

Factors That Contribute to the Development of Eating Disorders

Psychological factors

- Feelings of inadequacy or lack of control in life
- Low self-esteem
- Depression, loneliness, anger, anxiety

Interpersonal factors

- Troubled relationships: family and social
- Difficulty expressing feelings and emotions
- Physical or sexual abuse

Social factors

- Cultural pressures that glorify thinness
- Norms that overlook inner strengths and qualities and value individuals on the basis of physical appearance

Biochemical/biological factors (under investigation)

- Impairment of brain areas shown to be associated with eating disorders (i.e., amygdala, prefrontal lobes, hypothalamus, and pituitary gland)
- Imbalance of serotonin, norepinephrine, and dopamine, brain chemicals that are linked to mood, anxiety, and appetite



Medication and Eating Disorders

Medication is being used in the treatment of eating disorders in conjunction with a multidisciplinary treatment plan that includes

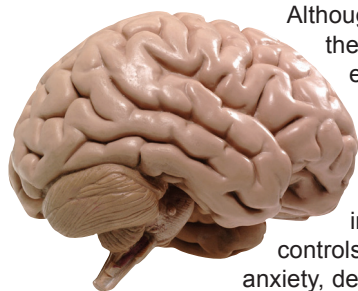
nutritional interventions and psychotherapy. Because individuals with eating disorders experience some of the same symptoms (e.g., obsessive behavior, lack of enjoyment, and distorted perceptions of reality) and similar brain impairment and neurotransmitter imbalance as individuals with psychiatric disorders (e.g., depression and obsessive-compulsive disorders), antidepressant and psychotropic medications are being used to treat both kinds of disorders.

Possible uses of these medications might be to:

- Treat comorbid psychiatric conditions (e.g., depression)
- Allow for weight restoration or loss
- Normalize thinking processes and mood
- Induce/reduce hunger; increase/decrease satiety
- Reduce anxiety and stress
- Prevent relapse

Other medications being used to treat eating disorders are stool softeners (for constipation), hormonal contraceptives (to boost estrogen and progesterone levels), and antihistamines (to stimulate weight gain; further research is needed for this use).

The Brain and Eating Disorders



Although researchers have not yet found the exact neurophysiological cause of eating disorders, they strongly suspect that brain dysfunction and neurotransmitter imbalance could be contributing factors. Specific areas of brain impairment might include the amygdala (which controls emotional activities such as anxiety, depression, aggression, and affection), the prefrontal lobes (which govern

motivation, reasoning, decision making, and restraint), the hypothalamus (which controls behaviors such as eating, sleeping, and sex and regulates body temperature, emotions, movement, and hormone secretions), and the pituitary gland (which controls thyroid and adrenal functions, growth, and sexual maturation).

Neurotransmitters associated with eating disorders include serotonin, dopamine, and norepinephrine. Serotonin has been associated with hunger, depression, sexual response, and anger; dopamine has been associated with weight, feeding behavior, reinforcement, and reward; and norepinephrine has been associated with stress and regulation of appetite.

Resources for Helping Teens with Eating Disorders

Books for Parents

Help Your Teenager Beat an Eating Disorder. James Lock and Daniel Le Grange, Guilford Press, 2004

Surviving an Eating Disorder. Michelle Siegel, Judith Brisman, and Margot Weinschel, Collins, 1997

The Body Betrayed: A Deeper Understanding of Women, Eating Disorders,

and Treatment. Kathryn J. Zerbe, Gurze Books, 1995

When Your Child Has an Eating Disorder: A Step-by-Step Workbook for Parents and Caregivers. Abigail H. Natenshon, Jossey-Bass, 1999

Books for Teens

What's Eating You? Tammy Nelson, Instant Help Publications, 2005

This Mean Disease: Growing Up in the Shadow of My Mother's Anorexia Nervosa. Daniel Becker, Gurze Books, 2005

Books for Professionals

Medical Management of Eating Disorders. C. Laird Birmingham and Pierre Beumont, Cambridge University Press, 2004

Eating Disorders: A Clinical Guide to Counseling and Treatment. Monika

Woolsey, American Dietetic Association, 2002

Handbook of Treatment for Eating Disorders, 2nd edition. David Garner and Paul Garfinkel (Eds.), Guilford Press, 1997

Comparative Treatments for Eating Disorders. Katherine J. Miller and Scott Mizes (Eds.), Springer Publishing, 2000

Defining the Problem

The most common eating disorders are anorexia nervosa, bulimia nervosa, and binge-eating disorder. Diagnostic criteria for these disorders are outlined by the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV-TR)*. The diagnostic criteria for anorexia include refusal to maintain body weight at or above minimum age-and-height norms (85% of what is considered normal); fear of becoming obese; distorted body image, (e.g., feeling fat even when emaciated); intense fear of becoming obese; and cessation of periods in postmenarchal females. The diagnostic criteria for bulimia include recurrent episodes of binge eating, recurrent inappropriate compensatory behaviors to prevent weight gain (e.g., self-induced vomiting, laxatives, diuretics, enemas, fasting, excessive exercise), depressed mood, and self-deprecating thoughts after binge eating.

Binge-eating disorder is characterized by frequent, repeated binge eating (often secretive), feelings of guilt, shame, depression, and loss of control. Individuals with binge-eating disorder are often obese with a history of diet failures. They eat to comfort themselves and to numb emotional pain, but they do not regularly vomit, compulsively exercise, or abuse laxatives (as bulimics do). While the prognosis of binge-eating disorder is considerably less severe than that of anorexia and bulimia, it is being frequently encountered in clinical practice and some researchers believe it may become the most commonly diagnosed eating disorder.

According to the National Institute of Mental Health (NIMH), an estimated 0.5% to 3.7% of females suffer from anorexia in their lifetime, and an estimated 1.1% to 4.2% of females have bulimia in their lifetime. Eating disorders are ten times more common in females than in males and occur in all ethnic groups, but appear to be most common among whites in industrial nations. Individuals in their teens and twenties are most often affected, but studies have reported eating disorders in children as young as six and adults as old as 76. About 1% of female adolescents have anorexia and about 4% of college-aged women have bulimia. Because individuals with bulimia tend to be secretive and do not seek medical attention, it is difficult to compute accurate statistics.



Goals in Developing a Treatment Plan

- To have teens realize and acknowledge that they need help to overcome their illness
- To help teens normalize their eating habits and overcome their disturbed perceptions of weight, eating, and size
- To identify and explore psychosocial and psychological precipitants of the illness
- To manage physical complications and comorbid psychological illnesses
- To involve family members in treatment program
- To maintain motivation and prevent relapse

Counseling Teens with Eating Disorders

The most effective treatment for teens with eating disorders involves an interdisciplinary team approach that includes mental health professionals, nutritionists, medical professionals, and a combination of individual and family counseling.

Strategies of Successful Treatment Teams

- Leave no aspect of treatment ambiguous; teens who cling to eating disorder behaviors for the feelings of self-worth they provide will use any lack of treatment consensus to their advantage.

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About Instant Help Charts

This chart is intended to provide a summary of the critical information available on helping teens with eating disorders to ensure that every teen gets the most appropriate and comprehensive consideration.

Assessing Eating Disorders

An assessment of a teen with symptoms of an eating disorder should include:

- Review of personal and family history
- Review of symptoms at presentation
- Thorough assessment of teen's medical status
- Screening and assessment for psychiatric issues or disorders, such as depression, anxiety, substance abuse, and personality

The initial assessment should evaluate such areas in the teen's life as weight history, history of dieting and food intake, weight-loss-related behaviors, body image perception and dissatisfaction, menstrual history, current and past psychological, family, social, and vocational functioning, past or present stressors, and readiness for change.

A more thorough assessment might include:

- Interviews with parents
- Interviews with other family members
- Interviews with friends and teachers

The purpose of these interviews is to obtain objective perspectives that might shed more light on the teen's problem. It is important to emphasize that the teen has a right to confidentiality; exercising this right may sometimes be appropriate because of abuse or stress in the family.

- Consultation with a registered dietitian for a nutritional evaluation
- Consultation with a psychiatrist or eating disorder specialist if the primary healthcare professional is a family practitioner or other clinician

Commonly used assessment tools include:

- *Eating Disorder Inventory* (Psychological Resources, 1979);

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Assessing Eating Disorders (continued)

Most popular and influential of available assessment tools; assesses thinking patterns/behavioral characteristics of anorexia nervosa and bulimia

- **Eating Attitudes Test** (Psychological Medicine, 1982); Distinguishes patients with anorexia nervosa from weight-preoccupied but otherwise healthy females
- **Bulimic Investigatory Test** (British Journal of Psychiatry, 1987); Assesses bulimic attitudes and behaviors
- **Perceived Body Image Scale** (Psychological Resources, 2004); Assesses body image disturbance, as does the Body Dissatisfaction subscale of the *Eating Disorder Inventory* mentioned earlier
- **SCOFF** (BMG Publishing Group, 1999); Assesses the five core areas of anorexia and bulimia: sick, control, one, fat, food, from which the acronym SCOFF is derived
- **Symptom Checklist-90-Revised** (Pearson Assessments); Measures current psychological symptom status

Because eating disorders are multifaceted, a thorough evaluation should use varied techniques that will provide information from multiple sources. In addition to the areas evaluated with reviews, assessments, screening, interviews and standardized assessment tools, healthcare professionals treating eating disorders need to remain keenly aware that suicidal ideation and history of sexual abuse are common among individuals with eating disorders.

Counseling Teens with Eating Disorders (continued)

- Acknowledge teens' feelings of conflict without attacking their inadequate strategies for coping with stress and issues of control.
- Identify stressors without placing or encouraging guilt in teen or family.
- Educate teen and family about the nature of the illness, serious health risks, and effective treatments, and emphasize the need for follow-up.
- Select individual, family, and group therapy on basis of teen's illness.
- Instruct teens about health and nutrition.
- Conduct regular evaluations of the treatment plan (with treatment team, teen, and family) to ascertain that the teen and family are progressing in treatment.
- Focus on prevention of relapse; recent studies suggest follow-up treatment for one to two years after weight restoration, as well as ongoing psychotherapy that incorporates cognitive behavioral therapy and use of antidepressants (e.g., selective serotonin reuptake inhibitors [SSRIs] such as fluoxetine).

Fast Facts

- The hallmark of eating disorders is "... the distorted attitude toward weight, eating and fatness that breeds the characteristic fear of fatness." (Hsu, L.K. George [1990]. *Eating Disorders*: New York: Guilford Press, p.12).
- Eating disorders have the highest mortality rate of any psychiatric disease, according to a review in the *British Journal of Psychiatry*. The review revealed that for anorexia, primary causes of death were suicide and starvation. For bulimia, primary causes of death were automobile accidents and suicide.
- Diagnosis of eating disorders, especially in their early stages, can be complicated because a wide variety of medical disorders can masquerade as eating disorders (e.g., inflammatory bowel disease, hyperthyroidism, chronic infections, and diabetes). Distinction: Most teens with medical conditions that lead to eating problems express concern over weight loss; most teens with eating disorders have a distorted body image and express a desire to be underweight.
- A number of psychiatric disorders (e.g., depression, personality disorders, affective disorders, obsessive-compulsive disorder, and substance abuse) co-occur with eating disorders. The most common comorbid conditions are major depression (~80%), obsessive-compulsive disorder (30%), and substance abuse (12-18% anorexia; 30-70% bulimia).

The Dos and Don'ts of Communicating

DON'T

- Blame the teen or anyone else for the eating disorder.
- Comment on other people's weight and appearance.
- Comment on the teen's appearance (because a comment about looking good may be misinterpreted as looking fat).
- Offer advice about weight loss, exercise, or appearance.
- Focus your relationship around the eating disorder.
- Be judgmental or label eating disorder behaviors as "sick" and "destructive."
- Make mealtimes uncomfortable by coercing the teen to eat or commenting about food.
- Lecture or be impatient. Eating disorder issues often take time to resolve.
- Put yourself in the role of diagnostician.
- Oversimplify the situation, e.g., by saying, "Just start accepting yourself as you are."

DO

- Express your love and support; show that you care.
- Be a good model for a positive self-image and healthy eating habits.
- Refer specifically to positive traits that are not related to appearance and weight, e.g., the teen's talent in art or music.
- Be informed. Make it a point to learn about eating disorders and body distortion.
- Plan social and one-on-one activities that do not involve food.
- Empathize with the teen's fear of gaining weight and being fat.
- Maintain a gentle, caring tone of voice when talking with the teen about health and nutrition.
- Encourage the teen to verbalize feelings, and listen carefully.
- Offer to accompany the teen to appointments with counselors, physicians, or nutritionists.

What Teachers Need to Know

Teachers can fill a critical need in promoting early detection and treatment as well as prevention of eating disorders. Ways to accomplish this include:

- **Becoming familiar with the signs and symptoms of eating disorders.** Teachers familiar with these symptomatic behaviors are more likely to notice them. For example, a physical education teacher may notice a student's plummeting weight; an art teacher may observe a teen whose work often portrays images of food and weight loss.
- **Serving as role models by being well nourished and feeling comfortable with their bodies.** Teachers should take care to not model body dissatisfaction or promote size discrimination.
- **Integrating topics related to eating disorders into health and science curricula such as:**
 - Good nutrition and body acceptance (grades 1-5).
 - Discussions of eating disorders (grades 4-6).
 - Emphasis on multiple causes of eating disorders (middle school).
- **Addressing issues related to eating disorders when teaching media literacy by:**
 - Challenging messages that equate beauty and thinness with self-worth.
 - Supporting products and messages that advocate healthy lifestyles.
- **Describing in a reassuring manner the normal diversity of body sizes and shapes that exists among teens' peers.**
- **Promoting a safe school environment by refusing to allow size and sexual discrimination, teasing, and name calling.**
- **Taking immediate action when concern arises about a student by:**
 - Keeping clear, concise notes of the student's behaviors that led them to their concern.
 - Sharing the concern about the student with other school personnel (e.g., eating disorder resource person, school counselor, school nurse, or fellow teachers).
 - Deciding with other school personnel on the best course of action regarding that student and who should talk to student and student's family.

More information on helping students with eating disorders and their prevention is available at: <http://www.bced.gov.bc.ca/specialed/edi/1.htm>.



What Parents Need to Know

Knowledge about eating disorders can enable parents to recognize early warning signs and symptoms.

Warning signs and symptoms for anorexia

- Weight loss of about 20% below normal
- Erratic or inadequate food intake and inability to regulate eating
- Compulsive exercise
- Tendencies to be perfectionistic, high-achieving, and people-pleasing
- Pathological fear of becoming fat
- Withdrawal from social activities

Warning signs and symptoms for bulimia

- Visits to bathroom immediately after meals (to intentionally vomit)
- Consumption of large amounts of food without weight gain
- Excessive concern about body, weight, or shape
- Use of laxatives and diuretics
- Withdrawal from social activities

Eating disorders are treatable and in many cases curable—with early detection and treatment. It is essential that parents provide understanding and support during treatment and maintenance. Parents need to understand that eating disorders are not about food and weight but rather about self-esteem, emotional imbalances, immaturities, and cognitive distortions. These disorders present an issue for the family; while parents do not cause an eating disorder, they need to acknowledge that they may have contributed to it.

Parents also need to know that:

- Eating disorder recovery does not happen quickly. Things may get worse before they get better, and relapses often occur;
- Treatment encompasses physiological, psychological, behavioral, and nutritional issues;
- The key to recovery lies in shifting the focus from body image to something that the teenager really loves;
- Successful treatment programs combine individual and family therapy and employ a team approach that includes a physician, nutritionist, and mental health professional.

A point that needs to be emphasized is that eating disorders are much easier to prevent than to cure, and parents—not physicians and therapists—are in the best position to help in their prevention and to spot early warning signs. More information on prevention is available at: <http://www.latimes.com/features/health/la-he-prevention3oct03,1,1941136.story>.

