Taking the lid off eating disorders

MARGARET REICH
Senior Staff Editor

Diet books proliferate in the bookstores of America. Television commercials promise svelte figures for only \$19.95 (check or money order, no CODs) for a month's supply of pills not available in any store!

There's no question that we live in a weight-conscious society. The idea that slim persons are somehow inherently better begins at a young age. By 7, girls already perceive other thin children as attractive. When shown pictures of fat persons, 6 to 9-year old boys and girls described them as lazy, lying, and cheating.

Certainly, cultural influence plays some role in eating disorders like bulimia and anorexia. However this alone does not fully explain why such abnormal eating patterns are reaching across all socioeconomic, racial, and sexual boundaries. Twenty percent of all teenage and college-age women reportedly suffer from bulimia. While statistics for anorexia among teenagers have been ranked as high as 3%, actual figures are hard to come by since 25 to 60% of anorexics may also have bulimia. Likewise, while statistics indicate only 10% of all anorexics and bulimics are men, these figures may be deceiving. Men are less likely to seek professional help, preferring to handle the problem themselves, until a medical complication forces them to see a physician.

Although the statistics and even the distinctions between bulimia and anorexia are not always clearly defined, experts agree that much more than food is involved when it comes to these eating disorders.

Bulimia

Bulimia involves consuming large amounts of high calorie, easily digested food—candy, cookies, ice cream—in less than two hours. Most of us are guilty of binging on a "tummy buster" sundae or some

other confectioner's delight on occasion, feeling guilty as we unbuckled that belt a notch or two. Bulimia is much more complicated. Considered a psychiatric disorder, it is further defined by the following criteria:

- Secret recurring binging episodes (usually twice a week for at least 3 months) in which anywhere from 1,000 to 10,000 calories are consumed. These binges usually end when abdominal pain or self-inflicted vomiting occurs, or when someone enters the room.
- Trying to lose weight by using laxatives or diuretics (water pills) or a strict diet.
- Weight fluctuations of 10 to 20 pounds because of alternate binge and fast periods.
- Realizing that binging and purging is disgusting but feeling unable to stop eating voluntarily.
- While a cleansing or feeling of relief follows purging, guilt and depression are not far behind. These can trigger another episode.

Who is susceptible?

Women aged 13 to 50 are most commonly vulnerable, with the bulimia most likely to start about age 18. However, men also suffer from this eating disorder, particularly athletes (wrestlers, runners, and jockeys, dancers), and any other professional for whom weight and physical attractiveness are of paramount importance.

A psychological profile

In bulimia, nourishment acts as a replacement for tenderness, affection, happiness and general fulfillment. Adolescent bulimics in particular have an egocentric view of the world. They feel as if someone is always watching them. What others think

is very important. While most persons accept the positive and negative aspects of their identity, the bulimic sees only the negative side.

Food becomes an obsession, consuming nearly every thought day and night. Fear of fat along with a sense of being out of control is a hallmark of this disorder. Likewise, fear of failure in school, business, or in personal relationships further influences this behavior.

When it comes to losing weight, these persons set very strict goals. Like most dieters, bulimics avoid favorite foods only to experience increased cravings. However, as the cravings grow stronger, so do the anger and resentment. This depressed state, often enhanced by alcohol or drug use, leads to a breakdown in will power or control, setting the stage for the binge and purge cycle.

Binging and purging

The urge to gorge may occur at the same time each day, but nighttime seems most common. Not surprisingly, after gulping 1,000 to 10,000 calories of food in less than two hours, a bloated feeling ensues. With that comes guilt for having gone too far. Purging is a way to relieve the fullness while cleansing the conscience of guilt. It also serves to prevent weight gain.

Self-induced vomiting is the most popular purging method. Fingers or cotton swabs stuck down the throat do the trick. Drinking lots of water after a binge elicits the same results.

For those who can't bring themselves to vomit, laxatives or diuretics offer an alternative. Taking as many as 15, 20, or even 100 laxatives at a time is not uncommon.

Unfortunately, the relief experienced after purging lasts but a short time before guilt and depression return, and with that the urge to binge once more.

Not all bulimics practice purging. Some turn to fasting as a way to lose the weight gained during a binge. In this case, succumbing to a craving by having one cookie is considered a failure. With that comes another binge.

Surprisingly, bulimics can keep this abnormal food behavior a secret even from loved ones. The wretching sounds of purging are masked by running water in the bathroom. A spouse may not be aware

of this eating disorder for years. Meanwhile, the bulimic resorts to hiding the food expense by shopping in different stores, charging the bills to various credit cards, and sometimes stealing food or laxatives.

Shame may keep someone with this disorder from engaging in social contact. Extreme cases can lead to suicide. Conversely, guilt often causes bulimics to seek professional help. Bulimics are truly embarrassed by this behavior. Admitting this problem exists makes initial treatment easier.

Physical complications

A dentist may be the first medical professional to note the disorder. The acidity in the vomitus, coupled with frequent regurgitation, and an inadequate diet, decays tooth enamel, sometimes to the point where teeth fall out.

The effects of self-induced vomiting go beyond dental decay. Tears in the lining of the throat may bleed. Likewise, the stomach may push through the diaphragm, creating a choking sensation. Knuckle calluses appear from constantly shoving fingers down the throat.

Laxative abuse inhibits natural intestinal contractions. Castor oil turns feces into liquid. As a result, the intestines move more frequently making it difficult for them to absorb liquid.

If taken in excess, water pills, often prescribed for women to relieve premenstrual bloating, can cause dehydration. Combined with an inadequate diet, dehydration creates a deficiency in sodium and potassium levels. Such an imbalance may cause kidney problems, muscle spasms, or even cardiac arrest.

In women, missed or irregular menstruation (amenorrhea) is a common side effect in near normal weight bulimics as well as those fasting instead of purging to control weight. This can occur when body fat falls below 22% of the normal body fat levels. In addition, the thyroid gland may not produce the right amount of hormones. Sometimes it takes one to ten years after weight gain and psychological improvement before menstruation resumes. Actually, these changes in the hormone secretion are the body's way of preserving energy during such starvation periods.

Anorexia nervosa

Bulimia may be more prevalent than anorexia, but the latter proves just as destructive. Skin becomes dry, nails turn brittle, and hair begins to fall out. Because of the reduced body fat, the anorexic is always cold. Heavy clothing is worn even in hot weather. Hyperactivity, especially excessive exercise, becomes commonplace despite the onset of weakness. Sleepless nights are spent planning the next day's menu.

What starts out as a simple diet progresses to obsessively avoiding foods perceived as fattening. These include carbohydrates (starches and sugars) which act as a major source of energy in a balanced diet. Due to false nutritional information, anorexics eat nearly the same thing daily. Cut into minute pieces, each morsel is slowly consumed. It's not surprising that 15 to 25% of the normal body weight is lost.

While reports of 50- and 60-year old women and men suffering from anorexia are not unheard of, most instances occur with the start of puberty, a time of great physiologic and social change.

Like the bulimic, an anorexic is frequently characterized as a perfectionist, someone who is polite, obedient, and intelligent. Unfortunately, an anorexic denies a problem exists. This denial often inhibits initial treatment.

Hunger definitely exists—it's just a matter of not succumbing to those pangs. Psychological reasons for such behavior are complex. Just like bulimia, fear seems to be a motivating factor. Fear of fat drives a 5-foot, 7-1/2 inch women, who weighs 100 pounds, to step on the scale as many as 20 times a day to check for weight gain.

Some anorexics diet not to keep off fat, but out of fear of intimacy, success or failure, or adulthood. Many anorexics are victims of physical or sexual abuse. In these instances, food may symbolize sex and pregnancy (in women), all the more reason not to eat.

Beyond the psychological causes

Multifaceted reasons that embody biochemical or genetic, family, and social forces lie behind eating disorders.

Biochemical

Certain chemicals produced by the brain have been linked to anorexia and bulimia. An overabundance of the stress hormone cortisol has been found in anorexics. Persons suffering from major depression, often considered a precipitating factor in eating disorders, have exhibited an excessive amount of cortisol hormones.

Similarly, bulimics appear to have low serotonin levels. This particular neurotransmitter regulates how much is eaten, as well as the body's cravings for carbohydrates and protein. Bulimics may overeat because the serotonin levels aren't high enough for the brain to tell the stomach it has had enough. Likewise, because carbohydrate and protein cravings are left unchecked, more of the wrong kinds of food are desired.

These factors, along with a possible genetic connection between depression and alcoholism, may predispose a person to anorexia or bulimia. A traumatic event—death of a parent, grandparent, close friend, or loss of a job—can trigger an eating disorder in such a person. Sometimes a father's comment about his child's increased weight can fuel these abnormal eating patterns.

Family

Frequently, parents of an anorexic child make nearly all that person's decisions—including what, when, and how much food to eat. When it comes time for the child to accept adult responsibilities, she or he feels overwhelmed. Control over food intake serves as an attempt to mature.

Social pressure

Undue pressure to excel in school, work, or on the social scene adds to life's burdens. For certain individuals, anorexia or bulimia provides an escape mechanism.

Getting to the heart of the matter

Professional assistance

Strong, but gentle urging from a trusted friend or family member is usually necessary before the anorexic or bulimic seeks professional assistance.

Sometimes, tagging along for support on that first visit makes reaching out for help a little easier. Too often, it's only when something physical goes wrong, like bleeding from the throat, that this person seeks medical attention.

While no simple answers exist, eating disorders can be treated—if not cured—using a combination of medical and psychological therapies. Since the line between anorexia and bulimia often overlaps, treatment for both remains similar. Depending on the physical state of the person, most treatment is performed on an outpatient basis.

A doctor and nutritionist slowly refeed the drastically underweight patient, carefully watching vital signs. During this time, temporary bloating, especially in the face, occurs. Reassurance from the dietician should prevent any panic over what the anorexic perceives as fat.

Nutritional counseling is a very important aspect on the road to recovery. Nutritionists recommend 10 to 15 calories per pound per day to maintain a healthy weight according to height. Short-term weight-gain goals are established. To meet them, the patient charts weight fluctuations and may be rewarded for adding pounds, and punished for any loss by taking away some privileges. Once the desired weight is reached, physical monitoring continues for about 3 months.

Addressing the hidden problem

Weight gain and proper nutritional counseling usually are not enough. A psychiatrist or psychologist aids the person suffering from an eating disorder discover and resolve the real reason behind this behavior.

Therapy begins once the patient gains some weight, even as little as 2 pounds. The most common approaches include individual or group therapy and family counseling.

Individual therapy is designed to correct the character deficit that causes the anorexic to see this behavior as normal in the first place. Someone suffering from bulimia might work on the inner conflict graphically illustrated in the binge and purge episodes. Once a patient begins to understand the motives behind such behavior, group therapy follows. This provides moral support during the

In search of professional help

These associations and societies offer anorexics, bulimics and their families help in locating therapists and support groups. Some may operate their own clinics.

- American Anorexia/Bulimia Association 133 Cedar Lane Teaneck, NJ 07666 (201) 836-1800
- National Association of Anorexia Nervosa and Associated Disorders Box 7 Highland Park, IL 60035 (312) 831-3438
- Anorexia Nervosa and Related Eating Disorders PO Box 5102 Eugene, OR 97405 (503) 344-1144
- National Anorexic Aid Society 5796 Karl Rd Columbus, OH 43229 (614) 436-1112

recovery process. Discussing the problem bolsters self-esteem.

Family counseling may prove beneficial when a youngster suffers from an eating disorder. During these sessions therapists work with the child and parents on developing trust in their relationship.

During separate sessions, parents receive counseling to reveal their frustrations that they may be physically or emotionally taking out on their child. At the same time, they are taught to "cut the apron strings" and allow their child to accept responsibility.

Drugs may be administered to increase appetite. Antidepressants commonly are prescribed in conjunction with therapy. However, side effects, such as light-headedness, dry mouth, constipation, and forgetfulness make finding the right antidepressant a trial and error process. Some antidepressants cause weight gain, a definite drawback for someone who already has a distorted

body image. Nonetheless, the decision to use medication of any kind rests with the psychiatrist.

Self-help

Besides nutritional and psychiatric counseling, relaxation techniques have helped some bulimics. Others have found exploring a wider variety of outside interests and spiritual guidance helpful in recovering from this disorder.

Is there a cure?

The road to recovery can be a long and arduous one. Whether or not these eating disorders are completely cured depends upon the individual. Understanding and support from family and friends certainly helps. Trust is the key to unlock the mystery of these eating disorders so food can be seen in its proper perspective again.

(All material in the Patient Health Guide is reviewed by JAOA physician referees.)

References:

Adolescent eating disorder: Bulimia. By Rolf E. Muuss, *Adolescence*, vol. 21, pp. 257-267, Summer 1986.

Anorexia and bulimia: The earliest clues. By Janet P. Crawshaw, *Patient Care*, vol. 19, pp. 80-95, October 30, 1985.

Anorexia nervosa in geriatric patients. By A. James Giannini and Nicholas Telew, *Geriatric Medicine Today*, vol. 6, pp. 75-83, December 1987.

Anorexia nervosa: The broken circle. By Ann Erichsen. Faber and Faber, London, 1985.

Athletic amenorrhea, major affective disorders, and eating disorders. By Warren J. Gadpaille, Charlotte Feicht Sanborn, and Wiltz W. Wagner, Jr., *American Journal of Psychiatry*, vol. 144, pp. 939-942, July 1987.

Bulimarexia: The binge/purge cycle. By Marlene Boskind-White and William C. White, Jr. W.W. Norton & Company, New York, 1983.

Bulimia nervosa complicated by deficiency of vitamin K-dependent coagulation factors. By Kenji Niiya, et al., *Journal of the American Medical Association*, vol. 250, pp. 792-793, August 12, 1983.

Bulimia recovery survey. National Association of Anorexia Nervosa and Associated Disorders, Highland Park, Ill, 1987.

Culture versus biology: Children's attitudes toward thinness and fatness. By W. Feldman, E. Feldman, and J.T. Goodman, *Pediatrics*, vol. 81, pp. 190-194, February 1988.

Depression, anorexia, Cushing's link revealed. *Science*, vol. 232, pp. 1197-1198, June 6, 1986.

Does my daughter have an eating disorder? *Patient Care*, vol. 22, pp. 125-126, March 15, 1988.

Drug and alcohol abuse by bulimic women and their families. By Cynthia M. Bulik, *American Journal of Psychiatry*, vol. 144, pp. 1604-1606, December 1987.

Eating disorders: Useful facts for physicians. By Michael P. Levine, *Postgraduate Medicine*, vol. 82, pp. 102-109, November 15, 1987.

How do eating disorders affect the thyroid? By Zeena Marshall and Steven Lippmann, *Postgraduate Medicine*, vol. 82, pp. 110-116, November 15, 1987.

Larger than life. By J. Kevin Thompson, *Psychology Today*, vol. 20, pp. 38, 42-44, April 1986.

Mind over meals. By Barbara DeBetz, *Health*, vol. 18, p. 6, December 1986.

Modern nutrition in health and disease, 7th ed. Edited by Maurice E. Shils and Vernon R. Young. Lea & Febiger, Philadelphia, 1988.

New hope for binge eaters: Advances in the understanding and treatment of bulimia. By Harrison G. Pope, Jr., and James I. Hudson, Harper & Row, Publishers, New York, 1984.

The treatment of anorexia nervosa. By L.K. George Hsu, *American Journal of Psychiatry*, vol. 143, pp. 573-581, May 1986.

Winning the battle against anorexia. ANAD working together (Newsletter), pp. 1,3, December 1987.

MOVING?

Don't Forget Us

Attach current mailing label,
print your new address, and
mail this form to:

Circulation Department
American Osteopathic
Association
142 E. Ontario St.
Chicago, Illinois 60611

Please allow 4-6 weeks for
delivery.

AFFIX LABEL HERE

NEW ADDRESS:

Name

AOA Number

Address

City

State

Zip

JAOPA

advertisers' index

Lever Brothers, Inc.
Dove Bar, 620

Marion Laboratories
Cardizem, 607, 608

Merck Sharp & Dohme
Clinoril, 578-580
Mevacor, 595-598
Vaseretic, 600-602

Merrell Dow Pharmaceuticals
Institutional, Cover 3
Lorelco, 637-640
Seldane, 669-672

Miles Pharmaceuticals
Cipro, 588-590

Muro Pharmaceutical Inc.
Bromfed, 613, 614

Parke-Davis
Meclomen, 569, 570
Tucks, Cover 4

Roche Products Inc.
Valium, Cover 2-1

Ross Laboratories
Isomil, 616

Smith Kline & French Laboratories
Tagamet, 583-587

Stuart Pharmaceuticals
Zestril, 649-652

Syntex Laboratories, Inc.
Anaprox, 625-628

University of Medicine and
Dentistry of New Jersey, 664

Upjohn Company
Micronase, 604-606
Xanax, 676-678

Welch Allyn, Inc.
AudioScope, 577
MicroTym, 619

Abbott Health Care Products,
Inc./Burroughs Wellcome
Hytrin, 592-594

Beecham Laboratories
Fastin, 610-612

Flint Osteopathic Hospital, 643

Glaxo Inc.
Zantac, 680-682

Key Pharmaceuticals
Nitro-Dur II, 683, 684
Normodyne, 572-574