Editorial

Thinness: a woman's conflict or Eating Disorders: Facts and the Search for Solutions

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Abnormal eating behaviours are often initiated as a response to feelings of insecurity and a distorted perception of the importance of body shape and size in determining self worth. Unfortunately in some extreme cases, this obsession with thinness can lead to serious distortion of body image and Eating Disorders (ED). Eating disorders are not due to a failure of will or behavior; rather, they are real, treatable medical illnesses in which certain maladaptive patterns of eating take on a life of their own.[1] They are considered to be psychiatric disorders characterized by abnormal eating patterns and cognitive distortions related to food and weight, which in turn results in adverse effects on nutrition status, medical complications and impaired health which can be some times life threatening.[2] The mortality rate associated with ED's is more than 12 times as high as the mortality rate among young women in the general population.[2,3]

Research shows 85% of ED has their onset during the adolescent years. Majority (90%) of those who have ED are females between the ages of 12-35 years. However increasing numbers of older women are having these disorders. Body image dissatisfaction in midlife has increased dramatically; more than doubling from 25% in 1972 to 56% in 1997. Sixty percent of adult women are engaged in pathogenic weight control, 40% are restrained eaters, another 40% are over eaters, 50% say their eating is devoid of pleasure and causes them a feeling guilt.[2-4] Although these figures reflect western scenario but it is important for health providers to note that often statistics on issues where psychological contributions to its initiation are strong, our society tends to remain numb due to the strong prejudices and stigma attached with people who suffer from these clinical conditions. ED was once considered to be the characteristics of upwardly modem females in technologically advanced nations; today the effects of rapid globalization have made it a world wide condition. Clinical ED, body image despair, severe dieting and weight preoccupation are no longer restricted to certain high risk groups in limited geographic, localities[4,5] and therefore require our understanding of its type, diagnosis and treatment options.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) classify ED's into four types. Anorexia nervosa (AN) which results from a morbid fear of obesity in which the person's distorted body image is reflected as fat when the body is actually undernourished and extremely thin from self starvation.[6,7] An estimated 0.5 to 3.7 percent of females suffer from anorexia nervosa in their lifetimes.[8] Bulimia nervosa (BN) in which cycles of gorging on large quantities of food are followed by self induced purging or use of diuretics to maintain "normal" body weight is estimated to be around 1.1 to 4.2 percent among females during their lifetime.[5,6,8] Binge Eating Disorders' (BED) where victims have episodes of eating large quantities of food in a brief period and feel out of control during the binge, however they don't try to get rid of food by inducing vomiting, fasting or laxative abuse.[5,6] Community surveys have estimated that between 2-5 percent of females experience binge-eating disorder in a 6-month period.[5,7] And the fourth type is Eating Disorder Not Otherwise Specified (EDNOS) which doesn't meet the criteria of any specific eating disorders but accounts for almost 50% of the population suffering with this condition. Dieting continues to be a common entry point in all types, with the greatest risk being the group of severe dieters.

Over a life time, an individual may meet diagnostic criteria for more than one of these conditions, suggesting a continuum of disordered eating. Attitudes and behaviors relating to food and weight overlap substantially. Nevertheless, despite attitudinal and behavioral similarities, distinctive patterns of comorbidity and risk factors have been identified for each of these disorders.

What causes eating disorders is not entirely clear, though a combination of psychological, genetic, social and family factors are thought to contribute to the disorder. Some research suggests that media images contribute to the rise in the incidence of eating disorders. Most women in advertising, movies, TV, and sports programmes are very thin, and this may lead girls to think that the ideal of beauty is thinness. This concern can begin at an alarmingly young age.[1,3,5] Research shows that 42% of first to third-grade girls want to be thinner, and 81% of 10-year-olds are afraid of being fat.[9] Frequently a person who develops an eating disorder has a low self-esteem and often the focus on weight is an attempt to regain a sense of control.

While eating disorders result from a serious mental and behavioral health condition, they can lead to other serious physical health problems. A person with anorexia or bulimia may experience dehydration as well as other medical complications. It can affect growth, bone mass and gastrointestinal problems. The continuous vomiting involved in bulimia can cause tears and severe inflammation of the esophagus, in addition to gastric disturbances, blood pressure problems, and erosion of tooth enamel. In advanced stages, it can affect the brain and cause symptoms such as dizziness, fainting, agitation, confusion, inability to concentrate, and loss of memory.[10]

It is common for people with eating disorders to act defensive and angry when confronted for the first time. They often have trouble admitting, even to themselves, that they have a problem. Trying to help a person who doesn't think he or she needs help can be hard. It is important that to approach concerns, in a supportive and non-threatening way.

Eating disorders clearly illustrate the close links between emotional and physical health. The first step in treating anorexia nervosa is to assist patients with regaining weight to a healthy level; for patients with bulimia nervosa interrupting the binge-purge cycle is a key. Expected rates of controlled weight gain or loss should start from the base and be realistic. Approximately 0.9 to 1.4 kg per week for most inpatients and 0.2 to 0.5 kg per week for most outpatients is a reasonable goal to achieve in most cases. Intake levels usually begin at 30 to 40 kcal/kg (1000 to 1500 kcal /day) and are advanced progressively.[I,3,10] For patients with binge eating disorder it is important to help them interrupt and stop binges. However, restoring a person to normal weight or temporarily ending the binge-purge cycle does not address the underlying emotional problems that cause or are made worse by the abnormal eating behaviour.[7] Psychotherapy helps individuals with eating disorders to understand the thoughts, emotions and behaviours that trigger these disorders. In addition, some medications have also proven to be effective in the treatment process. Because of the serious physical problems caused by these illnesses, it is important that any treatment plan for a person with anorexia nervosa, bulimia nervosa, or binge eating disorder include general medical care, nutritional management and nutritional counseling. These measures begin to rebuild physical well-being and healthy eating practices. Generally, the earlier the intervention, the shorter is the treatment that is required. If an eating disorder can be discovered before malnutrition or continual binge-purge cycles occur, the duration of treatment is even shorter.[l,2,3,10]

The nutritionist dietitian can play a major role by providing nutritional education about a healthy diet and the rationale for making changes in eating behaviours. She can also engage in concrete dialogue with the patient surrounding available meal or dietary options and give specific caloric or meal plan requirements.

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