Eating Disorders
Eating Disorders: An Overview

- **Major Types of Eating Disorders**
  - *Bulimia nervosa and anorexia nervosa*
    - Disruptions in eating behavior
    - Fear of gaining weight
  - **Sociocultural origins**
    - Westernized views
    - Because they occur in such a narrow group (90% females in upper middle-class to upper-class families), the origins are believed to be more socioculturally based than other disorders we discuss.
  - **Increasing rates** (1960-1995) 5% growth a year
    - Beginning to be seen in developing nations
    - Bulimia has increased from being almost non existent (in a clinic/treatment setting).
Eating Disorders: An Overview

• Obesity
  – 65% of US adults overweight
  – 30% obese
  – Rates are increasing
  – BMI versus weight
  – Health Risks
Bulimia Nervosa

• Binge eating
  – Excess amounts of food
  – Perceived as ‘out of control’
    • This perception is central to the diagnosis

• Compensatory behaviors
  – Purging
  – Excessive exercise
  – Fasting

• Belief that popularity and self-esteem are determined by weight and body shape (important qualifier in DSM)

• Gradual escalation of obsession/symptoms

• Self perpetuating
Bulimia Nervosa – Clinical Description

• Subtypes
  – Purging (most common)
    • Ineffective (laxatives, vomiting, diuretics)
    • Vomiting (50% of calories upper-limit), and laxatives/diuretics (none)
  – Nonpurging (6-8%) (exercise or fasting)

• Most individuals are within 10% of normal weight
Bulimia Nervosa

• Medical Consequences
  – Salivary gland enlargement
  – Erosion of dental enamel
  – **Electrolyte imbalance**
    • Kidney failure
    • Cardiac arrhythmia
    • Seizures
  – Intestinal problems
  – Permanent colon damage
Bulimia Nervosa

• Associated Psychological Disorders
  – Anxiety (75%)
    • Social phobia and GAD
  – Mood disorders (50-70%)
  – Substance abuse (36.8%)
Anorexia Nervosa – Clinical Description

• “Overly-successful” weight loss
  – 15% below expected weight
  – Intense fears
    • Gaining weight
    • Losing control of eating
  – Relentless pursuit of thinness
  – Often begins with dieting and then escalates
  – 20% die, 5% die within 10 years. **Highest mortality rate of any psychological disorder** we cover in this class
  – 1/2 deaths suicide
    • 50 fold increased risk of suicide when compared to general population
Anorexia Nervosa
Anorexia Nervosa – Clinical Description

- Subtypes
  - Restricting
  - Binge-eating-purging
    - Purging small amounts of food
    - More consistent too
  - Subtypes are not useful as patients switch back and forth (62% of restrictors report history of binge/purge)

- Associated features
  - Body image disturbance
  - Pride in diet and control
  - Rarely seek treatment
Anorexia Nervosa

- Medical Consequences
  - Amenorrhea
  - Dry skin
  - Brittle hair and nails
  - Sensitivity to cold temps
  - Lanugo
  - Cardiovascular problems
  - Electrolyte imbalance
Anorexia Nervosa

• Associated Psychological Disorders
  – Anxiety
    • OCD
      – Lots of rituals around eating
  – Mood disorders (33-60%)
  – Substance abuse
    • Suicide
Binge-Eating Disorder

- Food binges
- **No compensatory behaviors**
- Appendix of **DSM-IV-TR** (will likely be a new disorder)
- Experimental diagnostic category
Binge-Eating Disorder

• Associated Features
  – Many are obese
  – Older
  – More psychopathology
    • vs. non-binging obese
  – Concerned about shape and weight
Review

• What are the differences between Bulimia, Anorexia and binge eating?

• Why might subtypes not be appropriate for anorexia?
Bulimia and Anorexia: Statistics

• Bulimia
  – 90-95% female
    • Caucasian, middle to upper class
  – Onset = age 16 to 19
  – Lifetime prevalence
    • Females = 1.1%
    • College women = 6%-8%
  – Chronic, if untreated
Bulimia and Anorexia: Statistics

• Bulimia in men
  – 5-10% of cases are male
    • Caucasian, middle to upper class
    • Gay or bisexual
    • Athletes with weight regulations
  – Onset = older
  – Body dysmorphic disorder
Bulimia and Anorexia: Statistics

• Anorexia
  – 90-95% female
    • Caucasian, middle to upper class
  – Onset = age 13 to 15

– Chronic (less so than bulimia)
  • Even when the individuals have improved (no longer meet clinical criteria), they still generally carry subthreshold symptoms (low BMI and perceptions about image and body shape etc)

– Resistant to treatment?
Cross-Cultural Considerations

• North American minority populations

• **Immigrants to Western cultures**
  – Increase in eating disorders
    • Egypt Study
  – Increase in obesity

• Cultural values
  – China: acne is a leading precipitant to anorexia

• Standards for body image
Developmental Considerations

• Earlier and Earlier onset in Western World
  – More than half of girls 6-8 report wishing to be thinner. By 9, 20% were trying to lose weight and by 14, 40%.
  – In early onset cases, there is often fluid restriction as well.

• Adolescent onset

• Interaction with social ideals
  – Adiposity and weight gain
  – Puberty brings boys closer to ideal and girls farther away.

• Late onset eating disorders?
Causes of Eating Disorders

• Social Dimensions
  – Cultural imperatives
    • Thinness = Success & happiness
  – Ideal body size standards
    • Change rapidly
      – Playboy and miss America contestants
  – Media standards
    • Impossible to meet
  – Social and gender standards
    • Internal and perceived
Review

• These are the most culturally specific disorders in existence!

• Why are these disorders more common in college women?

• Why do they begin in adolescence?
Causes of Eating Disorders

- Social Dimensions
  - Dieting trends
    - Can actually cause weight gain
  - Perceptions of fat
    - Self image (attractive study)
  - Social and peer groups
    - Friends study
  - Dietary restraint (WWII study)
    - Dieting teenagers 8x more likely to develop ED
    - Restrainers more likely to over-eat!
Causes of Eating Disorders

• 1969: 30% of high-school females dieting
  20% of men
• 1993: 60.6% of females
  28.4% of men dieting

• Family Influences
  – “Typical” family
    • Successful
    • Driven
    • Concerned about appearance
    • Maintains harmony

  – History of dieting, eating disorders
    • Mothers
Causes of Eating Disorders

• Biological Dimensions
  – Heritability studies
    • Relatives 4 to 5x more likely
    • 23% monozygotic
    • 9% fraternal
      No adoption studies yet!
  – Inherited tendency to be emotionally responsive to stress, eat impulsively
  – Perfectionism
  – Hypothalamus?
    • Low Serotonin
      – Impulsivity and binge eating
Causes of Eating Disorders

• Diets alone are not enough to cause EDs

• Psychological Dimensions
  – Low sense of personal control
  – Low self-confidence
  – Perfectionistic attitudes
  – Distorted body image
  – Preoccupation with food and appearance
  – Mood intolerance
Drug Treatments of Eating Disorders

• Anorexia
  – No demonstrated efficacy

• Bulimia
  – Antidepressants
    • May enhance psychological treatment
    • No long-term efficacy
      – Prozac is better than placebo in the short term (lessening binge purge behavior)
        » But in the long term, it does nothing in terms of relapse
Psychological Treatment of Bulimia

- **Cognitive-behavior therapy (CBT)**-developed in 80s
  - Treatment of choice
  - Target problem eating behaviors
  - Psychoeducation about dieting
  - Small manageable meals (5-6 times a day) with no more than 3 hours between, helps to eliminate the alternating periods of over-eating and restriction (hallmarks of Bulimia).
  - Target dysfunctional thoughts

- **Interpersonal psychotherapy**
  - Improve interpersonal functioning
  - Similarly effective, long-term

- CBT may work quicker but if CBT doesn’t work, then interpersonal psychotherapy may help.

- Also, CBT appears to work better for Bulimia when paired with an SSRI
  - (CBT is superior to medication alone though)
Psychological Treatment of Binge-eating Disorder

• Cognitive-behavior therapy
  – Similar format to bulimia

• Interpersonal psychotherapy
  – As effective as CBT

• Medications
  – Prozac - no benefit
  – Meridia (antiobesity drug) - possible benefits
**Psychological Treatment: Anorexia Nervosa**

- If below 70% of average, or rapid weight loss occurs, then inpatient is recommended

- **Weight restoration**
  - May require hospitalization

- **Psychoeducation**

- Target dysfunctional attitudes
  - Body shape
  - Control
  - Thinness = worth

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**TABLE 8.3 Strategies to Attain Weight Gain**

1. Weight restoration occurs with other treatments, such as individual and family therapy, so that the patient does not feel that eating and weight gain are the only goals of treatment.

2. The patient trusts the treatment team and believes that she will not be allowed to become overweight.

3. The patient’s fear of loss of control is contained; this may be accomplished by having her eat frequent, smaller meals (for example, four to six times per day, with 400 to 500 calories per meal) to produce a gradual but steady weight gain (for example, an average of 0.44 pounds per day).

4. A member of the nursing staff is present during mealtimes to encourage the patient to eat and to discuss her fears and anxiety about eating and weight gain.

5. Gradual weight gain rather than the amount of food eaten is regularly monitored, and the result is made known to the patient; thus, the patient should be weighed at regular intervals, and she should know whether she has gained or lost weight.

6. Some negative and positive reinforcements exist, such as the use of graduated level of activity and bed rest, whether or not these reinforcements are formally conceptualized as behavior modification techniques so that the patient may thereby learn that she can control not only her behavior but also the consequence of her behavior.

7. The patient’s self-defeating behavior, such as surreptitious vomiting or purging, is confronted and controlled.

8. The dysfunctional conflict between the patient and the family about eating and food is not reenacted in the hospital or, if the pattern is to be reenacted in a therapeutic lunch session, the purpose is clearly defined.
Psychological Treatment of Anorexia (cont.)

• **Initial weight gain is a poor predictor of long-term outcome.**

• **Family involvement**
  – Communication about eating/food
  – Attitudes about body shape
  – Seeing parents separately may work better

• **Long-term prognosis**
  – Poorer than bulimia
Preventing Eating Disorders

- Identify specific targets
  - Early weight concerns

- Screening for at-risk groups

- Provide education
  - Normal weight limits
  - Effects of calorie restriction

- Can be internet-based

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**TABLE 8.4 Weight Concerns**

1. How much more or less do you feel you worry about your weight and body shape than other girls your age?
   a. I worry a lot less than other girls (4)
   b. I worry a little less than other girls (8)
   c. I worry about the same as other girls (12)
   d. I worry a little more than other girls (16)
   e. I worry a lot more than other girls (20)

2. How afraid are you of gaining 3 pounds?
   a. Not afraid of gaining (4)
   b. Slightly afraid of gaining (8)
   c. Moderately afraid of gaining (12)
   d. Very afraid of gaining (16)
   e. Terrified of gaining (20)

3. When was the last time you went on a diet?
   a. I’ve never been on a diet (3)
   b. I was on a diet about 1 year ago (6)
   c. I was on a diet about 6 months ago (9)
   d. I was on a diet about 3 months ago (12)
   e. I was on a diet about 1 month ago (15)
   f. I was on a diet less than 1 month ago (18)
   g. I’m now on a diet (21)

4. How important is your weight to you?
   a. My weight is not important compared to other things in my life (5)
   b. My weight is a little more important than some other things (10)
   c. My weight is more important than most, but not all, things in my life (15)
   d. My weight is the most important thing in my life (20)

5. Do you ever feel fat?
   a. Never (4)
   b. Rarely (8)
   c. Sometimes (12)
   d. Often (16)
   e. Always (20)

*Value assigned to each answer is in parentheses. Thus, if you chose an answer worth 12 in questions 1, 2, 3, and 5 and an answer worth 10 in question 4, your score would be 59. (Remember that the prediction from this scale worked for girls age 11–13 but hasn’t been evaluated in college students.)

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Obesity - Statistics

• Rapid increases in prevalence
  – U.S. adults
    • 1991 = 12%
    • 2004 = 32.2%
  – Teens and young children
    • 2000 = 13.9%
    • 2004 = 17.1%
  – Developing nations
  – Not in DSM?
  – Not just attributed to Binge eating (only 7-15% of obese individuals show symptoms)
Causes of Obesity

• Spread of modernization
  – Inactive, sedentary lifestyle + high fat foods

• Genetics
  – 30% of the cause

• Biological factors
  – Initiation and maintenance of eating

• Psychosocial factors
  – Impulse control, affect regulation, attitudes
Obesity Treatment

• **Progression from least to most intrusive**
  – Self-directed weight loss programs
  – Commercial self-help programs
  – Behavior modification programs
  – Bariatric surgery

• **Efficacy**
  – Moderate for adults
  – Higher for children and adolescents
    • Family involvement