SPECIAL TEACHER RESOURCES ON ANOREXIA AND BULIMIA

The following article is from materials available at the McKay-Dee Institute for Behavioral Medicine, McKay-Dee Hospital, Ogden, Utah.

DYING TO BE THIN
Eating Disorders Program

What is Anorexia Nervosa?

Anorexia is an eating disorder characterized by:

* Intense fear of becoming fat which does not diminish with weight loss
* Maintenance of an inappropriate body weight with weight loss 15% below that expected for normal health
* Disturbance in the way one's body weight, size, or shape is experienced, e.g. claiming to feel fat even when emaciated
* An absence of three menstrual cycles in females

What is Bulimia Nervosa?

Bulimia is an eating disorder characterized by:

* Recurrent episodes of binge-eating with an average of two or more binges per week
* Termination of the binge by purging via self-induced vomiting, use of laxatives and/or diuretics. strict dieting, diet pills or excessive exercise

To varying degrees, individuals with either Anorexia or Bulimia subscribe to harmful weight control measures and a denial of their illness. About 33% show evidence of having both disorders or vacillate back and forth between these disorders.

MEDICAL CONSEQUENCES

...OF BULIMIA

* Swollen and/or infected glands
* Severe digestive problems: peptic ulcers, damage to esophagus sometimes causing pain and/or internal bleeding.
* Bursting blood vessels in the eyes
* Damaged teeth and gums
* Dehydration and kidney failure
* Electrolyte imbalance which can cause abnormal heartbeat
* Depression

...OF ANOREXIA

* Loss of mensuration in females (amenorrhea)
* Excessive constipation
* Depression
* Loss of hair (head)
* Growth of fine body hair
* Extreme sensitivity to cold
* Low pulse rate
* Damaged to major organs
* General body starvation

The following article is from materials available at the McKay-Dee Institute for Behavioral Medicine, McKay-Dee Hospital, Ogden, Utah. Adapted from NAAS Newsletter VII (2), 1984.

BIOLOGY

While the predisposing biological factors can be inherited, there is no evidence that eating disorders are hereditary. The higher incidence of anorexia and bulimia within the same family is more likely to be explained by the social and psychological environment within the family. Because no single physiological problem has been found to be the cause of eating disorders, it is not possible to cure the problem simply by finding the right medication. Some medications can help in the recovery process of some individuals, but other methods of treatment are also required.

FAMILY ATTITUDES

The family can influence the development of an eating disorder in a daughter by the emphasis placed on weight and physical appearance, and the values placed on food. When a girl learns that she can elicit praise by losing weight or maintaining slenderness, she may rely on this in an extreme and distorted way when her other resources for self-worth falter. Many young women identify fears of becoming overweight like their mothers, who receive negative feedback from their husbands and are always dieting. Other young women strive to maintain a body weight at least a few pounds less than their mothers, regardless of body frame and height.

PERSONALITY DEVELOPMENT

The family also contributes to an individual's development of a sense of self and the ability to cope with the pressures and problems of adult life. Hilde Bruch, a psychiatrist who has worked with anorexic teenagers for over 30 years, had proposed that when parents raise their children according to the parent's needs and schedules, the children may have little opportunity to develop their own inner guidelines. As a result, they may have little confidence in their ability to deal with the world on their own.

Obviously children raised in the same way do not always respond in similar ways. Some take the initiative to explore the world on their own. Those who develop anorexia often try to maintain a sense of control during the changes of adolescence by remaining dependent on the family, in a somewhat childlike condition. People who develop bulimia tend to over-adapt, and attempt to maintain the appearance of what they believe is expected of them.

Some kind of rebellion is often necessary in order to achieve emancipation from the family. This is a developmental step in the adolescent's struggle for identity. It seems significant that the "best little girls in the worlds," to use a phrase of Dr. Steven Levenkron, turn to food as their means of rebellion. Unlike drugs or alcohol, it is legal., readily available, and relatively inexpensive. Unlike delinquency or sexual promiscuity, it is socially acceptable. Food abuse is a tool used by many people to cope with stress.

SOCIETY'S INFLUENCE

At the same time, social messages indicate women in particular, should be concerned and even preoccupied with their weight and appearance. Being thin is associated with being successful, admired and attractive. The role models presented to adolescent girls on television, in magazines, and in movies represent a very narrow range of body types. In order to help their daughters appreciate their own unique qualities, parents may have to re-evaluate their own attitudes about how a woman should look. They can help, by encouraging her as she struggles over separation from the family, and by valuing a variety of potential role models.

Family support groups offer parents an opportunity to obtain information about eating disorders from other parents, to get feedback from non-family members who are sensitive to the problems that are being dealt with, and to share support during a difficult time in the lives of all the family members, parents do not cause and cannot cure their child's eating disorders. With an openness to understanding the problem and a willingness to change, they can help to provide an environment in which recovery is possible.

FAMILIES: NEITHER CAUSE NOR CURE . . .
BUT THEY CAN CONTRIBUTE

During therapy and support group sessions, with the families of individuals who have anorexia and/or bulimia, parents have frequently been heard to ask similar questions. "When I read articles about eating disorders, they always make the parents sound so awful. Are we really that bad? Am I responsible for having caused my child's problems?" "What should we do to help our daughter get better?" "If the problems began at home, like the articles say, then why are our other children normal?"

While these are not easily answered questions, it may be helpful to share some of the insights we have gained.

The research in the field of eating disorders sometimes includes descriptions of family characteristics, from which a composite picture can be derived. The family is typically described as being in the middle or upper-middle socioeconomic class and upwardly mobile, and places a high value on measurable performance and success.

In most cases, both parents are living in the home, although several studies report a high percentage of marital dissatisfaction among parents. The family is often described as having higher than average incidence of alcoholism and drug abuse. Family members of a person with anorexia or bulimia are more likely to also have an eating disorder than members of the general population. Emotional problems, particularly depression, and intra-family conflict are also noted in the research about family characteristics.

Dr. Salvador Minuchin has described four major characteristics of dysfunctional families, such as families with eating disorders.

1. Enmeshment: The bonds between family members are too close, and individuality is not encouraged.

2. Overprotectiveness: The family has trouble allowing children to learn lessons by making their own mistakes.

3. Rigidity: Having inflexible rules and attitudes, with the expectation that family members will be loyal to the family's way of diving things.

4. Conflict avoidance: Family members do not openly express anger or other conflict-producing feelings, and therefore there is little opportunity for family members to become skilled in identifying resolving problems.

Many parents have protested that these descriptions are not accurate for their families. In some cases the family may be denying their problems. They may be unwilling to see the areas in which they need to change and grow. On the other hand, descriptions of family characteristics may vary depending on the nature of the eating disorder. Many factors play a part in the development of these disorders.

When parents ask, "Why my child?", it can be useful to identify several aspects of the total person which contribute to the development of anorexia nervosa or bulimia nervosa. These include the following:

1. A biological predisposition to problems concerning weight, appetite and metabolism.
2. Family attitudes concerning food and weight.
3. Factors related to personality development.
4. Peer pressure and society's influence on role models.

EATING DISORDERS
When Thinness Becomes An Obsession

by Dixie Farley

The following article is from WOMEN'S HEALTH, An FDA Consumer Special Report, Department of Health and Human Services, Food and Drug Administration, November 1991

Hula hoops, the bunny hop, punk hair styles. Fads come and go, and most are harmless. But when it's a fad to self-induced symptoms of a severe illness, the current craze isn't harmless anymore.

That hazardous fad involves bulimia nervosa, a severe eating disorder of compulsive bingeing and purging. People with bulimia rapidly eat tremendous amounts of food and then get rid of the food by vomiting or other means. Bulimia symptoms are found in 40% to 50% of patients with another potentially life-threatening disorder called anorexia nervosa, or compulsive self-starvation.

"Bulimia almost has celebrity status, the `in' thing to have," says Sue Bailey, M.D., medical director of Chevy Chase Associates, Washington, D.C., and clinical faculty member at Georgetown University School of Medicine, Washington, D.C. According to Bailey, victims think at first that they've found a great solution to weight control, that "they can eat whatever they want and get rid of it. Then, after a couple of years, it hits: `I thought I could stop any time. But I can't.'"

Bailey was medical consultant to a Gallop Poll on eating disorders which projected that about 2 million American women 19 to 39 and 1 million teenagers are affected by some symptoms of bulimia or anorexia. In her own survey of several priovate schools in the Washington, D.C. area, Bailey found that 28% of one school's eighth graders said they would consider vomiting to lose weight. Many reported dieting since age 13, being dissatisfied with their bodies since age 10, and always trying to be perfect. "In other words," she says, "many girls were showing a real vulnerability to an eating disorder."

Some U.S. studies of female high school and college students suggest a bulimia prevalence ranging from 4.5 to 18 percent. But in the *Journal of the American Medical Association* (Sept.4, 1987), David Schotte, Ph.D. and Albert Stunkard, M.D., reported that when they surveyed 1,965 students at the University of Pennsylvania, Philadelphia, they found only 1.3% of women met the American Psychiatric Association's diagnostic criteria for bulimia. "Thus,." they wrote, "although bulimic behaviors may be quite common among college women, clinically significant bulimia is not. Also . . . research with college students has found that as many as 50% of college women who met diagnostic criteria for bulimia during the fall semester of their freshman year no longer met these criteria when reassessed nine months later." Anorexia is estimated to affect as many as one out of every 100 females aged 12 to 18. Males are said to account for about 5 to 10 percent of bulimia and anorexia cases. (Because male victims are so few, we'll refer to all patients as females.) More research is needed to determine the exact incidence of bulimia and anorexia.

People of all races can develop bulimia and anorexia, but the vast majority of patients are white, which may reflect socioeconomic, rather that racial, factors. Yet the illnesses are not restricted to females with certain occupational or educational backgrounds. What causes the illnesses and why they occur primarily in females are unknown.

The disorders are obsessive—that is, most victims can't stop their self-destructive behavior without professional medical help. Left untreated, either disorder can become chronic and can result in several health damage, even death. The National Center for Health Statistics reports 67 deaths from anorexia nervosa in 1988, the latest year for which statistics are available, but does not have similar information on bulimia.

According to the American Psychiatric Association, all of the following criteria must be met for a diagnosis of bulimia or anorexia.

For the syndrome of bulimia nervosa:

* Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).
* A feeling of lack of control over eating behavior during the eating binges.
* The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict

dieting or fasting, or vigorous exercise in order to prevent weight gain.
* A minimum average of two binge-eating episodes a week for at least three months.
* Persistent overconcern with body shape and weight.

For the syndrome of anorexia nervosa:
* Refusal to maintain body weight over a minimal normal weight for age and height—e.g., weight loss leading to maintenance of body weight 15% below that expected; or failure to make expected weight gain during period of growth, leading to body weight 15% below that expected.
* Intense fear of gaining weight or becoming fat, even though underweight.
* Disturbance in the way in which one's body weight, size or shape is experienced—e.g., the person claims to "feel fat" even when emaciated, believes that one area of the body is "too fat" even when obviously underweight.
* In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary amenorrhea). (A woman is considered to have amenorrhea if her periods occur only following administration of estrogen or other hormones.)

Ordinarily, bulimia begins in adolescence or early adult life. However, because many bulimics are deeply ashamed of their bingeing and purging and therefore keep these activities a guarded secret, an actual diagnosis may not be made until a patient is well into her 30s or 40s. In *Cosmopolitan* (January 1985), for example, actress Jane Fonda revealed that she had been a secret bulimic from age 12 until her recovery at age 35—bingeing and purging as much as 20 times a day.

Bulimia usually begins in conjunction with a diet. But once a binge-purge cycle becomes established, it can get out of control. Some bulimics may be somewhat underweight and a few may be obese, but most tend to keep a nearly normal weight. In many, the menstrual cycle becomes irregular. Sexual interest may diminish. Bulimics may exhibit impulsive behaviors such as shoplifting and alcohol and drug abuse. Many appear to be healthy and successful, perfectionists at whatever they do. Actually, most bulimics have very low self-esteem and are often depressed.

Binges may last 8 hours and result in an intake of 20,000 calories (that's roughly 210 brownies, or 5 1/2 layer cakes, or 18 dozen macaroons). One study, however, showed the average binge to be slightly less than 1 1/3 hours and slightly more than 3,400 calories (an entire pecan pie, for instance). Most binges are carried out in secret. Bulimics often spend $50 or more a day on food and may even steal (food or money) to support the obsession.

To lose the gained weight, the bulimic begins purging, which may include using laxatives—from 50 to 100 or more tablets at one time—or diuretics (drugs to increase urination) or self-induced vomiting caused by gagging, using an emetic (a chemical substance that causes vomiting), or simply mentally willing the action. Between binges, the person may fast or exercise excessively.

Bulimia's binge-purge cycle can be devastating to health in a number of ways. It can upset the body's balance of electrolytes—such as sodium, magnesium, potassium, and calcium—which can cause fatigue, seizures, muscles cramps, irregular heartbeat, and decreased bone density, which can lead to osteoporosis. Repeated vomiting can damage the esophagus and stomach, cause the salivary glands to swell, make the gums recede, and erode tooth enamel. In some cases, all of the teeth must be pulled prematurely because of the constant wash by gastric acid. Other effects may be rashes, broken blood vessels in the cheeks, and swelling around the eyes, ankles and feet. For diabetics, bingeing on high-carbohydrate foods and sweets is particularly hazardous, since their bodies cannot properly metabolize the starches and sugars.

Bulimia's severe health risks and potential for becoming obsessive do not bode well for a decision to "try it out." Dr. Bailey points out, "Very rarely do I hear someone say, `Oh yes, I had bulimia for three years and I just stopped one day and now I'm fine.' It's very hard to give up the behavior. Once somebody tells me they've done this several times —in my mind, they're probably hooked."

While anorexia nervosa most commonly begins in adolescence, onset also is reported (albeit far less frequently) in people ranging in age from 5 to 60. The incidence in 8 to 11-year-olds is said to be increasing.

Anorexia may be a sudden, limited episode—that is, the person may lose a drastic amount of weight within a few months and then recover. Or the illness may gradually work itself into the victim's life and go on for years. A person may diet normally for several weeks, for instance, and then increasingly restrict her food intake until the diet gets out of control Anorexia may fluctuate between spells of improvement and worsening, or it may become steadily more severe.

Anorectics are described as having low self-esteem and feeling that others are controlling their lives. Some may be very overactive—exercising excessively despite fatigue. The preoccupation with food usually prompts strange food-related patterns, or rituals: crumbling food, moving it about on the plate, cutting it into very thin pieces to prolong meals, and not eating with the rest of the family. The anorextic sometimes becomes a gourmet cook, preparing elaborate meals for others while eating low-calorie food herself.

The anorectic becomes obsessed with a fear of fat and with losing weight. In her mind's eye, she sees normal folds of flesh as fat that must be eliminated. She may have trouble sleeping. Because there's no longer a fat tissue padding, sitting or lying down brings discomfort, not rest. As her obsession increasingly controls her life, she may withdraw from her friends.

Many of the anorectic's peculiar behaviors and bodily changes are typical of any starvation victim. Thus, some functions are often restored to normal when sufficient weight is regained. Meanwhile, the starving body tries to protect itself—especially its two main organs, the brain and the heart—by slowing down or stopping less vital body processes. Thus, menstruation ceases (often before weight loss becomes noticeable), blood pressure and respiratory rate slow down, and thyroid function diminishes —resulting in brittle hair and nails, dry skin, slowed pulse rate, cold intolerance, and constipation. With depletion of fat, the body temperature is lowered. Soft hair called lanugo forms over the skin. Electrolyte imbalance can become so severe that irregular heart rhythm, heart failure, and decreased bone density occur. Other physical signs and symptoms can include mild anemia, swelling of joints, reduced muscle mass, and lightheadedness.

When anorectics adopt the bulimic bingeing and purging, they risk their health even further. Some use the emetic syrup of ipecac to induce vomiting after a binge. The recording artist Karen Carpenter was an anorectic who died of syrup of ipecac abuse. Building up over time, the alkaloid emetine in the ipecac irreversibly damaged her heart muscle, which eventually let to her death by cardiac arrest.

What causes anorexia nervosa and bulimia is puzzle upon puzzle for researchers. They are just beginning to uncover clues, and not all experts agree with all theories. Writing in the March 1982 issue of *Psychosomatic Medicine*, Joel Yager, M.D., director of the Eating Disorders Program and the University of California, Los Angeles, Neuropsychiatric Institute, advises: "Given the present lack of knowledge, we need to remain skeptical about facile formulas that purport to explain anorexia nervosa. We are better off retaining a certain amount of confusion and ambiguity, waiting for additional information to support, modify, or refute the myriad of current hypotheses."

One theory about anorexia and bulimia is that many females feel excessive pressure to be as thin as some "ideal" perceived in magazines and on television. Evidence suggests that the pressure is increasing. For example, a study of *Playboy* centerfolds and Miss America contest winners from 1959 to 1978 showed a progressive decrease in the women's weight and bust and hip measurements.

David Jimerson, M.D., director of research, Department of Psychiatry at Beth Israel Hospital in Boston and associate professor of psychiatry at Harvard Medical School, suggests that a certain biological factor that is linked to clinical depression may contribute to the development or persistence of symptoms in anorexia and bulimia. Jimerson explains that a biological change in some people may predispose them to depression. "We're looking at whether that same biological predisposition, or some related alteration, might also predispose to the onset of an eating disorder." In fact, says Jimerson, 7 of 10 anorectics and bulimics are depression-prone, as are many of their relatives.

Jimerson points out that the neurotransmitter (a chemical involved in sending nerve "messages" to and from the brain) serotonin is linked to both mood and eating functions and that decreased serotonin

activity has been linked to impulsive behavior. Bulimics are often impulsive. Further, says Jimerson, antidepressant drugs "affect the brain's serotonin transmitter system—many bulimics appear to improve with antidepressant therapy." While the research studies are preliminary, Jimerson feels that "by looking at drugs that affect the serotonin and the other major neurotransmitter systems, we may be better able to help patients with eating disorders."

Several other theories suggest biological factors. For instance, malfunctioning of the hypothalamus occurs in anorexia and may precede onset of the illness. The hypothalamus is a part of the brain that controls such bodily functions as hormonal secretions, temperature and water balance regulation, and sugar and fat metabolism. Also, endorphin hormones, which are released during purging and excessive exercise (causing the famous jogger's "high"), are believed to be addictive.

Anorexia and bulimia may be triggered by an inability to cope with a situation in life: puberty, the first sexual contact, ridicule over weight, death of a loved one, or separation from family because of college. It's been suggested that choices afforded by the women's movement may be misinterpreted as obligations, thus creating another stress with which anorectics-to-be cannot cope.

In her book *Eating Disorders*, the late Hilde Bruch, M.D., offered this explanation: "The urgent need to lose weight is a cover-up symptom, expressing an underlying fear of being despised or disregarded, or of not getting or even deserving respect. Desperate about their inability to solve their problems, the patients begin to worry about their weight and get a sense of accomplishment from manipulating their body."

Bruch also maintained that patients with anorexia learned to eat, not to satisfy hunger, but to satisfy the expectations of others; thus, their eating or not eating involved their self-esteem. She described anorectics as struggling against overcontrolling parents to gain a sense of "leading a life of their own."

Some studies have found these characteristics in families of anorectics: poor communicating skills, conflict avoidance, overconcern with appearances, overemphasis on high achievement, and overinvolvement with another. But UCLA's Yager found that the significance of many of the researchers' observations could not be properly evaluated. "If common personality patterns are to be found in these families," he wrote, "they will have to be at more subtle levels."

While there are differences of opinion about treatments for anorexia and bulimia, the one point on which all agree is that early treatment is important to recovery. In fact, it is essential because, as either disorder becomes more and more entrenched, damage to the body becomes less and less reversible.

How then to treat these disorders?

According to Bruch, "A realistic body-image concept is a precondition for recovery in anorexia nervosa." Considering the anorectic's tenacious denial of being too thin or eating too little, convincing her that she needs to gain weight is no small task. A prime example of resistance is this defense by one of Bruch's patients, "Of course I had breakfast; I ate my Cheerio." In contrast, bulimics usually cooperate with the medical staff; they may even seek treatment voluntarily.

Several approaches are usually used to treat both disorders, including motivating the patient, enlisting family support, and providing nutrition counseling and psychotherapy. Behavior modification therapy and drug therapy may be used as well.

Hospitalization may be required for patients who have life-threatening complications or extreme psychological problems. If the patient's life is not in danger, treatment for either disorder is usually on an outpatient basis. Treatment may take a year or more.

Psychotherapy may be in many forms. In individual sessions, the patient explore attitudes about weight, food, and body image. Then, as she becomes aware of her problems in relating to others and dealing with stress, her attention is centered on feelings she may have about self-esteem, guilt, anxiety, depression, or helplessness. Constructive, nonjudgemental feedback is given to encourage growth and independence. In behavior modification therapy, the focus is on eliminating self-defeating behaviors. Patients may improve their stress management by learning skills in relaxation, biofeedback and assertiveness. Family therapy is designed to improve overall family functioning. Group psychotherapy

may help reduce a sense of isolation and secrecy and is especially effective for bulimics.

The National Association of Anorexia Nervosa and Associated Disorders, Inc. (ANAD), a support group, says it's important for patients to have confidence in the type of therapy used as well as rapport with the therapist. If some improvement isn't apparent after a reasonable time, says ANAD, the patient (or patient advocate, such as a parent) shouldn't hesitate to discuss this with the therapist or, if need be, to change therapists. Local places to ask for help in finding a therapist are: the psychiatry department of a nearby medical school; local hospitals; family physician; priest; rabbi or minister; county or state mental health or health and social services departments; and private welfare agencies.

Self-help, or support, groups are an adjunct to primary treatment. Through sharing of experiences, members give mutual emotional support, exchange information, and diminish feelings of isolation. Services may include: information on symptoms and treatment, lists of therapists, newsletters, book review, and bibliographies. Requests for information from the following nonprofit associations should be accompanied by a stamped, self-addressed, business-size envelope.

American Anorexia/Bulimia Association, Inc.
418 E. 76th St.
New York, N.Y. 10021

Anorexia Nervosa & Related Eating Disorders, Inc.
P.O. Box 5102
Eugene, Oregon 97405

Bulimia, Anorexia Self-Help
6125 Clayton Ave., Suite 215
St. Louis, Missouri 63139

National Anorexic Aid Society
5796 Karl Road
Columbus, Ohio 43229

National Association of Anorexia Nervosa and
Associated Disorders, Inc. (ANAD)
P.O. Box 7
Highland Park, Illinois 60035

One last word on treatment: Beware of health fraud. Fraud promoters are quick to capitalize on a person's desire to lose weight or cure a severe illness. As a guide against fraud, remember: if a product or practice sounds too good to be true, it probably is. To report suspected health fraud, call or write the nearest FDA district office listed in the telephone book.

TIPS FOR PARENTS

Whether their child is 10 or 20, parents of a patient with bulimia of anorexia may find it difficult to deal with such a constant, long-term problem. From the American Anorexia/Bulimia Association, Inc., here are some tips that may help:

* Do not urge your child to eat, or watch her eat, or discuss food intake or weight with her. Your involvement with her eating is her tool for manipulating parents.
* Do not allow yourself to feel guilty. Once you have checked out her physical condition with a physician and made it possible for her to begin counseling, getting well is her responsibility.
* Do not neglect your spouse or other children. Focusing on the sick child can perpetuate her illness and destroy the family.
* Do not be afraid to have the child separated from you, either at school or in separate housing, if it becomes obvious that her continued presence is undermining the emotional health of the family. Don't allow her to intimidate the family with threats of suicide. [But don't ignore the threats, either.]
* Do not put the child down by comparing her to her more "successful" siblings or friends. Do not ask questions such as, "How are you feeling?" or "How is your social life?"
* Love your child as you should love yourself.
* Trust your child to find her own values, ideals and standards, rather than insisting on yours.
* Do everything to encourage her initiative, independence and autonomy.
* Be aware of the long-term nature of the illness. Families must face months and sometimes years of treatment and anxiety.