emotional stress often triggers the binge-purge cycle, which usually is done in secret. Bingeing, which is accompanied by a

feeling of a loss of control, typically includes eating when not hungry and eating to the point of pain. In an attempt to counteract the effects of the binge, people with bulimia nervosa engage in purging through such means as vomiting or taking laxatives; rigorously dieting; over-exercising; or any combination of these. Many also take diuretics to treat perceived bloating. Unlike in anorexia nervosa, however, the body weight of people with bulimia nervosa tends to fluctuate around normal.

Self-induced vomiting can erode tooth enamel, enlarge the salivary glands in the cheeks (parotid glands), and inflame the oesophagus. Vomiting and purging can lower potassium levels in the blood, causing abnormal heart rhythms. Sudden death from repeatedly taking large quantities of ipecac to induce vomiting can occur, the result of an abnormal heart rhythm. Rarely, people who have this disorder eat so much during a binge that their stomach ruptures or their oesophagus tears, leading to life-threatening complications.

Compared with people who have anorexia nervosa, those who have bulimia nervosa tend to be more aware of their behaviour and to feel remorseful or guilty about it. They are more likely to admit their concerns to a doctor or other confidant. Generally, people with bulimia nervosa are more outgoing. They also are more prone to impulsive behaviour, drug or alcohol abuse, and depression.

Diagnosis and Treatment

A doctor suspects bulimia nervosa if a person, particularly a young woman, is overly concerned about weight gain and has wide fluctuations in weight, especially with evidence of excessive laxative use. Other clues include swollen salivary glands in the cheeks, scars on the knuckles from using the fingers to induce vomiting, erosion of tooth enamel from stomach acid, and a low level of potassium detected by a blood test. The diagnosis is not confirmed until the person describes binge-purge behaviour and reports having two or more binge-eating episodes a week for at least 3 months.

The two most effective approaches to treatment are cognitive-behaviour therapy and drug therapy.

In cognitive-behaviour therapy, dysfunctional thoughts are identified and examined, and the person is helped to give them up. The person meets with the therapist once or twice a week over a period of 4 to 5 months, for a total of about 20 sessions. Cognitive-behaviour therapy has been shown to reduce the frequency of bingeing in about two thirds of people with bulimia and to stop bingeing altogether in about one third. People who have undergone this type of therapy continue to reduce or refrain from bingeing for at least 1 year.

Drug therapy with selective serotonin reuptake inhibitors, a type of antidepressant, has been shown to work at least as well as cognitive-behaviour therapy in the treatment of bulimia nervosa. However, when the drugs are stopped, bingeing recurs.