Health Care Providers

Eating disorders are a serious health issue

Eating disorders can pose serious health risks to young people. Approximately 1 out of every 100 adolescent girls develops *anorexia nervosa*, and another 2 to 5 develop *bulimia nervosa*.[1] Both can lead to serious health complications and even death. *Binge eating disorder* affects millions more and can result in complications associated with obesity. Anorexia, bulimia, and binge eating disorder are serious and chronic mental health problems associated with anxiety and depression.

Children and adolescents should be routinely screened for eating disorders

Eating disorders are often preceded by troublesome eating behaviors known as *disordered eating* in children as young as 8 years old. As a primary care provider, you are in a unique position to detect eating disorders in the early or subclinical stages. Early detection through routine screening greatly increases the likelihood of successful treatment and recovery. The prevalence of eating disorders is increasing in boys as well as girls, and these disorders affect young people of most ethnic, cultural, and socioeconomic groups. Routine screening for eating disorders is an increasingly important aspect of your young patients' care.

The American Medical Association's Guidelines for Adolescent Preventive Services (GAPS) describe the recommended content and delivery of comprehensive clinical preventive services for adolescents between 11 and 21 years of age. GAPS recommends that all adolescents be screened annually for eating disorders and obesity by determining weight and stature, and asking questions about body image and dieting patterns.[2] The BodyWise sheet "**Tips for Health Care Providers**" offers an outline of signs to look for and questions to ask adolescent patients and their parents.

Adolescence is a time of change

Pre- and early adolescence is a time of dramatic physical and psychological change. Along with physical changes such as height and weight gains and sexual maturation, pre-adolescents often experience mood swings and wavering self-esteem. Influenced by the media and susceptible to peer pressure, young people may become increasingly concerned about body image during these years and base their feelings of self-esteem and self-worth on their appearance. They may be teased about their developing bodies by family or friends or may use food as a way of coping with the pressures in their lives. Body dissatisfaction, fear of fat, being teased, dieting, and using food to deal with stress are major risk factors associated with disordered eating.[3]

What defines an eating disorder?

Eating disorders are complex illnesses that rank as the third most common chronic illness in adolescent females, with an incidence rate of up to 5 percent.[4] The American Psychiatric Association's DSM-IV criteria for anorexia and bulimia are listed in Table 1. Binge eating disorder has been introduced provisionally in the DSM as a specific type of eating disorder not otherwise specified (EDNOS). The criteria are also described in Table 1.

Other types of eating disorders and disordered eating have been identified as follows:

- ***Eating Disorder Not Otherwise Specified*** (EDNOS) includes characteristics of one or more eating disorders but does not fit the diagnostic criteria for any one disorder.
- ***Disordered Eating*** refers to troublesome eating behaviors that are less frequent or less severe than those that occur in an eating disorder.
- ***Overexercising*** is exercising compulsively for long periods of time as a way to control weight. It is often viewed as a type of purging behavior, frequently associated with bulimia or anorexia.

Table 1. DSM-IV Diagnostic Criteria[5]

Anorexia Nervosa

- Refusal to maintain body weight at or above a minimally normal weight for height and age, or failure to make expected weight gain during period of growth, leading to body weight 15% below that expected.
- Intense fear of gaining weight or becoming fat, even though underweight.
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or denial of the seriousness of current low body weight.
- In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles.

Restricting type: The person does not regularly engage in binge eating or purging during the anorexia episode.

Binge eating/purging type: The person regularly engages in binge eating or purging during the anorexia episode.

Bulimia Nervosa

- Recurrent episodes of binge eating (eating an abnormally large amount of food in a discrete period of time, with a sense of lack of control over eating during the episode).
- Recurrent inappropriate compensatory behavior to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
- Binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.
- Self-evaluation is unduly influenced by body shape and weight.
- The disturbance does not occur exclusively during episodes of anorexia nervosa

Binge Eating Disorder

- Recurrent episodes of food consumption substantially larger than most people would eat in a similar period of time under similar circumstances.
- A feeling of being unable to control what or how much is being eaten.
- Associated with 3 (or more) of the following:
  - — Eating very rapidly.
  - — Eating until feeling uncomfortably full.
  - — Eating large amounts of food when not feeling physically hungry.
  - — Eating alone because of being embarrassed by how much one is eating.
  - — Feeling disgust, guilt, or depression after overeating.
- Marked distress or unpleasant feelings during and after the binge episode, as well as concerns about the long-term effect of binge eating on body weight and shape.
- Binge eating that occurs, on average, at least 2 days a week for 6 months.
- The binge eating is not associated with the regular use of inappropriate compensatory behaviors (e.g., purging, fasting, excessive exercise) and does not occur exclusively during the course of anorexia nervosa or bulimia nervosa.

Eating disorders can cause serious complications

Anorexia has the highest rate of premature death of any psychiatric illness, with 1 in 10 cases leading to death by cardiac arrest, starvation, other medical complications, or suicide.[6] Complications of anorexia may include heart failure due to malnutrition, hypometabolism, and increased risk of osteoporosis. Young women with anorexia have an increased risk of bone fractures.[7] In addition, anemia, reduced muscle mass, cessation of menstruation, and edema may accompany weight loss in anorexia.[8]

Most complications of ***bulimia*** result from electrolyte imbalance or trauma from repeated purging behaviors. Loss of potassium damages heart muscle, increasing the risk for cardiac arrest. Repeated vomiting can cause esophagitis, enlargement of salivary glands, and erosion of tooth enamel.[9]

Individuals with ***anorexia and bulimia*** have high rates of clinical depression, and often suffer from anxiety or personality disorders. Eating disorders may be related to other health risk behaviors, such as substance abuse and unprotected sexual activity.[10]

Binge eating disorder affects up to 4 percent of the general population. Complications are similar to those found in obesity, including high blood pressure, diabetes, and increased risk of gallbladder disease, heart disease, and some types of cancer. Individuals with binge eating disorder also have high rates of depression.[11]

Although large numbers of teenagers who have disordered eating do not meet the strict DSM-IV criteria for either anorexia nervosa or bulimia nervosa, many have similar levels of emotional distress. Up to 60 percent of adolescent girls consider themselves overweight and have attempted to diet. In one study, more than half of the adolescents evaluated for eating disorders had subclinical disease but suffered a similar degree of emotional distress as those who met strict diagnostic criteria.[12]

Eating disorders should be diagnosed in the context of multiple aspects of normal growth and development

Applying strict diagnostic criteria for eating disorders such as DSM-IV may not be the best way to detect eating disorders in adolescents. For example, weight loss—one of the diagnostic criteria for anorexia—is not necessarily present in younger adolescents whose weight may remain stable as they grow in stature. Severe nutritional deficits can occur even in the absence of weight loss in early adolescence. The use of strict criteria may also make it more difficult to recognize eating disorders in their early stages and subclinical form. It is essential to diagnose eating disorders in adolescents in the context of the multiple and varied aspects of normal adolescent growth and development.[13] The rate of most rapid weight gain for girls is from age 9 to 14. By the time a girls reaches 18 years, it is likely she will nearly double her weight.[14] Families and health care providers may notice this rapid weight gain but fail to provide adequate reassurance to the girls that their body sizes and weights are in the normal range. Adolescent depression may camouflage an underlying eating disorder that may go undetected but which requires a separate treatment plan.

Communicate with patients and parents

Patients with eating disorders often feel shame, guilt, and fear that their illness will be discovered. Their eating disorder is not simply a physical problem; it is a way of coping with emotional distress. They may distrust health care providers and resist pressure to give up the disorder. In order to trust you, they must perceive that you have empathy, respect, and a genuine concern for them. It is important to be sensitive to and validate your patient's feelings; provide a non-judgmental, caring environment; and ensure confidentiality.[15]

As a health provider, you are in a powerful position to intervene to help reduce the risk of eating disorders. These are some specific steps you can take:

- Obtain updated information on the risk and prevalence of eating disorders, including those of ethnic/racial and male populations.
- Remain informed about the warning signs and symptoms of eating disorders and the consequent medical complications.
- When interacting with patients, be aware of any prejudices you may have about weight and body shape.
- In a caring way, ask patients how they feel about and how they are taking care (or failing to take care) of their bodies.
- Remind parents of the importance of modeling appropriate eating behaviors and attitudes towards body image.
- Provide patients and family members with accurate information regarding healthy eating and realistic weight management strategies.
- Participate in local educational programs to assure that strategies to discourage disordered eating and promote early detection of eating disorders are integrated into the school culture and athletic activities.

The fact sheet for parents included in this packet can help you discuss eating disorders with your patients' parents.

A team approach is best

While you as the primary care provider play an essential role in the early diagnosis and treatment of an eating disorder, the complexity of the illness calls for a team approach. Assessment and ongoing management is best undertaken by a team of medical, nutritional, and mental health professionals to evaluate the severity and meaning of the symptoms and to both prescribe and provide care. It is essential that team members communicate regularly about the patient and clarify their roles in treatment on an ongoing basis, to the patient and the family, as well as to each other. You are a key player on that team.[16]

End Notes

[1] Office on Women's Health. *BodyWise handbook: Eating disorders information for middle school personnel.* Washington, DC.: Author, 1999.

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[3] French S.A., Story M., Downes B., Resnick M.D., Blum R.W. Frequent dieting among adolescents: psychosocial and health behavior correlates. *American Journal of Public Health.* 1995; 85:695-701; Striegel-Moore R.H., Silberstein L.R., Rodin J. Toward an understanding of risk factors for bulimia. *American Psychologist.* 1986; 41:246-263.

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[5] American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th edition). Washington, DC: APA Press, 1994.

[6] National eating disorders screening program: National mental illness screening project, 1999. http://www.nmisp.org/eat/eat-fact.htm.

[7] *Mayo Clinic proceedings.* Medscape Wire, October 14, 1999.

[8] Office on Women's Health. Information sheet: Eating disorders, 1999.

[9] Ibid.

[10] Ibid.

[11] Ibid.

[12] Rome E.S., Ammerman S., Rosen D.S., et al. Children and Adolescents with Eating Disorders: The State of the Art. *Pediatrics.* 2003 Jan;111(1):e98-108.

[13] Ibid. and Eating disorders in adolescents: A position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health* 1995, vol 16, pp. 478-480.

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[15] Pennsylvania Educational Network for Eating Disorders. (Spring 1999). *Food for thought*, spring 1999, vol. 15, no. 1; Something Fishy Web site on Eating Disorders, Tips for doctors, 1999, http://www.something-fishy.org/drtips. htm; and Muscari ME. Walking a thin line: Managing care for adolescents with anorexia and bulimia. *The American Journal of Maternal/Child Nursing*, vol. 23, no. 3, May/June 1998, pp. 130-141.

[16] Rome E.S., Ammerman S., Rosen D.S., et al. Children and Adolescents with Eating Disorders: The State of the Art. *Pediatrics.* 2003 Jan;111(1):e98-108.