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Eating disorders: A growing problem in American society

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Abstract

One of the newest and most difficult medical problems facing American society today is that of eating disorders. This paper will focus on two of the most common types of eating disorders: anorexia nervosa and bulimia. Physical, psychological, and behavioral changes which occur in individuals afflicted with either of these disorders will be developed, as well as the diagnostic characteristics of each disorder.

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One of the newest and most difficult medical problems facing American society today is that of eating disorders. This paper will focus on two of the most common types of eating disorders: anorexia nervosa and bulimia. Physical, psychological, and behavioral changes which occur in individuals afflicted with either of these disorders will be developed, as well as the diagnostic characteristics of each disorder.

Physical Change

Anorexia nervosa is sometimes called "the starvation sickness", or "the dieter's disease" (Gilbert & DeBlassie, 1984). This eating disorder is characterized by many symptoms. Usually, an anorexic is under 25 years of age, and 95% of the time a female (Sweeten, 1985). The victim will lose 25% or more of her/his body weight (Sweeten, 1985; Gilbert & DeBlassie, 1984; Kaplan and Woodside, 1987). If this loss of body weight is maintained over a longer period of time the following physical symptoms are likely to occur: (1) a very pale coloring of the skin, (2) lack of energy, (3) dark and brittle nails, (4) constipation and difficulty in urinating, (5) a numbing or tingling sensation in the arms and legs, (6) scalp hair becomes dull and lustreless, and falls out easily, (7) very fine, dark hairs called languo appear over much of the body, (8) heart rate is less than 60 per minute, (9) dizziness will occur when going from a sitting position to a standing position, and (10) menstrual irregularities or complete

loss of the menstrual period in females may occur (Kaplan & Woodside, 1987; Peters, Swassing, Butterfield, & McKay, 1984; Richards, 1985).

It is estimated that somewhere between 5 to 10% of those people diagnosed as having anorexia nervosa will die due to medical complications from malnutrition during the severe stage of this disorder (Gilbert and DeBlassie, 1984). Anorectics sometimes experience brain abnormalities that impair mental performance. Patients have been found to have slower reaction time and perceptual speed on IQ tests (Gilbert & DeBlassie, 1984). The starvation process can also change the levels of electrolytes, enzymes, cholesterol and carotene found in the body, and therefore further damage one's metabolic processes (Peters et al, 1984).

Bulimia literally means "ox hunger" (Neuman, Pratt, and Zarrett, 1985). It is said to be the sister ailment of anorexia nervosa. Neuman et al (1985) list the following as criteria for being diagnosed as bulimic: (1) recurrent binges, eating large amounts of food in a short time frame, (2) frequent weight fluctuations of more than ten pounds due to binging and fasting, (3) self-induced vomiting, (4) excessive use of laxatives and diuretics to lose additional weight, and (5) normal body weight for the person's age and height, or a weight that is slightly above what is considered normal for that particular individual.

The bulimic patient realizes that his/her eating pattern is abnormal. The bulimic fears that eating cannot be stopped volun-

tarily. After a binge eating episode the bulimic is often in a depressed mood, and this leads to self-depreciating thoughts (Richards, 1985).

Psychological Change

The psychological changes in the anorectic and the bulimic are alike in many ways. Thompson (1985) cites several ways patients with these disorders are similar. Individuals have an obsessive desire for thinness, and often deny that there is anything wrong with them. The bulimic often has a great fear of being discovered, while the anorexic will deny anything is physically wrong with him/her. Many patients have a grossly distorted image of physical size and appearance. They always fear that they are "too fat". Both types of patients tend to be perfectionists, and respond very critically to suggestions. Both anorectics and bulimics are very competitive and make whatever effort necessary to excel in everything they do. This causes them to lose many social relationships, and spend much time alone. This then leads the eating disorder person to become unhappy. The unhappiness is then followed by depression. All of these factors gradually cause anorectics and bulimics to have an extremely low self-esteem.

Many people with eating disorders engage in another compulsive action - kleptomania (Neuman et al, 1985). Many eating disorder patients are initially referred to therapists because of court appearances dealing with stealing or the writing of bad checks. Since many anorectics and bulimics are people of high principles,

this area of illegal activity is one being explored more by therapists working with eating disorder patients.

Thompson (1985) reported on a cycle that most bulimics seem to follow. Anxiety is created by a stressful event such as a test, mealtime, disappointment, or excitement due to an upcoming party or date. This anxiety causes the bulimic to respond by binging. He/She will then purge him/herself to relieve guilt and to prevent the gaining of weight. This leads to depression, and thus the cycle begins anew.

Oldis (1986) has found that many anorectics feel that they are not loved, both in their families and among peers. Another psychological change is that girls fear growing up and becoming sexually mature. These patients tend to feel that they can't control their lives, but they are able to control their eating and therefore control their bodies. This then many times is a source of attention, their thinness. The anorectic cycle is then perpetuated as the anorexic gets more attention the thinner she gets.

Behavioral Changes

As stated earlier anorectics will tend to become socially withdrawn. The number of friends and number of interests they have becomes smaller and smaller (Peters et al, 1984). Many victims lose interest in activities that were once very important to them. A large percentage then focus mainly on extensive exercising, dieting, and an over-attention toward schoolwork (Peters et al, 1984).

The metabolic changes discussed earlier in this paper have another detrimental affect on the anorexic person. These changes cause one's ability to concentrate to be reduced. This leads to a reduction in the amount of work completed by the anorexic. Thus, a student who has anorexia often spends many hours isolated doing schoolwork, but the result of the person's effort is that very little actually was accomplished. The anorexic will then often times turn to strenuous physical activity as a means of relaxation, as well as feeling that he/she has finally accomplished something. Of course, the accomplishment being the keeping off of weight. This physical activity generally causes hunger, but the anorexic will try to ease the feeling of hunger by drinking large quantities of low calorie liquids such as diet pop, water, or coffee (Peters et al, 1984).

Bulimics are contrasted to anorectics in that bulimics tend to keep more friends and do not become as socially isolated. However, friendships are often superficial as the bulimic must have secret times to binge and purge. Bulimics spend a great deal of time thinking of food or planning their next binge. Therefore, they often seem preoccupied and are not really interested in what is going on around them, even when with friends (Peters et al, 1984; Neuman et al, 1985; Caffary, 1987).

Causes

Physicians, psychologists, nutritionists, and therapists are unsure of an exact cause for an eating disorder. However, most

have concluded that no one event or issue can be listed as a cause. Instead, it is now believed that anorexia nervosa and bulimia are caused by many factors working together within an individual (Scott & Baroffio, 1986; Eisele, Hertsgaard, & Light, 1986; and Mitchell & Eckert, 1987).

Eisele et al (1986), using the Eating Disorder Instrument ((EDI), found that the central psychopathology of anorectics is to avoid psychological maturity through the avoidance of carbohydrates. Their findings also showed that girls whose fathers were unskilled scored higher on the maturity fears subscale of the EDI than girls whose fathers were farmers, skilled workers, or professionals. It appeared that girls whose future plans were unsettled were a higher risk to become anorectic or bulimic than the girls who had definite plans for their future. Eisele and her associates were quick to point out that their findings may not be accurate. This at-risk study relied on participants to answer honestly and accurately. Yet, people with eating disorders often deny that they have a problem. Therefore, the results of this study need to be viewed with caution.

Other family factors have been found as possible causes of anorexia and bulimia. Anorectics generally come from middle or upper-middle class families which appear to be socially and financially stable. However, the mothers have been characterized as having done everything for their child. They have pushed their values and desires onto their children (Peters et al, 1984).

Fathers of anorectics are characterized as being emotionally distant, often away from the home because of business, and have placed a good deal of emphasis on being successful academically as well as athletically (Peters et al, 1984). However, there are very few divorces in homes where children have developed an eating disorder. Instead, the parents tend to emphasize a happy home, though there seems to be disharmony between the parents (Sweeten, 1985). The children in these homes are well cared for, but do not mature emotionally as the parents make all the decisions in the household (Peters et al, 1984).

Anorexia patients many times come from homes where there is more than one child (Gilbert & DeBlassie, 1984). The addition of a new family member sometimes causes confusion among older children which could possibly lead to an eating disorder (Scott and Baroffio, 1986; and Caffary, 1987). So what appears to be a stable family from the outside can actually become a household filled with an emotional tension which sometimes leads to more problems.

Another possible cause of anorexia nervosa is an endocrinological defect (Caffary, 1987; and Sweeten, 1985). Because hypothalmic functioning is a key to normal maturation at puberty, some specialists believe that if something prevents this functioning from occurring, and maturation does not occur normally, that this could trigger one's aversion to food.

From the above paragraphs it is easy to see that no single cause for anorexia nervosa or bulimia has been found. Instead, a

myriad of possible causes have been found by medical and nutritional specialists. The general conclusion that these people have agreed upon is that anorexia and bulimia are the products of several physical, psychological, and behavioral components working together to form a dangerous, and sometimes fatal, combination.

Treatment

There is uncertainty as to what is the best treatment for anorexia nervosa and bulimia patients. Since causes of these disorders seem to be multidimensional, this poses a problem to therapists, doctors, counselors, and psychologists as to what avenue is most desirable to take when working with these patients. Caffary (1987) and Neuman et al (1985) believe the first factor needed in the treatment of anorexia or bulimia is a medical evaluation. What follows the medical examination differs according to the literature reviewed. Structured family therapy is used with a fair amount of success with adolescent females who are diagnosed as anorectic (Peters et al, 1984). This type of treatmetn is advocated since it treats the family as well as the individual. Also, family therapy tends to ease the burden on the rest of the family (Gilbert & DeBlassie, 1984). Specific issues within the family such as marital problems, parenting, and sibling and peer rivalry should be addressed in the family therapy sessions since these are thought to be some of the possible causes of anorexia.

Caffary (1987) feels that family therapy is not an adequate way to treat the problem because of denial of the problem on the part of the patient and family members. Parents often feel guilty for believing that they did not spend as much time with their child as they should have. Therefore, the first reaction of many parents is to be defensive. Denial can then lead to more serious consequences if the patient or parents do not acknowledge that there is a problem.

Another method used to treat patients with eating disorders is a group approach. Weber and Gillingham (1984) found that having both male and female counselors in a group was helpful whether the patient was being treated for anorexia or bulimia. They believed that groups led the participants to be more open with one another, which led to more group interaction and support. Weber and Gillingham (1984) feel that anorexics and bulimics can work well together in group therapy as they are able to learn from each other.

An additional type of group therapy proposes a multidimensional approach (Garfinkel & Garner, 1982). In this type of treatment the therapist uses principles from a variety of theoretical problems, depending upon the specific problems faced by group members. This study also points out that since patients have a variety of medical, psychological, and behavioral deficits that need to be worked on that it was unrealistic to assume that one treatment would be effective for all of the patients. Therefore, the group members need to be nearly alike in the problems they are experiencing.

Behavior therapy, or behavior modification, has become an important part of many inpatient treatment programs, especially in the early stages of treatment where weight gain is needed to reach medical stability (Mitchell & Eckert, 1987). This is especially true of anorectics, as bulimics are rarely hospitalized. It has been suggested that increased ward privileges and increased social opportunities be used as reinforcers for those who show weight gain. This nutritional education part of the therapy allows individuals to understand the negative aspects of their eating disorder. This lets the patients acquire a trust in a regular eating pattern so that the patients can learn to cope with problems in a way other than starvation (Caffary, 1987).

In the case of bulimics, behavior therapy is also used as a means of coping with the gorge-purge syndrome. Regularity of mealtime tends to diminish the gorge-purge desire. Additionally, careful monitoring of the types of food eaten helps patients to avoid extreme change in mood, such as overactivity and boredom (Sweeten, 1985). Assertiveness training and relaxation techniques are also a part of many behavior therapy programs (Polivy & Herman, 1985). Since bulimics are rarely hospitalized, the food intake facts and other information wanted by therapists is self-monitored by the patients. This means a close relationship between patient and therapist is essential for the treatment to progress effectively (Polivy & Herman, 1985).

Depending upon the psychological condition of the eating disorder patient, drug therapy is being used. This is used with those people who are severely depressed, those with sleeping problems, and those who are suicidal (Sweeten, 1985). Anti-depressants are also being used with anorexics who are hyperactive. Mitchell and Eckert (1987) have tried drug therapy, or pharmacotherapy, with anorexia nervosa patients with mixed results. Some treatments have helped in weight gain, however, care must be taken with those patients whose conditions have progressed far enough to include cardiac dysfunction, dehydration, or electrolyte abnormalities. The Mitchell and Eckert study shows that anti-depressants worked best after some weight recovery when patients seem to be more tolerant of side effects.

Eisele, Hertsgaard, and Light (1984) report on a type of therapy called the nurturant/authoritative model. In this mode of therapy the therapist takes the initiative in counseling process. He/She tries to regress the patient back in time to help the patient become younger and less mature. The therapist does this to assist the patient to learn how to accept emotional support. In other words, the therapist is the person who gradually guides the patient out of her/his loneliness, and to become more confident in the things he/she does. Therefore, the patient should be gaining more self-esteem.

In the nurturant/authoriative model, the therapist becomes an authority figure. This is especially true of the anorectic

patient. It is important that the therapist demonstrate an understanding of the patient and the illness so that the patient feels comfortable when with the therapist. Eisele et al (1984) stress that there must be a balance between the nurturant/authority, or the patient/therapist. Thus, this treatment would be conducted with individuals rather than in a group.

The preceding paragraphs have been designed to show some of the more popular methods used to treat people with anorexia nervosa and/or bulimia. Nearly everyone studying and experimenting in the area of eating disorders agrees that a multidimensional form of treatment is needed to help people with eating disorders. Studies have shown that there does not appear to be one single cause why a person develops an eating disorder. Rather, it is a series of events that will cause a person to almost starve him/herself, or that will cause a person to go on a gorge-purge behavior.

Because of the many causes, there are many physical, psychological, and behavioral traits that change. This makes for a difficult time in trying to form groups so therapists can assist everyone in the group. Though the ideal situation would be to treat patients individually, time of therapy and the number of new cases makes this very difficult. Groups can be important in the treating of eating disorders because of the help patients can give to each other throughout the time of the therapy.

The use of drugs to treat eating disorders has mixed reviews. The basic thought of most specialists, however, is to stay away from

the use of drugs, especially if the patient has severe medical problems. Specifically in anorectics, drug therapy will be used only after an appreciable weight gain has been achieved.

Conclusion

Eating disorders such as anorexia nervosa and bulimia are a growing problem in today's society. An increasing number of cases are being reported each year, especially among teenage females. Facts show that 95% of the people being treated for these disorders are female, white, and come from middle to upper-middle class families that appear to have stability that many families do not. However, an overprotective mother and a father who frequently is away for business purposes, yet pushes for academic and athletic excellence, is a situation that many therapists have found to exist in patients they've treated.

The media pushing the concept of "thinness" is also seen as a contributing factor. Particularly anorexics get caught up in this concept and feel that not eating, or eating very little, along with strenuous physical activity will lead to a thinner, more acceptable self. Comments from friends and family about losing weight and looking thinner reinforces this behavior.

Stressors such as dates, tests, and physical maturation are seen as being part of the cause of eating disorders. Fear of maturation is cited as a primary cause of anorexia nervosa among adolescent girls. The changing of bodily features and functions

is hard for many girls to cope with. Therefore, they don't eat as a way of trying to keep their boyish figures (Mallick, Whipple, and Huerta, 1987).

Diagnosis of an eating disorder can be difficult. There are many illnesses whose symptoms are very much like that of anorexia and bulimia. Also, athletes in some sports benefit from being and looking slim. Although they may look as if they have an eating disorder, they are actually very healthy (Mallick, Whipple, and Huerta, 1987). Diagnosis is also complicated by the fact that medical people use different guidelines to determine if a patient is anorexic, bulimic, or suffering from another illness. More specific guidelines are needed so that individuals suffering from an eating disorder can be identified earlier, and treatment begun.

Because eating disorders are generally recognized to be caused by a variety of physical, behavioral, and psychological deficits, identification of a desired treatment procedure is difficult. Group therapy is increasingly accepted as an approach in working with more eating disorder patients. Both family and individual therapies are being used with some success. Family therapy seems to be most successful with anorexic patients diagnosed in the early stages of the disorder.

As more and more information regarding eating disorders is obtained from patients, there is an ever-widening scope as to the major causes and treatments of eating disorders. With additional study constantly being conducted, the diagnosis and treatment of eating disorders should take on a more definitive pattern.

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