When Dieting Becomes Dangerous

A Guide to Understanding and Treating Anorexia and Bulimia

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With a Foreword by Arthur Crisp, M.D., D.Sc.

Yale University Press

New Haven and London

Published with assistance from the Yale University Press Mary Cady Tew Memorial Fund.

Designed by Nancy Ovedovitz and set in Swift Light type by Tseng Information Systems. Printed in the United States of America by Vail-Ballou Press.

Library of Congress Cataloging-in-Publication Data
Michel, Deborah Marcontell, 1964–
When dieting becomes dangerous : a guide to understanding and treating anorexia and bulimia / Deborah Marcontell Michel, Susan G. Willard ; with a foreword by Arthur Crisp.
p. cm. Includes bibliographical references and index.
ISBN 0-300-09232-6 (cloth : alk. paper) — ISBN 0-300-09233-4 (pbk. : alk. paper)
1. Bulimia. 2. Anorexia nervosa. 3. Women—Mental health. 4. Eating disorders.
I. Willard, Susan G., 1945– II. Title.
RC552.B84 M53 2002 616.85'26—dc21 2002069139

A catalogue record for this book is available from the British Library.

The paper in this book meets the guidelines for permanence and durability of the Committee on Production Guidelines for Book Longevity of the Council on Library Resources.

10 9 8 7 6 5 4 3 2 1

We dedicate this book to all the patients who have sought recovery with us. It has been a privilege to accompany them on their courageous journey and to witness their discovery of themselves. We have learned most of what we know from them.

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foreword

Severe eating disorders, as defined here, are common. The phobic fear of fat that underwrites them is widespread in the female population of the Western world. Many women live with it as a powerful factor within their makeup and social life without developing major or overt eating disorders. Others are not so fortunate. Bulimia nervosa can erupt and become a source, often secret, of longstanding social handicap and misery. Anorexia nervosa is among the most serious of the mental illnesses in terms of its crippling physical, social, and psychological effects and potentially fatal outcome. At the least, it reflects a significant compromise with suicide, as all physical growth and the psychological and social consequences that flow from such growth are aborted.

As attempted biological solutions to existential problems, often buttressed by fearful denial, these disorders demand genuine caring and professional expertise of the highest order if help is to be provided. The authors of this book are steeped in this perspective, and it is reflected in their text. The pages are replete with clinical experience and common sense, showing health care at its empirical best. The diagnostic approach is adopted for

its heuristic value, and its multidisciplinary origins are emphasized. Eating disorders in males are not neglected.

Here also is a publisher wise enough to encourage a text that is both at the cutting edge for the professional and eminently readable by the layperson. I am delighted to write this foreword to such a worthwhile contribution to the literature.

Arthur Crisp, M.D., D.Sc.
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preface

This book is written from a developmental perspective with the intent of assisting individuals with eating disorders, and those who care about them, in understanding these potentially devastating illnesses. More specifically, our clinical experience has alerted us to the need to help all those affected by eating disorders to understand the symptoms, the possible causes, and potentially successful treatment.

These pages represent a compilation of our knowledge, which is based on scientific research as well as years of experience in treating eating disordered individuals and their families. Our goal is to provide practical, "what-to-do" information for not only persons with eating disorders but also their families, friends, teachers, school counselors, and coaches. Contact information for various resources and organizations is given to assist readers in locating help. We recognize the importance of addressing eating disorders in males and have therefore outlined the special issues involved in their treatment. Finally, we have included a chapter aimed at health care professionals who do not specialize in eating disorders. Having consulted with such professionals over the years, we thought providing practical information for the nonspecialist was important.

As we wrote this book, we endeavored to succinctly present information that is essential to understanding eating disorders. Simple overviews are therefore provided on the basics of anorexia and bulimia. For those wanting more detailed information, references are given throughout the book and in the appendix entitled Supplemental Readings. Binge-eating disorder is touched upon only briefly, as it is beyond the scope of our book to present material that explains the development and treatment of this disorder and its associated condition of obesity. In addition, we do not discuss the special needs of children with eating disorders, although we include appropriate references.

Our chapters utilize a user-friendly, question-and-answer type format. There is some overlap because of the natural relatedness of the material, and also to remind readers of points made elsewhere. We strongly suggest that readers examine *all* chapters in order to appreciate the complex issues involved for patients, family members, friends, and health care professionals. Since the majority of eating disordered individuals are female, we address the afflicted population in the feminine gender, except in the chapter on eating disorders in males.

Please Note:
While our goal is to increase knowledge and comprehension of these disorders, we emphasize that only health care professionals can diagnose and treat eating disorders. This book is not intended as a substitute for professional health care.

D.M.M.
S.G.W.

acknowledgments

We are grateful to the following colleagues who assisted us in identifying resources on eating disorders: Fernando Fernández-Aranda, Ph.D.; Jean Chambry, M.D.; Ricardo Dalle Grave, M.D.; Bryan Lask, M.D.; and Walter Vandereyecken, M.D. We also thank Diane Mickley, M.D., for her generous feedback on the medical portions of the text.

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Introduction

Historically, anorexia nervosa and bulimia nervosa may have existed in some form since the days of "starving saints" and Roman vomitoriums. Yet not until 1973, when Hilde Bruch published her classic text entitled *Eating Disorders: Obesity, Anorexia Nervosa, and the Person Within,* did anorexia become widely recognized as a psychological disorder. Bulimia did not receive much attention until the late 1970s, and in fact was not even given a distinct name until Gerald Russell coined the term *bulimia nervosa* in 1979.

Today eating disorders constitute a major health concern. According to the National Eating Disorders Organization, between 5 million and 10 million girls and women, and 1 million boys and men, have some type of eating disorder. The American Psychiatric Association reports that more than 90 percent of those who have a diagnosis of anorexia or bulimia are female. In addition, there is evidence of an increasing prevalence of eating disorders, especially in countries that are more "Westernized" or "Americanized" in terms of cultural ideas of beauty and societal pressures to be thin. Complicating matters further, the options and resulting pressures on young women with regard to educa-

tion and career are greater than in decades past, while the traditional values of success based on marriage and children prevail as well.

Our young women are supposed to do it all: be thin and beautiful; have husbands and children; have professions, power, and money. In addition, our culture allows and promotes greater sexual freedom for women and girls, a phenomenon of our times that generates anxiety and fear around growing up. Thus, we see a frightening physical obsession begin to develop in girls as young as eight or nine years of age. The end product is that many girls and young women choose dieting as an imagined solution to their problems. This misguided attempt at coping may well lead to eating disorders.

Eating disorders are complicated psychiatric illnesses in which food is used to help deal with unsettling emotions and difficult life issues. When the suspicion or realization of an eating disorder hits, many questions arise. We attempt to answer some of them as simply as is possible for such multidimensional disorders. Chapter 2 describes the diagnosis of eating disorders, the emotional features that are often seen, and the medical complications that may be present. Warning signs and symptoms are included. Chapter 3 provides general information on the typical characteristics—age, race, and level of education—of people with eating disorders. Chapter 4 explains the multiple factors that contribute to the development of an eating disorder. These include biological factors, sociocultural factors, individual personality characteristics, and family characteristics. Chapter 5 advocates a multidisciplinary approach to the treatment of eating disorders, and each professional's role is examined. We also give information on getting and staying well, treatment outcomes, and how one can assess quality and level of care. We raise the matter of insurance, as well. In Chapter 6 we give practical information and general advice to concerned individuals on their

roles in effective intervention and treatment of someone with an eating disorder. In Chapter 7 we discuss the similarities of and differences between males and females in the development and treatment of eating disorders. The final chapter, intended for nonspecialist physicians, dentists, mental health professionals, and nutritionists, gives basic information on the assessment and care of persons with eating disorders. References for more detailed information are included.

When Dieting Becomes Dangerous can be used as a reference book dealing with major questions about the development, diagnosis, and treatment of anorexia and bulimia. It will help you understand these disorders, and know what to do if you suspect that you, or someone you care about, has one of these illnesses. Our book can also be used to obtain advanced references for a more thorough understanding of these and related disorders. Finally, it can put you in touch with organizations that offer help.

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What Is an Eating Disorder?

ANOREXIA NERVOSA

Features of the Disorder The formal psychiatric name for this illness is anorexia nervosa, but it is often shortened to simply "anorexia." Anorexia nervosa should not be confused with general anorexia, which means loss of appetite. People who have anorexia nervosa do not lose their appetites; rather, they refuse to maintain a normal body weight. They lose at least 15 percent of normal weight for height and have an intense fear of gaining it back or becoming obese. They often weigh themselves several times a day for fear of gaining weight and/or to see if they are continuing to lose. Anorexics also have a highly unrealistic view of their bodies, most often believing that they are fat even when they are severely emaciated. Their self-esteem and self-worth are based on size, weight, and body shape. Many anorexics wear baggy clothes to hide their bodies, while others wear revealing clothes to show off their underweight condition. Females stop having menstrual cycles after a certain amount of weight is lost or, in prepubescent girls, the menstrual cycle may not begin because of weight loss. Occasionally the period ceases some weeks

or months before the onset of weight loss, thus highlighting the psychological origins of the illness.

As the disease progresses, strange behaviors evolve relative to food and eating. The anorexic will often cut her food into tiny pieces, measuring and weighing everything she eats or drinks. She is likely to keep careful calorie and fat counts of every morsel of food she ingests. She may perform certain rituals, such as using particular plates or utensils or arranging her food items in lines or patterns. Even when she is at an unhealthy weight, the anorexic may exercise excessively and compulsively, insisting that she feels fine. Although she will deny hunger, her hunger pangs will become intense. She may be obsessed with reading and collecting recipes and may enjoy preparing food for others, but will not touch a bite herself. She may eat only when alone, for the presence of others at this time may feel like an intrusion.

Some anorexics start a pattern of binge eating followed by purging behavior to eliminate the calories they consume. Binge eating refers to eating a large amount of food in a relatively short period of time. The anorexic who binges feels out of control, as if she cannot stop herself, then feels tremendous anxiety over all she has eaten. Other negative feelings too, such as shame and guilt, cause her to use some means to get rid of the calories she has ingested. The most frequent form of purging is self-induced vomiting. Other means include laxatives, diuretics (fluid pills), enemas, and syrup of ipecac (a substance that induces vomiting). Some anorexics may use nonpurging methods such as fasting or excessive exercise. Studies have shown that anorexics who binge and purge are at greater risk for substance abuse than those who do not.

Personality changes, often observed along with physical changes, may include angry outbursts, isolative behavior, and depression. The depression may be secondary to the eating dis-

order, or it may be a primary problem. Anxiety, too, can be a primary problem or may be related to fears about food, body shape, and weight. It may also result from stressful or anxiety-provoking life circumstances. Anxiety disorders are quite common in anorexics and frequently occur before the eating disorder develops. Two studies showed that 60 percent and 83 percent, respectively, had an anxiety disorder at some point in their lives. Obsessive-compulsive traits can also be present, and may or may not be directly related to the anorexia. Obsessions are unwanted thoughts that repeatedly enter a person's mind and cause anxiety; compulsions are the behaviors that a person feels driven to do in order to decrease the anxiety caused by the obsessions. Examples of obsessive-compulsive behavior that are directly related to anorexia include constant calculation of calories and fat grams, frequent weighing, and compulsive exercising. Examples not directly related to an eating disorder may be frequent hand washing for fear of germ contamination, or checking repeatedly to confirm that appliances are turned off and doors are locked. At times, obsessive-compulsive behavior may be severe enough to warrant a diagnosis of obsessive-compulsive disorder and require treatment specifically designed for that disorder.

In addition to the emotional features already mentioned, the anorexic is likely to become irritable, indecisive, and defiant as she becomes entrenched in her illness. Typically, she withdraws from friends as her symptoms increase, and family quarrels over food and other issues intensify as her condition worsens. Sometimes family and friends feel she has become "another person," someone they no longer know. Her social withdrawal causes serious peer relationship problems, and her increasing physical debilitation creates panic, anxiety, and chaos within the family. The despair, isolation, and hopelessness of anorexia may even result in suicide. Observation of any combination of the warn-

WARNING SIGNS OF ANOREXIA

- Obsessive dieting
- Loss of menstrual cycle
- Claiming to feel fat when obviously not overweight
- Measuring self-worth in terms of weight and shape
- Preoccupation with food, calories, and nutrition
- Preparing food for others but not for self
- Hiding and collecting food
- Denial of hunger
- Excessive exercising
- Frequent weighing
- Use of laxatives and/or diuretics
- Vomiting to get rid of food eaten
- Strange behaviors relative to food and eating
- Exercise immediately preceding or following eating
- Complaints of feeling bloated or nauseated when eating normal or small amounts of food
- Attempts to get diet instructions and/or diet pills from doctors
- Fear of being unable to stop eating
- Isolation from peers and family
- Wearing bulky clothing to hide figure
- Sleep difficulties

ing signs and symptoms of anorexia should cause concern and provoke investigation into a potential problem.

Medical Complications Anorexia is a life-threatening condition that must be taken seriously, as it has one of the highest mortality rates of any psychiatric disorder. The death rate increases

with the length of illness, and is as high as 20 percent for those who have been followed for twenty years. Anorexics often suffer from organ failure, as the body can no longer withstand the stress of starvation. For anorexics who use laxatives and/or diuretics to purge, important body chemicals such as potassium are frequently lost. This deficit can result in irregular heartbeats or even death from cardiac arrest or kidney failure. Chronic abuse of laxatives adversely affects the gastrointestinal system. The syrup of ipecac that some anorexics take to induce vomiting can cause a variety of heart problems as well as gastrointestinal and neuromuscular difficulties. Finally, a number of diet pills and so-called diet aids (for example, herbal supplements with the stimulant "ma huang," or ephedrine) are used for weight loss. As with laxatives and diuretics, anorexics will often abuse diet pills or diet supplements by taking more than the recommended dosage and taking them more frequently than suggested. These products can be quite dangerous; it is a mistake to believe that the diet products marketed as "all natural" and sold in health-food stores are safe. In truth, these products often contain ingredients that can produce potentially lethal side effects. In fact, deaths related to these products have been documented by the Food and Drug Administration. Identification of any such risky behavior constitutes cause for serious concern and immediate intervention.

The weight loss seen in anorexic patients is an obvious and invariable complication. The body reacts to starvation by slowing down to preserve calories for continued functioning of the heart and brain. Specific symptoms include a slower heart rate and lowered blood pressure, as well as hormonal disturbances. Reduced body fat leads to lowered body temperature and intolerance for cold. Prolonged starvation and malnutrition can also cause irregular heartbeats, heart failure, and cardiac arrest. The major medical complications of anorexia affect the brain, the

PHYSICAL SIGNS AND SYMPTOMS OF ANOREXIA

- Slow heart rate
- Low blood pressure
- Low body temperature
- Hair loss
- Dry and yellowed skin
- Brittle nails
- Lanugo (thin coating of soft body hair)
- Loss of menstrual cycle
- Early morning awakening
- Intolerance of cold
- Abdominal pain
- Weakness
- Swollen joints
- Lightheadedness
- Hyperactivity
- Constipation
- Fatigue

heart and circulatory system, the blood, the kidneys, the stomach and intestines, and the body's overall metabolism.

Amenorrhea (loss of three consecutive menstrual cycles) is a characteristic of anorexia in females that may precipitate additional medical complications. The menstrual cycle is a complicated system, and the exact cause of amenorrhea remains unclear. It is known, however, that abnormally low body fat content in addition to other biochemical disturbances contributes to the condition. While the dangers of amenorrhea may not be readily apparent, the consequences can be severe. Loss of bone mineral density can occur, which places girls and women at risk for

osteopenia and osteoporosis. Various types of bone fractures may ultimately result. Current evidence suggests that these medical complications may persist even after the anorexic has restored her weight to normal. In terms of reproductive function, women who have a lifetime history of anorexia have been found to be at increased risk of obstetric complications, with the risk of miscarriage twice as great as for women with no history of anorexia. Furthermore, women who have been anorexic for a long period with chronic amenorrhea may compromise their reproductive function to the point of infertility.

Course of the Disorder Progress of anorexia over time varies greatly. Some anorexics recover fully after one episode of the illness; others return intermittently to a normal weight and then relapse. Unfortunately, some anorexics display a chronic course of symptoms that worsen over the span of many years, often ending in death. Females with anorexia are twelve times more likely to die than females the same age who have not had anorexia. Death most frequently results from the physical complications of starvation, electrolyte imbalance, or suicide. Chapter 5 gives relevant information and statistics.

BULIMIA NERVOSA

Features of the Disorder Although the formal diagnostic name for this illness is bulimia nervosa, it is better known by the public as bulimia. The disorder is characterized by binge eating, followed by eliminating the calories consumed in compensation for the binge. The bulimic usually either self-induces vomiting or takes laxatives or diuretics in an effort to eliminate the calories. She may diet strictly or fast between eating episodes to undo the damage, or she may exercise excessively in order to prevent weight gain. When binge eating, she feels out of control and be-

lieves she cannot stop. To meet the criteria for formal diagnosis, her binges occur at least twice a week over a three-month period, and she is persistently overconcerned with her body size, shape, and weight. This focus on the body strongly influences her negative self-image.

In spite of repeated binge eating, bulimics often manage to stay within five to ten pounds of normal weight. The typical bulimic is a professional dieter who often gains back the weight she loses and repeatedly feels like a failure. Her interest in her body and dieting becomes an obsession and she will often swing between strict dieting and periods of overeating. At some point in the process, she starts to feel great anxiety and may experience something akin to a "high" by ingesting large amounts of food. Like a drug, the food becomes a calming or numbing substance when anxiety and painful feelings about herself mount. Because of her overconcern with her body and her strong desire to be thin, the bulimic feels that she must get rid of the food and perhaps punish herself for what she considers to have been "bad" behavior. In an attempt to accomplish this task, she turns to purging or excessive exercise, usually within thirty minutes to an hour after the binge. Vomiting is typically induced by putting her fingers down her throat, although some individuals utilize foreign objects (spoons, forks, toothbrushes). These objects can be dangerous in and of themselves. Those who abuse laxatives usually take an excessive number to induce severe diarrhea after a binge and may increase the dosage over time.

As in anorexia, personality changes and emotional conditions are associated with bulimia. Depression is very common. Some of the depressive symptoms are directly related to binge/purge behaviors, along with the shame, guilt, and embarrassment associated with these practices. Much of the time, though, the depression that occurs is separate from bulimic behavior and has more to do with how the bulimic feels about herself, her family,

and her life in general. Anxiety, almost always present, has been shown to play a major role in maintenance of the binge-purge cycle. The soothing and self-nurturing feelings that initially accompany the binge are quickly replaced by extreme concern over the calories consumed and fear of weight gain. In turn, the behaviors that are used to get rid of the calories reduce this anxiety and the cycle continues.

As with anorexics, anxiety disorders in bulimics are often present before the eating disorder develops. As the illness continues, those closest to the bulimic may notice her increased withdrawal and isolation from others, as well as her negative feelings about herself. She may never eat around others for fear of losing control or of being discovered. Greater difficulty with impulse control may be evident; some bulimics engage in stealing, risky sexual behavior, and drug or alcohol abuse. This acting-out may perpetuate a cycle of low self-esteem, depression, and self-destructive behavior, which creates further personality changes that are often of a rebellious nature.

People who have these periodic binges followed by purging, fasting, and/or exercise are aware that their relationship with food is abnormal and out of control. At first the behaviors to get rid of the calories may feel like the perfect answer to a dieter's dilemma. As the food intake increases and control is lost, however, bulimia becomes a nightmare for its victims. They are usually quite private and ritualistic because of the secretive and remorseful nature of the disorder. Even though the physical problems associated with the disease may become severe, the bulimic may still be reluctant to tell her physician what she is doing to her body. A great number of individuals are burdened with the illness for many years before telling a single person.

When friends and/or family become aware of the binge-eating and purging, it is usually because they notice large amounts of food missing or recognize signs of purging in the bathroom.

When first confronted, most bulimics deny the problem. They often become angry or hostile and may feel intruded upon when someone dares to enter their secret world. Yet somewhere inside, they may wish to be discovered so that something can be done to stop the despised and seemingly never-ending cycle.

As the illness progresses, binge-eating episodes become more frequent and the amount of food consumed during a binge increases. Relationships, work, school performance, and self-esteem often suffer dramatically. The depression associated with bulimia can be severe; unfortunately, suicide is sometimes viewed as the only solution. It is imperative that bulimics receive prompt professional attention once the disorder is discovered.

Medical Complications In normal-weight bulimics, most of the medical complications of starvation seen in anorexics are not present. However, the same serious problems related to purging that were described in individuals with anorexia (the loss of important body fluids and minerals) occur in persons with bulimia. We do not know what percentage of bulimics die from complications of the illness, but we do know that many deaths have been reported and that most bulimics have an assortment of medical problems associated with the disease.

Common complications, though certainly not the most serious, are dental and throat problems. It is not unusual for the bulimic's dentist to be the first to suspect her illness. Cavities, enamel erosion, persistent throat irritation, and chronic hoarseness can be the result of frequent vomiting. Abdominal pain, heartburn, and/or stomach cramps are frequent complaints, usually associated with overeating or purging behavior. Often bulimics will have swollen glands at the angle of the jaw, a result of bingeing and purging. Swelling or bloating over the stomach or abdominal area and in the extremities (fingers and toes)

WARNING SIGNS OF BULIMIA

- Obsessive dieting followed by binge eating
- Overconcern with body size, shape, and weight
- Rapid fluctuations in weight
- Frequent weighing
- Overeating associated with stress and/or anxiety
- Trips to the bathroom right after eating
- Guilt about eating
- Secretive eating
- Measuring self-worth in terms of body size, shape, and weight
- Disappearance of large quantities of food
- Hiding and collecting food
- Excessive exercise, particularly just before or after eating
- Swollen glands beneath the jaw
- Stealing, especially of food items
- Evidence of vomiting or laxative-induced diarrhea
- Abdominal pain
- Constipation
- Use of laxatives, diuretics, and/or diet pills

is caused by the fluid imbalance created by purging. Frequent menstrual irregularities are also seen, and sometimes bulimics lose their cycles altogether. The menstrual problems are usually due to excessive exercise and/or low body fat content. Dehydration, dryness of the skin, or a fine rash can result when too much body fluid is eliminated. Sometimes calluses or scars occur over the knuckles of the hand used to purge, from chronic abrasion by the teeth when the fingers are forced down the throat re-

PHYSICAL SIGNS AND SYMPTOMS OF BULIMIA

- Abdominal pain, bloating, and/or stomach cramps
- Heartburn
- Dental problems
- Persistent throat irritation
- Chronic hoarseness
- Swollen glands beneath the jaw
- Swelling or bloating of the extremities
- Menstrual irregularities
- Dry skin
- Dehydration
- Dry, brittle hair
- Callus or scar formation over knuckles
- Weakness and/or dizziness
- Broken blood vessels in the eyes
- Frequent weight fluctuations
- Diarrhea
- Constipation
- Fatigue

peatedly to induce vomiting. The most serious, life-threatening consequences of bulimia are esophageal tears, stomach rupture, kidney failure, heart failure, and cardiac arrest.

Course of the Disorder Not much is known about the course of untreated bulimia. According to clinic samples, however, disturbed eating is likely to persist for at least several years. Some individuals may have periods of spontaneous improvement and then relapse. Others follow a more chronic course, in which the symptoms worsen over time. Community samples have reported modest levels of spontaneous improvement.

EATING DISORDER NOT OTHERWISE SPECIFIED

When an individual presents with symptoms of an eating disorder but does not have all the specific symptoms of either anorexia or bulimia, a diagnosis of "Eating Disorder Not Otherwise Specified" is made. Common examples include someone who has all the symptoms of anorexia nervosa but is not yet 15 percent below normal body weight or who has not yet missed her period for three consecutive cycles, or a person who does not binge and/or purge as often as stipulated to meet the psychiatric definition of bulimia nervosa.

Even though these individuals do not meet the formal diagnostic criteria, their disorders must be taken seriously. The psychological changes and disturbances associated with anorexia or bulimia are likely to be present in one form or another. In addition, the medical complications seen in anorexia and bulimia apply to these persons, depending on which symptoms are present. For example, someone who has not yet dropped 15 percent below normal weight but has quickly lost weight may suffer from medical problems associated with rapid weight loss. Finally, it is likely that an individual with these symptoms will progress into more severe eating disordered behavior if prompt professional intervention is not sought. Much of the information presented regarding the development and treatment of anorexia and bulimia applies to those with an unspecified eating disorder. The issues involved in the development of the eating disorders are similar, whereas treatment will vary depending on the type of eating disordered behavior involved.

BINGE EATING DISORDER

Binge eating disorder will not be discussed in detail, as it is beyond the scope of this text to fully address the disorder and the

typical coexisting problem of obesity (i.e., biological and genetic factors, medical complications, treatment). Instead, we offer a brief overview to familiarize readers with the illness. For more information on this particular disorder, see the supplemental readings in Appendix B.

Binge eating disorder, described as compulsive overeating in the past, is now recognized by the psychiatric community as a distinct problem. It consists of binge eating as seen in bulimia, but without the regular use of compensatory behaviors (purging, fasting, exercising) to get rid of the calories consumed during the binge. People who have this disorder feel out of control of their eating behavior and typically feel shame, guilt, depression, and/or embarrassment after bingeing. They often binge in secret, eat more rapidly than normal, and do not stop until they are uncomfortably full or are interrupted in some way. Their binges may last an entire day and continue over subsequent days. Studies have shown that people with this disorder eat more between binges than do people of the same weight who have no binge-eating problems. They also have great difficulty limiting their overall caloric intake, even though they have harsh personal standards for dieting. Unlike bulimics, those with this disorder report binges before engaging in any dieting behavior.

Obesity is common, and the medical complications that accompany it are often seen in binge eating disorder. It has been estimated that 30 percent of people seeking help for weight loss at university-based weight loss centers suffer from this disorder, and that about 8 percent of obese individuals in the community suffer from it, as well. Women are more frequently affected by binge eating disorder than are men, but not to the degree that we see in anorexia or bulimia. According to recent studies, women with this disorder outnumber men by a ratio of about three to two.

As with anorexia and bulimia, emotional changes are frequently seen. Most prominent is depression, which is often quite significant. During episodes of depression, individuals with this illness are particularly likely to gain weight as a result of severe bingeing. The depression may lead to a vicious cycle in which the person eats to relieve the feelings of depression, consequently gains weight, and then becomes even more depressed.

Much remains unknown about binge eating disorder because of its relatively new status as a distinct eating disorder. We do know, however, that it is treatable. The goals of treatment include normalization of eating (no bingeing, more control over eating behavior) and amelioration of accompanying psychological symptoms such as depression. The types of treatment described in later chapters for bulimia are, with certain modifications, applicable to binge eating disorder. Obese patients with binge eating disorder are likely to request assistance with weight loss. This type of treatment is often attempted after normalization of eating is accomplished. Dieting has not been shown to worsen binge eating in this group.

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