CHAPTER TEN

Eating Disorders

CHAPTER OUTLINE

• Symptoms of Anorexia
• Symptoms of Bulimia
• Diagnosis of Eating Disorders
• Frequency of Eating Disorders
• Causes of Eating Disorders
• Treatment of Anorexia Nervosa
• Treatment of Bulimia Nervosa
• Prevention of Eating Disorders
OVERVIEW

• Eating disorders are severe disturbances in eating behavior that result from the sufferer’s obsessive fear of gaining weight.
• The DSM-IV-TR lists two major types of eating disorders: **anorexia nervosa** and **bulimia nervosa**.
• The most obvious characteristic of anorexia nervosa is extreme emaciation, or more technically, the refusal to maintain a minimally normal body weight. The term anorexia literally means *loss of appetite*.

OVERVIEW

• **Bulimia nervosa**
  – Characterized by repeated episodes of binge eating, followed by inappropriate compensatory behaviors such as self-induced vomiting, misuse of laxatives, or excessive exercise.
  – According to the National Centers for Disease Control and Prevention, at any point in time 44% of high school females are attempting to lose weight compared with 15% of males (Serdula et al., 1993).
  – Bulimia nervosa literally means *ox appetite*.

**FIGURE 10-1**

Percentage of Women Reporting Dissatisfaction
SYMPTOMS OF ANOREXIA

• Refusal to Maintain a Normal Weight
  – The most obvious and most dangerous symptom of anorexia nervosa is a refusal to maintain a minimally normal body weight.
  – DSM-IV-TR contains no formal cutoff as to how thin is too thin but suggests 85 percent of expected body weight as a rough guideline.
  – The average victim of anorexia loses 25 to 30% of normal body weight.

SYMPTOMS OF ANOREXIA

• Disturbance in Evaluating Weight or Shape
  – A second defining symptom of anorexia nervosa is a perceptual, cognitive, or affective disturbance in evaluating one’s weight and shape.
  – Distorted body image
    • An inaccurate perception of body size and shape

SYMPTOMS OF ANOREXIA

• Fear of Gaining Weight
  – An intense fear of becoming fat is a third defining characteristic of anorexia.
    • The fear of gaining weight presents particular problems for treatment.
• Cessation of Menstruation (Amenorrhea)
  – The absence of at least three consecutive menstrual cycles
  – A reaction to the loss of body fat and associated physiological changes
SYMPTOMS OF ANOREXIA

• Medical Complications
  – Constipation, abdominal pain, intolerance to cold, lethargy
  – Lanugo: a fine hair on face or trunk
  – Anemia, impaired kidney functioning, cardiovascular difficulties, dental erosion, etc.
  – Electrolyte imbalance

• Struggle for Control

SYMPTOMS OF ANOREXIA

• Comorbid Psychological Disorders
  – Associated with other psychological problems, particularly obsessive–compulsive disorder, obsessive–compulsive personality disorder (Halmi, 2010)
  – Comorbid psychological problems may be reactions to anorexia, not the cause of it.
  – Depression is a common secondary reaction to starvation.
  – Anorexia often co-occurs with symptoms of bulimia.

SYMPTOMS OF BULIMIA

BINGE EATING
• Eating an amount of food that is clearly larger than most people would eat under similar circumstances in a fixed period of time
• Planned or spontaneous
• Fat, high carbohydrate
• Triggered by unhappy mood

INAPPROPRIATE COMPENSATORY BEHAVIOR
• Purging: designed to eliminate consumed food from the body
• Self-induced vomiting, misuse of laxative, diuretics, and enemas, exercise
• Purging has only limited effectiveness in reducing caloric intake
### SYMPTOMS OF BULIMIA

**EXCESSIVE EMPHASIS ON WEIGHT AND SHAPE**
- A symptom shared with anorexia nervosa
- Self-esteem and much of the daily routine is centered around weight and diet

**COMORBID PSYCHOLOGICAL DISORDERS**
- Depression is common
- May precede or follow the eating disorder
- Eating disturbances are more severe and social impairment greater when the two problems are comorbid (Stice & Fairburn, 2003)

### SYMPTOMS OF BULIMIA

- **Medical Complications**
  - Repeated vomiting can erode dental enamel.
  - Repeated vomiting can also produce a gag reflex that is triggered too easily and perhaps unintentionally.
    - **Rumination**: regurgitation and re-chewing of food
  - Enlargement of the salivary glands
  - Rupture of the esophagus

### DIAGNOSIS OF EATING DISORDERS

- **Brief Historical Perspective**
  - *Anorexia nervosa* coined in 1874 by Sir William Withey Gull, a British physician.
  - References to eating disorders were rare in the literature prior to 1960.
  - The diagnoses of anorexia nervosa and bulimia nervosa first appeared in the DSM in 1980 (DSM-III).
DIAGNOSIS OF EATING DISORDERS

• Contemporary Classification
  – Anorexia Nervosa
    • Defined by four symptoms
    • Includes two subtypes
      – Restricting type
      – Binge eating/purging type

• Bulimia Nervosa
  • Defined by five symptoms
  • Divided into two subtypes in DSM-IV-TR.
    – Purging type: regularly uses self-induced vomiting, laxatives, diuretics, or enemas
    – Nonpurging type: attempts to compensate for binge eating only with fasting or excessive exercise

BINGE EATING DISORDER AND OBESITY

• BED is characterized by episodes of binge eating but without compensatory behaviors
  – Emotional eating

• Obesity is defined as 20% above expected weight
  – Calling obesity a mental disorder is controversial
FREQUENCY OF EATING DISORDERS

- Anorexia nervosa is rare in the general population.
- It is far more common among certain segments of the population, however, particularly among young women (Keel, 2010).
- BED impacts 3.5% to 4.9% of women and 2.0% to 4.0% of men.
- AN is 10 times more common among women.
- BN is greater for women born after 1960.
### FREQUENCY OF EATING DISORDERS

#### STANDARDS OF BEAUTY
- Popular attitudes about women in the United States tell us that "looks are everything," and thinness is essential to good looks.
- Standards of beauty are relative, not absolute.

#### AGE OF ONSET
- Typically begin in late adolescence or early adulthood (Hudson et al., 2007)
- The onset of eating disorders has provoked much speculation about their etiology, including hormonal changes (Garfinkel & Garber, 1982), autonomy struggles (Minuchin, Rosman, & Baker, 1978) and various sexual problems (Covert, Kinder, & Thompson).

### CAUSES OF EATING DISORDERS

- **Social Factors: Physical Appearance**
  - Eating disorders are far more common among young women than young men.
  - The prevalence of eating disorders in the U.S. has risen, as the image of the ideal woman has increasingly emphasized extreme thinness.
  - Eating disorders are even more common among young women working in fields that emphasize weight and appearance, such as models, ballet dancers, and gymnasts.
What are the causes of eating disorders?

• Social Factors: Continued
  – Young women are more likely to develop eating disorders.
  – Eating disturbance increases with exposure to media.
  – Eating disorders are more common among White women.
  – Living in an industrialized society increases risk.
  – Arab and Asian women living in Westernized societies are at increased risk.

CAUSES OF EATING DISORDERS

• Social Factors
  – Troubled Family Relationships
    • Young people with bulimia nervosa report considerable conflict and rejection in their families, difficulties that also may contribute to their depression.
    • In contrast, young people with anorexia generally perceive their families as cohesive and nonconflictual (Fornari et al., 1999; Vandereycken, 1995).

• Psychological Factors
  – A Struggle for Perfection and Control
    • Hilde Bruch: German physician
      – Viewed struggle for control as the central psychological issue in the development of eating disorders
    • Perfectionism
      – Endless pursuit of control
      – Perfectionists tend to set unrealistically high standards, are self-critical, and demand flawless performance from themselves.
Psychological Factors

DEPRESSION, LOW SELF-ESTEEM AND DYSPHORIA

- Depression is often comorbid, but not always clinical depression
- Low self-esteem likely related with women being preoccupied with their social self
- Dsyphoria: negative mood state

NEGATIVE BODY IMAGE

- A highly critical evaluation of one’s weight and shape
- Negative evaluations of weight, shape, and appearance lead to disordered eating patterns, especially when combined with low self-esteem and the need for control

CAUSES OF EATING DISORDERS

- Psychological Factors
  - Dietary Restraint
    - Inappropriate dieting can contribute directly to subsequent binge eating.
    - Weight suppression
    - “Quick-fix” diets rarely work, and dieters are likely to be left with a sense of failure, disappointment, and self-criticism.
  - Dietary restraint also may directly cause some of the symptoms of anorexia nervosa.
CAUSES OF EATING DISORDERS

• Biological Factors
  – Weight set points: fixed weights or small ranges of weight
  – Genetic factors also contribute to eating disorders.
  – Genetics may influence some personality characteristic that, in turn, increases the risk for bulimia nervosa such as anxiety (Klump & Culbert, 2007).
  – Equifinality (Halmi, 1997)

TREATMENT OF ANOREXIA NERVOSA

• The treatments for anorexia nervosa and bulimia nervosa differ in approach and effectiveness.
• Treatment focuses on two goals:
  – Help the patient gain at least a minimal amount of weight.
  – Address the broader eating and personal difficulties.
• Some evidence that family therapy is more effective than individual therapy.

TREATMENT OF ANOREXIA NERVOSA

• Course and Outcome of Anorexia Nervosa
  – Evidence on the course and outcome of anorexia nervosa further shows the limited effectiveness of contemporary treatments.
  – Perhaps 5% of patients starve themselves to death or die of related complications, including suicide.
TREATMENT OF BULIMIA NERVOSA

INTERPERSONAL PSYCHOTHERAPY
- Focuses on difficulties in close relationships
- Does not address eating disorders
- Interpersonal psychotherapy versus cognitive-behavioral therapy

COGNITIVE BEHAVIOR THERAPY
- Christopher Fairburn: Three treatment stages:
  - Education and behavioral strategies
  - Address the client's broader, dysfunctional beliefs about self
  - Attempt to consolidate gains and prepare the client for expected relapses in the future

FIGURE 10-5
Percentage of Patients Who No Longer Purged

TREATMENT OF ANOREXIA NERVOSA
- Antidepressant medication
  - Medication alone is not the treatment of choice.
  - Relapse is common once medication has stopped.
  - Psychotherapy is an important component of treatment.
PREVENTION OF EATING DISORDERS

• Can eating disorders be prevented?
  – More successful prevention efforts do not directly focus on body image or disordered eating.
  – Instead, they attack the thinness ideal indirectly, or focus on promoting healthy eating rather than eliminating unhealthy habits (Stice et al., 2006).
  – Dissonance intervention
    • Participants complete tasks inconsistent with the thinness ideal.

FIGURE 10-6  Binge eating 6 and 12 months after either dissonance, healthy weight, or control interventions.

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