

Eating Disorders

Because of the secretive habits of many individuals with eating disorders, their conditions often go undiagnosed. In the case of anorexia nervosa, signs such as extreme weight loss and amenorrhea are more visible. Individuals struggling with bulimia who maintain normal body weight may be able to hide their condition from the casual observer. Many of the signs of eating disorders, though, may be signs of other emotional problems and should be evaluated by a health care professional. Family members might notice some of the following warning signs of an eating disorder:

- Odd rituals, such as cutting food into small pieces
- Fear of situations involving food (pot lucks, etc.)
- Binge eating
- Secretive eating
- Eating very slowly or very rapidly
- Cooking a lot without eating
- Perceiving certain foods as “good” or “bad”
- Excessive beverage consumption
- Excessive gum chewing
- Rigid or excessive exercise regimen
- Use of laxatives, enemas, fasting, diuretics, or purging to get rid of food
- Fear of becoming fat; regardless of weight
- Dressing in layers to hide weight loss or gain
- Preoccupation with food/weight
- Self-worth determined by weight
- Severe self-criticism
- Mood shifts
- Social withdrawal
- Need for approval to feel good about self

Responsibility for identifying eating disorders cannot fall solely on the family. Health care providers, particularly primary care, should be able to recognize an eating disorder. One recent study found that the chances for diagnosis often depend on the health care provider: nurse practitioners, often women, were significantly more likely than physicians to suspect and assess their patients for eating disorders. Findings like these demonstrate the need for strong primary care resources and increased awareness levels of eating disorders by the health care community and among other adults who interact with girls and young women, including teachers, coaches, and advisors.

Correct and timely diagnosis is also complicated by the fact that eating disorder symptoms like extreme weight loss and lack of appetite may be attributed to other diseases.

ANOREXIA NERVOSA

Anorexia nervosa affects up to 1% of the female population; its occurrence peaks in early to middle adolescence. According to the official guide for psychiatric illnesses, the DSM-IV, diagnostic criteria include:

- Refusal to maintain a body weight at or above 85% of a normal weight for age and height
- Intense fear of gaining weight or becoming fat, even though under weight
- Disturbance in the way in which one’s body weight or shape is experienced, disproportionate prominence given to body weight or shape in self-evaluation, or denial of the significance of the current low body weight

- Amenorrhea in postmenarchal women (absence of at least three consecutive menstrual cycles without the aid of hormonal administration)

In addition, people with anorexia nervosa may control their food by either restricting or binge eating/purging. To maintain an abnormally low weight, restricting types simply do not eat enough while binge eating/purging types engage in behaviors like self-induced vomiting or the misuse of laxatives, diuretics, or enemas. In both situations, the person with anorexia essentially starves herself to achieve dangerously low body weight.

Complications: The most severe and noticeable consequences of anorexia nervosa parallel those of starvation. The body reacts in a defensive manner to the lack of nourishment by decreasing metabolism and diminishing thyroid function, both of which contribute to brittle hair and nails, dry skin, lowered pulse rate, cold intolerance, and constipation as well as intermittent diarrhea. In addition, mild anemia, reduced muscle mass, amenorrhea, and swelling of joints may accompany anorexia.

Beyond the many fairly immediate effects of anorexia nervosa, the longer-term consequences of eating disorders affect the lives of the individuals, regardless of treatment. In addition to the risk of recurrence, an extreme electrolyte imbalance from malnutrition may cause irregular heart rhythms and heart failure. With calcium deficiency inherent in a restricted diet, anorexics place themselves at increased risk for osteoporosis both during the illness and in later life.

BULIMIA NERVOSA

Bulimia nervosa can and often does occur independently of anorexia nervosa, although half of all anorexics develop bulimia. Many of the same symptoms of anorexia nervosa appear in those suffering from bulimia nervosa, including amenorrhea and disinterest in sex. Individuals suffering from this disease also follow a routine of episodic binge eating followed by repeated behaviors to rid the body of calories consumed. As in anorexia nervosa, individuals with bulimia assign exaggerated significance to their body weight and shape in self-evaluation. Criteria for bulimia nervosa includes the following:

- During the “binge” abnormally large amounts of food are eaten within a set period of time but done with a sense of lack of control.
- During the inevitable “purge,” the individual consciously compensates to prevent weight gain.

Methods of requisite compensatory behavior are either (a) purging type: self-induced vomiting, misuse of laxatives, diuretics, enemas or other medications, (b) non-purging type: fasting or excessive exercise. This pattern persists at least twice a week for three months.

Complications: Most of the medical complications attributed to bulimia nervosa result from the electrolyte imbalance and secondary trauma of purging behaviors. Loss of potassium due to vomiting and damage to the heart muscle increases the risk of cardiac arrest. Bulimics who use ipecac to purge further damage their bodies since the emetic’s active ingredient is a cardiac and muscle toxin.

Repeated vomiting causes inflammation of the esophagus and a dramatic increase in the natural acidity levels of the mouth, leading to dental and enamel erosion.

BINGE EATING DISORDER (BED)

Although not currently classified as a mental disorder, binge eating disorder, according to the DSM-IV criteria, affects 1-3% of the general population. However, among participants in weight

control programs, the rate may reach up to 15%. BED occurs in women approximately twice as often as in men. In this disorder, the individual consumes an amount of food far beyond the point of satisfying physical hunger. These “binges” also involve eating within a discrete period of time but with a sense of lack of control over the eating. Unlike bulimia or anorexia nervosa, however, BED is not associated with inappropriate compensatory behavior such as vomiting or excessive exercise.

Patients with BED often show marked distress about their eating habits. Diagnosis of BED requires bingeing at least two days a week for six months and at least three of the following:

- Eating much more rapidly than normal
- Eating until feeling uncomfortably full
- Eating large amounts of food, independent of actual physical hunger levels
- Eating alone due to shame or embarrassment
- Feeling disgusted with oneself, depressed or guilty after binges

Complications: People with BED are often overweight because they maintain an insensibly high-caloric diet without expending a similar amount of energy. Physical health complications for this disorder usually relate to the medical problems associated with obesity. Individuals who are overweight may have increased cholesterol levels, high blood pressure, and diabetes, as well as an increased risk for gallbladder disease, heart disease, and some types of cancer.

EATING DISORDERS NOT OTHERWISE SPECIFIED

Far more common and widespread than defined eating disorders are atypical eating disorders, or “eating disorders not otherwise specified.” Individuals may engage in some form of abnormal eating habits that can be just as serious as definitive determinants of eating disorders. People with “eating disorders not otherwise specified” exhibit symptoms that do not meet the strict criteria for eating disorder diagnosis. An individual with disordered eating may meet all the criteria for anorexia nervosa but manage to keep a normal weight, while someone else may engage in purging behavior with less frequency or intensity than someone with “true” bulimia. This type of eating disorder is like BED in that its sufferers are more evenly distributed across the age spectrum. Approximately 2-13% of pre-pubertal females experience atypical eating disorders, while 3-6% of post-pubertal females in the general population are affected.