Eating Disorders

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1. Anorexia Nervosa

Introduction

Anorexia involves disordered eating patterns in which the person excessively restricts his or her calorie intake. People with anorexia also tend to experience a marked disturbance in their body self-perception (e.g., thinking that they are fat when they are clearly underweight) as well as an intense fear of gaining weight. Hence, people who suffer from this disorder are typically underweight. In more severe cases, patients may experience persecutory delusions, whereby they strongly believe that others are out to get them, despite contradictory evidence. For people with anorexia, self-worth is highly, if not completely, dependent on weight. Thus, just a small increase in weight can induce unpleasant feelings of worthlessness in individuals with anorexia.

As anorexia is a psychological condition that invariably impacts one's physical health, numerous medical complications may occur as a result of a person's anorexic behaviour. These include, among many other issues, dry skin, sensitivity to or intolerance of cold, lanugo (i.e., downy hair on limbs and cheeks), and cardiovascular problems as a result of chronically low blood pressure and heart rate. It is estimated that about 20% of those who suffer from anorexia will eventually die as a result of their illness.

Symptoms

According to the Diagnostic and Statistical Manual of Mental Disorders (fourth edition, text revision; DSM-IV-TR), some symptoms of anorexia nervosa include:

- Refusal to maintain body weight at or above a minimally normal weight (85%) for age and height
- Intense fear of gaining weight or becoming fat, even though underweight
- Disturbance in the way in which one's body weight or shape is experienced, undue of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight
- In post menarcheal females, amenorrhea (i.e., cessation of menstrual cycles defined by absence of at least 3 consecutive menstrual cycles)

There are two ways in which this condition may present itself. The first type is the restricting type, in which the person has not regularly displayed binge eating or purging behaviour, while the second type is the binge-eating/purging type, in which the person has regularly shown binge eating or purging behaviour.

Risk factors and causes

Anorexia is most commonly found among young females of upper-middle class or upper class socioeconomic status who are placed in a socially competitive environment. The main factor underlying the behaviour of people with anorexia seems to be their relentless, obsessive pursuit of thinness as their desire to achieve an elusive "ideal" body shape begins to take control of their lives. Unsurprisingly, perfectionism has been found to be implicated in this disorder, just as it also appears to play a role in obsessive-compulsive disorder and body dysmorphic disorder. Although a genetic predisposition (e.g., a family history of eating disorders) and environmental factors both play a part in shaping the course and onset of this disorder, many believe that anorexia is a culturally driven condition exacerbated by the media's pernicious and far-reaching influence. The promotion of overly thin silhouettes as the ideal female figure, and perhaps a susceptibility to social pressures, combine to engender increasing expectations for thinness among the population. life events, such as the end of a relationship, can also trigger – but not cause – the onset of anorexia.

Treatment

Because anorexic behaviour directly affects one's physical wellbeing, medical doctors, clinical psychologists, and even dieticians may be involved in recovery efforts. The first treatment goal of anorexia tends to be addressing any immediate health problems, working to correct those issues, and helping the patient to reach a more healthy weight.

Another possible component of treatment is nutritional counselling, which aims to encourage healthy eating such that the patient receives adequate nutrition from his or her diet and becomes able to maintain a healthy weight.

The psychological aspect of treatment may involve cognitive behavioural therapy (CBT) and family therapy. In CBT, the patient's dysfunctional beliefs and behaviour are targeted and modified, which help the patient develop more adaptive thinking patterns and behaviour. The behavioural component of treatment might involve the use of rewards as positive reinforcement to keep the patient focused on the goals he or she wishes to achieve. Besides addressing distorted cognitions, therapy can also be used to teach the patient how to better cope with difficult emotions or situations that may bring about a great deal of stress and distress.

Family therapy is a form of therapy that involves the patient's family and focuses on how the patient's illness affects the family relationship and dynamics. It is done by highlighting the often maladaptive role that the patients plays within his or her family context, as well as the disordered behaviour that maintains or contributes to that negative role. By involving the family in treatment, family members become responsible for the patient's recovery, and may even choose to play very active roles in the treatment process. The Maudsley approach encourages active family intervention, where parents are expected to be controlling, strictly monitor their child's eating behaviour, and try their best to get their child to eat.

2. Bulimia Nervosa

Introduction

Like anorexia nervosa, bulimia nervosa is also an eating disorder, but with a different pattern of disordered eating. Unlike people with anorexia who are seen as “starving” themselves, those with bulimia regularly engage in binge eating episodes during which they consume larger than average amounts of food. In addition, they use unhealthy compensatory behaviours to prevent weight gain, including purging. Similar to those with anorexia, people with bulimia base their self-worth on their body shape and weight. However, unlike those with anorexia, individuals suffering from bulimia are closer to their average weight and may not look as unhealthy. Despite this, the phenomenon of bulimia is similarly associated with cultural influences and social pressures, which promulgate the idea that thinness equates to beauty.

Unfortunately, the continuous cycle of binging and purging can have devastating effects on the person’s physical health. Repeated vomiting can result in enlargement of salivary glands, giving the face a chubby appearance, erosion of dental enamel on the inner surface of front teeth, and even tearing of the esophagus. In more serious cases, purging can upset the chemical balance of bodily fluids, including sodium and potassium levels, causing electrolyte imbalance, the primary risk factor for death in bulimia. Laxative abuse can also lead to intestinal problems, such as severe constipation or permanent colon damage.

Symptoms

According to the DSM-IV-TR, symptoms of bulimia nervosa include:

- Recurrent episodes of binge eating/ An episode of binge eating is typified by both
    - Eating an amount of food that is clearly larger than most people would eat during a similar period of time and under similar circumstances
    - A sense of lack of control over eating during that time
- Recurrent inappropriate compensatory behaviour in order to prevent weight gain (e.g., self-induced vomiting, misuse of laxatives, or excessive exercise)
- Binge eating and inappropriate compensatory behaviours both occur at least twice a week for 3 months on average

- Self-evaluation is unduly influenced by body shape and weight

There are two main presentations of bulimia nervosa. The purging type indicates that the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas. The nonpurging type indicates that the person has used other forms of inappropriate compensatory behaviours, including fasting and excessive exercise, although has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Risk factors and causes

The causal factors of bulimia are similar to those of anorexia: the all-consuming drive to be thin, perfectionism, genetic influences, and significant life stressors. However, why these factors sometimes translate into anorexic behaviour and into bulimic behaviour at other times is uncertain. As are all psychological disorders, anorexia and bulimia are complex conditions that cannot simply be broken down into a few constituent causal elements.

Treatment

Like anorexia, bulimia is typically treated using CBT and family therapy, although there is an additional focus on breaking the binge-purge cycle and promoting healthy eating patterns. Patients learn how to resist the urge to binge or purge by developing healthier eating habits and managing stress and other difficult emotions in more adaptive ways. Besides that, because the risk factors for bulimia and anorexia tend to overlap, they can be treated in similar ways, although modifications should be made to directly address each individual’s unique situation.

3. Binge Eating Disorder

Introduction

Binge eating disorder, like bulimia nervosa, involves repeated episodes of binge eating (or compulsive overeating), but which is not negated by any compensatory behaviour, such as purging or the use of laxatives. During these overeating episodes, which last about 2 hours on average, the person feels out of control and unable to stop. As a result, those with BED tend to eat despite not being hungry and continue eating even after they feel full. Although many people with BED are overweight, some of them are able to maintain a normal weight.

People with this condition generally find themselves dealing with strong feelings of guilt, disgust, and depression. They tend to be concerned about the effect their overeating may have on their weight and feel bad about their lack of self-control during the binge eating episodes. Usually, they want to stop overeating, but find themselves unable to do so. Some people, but not all, binge to alleviate their bad mood or some other negative affect. Thus, it is easy to see how a binge eating cycle can emerge. The person engages in overeating, which although provides temporary comfort, ultimately leads to remorse and self-hate. More tangible effects of the overeating, such as gaining weight, also contribute to poor self-esteem, engendering more feelings of disgust and guilt. As a result, the person again turns to food to feel better, completing the vicious cycle.

Symptoms

The proposed criteria for the inclusion of BED in the DSM-5 include:

- Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
    - Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances
    - A sense of lack of control over eating during the episode (e.g., feeling that one cannot stop eating or control what or how much one is eating)
- The binge-eating episodes are associated with 3 (or more) of the following:

    - Eating much more rapidly than normal
    - Eating until feeling uncomfortably full
    - Eating large amounts of food when not feeling physically hungry
    - Eating alone because of feeling embarrassed by how much one is eating
    - Feeling disgusted with oneself, depressed, or very guilty after overeating
    - Marked distress regarding binge eating is present
    - The binge eating occurs, on average, at least once a week for 3 months
- The binge eating is not associated with the recurrent use of inappropriate compensatory behaviour

Risk factors and causes

Certain biological causes have been implicated in BED, including a neurological impairment associated with the hypothalamus, the part of the brain that regulates appetite. For example, the hypothalamus might not be accurately detecting signs of hunger or fullness, resulting in eating despite being physically satiated. Research has also suggested the presence of a genetic mutation that contributes to food addiction, which might lead to the patterns of lack of control and overeating. A link between low levels of the neurotransmitter serotonin and compulsive eating has also been found.

Since part of the reason for binge eating may be negative affect, societal pressure to be thin may contribute to the problem by fostering feelings of shame or disgust associated with overeating, and encourage emotional eating. In addition, parents may have indirectly shaped such behaviour by using food to comfort or reward their children. Other factors that may be involved in the etiology of BED include lack of impulse control and poor coping skills or inability to deal with emotions appropriately. Feelings related to loneliness, poor self-esteem, and body dissatisfaction may also contribute to the development of this disorder.

Treatment

Based on the assumption that emotional eating plays a significant role in this disorder, working to encourage healthy eating becomes an important component of treatment. Healthy eating means that rather than eating to feel better emotionally, the goal of eating becomes simply to take in nutrients and achieve satiation. Although dealing with the binge eating behaviour is important, an effective treatment plan would also aim to

address any underlying factor that may be causing the maladaptive eating patterns. These would include the emotional triggers that result in binge eating and poor coping skills in response to life stressors or other negative emotions. Psychotherapy is one method of treatment that has found to be useful in reducing compulsive eating. In therapy, the patient learns how to control the urge to binge, develop healthier eating habits, better regulate eating and moods, and manage stress more effectively.

Medication can also be used in the treatment of BED. However, medication is usually used as an adjunct to a comprehension treatment strategy that includes therapy, group support, and nutritional counselling. Drugs that function as appetite suppressants (e.g., sibutramine) and antidepressants have been found to be helpful in decreasing binge-eating episodes. However, they are not without side effects and are ineffective in properly treating BED when used alone.