

Eating Disorders: Anorexia Nervosa and Bulimia

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EMERGING scientific evidence of the increasing prevalence of eating disorders, anorexia nervosa and bulimia in particular, necessitates that physicians be prepared both to diagnose and treat these disorders appropriately. Current estimates indicate that anorexia nervosa and bulimia affect 10% to 15% of adolescent girls and young women, and estimates of the prevalence of bulimia among college women range as high as 19% (1). However, despite increasing public attention to such eating disorders, many physicians are unfamiliar with both the increased prevalence and the appropriate approaches to diagnosis and treatment.

Unfamiliarity with these disorders clearly limits a physician's ability to identify anorexia nervosa or bulimia in his or her patients. Two problems are of particular concern: First, the physician unfamiliar with these diseases may inadvertently overlook their role as etiologic agents in other presenting medical problems, thereby missing the opportunity to address the root cause of a particular ailment. Second, the physician may overlook the presence of an eating disorder in an otherwise apparently healthy patient, thereby missing the opportunity to counsel the patient and treat the disorder early in its development.

Herzog and Copeland (2) have recently summarized characteristics of the disorders as follows:

Anorexia nervosa is a syndrome characterized by extreme weight loss, body-image disturbance, and an intense fear of becoming obese. Bulimia is a syndrome distinct from anorexia nervosa and is characterized by secretive binge eating episodes followed by self-induced vomiting, fasting, or the use of laxatives or diuretics. Bulimic symptoms can also be part of the anorexia nervosa syndrome. An intense preoccupation with food is common to both syndromes.

Knowledge of the cause and pathogenesis of eating disorders is still evolving. Balaa and Drossman (1) have described anorexia nervosa as an endocrine and psychologic disorder characterized by a pathologic fear of weight gain that leads to faulty eating patterns, malnutrition, and unusual weight loss. Persons with anorexia or bulimia engage in various compulsive acts and rituals to

lose or control weight, including abstaining from food, vomiting, ingesting cathartic or diuretic substances, and exercising vigorously to the point of exhaustion (1).

Evidence indicates an increase in the prevalence of eating disorders. Herzog and Copeland (2) have reported that the incidence of anorexia nervosa in treated patients in a county of New York increased from 0.35 per 100 000 between 1960 and 1965 to 0.64 per 100 000 between 1970 and 1976. A Swiss study (3) reported that the incidence of treated cases of anorexia nervosa increased from 0.38 to 1.12 per 100 000 patients from the 1950s to the 1970s.

Pope and colleagues (4, 5) have reported that anorexia nervosa and bulimia affect approximately 5% to 10% of adolescent girls and young women. Dr. Preston Zucker, President of the American Anorexia/Bulimia Association and Director of the Anorexia Nervosa Program at Montefiore Center in New York, has stated that 10% to 15% of women aged 12 to 25 years have mild to severe forms of anorexia or bulimia. Noting the epidemic proportions of bulimia, he has estimated that as many as 19% of college-aged women develop all the major symptoms of bulimia (Zucker P. Unpublished observations). Other studies have shown that the prevalence of bulimia ranges from 7.8% to 19.6% among college women (6, 7). In addition to college-aged women, other groups have been identified as vulnerable to the disorder, including jockeys, wrestlers, gymnasts, models, ballet dancers, and actors and actresses. It is important to note that eating disorders can occur in men as well as women.

Although eating disorders are assumed to develop most frequently in adolescent and college-aged women, anecdotal reports of eating disorders that persist late into life have been given by some physicians. Physicians should look for signs of eating disorders in women aged 30 to 50 years who may have been engaging secretly in anorectic or bulimic behavior for years (8).

Hedblom and associates (9) have reported the demographic characteristics of a sample of 75 patients (4 young men, 71 women) who had atypical anorexia. Two of the women were black and 8 were between 31 to 61 years old. Thirty-nine patients were 13 to 20 years old, and 28 ranged in age from 21 to 30. Of the entire group, 52 were from the professional, business, or management occupations.

According to Balaa and Drossman (1), anorexic patients have psychological, perceptual, and cognitive disturbances. Compared with the self-perceptions of normal and thin persons, anorexic persons overestimate their body width—particularly in the face, chest, waist, and hips—while their assessment of inanimate objects or oth-

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er persons' bodies remains undistorted. They distort hunger awareness, deny fatigue by being hyperactive, and fail to recognize emotional states such as anger, anxiety, and depression. Anorexic persons have deficits in conceptual thought and abstract reasoning, are unable to view situations in anything but extremes, and interpret events in rigid and highly personalized ways.

The consistency of patient characteristics suggests that sociocultural factors influence the development of the anorexia. Bennett and Gurin (10) noted that one contributing factor may be the change in ideal for women from plumpness in the previous century to slimness in the present century, which may be an expression of female liberation from the restrictive and traditional reproductive or maternal roles of the past. The pressure on women in this century to achieve and to be successful, independent, and competitive while maintaining the traditional role of wife, homemaker, and mother also may create an environment in which the disorder becomes more prevalent among those predisposed to it (2).

One of the difficulties facing the clinician is that the patient with bulimia generally appears physically healthy, but anxiety and depression have developed by the time he or she seeks help; 5% already will have attempted suicide. Most patients with bulimia are preoccupied with thoughts of eating, and binge-purge cycles interfere with work or social activities in one third of these patients (1).

The person susceptible to bulimia usually is a high achiever, has marked parental dependence, is socially ambitious, and has difficulty establishing personal relationships. Depression and impulsive or antisocial behavior including drug abuse, kleptomania, and sexual promiscuity are common (1). Fairburn and Cooper (11) found that 60% of bulimic patients went through a period of rigid dieting and purging before a period of bingeing and purging.

Although numerous questions about the origins of eating disorders and the most effective approach to treatment remain unanswered, recognition of the prevalence of these disorders among certain sectors of the population must be a high priority for those internists whose patient population includes persons apt to be at risk. In addition, for the practicing subspecialist, the possible role of eating disorders as an underlying factor in other presenting problems must be understood.

The American College of Physicians believes it essential that the practicing physician be aware of the apparently growing extent of the problem of eating disorders and thus be prepared to recognize and treat these ailments appropriately. Although many patients with these disorders seek professional assistance from psychologists, nutritionists, social workers, and others, a significant number seek the help of internists. Because anorexia and bulimia cause anguish and pain in patients and their families, the treatment of these disorders poses a challenge to the physician. In view of the increasing prevalence of these disorders, the internist must have a thorough knowledge of their nature and symptoms as well as diagnostic and treatment procedures needed.

Summary of Positions

1. The American College of Physicians believes that in view of the increasing occurrence of anorexia nervosa and bulimia, internists should be aware of the need for appropriate history taking in at-risk persons and should be sensitive to the possible existence of anorexia nervosa and bulimia in those patients presenting with other potentially related health problems.

2. The American College of Physicians believes that the internist treating a patient who has anorexia or bulimia must be sensitive to the patient's emotional insecurities and possible medical problems. He or she should be prepared to accept the role as central care provider on a team of medical, psychological, and nutritional professionals. The internist must be aware not only of appropriate clinical treatment but also of appropriate resources for patient referral.

3. The American College of Physicians supports the expansion of educational offerings for the physician-in-training and continuing medical education for the practicing physician to ensure appropriate understanding of the nature and symptoms of anorexia nervosa and bulimia, as well as current diagnostic and treatment approaches.

4. The American College of Physicians supports initiation of efforts toward appropriate education of the public about the problems of anorexia nervosa and bulimia, associated medical hazards, and approaches to treatment.

Position 1

The American College of Physicians believes that in view of the increasing occurrence of anorexia nervosa and bulimia, internists should be aware of the need for appropriate history taking in at-risk persons and should be sensitive to the possible existence of anorexia nervosa and bulimia in those patients presenting with other potentially related health problems.

There is no recognized single pathologic, physiologic, or psychiatric characteristic of anorexia nervosa. The diagnosis must depend on identification of behavioral features relating to attitudes about body images and eating that are consistent with this disorder and not with any other treatable diseases; few patients have such clearly evident cases that all diagnostic testing can be avoided. Furthermore, an ongoing controversy exists about the relation between anorexia nervosa and bulimia. The literature offers no classical model for the diagnosis of either disorder.

The internist may consider using the following "Diagnostic Criteria for Anorexia Nervosa" (Diagnostic and Statistical Manual—III, DSM-III) established by the American Psychiatric Association (1): intense fear of becoming obese that does not diminish as weight loss progresses; disturbance of body image—namely, claiming to "feel fat" even when emaciated; weight loss of at least 25% of original body weight, or, if under 18 years of age, weight loss from original body weight plus projected weight gain based on growth charts (to make the 25%); refusal to maintain body weight above a minimal normal

weight for age and height; and no known physical illness that would account for the weight loss.

The American Psychiatric Association (1) also has developed criteria to aid the practitioner in ascertaining the presence of bulimia. These criteria include the presence of recurrent episodes of binge eating and at least three of the following characteristics: consumption of high-caloric, easily ingested food during a binge; inconspicuous eating during a binge; termination of eating episodes by abdominal pain, sleep, social interruption, or self-induced vomiting; repeated attempts to lose weight through severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics; and frequent weight fluctuations of more than 4.5 kg caused by alternating binges and fasts. Other criteria include the patient's awareness that the eating pattern is abnormal and fear of being unable to stop eating voluntarily; the onset of a depressed mood and self-deprecating thoughts after eating binges; and the exclusion of anorexia nervosa or other known physical disorders as having caused the bulimic episodes.

The identification of patients with eating disorders who otherwise appear "healthy" poses a particular problem for the practitioner. However, because of the noted incidence of eating disorders in certain populations, particularly (although clearly not limited to) young women, each internist should consider giving special attention during history-taking and counseling sessions to those potentially at risk.

Thus, in addition to the usual complete patient history, the internist should consider using a series of questions particularly focused on identifying anorexic or bulimic persons among those patients at risk for these disorders. The following series of suggested questions to ask patients, developed by Staton (12), may help in the formulation of expanded histories for certain populations: Do you feel helpless in the presence of food? Are you a binge eater? Do you try every new diet and always end up gaining back the weight you lose? Do you try to control your weight by vomiting, use of laxatives or diuretics, over-exercise, or episodes of starvation? Do you eat when you are not hungry? Do you eat when you are anxious? Do you eat when you are depressed? Do you feel guilty after an eating binge? Do you eat sensibly around other people and then "pig out" when you are alone?

Position 2

The American College of Physicians believes that the internist treating a patient who has anorexia or bulimia must be sensitive to the patient's emotional insecurities and possible medical problems. He or she should be prepared to accept the role as central care provider on a team of medical, psychological, and nutritional professionals. The internist must be aware not only of appropriate clinical treatment but also of appropriate resources for patient referral.

It is usually the physician whom the patient with anorexia or bulimia approaches with various physical complaints. The effectiveness of the diagnosis and treatment of these disorders depends mostly on the clinician's attitude, perceptiveness, and special sensitivity in uncovering

the patient's underlying psychological problems that provoke such an intense fear of becoming obese.

In those instances in which the physician may be most active in managing the case of a patient with severe malnourishment and in providing psychological support, the internist should earn the patient's trust by honesty, objectivity, and dependability to foster a sense of autonomy that helps the patient effectively manage his or her life; involve the patient's family in the treatment; and serve as manager of the patient's care and as liaison among the other health professionals involved in the care (1).

Regimens for anorexic and bulimic patients that involve medical, psychiatric or psychological, and nutritional treatment may be the most satisfactory. However, because of the serious and extensive nature of the physical problems that attend the underlying psychological disorders, the physician should assume the lead role in rendering direct medical care as well as assuring the total care of the patient.

Balaa and Drossman (1) note that providing assistance to the anorexic patient in modifying dysfunctional eating behavior and managing his or her life generally involves three types of therapy: *insight-oriented therapy*, in which the patient is made aware of psychological defenses so he or she can recognize underlying conflicts and adopt more realistic beliefs and behaviors; *behavior modification*, in which symptoms as opposed to underlying disturbances are treated by reinforcing patient behaviors that increase weight; and *family therapy*, in which interactions among members of families that maintain incongruous communication and power struggles are explored. Case studies indicate that insight-oriented therapy is effective, although the method has not been tested adequately. Behavior modification relies on external reward systems; manipulation of a patient's behavior may heighten the sense of ineffectiveness and lack of control. Family therapy, on the other hand, has been shown to have long-term effects (1).

Balaa and Drossman (1) have noted that various drugs have been reported to be effective in the treatment of anorexia nervosa. However, the assessment of the effectiveness of these drugs in short-term trials has been confounded by concurrent treatments given in inpatient settings, including behavior modification and psychotherapy. In short, future trials are needed to clarify fully the effectiveness of these drugs.

The literature contains few data about the treatment of bulimia, and no specific forms of treatment have been established. Patients with bulimia recognize that their behavior is maladaptive and they can work with the physician to achieve a goal. Because the patient usually can interpret his or her symptoms in terms of current and past emotional concerns, the internist may discuss the psychological issues and help the patient adopt better coping methods (1).

Although the cognitive-behavioral approach used in the management of bulimia focuses on the control of eating as the primary problem and other difficulties as secondary (13), further controlled trials are needed to con-

firm the benefits of this approach (14). The treatment is accomplished in three stages.

Self-monitoring (two to three visits per week for 4 to 6 weeks): The patient records the type of food consumed, when it was consumed, and his or her degree of control. The physician accomplishes stimulus control by asking that the patient establish an eating pattern of three or four meals per day, reduce the amount of food available, and engage in other activities. (Note that stopping the vomiting is not emphasized; it ceases once eating is under control.)

Recognition of Stress-Binge Association and Development of Coping Strategies: The patient becomes aware of the association between a stressful event and a feeling of loss of control. With this recognition, the patient gains greater control of eating patterns, which in turn provides the physician the opportunity to help the patient develop more adaptive mechanisms.

Maintenance (bimonthly for 2 months): The physician advises the patient to write down tactics used to avert binge-purge cycles during stressful events, which reinforces more adaptive coping mechanisms.

Data on the use of drugs to treat bulimia are limited. Antidepressants have a theoretical value in treating this disorder: Almost 90% of bulimic patients have clinical depression or depression according to DSM-III criteria, and a high frequency of major affective disorders exists in first-degree relatives of bulimic patients (15).

In a placebo-controlled study, imipramine significantly benefited patients with bulimia by leading to decreases in the frequency and intensity of binges as well as preoccupation with food, and by increasing the patients' sense of well-being and scores on the Hamilton Rating Scale for depression. (These findings support those from previous uncontrolled case reports [1].) Community physicians have prescribed appetite depressants but with little evidence of benefit (1).

Three groups of bulimic patients with possibly different psychological profiles and prognoses have been identified. The mildest forms of bulimia occur among college women, who respond to brief group therapy or behavioral techniques. The second group consists of mostly college students who consume more food, binge and vomit more frequently each day, and require more intensive treatment—often including hospitalization. The third group consists of older patients who have chronic and stable bulimia; they have more established bingeing and purging patterns that occur daily. (These patients have come to terms with the disorder and the behavior does not disrupt their daily activities) (16).

Recommendations of available resource centers are difficult to obtain. Physicians and other health professionals caution that no standards exist by which to determine the appropriateness or quality of care provided by many of the centers that treat patients with eating disorders.

Position 3

The American College of Physicians supports the expansion of educational offerings for the physician-in-training and continuing medical education for the prac-

ting physician to ensure appropriate understanding of the nature and symptoms of anorexia nervosa and bulimia, as well as of current diagnostic and treatment approaches.

RATIONALE

Because of the current prevalence of eating disorders in certain populations, knowledge and understanding of anorexia nervosa and bulimia is essential both for the physician-in-training and the practicing physician who may not be familiar with the rising occurrence of these disorders. A widespread effort is needed to ensure that those internists most apt to encounter patients with anorexia or bulimia are familiar with methods of diagnosis and appropriate treatment.

Position 4

The American College of Physicians supports initiation of efforts toward appropriate education of the public about the problems of anorexia nervosa and bulimia, associated medical hazards, and approaches to treatments.

RATIONALE

Public education programs on anorexia nervosa and bulimia would serve as beneficial instruments in teaching women and men about the medical hazards of these disorders. Of particular concern is the need to deglamorize the effects of bulimia; in many instances those who become bulimic have learned about the process through friends or family members or through the current spate of media attention to the disorder. A critical need exists for providing the public with sufficient information on the true medical hazards of these eating disorders so that the attraction to trying these approaches can be offset. In addition to this effort, assistance to the public in identifying sources for treatment of such disorders should be initiated. The American Anorexia/Bulimia Association maintains an up-to-date listing of centers that offer individual and group therapy for eating disorders. (For more information, contact American Anorexia/Bulimia Association; 133 Cedar Lane; Teaneck, NJ 07666. Telephone, 201-836-1800.)

The American College of Physicians strongly supports identification of such resources for both the public and the physician community. Frequently, it is a concerned family member or friend who urges the person with an eating disorder to seek assistance; sound advice on appropriate avenues to pursue in obtaining such assistance would be useful.

► Requests for reprints should be addressed to Elnora Rhodes; American College of Physicians, 655 Fifteenth Street, N.W., Suite 425; Washington, DC 20005.

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