EATING DISORDERS

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COURSE OBJECTIVES

Upon successful completion of this home-study course, the student will be able to:

1. Define anorexia nervosa and bulimia.
2. Identify the sociological precipitants of eating disorders.
3. Identify the psychological precipitants of eating disorders.
4. Describe characteristic behaviors of both anorexics and bulimics.
5. List the medical complications for both anorexia nervosa and bulimia.
6. Discuss elements of the assessment interview.
7. Describe elements of treatment for eating disorders.
8. List the criteria for hospitalization of an eating disorder patient.
9. Describe the nurse's role in the clinical management of the eating disorder patient.
10. Discuss outcomes of treatment for eating disorders.

INTRODUCTION

Over the past two decades the incidence of eating disorders has more than doubled. At one time considered extremely rare, cases of anorexia nervosa and bulimia have risen to alarming proportions. Studies show that an estimated ten percent of American women have an eating disorder and on college campuses, the number often exceeds twenty percent (New York Times, 1988). It is estimated that five to fifteen percent of anorexics die after losing approximately one-half their normal body weight. An additional two to five percent commit suicide. In 1984, one death attributed to bulimia was reported (Consumer's Research, 1987).

Eating disorders are not new to the medical world. In fact, the term anorexia nervosa was coined over one hundred years ago by Sir William Gull, the most renowned British physician of his time. As early as 1689, Richard Morton described an illness he called "a nervous consumption", referring to an adolescent boy who wasted away while consumed with his studies. He described this patient as "a skeleton only clad with skin". (Burch, 1987).

Much still remains unknown about eating disorders. However, it does appear that no one factor predisposes an individual to an eating disorder. Rather it seems to be caused and maintained by an interaction of social, psychological and biological factors (Garfinkel, 1985). This course explores the contribution of all these factors, the elements of treatment and information to enable nurses in all areas of the profession to not only detect the illness and work with patients towards resolution, but also to examine their own attitudes and myths regarding weight so as not to contribute to the proliferation of the illness.

Although there are a growing number of males afflicted with eating disorders, females are by far the largest number represented in reported cases. This may partly be attributed to differences in the way our society views body size between males and females. A large man might be considered strong and masculine, rather than simply fat. And a man who exercises continuously and stays trim would only be considered athletic, rather than an exercise fanatic like his female counterpart. Because of the higher

percentage of reported female cases, the female pronoun will be used throughout this course. It is by no means discriminatory or to dismiss the probable large number of unreported cases in males.

CHAPTER ONE: DEFINING EATING DISORDERS

Eating disorders are divided into two classifications, anorexia nervosa and bulimia. Bulimia is also referred to as bulimia nervosa or bulimarexia. Vary often, however, patients will demonstrate behaviors from both classifications intermittently. It is difficult at times to define a patient as anorexic or bulimic because of the overlapping of symptoms and behaviors. The anorexic patient who starves herself for several weeks will often eventually break down and binge and purge for several days before beginning her fast again. Binge-purge behavior has been observed in approximately 50% of anorexia patients (Garner et al, 1985). Likewise, the patient who binges and purges on a regular basis will more than likely go through days of trying a starvation diet to pay for what she considers to be disgusting, out of control behavior. Both disorders are viewed as a perpetual cycle of self-defeating behavior built upon distortion and/or dissatisfaction with body image.

The individual will generally display a more predominant behavior pattern which serves to identify the patient as either anorexic or bulimic. Both disorders have characteristic behaviors, symptoms and psychological issues. The diagnostic criteria for eating disorders according to the American Psychiatric Association in the DSM-III-R provide definitions for both disorders.

Anorexia Nervosa

A. 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.
B. Intense fear of gaining weight or becoming fat, even though underweight.
C. 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.
D. 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 hormone, e.g., estrogen administration.)

The age at onset for anorexia is usually early to late adolescence. Although it can also begin in adulthood, especially when the onset is related to a stressful life event, such as death of a loved one, geographic relocation, marriage, birth of a child. It occurs predominately in females (95%) (DSM-III-R). Prevalence studies show a range of from 1 in 800 to 1 in 100 females between the ages of 12 and 18 (DSM-III-R). Mortality rates are from 5% to 18% due to complications of starvation.

There appears to be a familial pattern. Anorexia has commonly been found among sisters and mothers of those with the disorder, much more than among the general population. Studies also indicate a higher than expected frequency of major depression and bipolar disorder among first-degree biologic relatives of patients with anorexia nervosa (DSM-III-R).

Bulimia Nervosa

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).
B. A feeling of lack of control over eating behavior during the eating binges.
C. 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.
D. A minimum average of two binge eating episodes a week for at least three months.
E. Persistent over-concern with body shape and weight.

The age at onset is usually adolescence or early adulthood. A study of college freshman indicated that 4.5% of the females and 0.4% of the males had a history of bulimia (DSM-III-R). Studies have reported that the parents of these individuals are obese and there is a higher than expected frequency of major depression in first-degree biologic relatives of people with bulimia (DSM-III-R).

The addition to the diagnostic criteria, both bulimics and anorexics display characteristic behaviors which further help to identify the existence of an eating disorder. Cases of bulimia are less easily detected than anorexia. Bulimics usually appear to be of normal weight and their behavior is almost always conducted in private. Their binges usually involve copious amounts of easily ingested, high caloric foods, with little nutritional value. Their purge behavior is excessive, such as vomiting up to 20 or more times daily or taking 50 doses of a laxative per day. Although the anorexic will occasionally binge and purge, it is not the same as the bulimic who's binge-purge behavior is a ritual that controls her life.

Contrary to the anorexic who wears her thinness proudly, the bulimic lives in the constant fear she will be found out. Her behavior is punctuated by a constant need for secrecy and compulsively destroying any evidence of her binging and purging. Bulimics often succumb to stealing and lying in order to support their habit. The amount of money spent on food can lead to financial difficulties. Bulimic wives will go to great lengths to destroy food bills and cover up for funds spent on groceries. Bulimics live in a constant state of anxiety, feeling enslaved to their behavior and hating themselves for it.

Anorexics, on the other hand, feel proud of their ability to exert such extreme control over their bodies. Though the term anorexia literally means "lack of appetite", just the opposite is true of the illness. Afflicted individuals do not suffer from disinterest in food or poor appetite. They are actually obsessed with food and eating, but consider self-denial and discipline of such high virtue that hey condemn the satisfaction of their needs and desires as weak and indulgent, something to be ashamed of. This complete preoccupation with food is evidenced by such behaviors as recipe collecting, cooking large amounts of food for others and actually forcing food on others. They will cut food into tiny pieces and take an inordinate amount of time to eat one item. So hyper vigilant in their abstinence from calories, they may even refuse to like a postage stamp for fear of the calories that could exist (Burch, 1978).

Anorexics, much more than bulimics, are obsessive about exercise. They will engage in vigorous exercise for prolonged periods and several times per day. Their normal gait is brisk and they can often be seen running from one point to another. There is a case reported of a high-school girl who would arise in the morning hours before the rest of the household to do an hour of calisthenics, then pretend

to her parents that she would take the bus to school, while in fact she would run the 3.5 miles to get there, engage in after school sports, run home, then do another hour of calisthenics after the household had gone to bed. Anorexics can appear so strong and vital that an onlooker would have difficulty perceiving the existence of a life-threatening illness.

In America, many men and women diet and exercise in an effort to obtain a certain desired physique. However, an individual with an eating disorder has attitudes towards body image and food which are quite distorted and excessive, beyond a typical dieting mentality. Someone with an eating disorder is not only concerned about gaining weight, but absolutely terrified by the idea. Eating disorder victims typically overestimate their body size by 25-50%. Their behavior around food and/or exercise becomes the focal point of their lives, and indeed each day their self-esteem is predicated on how well they are able to control themselves in regards to food. The anorexic's perfect day of abstinence can give her a feeling of power and accomplishment, while the bulimic's constant out of control behavior fills her with debilitating low self-esteem, shame and depression. If the anorexic goes beyond the limits of her restricted diet, her sense of failure will prompt self-castigating activities such as over-exercise and even stricter rules around intake.

Both anorexia and bulimia are disorders with food-related behavior. In anorexia, the individual restricts her intake, or avoids food in an effort to deal with emotional issues. In bulimia, the patient turns to food and abuses it as a result of emotional conflict.

An eating disorder is a major health concern in America. In addition, there are many people with concerns about food, weight and body image who would not necessarily fit the criteria for an eating disorder, but who live with very unhealthy attitudes and practices around food and exercise. These attitudes are borne out of, and supported by, a culture consumed with thinness as a model for physical beauty. Our society's discrimination towards fat will now be explored as a precipitant to eating disorders.

CHAPTER TWO: SOCIAL PRECIPITANTS

Pressure to be thin

Ours is a society consumed with thinness. Television, movies and magazines all emphasize that one can be loved, respected and successful only when thin. Fashion magazines saw a dramatic change from the rounded feminine figure of the 1950's to the slim boyish figure of "Twiggy" in the 1960's. A study by David M Garner Ph.D. of the number of diet articles published in six popular women's magazines points out that from 1959 to 1978, diet articles increased from 17.1 articles per magazine in the first decade to 29.6 in the second (Squire, 1983).

Adolescents are extremely aware of their bodies and how they compare to their peers. The over-attention our society pays to physical beauty and the body type we accept as beautiful drives many healthy, robust girls to vigilant dieting and exercising. An eating disorder can begin as a mere diet to lose a few extra pounds and develop into the obsessive illness it is.

The thousands of products and services related to diet and exercise in a multi-million dollar industry are evidence enough of our society's preoccupation with "thin" as the ultimate in beauty. Though this preconceived idea of correct body type, size and shape has nothing to do with a realistic body size for the majority of the population, the public is not deterred from a generally unsatisfying trek from one diet product to another, and more and more exercise gimmicks in pursuit of that model thin figure. Though eating disorders are found to afflict 10 – 20% of the population, a far greater percentage of Americans are discontent with their bodies and continually diet in an effort to fit an impossible ideal. Almost everyone wants to lose a few pounds or would like to change something about their bodies. Self-esteem and happiness are affected by gaining versus losing, staying in control of one's diet, or "blowing it".

We are constantly bombarded with media images of what we should look like. Car advertisements show thin girls slinking around sexy expensive cars. The various diet companies are in constant competition on our T.V.'s and radios. Rock and roll superstars are thin, as are most of Hollywood's leading ladies.

Try having lunch out with a group of women friends. Is there anyone not counting calories, ordering a salad when she really wants pasta or not complaining when the meal is over about how she over-ate and feels guilty? And if we aren't watching every morsel that goes into our mouths, how many spouses, boyfriends or mothers are? How many husbands remind their wives, "Do you really think you should be eating that, dear?". Or well-intentioned mothers encourage teenage daughters to lunch on carrot strips and a hard-boiled egg instead of the sandwich that would really satisfy her hunger. The message is all around; for financial, social and career success, one best be thin. This is a national obsession. If you're not worried about your weight, everyone else will be.

Garner et al make the following quote in their literature (Garner et all., 1985): It has been suggested that "public derision and condemnation of fat people is one of the few remaining sanctioned social prejudices … allowed against any group based solely on appearance" (Fitzgerald, 1981). There is evidence that obese individuals are denied educational opportunities, jobs, promotion and housing because of their weight (Bray, 1976; Canning and Mayer, 1966; Karris, 1977).

It is interesting to note that fat in certain other cultures is viewed quite differently. In Pacific island cultures a large woman is her husband's pride. This is a sign of his success and ability to feed her well. In African and Hispanic cultures as well, a more voluptuous figure is desirable, particularly large hips and thighs. Our western culture must be viewed very oddly by the rest of the world, where starvation is self-induced in an atmosphere of plenty.

Garner et al discuss an interesting study which shows a trend towards increasingly thinner body types in both Miss America Pageant contestants and Playboy magazine centerfolds within a 20 year span. The ideal body type was depicted as having a smaller bust and hips, with a somewhat larger waist, which would give the person a more tubular, or boyish appearance. This is curious, they point out, because this trend towards thinness is actually in direct opposition to the actual changes in young women's

bodies over the last 25 years. Using Metropolitan Life Insurance weight tables, Garner et al found that the expected weight for women under 30 years of age increased at approximately the same rate as the average weight of Playboy centerfold models has decreased (Garner et al., 1985). Studies of the insurance profiles also showed that only about 5% out of 50, 107 female policy holders between the ages of 20 and 29 are as thin as the average Miss America Pageant winner between 1970 and 1978 (Garner et al., 1985).

The majority of women feel compelled to deny themselves food that would actually satisfy their hunger and taste good, in preference for low calorie and often unsatisfying foods. They often force themselves into an exercise program they don't enjoy for fear of gaining weight, rather than for the simple enjoyment of the activity as most men do. If a woman prefers a pleasant walk on a country trail versus working up a sweat on a stair machine, then by all means she should do it. If working in the garden is preferable to a four mile run, then she should feel free to make that choice. The fact is, many women listen to the "shoulds" about weight, food and exercise, denying themselves many things they might enjoy, while pursuing an often unrealistic ideal of beauty. We cannot ignore women's self-esteem as a cultural issue. Why do women feel so bad about themselves? For many centuries women have pushed and squeezed and puffed up different parts of their bodies in order to be considered desirable. Though we don't use the same contraptions as our foremothers, we are still trying to defy nature in pursuit of that perfect shape.

It has been found that dieting and/or exercise taken to extreme can cause loss of reproductive functioning and sexual appetite. It is curious, then, that extreme thinness became the ideal body type for women. It defies a woman's natural function in the cycle of life. Ancient cultures honored goddesses, of which many images have been found. Most show women with large breasts or abdomens to glorify their reproductive abilities, their earth mother qualities. As millennia have passed are we now to view women's bodies as decorative, rather than functional; no longer the givers and nurturers of life, instead the object of fashioned industry whims.

It has also been found that excessive exercise in men can actually reduce libido, ability to perform sexually and the ability to reproduce by lowering sperm count. Our ideals have nothing to do with reality. The Adonis we consider so virile may not be able to express his virility at all. One wonders, if we were not under constant barrage by the advertising industry and the media, what we might actually chose for ourselves as an ideal for beauty and virility. We would probably be more content with ourselves and accepting of others.

Much has been done in recent years to dispel certain myths about fat and dieting. An eating disorder is dieting and concern about weight taken to a dangerous extreme. When one recognizes the pressure in this country to be thin, it is not difficult to see how an individual with psychological and biological factors might be driven to the obsessive and addictive behaviors of an eating disorder. It is valuable to consider the latest findings about fat and to begin to develop new ideas about one's own body image and that of others. Understanding the body's limits and compensatory mechanisms during starvation is an important aspect of healing, for the general public in need of more self-acceptance and particularly for

the eating disorder patient. Dieters may starve in vain if working against the body's natural defense of and optimum weight, a weight the organism chooses as normal.

Garner et al make the following points in their literature:

1. In the past several decades, women have been victims of a tragic set of standards for physical appearance, which have placed them under intense pressure to diet to meet the social expectations for thinness.
2. Generally speaking, body weight resists change. Weight appears to be physiologically regulated around a "set point", or a weight that one's body tries to "defend". Significant deviations from this weight result in a myriad of physiological compensations amid at returning the organism to "set point".
3. Dieting is a relatively ineffective method of weight control, because it usually goes against these biological determinants of weight.
4. There are marked interpersonal differences in "set point"; some people are naturally heavier and some naturally thinner. Most women's "natural weight" is well above the current ideal for feminine beauty.
5. Bulimia, as well as certain distressing biological and social changes, may be linked to chronic dietary restriction.
6. Bulimia and vomiting become an escalating or vicious cycle, since vomiting allows the dieter to give in to her desire to eat without the fear of the caloric consequences.
7. The gradual return to the weight that one's body "prefers" leads to the gradual reduction of these symptoms, including the tendency toward binge eating.

Myths about fat and health risks

Traditionally, obesity is viewed as a health risk in and of itself, and even an indicator of psychological disturbance, such as depression or poor self-esteem. Researchers have found that the medical risks of obesity have been greatly exaggerated and misunderstood. Garner et al state that "it is an error to conclude that an association between obesity and illness necessarily implicates obesity as the cause". Health professionals have been taught to assume that fat is unhealthy, and therefore all obese patients must be put on a diet for health improvement. This is a gross misassumption that recent research seeks to correct.

Genetics play an important role in the development of disease. There may actually be a genetic predisposition towards obesity as with diseases such as diabetes mellitus, high blood pressure and heart disease. Obesity and these other illnesses may originate from the same genetic deviation (Garner et al., 1985).

Research indicates a lack of support for the relationship between obesity and high blood pressure, heart disease, cholesterol levels and diabetes mellitus. Garner et al discuss a study done in a community where the incidence of obesity was high, but where it was considered a socially acceptable condition. The researchers found a lower than average frequency of heart disease and diabetes. In addition, there are studies that suggest that obesity is associated with reduced risk of illness and "in some age

categories, obese individuals live as long or longer and survive illness better than their lean counterparts (Garner et al., 1985)". Garner et al defend traditional studies regarding extreme obesity and its health risks. However, this literature states that "virtually no data indicate that mild to moderate overweight has the same detrimental consequences (Garner et al., 1985)".

Kano points out that "higher weight also correlates with a lower incidence of cancer, some respiratory diseases, many infectious diseases, osteoporosis, some cardiovascular diseases, some gynecological and obstetric problems, anemia, diabetes type I, peptic ulcers, scoliosis and suicide. In addition, obesity is associated with a more favorable prognosis in diabetes type II, hypertension, hyperlipemia and rheumatoid arthritis (Kano, 1985)". Additional research indicates that overweight individuals who are not considered "obese", have the best chance of surviving to old age, and that individuals who are "model thin" have the least chance of surviving to old age; even greatly obese individuals have a greater chance of surviving to old age than model-thin women (Kano, 1985).

The weight cycling caused by repeated dieting is actually a greater health risk than strictly being fat (Garner et al., 1985). Individual's whose weight cycles as a result of constant dieting, tend to regain their weight in the abdomen, which is associated with greater health risks. Likewise, the hypertension found in obese people is not necessarily caused by the weight itself, but is more a result of the cycles of weight loss and gain (Kano, 1985). Kano cites the example of Samoan women, who are quite large, and happily so, who rarely suffer from hypertension, nor do they try to lose weight and suffer from the complications of weight cycling.

Kano also adds clarity to studies which correlate high weight with cardiovascular disorders. She points out that "excess muscle is the primary risk factor for cardiovascular disorders. Those at greatest risk are muscular, have a large frame and carry fat predominantly in the abdomen" (Kano 1985), as opposed to people who are simply considered fat. The literature supports this phenomenon with studies that indicate when a dieter's weight cycles they tend to gain fat in the abdomen, which is the most dangerous way to gain weight in regards to health risks.

There is much scientific data implicating the failure of dieting and achieving permanent weight loss (Garner et al., 1985). It should therefore be questioned as a cure for obesity. "Several studies and reviews have challenged the assumption that obesity is a significant health problem and have concluded that the fervor of treatment efforts reflects our prejudice rather than a realistic response to the risks inherent to the condition" (Garner et al., 1985). Even if there does exist some correlation between obesity and increased health risks, dieting is probably not the best solution a health professional can suggest. Garner et al states that "certainly the prescription of dieting is unwarranted for those who are not suffering from illnesses that are clearly complicated by obesity". This is particularly true if the patient is not expressing any concern or anguish about weight. The National Association to Advance Fat Acceptance (NAAFA) cites this as a gross discrimination and injustice towards large people. When a fat person goes to the doctor, possibly for something completely unrelated to weight, it is often assumed by the physician that the weight is a problem. Here, once again, is pressure from society to be a certain body type. This is particularly unfair when one considers the documented gross failure rate of diets, and

the humiliation and self-reproach experienced by those who "fail" to either lose weight or to maintain the weight loss.

Not only is it a myth that obesity is itself a health risk, it is also an unfair assumption that the obese person arrived at this condition due to psychological issues. The idea that fat people hide behind layers of flesh, that they have problems with sexuality, that they are depressed and thus gorge themselves with food, though certainly true in some cases, and certainly true among the general population, is a gross generalization and prejudice towards large individuals. Garner et al state that "while psychological factors may be responsible for overweight in some individuals, most controlled studies do not find the obese to be more neurotic, sexually inadequate, or emotionally disturbed than individuals of normal weight (1985)".

As mentioned earlier, genetics to play a role. Burgard (1993) mentions a study by Stunkard (1990) which compared weights of identical and fraternal twins who were raised either together or separately. Stunkard concluded that genetic influences, rather than environment, determined body size. These findings support earlier studies of the same nature (Burgard, 1993).

Though there have been attempts to attach a particular familial pattern or personality profile to obesity, none have thus far been found (Burgard, 1993). There is no typical psychopathological picture, and "obese and non-obese individuals differ little in overall levels of psychopathology (Burgard, 1993)". It is well to remember that, through depressed or dysfunctional obese individuals do come to the attention of mental health professionals, and their weight may in fact be a metaphor, symptom or result of a psychological issue, obese people who are functioning well, in satisfactory relationships, have commendable careers and high self-esteem, do not. It is difficult, in fact, for the general population to accept that large individuals might actually be happy, well-adjusted, have fulfilling lives and not feel bad about their weight. We are tempted to believe that, just as the bulimic or anorexic individual has a gross distortion of body image, so must the obese individual who does not seem worried about her weight. If she agonizes about it, trying to reduce and feeling worthless if she doesn't, we see this as a much more normal reaction. This is the extent to which we relate thinness to happiness.

Burgard (1993) quotes Bruch, a notable leader in the study and treatment of eating disorders as saying "It is necessary to differentiate between those psychiatric aspects of the obesity problem that play a role in the development of obesity and those which are created by the obese state, in particular for people living in a culture that is hostile and derogatory toward even mild degrees of overweight; finally there are the conflicts precipitated by reducing". The attempts to comply with the demands of a fat-hating society certainly cause psychological problems, particularly depression and low self-esteem. Many people in our society feel the pressure to be thin, the sense of "I'm only as good as my weight", yet not everyone develops an eating disorder. However, it is precisely this social pressure, in combination with other factors, which drives the eating disorder patient to compulsive and dangerous behavior.

Based on these new attitudes towards obesity and health risks, in her work Burgard focuses on health and self-acceptance, not weight loss. Exercise for enjoyment and general well-being is explored for large women, as well as eating for good health and satisfaction of hunger. In an interview, she pointed

out that in 1984 the National Institutes of Health (NIH) called obesity a killer disease. By 1992 the same organization had changed their opinion dramatically. They admitted to the failure of traditional treatment methods (i.e. dieting), warned the public about participating in commercial diet programs which could not show scientific data indicating long term participation and success rates, and recommended programs which focus on overall health benefits versus strictly weight loss, as a means of improving physical and psychological health.

Regular physical exercise does much to improve medical conditions such as hypertension and diabetes, reduces the stress often responsible for physical and psychological illness and improves body image, self-esteem and physical strength. An obese person engaged in regular enjoyable exercise might never achieve weight loss, but she certainly gains much in the way of overall well-being. Burgard suggests this must be the focus of healthcare personnel in treating obese patients. Take the focus away from weight loss and laboring in vain to match a weight on an insurance company's chart, and strive for overall good emotional and physical health.

Myths about dieting and weight loss

Many studies have been done in recent years denouncing the effectiveness of restrictive diets as an effective and permanent weight loss solution. When one begins to understand the unique mechanisms the body utilizes to fight the starvation process, it is easy to see how people can become trapped in the endless and futile pursuit of the perfect diet. For the person with an eating disorder, it is an emotionally and physically painful battle against powerful forces of nature which seek to keep the body at its optimal weight for functioning.

Thus, experts have established a concept called "set point", which is the body's attempt to defend a physiologically programmed weight level. This "set point" is so individual and is influenced by such things as genetics and metabolism that it would be impossible to standardize weight based solely on age and height. One person might be lean at their set point, while another obese. Everybody has different energy (energy=calorie) needs. Consequently, the body makes it difficult to go below, and stay below, its optimal level for survival. This is a phenomenon of nature, which has to do with survival of the species, a physiological coping mechanism during the body's perceived threat of starvation and extinction.

Garner et al discuss experiments by Keys et al in the Minnesota study performed in 1950, and Sims et al in 1968, which illustrate the resistance of most individuals to either gain or lose weight. Whether over-fed or under-fed, the body will find its way back eventually to set point. The studies show how metabolism slows down with weight loss so that calories will be used more efficiently and weight gain will occur. It has been found that dieting reduces the metabolic rate by 15 – 30% (Garner et al). And the longer one diets the more the metabolism slows down, so that it becomes more and more difficult to lose weight, and the dieter finds they must restrict intake even more than initially. The net effect, then, of dieting is actually paradoxical to the intent; the individual actually becomes more susceptible to weight gain and fat storage. Garner et al quote an interesting point form the literature of Wooley and Wooley, "that dieting – the major treatment for obesity – may also be a major cause of obesity".

This is an important concept to grasp in understanding the bulimic's addictive and frustrating cycle. If weight becomes increasingly difficult each time the bulimic begins a new diet, and the calories ingested during a binge are less likely to be burned off due to the body's attempt to conserve energy from the starvation period, the metabolic rate remains suppressed because the body has no opportunity to recover from the starvation, and the calories are more readily stored as fat. So the bulimic actually begins to gain more and more weight due to the cycling, and rather than achieving her goal of weight loss through her erratic eating habits, she is actually gaining weight and making it harder and harder to lose (Garner et al).

A study using rats documents that the starved animals gained weight at a rate many times greater than that of rats of normal weight who were fed the same amount. Rats that were starved 20% below their normal weight gained 29.6 g during re-feeding, whereas the non-starved rates gained only 1.6 g during re-feeding, and the starved rats were eating somewhat less (Garner et al).

The bulimic patient is starved thereby she eats a far greater amount of food to compensate for the body's need for calories. She feels physically uncomfortable and guilty, so she vomits. The vomiting imposes a break in the eating-satiety feedback loop. Where a person who eats normally would feel satisfied from the food and discontinue eating, the bulimic has relieved herself of the very mechanism which would lead her to stop eating. Instead, she is: 1) starved again and 2) giving herself permission to binge because she has gotten rid of the unwanted calories. The purge legitimizes the binge. She feels safe to continue eating. The purging initially starts as a method to control her out of control eating, but ultimately it only helps to continue the out of control binge-purge cycle (Garner et al). This cycle supports additional research which indicates that the incidence of binge eating occurs much more frequently in dieters than non-dieters (Garner et al). And dieters use food to deal with emotions during stressful situations much more than non-dieters.

Conversely, with weight gain above one's set point, hyper metabolism occurs so that excess calories are wasted and the individual returns to set point. Regular aerobic exercise has been found to speed up the metabolism and to re-set the set point to a lower weight.

Changes in mood and appetite also promote return to set point. The studies showed that when subjects were fed well below their average level of intake they became completely preoccupied with food, planning how and when they would eat their next meal. While eating they would be completely focused on the food, would become silent and socially isolated while they devoted their full attention to the meal. This is characteristic behavior of anorexic patients, and it appears from the literature to be a symptom of starvation, and the defense of the body toward set point.

Another interesting observation of the Minnesota study was that if the subjects broke the prescribed diet, they became uncontrollable in their behavior towards food. They would binge, just as a bulimic patient, until they had consumed up to 10,000 calories in some cases. Then, so consumed with guilt, it was not uncommon to vomit and be filled with self-reproach (Garner et al). This is the common behavior of bulimic patients; starving themselves until the body screams to be fed, and then finding it

impossible to stop due to the former deprivation. Once again, the body itself is making a vicious attempt to fight starvation and establish a normal caloric, or energy, intake.

Kano interviewed competitive wrestlers and rowers who traditionally employed severe dieting methods during their season. They experienced battles with set point and showed similar behaviors to eating disorder patients. The athletes would report starving themselves and restricting fluid intake prior to an event, then frequently bingeing afterwards due to feelings of starvation and deprivation. Though they would intend to keep the weight off even in the off-season so as not to put themselves through such a strict regimen during their season, the athletes would gradually gain back all of the weight once they had relaxed their eating patterns. These athletes had gotten well below their set points and could therefore not maintain such low weights without feeling starved.

The Minnesota study showed that the subjects underwent severe changes emotionally, physically, cognitively, socially and sexually while being starved. These specific complications will be discussed later in this course. However, what this illustrates, according to Garner et al, is the intense biological pressure on the body to return to "normal" weight. "It also demonstrates that the body is not simply 'reprogrammed' to adjust to a lower weight once it has been achieved. The volunteers' experimental diet was unsuccessful in overriding their bodies' strong propensity to "defend a particular weight level (Garner et al)." Once the subjects resumed their normal diets they did not gain significant weight. Within the first few months most gained back their original weight plus 10%. Then in the next six months their weight gradually declined back to their original pre-experiment weights.

This is interesting because it demonstrates the body's resistance to exceeding set point as well as the converse. Sims et al conducted a study in 1968 using prison in-mates as volunteers who were over-fed, often up to 10,000 calories per day, in an attempt to gain between 20 and 25% of their original body weight. Most of the men gained a few pounds initially, but then found it difficult to continue gaining. Just as the subjects in the Minnesota study experienced metabolic changes to compensate for the decrease in calories, so did the volunteers in the prison study in order to defer weight gain. The starved subjects developed hypometabolism in an effort to conserve energy and thus use calories more efficiently, while the prisoners who were over-fed developed hypermetabolism in order to more rapidly expend the excess energy. It was found that these men perspired profusely and complained of body heat. This is a process known as "diet-induced thermogenesis". The subjects had many complaints of physical discomfort as a result of the intense caloric intake and also experienced psychological problems. Once the experiment was over the volunteers lost weight rapidly and virtually re-established their pre-experiment weight levels without effort.

Kano discusses the importance of metabolic variance when considering weight gain or loss. Basal metabolism is affected by age, size, body composition (muscle: fat ratios) and gender. Even in individuals who are matched for all these characteristics, basal metabolism can vary by at least 15% to either side of the mean. Kano points out that studies show that "obese people consistently gain at least twice as much as lean people when they are overfed the same amounts". Additionally, there are studies which show that fat people do not necessarily take in greater amounts of food or more calories than people of average weight (Burgard, 1993; Kano, 1985).

The use of laxatives and diuretics to aid in weight loss is also a myth. Laxatives have been proven ineffective in controlling absorption of calories. Laxatives effect the emptying of the large intestine, which occurs after calories have already been absorbed by the small intestine. Those who abuse laxatives are fooled into believing they have lost weight, because an acute weight loss is achieved which is mostly fluid. The body compensates for this with rebound water retention, which may then result in an even higher than original weight. The body simply won't let us get away with anything! Diuretics have been found to have absolutely no effect on calories or body fat, and may cause water retention after discontinuation of use.

The diet industry exploits this phenomenon of water loss. The female body is comprised of 50% water. Most of the weight lost in the initial phase of a diet, particularly those with extreme calorie restriction is due to dehydration or water loss. This is how fad diets are able to make such seductive claims of instant weight loss. After the first few weeks, however, the weight loss is much less rapid because actual loss of body fat is slower than water loss. This is where many dieters become frustrated and discouraged and blame themselves for lack of will power. This is where a binge might occur, which would then lead to an even greater restrictive period, the feeling of starvation, binge and so on ad infinitum.

Chronic dieters, and especially individuals with an eating disorder, have gotten out of touch with their body's needs and messages. They often do not understand, or accept, hunger as a communication of the body's need. Nor can they perceive satiety before reaching levels of great discomfort from having gorged on food. Burgard feels that dieting encourages individuals to distrust their bodies and its signals. In treatment, Burgard re-introduces patients to their physical hunger and gives them permission to eat in accordance with these cues.

The dieter, and specifically the eating disorder patient, has "all-or-none" thinking, where certain foods are acceptable or good, and other foods are bad and forbidden. The dieter is then either "good" or "bad" based on her eating behavior. Self-esteem becomes completely predicated upon eating and weight. Is it any wonder that patients with an eating disorder become depressed, often suicidal and feel they are worthless failures? They can rarely achieve the impossible standards they have prescribed for themselves. Though they make a career out of dieting and being thin, their bodies vehemently resist such starvation levels, causing these individuals to engage in a constant battle against themselves.

Burgard discusses the fantasized future that often keeps the dieter disengaged with life in the present. The desired weight becomes the pot of gold at the end of the rainbow where all happiness can be found: "When I lose thirty pounds I will feel sexy, I'll have a boyfriend, buy pretty cloths, take up dance, go to Hawaii and lie on the beach, go out to dinner with friends, etc.." The disappointments of life in the present can be staved off for the ultimate goal of the perfect future. However, so too are the joys of present life kept at bay. While the dieter feels she is not worthy of the good things in life until she's thin, she puts off feeling good about herself, and treating herself well, simply for who she is, a valuable human being, capable of loving, being loved, having a good time and adorning herself attractively.

Dieting and the self-flagellating that women do over their appearances is the outer ramification of a deeper emotional issue, the subject of which has filled countless volumes, and that is the low self-esteem of many thousands of American's women. It is interesting to note that Burgard found that dieters scored significantly lower than non-dieters on tests which measured self-esteem and feelings of self-control. This could indicate that those individuals, whether thin, of average size, or obese, who were able to accept their size and eat in an unrestricted manner felt better about themselves than those continually trying to change themselves through diet. Burgard poses that the repeated failure experienced by dieters maintains an overall sense of ineffectiveness and worthlessness.

In summary, fat is neither a sign of physical or psychological infirmity. Normal weight varies tremendously among the population, with some people being lean at their set point and others being large. In trying to control our body's weight through diet we do little more than frustrate ourselves, and actually disrupt the body's natural ability to monitor the number of calories we consumed and the weight it requires for optimal health. A wealth of literature supports the idea that dieting is harmful to overall health and can actually cause weight problems that did not exist prior to the diet. Individuals with eating disorders are an extreme example of this.

CHAPTER THREE: PSYCHOLOGICAL PRECIPITANTS

So far we have seen how disturbed eating patterns are created by the social expectation of thinness and exist for a great majority of the population. However, the pathological extreme to which the eating disorder patient pursues thinness suggests psychological precipitants as well. Garner et al state that "extensive clinical and empirical evidence indicates that psychological disturbance is central to the development of anorexia nervosa and bulimia in many individuals". The following aspects of psychological functioning are important in understanding the development of an eating disorder.

Body Image Distortion

Body disparagement is rather common among the general population, hence the success of the diet industry. However, the self-loathing and preoccupation with weight observed among eating disorder patients is exceptional. The perception of "being larger than in reality stems more from a deep dissatisfaction with the body and the self than from a true disturbance in perception (Bryant-Waugh and Lask, 1992)". In a study done by Davies and Furnham in 1986 of adolescent girls with eating disorders, 40% considered themselves overweight, while less than 4% were actually overweight. Fosson's study in 1987 of early onset eating disorders found that 56% of the patient's gave fear of fatness as their main reason for restricting intake (Bryant-Waugh and Lask).

Low Self-Esteem

A primary deficit in anorexia nervosa is an overwhelming sense of ineffectiveness (Garner et al). The act of starvation, controlling one's intake and thereby controlling the body, is in essence a manifestation of the struggle for autonomy, competence, control and self-respect (Garner et al). Particularly for the anorexic patient, exercising such extreme control over the body provides a sense of security while they feel totally out of control of their lives. With eating disordered adolescents, this generally stems from an

over-controlling and enmeshed family dynamic. Adults who develop anorexia for the first time are often experiencing a stressful life event, such as marriage, having children or family crisis. Again, it may be the only factor in the person's life that can be controlled. In this instance the eating disorder becomes a coping mechanism, albeit an unhealthy one, but quite possible the only way the individual manages to function in a chaotic or dysfunctional environment.

Individuals with eating disorders also have an unrealistic striving for perfection and desire to attain success. Bryant-Waugh and Lask report on a study of emotional components of anorexic teenagers compared with a control group. The anorexic subjects scored highly in terms of moral adjustment, impulse control and education goals, but low in emotional tone, body and self-image and sexual attitudes (Bryant-Waugh and Lask). This would reflect family pressure to be well-behaved and striving towards success and excellence.

Fear of Maturity

Starvation becomes the solution for the girl who fears the expectations and responsibilities of adulthood, as she strives to keep her body in its prepubescent appearance. Hormonally and behaviorally, the anorexic can succeed in avoiding maturity. Her emaciated and vulnerable appearance causes family members and others to care for her as if she were a child. This is an individual who, while she is fighting for autonomy, feels quite dependent on others and incapable of dealing with the demands of adult life, which would include the possibility of a sexually intimate relationship.

Depression

The literature indicates that many individuals with an eating disorder also experience the symptoms of depression (Garner et al). A study of children aged 7-13 with eating disorders reported that 56% were clinically depressed. And another study of teenagers identified a high rate of depression amongst those with anorexia nervosa (Bryant-Waugh and Lask).

It is difficult to ascertain whether depression is a predisposing factor of eating disorders, or the result of starvation and electrolyte disturbances. It is likely that both are true. Several studies reported symptom improvement following a trial of antidepressant medication (Garner et al), and are in fact the most frequently prescribed psychotropic medication used to treat anorexia (Jones and Nagel, 1992).

Other Personality Features

Though there are certain personality traits that seem to be more characteristic of either the anorexic or bulimic patient, the most recent consensus is that there is no one personality pattern for either of these patients. Since eating disorder patients typically vacillate between starvation and the binge-purge cycle, perhaps behaving as an anorexic for several months and then switching to bulimia and then back to starvation, one might see features of both disorders at one time or another.

Despite this, there are certain tendencies that seem to emerge repeatedly. Anorexic patients tend to be obsessional, introverted, socially anxious, conscientious, perfectionistic, competitive, over-controlled, socially dependent, shy and "neurotic" (Garner et al). Bulimic patients are more impulsive, prone to addictive behaviors, emotionally turbulent and depressed (Garner et al).

Family Conflicts

Case studies indicate that the family plays an important role in the development of an eating disorder. The anorexic and the bulimic patient appear to have different family dynamics which typify them. In general, the anorexic family is seen as highly rigid and controlling and the bulimic family as more chaotic, or at least perceived that way by the patient (Garner et al). The following are generalizations for both, and are helpful from a therapeutic point of view in understanding the more profound psychological issues of eating disorders.

Anorexia Nervosa – Though anorexia can occur at any time during a woman's life, the foundation seems to be established in childhood. The real crisis lies in progressing successfully through puberty and managing the primary task of adolescence, which is to establish one's own identity as separate from one's family.

Anorexia seems to be characteristic of young women who have felt exploited and controlled by their families. They have not been allowed to lead a life of their own. These families are protective, controlling and extremely enmeshed in the thoughts and feelings of the other family members. In therapy, they will not identify their own feelings, but will speak for one another. They do not allow true expression of feelings, avoid conflict and are overly concerned about what others think. Girls growing up in this environment do not establish their own identity. The parents often control who the girl chooses as friends, what she does in her free time and the direction her life will take educationally and professionally. This leaves the girl feeling helpless and ineffective.

These girls are people-pleasers, seen by parents and teachers as model children. They are overly submissive and lack self-assertion. In need of acceptance, and so fearful of any criticism, they learn early in life exactly what they need to do for each person, in order to gain the love and acceptance they desperately need. They feel tremendous pressure to live up to family expectations of achievement and fear that if they do not, they will lose their parent's love. These girls are extremely dependent upon their families, feeling safe in the home environment where they can predict exactly how they must act to get approval. They are fearful of leaving home for an unknown environment where they will not know how to function. Since their identities are defined by their parents, there is a need to remain as children, in need of the protection and safety of their parents. By remaining in a child's body they can avoid the adolescent responsibilities which appear so frightening. The anorexic feels true repugnance for any feminine qualities of her body.

The total lack of control these girls experience in their lives can encourage them to seize control over the one area they feel is their own – their bodies. It is the one act of defiance they feel they can safely get away with. Anorexics are very angry with their controlling families. They turn their anger inward onto themselves by depriving their bodies of food because they cannot express these feelings or assert

themselves in any way. Through the act of starvation and severe weight loss, the girl gains a sense of specialness and great achievement. The delusion of achievement is an important one, since she has such a terrible fear of not measuring up to parental expectations. Most anorexics feel superior to others because of this difficult task.

It is the family's inability to acknowledge the control they have exerted on their child's life, and the inability to relinquish it, that sustains the illness. A common feature is that the child is not acknowledged as a person in her own right, but rather as someone who would make her parents' lives more satisfying and complete. The feelings the anorexic girl derives from her starving body are the only true feelings that originate from herself and are her only source of self-identity.

Anorexics often feel responsible for a troubled parent or for parents who have a difficult relationship. By being skinny and needing the protection of their parents, they feel they are the nucleus around which their parents revolve, thus keeping them together.

The anorexic is generally socially isolated. The extreme dependence on family is one explanation for this. However, her need to accommodate is another strong factor. Changing her personality to what she feels each person wants results in the girl feeling fragmented and vacant, as if there is no one inside. This inability to be a real person and foster intimacy which others results in a high turnover of friends. Also, her preoccupation with thinness and the superiority she feels serve to isolate her from other girls.

It must be pointed out that the anorexic is normally not cognizant of the underlying reasons for her unhealthy behavior. In fact, she will deny the existence of any problem at all. She truly believes her issue is one of "fatness" and that she has every reason to behave as she does. She does not consciously choose the behavior. Rather, it is an unconscious and desperate coping mechanism.

Following are two case studies which exemplify the thought processes and behaviors of anorexia nervosa:

> **Alma** – Outwardly, Alma's family would appear to be ideal. Her parents were very devoted and wanted to give their children everything. Her father was a successful businessman and was also involved in local politics. Alma's mother was a leader in many social activities. Both parents felt unfulfilled, however, because they had not pursued their own dreams. The father had wanted a professional career and the mother had dreams of the theater. Because circumstances had not supported their pursuit of these goals, both parents had accepted substitutes for what they really desired and were left feeling disappointed. The older daughter was an average student and her lack of achievement was disappointing to her parents. Alma, on the other hand, excelled in all areas – academically, athletically and socially. Her parents looked to her to live out their own unfulfilled dreams. Wanting to please her parents, she was everything they wanted, until the pressure became too great. It was at this point that Alma began to exert some control over her life, by starving herself to extreme thinness (Burch, 1978).

Mabel – In Mabel's family it seemed to be a house rule to always consider mother first, before making any decisions. Mabel's father is extremely involved in business and is often away from home. Therefore Mable grew up feeling a special attachment to, and responsibility for, her mother. She allowed her mother to dictate her academic pursuits, her choice of friends and the summer camps she attended, even if she detested them. She always pretended to enjoy her mother's choices, even volunteering for them, as she became adept at learning what would please her mother. She never wanted her mother to feel as if she had made any mistakes. In college Mabel received treatment for her anorexia. She was able to tell her therapist that her mother was egotistical and raised her children in a way that fulfilled her needs and wishes, and would be approved of by her friends. Regardless of how much progress Mabel made away from home, she continued to relapse whenever around her mother (Burch, 1978).

Bulimia – While anorexics are perceived as rejecting femininity, bulimics are actually deeply committed to the traditional female role. They tend to value the importance of relationships with men above all else, giving men the power to define how they act, think and feel. At the same time, they lack genuine intimate relationships, particularly with men.

With anorexics the problem lies in making the transition from childhood to adolescence, involving their changing body image. For bulimics, who traditionally enter adolescence successfully, the crisis exists in transitioning from adolescent to adult female responsibilities and the ensuing intimate relationships.

Bulimics are typically from homes where the mother occupied the traditional female position, tending to be over-involved with her daughter's life. The father is generally preoccupied outside the home. Though the mother actually has more power and influence in the home, she defers to her husband when he is present. The mother is often passive towards her husband, but controlling with her children. Garner et al describe a patient who openly admitted that her vomiting was an act of defiance against her controlling mother.

The bulimic girl often has a close alliance with her mother, while at the same time feels angry at her for her submissive role. She also covets the attention and approval of her father, who is often unavailable, and seems to focus on her appearance as an object of praise. She is encouraged to grow up, marry and be like mom.

Bulimics are perfectionists, dependent, in need of constant approval, filled with self-loathing and feelings of inadequacy and helplessness. They are extremely self-critical. They are conditioned to please others, particularly men. They are generally high achievers, talented and attractive.

Since perfectionism runs their lives, and since perfection is impossible, bulimics live with perpetual insecurity and feelings of unworthiness. These girls are obsessed with the fear of being fat, and therefore not perfect.

Precursors to bingeing are rejection, confrontation, disappointment and anxiety. Since they have been brought up to be agreeable, compliant and non-assertive, these girls have trouble expressing anger and will easily feel victimized by others. They then turn their anger inward by bingeing and purging. They are so sensitive to rejection that any slight can manifest the self-loathing that leads to a bingeing fury. After the binge and the accompanying shame and guilt, they purge in order to gain self-control. The purge has also been described as relieving tension, momentarily helping the individual to feel better and less pressured. Having re-established their disciplined ways, they can initially feel better, perceiving themselves as having achieved the perfection they seek. But often they are tormented by even greater shame and self-loathing. It is a vicious cycle which can lead to the extreme feelings of suicidality if not treated.

Many girls start their binge-purge behavior in college, where food is often used to nurture during periods of loneliness. Also, away from the family's meal-time routine, college girls will invariably gain weight. Thus begins the endless dieting and purging as they compare themselves with peers. Dating, sororities and other new social activities put pressure on these young women to be thin.

The profile of the bulimic wife appears to be one who was a high achiever prior to marriage, yet sought a relationship where she would be taken care of and not have any responsibilities. This conflict can cause the frustration, helplessness and self-disgust that lead to the binge-purge cycle.

A professional woman who becomes bulimic is generally a high achiever who receives much praise for her accomplishments. She is very often successful, yet inwardly she is insecure about her abilities and fearful that she will eventually be found incompetent. She will often go home and frantically binge and purge after a stressful day, where she has had to keep up a confident facade for her peers.

These women have a difficult time accepting praise or acknowledging their own accomplishments. They may have a professional life which appears full and rewarding, while their personal life is lonely and empty. Because of the isolative nature of the illness, bulimics have few friends.

Since bulimia is an illness carried on in secret, and the girl generally appears of normal weight, it can be difficult to detect. This behavior is often discovered when the young woman seeks professional help for other reasons, such as relationship problems, depression or low self-esteem.

Following are two case studies of bulimic patients:

> **Anne –** Anne had been bingeing and purging for months when she was invited to dinner by a man she felt attracted to. She enjoyed her time out, yet felt wracked with anxiety about the rejection she knew was coming. She went straight home after the date to engage in a bingeing and vomiting fury that left her filled with self-disgust. This served to reinforce her feelings of imperfection and the fact that she was "bad". She therefore felt unworthy of love, which provided her the excuse to withdraw from any other social interactions (Boskind-White, 1983).

Francine –Francine was filled with self-doubt and fear of failure. She kept up the perfect facade of the confident career woman heading for the top while at work, but at home she would break down and binge and purge on a regular basis. The role model her mother presented as hysterical, demanding and ineffectual did nothing to instill in Francine positive feelings about a woman making it in the work force. She determined to never be like her mother, yet feared perhaps she was. Francine's bulimia allowed her to reinforce negative feelings about herself, seeing herself as the same weak and ineffectual person as her mother (Boskind-White, 1983).

Demographics

Eating disorders typically affect females from upper income families, where financial, social and educational achievements are high. The behavior is rarely seen in lower socio-economic groups and has not been seen in underdeveloped countries. Until recently, there were no reports of eating disorders in children from other than white western backgrounds (Bryant-Waugh and Lask). However, more recent studies indicate cases of anorexia nervosa in children and adolescents of African and Asian heritage, and increased reports of bulimia nervosa among Asian teenagers. This cross-cultural prevalence of eating disorders has also been observed in adult patients (Bryant-Waugh and Lask). When eating disorders have been noted to cross-over the educational, ethnic and socio-economic lines, these families are generally upwardly mobile or success oriented, where there are siblings who have been successful or a great deal of attention is focused on the girl to succeed (Bruch, 1978).

Though most research refers to persons with an eating disorder as female, it has been found that 10% of the afflicted population is male (U.S. News and World Report, 1988). In fact, it is felt by researchers that this data inaccurately reflects the number of males actually suffering from this illness. Males traditionally are less likely than females to disclose any kind of personal problem or weakness. Furthermore, as anorexia and bulimia have been labeled female disorders, men may feel embarrassed to expose such behavior. As a society we accept the notion that growing boys need large amounts of food and that they become vigorously, often fanatically involved in sports. This seems so normal one might not consider the existence of an eating disorder by such behavior, as we might with girls. However, both males and females suffer from many of the same societal and familial pressures and issues. Undoubtedly, there are more men with eating disorders than statistics would show. As we enhance our awareness of body image issues and as the men in our society begin to feel more comfortable seeking professional help for emotional problems, we will more than likely see a raise in reported cases of males with eating disorders.

Sexual Abuse

Several studies indicate a correlation between childhood sexual abuse and the later development of an eating disorder. The various studies indicate a prevalence of sexual abuse from 23% - 83% of patients studied (Bryant–Waugh and Lask). Though a history of sexual abuse is often seen in eating disorder patients, it is a difficult correlation to make. Since one-third to one-half the female population report incidents of childhood sexual abuse, and most eating disorder patients are female, one could only conclude there would be a high incidence of sexual abuse. The sexual abuse may in fact play a role in

the later development of an eating disorder, and/or simply be one more factor in the overall highly dysfunctional family dynamic described earlier. Experts feel this is an issue that warrants further study before a definitive conclusion can be made (Bryant-Waugh and Lask).

CHAPTER FOUR: BIOLOGICAL PRECIPITANTS

Biological components are frequently cited as relevant to the pathogenesis of anorexia nervosa and bulimia (Bryant-Waugh and Lask), however experts are puzzled about whether these conditions are secondary to the eating disorder or if they are to be considered primary causative factors (Bryant-Waugh and Lask; Jones and Nagel).

Hypothalamic dysfunction is seen in anorexia. The question is whether this condition is secondary to malnutrition, or if there is a primary hypothalamic condition which precipitated the eating disorder. If hypothalamic dysfunction exists prior to the onset of illness, it might very well depress the appetite such that the individual would cease eating and take on a cachectic appearance. This condition is reversible upon re-feeding and weight gain.

Hypoglycemia, which causes carbohydrate craving and feelings of hunger, is a medical complication resulting from bingeing. However, if it existed prior to the illness, this could explain the frenetic binge-purge behavior of the bulimic.

Though experts continue to search for a primary organic precipitant to eating disorders, the literature strongly leans towards these biological anomalies as secondary to the manifestations of eating disorder (Bryant-Waugh and Lask, 1992).

Genetics

Research using studies of twins and families indicate the significance of genetics in the development of eating disorders. Jones and Nagel mention several such studies in their literature. One study by Holland et al (1988) took a sample of 45 twin pairs and found that of the non-identical sets only 5% both had anorexia nervosa, and of the identical sets, 56% were both found to share the disorder. A similar study described by Crisp et al (1985) of 30 pairs of twins, showed a concordance rate of 7% among non-identical twins, and 55% among identical twins. Interestingly, when sisters were studied, concordance rates were much lower, between 3% and 10% (Jones and Nagel).

Family studies indicate a higher incidence of anorexia among first- and second-degree relatives of anorexic patients, but similar correlations have not been found of bulimics (Jones and Nagel).

Jones and Nagel cite several studies on the correlation between affective disorders and eating disorders. All the literature reported similar findings in that over 50% of the mothers of anorexics had a history of depression. No correlation of this kind could be made of the purely bulimic population.

Thus far, it has been difficult to establish clear-cut data regarding the physiological causes of an eating disorder. Since patients present for treatment after their illness has been in full swing for some time, physicians often have no base-line data on these patients prior to illness. In regards to the family and

twin studies, there have been no comparisons between twins raised together and apart, which might tie in the important psychological aspects of environmental influences. As yet, researchers are not drawing definitive conclusions about the potential biological precipitants of eating disorders. Most will agree that this aspect requires further research and that psychological and socio-cultural influences are the primary precipitants of eating disorders.

CHAPTER FIVE: COMPLICATIONS

The cachectic condition that results from starvation and the continual abuse inflicted from bingeing and purging, have dramatic, sometimes lethal effects on the body. The reported mortality rate for anorexia is 5% to 15% (Bruch, 1973). Though bulimia is not normally lethal, the damage done to the body may result in chronic health problems, even after cessation of the binge-purge behavior. The medical complications of eating disorders are outlined below:

Anorexia Nervosa

Signs and symptoms

Herzog provides a good description of the anorexic woman. He states that "cachexia and breast atrophy are observable and the patient may look younger than her biological age. Her skin is often dry and may be yellow-tinged as a result of carotenemia. Cyanosis of the extremities is common, especially on exposure to cold temperature, as is lanugo, an increase in the fine hair on the body. The most common cardiovascular finding among anorexics is bradycardia; heartbeats as low as 25 beats per minute have been reported. However, there is no clear evidence that such a change predisposes a patient to malignant arrhythmias. Hypotension has been measured in up to 85% of hospitalized anorexic patients. Despite malnourishment, an anorexic woman is usually hyperactive and full of energy; lethargy is a worrisome finding because it is not usually present until the end stage of the illness and may reflect cardiovascular compromise (Herzog, 1992)".

Medical Complications of Anorexia Nervosa

Electrocardiographic Abnormalities – This is very common among low-weight individuals. These abnormalities include bradycardia, T wave inversions and ST segment depression. Of most concern are arrhythmias, including supra-ventricular premature beats, ventricular tachycardia with or without exercise and ventricular tachycardia following emetine (ipecac) use. It is rare to see a patient with Q-T intervals, but when present they can be life-threatening and may cause sudden death. All of these electrocardiographic abnormalities should revert to normal after weight gain. Hypotension and dizziness are also common. Clinicians must be aware of orthostatic hypotension, particularly in prescribing medication such as antidepressants.

Hematologic Changes – These would include pancytopenia, decreased neutrophils and anemia. Re-feeding will usually reverse these and sometimes iron supplements are necessary. The need for transfusion is rare.

Gastrointestinal Complications – Constipation and abdominal bloating are common. This is probably the result of delayed gastric emptying and slowed intestinal motility. Serum amylase levels and liver enzymes may be elevated. These abnormalities reverse with weight gain.

Renal Abnormalities – Increased blood urea nitrogen occurs as a result of dehydration. A decrease in renal concentrating capacity and abnormalities in vasopressin secretion can cause partial diabetes insipidus, resulting in polyuria. Dehydration also results in the formation of renal calculi. Hydration and weight gain will reverse all of these changes, although it may take longer for vasopressin secretion to return to normal.

Endocrine Abnormalities – Amenorrhea is characteristic of anorexia nervosa and sometimes occurs even before severe weight loss. Menses usually returns some time after weight gain. However, there are also many chronically underweight women who do not lose their menses. Testosterone levels decrease in males, which impairs reproductive capacity. Liver function becomes impaired, probably due to fatty degeneration from malnutrition (Bryant-Waugh and Lask).

Thyroid Abnormalities – Anorexics do not have primary hypothyroidism, however they may exhibit some of the clinical features of mile hypothyroidism. These include constipation, cold intolerance, bradycardia, dry skin and increased relaxation time of deep tendon reflexes. Thyroxine and thyrotropin levels are usually in the low-normal to normal range. The clinical signs mentioned are most likely due to a deficiency of triiodothyronine. These signs abate upon return to normal weight. Anorexics also demonstrate a lower basal metabolism. As explained earlier in this study, the body compensates for the reduced supply of calories by conserving its use of the body's energy.

Skeletal Abnormalities – Anorexic women are predisposed to osteoporosis. Bone density is decreased, which often leads to fractures of the vertebrae, sternum and long bones. This is related to the change in hormones which leads to amenorrhea and is normally seen in post-menopausal women. Return to normal weight does not insure an increase of bone density, and it is uncertain as to whether density levels normalize over a longer period of time. Bone growth may be permanently impeded in children and adolescents who restrict their food intake.

Cholesterol and Carotene – Interestingly, cholesterol levels are often elevated in anorexics, which is due to disturbed lipoprotein metabolism. Carotene levels are also elevated in many anorexics. Both reverse with weight gain.

Psychological and Sensorium Abnormalities – Biochemical changes may occur, which influence thinking, feeling and behavior. This includes disillusionment regarding actual body size. Anorexics become out of touch with bodily sensations, such as the inability to discern hunger from satiety. They also may experience heightened senses, with complaints of music being too loud, a feeling of being out of the body or psychic experience. The Minnesota study by Keys et al showed an increased incidence of depression, hysteria and hypochondriasis as a result of semi-starvation (Garner et al). Social isolation and decreased sexual interest were also apparent (Garner et al).

Cognitive Changes – The Minnesota study revealed impaired concentration, alertness, comprehension and judgment during the semi-starvation period (Garner et al).

Bulimia

Signs and symptoms

Bulimia can be difficult to detect because most bulimic individuals (those who only engage in binge-purge behavior and do not have prolonged periods of anorexic behavior) are of normal weight. There are few obvious signs which would lead one to suspect the presence of bulimia, as in anorexia. Certain complaints by a patient might lead a physician to further explore the existence of bingeing and purging. These are swelling of the hands and feet due to dehydration and rebound water retention, abdominal fullness, fatigue, headaches, swelling of the cheeks, dental problems, chest pain, constipation, rectal bleeding or fluid retention. These are fairly common and vague complaints. However, there are three characteristic symptoms of bulimia that are easily detected:

1. Russell's sign – skin changes over the dorsum of the hand, due to using the hand to stimulate the gag reflex.
2. Hypertrophy of the salivary glands, particularly the parotid glands. This is usually bilateral, painless and quite apparent.
3. Perimolysis, or dental enamel erosion, from the acidity of emesis.

Medical Complications

Fluid and Electrolyte Imbalance – Chronic self-induced vomiting causes hypokalemia (potassium deficit), hyponatremia (sodium deficit) and hypochloremic (chloride) alkalosis. Hypokalemia leads to muscle fatigue, weakness, numbness, arrhythmias, kidney damage and paralysis. Laxative abuse, though not an effective mechanism for true weight loss, also causes dehydration and electrolyte depletion, particularly of potassium bicarbonate, which leads to metabolic acidosis. Electrolyte imbalances may result in cardiac arrhythmias and sudden death (Garner et al).

Tissue Damage – Tissue damage from chronic vomiting is suggested by complaints of sore throat, abdominal pain, esophagitis and mild hematemesis. Esophageal tearing and bleeding are noted.

Cardiac Abnormalities – Emetine poising, from the use of ipecac to induce vomiting, can cause irreversible myocardial damage. Arrhythmias and the possibility of sudden death due to electrolyte disturbances.

Gastrointestinal Complications – Elevated serum amylase levels are common and reverse with cessation of vomiting. Reverse peristalsis can occur, where the stomach regurgitates spontaneously. Chronic laxative abuse impedes normal absorption and elimination by the digestive system, which leads to chronic constipation and loss of intestinal muscle tone. Hiatal hernias may occur.

Renal Abnormalities – As a result of dehydration, an increase in blood urea nitrogen occurs, as well as the propensity towards the development of renal calculi. These changes reverse with hydration.

Endocrine Abnormalities – Although amenorrhea is more common among anorexic women, one clinical study of normal weight bulimic women indicated that more than one-fourth of these patients had irregular menses or amenorrhea (Herzog, 1992). Infected or swollen salivary glands give the face a chipmunk-like appearance.

Dental Problems – Erosion of enamel occurs due to the hydrochloric acid content of vomitus. Also, gum disease, cavities and tooth loss are common.

Neurological Abnormalities – Abnormal electrical discharges in the brain have been found in some bulimic patients and is usually associated with electrolyte abnormalities. Epileptic seizures, muscle spasms (tetany) and tingling in the extremities (peripheral paraesthesia) have been reported (Garner et al).

Depression – This is the most frequent and debilitating consequence of bingeing, witnessed much more frequently in bulimic patients than anorexic patients. Bulimics continually feel like failures, thus the endless and frustrating cycle of binge-purge behavior. Depression is also a result of electrolyte imbalances. This can often be severe enough to lead to suicidal ideation.

CHAPTER SIX: MAKING THE DIAGNOSIS

The DSM-III-R criteria explained in Chapter One is the accepted guideline established by the American Medical Association for diagnosing eating disorders. In addition, various diagnostic tests have been developed. In general these diagnostic tests are viewed as having limited usefulness when employed exclusively (Bryant-Waugh and Lask, 1992). However, they can be helpful when used in conjunction with the structured assessment. A personal in-depth interview with the patient will provide important information necessary to formulate an appropriate treatment program. It also serves to establish rapport with the patient who may initially present with denial, distrust and resistance.

The following are some of diagnostic test available:

- ✓ Body Satisfaction Scale: Slade, Dewey and Ashcroft, 1986
- ✓ Body Shape Questionnaire: Cooper, Taylor, Cooper and Fairburn, 1987.
- ✓ Eating Attitudes Test (EAT): Garner, Olmstead, Bohr and Garfinkel, 1982.
- ✓ Children's Eating Attitude Test (ChEAT): Maloney, McGuire and Daniels, 1988.
- ✓ Eating Disorder Inventory (EDI): Garner, Olmstead and Polivy, 1983.
- ✓ Eating disorder Examination: Cooper and Fairburn, 1987.
- ✓ Clinical Eating Disorder Rating Instrument: Palmer, Christie, Cordle and Kenrick, 1987.
- ✓ Setting Conditions for Anorexia Nervosa Scale (SCANS): Slade and Dewey, 1986.

THE ASSESSMENT

Connars and Johnson feel that the first five minutes of the assessment interview are extremely important (Connars and Johnson, 1987). They recommend beginning the interview by asking how the person is feeling about coming for the consultation. It is important to assess whether the individual is there voluntarily or due to the coercion of family or friends. They may or may not be presenting with a

particular complaint about eating behavior. It may be some other distressing issue which actually brings them into therapy, such as feeling depressed and possibly even suicidal, having relationship difficulties, feeling stressed out or anxious. The patient may, in fact, be in denial about the extent of the eating disorder, and not see it as a problem at all. To the anorexic patient, her food related behavior may seem like the only part of her life which is under control and makes any sense. The bulimic patient may not see her eating behavior as a problem, but rather see herself as the problem; a failure, worthless, not good at anything, unable to achieve her goals, feeling taken advantage of by others, etc. It is up to the clinician to extract the proper diagnostic information, and then help the patient to admit there is a problem and agree to treatment.

The interviewer should ask if the patient has ever talked with anyone specifically about difficulties with food. Though the patient may present to the clinician acknowledging the eating disorder, she may never have exposed this to anyone else. Bulimics, in particular, are quite ashamed of their behavior and carry it on in secret as much as possible. Interestingly, though, more bulimic patients present for treatment than anorexics (Connars and Johnson, 1987). This is probably due to the fact that patients who restrict their diets feel in control and actually quite proud of their willpower and strength. They gain a sense of accomplishment from this that perhaps they don't receive anywhere else in their lives. Bulimics, however, feel quite out of control and panicky about their behavior. They want desperately to regain some control and will look for professional help in doing so. Anorexics, in general, are in much more denial and are quite resistant to treatment, often seeing nothing wrong with their eating habits.

If the patient has been in treatment before, the interviewer can ask what she found to be helpful and what was not helpful. Also, ask if the eating disorder was addressed at all.

Once these introductory questions are answered, the agenda for the consultation can be explained to the patient. The clinician explains that he/she has many questions to ask which may at times seem intrusive. However, the reason for asking so many questions is to quickly ascertain where the patient is in the course of the eating disorder and to make an appropriate treatment recommendation.

Connars and Johnson feel that the most important task of the first five minutes is to convey to the patient that the clinician is interested in a collaborative inquiry, rather than an inquisition into the patient's personal history which may have caused the development of her eating disorder.

Connars and Johnson recommended using a structured interview format, using specific questions which indicate to the patient that the clinician has an understanding of the particular issues and behaviors which accompany an eating disorder. The following is a list of their suggested questions.

Weight History

The objective of obtaining a weight history is to ascertain how weight preoccupations and fluctuations have affected the patient's self-esteem and life adjustment (Connars and Johnson, 1987). First, the clinician obtains the patient's current height, weight and ideal weight for metabolic functioning. It is advisable to investigate whether there are occupational considerations that affect the patient's attitude towards her body. For example, the fashion and entertainment industries generally place unrealistic

demands on a woman's appearance and thus the patient's self-esteem and livelihood are tied in together.

The interviewer then asks about the patient's highest and lowest past weights since the age of thirteen. If there are periods of significant weight fluctuations, the interviewer can explore potential correlations with stressful life events, such as family problems, losses or transitions. Having this information allows the therapist to work with the patient on identifying how she has learned to cope with stressful situations and then to learn new, healthier ways of dealing with life.

Next, inquire about how much attention the family and peers placed on thinness, dieting and appearance in childhood and adolescence. Ask about how the patient felt about her weight, given her family and peer group attitudes. Was she ever teased about her body, because of excessive weight or mature development? Who did the teasing or made comments, and how did this make the patient feel?

During periods of significant weight loss, what methods were used and how quickly did the patient lose? This is where the interviewer can determine whether the patient uses restriction as a means to control weight or bingeing and purging. It is also important to note whether amenorrhea ever developed as a result of weight loss and at what weight this occurred. This information helps the interviewer to establish what the minimal biologically acceptable weight is for the patient.

Body Image

The primary task of this phase of questioning is threefold; 1) to assess the level of body image distortion, 2) to uncover the psychological adaptation it may be serving and 3) to investigate the extent to which it interferes with life adjustment (Connars and Johnson). While the majority of women would admit that they are dissatisfied with their bodies, this dissatisfaction does not consume them as it does eating disorder patients. They are not completely obsessed and preoccupied with food and weight as an eating disorder patient, and this dissatisfaction does not interfere with the functioning of their overall life.

To obtain this information the interviewer can ask if the patient's self-consciousness about her body prevents her from doing various things, such as dating, becoming sexually involved, exercising or participating in activities which would expose the body.

At this point the patient's perception of her body size and her actual size can be compared to assess the level of distortion involved. If the perception is quite distorted, the interviewer can ask if others agree or disagree with the patient's assessment of her body. Patients who have a high level of distortion or delusional thought regarding their body will generally feel threatened by this line of inquiry and may react with hostile resistance. "Patient's who present with more delusional perceptions of their body size are often quite paranoid, have fragile and brittle intrapsychic resources, are treatment resistant and consequently have poorer outcomes (Connars and Johnson)."

Dieting Behavior

The primary purpose of this section is to assess the length of time the patient has dieted, why and whether there was a source of encouragement for dieting. It is significant to note if other family

members are diet or weight preoccupied. It is common for eating disorder patients to come from such families.

Early onset of dieting, and frequent dieting, are predictive of bulimic behavior among adolescents. Of significance here is how psychologically and physiologically deprived this patient is feeling. As discussed earlier in this study, feelings of deprivation, both psychological and physiological, lead to binge eating and subsequent purging.

It is important to assess the cognitive-behavioral attitudes that have developed around the patient's eating behavior. Does the patient think of certain foods as either "good" or "bad", and how does she feel when she eats "bad" foods? The interviewer can assess how much magical or superstitious thinking the patient has around food related behavior. This can be obtained by asking the patient to explain what calories are, how the body digests food, what the function of fat is and how fad diets work.

Scale Behavior and Exercise

Ritualistic behavior around body measurement and exercise are common among eating disorder patients. In this section the interviewer assesses how frequently the patient weights herself, how ritualized the behavior is and how fluctuations affect self-concept and daily activities.

It is also important to find out what has been the longest period of time during the past six months that the patient has abstained from weighing or measuring herself. Investigate the events that correlate with this period of time, and have they reoccurred with the same resultant behavior change.

Exercise, though healthy and appropriate for most people, is often a highly ritualized and obsessional activity for those with an eating disorder. The interviewer wants to assess what adaptive function the exercise serves. A good way to find this out is by asking the patient how she feels when unable to exercise. Exercise can serve a variety of purposes for the eating disorder patient, for example, to regulate such emotionally tense states as anger, anxiety or depression, particularly since many of these patients have found it difficult to express their true emotions within their family of origin. Another adaptive function of exercise is seen in its use as a self-punishment mechanism when having "lost control" of her eating, or it can also be seen as a narcissistic attention seeking behavior for the ability to perform in a manner high above the average person.

Adaptive Significance of Binge Eating

This phase involves looking at the binge eating behavior on two different levels, the Macro-assessment and the Micro-assessment (Connars and Johnson). First, with the Macro-assessment, the interviewer is interested in a general picture about when the binge eating behavior began, what circumstances were surrounding it and have fluctuations in her pattern of eating correlated with particular life events, such as bingeing during times of increased stress and abstinence during more emotionally stable times. Inquire as to the longest period of abstinence from the behavior, what were her life circumstances during this period of time and what was her emotional response to this symptom-free period. It is important to ask if the patient's binge eating behavior is exacerbated by her menstrual cycle.

The Micro-assessment focuses on very detailed information about the patient's daily routines. It is helpful to give the patient a diary to note what foods were eaten, when she ate, describe binge episodes, what events might have preceded her binge and the emotions she was feeling at the time. It is also helpful to have the patients describe in detail what she ate that she considers a reasonable meal and what she ate that she considers a binge. Because of the distortion around food, eating disorder patients often interpret any consumption of food as a binge, or total loss of control.

Phenomenological Experience

The goal of this phase is to determine what type of tension state they are attempting to regulate through the behavior around food. This is unique for each patient. It has been found that the act of bingeing and purging serves a variety of functions for patients, such as affect regulation, impulse expression, self-nurturance, oppositionality and self-punishment (Connars and Johnson).

Purging Behavior

As with bingeing, the interviewer wants to investigate the onset, precipitants, duration, frequency and method of purging behavior. The interviewer may be direct and ask if the patient does in fact purge, and what method she uses. Ask detailed questions about how often the patient purges; is it after every meal, just after a binge, associated with a particular life circumstance such a job stress, or a particular emotion such as low self-esteem and what was happening just prior to the purge. As with binge behavior, it is important to inquire about the longest period of abstinence the patient has experienced, what were the significant life events, how did the patient feel about the abstinence, did it simultaneously affect her bingeing and what successful methods did she use to abstain.

Personality Features

Many bulimics have difficulty with interoceptive awareness, or the ability to identify and articulate internal states. The degree of deficit in this area can be assessed by observing how quickly and precisely patients are able to talk about their feelings. In making this assessment it is important to distinguish between patients who are reluctant to express their feelings from those who do not know what they are feeling.

Affective instability is also common among bulimics. They often present with symptoms that are characteristic of agitated depression, anxiety disorder or panic states. These patients will complain of mood variability, recurrent anxiety, irritability, restlessness, boredom, difficulty falling asleep, short attention span and low frustration tolerance. Their anxious driven feelings often result in impulsive behavior (Connars and Johnson).

Though the majority of patients present with the above profile, there is a small group that present with symptoms of vegetative depression; low mood, persistent fatigue and lethargy, difficulty awakening and rising in the morning, frequent crying episodes and lack of motivation are common symptoms among this group (Connars and Johnson). As opposed to the larger population of bulimic patients whose

behavior is highly impulsive, this group will plan a binge and looks forward to it, for the comfort it offers (Connars and Johnson).

Experience of Self and Others

This phone of the interview questioning should give the clinician information about how the patient views herself and others and how these perceptions will affect her ability to engage in a therapeutic relationship (Connars and Johnson).

When asked how others see her and how she sees herself, the eating disorder patient will generally report a favorable and even above average opinion from others, as opposed to highly inadequate from the patient's point of view. This indicates a false self organization. These patients will generally display perceptions reflective of a low self-esteem. Feelings of inadequacy, worthlessness, ineffectiveness, self-criticalness, shame and guilt are quite characteristic.

As to how eating disorder patients view the world in relation to them, many see others as malevolent beings who are intrusive, manipulative, exploitive, abusive, destructive, dangerous and unreliable. Naturally, this type of patient would have difficulty establishing a trusting therapeutic relationship.

There are also those eating disorder patients who view others as caring and loving, generally coupled with their own sense of not deserving this type of attention from others, presenting a therapeutic alliance problem of a different nature.

Bulimics are usually so sensitive to the reactions and opinions of others that they will sensor their own feeling and responses rather than risk anger, rejection or ridicule. This can result in social avoidance and reclusive behavior. Or, remaining in dissatisfying relationships rather than risk assertiveness.

Cognitive Style and Defensive Adaptations

During the course of the assessment interview, the interviewer will be analyzing the patient's cognitive style. Is the patient concrete in her thinking? Is she obsessive or impulsive in her responses? Does she have the capacity for introspective thought? Does she have the ability to de-center from herself and view herself in a broader perspective (Connars and Johnson)?

In addition to the patient's cognitive style, her defense mechanism should be assessed in order to plan a therapeutic strategy. The following are defensive characteristics common to eating disorder patients:

> **Denial** – Can the patient acknowledge that there is a problem? Patients in complete denial are usually in treatment involuntarily and are at risk for non-compliance and termination.
>
> **Avoidance of affect** – Patients who are either frightened of various affects, or who have difficulty showing affect will use such strategies as suppression, repression, dissociation, distraction, splitting and intellectualization.

Projection – An individual uncomfortable with her own thoughts and feelings will illicit thoughts and feelings in another that resemble her own. For example, if a patient is feeling anger, but is uncomfortable with that emotion, she will provoke an angry response in the therapist.

Opposition – Does the patient demonstrate a need to undo, resist or customize her treatment? This is indicative of her need to feel in control.

Patients will generally present as one of two different cognitive/defensive styles, either paranoid or hysterical. The predominantly paranoid-obsessive style will display suspiciousness, hypervigilance to details, rumination, phobic concerns, projection and distancing. Patients with hysterical styles, are diffuse, impulsive, frantic, form quick attachments and are idealistic. Understanding these differences will help the clinician to plan an effective style and structure of treatment.

Family Characteristics

The patient's behavior may e serving some type of adaptive function within the family system, and that will need to be explored in order to help the patient to recognize the dynamic, as well as to change her behavior to a more healthy coping strategy. Also, the style of communication within the family will need to be assessed in order to implement the most appropriate and effective treatment approach. Patients from disengaged and chaotic families would benefit from an active and direct approach in therapy. On the other hand, patients from enmeshed and overprotective families would respond better to a less active style of therapy.

The following family dynamics should be explored:

Cohesiveness – The quantity and quality of involvement within in a family may be unhealthy. There may be either under- or over-involvement, which would both result in self-regulatory deficits. It is important to explore family boundaries, which refer to the rules that govern interpersonal issues, such as distance versus intimacy and autonomy versus symbiosis. A balance between these issues would be healthy.

In families of eating disorder patients, boundaries may be either weak or disengaged. In a family with weak boundaries there would be enmeshment, with extreme closeness and intensity in the family interaction and a high degree of over-protectiveness. This would cause the patient to have difficulty with self-regulation when separated from her family, since she would be used to family members regulating her behavior. She would also have poor ego differentiation, since she is accustomed to being defined by her role within the family. The food related behavior is often an attempt to regulate behavior in the absence of the family, or the external control.

The disengaged family is the opposite of the enmeshed family in their communication dynamic. These families have boundaries which are over-defined, rigid and insensitive to individual need. These patients feel disconnected from family members and lack meaningful involvement with others. These eating disorder patients are forced to develop autonomy prematurely and are often withdrawn. The self-regulatory deficits these patients develop are as a result of under-involvement from the family. In

the absence of external controls, these individuals make unhealthy attempts at establishing a sense of control by their behavior with food.

Communication Style – It is important to explore how the family exchanges information. There are three characteristic communication problems within families of eating disorder patients:

1. Disqualification and disconfirmation – the family conveys to the patient that her thoughts and feelings are inaccurate or not valued. Parents become almost god-like and their ability to control the patient's behavior through the idea that they have the only correct thoughts and feelings.
2. Incongruence and shifting of focus – narcissistic communication styles from the parents which result in the child withdrawing from efforts to communicate because it is an empty and disorganizing experience.
3. Double-binding – the child is given mutually exclusive messages, "This is okay for him but not for you". The result is anxious conflict and feelings of being trapped, paralyzed and hopeless (Connars and Johnson).

Conflict Resolution – It is important to assess how the family style of conflict resolution has affected the patient's freedom to express conflict, and whether the individual has had the opportunity within the family to deal with conflict when it arises. Very often, families of eating disorder patients deny conflict in an effort to maintain a pseudo-homeostasis within the family system. The patient may even have been attacked, criticized or rejected for expressing conflict. This results in patients feeling intimidated or nonassertive and they attempt to resolve these conflicts through food-related behavior.

Behavior Control – The family's method for rewarding or punishing behavior is important to examine. A healthy system would clearly state the rules and the punishment would be an appropriate and logical consequence of an infringement. However, the dysfunctional families of many eating disorder patients often demonstrate a system of rigidly enforced rules, which would contribute to the development of all-or-none thinking, and where the punishment is inappropriate for the behavior. An opposite and equally dysfunctional system would be absent or chaotic rules. This leaves the patient feeling abandoned, confused and needing to implement her own sense of control through food related behavior.

Does the family have normal and sensitive expectations, or are they unrealistic and self-seeking? Does the family reward positive behavior and high performance, which would foster self-esteem, or do they constantly criticize and ask for more and better levels of performance?

Roles – In a dysfunctional family each member has a role that fortifies and supports the family dynamic and the role of all the other members. It is important to assess the roles of each family member, and particularly the patient in regards to her food related behavior.

Do her "sickness and frailty" allow her middle-aged parents to hang onto her and thus not have to experience their own mid-life issues? Does the patient's thin figure give the parents a sense of gratification and achievement, when they may feel insecure about their own opportunities and success? Does the "sick" individual unite distanced parents around her illness?

The patient wields a lot of power in her role, and subconsciously knows that. Changing her role to a healthy one means she forces her family to face their own issues, and risk the crumbling of the family structure.

Capacity to Have Fun – Does the patient have any hobbies or activities she engages in regularly? Does she socialize? Or is she so driven to achieve, or simply get things done, that she can't take time out to have fun? If the patient is so hard on herself that she does not allow for fun in her life, or if she has isolated herself due to low self-esteem, bingeing may be her only outlet for non-performance related behavior.

Isolation may also be a barometer for how a patient's eating behavior has taken over her life. The bulimic patient will feel so much shame around her behavior that she often cuts off social interaction. The anorexic may have difficulty socializing since many events center around food.

Priorities and Willingness to Change – It is important to explore with the patient her goals and what is important to her. The patient may either recite what she considers to be socially appropriate goals, or she may be at a complete loss, being so out of touch with her own needs and feelings. Weight and appearance may indeed come up as the most important issues to the patient. A confrontive, yet realistic question is, "Would you be willing to gain ten pounds in exchange for giving up your behavior towards food?". The answer to this question may largely depend on how the behavior has affected the patient's life. Is she depressed, isolated, feeling terrible about herself, unable to engage in social activities due to low self-esteem? Or has her more slender body helped her to achieve career and social success she didn't have when she was heavier? If the latter is true, treatment will be more difficult. This patient may have experienced size discrimination prior to her eating disorder. It will be difficult to help her find reasons to give it up. She will be terrified to give u the behavior which she feels has gained her so much.

Motivation – If the patient is seriously debilitated by depression she may need to be treated with antidepressants before any progress can be made. Bulimic patients in particular are often paralyzed by their feelings of hopelessness, as they have seen how little control they have over their behavior. Without some motivation, treatment will not succeed. Though the patient may not have the capacity for motivation initially, it is part of the function of the interviewer in this preliminary assessment to impart a sense of hope to the patient. The interviewer can have a great influence on the patient's motivation to continue into treatment. Thus, the time taken to thoroughly and compassionately assess the patient gives the individual a sense that someone understands her problem, knows what to do about it and that help is available. This can give the patient a sense of hope when she feels at a loss to help herself.

Medical Issues

A medical examination should always be done prior to implementing a treatment program. It is important to assess whether any medical conditions existed prior to the onset of the eating disorder which may be precipitating factors, as well as treating the medical complications that have developed from the food-related behavior.

Lab tests should include a complete blood count (CBC), liver function, electrolytes, BUN, and glucose, calcium, phosphorous and magnesium levels. An EKG is recommended, and with some anorexics, a neurological assessment. A thorough cardiac assessment is suggested for patients who misuse ipecac. A urine sample may be obtained to detect diuretic and laxative use.

Personal Adjustment Issues

Life Adjustment – How has the eating behavior affected the patient's life, in regards to work, relationships and activities? How unmanageable has the patient's life become? Did the behavior originally yield positive results, and now become negative? What is the overall quality of the patient's life?

Capacity To Be Alone – Most bulimics have difficulty with unstructured alone time. The evening is the most common time for bingeing. During the day when the patient has outside influences, such as school or work to help her feel in control, she is able to abstain from bingeing. However, the unstructured alone time is the evening causes these patients to feel lost, abandoned and even panicky. The binge can be felt as soothing, nurturing, with the resultant purge as a release of pent up tension.

For patients who are obsessive and highly achievement oriented, unstructured alone time only serves as a void for rumination about things undone, and pressure to accomplish more and more in this "free time". This is the classic "woman who does too much". These individuals either exhaust themselves with endless chores that can never wait, or exhaust themselves by thinking about them, and berating themselves for not getting more done. A binge is a distracting activity for these compulsive individuals.

CHAPTER SEVEN: TREATMENT

The treatment of eating disorder patients is multifaceted and complex. Each patient must be viewed as an individual, with her own combination of precipitating factors based on information obtained from the assessment interview and adjunctive diagnostic tests, if used. An eating disorder is a psychological disturbance, yet one that causes extensive physiological problems. Both must be treated. And if the physical problems are debilitating, they must be the primary focus before psychotherapy can be effective.

A decade or two ago, many inpatient programs were developed to specifically treat eating disorders. However, very few still remain, primarily due to the lack of reimbursement by insurance companies. For this reason, it is important to manage the treatment program as much as possible on an outpatient basis. Inpatient treatment now would mean admission to a general psychiatric unit, or possibly a medical unit if treatment involved re-feeding by nasogastric tube or IV.

A cognitive-behavioral approach to therapy appears to produce the best results (Garfinkel and Kennedy, 1992). While the patient is beginning to understand the reasons for her behavior, she must also be changing the behavior, replacing it with more appropriate and effective methods. Many studies support this approach with documented improvements. The literature on cognitive-behavioral treatment up to 1985 estimates that 40% of patients were no longer bingeing by the end of treatment, 30% had a

reduction in symptoms of at least 50% and the remaining 30% showed little improvement (Garfinkel and Kennedy, 1992).

Studies of the benefits of interpersonal therapy indicate similar success rates. Many therapists chose a combination of cognitive-behavioral and interpersonal psychotherapy approaches. Group therapy is also seen as beneficial for treating bulimic patients (Garfinkel and Kennedy, 1992: Herzog, 1992). And family therapy would be important for the patient who lives with her family of origin.

Group therapy may not be as helpful for the anorexic patient as the bulimic patient. The competitive and perfectionistic qualities of anorexic patients often lead them to compete for thinness or severity of symptoms in a group environment. The bulimic patient, however, often feels relieved to see that other people have the same problem, and thus the group provides a more positive support mechanism.

The various elements of a cognitive-behavioral treatment approach are outlined below.

COGNITIVE-BEHAVIORAL TREATMENT

Goal Weight

Insurance company tables for normal weight should be avoided in this process. They do not take into consideration realistic variations in individual body types, based on genetics, activity level and overall health and well-being. As stated earlier, thinness is a national obsession, and in establishing a goal weight for a patient, the patient must be assisted to steer away from this cultural pressure. Rather than establishing an exact weight, it is recommended to assist the patient to find the weight at which she is comfortable and which does not require chronic dieting to maintain. According to set point theory, patients will probably initially gain more weight than they will actually keep, before their weight settles at a level where the body is comfortable and operating at optimum health.

This idea terrifies most eating disorder patients, who will often say that they would rather die than to gain weight. It is important to inform the bulimic patient, who is frequently sabotaging her efforts to lose weight by her binge-purge behavior, that upon resumption of normal eating she may even settle at a lower weight because of the metabolic paradoxes mentioned earlier in this study. This is a very difficult concept for patients to accept. Any success stories or examples from a patient population would be helpful to establish trust in this idea.

The patient should be discouraged from weighing herself at home. Patients with an eating disorder will often weigh themselves several times a day, and adjust their eating and exercise accordingly. If it is a necessary part of the treatment plan to monitor weight, or if the patient insists that she continue to weigh herself, it is best handled by the therapist, on a once a week basis (Garner et al, 1985). Patients may even be encouraged to give their scale to the therapist. This way any anxieties that arise over weight gain can be dealt with in the therapy session.

Normal Eating

It is imperative to help the patient establish a pattern of normal eating. Many patients who have been dieting since puberty have no idea what this is. Ellyn Satter (1987) describes normal eating as follows:

> Normal eating is being able to eat when you are hungry and continue eating until you are satisfied. It is being able to choose food you like and eat it and truly get enough of it – not just stop eating because you think you should. Normal eating is being able to use some moderate constraint in your food selection to get the right food, but not being so restrictive that you miss out on pleasurable foods. Normal eating is giving yourself permission to eat sometimes because you are happy, sad or bored, or just because it feels good. Normal eating is three meals a day, most of the time, but it can also be choosing to munch along. It is leaving some cookies on the plate because you know you can have some again tomorrow, or it is eating more now because they taste so wonderful when they are fresh. Normal eating is overeating at times: feeling stuffed and uncomfortable. It is also under-eating at times and wishing you had more. Normal eating is trusting your body to make up for your mistakes in eating. Normal eating takes up some of your time and attention, but keeps its place as only one important area of your life.

In short, normal eating is flexible. It varies in response to your emotions, your schedule, your hunger and your proximity to food.

The key to normal eating is flexibility (Satter, 1987). An important part of therapy is to help the patient to become more in touch with her internal signals. Eating disorder patients have lost the ability to assess hunger and satiety. If the patient begins to listen to her body's messages regarding when and what and how much it wants to eat, food will be eaten in normal and varying amounts, not gross amounts as the eating disorder patient would suspect. Because this individual has denied herself for so long, she is terrified of responding to her body's cravings because that could mean losing total control and eating monstrous amounts of food. She needs to learn, and come to believe through her experience, that she can trust her own body to know when to stop and it is satisfied. And the more she responds to her body's needs, the more easily it becomes satisfied with smaller amounts of food.

All foods are permissible. There is no such thing as a bad food. The patient does not necessarily need to sit down to a meal including the proper amounts of the four food groups. She need only eat what she feels like, when she feels like it. Amazingly, the cravings and bingeing will cease when she gives herself this permission. Food ceases to be the focus of her day, as it was when she was depriving herself.

Exercise

Exercise is an important part of treatment, but will need to be redefined. The anorexic who is accustomed to overly vigorous compulsive exercise will need to be discouraged from continuing this pace during treatment, since it will be important for her to gain weight. However, a minimal amount of body movement is beneficial. Exercise allows the new weight to be more evenly distributed, thus preventing the patient from panicking over her changed body. Minimal exercise such as stretching and walking are good initially. When the patient shows a good pattern of weight gain, a somewhat more

vigorous exercise in permissible. This should be something enjoyable, not a cardio workout or maximum fat burning as in aerobics. A redefinition of physical exercise and sports for pleasure should be emphasized. Likewise, bulimic patients should be encouraged to become more in touch with their body through some type of movement and physical exercise for the sake of pleasure.

Pleasurable physical activity is beneficial for reducing stress, allowing oneself free time, improving strength and self-esteem, socializing and overall good health. It needs to be reframed in this manner and away from the compulsive weight loss, fat burning focus which has become so popular.

Abstinence Verses Non-abstinence

There are different schools of thought on this subject. Most professionals agree that the patient must be made aware that to continue the dieting, bingeing and purging behavior are incongruous with recovery. They should be encouraged to abstain. However, relapses will occur and when they do the therapist must help the patient to deal with her feelings of guilt, shame and failure so that she can continue in treatment and not completely give way to her food behavior again. It is always good to remember the all-or-none thinking of these patients and not to reinforce this through a too rigid requirement to abstain. The therapist can help the patient to learn that life for most people includes this kind of up and down from day to day, and that it can be survived and is okay. Reinforce the idea that normal eating sometimes means eating more than you really need and that's okay. Each day is a new beginning and not a failure.

Insisting on abstinence as a prerequisite for treatment would prevent most eating disorder patients from ever getting the help they need. And it would be applying the same type of rigidity towards their eating behavior that they already employ.

Prevention of Bingeing and Purging

It has been found that patients tend to binge eat often as a result of depression, anxiety or stress. However, this has been found an unlikely response in non-dieting individuals. The patient's craving for certain foods and the resultant binge are a natural outcome of her feeling deprived through rigorous dieting. And because eating disorder patients have not learned how to handle stress in more positive, outcomes-oriented ways, filling themselves up with "forbidden" foods is a temporary comforting measure.

Therefore, two important areas of focus in the pre-binge state are: 1) to help the patient give up dieting and establish a normal eating pattern, and 2) to help her to learn to deal with stress in a more positive manner, which will be discussed under psychotherapy.

The patient will, at first, require much assistance in establishing a normal pattern of eating. Allowing the patient too much freedom initially is dangerous as it will increase her stress and confusion and the patient is likely to relapse. Certain methods can be employed to help the patient begin to understand what normal eating is, and this can then be reviewed in each session with the therapist. In a hospital setting, re-establishment of normal eating can happen rather quickly because of the daily, and

sometimes meal-by-meal, therapy the patient receives. On an outpatient basis the progress will be slower, but the outcome still achievable.

Meal planning – Meal planning involves building some structure into the patient's pattern of eating. This will involve quantity and quality of food, as well as appropriate spacing of meals throughout the day. The therapist can help the patient establish a normal diet. This may seem as rigid as the anorexic's starvation routine, however this kind of structure is necessary initially for these patients who have gotten completely out of touch with their body's signals, and will not know how to develop a normal diet. The goal is that eventually this becomes a process that the patient regulates based on her own body's needs and signals.

The amount of calories prescribed will depend upon the patient's weight, metabolic conditions and the patient's tolerance for change. The important thing is that it be consistent. The number of calories can be adjusted weekly to promote a gain of approximately one to two pounds per week (Garner et al). The therapist may want to use instead of calorie counting, the basic four food groups as a guide, or even the size of the meal so that she begins to develop a sense of what a normal meal looks like. The important thing is that the patient feels satisfied and not hungry. The urge to binge is far less compelling if an adequate amount of all kinds of food can legitimately be consumed on a daily basis. And to reiterate an earlier point, the patients who are used to starving, bingeing and purging will be surprised to find that they gain little or no weight as a result of normal eating.

The patient should be encouraged to incorporate small amounts of her "forbidden" foods into her daily diet, and that this does not indicate a "blown diet" or out on control behavior. By making these foods a part of her normal diet, the stigma of good or bad foods is dropped, and likewise the emotional attachment to them. Individuals who feel they can have cookies any time they want will rarely binge on the entire bag. Connars and Johnson state that "the best defense against binge eating is to eat".

Meal planning also involves putting thought into a meal and preparing and eating it with care, rather than rushing in the door from work and quickly grabbing something to binge on. A suggestion is to prepare a meal with different courses, set the table beautifully, even if the patient lives alone, light candles, put on music and focus on the meal so that it can be fully enjoyed, rather than distracting with T.V.. Turn meals into a process rather than a quick fix.

Meal spacing is an important concept to teach the patient. Most anorexic and bulimic patients tend to starve themselves all day in hopes of successfully making it through the day without eating. The result is that by evening their hunger is all-consuming during the most unstructured time of the day. It is easy for eating to become out of control under these conditions. The patient should be encouraged to eat three to four times per day (Garner et al). In the beginning this may seem rigid to the patient, but eventually she will learn when she is hungry and needs to eat, and self-regulation will let the individual know when and what to eat.

Naturally the patient will be overwhelmed by this initially. She will fear gaining an inordinate amount of weight. However, once again, refer to the body's amazing metabolic adjustments. Consuming more calories spread evenly throughout the day actually results in a higher metabolism. Garner et al state that "more calories are burned by frequent stoking of the furnace with fuel".

Record keeping – Keeping a written diary of meals is a good way for the patient to visibly see what a normal diet might consist of, as well as to record the situations and emotions that surround her eating. These tools allow the patient to write what might have provoked a negative eating behavior, or even how she feels about eating a normal meal. Is it frightening, rewarding, shameful or liberating? How did the patient feel before, during and after a meal? This provides a good forum for discussion at weekly sessions with the therapist. This provides the fuel for the psychotherapy sessions which will help the patient to begin to understand her behavior and make necessary changes.

Interruption at the pre-binge stage – A result of the self-monitoring mentioned above is that the patient will begin to identify the situations which increase her pressure to binge. Certain strategies can be employed to help break the cycle at this point. They are distraction, delay and parroting, or affirmations.

Bingeing and purging are impulsive behaviors. If the patient can at first distract herself from the situation for a few moments, she has a chance of over-riding the impulse and learning new ways to cope with stress. This distraction must be pleasurable and may need only last a few moments to be effective. Going for a walk, phoning a friend or putting on loud music and dancing around the room are possible suggestions.

Delay is another helpful method to break the cycle. The patient can tell herself she can only binge after she reads three pages of a novel, hits the tennis ball against the garage door for fifteen minutes or some other measured activity. The patient may find that delaying the impulse gets rid of it altogether. Both distractions and delays should be planned beforehand with the therapist, and even written down so that the patient can easily refer to them when the impulse strikes. The impulse to binge can be so strong that patients are unable to think about anything else at the time.

Parroting phrases, or affirmations, should also be written down and recited by the patient to herself on a daily basis and especially when the impulse to binge or purge arises. Examples of affirmations are "I can eat any food I like, any time I like and not gain weight", "I am a valuable person and I treat my body well". The therapist will need to help the patient develop phrases that are meaningful to her, as she will be at loss to create such positive statements about her body or food.

Identifying Mood States

After the patient has kept her food diary for awhile and practiced delaying the impulse to binge and purge, she will begin to be able to identify her emotions more easily. Previously, the food-related behavior would defuse the emotions before they could even be examined, and the emotions would be turned into feelings about her eating behavior or her body instead. The eating behavior prevented the patient from dealing with any real issues. Now the patient has an opportunity to identify her emotional

states, to recognize what her true needs are and to find ways to satisfy them or work through them in a healthy way. Is she lonely, angry, hurt, anxious? About what, whom? What can she do to actually change the situation, or to effectively relieve the feelings? Call a friend, punch a pillow, take a bubble bath, go for a long walk? This will be a painfully demanding task for these patients who have successfully avoided dealing with uncomfortable emotional states through food related behavior.

There are certain recurring emotional themes that make patients particularly vulnerable to bingeing:

Anger – This is an emotion that bulimic patients have particular difficulty with. They are extremely fearful of losing control and also fearful of the consequences of expressing this emotion. Such responses as disapproval, rejection or retaliation from others are terrifying. Thus the patient stuffs the feelings with food, and ends up feeling angry at herself for her bingeing, thus diffusing her real emotions. These patients have learned to be self-abdicating, and thus require assistance to change their behavior to one of acceptance for their angry feelings, recognizing these feelings as a signal that something is wrong and learning to assertively deal with the problem. The self-esteem gained from this helps a great deal in the prevention of bingeing behavior.

Perfectionism/Pressure to accomplish – Many eating disorder patients have difficulty with alone time because of a constant nagging need to accomplish things. Left alone with their own thoughts they will come up with a thousand projects that need to be done. This pressure is so great that bingeing is often the only escape they have from a perceived "duty", and in that it provides relief. The therapist can help the patient by giving her permission to be lazy, perhaps to take 30 minutes per day where she does absolutely nothing useful or redeeming in any way – watch a silly T.V. show, take a nap, lie in the sun, anything that is not an accomplishment and gives the patient a break from responsibility.

Self-nurturance – Because of the above mentioned pressure towards responsibility, eating disorder patients often feel empty and drained. Food may be the only means by which they feel nurtured. Taken in an impulsive way, they later feel guilty about it because they have so much difficulty actually giving to themselves. These patients have learned that it is selfish to indulge in their own needs. The therapist can help the patient to find ways to indulge herself, in small ways at first so that she can become comfortable with this practice. Such things as buying herself flowers, getting a manicure and eventually even working up to something as indulgent as a massage are all ways the patient can begin to give to herself so that food is not her only source of nurturance.

Problem solving – The perfectionistic and obsessive qualities of eating disorder patients can make the activity of problem solving so overwhelming that the patient becomes immobilized in her procrastination and indecisiveness. Her all-or-none thinking leads her to believe that unless she makes the "right" decision, catastrophe will follow. Hence, a binge, to avoid this most difficult of tasks. The therapist can help the patient learn basic problem-solving skills, such as making a list of pros and cons, identifying what the patient wants versus what she perceives others want and to understand that most decisions are not irrevocable, but can be revisited if the outcome is not satisfactory. And, there are no "mistakes' in making a decision based on information at the time. Life is static, not stagnant, situations change and so can the decisions which affect them.

Absence of social support – Many eating disorder patients will state they feel lonely; however, it is often self-created. So conscious of the opinions of others, they will not divulge true feelings to others and will avoid people when they feel depressed or hurt, the times when friends are needed most.

Once again they turn to food as their sole support. Again, the patient must be reminded that feelings are okay, nobody is perfect, everyone has problems and that's what true friends are for, to be there no matter what. The patient can be encouraged to risk this kind of disclosure on an emotional state or situation that is not a particularly sensitive matter. She can assess the response of the person she shared with to see if they might be able to tolerate more important issues at another time. She will be able to see that she did not crumble from the experience, and she will also begin to know which friends can be taken into confidence, and which friends are purely social.

Breaking the Post binge Cycle

It is the patient's compulsive all-or-none thinking that will keep her trapped in the vicious binge-purge cycle. Recovery from an eating disorder is not a linear event, i.e. once the patient starts therapy she will never binge again. There will be many relapses, many stops and starts and gradually there will be many more symptom-free days than days of bingeing and purging.

When the patient does relapse and experiences a binge, she can still at this point avoid the addictive cycle. Unfortunately, the kind of thinking she has about this experience can send her spiraling further and further along in the behavior. Common reactions to a relapse are, "I've blown it, I might as well keep bingeing all day", or "Now I'm not going to eat for another three days", or "I'll vomit and take twenty laxatives and run five miles", or any other combination of self-defeating behaviors. Hopelessness and shame are common emotions that can be debilitating.

Instead of falling victim to this entrapping cycle, the patient should continue the next meal exactly as planned. Once again, this is the greatest insurance against a future binge. It breaks the cycle. The patient will soon discover that disaster has not befallen her because she binged, and eventually her ability to self-regulate will eliminate the need to binge.

As with preventing the binge, similar techniques can be employed in the postbinge state to prevent purging. Distraction, delaying the purge by 45 minutes and talking to a supportive friend can often diffuse the need to purge.

When a relapse occurs the therapist can help the patient to learn from the experience by identifying the precipitant and discuss ways that it might better have been dealt with. The patient is also to be given credit for her binge-free period, and help her to note progress during this time when she will see nothing but hopelessness and despair.

Setting Behavioral Goals

Patients will need help in establishing goals that are meaningful, but at the same time not so unrealistic as to insure failure. In characteristic perfectionism a patient might say her goal is to abstain from bingeing for one week. In the initial phase of treatment this is a difficult task and a blow to the patient's self-esteem if not met. Perhaps a goal such as eating one normal meal per day is a reasonable first step, one that has a good chance of providing success and thus increasing the patient's sense of self-mastery. The therapist must help the patient to acknowledge any small success, as the patient will minimize these, not seeing them as enough progress made. The patient's all-or-none thinking can sabotage her goals if she is not supported and encouraged along the way through each small achievement.

Psychotherapy

An important task for the anorexic in psychotherapy is to discover a sense of self, a true identity separate from that which is dictated by her parents. Clinical staff should avoid "interpretations" of the patient's feelings, which reinforce her sense of inadequacy and dependence. Psychoanalytic interpretation mimics her home environment, where family members speak for other family members, interpreting and invalidating one another's thoughts and feelings.

In psychotherapy the patient should be allowed to uncover her abilities and resources for thinking, feeling and acting. She must learn that she does not need to be perfect and always pleasing others, but that she can take control of her own life and begin to do what she wants.

Involving the patient as much as possible in her treatment is a way of letting her feel she has some control. She can identify her goals for treatment and monitor her progress.

Since particular incidents can send a bulimic patient right into a binge, the therapist must assist her in identifying her "red flag" issues, and developing more positive problem-solving strategies. These red flags can be people or situations which make her feel rejected, defeated or incompetent.

Like anorexics, the bulimic patient must learn to better communicate her needs and to stop accommodating others. She must learn to be assertive and to appropriately express anger. She must be confronted each time she interprets what she thinks others are thinking of her. Since bulimics tend to focus on past failures or future tragedies, it is imperative to help them focus on the present, the reality at hand and how to deal with it.

The bulimic needs to learn it is all right not to be perfect. In goal-setting she should avoid setting herself up for failure with goals such as "I'll never binge again". Something like "I will try today to ask for help if I need it", or "I will do my best today to talk in group", are more likely to provide her with success. She must learn to reward herself for any small success, rather than berate herself for not meeting goals. Goals should reflect a commitment to trying, not to perfection.

The bulimic woman needs to redefine the feminine role from one of total abdication to others, particularly men, to one of strength, independence and capability. In a group setting the therapist can promote a strong sense of "sisterhood" among the members, thus increasing self-esteem as women.

Since the bulimic tends to use binge-purge behavior as a way to avoid anxiety and pain, the therapist can help her learn to use painful thoughts and feelings as a catalyst for growth and change.

Pharmacotherapy

Controlled trials of antidepressants have found a significant reduction in the frequency of behaviors associated with bulimia (Garfinkel and Kennedy, 1992). Interestingly, these medications have appeared to be as effective in treating bulimic patients who are non-depressed as well as those who are depressed. For this reason, it is proposed that the mechanism of action may not be antidepressant, but instead may affect the neurotransmitters, such as serotonin and norepinephrine, involved in the regulation of eating (Garfinkel and Kennedy).

In the treatment of anorexia nervosa, antidepressants, antipsychotics and antianxiety medications may be used. The benefits of these pharmacological agents are not as well documented as for bulimia (Garfinkel and Kennedy).

When Hospitalization is Necessary

In many cases anorexics and bulimics can be treated as outpatients. However, if the illness becomes debilitating, either emotionally or physically, the person must be hospitalized. The following are criteria for inpatient treatment:

- **Significant weight loss**
- **Metabolic abnormalities, especially hypokalemic alkalosis from bulimic complications**
- **Lowered mood; thoughts or intents of suicide**
- **Non-responsiveness to outpatient treatment**
- **Demoralized, nonfunctioning family (for the patient living with family of origin)**
- **Lack of outpatient facilities (Brownell, 1986)**

Before psychotherapeutic methods can be employed, it is first necessary to bring the patient's weight up to where normal psychological functioning can take place. In severe cachectic conditions, the body is in a toxic state which maintains an abnormal mental status.

The critical weight level is related to the height and body build of the patient and is generally felt to be around 90 to 95 pounds (Bruch, 1978). In extreme cachexia, bed rest may be required, along with intravenous fluid therapy, nasogastric tube feedings or hyperalimentation therapy. Solid food should be offered at the same time in order to retrain the patient to eat.

The patient should be watched closely for turning off the electronic infusion device. At this stage she is extremely angry about being "force-fed" and frightened about gaining weight. These patients are very manipulative and will do almost anything to sabotage their nutritional therapy.

This practice of giving back nutrition to the patient is a sensitive one. If her life is endangered due to her physical status, care givers must proceed with nutritional therapy, despite her protests. However, it must be done in such a way that her overall therapy program is not jeopardized due to control issues. It

is important to deal with this type of nutritional therapy with empathy and warmth. It is also imperative not to succumb to the patient's pleas to stop, nor to become angry and dictatorial. It should be remembered that this patient is extremely sick, both mentally and physically. The efforts to feed her are saving her life and must be carried out in a calm, caring and non-judgmental manner. An appropriate way for the care giver to deal with the patient's feelings at this time would be to simply validate them by repeating back to her what she is saying. Saying something like "It sounds like you're really angry with me", or "I know you're afraid of gaining weight", is more effective than getting into a verbal struggle. Her attitude may improve once she has been given the proper nutrients.

Different institutions and physicians will have their own parameters for when a patient can discontinue this type of re-feeding with bed rest, and begin minimal ambulation on the unit. From minimal ambulation, such as getting up to the bathroom or walking in her room, she may progress to stretching and walking exercises. Not until she has progressed significantly in her treatment program, with an acceptable weight gain, will she be allowed to engage in any vigorous exercise. A moderate exercise program is helpful in distributing the new weight evenly over her body. It is important that the weight gain not be so dramatic that the patient panic and return to her former habits.

Nursing Implications in Clinical Treatment

The nurse plays an important role in the successful hospitalization of eating disorder patients. It is imperative to foster a trusting relationship and establish honest communication. With this kind of relationship the nurse can recognize and acknowledge any slight distortions or misinterpretations in the patient's thinking. Good listening skills and responding with sensitive validation will give the patient something she has been deprived of throughout her development. These patients should always be approached with empathy and warmth.

Since patients with eating disorders are manipulative and tend to split staff, it is important for the staff to be cohesive with each other and consistent in the way they interact with the patient. These patients invariably incite anger and frustration among the nursing staff. In order for nurses to effectively care for these difficult patients, there must be a staff support meeting where nurses can express their feelings and receive support from their peers.

Nurses are responsible for monitoring behavior, weight, vital signs, physical activity and nutritional rehabilitation. The nurse may need to assist the patient with choosing a menu as anorexic patients can spend hours doing this and still end up with nothing. It may be necessary for a nurse to be with a patient while she eats and for a period of time afterwards, to insure against starvation or binge-purge behavior.

A nurse can help her patient discover new interests, particularly those she can become involved in during hospitalization. The nurse can help her explore ways she can treat herself well and have her make it a goal to do so once a day. This can be an activity such as taking a long hot bubble bath, buying flowers for herself or spending time reading her favorite magazine. The idea is to do something for herself which has nothing to do with anyone else's expectations or needs.

Patients should set up goals for the entire hospitalization, as well as daily goals. The nurse can assist the patient in identifying these goals and in prioritizing them, so that she only takes on what can reasonably be accomplished in a day. This will prevent the inevitable feeling of failure when she has taken on too much and cannot accomplish it all.

A nurse may confront a patient with her unhealthy eating behavior if it is noticed. You cannot force a patient to stop bingeing or purging, however you can bring it to her attention by "naming" the behavior when you see it. Continual confrontation and honesty from the staff is imperative for the patient to stop denying the existence of the problem and to make the decision to change.

Nurses must always remember, it is the patient who is responsible for her behavior. A power struggle will only result in both parties losing. Through honest, empathic communication, nursing staff can help these patients to help themselves.

OUTCOME OF TREATMENT

Studies of mortality rates in anorexia nervosa indicate that the rate of mortality increases the longer the patient has the disorder. One study showed a mortality rate of 5% at five years, 6.5% at ten years, 16% at twenty years and 18% at thirty-three years. The deaths were found to be secondary to anorexia nervosa and not due to other causes (Herzog, 1992).

Outcome studies of bulimic patients have found the course to be chronic with periods of remission and relapse (Garfinkel and Kennedy, 1992). A study by Swift et al reported on a group of bulimic women two years after discharge from a treatment program. They found that 27% were asymptomatic, 40% had an intermediate outcome and the remaining 33% had a poor outcome with bingeing or purging on a daily basis (Garfinkel and Kennedy, 1992).

The difficult in determining outcomes of treatment for anorexia nervosa and bulimia exists in the overlap of symptomatology during the course of the disorders. Switching behaviors is common, with a patient restricting intake for a period of time, then engaging in binge-purge behavior and then returning to a restrictive model once again. A study done by Herzog which followed the course of anorexia nervosa patients, bulimic patients and a mixed symptom anorexic-bulimic group for five years found considerable cross-over among the groups (Garfinkel and Kennedy, 1992). He found that the patients who started out in the mixed group had the poorest recovery rate (Garfinkel and Kennedy).

A more positive outcome was found by Brownell (1986) in a study of bulimic patients. It shows changes in the binge-purge frequency of fifteen bulimics from six months prior to treatment to the one year follow-up date. Seven patients showed complete abstinence in the follow-up study, while the remainder showed reductions in binge-purge activity ranging from 63% to 94%. Overall, a 91% reduction in binge-purge frequency was noted (Brownell, 1986).

Another study shows the medical and psychosocial outcome of fifty anorexic patients following family therapy. In 86% of the cases, treatment was effective. It appears most effective with younger patients

who receive treatment within the first year of the onset of their behavior, and whose families become involved in therapy (Minuchin, 1978).

CONCLUSION

As with any addictive behavior, progress must be evaluated on a day by day basis. The patient will be un-learning thought processes, behaviors and coping mechanisms that she learned at a young age and which may have been in place for many years. Not only is it an interpersonal struggle, but a battle against society's demands and prejudices as well. Genetic and biological factors also enter into the overall recovery process.

As well informed and sensitive health care professionals, we can do much towards helping eating disorder patients recover. Moreover, through education and information about body size as it relates to health we are better prepared to assist the general population of patients we deal with toward optimum health, physiologically and psychologically, without contributing to our society's pressure to be thin.

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COURSE EXAM

1. Which of the following is criterion for the diagnosis of anorexia nervosa, according to the American Psychiatric Association?
   a. The person recognizes she is extremely thin and needs professional help.
   b. The person has no interest in food.
   c. Intense fear of gaining weight or becoming fat, even though underweight.

d. Weight loss of at least 5% of original body weight.

2. Which of the following is criterion for the diagnosis of bulimia, according to the American Psychiatric Association?
   a. The person is able to control her binges and stop eating when she wants to.
   b. 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.
   c. Occasionally eating large amounts of food without concern.
   d. Both a and c.

3. Which of the following describes characteristic behavior(s) of a bulimic?
   a. Their binge-purge behavior is almost always carried on in private.
   b. They binge in the presence of others, such as at parties or holiday dinners.
   c. They may vomit up to 20 times daily or take up to 50 doses of laxatives per day.
   d. The person is able to control this behavior.
   e. Both a and c.

4. Which of the following describes characteristic behavior(s) of an anorexic?
   a. The person is ashamed of her emaciated body.
   b. The person has a poor appetite.
   c. She is not likely to exercise.
   d. She is completely preoccupied with food and eating.

5. In regards to the correlation between fat and health risks, which of the following is/are true?
   a. Researchers have found that the medical risks of obesity have been greatly exaggerated and misunderstood.
   b. Obesity causes high blood pressure, heart disease and diabetes.
   c. Genetics play an important role in the development of disease.
   d. Both a and c.

6. The following is a greater health risk than simple obesity:
   a. using diet products.
   b. the weight cycling caused by repeated dieting.
   c. over-exercising.

7. An appropriate treatment for obese individuals would be:
   a. to focus on overall good health and self-acceptance.
   b. to prescribe a weight loss diet.
   c. to encourage a rigorous exercise program to induce weight loss.

8. Many recent studies have shown that restrictive diets:
    a. are an effective and permanent weight loss solution.
    b. are not an effective and permanent weight loss solution.
    c. should be prescribed to all obese individuals.

9. Set point can be defined as:
    a. the body's attempt to defend a physiologically programmed weight level.
    b. the number of calories a person must ingest in order to lose weight.
    c. an individual's appropriate weight according to insurance company charts.

10. The net effect of dieting is actually paradoxical to the intent, as evidenced by which of the following statements?
    a. Metabolism speeds up with weight loss so that calories are used more efficiently.
    b. The longer one diets the more the metabolism slows down.
    c. The dieter must restrict intake more and more as she continues dieting.
    d. Both b and c.

11. Which of the following is/are true of the binge-purge cycle?
    a. The patient is able to achieve her desired result of weight loss.
    b. The patient gains weight due to the cycling which makes it harder and harder to lose weight.
    c. The bulimic will only lose weight if she also exercises excessively.

12. The Minnesota study showed that when subjects were starved they:
    a. become completely preoccupied with food.
    b. would become silent and socially isolated while devoting their attention to a meal.
    c. experienced severe changes emotionally, physically, cognitively, socially and sexually.
    d. all of the above.

13. Which of the following is a true statement regarding the use of laxatives and diuretics?
    a. These agents have been found to be effective in controlling absorption of calories.
    b. These agents are helpful in achieving weight loss because they encourage fluid loss.
    c. The use of these agents to aid in weight loss is a myth.

14. Which of the following is considered a psychological precipitant to an eating disorder?
    a. Body image distortion.
    b. Low self-esteem.
    c. Depression.
    d. All of the above.

15. Anorexics tend to be from families who:
    a. are extremely controlling.
    b. do not allow for the individual identities of each family member.
    c. express true feelings well in therapy.
    d. both a and b.

16. Individuals with an eating disorder were, as children, generally viewed as:
    a. trouble-makers.
    b. not trying very hard to achieve.
    c. model children.
    d. very assertive.

17. The crisis period for bulimics appears to be:
    a. the transition from childhood to adolescence.
    b. at the onset of their menses.
    c. the transition from adolescence to adulthood.

18. The bulimic's attitude towards the traditional feminine role is:
    a. one of abhorrence.
    b. something they are very committed to.
    c. highly influenced by a mother who represents the traditional female role.
    d. both b and c.

19. Which of the following is not a typical characteristic of a bulimic?
    a. Dependent.
    b. High self-esteem.
    c. Perfectionism.
    d. Feelings of inadequacy and helplessness.

20. Precursors to bingeing are:
    a. rejection.
    b. confrontation.
    c. anxiety.
    d. all of the above.

21. Which of the following is a false statement regarding the demographic background of an eating disorder patient?
    a. Females from upper income families are typically affected.
    b. Only recently have there been reports of eating disorders in children from other than white western backgrounds.
    c. Cases have been reported in underdeveloped countries.

22. In regards to biological precipitants of eating disorders, which of the following is false?
    a. Hypothalamic dysfunction is a proven cause of anorexia.
    b. There is confusion as to whether certain medical complications of eating disorders are not in fact, precipitants of the illness.
    c. It has been difficult to establish clear-cut data regarding the biological causes of an eating disorder.

23. Which of the following explains the difficulty in establishing clear-cut data regarding the physiological causes of an eating disorder?
    a. These patients are secretive and hide their symptoms out of shame.
    b. Eating disorder patients have so many physical complications that it is difficult to isolate out the cause of each symptom.
    c. Patients present for treatment after their illness has been in full swing for some time, and the physician often has no base-line data prior to the illness.

24. Which of the following electrocardiographic abnormalities is of most concern to the anorexic patient?
    a. Arrhythmias, including supra-ventricular premature beats and ventricular tachycardia.
    b. Bradycardia.
    c. T wave inversions.
    d. T segment depression.

25. Which of the following is not a medical complication of anorexia?
    a. Severe weight loss.
    b. Unusually sensitivity to cold.
    c. Anemia.
    d. High basal metabolism.
    e. Neuro-endocrine dysfunction.